



Save Our ERs

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Revisioning the Delivery of Health Care Services to Uninsured Patients in Harris County

Executive Summary

Introduction

In recent years, Harris County's emergency care system has become increasingly overburdened by growing emergency department (ED) volume, particularly among uninsured and Medicaid nonemergent patients to whom EDs are substitutes for more appropriate, yet frequently unavailable, community-based primary care. Since 2001, conditions reportedly have worsened to the point that a study commissioned by the "Save Our ERs" coalition (the Coalition) concluded that the already overburdened emergency system is likely to continue to decay to the point of collapse without corrective action in the near term.¹ This conclusion, together with projected high future population growth among populations historically unable to access appropriate care, has helped create consensus among Harris County's health care and business communities that a substantive restructuring of health care services is needed to reduce inappropriate ED use and fragmentation of care.

With this backdrop, The Lewin Group, Inc. (Lewin) was commissioned by the Coalition to assist them in creating a framework for revisioning the organization and delivery of health care services in Harris County by developing and examining three conceptually distinct and credible options for reconfiguring care to safety net populations in Harris County, arrayed by degree of system reorganization and resources required.

¹ Houston Trauma Economic Assessment and System Survey, Bishop+ Associates, prepared for Save our ERs, 2002.

Study Approach

Our approach to support development of three system reconfiguration options has been organized around an assessment of several key study questions:

- What are the magnitude and drivers of ED overcrowding in Harris County and what are the implications of continuing the status quo?
- What approaches for reducing inappropriate ED use, building capacity and better coordinating care have been successfully implemented in other communities? What are the potential benefits and challenges of these models for Harris County?
- What are the objectives, major components and expected outcomes of three alternative options for reducing inappropriate ED use and improving access to care for the uninsured in Harris County?

To address these complex questions and to provide the information needed to develop credible options to guide Harris County decision-makers, we employed a multi-tiered approach. Our study methodology integrated quantitative (survey and secondary data sources), qualitative (telephone interviews) and observational (on-site key informant interviews) methods to collect, analyze and synthesize available primary and secondary data. These activities were complemented and informed by an environmental assessment. Its purpose was to identify communities that have experienced success reorganizing care to the uninsured and other at-risk populations and profiling particularly promising practices that may inform revisioning of health care in Harris County.

The remainder of this executive summary highlights our findings regarding the questions outlined above and the key features of three distinct and progressively more comprehensive options to reduce inappropriate ED use and improve access to care for safety net populations in Harris County. Readers are referred to our final report for a more detailed examination of these issues.

Drivers of Inappropriate ED Use in Harris County

We derived a number of important conclusions from our analysis of the magnitude of inappropriate ED use, its root causes and the future implications for Harris County. These are summarized below, followed by data analysis highlights and conclusions.

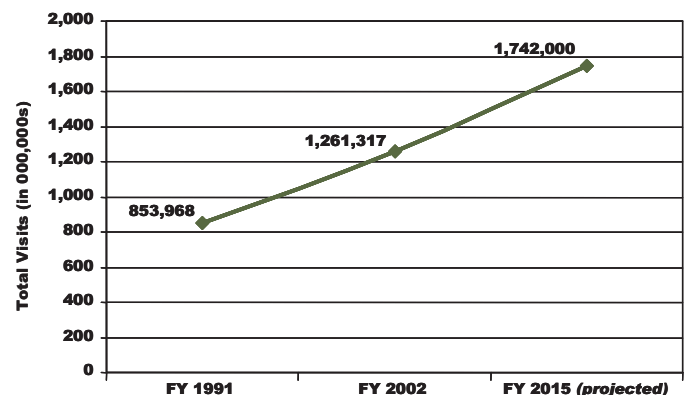
Key Findings

- ED use in Harris County is growing rapidly. As a result, absent intervention, ED overcrowding will remain a growing problem.
- Over half of current uninsured and Medicaid ED visits are inappropriate, but adequate community-based primary care and other capacity are unavailable.
- The main drivers of projected future growth in inappropriate ED use include:
 - Future population growth and demographic shifts.
 - Inadequate ambulatory care capacity to absorb nonemergent ED use.
 - Gaps in coordination of nonemergent care.
 - Small employer health care coverage trends.
 - Inadequate physician reimbursement for treating uninsured and other safety net populations.
- Effective strategies to reduce inappropriate ED use in Harris County must focus on better balancing the public and private health care delivery systems through new capacity and improved coordination of care.

Summary of Projected Trends in Harris County ED Use

We examined current and projected trends in both total and inappropriate ED use in Harris County. Based upon this assessment, we concluded that, if current trends continue and no action is taken, total visits to Harris County emergency departments will increase by about 38 percent between 2002 and 2015, after growing 48 percent between 1991 and 2002.

