



How a Detroit Program Expands the Safety Net

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With Medicaid expansion approaching, Catholic health care providers need to prepare for the influx of the newly insured and for the pent-up demand for services that is expected to follow. The influx, beginning in 2014, will require participation in outreach and education to the uninsured, facilitating and assisting with Medicaid enrollment and navigating through the health insurance exchange selection process.

Although the Affordable Care Act (ACA) will bring millions of low-income people into the health care system, there will continue to be some — often the poorest and the sickest — who don't qualify for basic health benefits through federal or state programs. For these people, Catholic health care organizations will continue their important role as safety-net providers, and some, such as St. John Providence Health System, can draw on their experience with established programs to help manage the influx of newly insured as well.

St. John Providence is a six-hospital system serving southeast Michigan, including the city of Detroit. For the past 10 years, it has collaborated with two other local hospital systems and the Wayne State University School of Medicine in Detroit in an evidence-based program that gives nonelderly, low-income, uninsured adults access to the full continuum of health care.

Developed in partnership with the W. K. Kellogg Foundation-funded Voices of Detroit Initiative (VODI), the program has proved to be a successful model of managing care for the unin-

sured that produces a transition from avoidable emergency department use to more cost-effective primary care medical home settings. It gives useful insight into the many challenges health care providers will face in increasing health care access to the population that, under health reform, will become newly insured.

The VODI demonstration project designed and built a coverage-and-care mechanism for the uninsured. Called the VODI Interventional Model, it showed that, if operational financing is in place and coverage and care are organized, then the pattern of care can be changed to improve access while reducing costs.

The VODI Interventional Model uses the emergency department as the

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portal for identifying patients who are using emergency services for care that is neither urgent nor an emergency, or for a chronic condition that requires regular primary care. Upon registration, 35 percent of VODI enrollees reported one or more chronic diseases. Patients are enrolled in a primary care medical home, and by linking emergency rooms and hospitals to the primary care settings, patients in this very vulnerable population can be helped to sustain the appropriate use of primary care over time. The model improves efficiencies, cost-effectiveness and accessibility and significantly decreases duplication of services. Said another way, the model gets the patient to the right place at the right time for the right level of care. The primary care medical home then becomes the conduit into a full range of medical services.¹

The model's demonstration project ran from 1999-2005. It enrolled and tracked the care of 33,000 Detroit residents who were without health insurance, and it helped 55 percent of those who were active emergency room users make the transition to primary care medical homes. The project resulted in cost savings of \$21.5 million, or 42 percent, achieved by reorganizing the delivery system to better link and align the right level of health care services to the patient's immediate clinical needs.

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INSIGHTS FOR ACA IMPLEMENTATION

Coverage is critical, but alone it is not enough to ensure access to care or to mean that care is used appropriately. The delivery system at the local level must be organized to facilitate access so the patient will be supported in obtaining care.

The VODI Interventional Model shows that an uninsured individual's access to needed medical care is affected by:

- How safety-net health services are organized and delivered
- How the delivery system assures a regular source of care
- How the cost of basic primary care is addressed

Safety-net providers, in particular the federally qualified health centers

(FQHCs), are very important sources of primary care and other enabling services needed by low-income populations. They are typically located in medically underserved areas or serve medically underserved populations, and it is essential for them to be integrated into the local delivery system of care. They are often the only agencies able to access certain pools of federal funding to support care for the soon-to-be newly insured and for those who will remain uninsured.

The ACA provides \$11 million in funding for FQHC expansion, and this expansion is already occurring around the country. Detroit has added 13 local FQHC sites since 2000. The ability of local communities to obtain these dollars is strengthened by a local collaborative approach.

Outreach and education are critical components and are facilitated by collaborating with other agencies serving

this population. Agencies such as local health departments and other human service agencies are able to support enrollment, increase awareness and serve as a venue for preventive education for lifestyle changes such as healthy foods, safe places to walk, etc.

Prevention, early identification and management of chronic disease are essential. The well-documented chronic disease epidemic in the U.S. — diabetes, heart failure, hypertension and the like — is a predictor of the pent-up demand for services that will be manifest when Medicaid coverage is expanded. It will be essential to expand the safety-net primary care providers in order to meet the needs of this population in managing chronic disease, reducing avoidable hospitalizations and reducing the cost of care.

In addition to helping patients manage these diseases, as systems and as community members, providers need

FQHC PARTNERSHIP: HOW IT WORKS

Federally qualified health centers (FQHCs) are funded by the Health Resources and Services Commission (an agency of the U. S. Department of Health and Human Services) to provide services in medically underserved areas and/or with medically underserved populations. The centers are nonprofit, private entities that provide primary and preventive health care, including such services as social work and dental care. They are required to have a governing board with a majority of consumer members.

