Community Health Centers: Health Care Homes

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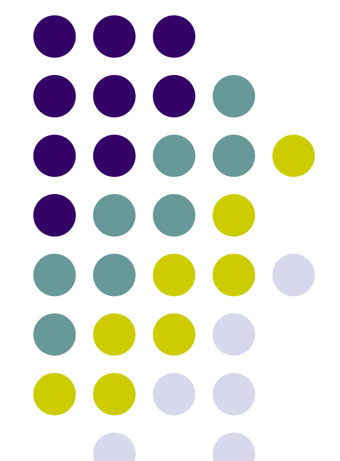
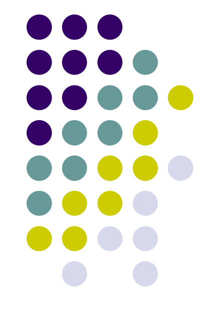


CHC Patients



- 18 million **people** at over 7000 sites
- 1 in 8 **Medicaid** beneficiaries
- 1 in 7 **uninsured** persons, including 1 in 5 **low income** uninsured
- 1 in 3 people in **poverty**
- 1 in 4 **low income, minorities**
- 1 in 9 **rural** Americans

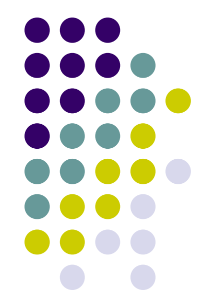
CHC Program Requirements

- **Primary care**
- **After Hours availability**
- **Hospitalization coverage**
- **Case management services**
- **Diagnostic laboratory and radiologic services**
- **Referrals to other providers**
- **Formalized Quality Improvement Program**
- Preventive services including prenatal care
- Cancer and other disease screening
- Well child services

CHC Program Requirements, Cont

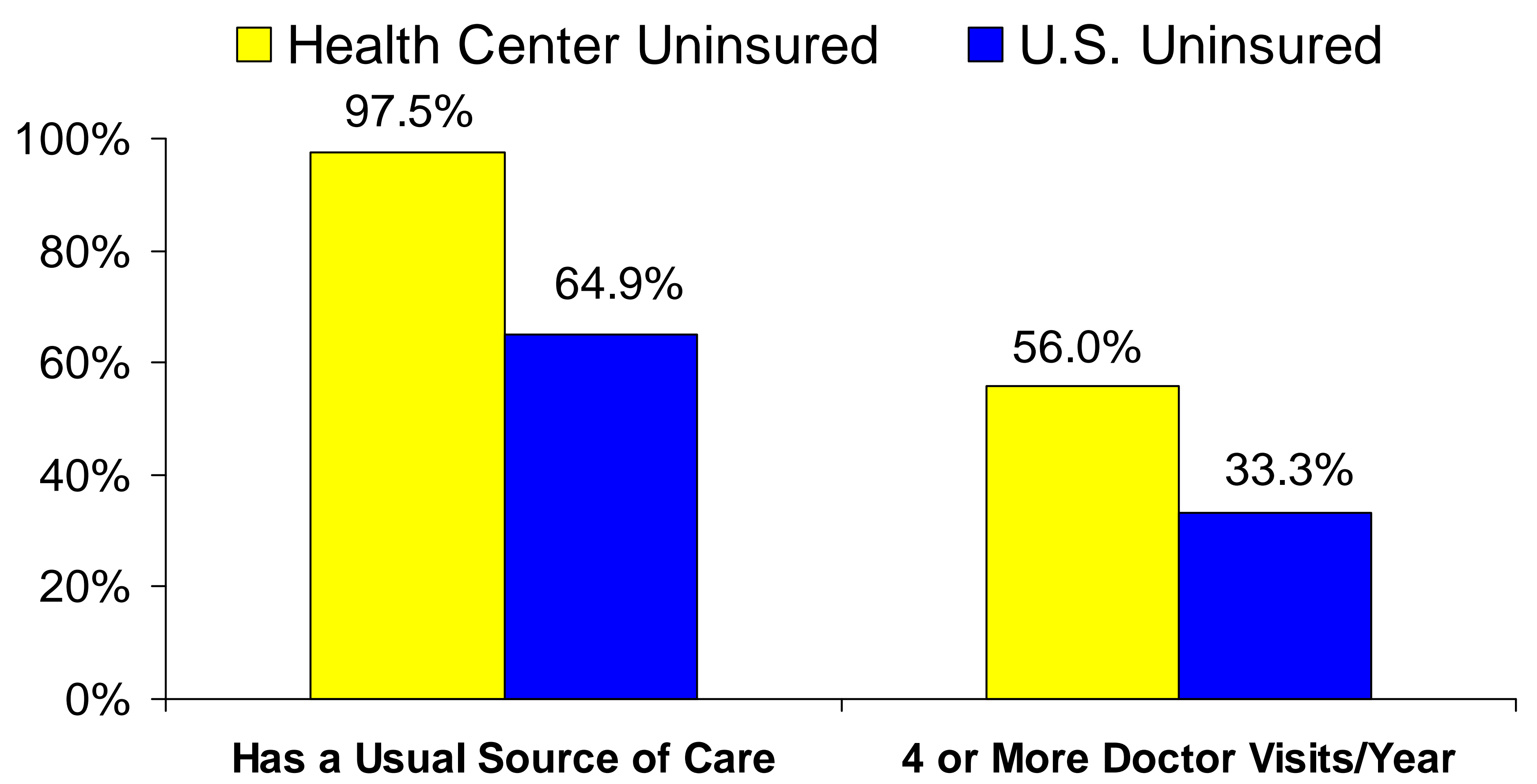
- Family planning services
- Community Needs Assessment
- Preventive and emergency dental services
- Pharmaceutical services as appropriate to a particular health center
- Community Governance

