

COMMUNITY HEALTH CENTERS
AND HEALTH REFORM:
*Highlights from a National Academy for
State Health Policy Forum*

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OCTOBER 2008

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HIGHLIGHTS FROM A NATIONAL ACADEMY FOR STATE HEALTH POLICY FORUM

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ACKNOWLEDGEMENTS

This report benefited greatly from the thoughtful consideration and input of Catherine Hess, senior program director, National Academy for State Health Policy (NASHP); research assistance from Elizabeth Osius, NASHP; and input from Lynn Spector, Amanda Reyes, and Shannon Dunne-Faltens with the Health Resources and Services Administration (HRSA). We also would like to thank the NASHP Steering Committee members who served as project advisors and the teams of state primary care office and association representatives from Alaska, the District of Columbia, Hawaii, Michigan, Massachusetts, and Mississippi who generated the ideas for and reviewed a draft of this paper. Thank you for your assistance and support. This paper was produced by NASHP through a National Cooperative Agreement with HRSA's Bureau of Primary Health Care, Grant #U30CS07494.

INTRODUCTION

The purpose of this paper is to help state policy makers understand how federally qualified health centers (FQHCs)¹ can fit into states' health care reform plans and help achieve state reform goals related to access, quality, and cost. This topic was the subject of a day-long meeting hosted by the National Academy for State Health Policy (NASHP) on May 5, 2008, in Washington, D.C.

The forum was attended by 40 participants, including NASHP members from governors' offices and state Medicaid and public health agencies. Also in attendance were five teams of representatives from state primary care associations and offices and, in some cases, their Medicaid colleagues.² National partners working cooperatively to address health policy issues related to FQHCs also participated. These included the National Association of Community Health Centers, the National Conference of State Legislatures, and the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA) Bureau of Primary Health Care.

Health care reform initiatives have gained momentum in recent years, with at least 15 states creating comprehensive health care initiatives³ and presidential candidates promising action if elected in November 2008. Expanded insurance coverage is one element of reform that many states have undertaken:

- : 26 states have enacted new coverage for children, mostly through State Children's Health Insurance Program (SCHIP) expansion;*
- : 18 states have increased the number of adults eligible for Medicaid or other public programs (including expansions for pregnant women); and*
- : 15 states have enacted insurance reform, including extending the age that children may remain on their parents' health policies.⁴*

Health insurance helps provide access to health services, but financial access is hardly a guarantee of appropriate use or receipt of high-quality services.⁵ A literature review by Dr. Barbara Starfield showed that increasing Medicaid eligibility leads to greater coverage but actually may exacerbate disparities in health status between population subgroups because of the use of poor regular sources of care (that is, not doctors' offices).⁶ This illustrates the importance of sufficient sources of primary health care and the resources to help people make that connection.

States play an instrumental role in ensuring that health service delivery systems are able to respond to the needs of the newly insured as well as the uninsured, and that regular sources of primary health care services exist and are accessible, affordable, and high quality. Despite the best plans for universal health coverage and a "card for everyone," there always will be some, such as undocumented immigrants, who remain uninsured and need a place to go for care. FQHCs are an important source of primary health care for the underserved, including the publicly insured and uninsured. In 2007, federally funded health centers served 6.2 million uninsured and 5.7 million Medicaid patients, numbers that show why FQHCs may fill a critical role in states' health reform plans.⁷

This paper provides an overview of ways in which community health centers can help policy makers meet their reform goals, based on presentations and discussion at the May forum. The forum began with an overview of state health reform. State officials from Delaware and Pennsylvania then provided a closer look at their states' reform proposals and how the safety net fits into both incremental and more

comprehensive reforms. Delaware is considering incremental reform, and Pennsylvania is proposing more comprehensive changes. Joan Henneberry, executive director of the Colorado Department of Health Care Policy and Financing, led a morning discussion about how states can shore up service capacity. Anthony Rodgers, director of the Arizona Health Care Cost Containment System, led the afternoon discussion about how states can ensure quality and efficiency and how FQHCs can fit into these efforts.

