

Strategies for Ryan White providers to partner/transition to community health centers in a post-Affordable Care Act world

Jan. 14, 2015

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Moderator: Andrea Weddle, Executive Director, *HIV Medicine Association*

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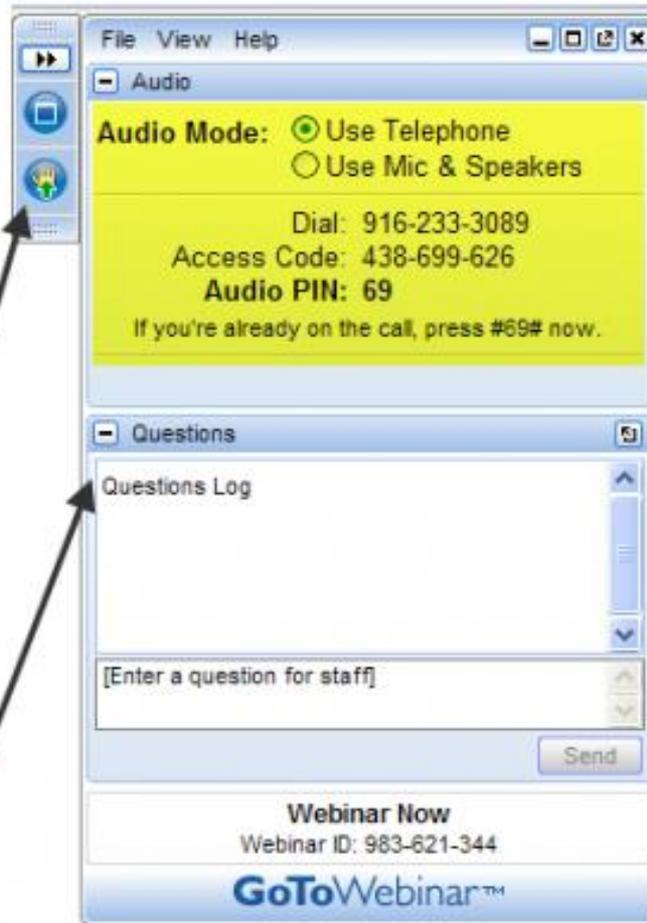
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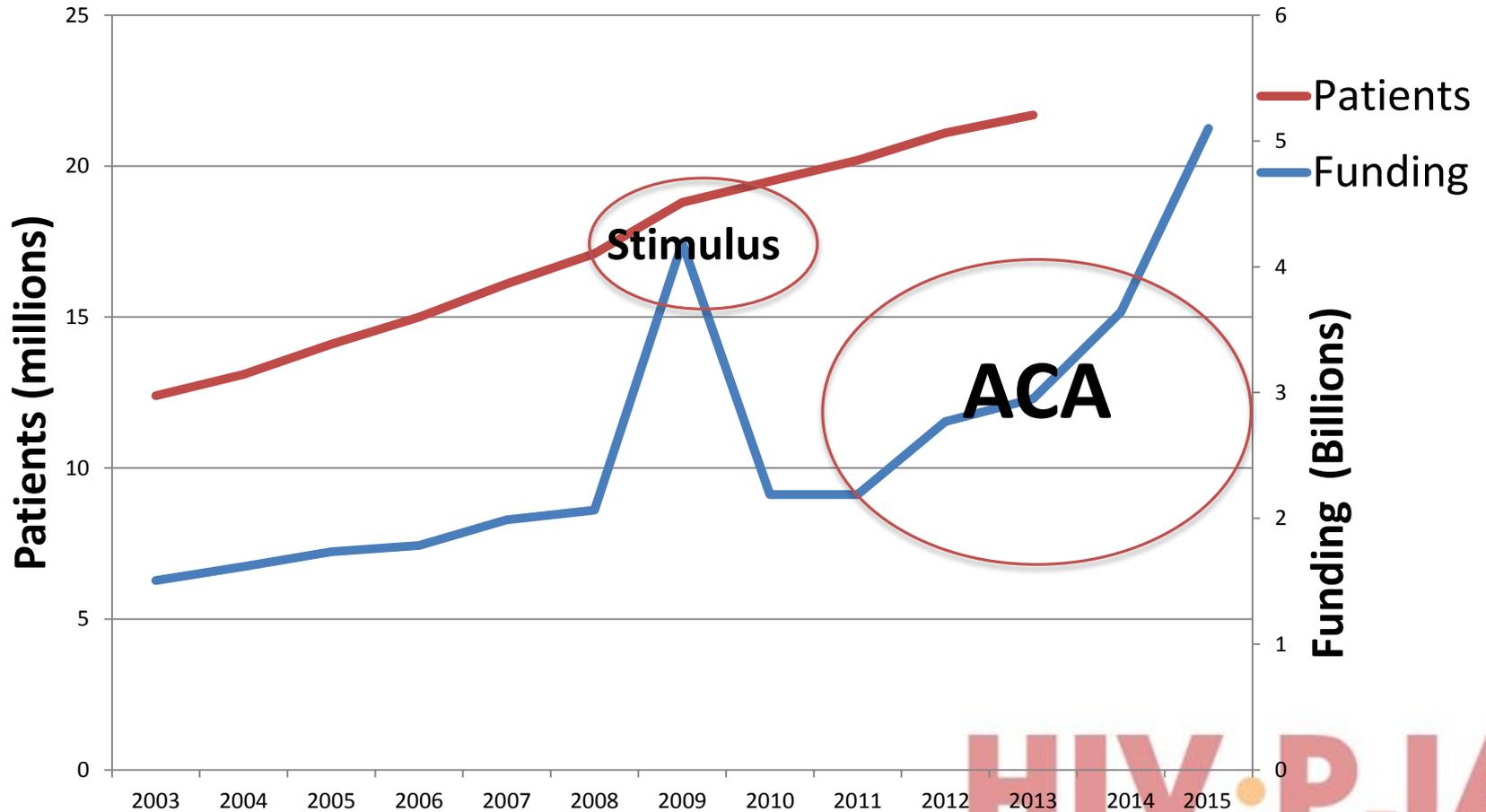
Today's Agenda

