

Alaska  
Primary Care  
Association



## Alaska's Community Health Centers (CHCs)

Presentation for the  
Alaska Health Care  
Strategies Planning Council  
September 17, 2007

### CHCs and the Task At Hand

- **Description of current system in Alaska**
- **A plan to address issues**
  1. **Access**
  2. **Cost**
  3. **Quality**

## CHCs and the Task At Hand

### GOOD NEWS

- |            |                |
|------------|----------------|
| 1. Access  | INCREASE       |
| 2. Cost    | COST-EFFECTIVE |
| 3. Quality | HIGH           |



### Community Health Centers

### CHC Model

- Not-for-profit, community-specific
- Volunteer community board (51% users)
- In medically underserved communities
- Open to all Alaskans, target low-income

## CHC Model



- **Quality, comprehensive primary care**
- **“Primary Care” includes basic**
  - **Medical care**
  - **Dental services**
  - **Behavioral health care**

## CHC Model



- **ALL SERVED regardless of insurance status or ability to pay**

**DO NOT TURN PATIENTS AWAY**

**Seniors**

**Uninsured**

**Veterans**

**Children**

**Low Income**

**Seasonal Workers**

- **Sliding fee scale: accountability**

## CHCs Across America



- 40 year history
- Broad, bi-partisan support
- Serve 16 million Americans
- Over 5,000 delivery sites

## Community Health Centers

Expect**More**.gov



☆☆☆ **Effective**

HIGHEST RATING POSSIBLE

- ✓ Set ambitious goals
- ✓ Achieve results
- ✓ Are well-managed
- ✓ Improve efficiency

“... in the 4th decade of solid, cost-effective, quality performance....”

## CHC History in Alaska

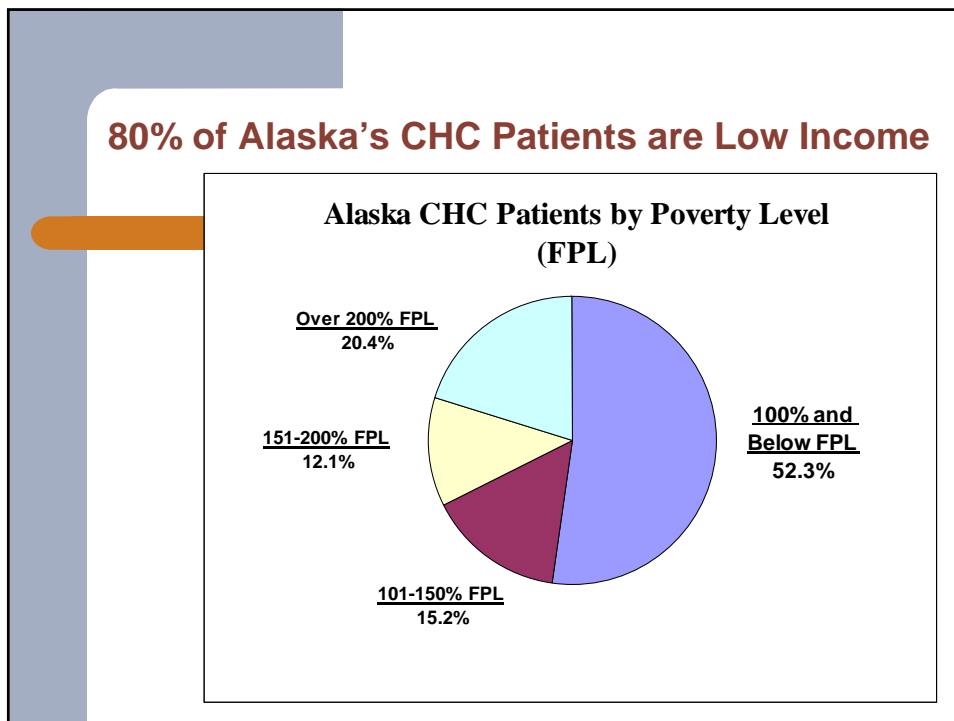
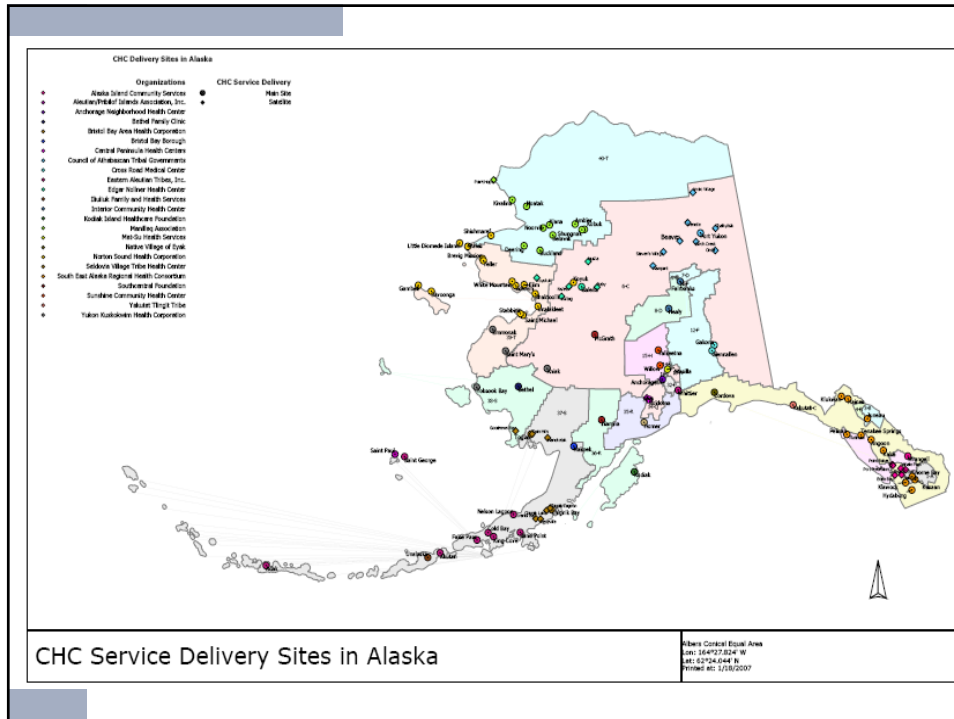