**Figure 1:
Trends in Total Harris County ED Visits
1991 - 2015**



Source: AHA and the Draft HCHD Strategic Plan

As summarized in **Figure 2**, in a 2002 analysis of emergency department use in five major Houston safety net hospitals, researchers found that over half of all ED visits were inappropriate. They also found that ED use by uninsured and Medicaid recipients, the major safety net populations, accounted for about half of all inappropriate use. In the absence of meaningful system change, inappropriate ED use among Harris County's safety net populations likely will parallel growth in total ED use, increasing from an estimated 355,000 visits in 2002 to almost 491,000 by 2015.

Figure 2:
Estimate of Countywide Inappropriate Uninsured and Medicaid Emergency Department Visits, FY 2002 Compared to FY 2015 Estimate (assuming no system change)

	FY 2002	FY 2015 (projected)
Total Countywide ED Visits	1,261,317	1,742,000
Percent of Inappropriate ED Visits	54.5%	54.5%
Estimated Number of Inappropriate ED Visits	687,418	949,390
Uninsured and Medicaid Share of Inappropriate ED Visits	51.7%	51.7%
Uninsured/Medicaid Inappropriate ED Visits	355,395	490,835

Notes:
 1 Total county-wide ED visits from AHA 2002 Annual Hospital Survey.
 2 Percent of inappropriate ED visits from the, "Houston Safety Net Hospitals Emergency Department Use Study," Final Report.
 3 Uninsured/Medicaid share of inappropriate ED visits from 17 hospitals responding to the Save Our ERs data request, representing 68% of county-wide ED use.
 4 Source for FY 2015 estimated ED visits: HCHD strategic plan.

Major Drivers of Projected Growth in Harris County Inappropriate ED Use

No single factor accounts for the high level of inappropriate ED use in Harris County. Instead, ED

overcrowding is a symptom of a larger set of complex and overlapping environmental factors, including:

- Population growth and demographic trends.
- Small employer health care coverage trends.
- Lack of appropriate ambulatory care capacity.
- Inadequate physician and clinic reimbursement for treating uninsured and other safety net populations.

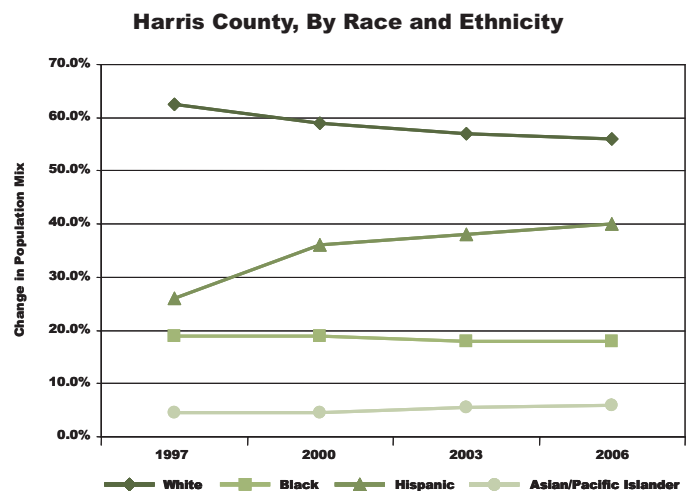
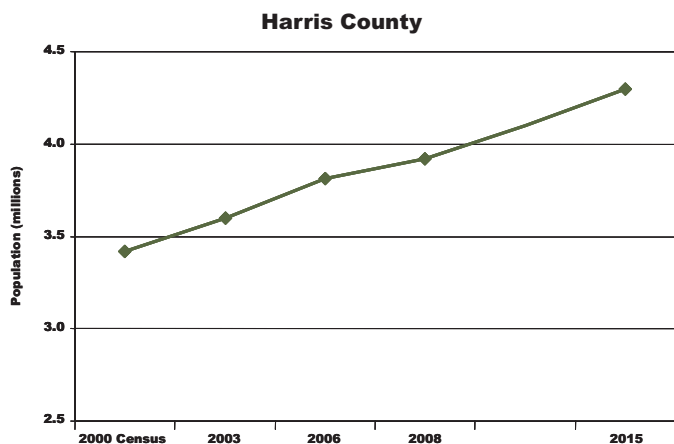
Population Growth and Demographic Trends

Harris County's population is projected to grow significantly in the coming decade, most notably among groups that historically have had difficulties accessing appropriate care. As depicted in **Figure 3**, the population of Harris County is expected to increase by about 26 percent between 2000 and 2015, with much of the near-term growth concentrated among Hispanic and Asian populations.

