House HHS Finance Committee

February 3, 2011

MINNESOTA'S COMMUNITY HEALTH CENTERS

1. What are Community Health Centers?
2. How Community Health Centers make a difference?
   - What do CHCs deliver?
3. Exporting the model & lessons from GAMC/CCDS.

Community Health Centers
The Basics

- Not-for-profit corporations.

- Locally controlled - 51% of the Board of Directors are patients of the health center.

- Serve a Medically Underserved Area (MUA).

- Offer comprehensive primary care including medical, dental and mental health.

- Offer a sliding fee schedule (<200% of poverty) to the uninsured and serve everyone regardless of ability to pay.
  - Served nearly 70,000 uninsured Minnesotans in 2010.
  - Roughly $36 million of care in 2010.
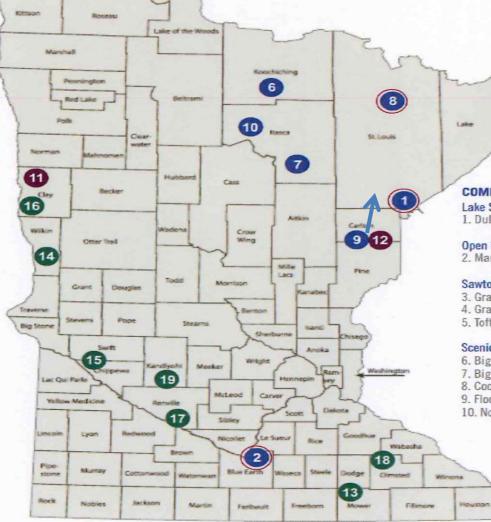
- 18 CHCs at 55+ sites serving 180,000 patients.

The History of CHCs

- 1965: First two Community Health Centers in US
  - Mound Bayou, Mississippi
  - Columbia Point, Boston

- 2010: 1,250 health centers serving 20 million patients in the US.

- 1965 -> 2010: Bi-partisan support
  - Legacies of both Sen. Ted Kennedy and President George W. Bush

CHC Locations in Minnesota

COMMUNITY HEALTH CENTERS (CHCs)

Lake Superior Community Health Center
1. Duluth (D) (M)

Open Door Health Center
2. Mankato (D)

Sawtooth Mountain Clinic
3. Grand Marais (M)
4. Grand Portage
5. Tofte

Scenic Rivers Health Services
6. Big Falls
7. Bigfork
8. Cook (D)
9. Floodwood
10. Northome

DENTAL ONLY SITES

Family Healthcare Center**
11. Moorhead

Scenic Rivers Health Services
12. Floodwood

MIGRANT HEALTH SERVICES

Migrant Health Services, Inc.
13. Blooming Prairie
14. Breckenridge
15. Montevideo
16. Moorhead (Main Site)
17. Olivia
18. Rochester
19. Willmar

(D) = Also provides dental services at this site
(M) = Also provides mental health services at this site

** Peer organization based in North Dakota, not a member of MNACHC.

>Hover over location for details
>Click location for web link

CHC Locations in Metro

Community Health Centers Geographic Reach
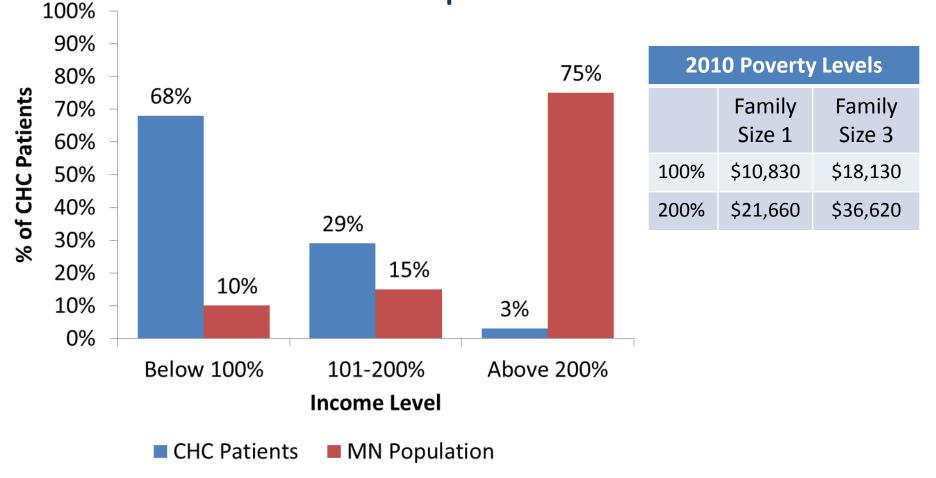
- CHCs are located in 16 of Minnesota's 87 counties, yet reach patients from 417 of Minnesota's 827 zip codes (50%).

