THE AFFORDABLE CARE ACT, MEDICAL HOMES AND CHILDHOOD ASTHMA

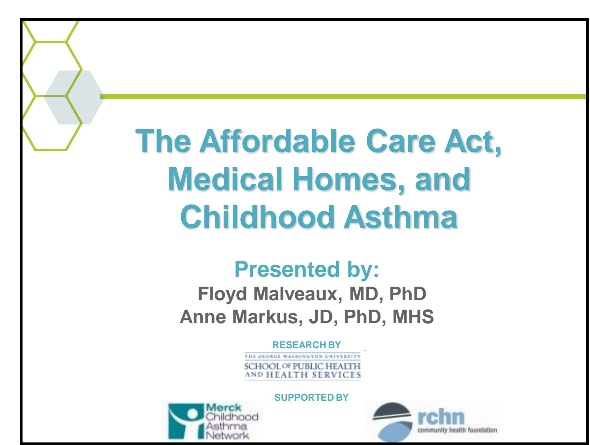
DECEMBER 2, 2010

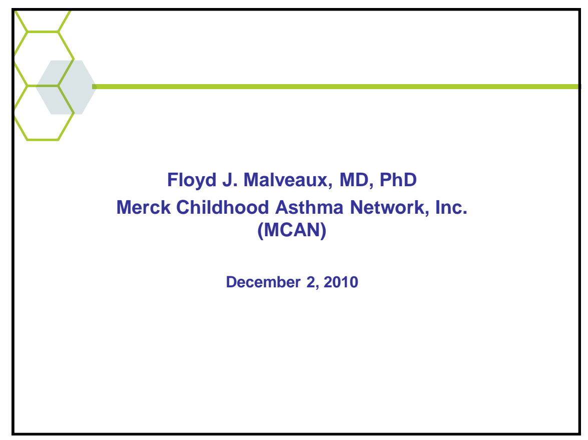
Introductions:

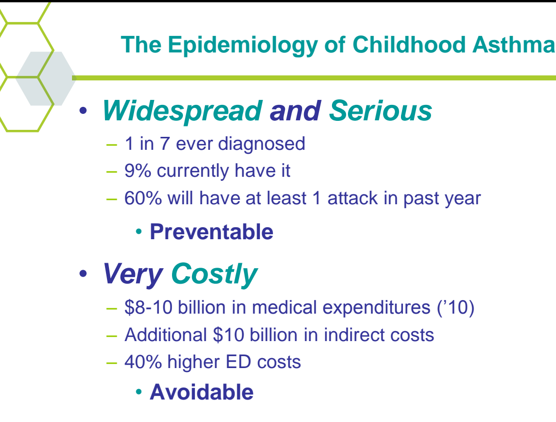
Welcome and Introduction to the RCHN Community Health Foundation Webcast Series:

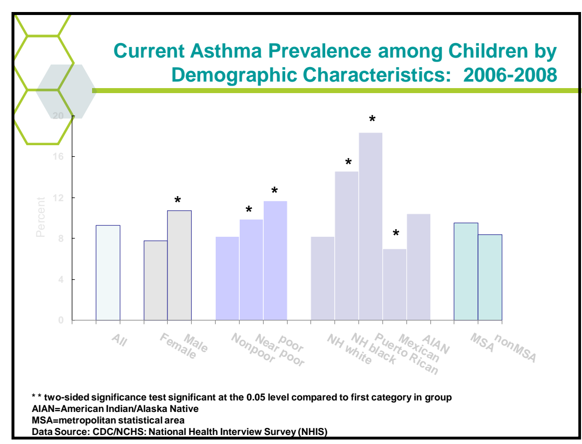
- ***Feygele Jacobs, MPH, MS***

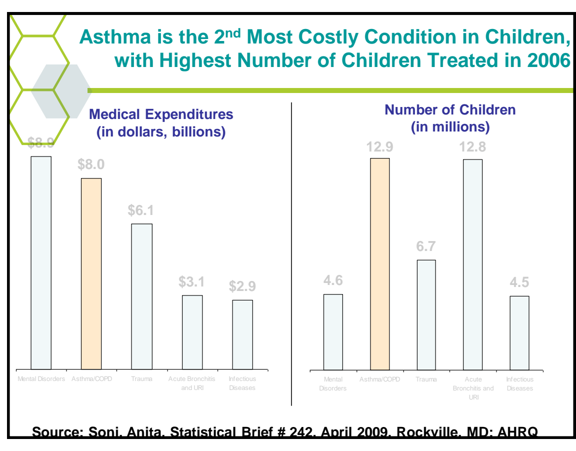
EVP/Chief Operating Officer
RCHN Community Health Foundation

