Local Health Departments and Federally Qualified Health Centers; sharing a common mission to improve community health

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EXECUTIVE SUMMARY:

Local Health Departments (LHDs) and Federally Qualified Health Centers (FQHCs) share a common mission to improve community health, particularly among vulnerable and underserved populations.

Representatives of three LHDs and Passport Health Plan, one of 5 managed care organizations in KY, joined together to explore this type of collaborative relationship in Kentucky. Presently, LHDs are seeking unique relationships with other healthcare agencies and local providers in KY and across the nation. Historically Public Health was filling a gap in access for the uninsured and underinsured. As Public Health continues the struggle to define itself within the changing healthcare landscape in the United States and more specifically, KY, there may be greater interest in these types of partnerships that did not exist prior to the implementation of the Affordable Care Act.

Today, the reasons for partnerships between LHDs and FQHCs are very compelling. The passage of the Affordable Care Act signaled an overhaul of the health care system. With this came a message and intent for integrated and coordinated care across the health system. There was an emphasis on primary care, prevention and collaboration among the health care providers in every community.[1]

The following paper reviews steps taken to share in greater detail what types of partnerships exist in KY today, to educate on what types of partnerships can be entered into between LHDs and FQHCs, and to promote further collaboration in pursuit of common goals within the local communities in KY.

INTRODUCTION/BACKGROUND:

In the early 1960s, millions of Americans living in inner-city neighborhoods and rural areas suffered from deep poverty and lack of access to healthcare. FQHCs trace their history back to the Neighborhood Health Centers that emerged from the Lyndon Johnson administration's War on Poverty in 1965. Neighborhood Health Centers were created at the federal level to provide health and social services in poor and underserved communities. The War on Poverty's community empowerment ideals were advanced through a federal funding model that bypassed state interference, and by a management model that incorporated constituent involvement to ensure responsiveness to community needs.

Through the 1970s, Congress authorized separate primary health care programs for migrant, homeless and public housing populations. The Health Centers Consolidation Act of 1996 combined these separate authorities under section 330 of the Public Health Service Act.[2]

The term Federal Qualified Health Center was coined in 1989. The FQHC program established preferential "cost based" reimbursement for FQHCs under both Medicaid and Medicare. This reimbursement strategy has undergone modifications, but an FQHC is still defined as an outpatient facility that receives federal grant funds under section 330 of the Public Health Service Act.[1] Community health centers that meet FQHC program qualifications, short of actually receiving section 330 grants, are sometimes called FQHC "look-alikes." In KY there are approximately 23 FQHCs. This number would include sites in bordering states that serve KY's population. Between all of these FQHCs, there are approximately 262 sites.

A LHD is a government agency in the United States on the front lines of public health. Local health departments may be entities of local or state government and often report to a mayor, city council, county board of health or county commission. There are 47 county health departments and 13 district health departments in KY. These county and district health departments cover all 120 counties in KY and make up approximately 129 individual sites not including any school sites.