- **Opening Remarks and Overview**
 - Andrea Weddle, Executive Director, HIV Medicine Association
- **FQHCs: Partnering to improve the primary care home for PLWHA**
 - Brian Toomey, CEO, Piedmont Health Care Services
- **FQHC Case Study: No/AIDS Task Force**
 - Noel Twilbeck, CEO, NO/AIDS Task Force
- **Partnerships – CBO's & FQHC's**
 - Valerie Mincey, Executive Director, NWFL, Inc.
- **Resources:** Kathy McNamara, National Association of Community Health Centers
- **Q&A**

Why the Focus on FQHCs?

Andrea Weddle, MSW, Executive
Director, HIV Medicine Association

Building Primary Care Capacity in Underserved Communities



FQHC Benefits and Opportunities

Skimming the Surface – Learn More:
National Association of Community Health Centers &
HRSA Bureau of Primary Care

Program Level

- Cost-based Medicaid & Medicare Reimbursement
- Coverage under the Federal Torts Claim Act
- Access to 340B drug discounts
- Diversified and expanded financing and client/patient populations

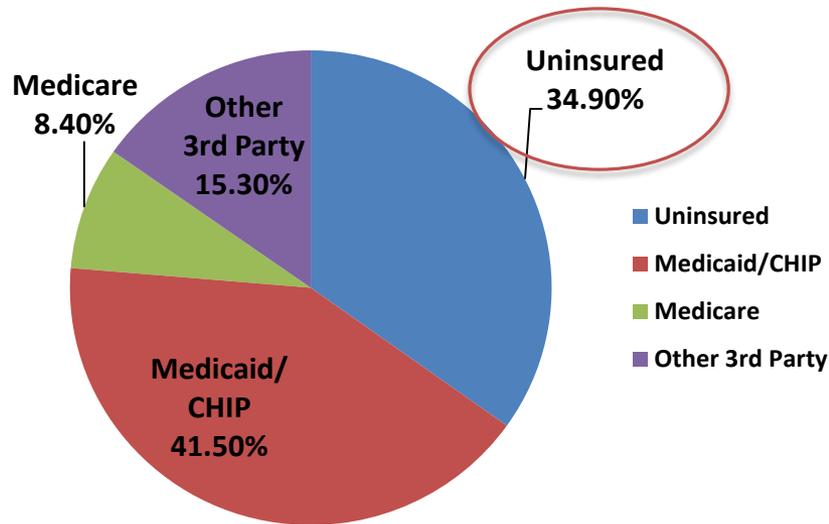
Community/Systems Level

- Integrated rather than parallel systems of care
- Comprehensive community-based prevention and care networks

