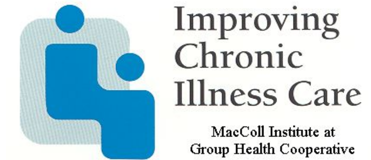

Community Health Centers: Medical Homes in the Safety Net

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Safety Net Medical Home Initiative Funders

Project Sponsor: The Commonwealth Fund	
Co-Funders:	
Colorado Health Foundation	Jewish Healthcare Foundation
Northwest Health Foundation	Partners HealthCare
The Boston Foundation	Blue Cross Blue Shield of Massachusetts Foundation
Blue Cross of Idaho Foundation For Health	Beth Israel Deaconess Medical Center

Overview

- Community Health Centers (CHCs): A (very) brief introduction
- Can CHCs be “medical homes” for Medicaid enrollees? Aren’t they already?
- Supporting Transformation: The Safety Net Medical Home Initiative (SNMHI)

What is the Safety Net?

Providers who and institutions that:

- Organize and deliver health care to the uninsured, Medicaid, and other vulnerable or low-income populations
- Provide services regardless of ability to pay
- Have little or no ability to cost-shift
- Typically provide enabling services (e.g., translation services, transportation) in addition to primary care

The Backbone of the Safety Net: Federally Qualified Health Centers
(aka Community Health Centers)

- Funded under Section 330 of the Public Health Service Act; administered by HRSA
- > 1,250 centers and >6,000 service delivery sites
- Provide care to > 20 million patients with limited resources
- ~35% Medicaid & ~40% uninsured

Nationwide Distribution of Community Health Center Sites, 2008

CHC sites
Counties
States

Adashi E et al. N Engl J Med 2010; 362:2047-2050

Percentage of the Population of Each State Served by Community Health Centers, 2008

Washington 10.1%
Oregon 6.4%
California 6.9%
Nevada
Idaho 7.1%
Montana 8.8%
Wyoming 3.8%
Utah 3.9%
Arizona 5.5%
Colorado 8.5%
New Mexico 13.0%
North Dakota 4.1%
South Dakota 6.9%
Nebraska 3.0%
Kansas 3.9%
Oklahoma 2.8%
Texas 3.4%
Minnesota 2.9%
Iowa 4.6%
Missouri 5.9%
Arkansas 4.4%
Louisiana 3.8%
Wisconsin 3.5%
Illinois 7.6%
Missis-sippi 10.1%
Michigan 4.7%
Indiana 3.4%
Kentucky 5.7%
Tennessee 5.0%
Alabama 6.5%
Ohio 3.3%
West Virginia 19.1%
Georgia 2.8%
Florida 4.8%
South Carolina 6.6%
North Carolina 4.2%
Virginia 2.9%
Pennsylvania 4.4%
New York 6.6%
Vermont 13.3%
New Hampshire 4.7%
Maine 12.5%
Massachusetts 8.2%
Rhode Island 10.0%
Connecticut 6.9%
New Jersey 4.0%
Delaware 3.8%
Maryland 4.2%
Washington, D.C. 18.2%
Alaska 11.8%
Hawaii 9.1%

<5%
5 to <10%
10 to <15%
≥15%
Data unavailable

Adashi E et al. N Engl J Med 2010; 362:2047-2050

Percent of Health Centers Offering Key Services, 2007

Service	On-Site	On-Site or by Referral
Primary Medical Care	99%	100%
Preventive dental care	74%	99%
Mental health treatment	77%	99%
Substance abuse treatment	51%	98%
Pharmacy	35%	95%
Urgent care	86%	99%

Source: Shin et al.Financing community health centers as patient- and community-centered medical homes: a primer. (2009) http://www.gwumc.edu/sphhs/departments/healthpolicy/CHPR/downloads/PCMH_CHC.pdf

Percent of Health Centers Offering Key Enabling Services, 2007

	On-Site	On-site or by Referral
Case management	92%	98%
Health education	97%	98%
Home visiting	60%	91%
Interpretation/ translation	90%	97%
Follow hospitalized patients	75%	98%

Source: Shin et al.Financing community health centers as patient- and community-centered medical homes: a primer. (2009) http://www.gwumc.edu/sphhs/departments/healthpolicy/CHPR/downloads/PCMH_CHC.pdf

Aren't FQHCs/CHCs "Medical Homes" by Definition?

If (MH:⇔PC),

then it is axiomatic that

(FQHC=MH),

$\because$ FQHC $\Rightarrow \sum_{\text{PC Soup}}^{\text{PC Nuts}}$

Δ, we're done.

But, if MH :⇔ (PC + {n_1 + $n_{2\ldots}$ + n_x }

where n = some second order design characteristic, then maybe not…

"Closing the Divide: How Medical Homes Promote Equity in Health Care*"

Medical Home Survey Definition

1. Regular doctor or source of care
2. Not difficult to contact provider over telephone
3. Not difficult to get care or medical advice after hours
4. Doctors' office visits are always or often well organized and running on time

**Beal et al. The Commonwealth Fund, June 2007*

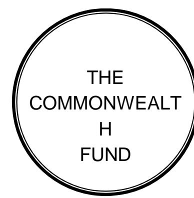
The Good News: Racial and Ethnic Differences in Getting Needed Medical Care Are Eliminated When Adults Have Medical Homes

Percent of adults 18–64 reporting always getting care they need when they need it

	Medical home	Regular source of care, not a medical home	No regular source of care/ER
Total	74	52	38
White	74	53	44
African American	76	52	31
Hispanic	74	50	34

Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.