CHC Program Requirements, Cont



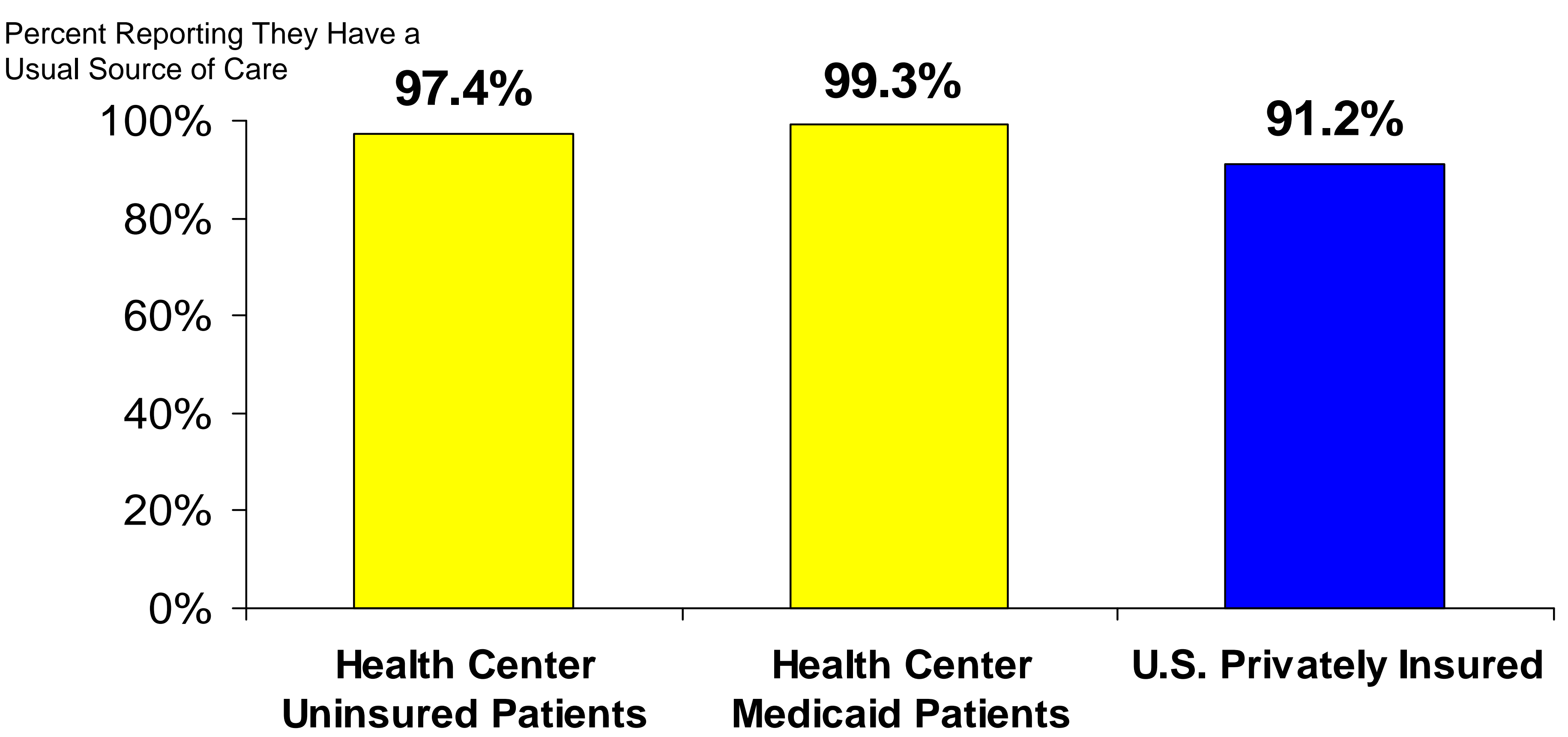
- Services to assist the health center's patients gain financial support for health and social services
- Enabling Services
  - Outreach
  - Transportation
  - Interpretive services
- Education of patients and the community regarding the availability and appropriate use of health services

