

**OPENING REMARKS
FOR THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
APRIL 9, 2008
BY THE PENNSYLVANIA ASSOCIATION OF COMMUNITY HEALTH CENTERS**

Good Morning Mr. Chairman and members of the Committee. Thank you for allowing the Pennsylvania Association of Community Health Centers this opportunity to speak on behalf of the Commonwealth's Federally Qualified Health Centers (FQHC) and Federally Qualified Health Center Look-Alikes (FQHC-LA) and their role in the health care delivery system.

Launched in 1965 as part of America's War on Poverty, the concept and precepts of federally qualified health centers have remained constant throughout their history. For more than forty years FQHCs have widened access to an affordable and regular source of care for the uninsured and underserved, helping to break the cycle of disease and poverty. Community health centers in PA are part of a national network of over 1,000 health centers which serve 16 million people through 6,000 service delivery sites in all 50 states, Puerto Rico, the District of Columbia, Guam and the US Virgin Islands.

FQHCs collectively known as community health centers serve communities that otherwise confront financial, geographic, language, cultural and other barriers. These include migrant and seasonal farmworkers, homeless individuals and families, public housing communities and school-based facilities. These safety net providers combat health disparities every day.

Pennsylvania's Community Health Centers are the medical home for more than 600,000 Commonwealth residents. These 42 non-profit organizations provided more than 2 million patient visits at more than 190 service delivery sites located in 39 counties. These sites are located in or near federally designated medically underserved areas and must be accessible to the individuals and families lacking access to primary health care services.

The health center is governed by a consumer-based Board—at least 51% of the Directors must be patients of the health center. This allows the FQHC to assess community need and respond to those gaps in services in their community and to develop relevant health care delivery systems. Community Health Centers turn no one away; all patients are provided care regardless of ability to pay or insurance status. Patients are assessed a sliding fee cost based on income and family size. 1 in 10 of the Commonwealth's Medicaid recipients and 1 in 6 of the uninsured in the state are patients of FQHCs.

FQHCs provide comprehensive and high quality primary and preventive care services for all ages tailored to fit the special needs and priorities of their community in a linguistic and culturally appropriate manner. This care is provided by highly skilled, full time professionals: 233 FTE physicians; 112 FTE midlevels. All FQHCs offer after hours coverage. Services vary by site, but may include internal medicine, pediatrics, OB-GYN, emergency and urgent medical care, laboratory, X-ray and pharmacy. The focus of health center services is primary and preventive care. However, all health centers are expected to assess the full health care needs of their target populations,

form a comprehensive system of care incorporating appropriate health and social services, and manage the care of their patients throughout the continuum.

The majority of FQHCs (75%) provide on-site general dental care. If dental services are not offered on site, the organization must have a formal referral system in place to address patients' dental needs. Health centers in 2006 employed 64 FTE dentists and 30 FTE dental hygienists. Unfortunately, the wait for routine dental care at a health center can be 6 months. Those that have established emergency or walk-in dental hours see patients lining up in the parking lot at 5:30 AM to be seen that day. Dental capacity enhancement is a strong FQHC need.

Additionally, FQHCs must provide either directly or through referral behavioral health and substance abuse treatment. These health centers have on staff 97 FTE mental health providers. Other "enabling services" offered by community health centers are health education, case management, translation, and eligibility assistance just to name a few.

The majority of FQHCs in PA utilize the nationally recognized chronic care model to improve outcomes and reduce unnecessary hospitalizations. Out of the 33 BPHC grantees only 5 have not participated in the Health Disparities Collaborative which is the Bureau's chronic care, quality improvement initiative. The majority have applied these principles to diabetes. Many have also "spread" the model to cardiovascular disease, asthma and depression.

FQHCs are small businesses and economic generators in their local communities. In 2006 community health centers provided over 2,600 full time equivalent jobs. According to a National Association of Community Health Centers report *Access Granted: The Primary Care Payoff* (August 2007), the total economic benefit generated by Pennsylvania health centers in 2005 was over \$337 million.

FQHCs save the Commonwealth money. The average annual cost per medical patient in 2006 was \$312. The dental cost per dental patient was \$328. The effective community-based primary care provided by these medical homes also impacts hospitalization. The Pennsylvania Health Care Cost Containment Council stated in their November 2004 *Research Briefs, Issue #3*, that 10% (109,169) of all Pennsylvania hospitalizations were potentially avoidable. "Timely and effective primary care may reduce the likelihood of hospitalization for certain conditions including pneumonia, diabetes, asthma, and hypertension."

A medical home can also reduce avoidable emergency room visits. The *National Association of Community Health Centers, Access to Community Health Databook, Pennsylvania* estimates that in 2006 the Commonwealth's expenditures on avoidable emergency room visits amounted to \$790,754,728. A report published in the January – March 2006 *Journal of Ambulatory Care Management* entitled "Comparative Effectiveness of Health Centers as Regular Sources of Care" found FQHCs impacted emergency room utilization and hospitalization rates. This report analyzed claims data of 1.6 million Medicaid beneficiaries in 4 states including Pennsylvania. Medicaid beneficiaries relying on health centers for usual care were 19% less likely to use the ER for ambulatory care-sensitive (ACS) conditions and 11% less likely to be hospitalized for an ACS condition.

In summary, Federally Qualified Health Centers are community-based, medical homes whose mission is to provide primary and preventive health care to underserved populations. They do this through high quality clinical services that demonstrate an impact on health outcomes. Community health centers have an infrastructure that can adapt and survive the challenges of a transformational health care environment. These mission-driven, non-profit organizations are a significant part of the Commonwealth health care delivery system and can provide a major boost to safety net efforts.

However, some of the challenges and concerns that health centers face are daunting:

- Direct State Funding - Pennsylvania is one of only fifteen (15) states that do not provide direct state funding to community health centers. Of those states, Pennsylvania is the most populous.
- Digital Divide related to Health Information Technology—We do want to thank the Senate for passing SB 8 with provisions for community health centers to have access to health information technology dollars. An internal community health center survey identified money as the key obstacle to the acquisition and implementation of electronic health records. Electronic health records enhance patient safety and quality of care. We hope this tool is available to all, regardless of the economic status of the population served.
- Capacity and Access to Care even with Health Insurance Coverage—The National Association of Community Health Centers publication entitled *Access Denied: A Look at America's Medically Disenfranchised* (2006) states: "While health insurance is an important facilitator to care, having a medical home is more likely to improve appropriate health care use and health outcomes than having insurance alone." Coverage and capacity must both be present in order to address the present health care crisis. The recent Massachusetts experience shows how increased insurance coverage without the capacity to serve is not the answer to Pennsylvania's health care problem. Newly insured individuals and families are experiencing significant delays in obtaining appointments, similar to the PA FQHC dental access problems mentioned earlier. Health centers need the resources to expand their capacity to see more patients.
- Workforce Availability and Distribution—Community Health Centers exist in communities lacking a sufficient supply of trained clinicians that accept uninsured or patients with publicly reimbursed coverage. Health centers struggle to attract doctors, dentists and nurses to serve in these areas. Without sufficient, trained, and community sensitive providers, these designated underserved areas will not have a viable primary care delivery system.

Again, we thank you for this opportunity to speak with you. We are happy to answer any questions.