- Anchorage Neighborhood Health Center established - 1974
- Interior Community Health Center in Fairbanks established - 1995
- Alaska Primary Care Association established - 1995

## CHCs in Alaska - 2007

- Alaska network of 26 CHC organizations
- 124 delivery sites
- Serving 80,000 Alaskans
- 355,000 patient visits
- Tribal and non-tribal models





## Many Alaska CHC Patients are Uninsured

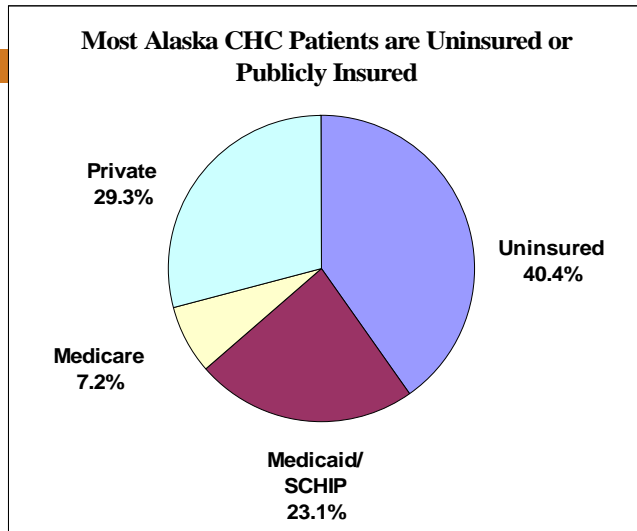
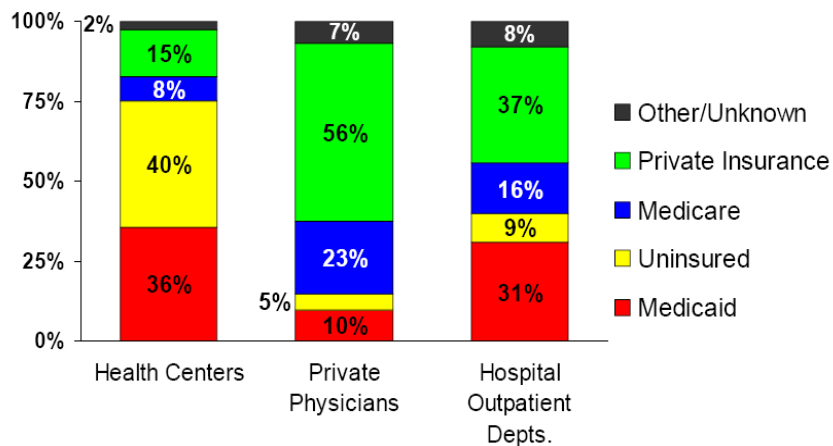


