ACCESS
TO HEALTH CARE FOR ALL OF MICHIGAN

MICHIGAN
Primary Care
ASSOCIATION

Promoting, supporting, developing quality, comprehensive, accessible,
and affordable community-based primary health care services to everyone in Michigan.

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Michigan CHCs and the State's Environment: A Background

Michigan Community Health Centers (CHCs) are local, non-profit, community-owned providers of health care that serve low-income and medically underserved communities. The U.S. Department of Health and Human Services designates communities as medically underserved based on income, morbidity and mortality rates, and access to primary care professionals. Health care is needed but scarce in these areas.

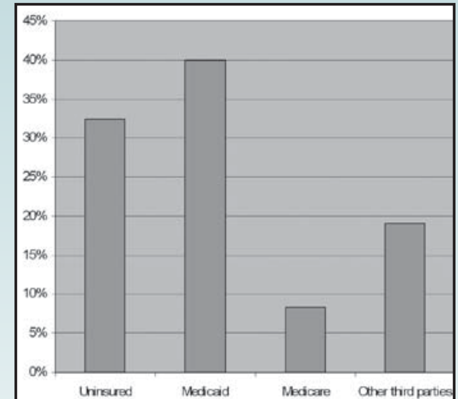
For over 40 years, Michigan CHCs have provided high-quality, affordable, comprehensive primary, oral, and mental health/substance abuse services to Michigan's most vulnerable populations—people who even if insured would likely remain isolated from traditional forms of medical care because of where they live, the language they speak, and their complex health care needs. Community Health Centers also provide enabling services that many other providers do not, such as translation, transportation, and culturally sensitive health care. These services promote access to health care for everyone in the community in all stages of the life cycle.

The doors to Michigan CHCs are open to all community members regardless of their ability to pay or insurance status. Patients are charged for services on a sliding-fee scale that is based on family size and income.

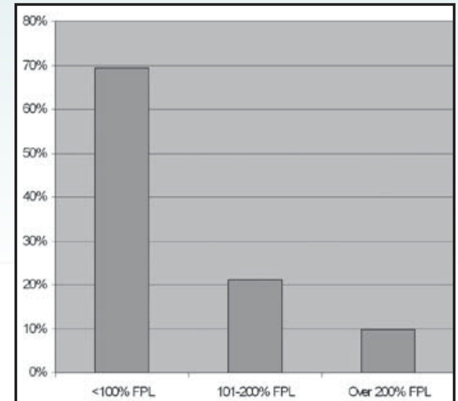
Many Michigan CHC patients belong to vulnerable populations that have been marginalized, particularly the low-income, minorities, and women. In 2006, women aged 18 years and older comprised 40% of total patients served by Health Centers. Additional demographic data of the patient population are shown in the bar graphs on this page.

Eliminating health disparities is a major focus of Michigan Health Centers. CHCs are committed to increasing the quality and years of healthy lives for all Michigan residents regardless of age, race, and ethnic or socioeconomic status. To improve health outcomes, Michigan CHCs participate in innovative disease management programs. Studies show that where there is a

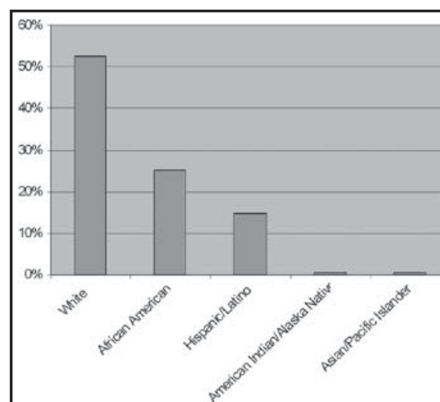
Michigan Health Center Patients by Insurance Status (2006)



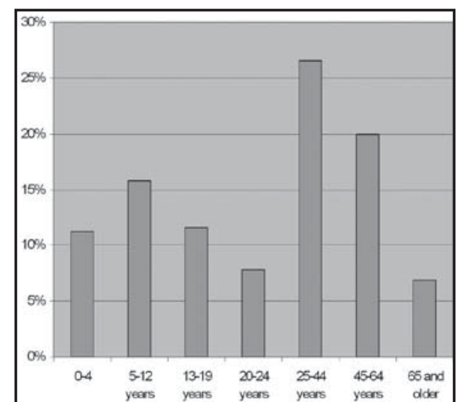
Michigan Health Center Patients by Income Level (2006)



Michigan Health Center Patients by Race/Ethnicity (2006)



Michigan Health Center Patients by Age (2006)



A Background of Michigan CHCs and the State's Environment

Health Center, the health of the community is improved. For example, infant mortality rates are reduced by at least 10% more in communities served by Health Centers than in comparable communities not served by Health Centers. The provision of Health Center services has also been linked to improvements in the use of prenatal care and reductions in the incidence of low birth weight.