Health Center Uninsured Patients Receive More Care than the Uninsured Nationally



Source: Leiyu Shi, "The Role Of Health Centers In Improving Health Care Access, Quality, And Outcome For The Nation's Uninsured." Testimony At Energy and Commerce Committee, Subcommittee on Oversight and Investigations Congressional Hearing "A Review Of Community Health Centers: Issues And Opportunities." Washington, DC. May 25, 2005. Based on Community Health Center User Survey, 2002, Preliminary Tables August 2004; and National Health Interview Survey, 2002.

Health Center Uninsured and Medicaid Patients are More Likely to Have a Usual Source of Care than the U.S. Privately Insured



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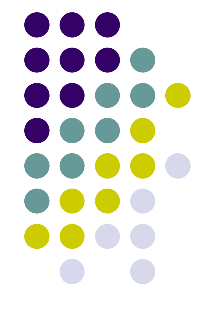
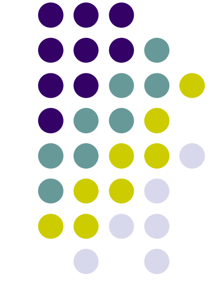
Hudson River HealthCare



- 14 practice sites in 6 counties of NY
- 60 primary medical care providers
- 190,000 visits/year
- Urban, migrant, homeless, public housing, and Ryan White funding
- JCAHO 1998, 2001, 2004, 2007

HRHCare Sites
New Paltz
Walden
Monticello
Goshen
Haverstraw
Pine Plains
Amenia
Poughkeepsie (2)
Dover Plains
Beacon
Peekskill (2)
Greenport
Riverhead
Health Center
Migrant Health
Migrant Voucher program
Public Housing

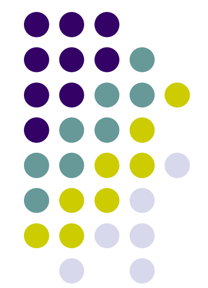
HRSA Quality Collaboratives



- Transforming Health Center practice from episodic to continuous care
- Based on Wagner Care Model
  - Clinical Information Systems
  - Self Management Support
  - Decision Support for Evidence-based Practice
  - Delivery System Redesign
- Nearly all Health Centers trained and involved
- Common reporting on clinical measures
- Currently over 400,000 patients in registries

