



Highlighting the Role of Enabling Services at Community Health Centers: Collecting Data to Support Service Expansion & Enhanced Funding

The Enabling Services Accountability Project

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For more information, visit <http://enablingservices.aapcho.org> or contact:

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Highlighting the Role of Enabling Services at Health Centers: Collecting Data to Support Service Expansion and Enhanced Funding

Introduction

The national network of Community, Migrant, Homeless, and Public Housing Health Centers has a 45-year history of delivering high-quality, community-tailored, and affordable primary and preventive care to underserved communities experiencing the most acute health disparities. Also known as Community Health Centers (CHCs) or Federally-Qualified Health Centers (FQHCs), these centers provide a wide range of primary and preventive health services, often including dental, pharmacy, behavioral health, vision, and social services, as well as public health interventions. Chronic care management has also become a regular, and increasingly critical, service. Among their repertoire of care delivery, services that are not clinical in nature but facilitate access to needed care are foundational. Generally known as “enabling services,” they often include case management, interpretation, transportation, and other mechanisms by which patients are directly linked to preventive medicine and necessary treatments. These services break down barriers to care while ensuring care is delivered in culturally and linguistically appropriate settings, and are therefore vital for ensuring access to all forms of care.

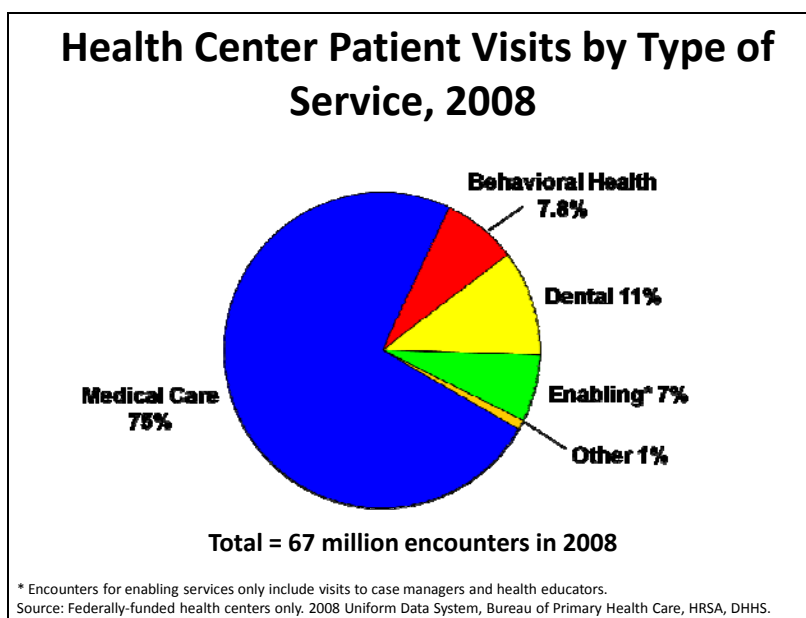
Each of the 1200-plus federally qualified health center organizations provides enabling services (ES), one of the many features that sets health centers apart from most other providers, and hypothesized to be one of the explanations behind health centers’ stellar performance.^{1,2} As more attention is paid to tying reimbursement to “medical homes,” ES help characterize health centers as more comprehensive “health care homes.” Moreover, these services are becoming more vital as growing numbers of health center patients are diagnosed with chronic illness or have barriers to care such as limited English proficiency (LEP).³ ES are key features of health centers and yet health centers are not likely to be adequately reimbursed or funded for their ES, obliging health centers to absorb the costs at the expense of other services or reaching new patients. Medicaid prospective payment rates and federal health center grants have not kept up with the new paradigm and cost of patient care.⁴

A shift in patient insurance mix, either through economic recessions or broad private or public insurance expansion, and an influx of new communities served means that ES will play an increasingly important role in promoting access to health care and improving health outcomes for high-risk populations. For instance, health centers will be called on to assist with insurance enrollment efforts under recently enacted health care reform. Moreover, reaching new communities previously unserved will often require additional ES to break down deep-rooted barriers to care. Yet the lack of data on ES – in terms of its scope, volume, and patient users – is a crucial barrier to securing financial support for these services. Enhanced data collection, as built into health centers' current documentation systems, may persuade payers to enhance payment first by demonstrating the extent of ES services provided and the staff time involved, and second by providing data necessary to evaluate the link between ES and cost savings and improved patient outcomes.

