Hard to Stay: Looking to FQHCs as Models for Better Primary Care

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Well, we're living here in Allentown
And they're closing all the factories down
Out in Bethlehem, they're killing time
Filling out forms, standing in line

Well, we're waiting here in Allentown
For the Pennsylvania we never found
For the promises our teachers gave
If we worked hard, if we behaved

And we're living here in Allentown
But the restlessness was handed down
And it's getting very hard to stay

—Billy Joel, “Allentown”

In 1982, Billy Joel’s “Allentown” emerged as a folk-rock anthem elegizing the decline of what was once a powerhouse of American manufacturing. Allentown, the largest city in Pennsylvania's Lehigh County, once neighbored the headquarters of the legendary Bethlehem Steel corporation.[1] Throughout the twentieth century, Bethlehem Steel seemed indomitable, reigning as the second-largest steel production company in the United States. At its peak in 1975, the company employed 110,000 people. By 1980, it employed 83,800. In 1984, in lockstep with many great American industries at the time, that number had halved.[1]

Though stirring controversy for its pessimism, Joel’s song became iconic, not solely because of its somberness and theatricality but also because it captured, in song, the curtain call of American industry. It captured an absurdity well-known to the inhabitants of the so-called Rust Belt. It rang true for those in Gary, Indiana, in which the decline of the steel industry left so many impoverished that the city is now relocating its inhabitants. It rang true to those in Detroit, Michigan—a city at its peak the fourth-largest city in the United States, and is now notorious for its crime and poverty. It rang true in Youngstown, Ohio, once known as an epicenter of steel production, and today known for housing prisons within its metropolitan city limits.[3,4,5]

With poverty come many ailments. Sociologically, rates of crime and unrest grow. Life expectancy shortens. Individuals themselves become sicker: impoverished neighborhoods have some of the highest rates of undiagnosed mental illness and chronic disease.

The industrial decline of once-renowned cities brought an uncomfortable question to the fore: when a system fails so miserably—when factors, so large that they seem only to be representable in song, strip-mine entire communities of their prosperity—how can it possibly offer any hope of remediation?

Allentown, once a keystone of East Coast manufacturing, a third point to a metropolitan triangle branching between Philadelphia and New York, faced the departure of industry giants like the Bethlehem Steel and also General Electric.[5,6,7] This resulted in increased unemployment, causing poverty to skyrocket and, ultimately, medical services to suffer. The despair was so evident, a community health profile in 2012 which evaluated factors such as burden of illness and morbidity, crowned the Lehigh Valley as one of the sickest regions in Pennsylvania.[9]

In January 2019, Star Community Health, a Federally Qualified Health Center Look Alike (FQHC-LA), launched its operations to tackle this issue. Equipped with government grants, prospective payment systems, and enhanced Medicare and Medicaid reimbursement, this community health center was fit to overcome geographic, cultural, and other social determinants of health brought about by poverty at the time of its establishment.[9]

A key to overcoming the barriers to equitable health access in Rust Belt cities, such as Allentown, may lie in the structure offered by Star Community Health. That is to say: primary care offices that, in addition to addressing organic causes of health issues, also target social determinants of health (SDoH) to enhance quality and effective health services rendered and, in turn, bring about restoration to a once healthy population.

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In the early 1960s, a young doctor and activist by the name of H. Jack Gieger was avidly submitting proposals to the U.S. Office of Economic Opportunity, or OEO. Motivated by the community-based healthcare model he had seen employed in South Africa—which addressed the health needs of the country's poorest citizens—he lobbied the United States government to pioneer a similar program throughout its rural and inner city communities; thus were born neighborhood health centers.[10] Written into legislation under the Economic Opportunity Act of 1964 as part of Lyndon B. Johnson's War on Poverty, these federally funded centers were the precursors to modern community health centers. Specifically built to service medically-underserved areas, or MUAs, these health centers provided not just primary care, but other holistic and preventative health resources, including employment and social assistance and mental health, dental, and pharmaceutical services.[11]

A central tenet of Gieger's community health philosophy was funding social services to *prevent* rather than *react* to illness; the populations he worked with were overwhelmingly poor and primarily Black. During an era of virulent racism and Cold War suspicion to government, Gieger's proposition to use federal funds to uplift minority communities was met with hostility. He was called a carpetbagger and a communist.[12] His innovation frustrated his opponents. During the development of one of the early health centers, Gieger and his team would write prescriptions for food to patients facing malnutrition and bill the charges to the local pharmacy. A representative from the OEO heckled Gieger, reminding him that pharmacies were exclusively for the treatment of illnesses. To this, Gieger responded: "The last time I looked in my medical textbook, the most effective therapy for malnutrition is food."[12]

