Primary Care Access and Stabilization Grant: Sustainability Strategy Guide

Introduction

As we pass the half-way point in the three-year Primary Care Access and Stabilization Grant our focus on strategies for sustainability must sharpen. While uncertainty around state and federal health policy affecting the environment in which PCASG-funded providers operate persists, many participants are asking the question: *What should we be doing to maintain our gains and decrease our chances of having to scale back or shut down once the grant ends?*

This brief strives to provide a clear answer to that question, and is organized according to:

I) Actions that should be taken by participating organizations internally to increase chances for sustainability, and
II) Actions that should be taken to help influence the policy environment externally.

This is a working document that will evolve over time, and your feedback on improving it is welcome (please contact Clayton Williams: cwilliams@lphi.org).

I. Actions that should be taken by organizations INTERNALLY to increase chances for sustainability beyond grant funds

We have been working hard towards gains in access, quality, systemness and sustainability, and while much progress has been made, the data show we have much room for improvement. Perhaps the single biggest predictor of our ability to thrive into the future is the extent to which we make good use of the abundant resources available to us now—the key to success is producing valuable results. Our goal should be to create a product that is so valuable to the people being served and other stakeholders that when the time comes for decisions to be made about making further investment, the conclusion will be: *We cannot afford to lose this.*

With a robust evaluation underway, the focus of the participating organizations can be squarely on advancing our shared goals. While there are those who are increasingly cautious about investing in expansion and improvement given where we are in the grant cycle, there are also those who believe we cannot afford NOT to continue momentum.

The remainder of this section of the Guide will:

- Outline each grant goal;

- Present available data to indicate progress and room for improvement in the goal area;
- Make suggestions about specific actions that can be taken by participating organizations to advance the goal; and
- Make reference to technical assistance and other resources available to assist.

Grantee-Level Dashboards

LPHI is producing data dashboards that summarize and repackage information submitted at the grantee organization level according to performance in relation to PCASG goals. These dashboards strive to help your organization understand and track status and progress, and provide comparisons to relevant peer organizations (in aggregate) and established national benchmarks.

Goal 1: Increase access to care on a population basis

What the data show for Goal 1

While our overarching goal is to provide access to high quality primary and behavioral healthcare to *everyone*, without regard to ability to pay, the federal investment was made specifically to fill gaps and remove barriers to access; therefore, an indicator of our success in achieving this goal is the extent to which we provide access to a continuous source of affordable primary care for the uninsured in the New Orleans Region.

Table 1. PCASG target population analysis	
A. Estimated uninsured population DHH Region I (as of 4th Q 2008)	135,167
B. Uninsured PCASG primary care patients (Sept 07 - Sept 08)	58,251
C. Estimated uninsured population that did not visit a PCASG primary care patient from Sept 07 to Sept 08	76,916
D. Estimated percent of uninsured population that were NOT a PCASG primary care patient from Sept 07 to Sept 08	56.9%
Sources: Synthetic estimates constructed by LPHI using data from the US Census CPS, Louisiana Health Insurance Survey, ESRI, and PCASG administrative data	

While PCASG administrative data and findings from the Kaiser Family Foundation 2008 household survey show substantial progress in increasing access to care in the region, if we

assume PCASG includes the lion's share of the safety net for DHH Region I, it is clear we have much work to do to establish medical homes for the portion of the estimated 76,916 people that have a need. While the specific portion of these individuals in need is uncertain, it is certain there are still tens of thousands without a regular source of care that is not the emergency room. Walgreens and Wal-Mart are examples of companies setting up convenient (and most likely profitable) alternatives in the New Orleans area for preventive and episodic care. This type of development will likely not only provide alternatives to inappropriate ED use, but also compete with primary care providers' ability to establish ongoing relationships with community members.

PCASG administrative data show potential for growing capacity in the short term lies primarily in increasing hours of operation. Table two below shows that less than half of PCASG service delivery sites offer evening or weekend hours. Many working people need alternatives to regular business hours.