This issue brief, written collaboratively between the Association of Asian Pacific Community Health Organizations (AAPCHO) and the National Association of Community Health Centers (NACHC), describes the relevance of ES and how better quantifying their provision can demonstrate their value to

private and public payers. Federally-funded health centers submit some information on their ES to the Bureau of Primary Health Care (BPHC) as part of their annual Uniform Data System (UDS) reports, but the UDS poorly tracks the scope of enabling services actually provided and needed by health centers. According to the UDS 2008, enabling services make up 7% of all health center services, which is likely an underestimate (**Figure 1**). These services cost health centers \$1.2 billion in 2008.⁵ The current UDS fails to demonstrate the critical impact of these services and the need to adequately finance them to ensure full primary care access and utilization among medically underserved patients. We suspect an underestimate of the amount of ES currently provided. More data are needed to document the scope, extent, and efficacy of ES to support appropriate reimbursement and service expansion.

Figure 1: Health Center Patient Visits by Type of Service, 2008



This issue brief also describes the emerging Health Centers Enabling Services Accountability Project, whereby health centers have implemented a uniform ES tracking system based on a model created by AAPCHO and several of its member centers. The Enabling Services Accountability Project is now expanding to reach more health centers, which can implement their own ES data collection system and take advantage of NACHC and AAPCHO's training and technical assistance.

Background

What are Enabling Services? Enabling services (ES) are non-clinical services that support the delivery of basic health services and facilitate access to comprehensive patient care as well as social services. They include case management, benefit counseling or eligibility assistance, health education and supportive counseling, interpretation, outreach, transportation, and education of patients and the community regarding the availability and appropriate use of health services. Federal law detailing health center program requirements places equal emphasis on ES as it does primary care services, requiring that health centers provide a basic level of each.⁶⁷ Health centers customize their design to fit the needs of their communities, thereby ensuring that ES tackle common and unique barriers to care. Accordingly,

the exact nature of how ES are delivered will vary from community to community, but the purpose remains the same. This customization is critical to increase access to care and ensure full health center participation for all medically underserved patients.

Why are Enabling Services Important? Clearly, ES strive to bring care to patients who would otherwise go without. They often serve to “bring patients in the door,” but can also bring the care to the patients. In breaking down both common and personal barriers to care, ES are particularly important for those communities that experience the most acute health disparities in terms of access and outcomes. These include the poor, members of racial and ethnic minority groups, the uninsured and underinsured, and geographically and culturally isolated populations – the very communities served by health centers. ES are also of growing importance for patients with chronic illness, given their need for frequent health care visits and the complicated services necessary for chronic care management. Patient visits for treatment of chronic illness now make up a quarter of all recorded visits.⁸

ES ensure that underserved, minority patients can obtain culturally and linguistically appropriate health care. Research demonstrates that case management improves access to care for substance abusers⁹ and those with chronic disease.¹⁰ Interpretation services are particularly important because health disparities are often magnified for patients who are Limited English Proficient (LEP). These services increase timeliness of care for children in Medicaid managed care.¹¹ Interpretation services also increase satisfaction among Spanish-speaking patients for physician and hospital care, and are associated with reducing emergency room visits, thereby reducing costs.¹² Further, health education positively affects general nutrition knowledge and dietary intake behavior,¹³ and improves diabetes health outcomes among African American and Latino minorities nationally^{14 15 16} as well as cardiovascular disease outcomes for high-risk Latinos served by Community Health Centers.¹⁷ Eligibility assistance and enrollment in health insurance programs alleviate patient financial concerns, and transportation services facilitate patient access to the clinic. Of course, barriers to care are often complex and interrelated, making the need for a variety of ES that much greater.¹⁸

Although there has been very little research conducted to date on health centers’ provision of ES, multiple studies show better access to primary and preventative care among health center patients relative to their non-health center counterparts, with enabling services highlighted as a significant contributor to that difference.¹⁹