The forum was convened and this brief was developed through a National Cooperative Agreement with the Health Resources and Services Administration (HRSA), Bureau of Primary Health Care. Cooperative agreements are intended to inform state policy making and promote communication between state policy makers and community health centers. The agreements also support achievement of the shared goal of improving access to quality, affordable health care for our nation's most vulnerable populations.

LOOKING AT ISSUES BEYOND THE COVERAGE

“What if everyone had a card and the financing was fixed? What would this mean for state health care systems and the role that community health centers play?” These questions raised by Joan Henneberry helped frame some of the forum's discussion and provided a lively conversation about how states and their FQHCs can collaborate to identify and enroll individuals in need of insurance while ensuring capacity, quality, and cost efficiency.

IDENTIFYING AND ENROLLING INDIVIDUALS IN NEED OF INSURANCE

By federal mandate, FQHCs must be located in medically underserved areas or serve medically underserved populations. Therefore, they are a logical base for identifying and enrolling the uninsured.⁸ Under Medicaid law, states are required to pay for the processing of applications to enroll low-income pregnant women, infants, and children at outreach locations such as FQHCs in order to reach vulnerable populations. States expanding coverage of the uninsured may look to FQHCs for help enrolling eligible populations.

Two states represented at the forum – Delaware and Pennsylvania – use surveys to help target enrollment efforts. Pennsylvania performed a comprehensive survey that provided data to identify and locate the uninsured. The survey found that 9 percent of the state’s population was uninsured – more than 900,000 Pennsylvanians. Data also showed that 23 of 67 counties had no community health centers. This data, combined with the fact that Pennsylvania’s rate of emergency room visits is 14 percent higher than the national average, placed access to safety net providers high on the state’s health care reform agenda.⁹ The state’s response was to provide \$2.9 million in seed money in FY 07-08 for FQHCs, nurse manager centers, and mobile wellness vans. The state added \$2.9 million in the following year.¹⁰

Paula Roy, executive director of the Delaware Health Care Commission (DHCC),¹¹ spoke about Delaware’s efforts to position FQHCs prominently in state efforts to identify and enroll the uninsured in its health reform plans. In February 2008, the Delaware Public Policy Institute, a nonprofit research organization composed of diverse public/private stakeholders (including the DHCC), released a report, *Small State, Big Opportunity: Taking Action for the Uninsured in Delaware*, which recommended a two-pronged approach to covering the uninsured. The proposal focuses on outreach to target: (1) those eligible for but not enrolled in existing public programs (which, according to an annual state survey of the uninsured, constitutes 25 percent of the uninsured population); and, (2) low- to moderate-income uninsured workers and their families (another 33 to 50 percent of Delaware’s uninsured).¹²

Efforts to target and enroll these two populations build on an existing program known as the Community Healthcare Access Program (CHAP), administered by the DHCC.¹³ CHAP uses Delaware Tobacco Settlement Funds and private sources to identify and enroll the uninsured. Care coordinators based at FQHCs and hospitals emphasize the importance of enrolling and obtaining a medical home. In addition, a public media campaign reinforces these messages and advertises a toll-free number. CHAP beneficiaries must be Delaware residents who are uninsured and ineligible for state medical assistance programs and have incomes up to 200 percent of the federal poverty level. CHAP’s efforts also were boosted by participation in the Robert Wood Johnson Foundation’s Covering All Kids and Families program, which focused on finding eligible but unenrolled people. The state plans to continue that program’s work despite the end of foundation support.

Arizona is planning to use similar health information technology (HIT) to augment enrollment efforts being performed in FQHCs by out-stationed workers. Right now, enrolling with an FQHC representative takes up to 40 minutes. The plan is to streamline this process so that applicants can fill out their own forms using video and e-learning tools. The state also hopes that by installing a camera, the face-to-face interview it now requires might be eliminated during recertification.