- In **Hennepin County**, CHCs serve patients from all 74 zip codes.

- In **Ramsey County**, CHCs serve patients from all 33 zip codes.

- Economic forces (more uninsured and underinsured) results in patients actively seeking out CHCs.

CHC Patient Demographics

Chart 1 : Insurance Status, CHC Patients & MN Population

CHC Demographics
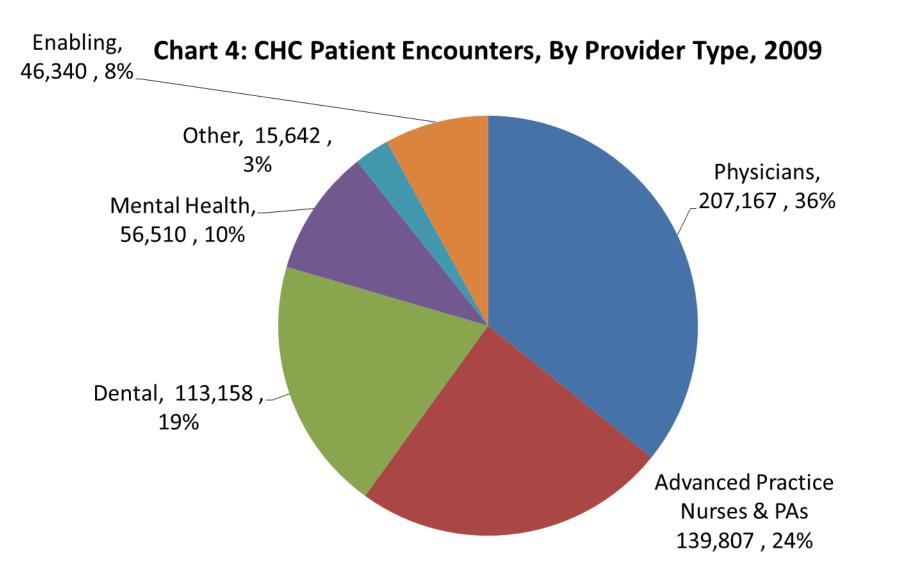
Chart 3 : Income Level, CHC Patients & MN Population

2010 Poverty Levels		
	Family Size 1	Family Size 3
100%	$10,830	$18,130
200%	$21,660	$36,620

CHC Services

Chart 4: CHC Patient Encounters, By Provider Type, 2009

Enabling, 46,340 , 8%

Other, 15,642 , 3%

Mental Health, 56,510 , 10%

Dental, 113,158 , 19%

Physicians, 207,167 , 36%

Advanced Practice Nurses & PAs 139,807 , 24%

Uninsured at CHCs

Chart 5: Number of Uninsured Served at CHCs in MN

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COMMUNITY HEALTH CENTERS

Financing Minnesota's CHCs

Chart 6: CHC Revenue, By Source, 2009 ($s in Millions)

- Foundation, $9.6 — 8%
- Local, $10.9 — 9%
- MHCP, $46.7 — 40%
- State, $6.0 — 5%
- Other Federal, $6.9 — 6%
- Federal Uninsured, $17.4 — 15%
- Self Pay (Uninsured), $6.5 — 5%
- Commerical, $7.8 — 7%
- Medicare, $5.7 — 5%