Among the four health centers participating in AAPCHO’s ES demonstration study, health center ES users have better immunization rates and better outcomes for diabetes compared to those health center patients that did not use ES.²⁰ **(Figures 2 and 3)** Although the ES used by these health centers varied by individual health center, as an aggregate, the most common were financial counseling/eligibility assistance and interpretation. A separate study also found that average HbA1c level significantly improved for active ES health education users than non-active users one year after baseline, indicating that utilization of ES is associated with improved diabetes outcomes.²¹ **(Figure 4).**

Figure 2: Impact of Enabling Service Utilization on HbA1c

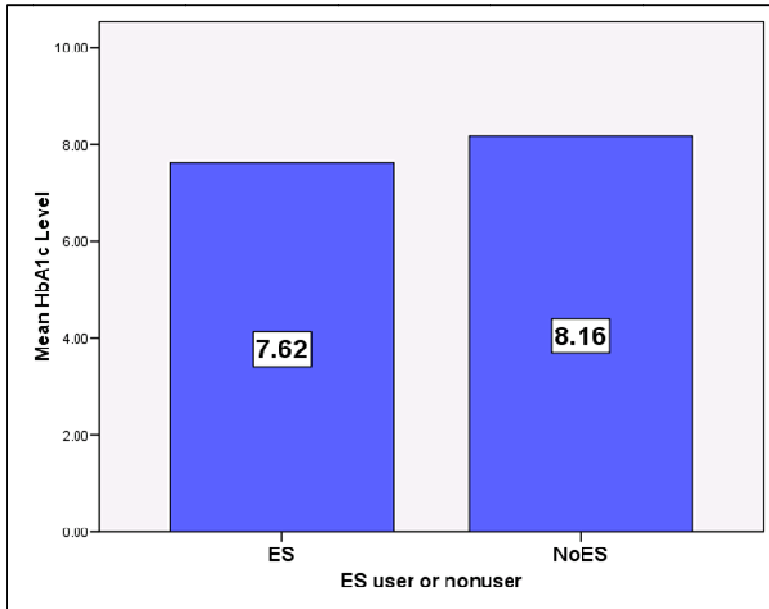


Figure 3: Impact of Enabling Service Utilization on Immunization

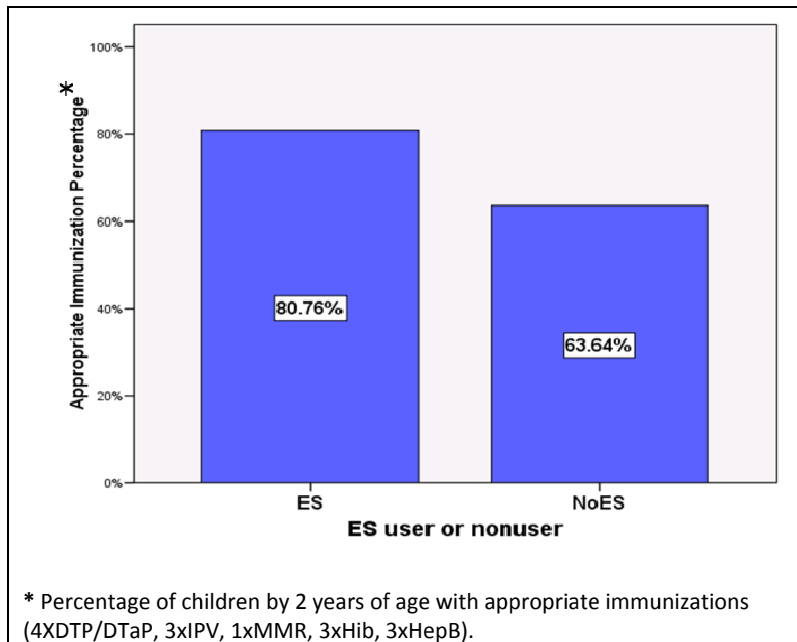
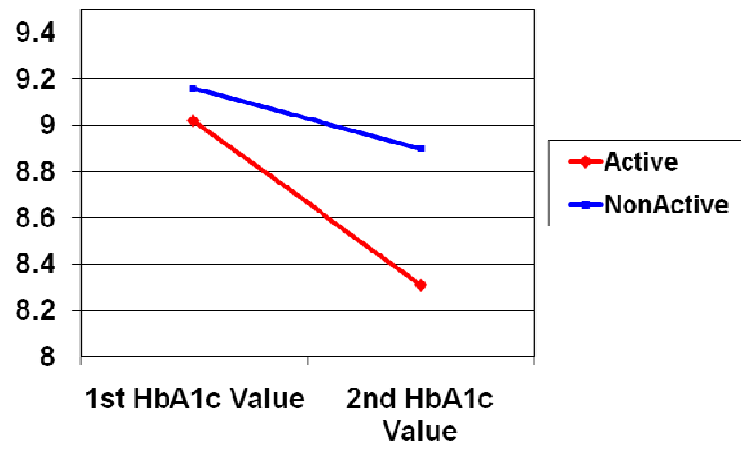