Small Employer Health Care Coverage Trends

Between 1990 and 2000, Harris County enjoyed employment growth averaging 2.1 percent annually.² The Houston-Galveston Area Council projects similar employment gains through 2025. Much of this growth is expected to be among small businesses, many of which historically have provided limited or no health care coverage for employees and their dependents. Continuation of these trends threatens to increase the number of uninsured and place additional pressure on Harris County's already strained emergency care system.

Figure 3:
Projected Population Growth Trends 2000 - 2015



² Houston-Galveston Area Council 2025 Regional Growth Forecast, May 2003.

Lack of Physician and Appropriate Ambulatory Care Capacity

When compared to national and state norms and several surrounding counties, Harris County currently has enough primary care physicians to meet population need. However, lack of adequate federal and state physician reimbursement presents a significant barrier to care for the uninsured and other local safety net populations.

The inability to access community-based physicians, due largely to financial barriers, further is compounded by a shortage of other appropriate primary care access points, such as hospital and community-based clinics and Federally Qualified Health Centers. As a result, it is estimated that primary care capacity currently available in these settings addresses only about half of the estimated demand for primary care among Harris County's uninsured safety net population.

Conclusions

Analysis of available primary and secondary data led to a number of conclusions regarding inappropriate ED use in Harris County. These include:

- ED overcrowding is a symptom of a larger set of systemic issues that historically have impaired access by the uninsured to more appropriate community-based care.
- Inappropriate ED use is significant and, absent effective intervention, will continue to grow, due in part to factors outside the health sector's control.
- Continuing the status quo is unacceptable, as projected trends will exacerbate current stresses on the local health care delivery system and further compromise the ability of many Harris County residents to access needed care on a timely basis.
- Strategies focused solely on redirecting inappropriate ED use likely are to fail, due to lack of adequate alternative capacity.
- Any adopted strategy must seek to better balance the health care system through building new capacity and improving coordination of care.

Approaches and Models of Care Implemented in Other Communities

Many of the problems that Harris County is experiencing are, in varying degrees, present in other

communities across the Nation. We conducted an environmental scan to identify innovative approaches tested in other communities to address system fragmentation and reduce inappropriate emergency department use that may be of interest to Harris County.

The environmental scan is divided into four sections, each highlighting promising practices tested in other communities, including models for:

- 1) Expanding health care coverage for the uninsured.
- 2) Building ambulatory care capacity.
- 3) Consolidation of public health services and improved service coordination.
- 4) Governance

Expanding Health Care Coverage for the Uninsured

One of the key reasons for emergency department overcrowding is lack of health insurance. The uninsured include both the working poor and the indigent.

Muskegon County, Michigan, has developed "Health Access," a program to help small employers provide affordable health insurance to their employees and their dependents. Specifically, employers and employees of small businesses each pay for 30 percent of the cost for a health insurance-like product, while the community picks up the other 40 percent using Disproportionate Share Hospital (DSH) funds. Employees receive a basic benefits package and have their care managed by a primary care physician located in Muskegon County. High-cost specialty care is covered by Medicaid by employing spend-down strategies.

Marion County, Indiana also has developed a health care product for residents unable to afford health insurance. "Wishard Advantage" was created to provide a medical home for the uninsured and better track and monitor quality care. Local taxes and redirected DSH funds are used to create a managed care-like program, free of charge for low income, uninsured county residents. Uninsured residents are enrolled and assigned to a primary care provider who coordinates their care. The program includes an urgent visit center to complement Wishard Hospital's Level I trauma center, a 24-hour call center that can redirect emergency calls to primary care providers and a focus on referring patients back from the specialist to the primary care provider of record.

An insurance-like product in Harris County, specifically one geared for the County's high proportion of small employers, could help alleviate stress on the EDs by funding access to more appropriate care.

Building Ambulatory Care Capacity in FQHC and FQHC Look-alike Settings

Many counties and cities around the Nation have achieved "Federally Qualified Health Center" (FQHC) status for their clinics. With this designation, clinics receive Section 330 grant funds, enhanced Medicare and Medicaid reimbursement, medical malpractice coverage and favorable drug pricing. In August 2001, the Bush administration launched the "New Access Point Initiative" to expand current FQHCs and to add new FQHCs around the US. The five-year program calls for \$1.2 billion to fund 1,200 new or expanded FQHCs. Of the 1,200 sites, 570 will be expansions of current FQHCs. Of the 630 remaining sites, 420 will be expansions of existing health centers, and 210 will be new-start community health centers. New sites will receive a maximum grant of \$650,000 per year, and expansion sites will receive a maximum grant of \$550,000.

Access Community Health Network is a large FQHC system serving residents living primarily on the South and West sides of Chicago. The Network operates 42 clinics under a single corporate structure. Federal funds for FQHCs are passed through the Network to those specific clinics. The Network itself enjoys some of the benefits of the FQHC status as well, including medical malpractice coverage. The Network has referral relationships with a number of hospitals, allowing patients access to specialty care.

