Agenda

- NACHC and Health Centers
- Collaboration Models
- Social Determinants of Health
National Association of Community Health Centers (NACHC)

- Founded in 1971

- **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 populations.

- Voice of America’s Health Centers:
  - Research-based advocacy
  - Education about the mission and value of health centers
  - Training/TA to health center staff and boards
  - Clinical Workforce, Innovation, Performance

NACHC Priorities

- **Shift from Volume to Value Based Payment**

- Integrate public health, oral health and behavioral health with primary care

- Invest in the workforce of the future to work in emerging models

- Alignment of measures across systems of care: Payers, NQF, CMS, CDC, HRSA/BPHC, ONC, USPSTF/ACIP
Public Health and Primary Care Integration


Health Center Profile

- 1,375 health center organizations
- 9,300 delivery sites
- 20,000 clinicians
- 24 M patients per year in 13 people in the US
- 92.5% are low-income patients
- 49% are rural
- 98% using EHRs
Health Centers

Include:
- Community Health Centers
- Health Care for the Homeless Centers
- Migrant Health Centers
- Primary Care Programs in Public Housing
- School-based Health Centers

*Each health center is an independent, 501(c)(3), non-profit*

Five Essential Elements

1. Located in *high-need areas*

2. Provide *comprehensive* health and related services (especially “enabling services”)

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
Governed by: A Board of Directors

- Reflect community served
- 51% or more must be health center patients

Health Center Funding

Source: 2015 UDS Data, BPHC/HRSA
Health Center Services

- **Health Services related to:**
  - Family Medicine
  - Internal Medicine
  - Pediatrics
  - Obstetrics
- **Diagnostic Laboratory and Radiologic Services**
- **Dental Screenings**
- **Pharmaceutical Services**

- **Referrals to Other Providers**
- **Patient Case Management**
- **Enabling Services:** Translation, Transportation, Outreach, and Health Education

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Health Center Program Growth

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2015</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of Grantees</strong></td>
<td>1,124</td>
<td>1,375</td>
<td>+22.3</td>
</tr>
<tr>
<td><strong>Total Patients</strong></td>
<td>19,469,467</td>
<td>24,295,946</td>
<td>+24.8</td>
</tr>
<tr>
<td><strong>Total Visits</strong></td>
<td>77,069,234</td>
<td>96,951,585</td>
<td>+25.8</td>
</tr>
</tbody>
</table>

Source: 2015 UDS Data, BPHC/HRSA
### Age and Gender

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 18</td>
<td>3,786,434</td>
<td>3,803,015</td>
<td>7,589,449</td>
<td>+6.1</td>
</tr>
<tr>
<td>18–64</td>
<td>5,637,199</td>
<td>9,148,357</td>
<td>14,785,556</td>
<td>+5.8</td>
</tr>
<tr>
<td>65 and Over</td>
<td>770,520</td>
<td>1,150,421</td>
<td>1,920,941</td>
<td>+10.0</td>
</tr>
<tr>
<td>Total</td>
<td>10,194,153</td>
<td>14,101,793</td>
<td>24,295,946</td>
<td>+6.2</td>
</tr>
<tr>
<td>Percent</td>
<td>42.0</td>
<td>58.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: 2015 UDS Data, BPHC/HRSA

### Race/Ethnicity

- Non-Hispanic White: 41.9%
- Racial and/or Ethnic Minority: 64.8%
- Hispanic/Latino Ethnicity: 35.2%
- Black/African-American: 23%
- Asian: 3.9%
- American Indian/Alaska Native: 1.3%
- Native Hawaiian/Other Pacific Islander: 1.1%
- More than one race: 3.5%

Source: 2015 UDS Data, BPHC/HRSA
Insurance Status

- 24.4% Uninsured
- 16.8% Other Third Party
- 8.9% Medicare
- 48.9% Medicaid/CHIP

Source: 2015 UDS Data, BPHC/HRSA

Income as a Percent of Federal Poverty Level

- 70.9% 100% & Below
- 21.3% 101-200%
- 7.8% Over 200%

Source: 2015 UDS Data, BPHC/HRSA
## Most Frequent Primary Medical Visits

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th># Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>3,993,203</td>
</tr>
<tr>
<td>Diabetes</td>
<td>2,118,178</td>
</tr>
<tr>
<td>Depression/Other Mood Disorders</td>
<td>1,939,489</td>
</tr>
<tr>
<td>Asthma</td>
<td>1,190,679</td>
</tr>
<tr>
<td>Otitis Media/Eustachian Tube Disorders</td>
<td>822,929</td>
</tr>
</tbody>
</table>

Source: 2015 UDS Data, BPHC/HRSA

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### Health System Transformation:

*Policy, Partners, Payers, Providers, Patients*
Health Home and Transformation Framework