According to the *National Association of Community Health Centers Chart Book 2008*, CHCs provide approximately 22% of all uninsured ambulatory care visits and CHC uninsured patients receive more care than the uninsured nationally. It reports that 56% of CHC uninsured patients have four or more doctor visits per year compared to 33% of U.S. uninsured patients.

In Michigan, 1 in 6 uninsured people are Health Center patients. Nationally, 1 in 7 uninsured people call a Community Health Center "home." Individuals with access to regular preventive care at a Community Health Center they call home are less likely to be taken to the emergency room or hospitalized than those without access to a CHC.

According to a 2004 study uninsured people living within close proximity to a CHC are less likely to have an unmet medical need, less likely to have postponed or delayed seeking needed care, more likely to have had a general medical visit, significantly less likely to have had an emergency room visit, and less likely to have had a hospital stay compared to other uninsured people. This saves communities money.

What's more, a 2007 study found that CHC uninsured patients were more likely to receive preventive screenings such as a breast examination, mammogram, and colonoscopy than uninsured patients nationally.

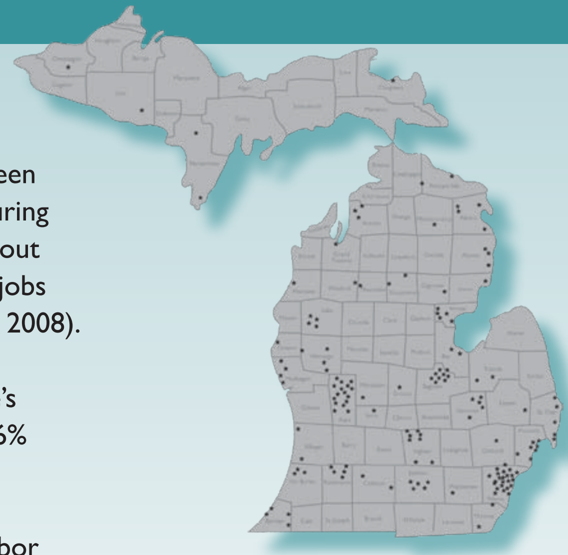
Community Health Centers are key players in both state and federal efforts to improve access to health care. Not only have they demonstrated that they improve access to care, they have proven to do it in a cost-effective manner. A study conducted by the Institute for Health Care Studies at Michigan State University unequivocally demonstrated that Medicaid beneficiaries using CHCs cost the state less money.

Upon review of 2003 and 2004 data of the Michigan Medicaid fee-for-service payment system, the study findings showed an overall savings to Medicaid of $44.87 per member per month when comparing Medicaid recipients cared for in CHCs to those cared for elsewhere. These savings are likely attributed to prevention, chronic disease management, reduced pharmaceutical costs, and reduced emergency room utilization.

Extrapolated to all 214,638 CHC users who were Medicaid beneficiaries in 2007 for an average of 10 months (average length of enrollment for 18-64 year old non-disabled recipients [other groups were on longer]) this resulted in a savings of $96,308,071 to the Medicaid program. In 2007, the state portion of Medicaid costs was 43.62%. That means that CHCs can reasonably be credited with saving the State of Michigan $42,009,580 in 2007.

Community Health Centers serve as economic engines in communities, creating new jobs and resources. CHCs are a source of stable employment for residents and generate direct economic output. They provide job training for community residents and have often times played a significant role in revitalizing business districts of the communities in which they are located.

According to *Access Denied,* a 2008 report of the National Association of Community Health Centers, Michigan CHCs have an economic



impact on the state totaling $323,800,000 and are the source of employment for over 3,700 full-time employees. Because CHCs serve as economic engines in their communities across the nation, their $7 billion budget has produced approximately $20 billion in overall economic output for communities (Grant Makers in Health Care).

Michigan currently has the worst economy in the United States and, according to an October 2007 National Public Radio report, there are many indications that it will take years to recover from this economic downturn. There is much speculation as to the exact cause of this economic downturn—it is likely a combination of the state's job losses, distressed real estate market, declining population, and shift from reliance on the auto industry.

