

HIGHMARK. FOUNDATION



SAFETY NET PROVIDERS:

Filling the Gap, Increasing Access and
Improving Health Outcomes

About the Highmark Foundation

The Highmark Foundation, created in 2000 as an affiliate of Highmark Inc., is a charitable organization and a private foundation that supports initiatives and programs aimed at improving community health. The foundation's mission is to improve the health, well-being and quality of life for individuals who reside in the Pennsylvania communities served by Highmark Inc. The foundation awards two types of grants: Highmark Healthy High 5, which includes a focus on the health and well-being of children in the areas of physical activity, nutrition, self-esteem, bullying and grieving; and its traditional four areas of general health focus, which include chronic disease, communicable disease, family health and service delivery systems. Where possible, the foundation looks to support evidence-based programs that impact multiple counties and work collaboratively to leverage additional funding to achieve replicable models. For more information about the Highmark Foundation, visit www.highmark.com.




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This is the third in a series of briefs that addresses an issue of importance to the Highmark Foundation. The first, *Addressing the Nursing Shortage in Pennsylvania through Grantmaking*, explored the successful efforts of the Foundation in assisting college and university nursing programs in western and central Pennsylvania with building capacity to improve or expand opportunities to address nurse workforce challenges with grants totaling over \$1.0 million. The second, *Improving Access to Diabetes Care & Services in Pennsylvania through Coordinated Strategies* examined comprehensive, multi-level strategies that showed new, replicable, and sustainable ways to reduce the prevalence of diabetes. Grants totaling \$1.6 million from the Highmark Foundation assisted these community-based programs in demonstrating effectiveness in reducing the effects of diabetes in underserved populations.

Since 2006, the Highmark Foundation has significantly impacted 31 safety net providers located in western and central Pennsylvania with grants totaling \$4.1 million. This brief will highlight grants to 10 safety net providers totaling \$2.2 million. These safety nets have expanded access to oral health care, diabetes care, primary health care, and quality management to improve patient outcomes, health and well-being for underserved populations in the communities served by Highmark Inc. The Highmark Foundation also supported 21 safety net providers with grants totaling \$1.9 million to assist with improving access to oral health and dental care to underserved populations.

This brief, *Safety Net Providers: Filling the Gap, Increasing Access and Improving Health Outcomes*, will discuss safety net providers such as Federally Qualified Health Centers (FQHCs) also known as Community Health Centers (CHCs), Federally Qualified Health Center Look-Alikes (FQHC-LAs), Free Clinics, and Rural Health Centers (RHCs) ability to reduce costs of chronic disease through access to preventive health programs for potentially 44.8 million Americans living without health insurance coverage and an additional 16 million who are underinsured. Safety net providers provide high-quality primary care at a significant savings for millions of Americans who otherwise would have little to no access to care.



Despite significant federal funding increases, community health centers, the backbone of the nation's safety net are struggling to meet the rising demand for care, particularly specialty medical, dental, and mental health services. These health centers continue to adapt to meet the increased demand for care. A trend in meeting that demand is a new national initiative to transform safety net clinics into medical homes. This initiative is currently being piloted in five states with the goal of developing a replicable and sustainable implementation model for medical home transformation.

Approximately 18 million patients receive primary and other health services from 1,200 non-profit FQHCs in the United States with 7,000 urban and rural delivery sites. In Pennsylvania, more than 500,000 patients receive those same services from 36 health centers in 206 delivery sites. These health centers are cost effective, reduce health disparities, and improve clinical outcomes for patients with chronic diseases.

BACKGROUND

Community, Migrant, Homeless, and Public Housing Health Centers represent a federally-designated program of health care that meets five core prerequisites set in statute. These five unique features make health centers the backbone of the U.S. primary care safety net. They must:¹

1. Be located in a federally-designated medically-underserved area or serve a designated medically-underserved population;
2. Have non-profit, public, or tax-exempt status;
3. Provide comprehensive primary health care services, referrals, and other services needed to facilitate access to care, such as case management, health education, translation, and transportation;
4. Be open to all community members, regardless of the ability to pay or insurance status, and offer a published sliding fee scale that prospectively adjusts fees charged on patient's ability to pay; and
5. Be governed by a board, a majority (51%) of whose members are health center patients.

The legislative authority establishing the health centers program is found in Section 330(e) of the Public Health Service Act, which provides grants to develop and operate primary health care clinics that furnish care to residents of geographic areas considered medically underserved, or specially, medically-underserved populations such as migrant farm workers or homeless persons. Unlike other federal grant programs that provide funding to states in the form of block grants to serve designated populations (such as persons with serious mental illness or mothers and children), health centers receive direct funding. In this sense, the health centers program represents a distinct federal investment in community health.²

In federal policy context, there are actually two classes of health centers: the large number that receives federal grants under Section 330(e); and a much smaller but important group of entities that meet all Section 330(e) location, service, affordability, and governance requirements but whose operating grants come from state, local, and private sources. The latter group of entities is known as “look-alike” health centers. These centers, like their federally funded counterparts, qualify for special coverage and payment treatment through Medicaid and Medicare.³

Safety net providers, such as Federally Qualified Health Center Look-Alikes (FQHC-LAs), Rural Health Clinics (RHCs), and Free Clinics remove common barriers to care by serving communities that otherwise confront financial, geographic, language, cultural, and other barriers. The most widely known federally designated centers are those FQHCs supported by HRSA (Health Resources and Services Administration Bureau of Primary Health Care). HRSA’s primary care health programs have their roots in the Migrant Health Act of 1962 which funded medical and support services for farm workers and their families; and the Economic Opportunity Act of 1964, which established funding for the first community-based clinics that were to become the current Health Center Program. The National Hansen’s Disease Program, formerly the National Leprosarium, was established in 1921. More recently the Free Clinics Medical Malpractice Program was established in 2004.⁴

The CHC initiative was launched in 1965 as part of the Lyndon B. Johnson administration’s War on Poverty by providing federal funds for two neighborhood health centers started by two physicians at Tufts University in Boston. Those first two centers created an innovative new model of community-based, comprehensive primary health care that focused on outreach, disease prevention, and patient education activities. The early centers also promoted local economic development, job training, nutritional counseling, sanitation, and social services. Most importantly, they established one of the enduring principles of the program: respect for patients and communities and their involvement in the operation and direction of health centers.⁵