Population Health & Reduction of Disparities

Health Center engagement in local health system & community health improvement

Effective Teams & Care Integration: Public Health-Primary Care

Meaningful Use & HIT Infrastructure

Health Home Recognition/Accreditation programs

Value: Superior Cost & Quality Outcomes

Patient, Family & Community Engagement

Meaningful Use & HIT Infrastructure

The Larger Health Center Dynamic

Processes

• Analyze Workflows/Identify Improvement Opportunities
• Design/Configure Interventions
• Measure and Benchmark
• Standardize Workflows
• Spread Successful practices

Data & Technology

• Population Management Data Reporting & Analytics
• Web-based Collaborative Workspace
• Other HIT Systems & Tools (EHRs, Registries, CDS, HIE)

People

• Partner Solicitation/Selection
• Stakeholder Engagement
• Team Preparation & Training
• Transformation Culture
• QI Coaching
• Peer Learning Opportunities
• Financial Incentives
Health Center Controlled Networks (70)
- Data Warehousing
- EHR adoption and upgrade Training
- Workflow
- EHR Optimization
- Regulatory Compliance & Reporting (UDS)
- Clinical quality performance analysis/feedback

Primary Care Associations (52)
- Communication Infrastructure
- Committees
- New Health Centers
- Health Reform and ACO development
- BPHC: FQHC 330 Program Requirements
- Quality:
  - Coaching
  - Peer Learning
  - Training & Technical Assistance

NACHC: Research–based advocacy and Education about the mission and value of health centers. T/TA to HCCNs, PCAs, health center staff and boards. Develop community and public health alliances to increase access to primary care for the safety net.

Collaboration Models
Social Determinants of Health
“I left private practice to work in health centers to do what I believe in to improve the health of my patients. In private practice I had to do it alone, in health centers I have an entire national and state infrastructure to support the work.”

“Model Partnership”
- CA Public Health Adult Imm

Why?
- Built on Trust
- Foundation in Primary Care
- Framed in Value-Based Payment
- Use the Expanded Care Team
- Regular structured Communication
HOW?

• **Start** Partner with the Primary Care Association to design implementation and sustainability with health centers
  – Contact the Medical Director or QI lead
  – PCAs broker relationships with health centers

• **Define** mutually beneficial and reinforcing activities

• **Share** public health data with PCAs and health centers

• **Health centers are mission driven:** build on the mission and care for their patients

Results

• 3 Health Center Controlled Networks (HCCN) with member health centers are beta testing CAIR 2.

• CA Public Health provided health center immunization data to (HCCN)

• CA Public Health presented to CA PCA Medical Directors

• Joint presentation planned for CA Quality Conference to include CA Public Health, HCCNs, Health Centers

• CA PCA meets monthly with CA Public Health
Why Partner with PCAs, HCCNS, and NACHC?

- **Collaborative partnership** in a complex environment of Health System Transformation

- **Leverage existing infrastructure** with partners, payers, providers and patients in primary care

- **Reach to the field** of 24,000,000 patients, 20,000 clinicians, and 9,300 sites

- **Architects of the new models** of health care to improve population health

- **Efficiency and consistency**

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- **Social Determinants of Health**
About OCHIN

• One of the nation’s Largest Health Center Controlled Networks (HCCN) (EPIC)
• Provide EHR/IT, analytics, billing, quality improvement, and consulting services
• Customers: Federally Qualified Health Centers, Rural Health Centers, County Health Depts, and nonprofit clinics
• Conduct Research

About OCHIN

• 95 member organizations across 18 states nationwide
• Approximately 500 clinic locations
• Approximately 4,000 primary care providers
• 900K unique patients and 3.2M visits in 2015
OCHIN Influenza (NQF 0041) Immunization Rates by Race, August 2015–2016

OCHIN Pneumonia (NQF 0043) Immunization Rates by Race, August 2015–2016
OCHIN Influenza (NQF 0041) Immunization Rates by Ethnicity
August 2015–2016

OCHIN Pneumonia (NQF 0043) Immunization Rates by Ethnicity
August 2015–2016
OCHIN Pneumonia (NQF 0043) Immunization Rates by Gender
August 2015-2016

OCHIN Pneumonia (NQF 0043) by Insurance Coverage
August 2015–2016
Resources

- Research and Data [http://www.nachc.org/research-data.cfm](http://www.nachc.org/research-data.cfm)


- Partnerships between FQHCs and Local Health Departments for Engaging in the Development of a Community-Based System of Care. [https://www.nachc.com/client/PartnershipsBetweenFederallyQualifiedHealthCentersAndLocalHealthDepartmentsforEngagingInTheDevelopmentOfACommunityBasedSystemOfCareNACHCOctober2010.pdf](https://www.nachc.com/client/PartnershipsBetweenFederallyQualifiedHealthCentersAndLocalHealthDepartmentsforEngagingInTheDevelopmentOfACommunityBasedSystemOfCareNACHCOctober2010.pdf)

Thank You

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