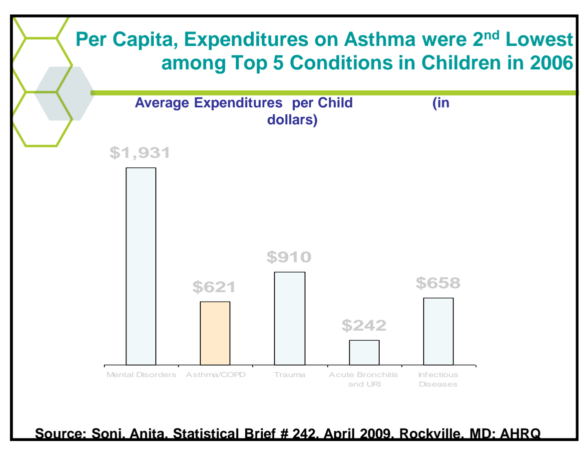












Asthma Disparities in Children

- **Poverty is a significant predictor of asthma and disparate outcomes: children from low income families account for app. 37% of all U.S. children, but represent app. 58% with asthma.**
- **Minority children with asthma have disproportionately high school absenteeism, ER visit, and hospitalization rates.**
- **Community Health Centers represent a critical point of entrance to health care: A medical/health care home for 6 million high risk children (1 in 4 low income children nationally)**
- **Up to 20% of children with a CHC-based health/medical home have asthma**

What is a Medical/Health Home?

"*The Medical Home* is the model for 21st century primary care, with the goal of addressing and integrating high quality health promotion, acute care and chronic condition management in a planned, coordinated and family-centered manner."

-*American Academy of Pediatrics*

Medical/Health Home

- Team approach with PCP in the lead
- Patient/Family centered— respectful, quality care
- MH Staff— participate in asthma environmental trigger education, spirometry, flu shots, etc.
- Specialists—support for difficult cases, education
- Schools—asthma education, symptom recognition, and appropriate care when needed
- Insurers— adequate reimbursement for services and outcomes. surveillance for med use,
- Community Providers—Care coordination educators/managers, social workers, environmental counselors

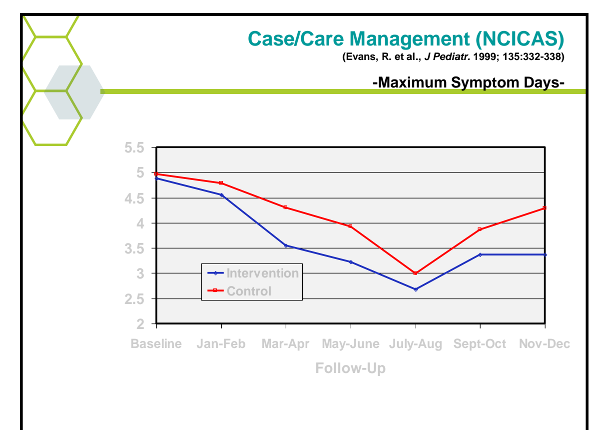
Resources/Care Coordination Services

- Care Coordination services for referrals, visit planning, equipment, collaboration with other providers – may serve as the link between patient/family and school and/or CHC
- Centralized data base (paper or electronic) of local resources
- Family Support Networks for Parent-to-Parent support
  - Community asthma educational supports
  - Smoking cessation programs for patient, family
  - School nurse links for acute care
  - Referral assistance; information exchange with other providers
  - Specialty providers for allergy, pulmonology evaluations
  - Local suppliers for environmental controls, spacers, nebulizers, oximeters

Case/Care Management (NCICAS)