Figure 4: Mean HbA1c Values by Active and Non-Active Enabling Service Users



Funding for Enabling Services

Despite their importance for improving access to care and potential to reduce health disparities, ES are often inadequately funded. For example, nearly one-third of all health center patients, or 6 million people, have limited English proficiency (LEP). Although serving LEP patients adds 5-30 minutes (average 15 minutes) to a patient visit, or double the time for non-LEP patients, only 5% of surveyed CHCs reported receiving reimbursement for these services.²² Based on these survey results, NACHC estimates that the gross cost of language services for all health centers nationally is more than \$200 million per year. Although CMS approved payments for language services ten years ago, only 12 state Medicaid programs currently reimburse for these services.

ES are often jeopardized during times of political and financial pressures because they are usually non-billable or non-reimbursable services, and are often funded through disjointed and term-limited grant funding. Managed Care Organizations often are not required to provide these services, and fund only 55% of language services and 32% of health education services.²³ It is possible that with a need to cut costs, funding non-reimbursable services could become more difficult. Unfortunately, due to lack of data, one is unable to determine whether services were cut, or became underfunded. Adequate and sufficient funding should be explicitly directed to pay for ES to assure they are provided where and when needed in sufficient volume and with appropriate staffing levels. However, the current lack of data on enabling services impedes the ability to quantify the need and demand for services, or to demonstrate their effectiveness.

Health centers are not likely to be adequately paid for the full scope of care delivered. While three-quarters of patients nationally are uninsured or enrolled in Medicaid, neither Medicaid prospective payment rates nor federal health center grants have kept up with the cost of patient care. Medicaid remains the most reliable payer across all other third-party payers, yet still only covers 83% of health centers' total Medicaid costs.²⁴ And this proportion has been slipping over the last few years despite a

2005 report from the US Government Accountability Office (GAO) warning that many states were not properly setting or rebasing the Medicaid Prospective Payment System (PPS) to account for all Medicaid-covered health services at health centers, and that the medical inflation index used to set PPS did not adequately adjust for costs increases.²⁵ Federal health center grant dollars, when calculated per patient or per uninsured patient, have been declining in both real and nominal dollars over the last 10 years.

While Medicaid and federal grants make up the two largest sources of health center revenue nationally, reflecting the larger proportion of Medicaid-enrolled and uninsured patients nationally, Medicare, other public, and private insurance remain significant sources of revenue for many health centers as well as important sources of insurance coverage for their patients. Medicare, other public, and private insurance sources pay only 65%, 61%, and 57% of their related patient costs, respectively. The proportion of patient mix and revenue derived from these sources will increase as patients age, and under insurance expansions that will come under health reform. As of 2008, the most recent year of national health center data, 16% of health center patients nationally are privately insured, a slight uptick from previous years.²⁶

However, state budget shortfalls and economic recessions have placed added burdens on health centers as they struggle to keep up with rising numbers of uninsured and underinsured patients with fewer resources to cover their costs. The recent economic crisis has intensified the demand for underfunded enabling services, especially with many more uninsured patients. Reliance on federal funding, including the recent \$500 million in capacity funding health centers received over two years under the American Recovery and Reinvestment Act of 2009, is particularly crucial for building ES, but it is the gap in payments from third-parties as well as cuts in direct state grants to health centers that quickly drain and divert these federal resources.