THE ROLE OF COMMUNITY HEALTH CENTERS

Spread across 50 states and all U.S. territories, CHCs are the primary source of low-cost health care in the United States. Approximately 18 million patients receive primary care and other health services from 1,200 non-profit CHCs in the United States with 7,000 urban and rural delivery sites. CHC patients are disproportionately poor. About 40% of these patients are uninsured, 35% covered through Medicaid, and the remainder are Medicare beneficiaries or have private insurance. More than two-thirds of CHC patients are members of racial or minority groups (62% Hispanic, 9% African American, 13% Pacific Islander, and 1% Native Alaskan/Native American) and may lack proficiency in English.⁶ More than 70% live on incomes at or below 100% of the federal poverty level and 90% live under 200% of poverty. These centers serve patients throughout the life cycle with the largest concentration of patients (28%) ages 25-44 who are more likely to have chronic illnesses such as mental disorders, diabetes, asthma, and hypertension than patients of office-based physicians.⁷

Table 1 shows the number of safety net providers, underserved residents, and number of visits made by patients to centers in the United States and Pennsylvania. Less than 10% of low-income persons are served by health centers. As a result of the extensive data collected through the Uniform Data System (UDS), a great deal is known about FQHCs and its patients.^{8,9}

Table 1: United States and Pennsylvania Safety Net Providers

	FQHCs and Look-Alikes			
	Centers	Delivery Sites	Patients Served	Patient Visits
United States	1,200	7,000	18,000,000	63,036,475
Pennsylvania	36	206	521,194	1,812,766

REQUIRED PRIMARY HEALTH SERVICES¹⁰

The following services are necessary for the adequate support of primary health for all residents served by health centers.

- Basic health services consisting of those related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology, that are furnished by physicians and where appropriate, physician assistants, nurse practitioners, and nurse midwives.
- Diagnostic laboratory and radiologic services.
- Preventive health services, including prenatal and perinatal services, cancer screening, immunizations, screenings for communicable and chronic diseases, preventive dental services, pharmaceutical services as may be appropriate for particular centers, referrals to providers of medical services (including specialty referrals when medically indicated), patient case management services (including counseling, referral, and follow-up services), supportive outreach, transportation services, translation services, and education of patients and the general population served by the health center regarding the availability and proper use of health services.

QUALITY IMPROVEMENT INITIATIVES: HEALTH DISPARITIES COLLABORATIVE

CHCs also participate in quality improvement initiatives. The Health Disparities Collaborative was developed to help primary health care practices change to improve the health care provided to patients and eliminate health disparities. The Health Disparities Collaborative, sponsored by the BPHC in collaboration with health centers nationwide, began by focusing on diabetes in October of 1998. The BPHC funded one Primary Care Association/Clinical Network in each of five regional clusters. National Clinical Networks focused on oral health, migrant farm worker health care, and homeless health care worked with the Institute for Healthcare Improvement to develop the infrastructure that provided technical assistance and information systems support to CHCs participating in the collaboratives.

Since then, the Collaborative has expanded to cover multiple chronic illnesses such as cardiovascular disease, hypertension, depression, cancer, asthma, and has also branched into chronic illness prevention and finance/redesign. The goals of the Collaborative are to decrease or delay the complications of disease, decrease the economic burden for patients and the community, and improve access to quality chronic disease care for underserved populations.¹¹ Research has demonstrated that these collaboratives have been successful in significantly improving the process of care at CHCs nationwide.¹² Today, the BPHC is no longer funding these collaboratives due to budgetary constraints. Health centers wishing to continue the work of the collaboratives must provide the funding.¹³

OTHER SAFETY NET PROVIDERS

Other safety net providers such as FQHC-LAs, Free Clinics, RHCs, public hospitals, and local health departments perform similar functions to FQHCs in some cases without the benefit of Section 330 (e) federal grants.¹⁴ Several important differences between community health centers, free clinics, and rural health clinics are summarized in Table 2 below. There is little competition between these safety net providers. Because the need is so great, even a network of community health centers cannot handle all of the uninsured patients in its service area. There are 3,751 RHCs in the United States with 66 (1.8%) in Pennsylvania.¹⁵

Table 2: Summary of Safety Net Providers

Community Health Clinics/Look-Alikes	Free Clinics	Rural Health Clinics
Non-profit	Non-profit	For-profit or not-for-profit, public or private
Federal and local support (Section 330e: FQHCs only)	Local support only	Federal and local support only
Medicaid: always accepted	Medicaid: rarely accepted	Medicaid: always accepted
Paid practitioners	Volunteer practitioners	Paid physicians and mid-level practitioners (such as nurse practitioners, physician assistants, and certified nurse midwives)
Primary care always; specialty care rarely	Both primary care and specialty care	Both primary care and specialty care
Low-income, poor and uninsured	Only the poor and uninsured	Low-income, poor and uninsured
Dispense medications: rarely	Dispense medications: usually	Dispense medications: rarely

HEALTH CENTER FINANCING

CHCs require a significant amount of funding to meet the growing demands for low-cost quality health care. Patient service revenues represent the largest source of CHC revenue. In 2007, the national average for patient service revenues as a percent of total revenues was 59%. This is largely because of cost-based reimbursement for public health insured visits and federal grants, which can be reinvested to treat additional uninsured patients. However, the national average for federal BPHC grant funds was 19% of CHC total revenues. The remaining 22% (based on 2007 figures) of CHC revenues come from a wide variety of sources including one-time grants from private donors such as local hospitals, private foundations, churches, and charitable organizations for specific projects or programs. Private funding usually represents only a small portion of most CHC budgets.¹⁶

An additional funding source is \$2.8 billion in stimulus funds set aside from the American Recovery and Reinvestment Act (ARRA) of 2009 for free and low-cost health clinics. These grants are meant to be a short-term solution, not a long-term health care fix. ARRA funds will help to bring more doctors, nurses, and facilities to rural and urban communities.¹⁷ These funds will also help to create and retain jobs in these communities. A total of 36 Pennsylvania FQHCs received ARRA Increased Demand for Community Health Services (IDS) grants totaling \$9,448,774, including six new access points (new FQHCs); four in western Pennsylvania and two in central Pennsylvania for a total of \$6,716,568. Approximately 180 projected new or retained jobs and an estimated 59,603 new patients will benefit from these grants.¹⁸

COMMUNITY BENEFIT: A SMART INVESTMENT FOR HEALTH CARE AND COMMUNITIES

Health centers provide substantial benefits to communities and are consistently rated as one of the most effective uses of federal funds as a result of their economic value in terms of cost savings, economic growth, and production of jobs. Benefits to patients and communities include:^{19,20}