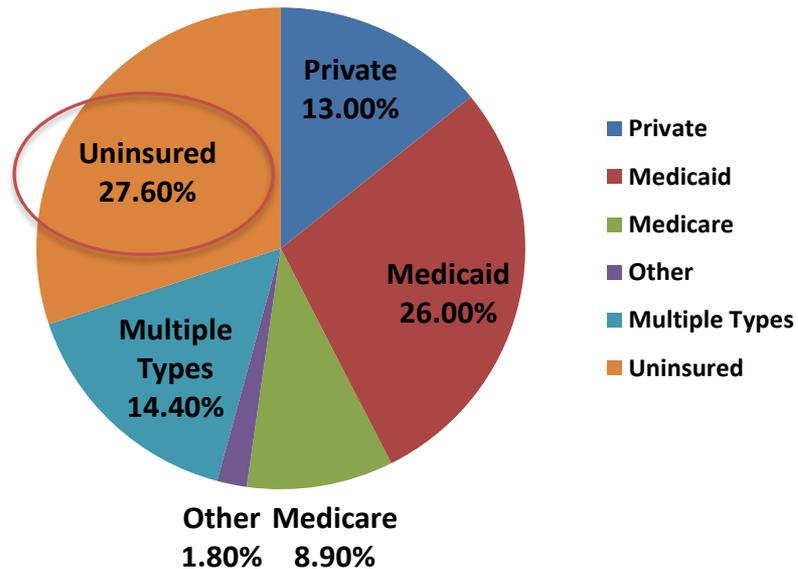
Disclaimer: Becoming an FQHC is not for everyone!

FQHCs and Ryan White Programs: Meeting the Needs of the Uninsured

Health Center Patients Insurance Status
(2013)



Ryan White Client Insurance Status
(2012)



FQHCs: Partnering to improve the primary care home for PLWHA

Brian Toomey, MSW, CEO

Piedmont Health Services, Inc.

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The Broad Mission of Federally- Qualified Community Health Centers

Begun in 1965 as a Federal demonstration program, Federally-Qualified Community Health Centers (FQHCs) are charged nationally with addressing barriers to primary health care access for health care underserved populations. Services are generally targeted to meeting the needs of individuals living below 200% of the Federal Poverty Guideline.



FQHC Fundamentals

- ▶ **Administered by HRSA's Bureau of Primary Health Care, there are 19 core program requirements for FQHC clinical operations, financial operations, and governance. Basics:**
- ▶ **Located in or serve a high need community** - defined service area must contain designated Medically Underserved Area or Population.
- ▶ **Governed by a community board – must be** composed of a majority (51% +) of health center patients who represent the population served (helps to assure consumer input).
- ▶ **Provide required primary health care services** as well as supportive services (education, translation and transportation, etc.) that promote access to health care.
- ▶ **Provide services available to all** -with fees adjusted based on ability to pay (sliding-fee scale).

More About Community Health Centers: North Carolina and Nationally

- Spread across 50 states and all U.S. territories, there are **1,200 Community Health Center organizations** nationally with thousands of community health center sites.
- Provide vital primary care to 20 **million Americans with limited financial resources** (in 2009).
- There are **35 federally qualified community health centers (FQHC) organizations in North Carolina**.
- Health centers focus on meeting the basic health care needs of their individual communities. Health centers maintain an open-door policy, **providing treatment regardless of an individual's income or insurance coverage**.

Organizational Benefits of FQHC status

- FQHCs receive enhanced rate from Medicare and Medicaid.
- Access to several important programs:
 - Federal Tort Claim Act (malpractice coverage)
 - 340B Drug Program (affordable medication)
 - National Health Service Corp (provider recruitment)

PHS Overview

- 8 community health center locations
- FQHC grant roughly 13% of our operating budget.
- ~42,000 unduplicated patients served annually, ~107,000 medical and 18,000 dental visits.
- 53% uninsured, 27% Medicaid/CHIP, 6% Medicare, 14% private pay; 98% live below 200% of poverty.
- 36% prefer care in another language (predominantly Spanish, also Burmese refugee population)



PHS Overview

- Small # of PHS patients with HIV/AIDS (not a direct Ryan White grantee), but significant prevalence in our service area, and significant population in our centers at-risk.
- Board/staff deeply concerned with the HIV/AIDS disparities in the Southeast (e.g. new case rates, undiagnosed) and FQHC responsibility for trying to address it.