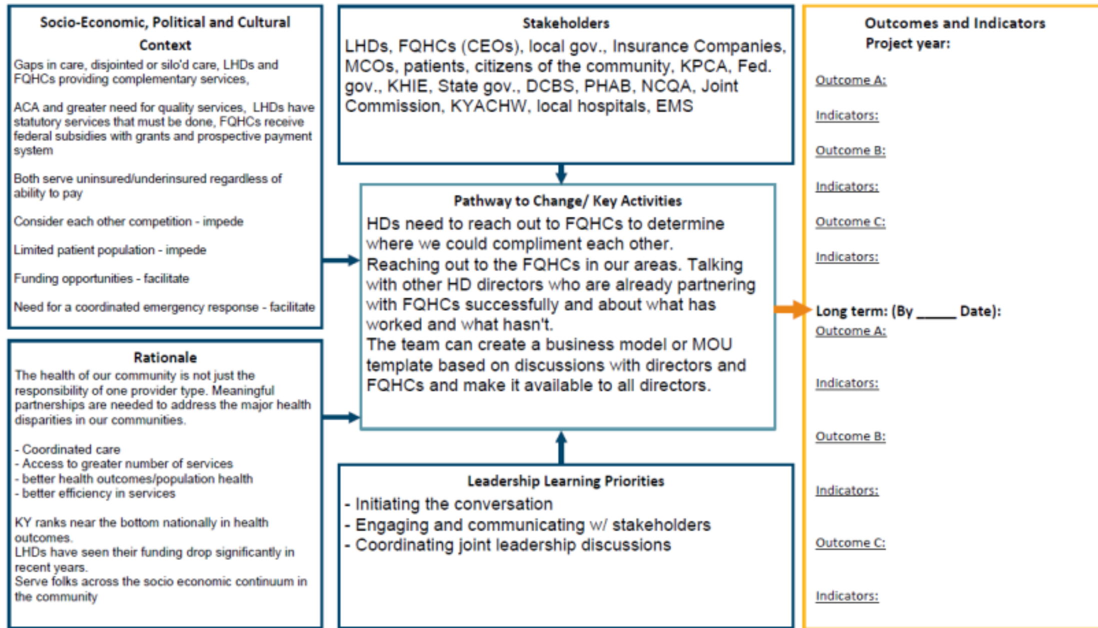
Local health departments help create and maintain conditions in communities that support healthier choices in areas such as diet, exercise, and tobacco. They lead efforts that prevent and reduce the effects of chronic diseases, such as diabetes and cancer. They detect and stop outbreaks of diseases like measles, tuberculosis, and foodborne illnesses. They protect children and adults from infectious diseases through immunization. Local health departments also conduct programs that are shown to effectively make communities healthier.

LHDs and FQHCs can collaborate in a variety of ways. LHDs can help individuals in need and link them to FQHCs for care. FQHCs, in turn, can provide referrals to no or low cost prevention programs run by LHDs. Both entities can also work with other providers in their communities as well as hospitals to coordinate community-wide interventions that address the needs of all individuals with or at risk of chronic conditions such as diabetes or high blood pressure. The goal of this project was to shed light on the many positives of this type of partnership and to bring awareness to those in LHD leadership about the FQHCs in their communities. We also wanted to educate on the major types of partnerships and provide a resource for LHD leadership to reference when searching for the FQHC that serves their community.

Problem Statement:

This study was developed to address the observation/question, "Despite sharing a common desire to improve community health, why are there not a greater number of LHD partnerships with FQHCs?"

Big Picture Document:



