

Community Health Centers

A Key Solution to the Health Crisis

A Companion Report to the Arkansas Health Crisis Summit Report



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PURPOSE

Community Health Centers of Arkansas, Inc. (CHCA), Arkansas Primary Care Association, which represents twelve federally qualified health centers and their 55 (soon to be 58) health centers, known as “health care homes,” offers this report entitled ***COMMUNITY HEALTH CENTERS: A KEY SOLUTION TO THE HEALTH CRISIS***, as a follow-up to the recently released **Health Crisis Summit Report**. The purpose of this report is to show how Community Health Centers (CHCs) address the fundamental recommendations in resolving the health crisis in Arkansas as made during the Health Crisis: A Health Policy and Legislative Summit. Most recommendations made during the Health Crisis: A Health Policy and Legislative Summit sponsored by CHCA, Inc. and attended by more than 215 participants from 76 state agencies, organizations, associations, and legislators fell into the following categories:

Availability / Access
Quality / Cultural Competence
Affordability / Coverage / Economics
Education / Training
Collaborations / Partnerships

These recommendations stemmed from four major questions that the Summit participants discussed during the August 15, 2007 ***Health Policy and Legislative Summit***:

What strategies should Arkansas develop and /or expand to ensure access to affordable comprehensive quality primary and preventive health care?

What should Arkansas develop and/or expand to reduce/eliminate the inequities and disparities that impact health care access and health care costs?

How can Arkansas reduce the costs of health care, the costs of health care coverage, and better utilize the existing health care resources?

What public health policies and health care legislation and funding, which are designed to help address the health crisis in Arkansas, should the state of Arkansas support and/or pass?

CHCA hosted the Summit as an initial call to action after reviewing the health status of Arkansans, the health care delivery system, the economic depravity and poverty, health disparities, the lack of health care homes for more than **500,000**¹ Arkansans, the inappropriate use of the emergency departments, the rising costs of health care and health care coverage, the increasing number of uninsured, and the lack of funding comprehensive primary and preventive health care and a trauma system in Arkansas.

AVAILABILITY / ACCESS

Community Health Centers of Arkansas (CHCA) and all its members want to ensure that all Arkansans have a **health care home** - a consistent home-base for quality primary and preventive health care that is comprehensive and treats the patient as a “whole”, rather than just an isolated condition or cluster of symptoms. Therefore, the goal is **not** merely treating patients episodically for an acute sickness, but seeing patients at regular, planned visits and preventing undesirable health outcomes.

In 2006, the Arkansas CHCs served as the health care homes for over 120,000 individuals and recorded over 460,000 patient visits, including over 40,000 dental visits. Slightly over 25% of the patients last year were children and youth, whereas 11% represented older adults aged 65 and older. Over 33% of the users were women of childbearing age.²

CHCs help many overcome barriers to care. CHCs provide **access** opportunities and the **availability** of affordable, quality comprehensive and continuous health care services. CHCs are located throughout Arkansas. Many are in areas deemed in-need by the federal government, being poverty-stricken, and/or rural having above-average infant mortality rates, and/or suffering from physician shortages. Thirty-six out of seventy-five counties in Arkansas have a CHC. Currently, there are 55 CHCs operational in Arkansas. Though some of the residents of these counties are geographically isolated and have **transportation issues** that could prevent them coming to a CHC, the CHC will assist in providing transportation using its own transportation service if available, and if not, exploring other options such as Area Agency on Aging vans or services provided through Medicaid grants. With **expanding** the number of CHCs, more people with limited transportation in underserved areas could be helped. One of the twelve FQHCs in Arkansas, after getting a “change of scope” approval from the Bureau of Primary Health Care (BPHC) and Health Resources Services Association (HRSA), incorporated mobile examination units that could venture out to pockets of communities, areas medically underserved and not within the coverage area of a CHC safety net.