A forum participant from Massachusetts emphasized the importance of preparing for workforce demands when implementing universal coverage. Massachusetts community health centers report a tremendous burden on their staffs related to eligibility determination and the enrollment of new and current patients in

programs created by health care reform. This has been true even with some auto-enrollment policies and Web-based tools, such as the virtual gateway in place to assist the process. (The virtual gateway is a one-stop online eligibility system for a broad range of state service programs.) Massachusetts participants also emphasized the importance of developing the right message to explain why individuals need coverage. The Massachusetts League of Community Health Centers – the state’s primary care association – has helped get that message out by co-sponsoring events where the Commonwealth Health Insurance Connector Authority can help residents better understand options available to them under the state’s health care reform law. Connect to Health events have been held across the state to allow individuals and businesses to talk directly with experts and gain better understanding of their responsibilities under the law. Eligible attendees can enroll in one of the state’s insurance plans at these events.¹⁴

Also in Massachusetts, the Department of Public Health (MDPH) has been working to build a network of community health workers (CHWs) to work with individuals, particularly those whose culture and language may present barriers to care, access, and navigation of the health care system. As part of health care reform, the Massachusetts Legislature mandated the MDPH to study the CHW workforce and its impact on increasing access and reducing health disparities. Based on the findings, MDPH made recommendations for a sustainable CHW program, including training, certification, and financing. The investigation found that CHWs increase access, improve the quality of care, reduce health disparities, and can reduce costs, such as those associated with inappropriate use of the emergency room. Many community health centers in the state are using community health workers to help expand the reach of their primary care team.¹⁵

Enrollment efforts often result in the identification of individuals who are ineligible for health care coverage, such as undocumented immigrants. Many states at the forum said extending insurance to undocumented immigrants is a politically volatile source of chronic tension that is “off the table.” FQHCs, as part of the larger safety net, are critical to providing care for this population. Under the reform plan in Massachusetts, the Uncompensated Care Pool has been replaced by a “health safety net” to provide health care at community health centers and hospitals to those who are not eligible for public coverage or who cannot afford to purchase health insurance. Undocumented immigrants are eligible for coverage under the health safety net as long as they live in Massachusetts.

ASSURING ACCESS, QUALITY, AND MEDICAL HOMES

Connecting people to a primary care provider that functions as a medical home can bring value and quality to a state reform plan.¹⁶ Patient-centered medical homes have been associated with high quality, high performing, cost-effective health systems.¹⁷ Although there isn't a single definition of a medical home, four core principles help identify a medical home:

- : *A personal physician or provider who provides first-contact care or a point of entry for new problems;*
- : *Ongoing care over time;*
- : *Comprehensive care; and*
- : *Coordination of care across a person's conditions, providers, and settings.*¹⁸

FQHCs have been shown to outperform health maintenance organizations (HMOs) on these primary characteristics of medical homes.¹⁹ Issues raised during the NASHP forum's discussion included identifying the value that FQHCs bring to state health care systems and what states can do to make sure FQHCs are utilized to their fullest capacity.

CONNECTING TO PRIMARY CARE

Once individuals are identified and enrolled in insurance coverage, what is the state's role in helping them establish a source of ongoing primary care if they do not already have such a relationship? The issues discussed at the forum included how health centers can assist in states' efforts to ensure that "enabling" services that address transportation, communication, language, and cultural barriers are provided. The importance of ensuring primary care – and many urgent care – services are provided in a primary care setting and not an emergency department, also was discussed.

Recognizing the importance of helping individuals find and utilize their providers, Congress mandated FQHCs to provide enabling services, including:

- : *Case management services;*
- : *Services to help health center patients to gain financial support for health and social services;*
- : *Referrals to other providers of medical and health-related services, including substance abuse and mental health services;*
- : *Services that enable patients to access health center services such as outreach, transportation, and interpretive services; and*
- : *Patient and community education regarding the availability and appropriate use of health services.*²⁰

Some states use their own care coordinators, often located in public health departments, to help individuals find providers. Many states collaborate with FQHCs to provide care coordination. In Delaware, once an individual is enrolled in the CHAP program, care coordinators help him or her find a primary care provider, either an FQHC or a volunteer physician. CHAP has partnered with these providers, including specialists, to provide free or reduced-cost health care to CHAP beneficiaries. Delaware's CHAP care coordinators are found in FQHCs and other facilities and provide enabling services such as transportation and translation to help CHAP patients access the health care system.

