Enabling Services at Health Centers: Eliminating Disparities and Improving Quality

Challenges and Opportunities for Health Centers
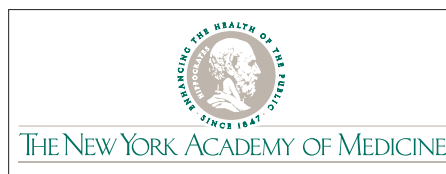in Collecting Data on Enabling Services
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Acknowledgements:

Executive Summary

Enabling services are defined as "non-clinical services that aim to increase access to healthcare and improve health outcomes," and include services such as health education, interpretation, and case management. Federally qualified health centers (FQHCs), also known as community health centers or health centers, are a key component of the nation's safety net, providing comprehensive primary and preventive care to low-income, racially and ethnically diverse, and uninsured populations. These health centers have implemented enabling services to help their patients overcome the multiple barriers they face in obtaining care. Enabling services are integral to the services that health centers provide, and their patients often rely on these services to access health care. Studies have shown that health centers provide high quality primary care for their patients, with higher rates of screening and health promotion counseling. Enabling services contribute to effective and efficient primary and preventive care at health centers which results in improved health outcomes.However, due to the lack of data on enabling services, there are few studies that have been able to examine and quantify the impact and utilization of enabling services in health care. Furthermore, enabling services are often underfunded and not reimbursed, making it difficult to ensure their sustainability or expansion when needed.

Currently, the only national data on enabling services at health centers is available through the Uniform Data System reported by health centers receiving grant funding from the Bureau of Primary Health Care, and has limited information on the levels of utilization or characteristics of enabling service users. Recognizing the need for more data on enabling services, several projects have been conducted at health centers. In this report, we describe one pilot study conducted by the New York Academy of Medicine in collaboration with the Association of Asian Pacific Community Health Organizations and four of their member health centers. Through this project, a uniform dataset on enabling services was created and a standardized method for collecting data was implemented. The data demonstrates that a high percentage of patients at health center utilize enabling services, and each user receives more than one enabling service. The data is able to provide information on the variations in utilization of enabling services and user characteristics at each health center due to differences in the communities that they serve.

In conclusion, enabling services are essential to access and quality care for health center patients. However, there is limited information on enabling services in health care, and many challenges to providing and funding enabling services. Based on discussions and comments by participants of the Enabling Services Roundtable meeting held on September 29, 2005, recommendations include: support a coordinated and national effort to collect enabling services data at health centers, monitor projects on enabling services in health care nationwide, collaborate with funding sources to ensure that enabling services are adequately supported, and conduct additional studies to examine the impact of enabling services on reducing disparities and improving quality of care for underserved populations.

II. Introduction and Background

Enabling Services are Integral to Care at Health Centers

Disparities in health care have been shown to exist for racial and ethnic minorities, and particularly for those who are low-income, lack health insurance, have immigrated to the U.S., and have limited English proficiency. Studies have found that health disparities are associated with socio-economic factors, as well as with race and ethnicity, and could be attributed to differences in risk factors for specific conditions, access to care, and patient and provider behavior and attitudes.[1] Health centers, also known as federally qualified health centers (FQHCs), have been leaders nationally in the effort to reduce health disparities by providing care to over 15 million patients, with as many as 64% from racial or ethnic minority groups, 71% with incomes less than federal poverty level, and 40% uninsured.[2] FQHCs are non-profit providers that receive grants under Section 330 of the Public Health Service Act and have governing boards with representatives of the communities they serve. Health centers provide comprehensive primary and preventive care to patients regardless of the ability to pay, and are a key component of the nation's safety net, serving the growing numbers of uninsured. In this report, we focus on enabling services at health centers because enabling services are critical for health center patients. Furthermore, more information on enabling services at health centers can inform the development of strategies, or "best practices," for providers who serve diverse and vulnerable populations.

Health center patients face many challenges in getting the care they need including barriers to access and racial and ethnic disparities in health. In a nationwide survey of health centers, the most frequently cited barrier for patients was the inability to pay for services (90%).[3] Most health centers (82%) also cited cultural and language barriers, and 79% cited geographical access in needed areas. Patients frequently have multiple issues that must be addressed. For example, a patient may not only lack health insurance and have multiple comorbidities, such as diabetes and heart disease, but also have a history of mental illness, and limited English proficiency.

Health centers help reduce the multiple barriers to care that many of their patients face. In order to ensure access to and provide quality care for their diverse and underserved populations, health centers have incorporated a wide range of enabling services to supplement medical services. Enabling services have been defined in previous studies and reports as "non-clinical services that aim to increase access to health care, and to improve health outcomes."[4] While enabling services are an integral part of services at all health centers, the types of enabling services are driven by community needs. According to an analysis of data reported by health centers in 2004, 85% of health centers provide interpretation/ translation on-site, 57% provide transportation, 87% provide eligibility assistance, 12% provide child care, and 90% provide case management services (Figure 1).[5] Between 1996 and 1999, 38% of health centers reported an increase in the number of enabling service categories they offered, and 24% reported a decrease.[6] Health centers that reported an increase in the number of uninsured patients were more likely to have added enabling services rather than discontinued services. While this increase may explain a health center's response to the needs of a growing uninsured population, it is also possible