Three new Arkansas CHCs will be opening soon, bringing the new total to 58. **Every new CHC opened or expanded means greater access to comprehensive, affordable primary and preventive quality health care for more people.**

CHCs' **workforce** includes 690 health professionals and paraprofessionals. Each CHC has at least one physician, totaling 63 full-time equivalents (FTEs). CHCs actively recruit new physicians by offering competitive salaries and benefits packages, and student loan repayments. Some CHCs offer signing bonuses. Also, CHCs remind potential physicians and dentists of no overhead or administrative costs. There are 27 Advanced Nurse Practitioners/ Physician

Assistants and approximately 120 RN/LPNs. Some of the Centers have dentists, 15 FTEs, and dental hygienists. Some CHCs have psychologists. The rest of the workforce includes other professionals and support staff dedicated to serving medically underserved rural/urban communities in Arkansas. ²

CHCs offer **comprehensive** primary medical, dental, and mental health interventions, as well as affordable prescription drugs under the 340B plan and indigent drug programs, x-rays, and laboratory testing. In addition, the CHCs offer enabling services such as case management, transportation, outreach, patient education, translation/interpretation, community education, environmental health risk reduction, and eligibility assistance.

The diversity and comprehensiveness of the CHCs make them a rich training environment for future health care professionals. For example, through collaborations with Arkansas Health Education Centers (AHECs), and after rotating through some of the rural clinics, Arkansas physicians-in-training may be inspired to **stay** in Arkansas to practice. In addition, graduate students working on certain Master degree programs like Public Health, Public Administration, Health Services Administration, or Health Sciences may benefit from internship programs that showcase the inner-workings of a community health center.

The comprehensive nature of a CHC includes health promotion/education and health screenings. Example screenings include cancer screenings (breast, cervical, prostate, colorectal, oral, and skin), and hearing, vision, TB testing, depression, and sickle cell. Some CHCs provide family planning, HIV testing and counseling, and immunizations. Under a directive from the Bureau of Primary Health Care, all CHCs offer testing for blood lead levels.

QUALITY / CULTURAL COMPETENCE

Currently, 33% of the FQHCs in Arkansas are accredited and have The Joint Commission (TJC) distinction. The rest maintain the **exact** same TJC standards, but the costs associated with the official certification proved to be cost prohibitive. Nevertheless, CHCs adhere to Clinical Best Practices with working environments stressing a high quality, interdisciplinary team approach.

Two applicable areas of quality assurance and quality improvement come via CHCs' approach to a **pay for performance** model and with their gradual incorporation of **electronic health records** (EHRs).

In an ideal "pay for performance" model, health care providers would be rewarded financially for successful outcomes and pre-established targets in their delivery of quality and efficient health care. In Arkansas, payors, providers, and the QIO through its Regional Quality Initiative through the Arkansas Foundation For Medical Care, are establishing a system whereby providers will eventually be rewarded for achieving the following four HEDIS measures: cervical cancer

screening, comprehensive diabetes care, well-child visits (3rd, 4th, 5th and 6th years of life) within their practices.

The Arkansas CHCs have been actively engaged since 2001 in the Health Disparities Collaborative, a chronic disease quality improvement initiative. Arkansas CHCs have been more forward-thinking by concentrating on outcomes rather than processes, but they are not rewarded for their patients' improvement and attainment of key chronic disease health care measures/outcomes. These outcomes are based on the highest standards of care and the interventional outcomes are tracked (i.e., diabetes management and HbA1c). This quality-improvement initiative Health Disparities Collaboratives (HDC), established by the Institute of Health Improvement and HRSA/BPHC, is ranked by the Office of Management and Budget as the **most efficient and effective** program in dealing with health disparities and quality improvement.

