Expanded Community Health Center – Academic Medical Center Partnerships

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The nation has taken the first step on the difficult journey to health care reform via enactment of the Patient Protection and Affordable Care Act (ACA) of 2010. Skepticism regarding the achievement of affordable care has fueled concern regarding the impact of this legislation on national health care costs. Additional concerns relate to its focus on improving access to medical care with few incentives to improve health outcomes in the population.

We propose expansion of partnerships between community health centers (CHCs) and academic medical centers (AMCs). This could lead to more affordable care and better outcomes for many of the estimated 32 million people who will acquire health insurance or Medicaid eligibility as of 2014 and are likely to be cared for by CHCs. The model we propose—the Community Health and Academic Medical Centers Partnership (CHAMP)—would build upon a long history of collaboration between CHCs and AMCs,[1] as documented in a recently conducted survey.[2]

A major expansion of these collaborative relationships is now possible. Enactment of the ACA, with its support for primary care and teaching health centers (THCs), holds great potential for CHAMPS to have substantial impact in facilitating the further development of CHCs as a key component of a reformed health care delivery system that emphasizes cost control and improved outcomes.

Federally qualified CHCs are a nationwide system of non-profit health care clinics. Their characteristics and growing importance recently have been described in detail.[3,4] Future ACA funding will enable CHCs to serve nearly 20 million new patients by 2015, while adding an estimated 15,000 new providers[4]. This expansion, however, may be severely curtailed by the current difficulty in recruiting primary care physicians.[3]

We describe herein how the THC provides the foundation for the CHAMP, by serving as the community academic home for AMC primary care faculty who perform patient care, teaching, and health services research. The ACA provides funding for both CHC primary care residents and for these faculty who could pursue innovations in 4 critical areas:

- health professional training and outreach education
- cost containment
- health services research
- health promotion and disease prevention

Health Professional Training and Outreach Education

Essential to the CHAMP is a link between primary care graduate medical education and care for patients in CHCs. This can be achieved by CHAMPs through development of THCs in CHCs that are committed to establishing a patient-centered medical home practice environment and electronic medical records, as recently described.[5] Family medicine, primary care general internal medicine, and pediatric residents would receive their final year of training in these settings and subsequently have the incentive of National Health Services Corps debt repayment to practice in CHCs. Primary care residents trained in this setting would immediately increase the clinical capacity of these CHCs and ultimately expand the primary care work force for all CHCs. Once established, the CHAMP setting would be excellent for training medical, dental, and allied health students.

CHAMP faculty would conduct continuing medical education directed toward all CHC physicians in the region. This would include encouraging these physicians to use objective evidence, comparative effectiveness, and outcomes data as the basis for medical decision making. Academic detailing, which would provide evidence-based prescribing information from faculty as opposed to the pharmaceutical industry, would be an additional important program.[6] These outreach activities could be carried out by personal contact with CHAMP faculty, as well as via electronic and published communication.

Cost Containment

Programs leading to cost containment that could be pursued effectively by CHAMPs include the following:

- The previously described initiative in Graduate Medical Education, which would provide rapid cost-effective expansion in the number of patients served by THCs due to its physician multiplier effect, and ultimately facilitate expansion of all CHCs by increasing their number of primary care physicians.
- The CHAMP Medicaid ACO.[7] This novel health care delivery model for Medicaid would combine the subspecialist expertise, medical technology, and inpatient

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care of local academic medical centers with the primary care expertise of CHCs. It would use an emerging group of CHCs known as Teaching Health Centers (THCs) to create a distinctive form of Accountable Care Organization (ACO). By combining the best elements of AMCs and CHCs, these CHAMP ACOs could deliver high-quality, cost-effective care to low-income Americans. Eleven potential sources of savings that could be produced by this model have been described recently.[7]

- Development and implementation of electronic consultation and physician point-of-care decision support tools for CHC physicians. This would enhance their cost-effectiveness by decreasing dependence on costly subspecialty consultations. Electronic communication with AMC subspecialists prior to actual referral would help provide the coordination of primary and specialty care services necessary for improvement of outcomes.
- Outreach educational activities involving academic detailing and dissemination of comparative effectiveness research findings.