Figure 1. Enabling Services Provided by Health Centers On-site

| Service	Percentage
Interpretation/Translation	85%
Transportation	57%
Eligibility Assistance	87%
Child Care	12%
Case Management	90%
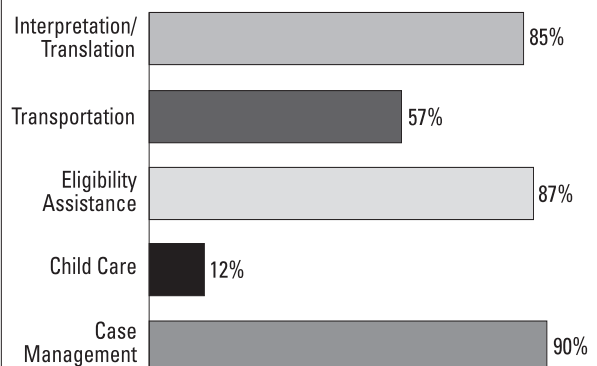
Source: Center for Health Services Research and Policy analysis of 2004 UDS

that uninsured patients are more likely to be attracted to health centers with expanded enabling services. This study was able to report only changes in the scope of enabling services, since there is limited data on volume or utilization of services.

Health Centers Reduce Health Disparities and Provide Quality Care

Studies show that health centers provide high quality primary care and cost-effective care to vulnerable populations with complex conditions and needs. One study found that a lower percentage of low birth weight babies are born to minority patients at health centers compared to other low-income minority patients or to the U.S. population overall.[7] Health center patients are more likely to have a usual source of care (98% vs. 65%) and more likely to have more than four doctor's visits per year (56% vs. 33%) than the U.S. population overall. (Figure 2)[8] For preventive care, health center patients have higher rates of screening than the U.S. population when adjusted for income. Of those individuals covered by Medicaid, 92% of health center females had received a pap test as compared to 84% of females below federal poverty level in the U.S. as a whole.[8] At health centers, 63% of diabetes patients had received an eye exam in the past year, as compared to 52% of low-income diabetes patients in the U.S.[9] Health center uninsured patients were also more likely to receive health promotion counseling, such as discussions around diet and eating habits, physical activity and smoking, than U.S. uninsured adults.[10]

Figure 2. Access to Care: Uninsured Patients Face No Access Barriers at Health Centers
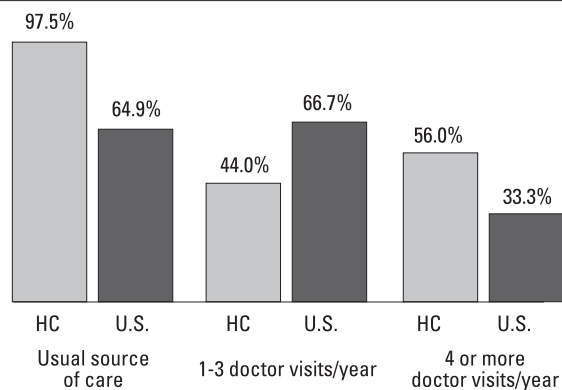
Sources: Community Health Center User Survey, 2002. Preliminary Tables August 2004 National Health Interview Survey, 2002.
Note: Odds ratio: 15.8, P-value: <0.001, among uninsured CHC users, compared to uninsured U.S. residents who has usual source of care. Odds ratio: 2.07, P-value: <0.001, among uninsured CHC users, compared to uninsured U.S. residents who visited doctor 4 or more times. The control variables were age group, sex, poverty status, race/ethnicity, time in U.S. (Hispanics only), education, health status, and disability status.

Ambulatory care sensitive conditions (ACSCs) are conditions for which timely and appropriate primary care can reduce the likelihood of adverse events that lead to inappropriate and costly hospitalizations or emergency room visits. Studies have shown that hospitalization rates for ACSCs are higher among lower-income and uninsured populations. Health centers are often the regular source of preventive and primary care for many low-income individuals, many of whom are Medicaid beneficiaries. A recent study of Medicaid beneficiaries in four states (Alabama, California, Georgia, Pennsylvania) found that health center patients were significantly less likely to experience ACSC admissions and emergency room visits than those patients who relied on other Medicaid providers.[11] This suggests that relying on health centers as a usual source of care can reduce hospitalizations for ACSCs. This analysis included only low-income Medicaid beneficiaries to control for insurance and socioeconomic status, as well as controlled for case mix to take into account the presence of underlying conditions.

Health centers have been leaders in innovative ideas for addressing the challenges faced by their patients, and have implemented enabling services to improve the health of their patients. With the recent focus on quality and health care disparities, there has been an increasing interest in understanding what characterizes the care that health centers provide that contribute to increased access or improved health outcomes for diverse and underserved populations. However, the role of enabling services specifically in quality improvement and reducing healthcare disparities is largely unknown due to limited data, making it difficult to demonstrate improved outcomes or a quantifiable impact on health.

Introduction and Background

Challenges in Funding and Reimbursement of Enabling Services

Despite the fact that enabling services are considered critical to quality care, they are generally not reimbursed nor have continuous funding. This is of particular concern because health centers have limited resources. Currently, enabling services at health centers are funded by various sources. On average, 40% of health center patients are uninsured, and 36% are covered by Medicaid. Therefore, the primary sources of funding for enabling services are: 1)BPHC Section 330 Grants, 2) Medicaid reimbursements, including fee-for-service, managed care, and wraparound funds, and 3) other grants, including state, local and private funding. Funding through BPHC for the health center program to assist with providing care for underserved populations has helped support enabling services for their patients. Although BPHC funds cover the scope of the health center program, these funds are becoming stretched with the rising number of uninsured patients.