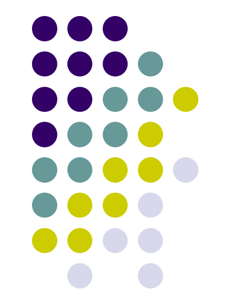
Hudson River HealthCare's Quality Journey

- 1993-1999 Childhood Immunization-HRSA
- 1998 Improving Efficiency and Access-IHI
- 2000-2007 Diabetes-HRSA
- 2002 HIV
- 2004-5 Prevention Pilot
- 2005 Patient Visit Redesign
- 2005 Planned Care Innovation Community
- 2006 Harvesting Meeting



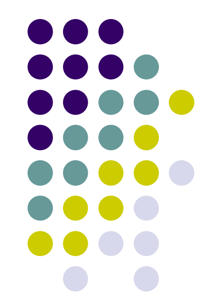
Common Themes of the Projects

- Integrated Clinical Practice Teams
- Consistent support staff with defined roles
- Work centered around the patient: on site testing
- Planning of visits-chart review in advance
- Standing orders for nurses
- Rooms and equipment stocked and ready
- Use of information systems to track patients and analyze performance



Quality Lessons Learned

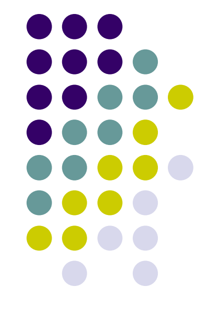
- System change should precede technology introduction
- Relentless Board and Senior Leadership essential
- Quality management **IS** management-not a separate function
- National expertise in change and leadership (IHI,HRSA) adds value



NCQA
Physician Practice Connections

- HRHCare application in 2006
- Assistance from local IPA
- Fees paid for by IPA
- Notified of recognition in 2007

NCQA Medical Home Content

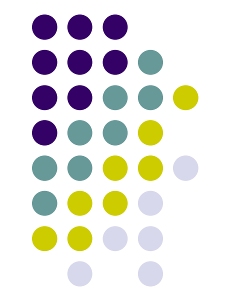


1. Access and Communication
2. Patient Tracking and Registry Functions
3. Care Management
4. Patient Self-Management Support
5. Electronic Prescribing
6. Test Tracking
7. Referral Tracking
8. Performance Reporting and Improvement
9. Advanced Electronic Communications

PCMH Standard: Access and Communication

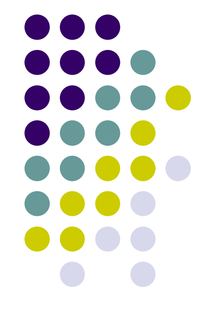
15
10
5
0
Days
2004
2005
2006
2007
2008
Time to 3rd Open Appointment

