



# Health Centers: America's Primary Care Safety Net Reflections on Success, 2002-2007

U.S. Department of Health and Human Services  
Health Resources and Services Administration  
Bureau of Primary Health Care



## Acronyms

BPHC	Bureau of Primary Health Care
FQHC	Federally Qualified Health Center
HCH	Health Care for the Homeless Program
HHS	U.S. Department of Health and Human Services
HRSA	Health Resources and Services Administration
LBW	Low Birthweight
MHC	Migrant Health Center Program
NHSC	National Health Service Corps
PCA	Primary Care Association
PCO	Primary Care Office
PHPC	Public Housing Primary Care Program
PHS	Public Health Service Act
SCHIP	State Children's Health Insurance Program
UDS	Uniform Data System

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# The Health Center Program: An Overview

For more than 40 years, health centers in the United States have delivered comprehensive, high-quality primary health care to patients regardless of their ability to pay.

During that time, health center grantees have established a tradition of providing care for people underserved by America's health care system: the poor, uninsured, and homeless; minorities; migrant and seasonal farmworkers; public housing residents; and people with limited English proficiency.

Federal support for entities that would later be called health centers began in 1962 with passage of the Migrant Health Act, which funded medical and support services for migrant and seasonal farmworkers and their family members. Two years later, the Economic Opportunity Act of 1964 provided Federal funds for two "neighborhood health centers," which were launched in 1965 by Jack Geiger and Count Gibson, physicians at Tufts University in Boston.<sup>1</sup>

Those first two centers created an innovative new model of community-based, comprehensive primary health care that focused on outreach, disease prevention and patient education activities. The early centers also promoted local economic development, job training, nutritional counseling, sanitation, and social services. Most importantly, they established one of the enduring principles of the program: respect for patients and communities and their involvement in the operation and direction of health centers.<sup>2</sup>

### Health Center Program Fundamentals

Located in or serve a high need community designated as a medically underserved area or population.

Governed by a community board composed of a majority (51 percent or more) of health center patients who represent the population served.

Provide comprehensive primary health care services as well as supportive services (education, translation, and transportation, etc.) that promote access to health care.

Provide services available to all with fees adjusted based on ability to pay.

Meet other performance and accountability requirements regarding administrative, clinical, and financial operations.

In the mid-1970s, Congress permanently authorized neighborhood health centers as “community health centers” and “migrant health centers” under sections 329 and 330 of the Public Health Service Act. Congress expanded the health center system in the later years of the 20th century. In 1987 the Health Care for the Homeless program was created by the McKinney Homeless Assistance Act and 3 years after that the Public Housing Primary Care program was established by the Disadvantaged Minority Health Improvement Act of 1990. Passage of the Health Centers Consolidation Act of 1996 brought authority for all four primary care programs (community, migrant, homeless, and public housing) under section 330 of the PHS Act.

In its 4 decades of existence, the national network of health centers has grown substantially—and so has the range of services offered. Today, more than 1,000 health centers operate 6,000 service delivery sites in every U.S. State, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin. Besides primary health care, most of those sites now offer access to oral health, mental health, substance abuse services, and pharmacy services. Slightly more than half of all health center grantees—52 percent—serve rural America; the remainder are found in urban areas.

The last 6 years have been a period of unprecedented growth in the health center system. This expansion was accomplished through President Bush’s Health Center Growth initiative. Approved by the President in 2001, and supported by Congress, the initiative’s goal was to support 1,200 new or expanded health center sites across the Nation. Since 2000, Federal investments in the health center program have nearly doubled, from a little more than \$1 billion in 2000 to more than \$2 billion today, the largest funding increase in the program’s history.

In 2007, health centers provided “health homes” to more than 16 million patients at an average cost per patient of \$559. The 63 million patient encounters that health centers totaled that year were paid for from a variety of sources. The grants health centers receive from the Health Resources and Services Administration—an agency of the U.S. Department of Health and Human Services that oversees the health center network—amount to only about a fifth of an average health center’s budget. Other financial support for health centers comes from Medicare, Medicaid, the State Children’s Health Insurance Program, other government programs, patients’ payments, and independent sources such as foundations.

