SEARCHING FOR SUSTAINABILITY: OUR COMMUNITY HEALTH CENTER JOURNEY

May 8, 2023

Jewish Family Service of Greater Dallas

An open door to all in need

Purpose

- Share JFS Dallas experience in our journey to open a primary care clinic

“Do not go where the path may lead, go instead where there is no path and leave a trail.”

-Ralph Waldo Emerson

Agenda

- Meet your presenters
- Introduction to JFS-Greater Dallas
- The Challenge: Groundhog Day
- The Solution: A Community Health Center
- The Journey
- Lessons learned along the way

Presenters

- Cathy Barker: President and Chief Executive Officer, JFS Greater Dallas
- Deizel Sarte: Chief Operations Officer, JFS Greater Dallas
- Greg Facktor: Managing Partner, Facktor Health
- Darrell Gardner: Partner, Facktor Health

Introduction to JFS

- *Tag Line*: **"An open door to all in need"**
- *Vision Statement*: **"Self-sufficiency and well-being for all"**
- *Mission Statement*: **"To provide effective and accessible whole-person care that promotes lifelong self-sufficiency and well-being for the Greater Dallas community"**

Guided by our core Jewish values, JFS is

WELCOMING

We are a **welcoming** community that fosters inclusivity and belonging.

RESPONSIVE

We **respond** with integrity to unexpected challenges when they arise.

COMPASSIONATE

We provide each client with **compassionate** care by respecting and addressing their individual needs.

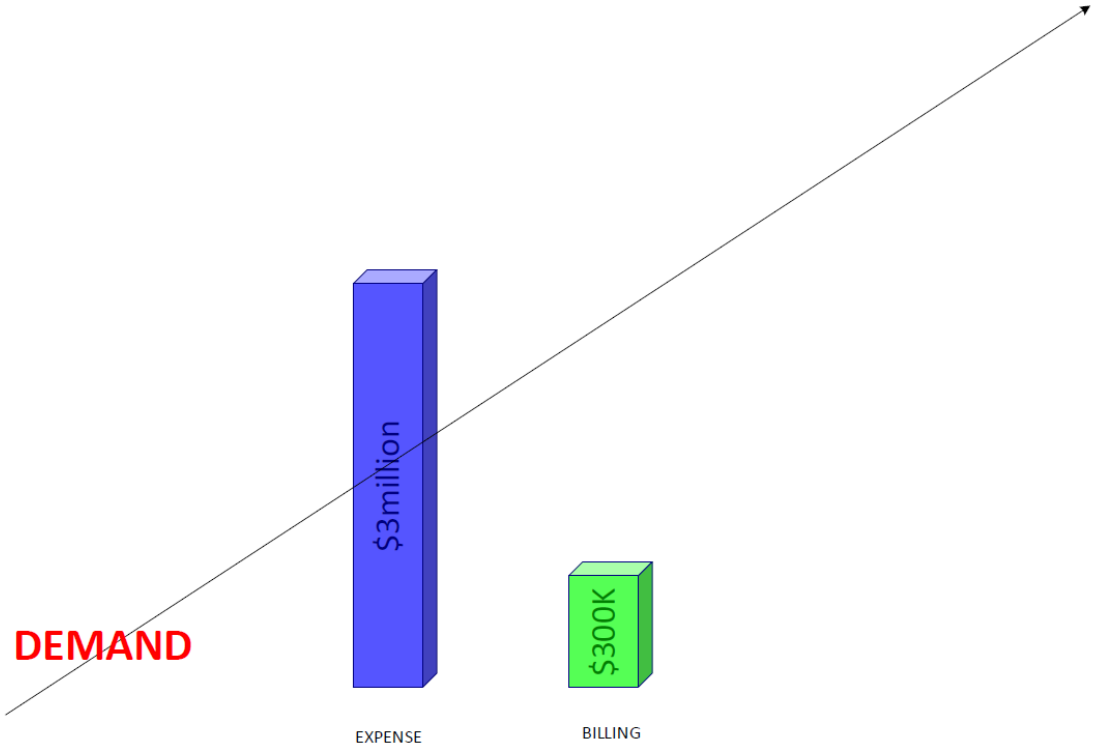
DEDICATED

We are a team of **dedicated** professionals who provide the highest standard of excellence in service.