Enabling services are also partially funded for Medicaid beneficiaries through payments by Medicaid. The prospective payment system (PPS) Medicaid rates in some states include a portion of the cost for enabling services. In states with a cost-based system and payments through Medicaid managed care wraparound, payments to health centers are made based on the cost of providing care when the rates are unable to compensate for the services that the patients need. The availability of funds to cover these costs, however, is subject to policy changes and budgetary pressures. Therefore, these payments may not always be sufficient to account for the total cost of providing the services, or to expand or enhance services when needed. In fact, a report by the Government Accountability Office (GAO) in 2005 concluded that Medicaid PPS rates in at least one-third of all states may not include all Medicaid-covered services and that many states have not created a process for rebasing PPS rates based on a change in a health center's scope of services, or for inflation.[12]

Increasingly, health centers are being reimbursed through capitation payments by managed care organizations (MCOs), as Medicaid moves to a managed care system. In fact, the percentage of Medicaid enrollees in managed care nationally has increased from 40%, or 13 million enrollees, in 1996 to 61%, or 27 million enrollees, in 2004.[13] A survey of Medicaid MCOs in 1998 examined the extent to which they provide or pay for enabling services: case management, health education, transportation, and language interpretation.[14] The study found that as many as 97% provided case management services, 87% provided health education programs, and over half provided all four enabling services. Even though MCOs may provide or pay for the service, there is considerable variation in the manner in which MCOs do so. Some MCOs reimburse providers for selected enabling services, but there is no standard methodology for payment or for negotiating the cost of services. In addition, it is not clear whether MCOs collaborate with providers to make enabling services available to their members. Although the survey suggests that MCOs are often guided by state contracts and requirements to provide or cover the services, some MCOs provided the service even when the state did not require it or included payment for this service in its capitation rate. For example, 55% of MCOs reported that they were providing language services even though their state did not include payment for this service in its capitation rate.

In order to supplement the payments from these sources, it has been necessary for health centers to turn to other grant funds, such as those available through state and local government agencies, or private foundations, to support and expand their enabling services as needed. Grant funding has allowed health centers to design and implement innovative programs and methods for improving access to care for their patients. However, for many health centers, grant funding is often disjointed because the scope of the grants may only provide funding for a short time period, cover one component of enabling services, or support services for a subgroup of patients, which may make it difficult to design a comprehensive and continuous long-term program for patients. Health centers also dedicate many resources to apply for and administer grants, and for health centers with financial constraints, it may not be possible to divert existing resources in order to develop strategies to fund necessary enabling services.

III. Data and Projects on Enabling Services at Health Centers

As the nation focuses on the quality of healthcare, reducing health disparities, and utilizing health information technology, it is timely to discuss the need for better data and evaluation of enabling services at health centers. Capturing information on enabling services and assessing their impact on health care access and outcomes can provide valuable information for other health centers and providers that serve diverse and underserved populations in developing effective strategies and "best practices." Evaluation of enabling services can provide information to managers in allocating resources and monitoring quality. In addition, a systematic method of collecting data nationally, or for multiple health centers, can begin to provide the foundation for developing methods for reimbursement and cost calculations and can help advocate for sustainable funding.

> A lot of enabling services are paid for grant by grant. People assume that the federal grant covers the cost of enabling services, such as interpreters, but it doesn't cover the whole cost; grant funding drives enabling services.

Evaluations of enabling services have primarily focused on specific enabling services or programs such as interpretation services or health education that target a health condition. There have been few documented studies that have been able to standardize enabling services data, or examined the impact of multiple enabling services on health care access and outcomes. Analyses often focus on selected groups of participants and over a limited time frame, and thus, it has been difficult to measure the impact on the health center population as a whole, or monitor the overall patient population or community. Recognizing the importance of collecting enabling services data, health centers have initiated projects to establish a method for tracking enabling services such as those described below.

The Uniform Data Set of the Bureau of Primary Healthcare

Currently available national data on enabling services at health centers is collected through the Uniform Data Set (UDS), the annual reporting system by which federally-funded health centers report to the Bureau of Primary Health Care (BPHC).[15] The UDS includes data on the following enabling services provided by many health centers: case management, child care, discharge planning, eligibility assistance, environmental health risk reduction, health education, interpretation/translation, nursing home and assisted-living placement, outreach, transportation, out-stationed eligibility workers, home visits, parenting education, special education, and a category for "other". As of 2004, the UDS includes whether the health center provides the service, the number of staff that provide the services, and total costs of providing services. Total encounters are reported for some categories.

Development of a Coding Methodology for Enabling Services, MGMA, Inc.

A study was conducted in 2000 for the National Association of Community Health Centers (NACHC) by the Medical Group Management Association, Inc. (MGMA) to validate pilot project studies' results on enabling services at the Oregon Primary Care Association, the Providers of Health Care for the Homeless, and the Waianae Coast Comprehensive Health Center.[16] This study noted that in a fee-for-service environment, the expenses associated with enabling services are often included in the calculation for payment. Health centers track the overall utilization and

expenses associated with these services, but there has been no mechanism for tracking and monitoring the different types of enabling services for reimbursement or evaluation purposes. Payment for services are often through negotiated contracts with managed care organizations (MCOs) using a methodology based on relative value units (RVUs). RVUs assign relative values to medical and dental procedures and are based on codes that help track productivity and expense data, but do not allow for risk adjustment or case severity. RVUs provide a standardized method for

analyzing the resources involved
CPT codes are used to develop
through capitation payments.
codes for enabling services,
MCOs have included the cost of
ated rates, there is currently
reimbursement directly for any
be included in the rates either

> Research questions include: Do Enabling Services improve access compared to not having Enabling Services? How do you provide Enabling Services the most cost-effective or best way possible?

in the provision of a service.
payment rates when reimbursed
However, there are no CPT
and thus while in some cases
these services within the negoti-
no mechanism for collecting
services or costs that might not
through the MCO or the state.