A recent study of health center enabling services found that those health centers with more managed care contracts and more staff tended to provide a broader range of ES, as well as more ES visits compared to other health centers. The same study found that the more health centers rely on federal grants, the fewer the ES visits they could provide. However, the higher the total revenue, the more ES are provided, thereby indicating the importance of Medicaid and other revenue sources in terms of supporting health centers' ability to serve all patients.²⁷

Adequate and consistent funding is necessary to support and expand ES for vulnerable populations. Health centers are historically committed to providing these services and have been absorbing their costs. Yet insufficient payment means that health centers are limited in their ability to fully utilize ES to reach more patients. ES represent an indispensable tool for ensuring access and utilization to appropriate care, yet the business case for adequate payment from third-party payers has not been made.

The Enabling Services Knowledge Gap

While Community Health Centers (CHCs) are a vital component of our nation's safety net, there is limited information on the scope of their ES, and the exact benefits they bring to patients and payers. Despite the fact that there is some evidence of the positive impact ES have in access to care and quality improvement, this information is spotty and data are generally unavailable to help health centers target or improve their ES. At a national enabling services roundtable convening, some health centers, providers, and federal officials have indicated enabling services make a substantial impact on improving

health care access and outcomes for medically underserved patients, but have not been adequately supported and funded.²⁸

Currently, the ability to develop studies at health centers to understand the scope and impact of enabling services is limited due to the general lack of data and data collection tools/registries on enabling services. An examination of the level of utilization and the characteristics of health center enabling services users can increase our understanding of the need and demand for enabling services by different underserved groups served by health centers. Such new data collection and associated data collection tools developed can then be used as the foundation for the design of larger, more comprehensive studies examining the impact of enabling services on quality of care and health outcomes. The data can also be used by health center managers and executives for developing new programs and allocating their limited resources to best serve their underserved patient populations. For example, if results indicate that medical staff spend the majority of their time providing interpretation services, more resources could be allocated to hiring interpreters. Ultimately, the data can provide important new information about the enabling service needs and their impact on health care and outcomes for medically underserved patients served by community health centers.

Building the Business Case for Enabling Services

Tightening budgets necessitate that health centers and payers carefully weigh program costs with benefits. The business case for ES must demonstrate the value of these ES – that is, document the scope and volume of ES provided and to whom, as well as the association of ES with improving patient outcomes and health care savings. Only by quantifying these services can health centers validate the need for improved payment of ES and evaluate the effectiveness and efficiency of specific ES. Moreover, measuring ES delivery could also uncover needs for new types of ES, or particular patient populations that could benefit from targeted ES. As budgetary crises ensue, it becomes especially crucial to document the importance of enabling services.

Currently, little is known about the utilization of enabling services, or the methods of delivery of these services and their impact on health outcomes. Moreover, a uniform mechanism to track or evaluate the effectiveness of ES does not currently exist. For example, we currently do not know how many patients access this set of services, the types of patients who use them, how often patients require these services, and how many resources per individual patient are required to provide each service to each individual patient. Health centers' UDS reports include partial information about ES staffing for case managers, patient/community education specialists, outreach workers, transportation staff, eligibility assistance workers, interpretation staff, and other enabling services. The UDS also provides a limited accounting of patient users and patient visits for ES, but only for those seen by case managers and education specialists, and does not indicate which patients are actually receiving these services.

Establishing nationally recognized standards is an essential first step in fully quantifying the value of ES on health care delivery and outcomes, as well as help support the delivery of health care that is culturally and linguistically appropriate for mitigating health disparities. The lack of such standards and data collection protocol for ES restricts health centers in collecting comparable data needed to justify these services and for negotiating roles, responsibilities, and payment with Medicaid or managed care organizations. Both private and public payers are more inclined to pay for services that are coded and documented through nationally recognized standards. Furthermore, with sufficient evidence on the

volume and value of enabling services for our underserved populations, federal funding agencies may be more likely to provide funding support.²⁹

The Enabling Services Accountability Project: Developing Nationally Recognized Standards

Attempts to establish standards for collecting ES utilization data began in 2000, when NACHC contracted with the Medical Group Management Association, Inc. (MGMA) to validate pilot project study results on ES at three separate CHCs.³⁰ MGMA came up with nine broad categories for standardizing ES data collection. The study found that although the health centers tracked the overall utilization and expenses associated with ES, there was no tracking and monitoring of these services for evaluation purposes or for purposes of determining reimbursement.