Getting people with differing language or cultural needs connected with their provider is a daunting challenge and one that health centers are skilled at addressing. A 2007 National Association of Community Health Centers survey found that health centers serve large numbers of patients with limited

English proficiency (LEP). Eighty-four percent of community health centers routinely care for patients with LEP, which translates to about one in three patients.²¹ Most health centers have bilingual staff on hand, although 11 percent rely solely on external sources such as ad hoc interpreters, telephonic services, external language agencies, or volunteers.

Expanded hours are an important aspect of medical homes, helping to ensure that care is provided in a timely manner and in a primary care setting. One forum participant spoke about the need for FQHC services to be designed around consumer, rather than provider, convenience. Many FQHCs already have expanded hours and now find themselves competing with emergency rooms for after-hours care. While one state official suggested that FQHCs might consider providing walk-in clinic services and becoming a backup network of support for other providers, the HRSA representative expressed concern about this role for FQHCs given their mission as comprehensive care providers promoting care continuity. Others saw this as an opportunity for FQHCs to fill the need for an alternative to the emergency room.

ONGOING CARE IN FACE OF WORKFORCE CHALLENGES

Having a regular source of primary care is a key component of a medical home, but, due to workforce shortages, it is also one of the most challenging. The relationship between the number of primary care physicians and various health measures has been studied at the state level. States with more primary care physicians have lower mortality rates for a number of diseases and greater life expectancy, even after controlling for income.²² Many states are working to address their workforce recruitment and retention problems while anticipating increasing shortages when newly insured people seek care as a result of health care reform.

In 2004, Pennsylvania created a Center for Health Care Careers to raise awareness and address critical shortages in health care occupations, including direct care workers. Grants to nursing schools to address faculty shortages in 2006-07 resulted in a 50 percent increase in admissions to nursing schools statewide.²³ The state also is working to remove scope-of-practice barriers for nurse practitioners, nurse midwives, and dental hygienists to create an environment where multi-disciplinary teams can perform. While not limited to FQHCs, such measures will allow each member of the team to practice to the fullest extent of his or her professional training, allowing physicians and dentists to focus on more complex patients.

Alaska has no formal workforce commission, but it does have a collaborative that includes the state primary care and nursing associations and a university to address recruitment issues. The state has been progressive in addressing scope-of-practice issues, using mid-level practitioners significantly more than other states. The state also licenses and certifies lay alternative providers through the community health aide program within the tribal system. Other states' activities include:

- : *Delaware uses its loan repayment program to place people where it needs them most: in urban and rural areas.*
- : *The District of Columbia recently has provided tuition reimbursement to providers who commit to stay in the primary care system for at least two years. The District also is working to expand primary care teams by training community health workers.*
- : *Michigan is creating in its undergraduate programs an accelerated path for students who commit to work in underserved areas after completion of their training.*
- : *Arizona is exploring using residency training programs as a way to fill in the primary care gap at FQHCs. By developing a feeder system in which residents are introduced to a certain FQHC or area of the state, physicians may be more inclined to stay.*

: A New Mexico forum participant suggested creating a program to pay off educational bills and loans while providers are still in residency.

Although many states and primary care associations at the forum shared similar stories about being unable to pay competitive primary care wages, discussion turned to the importance of improving provider satisfaction as a recruitment tool.²⁴ Work started by a Washington state ad hoc group formed by a university physician and a major health plan resulted in legislation that funded a loan repayment program and also created opportunities to train providers through collaboratives. Medical home collaboratives were formed and initially began work on diabetes and disease management. The collaboratives were found to greatly increase provider satisfaction.

State-of-the-art health centers, with access to innovative technology, are another way to recruit and retain providers. In western Massachusetts, one health center received funding for a state-of-the-art dental department, which enabled the center to establish connections with three dental schools and arrange housing for residents. The center is swamped with appointments and has no shortage of dental providers.

