National Health Policy Forum

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New Orleans Health Department Mission

- **To ensure that all citizens have access to affordable, quality and convenient health care and services.**

- **Coordinate and partner with other health care providers to ensure that the medical needs of New Orleans communities are being met.**

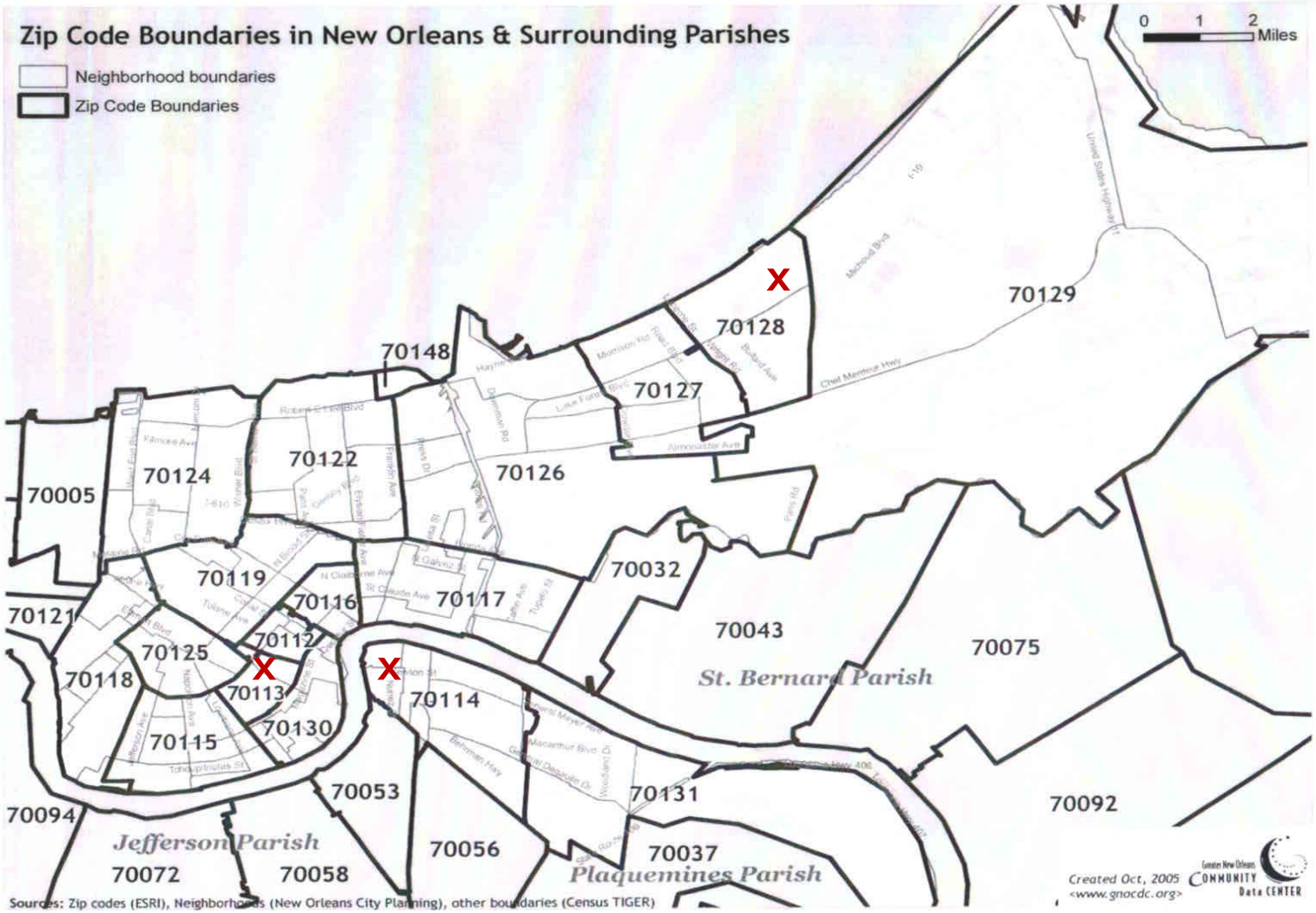
<u>Pre-Hurricane the Uninsured</u>

Used ER care

Charity hospital care clinics

No care

City of New Orleans Health Clinics: 2010



City of New Orleans Current Clinic Services 2010
Adult Primary Care
Pediatric Care
Diagnostic Test/Screen
Family Planning
OB/GYN Services
Developmental Screen
Immunizations
Vision/Hearing Screen
Health Education
Care Management
Case Management
Discharge Planning
Translation Services
Eligibility Enrollment
Transportation
Comprehensive Dental
Food Bank/Meals
Nutrition
Housing Assistance
Pharmacy
HIV Testing
Substance Abuse Treatment
Mental Health Services
Prenatal Care
WIC

Primary Medical Care:

- 3 distinct Primary Care Clinics located in high-need areas.
- 3 sites are HRSA designated HPSA/MUA/MUP.
- Located in New Orleans East, Central City and the Westbank.
- Operated with LSU, Tulane, MHSA and Excelth.

Dental Services:

- 2 mobile dental vans – 1 school based van visits K-12 schools.
- Louisiana is ranked #1 nationally by HRSA as a Dental HPSA.

Emergency Medical Services

- Severe transportation needs: no public transport; vehicle ownership.

PCASG Funding

- **The 4-parish Greater New Orleans Region receiving PCASG funding – has more NCQA recognized medical homes than any other area of the country.**
- **In 3-years, the CNOHD has been a part of a network of providers that includes 25 partners – at over 90 sites.**
- **Allows for a Holistic Care Model: Medical, Mental Health, Dental, Sub-Specialty Care**
