Leveraging FQHC status across the community

Workforce Considerations in Evolving Times




Shaping Healthy Communities.

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History

- Opened in 2002 as a local, grassroots clinic
- Financially supported by board and community donations
- FQHC status provided a mechanism to achieve sustainability and the ability to expand services by leveraging benefits of the status
- Secured FQHC status in December 2004

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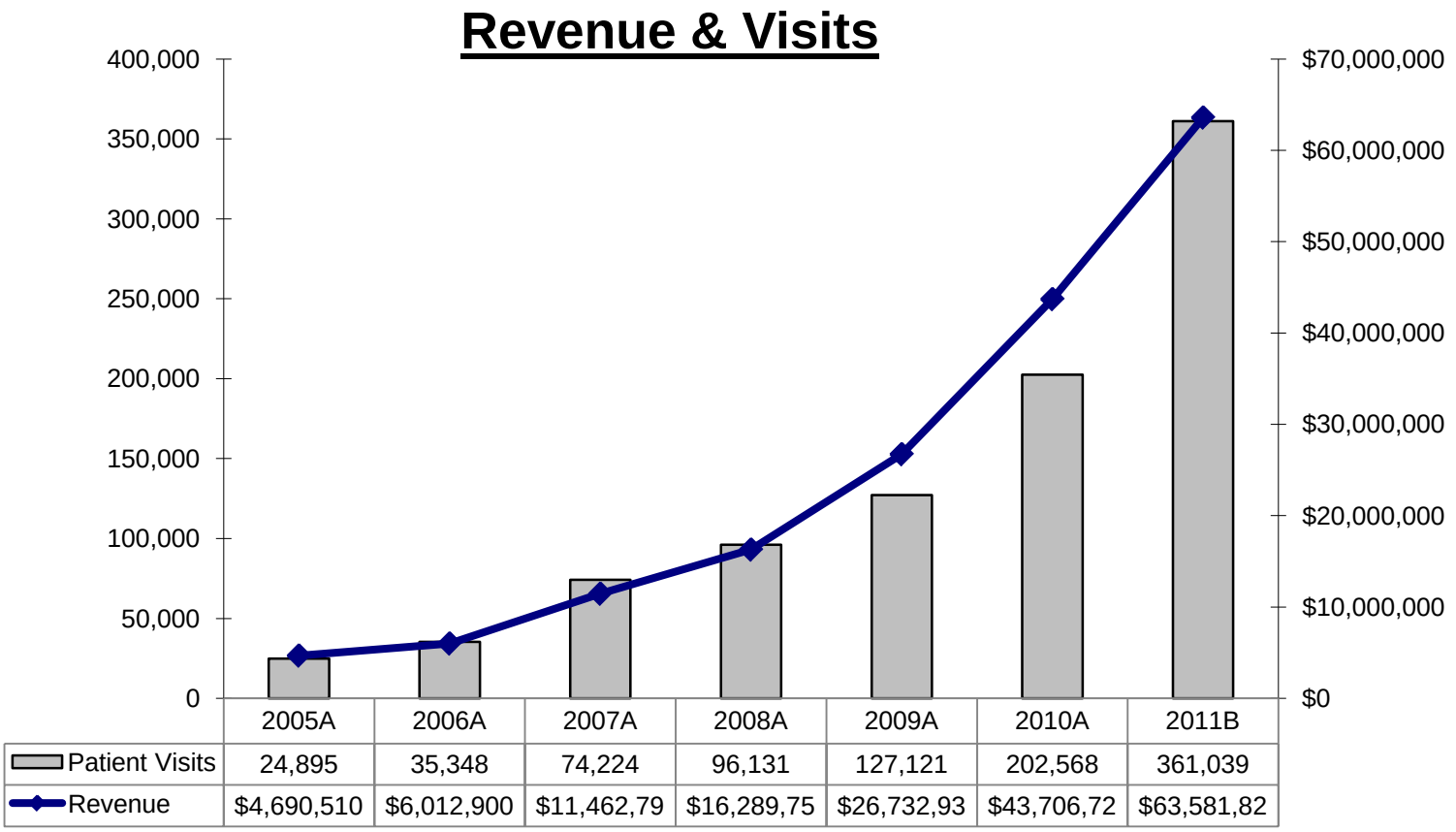
LSCC Growth



	2005A	2006A	2007A	2008A	2009A	2010A	2011B
Patient Visits	24,895	35,348	74,224	96,131	127,121	202,568	361,039
Revenue	$4,690,510	$6,012,900	$11,462,79	$16,289,75	$26,732,93	$43,706,72	$63,581,82

LSCC Model Elements

- View FQHC status as community asset
- Engage with existing systems to create “win/win” collaborations that increase access and address shared objectives
- Apply FQHC benefits as a “utility” allowing multiple health care players in a community to realize positive outcomes
- “Walk the Walk” on patient-centered health home and “new” ACO approach

Real Life Examples

- Seton/St. David's/Scott & White
- Solving for both organization's **issues/needs** in a collaboration
- Specialty Care for the uninsured
- Integrated Behavioral Health Services—a behaviorally enhanced healthcare home model
- Obstetrics Model, Labor & Delivery
- ER Alternative
- Patient-Centered Health Home/ACO Development

Challenging the Current System

- Existing operating models and traditional training/certification attainment **NOT** currently designed for the emerging healthcare world

- No real agreement on key terms and concepts
  - Health Home
  - ACO
  - “Managed” HMO

Challenges & Solutions

- Training must begin to look at emerging and evolving process changes
- Leadership and senior managers must become involved participants and careful observers of emerging trends in reform
- Providers of healthcare must regain control over how they deliver services as patients are encouraged to take a more active role in seeking services in a competitive marketplace

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Challenges & Solutions (continued)

- Third party “intermediaries” must demonstrate real and incremental value in the delivery model or “get out of the way”
- The industry must not cede control of the developing reform environment to government or other influences
- The current system does not create a patient- or customer-centered dynamic
- Simply declaring the need for “patient-centeredness” will not solve the problem

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Outcomes as Success Measures

- Which ones matter?
- Who decides and how do you align economic incentives to achieve patient-centered outcome improvements?
- How do you improve efficacy of desired outcomes over time?
- How are we training the leaders of tomorrow to answer these questions?

New Skills for New Models

- Patient Navigation/Health Coaches vs. traditional support staff
- Care Continuum vs. “Pre/Post Acute Care”
- Maintaining Wellness vs. Treating Illness
- “Virtual ACO” vs. Closed Network
- HIT as an agent of change
- Proactive and involved administrators who provide the capital and structure required to achieve ACO/patient-centered goals

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The Future

- LSCC will grow past $100M and 700,000 patient visits by 2013 **without healthcare reform** (even more growth will take place if the PPACA survives)
- The most innovative FQHCs have already created “virtual” ACO health homes for their patients
- Preventative and Primary Care (i.e. wellness) could become the target of new and/or shifted investments
- We must agree to some definitions and conceptual framework for reform so we can start training the workforce of tomorrow

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TOMORROW IS HERE


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