Services

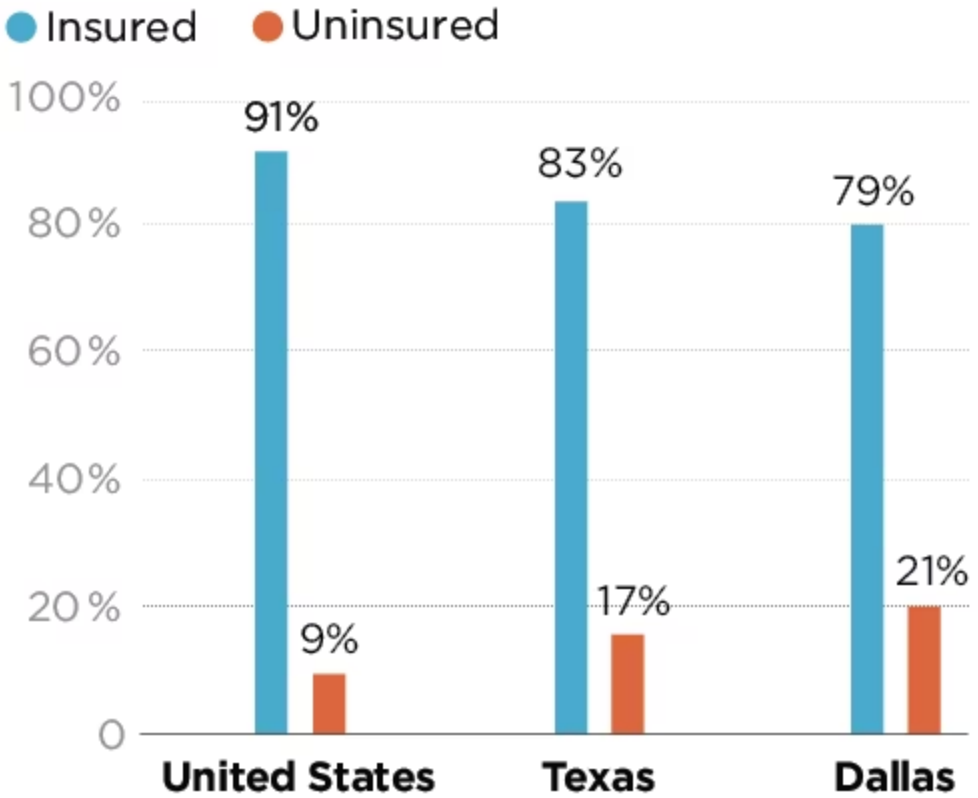
- Behavioral Health Counseling
- Emergency Financial Assistance
- Hunger Relief
- Case Management
- Career and Financial Coaching
- PLAN Clubhouse and Peer Support

The Challenge



- Increased demand in behavioral health counseling services
- Inadequate billing revenue
- Grant funding not a sustainable solution
- Competitive labor market

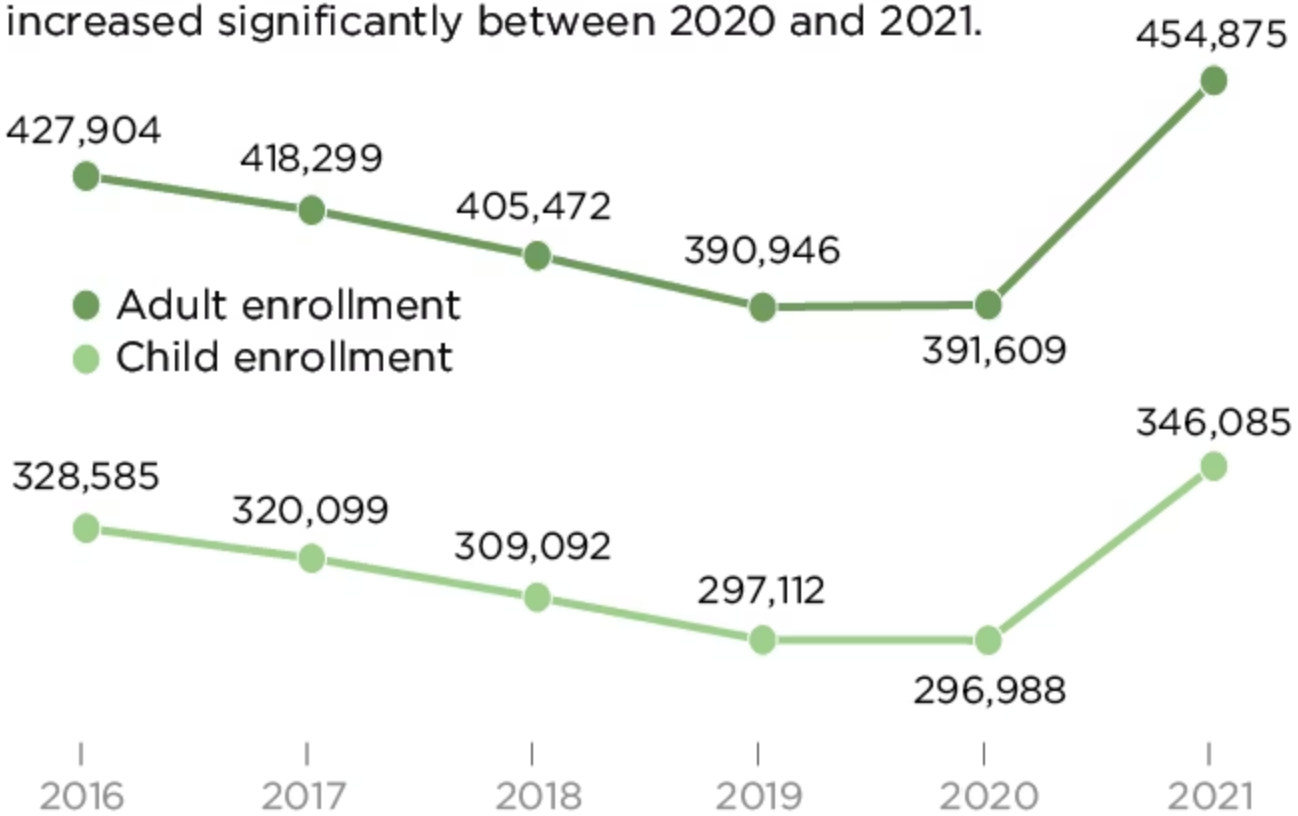
Health insurance coverage in Dallas County