Ryan White in North Carolina

- Only Mecklenberg County (Charlotte Transitional Grant Area) receives Part A funding (not in PHS service area).
- Non-TGA dollars (e.g. Part B, C, D, F) are distributed to agencies in 10 Regional HIV Networks.
- PHS' Federally-designated 7-county service area lies in both Region 4 and Region 6.



History of PHS Partnerships to better serve PLWHA and population at-risk

- PHS has taken a collaborative approach to partnering with both the NCDHHS HIV Branch, and also with Regional 4 and 6 Ryan White grantee organizations as a subcontractor. These collaborations improve the quality and continuity of care we can deliver to PLWHA and the community at-risk.



Timeline: PHS Partnerships to better serve PLWHA and population at-risk

- 2007: 1 of 6 southeast FQHCs in *Putting Patients First: Health Centers as Leaders in HIV Testing and Prevention Pilot*.
- Received technical assistance to implement broad population HIV screening as routine part of primary care for patients 13-64 per CDC guidelines using Uni-Gold rapid HIV test.
- Our success in this pilot in testing thousands of patients and our data led the state HIV branch to include us in their Free Rapid HIV testing program (we receive free testing kits).



Timeline: PHS Partnerships to better serve PLWHA and population at-risk

- 2009-present: We were approached by the UNC Infectious Disease Department to collaborate with them on their Part C grant. We are focused on providing high-quality primary care to stable HIV patients at one health center site in Alamance County. The collaboration with UNC ID has increased our primary care provider knowledge and comfort with routine HIV care.



Timeline: PHS Partnerships to better serve PLWHA and population at-risk

- 2011: PHS participated in *The HIV in Primary Care Learning Community* led by HealthHIV and funded by HRSA's AIDS Education and Training Centers Program and the Minority AIDS Initiative. It focused on assuring primary care access for PLWHA with many learning community concepts overlapping with our on-going work on open access.



Timeline: PHS Partnerships to better serve PLWHA and population at-risk

- 2012: While not explicitly focused on PLWHA, PHS implemented an organization-wide LGBT initiative focused on 1) creating an atmosphere of intentional inclusivity for the LGBT community and 2) best-practice care. We used state and national consultants to provide specific CME on care of the transgendered community, and best practice in sexual history taking.



Timeline: PHS Partnerships to better serve PLWHA and population at-risk

- 2015: We are currently developing a collaboration with Central Carolina Health Network (Ryan White Part B and D grantee) and Duke University (specialist contract) to implement Alamance County's first specialist HIV clinic once day monthly at one of our Alamance CHC sites. Change in scope with HRSA to add specialty service in process and we hope to start this spring.



The Culture of CHCs vs. Ryan White Clinics

- Similar orientation to serving underserved populations and eradicating health disparities.
- However, with the exception of 3 types of legislated special population health centers (homeless, migrant/seasonal farmworkers, public housing), CHCs must serve all-comers (people of all ages and backgrounds with all types of illnesses. It is not a specialist, disease-specific model.



The Culture of CHCs vs. Ryan White Clinics

- Important difference: Oversight by different parts of HRSA; must comply with different Federal statute and regulations.
- Compliance Challenge: Developing programs and data collection and reporting strategies that satisfy “both masters.” (e.g. determining eligibility for services, reporting outcomes in Care Ware vs. UDS).



