# TAKING THE FULL MEASURE OF HEALTH CENTER

*By David Hartzband, D.Sc. and Feygele Jacobs*

Community health centers today provide comprehensive primary and preventive services to over 23 million people at more than 9,000 delivery sites, forming the single largest primary care system in the country and serving as the backbone of the nation's safety net. As defined in Section 330 of the Public Health Services Act that authorizes the Health Center Program, health centers under the program are required to provide a broad range of primary health services to their patients[1].

In addition to a full range of basic and preventive health services for adults and children, community health centers must offer specialty referral, patient case management, and supportive services that facilitate and enable access to care, such as outreach, transportation, translation and interpretation, as well as patient and population education related to the use of health services.

Health centers may also offer additional services that, while not required, are "appropriate to meet the health needs of the population served by the health center involved"[2]. Because they serve designated medically underserved patients who may experience a myriad of economic, cultural, linguistic or other barriers to care, these additional services are typically those necessary to meet the unique local needs of the vulnerable patients they serve.

As more emphasis is placed on establishing medical homes and enhancing patient-centered care, enabling services often bridge the gap, linking patients to care and ensuring continuity.

A significant body of research documents the role that health centers play in improving access to high quality health care services, while reducing the overall cost of health care services,[3] and indeed, health center use has been associated with a lower rate of avoidable acute care utilization.[4]

### The need for non-clinical services data

Enabling services are believed to be an important part of the equation because they reduce the barriers that may impede or prevent vulnerable individuals and families in obtaining care.[5] However, quantifying the specific advantage of enabling or additional services has been difficult, in large part because of the limitations of the data captured today in practice management and EHR applications.

The Uniform Data System (UDS) [used by the federal government to collect, track and report certain health center data to improve health center performance and operations] also likely undercounts enabling services. While some enabling services are counted as part of the patient visit, many enabling services – such as transportation service encounters, for example – are not captured, either because they are not directly billable or are not part of the routine workflow. While enabling services are

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1 42 USC §254b Section 330 (B)(1)(A)(ii-v)

2 as cited: (B)(2)(A-D)

3 Streeter S, Braithwaite S, Ipakchi N, Johnsrud M. (2009) The effect of community health centers on healthcare spending & utilization. Washington, DC: Avalere Health

4 Falik, M., Needleman, J., Wells, B. L., & Korb, J. (2001). Ambulatory Care Sensitive Hospitalizations and Emergency Visits: Experiences of Medicaid Patients Using Federally Qualified Health Centers. Medical Care , 39 (6), 551-561.

5 Politzer RM,YoonJ,ShiL, et al. (2001) Inequality in America: the contribution of health centers in reducing and eliminating disparities in access to care Med Care Res Rev 2001;58(2):234

an essential part of the health center model, establishing a firm business case for their value and quality rests on improved data collection and analysis.

It is also important to remember that co-location is not synonymous with integration and although the comprehensive community health center model supports the provision of many enabling services on-site, mechanisms are needed to capture, store and analyze data that fall outside of existing systems.

In recognition of the limitations of existing data, several recent efforts have focused on developing more effective approaches to identifying, quantifying and reporting enabling and other services. One significant effort is the Enabling Services Accountability Project carried out by the Association of Asian Pacific Community Health Organizations (AAPCHO) and several member centers[6].

In an issue brief developed in conjunction with the National Association of Community Health Centers (NACHC), APCHO noted that of 67 million encounters reported in the UDS in 2008, just 7% were reported as enabling services. Data on the scope of enabling services were determined to be incomplete: "The current UDS fails to demonstrate the critical impact of these services and the need to adequately finance them to ensure full primary care access and utilization among medically underserved patients."

Building on an earlier study for NACHC by the MGMA[7] (Medical Group Management Association), AAPCHO centers piloted the use of customized tracking forms based on a common Enabling Services Data Collection Template[8] These tools and model may be adapted to local needs, allowing individual health centers to determine how best to integrate the data capture with their existing workflows and systems.

Recognizing the challenges of both data capture and reimbursement, several other initiatives have also attempted to tackle the issue of documenting enabling and supportive services. First, Health Outreach Partners [a national organization that provides education and training to help community-based organizations improve the quality of life of hard-to-reach populations] has developed a number of resources and recommendations[9] to assist staff with identifying and documenting enabling services, and analyzing utilization information.

In a related vein, a recent study from the Institute of Medicine (IOM) that focuses on adding social and behavioral determinants of health into electronic health records (EHRs) developed a set of six criteria[10] that can be used to identify core domains for inclusion in EHRs. These criteria are:

- Strength of the evidence of the association of the domain with health;
- Usefulness of the domain, as measured for the individual, population, and research;
- Availability and standard representation of a reliable and valid measure(s) of the domain;
- Feasibility for the patient and clinician and in terms of administrative time and cost of interfaces and storage;
- Sensitivity, such as for revealing personal information; and
- Accessibility of data from another source.

