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ANALYSIS & COMMENTARY

Partnering Private Primary Care Practices With Federally Qualified Health Centers In The Care Of Complex Patients

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ABSTRACT Federally qualified health centers and small primary care practices have many challenges in common: uninsured patients; growing numbers of chronically ill patients with complex needs; inadequate reimbursements by commercial health plans; and persistent staffing problems. Smaller primary care practices also face sizable barriers to participating in new delivery and payment models that are likely to proliferate in the wake of health reform. To help remedy primary care shortages in the context of implementing health reform, independent primary care providers could contract with nearby federally qualified health centers to provide comprehensive care management services for patients with complicated health problems. Small practices could then concentrate on providing individualized medical care, while health centers would receive additional income to help cover operating expenses.

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Federally qualified health centers and community-based primary health care providers have become increasingly important health care resources for lower-income and uninsured people. The centers will treat an estimated twenty million patients in 2010—double the number of a decade ago—and the forecast is for increased demand in the years immediately ahead. The Patient Protection and Affordable Care Act of 2010 provides a funding boost for the centers that will help them meet the challenges they face: uninsured patients, inadequate reimbursements by commercial health plans, and persistent staffing problems.¹

These are familiar issues for the thousands of small, private practices through which most Americans receive primary care. This paper suggests that as new delivery and payment models take hold following health reform, small practices and federally qualified health centers could form partnerships to their mutual benefit.

Patients With Complex Illnesses

All types of primary care providers now face a growing number of patients with complex health care needs: patients with severe or multiple chronic illnesses; people who are mentally ill or physically or developmentally disabled; recent immigrants and refugees facing cultural and language barriers; and the frail elderly. Such patients often require expanded services: coordination of care among multiple specialists; coordination of ancillary therapies and medical equipment; advocacy to acquire special services, such as improved housing or assistance with transportation; and other services that can contribute to health, such as access to affordable food or paid employment.

The time and resources required to provide such a broad array of services are usually beyond the capacity of the staff in a small private practice. Hiring additional staff dedicated to these tasks is economically unfeasible because of the lack of reimbursement for such services.

New Models For Chronic Care

New models for chronic care likely to be stimulated by the enactment of health reform legislation rely on the provision of these services in primary care settings. In the patient-centered medical home, a trained primary care physician develops and sustains relationships with individual patients, and directs a team of practice staff who assist with patient care. Although providing individualized attention to patients is something that smaller practices have always done well, meeting the detailed standards—including the need for specialized staff—for attaining patient-centered medical home status and thus qualifying for higher reimbursement rates is beyond the reach of most small practices.²

The well-known Chronic Care Model^{3,4} also identifies the essential elements of high-quality chronic disease care, which include integrating patient care within a larger health system and the community. Under the Chronic Care Model, a broad array of medical and nonmedical primary care services may be best accessed through physician referrals and help with transitions among various levels of care. The additional services and referral networks necessary to meet the requirements of both the patient-centered medical home and the Chronic Care Model suggest an avenue through which small private practices and federally qualified health centers can connect to deliver comprehensive and individualized primary care services for patients with complex needs.⁵

Variations Among Health Centers

Federally qualified health centers take different forms, based on the populations they serve and the resources available. Many centers and similar organizations have already developed a comprehensive array of medical and nonmedical services to meet the needs of patients with complex chronic illnesses. These services overlap with but do not correspond exactly to the services provided in the patient-centered medical home model. Although the core staff at federally qualified health centers usually includes family physicians, internists, pediatricians, nurse practitioners, and physician assistants providing primary care, the centers often provide other services as well: dental, vision, mental health, hospital, and nursing home care; pharmacy; legal aid; tutoring; emergency food provision; and a variety of other social services. More than a medical home, the federally qualified health center creates a medical neighborhood.⁶

A center's services are often coordinated among the different arms of the center, and between the center and outside agencies, through a

team approach and the use of case management services. In this way, the center serves as a home base for its patients, who rely on it as the starting point for addressing a variety of needs. Each individual, however, has one locus of care to which he or she returns after encounters with other caregivers, to avoid duplication of services and ensure that needed preventive and chronic care are not overlooked in a fragmented system.