### What is a Health Home?

A “health” or “medical” home is not a building, house, or hospital, but rather an approach to providing comprehensive primary care. According to the American Academy of Pediatrics, a medical home is defined as primary care that is:

- ◆ Accessible
- ◆ Continuous
- ◆ Comprehensive
- ◆ Family centered
- ◆ Coordinated
- ◆ Compassionate
- ◆ Culturally effective<sup>3</sup>

Academic researchers have highlighted health centers’ success in increasing access to care, improving health outcomes for patients, reducing health disparities among U.S. population groups, and containing health care costs. The World Health Organization recognizes health centers as a model of primary care delivery and has encouraged its replication and expansion in industrialized and developing nations.<sup>4</sup>

### Bureau of Primary Health Care’s Mission

Improve the health of the Nation’s underserved communities and vulnerable populations by assuring access to comprehensive, culturally competent, quality primary health care services.

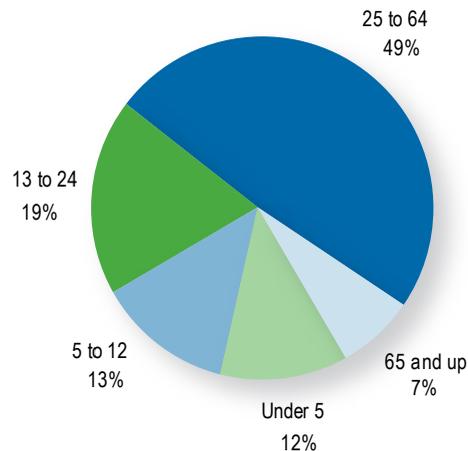
# Critical Connections: Health Centers, America's Health Care Home

## Whom do Health Centers Serve?

Health centers serve an increasingly diverse population from a variety of backgrounds and with a wide range of health needs.

- ◆ **People of all ages.** 36 percent of patients in 2007 were children (age 19 and younger); about 7 percent were 65 or older.

Figure 1. Health Center Patients by Age Group, 2007\*



\* Based on preliminary estimates

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care. Uniform Data System. Rockville, Maryland: U.S. Department of Health and Human Services, 2007.

## ◆ People without and with health insurance.

Nearly 4 in 10 patients were without health insurance in 2007. While the proportion of uninsured patients of all ages has held steady at nearly 40 percent, the number of uninsured patients increased by 55 percent from 4 million in 2001 to over 6 million in 2007.

Table 1. Health Center Patients by Principal Third Party Insurance, 2007\*

Type of Third Party Insurance	Percent and Number of Health Center Patients	
	Percent	Number
<b>Uninsured</b>	39%	6,205,660
<b>Medicaid</b>	35%	5,675,125
<b>Medicare</b>	8%	1,221,840
<b>Other Public</b>	3%	466,228
<b>Private Insurance</b>	16%	2,507,987

\* Based on preliminary estimates

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care. Uniform Data System. Rockville, Maryland: U.S. Department of Health and Human Services, 2007.

- ♦ **People of all races and ethnicities.** About two-thirds of health center patients are minorities. In 2006, 23 percent of health center patients were African-American and 36 percent were Hispanic/Latino—almost twice the proportion of African-Americans and over two and a half times the proportion of Hispanics/Latinos reported in the overall U.S. population.

Table 2. Trends in Percent of Patients by Racial/Ethnic Minority Status, U.S. versus Health Center Population, 2001 and 2006

	Percent		Percent	
	2001	2006	2001	2006
	U.S. Population		Health Center Program Population	
<b>Asian/Pacific Islander</b>	4.0	4.5	3.4	3.5
<b>Black/African-American</b>	12.0	12.5	25.1	23.0
<b>American Indian/American Native</b>	0.8	0.8	1.0	1.1
<b>Hispanic/Latino</b>	13.0	14.8	34.8	36.1
<b>White</b>	69.8	67.4	35.7	36.3

Source: U.S. Census Bureau, Population Division. Table 3: Annual Estimates of the Population by Sex, Race, and Hispanic or Latino Origin for the United States: April 1, 2000 to July 1, 2006 (NC-EST2006-03) and Table 4: Estimates of the Population by Race and Hispanic or Latino Origin for the United States and States: July 1, 2006 (SC-EST2006-04). May 17, 2007.

