

Community Coalitions for Access and Quality Improvement (CCAQI)

Purpose of this Legislation

To fund the creation and operation of a national network of local community access coalitions throughout the United States accountable for the development of integrated and efficient health care delivery systems that assure all residents in a geographic area have access to a broad range of coordinated, high quality services. The ongoing responsibilities of a community access coalition include:

- ▶ **Convening** diverse *partners* to work on common initiatives among separate organizations;
- ▶ **Leveraging** existing *resources* from multiple sources to apply towards common access and quality improvement goals that save money over the long run;
- ▶ **Piloting** innovative *solutions* and replicating those that are successful;
- ▶ **Sustainability** of critical service capacity; and
- ▶ **Evaluating** and communicating community *outcomes* for better health, access for all and cost effectiveness.

Principles of a Community Access Coalition

- ▶ A medical home for all participants with access to primary care, mental health services, pharmaceuticals and oral health care
- ▶ A focus on wellness and appropriate preventive services
- ▶ Referrals as needed with consistent follow-up
- ▶ Removal of bureaucratic and other barriers to care
- ▶ Accountability to the community as a whole (vs. a specific constituency or organization)
- ▶ Balanced representation of the range of providers, consumers, and purchasers
- ▶ Govern through collaborative decisions
- ▶ Integrate the continuum of services and pool funding silos

Need for Federal Grants

- ▶ The Citizens' Health Care Working Group has heard across the country "serious concerns related to a lack of primary care providers, the inability to access specialty care; and, difficulties in navigating a complicated health care system, especially for those with chronic conditions." In response, the Group has recommended fostering the development of innovative integrated community health networks to address the concerns.
- ▶ There is no need to reinvent this wheel--250 such community health coalitions are already operating in every state in the U.S. as a result of previous investments from the Federal government. Federal funding is needed to sustain existing coalitions and grow an adequate national network.
- ▶ The Federal government has an incentive to continue investment in these coalitions because they save the money and augment public dollars with significant private dollars. Evaluation results indicate that these coalitions were able to leverage \$6 for every federal dollar invested and to provide access to 6.2 million more people while saving \$2 billion in 2006.
- ▶ The vast majority of the services provided by these coalitions are coordination and enabling services—services that are crucial to increased access and quality, but not reimbursable under almost all coverage plans.

Key Provisions of the CHCAQI Legislation

- ▶ Authorizes a new program and necessary appropriation until 2012 to strengthen effectiveness, efficiency, and coordination of health services within communities. The Secretary shall submit an evaluation to Congress by September 30, 2012.
- ▶ Defines a community access coalition and gives the Secretary the authority to award grants to eligible coalitions.
- ▶ Eligible coalitions will have balanced representation and formal membership that at least includes: 1) Community Health Centers and/or Rural Health Clinics; 2) hospitals that serve more than 25% of the under-served, Critical Access Hospitals; 3) public health, and 4) public or private sector health care providers or organizations that have traditionally served the uninsured and low-income individuals.
- ▶ A competitive application will prescribe the geographic community to be served, providers and businesses that will participate and their contributions, activities to be performed, and community involvement.
- ▶ The coalition applicant must demonstrate:
 - It is an established coalition with fiscal and management systems in place;
 - Is able to develop a coordinated local system of primary, secondary, tertiary, pharmacy, behavioral health, and oral health services;
 - A commitment to serving the low-income and uninsured, including the ability to enroll individuals in public and private health coverage programs and arrange for free or reduced charge care for the poor;
 - A plan to leverage additional state, local and private funds; and
 - A plan to evaluate activities and progress.
- ▶ Priority will be given to coalitions that show the greatest unmet community need or percentage of uninsured and focus on:
 - Expanding use of prevention and primary care services;
 - Improving coordination between health care and social service providers;
 - Collaborating with state and local governments; and
 - Demonstrating sustainability by making use of non-federal contributions.
- ▶ The coalition may receive a grant for 3 years, with an opportunity to request an additional 2 years based on proof of performance. Coalitions are not prohibited from submitting a new competitive application if the program is reauthorized.
- ▶ Grant funds may be used for a range of specific purposes,¹ including direct expenses associated with achieving an integrated health care system and direct patient care (not to exceed more than 20% of total grant funds).
- ▶ Seven percent of the federal appropriation for this program can be reserved for national program purposes, including technical assistance to grantees that may be subcontracted.
- ▶ Grantees must evaluate and report progress to the Secretary annually.

¹ Outreach and referral, care management, patient navigation, coordination of transportation and language access, volunteer provider networks, information systems, prevention and disease management tools, cancer detection, treatment and management.