SOURCE: U.S. Census Bureau, 2016-2020 American Community Survey

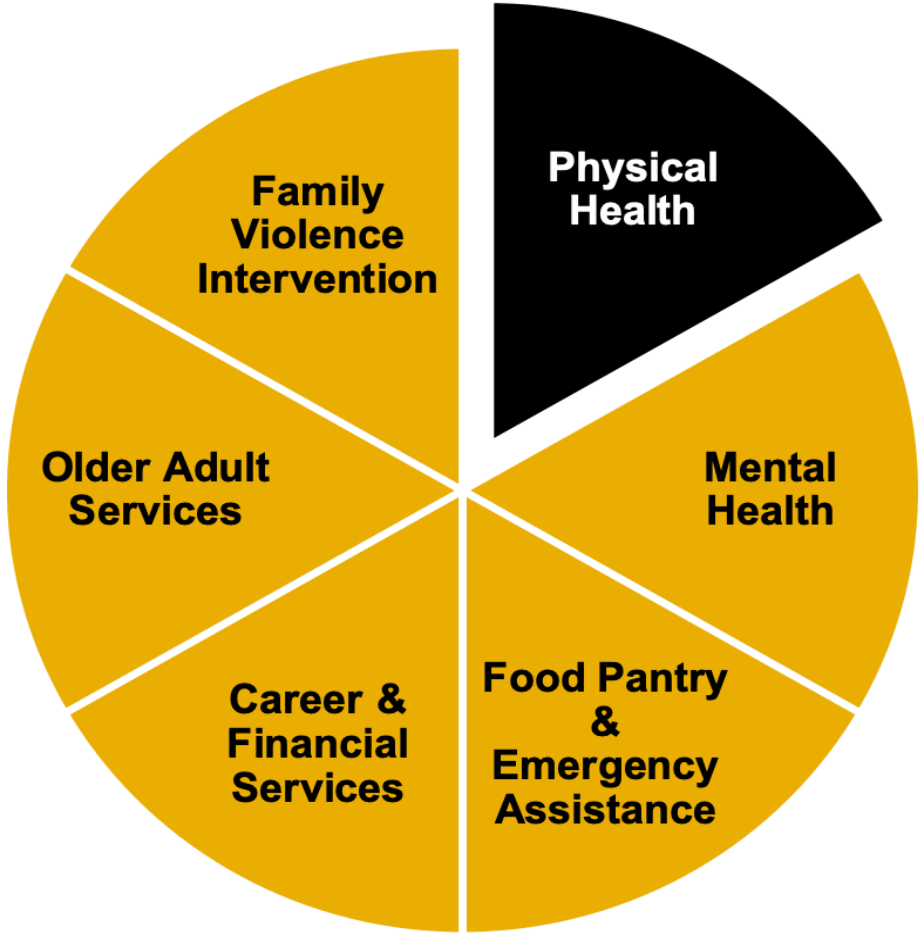
Dallas County Medicaid enrollment

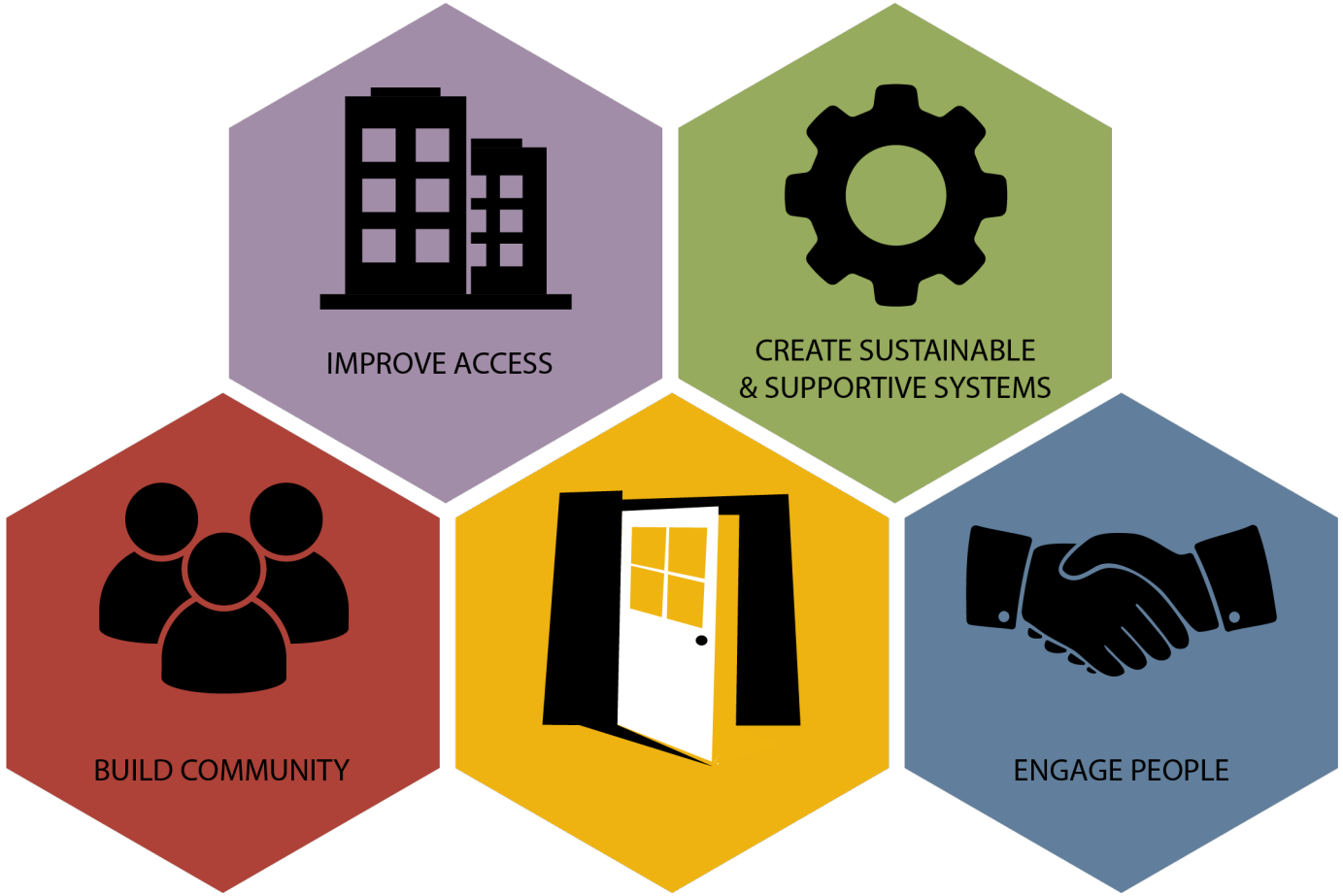
The number of Medicaid enrollees in Dallas County increased significantly between 2020 and 2021.