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care. Uniform Data System. Rockville, Maryland: U.S. Department of Health and Human Services, 2001 and 2006.

Note: 2006 data regarding race and ethnicity are used throughout this document due to a change in 2007 health center reporting of racial/ethnic identity. In 2007, an additional race category, “More than one race” and information about Latino / Hispanic identity were added. With the addition of this information, the UDS racial classifications are consistent with those used by the Census Bureau and the standards used to collect and present Federal data on race and ethnicity.

- ♦ **Special Populations.** Some health centers also receive specific funding to focus on certain special populations including migrant and seasonal farmworkers, individuals and families experiencing homelessness, and those living in public housing.

**Migrant Health Centers.** In 2007, HRSA funded health centers served more than 826,000 migrant or seasonal farmworkers and their families. It is estimated that HRSA funded health center programs serve more than one quarter of all migrant and seasonal farmworkers in the United States. The Migrant Health Center program provides support to health centers to deliver comprehensive, high quality, culturally-competent preventive and primary health services to migrant and seasonal farmworkers and their families with a particular focus on the occupational health and safety needs of this population. Principal employment for both migrant and seasonal farmworkers must be in agriculture.

**Health Care for the Homeless Program.** The Health Care for the Homeless Program is a major source of care for homeless persons in the United States, serving patients that live on the street, in shelters, or in transitional housing. In 2007, HRSA funded health centers served over one million persons experiencing homelessness. Health Care for the Homeless grantees recognize the complex needs of homeless persons and strive to provide a coordinated, comprehensive approach to health care including required substance abuse and mental health services.

**Public Housing Primary Care Health Centers.** The Public Housing Primary Care Program provides residents of public housing with increased access to comprehensive primary health care services through the direct provision of health promotion, disease prevention, and primary health care services. Services are provided on the premises of public housing developments or at other locations immediately accessible to residents. In 2007, HRSA funded health centers served over 133,000 residents of public housing.

### What is Primary Health Care?

Over 10 years ago, the Institute of Medicine convened a committee to discuss the future of primary care. They also established a definition of primary care—one that embodies the work that health centers have been doing for the past 40 years, and continue to do every day.

The committee defined primary care as: “The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.”

Most importantly, in the committee’s view, “no health care system can be complete without primary care, indeed it is the foundation of health care delivery.”<sup>5</sup>

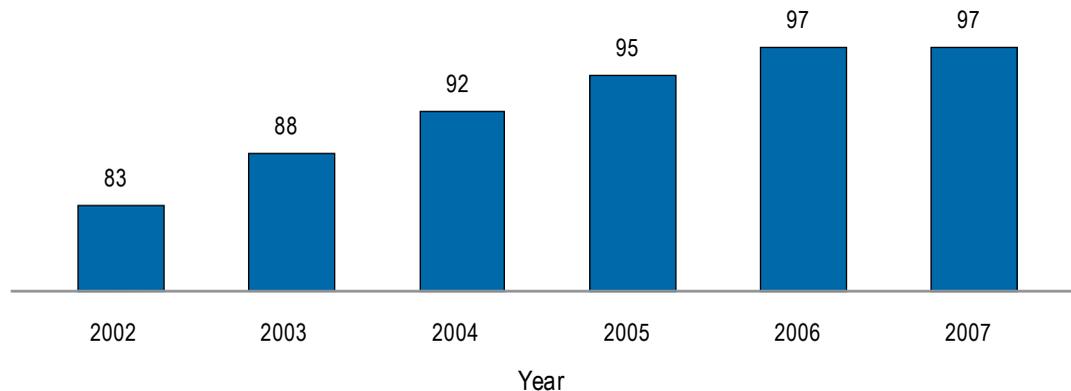
Table 3. Trends in Health Center Program Special Population Patients, 2001-2007