Table 2. PCASG Clinic Hours of Operation Analysis

Site Type	Total Fixed Sites	Open 40 hrs/wk or more	Open less than 40 hrs /wk	Open less than 20 hs/wk	Offer Evening Hours	Offer Weekend Hours
Behavioral Health	25	25 (100%)			11 (44%)	3 (12%)
Primary Care	43	38 (88%)	5 (12%)	1 (2%)	5 (12%)	16 (37%)
School Based Health Center	3	3 (11%)				
Dental	3	1 (33%)	2 (7%)			
Total	**74**	**67 (90%)**	**7 (9%)**	**1 (<1%)**	**16 (22%)**	**19 (26%)**

Review of utilization data show opportunities for gains in efficiency by adopting national standards/benchmarks for appropriate provider panel size. This is a way to get more people the care they need without adding staff and space. A preliminary analysis of panel sizes across PCASG-funded organizations shows the vast majority do not meet established benchmarks in terms of panel size nor annual encounters per provider. While further analysis is required, the data show some attention to this area would be time well spent. Organization-specific data dashboards created by LPHI contain information on these indicators to assist in improvement efforts.

In March of 2009 LPHI conducted a focus group with neighborhood residents and clinic users, and the findings suggest that quality, good customer service, and a trusting personal relationship with a provider and clinic staff is more important than convenience or location. In addition hours of operation are very important—everyone mentioned the need for evening and weekend services, particularly for working adults (regardless of insurance status).

Finally, LPHI's semi-annual mystery shopper study shows significant room for improvement in terms ability to obtain appointments by phone and responsiveness via phone. As of September 2008:

- Mystery shopper callers were only able to schedule an appointment by phone 37% of the time
  - 10% clinics were “walk-in only” for new patients, 19% required an intake coordinator call back to triage, and 8% had automated messaging systems with no opportunities for call backs (e.g. messages full, etc) or were unreachable
- In cases where sites indicated that they would call a patient back, or if the patient left a voice message for a return call:
  - Just 2 out of 32 (6%) of primary care calls were returned
  - Just 9 out of 29 (31%) of behavioral health calls were returned

Table 3. Implicated priority ACTIONS to improve access to care and TA resources available

Recommended Action	**Technical Assistance and Resources**
1. Improve scheduling, phone responsiveness and customer service focus	Quick Tips: Phone Management http://www.lphi.org/LPHIadmin/uploads/quick-tips--phone-management-96058.pdf
2. Identify and work towards panel sizes consistent with established benchmarks	1. Murray, M., Davies, M., Boushon, B. Panel Size: How many patients can one doctor manage? *Family Practice Management,* 44-51. www.aafp.org/fpm 2. Texas Association of Community Health Centers (TACHC): http://www.tachc.org/HDC/Docs/Connie%20Sixta_WCC%20Provider%20Panels%20and%20Continuity.pdf [This PowerPoint presentation may be helpful in determining panel sizes for both adult and pediatric populations] 3. Yarnall, K. S.; Pollak, K. I.; Ostbye, T.; Krause, K. M.; Michener; J. L. (2003). Primary care: Is there enough time for prevention? *American Journal of Public Health,* 93: 635-641: http://www.ajph.org/cgi/reprint/93/4/635 [This article may be helpful in determining panel sizes for both adult and pediatric populations] 4. Readers Speak Out on the Turtle vs. Rabbit Controversy: *http://www.aafp.org/fpm/990700fm/19.html* 5. Murray, M. & Berwick, D. M. (2003). Advanced access: Reducing waiting and delays in primary care, JAMA, 289, 1035-1040. 6. Article that describes Advanced Access in 4 case studies in primary care settings: Murray, M.; Bodenheimer, T.; Rittenhouse, D., Grumbach, K. (2003). Improving timely access to primary care: Case studies of the advanced access model. *JAMA, 289,* 1042-

	1046.
3. Expand hours of operation (especially evenings and weekends)	PCASG organizations that offer evening and weekend hours may significantly reduce emergency department (ED) usage. A number of studies in primary care settings have concluded that offering evening and/or weekend hours may reduce ED usage. One study conducted by Lowe and colleagues studied primary care practices serving a Medicaid population to determine whether certain practice characteristics are associated with ED use. Although further research is required, the findings suggest that the more evening hours a practice had, the lower was ED use by its patients. Most dramatically, patients in practices with 12 or more evening hours a week used the ED 20% less than patients in practices without evening hours. The effect was more marked for adults than for children. Weekend hours were also associated with lower ED use, but did not reach statistical significance. [http://www.upenn.edu/ldi/issuebrief10_8.pdf]
4. Community engagement: Actively develop awareness of community needs and challenges among staff and leadership, and involve community members in priority setting and governance	Community Oriented Primary Care: Health Care for the 21st Century by Robert Rhyne and American Public Health Association People's Institute for Survival and Beyond: http://www.pisab.org/
5. Focused outreach at community level	-Primary Care Outreach Campaign (PCOC) will support high-level awareness building -LPHI staff can be of assistance to organizations planning outreach efforts (contact PO if interested)
6. Participate in regional planning efforts	-Mapping and data support provided by LPHI to inform decision-making -Impending 504Healthnet/ LPHI/ LPCA planning process