Source: The Commonwealth Fund 2006 Quality of Care Survey



The not so good news…

- Survey indicated that safety net clinics are less likely than private doctors' offices to be medical homes

"Community health centers and other public clinics, in particular, should be supported in their efforts to build medical homes for all patients."

**Beal et al. The Commonwealth Fund, June 2007*

Examples of
"second order design characteristics"

- Systematic approach to assuring continuity of care with specific providers and provider teams
- Systematic "population management"
- Systematic focus on care coordination
- Systematic focus on assuring care sensitive to the needs of individual patients, with incorporation results of patient experience into care delivery

Enhancing the Capacity of Federally Qualified Health Centers to Achieve High Performance

Results from the 2009 Commonwealth Fund National Survey of Federally Qualified Health Centers

May 2010

Indicators of a Medical Home

INDICATORS OF MEDICAL HOME	Total
Medical Home Capacity—Total Number of NCQA Domains	
Capacity in All 5 Domains	**29%**
Capacity in 3 to 4 Domains	**55%**
Capacity in 0 to 2 Domains	**16%**
1) NCQA Domain—Patient Tracking and Registry Functions: Can easily generate a list of patients by diagnosis with the current patient medical records system	69%
2) NCQA Domain—Test Tracking: Provider usually receives an alert or prompt to provide patients with test results; or laboratory test ordered are usually tracked until results reach clinicians	60%
3) NCQA Domain—Referral Tracking: When clinic patients are referred to specialists or subspecialists outside largest site, center usually or often tracks referrals until the consultation report returns to the referring provider	70%
4) NCQA Domain—Enhanced Access and Communication: Patients usually are able to receive same- or next-day appointments, can get telephone advice on clinical issues during office hours or on weekends/after hours	71%
5) NCQA Domain—Performance Reporting and Improvement: Performance data are collected on clinical outcomes or patient satisfaction surveys and reported at the provider or practice level	99%

Notes: Easily means they can generate information about the majority of patients in less than 24 hours.
Usually means 75% to 100% of the time and Often means 50% to 74% of the time.
Source: The Commonwealth Fund National Survey of Federally Qualified Health Centers (2009).

Health Centers with Greater Medical Home Capacity Report Better Notification About Care Their Patients Receive in the ER and Hospital

Percent of centers reporting they usually . . .

	0–2 MH domains	3–4 MH domains	Medical home (5 domains)
Are notified of patient's ER visit	20	31	45
Are notified patient was admitted	14	21	31
Receive discharge summary	21	34	45

Notes: Usually means 75% to 100% of the time. Medical home (MH) includes measures of access, patient tracking, and registry functions; test tracking, referral tracking, and performance reporting and improvement.
Source: The Commonwealth Fund National Survey of Federally Qualified Health Centers (2009).

The Safety Net Medical Home Initiative

What are we trying to achieve?

Benchmark Performance in Quality and Efficiency

Clinic-level Aims

- Improve the operational efficiency of clinics
- Improve quality of care for patients
- Improve patients' health care experiences
- Improve clinician/staff experience
- Reduce disparities in access to care and quality of care

Regional Aims

- Enhance capacity in the community to support and sustain practice improvements.
- Improve health policy by involving Medicaid and other stakeholders to encourage action towards appropriate reimbursement levels to sustain practice efforts.

Participants: Regional Organizations from Five States Supporting 65 Clinics

Five Regional Coordinating Centers (orange) were selected from 42 applicants (blue) to participate

Regional Coordinating Centers

1. **Massachusetts League for Community Health Centers and Executive Office of Health and Human Services (MA)**
2. **Oregon Primary Care Association**
3. **Colorado Community Health Network**
4. **Idaho Primary Care Association**
5. **Pittsburgh Regional Health Initiative**

Medical Home Change Concepts: A Framework for Transformation

- Empanelment
- Team-based Continuous Healing Relationships
- Patient-Centered Interactions
- Engaged Leadership
- QI Strategy
- Enhanced Access
- Care Coordination
- Organized, Evidence-based Care

Technical Assistance

Facilitation of "community of practice": sharing best practices among RCCs/sites

Support of regional Medical Home Facilitators

Webinars, electronic and telephonic communication with sites

Technical consultation from experts in specific domains of the change concepts

Free SNMHI Resources Available for All: www.qhmedicalhome.org

- Webinars on topics such as:
  - *Creation and deployment of care teams*
  - *Empanelment*
  - *EHR and the medical home*
  - *Integrating patient experience into practice redesign*
- *Medical Home Digest*
- Implementation Guides-Roadmaps for implementing the change concepts

A Few Policy Issues..

- Reconfirmation of the tyranny of fee for service, especially when important services (e.g., care coordination/case management) not compensated
- Efficiency benefits accrue primarily to others
- Specialty access and the "medical neighborhood"
- Occasionally less-than-seamless integration with plethora of other local "medical home" initiatives: role of strong state leadership

Questions

For more information:

www.qhmedicalhome.org