10 Essential Public Health Services/National Goals Supported:

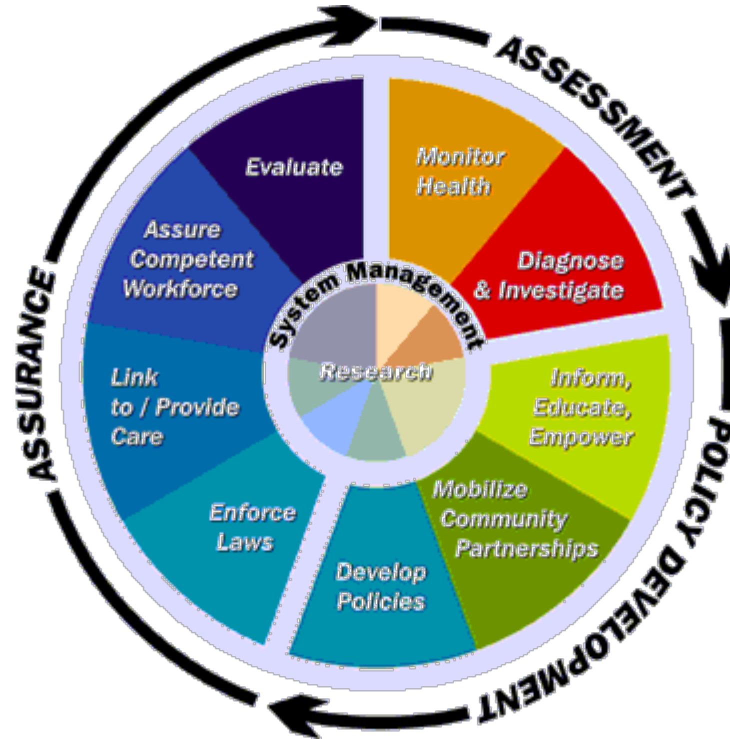


Figure 1: This picture is from Centers for Disease Control and Prevention

Public health systems are commonly defined as “all public, private, and voluntary entities that contribute to the delivery of essential public health services within a jurisdiction.[3] The public health system includes many different types of entities that fall into the above definition but the two we are focusing on are;

•Public health agencies at state and local levels

•Healthcare providers

The 10 Essential Public Health Services describe the public health activities that all communities should undertake. Public health systems should work to foster these services within their community. By collaborating, LHDs and FQHCs do just this. The potential benefits of these partnerships extend beyond the exam room and into the community. In general, these partnerships improve access to care, health outcomes and decrease health disparities.

PROJECT OBJECTIVES/DESCRIPTION/DELIVERABLES:

The goals of this project were to shed light on the many positives of this type of partnership as well as bring awareness to those in LHD leadership about the FQHCs in their communities. We also wanted to educate on the major types of partnerships and provide a resource for LHD leadership to reference when searching for the FQHC that serves their community. We will be able to do this by offering reference material, survey data, in-person recorded interviews with four individuals currently leading LHDs in KY and access to an incredible resource from the KY Primary Care Association.

METHODOLOGY:

Literature Review

Unbeknownst to each of us, there is information out there that can be used as reference for support of a partnership as well as education on what types of standard collaborative agreements there are. Due to the sensitive nature of each of the collaborating entities, attention to detail is imperative. The paper will highlight three common types of partnerships.

Data Collection and Review

When the team decided the direction of this project, we agreed that it would be from the perspective of a LHD director. This made sense to us as we had two current directors working directly on the project. We also had ready access to directors across the state. We used a survey to collect data regarding knowledge, use and current relationships with FQHCs. We sent this survey out to all LHD directors. Thirty-one directors responded to our survey. Of the 31 responses, 16 directors were willing to be interviewed by our team. Each of us attempted to interview four directors, three on the phone or by email, and one on camera. We used a standard set of questions. Our survey only allowed one answer to the "type of agreement" question. Several directors answered "other" because they have more than one type of the three options. Due to this, the percentage of each type of agreement is higher than indicated in the graph. We decided to present our final presentation as a video of the on-camera interviews.

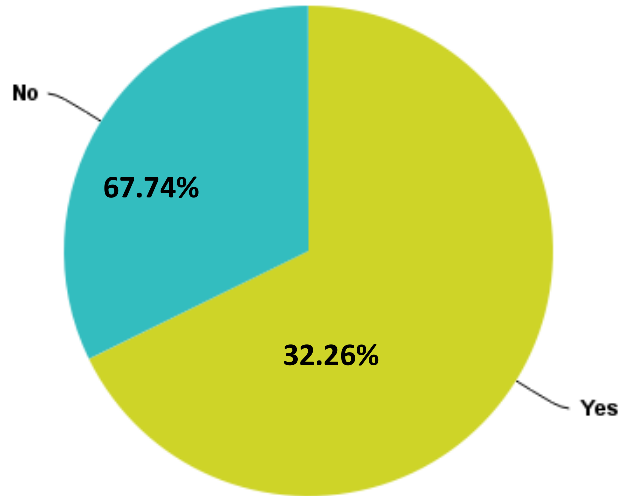
Resource

While researching if there were any available reference tools for LHD leadership to use as assistance in learning more about FQHCs in their area and the services they provide, a gift was handed right to us. One of the team members, through conversation with a state based association regarding the creation of the proposed resource, learned that such a resource already exists. What ensued was a positive sharing of information and willingness to freely provide this tool to anyone who may request it.