Goal 2: Provide high quality, evidence-based healthcare

What the data show for Goal 2

An important indicator of quality at the system level is the rate of ambulatory care sensitive condition presentations to emergency rooms. National statistics confirm this as a problem all over the country. For example, the national rate in 2003 of ACSC's for Medicare patients was 7,278 admissions per 100,000 beneficiaries. Further, in 2003, Louisiana had the second highest state rate of Medicare ACSC admissions at over 11,000 per 100,000 beneficiaries, second only to Mississippi. (Commonwealth Fund State Scorecard on Health System Performance, 2007) In addition, DHH Medicaid reports that over half of all emergency room presentations among Medicaid enrollees in DHH Region I result from conditions that would be more effectively and efficiently managed in the outpatient setting. Generally speaking, except for Medicaid, data for

this indicator are not readily available for DHH region I currently, but this is being tracked and will be analyzed and reported as part of the PCASG evaluation being conducted by the research team at UCSF.

The PCASG quality improvement program is anchored in the framework of the National Committee for Quality Assurance (NCQA) Patient Centered Medical Home. Both the minimum required quality standards and the optional quality incentive payment program draw from this framework.

Table 4. PCASG Quality Improvement Program Progress

Component	Status
Minimum Requirement: Provide 24/7 access to clinician by phone for existing patients	Imposed as a minimum grant requirement in July 2008, all grantees report the provision of 24/7 access to clinicians for existing patients through a variety of methods including physician or nurses on call during after hours and/or contracting with after hours call services for triage.
Minimum Requirement: Provide same day appointments for urgent care for existing patients	Imposed as a minimum grant requirement in July 2008, all grantees report same day appointments through enhanced patient triage to determine urgency, providing open access scheduling or working patients in to be seen preferably by their assigned provider.
Minimum Requirement: Identify three important conditions among patients served and implement an evidence-based guideline for managing one of the top three conditions.	In Sept 2008, each grantee reported its top three clinical conditions and selected one evidence based guideline (EBG) to implement within their organization. In December 2008, grantees were required to submit results from a Plan Do Study Act (PDSA) cycle on their progress towards implementing the EBG These reports are currently under review. The next round of data associated with this minimum requirement is due in June 2009.
Optional: Quality Incentive Payment (QIP) program	Thirteen organizations representing 36 service delivery sites (SDS) were recognized by NCQA as Patient Centered Medical Homes: 11 organizations representing 33 SDS received NCQA Level 1 Recognition; one organization, representing one SDS was recognized at Level 2; and two organizations, representing two SDS received the highest level of NCQA recognition, Level 3.

Table three shows great progress towards achieving NCQA standards. For minimum quality standards, efforts to optimize these can result in more timely and cost-effective healthcare utilization—helping people avoid utilizing the ED for conditions more effectively and efficiently managed in the outpatient setting.

An analysis of the evidence-based guideline adoption among grantees shows organizations primarily focused on the following conditions in rank order by frequency: hypertension/ cardiovascular disease, diabetes, and depression. There are opportunities for better coordinating these efforts across organizations to achieve optimal results at a system level—something that will help the case for further investment in this model of care.

For the optional quality incentive payment program, opportunities exist for additional PCASG-funded organizations to participate in the final round (which wraps up in December 2009). Organizations receiving recognition in rounds one or two may advance to a higher recognition level or PCASG payment tier by submitting an add-on survey in the final QIP round.