- **Supports and makes possible "Neighborhood Care"**
- **Would not have been able to fund the New Orleans East Clinic and the two Mobile Dental Vans**
- **Monetary incentives provided to become medical homes**
- **Cultural appropriateness of terminology: "Medical Home" = "Nursing Home"**
- **Ability to provide services to citizens in accessible sites in their community without having to travel**

Increased patient satisfaction and compliance

PCASG Sustainability

- Old model does not encourage care coordination
- No financial incentives to partner and integrate care into a holistic regional service delivery system
- Maximize existing efficiencies and resources
- Partnering and coordinating care with hospitals
- Decrease number of costly ER visits
- Decreased work absenteeism
- Cost-effectiveness of early intervention/prevention services
- 70% uninsured rate – without government funding support – model isn't self-sustaining
- Requires "Bridge Funding" until a viable funder mix can be established
- When Medicaid/Medicare reimbursement rates are increased to competitive levels
- Approaching untraditional funding partners
- Cost-benefits and savings in comparing existing ER model of care vs. PCASG community model

Health Care Reform Road Map Directions

As the Uninsured Become Insured:

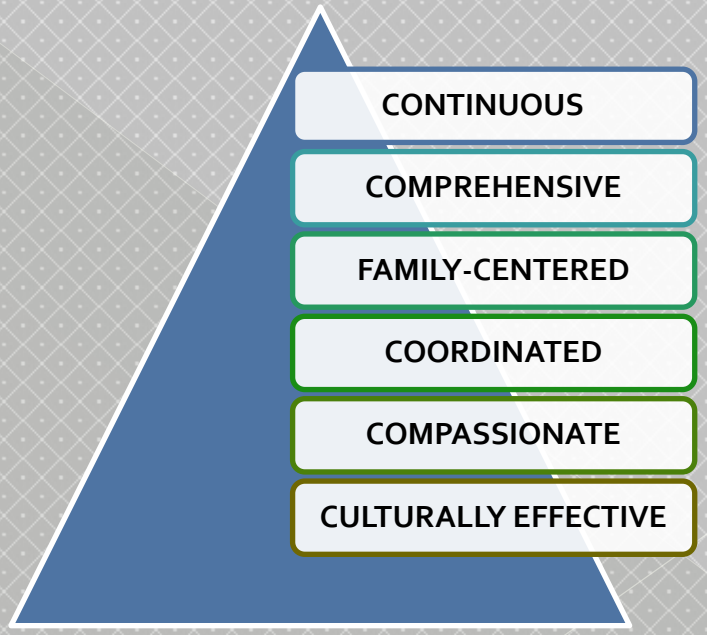
- They will access care earlier
- Will move from historical ER care to early intervention and preventative care model
- Ability to diagnose and treat earlier – better outcomes and cost effective
- Establish a system-wide infra-structure for actual implementation of medical homes
- Creates a diverse set of providers – broadens choice of providers in communities
- Provides incentives for quality services and care for the uninsured
- Provides initial technical assistance and oversight