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A Partnership for Life

Noel Twilbeck, CEO, NO/AIDS Task Force

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Benefits to the Health Center

<http://bphc.hrsa.gov/about/benefits/index.html>

- Section 330 grant funds
- PPS reimbursement for Medicaid
- Cost-based reimbursement for Medicare
- PHS drug pricing discounts (340B program)
- Access to FTCA coverage
- Access to NHSC

Additional application, registry, or deeming processes

Program Requirements (19)

<http://www.bphc.hrsa.gov/about/requirements/index.html>

- Need
- Services
- Management and Financial
- Governance

NO/AIDS Task Force founded in 1983

	2006	2008	2010	2011	2012	2013	2014	2015
<i>Annual Budget</i>	<i>\$3.5m</i>	<i>\$6.6m</i>	<i>\$11.9m</i>	<i>\$14.8m</i>	<i>\$19m</i>	<i>\$20m</i>	<i>\$27m</i>	<i>\$28m</i>
<i>Paid Staff</i>	<i>36</i>	<i>68</i>	<i>107</i>	<i>131</i>	<i>170</i>	<i>184</i>	<i>220</i>	<i>220+</i>
<i>Volunteers</i>	<i>150</i>	<i>350</i>	<i>400+</i>	<i>400+</i>	<i>400+</i>	<i>400+</i>	<i>400+</i>	<i>400+</i>

Section 330 award (FQHC) 11/6/13

2013 *2,884 clients (HIV+)*
1,522 in PMC

2014 *4,275 clients (48%)*
2,774 in PMC (82%)



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Challenges

- Move from primarily grant driven reimbursements to billing/payment methodology
- Billing / sliding-fee / collections
- Expanded mission (not strictly HIV focused)
- Structural changes (administrative / cultural)
- Board composition & responsibilities
- Compliance / reporting





- Target population
 - People living with HIV
 - Partners and family of current (HIV) constituents
 - LGBT population
 - Service industry personnel
 - Those living in geographic vicinity





3 CHC sites under Scope of Service

- CrescentCare Health and Wellness Center
- Family Care Services Center
- Crescent Care Specialty Center





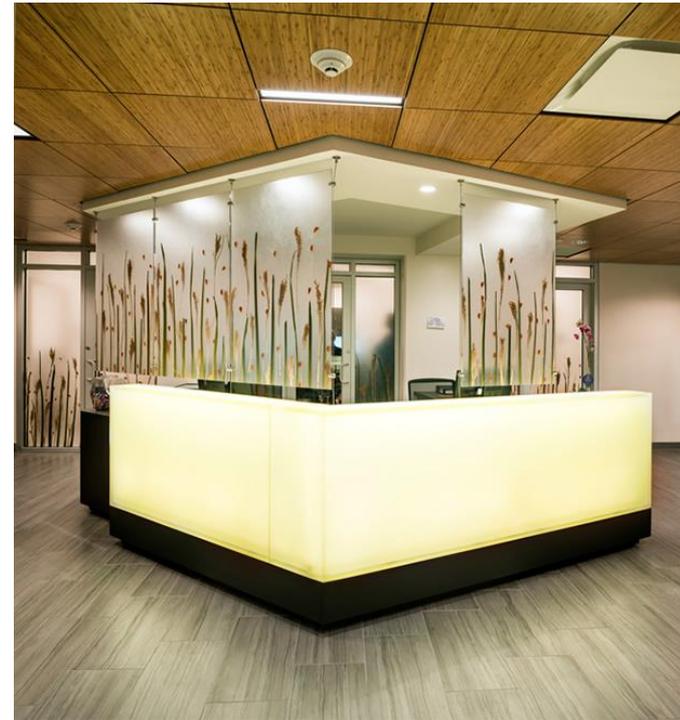
- **New services**
- Pediatrics
- Obstetrics/Gynecology
- Family Medicine
- Internal Medicine
- Integrated Behavioral Health
- Outreach/Enrollment
- Employment Services
- Medical/Legal Partnership
- Case Mgmt./Care Completion
- Patient/Community Education
- PrEP Clinic
- Labs



- Transition from ASO to CHC
- Expanded Mission
- Maintain organization legacy
- Expanded Information Technology

- EHR/practice mgmt. system
- Billing and sliding-fee-scales
- New community partnerships
- Increased CQI activities

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- Patient Centered Medical Home (NCQA Level III)
- CARF Accreditation



- Funding streams
- Program income
- Personnel (skills/expertise)

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- Newly insured
- Revenue increase by 35%
- 48% increase in overall clients
- 82% increase in PMC clients
- Improved health outcomes
- Patient satisfaction feedback improving
- Meaningful Use
- Incentive payments

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2015

- STD program partnership
- Dental Services (suite)
- Psychiatry
- Contract pharmacy (new site)
- Transgender clinical care
- Centering Pregnancy
- HCV testing/treatment
- Nutrition





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Noel Twilbeck, CEO,
NO/AIDS Task Force

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Partnerships – CBO's & FQHC's

Valerie Mincey, Executive Director,
NWFL, Inc.