Gieger's community health centers would transform and expand substantially throughout the twentieth century. In its pilot form, the Community Health Centers Program established two neighborhood health centers, one in Boston, Massachusetts and the other in Mound Bayou, Mississippi, in 1965.[12] In 2021, there now exist 1,128 centers in all fifty states serving a population of over 20 million patients. They became today's modern FQHCs through the Omnibus Budget Reconciliation Act of 1989, which continued to provide government grants and enabled enhanced Medicare and Medicaid payments via cost-based reimbursement for services rendered.[21] This model of repayment—called the Prospective Payment System, or PPS—allowed health centers to be reimbursed by Medicaid, per patient encounter, based on the 100% of their historic cost.[13]

Compare this reimbursement model to a traditional fee-for-service primary care visit. In the former case, the primary care office would be reimbursed only $75 for a Medicaid patient visit; in the latter, an FQHC would receive $175. As such, health centers have an advantage of serving a large number of Medicare patients compared to traditional clinics. Medicaid recipients do not pay health centers additional fees as all of their services are covered in full. In addition, FQHC are eligible for additional government grants such as planning grants, operating grants, access grants, and infant mortality grants.[21] These grants serve to fund specific operations at regular sites. This combination of funding sources allows FQHCs to administer comprehensive care based on the patient's needs. Recently, under the Affordable Care Act, $11 billion was apportioned to FQHCs to increase their operations.[13] Today, FQHC funding covers migrant health centers, homeless health centers, and public housing primary care programs. [13]

The revolutionary potential of these centers, which provide comprehensive health services to millions of Americans in remote and impoverished communities, is owing in part but

not entirely to their robust federal funding. Outlined in the pages below are a range of social services that FQHCs provide to facilitate adherence to outpatient treatment plans. These services work towards an opposite goal than in the traditional fee-for-service model: the FQHC incentive structure itself promises a model of primary care in which the patient is insured against unnecessary return visits.

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Federally qualified health centers address social determinants of health by incorporating social work into the primary care approach.

Primary care offices in poor neighborhoods are all too familiar with the problems that prevent their patients from making full use of their available health services—homelessness, lack of transportation, unemployment, poor health literacy, food insecurity, stress, difficulty with coordinating subspecialty care. The list, as many frustrated clinicians understand, is endless.

Under law, FQHC funding covers extensive social work services to address issues affecting adherence to recommended outpatient treatment plans. Social workers conduct a needs assessment to identify nonmedical factors that affect patient care. After these assessments are completed, social workers link the patient to resources including patient education, transportation services, housing services, and food assistance programs.[14] In some complex medical cases, social workers conduct motivational interviewing and cognitive behavior therapy to provide patients with problem-solving and coping strategies needed to attain goals. For conditions that are complex and require higher management of coordination of care, social workers actively work to set up and coordinate subspecialty appointments, to improve adherence to treatment plans.[14] Lastly, acquired information found in the interaction with the patient can be relayed to the clinician to assist in making appropriate treatment plans and goals based on the patient's limitations.

In providing social work services to patients, FQHCs work to connect patients to all available resources to improve adherence to their outpatient treatment plan. There is an incentive to prevent unnecessary return visits and ensure that patients are able to manage their care to the best of their abilities.

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Federally qualified health centers address social determinants of health by providing patients with financial services to help them overcome their financial barriers in order to obtain their care.

Low-income families at primary care offices face a multitude of financial barriers in attaining the health care services they need. They incur high medical debt, lack sick days and work long hours. The most significant burden for many patients is their ability to pay for medication and services rendered. It's estimated that over two-thirds of medication non-adherence is due to cost.[15]

FQHCs are equipped with financial counselors to help mitigate these issues. They first assess patients' current insurance status. They conduct a screening program that shows eligibility based on the resident's income, family size and assets, and legal status, and are responsible for informing patients on available health coverage programs in the community. Trained counselors assist with the application process to ensure accuracy. Additionally, the FQHC is able to offset any cost out of the range of the patient's ability to pay using the sliding-fee-scale service program.[13] Uninsured patients are included in this service. Therefore, patients are able to be seen regardless of their ability to pay.

Further, the 340B Drug Discount program—which requires drug manufacturers participating in Medicaid to provide outpatient drugs at a significantly discounted price—is a benefit of an FQHC program that addresses the unaffordability of prescription medications to

certain individuals.[13] By keeping prices low, patients are able to obtain the drugs necessary to avoid exacerbation of chronic conditions and avoid costly re-hospitalizations.

With public monies on the line, FQHCs have a built-in incentive to expend resources in advance to ensure patient adherence to treatment plans. One crucial component of this strategy is ensuring that patients are able to afford necessary medications, procedures, and insurance policies.