SOURCE: Texas Health and Human Services health care statistics

Our Vision: Whole-Person Care





Jewish Family Service of Greater Dallas
Strategic Plan 2023-2025

Jewish Family Service
of Greater Dallas

Our Vision for a Healthier Community

DEIZEL SARTE

Chief Operations Officer

Integrated Primary and Behavioral Care

- Best practice approach
  - Improved mental health
  - Increased adherence to treatment
  - Improved quality of life
  - Increased patient engagement
  - Increased patient satisfaction
  - Increased provider satisfaction
  - Reduction in healthcare costs

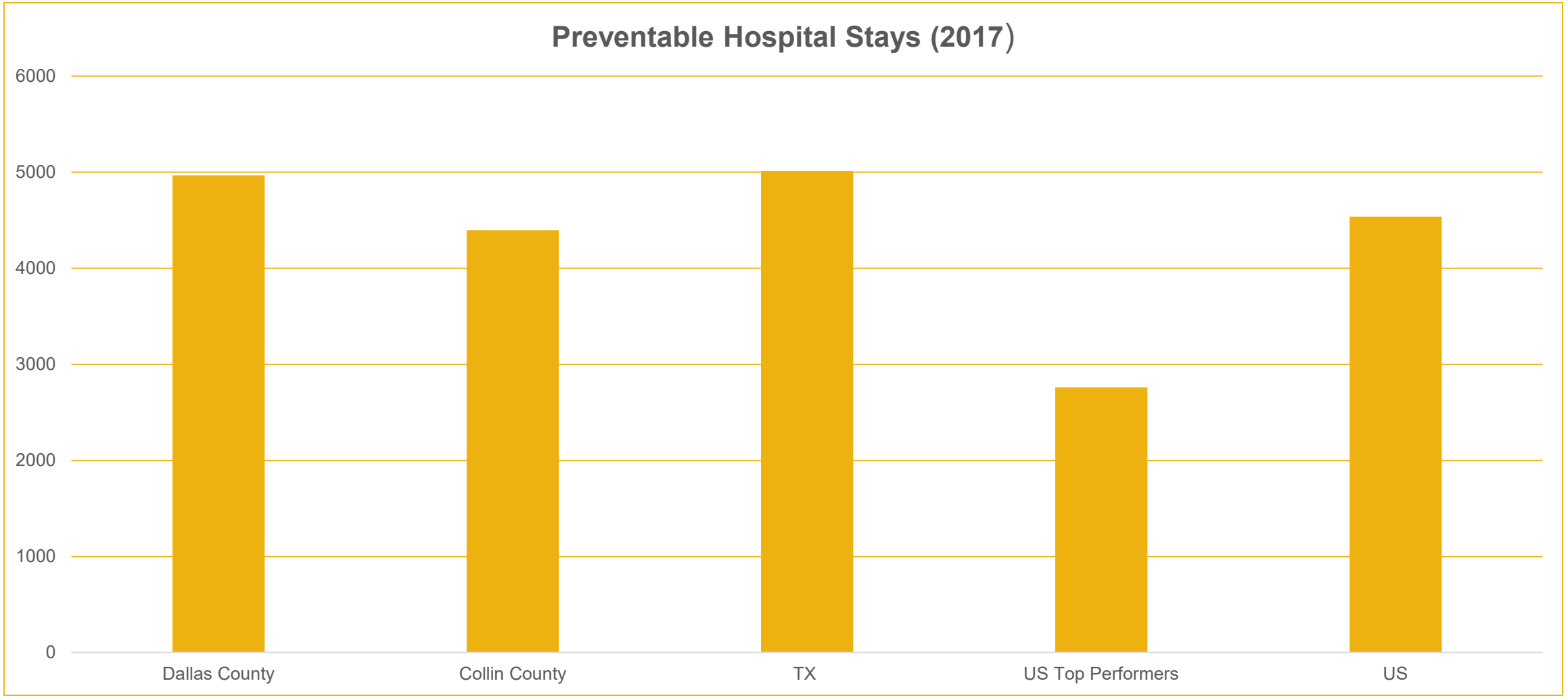
Community Health Needs Assessment

Measures	Dallas County	TX	US Top Performers	US
Primary Care Providers	1:1440	1:1640	1:1030	1:1330
Dentist	1:1200	1:1730	1:1240	1:1450
MH Providers	1:680	1:880	1:290	1:400