PCMH Standard: Patient Tracking and Registry Use

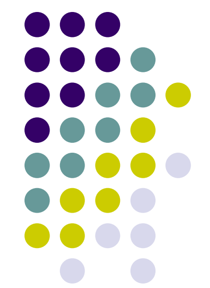


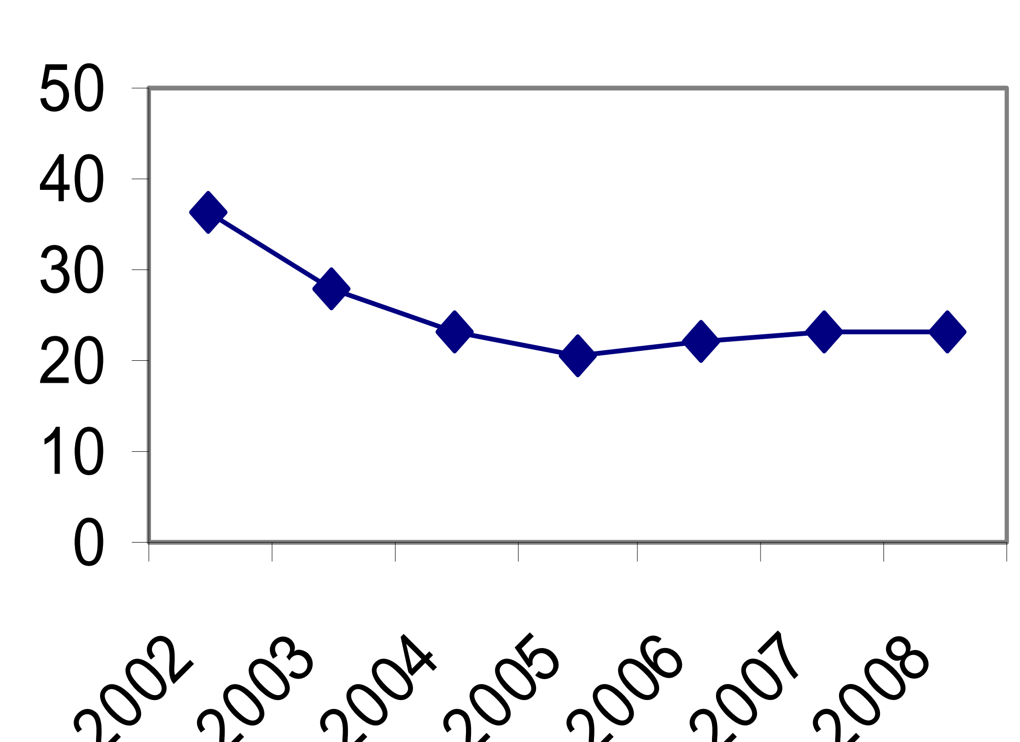
- Registry Use
  - Identified 3 conditions: Diabetes, HIV, Hypertension
  - 7 year history of use
- EMR
  - EMR use 100% at 4 sites; 100% by 2008
  - EMR functions and interfaces
  - Prescribing and decision support

PCMH Standards: Care Management



- Care of Chronic Conditions
  - Use of practice guidelines
  - Patient Care Partners for case management, tracking, and prescription assistance
- Coordination of Care
  - Community Care Partners stationed in local ERs: NY State Patient Safety Award 2006
- Care of a High Risk Condition: HIV
  - Counseling and adherence support





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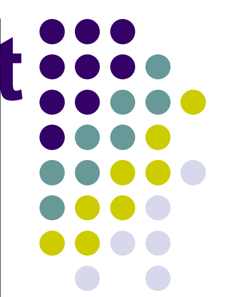
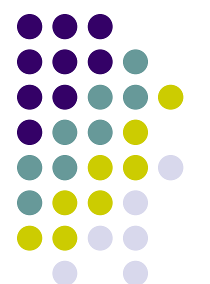
PCMH Standards: Self Management Support and Performance Improvement



- Educational Resources
  - Assessment of language and learning needs
    - JCAHO requirement
  - Availability of multilingual resources
- Performance Improvement
  - Data produced monthly by provider and site
    - Diabetes
    - Immunizations
    - Access
    - Patient Satisfaction

NCQA Survey Results

- Awarded 6 of 9 modules
- All sites and providers listed on NCQA website
- Certificate for each practice
- 3 year recognition



NCQA PPC-PCMH Projection

- We estimated a score of 60-65 (Level 2) for our practices using a registry, and 80-85 with full EMR (Level 3)
- **Health Centers should achieve Level 1 if they are in compliance with HRSA Program Expectations**
- Health Centers participating in Health Disparities Collaboratives using registries should be able to achieve Level 2

CHC Challenges

- Appointment access: supply and demand
- Access to specialists and diagnostics
- Patient perception of off hours availability
- Community coverage challenges
- Mobile and undocumented populations
- Access to capital for IT and facility needs

Beyond the Medical Home: Expanding the Definition

- Building community trust

  -diversity of staff, identification of community needs, patient support from community organizations, community advisory boards, community involvement, outreach
- Access: continuity regardless of insurance status
- Assistance with access to pharmaceuticals
- Comprehensiveness of services onsite
- Recognition of poverty level of population