(Evans, R. et al., *J Pediatr.* 1999; 135:332-338)

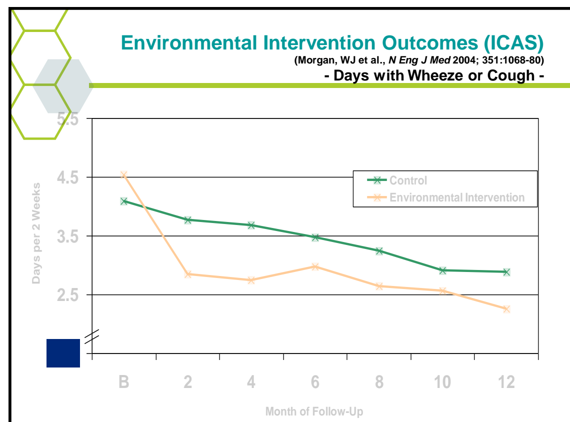
-Maximum Symptom Days-



Environmental Intervention Outcomes (ICAS)

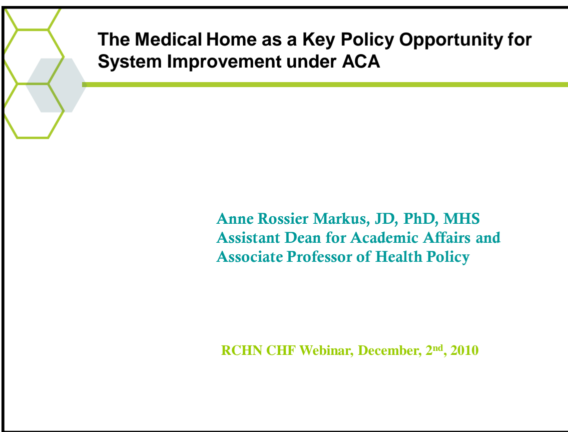
(Morgan, WJ et al., *N Eng J Med* 2004; 351:1068-80)

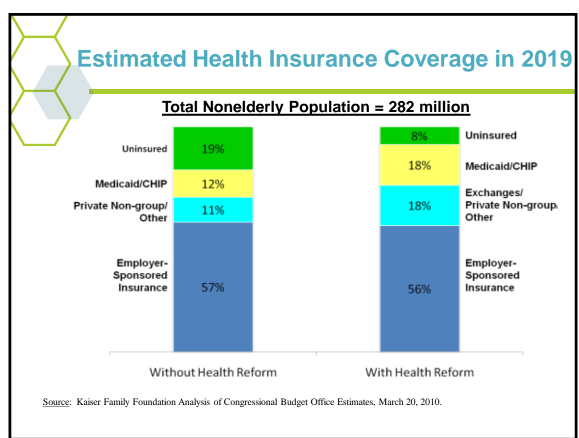
- Days with Wheeze or Cough -



Care Coordinators Aid in Co-management with PCP/Specialists

- Care coordinators as bridges to education, service, and environmental (especially home) management
- Assist in sending referral data sent and follow-up visits
- Coordinate access to specialist records (letter, fax-back, electronic)
- Phone/email dialogue concerning health/care status
- Assist in specialty follow-up at PCP office (hospital/ED follow-up, labs, etc)
- Synthesis of thought from multiple specialists
- Should be recognized members of the health care team!





Concept of Medical Home

- Started with AAP/pediatrics, now also seen as a way of improving primary care for all patients
  - Patients: Particularly useful for managing medically complex needs
  - Providers: Improvement of clinical and non-clinical management and recognition for reimbursement
  - Payers: Cross-payer, i.e. public and private, model, with expected improvement in outcomes and cost-savings

Statutory Definition of Medical Home

"a mode of care that includes (A) personal physicians; (B) whole person orientation; (C) coordinated and integrated care; (D) safe and high-quality care through evidence informed medicine, appropriate use of health information technology, and continuous quality improvements; (E) expanded access to care; and (F) payment that recognizes added value from additional components of patient-centered care."