Non-Patient Revenue = $50.8 Million/43%
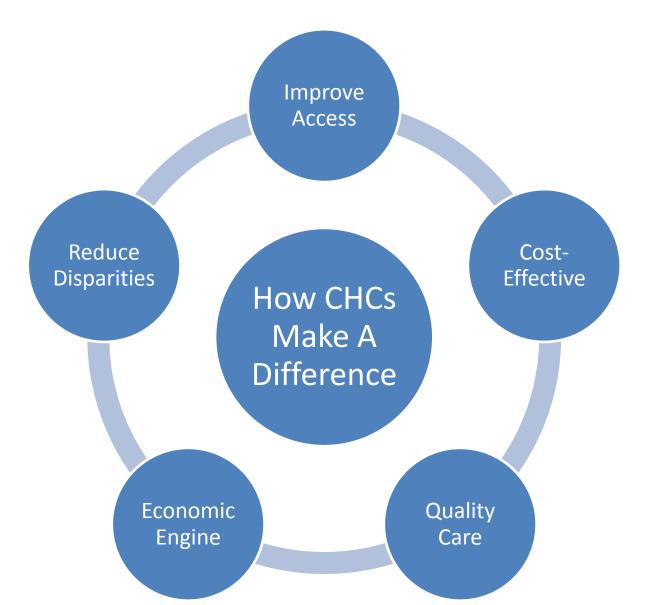
Patient Revenue = $66.6 Million/57%

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How Do CHCs Make A Difference?
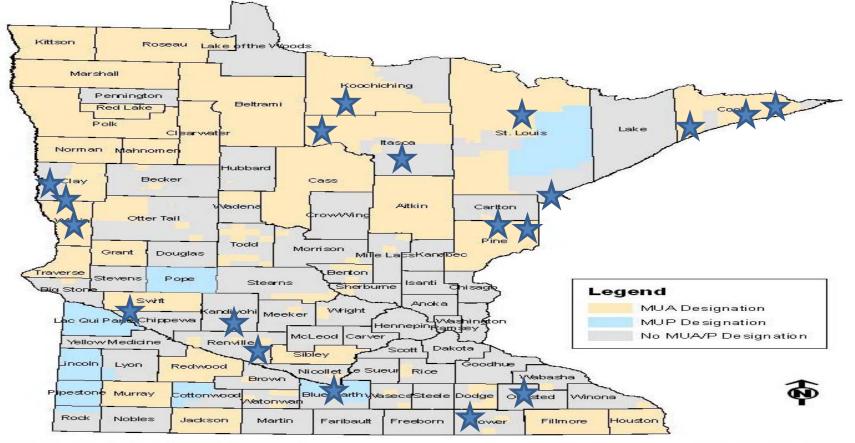
Improving Access

Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs)

Legend
- MUA Designation
- MUP Designation
- No MUA/P Designation
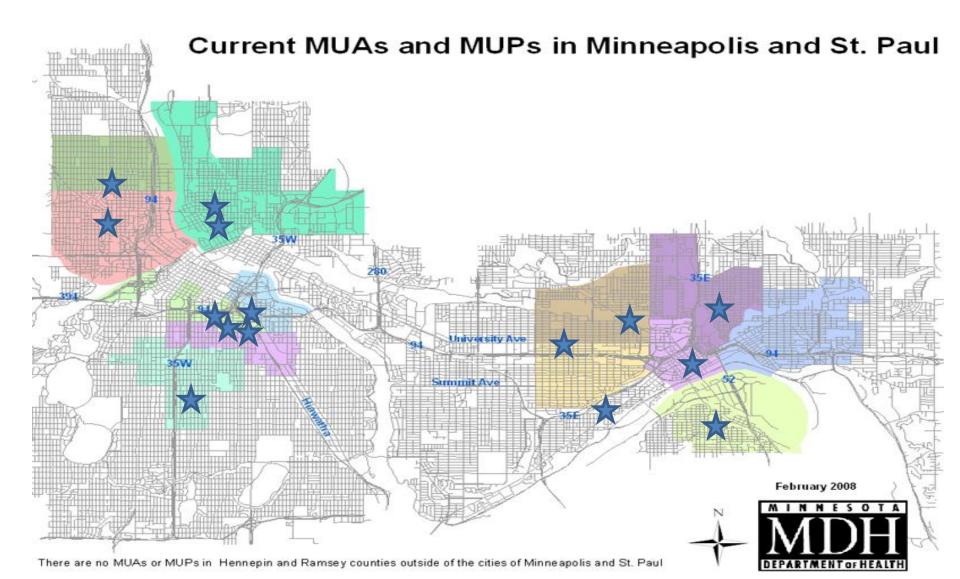
Source: Minnesota Department of Health
Office of Rural Health and Primary Care
February 2008
S:\\CFH\ORHPC\ArcView\Map Projects\MUA Feb 08.mxd
1:3,400,000