The Health and Hospital Corporation (HHC) of Marion County currently is seeking FQHC look-alike status for each of its seven clinics. Unlike FQHC status, look-alike status is noncompetitive. However, it also has fewer benefits, as FQHC look-alikes are not eligible for Section 330 grant funding and malpractice coverage. The seven clinics affiliated with HHC currently are under review for FQHC look-alike status.

A network of FQHCs and FQHC look-alikes could become financially sustainable in several years and provide Harris County residents with easier access to appropriate health care.

Consolidation of Public Health Services and Improved Service Coordination

Many counties and cities have developed mechanisms to achieve economies of scale and better coordination of

service delivery through consolidation of public health and indigent health care and/or by creating referral networks between hospitals and community-based providers.

Marion County, Indiana consolidated public health and health care functions into a single authority, the Health and Hospital Corporation (HHC). In the late 1990s HHC's hospital division assumed authority to operate the seven clinics within HHC, thereby maximizing reimbursement and better integrating specialty care with the Hospital.

The Denver Health Authority (Denver Health) provides public health services and medical care to underserved populations in the City of Denver. Denver Health is an integrated, city-wide health system that includes a 349-bed acute care hospital, eight family health centers (all are FQHCs), 13 school-based clinics and four public health clinics. Denver Health also operates the majority of public health functions for the City of Denver, including an infectious disease clinic, communicable disease control and vital records.

In 1991, *Cook County, Illinois* established the Bureau of Health Services (CCBHS) to provide health, hospital, public health and health education services throughout Chicago and its suburbs. CCBHS operates over 30 community-based clinics and provides care to specific patient populations, including HIV/AIDS, chronic care and detainees in the correction system. CCBHS also includes the Department of Public Health, which provides traditional public health services in Cook County outside of Chicago.

Since 1985, Cook County also has maintained a referral system with nonaffiliated clinics. This network allows clinics in Cook County's Ambulatory & Community Health Network (approximately 30) and nonaffiliated clinics (approximately 60) to refer patients to Cook County Hospital for specialty care, as well as allowing Cook County's ED to redirect patients to clinics for more appropriate care. Clinics in the network use a Web-based referral system for their patients.

By establishing a countywide referral system, Harris County could create a better integrated system that could facilitate cost savings and improve access to care for safety net populations.

Governance

Specific models of governance have evolved to manage a number of the large entities providing both public health services and medical care for the uninsured.

Denver Health is governed by a nine-member board, appointed by the Mayor and confirmed by the City Council for a five-year term. The City of Denver contracts with Denver Health, per the city charter. As a result, the Mayor and City Council have no direct authority over Denver Health beyond board appointments. The Board has complete authority over Denver Health, while each of the eight FQHCs in the system has its own board, to remain compliant with Section 330 requirements. Two members of the Denver Health Board are also members of each FQHC board.

Marion County, Indiana’s Health and Hospital Corporation (HHC) is governed by a seven-member Board of Trustees, three appointed by the Mayor, two by the City-County Council and two by the Board of Commissioners. HHC’s annual budget must be approved by the County Council. However, modifications made by the Council can be appealed to the state. As a consolidated taxing authority, HHC must work with the State Board of Accounts, which must approve all tax levies made by HHC.

Cook County, Illinois’s Bureau of Health Services (CCBHS) is an executive agency of Cook County, under the President of the County. The Cook County Board of Commissioners acts as the governing board for the Bureau’s seven operating divisions, which are run by a Bureau Chief. The Bureau Chief is appointed by the President of the County, with the consent of the Board of Commissioners. The Chief Operating Officer of each of the seven operating divisions reports to the Bureau Chief.

Any large-scale changes to Harris County’s current governance system for public health care services likely would require state approval and support from local governing authorities.

Summary of Lessons Learned from the Experiences of Other Communities

After examining approaches and models of care implemented in other communities, several important common themes, or lessons learned, emerged that we believe are relevant for Harris County as it considers models to strengthen service delivery and coordination. These include:

- Strong and consistent leadership is essential for success.
- Consensus may be difficult to achieve but, it is important to keep stakeholders engaged in the process.