PPACA §3502 (c) (2)

Testing Innovative Payment/Delivery Models

- CMS to award pilot funding in Medicare/Medicaid of Accountable Care Organizations (ACOs), bundled payment & shared savings arrangements, will possibly focus on high cost conditions like asthma to demonstrate performance
- CMI to test innovative payment and service delivery models to reduce expenditures and enhance quality, including a patient-centered medical home model, with asthma explicitly listed

Paying for Innovative Models

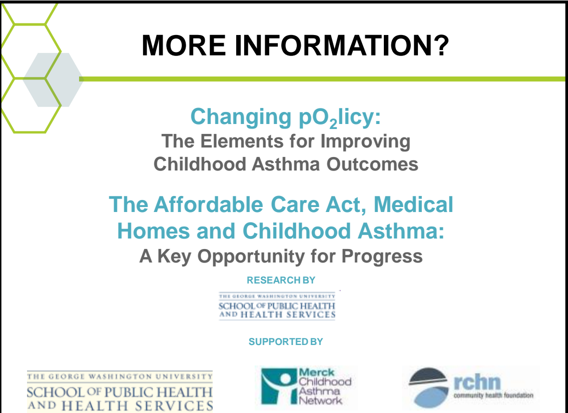
- State Medicaid option to permit individuals with one or more chronic conditions-asthma specifically listed-to select a health home (e.g., CHC, health team) responsible for comprehensive care management, care coordination and health promotion, and use of HIT to link services as feasible and appropriate
  - Planning grants in 1.2011, with enhanced FMAP of 90% for first 8 quarters of state participation
  - Increased funding of $11 billion for FY 2011-15 for CHCs, which already are or can become health homes and increase access to primary care in medically underserved communities
  - CHWs as part of the health team managing chronic diseases
- HHS to develop a national quality measure capturing use of medical homes by private insurers, which can be tied to performance incentives

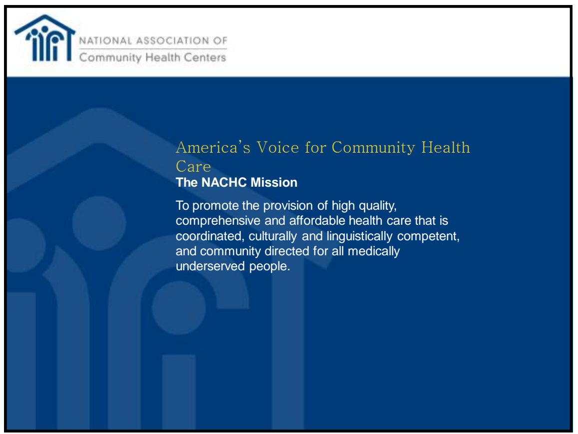
Recommendations for Implementation of Medical Homes for Children with Asthma

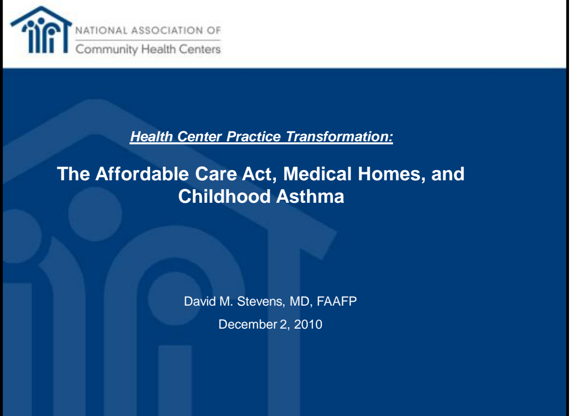
- Updated guidance by CMS to Medicaid programs on improving the quality of care for children with asthma, can be tied to CHIPRA (publicly-insured)
- Adoption of medical homes by private insurers tied to national quality measurement, includes future medical home measure (privately-insured in group or HIE products)
- Development of all-payer performance measures in pediatric asthma to track overall system performance
- Objectives/indicators of meaningful use of EHRs by providers published by ONC broad enough to include pediatric care, including asthma care
- Incorporation of the measures on pediatric asthma into health home/medical home performance assessment (e.g., health centers), linked to performance incentives by private and public insurers