Mandated Primary Care Services Provided by FQHCs

All health center programs must provide, directly or through contracts or cooperative arrangements, basic health services including: primary care; diagnostic laboratory and radiological services; preventive services including prenatal and perinatal services; cancer and other disease screening; well-child services; immunizations against vaccine-preventable diseases; screening for elevated blood lead levels, communicable diseases, and cholesterol; eye, ear, and dental screening for children; family planning and preventive dental services; emergency medical and dental services; and pharmaceutical services as appropriate to a particular health center.²⁵

that do not use centers.²⁶

The importance of providing comprehensive health care can be illustrated when it comes to managing chronic disease. Ann Torregrossa, deputy director and policy director for the Pennsylvania Governor's Office of Health Care Reform, pointed out that Pennsylvania spends a majority of its health care dollars – 80 percent – on a minority of the population: the 20 percent of its Medicaid population with chronic conditions. Many states have placed chronic care first in their reform plans, mainly because of the need to

An average of 40 percent of FQHC patients are uninsured. A forum participant raised the question: "Once provided with health insurance, will these patients remain loyal customers or seek care elsewhere?" In Massachusetts, where universal coverage is underway, most FQHC patients who now have coverage continue to seek care at their FQHC. But a representative from Massachusetts added that newly insured individuals without a previous connection to FQHCs are attracting competition for their care from all types of providers.

COMPREHENSIVE SERVICES

An important role of a medical home is to provide a range of services that meet all common health needs of an individual and also be able to arrange for services that are uncommon. FQHCs are mandated by law to provide a range of comprehensive primary and preventive care services.

This emphasis on comprehensive services results in better health outcomes for the FQHC population compared with similar populations

control health care costs. Health centers are well equipped to work with states to reduce the prevalence of chronic disease because of their success with Health Disparities Collaboratives (HDCs).

HRSA's HDCs are a national effort to eliminate disparities that put minorities and people living in poverty at much higher risk for chronic disease and death than other Americans, and to improve the delivery system overall. Past HDC focuses have included diabetes, asthma, cardiovascular disease, and depression. Approximately 800 health centers are currently participating in HDCs, including almost 150 health centers involved in regional "initial learning" experiences.²⁷ The HDCs are supported by the HRSA Knowledge Gateway, which includes Web sites and virtual offices; communication and data-sharing modules; and helpdesk functions, as well as coordination with national faculty. They work with state primary care associations' (PCA) staff and other regional support staff such as Health Center Controlled Networks (HCCN) partners, Centers for Disease Control (CDC) staff in public health departments, and National Institutes of Health (NIH) supported staff, depending on the specialty area. The role of state health agencies in the HDC varies but might include participation on monthly calls with HDC coordinators, collaborative participants, and the CDC. A state health agency representative sits on a variety of steering committees and may provide training and resources for local community health centers.²⁸ HRSA has committed to spreading this new evidence-based knowledge to the health center safety net across the nation.²⁹

By an executive order, Pennsylvania Gov. Ed Rendell created a Chronic Care Commission to work toward establishing the infrastructure needed to change how chronic care is delivered in the state. The commission's plan was presented to the governor and legislative leadership in February, and implementation began in Philadelphia in May 2008; it will spread to other parts of the state in September. According to Torregrossa, Pennsylvania's FQHC representatives were the commission's most passionate members, and because of their experience participating in HDCs, they provided the expertise needed to get the legislature's attention. Torregrossa reports that insurers in the state are very willing to contract with FQHCs because of their experience working with chronic diseases and their demonstrated outcomes with the most expensive populations.

With private support, Colorado is one of several states working on a national collaborative with health centers, local health plans and providers, consumer organizations, and other stakeholders. The goal is to improve the quality of care received by Medicaid's highest-need, highest-cost adult clients by better coordinating physical health, mental health, and substance abuse services.³⁰ The Colorado Regional Integrated Care Collaborative aims to support providers by improving infrastructure for case management, care coordination, and supplemental benefits. It also intends to monitor and oversee oversight care delivery. Through an executive order, Colorado's governor created the Center on Value and Healthcare to explore ways to reimburse and recognize providers who follow clinical guidelines.