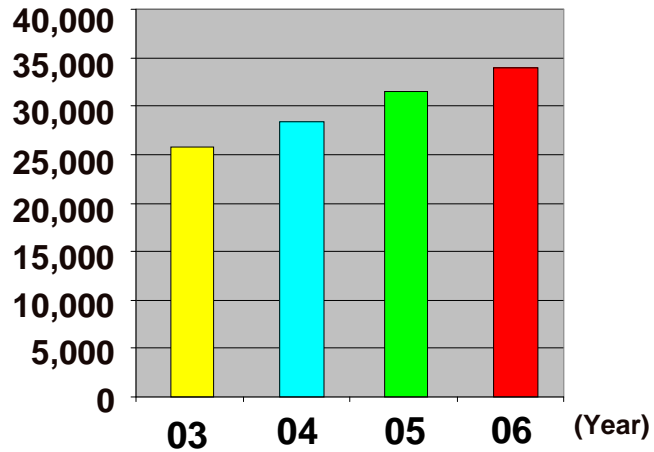
Figure 1.5

## Health Center Patient Mix Is Unique Among Ambulatory Care Providers

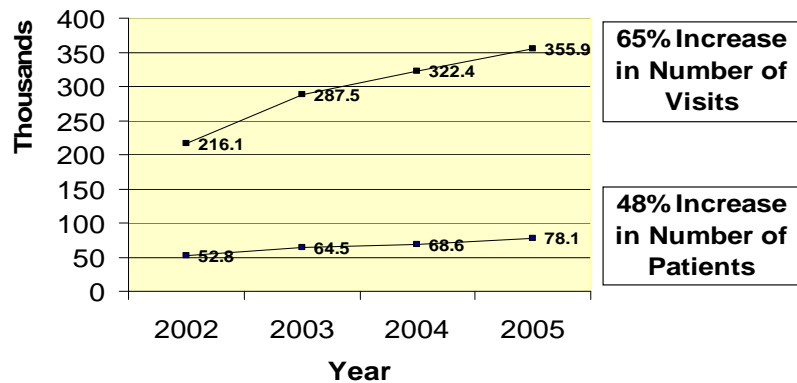


Notes: Other public includes non-Medicaid SCHIP and other state-funded insurance programs. Health Center data are from 2005, private physician and hospital outpatient data from 2004.  
 Sources: Health Center from 2005 Uniform Data System. Private Physicians from 2004 NAMCS (CDC National Center for Health Statistics, 2006). Hospital Outpatient from 2004 NHAMCS (CDC National Center for Health Statistics, 2006).

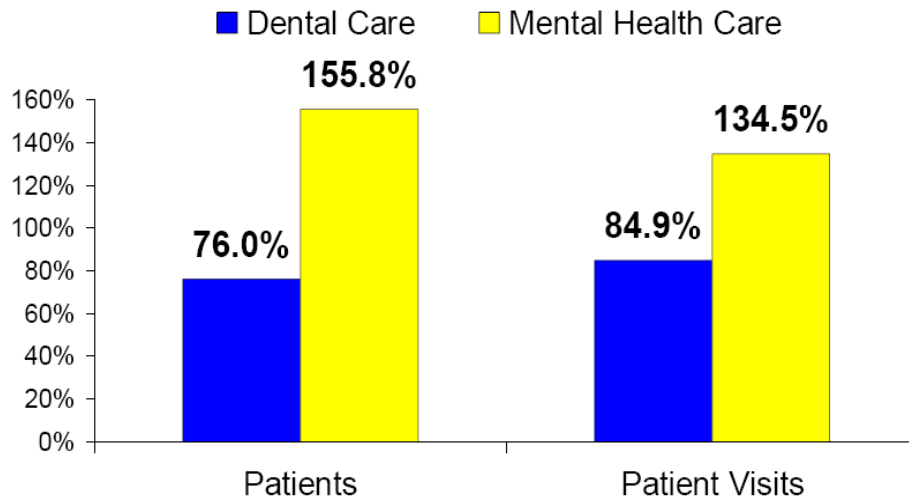
## # of Uninsured at Alaska's CHCs on Rise



## The Number of Alaska CHC Patients and Visits Continues to Grow



## Growth in Health Center Dental & Mental Health Care, 2000-2005



Note: Mental health does not include substance abuse.

