America’s Federally Qualified Health Centers (FQHC) Program

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America’s Federally Qualified Health Center (FQHC) Program: Comprehensive Primary Care for Underserved Populations
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• Health Center Model, & Infrastructure and Patient Population
• Outcomes: clinical care, affordability, community economic vitality

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Federally Qualified Health Centers (FQHCs) or “Health Centers”

*Roots: social medicine & US civil rights and anti-poverty initiatives*

- Comprehensive scope of primary & preventive health care tailored to community needs and assets
- Located in medically underserved area or serve a medically underserved population
- Enabling services—breaking down barriers to care & health
Federally Qualified Health Centers (FQHCs) or “Health Centers”

*Roots: social medicine & US civil rights and anti-poverty initiatives*

- Services for all residents, regardless of ability to pay, with charges prospectively set based on income

- Governed by a community based board of directors, consisting of a majority of active patients to assure accountability to local needs

- Held to comprehensive performance and accountability standards for administrative, clinical, financial operations and governance
Health Centers today

• 24+ million patients
  • 1 in 14 US residents
  • 1 in 7 Medicaid beneficiaries
  • 1 in 5 low income, uninsured
  • 1 in 3 people in poverty
  • 1 in 4 minority individuals below poverty

• 1300+ organizations with 9000+ sites
• 92% with EHRs
• 68% recognized Patient Centered Medical Homes (PCMH)
• Employed nearly 157,000 full time positions while creating 230,000 other local jobs
• “Grow our own” with professional training programs & academic partnerships

BPHC/HRSA, 2015
NACHC, America’s Health Centers Fact Sheet. March 2016
Health Center Patients are a Diverse Population

- 62% of health center patients are members of racial and ethnic minority groups
  - Hispanic/Latino Ethnicity: 35%
  - Black/African American: 23%
  - Asian 4.0%
  - American Indian/Alaska Native 1.3%
  - Native Hawaiian/Other Pacific Islander: 1.2%
  - Best served in another language: 23%
- Children below age 18: 31%
- Adults (18-64): 61%
- Older Adults (over 65): 8%
- Women: 58%; Men: 42%
- Vulnerable/Special Populations: homeless, agricultural workers, public housing, school-based, veterans

Source: Federally-funded health centers only. 2015 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS. Note: Based on percent known. Percents may not total 100% due to rounding.
Health Centers: **Team Based**
Comprehensive & Coordinated Health Services

- **Health Services:**
  - Family Medicine
  - Internal Medicine
  - Pediatrics
  - Obstetrics
  - Diagnostic Laboratory and Radiology Services
  - Oral Health Care
  - Pharmaceutical Services
  - Mental/Behavioral Health
  - Substance Abuse

- **Referrals to Other Providers**
- **Patient Case Management**
- **Enabling Services**
- **Emergency Preparedness**
Breaking Barriers: Non-Clinical Services at Community Health Centers

• Enabling Services reported by health centers (18,859 FTEs)
  – Case management, transportation, eligibility assistance, interpretation, health education, outreach, housing assistance,
    Employment referral/counseling, food pantry,
    Parenting education

• Examples of other services to address the social determinants
  – Charter School
    • Mary’s Center in DC, Urban HealthPlan in NY
  – Environmental Health Dept.
    • Sixteenth Street CHC in Milwaukee, WI
  – Small Business Grants
    • Beaufort Jasper Comprehensive Health Services, SC
  – Youth programs and college scholarships
  – Sea Mar Community Health Centers, Seattle, WA
  – Medical-Legal Partnerships
  – Erie Family Health Center, Chicago, IL
  – Home improvements
    • Hudson River Healthcare, Peekskill, NY

Institute for Alternative Futures (IAF). Community health centers leveraging the social determinants of health. 2012.
Nat’l Center for Medical Legal Partnership. Building resources to support civil legal aid access in HRSA-funded health centers, 2016.
Community Governance

• At least 51% of health center board must be active patients at community health center
• Board makes decisions on services offered, monitors finances and operations, sets policy, drafts strategic and business plans, guides regular community health needs assessments
• Majority of board chairs are community or consumer members
• Consumer majority boards ensure better procedures for patient complaints, a holistic view of health and community partnerships

Health Center Organizations: Models for Regional Collaboration

• State & Regional Primary Care Associations (PCA)
  • Private, non-profit membership organizations of health centers/safety net practices
  • Capacity building focused on improved performance, expanding access to primary and preventive care for underserved communities & state health reform
  • Facilitating or strengthening partnerships among state and local agencies, community based organizations, and the private sector.

