

America's Voice for Community Health Care

The National Association of Community Health Centers (NACHC) represents Community and Migrant Health Centers, as well as Health Care for the Homeless and Public Housing Primary Care Programs and other community-based health centers.

Founded in 1971, NACHC is a nonprofit advocacy organization providing education, training and technical assistance to health centers in support of their mission to provide quality health care to medically underserved populations.



NATIONAL ASSOCIATION OF
Community Health Centers

America's Voice for Community Health Care

The NACHC Mission

To promote the provision of high quality, comprehensive and affordable health care that is coordinated, culturally and linguistically competent, and community directed for all medically underserved people.



Patient Centered Medical Home and Meaningful Use

**Kathy McNamara
Asst. Director Clinical Affairs
NACHC**

**NASTAD Annual Meeting
May 23, 2011**

Patient Protection and Affordable Care Act

- Access to Care
- Quality of Care
- Cost/Value



Challenges for Health Care Reform

- Access to Care
- Cost of Care
- Quality of Care
- Workforce
- Health Results = Health Outcomes

- **Prevention and Public Health Fund**

- \$15 billion over 10 years : permanent authorization at \$2 billion a year

Uses of the Fund

- community prevention
- building the infrastructure
- improving the evidence base
- public health workforce development

- **Medical Home Demonstration**—\$40 million to support creation of patient-centered medical homes
- **Health Professions**-Health care workforce shortages are likely to increase... An additional \$170 million to expand health-training programs
- **Rural Physician** –\$5.1 million for a newly authorized program to create opportunities for primary care physicians to train in rural areas.

- **National Prevention, Health Promotion and Public Health Council**
 - Chaired by Surgeon General
 - HHS, USDA, ED, FTC, DOT, DOL, DHS, EPA, ONDCP, DPC, Asst. Secretary for Indian Affairs, VA, DOD
- **National HIV/AIDS Strategy** *July 2010*
- **National Quality Strategy** *March 10, 2011*
- **National Prevention and Health Promotion Strategy**
due March 23, 2011



Community Health Centers 2011

Environment

- **Patient Protection and Affordable Care Act**
- **Integration Models** (*BH, HIV, Oral Health*)
- **Medical Home**
 - Demonstrations
 - Legislation
 - Certification
 - Accountable Care Organizations
- **Meaningful Use**
- **Federal focus on**
 - National Prevention and Health Promotion Strategy
 - National HIV/AIDS Strategy
 - National Quality Strategy

The *National HIV/AIDS Strategy* confirms and recommends the implementation of medical homes for people living with HIV.

I. Access and Continuity

- Access during and **after office hours**
- Electronic access
- **Continuity**
- **Patient/ Family Partnership**
- **Cultural/linguistic appropriate services**
- Practice organization (team based care)

II. Identify/manage patient populations

- Electronic basic and clinical searchable data
- **Comprehensive health assessment**
- Use data for population management

III. Plan and manage care

- Guidelines for important conditions
- Care management
- Medication management
- Electronic prescribing

IV. Self management support

- Self care process
- Self-care plan & monitoring tools

V. Track and Coordinate Care

- Test & referral tracking/follow-up
- Care transitions
- **Referrals to community resources**

