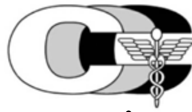

San Francisco Community Clinic Consortium
1550 Bryant Street, Suite 450 • San Francisco, CA 94103 • Phone 415/355-2222 • Fax 415/865-9960 • www.sfccc.org

San Francisco Community Clinic Consortium Partner Health Centers Provide "Medical Homes" to 70,000 of the City's Uninsured/ Underserved Residents. Why Is This Important?

For over 30 years SFCCC partner clinics have been providing culturally and linguistically appropriate medical homes to the City's diverse low-income and uninsured communities. SFCCC clinics are now the medical homes for 70,000 San Franciscans per year.

Since 2007, the City of San Francisco has been reinforcing and expanding the medical home model through "Healthy San Francisco" (HSF), which aims to provide access to care and medial homes for all the City's 72,000 uninsured residents. As a key community partner in HSF, 9 of 10 SFCCC partner clinics are establishing HSF enrollees in medical homes.

The medical home model is the core of HSF, and is designed to provide each participant with a primary care provider and care coordinator, allowing a greater focus on preventive care while linking with local hospitals to provide specialty, pharmacy, inpatient, and diagnostic services. SFCCC community health clinics provide medical homes to 40% of the 26,000+ Healthy San Francisco enrollees as of July 26, 2008. Over 94% of the total HSF enrollees to date are below 200% of the Federal Poverty Level. As more employed San Franciscans sign up for HSF over the next year, the program will become the source of essential medical home services and care management for the broader spectrum of the City's uninsured residents.

So why are medical homes important? Why are they particularly important to the uninsured, low income, underserved and ethnic minorities experiencing significant disparities in both access to care and health status? What needs to be done to assure that sufficient, high quality medical homes are available to those who need them?

To answer those questions, we offer the following excerpt from comments made by Dan Hawkins, Sr. Vice President of Policy and Programs – National Association of Community Health Centers, at a recent Congressional briefing on the topic:

"For over 40 years, the nationwide network of community health centers has provided high-quality, affordable primary care and preventive services to medically disenfranchised and underserved communities. Health centers serve as medical health care homes to more than 16 million low-income people, a majority of whom are uninsured or rely on public coverage, like Medicaid and Medicare. Nearly two-thirds of their patients are members of racial and ethnic minority groups. They exist especially to serve those who do not and cannot access primary care elsewhere. Health centers do not choose their patients – their patients choose them. And health centers are chosen because they do an excellent job of providing care.

Study after study has found that health centers are especially effective in terms of access, quality, and cost because they remove barriers to care and deliver services in a manner adapted to patient need, improve outcomes, mitigate health disparities, and are affordable.

A recent report from The Commonwealth Fund (TCF), entitled *Closing the Divide*, makes a powerful argument in support of "medical homes" as essential to eliminating racial and ethnic health disparities and promoting health care equity. The nation's community health centers welcome this report, in particular because it underscores – in the clearest terms – that achieving equity in health care will necessarily involve *both* the availability of affordable, comprehensive insurance coverage *and* the presence of a committed, regular source of care for every individual.

Although medical homes are hardly restricted to primary care providers, it is undeniably clear that all primary health care providers are crucial to any effort to ensure that everyone in America has a medical home. This past spring, the National Association of Community Health Centers (NACHC) collaborated with the AAFP's Robert Graham Center to produce a report that found that 56 million people – nearly one of every five Americans – living in every state of the union, of all income levels and insurance coverage status, have no or inadequate access to primary health care. These are the country's medically disenfranchised – people whose unmet health care needs are left to languish in a health care system that has turned its back on preventive medicine.

Virtually all health care experts support a major investment in a strengthened primary care system, underscoring the importance of moving primary care to a central place on the nation's health reform agenda. Extensive evidence on the impact of primary health care shows that, regardless of how its effect is measured, more and better primary care results in more and better health outcomes, reduced health disparities, and reduced expenditures for avoidable institutional care, especially for low-income, minority, uninsured, and medically underserved people whose health is more likely to be compromised and who run the greatest risk of avoidable institutional care.

NACHC (and SFCCC) believe there are four key steps that are necessary to achieve this goal:

1. Making a primary health care home for every American within the next 15 years an explicit goal of reform. This necessarily entails providing enhanced support for health care safety net providers, especially those who serve disenfranchised and underserved communities that otherwise could not afford to maintain a health care infrastructure. And America's federally-funded Health Centers have a strategy – *ACCESS for ALL America* which charts future health center growth so that, over the next eight years, they can become health care homes for an estimated 30 million Americans, nearly twice the number of patients currently served. Eventually, the *ACCESS for ALL America* plan envisions program growth to reach 51 million Americans, with health centers serving as the model and innovation leader for what primary care practice could become.

2. Investing in education and training of a significantly expanded primary care workforce, covering medicine, nursing, dentistry, mental health, and other primary and community service specialties. However, any public assistance for this purpose must clearly be targeted at either reversing the decline in the primary care workforce or expanding its diversity – and all of it should carry a service payback requirement in underserved areas.

3. Stemming the erosion in primary care through payment reforms that reward results and quality of care improvements. The evidence strongly suggests that current Medicare and Medicaid policy significantly underpays for primary care in both safety net and private practice settings. There is growing evidence of the inadequacy of primary care compensation among private insurers and health plans, as well. A system of payment incentives – both public and private – is needed that is expressly grounded in primary care improvement and that rewards health system management reforms, health information technology (HIT) adoption, and health quality outcomes.

4. Stimulating investment in primary care facilities, equipment, HIT, and performance improvement. Carefully planned capital investments are needed in certain areas, such as development of new facilities where needed, the acquisition of appropriate equipment as part of a modernization of primary care, and of course, HIT adoption. This is especially important for health centers and other safety net providers (which disproportionately serve low-income and minority populations) where the risk of ever-widening disparities is significant.

While the large number of individuals without any, or adequate, health insurance coverage creates challenges for achieving the type of fundamental health system change that is needed, it is possible, through targeted investments, to make significant and meaningful improvements in the accessibility and quality of primary care quickly and inexpensively. We simply have to summon the political will to invest more in preventive and primary health care – especially in communities that have too little of it for the people living there."