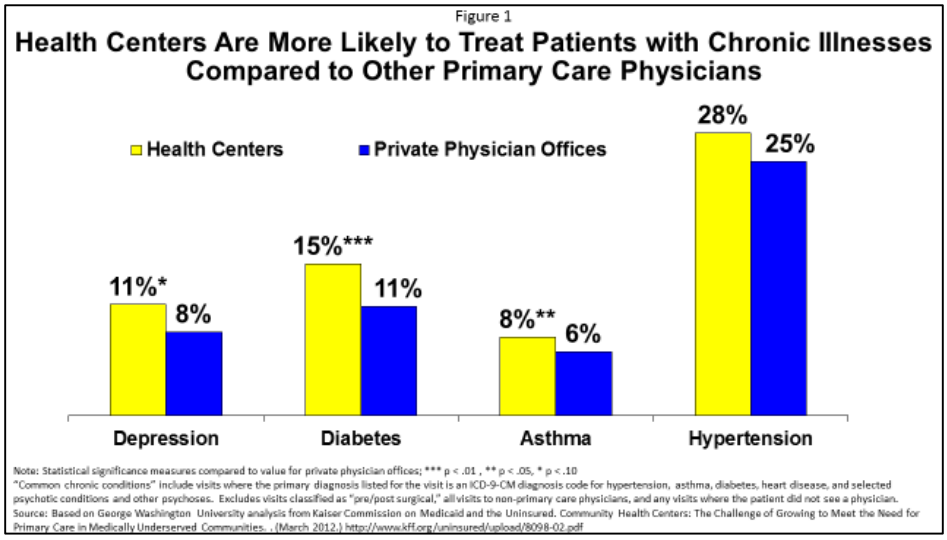
Snapshot:
Health Centers Disproportionately Serve Patients with Costly Chronic Conditions

Hypertension, diabetes, depression, and asthma are some of America's most burdensome chronic conditions, costing the US health care system an estimated $200 billion, $174 billion, $83 billion, and $56 billion a year respectively.[1] These chronic conditions disproportionately affect Americans of diverse racial and ethnic backgrounds and of lower socioeconomic status,[2] populations that make up the vast majority of health centers' patient populations. Due to their high prevalence and high costs, these conditions are considered priorities for action by Healthy People 2020 and the Agency for Healthcare Research and Quality (AHRQ).[3]

Diabetes, hypertension, depression, and asthma are the most commonly seen chronic illnesses at health centers.[4] Health centers serve large volumes of these patients and also disproportionately serve more patients with these chronic conditions than other providers (Figure 1).

Figure 1



Despite the complexity of serving at-risk patients with a high burden of chronic illness, health centers provide high quality chronic care that meets or exceeds national practice standards,[5] improves outcomes and reduces complications,[6] and generates savings through effective care management and prevention.[7] Overall, health centers save the health care system $24 billion annually.[8]

[1] Total costs include both direct costs of health care services, indirect costs represented by missed days of work, disability, premature mortality, and costs of complications associated with each condition. Heidenreich PA, et al. Forecasting the Future of Cardiovascular Disease in the US: A Policy Statement from the American Heart Association. *Circ*. 2011; 123:933–44. Centers for Disease Control and Prevention. Asthma's Impact on the Nation: Data from the CDC National Asthma Control Program, 2011. Atlanta, GA: DHHS, CDC, 2011. American Diabetes Association. Economic Costs of Diabetes in the US in 2007. *Diabetes Care* 2008; 31:596–615. Greenberg PE, et al. The Economic Burden of Depression in the US: How Did It Change between 1990 and 2000? *JCP* 2003; 64:1465-75. [2] Centers for Disease Control and Prevention. CDC Health Disparities and Inequalities Report—United States, 2011. *MMWR* Jan 2011. Vol. 60. [3]Agency for Healthcare Research and Quality. Priority Areas for National Action: Transforming Health Care Quality. National Academics Press: 2003. Edited by Karen Adams and Janet M. Corrigan, IOM Committee on Identifying Priority Areas for Quality Improvement, Healthy People 2020, Topics and Objectives. Accessed on April 11, 2014 at http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx. [4] 2012 Uniform Data System, Health Resources and Services Administration, Bureau of Primary Health Care, Department of Health and Human Services. [5] Goldman, LE, et al. Federally Qualified Health Centers and Private Practice Performance on Ambulatory Care Measures. *Am J Prev Med.* 2012; *43*(2):142-149. [6] Chin, M. Quality Improvement Implementation and Disparities: The Case of the Health Disparities Collaboratives. *Med Care*. 2010 Aug;48(8):668-75. [7] Huang E, et al. The Cost Consequences of Improving Diabetes Care: The Community Health Center Experience. *Jt Comm J Qual Saf.* 2008 Mar; 34 (3): 138-146. [8] NACHC analysis based on Ku L, et al. *Using Primary Care to Bend the Curve: Estimating the Impact of a Health Center Expansion on Health Care Costs.* Geiger Gibson/RCHN Community Health Foundation at the George Washington University. Policy Research Brief No. 14. September 2009.

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