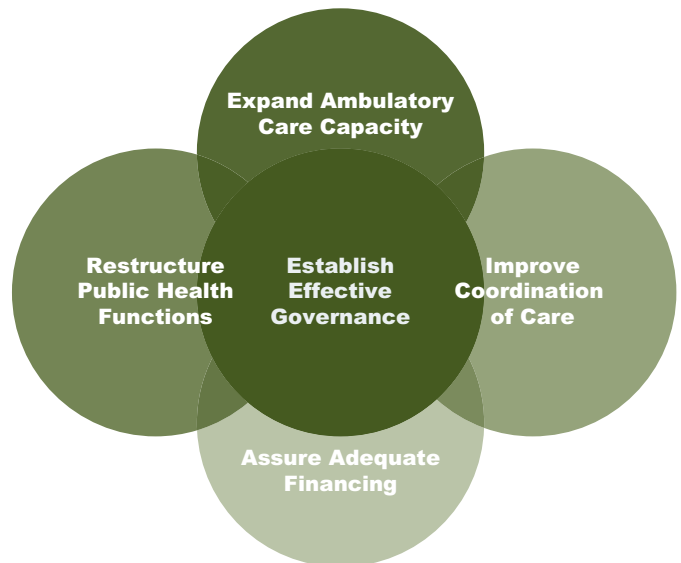
- It is important to anticipate and flexibly plan for future policy, economic and other environmental developments.
- Sound financial analysis and planning are critical to ensure the long-term financial viability of alternative models and to make the “business case” for investment.
- The need to establish transition planning, including leadership succession planning, as implementing meaningful changes takes time.

Strategic Options for Harris County

After assessing the extent of stresses on Harris County’s delivery system, stemming from lack of access to appropriate care for local safety net populations, and reviewing approaches adopted in other communities, we created a framework around which to develop and compare three actionable strategic options. The framework is grounded in our conclusion that the scope of the problem in Harris County calls for a multi-faceted and well coordinated approach. Each option below includes most or all of the following five critical elements:

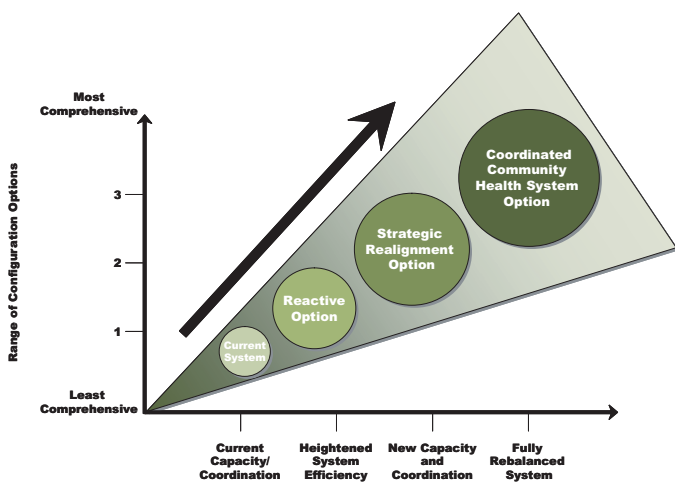
- 1) Expanding appropriate ambulatory care capacity.
- 2) Improving coordination of care.
- 3) Assuring adequate financing.
- 4) Restructuring public health functions.
- 5) Establishing effective governance.

**Figure 4:
Critical Elements to Strategic Options Framework**



In developing three conceptually distinct and realistic strategic options, two categories emerged: a minimalist or reactive option, which seeks to improve system efficiency while minimizing new funding commitments; and two more proactive responses, which seek to expand health system capacity through multiple access points and improve system efficiency and coordination. Figure 5 illustrates graphically our framework for reversioning the delivery of health care services in Harris County. The vertical axis portrays the potential scope of reconfiguration options, from least to most comprehensive, while the horizontal axis depicts in an additive fashion new capacity, coordination and funding that accompany each reversioning scenario.

**Figure 5:
Coordinated Community Health System**



Based upon our estimates of current need among local safety net populations, the following describes key features, requirements and projected outcomes of three options for reversioning organization and delivery of health care services in Harris County. These options are arrayed by the order of magnitude of system reorganization and resources required and are designed to be additive. That means the first proactive option builds upon the components of the less ambitious Reactive option, and the most far reaching second proactive option builds upon the components of both the two less ambitious alternatives. This approach acknowledges the complexity of change required and provides stakeholders the flexibility to move up or down the proposed continuum of change presented in Figure 5, based upon feasibility.

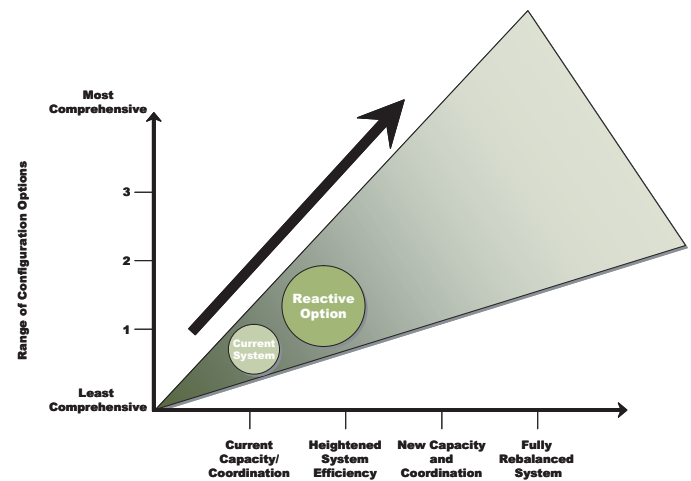
Option 1: A Reactive Option

Overview

Under this option, Harris County would seek to move incrementally and opportunistically toward its reversioning