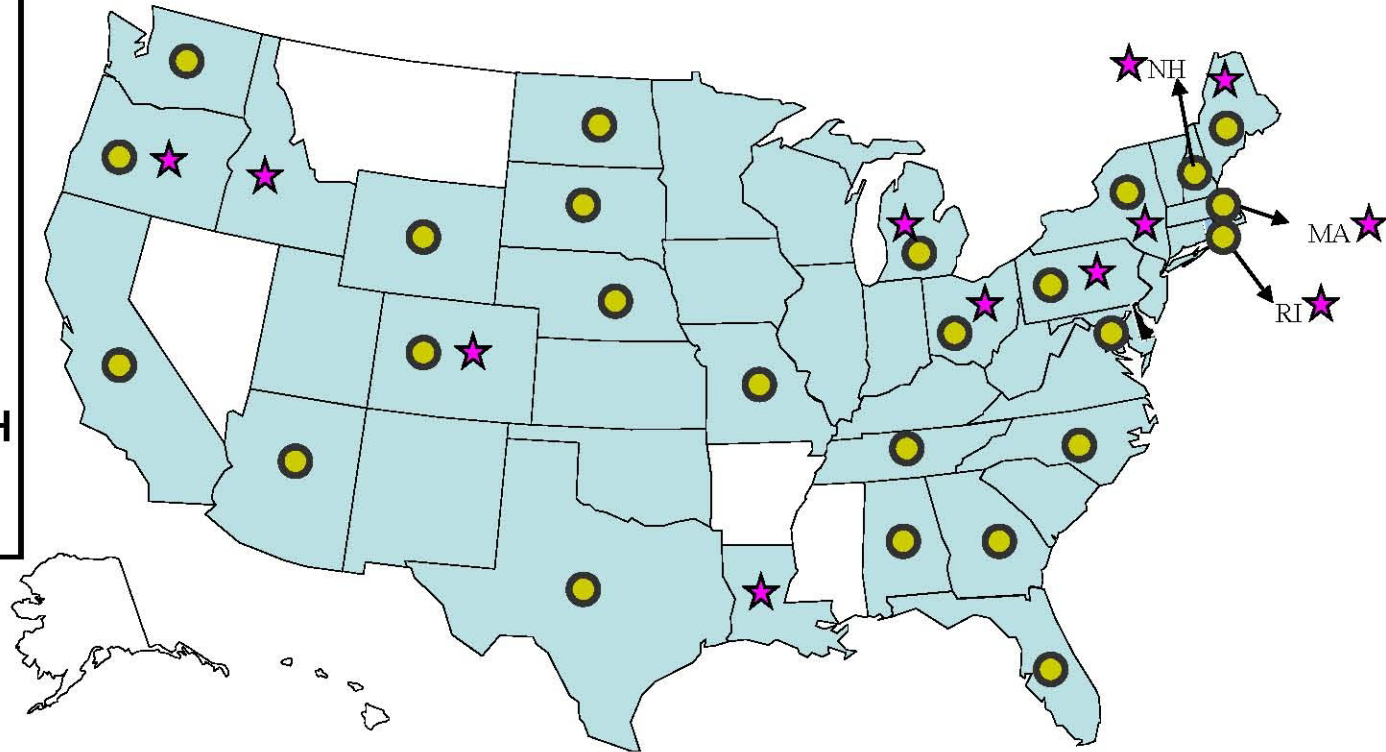
VI. Performance Measurement & QI

- Performance measurement
 - Prevention, chronic disease, overuse, utilization measures
 - **Stratified for vulnerable pops.**
- Patient/Family feedback
- Quality improvement
 - **Patient/family involvement in QI**
 - **Improvement in health disparities**
- Electronic reporting of performance measures
 - To consumers health plans public

Overview of Medical Home Demonstrations, Multi-Payer Activity and Evaluations

3 Federal Demos:

1. Medicare Medical Home
2. Advanced Primary Care Pilot with state Medicaid programs
3. Medicare FQHC MH pilot program



- ★ Independent evaluations
- Multi-Payer pilot discussions/activity
- Identified pilot activity
- No identified pilot activity – 6 States

What Does This Mean?

Provider Home

(Access to Care + Quality of Care)



Electronic Home

(Meaningful Use, Health Information Exchanges, Insurance exchanges)

Patient Centered Medical Home

American Recovery and Reinvestment Act, P.L. 111-5

- Title XIII : Health Information Technology for Economic and Clinical Health
 - Changes to HIPAA Privacy and Security Rules
 - Add Breach Notification Rule to HIPAA
 - EHR Incentive Program and Meaningful Use
 - Workforce development grants for educational institutions
 - Regional Extension Centers



Nationwide Health Information Network

“The nationwide health information network is a set of standards, services and policies that enable secure health information exchange over the Internet. The network will provide a foundation for the exchange of health information across diverse entities, within communities and across the country, helping to achieve the goals of the HITECH Act. This critical part of the national health IT agenda will enable health information to follow the consumer, be available for clinical decision making, and support appropriate use of healthcare information beyond direct patient care so as to improve population health.”

- ONC website, National Health Information Network,
www.healthit.hhs.gov



Medicare and Medicaid EHR Incentive Programs

- CMS Medicare and Medicaid EHR Incentive Programs
Final Rule
 - Published July 28, 2010
- ONC Health Information Technology: Initial Set of
Standards, Implementation Specifications, and
Certification Criteria for Electronic Health Record
Technology
 - Published July 28, 2010



Meaningful Use Policy Priorities

- Improve quality, safety, efficiency, and to reduce health disparities
- Engage patients and families in care
- Improve care coordination
- Ensure adequate privacy and security protections for personal health information
- Improve population and public health

Meaningful Use: HIV Measures

March 2011

HIV/AIDS			
Care Coordination			
NQF Measure #	Measure Title	Measure Steward	eMeasure
407	Viral Load: HIV/AIDS-HIVRNA control after 6 months of potent Antiretroviral Therapy	NCQA	No (eligible for retooling)
403	Medical Visits	NCQA	No (eligible for retooling)
406	HAART for Patients with AIDS	NCQA	No (eligible for retooling)
405	PCP Prophylaxis	NCQA	No (eligible for retooling)

Patient Centered Medical Home Implementation: NACHC Strategy

Population Health

Reducing HIV-related disparities



Workforce

Engagement

Patient and community

Based upon IHI 'Triple Aim'