Financial Pressures And Payment Policy Changes

The financial pressures on both primary care practices and federally qualified health centers have been mounting for a number of years. Higher public reimbursements and grants enable the centers to offer a wide spectrum of chronic care and support services. Nevertheless, increasing numbers of uninsured patients and inadequate payments from commercial insurers can challenge the centers' ability to deliver comprehensive services to their patients without going bankrupt. At the same time, both public and private payers' reimbursement policies are pinching private practices' revenues.

New primary care payment policies based on improved patient health status are essential to alleviate these pressures. Even so, smaller practices encounter sizable barriers to participation in these new approaches, such as the sharing of savings envisioned for accountable care organizations or the payment incentives available for the patient-centered medical home. To earn higher payments, practices will need to develop external partnerships for patient care and use electronic health records to streamline these connections. One particularly promising avenue for such partnerships would be for clusters of independent primary care providers to contract with nearby federally qualified health centers to ensure comprehensive care management services for their patients with complex needs.

Under such a contract, a federally qualified health center could serve as the "primary care comprehensive extension center" for a group of private practices. The patients involved would be able to obtain the full range of medical and nonmedical care management services that federally qualified health centers offer. Physicians in small practices would be able to concentrate on providing individualized medical care and would be spared the financial and logistical burdens of developing in-house comprehensive services. Electronic health records and health information exchanges would ensure seamless sharing of patient information. And referral of complex patients to the centers would give those

institutions a new and reliable source of income to help cover their operating expenses.

The contracts would need to be well defined. Federally qualified health centers would require payment arrangements that compensated them fairly, including for unconventional patient encounters by telephone and e-mail and through home visits. Safeguards would need to include provisions to avoid the private practice's losing patients to the federally qualified health center and to delineate which responsibilities would remain with the primary physician. In addition to procedures for referrals and sharing patient information, referring physicians might want to have a voice in the center's staffing and services. Most important, sustainable financial arrangements would be required. Referring physicians would need to pay a portion of their additional, performance-based revenue to the center for care management services.

Primary Care Comprehensive Extension Centers

Here is an illustration of how an arrangement with a primary care comprehensive extension center might work. A patient with lupus visits her primary doctor, who assesses her medical needs; adjusts the doses of her pain medications; and determines the priorities for her next visits to her rheumatologist, nephrologist, and psychiatrist. At the conclusion of the visit, the physician completes a form, either electronically or on paper, outlining which services the patient needs from the extension center: a consultation with a pharmacist, coordination of timing and transportation for her specialist appointments, assistance with her disability insurance paperwork, and behavioral health counseling that

could be done at the center.

Before the patient's next visit with her doctor, she might also receive a phone call from a nurse practitioner at the center to determine whether her medication dosages need further adjustment, or whether she needs to be on a short course of steroids to reduce inflammation and relieve symptoms. The details of any new interventions would be relayed back to her primary care physician in much the same format as he or she might receive a lab report or a letter from a consultant.

Public and private payers should consider testing this concept. Existing federally qualified health centers would need to expand their capacity so as not to be overwhelmed by the added volume of patients. Where appropriate, the centers could integrate their services with urgent care centers, home care agencies, labs, and pharmacies, building a defined safety net of specialty providers to ensure the availability and affordability of referrals and medical procedures^{6,7} and streamlined communication of results. Pathways for integrating medical residents, as well as graduate students in nursing, social work, and other programs, into the system as part of a primary care residency program should be explored.^{5,7}

Conclusion

A strong primary care infrastructure is the foundation of a high-performing health care delivery system that maximizes patients' health and outcomes and decreases net health care costs. Inventing new care pathways that make efficient use of all primary care resources, particularly those that are most relevant to at-risk patients, is both good business and good health care. ■

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NOTES

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