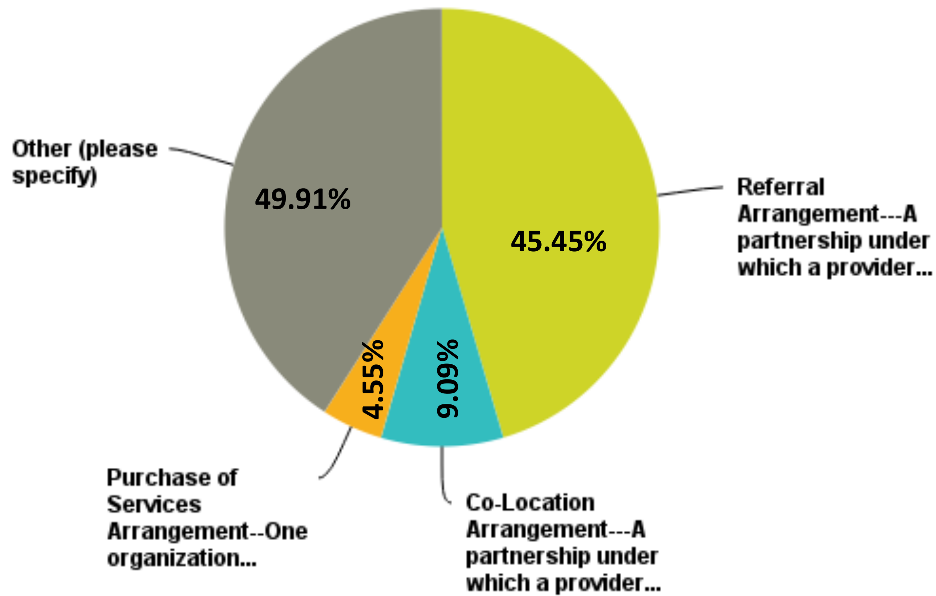
RESULTS:

The following is a visual presentation of the survey responses from 31 LHD directors. Of the 31 respondents, 16 directors agreed to be interviewed. Their partnerships ranged from just beginning 3 months ago to lasting over ten years.

Percentage of the 31 responding LHDs currently in a partnership with a local FQHC?



What type of partnership do you have with your FQHC?

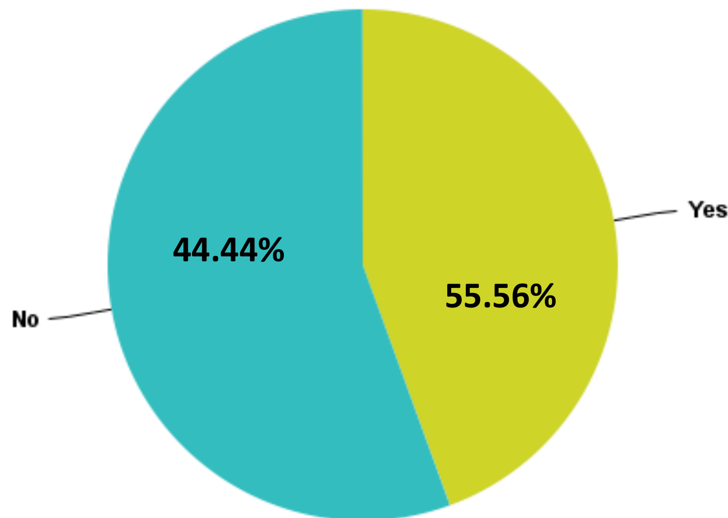


40% indicated their partnership is something other than the three options. As mentioned previously, several directors answered "other" because they have more than one type of partnership and the survey only allowed one selection for this question.

Here are the answers:

Referral for prenatal and purchase for family planning and breast/cervical services
Don't have a FQHC but have a Charitable Primary Care Clinic
MOU to provide Vaccines for Children
Co-location agreement
Referral agreement- one district has three
Underinsured immunizations
Referral agreement
Purchase of services agreement
MOU to provide Vaccines for Children
Informal referral relationship
Would like to have a partnership but no FQHC covering my county

Would you be interested in entering into a partnership with your local FQHC if you are not currently partnering?