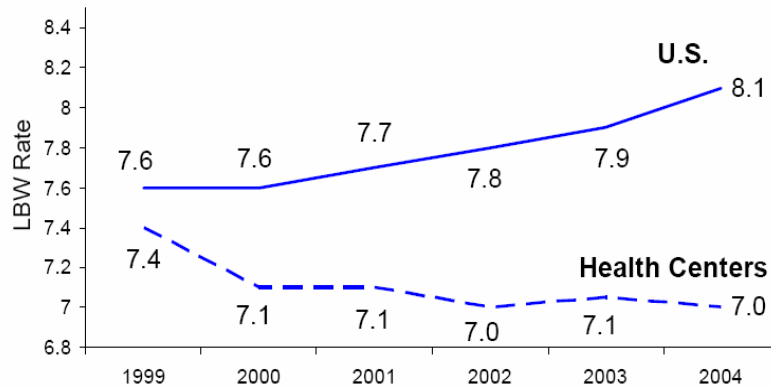
### State Support:

### Access & Quality

- CHCs → expand health care access
- Access → healthy people and communities
- Communities with CHCs → fewer sick days

Figure 5.4

## Health Center Patients Have Lower Rates of Low Birth Weight than the U.S. Average



### State Support:

### Access & Quality

- A regular source of primary care lowers health status disparities.
- CHC uninsured patients are far more likely to use the CHCs as their regular source of care than uninsured patients seen elsewhere.
- CHCs contribute significantly to reducing disparities.
- Lower incidence of chronic disease and disability in community with CHC.

## CHC Funding Streams

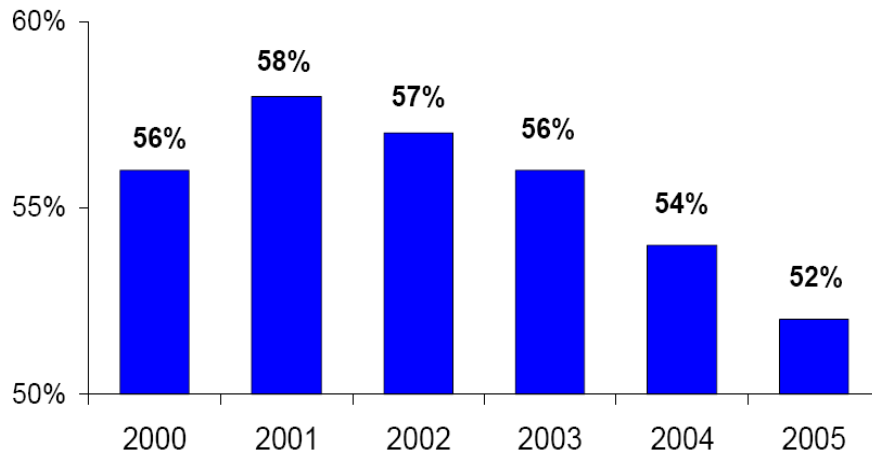
- HRSA Bureau of Primary Health Care
- Patient care revenue
  - Private insurance
  - Patient co-pays
  - Sliding fee scale
  - Medicaid and Medicare
- Local/private funding
- State revenue  
(in 37 other states)



Figure 10.2

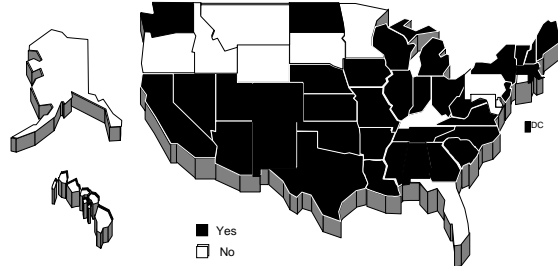
### Federal Grants are not Keeping Pace with Costs or Uninsured Patient Growth

Federal Grant as Percent of Uninsured Patient Costs



## Other States Invest in CHCs

Map 2  
37 States Provide Direct State Funding to Health Centers, FY 07



Note: Excludes third party payers.  
Source: NACHC, *Gaining Ground? State Funding, Medicaid Cuts, and Health Centers*, State Policy #12, October 2006.  
[www.nachc.com](http://www.nachc.com)

## Expanding Primary Care is Smart

- **Access to primary care is fundamental to a high-performance health care system and plays an important role in health care quality, costs, and outcomes.**

**Primary Care And Health System Performance: Adults' Experiences In Five Countries.** Schoen, Osborn, Huynh.. Study funded by Commonwealth Fund. *Health Affairs: The Policy Journal of the Health Sphere*. October 2004.

## Strengthening CHCs Makes Sense

State Support:

Wise Investment

Medical expenses  
for CHC patients are  
41% lower  
compared to patients  
seen elsewhere.

