TPCA: Supporting Federally Qualified Health Centers (FQHCs) in Transitions of Care and Reductions in Hospital Readmission Rates

Transitioning Patients Across the Care Continuum (TPACC) Meeting – 2/21/17

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Connecting Communities Who Care

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Objectives

- Identify Role of the Tennessee Primary Care Association and Federally Qualified Health Centers (FQHCs) in Care Transitions
- Partnerships and Collaborations with Local Hospitals-ACOs, and Specialty Clinics
- Patient Centered Medical Home (PCMH) and Patient Partnerships
- Integrated Care to achieve Population Health and Patient Navigation Strategies

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Who is the Tennessee Primary Care Association?

- A non-profit, statewide corporation working to strengthen community-based primary health care systems in Tennessee.
- Core members are Tennessee's federally-qualified health centers, known as FQHCs.
- Other members include primary health care clinics, Rural Health Clinics and health professions schools.
- TPCA members serve nearly 385,000 patients annually at almost 200 sites.

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What is a Federally Qualified Health Center (FQHC)?

- Private, not-for-profit health center
- Provide high quality, cost-effective and *comprehensive* primary and preventive care
- Open to all – receipt of services not contingent on ability to pay or insurance status
- Has a sliding fee scale
- Located in high need areas – medically underserved areas and populations (MUAs/MUPs) and Health Professional Shortage Areas (HPSAs)
- Required to meet rigorous quality of care, service and cost standards

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Health Center Basics

- Federal support for health centers began in 1965.
- The Health Center Program is authorized under section 330 of the Public Health Service Act.
- FQHCs are eligible for:
  - Section 330 grant funds
  - Enhanced Medicaid and Medicare reimbursements
  - Federal Tort Claims Act (FTCA) malpractice coverage
  - Participation in 340B (discounted) Drug Pricing Program

Characteristics of Primary Care

- First point of contact for care.
- Care is comprehensive and integrated.
- Services include preventative care, health maintenance, chronic disease management, and treatment for acute conditions in a **medical home.**

It is estimated that FQHCs save the national health care system between 9 and 17 billion dollars per year by improving the use of preventative care and decreasing more costly emergency room services.

FQHC Services

- Primary medical care
- Preventative screenings
- Dental
- Behavioral health
- Pharmacy
- Lab services
- Emergency / Urgent care

Note: services can be provided at the health center or by another provider through a contract.

This is not a complete list. FQHCs provide services either directly or by contracted agreement.

FQHC Patient Demographics (2015)

	Tennessee	United States
FQHC Organizations	30	1,375
FQHC Clinic Sites	187	10,753
Total Patients Served	369,445	24,295,946
Patient Financial Classification		
• Uninsured	34.8%	24.4%
• Medicaid	34.1%	49.4%
• Medicare	11.6%	8.9%
• Dually Eligible	5.1%	3.4%
• Other Third Party	19.6%	17.2%

Source: 2015 Health Center Data, BPHC Data Center; Total clinic sites as of 2/20/17

Emerging Landscape of Accountable Care

- Emphasis on population health and preventative care
- Delivery of care will be collaborative between providers, hospital systems, and community providers and resources
- FQHCs are uniquely positioned as a partner for hospital systems to improve health outcomes
- Goal is to create integrated models of care to provide coordinated services to improve outcomes for targeted populations

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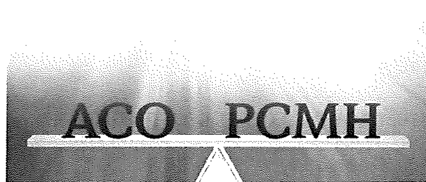
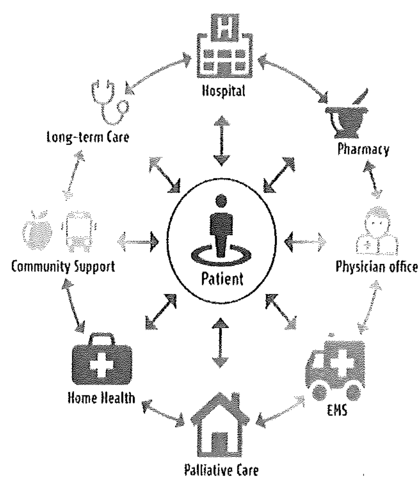
FQHCs and Care Transitions





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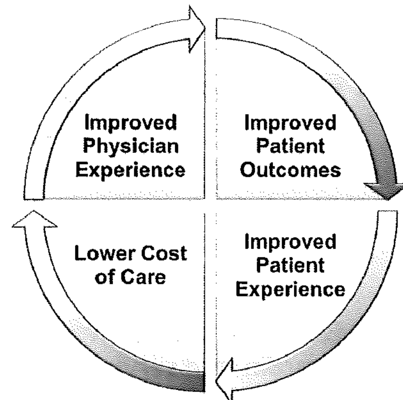
Quadruple Aim

- Hospitals that work with FQHCs will be better positioned to provide:
  - –High quality care
  - –Cost effective episodes of care
  - –Patient centered care



The Quadruple Aim

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Collaborative Community Efforts

- Collaborative efforts to completing and implementing a "Community Needs Assessment"
- Thinking outside institutional walls
- Moving from compliance mentality to transformational commitments
- Support from hospital institutions for FQHCs and PCMHs, as mutually beneficial collaborations that reduce costs

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Examples of Beneficial Collaborations

(Think Efficiency, Effectiveness, Affordability)

- Referral and discharge coordination that reduce hospital readmissions through FQHC Care Management and Care Coordination team members
- Investments in Health Information Networks that allow for connectivity and communication between organizations
- Working towards seamless referral networks between services such as laboratory, radiology, specialty care, telehealth and telemedicine
- Care transition handoffs between hospital services and returning or "enrolling" patients in a PCMH Primary Care Provider Program

