JIM MACRAE STATEMENT
BEFORE THE COMMITTEE ON HEALTH EDUCATION LABOR & PENSIONS
SUBCOMMITTEE ON PRIMARY HEALTH AND AGING

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Mr. Chairman, Ranking Member, and Members of the Committee, thank you for the opportunity to testify. I am Jim Macrae, Associate Administrator of the Bureau of Primary Health Care in the Health Resources and Services Administration (HRSA). I am pleased to join my other colleagues in appearing before you today.

HRSA Overview:

The Health Resources and Services Administration helps the most vulnerable Americans receive quality primary health care, without regard to their ability to pay. HRSA works to expand access to health care for millions of Americans— the uninsured, the underserved and the vulnerable. HRSA recognizes that people need to have access to primary health care and, through its programs and activities; the Agency seeks to meet these needs.

HRSA delivers on its obligation to address primary care access through the six Bureaus and thirteen Offices that comprise the Agency. The Agency collaborates with government at the Federal, State, and local levels, and also with community-based organizations and non-profit foundations, to seek solutions to primary health care challenges. HRSA provides leadership and financial support to health care providers in every State and U.S. territory.

HRSA's Vision, Mission and Goals:

HRSA's vision for the nation is healthy communities and healthy people. Our mission is to improve health and achieve health equity through access to quality services, a skilled health workforce and innovative programs.

The Agency seeks to further our vision and carry out our mission through four major goals:

- Improve Access to Quality Care and Services
- Strengthen the Health Workforce
- Build Healthy Communities; and
- Improve Health Equity.

At HRSA we also believe that primary care is more than having a place to go when you are sick. We view primary care as the Institute of Medicine (IOM) does:[1] providing integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of the family and the community.

Health Center Program Overview:

For more than 40 years, health centers have delivered comprehensive, high-quality, cost-effective primary health care to patients regardless of their ability to pay. During that time, health centers have become an essential primary care provider for America's most vulnerable populations: people living in poverty, uninsured, or homeless; minorities; farmworkers; public housing residents; people who are geographically isolated; and people with limited English proficiency.

Health centers advance preventive, coordinated, comprehensive, and patient-centered care, coordinating a wide range of medical, dental, behavioral, and social services. Today, more than 1,100 health centers operate over 8,000 service delivery sites that provide care in every U.S. State, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin.

In FY 2009, these non-profit and public, community-based and patient-directed health centers served 18.8 million patients, providing almost 74 million patient visits, at an average cost of $600 per patient. Patient services are supported through a variety of revenue sources, including but not limited to Medicaid, Medicare, and state and local grants. The Health Center Program grant funds from HRSA account on average for 20% of total revenues for health centers.

Health Center Research:

Research continues to highlight health centers' success in increasing access to care, improving health outcomes for patients, reducing health disparities, and containing health care costs.

Health centers increase access to health care through an innovative model of community-based, comprehensive primary health care that focuses on outreach, disease prevention, and patient education activities. For example, studies found:

- Uninsured people living within close proximity to a health center are less likely to have an unmet medical need, less likely to have postponed or delayed seeking needed care, and more likely to have had a general medical visit .[ii]
- Health center uninsured patients are more likely to have a usual source of care than the uninsured nationally (98% versus 75%).[iii]
- Medicaid beneficiaries receiving care from health centers are more likely to report having access to care.[iv]

Despite serving sicker and more at risk patients than seen nationally, health centers continue to demonstrate a strong track record in delivering high quality care and reducing health disparities. For example, studies found:

- Health center patient rates of blood pressure control were better than rates in hospital-affiliated clinics or in commercial managed care populations, and racial/ethnic disparities in quality of care were eliminated after adjusting for insurance status. [v]
- Health center low birthweight rates continue to be below the national averages for all infants. In particular, the health center low birthweight for African-American patients is below the rate observed among African-Americans nationally (10.7% versus 14.9% respectively).[vi]

- Health centers play a critical role in providing health care services to rural residents who tend to have higher rates of chronic diseases, such as the 27% of rural residents suffering from obesity[vii] and nearly 10% diagnosed with diabetes.[viii]

Health centers provide high-quality care to rural and urban populations alike by focusing attention on improving public health through preventive care in addition to direct patient care. The health center model of care has been shown to reduce the use of costlier providers of care, such as emergency departments and hospitals. For example, studies found:

- Medicaid beneficiaries receiving care from a health center were less likely to be hospitalized.[ix]
- Medicaid beneficiaries receiving care from a health center were less likely to be inappropriately hospitalized and less likely to visit the emergency room inappropriately.[x]
- Rural counties with a community health center site had 33% fewer uninsured emergency room/department visits per 10,000 uninsured population than those without a health center.[xi]

Emergency Room Diversion Program:

In the past several years, HRSA has worked with our counterparts in the Centers for Medicare & Medicaid Services (CMS) on Emergency Room Diversion programs. In 2008, CMS awarded grants to twenty states with the goal of reducing the use of hospital emergency rooms by Medicaid beneficiaries for non-emergent reasons. One community health center project in Colorado focused on three goals: 1) to educate the Medicaid population about alternative nonemergency care options; 2) to offer real time referrals to alternative non-emergency care through the use of Outreach Case Managers; and 3) to promote the concept of a medical home for Medicaid patients so that they will have a better understanding of their healthcare options and appropriately use health care services. Additionally, Connecticut proposed to utilize a web-based application to connect providers in federally qualified health centers (FQHCs) and hospitals in designated communities throughout the state to create a common platform to search and schedule appointments for Medicaid enrollees. This approach was designed to facilitate access to primary care and enhance linkages between emergency departments and community-based primary care providers.