Through this study, a standard-
establishing enabling services
process involved defining ser-
service, provider type, length of
sity or complexity, and location.
track the frequency or utiliza-
using a tracking form over a

ized coding methodology for
RVUs was developed. This
vice units, or components of a
time, as an indicator of inten-
A time study was conducted to
tion of each enabling service,
four-week period. Using the

risk-based relative value system (RBRVS) methodology, enabling services RVUs and cost factors for each RVU were developed. The frequency of services is multiplied by RVUs deriving a weighting factor. Total RVUs are then divided by number of visits to calculate an average RVU. To calculate the cost per RVU, the total cost per visit is calculated, including any and all direct and indirect expenses. Total costs are then divided by total RVUs to derive total cost per RVU. This methodology would make it possible to develop reimbursement methods for enabling services. However, the authors note that the study was limited by the lack of enabling services data which is needed to validate the methodology. For the full report, you may contact Neill Piland, DrPH, at pilaneil@isu.edu.

Health Care for the Homeless UDS Pilot Study

In 2000, a group of Health Care for the Homeless (HCH) project representatives in Region IX (Arizona, California, Hawaii, Nevada) initiated a pilot project to collect additional data by HCH projects for inclusion in their annual reports for the UDS.[17] The HCH projects are federally funded by BPHC as part of the consolidated health centers program and provide important services to the homeless population. Participants believed that the current UDS report did not reflect the significant amount of time and resources that are spent in providing these services, and

managers undercount or underreport their program's activities. The goal of this pilot project was to develop a tool to document the services delivered and a tool to measure service outcomes. The data collected included seven major categories: case management, mental health, health education, substance abuse, medical, nursing, and outreach services. The data provided new information to demonstrate the different levels of service during patient encounters. The programs that participated in the pilot project indicated that the new

information captured through the project was helpful in preparing budgets and staffing patterns and could help assure that resources are available to support these services. The participants recognized, however, that modifying existing data collection systems to capture and track the complexity of the services provided, ongoing information technology support, and the time for data collection activities require additional funding and resources.

Community Health Center Network Project to Track Enabling Services

A project to collect enabling services data to explore tracking and reimbursement of enabling services was initiated by a network of health centers located in Alameda, California. The Community Health Center Network (CHCN) is a partnership of 7 health centers in Alameda County, California, founded in 1996. The network of health centers serve approximately 100,000 patients, of which 30,000 are in Medicaid managed care, and have 132 providers. CHCN supports the health centers in providing management services, such as contracting with health plans, practice management and information technology support, data warehousing, clinical quality improvement or utilization management, and educational support. The patients served by this network of health centers are predominantly from minority groups, with 25% Asian, and 47% Latino.

Figure 3. Mean Number of Annual Office Visits of Clinic "A" Enabling Services Users and Non-Users, 2004
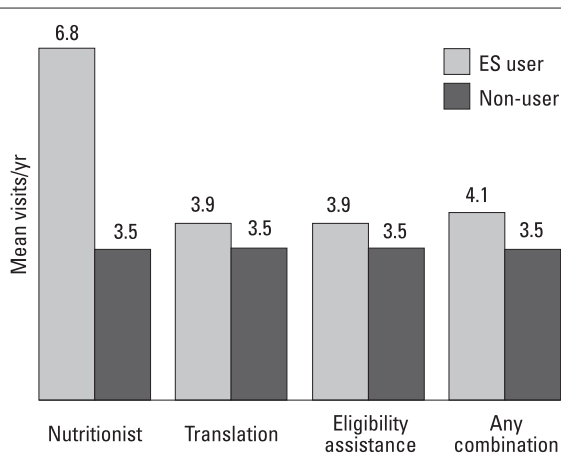
Note: Means of ES users and non-users are statistically different at p < 0.05 in each ES category

CHCN health centers were interested in obtaining data on enabling services encounter data, and in 2002, a project was designed for reporting eligibility assistance, interpretation/translation, and case management (provided by staff other than a physician) for a data warehouse at CHCN.[18] By 2004, only one health center had implemented this process, and the data were analyzed. At this health center, as many as 78% of all patients at the health center had used an enabling service. Translation or interpretation was the primary enabling service provided, making up close to 80% of all enabling services reported for this health center. Patients with high morbidity levels are more likely to use enabling services, suggesting that individuals with greater health needs also have greater need for enabling services. When enabling services (ES) users at this health center were compared with non-ES users, the found that ES users were more likely to have more annual office visits (Figure 3). These results indicate that ES users were disproportionately younger and older, and sicker. While enabling services improve access to care for this population, there is also a higher need for enabling services by the most vulnerable patients. For additional information on this study, please contact Ray Otake at rotake@chcn-eb.org.

IV. Pilot Study to Collect Uniform Enabling Services Data at AAPCHO Health Centers

Background and Overview of Participating Sites

The New York Academy of Medicine (NYAM) and the Association of Asian Pacific Community Health Organizations (AAPCHO) engaged in a project to develop a uniform dataset on enabling services at four AAPCHO health centers in order to begin laying the foundation for evaluation and research studies. The project aimed to develop flexible protocols and tool kits with the intention to replicate and expand the project to other health centers. Funding for this project was provided by MetLife Foundation, the Office of Minority Health, California Wellness Foundation, and Agency for Healthcare Research and Quality.

