

PRELIMINARY REPORT
to the McKinley Community Health Alliance on
PROGRAM & FUNDING OPPORTUNITIES UNDER THE
PATIENT PROTECTION & HEALTH CARE ACT OF 2010
by Northwest New Mexico Council of Governments
September 19, 2011

Purpose

With funding from the ConAlma Foundation, the McKinley Community Health Alliance asked the Northwest New Mexico Council of Governments to scan through the *Patient Protection and Health Care Act (PPACA)* for potential strategies to fund local prevention activities.

With this information in hand, the Alliance hopes to gather the health provider community around a collaborative table to strategically engage everyone in universal, coordinated, community-based initiatives to promote public health and prevent chronic disease.

Approach and Status of Research

The Council of Governments analyzed the PPACA and, with the help of the New Mexico Congressional Delegation Office, drilled down into programs and funding sources currently published by the US Department of Health & Human Services. We also scanned about a dozen articles on the “medical home” model and the support for it to be found in the PPACA.

The current report provides a summary of PPACA prevention programs identified by this process, along with pertinent information on eligibility and other factors inherent within those programs. The report “scratches the surface” of a complex legislative organism and should be seen as the beginning of a collaborative process that will continuously refine our collective knowledge and skills in accessing PPACA funding and program support for local purposes.

In embarking on this preliminary PPACA review, we understood that there was some interest in the “medical home model” of primary care, and then came to understand an even stronger interest in the “community-based health home” model from a public health perspective. A preliminary summary of this discussion is included as an appendix to this report.

Patient Protection and Health Care Act (PPACA) [PL 111-148]

The PPACA is an extremely complex piece of legislation, and this preliminary report may be seen to “scratch the surface” in terms of potential avenues MCHA might take in accessing funding and program support tied to that landmark legislation.

For current purposes, we drilled down into Title IV of the Act, "Prevention of Chronic Disease and Improving Public Health." We also did a cursory compilation of programs under Subtitle B, part III, "Indian Health Care Improvement," of Title X, "Strengthening Quality, Affordable Health Care for All Americans."

To focus our research efforts, we received timely assistance from Kristine Dietz of the New Mexico Congressional Delegation Office in Washington, DC. Ms. Dietz has committed to assist us further in tapping the most relevant and timely program and funding information and to connect us with health policy staff to New Mexico Senator Jeff Bingaman.

The appendix to this preliminary report contains several compilations, based on our research into the Act and into programs actually being implemented by the US Department of Health & Human Services. These include:

- (1) Outline of Subtitles and Sections in Title IV, "Prevention of Chronic Disease and Improving Public Health"
- (2) Summary of Prevention and Public Health Programs and Funding Sources, PPACA
- (3) Published prevention-related programs (grants and cooperative agreements) in the Catalogue of Federal Domestic Assistance (CFDA), administered by the Centers for Disease Control and Prevention [as guided by the New Mexico Congressional Delegation Office]
- (4) Detailed summary of the CFDA programs in prevention and disease control.

The following narrative briefly summarizes the programs most relevant to MCHA's objectives for this study. While there are several titles of potential interest to MCHA, there appears to be only one with any funding availability in FY 2012, except that further consultation with the New Mexico Department of Health could uncover programs being funded through the states. The title with particular relevance and availability is as follows:

Applied Leadership for Community Health Improvement [CFDA # 93.055; *Public Health Service Act*, Section 301].

The purpose of this program is to improve community health through applied, team-based meta-leadership development. Specifically, this program will:

- Establish a national health applied leadership training program to provide customized public health applied leadership training to local and state public health officials and their allies.
- Assemble, train and provide technical assistance to local teams of 3-5 leaders to effectively address local public health problems as part of a Community Health Improvement Project.
- Document and evaluate the applied public health training approach. Foster replication through train the trainer and e-learning models to increase the programs reach and impact.
- Document and evaluate the Community Public Health Improvement projects used by the teams and to submit the promising and effective strategies and interventions utilized to the CDC for further evaluation and potential dissemination.

This program addresses the “Healthy People 2020” focus area(s) of Public Health Infrastructure; activities arising from this program may address many other focus areas. Measurable outcomes of the program will be in alignment with one (or more) of the following DHHS and Healthy People 2020 performance goal(s): 1) Strengthen the Nation’s Health and Human Service Infrastructure and Workforce; and 2) Ensure that Federal, State, Tribal, and local health agencies have the necessary infrastructure to effectively provide essential public health services.

For this program, funding will be directed to a single competitively-selected grantee. NGOs may also be eligible for funding opportunities. \$1 million is available nationwide in FY 2012.

