



Central Valley Health Network

Medical Homes

If every American made use of primary care, the health care system would see \$67 billion in savings annually.¹ This reflects not only those who do not have access to primary care, but also those who rely extensively on costly specialists for most of their care, leading to inefficiencies in the system. More specifically, the expansion of medical homes can even more dramatically impact and facilitate effective use of health care, improve health outcomes, minimize health disparities, and lower overall costs of care.² Medical homes are patient-centered, regular, and continuous sources of care, coordinated by a team of medical professionals committed to quality improvement.³

While health insurance often facilitates access to care, it does not guarantee or equal access to a regular source of care or to a medical home.⁴ Additionally, the individuals who receive more primary or preventive care are in fact the same people who actually have a regular source of care regardless as to whether or not they have health insurance. But not surprisingly, those who have both, a medical home and health insurance fare best.⁵ Having a medical home is associated with better utilization and outcomes, including recognizing the need to seek care, receiving earlier and more accurate diagnoses, reduced emergency department use, fewer hospitalizations, lower overall costs, better prevention, fewer unmet needs, and higher patient satisfaction.⁶ Moreover, primary care characterized by enhanced accessibility, continuity, and interpersonal relationships with physicians is associated with better self-rated general and mental health, and is found to mitigate disparities related to income, race and ethnicity, and insurance inequalities.⁷ Low income, minority, and uninsured populations would especially benefit from the expansion of medical homes because their health is more likely to be compromised and they run the greatest risk of using costly hospital-based care for avoidable conditions.⁸

Clearly, medical homes play an important role in the balancing of health care cost, access, and quality. With growing numbers of uninsured and underinsured individuals, policymakers will want to pay close attention to where those individuals are able to turn for affordable, accessible primary health care, both now and after they gain coverage. One such viable solution are Community Health Centers also known as Federally Qualified Health Centers (FQHCs).

Community health centers are designed to overcome access, quality, and cost challenges in a health care marketplace that too often leaves the most vulnerable behind. Community health centers accomplish this by supporting the development and operation of local community health centers that:

- ✓ Remove barriers by being located in areas designated as medically underserved and where too few physicians and other health care sources locate,
- ✓ Serve all without regard to insurance coverage or ability to pay,
- ✓ Customize their services to meet the specific health care and cultural needs of their patients, and
- ✓ Offer services that make accessing health care easier, such as transportation, translation, case management, health and nutrition education, and home visits.

Community health center patients are predominately low income, uninsured or publicly insured, and members of racial or ethnic minorities. Nearly 40% of community health center patients are uninsured, but because they have access to care, they enjoy better health.⁹ Another 35% of community health center patients depend on Medicaid. Moreover, 71% of community health center patients have family incomes at or below 100% of poverty. Two-thirds of health center patients are members of racial or ethnic minorities. Central Valley Health Network's 530,000 patients are 77% at or below 100% of federal poverty level, 49% Medi-Cal, 35% uninsured, and 74% Latino.

Community health centers also go above and beyond the traditional role of preventive medicine, providing dental, behavioral health, pharmacy, and community outreach service. This longstanding mission of providing comprehensive health care under one roof, engagement in quality improvement initiatives, delivery of patient-centered care, and a “team approach” to care, have lead to improved screening rates and outcomes, as well as reduced health care disparities, for their patients.¹⁰ In fact, numerous independent experts have found community health centers’ quality of care is as good as or better than the quality of other primary care providers.¹¹

By serving as effective medical homes – indeed, health care homes – community health centers have the ability to create a much more efficient health care system.

About the Central Valley Health Network

Incorporated in 1998, the Central Valley Health Network (CVHN) is a consortium of 13 Federally Qualified Health Center corporations that provide comprehensive preventive primary care services and advocate on behalf of low-income and medically underserved families throughout the northern, Central Valley and Inland Empire areas of California. In most Central Valley communities, CVHN members are the only safety net provider.

CVHN has 116 sites in 20 counties that provide 2.1 million encounters to 530,000 patients annually of whom 77% are at or below 100% of federal poverty level, 49% Medi-Cal, 35% uninsured, 74% Latino, and 40% farmworkers. CVHN members provide services in urban disadvantaged areas and rural and remote areas throughout California and are active at the local, state, and federal level advocacy for low-income families partnering with local and regional agencies to ensure low-income families have access to health care services.