	Number of Patients						
	2001	2002	2003	2004	2005	2006	2007*
<b>Migrant and Seasonal Farmworkers</b>	686,166	708,611	694,040	726,813	776,668	807,153	826,639
<b>Homeless</b>	572,608	621,485	678,075	703,023	795,482	828,570	1,000,734
<b>Public Housing Primary Care</b>	70,026	93,642	110,266	106,322	122,113	129,280	133,404

\* Based on preliminary estimates

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care. Uniform Data System. Rockville, Maryland: U.S. Department of Health and Human Services, 2001-2007.

Figure 2. Average Number of Providers and Staff per Health Center: Growth, 2002-2007



\* Based on preliminary estimates

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care. Uniform Data System. Rockville, Maryland: U.S. Department of Health and Human Services, 2002-2007.

### How do Health Centers Serve their Patients? Health Center Workforce

Increasing access and reducing disparities in health care requires quality providers who can deliver culturally-competent, accessible, and integrated care.

Health centers recognize this need and support a multi-disciplinary workforce designed to treat the whole patient. In keeping with the growing demand for primary care, in 2007 health centers employed:

- ♦ 8,000 physicians, a 40 percent increase from 2002.
- ♦ Over 4,700 nurse practitioners, physician assistants, and certified nurse midwives—a 49 percent increase from 2002.
- ♦ 50 percent of the National Health Service Corps' field strength.

### Health Centers Services

Health centers provide comprehensive services that must address the major health care needs of the target population and ensure the availability and accessibility of essential primary and preventive health services, including as appropriate, oral health, mental health, and substance abuse services.

Recognizing that barriers to care take various forms, health centers also include a variety of supportive and enabling services that promote access and quality of care such as translation/interpretation, case management, community outreach, nutrition, and transportation.

### Building the Health Center Workforce

For more than 25 years, family medicine residencies have worked with health centers to train family physicians. A recent study compared health center and non-health center trained family physicians to investigate the impact on practice location, job and training satisfaction, and recruitment and retention to underserved areas.

Health center trained family physicians were over two and a half times more likely to work in underserved settings than non-health center trained family physicians. Residents trained in health centers also had high practice satisfaction ratings, a broad scope of practice, and felt they were well prepared in their residency training.

This study indicates that training family physicians in health centers may assist in meeting health workforce needs of the underserved, enhances the recruitment of family physicians to health centers, and prepares family physicians similarly to their non-health center trained counterparts.<sup>6</sup>

Table 4. Trends in Health Center Workforce by Provider Type, 2002-2007

Type of Providers	Number of Providers					
	2002	2003	2004	2005	2006	2007*
<b>Medical</b>	25,231	27,815	29,576	31,864	34,412	36,873
<b>Dental</b>	3,904	4,549	5,073	5,650	6,250	6,877
<b>Mental Health</b>	1,265	1,444	1,857	2,131	2,363	2,689
<b>Substance Abuse</b>	557	677	691	679	655	713
<b>Other Professional</b>	676	754	694	774	802	758
<b>Pharmacy</b>	1,179	1,409	1,634	1,820	2,025	2,182
<b>Enabling Services</b>	7,855	8,326	8,575	8,971	9,627	9,339
<b>Other Programs and Services</b>	1,570	2,280	2,398	2,603	2,691	2,862
<b>Administration and Facility</b>	27,720	30,842	33,191	35,715	38,615	41,295
<b>Total Full-time Equivalents</b>	69,956	78,096	83,688	90,206	97,440	103,588

\* Based on preliminary estimates

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care, Uniform Data System. Rockville, Maryland: U.S. Department of Health and Human Services, 2002-2007.