Bridging the Two Key Areas of Reform

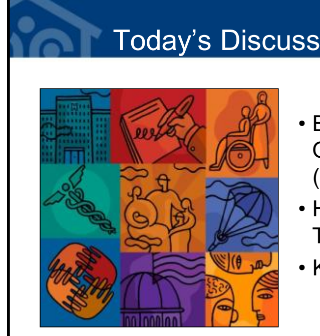
- Health Insurance & Clinical Care
  - Insurance Reforms
  - Coverage Expansions, EHBs, and Reimbursement
  - National Quality Improvement Strategy
- **Innovative Delivery and Payment**
- Public Health
  - Prevention Trust Fund
  - Community Transformation Grants
  - CHWs as part of the health team







Today's Discussion…



- Background: Federally Qualified Health Centers (FQHCs)
- Health Center Practice Transformation
- Key Issues

Overview of Health Centers

- **Five Essential Elements**
  1. Located in *high-need areas*
  2. Provide *comprehensive* health and related services (especially "enabling services" such as translation, transportation & case management)
  3. *Open to all* residents, regardless of ability to pay, with sliding scale fee charges based on income
  4. Governed by *community boards*, to assure responsiveness to local needs
  5. *Follow performance and accountability requirements* regarding their administrative, clinical, and financial operations

Health Center Program CY 2008

- 18.8 million patients
  - 92% at or below poverty level
  - 38% uninsured
  - 63% racial/ethnic minorities
  - 1,131 grantees: half rural with 7,900 service sites
- 2011 HRSA Strategic Priorities
  - Improve Access to Quality Health Care & Services
    - New communities, site development & expansion
    - Health home development & meaningful use implementation
  - Strengthen the Workforce
  - Build healthy communities & Improve health equity

What We Want To Accomplish: The21st Century Health Center

Population Health
- Access For All America
- Healthy communities
- Eliminate health disparities

Patient & Community Activation
- Patient-Centered
- Equity/Access

Value: Quality/Cost
- Effective
- Strong Workforce Teams
- Efficient
- Safe
- Timely

*80% Participate Rate**

Health Disparities Collaborative: a foundation for health reform

- Leadership
- Model of Care: Wagner Care Model
- Models for Improvement
- Infrastructure: registry, state based improvement support for practice transformation and learning
- Partnerships: national and local public and private organizations
- Several clinical issues, including asthma**
  - Standard shared guidelines
  - Standard nationally recognized core metrics
  - Improvements in assessments of severity, treatment with anti-inflammatory medication, assessment of exposure to smoke and other triggers and use of management/action plan

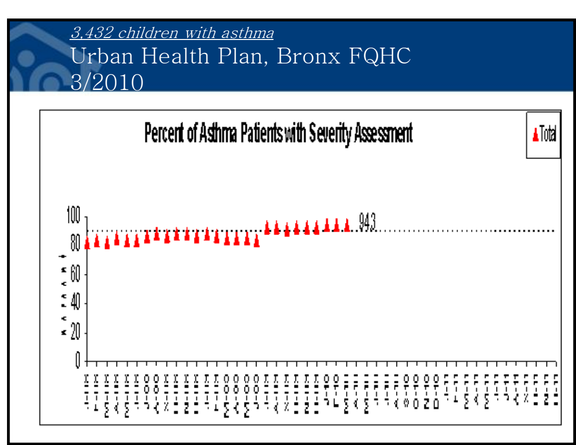
*2009 Commonwealth Fund National Survey of Federally Qualified Health Centers (May, 2010) www.commonwealthfund.org

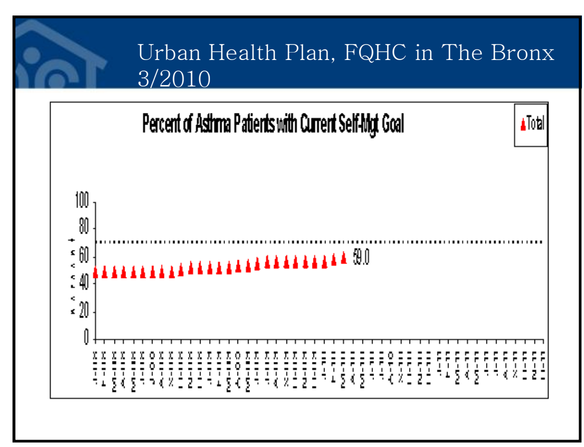
**Landon BE, Hicks LS, O'Malley AJ , et al. Improving the management of chronic disease at community health centers. N Engl J Med. 2007; 356:921-934