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FQHCs address social determinants of health by bringing forth on-site mental health services that were, in the past, not accessible to low income, uninsured, or Medicaid populations.

Mental health and substance abuse disorders are epidemic in the United States, and they primarily afflict the poor. Since 2013, there has been a 600% increase in opioid overdose-related deaths in the United States, and the state of Pennsylvania in ranked the third most drug overdose rate.[16,17] The bulk of those individuals are unsurprisingly low-income. Studies suggest that 30%–80% of primary care visits are at least partially driven by behavioral health problems. An approach to primary care which neglects to consider these statistics does a disservice to its patient constituency.[18]

Because patients often prefer to receive treatment from their primary care clinician, primary care is often the first point of contact for the detection and treatment of mental and substance abuse disorders. FQHCs, at minimum, are required to provide referrals to substance abuse and mental health providers. The expansion of the Mental Health Parity and Addiction Equity Acts in 2008 allowed for greater allocation of federal funds to such resources.[19,20]

A majority of FQHCs have onsite mental health or substance abuse staff that help initiate treatment and provide crisis intervention. In addition, some clinics provide suboxone and alcohol

abuse substance treatment programs. Providing mental health and substance abuse programs in a primary care office adopts a whole-person, recovery-oriented system of care. Such an approach is needed in order to provide meaningful care.

With the understanding that mental health and substance abuse issues are very often tied to socioeconomic predicaments, FQHCs preempt unnecessary return visits by linking patients to available resources; and by providing on-site services for said disorders, FQHCs validate the intricate linkage between mental and physical health which are elsewhere neglected in modern medicine.

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In spite of all the evidence of the clear benefits of the FQHC model, the majority of clinics in the United States are gridlocked into the fee-for-service (FFS) model of care—encouraging over-utilization, discouraging primary and secondary prevention, and failing to promote integrated, coordinated care.[2] In a system in which the volume of patients and procedures are prioritized over quality of care, the pressure is on primary care physicians to intervene excessively, addressing only proximal causes of illness and rarely, if ever, attempting to rectify the health barriers that caused or exacerbated them in the first place.[21]

The FFS approach is commonly understood to be ineffective, outdated, and, most gravely, harmful for patients. Every provider has witnessed some iteration of the same common, preventable tragedies: the patient with diabetes who presents to the hospital in diabetic ketoacidosis as a result of gaps in medical understanding; the patient with hypertension, who, after failing to complete follow-up recommendations because of transportation issues, presents with end-stage organ damage; the asthmatic mother who must sacrifice her inhalers in favor of

feeding her children. Across a variety of sectors, people have come to realize that addressing factors *outside* the hospital are key to providing better health outcomes.[22]

It is our duty as primary care physicians to advocate for a paradigm shift in health care delivery. It is our duty, for the very definition of a primary care doctor instructs us to do so. The 1966 Willard report, which outlined guidelines for education on family practice, many of which are still in use today, underscored the uniqueness of the primary care doctor's role. The family physician, the report argued, serves as a first contact with the patient, providing a means of entry into the healthcare system. Her or she evaluates the patient's total health needs, assumes and accepts responsibility for the patient's comprehensive and continuous health care, and acts as a leader or coordinator of the team that provides health services.[23,24] Central to the training of Osteopathic Medicine is the acknowledgement of the patient as more than their disease; one of the pioneers of modern medicine, Sir William Osler, once famously stated: "The good physician treats the disease; the great physician treats the patient who has the disease."

Though Billy Joel depicted a dismal fate for the city of Allentown, the city has taken on a new anthem, one of hope and resilience. With the city's investment of $455 million into its downtown area, and its commitment to urban renewal projects through the Neighborhood Improvement Zone—a law that allocates special taxes from the city and state for redevelopment—the city and its residents have proven a commitment to proactive community change.[25] Star Community Health is a key player in the renewal initiative. It has come forth to bring about revitalization for a healthy population by operating an FQHC Look-Alike. Today the women's health, pediatric, dental and family medicine clinics provide a range of services accessible to the medically underserved area. The community health center operates in fifteen

sites, and includes services like primary care, pediatrics, dental, and women's health. In the first quarter of 2021 alone, Star Community had over 13,000 patient visits.

It is time that we, as primary care physicians, draw from the examples provided by pioneers of the field who came before us, to fight change within our own medical specialty for the betterment of our patient population. For most patients, we represent the gate of entry into the medical system. The responsibility that comes with that role is profound.

Modern medicine is in mismatch. The behemoth structure of fee-for-service is at deep odds with the values that inspire providers to pursue the road to doctorhood in the first place. As such, it is our hope that our primary care clinics—especially those found in medically underserved areas—embody the ideals of a Federally Qualified Health Center.

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