Michigan's economy has traditionally relied heavily on the auto industry. A 2007 *Detroit Free Press* report found that Michigan's economy is 700% more concentrated in the auto industry than that of the national economy. The Big Three automakers, Ford, GM, and Chrysler, have posted record losses and, as a result, have had to cut jobs.

According to Sean McAlinden, chief economist with the Center for Automotive Research, the Big Three announced the shutdown of 35 plants between 2005 and June and 2008. During that time, they eliminated about 149,000 hourly and salaried jobs (*Huffington Post*, October 24, 2008).

In December 2008, the state's unemployment rate was 10.6% compared to the national unemployment rate of 6.3% (Michigan Department of Labor and Economic Growth). In 2007, Michigan was number three in the nation for home foreclosures and the City of Detroit was eighth in the United States for foreclosure rates within metropolitan areas.

As the result of the economic crisis marked by rising unemployment and a decline in employer-sponsored health care coverage, the number of uninsured individuals in Michigan and across the country continues to rise.

While the uninsured population in Michigan is estimated at over 1 million (11.6% of the population), this number is steadily increasing. The report *Cover Michigan* cited a 1.1% increase in the number of Michigan residents lacking health coverage from 2006 to 2007.

The vast majority of the uninsured are in working families. The Michigan State Planning Project for the Uninsured reported that 80% of uninsured households had at least one employed adult, and of those households, 73% had a member working 40 or more hours per week.

As policy makers consider policies aimed at expanding health care coverage, it is equally important to maintain and strengthen the system already in place through which the uninsured receive medical care, namely Community Health Centers.

While the uninsured population in Michigan is estimated at over 1 million (11.6% of the population), this number is steadily increasing.

Priority Needs of Community Health Centers

It is the Michigan Primary Care Association's (MPCA) mission of promoting, supporting, and developing primary health care services for everyone in Michigan that drives the recommendations in this *Access to Health Care for All of Michigan* plan. While Michigan CHCs treat an increasing percentage of Michigan's population each year, there are still gaping health disparities between races, income levels, and access to primary health care services. A great deal has yet to be done.

MPCA's *Access to Health Care for All of Michigan* plan is designed to expand the system of care beyond medical care to improve the health status of patients and communities, put patients in the center of the health and human services equation, and create access to *what* people need *when* they need it regardless of the time of day or day of the week.

Recently, MPCA conducted an assessment of Michigan CHCs to identify areas of technical assistance, training, or other resources they need. The CHCs identified assistance in workforce recruitment and retention, establishment of additional oral and behavioral health services, and assistance in developing new or expanded facilities to address the unmet needs of their communities as areas of highest priority. This *Access to Health Care for All of Michigan* plan outlines the vital role of Michigan CHCs, identifies several immediate challenges they face, and makes recommendations for increasing access to health care for all Michigan residents.

Secure Direct State Funding for Community Health Centers

CHCs are obligated to treat all patients that come through their doors, including patients who do not have insurance. With the number of the uninsured continually increasing, Michigan CHCs need to expand so all Michigan residents have access to care. A significant barrier is that most CHCs do not have the financial reserves, or future profit margins, available to fund the expansion themselves. The federal government has made some money available for CHC expansion, but that money is spread between all 50 states so the amount that Michigan CHCs may receive in any one year is very small.

Lack of capital is a significant barrier to Michigan CHCs implementing Health Information Technology (HIT). HIT could, however, serve as a

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Expanding CHC services in Michigan will need to be paid for with Michigan dollars. Based on a statewide capital needs survey completed this year, Michigan CHCs need $95 million to expand capacity to meet the needs of the uninsured over the next 7 years. That includes:

- $56 million for new facilities
- $11 million to expand current facilities
- $13 million to renovate current facilities
- $10 million to purchase new medical and other equipment
- $5 million to invest in Health Information Technology

RECOMMENDED ACTIONS
for Securing Direct State Funding for Michigan CHCs:

- Utilizing the demonstrated cost savings generated by Michigan CHCs to the Medicaid program, state policy makers should directly invest at least $21 million to provide expanded services in CHCs throughout the state.
- CHCs should be considered priority investment areas in any economic stimulus activity.

Numerous reports forecast a critical shortage of Michigan's health care workforce in the near future. The state's medically underserved communities are most affected by health care provider shortages.

transformative tool for continuous quality management and efficient Health Center management. It allows for patient data to interface directly with software in real-time or be entered at point-of-care.

