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A Medical Home for the Uninsured

A Kansas City-area free clinic is making the concept of a medical home a reality for 450 chronically ill patients

By providing a medical home for patients with expensive chronic illnesses who do not qualify for traditional indigent care programs, the Jackson County Free Health Clinic is filling an important gap in the region's health economy.

By Dr. Bridget McCandless

Executive Director
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It's a common misconception that medical providers can't change the behavior of uninsured patients who have chronic conditions. At the Jackson County Free Health Clinic in Independence, Mo., we're proving this assumption wrong by providing our patients with a medical home: easy access to a provider and a holistic approach to medical care.

According to the U.S. Census Bureau, there are 47 million uninsured people in the United States.¹ A recent study by the Commonwealth Fund found that uninsured patients achieve better outcomes if they have a medical home, and yet more than one of three adults with chronic conditions do not get adequate support to manage their conditions.²

The Jackson County Free Health Clinic is addressing these and other problems by providing a medical home for 450 people—mostly women between the ages of 35 and 55—who lack insurance.

When I first became executive director, I found that our health economy left a vast number of people in Eastern Jackson County underserved. Missouri's Health Insurance Program for Kids provided health insurance for low-income children; Planned Parenthood provided care for many women and the Federally Qualified Health Care facilities handled many walk-in patients. But Eastern Jackson County lacked a medical home for some 8,000 patients with chronic conditions but no health insurance.

We made a conscious decision to concentrate on these patients. The need is great—patients come from 36 zip codes, some from almost an hour away. Eighty percent have

2007 Federal Poverty Levels

| Persons in Family or Household | 48 Contiguous States and D.C. |
|---------------------------------|-------------------------------|
| 1 | \$10,210 |
| 2 | 13,690 |
| 3 | 17,170 |
| 4 | 20,650 |
| 5 | 24,130 |
| 6 | 27,610 |
| 7 | 31,090 |
| 8 | 34,570 |
| For each additional person, add | 3,480 |

Source: Federal Register, Vol. 72, No. 15, January 24, 2007, pp. 3147-3148

Patients at the Jackson County Free Health Clinic earn no more than twice the federal poverty level.

Even though we have a challenging population, we have very good outcomes because we know our patients very well.

Our patients face a lot of challenges, so we negotiate treatment plans. I can't just set out a schedule of insulin and send them home. Many patients work nights or rotating shifts. We have to design programs that are flexible for our patients' needs. We must explore what patients are able to do, and how we can create treatment plans that fit into their lives.

We also expect patients to come to their visits. Our clinic has a long waiting list. Patients may miss a total of three appointments—after that, they can no longer come to the clinic for care. Because transportation is such a huge issue, we allow them to

five or more chronic illnesses, and half are on eight or more medications.

Our patients range in age between 18 and 64, and their racial mix mirrors that of Eastern Jackson County—about 15 percent minority. Their incomes range from zero up to twice the federal poverty level. Contrary to stereotypes, most hold a job, or even two. Many of these patients are “functionally uninsured,” meaning their deductible is so high they can't afford to pay it.

The clinic offers a wide variety of services on site. In addition to primary care services from volunteer family practice or internal medicine physicians, we offer vaccinations, laboratory services, diagnostic radiology and medications. Since these services come in a package, we never have to worry that people don't get their prescriptions filled; we fill them ourselves. We don't have to worry that people get their eyes checked because their eye visit is on site.

Even though we have a challenging population, we have very good outcomes because we know our patients very well. I give out my cell phone number and make myself available to patients whenever they have questions or concerns. They are respectful and generally only call when they have an urgent need. I also communicate with them through e-mail, although not as often as I'd like. Unfortunately, not enough patients have access to e-mail. Whenever a patient has blood work done, I call them to go over the results and give them the opportunity to ask questions. I want them to understand their labs, and, if I have made any changes in their regimen, I want to know how they are progressing. This sort of open communication between provider and patient fosters a sense of ownership and control. During our phone calls, I consistently give patients feedback on their goals, so they know where they stand. It helps them play a much more active role in their own care.

call in and tell us they aren't going to make it. But if they just don't bother to show up, we tell them, "I've got somebody else who can take your spot." We also encourage patients to ask lots of questions, the logic being that if they don't understand how to take care of themselves, they cannot successfully control their condition. For these and other reasons, our patients strongly identify Jackson County Free Health Clinic as their medical home.