State Support:

Wise Investment

- CHCs reduce cost of care
  - Group purchasing
  - Discount arrangements with other service
  - Midlevel practitioners and MDs
  - Technical assistance from APCA

**State Support:**

**Wise Investment**

- **CHCs reduce cost of care**
  - Health disparities collaboratives
  - Prevention and early intervention
  - Less unnecessary ER use

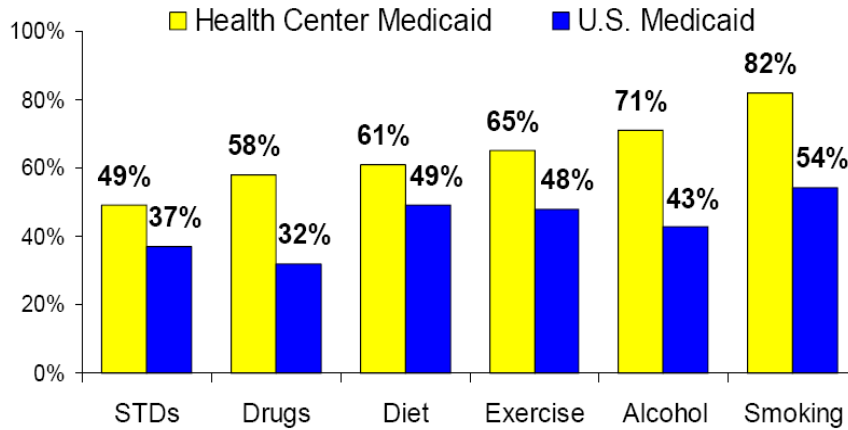
**State Support:**

**Wise Investment**

- **MEDICAID patients seen in CHCs have**
  - Lowest total health care costs
  - Lowest cost per ambulatory visit
  - Lowest rate of hospital inpatient days
  - Lowest inpatient care costs compared to Medicaid patients seen by private physicians and hospital outpatient departments
  - 22% less likelihood of hospitalization for avoidable conditions

Figure 4.5

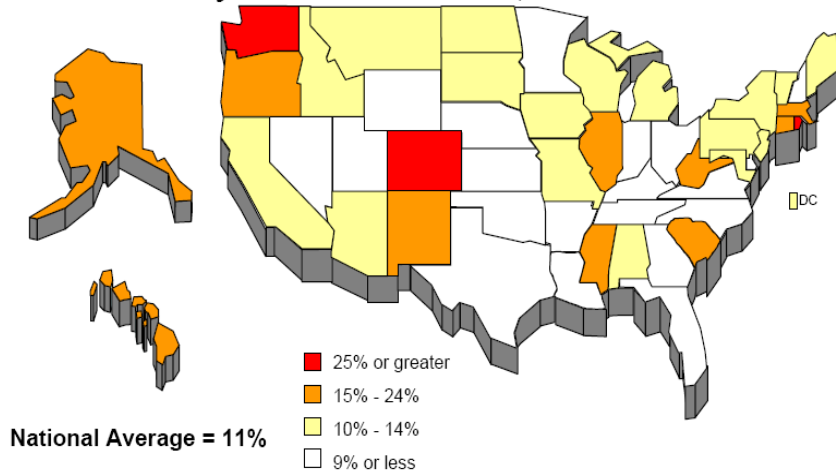
## Health Center Medicaid Patients Receive More Health Promotion Counseling than Medicaid Patients Nationally



Source: Leiyu Shi, "The Role Of Health Centers In Improving Health Care Access, Quality, And Outcome For The Nation's Uninsured." Testimony At Energy and Commerce Committee, Subcommittee on Oversight and Investigations. Congressional Hearing "A Review Of Community Health Centers: Issues And Opportunities." Washington, DC, May 25, 2005. Based on Community Health Center User Survey, 2002; and National Health Interview Survey, 2002. Created by: BA Bartman, CQSB/DCQ/BPHC/HRSA, July 2004.

Figure 3.6

## Percent of State Medicaid Beneficiaries Served by Health Centers, 2005



Source: NACHC, *Access to Community Health Databook*, 2005. [www.nachc.com/research/ssbysdat.asp](http://www.nachc.com/research/ssbysdat.asp).