goals. In the spirit of the assumptions underlying this scenario, county providers would minimize new investment and maximize reimbursement through the selective conversion of existing community-based ambulatory care capacity to better reimbursed FQHCs and FQHC look-alikes and modest expansion of urgent care centers. Little meaningful structural change in current health system organization, coordination across providers and governance would take place. Instead, the focus of this “small fix” approach would center around maximizing the efficiency of the current system.

**Figure 6:
Coordinated Community Health System:
A Reactive Option**



Summary of Option Components

The major components of this Reactive option include:

- Several new urgent care centers built by private hospitals near their EDs to redirect nonemergent care and reduce financial losses.
- Converting several existing community clinics to FQHCs or FQHC look-alikes to maximize reimbursement, but little investment in new capacity or referral linkages to other providers.
- Maximizing revenue and reducing inappropriate ED use through improved billing and collections, along the lines of HCHD’s “Everyone Pays” initiative.
- Maintaining independent city and county public health departments.
- No new organizing or governance structure to better coordinate efforts.

Summary Assessment

We examined the dimensions of such a system, including benefits and risks for Harris County, and compared its outcomes with the status quo. We concluded that, despite

some improved system efficiencies, this option will not infuse enough new capacity to meaningfully improve access to care for the uninsured and other safety net populations and will not build needed coordination linkages across provider sites and levels of care to reduce system fragmentation and inappropriate ED use.

Two Proactive Options

Proactive options seek to build a system with greater capacity and coordination that is maximally efficient and effective in both operation and outcome. The two proactive options we developed and examined are more ambitious in scope than the Reactive option, but differ in their degrees of boldness in reimagining health care in Harris County.

Both of these options present scenarios that minimize fragmentation across the continuum of ED, behavioral health, primary and tertiary ambulatory care and public health services. However, while both proactive options propose significant reorganization and expansion of services, they differ in scope with respect to factors, such as:

- Community orientation;
- Expansion of linkages between public and private not-for-profit health systems;
- Scale of commitment to investment in new ambulatory care access points;
- Possible consolidation of city and county public health departments; and
- Willingness to address governance issues by creating new coordinating entities that consolidate currently fragmented efforts.

We developed these proactive options and compared their expected outcomes with the status quo. Based upon these comparisons, we then recommended a preferred option for Harris County.

Option 2: Strategic Realignment

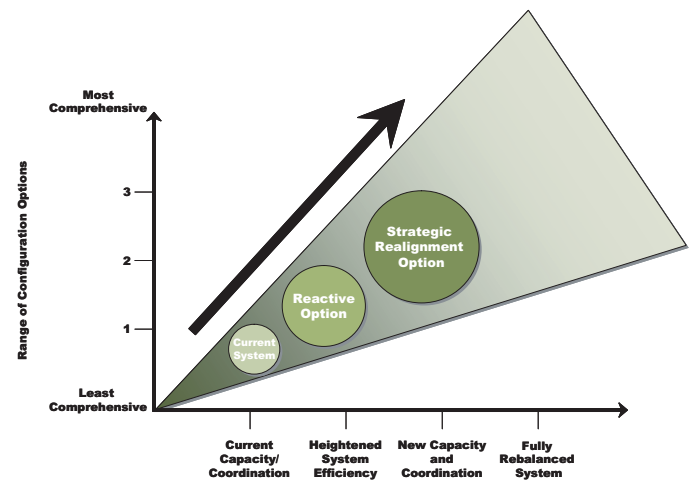
Overview

The Strategic Realignment option assumes that investment in new capacity and coordination is imperative to offer appropriate lower cost alternatives to nonemergent ED use and reduce system fragmentation. The proposed new capacity, scheduled to phase in by

2015, is diverse and balanced, featuring a variety of access points to care. It is grounded, however, on a pragmatic assumption that funding and commitment may not be available to support the full complement of new capacity needed to address current unmet need among safety net populations in Harris County.

In addition to building new capacity, this option calls for establishing a limited referral network for redirecting inappropriate ED visits to clinics, FQHCs, FQHC look-alikes and urgent and specialty care centers. It also calls for transferring selected patient care services from the city and county public health departments to the Harris County Hospital District (HCHD) and encouraging greater collaboration between the two public health bodies to achieve operating efficiencies.