Figure 4. Overview of Participating CHCs (2004)

	FQHCs Average	AAPCHO FQHCs	CHC 1	CHC 2	CHC 3	CHC 4
# of medical users	12,691	12,740	27,189	10,894	7,691	23,602
# of medical encounters	43,301	52,652	145,398	35,506	30,652	102,054
% non-white	63%	88%	99%	97%	85%	82%
% at or below 200% FPL	91%	90%	90%	89%	87%	76%
% uninsured	40%	38%	24%	26%	46%	17%

Source: BPHC National Rollup, 2004; UDS, 2000

This project emerged from the recognition that Asian Americans and Pacific Islanders (AAPIs) at health centers have a high need for enabling services. Health centers that are members of AAPCHO serve a predominantly minority population, with greater than 50% Asian American or Pacific Islander patients. On average, 77% of patients at AAPCHO health centers are AAPI, many of whom have recently immigrated to United States, and have limited English proficiency.[19] AAPIs at health centers experience many barriers to care. Similar to other health centers, approximately 91% of AAPCHO health center patients have incomes less than 200% federal poverty level, and 39% are uninsured or self-pay (Figure 4).[20] Furthermore, almost two-thirds of their patients are best served in a language other than English, twice as high as the average at health centers nationwide (29%). Reflecting the needs of the population, AAPCHO health centers also had a higher average number of enabling services encounters, and higher average costs than health centers nationwide, as defined by the UDS reporting guidelines (Figure 5).[21]

The four pilot sites are representative of AAPCHO health centers, with 76% to 90% of patients at or below 200% of federal poverty level, and 17 to 46% uninsured or self-pay (Figure 4). The health centers in our project provided geographic diversity and also reflected a range in size and patient mix. The health centers are located in New York City, New York, Seattle, Washington, Honolulu and Waianae, Hawaii. In 2004, the health centers

Figure 5. Costs for Enabling Services Increased from 2000 to 2003 both at AAPCHO Health Centers and Nationally

Average Financial Cost of Enabling Services
(Total cost after allocation of facility and administration)

National 03	$592,565
National 02	$563,886
National 01	$536,980
National 00	$480,402
AAPCHO 03	$1,509,036
AAPCHO 02	$1,510,101
AAPCHO 01	$1,439,043
AAPCHO 00	$1,301,818
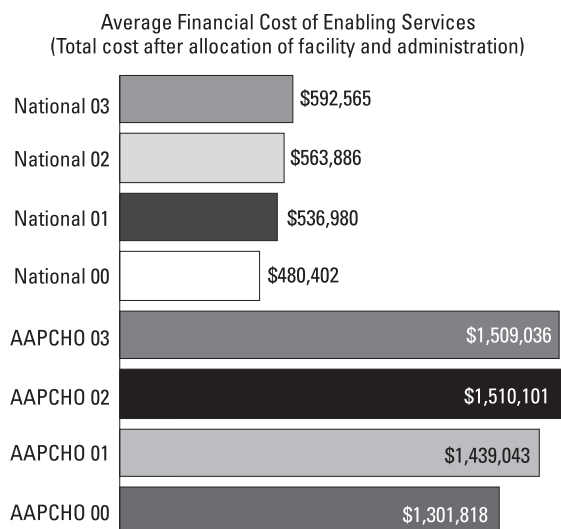
Source: UDS

had between 10,894 and 27,189 medical users and 30,652 and 145,398 medical encounters. In addition, between 82 to 99% of patients were from minority groups, and were primarily Asian American and Pacific Islander.

Implementation and Methods

Implementation began with a needs assessment at the four sites to categorize the different types of enabling services, to determine what enabling services (ES) data was available, and to obtain an overview of other electronic data that could be included in the dataset. The four sites had different practice management systems and different levels of technical support. However, all four health centers in our project had the existing capacity for implementing data collection, which would require new processes and procedures, and the development of electronic databases. Some data on enabling services was already being captured. The most common method of data collection was a handwritten log of services provided with notes for each case, with limited electronic data at each of the health centers.

One of the key aspects of implementation was developing uniform definitions for enabling services. Definitions and the elements of the dataset were developed through a consensus reached by individuals on the AAPCHO Enabling Services Advisory Committee, which included the senior executives and key management personnel from participating AAPCHO health centers. First, enabling services were defined for the purposes of this project as "non-clinical services provided to health center patients that promote and support the delivery of health care and facilitate access to quality patient care," modified from the definition for the UDS by BPHC and the MGMA enabling services project (2000). Interviews with ES providers and discussions with health center managers were conducted to develop ES categories and their definitions for the pilot study. Although the provision of enabling services varied by site, the following eight broad categories were developed to simplify data collection, as well as coding processes, and allowed for flexibility in data collection: case management assessment, case management treatment and facilitation, case management referral, health education, interpretation, eligibility assistance or financial assistance, outreach, and transportation. We also provided an "other" category for this pilot study to capture any enabling service that the health center provided that could not be grouped into one of the eight categories. The common definitions made it

A female patient who was approximately 60 years old with a primary language of Cantonese came into the health center in October of 2001 to seek assistance with financial issues. She resided in Chinatown with her husband, who was disabled, and was at home at the time of the attack on the World Trade Center on September 11th. She was seeking employment, but after the 9/11 disaster, she had even greater difficulty in finding work. In addition, she was very fearful of loud noises and displayed symptoms of post-traumatic stress disorder (PTSD). She did not have health insurance and was hesitant to seek additional medical care. Our Cantonese-speaking providers were able to help her apply for Medicaid, social security, and food stamps, and made an appointment for her to see a mental health provider. Unfortunately, she did not keep her appointment. We learned that her husband would not accept her diagnosis and discouraged her from keeping her appointments. Thus, I called her husband to provide information about her condition, and to encourage him to assist his wife in getting the services she needed. After our conversation, her husband felt more comfortable with her diagnosis, and his wife now receives benefits and her condition has stabilized with the appropriate medication and care.