## Health Centers as Critical Economic Engines

Not only do health centers provide critical, high quality primary care in the Nation's neediest areas, they have and continue to serve as essential sources of employment and economic growth in their communities. Health centers generate economic growth by employing community members, purchasing goods and services from local businesses, and engaging in capital development projects.

According to a recent study, in 2005 health centers:<sup>7</sup>

- ♦ Injected \$7.3 billion of operating expenditures directly into their local economies;
- ♦ Directly generated 90,000 full-time equivalent jobs;
- ♦ Produced additional indirect and induced economic activity\* of \$5.3 billion; and
- ♦ Created an estimated additional\* 53,000 full-time equivalent jobs.

Total direct, indirect, and induced economic impact of health centers generated \$12.6 billion in economic activity and 143,000 jobs.

*\* Additional, indirect, and induced economic activity refer to responses by all local industries caused by the expenditures of new and increased health center expenditures. For example, if a health center purchases waiting room chairs from a local furniture store (direct effect), the furniture store in turn purchases paper from an office supplies store to print receipts and a truck from a car dealer to make deliveries (indirect effect). The furniture store, the office supplies store, and the car dealership all hire staff and pay them salaries to help run the various businesses (additional jobs). These employees spend their income on everyday purchases such as groceries, clothing, cars, and TVs (induced effect).*

## Where are Health Centers Located?

Health centers provide high quality, culturally competent care to patients in every State, the District of Columbia, Puerto Rico, the Virgin Islands, and the Pacific Basin.

More than half (52 percent) of all health centers serve rural populations.

As the essential health care homes for some of the Nation's most vulnerable groups, they are delivering care where it is needed most.

## National Impact: Health Centers as Critical Providers

Since the Health Center Program serves a much higher proportion of racial and ethnic minorities, individuals living in poverty and the uninsured than seen nationally—it is uniquely positioned to spread the benefits of community-based and patient centered care to these populations. The impact of the expansion of primary care through the Health Center Program is well-evidenced when looking at the national role of health centers reaching an estimated 20 percent of the 48 million underserved in areas lacking access to primary care providers.

Looking at national numbers, health centers serve:<sup>8, 9</sup>

- ♦ 1 in 20 individuals;
- ♦ 1 in 12 African-Americans;
- ♦ 1 in 9 Hispanic/Latinos;
- ♦ 1 in 8 uninsured;
- ♦ 1 in 7 individuals living below 200 percent of the Federal poverty level; and
- ♦ 1 in 4 homeless individuals and migrant/seasonal farmworkers.

Table 5. Comparison of U.S. Population to Health Center Program Population: Uninsured, Poverty, and Racial/Ethnic Minority Status, 2006

	Percentage of Population	
	U.S. Population	Health Center Program Population
<b>Ethnic / Racial Minority</b>	33	64
<b>Uninsured</b>	16	40
<b>At or Below 200 Percent of Poverty</b>	31	92

*Source: U.S. Census Bureau, Current Population Reports. Income, Poverty, and Health Insurance Coverage in the United States: 2006. August 2007.*

*Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care. Uniform Data System. Rockville, Maryland: U.S. Department of Health and Human Services, 2006.*

# The Health Center Model of Care

**H**ealth centers build on and complement other Federal and non-Federal health service efforts and fill major gaps where there are no existing programs or resources. For example, while the Federal Government and States broaden access to health care through financing streams such as Medicaid, Medicare, and SCHIP, health centers ensure access to a comprehensive and regular source of care for the populations covered by these funding streams. This is of particular importance during a time when the proportion of physicians serving existing Medicaid and uninsured patients and those willing to accept new Medicaid or uninsured patients has continued to decline. Accordingly, over 45 percent of health center patients are Medicaid, Medicare, SCHIP, or other public insurance beneficiaries and nearly 40 percent are uninsured.

As funding and eligibility for health center services are not tied to individual patient characteristics (e.g., women or infants) or specific health conditions (e.g., diabetes or HIV/AIDS), health centers have the unique ability to reach certain underserved populations often excluded from existing Federal, State, or private sector health funding streams such as non-elderly, non-disabled, low-income men.