Implementation would enable Michigan CHCs to increase the number of chronic disease patients they monitor and manage, achieve Healthy People 2010 objectives for patient populations, increase data accuracy by eliminating manual data entry, and increase efficiencies within Health Centers. With the large number of underinsured and uninsured patients accessing CHC services, Health Centers are challenged to make every visit count.

HIT implementation requires investment in a data warehouse, data warehousing products, tablet computers, and software. Today, 14 of Michigan's 32 CHCs have registry penetration in the state, and just four have implemented electronic medical records.

Develop Michigan's Health Care Workforce

Numerous reports forecast a critical shortage of Michigan's health care workforce in the near future. To prepare for the shortage, Michigan's planning is well underway with continuous, systematic monitoring of the various markets for the availability and utilization of specific types of health professionals in all of the state's regions. Development of the Michigan Health Care Workforce Center has assisted in coordinating the many workforce initiatives currently active statewide.

The state's medically underserved communities are most affected by health care provider shortages. Today, 65 counties in Michigan are federally designated as full or partial county primary care health professional shortage areas. It is imperative that we create incentives for providers to work in these underserved communities. Systems must be created to provide incentives to health professions training programs to train clinicians to work in underserved communities and to work effectively on interdisciplinary teams.

As medical schools recognize the impending provider shortage and create additional slots within their programs, systems must be developed to assure this training is provided in the areas and settings of highest need. Public funding for medical education should be geared to systems that promote training and placement in areas and settings of underservice, recognizing that educational placements in these communities and in primary care settings are critical in the retention of health professionals in Michigan and in medically underserved communities.

Not only should incentives be directed to training programs, they should also be implemented

Priority Needs of Community Health Centers

As a result of the dismal economic picture in Michigan, many graduates leave the state to find work.

for placement of professionals where they are needed most. The State Loan Repayment Program should be retained and expanded in order to motivate providers to locate in areas of greatest need. This rational approach will result in the appropriate numbers of professionals in appropriate locations, and Michigan residents will be better able to access health care in the most appropriate and cost-effective manner. Additional incentives, such as tax incentives or supplemental reimbursement for services, should be considered to promote redistribution of health care providers to underserved areas.

With the candidate pool shrinking, recruiting all levels of clinic staff is a challenge for Michigan CHCs. They must be sure their opportunities are competitive as they are choosing from the same pool that larger hospital systems and for-profit provider practices are choosing from.

The Council of Graduate Medical Education (COGME) found that in 2007 there were 272.9 physicians per 100,000 population in Michigan. This number is significantly less than the ratio of 300 or more physicians per 100,000 population recommended by COGME to adequately meet demand. Rural Michigan has only about one-half the recommended ratio (165 physicians per 100,000 population).

Michigan's three medical schools have responded to this crisis by increasing the number of slots available within each class. While this is helpful in training more health professionals in Michigan, statewide strategies must be in place to retain these professionals upon graduation.

As a result of the dismal economic picture in Michigan, many graduates are leaving the state to find work. A 2007 *Detroit Free Press* poll found that two-thirds of University of Michigan and Wayne State University undergraduates planned to leave Michigan after graduation. The number one reason given was lack of jobs in the state.

In addition to recent graduates leaving the state, many physicians currently practicing medicine are leaving or planning to leave the profession. A 2007 Michigan State Medical Society report found that

RECOMMENDED ACTIONS
for Developing Michigan's Health Care Workforce:

- All health professions training programs receiving funding from the State of Michigan should be required to establish collaborative relationships with safety net providers such as Community Health Centers.
- When awarding State of Michigan grants or contracts, preference and priority should be given to projects that include safety net providers.
- Funding preference should be given to health professions training programs that utilize evidence-based approaches to the recruitment of underrepresented students to health care fields. This may include the recruitment of bilingual or minority students.
- Michigan should adopt new, and improve current, incentives for providers who serve underserved communities in order to encourage long-term employment commitment.
- Michigan should adopt policies that promote an interdisciplinary approach to health care, including mid-level providers and behavioral and oral health clinicians.

38% of Michigan doctors plan to retire by 2020, and according to a 2007 Michigan Department of Community Health physician survey only 41% of Michigan's active physicians plan to practice medicine for just 1 to 10 more years citing retirement as the top reason. This combination of factors makes recruiting and retaining the state's health professions workforce exceptionally challenging.