Table 5. Implicated priority ACTIONS to improve quality of care and TA resources available

Recommended Action	Technical Assistance and Resources
1. For those not doing so already, participate in PCASG QIP	**Step by Step for Grantees New to QIP:** **In accordance with published timelines:** Step 1: Submit the Revised PCASG Memorandum of Agreement (MOA) to LPHI. Step 2: Complete the NCQA LPHI ORDER FORM and fax to NCQA as instructed. NCQA will send out series of emails, which will enable the grantee to access the NCQA web-portal and download the Application and Practice Workbook. Step 3: Sign two originals of the NCQA Agreement (outlined in the first page of the NCQA Application and Practice Workbook) to NCQA via postal mail. Step 4: Forward the completed NCQA Application and Practice Workbook one week in advance of submitting the PPC-PCMH Web-based Survey Tool(s) to NCQA Step 5: Submit the PPC-PCMH Web-based Survey Tool(s) to NCQA
2. For those that did not achieve level 3, work towards higher score and submit add-on survey in QIP round three	**Step by Step for Grantees Seeking NCQA Reassessment for QIP:** In accordance with published timelines: Step 1: Apply for an Add-On Survey(s) for specified service delivery sites directly with NCQA

	and notify LPHI of request, Step 2: Submit Add-On Survey(s) to NCQA.
3. Fully implement the NCQA standards and maintain momentum for improvement. Achieving NCQA recognition is a beginning, not an end.	See www.NCQA.org and www.lhcqf.org Collaborative to Improve Behavioral Health Access (CIBHA) http://lphi.org/home2/section/generic-165/ Many other QI resources available locally and nationally- submit specific resource requests though PO
4. Work together to identify opportunities for peer learning, coordination of disease management and pooling of results	LPHI will support a forum for committed medical directors interested in working together in this way

Goal 3: Create an organized system of care

What the data show for Goal 3

Vertical Integration. In order to effectively manage the chronic conditions that so often result in unnecessary dependence on the emergency room and hospitalization, people must have timely access to a range of diagnostic and specialty care services. Achieving vertical integration among a federated group of independent healthcare providers is challenging without a clear set of financial drivers in place to reinforce it, but advances are possible. For example:

- MCLNO has recently defined evidence-based rules and guidelines to enable referrals to their specialty and diagnostic services, and CLIQ is available for timely access to most reports and results

- There is also increasing evidence of collaboration among community health centers making specialty and diagnostic services more accessible (e.g. St. Thomas Community Health Center's cancer screening and cardiology consultation)

- LPHI is working closely with federal, state and private partners to identify resources and technical assistance on increasing access to low cost or no-cost medications for PCASG patients. LPHI has reserved $7.395 million in supplemental payments over three years for PCASG recipients offering eligible pharmacy services to their patients. To date, 21 of the 25 PCASG organizations routinely offer at least one of these eligible services which include: 340B discount pricing programs; industry based pharmaceutical assistance programs (PAP); on-site pharmacy services; and/or medications distribution on-site or drug voucher programs in collaboration with local pharmacies.

Primary Care – Behavioral Health Integration. The importance of linking primary care and behavioral health services is well documented, and is particularly important in the New Orleans Region due to elevated levels of disease burden. It is also well documented that a poorly managed behavioral health condition (e.g. depression) can compete with an individual's ability to effectively manage a chronic disease (e.g. diabetes).

School Based Health Care. School based health centers (SBHCs), represent an opportunity for PCASG participants to expand their reach in providing preventive and early intervention services to youth, who are underserved. In addition, growing numbers of school age children are being diagnosed with chronic diseases such as Type II diabetes and hypertension. SBHCs provide an opportunity for early intervention of these conditions that might otherwise go undetected until an emergency room visit is required. SBHCs are now specifically defined by Congress as a provider type in the State's Children's Health Insurance Program (SCHIP) Reauthorization Act of 2009. It makes sense to optimize this opportunity to expand services in high need environments such as our public schools.

Table 6. Implicated priority ACTIONS to help create an organized system of care, TA and resources available

Recommended Action	**Technical Assistance and Resources**
1. Establish relationships with providers of diagnostic, specialty care and other services not available on site.	To Enroll as an MCLNO Ordering Physician and have the ability to order MCLNO diagnostic/outpatient services and consultant services for your patients, go here: http://lphi.org/CMSuploads/APPLICATION-FOR-DIAGNOSTIC-AND-CONSULTANT-SERVICES-21290.pdf Mid-level providers are eligible to enroll, only if the physician that signed their collaborative agreement has MCLNO privileges. To Gain Access to MCLNO Evidence-based Medicine Clinic Referral Forms, go here: https://www.lsuhsc.edu/hcsd/EBMCRL/. Common Ground Resource Guides: http://www.commongroundclinic.org/j15/index.php?option=com_content&view=article&id=23&Itemid=8&lang=en
2. Actively pursue strengthening linkages between PC and BH (participate in the Collaborative to Improve Behavioral Health Access; Reach NOLA's MHIT, etc.)	Collaborative to Improve Behavioral Health Access (CIBHA) http://lphi.org/home2/section/generic-165/ Mental Health Infrastructure and Training Project (MHIT): http://reachnola.org/mhitabout.php
3. Work together to identify opportunities for improving referrals and information	-Historically LPHI/PATH has supported this effort among community clinics and MCLNO -LPHI will continue to support this type of collaborative work