Community Health Needs Assessment

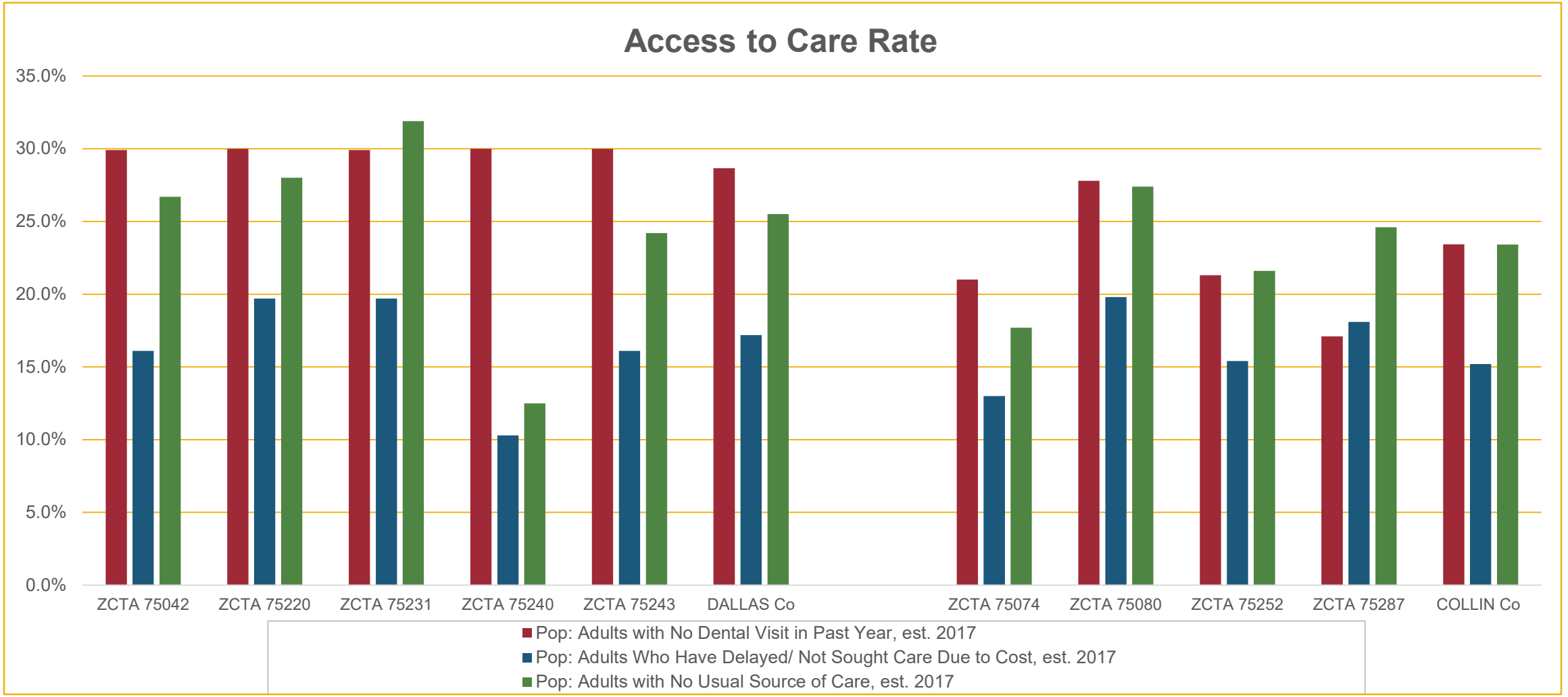
Demographic and Socioeconomic Comparison (2014-2018 census.gov data unless otherwise noted)				
Geography		US	Texas	Dallas Co
Population	Population est. - (July 2019)	328,239,523	28,992,881	2,635,516
Income / Poverty	Population living below Poverty	11.8%	14.9%	14.2%
	Median HH Income	$60,293	$59,570	$56,854
	Per Capita Income	$32,621	$30,143	$31,219
Economy	Population in the Civilian Labor Force	62.9%	64.2%	68.7%
	Unemployment Rate (2019 US Labor Bureau & TWC)	3.7%	3.4%	3.2%

Community Health Needs Assessment



(countyhealthrankings.com)

Community Health Needs Assessment



JFS Client Survey Results

- **30%** of clients reported that they are currently without health insurance.
- Of those who do have health insurance, **16%** have Medicare.
- Reasons for No Health Insurance:
  - Cannot Afford Insurance
  - High Cost of Insurance
  - Unemployment
- **88%** of clients reported they would be very likely or somewhat likely to use medical services at Jewish Family Health Service.