Disparities in health care for different minority populations and economically disadvantaged populations result in differences in rates of mortalities and morbidities from certain health conditions like cardiovascular disease and diabetes. HRSA and BPHC addressed disparities through the HDC. Community Health Centers participate directly in the HDC. This requires a FQHC to choose at least one condition that it will track within a formalized protocol. Some CHCs are using EHRs. Such record-keeping software, with a consistent method of capturing data, allows for quality improvement gains and plays a role in reducing disparities and provides opportunities to document the complexities of service utilization.³

The patients' progress and outcomes are monitored throughout time to demonstrate improvement. All the FQHCs in Arkansas track at least one condition. Last year conditions followed include diabetes, cardiovascular disease, and depression. This included approximately 14,000 people. Future collaboratives may include asthma, well-child, and cancer.

The HDC's quality improvement initiative calls for patients to manage their health and health care and emphasizes the patients' central role in managing their health (**personal accountability**). Strategies include assessment, goal-setting, action planning, problem-solving, and follow-up. Patients are encouraged to organize internal and community resources to provide ongoing self-management. CHCs help coordinate community resources and health promotion activities that aid the patient in his or her self-management. Last year, 70% of patients participating in the collaborative in Arkansas set self-management goals.

CHCs have been credited by the General Accounting Office (GAO) and Institute of Medicine (IOM) for reducing and eliminating the health gaps for the impoverished and for minorities. In 2005, the National Association of Community Health Centers, Inc. reported "health centers are associated with reducing racial and ethnic disparities in such key areas as infant mortality and tuberculosis."

They also concluded that another study found disparities in health status to be absent among Community Health Center consumers and attributed it to “culturally sensitive practices” that may be lacking from other primary care environments.⁴ CHCs alter their services to fit the special needs of their population. For example, nationwide one-third of CHCs’ patients are better served in languages other than English; therefore, translation services are available in some CHCs in an order to meet the patient’s needs.

Best Practices/protocols such as the above-detailed HDC are always in place in CHCs to safeguard against disparities or inequities. These Best Practices/protocols allow for built-in preventive and patient self-management components that are critical in optimizing health outcomes. The mission of CHCA and its CHC members is to develop and protect resources that ensure quality healthcare for all; this translates to a goal of 100% access and 0% health disparities, to serve everyone regardless of ability to pay. **CHCs reduce and eliminate inequities and disparities that impact health access and health care costs.**

CHCs have been named one of the ten most successful federal programs by the OMB.

The quality of care at these health centers is equal to or greater than the same type of care in other primary care settings. In wide-spread surveys, over 98% of users of Community Health Centers reported being satisfied with their care.⁴

AFFORDABILITY / COVERAGE / ECONOMICS

CHCs are open to all state residents, regardless of insurance status, and provide affordable, high quality health care; and, the fees collected are determined on a sliding fee scale using federal poverty guidelines. Approximately 45% of patients are uninsured, 23% are Medicaid patients, 19% have private insurance, and 13% are Medicare recipients.² Most of the CHCs stay open late at least one day a week to accommodate working people. Some open a few hours on Saturdays. The majority of CHCs have mechanisms in place that all patients can contact them 24 hours a day.

Prevention programs and health education promotional activities ultimately reduce costs of health and can further reduce the costs associated with health care coverage. Community Health Centers’ screenings and preventive services include all age groups from pediatrics to geriatrics. CHCs provide management of chronic diseases. Proper management of chronic disease, similar to the preventive and educational programs, has been associated with reduced costs for health care and health care coverage, as has proper use of emergency department services. In Arkansas, tens of millions of dollars annually are attributed to services that were non-emergent and could have been handled by a CHC by way of preventive and/or primary care services. Studies suggest that 55% of emergent department visits are low acuity non-emergent (LANE) which

translates to over 60 million avoidable annual visits or \$24 billion a year in preventable emergency department costs. Five of the main reasons for the ever-increasing number of LANE visits include: lack of access and availability of health services, transportation issues, lack of patient education, inadequate case management programs, and health care coverage issues. Already mentioned, CHCs address every one of these reasons.⁵ It logically follows that more CHCs would mean less resources wasted in emergency departments and the entire healthcare delivery system. Though LANE visits may be vital to many critical access and rural hospitals' overall revenues, misuse of such emergency services by uninsured or indigent individuals and the subsequent debts generated could be **reduced** if those patients accessed primary and preventive care within a CHC.