## Health Centers: A Coordinated Effort and Investment

Health centers must:

- ♦ Coordinate and collaborate appropriately with other health care and social service providers in their area to ensure the most effective use of limited health resources and to provide access to the most comprehensive array of services and critical assistance including, housing, food, and job support.
- ♦ Maximize all sources of revenue, including non-grant resources.

## Health Center Financing

Financing and revenue sources play a key role in the ability of health centers to address their goals of increasing access, improving quality, and reducing health disparities.

Health centers rely on a number of revenue sources. The major source for all health centers is Medicaid with over one-third of health center revenue coming from the program.

- ♦ About one-fifth (19 percent) of health center revenue comes from the Federal health center grant.
- ♦ Remaining funding comes from: State, local, and philanthropic organizations; other third party sources, sliding fee schedules, and Medicare; as well as other Federal programs or payors.

Given this mix of funding and revenue sources, it is imperative that health centers continue to coordinate and collaborate with payors at Federal, State, and local levels to continuously demonstrate their value and role in increasing access and eliminating disparities as health care homes.

## Is Health Center Care Free?

While all health centers and FQHC Look-Alikes must provide access to services without regard for a person's ability to pay, services are not free. Rather, each health center has a set schedule of fees and corresponding discounts—often referred to as a “sliding fee scale” for the services they provide. The sliding fee scale is based on a patient's ability to pay, as determined by annual income and family size according to the most recent Federal poverty guidelines.

In order to remain financially viable and competitive in their local marketplace and to help improve access to care, health centers also assist patients with screening and enrollment into all available public and private insurance programs such as Medicaid, Medicare, and SCHIP.

Health centers must always ensure that billing for patients without insurance, collection of copayments and fees, and screening for financial status, is done in a culturally appropriate manner to ensure that these steps do not present a barrier to care.

### How does the sliding fee scale work?

All patients whose annual individual and/or family income is below 200 percent of the poverty guidelines are eligible for discounts on the care they receive.

- ♦ Patients whose incomes fall below 100 percent of the poverty guidelines receive care at no cost or for a small fee.
- ♦ Patients whose incomes fall between 100 and 200 percent of the poverty guidelines pay some portion or percent of the care received, the amount or percentage is determined through policy set by the health center's governing board.

### Health Center Performance

Health center data, peer reviewed literature, and major reports continue to document that health centers successfully increase access to care, promote quality and cost-effective care, eliminate health disparities and improve patient outcomes, especially for traditionally underserved populations.

### Prenatal Care and Birth Outcomes

Identifying maternal disease and risks for complications of pregnancy or birth during the first trimester helps improve birth outcomes. By monitoring timely entry into prenatal care, the Health Center Program can assess both quality of care as well as health center outreach efforts.

Results over the past few years demonstrate improved performance as the percentage of pregnant health center patients that began prenatal care in the first trimester grew from 60.7 percent in 2001 to over 64 percent in 2006.

Appropriate prenatal care management can also have a significant effect on the incidence of low birthweight (LBW), the risk factor most closely associated with neonatal mortality. Monitoring birthweight rates reflects both on quality of care and health outcomes for health center women of child-bearing age, a key group served by the Program.