The Connection

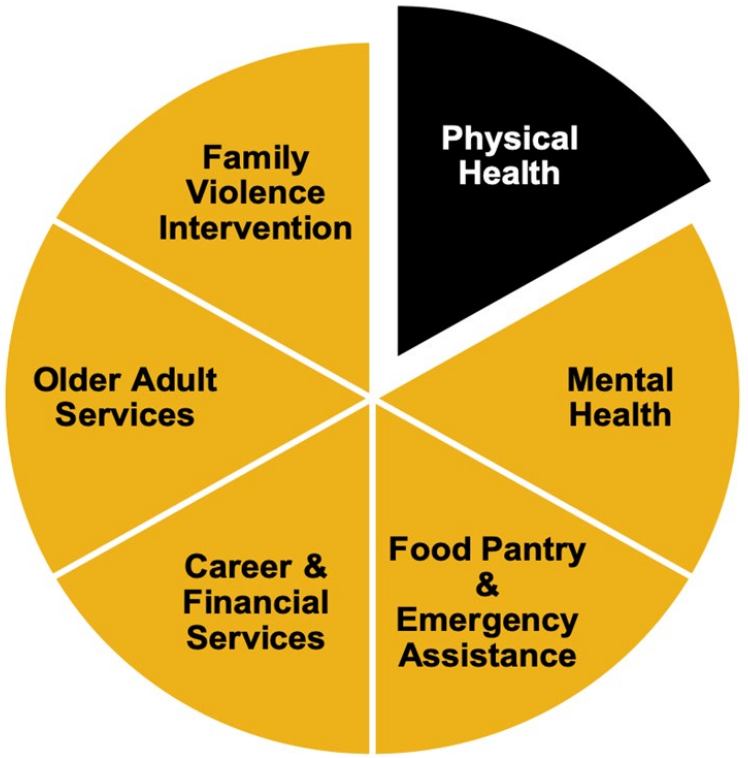
Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education		Stress	
Support	Walkability				
	Zip code / geography				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

KFF
HENRY J KAISER FAMILY FOUNDATION

JFS Services



Facktor

GREG FACKTOR – MANAGING PARTNER
DARRELL GARDNER - PARTNER

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An Introduction to Federally Qualified Health Centers

community health centers

Community Health Center Movement

- Civil rights
- Social justice
- Health equity
- Anti-racism
- Economic opportunity

What is an FQHC Community Health Center?

- **Vision:** Health Equity for All Americans
  - 100% Access
  - 0 Health Disparities
- **Mission:** Improve the health and wellbeing of underserved and often marginalized communities by providing high quality, coordinated and comprehensive primary care including medical, dental, and behavioral health services
- **Governance:** Community-based nonprofit governed by the people who are served

Types of Community Health Centers

Federally Qualified Health Centers (FQHC)

Receive federal funding and enhanced Medicaid (Medi-Cal) reimbursement rate

Rural Health Centers (RHC)

Medicare certified as shortage area in a rural community

Migrant Health Centers

Additional funding and requirements for an FQHC that serves a migrant population.

Health Care for the Homeless

Additional funding and requirements for an FQHC that serves people who are unhoused.

Look-alike Health Centers

All the requirements of an FQHC, eligible for enhance Medicaid rate. No federal grant.

Tribal and Urban Indian Health Centers

All the requirements of an FQHC; primarily serve Native Americans and Alaska natives. Managed by Indian Health Service, a division of US Department of Health and Human Services.

Benefits & Requirements of an FQHC

Benefits

- Eligible for Federal Grants
- Receive enhanced Medicaid reimbursement (Prospective Payment System – PPS)
- Eligible for federal drug discount program (340b)
- Eligible for federal professional liability insurance (FTCA)

Requirements

- Serve everyone regardless of ability to pay
- Comply with HRSA standards set forth in the Health Center Program Compliance Manual
- Annual re-application
- Site Visit Audit every 3 years

FQHC History, Facts, & Figures

History in the Health Center Movement

1965

1965 First CHCs funded

(LB Johnson War on Poverty)

100,000 patients

1975 - 1977

CHC program becomes permanent. Section 330 Legislation.

(Override Ford's veto)

1M patients

1980 - 1986

Funding threatened under block grants.

(Reagan Era)

5.5M patients

1987 - 1992

Expansion of Programs & Funding (HCH, FTCA, Migrant, CHIP)

9M patients

2009 - 2014

Affordable Care Act

(Obama)

22M patients

The Earliest Days

The first “Neighborhood Health Centers" are funded under demonstration authority by the federal Office of Economic Opportunity (OEO), the lead agency in President Lyndon Johnson’s “War on Poverty”.

Physician leaders Drs. H. Jack Geiger and Count D. Gibson Jr. pioneer the founding of the first two health centers in the nation at Columbia Point, Dorchester MA, and Mound Bayou, Mississippi,

The first health center west of the Mississippi opens in 1966 in Denver, CO. Senator Edward M. Kennedy, elected in 1962, begins his life’s work championing care for the underserved and the health center cause.

Section 330 Authorization: 1975 - 1977

- Community Health Centers program is authorized for first time as a permanent program, after 10 years as a demonstration project.
- The Migrant Health program is also reauthorized as Sec 329 in S. 66 (Public Law 94-63), but only after House and Senate each override President Gerald Ford's veto.
- President Jimmy Carter calls for major expansion of health centers, including the “Rural Health Initiative,” doubling program funding over 4 years.