Improving Access

Current MUAs and MUPs in Minneapolis and St. Paul

February 2008

There are no MUAs or MUPs in Hennepin and Ramsey counties outside of the cities of Minneapolis and St. Paul
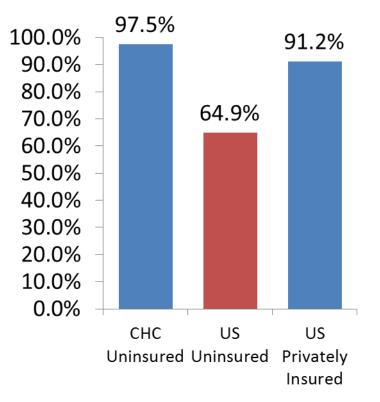
Improving Access to Care

- Improve Access to Primary and Preventive Care
  - Health education, mammograms, pap smears and other preventive screenings.
  - CHC Medicaid women aged 40 years or older were significantly more likely to have a mammogram in the past 2 years than Medicaid women nationally. [1]
  - Medicaid CHC patients 13.4 times more likely to have usual source of care compared to non-CHC Medicaid patients (more pronounced differences for African American and Latino populations). [2]

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Having A Usual Source of Care [2]

|		
97.5%	64.9%	91.2%
CHC Uninsured	US Uninsured	US Privately Insured

[1] Shi, L and Stevens, GD. "The Role of Community Health Centers in Delivering Primary Care to the Underserved." April-June 2007 *J Ambulatory Care Manage* 30(2):159-170.
[2] Shi L, Stevens G and Politzer R. "Access to Care for U.S. Health Center Patients and Patients Nationally - How Do the Most Vulnerable Populations Fare?" March 2007 *Medical Care* (45)3: 206-213.

Cost Effective

- Overall, CHCs MEDICAID patients mean medical expenditures are 32% lower than non-CHC patients and 35% less likely to use the ER

Table 1: Comparing Per Patient Medical Expenditures

Category	Mean Medical Expenditures CHC Patient vs. Non-CHC Patient
African American	62% less
Poor	44% less
Medicaid	32% less
Uninsured	43% less

Source: 2004 Medical Expenditure Panel Survey of 213 million persons with an office visit in 2004. Robert Graham Research Center.

Table 2: Comparing Emergency Department Use

Category	Any ED Use During Calendar Year	
	Not CHC User	CHC User
African American	20.8%	13.0%
Poor	24.0%	16.4%
Medicaid	21.4%	13.8%
Uninsured	19.0%	18.3%

Source: 2004 Medical Expenditure Panel Survey of 213 million persons with an office visit in 2004. Robert Graham Research Center.

Quality Care

- Scored at or above average on 7 of the 12 measures reported by the Statewide Quality Reporting and Measurement System.

  – Respiratory infection treatment, chlamydia screening, cervical cancer screening, controlling high blood pressure, breast cancer screening.

- Patient Satisfaction scores exceed 90%.

  – Would recommend CHC to family or friend, overall care, and met specific cultural/socio-economic needs.