- Stimulates local economies by employing more than 100,000 people in underserved communities.
- Health center low birth weight rates continue to be lower than the national averages for all infants. In particular, low birth weight for African Americans is lower than the rate observed among African Americans nationally (10.7% versus 14.9% respectively).
- Health centers are effective in reducing chronic diseases. As health centers serve more low income residents, states' black/white health disparities in overall mortality decline significantly.
- CHCs assist other care providers by helping reduce bad debt and uncompensated care, as well as unnecessary emergency room visits. CHCs clearly stand as a health care success story and are necessary for promoting access to care in urban and rural communities.²¹

ECONOMIC IMPACT

The Access for All America Plan was created to grow the health center program by developing new and expanding existing CHC sites, increasing workforce primary care training programs, increasing support for new facilities, health information technology, and quality/performance improvement. As a result of Access for All America, it is estimated that health centers could save the health care system \$9.9 to \$17.6 billion annually, a figure that could grow to \$22.6 billion or produce an additional \$40.7 billion in overall economic activity once health centers are expanded to serve a total of 30 million people by 2015. Upon reaching 30 million patients, the number of medically disenfranchised individuals is projected to dramatically decline from 19% to 13% of all United States residents.

Medical expenses for health center patients are lower compared to patients seen elsewhere. CHC patients spent about \$2,569 per year on each patient's care, compared with \$4,379 per patient per year for those who did not receive the majority of their care from a CHC, a 41% (\$1,180 per person) difference.²² These substantial savings are attributed to a host of factors, not least of which is a reduced reliance on hospital emergency departments among Medicaid beneficiaries, health centers' record as effective medical homes which is a growing trend, and populations increasingly marginalized from primary care health services.²³

HEALTH CENTERS IN PENNSYLVANIA

The 36 FQHCs in Pennsylvania are also economic key drivers providing \$370 million in local economies and providing more than 2,600 full-time jobs in the Commonwealth. The direct economic benefit generated to Commonwealth communities is \$337,934,781. These centers have also been effective in keeping the costs of care aligned with those of the United States. The average costs per Pennsylvania health center patients mirrors that of the United States. Table 2 shows these costs are typically much lower than those for medical and dental insured visits. Total cost per total patient (includes the total cost of all services over total users) in Pennsylvania is \$422 and the United States is \$562, a difference of only \$140.²⁴

Table 3: Health Center Average Costs per Patient

	Medical Costs per Medical Patient	Medical Cost per Medical Patient Visit	Dental Costs per Dental patient	Dental Cost per Dental Patient Visit
Pennsylvania	\$318	\$112	\$335	\$129
United States	\$386	\$123	\$344	\$144

The Highmark Foundation is aware of the challenges and barriers faced by Pennsylvania CHCs in delivering quality care. As the number of uninsured individuals in Pennsylvania continues to grow (1,206,115 or 9.8%)²⁵, CHCs face greater challenges to providing care. From these CHCs, the Highmark Foundation learned that uninsured individuals were not able to receive needed services in a timely manner, individuals waiting from 2:00 a.m. until 7:30 a.m. for first come, first served dental care, diabetic patients with HbA1c levels higher than the national norm of 6.5%, private dentists unwilling to accept Medicaid, underserved individuals who have not had dental care for years, shortage of dental and medical providers accepting public health insurance (Medicaid and/or Medicare), inability to secure specialty care, insufficient staffing to meet the demand for care, demand for services continues to exceed resources allocated for center effectiveness, and lack of adequate funding to address these long-term issues.

With grantmaking, the Highmark Foundation continues to address these issues by investing in health centers' programs created to reduce health disparities, promote awareness of chronic disease, eliminate barriers to receiving quality care, strengthen the dental safety net, decrease emergency room use for non-life-threatening illnesses, and leverage additional grant funds to assist these providers in fulfilling their mission. Outcomes to date demonstrate the significant impact the Highmark Foundation has in reducing or delaying the effects of chronic disease. The goal is to realize long-term and measurable lasting effects.

HIGHMARK FOUNDATION'S APPROACH TO FUNDING SAFETY NET PROVIDERS

Since 2006, the Highmark Foundation has supported 31 safety net providers with grants totaling \$4.1 million:

- Programmatic grants totaling \$2.2 million to 10 safety net providers in western and central Pennsylvania to increase staffing, expand medical and dental care, and improve diabetes outcomes through coordinated, comprehensive and supportive services; and
- Dental access grants totaling \$1.9 million awarded to 21 safety net providers in three priority funding areas: challenge grants to improve coordination and build capacity, regional strategies to support expansion of services, and expand or improve existing dental equipment to improve access to oral health and dental care for underserved populations.

Described below are 10 health centers that received Highmark Foundation grants and the impact on the centers' ability to increase access to care. These grants have provided health centers with opportunities to reduce chronic disease, increase access to preventive care, and improve health outcomes for uninsured individuals and their families.

CATHOLIC CHARITIES FREE HEALTH CARE CENTER (PITTSBURGH, PA): PROVIDING HELP AND CREATING HOPE FOR PITTSBURGH'S UNINSURED

Before Rochele Wallace and her husband Hugh came to the Catholic Charities Free Health Care Center earlier this year, they were sharing medications for chronic health conditions that include diabetes and hypertension. The couple had lost their jobs and their health benefits last fall. Both were, as Rochele says, “becoming highly stressed and depressed” over their situation until a friend told them about the Free Health Care Center.



Responding to a growing need for primary health care for others like the Wallace's, Catholic Charities opened the doors to the Free Health Care Center in November, 2007. Since then quality medical and dental treatment is provided by a staff of six full-time employees, a dedicated team of more than 120 medical, dental, and administrative volunteers to patients without health insurance benefits.

A \$250,000 grant from the Highmark Foundation and a \$250,000 grant from Highmark Inc. awarded in 2008 created an opportunity for Catholic Charities to increase access to no cost primary health, dental, and specialty care including dermatology, endocrinology gynecology, ophthalmology and psychiatry for underserved populations in southwestern Pennsylvania. From May 2008 through April 2009, Catholic Charities provided services to almost 3,000 patients; approximately 250 per month. A total of 5,979 patient visits were made; 46% (2,749) were medical visits and 54% (3,230) were dental visits.

Due to overwhelming need for oral health and dental care, efforts are currently underway to recruit a dentist to help reduce more than 700 individuals waiting three months or more for a dental appointment. Efforts are also underway to recruit dentists who are willing to help from their private practices in order to serve more patients.