On national average, Community Health Centers provide comprehensive health care for about **\$1.40** a day per patient served, **ten times** less than the average per capita spending on personal health care spent in other facilities. Because Community Health Centers offer comprehensive, continuous primary and preventive services, many patients have fewer referrals to specialists and fewer hospitalizations. Consequently, Medicaid could see a 30% decrease in overall payments which translates to a savings that goes well into the billions of dollars.⁴

Nationwide, Community Health Centers save the health care system between \$10 and \$20 billion annually and have an annual economic impact of \$13 billion while providing for 143,000 jobs. In Arkansas, the Community Health Centers had an overall economic impact of \$90 million in 2005. Community Health Centers supported 1,047 full-time equivalent jobs, infused \$60 million of operating expenditures directly into their local economies and \$30 million indirectly during this same year.⁶⁻⁸

By Congressional investment in Community Health Centers, approximately 30 million people could have access to high quality health care by the year 2015 while saving the health care system between \$20 billion and \$40 billion year. Meanwhile, nearly a half million full-time equivalent jobs will be provided from Community Health Centers in the next decade.⁷⁻⁸

The economic impact shows how the three roles played by every CHC, that of community service provider, employer, and local business, enhances both the community and the economy. An investment in the CHCs in Arkansas is a direct investment into local communities, the state, and the nation **because CHCs reduce the overall costs of health care while increasing the health care coverage.**

EDUCATION / TRAINING

CHCs provide prevention/educational materials about such topics as: tobacco cessation, women's health, diabetes, cardiovascular disease, hypertension,

depression, asthma, cancer, HIV/AIDS, eligibility criteria for state benefits, oral health, behavior health, primary eye care, and immunizations. This information manifests as clinic-based educational materials or in community-based preventive health programs.

Arkansas CHCs support public school health. Selected personnel participate in student health education programs such as campaigns aimed against tobacco use and other demonstrations promoting a healthy life. Some CHC personnel go into public schools and provide physical examinations for student athletes before they begin their sporting seasons.

In addition to providing public health education to patients and communities, CHCA has a Training Program Plan that assesses training needs of CHC staff to help them become more efficient and effective in their system of service delivery. CHCA partners with its NACHC, BPHC, many statewide organizations, and associations in the delivery of these trainings.

PARTNERSHIPS/COLLABORATIONS

In order to share ideas and strengthen programs, Arkansas CHCs and CHCA work with NACHC, HRSA/BPHC, and nonprofit organizations, community health leaders, government agencies and officials, legislators, health information source, and policy think-tanks. Collaborating and forming partnerships makes for a stronger program and increases community awareness about CHCs' efforts and services.

CHCs serve as vital linkages to other community organizations for referral and additional resources that patients may need for complete health care services. CHCs depend on the community to drive its successes. For example, after being diagnosed with cancer, a CHC may navigate the patient to Community Cancer Awareness or to home care services, psychosocial services, spiritual guidance, community education, nutrition services, hospice, palliative care, or to another physician.

SUMMARY

Health leaders and politicians gave recommendations for handling the health care crisis in the state of Arkansas. The top five categories of recommendations included: availability/access, quality/cultural competence, affordability/coverage/economics, education/training, and collaborations/partnerships. After reviewing these recommendations and then considering the existence of Community Health Centers and their tremendous health impact, community impact, and economical impact, it seems clear that CHCs have the most potential to provide levity in the health crisis because CHCs are **already** providing relief. With continued, guaranteed support, these CHCs can grow and help more individuals and more communities **ultimately impacting the health status of Arkansans**.

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