State Support:

Wise Investment

Medicaid patients  
who use CHCs as their  
regular medical homes  
save 30-33%  
in Medicaid costs

## State Support Request

- Workforce: Recruitment & Retention
  - Loan repayment
  - Housing assistance
  - Salary differential
  - Relocation assistance
- HIT
- Utilities, employee benefits, locum tenens
- Local and statewide marketing

\$13,000,000

## Q & A

- **Dr. Tom Hunt, Medical Director**  
Anchorage Neighborhood Health Center
- **Joan Fisher, Executive Director**  
Anchorage Neighborhood Health Center
- **Marilyn Kasmar, Executive Director**  
Alaska Primary Care Association
- **Sonia Handforth-Kome, Executive Director**  
Iliuliuk Family and Health Services

## Contact:

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**907-929-2728**

**Available upon request: *Research and Studies on  
Community Health Center Cost Effectiveness***

# Alaska Primary Care Association

*"...uncompromising in the pursuit of access to primary care for all Alaskans."*



## Data and Research Sources "Alaska's Community Health Centers" Presentation to the Alaska Health Care Strategies Planning Council September 17, 2007

- 1. Uniform Data System (UDS) State Aggregate (Roll-up) Alaska.** 2000-2006. U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Bureau of Primary Health Care. Research analysis by Alaska Primary Care Services, Chris Hall, Special Projects Coordinator.  
Health centers are required to report data through the Uniform Data System (UDS) administered by HRSA. A core set of information appropriate for monitoring and evaluating health center performance and reporting on trends is collected. The data are analyzed to ensure compliance with legislative mandates, report program accomplishments and justify budget requests to the U.S. Congress, and to look at differences between the U.S. population at large and those individuals and families who rely on the primary care safety net.
- 2. Studies of Health Center Cost Effectiveness.** October 2006. *National Association of Community Health Center.*  
A compilation of research about the cost effectiveness of Community Health Centers from the 1970s through October of 2006.
- 3. Access Granted: The Primary Care Payoff.** August 2007. The Robert Graham Center for Policy Studies in Family Medicine and Primary Care, National Association of Community Health Centers and Capital Link.  
The study finds that Community Health Centers are a smart investment for a nation desperate for high quality, accessible and affordable health care. This study shows that investing in Community Health Centers results in significant savings to the health care system and substantial economic benefit for the communities they serve. Key findings include: 1) Medical expenses for Community Health Center patients are 41% lower (\$1,810 per person annually) compared to patients seen elsewhere; 2) Community Health Centers save the health care system between \$9.9 and \$17.6 billion a year; 3) Community Health Centers generate an overall economic impact of \$12.6 billion, and they produce 143,000 jobs in some of the country's most economically deprived neighborhoods. Every dollar spent in support of Community Health Centers reduces health disparities and costs while contributing to local economies.
- 4. NACHC State Policy Report #12: Gaining Ground? State Funding, Medicaid Cuts, and Health Centers.** October 2006. National Association of Community Health Centers.  
The fifth annual report by the National Association of Community Health Centers on state funding for health centers finds that as the states are emerging from the fiscal crises many of them faced over the past few years; health centers too have been climbing back and state support for health centers is definitely on the rise. The vast majority of states now provide funding for health centers; many are making larger investments each year.
- 3. Inequality in America: The Contribution of Health Centers in Reducing and Eliminating Disparities in Access to Care.** Politzer R, Yoon J, Shi L, Hughes R, Regan J, and Gaston M. 2001. *Medical Care Research and Review* 58(2):234-248.  
Reviews literature showing that health centers improve access to preventive services, health outcomes, and have been successful in reducing or eliminating health disparities.
- 4. Medicaid/SCHIP Cuts and Hospital Emergency Department Use.** Cunningham, PJ. January/February 2006. *Health Affairs* 25(1):237-247.  
The authors find that uninsured people living within close proximity to an FQHC are less likely to have an unmet medical need, less likely to have postponed or delayed seeking needed care, more likely to have had a general medical visit, significantly less likely to have had an emergency room visit, and less likely to have a hospital stay compared to other uninsured. Thus, expanding health center capacity would reduce unmet need and increase the percent of uninsured with a usual source of care. At the same time, expanding health centers

could improve the efficiency of the entire health care delivery system due to their ability to provide timely care and lower hospital and emergency room use, thereby offsetting the costs expanding health center capacity.