-Enabling Services Provider, Charles B. Wang Community Health Center

possible for the health centers to engage in discussions around their enabling services, and to aggregate their data for evaluation and research purposes.

Figure 6. "Standard" Enabling Services Encounter Form

A data collection process was established at each of the health centers which began with the development of an encounter form and database at each health center. The "standard" encounter form included the minimum elements for the dataset, but the format of the form was tailored to the specific needs of each site. (See Figure 6 for "standard" encounter form.) Health center management believed that this method was easier to implement than to start data collection using many different specific categories that may not apply to them, or might be difficult to define. However, two of the participating sites chose to include subcategories that captured greater detail of enabling services for their own management purposes.

Enabling services encounter data was collected during each encounter with a patient. The enabling services providers completed an encounter form by indicating the type of service provided and the time spent on each service during the encounter. Patient registration data from existing databases were then linked to patient ID numbers to provide information on patient characteristics and demographics. For tools and details on implementation, please refer to the Enabling Services Data Collection Implementation Packet which can be requested from Rosy Chang Weir, PhD, at rcweir@aapcho.org

Utilization of Enabling Services

To obtain quantitative, descriptive data on enabling services at the four health centers, data from 2004 was analyzed for each individual site, and aggregated for analysis of all four sites. For this analysis, each enabling service that is provided is defined as an "encounter" although it is common for a patient to receive more than one enabling service during one visit. The number of ES encounters provided during the one-year project period ranged from 7,510 to 24,847 ES encounters provided for 2,410 to 11,705 users for an average of 2.7 ES encounters per user (Figure 7). At CHC 1, the project was implemented in the social services department only, and thus, these data only represent a portion of enabling services provided by this health center.

Figure 7. Number of Enabling Services Users, 2004

ID		Quarter in 2004			
	Q1	Q2	Q3	Q4	Total
CHC 1	877	575	498	460	2,410
CHC 2	3,359	1,996	1,523	4,825	11,705
CHC 3	1,104	661	513	2,134	4,412
CHC 4	N/A	2,219	1,643	941	4,803+

Number of ES Encounters, 2004

ID		Quarter in 2004			
	Q1	Q2	Q3	Q4	Total
CHC 1	1,393	2,673	2,649	3,170	9,885
CHC 2	5,570	6,156	6,192	8,929	24,847
CHC 3	2,063	1,782	1,499	2,166	7,510
CHC 4	N/A	4,653	5,784	4,424	14,861

The types of services that health centers provide are very diverse, and represent the needs and demand of the communities they serve (Figure 8). Public transportation is not very accessible for patients at CHC 4 and the health center is located approximately one hour from the nearest city by car. Thus, transportation is one of the major enabling services at this site. At CHC 2 and CHC 3, patients speak many different languages, and thus, interpretation is a key enabling service for

Figure 8. Type of Enabling Services Provided by Health Centers
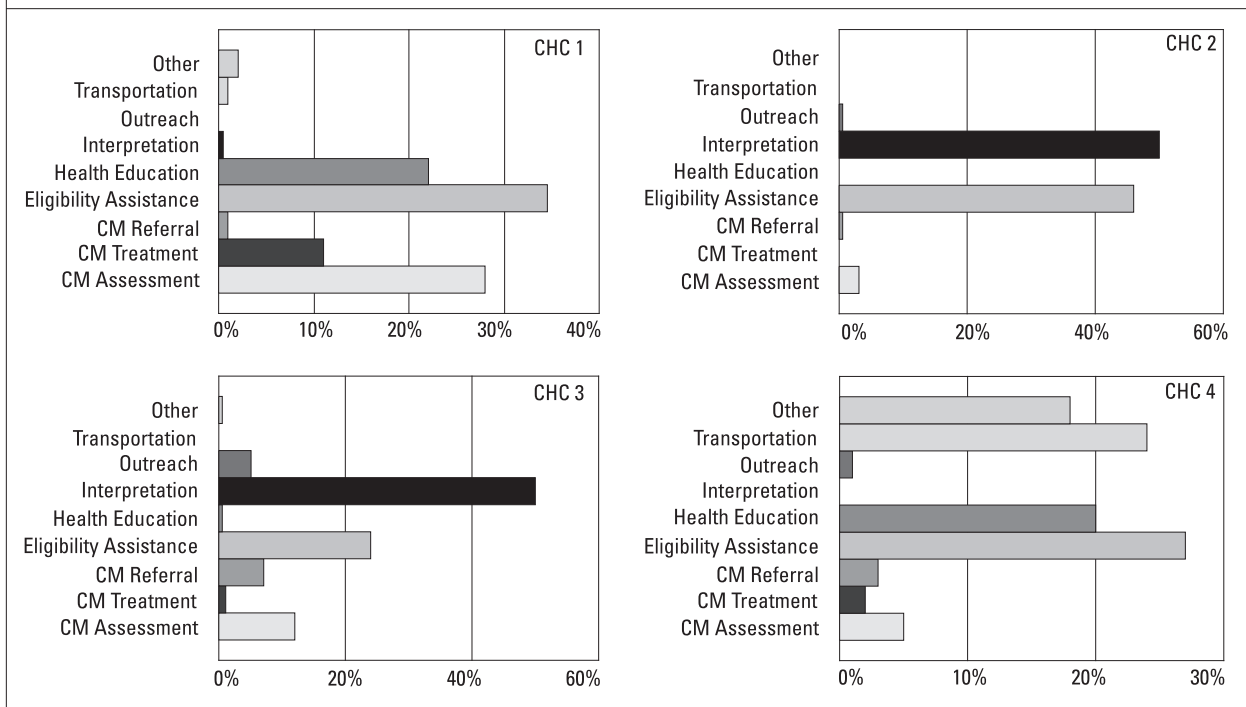
these health centers to ensure that patients are able to communicate with providers, and obtain the health information they need. Many of the ES users at CHC 1 are pregnant women, and case management assessment and eligibility assistance are key enabling services that are provided by their social services providers. The mean length of one enabling service encounter was 19.5 minutes, and the average length of a service ranged from 13 to 34 minutes.