Community Health Services Research

Creating a CHAMP would establish "academic centers" in the community, which could provide the setting to launch community-based research that could determine and tackle the existent roadblocks to high-quality care. CHAMPs could develop and validate strategies that would allow all CHCs to better organize, manage, finance, and deliver high-quality care, reduce medical errors, and improve medication adherence and patient safety.

AMC faculty in CHCs, in addition to their teaching role, could partner with other health care providers in the CHCs and with community organizations to develop research studies that are understood and welcomed by community members. The CHC faculty also could collaborate with appropriate faculty at their home institutions, thereby expanding the range of investigations possible, with support from NIH clinical translational sciences award grants (eg, type 2 community collaborative or community health sciences grants).

Health Promotion and Disease Prevention

The current health insurance system in the United States rewards providers for delivering more care, with few rewards for preventive care. In contrast, CHCs have a longstanding track record of high quality preventive services. The proposed CHAMPs would build upon this tradition by encouraging evidence-based clinical preventive services for all CHC patients. CHAMPs could build integrated health information systems that would assure high levels of preventive service.

CHAMPs could also provide health care providers with more opportunities to participate as an active member of the new "public health system" envisioned in a recent Institute of Medicine report.[8] This new system goes beyond the traditional focus on governmental public health departments to include health care organizations and academia, as well as employers, the media, and community organizations. The establishment of CHAMPs would take 1 small step and begin to translate this theoretical public health system into reality by providing a setting to engage other community organizations in population health improvement efforts that extend beyond the borders of the clinic and into the community.

Discussion

CHCs currently provide extremely cost-effective care with predicted CHC generated savings of $316 billion over the next decade. Those CHCs participating in CHAMPs would greatly increase their clinical capacity (and thereby their capacity to generate savings) through the addition of third year primary care residents. The ultimate resulting increase in CHC primary care physicians would provide expanded access in all CHCs—key to the transformation necessary to promote affordable health care. The innovations we propose herein require rigorous study via well-designed pilot programs in order to validate their efficacy.

Feasibility of CHAMP development has been facilitated by several ACA provisions. Included are substantial authorizations for CHC construction and programmatic support, resident and faculty funding via support for THCs and section 747 of Title VII, and physician debt repayment that will facilitate resident and faculty recruitment.[4] Additionally, pilot programs of the new Center for Medicaid and Medicare Innovation are a potential source of support for research.[9]

Many of our 131 AMCs are in a position to pursue this type of partnership with CHCs. Establishing CHAMPs would increase the proportion of physicians practicing in health professions shortage areas—1 of the measures used to rank the "social mission" of ranking US medical schools.[10] This collaborative achievement of more affordable care and better health outcomes would greatly facilitate the challenging journey to healthcare reform.

References

1. Morris CG, Johnson B, Kim S, Chen F. Training family physicians in community health centers: a health workforce solution. *Fam Med* 2008;40: 271-276.

2. Brutger R. Academic health centers and community health centers: the landscape of current partnerships. Washington: association of academic Health Centers, 2010.

3. Iglehart JH. Health centers fill critical gap, enjoy support. *Health Affairs.* 2010;29(3):343-345.

4. Adashi EY, Geiger HJ, Fine MD. Health care reform and primary care – the growing importance of the community health center. *N Engl J Med.* 2010;262(22):2047-2051.

5. Rieselbach RE, Crouse BJ, Frohna JG. Teaching primary care in community health centers: addressing the workforce crisis for the underserved. *Ann Intern Med.* 2010;152:118-122.

6. Avorn J, Soumerai SB. Improving drug-therapy decisions through educational outreach. a randomized controlled trial of academically based "detailing". *N Eng J Med.* 1983;208(24):1457-1463.

7. Rieselbach RE, Kellermann AL. A model health care delivery system for Medicaid. *N Eng J Med.* NEJM.org. Accessed June 2, 2011

8. Institute of Medicine. The Future of the Public's Health in the 21st Century. 2002.

9. Mechanic R, Altman S. Medicare's opportunity to encourage innovation in health care delivery. *N Eng J Med* 2010;362;9:772-774.

10. Mullan F, Chen C, Petterson S, Kolsky G, Spagnola M. The social mission of medical education: ranking the schools. *Annals of Intern Med* 2010; 152:804-811.

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