Results

Over the last four years, the clinic has been outcomes driven. Everyone who works on the staff is aware of our statistics and works to improve them. Pharmacists, for example, ask heart patients whether they are taking their ACE inhibitors. We base everything we do on relationships, training our staff to ask three questions:

- Do you take your medications?
- Do you understand your medications?
- Do you have any concerns?

Outcomes for the Jackson County Free Health Clinic

| | Benchmark data | GOAL 2007 | Jun-07 |
|--|--------------------|-----------|----------|
| Number of patients | | 100 | 92 |
| A1C | | | |
| Well controlled with A1C less than 7.0 (represents normal average blood sugars) | 37% ¹ | 44% | 55.4% |
| Poorly controlled with A1C greater than 9.1 (patients with highest risk of complications) | 29.7% ² | <12% | 15.2% |
| LDL ("bad" cholesterol) | | | |
| Well controlled at less than 100 | 43.8% ² | 55% | 46.7% |
| Blood pressure at or below goal 135/85 ***Lowered goal to 130/80 in 2007 | 36% ¹ | 70% | ***52.2% |
| Microalbumin (urine protein) | | | |
| Documented on chart within the year | 55.1% ² | 100% | 95.6% |
| Kidney disease treated with ACE | | 100% | 100.0% |
| Aspirin compliance | 20% ¹ | 99% | 97.8% |
| Pneumonia vaccination | 21% ³ | 90% | 96.7% |
| Flu vaccine | 40% ³ | 80% | 81.4% |
| Yearly eye exam | 54.8% ² | 85% | 75.0% |
| Documented foot exam | | 80% | 94.6% |

***Changed BP goal from 135/85 to 130/80 to conform with American Diabetes Association guidelines

JCFHC data is obtained by chart review and computerized medical record review.

Patients are included if they have been seen within the preceding 9 months and have been under care for at least 3 months.

There will be fluctuation in the number of patients due to some transience in the population and movement on and off of Medicaid/Medicare.

¹HEDIS (Health Plan Employer Data and Information Set) reports data on insured patients for NCQA (National Committee for Quality Assurance)

²NHANES (National Health and Nutrition Examination Survey) conducted by the Centers for Disease Control

³CDC (Centers for Disease Control) <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4842a3.htm>

The Jackson County Free Health Clinic is offering a high standard of care, in some cases beating outcomes for privately insured patients.

We are following diabetes in particular, in part because it is well documented that quality care results in reduced complications, disability and death. For example, moving a patient's A1C from 9 to 8 reduces his or her risk from complications by 43 percent. And the complications are, of course, terrible—heart attack, amputation and kidney failure to name a few.

So far, the results for our diabetic patients (about 100) have been most encouraging. We've actually beaten outcomes levels for privately insured patients. *Fifty-five* percent of our clinic's patients are at their HA1C goal. This means that for the last 3 months, they have had to make good choices almost every day. Among the insured population, that figure is 37 percent, and among the Medicaid population, it's only 29 percent.

Providing condition management for the uninsured makes financial sense

As a hospital administrator, I spend a lot for time looking at numbers, and one really worries me. Our hospital system, Carondelet Health, together with other providers in the Kansas City metropolitan area region, spend \$388 million for uncompensated care for the uninsured.

We can't keep doing it.

Most of our patients are on Medicare, a federal program for the elderly. Medicaid reimbursement rates don't cover our fixed costs—the money we spend building and maintaining our healthcare infrastructure. As Medicare reimbursements drop, we turned to outpatient services for more revenue, but that's getting tougher. More and more people go to ambulatory surgicenters—not hospitals—for outpatient services. These facilities do not have the same fixed costs of hospitals and are, therefore, more profitable. Given this spiral, it's not long before we are not going to be able to make money. Our system is broken. Unless we do something about it, the health economy will collapse under its own weight.