Implement the Primary Care Medical Home Model in Michigan

Primary care is in crisis in the United States and in Michigan. Patients are having difficulty gaining access to primary care providers, current providers are leaving, and medical students are not selecting primary care residencies to replace them. What's more, payment to primary care providers continues to fall farther behind payment to other medical providers, and the complex nature of the primary care visit, expected to be completed in a 12-minute session, meets no one's needs—not the patient, not the provider, and not the payer.

System transformation is necessary to create a comprehensive patient centered model of care that meets the needs of patients while addressing the quality of professional life issues of providers. The Patient Centered Medical Home (PCMH) model is an approach that can do just that. Developed and promoted by primary care providers nationally and being piloted throughout the country, PCMH provides comprehensive primary care for people of all ages. It facilitates partnerships between individual patients, their providers and, when appropriate, the patient's family. PCMH practices are physician directed medical practices that focus on the whole-person. Care is integrated and coordinated, payment incentives are aligned, and quality and safety are paramount. Enhanced access is made possible by system advances and new communication options.

Clinicians practicing in PCMHs use decision support tools, measure their performance, proactively engage patients in their own care, and conduct quality improvement activities to improve care delivery and health outcomes.

Michigan CHCs are an illustration of the core principles of the PCMH, with comprehensive primary care serving as the foundation of the

RECOMMENDED ACTIONS
for Implementing the Primary Care Medical Home Model in Michigan:

- Promote the development, implementation, and ongoing evaluation of systems' redesign that accelerates and sustains the achievement of PCMH status and operational excellence in primary care medical and health provider practices throughout Michigan.
- Promote the development of reimbursement policies that support informed, value-based health care purchasing decisions that facilitate, promote, and sustain the continued implementation of the PCMH model. This includes meaningful involvement of consumers in their own care, effective coordination of care among all points of interaction in care delivery in the health care and human services systems, and adopting proven and appropriate technological information solutions.
- Create incentives for transformation of health professions' training curricula to include skill building in critical elements of the PCMH model. Health professionals should be fully competent in application of principles of interdisciplinary care delivery, patient self-management, systems redesign, utilization of registries, and implementation of the care model at minimum.

Priority Needs of Community Health Centers

The number of uninsured individuals in Michigan and across the country continues to rise, as does the unemployment rate which reached 10.6% in Michigan in December 2008.

CHC delivery model for over 40 years. As a result, CHCs have been more responsive to community needs than other providers and have neutralized the disparities in how care is delivered to populations served by Health Centers, including migrant/seasonal farmworkers and their dependents as well as homeless individuals and families.

Michigan CHCs have also shown that comprehensive primary care, including dental health, mental health/substance abuse services, and preventive services, can be delivered while saving money (over $44 per Medicaid client per month). Health Centers have undertaken extensive quality improvement processes, including implementation of patient self-management, systems redesign, and use of patient registries in utilizing the chronic care model. There is, however, more to be done through Health Centers and other primary care providers to fully involve patients in their care and create 24/7 access to appropriate care.

Provide Health Coverage for all Michigan Residents

Public policy makers must address the dire need for health care coverage by making it affordable and available to all Michigan residents and include a subsidy for low-income individuals.

According to a new report released by Cover Michigan, approximately 11.6% of Michigan's total population—1.1 million people—lacked health coverage in 2007, up from 10.5% in 2006. In 2006, only 4.7% of Michigan's children were uninsured, but in 2007 that percentage increased to 6.2%. Average family premiums for those with private health insurance increased 68% from 2000 to 2006; average family deductibles increased 25% since 2002.

As you can see, the number of uninsured individuals in Michigan and across the country continues to rise, as does the unemployment rate which reached 10.6% in Michigan in December 2008. When individuals become unemployed they not only face a loss of income they are also faced with a loss of health insurance. While the Consolidated Omnibus Budget Reconciliation Act of 1984 (COBRA) was designed to help people continue their health coverage after losing a job, not all individuals qualify and fewer can afford the COBRA premiums. According to the Kaiser Commission on Medicaid and the Uninsured the average monthly premium for family COBRA coverage is about 78% of the average monthly unemployment benefit.

Due to lack of federal action, states are leading the way in health care reform. They are using Medicaid and SCHIP expansions, as well as public-private partnerships, to increase access to and affordability of health care coverage. The Michigan Primary Care Association proposes that Michigan provide primary care coverage for the uninsured.

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- Michigan policy makers should adopt a health care coverage program available to all Michigan residents and include a subsidy for low-income individuals.

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