Transforming Practices

Creating A Unique Health Center Network Through Partnerships and Collaboration

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Learning Objective

Develop an understanding of how CP of NYS and a number of "Affiliates" are partnering to develop a Health Center network to transform established Diagnostic and Treatment Centers (D&TCs) into financially sustainable Community Health Centers in collaboration with existing Federally Qualified Health Centers.

The Partnerships' Goals

Leverage FQHC designation in support of its mission to serve current patients with disabilities and chronic health conditions and their families as well as new community patients with like-needs.

- **Utilize the program as the vehicle for providing accessible, improved, sustainable primary medical care and related services to vulnerable, high cost patients with complex needs.**

Barriers

- **HRSA does not recognize people with disabilities and chronic health conditions as a “Medically Underserved Population”, presenting a significant barrier in successfully applying as an FQHC Look-Alike or New Access Point.**
- **NYS DOH’s designation of “CP D&TCs” as safety net providers has no bearing.**

A Viable Option

The new Health Center operator arranges a Sub-Recipient Agreement, partnering with an existing FQHC.

- **The FQHC's application for expansion of Scope of Services through a Sub-recipient Agreement to HRSA does not require detailed criteria for establishment of need as in a NAP.**

Creating the New FQHC

- Develop new HRSA compliant Board and P & P: Health Center Operations, Discount Sliding Fee Policy, Scope of Services, HR Handbook, Credentialing.
- Implement comprehensive QI Plan.
- Develop sub-recipient and service agreements with Grantor FQHC.

Sponsor Agreements

The new FQHC will operate the existing sponsoring CP "Affiliate" D&TCs under new Article 28 licensing and...

- **Lease facilities from "Affiliate" at fair market value.**
- **Lease non-provider staff at cost.**
- **Contract administrative services at cost.**

Enhanced Medical Homes

The model incorporates an *enhanced* Medical Home (*e*-MH) which embraces a Transdisciplinary Team approach with interoperable HIT to plan, provide, arrange and coordinate a "core" of services associated with the typical needs and co-morbidities of the target population which presents extraordinary complex needs.

Expected Health Outcomes

- **Expanded access improves community health inclusively.**
- **Reduce use of emergency departments.**
- **Reduce length and frequency of hospital stays.**
- **Reduce re-hospitalizations.**

What Will be Accomplished?

- **Creates new collaborations with FQHCs with complimentary agreements to benefit each organization's patients.**

- **Addresses CMS' "Triple Aim": better care for individuals; better health for populations and reducing per-capita costs.**

Contact Information

Duane Schielke
Executive Vice President,
Health Management Initiatives

Cerebral Palsy Associations of NYS
330 West 34th Street, 15th Floor
New York, NY 10001
212-356-1204
dschielke@cpofnys.org