exchange	- An updated map and resource directory of PCASG grantee service delivery sites: http://www.lphi.org/LPHIadmin/uploads/PCASG_map_directory_Dec2008-75747.pdf
4. Increase access to medications for patients who are unable to afford them by participating in a variety of low- or no-cost pharmacy services	To find more about the PCASG Supplemental Payment Pharmacy Allocation program, visit: http://lphi.org/CMSuploads/CriteriaPharmacyServicesV8Template-20691.doc To learn more about CMAP, the free central pharmacy service available for eligible uninsured New Orleans area residents with easy provider and patient enrollment, visit www.cmaprx.org.
5. Fully implement electronic medical records systems with registry/population management capabilities (using non-PCASG funds; however, income generated as a result of PCASG funds, "program income", may be used for this purpose)	Guidance & Technical Assistance aligned with the Office of the National Coordinator (systems integration, optimization) http://www.hhs.gov/healthit/ Louisiana Healthcare Quality Forum http://www.lhcqf.org/ http://www.lhcqf.org/documents/vision.pdf Health Information Security & Privacy Collaboration http://www.secure4healthla.org/ Economic Stimulus for Healthcare IT http://www.himss.org/EconomicStimulus/

Goal 4: Create sustainable business entities

What the data show for Goal 4

Our first priority under sustainable business entities in the realm of the PCASG must be to comply fully with the terms and conditions of the grant and be good stewards of taxpayer dollars. If this bar is not met, advancement towards grant goals will be distracted by responding to findings of the litany of auditors looking into these things.

A diversified payor mix is necessary for sustainability. LPHI systematically assesses third-party billing in order to monitor and track progress towards becoming sustainable business entities. Between Dec 07 and Sep 08, there was a 21% increase in Medicaid billing enrollment among the 25 PCASG organizations. The upcoming PCASG planning tool will reassess this capacity, however as of Sept 08, there was still room for improvement among the organizations providing primary care services. LPHI/LDHH acknowledges challenges among select behavioral health entities to become Medicaid providers/practices.

Table 7. Implicated priority ACTIONS to help create business entities and TA resources available

Recommended Action	Technical Assistance and Resources
Maximize revenue by improving ability to screen, enroll, electronically bill and collect -Medicaid billing -Contracts with other 3rd party payors	Resources to become a Medicaid Enrollment Site: http://lphi.org/home2/section/generic-144/ Screening Tool for Medicaid / LaCHIP eligibility: http://lphi.org/CMSuploads/Medicaid-screening-tool-35583.pdf Link to Medicaid Provider Website: http://www.lamedicaid.com/provweb1/default.htm Resources for third-party billing: http://www.ama-assn.org/ama1/pub/upload/mm/368/prepare-that-claim.pdf
Create business plans for the future with goals and targets with contingencies that include: -Maximizing PCASG grant awards by expansion and minimizing data errors -Leveraging of private funding	Resources for Final PCASG Payments, June and December 2009 • PCASG Technical Assistance Brief, Minimizing Data Errors and Maximizing Payments: http://lphi.org/CMSuploads/PCASG-Technical-Assistance-Brief---Reducing-Data-Errors-and-Maximizing-Payments-37597.pdf • PCASG Allowable Expenditures (Exhibit L): http://www.lphi.org/LPHIadmin/uploads/Exhibit_L_Clinic_Covered_Expenses-v4-4-30-08-79220.pdf • PCASG Clinic Covered Services: http://www.lphi.org/LPHIadmin/uploads/Exhibit_K_Clinic_Covered_Services-79539.pdf PCASG Budget Guidance: http://lphi.org/CMSuploads/Budget-Preparation-Guidance--draft-v13-3-06-09-00840.pdf
Actively participate in LPHI financial sustainability modeling process by informing model development and contributing global (non-PCASG) revenue/expense data	Daniel Cocran, CPA is LPHI's lead on the development of this model that will project gap anticipated after PCASG funding ends necessary to maintain anticipated scope and scale of services, and present scenarios given different possible external policy circumstances