**Figure 7:
Coordinated Community Health System:
Strategic Realignment**



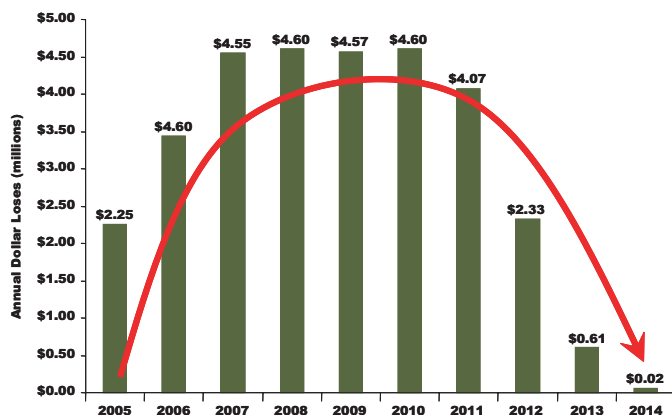
Summary of Option Components

The major components of the Strategic Realignment option include those in the Reactive option, plus:

- New ambulatory care access points, including:
 - A network of seven new FQHC and FQHC look-alikes sufficient to accommodate 175,000 visits annually, or about 25 percent of current estimated unmet need for primary care by the uninsured in Harris County.
 - New outpatient specialty clinics and urgent care centers to accommodate referrals from new ambulatory care access points and other community providers.

- The new FQHC/FQHC look-alike network will require support of annual operating deficits, including:
 - Financing of about \$31 million will be required to meet operating deficits projected to occur between 2005 and 2014 as new capacity is phased in.
 - Figure 8 depicts estimated annual operating losses during the multi-year phase-in of this new community-based capacity.

**Figure 8:
Estimated Annual Operating Losses
of Seven New FQHCs and FQHC Look-alikes
2005 - 2014**



- New initiatives for better coordinating care, including:
 - Establishing a limited referral network between hospitals and ambulatory care centers to refer nonemergent patients from EDs to appropriate ambulatory care sites and referring patients from those sites to hospitals for specialty and diagnostic services.
 - Expanding the county telephone nurse triage system and current community health education efforts.
- New governance, featuring a coordinating board to provide oversight and a unified planning structure for the FQHC and FQHC look-alike network. Board representation should reflect the diversity of Harris County and include community, government and private and public health care sector representation.
- Maintaining the current autonomy of city and county public health departments, but transferring selected women and children’s patient care services to HCHD.

Benefits of the Strategic Realignment Option:

- The pragmatic approach by this option of meeting a predefined scope of need limits the risk of implementation failure.
- This option adds meaningful capacity in a carefully phased-in manner that limits annual deficit funding requirements and financial risk.
- This option builds some coordination between hospitals and ambulatory care sites, improving coordination of care, reducing inappropriate ED use and enhancing access to specialty and diagnostic services for uninsured and indigent patients.
- This option lowers systemwide costs to the extent that nonemergent care can be appropriately redirected to lower cost alternatives.
- Transfer of selected patient care services to HCHD improves care coordination and facilitates “one stop shopping” for consumers.
- This option may prove an acceptable fallback if the implementation risks of the second, more ambitious proactive option described in the third option prove too daunting for Harris County.

Summary Assessment

After examining the dimensions of the Strategic Realignment option in the context of its likely effectiveness in addressing Harris County’s health care issues, we concluded that this approach clearly is superior to the Reactive option. In return for some investment, it partially rebalances the system by adding valuable primary care and other capacity, builds some system coordination infrastructure and creates a foundation for future expansion. However, we believe implementing this option will, at best, buy time, as significant unmet need and fragmentation of care will remain and likely grow, and ED overcrowding, although temporarily reduced, will follow suit.

Option 3: The Coordinated Community Health System (CCHS) Option

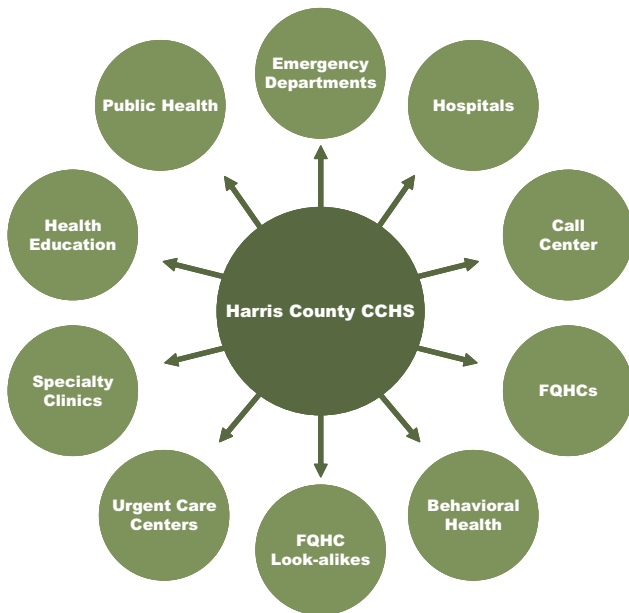
Overview

Efficient and effective health care requires a balanced and integrated system of services designed to move the patient rapidly to the most appropriate treatment setting. The framework of this second proactive option is designed to help put in place the infrastructure to help achieve this in Harris County. While it encompasses the elements of both the Reactive and Strategic Realignment