Catholic Charities Executive Director Susan Rauscher states that the Free Health Care Center has become a vital, visible community asset by providing help, creating hope, and serving all in their time of greatest need.



CENTRE VOLUNTEERS IN MEDICINE (CVIM) (CENTRE COUNTY, PA): CREATING SMILES

In 2003, when CVIM opened its doors, the very first medical clinic patient presented with a dental emergency. However, a dental clinic was not a consideration at that time. Later that year, CVIM

collaborated with a local partner to provide dental exams, cleanings, emergency evaluations, and referrals from a mobile unit in the clinic's parking lot to address the growing demand for dental care in Centre County. This cooperative helped identify the extreme need for dental care. With a Pennsylvania Department of Health Challenge Grant, CVIM opened a two operator in-house dental clinic in April 2005. The scope of services expanded to include x-rays, hygiene services, extractions and restorative work. The demand for dental services quickly out-paced CVIM's ability to provide care with volunteer dentists. By 2007, CVIM had more than 1,200 people waiting to receive dental care. As a result of poor dental health, an average of six to seven dental visits per patient is needed to achieve good dental health.

During the fall of 2007, CVIM applied for grant funding from the Pennsylvania Department of Health to fund a more robust dental program and hire a dentist to work part-time in order to improve the timeliness in which patient care is provided and increase access to dental care. The grant was awarded and the dentist hired is currently practicing at CVIM.

CVIM received a \$175,000 grant in March 2008 from the Highmark Foundation to support the expansion of the CVIM dental clinic in Centre County to serve the underinsured and uninsured residents. Patient statistics for fiscal years 2007, 2008 and 2009 demonstrate how the Highmark Foundation grant has increased CVIM's ability to provide dental care and treatment, thereby reducing the dental wait list. The impact is immeasurable.

	FY 2007	FY 2008	FY 2009	Totals
CVIM Dental Visits	1,455	1,686	2,567	5,708
Unique Dental Patients	594	763	970	2,327

COMMUNITY HEALTH CLINIC OF BUTLER COUNTY (CHCBC) (BUTLER COUNTY, PA): COORDINATING DIABETES AND DENTAL CARE



The Highmark Foundation grant of \$180,000 awarded in 2009 will allow the Community Health Clinic of Butler County, a free clinic to expand high-quality education, medical, and dental services for the county's uninsured, underinsured, and income eligible adult diabetic population. Butler County's population is 181,934 and 7.9% (14,300) are affected by diabetes. The goal is to lessen the burden of diabetes by providing a program designed to provide comprehensive care at no cost through three components for approximately 500 individuals: medical care, dental services, and diabetic education using a new teaching tool.

Although the project is just beginning, it will have the potential to positively impact the health of diabetic patients by:

- Increasing awareness of diabetes through community prevention programs.
- Lowering HbA1c levels at least .5%. The ultimate goal is to have patients within the national HbA1c target of 6.5 to 7.0%.
- Increasing awareness of regular oral health for disease management and prevention.
- Reducing incidence and prevalence of gum disease and tooth decay through routine oral health and dental care.

It is typical for diabetic patients of the CHCBC to have many dental needs as a result of the lack of preventive dental care. As a result, patients are paying for much needed dental care in a variety of creative ways. Cheryll B. is concerned that she may have to scrape up money for extractions and a possible lower denture due to poor dentition. Cheryll, her family and friends have gathered aluminum cans in the past until she had the necessary funds to pay for dental care. The benefit of the Highmark Foundation grant is two-fold. Cheryll will now be able to receive coordinated dental care without worrying about paying, and she will now have a medical and dental home.



COMMUNITY HEALTH CLINIC (CHC) (NEW KENSINGTON, PA): INCREASING ACCESS TO ORAL HEALTH CARE

With a \$200,000 one-year grant from the Highmark Foundation awarded in 2006, CHC created a dental clinic which provided comprehensive oral health services to underserved individuals and their families in the Alle-Kiski Valley (Allegheny, Armstrong, Butler, and Westmoreland counties). CHC became a fully Federally Qualified Health Center in 2009.

The need for this clinic was huge. CHC physicians are the first line of defense for oral health care. Physicians reported more than 50% of patients they treated required extensive oral health care for broken or decayed teeth. They were only able to prescribe antibiotics due to abscesses or infection, which temporarily treated the symptoms rather than the causes. A unique feature is dental patients are referred for medical care and medical patients are referred for dental care. A dual-system approach means more patients are more likely to be treated.

From the time when the grant was received, CHC struggled to recruit dental providers who wanted to practice public health dentistry. After many months of recruitment, CHC was able to hire three dentists over a two-year period; arranging their schedules to ensure adequate coverage during clinic hours. Since that time, the impact has been significant. There have been 1,319 visits from 522 patients that included 2,221 dental procedures for curative purposes and preventive care. There are approximately 350 individuals on the dental waiting list who have been waiting six or more months for dental services. Through the efforts of Highmark Inc. and United Concordia, a one-day screening event was held in November 2008 to assist with reducing CHC's dental wait list. Approximately 100 uninsured individuals received dental services. At the conclusion of the one-day event, patients are now able to receive ongoing preventive dental care and services as patients of the CHC.

COMMUNITY HEALTH NET (CHN) (ERIE, PA): EXPANDING ACCESS IN ERIE COUNTY

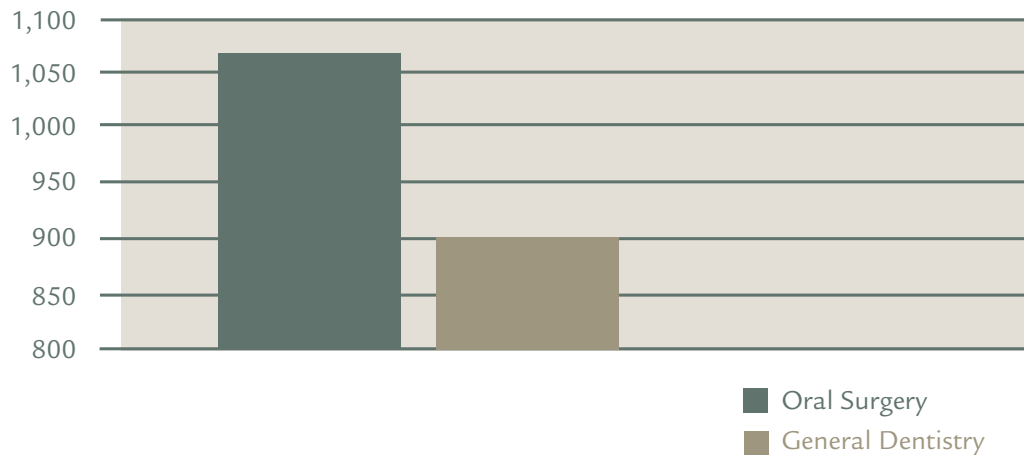
A \$210,000 grant awarded in 2007 from the Highmark Foundation provided Community Health Net (CHN), a Federally Qualified Health Center, with an opportunity to expand access to dental care for the uninsured and underinsured in Erie County. The Highmark Foundation grant was leveraged along with grants from the Erie Community Foundation (\$80,000) and Hamot Health Foundation (\$50,000) combined with CHN funding to open a much-needed dental clinic on June 1, 2008 at the Bayfront NATO Martin Luther King Center in Erie.