Co-locating primary care and mental health services was discussed at length at the forum. Co-location offers many benefits other than the convenience of "one-stop shopping." For patients, access may be improved if same-day appointments at the same location are allowed. Also, having mental and primary health providers in one location may lessen the stigma of visiting a building that provides only mental health services. And for providers, face-to-face contact with both disciplines may improve coordination of patient care.³¹ A representative from Washington, D.C. spoke about how hard it is for people to make appointments in two different buildings, one for primary care and the other for behavioral health.

Participants at the forum spoke about work being done in their states to integrate behavioral care with acute care, especially at the health centers. In Alaska, many health centers have roots in behavioral health

programs, with FQHCs growing from mental health clinics. One Alaskan FQHC merged its facilities and board with a community mental health center. The Denali Commission has helped in the state's integration effort. The commission's purpose is to provide critical utilities, infrastructure, and economic support to distressed rural communities in Alaska through a competitive grant process.³² The commission supports facilities that offer multiple services, such as behavioral and dental, under one roof.

In Washington, many community health and mental health centers are integrating services. MaryAnne Lindeblad, director of the Division of Health Care Services of the Washington Health and Recovery Services Administration, spoke about the Washington Medicaid Integration Partnership. This partnership has been underway for two years, bringing Medicaid-funded mental health services, long-term care, and alcohol and substance abuse treatment together in a coordinated, client-centered framework.

Many participants agreed that challenges lie in combining different cultures, not just funding streams. Pennsylvania is trying to address the disconnect between substance abuse and mental health through joint licensure of professionals. The Department of Public Welfare and Department of Health jointly credential mental health and substance abuse treatment providers who treat patients with co-occurring disorders.³³

COORDINATION OF CARE

Coordination of care in a medical home model means there is visit continuity with a qualified provider and/or medical record continuity from visit to visit, and referrals are coordinated and tracked by the provider.³⁴ These types of services would be greatly enhanced through HIT and information sharing. Many states are funding projects to provide these kinds of improved services.

The District of Columbia Primary Care Association, with \$5 million in city government funding, is working to provide low-income city residents with consistent, coordinated care, including preventive care. As part of its D.C. Medical Homes initiative, the PCA has purchased software to give patients a place where their medical histories are known so they can obtain treatment before health problems escalate into emergencies. The system also will support practice management: billing, scheduling, and eligibility checks, among other functions. The PCA also will aggregate information about city residents' health, looking for trends, emerging health issues, and evidence of the quality of care delivered at the clinics. The system links with Medicaid and other payers, and eventually could become part of a larger health information exchange that serves hospitals and other Washington-area health providers.³⁵ Other aspects of the D.C. Medical Homes initiative include expansion of clinic buildings, new and better equipment, and payment for preventive care services rendered to low-income city residents. Hospitals have posed a challenge for the D.C. health information exchange. True integration and coordination of health systems involves the exchange of data between primary care and tertiary care centers. One participant emphasized the importance of the state (or district, in this example) using its purchasing power to bring major providers to the table to ensure data integration.

In Colorado, health centers are ahead of other primary care providers in terms of electronic medical records (EMRs) and disease registries. Denver Health, Colorado's primary safety net institution,³⁶ uses an integrated system to bring together information from primary clinics, public health, hospitals, and small rural health clinics. Statewide efforts to bring HIT interoperability are funded by the Colorado Health Foundation, as well as state and federal sources.

Sharing resources, including space and staff, is an effective way to improve service coordination in a health care system. In Montgomery, Ala., an FQHC pays \$1 per year in rent for the space it shares with the county health department. This arrangement allows for service coordination between the health center

and health department, such as sharing an FQHC social worker and health department case management workers. Another benefit is the convenience of having public health services such as Women, Infants, and Children and food stamps under the same roof as health services.