Characteristics of Enabling Services Users

The health centers also standardized the patient data to be included in the dataset to understand the characteristics of enabling services (ES) users. In response to the need for more data on AAPI subgroups, the dataset included disaggregated AAPI data, and primary language (Figure 9). ES users at CHC 1 are predominantly Chinese American, with approximately 51% with a primary language of Cantonese, and 49% with a primary language of Mandarin. Other languages included Fukien and Vietnamese. Approximately half of ES users at CHC 4 are Native Hawaiian, and almost all patients had a primary language of English. The average age of ES users also varies. At CHC 1 and CHC 4, ES users are mostly younger than 30 years old, while at CHC 2 and CHC 3, ES users are mostly older than 30 years old. At all four health centers, the majority of ES users are female, similar to the demographics of the overall patient population at each of the health centers.

An analysis of the data compared the characteristics of patients who use enabling services to those who did not use enabling services, as

Figure 9. Race/Ethnicity of Enabling Services Users
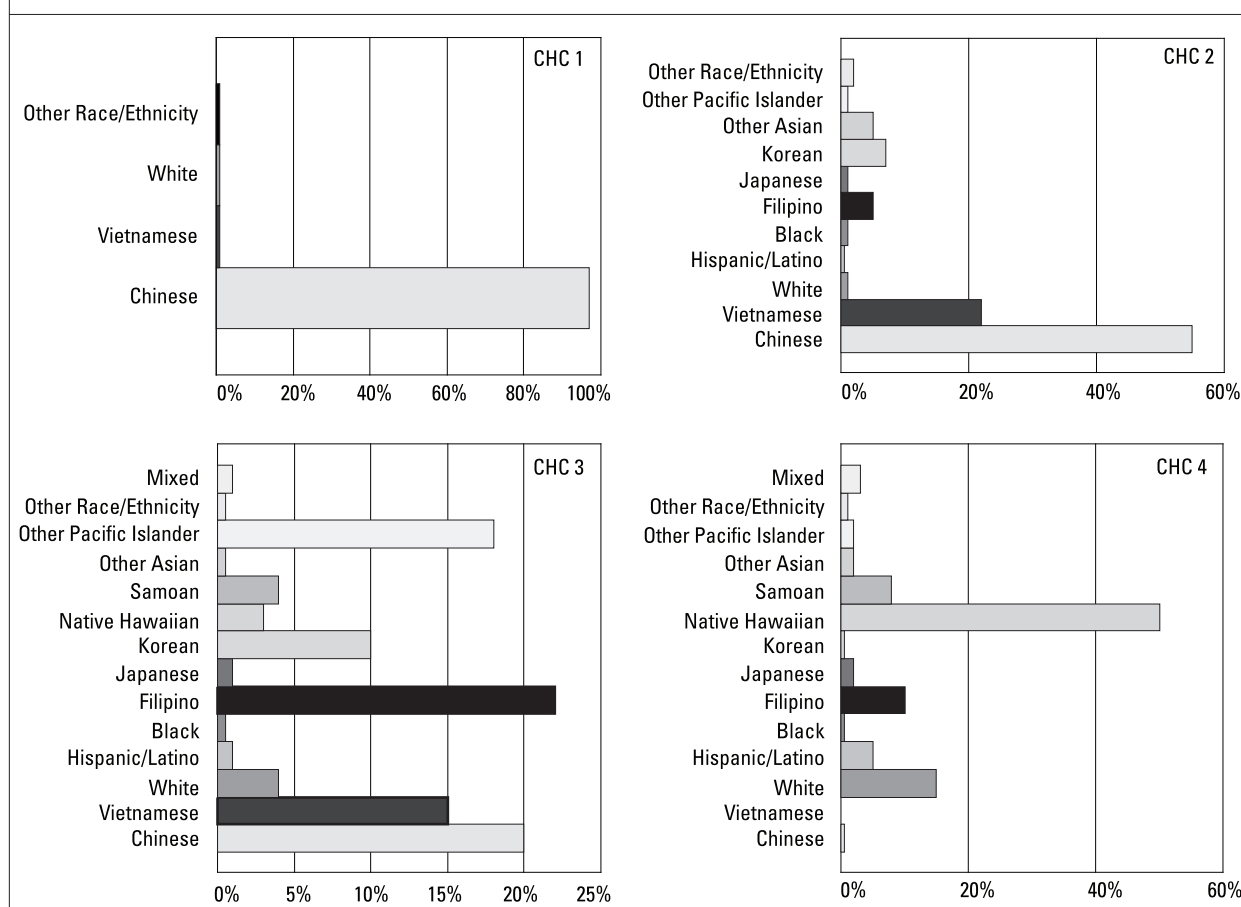
defined by this study. We determined whether patients who had a medical visit in June 2004 had received any enabling service in the previous year (data not shown). Based on our analysis, those patients who had an enabling service were more likely to be non-white, older, female, and uninsured than patients who had not received an enabling service (p<.05). It is not known whether ES non-users had received an enabling service prior to the implementation of the project, and other factors may contribute to the differences observed. Future studies include an analysis of characteristics of patients with different types of enabling services, and an examination of ambulatory care sensitive conditions (ACSCs) and diagnosis by type and number of enabling services received. It is possible to design studies to examine the effectiveness of enabling services on health care access and outcomes for different conditions. For example, the effect of health education or case management on the outcomes of chronic conditions can be analyzed.