Patient-Centered Medical Home Model (PC-MH)

PROVIDER INCENTIVES

- Additional pay for measurable outcome & conduct continuous quality improvement
- Monetary incentives as "Medical Homes"
- Physicians share in savings – Decreased ER visits and reduced hospitalizations
- Qualified NCQA = Increased Reimbursement

Medical Home Model Operational Characteristics



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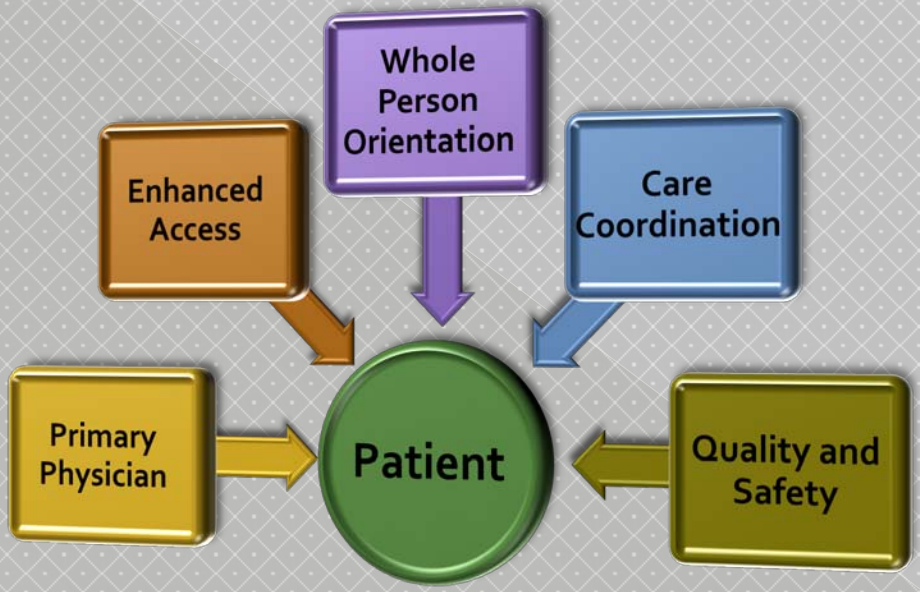


Whole Person Orientation

Provides for ALL of a patient's collective health care needs
Responsible for arranging care for all other health needs
Care over the continuum of life: acute, chronic, preventive, end of life
Patient participates in decision-making regarding health services

Primary Physician

Patient has on-going relationship with a single personal physician
Practice takes responsibility for the ongoing care of all patients
Patients receive care when and where they need and want it

Enhanced Access

Patient is offered open scheduling options
Expanded hours of operation, on-call
Expanded communications between patient and provider and staff