Referring uninsured or Medicaid patients to specialists is a challenge for many primary care providers. In Delaware, the CHAP program relies on the Medical Society of Delaware's Voluntary Initiative Program (VIP). VIP is a statewide network of private physicians who accept CHAP patients and serve as their health home or provide medical subspecialty services free or at discounted rates. About half of the 500 volunteer physicians are specialists who have become a key resource for FQHCs that need to refer patients. Many at the forum discussed the future of telemedicine as it relates to the issues around specialty referrals, particularly for rural areas. Colorado and Arizona are in the planning stages of addressing Medicaid reimbursement for telemedicine.

The Road Ahead Requires Technology

According to Anthony Rodgers of Arizona, the lack of infrastructure enabling HIT and information sharing is a primary barrier to an optimized, integrated health care system. His vision is a network that uses Medicaid as an HIT hub that hosts data and serves as a Web portal. With Medicaid as the hub, the state could connect providers through a common interface, employing a single document for public-private partnerships and having one legal framework to which everyone agrees.

With Medicaid hosting the data, the state could better manage population health and design logical health care systems based on the data it receives through the portal. In Arizona, Medicaid will not provide EMRs, but it will expect other systems to receive Medicaid data. Providers' HIT systems will need to be certified to enable this data exchange. Then, data can be "pushed or pulled" as a patient moves from one provider to the next – the data follows the patient – which is critical to virtual integration.

Rodgers would like to see FQHCs develop a standard system that can connect easily to Medicaid. If FQHCs teamed with other primary care providers to jointly purchase and have an Application Service Provider (ASP) arrangement, it would be more efficient and less costly than each trying to create their own repository for EMRs. With one ASP arrangement, Medicaid would just need to write one interface for data to be exchanged, giving FQHCs an advantage over providers not connected to Medicaid. The advantage, according to Rodgers, would be access to data that allows better management of patient and population health.

Rodgers envisions FQHCs as training hubs for community-based physicians who want to learn about connecting to the system. These FQHC hubs also could become innovation centers where new technologies are modeled and tested in the real world. FQHCs could become the champions for state networks by using Web and e-learning tools to raise health literacy for consumers and demonstrate how FQHCs can be part of the solution. As chair of the Medicaid Directors' Multi-State Collaboration for Medicaid Transformation, Rodgers feels that a deeper competency within Medicaid is needed to take a more prominent role in making HIT with information exchange a reality.

CONCLUSION

States with health care reform efforts underway are also working to ensure that health service delivery systems are able to respond to the needs of the newly insured and the uninsured. States understand they must make sure that regular sources of primary health care services exist and are accessible, affordable, and of high quality. There are many ways that FQHCs can help states meet such goals.

Identify and enroll individuals in care. Many states are working with FQHCs to identify and enroll eligible populations using care coordinators and outreach workers. They also are improving technology to streamline eligibility processes.

Enable access to a regular source of ongoing health care. FQHCs are located in areas of underserved populations, and they provide important enabling services that remove or reduce cultural, ethnic, and language barriers to care. These services are mandated by Congress and also include case management and transportation services. Some FQHCs are extending their hours to better meet the needs of individuals. FQHCs' roles as important sources of ongoing primary care face significant workforce challenges that will be strained further as newly insured individuals seek health care. States are involved with a number of recruitment and retention programs to address primary care workforce shortages, but there is a great deal of work ahead to assure that state health care systems, including FQHCs, have the manpower needed to address current and future needs.

Provide comprehensive and coordinated services. Individuals who receive comprehensive primary care services have better health outcomes and lower expenditures than those who do not. FQHCs have a great deal of expertise in providing primary care services, chronic disease management, and behavioral and mental health services – often under one roof. Ensuring visit and medical record continuity with qualified providers is an important aspect of care that can reduce unnecessary visits, treatments, and expenditures. Access to specialists for FQHC patients remains a challenge, and some states are working on information technology solutions that may partially address this problem. Coordinated care can be enhanced through HIT and information sharing. Many states are funding HIT projects, including telemedicine technology that connects FQHCs. FQHCs also are leading efforts to integrate with other health care systems to better coordinate care. But HIT with information sharing from provider to provider and across systems and state borders will require support from both state and federal governments in order to become a reality.