For these and other reasons, Carondelet Health is working with the Jackson County Free Clinic, Cerner Corporation and others to figure out how to provide better electronic

| Fiscal Year | ER Visits |
|-------------------|-----------|
| FY 2004 | 5,980 |
| FY 2005 | 6,937 |
| Projected FY 2006 | 7,853 |

Source: Carondelet Health

communication between Dr. McCandless and her diabetic patients. Better preventive care for the uninsured means fewer trips to the emergency room and less uncompensated care for us to cover. Beyond these financial considerations, Carondelet, and our parent organization, Ascension Health, is committed to healthcare that works, is safe and that leaves no one behind.

If we can provide a medical home for these patients and more consistent managing of their condition(s), we think we can help them lead safer, more productive lives, and by the same token, save some dollars. The money is in our system, in our health economy, but it's not allocated properly. By spending more money on condition management, we can take care of the people and keep them out of emergency rooms throughout the city. [TCQ](#)

-Bob Frazier, Executive Vice President of Mission and Community Services, Carondelet Health

Technology drives better outcomes

Jackson County Free Health Clinic has been using an electronic health record (EHR) specially tailored to the needs of free clinics, and it has greatly enhanced the care we offer.

The system helps us process eligibility applications for free medications available through patient assistance programs of pharmaceutical companies. The system loads information automatically into forms that patients need to qualify for free pharmaceuticals from companies like Bristol Myers Squibb and Schering-Plough. The volunteers complete at least one form for every medication, for each patient, every three months. Without such an electronic system, it would be difficult to keep up with the copious amount of paperwork.

Drug recalls are also a lot easier to handle with the EHR. We can generate a letter to patients taking certain medications without doing chart pulls or other time-consuming processes. When concerns surfaced that a diabetes medication increased the risk of heart attack, we searched for patients taking the drug and got them off of it. In general, the technology helps us offer safer medical care by making us aware of subpopulations within our patient mix. Most doctor offices

can't generate a disease registry at all; we can do it on any disease we choose. If I want to search for obese patients with high blood pressure or smokers with asthma, it's easy. If a new drug becomes available for smoking prevention, but the drug is not advised for a particular population, it's easy to see who would be endangered if they used the drug.

We also use our EHR extensively in grant writing. Most free clinics cannot make a good business case; we can. We use technology to turn lab data into real money. Being able to draw straight lines between a particular intervention or policy and improvements in outcomes helps grantors feel they have spent money effectively and makes them more apt to give again.

Technology could also help us keep better track of where patients go to receive care. According to the *New York Times*, hospitals and charity clinics in Austin, Texas, have "joined in a pioneering data-sharing system to track visits by uninsured patients and fight unnecessary use of the emergency room."³

Jackson County Free Health Clinic At a Glance

Location: Independence, Mo.

Patients: 450 chronically ill patients
between ages 18 and 64 without insurance

Hours: Tuesday nights and on the fourth
Friday of the month

Wait to become a patient: 6 months

**Ratio of cash donations to leveraged
goods and services:** \$1 : \$14

Staffing: 100 volunteers with one half-time
employee

Value of donated medicines per year:
\$315,000

Value of donated services per year:
\$320,000

Website: www.jcfhc.org

Future thought: A patient-controlled record for diabetics

Here in Kansas City, we are talking with Carondelet Health System about how to get computers into the homes of 20 of our diabetes patients who would use information technology to send glucometer readings to our office. The solution would also provide secure messaging, so our patients could converse with us electronically. With secure electronic messaging, our patients could contact us to see if they really do have to make a trip into the clinic, or if they should continue taking medications when they go to the dentist. If their medications come in, we could save a lot of time and trouble by simply sending them an e-mail to let them know.

In general, the idea of a medical home for the uninsured is attractive to other provider organizations within the Kansas City health economy as a way to cut down on uncompensated costs. Hospital Corporation of America (HCA) donates the space for our clinic. The majority of our patients would go to either HCA's new Centerpoint facility in Independence or to St. Mary's Medical Center, which is part of the Carondelet Health, a member of the Ascension Health system.