Economic Engine
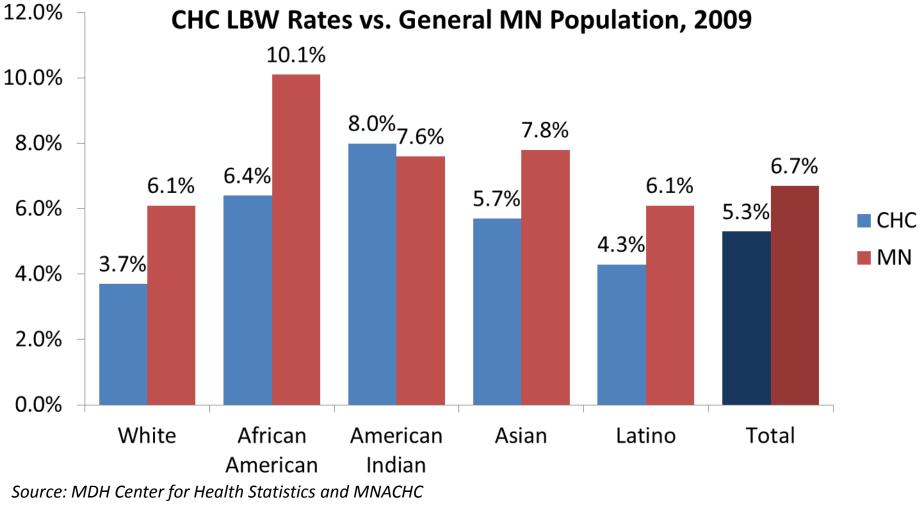
- Community Health Centers generate both direct and indirect economic activity in some of the state's areas with highest unemployment.

	Greater MN	Twin Cities	TOTAL
Direct FTE	227 FTE	856 FTE	1,083 FTE
Direct Activity	$21.1 Million	$95.6 Million	$116.7 Million

Note: Above estimates do not include "indirect" jobs and economic activity that result from CHC operations.

Source: MNACHC Uniform Data System, 2009

Reducing Health Disparities

CHC LBW Rates vs. General MN Population, 2009

Group	CHC	MN
White	3.7%	6.1%
African American	6.4%	10.1%
American Indian	8.0%	7.6%
Asian	5.7%	7.8%
Latino	4.3%	6.1%
Total	5.3%	6.7%

Source: MDH Center for Health Statistics and MNACHC
Note: LBW = Less than 2,500 grams

"Breaking Down" Barriers to Care

- ENABLING SERVICES are key to patient access and eliminating disparities based on race and socio-economic status.
  - Patient and Community Education
  - Patient Outreach
  - Transportation
  - Case Management
  - Translation/Interpretation
- Dramatic growth in these services over the last 5 years.

Challenges for CHCs

- Financing the increasing numbers of uninsured at CHCs

    – Average annual increase of 11% per year.

- Fundraising/philanthropy challenges.

- Access to specialists – especially the uninsured.

- Workforce shortages (and getting worse)

    – Family practice, mental health providers (e.g, clinical nurse specialists) and skilled IT staff.

GAMC Lessons Learned

- 6,000 GAMC patients at CHCs
  - Disrupted care for patients with complex needs that relied on small CHCs as their health care home.
  - Some patients stayed with CHCs – as uninsured, especially in greater MN

- "Silver Linings" from GAMC experience:
  - Investments into primary care yield lower costs to the system (avoid trips to the ED, hospitalizations).
  - Cannot separate mental health and/or dental services part of a persons 'health'
  - Some hospitals (CCDS) utilized the CHC outpatient expertise (especially around mental health) to serve GAMC population

Exporting the CHC Model

- **<u>Setting (Mandating) Expectations</u>**
  - Primary care across all life cycles
  - Offer "enabling services" to enhance access for patients that face barriers
  - Case management and patient education (e.g., community health worker)
  - Integrating care – medical, mental health and dental
  - Sliding fee schedule to the uninsured

- Local/community approaches to meeting expectations.

- **<u>Helpful Tools For CHCs</u>**
  - Federal/State/Local grants.
    - CHC Appropriation from MDH
  - Private philanthropic grants.
  - Protecting low-income patients access to CHCs under delivery models.
    - Stay with health care home
    - Patient satisfaction
  - IT connectivity throughout system
  - Workforce strategies, especially primary care

Contact Information

www.mnachc.org

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