• Health Center Controlled Networks (HCCN)
  • A group of health centers/safety net providers (a minimum of three collaborators)
  • Collaborate horizontally or vertically to improve access and quality of care
  • Achieve cost efficiencies through the redesign of practices to integrate services, optimize patient outcomes, and/or
  • Negotiate managed care contracts on behalf of the participating members.
Today’s Discussion....

- Health Center Model & Infrastructure, and Patient Population
- Outcomes: clinical care, affordability, community economic vitality, workforce development
Health Centers Provide More Preventive Services than Other Primary Care Providers

- **Health Education**
  - Health Center Patients: 51%
  - Other Providers: 37%

- **Immunizations for 65 years and older**
  - Health Center Patients: 70%
  - Other Providers: 65%

- **Pap Smears in the last 3 years**
  - Health Center Patients: 85%
  - Other Providers: 81%

- **Tobacco Cessation Education for Smoking Patients**
  - Health Center Patients: 33%
  - Other Providers: 19%

- **Asthma Education for Asthmatic Patients**
  - Health Center Patients: 24%
  - Other Providers: 15%

Cost Effective Care: Medicaid Enrollees in Health Centers Vs. Other Primary Care Settings

Fee for service Medicaid claims from 13 diverse states in 2009 compared patients in FQHCs with comparison groups receiving primary care in other settings. Health Center patients had lower use & spending across all services than control group:

- 22% fewer visits
- 33% lower spending on specialty care
- 25% fewer admissions
- 27% lower spend on in-patient care
- Total spending was 24% lower for health center patients


The Health Disparities Collaboratives are quality improvement infrastructure and process focused on community health centers. They employed the “Chronic Care Model” and change processes to enhance care for specific diseases and preventive services as well as to improve the operation of community health centers.
Health Disparities Collaboratives: 1998-2008

“Share senselessly and steal shamelessly”

• Key strategies:
  – Engage senior leadership
  – Implement care, improvement and learning models
  – Change practice supported by Quality Improvement infrastructure
    • State Based Infrastructure to support and sustain improvement and continuous learning.
    • Quality improvement coaches, common metrics and transparency, and electronic patient registry
  – Develop supportive partnerships at the local and national level
  – Focus on patient and population outcomes

• Scaled to 85% participation of health centers in HDC*

*Commonwealth Survey of FQHCs, 2009. see: www.commonwealthfund.org
Health Disparity Collaboratives: The PCA Cluster Infrastructure

- Pacific West Cluster
- West Central Cluster
- Midwest Cluster
- Northeast Cluster
- Southeast Cluster
Health Disparities Collaboratives: Patient and Health Center Staff Outcomes

Systematic Review of 23 peer reviewed articles 1998- 2010

- HDCs improve clinical processes of care over period of 1-2 years and both clinical processes & outcomes over longer period of 2-4 years
- Most participants perceive HDC successful and worth the effort
- Diabetes Collaborative is cost-effective
- Gaps: resources, assistance with patient self-management, information systems, and supporting providers to follow guidelines

Conclusion:
“The HDCs are one of the most important efforts to improve quality of care and reduce disparities for vulnerable populations. They are also the largest example of implementation of the QI collaborative approach. The HDCs demonstrate that such approaches can be successful, but that thoughtful policy and managerial initiatives will be necessary to complement clinical leadership for long-term viability.”

Chin MH. Quality improvement implementation and disparities: the case of the health disparities collaboratives. Med Care 2010; 48:668-675.
Patient Narrative

“What is so special about a Health Center (Salud Family Health Center)? For the most part a Health Center offers an individualized caring relationship with their patients without economic bias which are hard to find in any other type of health organization. At a Health Center all patients are equal and cared for with utmost compassion because uninsured or underinsured will not be turned away. My Health Center has been a huge help in my life; it has literally saved my life.”

Elizabeth W.
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Questions & Brief Discussion

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