For LHDs and FQHCs interested in exploring partnerships, the following is an explanation of the three most common arrangements.

A referral arrangement is a partnership under which a provider agrees to furnish services to those patients who are referred to it by another provider. The provider referring the

patient typically agrees to utilize the other provider as its preferred, albiet not exclusive, provider of choice for particular services.[1]

Under a referral arrangement, the FQHC and the LHD retain their own separate and distinct patient care delivery systems and locations. Each is legally and financially accountable for the services it directly provides. This type of agreement may serve as a precursor to a more collaborative relationship.
There are both formal and informal referral arrangements.

Under a formal arrangement, the FQHC is responsible for the patient's overall treatment plan and and provides and/or bills/pays for follow-up care based on the outcome of the referral. Under formal referral arrangements, if the actual service is provided and paid/billed for by another entity, then the service is not included in the FQHC's scope of project. Formal referral arrangements are included in an FQHC's Form 5-Part A, Column III. Adding a service included on Form 5-Part A requires prior approval from HRSA.

Under an informal referral arrangement, which cannot be used to provide required or other in-scope services, the FQHC refers a patient to another provider who is responsible for the overall treatment plan and billing for the services provided and no grant funds are used to pay for the care provided. These informal arrangements are not required by HRSA to be documented in a written agreement and do not require the other provider to refer patients back to the FQHC for appropriate follow-up care. In an informal arrangement, the service and any follow-up care provided by the other entity are considered outside the FQHC's scope of project. These arrangements do not require HRSA's prior approval.

A protocol should be developed describing how referrals will be made and processed. The FQHC must charge the patients referred by the LHD in accordance with the FQHC's fee schedule and schedule of discounts and must serve all patients referred by the LHD regardless of ability to pay, subject to reasonable capacity limitations.

Unlike referral arrangements, in a co-location agreement, the healthcare professional furnishing the services is physically located at the other organization's site, either on a full or part-time basis. If the LHD establishes a site within the FQHC, the FQHC is not required to change its approved scope of project because it is not adding or removing a site. Patients are simply referred to the LHD as they would be under the standard referral relationship.[1]

If the FQHC establishes a site within the LHD, the FQHC must obtain prior approval from HRSA to add the site to its scope of practice. To avoid legal liabilities, the co-located provider should be clearly identified as a provider furnishing services separate from the other organization. It should be made clear that the co-located health care professional is not employed by, or contracted to, the other organization. The co-location arrangement typically consists of a lease outlining space cost.[1]

Under the purchase of services arrangement, one organization purchases services from the other organization, which provides services as a vendor and on behalf of the other "purchasing" organization. Typically the purchase of services is for health care services but may also include the purchase of administrative services.[1]

The purchaser compensates the other agency for the provision of services based on fair market. The patients under this type of arrangement would all be considered FQHC patients for all services provided. The LHD should obtain and carry professional liability insurance for both itself and its contracted provider.

CONCLUSIONS:

There may be more LHDs and FQHCs partnering than this paper represents as we only received responses from 31 of 61 health departments. The partnerships represented in this project vary but all fall into one of the three categories mentioned above. There are many possibilities for FQHCs and LHDs to partner and eliminate duplication of services while providing a streamlined approach to health care in their respective communities.

Presently, primary care and public health in KY largely operate independently, with complementary functions. By working together more closely, they can achieve their own goals while also having a greater impact on the health of populations as compared to working independently. In a sense, direct provision of clinical services is an integrative activity in the larger community health system as LHDs cover gaps not being addressed by other primary care providers. However, true integration occurs only when LHDs and/or their partners identify gaps in existing services and then partner to address those gaps. Such partnering may include the alignment of organizational goals/priorities and associated strategies such as, effectively preventing and managing chronic diseases, and assignment of complementary tasks or procedures.

It would be beneficial to have a focus, perhaps in the form of several regional representatives, on developing and enhancing these partnerships throughout the state. As funding continues to be uncertain for LHDs and as public health in Kentucky continually redefines itself in an ever-changing political landscape, the use of local tax dollars may be reduced through effective partnerships between LHDs and FQHCs.