Patient-Centered Medical Home Initiative:

As highlighted by GAO, one reason health centers reduce the use of hospital emergency departments for non-urgent care is because they have attributes of the medical home model. Studies have shown that having a “medical care home” reduces emergency department use significantly, not only among healthy patients but also among those who are sicker and have greater health care needs. Patient-centered medical homes (PCMHs) utilize interdisciplinary teams that re-distribute care responsibilities to those most capable and most accessible. A PCMH then coordinates care within this interdisciplinary team and with others in the community including hospitals and specialists.

HRSA is dedicated to assisting health centers move toward the medical home model, and health centers are well-positioned to adopt and showcase innovations in care delivery because they are experienced with quality improvement that uses evidence-based models like the Chronic Care Model. To date, more than 125 health centers have enrolled in HRSA's recently announced Patient Centered Medical/Health Home Initiative. Additionally, through the CMS Center for Medicare and Medicaid Innovation, a Medicare FQHC Advanced Primary Care Practice Demonstration project will be implemented soon to engage up to 500 FQHC sites and up to 195,000 fee-for-service Medicare beneficiaries in a medical home demonstration. One of the key expected outcomes of this demonstration is a decrease in ED utilization by those that participate.

Health Center Support Services:

Another core component of the comprehensive model of primary care provided by health centers is the non-clinical services that aim to increase access, improve health care quality and reduce emergency use. The provision of these enabling services is a distinguishing feature of health centers, which recognize that barriers to care take various forms. Health centers offer a variety of supportive and enabling services to their patients including:

- Case management for chronic conditions, reducing the need for emergency services;
- Eligibility and enrollment assistance for health and social services;
- Outreach and transportation services; and
- Education of patients and the community regarding the availability and appropriate use of health services, including emergency rooms.

Health Center Care is Affordable, Accessible and Reduces the Need for Emergency Room Care:

Health centers offer affordable care to people in need. Health centers are required to provide care to all patients regardless of ability to pay, and to offer discounts based on a sliding fee scale for all patients at or below 200% of the Federal poverty level. This requirement helps ensure that financial concerns do not prevent patients from accessing the health center's primary and preventive services offered in a timely manner.

Health Centers offer care that is accessible. Health centers are required to provide services at times and locations that assure accessibility and meet the needs of the population to be served. For example, health centers frequently offer evening and weekend hours to ensure they are accessible to working adults. They are located in areas convenient to where the target population lives or works, including schools, homeless shelters, and/or through mobile van services.

Health centers are also required to provide professional coverage for medical emergencies during hours when the center is closed. This coverage must be clearly defined, and include telephone access to a clinician who can assess the patient's needs and recommend appropriate follow-up care. This includes advising the patient on whether a visit to an ED is appropriate.

Conclusion:

In closing, we recognize the key role that health centers do and can play in the reduction of inappropriate emergency room use. I appreciate the opportunity to testify today, and I would be pleased to answer any questions at this time.

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[i] Donaldson M, Yordy K, Vanselow N, eds. Institute of Medicine. Defining Primary Care: an Interim Report. Washington, DC: National Academy Press, 1994:16.
[ii] Hadley J and Cunningham P. Availability of Safety Net Providers and Access to Care of Uninsured Persons. Health Services Research 2004;39(5):1527-1546.
[iii] Carlson, BL et al, "Primary Care of Patients without Health Insurance by Community Health Centers." April 2001 *Journal of Ambulatory Care Management* 24(2):47-59.
[iv] Shi L, Stevens GD, and Politzer RM. "Access to care for U.S. Health center patients and patients nationally: how do the most vulnerable populations fare?" 2007 *Med Care* 45(3):206-13.
[v] Hicks LS, et al. The Quality of Chronic Disease Care in US Community Health Centers. Health Affairs 2006;25(6):1713-1723.
[vi] Shi, L., et al. America's health centers: Reducing racial and ethnic disparities in perinatal care and birth outcomes. Health Services Research, 2004; 39(6):1881-1901.
[vii] Bennett, K. J., Olatosi, B., & Probst, J.C. (2008). "Health Disparities: A Rural – Urban Chartbook." South Carolina Rural Health Research Center.
[viii] Pleis JR, Lethbridge-Çejku M. Summary health statistics for U.S. adults: National Health Interview Survey, 2006. National Center for Health Statistics. Vital Health Stat 10(235). 2007.
[ix] Falik M. et al. Ambulatory care sensitive hospitalizations and emergency visits: experiences of Medicaid patients using federally qualified health centers. Medical Care 2001;39(6):551-561.
[x] Falik M. et al. Comparative Effectiveness of Health Centers as Regular Source of Care. Journal of Ambulatory Care Management 2006;29(1):24-35.
[xi] Rust George, et al. "Presence of a Community Health Center and Uninsured Emergency Department Visit Rates in Rural Counties." Journal of Rural Health Winter 2009 25(1):8-16.