Emergency room care for uninsured patients costs on average between \$3,000 and \$5,000 per encounter—money these hospitals would have to absorb. Inpatient medical stays for diabetes are generally much more expensive. End-stage treatment for maladies such as a stroke, heart attack or amputation can run as much as \$100,000.

The value of a medical home

Providing a medical home for the uninsured makes sense medically and financially. This model for care is successful because it fosters relationships. It makes both the patient and the provider responsible for the outcome and gives people a place to ask questions so that they can get the right care at the right place at the right time.

In medicine, we're seeing a shift away from relationships, and I hope the pendulum swings back. People are figuring out that the family doctor model is both cost and health effective. Being well is always cheaper; and using medicine wisely as a tool is more effective both in making people well and in using our very limited resources efficiently.

Providing a medical home for the uninsured makes both the patient and the provider responsible for the outcome.

The current reimbursement structure within our health economy, however, does not foster these medical homes. We do not pay physicians to think; we only pay physicians to do. There is a perverse incentive for me to order more tests and to do more procedures. Our system does not reward spending time with complicated patients managing their medications. Instead, we've built a system that doesn't reward physicians for making people well. Indeed, we get paid a lot more if people are sick; we profit from illness care, not wellness care.

For the most part, our health economy does not reward quality. We offer physicians no monetary incentive to offer good care. If you're getting a divorce, you would pay more for the best divorce lawyer in town. But if you go to the best physician or the worst, you pay the same.

We also have a problem with continuity of care. In January each year, we have an enormous turnover in insurance plans, and people have to change their physicians. Our health economy disrupts the physician-patient relationship because of the transience of this financial arrangement. And so every year, I learn new people, and the patients have to tell their story again to someone new.

In the physician's defense, most primary care doctors go into medicine for the relationship, something they work hard to preserve. But there is a lot of financial pressure on them to focus on volume instead of quality. Yes, there are some trends toward pay for performance, but you can't quantify the magic of medicine that really keeps people well and out of the hospital. If Mr. Jones calls me and says he has chest pains, I tell him to go take some Tums. If Mr. Smith calls me and says he has chest pains, I tell him to go to the hospital, and I'll see you there. Medicine should be about knowing your patients, but through our health economy's upside-down financial reward system, we have told physicians this is something we no longer value.

One of the trends in healthcare is concierge medicine in which people say they are willing to pay more for some extra attention. But those who need concierge medicine the most in our health economy are the people who are least able to pay for it—the poor, the sick and the complicated. As a society, we must give them a place to call home. [fco](#)

1 "Income, Poverty, and Health Insurance Coverage in the United States: 2006." U.S. Census Bureau; August 2007. Table 6, pp. 21.

2 Beal AC, Doty MM, Hernandez SE, Shea KK and Davis K. *Crossing the Divide: How Medical Homes Promote Equity in Health Care*; June 2007.

3 Eckholm E. "Hospitals Try Free Basic Care for Uninsured." *The New York Times*; Oct. 25, 2006.



Bridget McCandless, M.D., MBA

Executive Director

Jackson County Free Health Clinic

Dr. Bridget McCandless is the medical director of the Jackson County Free Health Clinic in Independence, Mo. She is a board member and co-founder of the clinic.

McCandless has a long history of helping the underserved, working as a volunteer physician at the Hope House Women's Shelter in Independence as well as the Program for Health Care for the Underserved, and the Women's Center and Shelter in Pittsburgh, Pa. She serves on the board of directors of the Health Care Foundation of Greater Kansas

City and chairs the Healthy Independence Coalition. In 2005, she was recognized as Citizen of the Year for the City of Independence.

McCandless earned her bachelor's degree in biology and medical degree from the University of Missouri-Columbia. She completed her residency in internal medicine at the University of Virginia Health Sciences Center in Charlottesville, Va. and recently earned a master degree in business administration from Rockhurst University in Kansas City, Mo.