The forum that led to this paper provided a vehicle for invited states to identify and discuss issues and ideas about how FQHCs can contribute to state health care reform. We hope this paper stimulates discussion among state policy makers, FQHCs, and other stakeholders to arrive at informed solutions to better serve state residents, especially uninsured and underserved populations.

NOTES

1 The term “Federally Qualified Health Center” (FQHC) applies to three types of clinics: (1) Community Health Centers, also known as health centers, are public and private nonprofit clinics that meet certain criteria under the Medicare and Medicaid programs and receive federal grant funds under the Health Center Program, Section 330 of the Public Health Service Act (PHSA); (2) Look-Alike Health Centers are public and private nonprofit clinics that meet certain criteria under the Medicare and Medicaid programs and meet the definition of “health center” under Section 330 of the PHSA, but do not receive federal grant funding; and (3) Tribal or Urban Indian Federally Qualified Health Centers are outpatient health programs or facilities operated by tribal or urban Indian organizations.

2 As part of NASHP’s National Cooperative Agreement with HRSA’s Bureau of Primary Health Care, six states were selected through a competitive process to help guide the project work of this grant, assisting with site visits, publications, Webcasts, and conferences. States were selected based upon their demonstration of an active partnership between the PCO and PCA offices. The six states are Alaska, District of Columbia, Hawaii, Massachusetts, Michigan, and Mississippi. Hawaii’s representatives were unable to attend the Primary Care Forum.

3 John McDonough, Michael Miller, and Christine Barber, “A Progress Report on State Health Care Access Reform,” *Health Affairs* 27, no. 2 (March/April 2008): w105-w115. Published online 29 January 2008; 10.1377/hlthaff.27.2.w105.

4 Ibid.

5 Barbara Starfield and Leiyu Shi, “The Medical Home, Access to Care, and Insurance: A Review of Evidence,” *Pediatrics* 113, no. 5 (May 2004): 1493.

6 Ibid., p. 1497

7 U.S. Department of Human Services, Health Resources and Services Administration, Bureau of Primary Health Care, *Section 330 Grantees Uniform Data System: National Roll Up Report* (Rockville, MD: Bureau of Primary Health Care, July 2008). Accessed 19 August 2008. <ftp://ftp.hrsa.gov/bphc/pdf/uds/2007nationaluds.pdf>.

8 1861 (aa)(4) of the SSA [42 U.S.C.].

9 PowerPoint by Ann Torregrossa at NASHP’s Primary Care Forum, Washington, D.C., May 2008.

10 Ibid.

11 Created in 1990 by the Delaware General Assembly, the Delaware Health Care Commission is comprised of four government officials – the Secretary of Finance, Secretary of Health & Social Services, Secretary of Children, Youth & Their Families, and the Insurance Commissioner – and six private citizens appointed either by the governor, the Speaker of the House, or the President Pro Tempore of the Senate. The composition is a balance between the executive and legislative branches of government and the public and private sectors. By creating the Commission as a policy-setting body, the General Assembly gave it a unique position in state government. It is intended to allow creative thinking outside the usual confines of conducting day-to-day state business. (<http://dhcc.delaware.gov>).

12 PowerPoint by Paula Roy, “Health Care Reform and the Safety Net: Delaware’s Experience,” at NASHP’s Primary Care Forum, Washington, DC, May 2008.

13 Delaware’s CHAP program evolved from the Community Access Program grant from HRSA; Delaware was one of the original 24 HRSA grantee states. The original CHAP grant focused on network adequacy and building a system of delivery. When the CHAP grant was discontinued, CHAP evolved through funding from tobacco settlement money.

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15 Email correspondence from Julia Dyck, Massachusetts Department of Public Health, to Mary Takach, NASHP, September 11, 2008.

16 Anne Beal et al. *Closing the Divide: How Medical Homes Promote Equity in Health Care: Results from the Commonwealth Fund 2006 Health Care Quality Survey* (New York, NY: The Commonwealth Fund, 2007).

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