More recently, AAPCHO partnered with four health centers serving predominantly Asian American, Native Hawaiian, and Pacific Island populations and NACHC to pilot the Enabling Services Accountability Project. The project builds off MGMA's recommendations, and simplifies many of its tracking system recommendations. Over the last three years, these health centers have collected and monitored standardized ES utilization data through customized tracking systems. Each of the four health centers adopted their own enabling services encounter form based on the AAPCHO uniform data collection template (**Figure 5**) and tailored it to their health center protocols and system, including EHR. See **Figure 5** for the standard template and **Figure 6** for a sample ES EHR template. Thus, although some health centers may have added additional categories or sub-categories into their enabling service encounter forms, they ultimately collected and reported the same broader categories of uniform ES data. The protocols for collecting data build off the NACHC/MGMA report, but made several adjustments to refine the measures collected within broad ES categories, and to address differences in staffing and information technology capacity among multiple health centers.

Figure 5: Uniform Enabling Services Data Collection Template

Service Date	Provider ID	Patient ID	Patient DOB	Patient Gender <input type="checkbox"/> M <input type="checkbox"/> F	Pt. Zip Code										
Encounter Type (check only one):		<input type="checkbox"/> Face to Face	<input type="checkbox"/> Telecommunication	<input type="checkbox"/> Off-site											
Appointment Type (check only one):		<input type="checkbox"/> Scheduled	<input type="checkbox"/> Walk-in												
Group or Individual (check only one):		<input type="checkbox"/> Group	<input type="checkbox"/> Individual												
B. Payor Source at time of service (check)															
A. Managed Care <input type="checkbox"/> Y <input type="checkbox"/> N			B. Sliding Fee <input type="checkbox"/> Y <input type="checkbox"/> N												
C. Carrier at time of service (check only one)															
<input type="checkbox"/> Medicaid		<input type="checkbox"/> Medicare	<input type="checkbox"/> Other Public including Non-Medicaid CHIP												
<input type="checkbox"/> Private		<input type="checkbox"/> Self-pay	<input type="checkbox"/> Other (please specify):												
D. Primary Language (check only one)			E. Race/Ethnicity (check only one)												
<input type="checkbox"/> English	<input type="checkbox"/> Mandarin	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Asian Indian/ South Asian	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> White										
<input type="checkbox"/> Cantonese	<input type="checkbox"/> Samoan	<input type="checkbox"/> Visayan	<input type="checkbox"/> Chinese	<input type="checkbox"/> Guamanian/ Chamorro	<input type="checkbox"/> Hispanic/ Latino										
<input type="checkbox"/> Hmong	<input type="checkbox"/> Spanish		<input type="checkbox"/> Filipino	<input type="checkbox"/> Samoan	<input type="checkbox"/> Black/ African American										
<input type="checkbox"/> Japanese	<input type="checkbox"/> Tagalog		<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> Mixed – AAPI										
<input type="checkbox"/> Khmer	<input type="checkbox"/> Tibetan	<input type="checkbox"/> Other (please specify):	<input type="checkbox"/> Korean	<input type="checkbox"/> American Indian/ Alaskan Native	<input type="checkbox"/> Mixed – Other										
<input type="checkbox"/> Korean	<input type="checkbox"/> Thai		<input type="checkbox"/> Vietnamese		<input type="checkbox"/> Other (Please specify):										
<input type="checkbox"/> Laotian	<input type="checkbox"/> Tongan		<input type="checkbox"/> Other Asian		_____										
Check if applicable:															
<input type="checkbox"/> Cannot read/write primary language															
<input type="checkbox"/> Service provided in language other than English															
Specify language _____															
F. Place of Birth (check only one)			G. Job Type (check only one)												
<input type="checkbox"/> U.S.	<input type="checkbox"/> Laos	<input type="checkbox"/> Africa	<input type="checkbox"/> General Enabling Services Provider	<input type="checkbox"/> Administrator/Clerk/ Facility Staff	<input type="checkbox"/> Physician (MD or DO)										
<input type="checkbox"/> Pacific Islands	<input type="checkbox"/> Philippines	<input type="checkbox"/> Latin, Central, or South America	<input type="checkbox"/> Case Manager	<input type="checkbox"/> Community Health Worker	<input type="checkbox"/> Physician's Assistant										
<input type="checkbox"/> China	<input type="checkbox"/> South Asia		<input type="checkbox"/> Eligibility/Financial Worker	<input type="checkbox"/> Counselor/Therapist (certified or licensed)	<input type="checkbox"/> Social Worker (certified or licensed)										
<input type="checkbox"/> Taiwan	<input type="checkbox"/> Thailand	<input type="checkbox"/> Other Place of Birth (Please specify)	<input type="checkbox"/> Health Educator	<input type="checkbox"/> Dental Personnel	<input type="checkbox"/> Traditional Healer										
<input type="checkbox"/> Japan	<input type="checkbox"/> Vietnam	_____	<input type="checkbox"/> Counselor/Therapist	<input type="checkbox"/> Medical Assistant											
<input type="checkbox"/> Korea	<input type="checkbox"/> Other Asian Country		<input type="checkbox"/> Interpreter	<input type="checkbox"/> Nurse (NP, RN, LVN, Midwife)	<input type="checkbox"/> Other (please specify)										
<input type="checkbox"/> Cambodia	<input type="checkbox"/> Europe		<input type="checkbox"/> Outreach Worker	<input type="checkbox"/> Nutritionist	_____										
			<input type="checkbox"/> Transportation Provider	<input type="checkbox"/> Pharmacist											
			<input type="checkbox"/> Volunteer												
H. ENABLING SERVICE		CODE	MINUTES (Circle one or specify in Other if > 120 minutes)										Other		
Case Management – Assessment		CM001	10	20	30	40	50	60	70	80	90	100	110	120	
Case Management – Treatment and Facilitation		CM002	10	20	30	40	50	60	70	80	90	100	110	120	
Case Management – Referral		CM003	10	20	30	40	50	60	70	80	90	100	110	120	
Financial Counseling/ Eligibility Assistance		FC001	10	20	30	40	50	60	70	80	90	100	110	120	
Health Education/ Supportive Counseling		HE001	10	20	30	40	50	60	70	80	90	100	110	120	
Interpretation Services		IN001	10	20	30	40	50	60	70	80	90	100	110	120	
Outreach Services		OR001	10	20	30	40	50	60	70	80	90	100	110	120	
Transportation		TR001	10	20	30	40	50	60	70	80	90	100	110	120	
Other: describe services below		OT001	10	20	30	40	50	60	70	80	90	100	110	120	