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Examples of Beneficial Collaborations

(Think Efficiency, Effectiveness, Affordability) (Slide 2)

- Opportunities for innovative financing partnerships through grant funded specialty programs for population health management (State DPOH, CDC, Robert Woods Johnson)
- Mandatory collaborations set by the ACA/HRSA
  (Ex.: Outreach and enrollment, specialty programs e.g Childhood obesity, asthma, diabetes, hypertension)
- Improved outcomes and quality improvement initiatives for management of chronic care populations

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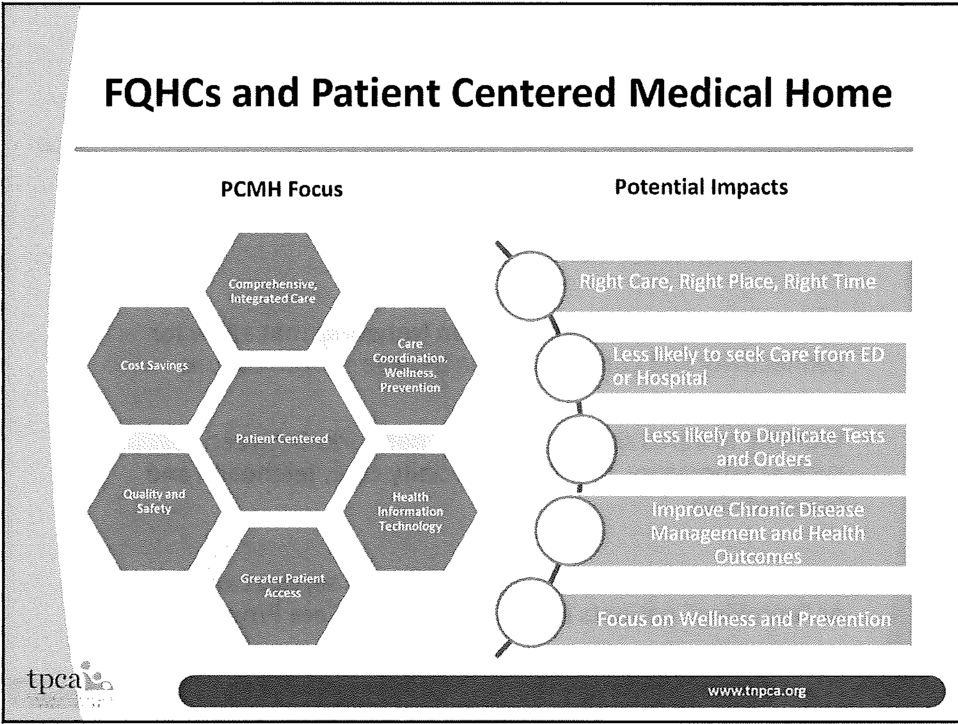

Integrated Care and Population Health Management

- Medical, Dental, Behavioral Health
- E-communication-Patient Portal
- Telehealth /Telemedicine for clinical decision support
- Team approach
- Outreach and Education
- Shorter wait time
- Optimizes patient visits
- Alternatives to in office visits
- Electronic order entry / prescribing
- Extended hours
- Maximizes staff involvement in care working to the top of their licensure / certification

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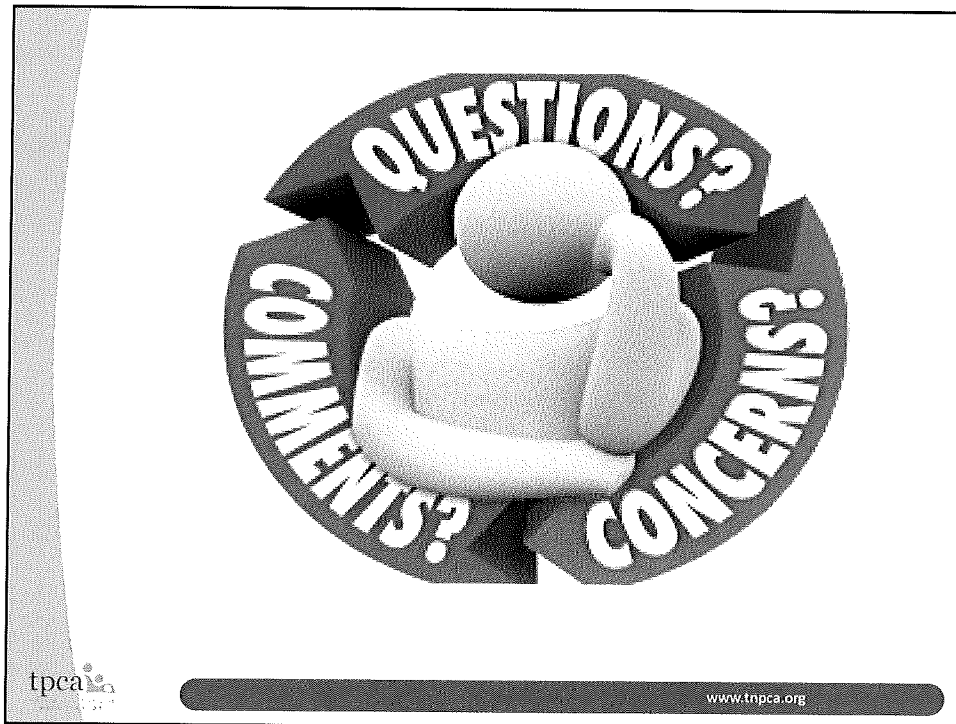

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Citations

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