options, it is bolder and more far-reaching and is the strategy of choice. The cornerstone of such a system for meeting the needs of the uninsured and other safety net populations in Harris County is a strong, well coordinated ambulatory care network.

By 2015, CCHS calls for substantial investment in new capacity sufficient to bridge the gap between current demand for primary care by the uninsured and available public and private sector capacity. It also calls for significant improvements in systemwide coordination through a countywide patient referral network similar to Chicago’s, expanded and coordinated patient call center and community health education center capacity and consolidation of city and county public health functions. Achieving these goals also will call for the State to provide Harris County with greater flexibility to advocate for funding support at the federal level. To maintain the high degree of coordination and communication required for effective system functioning, a high level public-private governance structure is recommended.

**Figure 9:
The Coordinated Community Health System**



Summary of Option Components

The major components of the CCHS option include those described in both the Reactive and Realignment options, plus:

- *A countywide coordinated network of new ambulatory care access points, including:*
 - 5 new FQHCs and 9 FQHC look-alikes, each able to see 50,000 visits annually, to address unmet need for primary care by the uninsured.

- Additional outpatient specialty clinics and urgent care centers, as called for by the HCHD strategic plan, to accommodate referrals from new ambulatory care access points and other community providers.
- Additional school-based health services and education.
- *We believe a network of FQHCs and FQHC look-alikes should address demand for primary care in Harris County more effectively and with less financial risk than other clinic options for the following reasons:*
 - Financial sustainability. FQHCs and FQHC look-alikes are eligible for enhanced Medicare and Medicaid reimbursement and discounted drug pricing. FQHCs also may receive medical malpractice coverage and federal Section 330 grant funding up to \$650,000 annually.
 - Accessibility. These sites are required to provide directly, or by arrangement, a wide range of primary, preventive and behavioral health services for a minimum of 32 hours per week.
- *The new FQHC/FQHC look-alike network will require a substantial commitment to financing operating deficits during the network phase-in period.*
 - Total estimated operating losses of about \$158 million are projected between 2005 and 2017 as new capacity is phased in.
 - Figure 10 depicts estimated annual operating losses during the full phase-in of the 14 sites. We assume that FQHCs can become financially sustainable in three years and FQHC look-alikes in four.

**Figure 10:
Estimated Annual Operating Losses
14 New FQHCs/FQHC Look-alikes
2005-2017**



Option Benefits

Implementing CCHS offers Harris County residents many benefits, including:

- A governing body that maximizes system coordination and funding opportunities.
- A much better balanced network of health care providers and services.
- Significantly reduced inappropriate ED use.
- Greatly strengthened system coordination and linkages across levels of care.
- Improved public health efficiency and effectiveness.
- Expanded community access to appropriate care, emphasizing **lower cost** primary and preventive services.
- Better integration of behavioral health with community-based primary care.
- More appropriate and cost-efficient use of health care by consumers through expanded and coordinated health education and call center capacity.

Option Challenges

The relative boldness of this option carries with it a number of significant implementation challenges, such as:

- The need for significant investment in new capacity in the face of possible funding constraints, including:
 - Stiff nationwide competition for and limited availability of federal funding for future FQHC and FQHC look-alike expansion.
 - State cutbacks in Medicaid and CHIP eligibility.
 - Little likelihood that the Texas legislature will increase Medicaid outpatient and physician payment rates.

- The ability to maintain continuity of strong and committed leadership over time will be a critical success factor.
- Clinical staff recruitment for the expanded network may be challenging in the face of nationwide work force shortages.

Study Conclusion and Recommendation

On balance, CCHS appears to be the best strategic option for Harris County. While challenging to implement, we believe CCHS will, more than the other two options examined, reduce inappropriate ED use and fragmentation of care in the most efficient and effective manner, assuring optimal use of public and private financial resources, while proactively positioning Harris County for the future. By implementing this approach, Harris County also will assume a heightened health care leadership profile among municipalities nationwide and enhance its ability to attract new businesses to spur employment and continued regional economic growth.

This Executive Summary was prepared by The Lewin Group, Inc. for the Save Our ERs Coalition to assist in creating a framework for revisioning the organization and delivery of health care services in Harris County, Texas.



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