Limitations of the Data

It is important to note that the data collected from this study is likely to be an underestimate of the number of encounters and patients served. The pilot study included only those patients who have had a medical encounter and excluded those patients who may have received an enabling service but did not receive medical services from the health center. Inclusion of ES encounters for other health center users is

planned. In addition, encounters that were less than 10 minutes in duration were excluded to limit the burden of data collection for enabling services staff. However, only 25% of enabling services encounters, on average, were less than 10 minutes, and are likely to be a small proportion of all time spent on enabling services. Furthermore, we found that collection of data varied by monitoring and training of staff. At one of the pilot sites, specific enabling services were reimbursed for a period of time, and thus, the data for these services at this site were found to have higher rates of accuracy and completeness. Incentives and performance reviews improved the quality of the data collected. Periodic trainings and feeding the data back to staff also improved the accuracy of the data.

In addition, quantitative analyses may not be able to fully capture the complexity of the enabling services at health centers. For example, an enabling services provider may be working with one patient intermittently for a whole day, and in other cases, it is necessary for the provider to have multiple contacts with the patient and/or family over a period of time to ensure that the patient gets the care s/he needs. Furthermore, utilization can also be affected by the demand for and the ability to provide enabling services due to environmental or external factors. At one health center located in lower Manhattan, there was a greater need for enabling services after the World Trade Center Disaster. The health and economic impact of this tragedy led to the greater need for not only health services, but also case management, health education, and eligibility assistance. Qualitative data and case studies can be used to supplement the data analysis to provide in-depth information about the impact of enabling services on health. Despite these limitations, this project is significant in that we have been able to collect uniform and standardized enabling services data

at four different health centers, and the protocols and implementation process that have been developed can be replicated. The data provides new information on the volume of services, time spent, and staffing.

The data can also be linked to patient health information for evaluation studies to help health centers understand the impact of services on their patients, as well as negotiate adequate reimbursement or funding to ensure enabling services are available and continue to be available for those patients who need them.

V. Conclusions and Recommendations for Action

The data from the Pilot Study demonstrate that there is high utilization of enabling services by health center patients, and the provision of enabling services is a major component of health center activities. Most patients at health centers utilize enabling services and often receive more than one type of service. In fact, the most vulnerable patients – individuals who are uninsured, have limited English proficiency, and experience multiple barriers to care – rely on enabling services to access health services. It is clear that enabling services are critical to the health care that is provided for underserved and minority patients, and that enabling services are a component of culturally competent and patient-centered care.

It is not surprising that health center executives and financial officers in this study have prioritized the collection of enabling services data and the evaluation of these data despite limited resources. The health centers have voiced concern over the growing need for enabling services and the continuity and improvement of these services in the face of budgetary pressures, higher health costs, and the more complex health issues of their patients. While this data collection project required additional resources to implement and sustain, the health centers were able to use the data from the pilot study to expand, improve and manage their enabling services.

An Enabling Services Roundtable meeting, made possible with funding from MetLife Foundation, was held in September 2005, bringing together executives from health centers nationwide, researchers, representatives from federal agencies, and other stakeholders. The Roundtable participants discussed the implications of enabling services data, and the projects that have been initiated by health centers to better understand the impact of enabling services on the health of their patients. As a result of participant comments regarding enabling services data collection,

reimbursement and funding, and research and evaluation, the following recommendations were developed:

• Support a coordinated national effort and the development of national standards for collecting more data on enabling services at health centers

Despite the importance of enabling services to health centers and their patients, there is little known about these services. The few existing studies on enabling services in health care have called for better and more detailed data on the utilization and cost of enabling services. There have been several efforts to define enabling services categories, and to design methods of implementing data collection. A coordinated effort by health centers, potentially through federal organizations or agencies, to collect more data on enabling services using standardized and uniform definitions would fill this gap in knowledge.

• Monitor and share grassroots projects on enabling services data collection and evaluation

Other health centers have initiated efforts to collect enabling services data, and have participated in evaluation efforts for their own purposes. It would be useful to develop a forum for health centers to share their experiences and studies conducted around enabling services. By monitoring other projects, health centers can learn from one another and can pool their resources to assist other health centers with implementation, or develop collaborative efforts to collect enabling services data.

• Collaborate with funding sources to develop reimbursement strategies to cover the costs of enabling services at health centers

Based on reports from health centers, enabling services are not adequately funded. Managed care organizations (MCOs) and state agencies have made some efforts to support enabling services. Collaboration between health centers, MCOs and state Medicaid offices to develop strategies to fund enabling services, such as ensuring that payment rates reflect the total cost of treating a patient, as well as to deliver enabling services to enrollees and beneficiaries could lead to increased access and higher quality of care. It is important that health centers are proactive in developing funding solutions to assure enabling services are provided where and when needed with the appropriate levels of support and resources.

• Demonstrate the impact of enabling services at health centers through evaluation and cost-effectiveness studies

Support for enabling services depends on a clear articulation of which patients would benefit from services, the nature of their need, consensus about which services are effective, and a method for monitoring cost. The lack of sufficient data on enabling services, and specifically those data that can be directly linked to patients and their health data, has made it difficult, if not impossible, for research studies on effectiveness. Researchers, as well as health center managers, indicate that more studies on the effectiveness and impact of enabling services are necessary and can inform the development of strategies to reduce health disparities and improve quality of care for vulnerable populations.

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Footnotes:

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