VIEWS FROM THE FIELD
MARCH 5, 2007
GRANT MAKERS IN HEALTH

A Foundation Helps Launch an FQHC

KAREN WOLK FEINSTEIN, PH.D.
President and CEO, Jewish Healthcare Foundation

For the past decade, free-market thinking has all but dominated the national discussion of health care. New kinds of coverage have resulted, including health savings accounts, along with new players in delivery, like the urgi-care clinics at Wal-Mart.

But even as Bush Administration officials have championed this activity, the White House has relied heavily on a federal solution for expanding access to the nation's uninsured – federally qualified health centers (FQHCs). FQHCs are nonprofit, community-led corporations conceived during the Johnson era as a means of providing primary health care in underserved areas. These centers receive federal authorization based on findings of community need and, once authorized, are eligible for federal financial support. Once established, FQHCs also enjoy other federal benefits, including federal grants that average about one quarter of their annual operating expenses, enhanced Medicaid and Medicare payments, and significant federal discounts on prescription drugs.

Praising FQHCs for their cost effectiveness, quality, and responsiveness to community needs, the Bush Administration set a goal of increasing the capacity of this safety net by more than half – to accommodate 16 million patients, up from 10.3 million in 2001 – both by expanding existing FQHCs and by adding new ones.

Indeed, research suggests FQHCs stack up well on outcomes. One recent study, for example, found they outperform other primary care settings where Medicaid patients receive care. The study, published in early 2006 in the *Journal of Ambulatory Care Management*, reviewed claims data from 1.6 million Medicaid beneficiaries and found that FQHC patients were 19 percent less likely to visit emergency rooms with ambulatory care sensitive conditions and were 11 percent less likely to be hospitalized for such conditions. Generally speaking, ambulatory care sensitive conditions are illnesses for which hospital use is considered avoidable, given proper access and health maintenance.

In some ways, such findings should come as no surprise. Some would argue that private sector primary care is in crisis because payment policies are biased toward procedures and hospitalization. Often, best practices for prevention and health maintenance are compensated inadequately, if at all. With salaried staffs, subsidies, and less dependence on insurance payments, FQHCs like the Veterans Administration Health System – known in recent years for leadership in patient safety – can pursue innovations that the private sector largely has not. Under a directive from the Health Resources and Services Administration, for example, FQHCs are implementing new models for delivering care to people with chronic diseases such as diabetes. Moreover, FQHCs typically house medical, mental health, dental, pharmacy, and sometimes other services under one roof, providing greater integration of care.

The emphasis on quality and innovation were just two of the attractions the Jewish Healthcare Foundation (JHF) found for helping to establish an FQHC to provide care in several underserved Pittsburgh neighborhoods. Opened last year, the Squirrel Hill Health Center (SHHC) represents a harmonic convergence of all of JHF's interests. The center recalls Montefiore Hospital's history of hosting neighborhood clinics. The clinics closed following the hospital's 1990 sale, whose proceeds funded JHF's endowment. JHF hoped that SHHC would fill the void, serving some of the same neighborhoods as Montefiore once did. The center also fit with many other JHF aims. Situated at the edge of a large Jewish community, it would serve the foundation's founders, while also serving diverse neighborhoods that are home to many of Pittsburgh's immigrants. It could also provide a showcase for the best, evidence-based practices of medicine, expand access for vulnerable populations, and offer a chance to demonstrate quality improvement methods that JHF has pioneered through two supporting organization: the Pittsburgh Regional Health Initiative (PRHI) and Health Careers Futures (HCF). In addition, it afforded an opportunity to leverage JHF's funds with grants from other foundations and from the federal government.

The demographics of the service area called for strong geriatric services, in keeping with JHF's longstanding programmatic focus on care for the elderly, and for culturally sensitive, patient-centered care. The center's location is convenient not only to large numbers of the region's elderly, low-income Jewish residents, and Russian émigrés, adjacent neighborhoods take in growing populations of Asians, Hispanics, Eastern European immigrants, and immigrants from the Middle East, including many of the Muslim faith.

There are four public housing projects in surrounding neighborhoods. Overall, 16 percent of the targeted population is 65 or older and more than 20 percent are racial and ethnic minorities. Roughly 36 percent of the residents have incomes at or below 200 percent of the federal poverty level.