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Motivation to partner with the local FQHC

- FQHC's are funded by the government
- They have many resources and programs
- They can help stretch your limited RW dollars to cover vital services to your clients (i.e. ambulatory, dental)
- FQHC's have a variety of clients and when it come

Process to Create Partnership

- ▶ Identify key personnel
- ▶ Helpful if you know CEO; Director of Operations, or someone that is a decision maker to schedule a meeting to describe your agency and the benefits of partnering
- ▶ Create a fact sheet on your programs and how they will enhance their programs
- ▶ Describe the resources you have for primary care and dental services
- ▶ Create an open door policy between the two organizations



Details of Partnership

- Know what services each entity offers
- Develop a MOA/MOU detailing what specific service each will offer under this partnership
- Agree upon a rate agreement for services provided by the FQHC
- Identify key point of contact for each entity



Benefits of the partnership to clients

- Clients have a team that work closely together to ensure continuity of care
- The physicians, case managers and prevention specialist work closely together and communicate notes and outcomes of meetings with clients (of course you must have a release of information signed by the clients)



Future plans to continue and expand the partnership

- This collaborative partnership is in its third year
- Both partners agree this is a long-term partnership due to the benefits to the clients, FQHC, BASIC and the community when it comes to overall community health
- The FQHC quotes “We would like to expand into behavioral health soon and hope BASIC can be a partner in that project”



Thank you for your participation!

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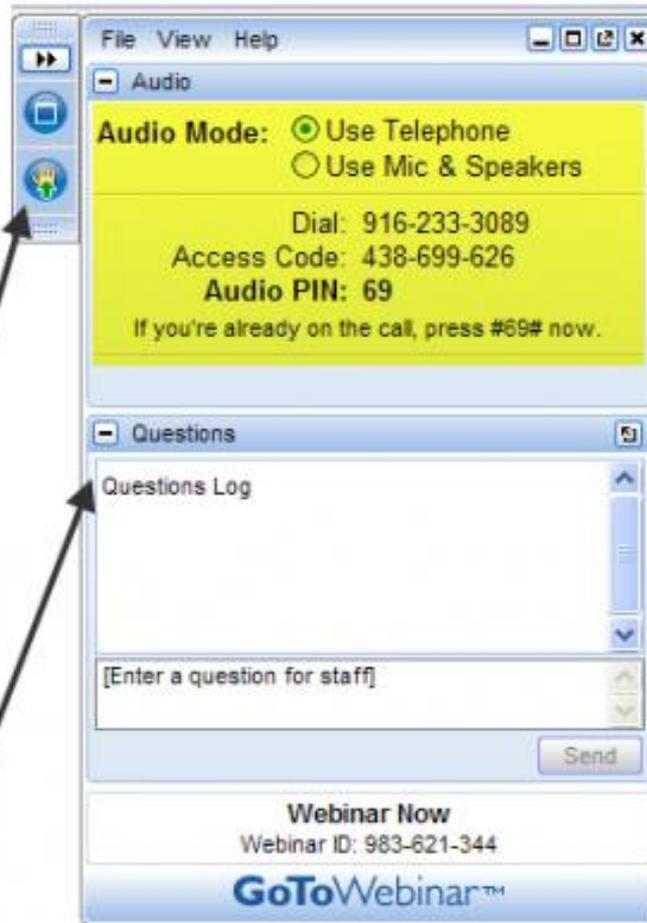
Resources

Kathy McNamara, Assistant Director of
Clinical Affairs, National Association of
Community Health Centers

Learn More

- [National Association of Community Health Centers - www.nachc.org](http://www.nachc.org): program requirements, technical assistance, policies
- State & Regional Primary Care Associations - <http://www.nachc.com/nachc-pca-listing.cfm>
- HRSA Bureau of Primary Care – <http://bphc.hrsa.gov/>: program data, policy requirements, program information
- www.hivclinician.org: issue briefs, case studies & resource links for RW providers (supported by HIVMA)

Questions?



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- **HIV Medicine Association**
 - Andrea Weddle, Executive Director
 - Email: aweddle@idsociety.org
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 - Twitter: @HIVMA
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hiv medicine association



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