Figure 6: Sample Enabling Services EMR Template

SW Enabling Service: A TEST

Time per Enabling Service (in minutes)

Assessment [Dropdown]

- SW Intake Assessment
- SW Ongoing Assessment

Treatment and Facilitation [Dropdown]

- SW Individual Support Counseling
- SW Marriage/Partnership Counseling
- SW Family Counseling
- SW Parenting Counseling
- SW Review Reproductive Health Care Options
- SW Case Coordination
- SW Case Advocacy
- SW Provide Information/Resource

Referral Services [Dropdown]

- SW Early Intervention/Special Education
- SW VNS/VNR/Homecare
- SW Domestic Violence Service
- SW Home Care
- SW Housing
- SW WIC
- SW Other Referral

Health Education [Dropdown]

- SW Individual
- SW Group

Financial/Eligibility Counseling [Dropdown]

- PCAP
- Medicaid
- Medicare
- Managed Care
- SSI
- Public Assistance
- Public Housing
- Other

Interpretation Services [Dropdown]

Outreach Services [Dropdown]

Transportation [Dropdown]

Other [Dropdown]

Prev Form (Ctrl+PgUp) Next Form (Ctrl+PgDn) Close

AAPCHO and the partnering health centers have successfully implemented data collection protocols within a few months to a year depending on the time health centers were able to dedicate to implementing the system. One health center was able to use the data to obtain better reimbursement from a Medicaid managed care payer.³¹ Moreover, AAPCHO analysis of the data found that ES utilization is associated with better diabetes outcomes and child immunizations, despite the fact that ES users were more likely to be minorities with no or public insurance compared to other health center patients.