II. Actions that should be taken by organizations EXTERNALLY to increase chances for sustainability beyond grant funds

The purpose of this section is to clarify the external issues at play so individuals from all organizations concerned about the sustainability of the gains made with the Primary Care Access and Stabilization Grant have an answer when asked the question: *What do you need?*

Financial Sustainability Modeling

The question first asked by someone in a position to make decisions about further investment in the PCASG providers (e.g. federal or state government, philanthropy) will be: *How valuable is this?* Value is the quality of the product/service versus the cost. The previous section addresses the *quality* component, and that component will continue to be documented by your organizations individually, by LPHI and by our external evaluators at UCSF.

On the cost side of the value equation, LPHI is in the process of determining a financial model that will help project the financial gap remaining at the end of the PCASG that will need to be filled if we are to have the means to maintain current scope and scale of essential services. This model can only be built with the active participation of PCASG organizations in shaping the model and contributing current and historical financial data—both revenues and expenses.

Potential Sources of Future Funding

Once we know the expected gap, we will need to develop strategies to identify and secure revenue. Many PCASG-funded organizations get audiences with individuals and organizations that will be influential in defining and executing solutions, so having knowledge of policy initiatives and other strategies that may offset projected September 2010 gaps can help guide those conversations. Absent a lump sum from the state or federal government (which doesn't appear likely in this economic climate), it is most likely the funding solution will be piecemeal. Likely targets include:

1. **Medicaid expansion**. While this seems increasingly unlikely in tough economic times, any increases in Medicaid eligibility (such as those in LA's 1115 Medicaid waiver request that is currently pending disposition at the US Department of Health and Human Services/ CMS) will result in a decrease in the number of uninsured—the population most dependent on federal subsides such as PCASG.
2. **Granting flexibility in the state's ability to use Medicaid Disproportionate Share (DSH)** dollars (also outlined in LA's 1115 waiver) so it can be used to support outpatient primary care, including associated clinician costs. Currently these dollars can only be used by public and rural hospitals for expenses associated with inpatient care.

3. **Expansion of the Federally Qualified Health Center program in the New Orleans Region** and the state to bring it in line with levels of funding received by states/ regions with similar needs. This strategy includes expansion of existing FQHC's and the addition of new grantees. Benefits of achieving variations on this designation include enhanced Medicaid reimbursement rates, breaks on malpractice insurance, and access to discounted pricing for medications. It also could include eligibility for a variety of sources of grant funding to offset costs of caring for the uninsured. Here is a PowerPoint about becoming an FQHC from the Texas Primary Care Office: http://www.dshs.state.tx.us/chpr/pdf/FQHC%20101.ppt
4. **Employer Engagement.** A network of willing and qualified providers could package their services and get contracts or grants from employers struggling to get affordable healthcare services for their employees. Those employers with substantial numbers of employees already benefitting from the services of a PCASG provider would have an interest in supporting the sustainability of those services, and if they saw the value clearly, may be willing to pay for it.
5. **State Contracts.** The State of Louisiana is looking for ways to provide services under their purview in the most effective and efficient way possible, and PCASG providers may be able to play a role and gain additional revenue in the process.

Shared Services Organization/ Provider Network Development

There are many gains that can be realized through network development. An example of a an emerging network that has potential to gain efficiencies and help secure sustainability is 504Healthnet (visit http://www.504healthnet.org/).

Investment in Health Information Technology and its implementation

Per OMB's restriction, grant dollars cannot be used for this purpose. Additional funding/ investment is required immediately if we are to get the most from this federal investment in terms of sustainable efficiency and outcomes. PCASG stakeholders need to consider re-submitting the request to change this rule and the parameters that would guide the expenditures.

The American Recovery and Reinvestment Act (A.K.A. *stimulus package*) includes provisions for HIT. There are provisions that would support providers with substantial proportions of Medicare and Medicaid patients, as well as provisions that would support health information exchange across providers. PCASG grantees should be familiar with these provisions and follow the rollout (a good source of information on this is the LA Health Care Quality Forum which has been designated as the state's partner in coordinating the effort).