An oral surgeon provided surgical and general dental services for the first three months of the clinic's operation. In mid August, 2009 he was joined by a general dentist. With the addition of the dentist, the clinic is able to see more and more new patients. Approximately 91% of the patients are covered by Medical Assistance insurance and 5% are self-pay based on their ability to pay. Only 4% have private insurance coverage.

A total of 1,991 unduplicated patients were seen at the clinic during its first year of operation, with oral surgery patients (1,081 or 54%) exceeding general dentistry (910 or 46%) patients due mainly to extractions. A total of 2,151 visits have been made as a result of significant community outreach with one-third of those patients being new to CHN. Net patient revenue was \$372,623 with oral surgery (61%) generating higher revenues than general dentistry (39%), (\$229,107 versus \$143,516). The significance is that revenue is reinvested into the clinic so that CHN can serve additional patients.

Improving access to dental care is the number one need of underserved residents of Erie County. Because of the addition of this clinic and two dentists, access is improved by 17.5%, exceeding the goal of removing 10% of the dental professional shortage. CHN intends to continue expansion of dental services to the rural areas of the county in the future.



One of those areas, Union City, is the most impoverished in Erie County. CHN planned to expand dental services to Union City. However, this expansion is more challenging than expected. An existing office in Union City was evaluated, however the equipment was obsolete and the dentist wished to retire. As a result, there was not adequate staff or equipment to open at that time. St. Vincent Health System (Erie) currently operates a medical clinic in the former Union City Hospital building with room for expansion to include dental operatories. CHN plans to expand its dental services in 2010 by establishing a medical and dental clinic to serve Union City. A Pennsylvania Primary Care Challenge Grant was submitted to the Pennsylvania Department of Health on behalf of CHN in April 2009 and was funded for \$200,000. A portion of these funds will be used to support dental services in Union City.

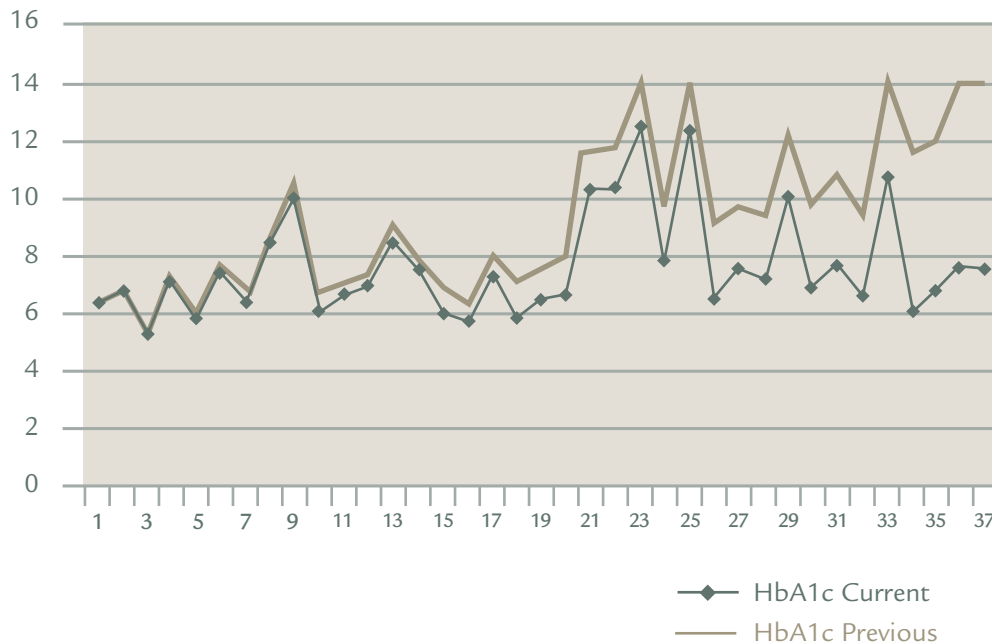
HAMILTON HEALTH CENTER (HARRISBURG, PA): DIABETES HEALTHY OUTCOMES PROGRAM FOR UNINSURED DIABETICS (DHOP)



After being seen in the emergency room for treatment of the effects of a fire, Gerald learned that he had diabetes that went untreated for approximately 10 years. His blood sugar was over 300. Normal range is 80 to 120. What's worse, Gerald was uninsured and could not afford proper treatment for diabetes. Gerald's doctor told him about the Diabetes Healthy Outcomes Program (DHOP) which is funded by the Highmark Foundation. The two-year \$250,000 grant from the Highmark Foundation awarded in 2007 is helping Hamilton Health Center to provide a high-quality program for uninsured diabetics at no cost. DHOP makes diabetes care accessible for uninsured patients by delivering coordinated, comprehensive and supportive services (dietitian, podiatrist, ophthalmologist, and dentist) at the same visit eliminating barriers for patients completing treatment and self-care management plans. Reducing the number of visits also increases compliance. The goal is to reduce the complication of diabetes, reduce emergency room visits, and improve HbA1c levels. As a result of the grant, Gerald is receiving much needed care and is now a patient of Hamilton Health Center.

Hamilton Health Center currently cares for 1,179 diabetic patients. Like Gerald, 24% (282) are uninsured while another 43% (506) are covered by Medicaid. DHOP has served 210 uninsured diabetes patients already exceeding its projected goal of serving 200 uninsured diabetics. DHOP's primary outcome is reduction of HbA1c, the most important measure of diabetes control.

