Leveraging FQHC status across the community

Workforce Considerations in Evolving Times

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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
LSCC Growth

Revenue & Visits

<table>
<thead>
<tr>
<th>Year</th>
<th>Patient Visits</th>
<th>Revenue</th>
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</thead>
<tbody>
<tr>
<td>2005A</td>
<td>24,895</td>
<td>$4,690,510</td>
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<td>2006A</td>
<td>35,348</td>
<td>$6,012,900</td>
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<td>2007A</td>
<td>74,224</td>
<td>$11,462,79</td>
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<td>2008A</td>
<td>96,131</td>
<td>$16,289,75</td>
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<td>2009A</td>
<td>127,121</td>
<td>$26,732,93</td>
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<td>2010A</td>
<td>202,568</td>
<td>$43,706,72</td>
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<td>2011B</td>
<td>361,039</td>
<td>$63,581,82</td>
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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
• 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
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
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
TOMORROW IS HERE