Participating in the Enabling Services Accountability Project

The Enabling Services Accountability Project is now ready to expand. With only four health centers, it is difficult to measure the true impact of each ES measure. Yet the tracking system that is already in place can be incorporated into other health centers' practice management and/or electronic health record systems. This program stands as a real opportunity for those health centers that want to collect a higher level of ES data and make the business case for their provision.

Uniform enabling services data will make it possible to better understand the integral role of these services at health centers, and to examine the impact of enabling services in improving access to and quality of care. In AAPCHO's experience, the ES data provide health center managers with the tools to allocate their limited resources to meet the needs of their patients, as well as inform the development of new strategies and interventions. For example, health centers have been able to better allocate appropriate interpretation services in languages to match the profile of patients who need them, as well as made management decisions to bring in health plan representatives onsite to assist with eligibility assistance for uninsured patients, thereby improving effectiveness and efficiency of services.

As next steps, the replication of data collection efforts and utilization of uniform data collection tools nationally across the health center system and more research studies could provide valuable information for policy makers and other providers in reducing health disparities and improving quality for all, particularly for the most vulnerable populations.

AAPCHO and NACHC are working collaboratively to bring the Enabling Services Accountability Project to more health centers. We will be recruiting health center volunteers to participate in data collection, providing technical assistance to support this effort, housing a national data repository, and analyzing de-identified data to determine the patient-, community-, payer-, and health center-level benefits these services bring .

Important Resources. The Enabling Services Accountability Project provides a model of data collection for health centers, including feasible tools for health centers to assist them with implementation. The Enabling Service Data Collection Implementation Packet³² includes standardized definitions of enabling services, a valuable handbook on data collection procedures, sample data collection templates for health center electronic health records or practice management systems, and sample encounter forms that health centers can use to support their data collection. These enabling services resources can be found at: <http://enablingservices.aapcho.org>. AAPCHO can also provide technical assistance services. The packet is designed to help health centers collect their own data and use it to advocate for enabling services funding, as well as for their quality management purposes. Health centers may also work with AAPCHO to compile their ES data with other health centers to advocate for funding. This model could be used by all CHCs to initiate a data collection effort.

As data collection efforts occur relating to ES in CHCs, AAPCHO and NACHC envision developing a forum for the centers to be able to share experiences and best practices so that they can learn from one another while encouraging the shared standards of ES definitions and data collection. This would allow CHCs to collaboratively and successfully advocate for adequate reimbursement and appropriate funding for provision of enabling services at CHCs nationwide and thereby improve care for medically underserved populations at large.

To learn how your health center can become engaged, visit <http://enablingservices.aapcho.org>.

Conclusion

Enabling Services are often the mechanism by which patients get the care they need, especially for hard-to-reach patients such as those with limited English proficiency, chronic illnesses, geographic, and cost barriers. Most patients experience more than one of these obstacles. Despite the ability of ES to facilitate access to care and potentially improve outcomes, these vital services are regularly underfunded.

Health centers' constrained budgets will become only more so as demand for health center services increases. This is the case regardless of whether health centers experience an influx of new uninsured or insured patients. Many new patients will be especially reliant on ES, such as insurance enrollment assistance, translation and interpretation, transportation, and case management, especially those with chronic illness and multiple co-morbidities. Enhanced financial support is therefore essential to ensure that ES are provided to underserved patients who require them, and by extension, to ensure these patients receive the high-quality clinical care they need.

Standardization of an enabling services data collection protocol will ensure that all health centers have the tools they need to provide funding agencies with the information they require. The data will also provide crucial information, such as the cost and level of resources required to provide these services, and justify the need for adequate funding of these critical services. Overall, the documentation and examination of enabling services will help improve health outcomes and reduce health disparities for underserved populations.

A model is currently in place for health centers that want to build the business case for ES. Any health center wishing to join the Enabling Services Accountability Project should contact AAPCHO at the contact information listed below.

Enabling Services Resources

<http://enablingservices.aapcho.org>

Contact Information

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