Focusing on the first two criteria, the IOM's consensus report identified 17 socio – demographic, behavioral and psychological domains that should be tracked for a complete picture of healthcare delivery. The domains encompass both individual patient factors as well as Individual-Level Social Relationships and Living Conditions and Neighborhoods/Communities dimensions.[11] Subsequent reports will address the specific measures to be captured, and make recommendations for linkages between public health departments, social service agencies, and other relevant non–health care organizations to capture the full range of issues and service needs.

Finally, the Oregon Primary Care Association worked with health centers, clinics and the state Medicaid agency to develop and pilot a capitated Alternative Payment Methodology[12] (APM). This non-encounter based reimbursement method is intended to better align payment with quality by encompassing the full range of services provided by the participating health centers.

### Integrating data collection into existing systems

Given that most health centers today are operating in an encounter-driven model, and with constrained data systems, how can data collection be accomplished? As evidenced by the AAPCHO templates, some of the required data, such as type of encounter, type of appointment, sliding fee use, or insurance carrier can be gathered from most practice management systems, but a specific data collection form is needed to capture the full range of essential information.

Each health center will have to modify this template to reflect the specific services that it offers as the template covers those enabling services as required in the Section 330 law, grouping

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[6] Weir, R.C. and Proser, M. 2010. Highlighting the Role of Enabling Services at Community Health Centers: Collecting Data to Support Service Expansion & Enhanced Funding. The Enabling Services Accountability Project. http://enablingservices.aapcho.org

[7] Medical Group Management Association, Inc. Health Center Enabling Services: A Validation Study Of the Methodology Used To Assign Coding Structure And Relative Value Units To Currently Non-Billable Services. (2000) Prepared for the National Association of Community Health Centers and the Bureau of Primary Health Care.

[8] Weir, Op.cit. Page 11, Figure 5.

[9] Patients, Encounters, and Data Not Captured on the Uniform Data System (UDS) Reporthttp://web.outreach-partners.org/resources/outreachconnection/35

[10] Institute of Medicine. (April 2014.) Capturing Social and Behavioral Domains in Electronic Health Records: Phase 1. ISBN 978-0-309-30110-7. National Academies Press. Washington, DC.

[11] IOM, p. 6, Table S-1

[12] OPCA, Alternative Payment & Care Model . http://www.orpca.org/initiatives/alternative-care-model

all other services as "other." But the template can easily be adapted to permit detailed tracking of sub-categories as well as other significant services such as medical-legal, child care, or employment counseling that may be offered.

However, in order to be useful for tracking and analysis, the templates must be integrated with the health center's existing systems. This will require programming, either directly or under contract, to produce the template and incorporate it into the in-use EHR so that there is no workflow disruption, and so that the data can be queried and recovered through the EHR and/or reporting interface. The enabling service data obtained through the templates must additionally be included in any data extract or data warehouse activity so that it can be used in analysis.

In addition, data collection will need to be incorporated into new workflows and supported by appropriate training. The collection of non-clinical data is probably most efficiently done by front office staff using the practice management (PM) system, as this is the system where collection of demographic and non-clinical data is centered. Staff will have to be trained in the definitions required to enter the data as well as in the data entry itself.

Enabling service data may also be collected through the EHR interface, in which case providers may also have to be trained. In settings where the same vendor provides both the PM and EHR systems, it may be possible to have a data entry template that shares information across both systems. This may be the best case so long as the workflow for data collection is clear.

Other new applications provide information to identify the need for services and help link patients to services and resources in the community.

One example is Healthify (https://www.healthify.us/en). The Healthify platform supports dynamic screening to help providers identify patient needs for housing, employment, child care, mental health, and food assistance. The screening tool is linked to a resource database of local service providers and a matching module that offers recommendations for referral services based on the best match between the patient's needs and the available services, and provides information including contact information, intake requirements, and languages spoken. It also evaluates the patient's eligibility for these services.

The introduction of these new applications may provide a pathway for obtaining and integrating data in the health center setting. In addition, patient portals supplied by both payer and provider organizations are beginning to make available benefit-related and educational information. As these portals begin offering more access to new benefits and services, the information regarding service utilization might be provided as data to the EHR, PM or other relevant systems.

Enabling services that health centers are required to provide, as well as those additional services offered to meet specific local needs, are focused on lowering the barriers to health and healthcare. Currently, the collection and recovery of specific data regarding these services is difficult, which makes justifying appropriate payment, or even quantifying current value, challenging.

The collection and storage of an expanded data set, incorporating enabling services as part of the practice management and/or EHR data, is essential so that provision and use of these services can be documented, analyzed, and evaluated. Quantifying the scope of services will begin to allow calculation of value and value-added. This, in turn, can provide evidence to help support reimbursement and allow centers to make better-informed decisions about what services to offer to best serve their patients, improve outcomes and contain costs.

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## UPCOMING EVENTS

**MARCH 18-22, 2015**
2015 Policy & Issues Forum
*Washington, DC*

**MAY 5-7, 2015**
2015 National Farmworkers Health Conference
*San Antonio, TX*

**AUGUST 21-25, 2015**
2015 Community Health Institute & Expo
*Orlando, FL*