5. **Health Centers and the States: Partnership Potential to Address the Fiscal Crisis.** Hawkins D. and Schwartz R. Health. October-December 2003. *Journal of Ambulatory Care Management* 26(4):285-295.  
Reviews the cost effectiveness of health centers through reducing high-cost specialty and hospital care. For these reasons, the authors find that states could save money by increasing their investment in health centers.
6. **Costs vs. Quality in Different Types of Primary Care Settings.**  
Starfield B, et al. 28 December 1994. *Journal of the American Medical Association* 272(24):1903-1908.  
Finds that having a regular source of care is a greater predictor of receiving care than having insurance alone. Based on an extensive review of literature, the ability to identify a particular practitioner rather than a particular place as a medical home is generally associated with better utilization and outcomes, including needs recognition, earlier and more accurate diagnoses, reduced emergency room use, fewer hospitalizations, lower costs, better prevention, fewer unmet needs, and increased patient satisfaction. Primary care is particularly important for narrowing disparities among low income and minority communities. Care provided by health centers is associated with better health outcomes when compared to low income communities not served by health centers.
7. **An Evaluation of the Cost Effectiveness of Federally Qualified Health Centers (FQHCs) Operating in Michigan.**  
McRae T. and Stampfly R. October 2006. *Institute for Health Care Studies at Michigan State University*.  
FQHCs patients incur lower total pre-member per-month Medicaid costs than non-FQHC users, even controlling for age and disability status. The study found that health centers save the State of Michigan \$44.87 per member per month in Medicaid spending – totaling \$17.8 million for the study period.
8. **Availability of Safety Net Providers and Access to Care of Uninsured Persons.**  
Hadley J and Cunningham P. October 2004. *Health Services Research*, 39(5):1527-1546.  
The authors find that uninsured people living within close proximity to an FQHC are less likely to have an unmet medical need, less likely to have postponed or delayed seeking needed care, more likely to have had a general medical visit, significantly less likely to have had an emergency room visit, and less likely to have a hospital stay compared to other uninsured. Thus, expanding health center capacity would reduce unmet need and increase the percent of uninsured with a usual source of care. At the same time, expanding health centers could improve the efficiency of the entire health care delivery system due to their ability to provide timely care and lower hospital and emergency room use, thereby offsetting the costs expanding health center capacity.
9. **Comparative Effectiveness of Health Centers as Regular Source of Care.**  
Falik M, Needleman J, Herbert R, et al. January-March 2006. *Journal of Ambulatory Care Management* 29(1):24-35.  
Researchers found when health center Medicaid beneficiaries had one third fewer ACS events compared to other providers (5.7 vs. 8.2 ACS hospitalizations and 26.1 vs. 37.7 ACS emergency department visits, respectively, per 100 persons). Medicaid beneficiaries relying on health centers for usual care were 19% less likely to use the emergency department for an ACS condition and 11% less likely to be hospitalized for an ACS condition than Medicaid beneficiaries using outpatient and office-based physicians for usual care, even after controlling for case mix and other factors. ACS admissions were more likely in the groups who had mixed use (25% or more of their care at multiple provider types) or low use (0 to 1 primary care visits). Health centers were found to be effective regular sources of care, and the authors recommended increasing both the number and capacity of health centers.
10. **The Medical Home, Access to Care, and Insurance: A Review of Evidence.** Starfield B and Shi L. May 2004. *Pediatrics* 113(5):1493-8.  
Finds that having a regular source of care is a greater predictor of receiving care than having insurance alone. Based on an extensive review of literature, the ability to identify a particular practitioner rather than a particular place as a medical home is generally associated with better utilization and outcomes, including needs recognition, earlier and more accurate diagnoses, reduced emergency room use, fewer hospitalizations, lower costs, better prevention, fewer unmet needs, and increased patient satisfaction. Primary care is particularly important for narrowing disparities among low income and minority communities. Care provided

by health centers is associated with better health outcomes when compared to low income communities not served by health centers.

**11. Health Services Utilization and Costs to Medicaid of AFDC Recipients in California Served and Not Served by Community Health Centers.**

Duggar BC, et al. *Center for Health Policy Studies*. 1994.

California Medicaid FFS patients using health centers regularly in 1993 were 33% less expensive overall (controlling for maternity services), and had 27% less total hospital costs. When including maternity in total costs, regular users were 14% less costly per AFDC case. Approximately half of the savings associated with FQHC regular use is achieved through reduced inpatient care, and the remainder through reduced payments for outpatient care and other services.

**12. Utilization and Costs to Medicaid of AFDC Recipients in New York Served and Not Served by Community Health Centers.** Duggar BC, et al. *Center for Health Policy Studies*. 1994.

New York Medicaid FFS patients using health centers regularly in 1994 were 22% less costly than non-users and 26% less when excluding maternity and newborn patients, and had 41% lower total inpatient costs (58% less when excluding maternity and newborn patients); diabetics and asthmatics who were regular health center users had 62% and 44% lower inpatient costs, respectively. Cost savings are a function of lower admission rates, lower lengths of stay, and admissions for less costly DRGs. Regular users are also associated with savings in ER use – about 50% less than non-users.