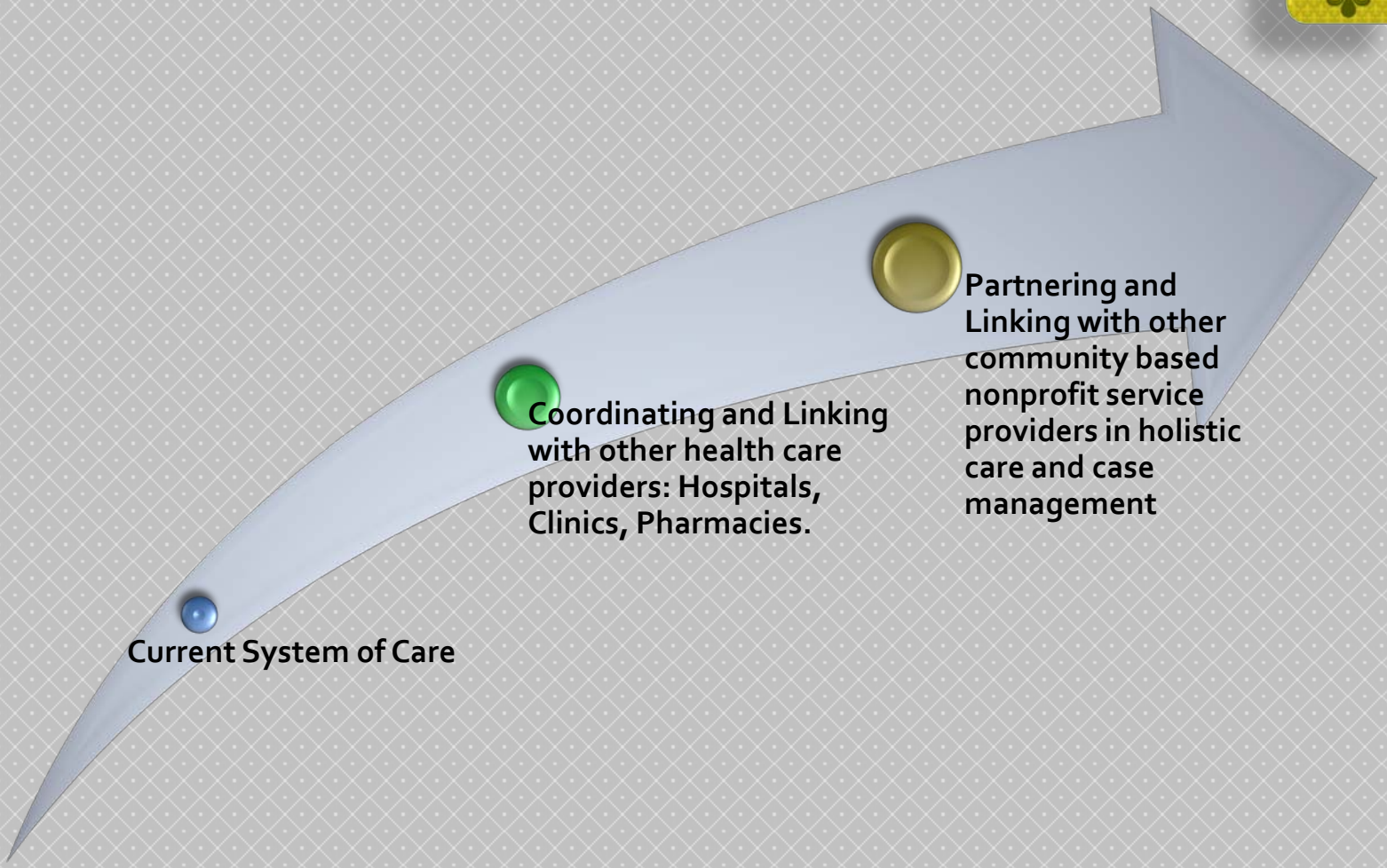
Care Coordination

Care is coordinated across all elements of the complex health care system
Integration of information technology, EHR and health info exchange
Recognizes case mix differences in patient populations being served

Quality and Safety

Services are provided in a culturally and linguistically appropriate manner
Care measured by optimal patient-centered outcomes
Uses evidence-based medicine and practices: Measured through HIT
Accountability measured through continuous quality improvement

NEW ORLEANS TRAJECTORY OF CARE



Building on the Existing System: Leveraging the PCASG Grant Opportunity