The centers are eligible for certain federal grants, and they receive benefits such as cost-based reimbursement from Medicaid, Medicare and CHIP programs, discounted drug pricing and federal tort claims coverage vis-à-vis medical malpractice for physicians operating in their sites.

Services at an FQHC are not free, but they are provided at a discount for

those with incomes less than 200 percent of the federal poverty level. They require hospital and medical specialist collaboration in order to give patients access to the full continuum of care, and they may contract with a hospital to procure clinical services for their patients. They also may work with hospital residency programs.

St. John Providence Health System began a partnership with a local FQHC in 2000 and together planned the successful expansion for two new federally funded sites. The health system provided a grant writer and other resources to support the start-up of the health centers and worked with the health centers on a project to refer self-pay (uninsured) and Medicaid patients without a usual source of care or primary care provider to the FQHC site nearest their home.

The partnership has been mutually beneficial, and low-income Medicaid

and uninsured patients have benefited from the care provided at these health centers. A memorandum of agreement outlines the working relationship and includes:

- A lease agreement for the two sites
- The health system appoints two members of the health center governing board. By federal rules, the two appointees are unable to hold an office on the board even though they are voting members
- All medical providers will be on staff or credentialed at a St. John Providence hospital to facilitate referrals for hospital-based services
- Patient access to the St. John Providence network of volunteer specialty physicians, and the consultation is provided at no charge to the patient
- Prenatal patient referrals to a St. John Providence hospital for delivery



to be more involved in keeping our communities healthy through partnerships focusing on education and prevention such as diabetes education, promotion of access to healthy foods, promotion of physical activity to reduce obesity, infant mortality reduction and the like.

In preparation for the influx of the newly insured and Medicaid patients, St. John Providence has been adding physicians to its medical staff, including primary care, and it has reorganized to ensure a focus on the care continuum, including ambulatory departments such as urgent care. A newly hired team of care coordinators will initially focus on reducing readmissions in order to create capacity to serve more patients, in anticipation of the pent-up demands. Primary care offices are adding nurse practitioners, physician assistants and other physician extenders in order to handle a large panel of patients.

St. John Providence also is establishing additional FQHC partnerships to increase capacity to serve new patients and manage their care, and it has laid the foundation for an accountable care organization by creating a formal partnership with a group of 2,300 physicians and the system hospitals.

Though the number of FQHCs has increased across the country, more are needed — and these centers must be integrated into the health care delivery system as important providers, especially for Medicaid enrollees and the newly insured. However, along with the social, mental and dental health needs that FQHCs can address, providers can't lose sight of this population's significant non-medical needs that affect health outcomes, such as adequate housing, assistance in applying for safety-net programs, adequate food and transportation, to name a few.

By increasing the number of people who have health coverage, the ACA is expected to help providers reduce their losses to bad debt as well as their expenditures on charity care. However our communities will still encompass an uninsured population, and our community needs will continue to require

THE VODI INTERVENTION MODEL

To serve the uninsured and to improve their access to health care, the Voices of Detroit Initiative Intervention Model integrates the care delivery system at the local level both horizontally and vertically. The premise of this interventional model is that collaborating, coordinating, implementing coverage and organizing care for the uninsured population would improve their use of primary care, decrease avoidable and high use of emergency and hospital services and produce cost-effective results.

The collaboration involved the three major health systems in the city of Detroit, including the only Catholic one, St. John Providence Health System. A Kellogg Foundation grant brought the systems together in 1999 to build a framework for agreement and commitment to demonstrate how to improve access over a five-year period to primary care for 27,000 uninsured, non-elderly adults.

The systems agreed on a common set of services and activities based on identified needs of the uninsured and the experiences of the existing safety-net providers. This coordinated approach set common eligibility criteria and enrollment processes for all partner providers.

Each collaborative member partnered with one of Detroit's three federally qualified health centers. At registration, each enrollee was assigned to a primary care medical home and a network of providers for his or her coordinated health services in a continuum of care.

The collaborative developed a virtual health insurance plan that included an agreed-upon set of services or benefits to be financed by each provider's current charity care policy including hospital-based services. The coverage goal was to register, enroll and track the care for the uninsured patients assigned to each network.

expanding health programs and initiatives funded by the health system, grants and by partnerships and collaborations that share resources.

As health care safety net providers, Catholic organizations must maintain efforts to improve the health of communities, with special attention to the poor, vulnerable and those who will remain uninsured.

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NOTE

1. James D. Chesney et al., *Taking Care of The Uninsured: A Path to Reform* (Detroit: Wayne State University Press, 2008) documents the success of the VODI model in terms of moving avoidable emergency department visits to primary care.

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