At the time JHF made the decision to pursue an FQHC application, study after study – including high profile reports from the Institute of Medicine – exposed errors, inefficiencies, and ineffectiveness in health care. At the same time, PRHI was in the process of introducing its Toyota-based Perfecting Patient Care℠ principles to southwestern Pennsylvania's health care providers. Launching an FQHC seemed like an opportunity to design a small part of the health care system from the ground up.

No one thought the application process would be easy, but no one quite foresaw the complexities or obstacles either. JHF applied three times and was turned down twice after painstaking work on submissions that each took a year and required greater investments of time and money than anyone imagined. As many as eight staffers worked on the project at various junctures; two worked almost full-time, in addition to consultants, including architects, lawyers, and others. Among the early tasks were preparing a community needs assessment that the federal government ultimately scores as part of the approval process, pulling together a representative community board, projecting financial results, and securing a site.

Bureaucratic contradictions, red tape, fine print, and frustrations were everything one might think – and then some. For example, from the outset, the center needed a community board that drew 51 percent of its members from among consumers of services that did not yet exist. Other obstacles cropped up continually as staff attended to a thousand little details, each dependent on another.

The submission of JHF's first application coincided with a revision in funding priorities for FQHCs. The change gave preference to centers serving migrant workers, whom SHHC would not serve in its urban location. That resulted in the first rejection. Still, going into the second try, there was optimism because the first application had otherwise passed federal standards. Logic argued it would win approval, but it did not. Although the first application met government criteria for community need, the second application fell short. The need had not changed, nor had the application. A different set of reviewers had simply scored the application differently. This inconsistency halted some of JHF's plans. For example, the first location identified for the health center was unavailable by the time JHF won approval. Similarly, a physician identified to serve as medical director had moved.

The third time was the charm. SHHC was approved for $650,000 in federal funding. Actual receipt of the funds would take nearly another year, but work had to continue. Federal rules require that FQHCs open their doors to patients 120 days after they are funded. Meeting the timetable not only required a race to the finish, it meant spending money that was not yet in hand.

The application process made it hard to imagine how a shoestring community organization could hope to launch an FQHC on its own. JHF spent $150,000 for the application process, not counting staff time, and fronted another $300,000 in start-up costs. Other benefactors, including the Staunton Farm, FISA, and Highmark foundations, provided grants to support mental health programming, services and accommodations for those with physical limitations, as well as training in quality improvement disciplines. It is also hard to imagine how an applicant without JHF's in-house technical expertise and community health care connections would meet other requirements within the timeframe. Just getting physicians at a new health center empanelled in managed care plans can take months, for example.

But all of the work has paid off. The center opened June 30, 2006 and is building volume on pace with projections, with nearly 1,000 patient encounters so far. Roughly one-third of patients have no insurance; another third are covered by Medicaid or Medicare. The remaining third have private insurance, which suggests a healthy confidence in the quality of care available.

So far, the patients have ranged in age from seven months to more than 90 years old. The center's medical director is a geriatrician, underscoring SHHC's dedication to providing model treatment for the elderly. On-site mental health care is being offered, and SHHC is working cooperatively on referrals with a network of community organizations and social service agencies. On-site dental care is in the planning stage.

The language translation skills SHHC put in place (Spanish, Russian, Hebrew, and American Sign) are paying off as well. The center already seems to be a magnet for the growing Hispanic population in Pittsburgh's nearby Oakland section. As anticipated, it also is drawing a significant number of Russian immigrants and Hebrew speakers; the first deaf patient visited in January. Somali patients also are trickling in, along with Asians. Other cultural and religious differences also have been addressed in many aspects of SHHC's services. These include Sunday hours, for those who celebrate different Sabbaths, and provision of same-sex physicians for patients whose religions prohibit examinations by providers of the opposite sex.

As mandated by law, SHHC has its own management and board. JHF lends a hand in innovation. Coaches from the foundation's supporting organizations are teaching the health center's new staff PRHI's Toyota-based quality engineering methods, which are aimed at continuous improvement through elimination of waste and error.

As anyone in health philanthropy knows, finding a way to directly serve people without coverage is fulfilling in and of itself. Extending care with this kind of excellence may seem like icing on the cake, but it is what JHF is about. Pursuing an FQHC was a big step, a big risk, and an even bigger win for JHF and the community it serves.

VIEWS FROM THE FIELD *is offered by GIH as a forum for health grantmakers to share insights and experiences. If you are interested in participating, please contact Anne Schwartz, GIH's vice president, at 202.452.8331 or aschwartz@gih.org.*