At least 63% of the existing DHOP participants had HbA1c levels over 7% (indicative of poor control) when they enrolled in the program. The average baseline HbA1c for DHOP participants was approximately 8.1%. For those having two or more HbA1c tests, the average decrease in HbA1c was approximately 1.0 points; the highest decrease was 4.3 points and the lowest decrease was 0.1 points. A one point change in HbA1c significantly reduces risk of diabetes complications. Hamilton Health Center reports that the majority of patients' health outcomes improved as a result of DHOP.



NORTH SIDE CHRISTIAN HEALTH CENTER (NSCHC) (PITTSBURGH, PA): IMPROVING CHILD HEALTH

A pediatric department funded in 2007 with a three-year \$356,250 grant from the Highmark Foundation has brought a care focus not available elsewhere in NSCHC's medically underserved area. With Highmark funding to support the salary of a pediatrician, open scheduling for all sick children has been established.



Prior to receiving the grant, NSCHC's pediatric care was limited. It was only provided by family physicians and had to be integrated into an already overburdened schedule. Prior to receiving the Highmark Foundation grant, NSCHC turned away 3 to 5 pediatric visits daily because a pediatrician was not available, forcing families to seek care elsewhere. Moreover, there was no space for a separate pediatric department and finding a certified pediatrician interested in community medicine was not an easy task. Part of the issue was several prospective candidates wanted part-time employment, and others higher compensation. This issue was resolved in 2008 when NSCHC moved into a large, newly renovated building in the same Northside community. NSCHC established a separate pediatric department and hired an onsite, half-time pediatrician with the intent of becoming full-time. The addition of this pediatrician, hired 13 months ago, now gives sick and at risk children same day priority, thereby reducing wait times.

In addition, NSCHC assumed the medical home responsibilities of the Northview Heights Housing Project and also has expanded the pediatric department to the Northview Heights Health Center. From October 1, 2008 to June 1, 2009, the pediatrician has seen 895 pediatric patients [ages 0-17 years] at both sites. A total of 752 immunizations have been administered, and 1,348 encounters have been documented. NSCHC has also hired a newly graduated family practice physician with Highmark Foundation funds. She began seeing patients in late summer 2009. With two pediatricians now on staff, the number of children seen at both sites is expected to increase twofold.

Coordinating pediatric and adult care in the same facility also increases the likelihood that parents will maintain their own medical appointments. This eliminates parents from having to make and keep multiple appointments at different locations.

NSCHC leveraged Highmark Foundation funding to help bridge this new service delivery locally. The Pittsburgh Foundation awarded a \$375,000 start-up grant to NSCHC. More importantly, NSCHC was also awarded full FQHC status in 2009 through the New Access Points Program changing its status from a FQHC Look-Alike. NSCHC received more than \$1 million in federal grants under this program and is now eligible to receive Section 330(e) funding. In addition, a \$20,000 grant awarded in 2009 from Dominion Resources enabled NSCHC to provide services to more people. More than 100 free health clinics in 14 states, including three in western Pennsylvania received grants. NSCHC was selected to share a \$1 million donation from Dominion's corporate giving program along with more than 100 health clinics in 14 states. These grants will provide immediate medical care to the uninsured and those that cannot afford necessary health care. They will also pay for doctor's exams, prescriptions, lab work, and other necessary diagnostic procedures.



PRIMARY CARE HEALTH SERVICES (PCHS) (PITTSBURGH, PA): EXPAND EXISTING DENTAL PROGRAM IN MCKEESPORT AND WEST END COMMUNITIES

The Highmark Foundation awarded a grant in the amount of \$275,000 in 2007 to Primary Care Health Services, Inc. (PCHS) to expand dental services into two underserved communities in Allegheny County, Pennsylvania: McKeesport and the West End. The purpose of the grant was to assist PCHS with filling a needed gap by establishing dental clinics into existing health center sites for individuals and families without dental insurance. Currently, these individuals are accessing free or low-cost dental care outside of their respective communities or they are going without care.

Numerous attempts to recruit a dentist have been unsuccessful, and PCHS has not provided services as indicated by the grant in either site. Part of the issue is salary. Typically, community health dentists receive lower salaries than those in the private practice, which makes it difficult for a community health center to attract qualified dentists and/or compete with the private sector.

The inability to secure qualified health professionals (physicians and dentists) to practice in community health centers is widely known. There is often great unmet need for dental services and inadequate funding for service provision. Although most dental services provided in community health centers are paid for by Medicaid reimbursement and grants, there are simply not enough resources within these funding streams to provide higher levels of compensation. Lack of funding to hire qualified dental providers, however, was the fundamental restriction on service among dental clinics.

The Highmark Foundation is also aware of the difficulties that community health centers have encountered in attracting qualified dentists and is working proactively with PCHS to ensure that individuals in these communities have access to affordable dental care.



SOUTHEAST LANCASTER HEALTH SERVICES (SELHS) (LANCASTER, PA): DENTAL EMERGENCY WALK-IN CLINIC

The Highmark Foundation's three-year \$225,000 grant awarded in 2007 to Southeast Lancaster Health Services' (SELHS) Dental Emergency Walk-In Clinic has addressed one of Lancaster's greatest health care access needs.

SELHS' Dental Emergency Walk-In Clinic is the only emergency dental service of its kind in Lancaster County and the surrounding area. Patients begin registering as early as 4:00 a.m., with clinic hours from 7:30 a.m. until 12:00 p.m. On average, the number of patients seen in the dental clinic is 18-32 patients per clinic day. The clinic is held 2 days per week for 4½ hours on each of the days. All patients that present to the Emergency Dental Walk-in Clinic are offered the opportunity to have their names placed on a new patient waiting list. This is significant because these patients can now receive preventive dental care rather than seeking emergent care. Approximately 20% of walk-in patients became regular dental patients of SELHS.

Other than the hospital emergency department, there are often no other options for these patients. People in the community who present at a local emergency room with a dental issue are generally given a pain-killer and/or an antibiotic and told to contact SELHS. In the past three years, the program has provided over 6,000 dental visits to nearly the same number of unduplicated users reducing emergency room usage for dental problems. Approximately 60% of those patients were uninsured (three times SELHS's system-wide rate of uninsured patients) and all of them presented with infection, swelling, pain or bleeding, or any combination of the four.

Given that only one dental practice in the Lancaster community is currently accepting new Medical Assistance patients, a majority of patients had been without dental care for as long as a decade. One mother of an uninsured child sent a note to say thanks for eliminating her daughter's pain so she could return to school and concentrate on her school work.