Value

Improve quality; reduce cost

Training and Capacity Building

Building the Foundation

- Evidence based HIV care
- Leadership role in HIV care and systems
- Improvement Strategy for HIV care
- Stakeholder partnerships for continuity of HIV care
- Understanding of health center HIV population
- Implementing Meaningful Use measures
- Empanelment

Designing the HIV PCMH system

- Team Based HIV Care
- Patient Centered Care
- Work flow
- Maximizing Revenue for HIV services
- Staff vitality
- Data for Decision Making: HIV and Meaningful Use & HIT

Integrating with external systems

- Partnerships
- Care management
- Care coordination
- Managing the health and costs

HIV clinical curriculum + System Redesign

Leading the Change

- Aligning the leadership and business strategies in support of practice transformation; maximizing leadership talent, culture and strategy in support of boundary spanning.

“Lean” Toward Excellence, Part I

- Defining and measuring “value” from a customer’s point of view.
- Strategic considerations for examining interconnected processes (problem solving, information management, and patient flow) and reducing waste.

Designing and Building Strategic Partners

- Community and State partnerships
- Part A, B, C, D and health centers

Measuring Impact

- Define Learning Community metrics and dashboard.

Redefining Roles and Building Integrated Care Teams

- Building integrated care teams and integrating behavioral and mental health. Address the concept of ‘joy in work’.

“Lean Toward Excellence, Part II

- Rethinking work flow to maximize value;
- Striving for organizational transparency and pursuit of excellence

Continuity through Empanelment

- Fundamentals of empanelment including implications for leadership

Increasing Access

- Outline step-by-step approaches to improving access

Managing Revenue

- Revenue cycle management. To include a focus on optimized coding and billing, particularly around HIV care and services.

COMPREHENSIVE, COORDINATED, & INTEGRATED CARE

Definition: A comprehensive, coordinated, continuous, and whole person plan of care for a particular patient, progressing without interruption; includes referrals, test results, and record transfer. Services are well integrated with other health care and community resources.

Concepts: Care planning and management; continuous care; comprehensive and whole person (physical, mental and social) care; continuity of care, with referral and test tracking; coordination of care with other providers, and including coordinated information flow); enhanced communication with providers, patients, families, and the community; strong community linkages.

METRIC	GOAL
Primary Care	
Congestive heart failure (CHF) medication follow-up	100% of CHF patients on diuretics or digoxin have follow-up lab tests performed per guidelines.
Referral follow-up	100% of referrals made by a referral nurse are tracked for patient follow-through.
HIV	
Dental referrals	100% of HIV patients have a dental referral annually.
Retention in care	100% of HIV patients are seen at least twice annually, with visits at least 60 days apart.
Behavioral Health	
Duration of treatment	For 80% of BHC patients, duration of treatment should be 8-12 weeks.
Outpatient follow-up	100% of BHC patients discharged from in-patient care receive at least one follow-up outpatient visit with a BH provider within 30 days of discharge.
Meaningful Use—Level 1	
Patient reminders	Reminders are sent to at least 20% of patients 65 and over or 5 years and younger.
Transition of care summary	Provide summary of care record for at least 50% of transitions of care and referrals.

Metric Pak: HIV

METRIC	GOAL
Access & Cycle Time	
Easy access to Case Manager	100% of HIV patients report success in seeing desired Case Manager on preferred day.
Rapid HIV testing	Rapid HIV tests are provided and results are reported during the same visit to 100% of patients.
Comprehensive, Coordinated & Integrated Care	
Dental referrals	100% of HIV patients have a dental referral annually.
Retention in care	100% of HIV patients are seen at least twice annually, with visits at least 60 days apart.
Clinical Quality & Safety	
Viral load or CD4 count	Viral load / CD4 count measured at least twice annually on 100% of HIV patients.
Maximum viral control	100% of HIV patients achieve maximal viral control at least six months post-antiretroviral therapy (ART) initiation.
Prevention & Health Promotion	
Risk counseling	When applicable per guidelines, CHC patients receive risk counseling.
TB screening	100% of HIV patients have an annual PPD screen.
Patient & Community Relationships	
Case Management referrals	HIV patients report that their Case Managers assist them in obtaining services not provided at their clinic/program.
Designated personal provider	HIV patients report that they are always able to see their designated provider or team member when needed.



NASTAD – NACHC Partnership

- Webinar series:
 - Fundamentals on coding, billing and reimbursement for HIV testing, care and treatment
 - PCMH and partnerships

- Defining a new role?
- Public and Private sector alignment
- Workforce development
- Know your state and get engaged
 - National Strategies implementation
 - Medical Home, Meaningful Use
 - Training and capacity building

Thank You!

Kathy McNamara

Asst. Director of Clinical Affairs

NACHC

(301) 347-0400

Kmcnamara@NACHC.com