Our team felt it would benefit LHDs to have a single resource listing of all FQHCs in Kentucky. One of our goals was to create this list. Through our efforts we discovered the resource already exists. LHDs interested in contacting their local FQHC can find a list of FQHCs in Kentucky in the 2017 Health Centers Booklet located at http://www.kypca.net/resource-library.

LEADERSHIP DEVELOPMENT OPPORTUNITIES:

David Wallace

I didn't know what to expect going into the KPHLI Program. When I got to the first summit and found out that I was selected for the Executive Track Team, I really thought I was in way over my head! I hung in there, came to know my team mates and was very impressed with them and their ideas about the work we needed to accomplish. Now, I can say that I was blessed to be part of this team known as the "Brainstormers." Thank you to all of my team for helping me through this. I am very grateful that I had this opportunity to learn how to be a better leader.

Laura Hawes-Hammons

I was honored to be offered the opportunity to participate in KPHLI. As a new director I was concerned about the time commitment of the program, but I also realized there was probably not going to be a "perfect" time. The past year has given me the opportunity to get to know a variety of people I might not otherwise have gotten to know. Learning from our mentors and from each other was so valuable to me personally and professionally. Examining my strengths and weaknesses has allowed me to work more effectively with others, and being a part of the Brainstormers Team was one of the highlights of my year. We had a good time together at the retreats, hiking, making a rocket, watching Noel walking on the moon, phone calls, ITV meetings and brainstorming on the deck with Georgia, Cynthia, and Shawn. I recommend this program to others who want to expand their leadership skills.

Noel Harilson

The KPHLI program has been an incredible asset to me. It has provided me with invaluable insight in regards to my personality strengths, behavioral attributes and how I deal with change. All of this is tied together to assist me in becoming a better leader in my personal and professional life. Through the process I have been able to identify not only areas of weakness but work on how to better convey my natural strengths as well. Being part of the inaugural Executive Track, I wasn't very sure of what was expected. Upon meeting my teammates, I quickly realized that this was going to be a ton of fun. We had a great time getting to know each other in the first summit and had some great laughs at the second summit. I particularly enjoyed our hike to chain rock. I was impressed with David as he hiked the entire way in wing tip loafers. We were all hot, sweaty messes and after Julie came cruising in barefoot, we finally made it back to the session…late, but together! No man left behind! It was at the second summit that the lightbulb came on with me due to a conversation with Shawn Crabtree. Up to that time, I was so concerned with the final project and some bar that I had set for it that it took Shawn to tell me to focus on the process and not on the final product. That was such a relief. I have learned so much and to cap it off, I accepted a management position and start on April 12.

Julie Bush

KPHLI has given me the opportunity to examine my strengths and weaknesses as a leader. It has allowed me to meet and work with a great group of scholars on the

Executive Track. Each of us brings a unique perspective and it has been such a pleasure working with such a great team. I feel like we have each experienced personal growth along the way. I always strive to be the best I can be, and the knowledge I have gained through the assessments gives me a better understanding of myself as well as how others see me. It strengthens my resolve to become the best leader I can be. I am determined to improve in areas that are weak, to face all challenges head on, and to take my leadership skills to the next level.

REFERENCES

[1] Feldesman Tucker Leifer Fidell LLP. Partnerships Between Federally Qualified Health Centers And Local Health Departments For Engaging In The Development Of A Community-Based System Of Care. National Association of Community Health Centers (NACHC); 2010:5.

[2] Goebel J. A Brief History of Federally Qualified Health Centers (FQHC) | NotifyMD. NotifyMD. 2017. Available at: http://www.notifymd.com/a-brief-history-of-federally-qualified-health-centers-fqhc/. Accessed March 22, 2017.

[3] CDC - Public Health System and the 10 Essential Public Health Services - NPHPSP. Cdcgov. 2017. Available at: https://www.cdc.gov/nphpsp/essentialservices.html. Accessed March 23, 2017.