Recommendations

- (1) Continue the Resource-Linking Process.** The current report is the result of a preliminary scan and analysis of the PPACA legislation and the corollary program implementation information published by the Administration. As such, it represents a first step in de-coding the PPACA and attempting to link Federal resources to local action. We recommend continuing the process, to include maintaining consultation with funding and health policy staff in Washington (most prominently at this point, the New Mexico Congressional Delegation Office). Initial feedback from Washington staff suggest that “there is a lot of money” tied to the nationwide healthcare reform initiative, and in this light our continued efforts may bear fruit.
- (2) Track Down Existing Appropriations.** The PPACA has already been implemented along a number of appropriations paths, and the Alliance would do well to understand where existing investments are currently being made. For example, of the \$70 million identified as being spent in New Mexico, where are those funds being utilized? What programs and projects are already being funded?
- (3) Enrich the Screen.** As our collective research effort proceeds forward, the Alliance advises “enriching the screen” through which we search for relevant and timely information on resources, for example, by sorting information according to McKinley County’s unique issues and the Alliance’s strategic concerns, e.g.: “rural,” “public health,” “community-based,” “equity,” etc.
- (4) Articulate the Power of Prevention.** There is a desire by the Alliance to engage local public officials as allies in the push for increased investments in public health, disease prevention and health promotion. The Alliance can draw upon available studies in the field (for example, recent articles by New Mexico Voices for Children) to articulate the “prevention message,” including its social and financial benefits.

(5)

APPENDIX**Medical Home and Community-Based Health Home****Medical Home**

The patient-centered medical home model refers to an approach to providing comprehensive primary care that facilitates partnerships between individual patients, their personal providers and when appropriate, the patient's family. The goal is better access to health care, increased satisfaction with that care and improved health. Or more robustly (as defined by Martin and Bowman in *Annals of Family Medicine*, 2004): "The services should be accessible, accountable, comprehensive, integrated, patient-centered, safe, scientifically valid, and satisfying to both patients and their physicians."

In 2007 a consortium of the largest primary care physician organizations in the USA published the *Joint Principles of the Patient-Centered Medical Home*, summarized as:

- Personal physician with an ongoing patient relationship
- Physician-directed medical practice, led by the personal physician with a team of practitioners
- "Whole-person" orientation
- Coordinated and/or integrated care across disciplines and specialties
- Quality and safety ensured by care planning, evidence-based medicine, clinical decision-support tools, performance measurement, active patient participation in decision-making, and other measures
- Enhanced access to care
- Payment structures that reflect the added value of the medical home approach and recognition of case-mix differences in the patient population being served by the physician

These joint principles have gained a some support in the physician and health policy communities. By 2009, 10 states (not New Mexico) were considering legislation to promote medical homes, and there were at least 26 pilot projects involving medical homes with external payment reform being conducted in 18 states – including over 14,000 physicians caring for nearly 5 million patients. (Bitton, Martin & Landon, "A nationwide survey of patient-centered medical home demonstration projects, *Journal of General Internal Medicine*, June 2010)

The Medical Home concept, which identifies a multi-disciplinary "home" for each patient, requires advanced management techniques like electronic medical records and easy patient access, and pays for prevention and care coordination, is supported through an "Innovations Center" and the law requires payment for these services from insurers. (Josh Freeman, "PPACA, the New Health Reform Law: How will it affect the public's health and primary care?", *Medicine & Social Justice* blog, April 22, 2010)

The PPACA legislation contains at least 5 pilot projects and 30 demos. Section 3021 establishes the Center for Medicare and Medicaid Innovation within CMS. The purpose of the Center will be to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patients in each program. Dedicated funding is provided to allow for testing of models that require benefits not currently covered by Medicare. Successful models can be expanded nationally. [Thus appear better to fit the definition of “pilots”]

The PPACA includes 18 different models for possible testing, one of which is “Promoting broad **payment and practice reform in primary care**, including patient-centered medical home models for high-need individuals.”

Additionally, health commentators (Foley & Lardner LLP, E-Newsletter, 5/13/2010) provide the following:

- **Community Health Teams.** The Secretary must establish a program to provide grants to, or enter into contracts with, entities to establish community-based interdisciplinary, inter-professional teams, called “Health Teams,” to support primary care practices within hospital service areas served by the entities. These Health Teams must demonstrate a capacity to implement and maintain HIT that meets the requirements of certified EHR technology
- **Health Homes .** The PPACA permits states to implement a state plan amendment providing medical assistance under the Medicaid program to eligible individuals with chronic conditions who will select a designated provider as that individual's “health home.” States must include in the state plan amendment a proposal for use of HIT in providing services and improving service delivery and coordination across the care continuum, including the use of wireless patient technology to improve coordination and management of care and patient compliance with provider recommendations. In addition, when appropriate and feasible, a designated health home provider must use HIT in reporting to the state on applicable measures for determining the quality of the services rendered. The health home services to be provided pursuant to the state plan amendment.

Community-Based Health Home

As a health council and consortium, the McKinley Community Health Alliance acknowledges the primary care benefits that may be derived from the medical home approach, but has a more direct interest in the “community-based health home” model, which takes a broader look at inter-provider consultation and coordination at the community level as related to public health. Additionally, the Alliance embraces the primacy of “health” – rather than just “health care” – as its broader and more strategic concern. With an eye to public health, the Alliance hopes that a refined understanding of funding and program support available under the PPACA will help bring in much-needed resources bring together the diverse elements of the local health provider community in fashioning a coordinated and collaborative system.