The performance of the program has gained such prominence that a newly retired oral surgeon joined this year as a volunteer, allowing SELHS to perform even more services for this patient population, which often presents with complicated dental (and overall) health issues. On behalf of all of the patients this program has served, SELHS acknowledges the Highmark Foundation for its tremendous support. Lives have been changed, and even saved, by this commitment to creating access to health care.

SQUIRREL HILL HEALTH CENTER (SHHC) (PITTSBURGH, PA): PERFECTING PATIENT CARE

The force behind the SHHC was the Jewish Healthcare Foundation (JHF). The JHF conducted research, planning, a feasibility study, and subsequently secured the FQHC status necessary to begin center operations. In 2006 The Highmark Foundation awarded SHHC a two-year \$125,000 grant to implement the Perfecting Patient Care® system of quality management in a new primary care setting. The Highmark Foundation grant was used to provide training and coaching in the Perfecting Patient Care model and also to help implement an electronic medical record (EMR) system, NextGen, with the goal of using the EMR to ensure and track quality.

SHHC's diverse patient population includes older adults, immigrants and refugees, and uninsured patients of all ages, as well as patients with private insurance who choose the Center because of its fine clinicians and high quality care. Perfecting Patient Care helped SHHC create an environment that focuses first and foremost on each patient's individual needs, treats everyone with dignity and respect, and provides care that is culturally competent and respectful of the wide variety of languages, beliefs, and backgrounds of SHHC patients, who speak a total of 36 different languages.

Outcomes through November 2008 (conclusion of the grant) show that SHHC has been successful in integrating the PPC system in chronic disease programs. In the two years that Highmark

Foundation's funding helped support SHHC's quality and EMR systems, the Center grew from zero patients to 2,765. A total of 3,700 individuals have now been served and the Center continues to add an average of 100 new patients each month. The total number of encounters was 10,580 with four encounters per patient.

Perfecting Patient Care helped SHHC create an environment that focuses on each patient's individual needs. EMR enables staff to track chronic conditions, communicate internally, integrate behavioral health services with medical care, and follow the ever shifting demographics of the patient population. With the addition of a pediatrician/internist and an obstetrician/gynecologist to the SHHC staff, EMR is also used to track pediatric data such as immunization rates and data on OB outcomes, such as birth weights. This data will be extremely useful in efforts to improve the rate of low birth weight babies.

SHHC has leveraged Highmark Foundation funding to receive an additional \$460,000 in local funding from The Pittsburgh Foundation, The Harry & Jeanette Weinberg Foundation, The United Jewish Foundation, and Naomi Weisberg Siegel and Eric Cooper. These grants are for varying purposes, but include EMR equipment and support to better track and report patient outcomes. In addition, SHHC received a five-year federal grant as a community health center in the amount of \$3,250,000 (\$650,000 per year). The grant was approved in December 2008 with the funding period beginning January 1, 2009. This grant will assist with sustaining center operations.



DENTAL GRANTS THROUGH REQUEST FOR PROPOSALS (RFP)

In 2008, the Highmark Foundation launched an oral health and dental care program to help improve access to oral health and dental care for low-income, rural, uninsured, underinsured, and underserved populations. From the RFP, the Highmark Foundation awarded \$1.9 million in grants to 21 oral health programs across its 49-county Pennsylvania service region. These programs are delivered by safety net providers including local hospitals, health departments and programs that provide dental services. Listed below are only those FQHCs and Look-Alikes funded through the competitive RFP process. A total of eight (8) health centers received grants totaling \$742,718.

Health Center	Grant Award
Cornerstone Care	\$125,000
East Liberty Family Health Care Center	\$147,500
Family First Health	\$50,000
F.O.R. Sto-Rox	\$56,500
Hamilton Health Center	\$100,000
Primary Health Network	\$50,000
Sadler Health Center	\$100,000
Welsh Mountain Medical and Dental Center	\$113,718
TOTAL	\$742,718

ISSUES AFFECTING COMMUNITY HEALTH CENTERS

Many issues affecting health centers are challenging. Resolution of these issues will maximize the efficiency of health centers. Maintaining the momentum in which health centers are moving will require strategic partnerships, innovative thinking, and development of a new infrastructure to effectively serve more uninsured individuals and their families. These issues include:

- The state of Pennsylvania having an insufficient number of primary care physicians and dentists that accept Medicaid.
- Delivering affordable care and improving health outcomes while saving costs.
- Outdated medical and dental equipment.
- Lack of national and/or local funding support. Grants are not keeping pace with patient growth.
- Recruiting and retaining newly graduated dentists; increasing the limited number of dentists practicing public health dentistry.

TRENDS IN COMMUNITY HEALTH CENTERS

The trends described below provide new, exciting and innovative ways to address issues facing community health centers and the health needs of the uninsured. To address these issues; foundations, community hospitals, federal government, health insurers, and other organizations are working together to develop unique and creative ways to significantly affect access to health centers with long-term outcomes.

Funding Sources

Federal and foundation grants supply necessary funding to launch new initiatives that strengthen safety net providers.

- **Access for All America Plan** is a comprehensive plan to reduce the ranks of America's medically disenfranchised by preserving, strengthening, and expanding health centers to reach a total of 30 million patients by the year 2015. The goal of the plan is to provide better care at lower costs.²⁶
- The Commonwealth Fund in collaboration with eight co-funders is launching a **National Safety Net Medical Home** which will provide \$6 million to help 68 community health centers in five states transform into patient-centered medical homes. Forty-two (42) organizations from 32 states applied to become a part of the initiative. Five (5) Regional Coordinating Centers were selected, including the Pittsburgh Regional Health Initiative will be given training and ongoing support to improve how care is delivered to patients.
- **The American Recovery and Reinvestment Act (ARRA)** provides \$2 billion to be invested in community health centers, an unprecedented opportunity to serve more patients, stimulate new jobs, and meet the significant increase in demand for primary health care services among the Nation's uninsured and underserved populations. Over the next two years ARRA funding will be invested in community health centers to support critically needed health care services, renovations and repairs, and investments in health information technology. **Total Obligated Health and Human Services Funds:** \$42.4 billion (as of 08/21/09) and **Total Gross Outlays:** \$28.4 billion (as of 08/21/09).²⁷

New trends have emerged, including ways to deliver better care.