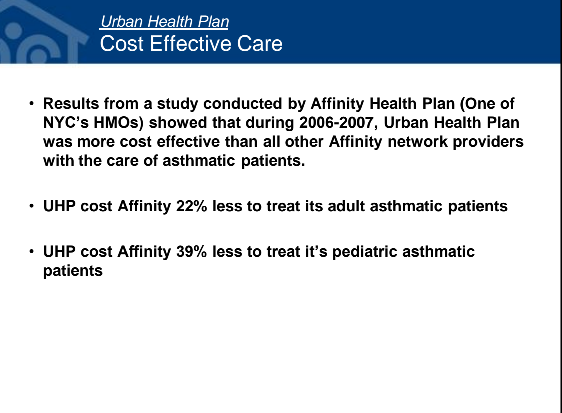
Chin, MH. "Quality Improvement Implementation and Disparities: The Case of the Health Disparities Collaboratives. Med Care

3,432 children with asthma

Urban Health Plan, Bronx FQHC 3/2010





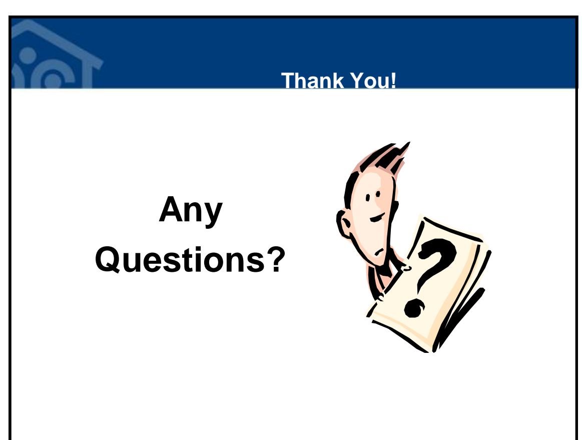


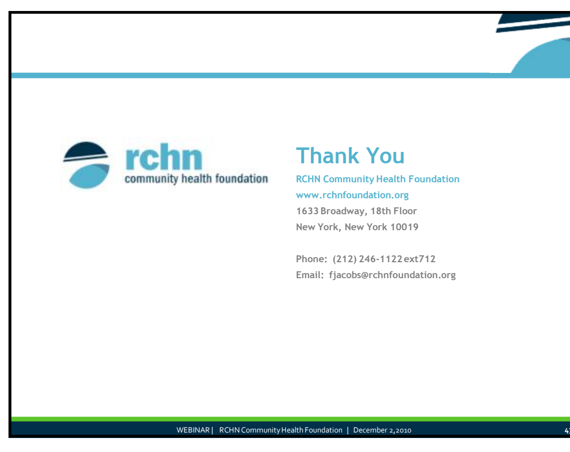
Key features of a Patient Centered Medical Home: Commonwealth Fund Safety Net Medical Home Initiative

- Engaged Leadership
- Quality Improvement Strategy
- Empanelment(provider/team accountability
- for specific population of patients)
- Enhanced access
- Continuous, team based healing relationships with patients
- Patient centered interactions (e.g. self-manageme support
- Organized evidenced base care
- Care coordination

Key Issues for Health Centers: Childhood Asthma and Beyond

- Access to specialty care for uninsured and insured health center patients
- Achieving meaningful use for effective population and patient management
- Strengthen primary care work force
- Strengthening public health infrastructure and collaboration with health centers to address environmental health issues
- Assuring participation and leadership role for health centers in evolving systems of care, e.g. accountable care organizations, insurance exchanges
- Support for practice transformation and health home recognition
- Strategies to support & sustain family understanding and engagement in health home





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Thank You
RCHN Community Health Foundation
www.rchnfoundation.org
1633 Broadway, 18th Floor
New York, New York 10019
Phone: (212) 246-1122 ext712
Email: fjacobs@rchnfoundation.org
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