Features

Exploring the Medical Home in Ryan White HIV Care Settings: A Pilot Study

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Amid increased attention to the cost of health care, health information technology, and specialization and fragmentation in medicine, the medical home has achieved recognition as a model for more effective and efficient health care. Little data are available on recently funded HIV medical home demonstration projects, and no research richly describes existing medical home characteristics, implementation challenges, and impact on outcomes in longstanding HIV outpatient settings. The Ryan White HIV/AIDS Program (RWP) provides federal funding for primary and specialty care for people living with HIV. Although RWP clinics developed independently of the medical home model, existing data indirectly support that, with emphasis on primary, comprehensive, and patient-centered care, RWP clinics operate as medical homes. This study explores the development, definition, and implementation of medical home characteristics by RWP-funded providers in order to better understand how it fits with broader debates about medical homes and health care reform.

(Journal of the Association of Nurses in AIDS Care, 25, *191-202*) *Copyright © 2014 Association of Nurses in AIDS Care*

Key words: *HIV, medical care, medical home, Ryan White*

Introduction

Amid increased attention to the rising cost of health care, health information technology, and specialization and fragmentation in medicine, the medical home has achieved national recognition as a viable model for advancing care quality, improving outcomes, and reducing costs, while providing treatment for patients with chronic diseases. The medical home, including its development within the Ryan White HIV/AIDS Program (RWP), was identified by the Obama Administration as a crucial component of the National HIV/AIDS Strategy (White House Office of National AIDS Policy, 2010). In the past few years several HIV medical home demonstration projects have been funded and are in the implementation phase, but little data are yet available. To date, there has been scant research with rich descriptions of medical home characteristics, implementation challenges, and impact on outcomes in RWP outpatient settings with a long history of providing care. Despite this, the RWP community has been charged

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Financial support for this study was received from a Developmental Core Micro Grant from the Center for AIDS Research at Emory University (P30 AI05409).

http://dx.doi.org/10.1016/j.jana.2013.10.007
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with sharing medical home model experiences with community health centers and private physicians providing HIV care. Our study explores the development, definition, and implementation of medical home concepts and characteristics by RWP-funded providers to better understand how the experiences of RWP providers fit within broader debates about and institutionalization of the medical home.

The American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association (2007) outlined patient-centered medical home principles as "coordination of care to enhance the patient physician relations, focus on quality and safety, enhanced access to care, a payment structure that recognizes the value of and pays physicians appropriately for coordinated services and care management" (p. 86). These principles have since been adopted by the delegates of the American Medical Association (Bein, 2009). Over the past 2 decades, patient-centered medical homes (*medical homes*) have been described as providing holistic, continuous, comprehensive, and coordinated services with a focus on patient–provider relationships and patient engagement (Kilo & Wasson, 2010).

There has been speculation that the adoption of medical home principles will lead to improved health outcomes because identification with a personal physician would facilitate more effective and equitable care (Starfield & Shi, 2004) and because the fundamental objective of the medical home is to improve individual- and population-level health outcomes (Gottlieb, 2009). There is increasing evidence of reduced morbidity and mortality in medical homes. For example, the Patient-Centered Primary Care Collaborative reported on 14 prospective medical home evaluations and consistently found that clinics experienced reductions in both costs and emergency room hospitalizations (Grumbach, Bodenheimer, & Grundy, 2010). Eight of these 14 evaluations compared control groups to medical homes and found the latter to reduce morbidity, as measured directly or by hospitalization rates; two of those medical homes reported a reduction in mortality. Medical home interventions were also found to lower staff burnout, reduce appointment waiting times, increase screenings, and improve patient satisfaction. Health plans and state Medicaid programs are also implementing medical homes, with promising cost-savings and returns on investment for infrastructure development, but challenges remain (Rosenberg, Peele, Keyser, McAnallen, & Holder, 2012).

While these results are encouraging, implementation challenges remain. Moreover, no research exists evidencing the association between medical homes, improved health outcomes, and linkages to health disparities. Despite this, there has been a push to establish the operational and financial feasibility of medical homes, both through demonstration projects and through the National Committee for Quality Assurance certification process (Nutting et al., 2009). Health disparities are particularly problematic with HIV and are exacerbated by the fact that Black Americans are overrepresented in people living with HIV (PLWH) and in estimated deaths (Fullilove, 2006). RWP clinics are specifically funded to address health disparities, making them uniquely positioned to impart experience based on more than 20 years of providing care. Most recently, the HIV Medical Home Resource Center, funded by the Health Resource and Service Administration's HIV/AIDS Bureau, is providing training and technical assistance for RWP-funded clinics to become certified medical homes. The HIV Medical Home Resource Center works closely with the AIDS Education and Training Centers, a national network of clinical experts offering training and technical assistance for those providing or seeking to integrate HIV care into their practices.

The Ryan White Model of Care

Initiated in 1990, the RWP allocated federal funding to facilities to provide support services and primary and specialty care for PLWH with insufficient health care coverage and access to HIV medications. The availability of combination antiretroviral treatment in the United States has significantly increased the life expectancy of PLWH (HIV-CAUSAL Collaboration, 2010), effectively transforming HIV into a chronic disease that requires both specialty and primary care expertise. As with other chronic diseases, the management of HIV requires months and years of therapeutic interventions, including comprehensive medical and social services to ensure adherence to HIV treatment and access to care.

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