**13. Keeping Children Out of Hospitals: Parents' and Physicians Perspectives on How Pediatric Hospitalizations for Ambulatory Care-Sensitive Conditions Can Be Avoided.** Flores G, Abreu M, Chaisson CE, and Sun D. November 2003. *Pediatrics* 112(5):1021-1030.

Upon surveying patients and physicians on avoidable hospitalization conditions among children in Boston, authors found that between 13 to 46% of all hospitalizations could have been avoided through better parent education on their child's condition and appropriate primary or outpatient care. Moreover, the study found that states could save \$17 billion annually by preventing avoidable hospitalizations.

**14. Improving Medicaid Pediatric Care.** Stuart ME, et al. Spring 1995.

*Journal of Public Health Management Practice* 1(2):31-38.

In a review of Maryland Medicaid patient records, health centers scored highest among all providers for the proportion of their pediatric patients who had received preventive services, including immunizations.

**15. Ambulatory Care Sensitive Hospitalizations and Emergency Visits: Experiences of Medicaid Patients Using Federally Qualified Health Centers.** Falik M, Needleman J, Herbert R, et al. January-March 2006. *Journal of Ambulatory Care Management* 29(1):24-35.

Researchers found when health center Medicaid beneficiaries had one third fewer ACS events compared to other providers (5.7 vs. 8.2 ACS hospitalizations and 26.1 vs. 37.7 ACS emergency department visits, respectively, per 100 persons). Medicaid beneficiaries relying on health centers for usual care were 19% less likely to use the emergency department for an ACS condition and 11% less likely to be hospitalized for an ACS condition than Medicaid beneficiaries using outpatient and office-based physicians for usual care, even after controlling for case mix and other factors. ACS admissions were more likely in the groups who had mixed use (25% or more of their care at multiple provider types) or low use (0 to 1 primary care visits). Health centers were found to be effective regular sources of care, and the authors recommended increasing both the number and capacity of health centers.

**16. Patient-Mix Differences Among Ambulatory Providers and Their Effects on Utilization and Payments for Maryland Medicaid Users.**

Stuart ME and Steinwachs DM. December 1993. *Medical Care* 34(12):1119-1137.

Health center Medicaid FFS patients in Maryland in 1993 had lowest total payments and ambulatory visit cost when compared to private, office-based physicians and hospital outpatient departments even after adjusting for patient mix. Health center Medicaid patients also had fewer incidence of inpatient days and lower inpatient day cost than outpatient departments, and similar incidence of inpatient days and inpatient day cost compared to office-based physicians, after adjusting for patient mix. Health center patients were one-third as likely as hospital outpatient unit patients to be admitted on an inpatient basis and were half as likely to have unstable chronic medical diagnoses as patients of other providers.

17. **Using Medicaid Fee-For-Service Data to Develop Health Center Policy.** Braddock D, et al. 1994. *Washington Association of Community Health Centers and Group Health Cooperative of Puget Sound.*  
Health center Medicaid FFS patients in Washington State in 1992 were found to be 36% less expensive for all services than Medicaid FFS patients seen in the private/commercial sector. This comparison also found that health center Medicaid FFS patients used 31% fewer ER services, 34% fewer X-ray and lab tests, 44% fewer prescriptions, and 71% fewer hospital outpatient visits.
  
18. **Utilization and Costs to Medicaid of AFDC Recipients in New York Served and Not Served by Community Health Centers.** Duggar BC, et al. 1994 *Center for Health Policy Studies.*  
New York Medicaid FFS patients using health centers regularly in 1994 were 22% less costly than non-users and 26% less when excluding maternity and newborn patients, and had 41% lower total inpatient costs (58% less when excluding maternity and newbornpatients); diabetics and asthmatics who were regular users had 62% and 44% lower inpatient costs.. Cost savings are due to lower admission rates, lower lengths of stay, and admissions for less costly DRGs.. Regular users are also associated with savings in ER use – about 50% less than non-users.
  
19. **Critical Condition: State Budget Crisis Threatens to Put Health Centers on Life Support.** Mizeur, H.R. March 2003. *National Association of Community Health Centers.*  
This state policy issue brief highlights many of the states' proposed cuts in spending for health programs and proposed changes in health policies that impact health centers and the patients that they serve. A portion of the report focuses on Medicaid spending and the impact of cuts to Medicaid in overall costs. A summary of findings from state Primary Care Associations with a corresponding chart concludes the report.