CVHN’s mission is to facilitate community health centers’ strength in the marketplace and to support member community health centers’ effective delivery of high quality accessible health care to residents of their respective communities with special focus on advocacy for attaining optimal health for the medically underserved. CVHN staff support members through advocacy, technical assistance, program development and administration, and training. CVHN supports workforce and community development through the Oral Health and HealthCorps Programs, provides nutrition and physical activity education through the Nutrition Education Program, promotes food stamps through the Food Stamp Outreach Program, and administers several Quality Improvement and Health Information Exchange programs through training and technical assistance.

¹ Spann SJ. “Task Force 6: Report on Financing the New Model of Family Medicine.” December 2004 *Annals of Family Medicine* 2(2 Suppl 3):S1-21. doi: 10.1370/afm.237.

² Shi L, et al. “Income Inequality, Primary Care, and Health Indicators.” 1999 *Journal of Family Practice* 48(4):275-284. Parchman ML and Burge SK. “The Patient-Physician Relationship, Primary Care Attributes, and Preventive Services.” January 2004 *Family Medicine* 36(1): 22-27. Starfield B and Shi L. “The Medical Home, Access to Care, and Insurance: A Review of Evidence.” May 2004 *Pediatrics* 113(5): 1493-1498. Williams C. “From Coverage to Care: Exploring Links Between Health Insurance, a Usual Source of Care, and Access.” Policy Brief No. 1. Robert Wood Johnson Foundation, September 2002. http://www.rwjf.org/publications/synthesis/reports_and_briefs/pdf/no1_policybrief.pdf.

³ American Academy of Family Physicians Press Release, “Joint Principles of a Patient-Centered Medical Home Released by Organizations Representing More Than 300,000 Physicians.” March 5, 2007. <http://www.aafp.org/online/en/home/press/aafpnewsreleases/20070301releases/20070305pressrelease0.html>

⁴ Shi, et al, 1999. Starfield and Shi, 2004. Williams, 2002. Institute of Medicine (IOM). *Coverage Matters: Insurance and Health Care*. National Academy of Sciences Press, 2001.

⁵ Phillips RL, et al. “The Importance of Having Health Insurance and a Usual Source of Care.” Robert Graham Center One-Pager #29, September 2004. <http://www.graham-center.org/onepager29.xml>. See also DeVoe JE, 2003.

⁶ Starfield and Shi, 2004.

⁷ Shi L, et al. “Primary Care, Self-Rated Health, and Reductions in Social Disparities in Health.” Jun 2002 *Health Serv Res* 37(3):529-50. Shi L, et al, 2005; Beal AC, et al. “Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From The Commonwealth Fund 2006 Health Care Quality Survey.” The Commonwealth Fund, June 2007.

⁸ Politzer RM, et al. “The Future Role of Health Centers in Improving National Health.” 2003 *Journal of Public Health Policy* 24(3/4):296-306.

⁹ Politzer RM, et al. “Inequality in America: The Contribution of Health Centers in Reducing and Eliminating Disparities in Access to Care.” 2001 *Medical Care Research and Review* 58(2):234-248. Shi L. “The Role of Health Centers in Improving Health Care Access, Quality, and Outcome for the Nation’s Uninsured.” Testimony at Energy and Commerce Committee, Subcommittee on Oversight and Investigations Congressional Hearing, “A Review Of Community Health Centers: Issues And Opportunities.” Washington, DC. May 25, 2005. Based on Community Health Center User Survey, 2002, Preliminary Tables August 2004, and National Health Interview Survey, 2002.

¹⁰ Frick KD and Regan J. “Whether and Where Community Health Centers Users Obtain Screening Services.” November 2001 *Journal of Healthcare for the Poor and Underserved* 12(4): 429-45. Hicks LS, et al. “The Quality of Chronic Disease Care in U.S. Community Health Centers.” November/December 2006 *Health Affairs* 25(6):1713-1723. Chin MH, et al. “Quality of Diabetes Care in Community Health Centers.” March 2000 *American Journal of Public Health* 90(3): 431-4. Carlson, BL et al. “Primary Care Patients without Health Insurance by Community Health Centers.” April 2001 *Journal of Ambulatory Care Management* 24(2):47-59.

¹¹ Partridge L and Szlyk CI. *National Medicaid HEDIS database/ benchmark project, pilot-year experience and benchmark results*. American Public Human Services Association, 2000. Stuart ME, et al. “Improving Medicaid Pediatric Care.” 1995 *Journal of Public Health Management Practice* 1(2):31-8. Starfield B, et al. “Costs vs. Quality in Different Types of Primary Care Settings.” 1994 *Journal of the American Medical Association* 272(24):1903-1908.