- The medical home model is one of the most widely known approaches to providing comprehensive primary care. This model has shown promise as a way to provide high-quality, cost-effective health care to low-income and minority patients while

reducing racial and ethnic health disparities, improving the coordination of information between primary care and specialty care or community providers, using information technology to identify patients with unmet needs, and improving care for those with chronic conditions, and systematically obtaining feedback from patients for quality improvement.²⁸ A medical home is defined as primary care that is:²⁹

- Accessible
 - Continuous
 - Comprehensive
 - Family centered
 - Coordinated
 - Compassionate
 - Culturally effective
- Newly funded FQHCs are now required by Bureau of Primary Health Care (BPHC) to provide dental in addition to medical services allowing patients to receive coordinated services in one location.
 - More federal funding available to support innovations in technology to fill gaps in missing data. Better data is necessary to obtain better patient outcomes.
 - Operational support for equipment, salaries, and personnel.
 - Federal loan repayment programs to reduce dental school debt.

Highmark Foundation continues its efforts to support CHCs by assisting them with grants to build capacity to increase the quality and quantity of services to underserved populations.

SUMMARY

As the number of uninsured grows, strategies such as the medical home model, large-scale plans to increase access, and major funding commitments could be successful in demonstrating the effectiveness of community health centers. The common theme throughout the strategies is to ensure that the medically disenfranchised population is able to access and receive high-quality primary and dental care through effective and efficient sources of care. Community health centers offer a promising solution to a persistent problem.

The Highmark Foundation has used grantmaking to invest in community health by helping safety net providers meet the needs of the uninsured. This investment has demonstrated the ability to reduce health disparities regarding chronic diseases, eliminate barriers, improve quality of care, programs and services, enhance equipment, increase staff, increase access, and expand primary medical and dental care to those who need it the most. Many programs and services supported by the Highmark Foundation have been continued or expanded, staff have been hired as full time employees, and grants have been leveraged to secure additional funding from other sources. These grants have the power to influence a system of care with far reaching effects.



FOOTNOTES

- ¹ National Association of Community Health Centers and Capital Link. 2008. Access Capital: New opportunities for meeting America's primary care infrastructure needs. 26 pp.
- ² Rosenbaum, SJ and P. Shin, Health Centers Reauthorization: An overview of achievements and challenges. (Kaiser Family Foundation, Washington, D.C., 2006). Available at <http://www.kff.org/kcmu> (Accessed August 5, 2009).
- ³ Ibid.
- ⁴ National Association of Community Health Centers: U.S. Health Center Fact Sheet, 2008. [cited August 24, 2009]; Available from <http://www.nachc.com/about-out-health-centers.cfm>.
- ⁵ Health Centers: America's Primary Care Safety Net Reflections on Success, 2002-2007. U.S. Department of Health and Human Services Health Resources and Services Administration Bureau of Primary Care. 2008 [cited August 3, 2009]; Available from www.bphc.hrsa.gov.
- ⁶ Ibid.
- ⁷ Based on Bureau of Primary Health Care, HRSA, DHHS, and 2007 Uniform Data System.
- ⁸ Rosenbaum, SJ and P. Shin, Health Centers Reauthorization: An overview of achievements and challenges. (Kaiser Family Foundation, Washington, D.C., 2006). Available from <http://www.kff.org/kcmu> (Accessed August 5, 2009).
- ⁹ USD data allow a relatively close examination of the patients served, services furnished, the health center workforce, and revenues received. No federal data is collected on look-alike health centers; however, the National Association of Community Health Centers collects and makes available a limited amount of patient data from these clinics.
- ¹⁰ The Health Center Program: Section 330 of the Public Health Service Act (42 USCS § 254b). [cited August 24, 2009], Available from <http://bphc.hrsa.gov/about/legislation/section330.html>.
- ¹¹ Health Disparities Collaboratives. [cited August 25, 2009]: Available from <http://www.tachc.org/HDC/Overview/Background.asp>.
- ¹² Landon, BE, Hicks, LS, O'Malley, AJ, et al. Improving the management of chronic disease at community health centers. *N Engl J Med* 2007; 356:921-934.
- ¹³ Personal communication with CHC Executive Director.
- ¹⁴ A Prospective Payment System (PPS) is a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, diagnosis-related groups for inpatient hospital services).
- ¹⁵ Ibid.

- ¹⁶ Community Health Centers: Key partners in the continuum of care for the uninsured and underinsured. MGMA Connexion 2009; 9:24-27.
- ¹⁷ Roadmap to Recovery: Increasing Access to Health Care for People Across the Country. [cited August 26, 2009]; Available from <http://www.hhs.gov/recovery/index.html>.
- ¹⁸ Increased Demand for Community Health Care Services (IDS) Grants by State. [cited August 27, 2009]; Available from <http://transparency.cit.nih.gov/RecoveryGrants/grant.cfm?grant=Increased Demand>.
- ¹⁹ Factsheet: Primary Health Care. Health Resources and Services Administration (HRSA). [cited August 24, 2009]; Available from <http://www.hrsa.gov>.
- ²⁰ Health Centers: America's Primary Care Safety Net Reflections on Success, 2002-2007. U.S. Department of Health and Human Services Health Resources and Services Administration Bureau of Primary Care. 2008 [cited August 3, 2009]; Available from www.bphc.hrsa.gov.
- ²¹ Ibid.
- ²² National Association of Community Health Centers and Robert Graham Center. 2007. Access Denied: A look at America's disenfranchised. 43 pp.
- ²³ National Association of Community Health Centers and Capital Link. 2008. Access Capital: New opportunities for meeting America's primary care infrastructure needs. 26 pp.
- ²⁴ Based on Bureau of Primary Health Care, HRSA, DHHS, and 2007 Uniform Data System.
- ²⁵ Kaiser Family Foundation [statehealthfacts.org](http://www.statehealthfacts.org). [cited September 3, 2009]; Available from <http://www.statehealthfacts.org/comparecat.jsp?cat=3&gsa=1>.
- ²⁶ Access for all America. 2009. [cited August 26, 2009]; Available from <http://www.nach.com/ccess-for-america.cfm>.
- ²⁷ American Recovery and Reinvestment Act (ARRA): Community Health Centers. 2009. [cited September 1, 2009]; Available from <http://www.hhs.gov/recovery/hrsa/healthcentergrants.html>.
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- ²⁹ Health Centers: America's Primary Care Safety Net Reflections on Success, 2002-2007. U.S. Department of Health and Human Services Health Resources and Services Administration Bureau of Primary Care. 2008 [cited August 3, 2009]; Available from www.bphc.hrsa.gov.



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