FQHC Basics

FQHCs are community-based health care providers that receive funds from HRSA's Health Center Program to provide primary care services in underserved areas

Must meet a stringent set of requirements – see ***Health Center Program Compliance Manual***:

- 93 elements for compliance including:
  - Sliding Fee Scale based on ability to pay
  - Operate under a governing board:
    - Consumer majority
    - Representative of the community

FQHCs may be:

Community Health Centers

Migrant Health Centers

Health Care for the Homeless

Health Centers for Residents of Public Housing

Prospective Payment System 2000

- Previously Cost-based Reimbursement
- Changed to a per-visit payment system
- Federal funding for health centers surpasses $1 billion

Enhanced Payment for CHCs: PPS

- Single payment rate for any visit regardless of service provided
- Face-to-face visit with a licensed provider *(now includes phone and video visits)*
  - MD, DO, NP, DDS, Psychologist, LCSW, Chiropractor, Acupuncturist, Comprehensive Perinatal Services Provider (CPSP)
  - No same day visits are billable except with a dental visit
  - NOT – nursing visits or social work (unlicensed)
- Payment rate is related to costs but is not full cost

PPS Rate Rules

Rate is set for each licensed site based on reimbursement in 2001 or when site opened

Increases annually based on MEI

Ability to have rate reviewed based on “triggering events” (not growth or increase in costs)

Investment & Bold Expansion

- The American Reinvestment and Recovery Act (ARRA) is the single largest investment in health center history, providing $2 billion in direct CHC funding to cover the costs of caring for new patients and the capital expenditures required to support expansion
- $300 million for National Health Service Corps (NHSC)
- Medicaid funding expansions that include assistance to health centers approaching an additional $1 billion for Health Information Technology (HIT) adoption.

Since the Affordable Care Act

The ACA provide$11 billion in increased CHC funding; health centers double capacity

$1.5 billion for National Health Service Corps to increase the number of clinicians

Medicaid Expansion

- Income eligibility up to 138% of federal poverty level
- No requirement to have children (single adults now eligible)
- Assets such as house and car not included in eligibility

Impact of the ACA: Insurance Coverage Saves Lives

- 39 States Participated in Medicaid Expansion
- Patients served by CHC grew by 9M between 2009-2018
- Reduced uninsured rate by 50%
- 55% reduction in hospital uncompensated care
- Medicaid expansion saved the lives of 19,200 adults aged 55 to 64 between 2014 and 2017.
- Conversely, more than 15,600 older adults died prematurely because of state decisions not to expand Medicaid.

Community Health Centers Today

In 2021, for the first time in a single year, health centers served over

30 million patients

Over 1,400 Community Health Centers and Look-alike organizations provided care at more than 14,000 locations across the country in 2021.

1 in 11 Americans are health center patients, of whom:

20%	are **uninsured**
59%	are **publicly insured**
90%	are **low-income**
65%	are members of racial and/or ethnic **minority groups**
42%	live in **rural communities**

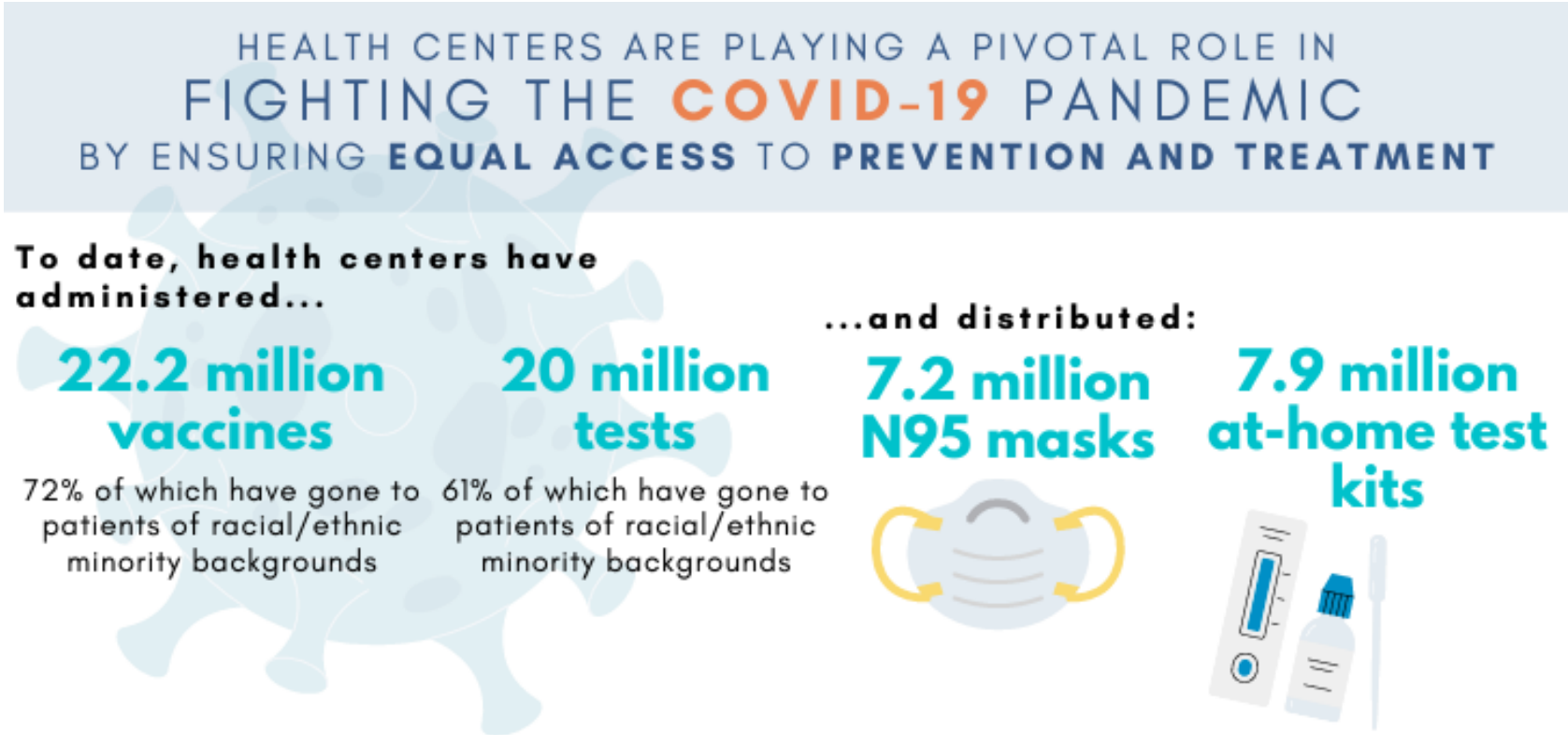
HEALTH CENTERS DRIVE ECONOMIC GROWTH

270,000
EMPLOYEES (FTE)

$63 billion
ECONOMIC ACTIVITY GENERATED IN COMMUNITIES SERVED

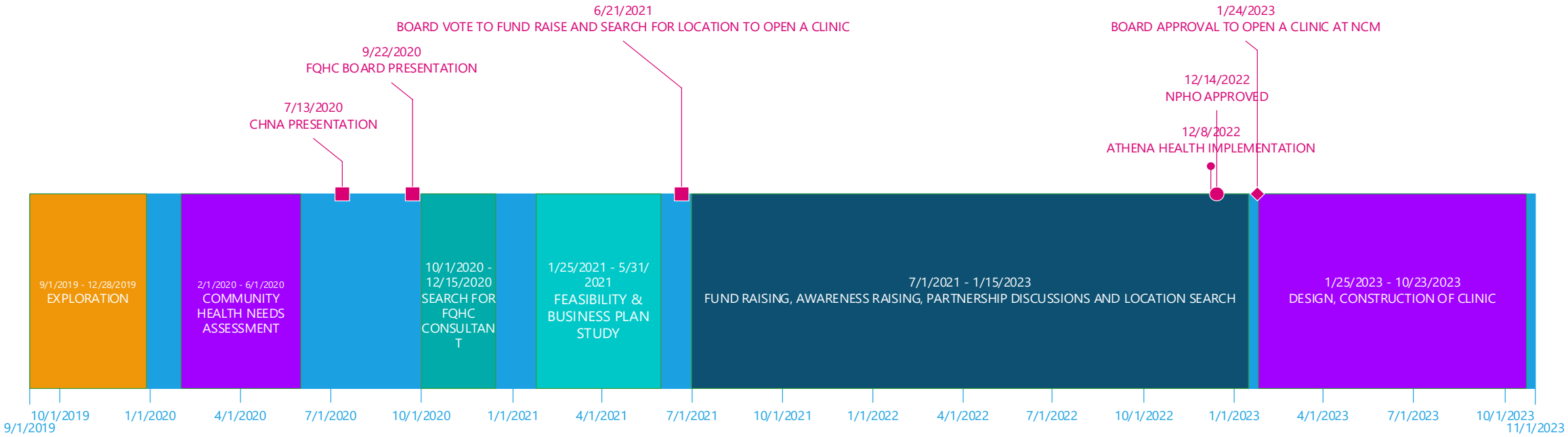
$24 billion
SAVINGS TO THE HEALTH SYSTEM ANNUALLY

Community Health Centers: Backbone of Public Health



- **Watch your email for an invite to our virtual workshop!**

The Journey



JFS DALLAS COMMUNITY HEALTH CENTER JOURNEY

Role of the Board

- First, understand the why?
- Then…understand the what, when, where, who, how?
- Direct the research
- Establish committees

The Challenges

- Change Management and Alignment
- Addressing How This is “Jewish”
- The Corporate Practice of Medicine
- Funding
- Medicine is VERY complicated

The Challenges: Change Management

- Leadership Retreat
- Staff Retreat
- Educational Series
- Town Hall Meetings
- Panel of Experts
- Drop-in at Department Meetings

“Communication, Communication, Communication”

The Challenges: How is this “Jewish”?

Comments:

- “You will just be serving more non-Jews by doing this.”
- “There won’t be enough services for just Jewish clients anymore.”
- “I only want to fund programs and services that help our Jewish community.”

Ode to HIAS:

“We used to help others because **they** were Jewish; now we help others because **we** are Jewish.”

The Challenges: The Corporate Practice of Medicine

- The corporate practice of medicine doctrine is a legal doctrine, which generally prohibits corporations, entities or non-physicians from practicing medicine.

- Remedy: Establish a Non-Profit Healthcare Organization (NPHO)

The Challenges: Funding

- **Capital Expenditure:**
  - Hard Cost: $ 1,268,779.00
  - Soft Costs: $232,100.00
  - Total Capital Expenditure: **$1,500,879.00** Leasehold improvement allowance: $341,700

Proforma:

- 1st Year Operational Cash Budget: $ (762,648)
- 2nd Year Operational Cash Budget: $ (867,906)
- 3rd Year Operational Cash Budget: $ (181,428)

Total Cash Required: $3,312,861.00

The Challenges: Medicine-It's COMPLICATED

- Physician Recruitment and Medical Staffing
- Licensing and Credentialing
- Federal Requirements
- Insurance Contracts
- Professional Liability
- Practice Management and Electronic Health Records
- Clinic Policies and Procedures
- Contracts with Lab, Medical Supply, Biohazard Vendors
- Partnerships with Hospitals and Specialty Providers
- Accreditation
- Etc, etc, etc…

Q & A