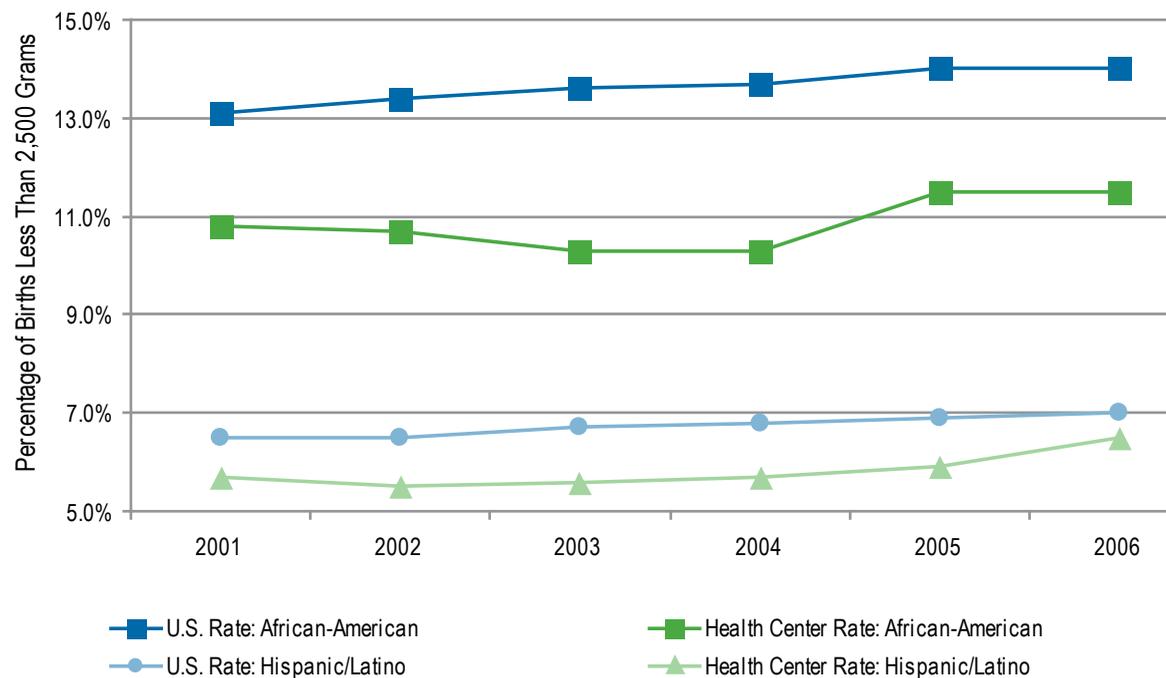
When compared to the national rate, health centers demonstrate impressive performance. In 2005, 7.3 percent of health center patients had LBW infants, a rate that was 11 percent lower than seen nationally (8.2 percent, 2005 national LBW rate). Overall, between 2001 and 2006, health center LBW rates have continued to follow a steady pattern at about 7 percent, more than 7 to 13 percent lower than national rates which have continued to rise.<sup>10</sup>

Table 6. Improving Health Outcomes: Timely Entry into Prenatal Care at Health Centers, 2001-2006

	Year					
	2001	2002	2003	2004	2005	2006
<b>Percentage of Health Center Patients Served Starting Prenatal Care in First Trimester</b>	60.7%	60.1%	62.2%	63.3%	63.4%	64.2%

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care. Uniform Data System. Rockville, Maryland: U.S. Department of Health and Human Services, 2004-2006.

Figure 3. Reducing Health Disparities: Health Center African-American and Hispanic/Latino Low Birthweight Rates, Consistently Below U.S. Rates, 2001-2006



Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care. Uniform Data System. Rockville, Maryland: U.S. Department of Health and Human Services, 2001-2006.

Source: Hamilton BE, Martin JA, Ventura SJ. Births: Preliminary Data for 2006. National vital statistics reports; vol 56 no 7. Hyattsville, MD: National Center for Health Statistics. 2007.

Source: Martin JA, Hamilton BE, Sutton PD, Ventura SJ, Menacker F, Kirmeyer S, Munson ML. Births: Final data for 2005. National vital statistics reports; vol. 56 no. 6. Hyattsville, MD: National Center for Health Statistics. 2007.

It should also be noted that health centers serve a higher risk prenatal population than seen nationally, making progress on these performance indicators a particular accomplishment.

### Health Centers Rated Among Top Federal Programs

A 2007 Office of Management and Budget review tool used to assess all Federal programs awarded health centers the highest possible rating of Effective—a ranking achieved by only 19 percent of all programs.<sup>11</sup> Key findings include that the Health Center Program:

- ◆ Effectively extends access and delivering high quality health care to underserved populations;
- ◆ Demonstrates progress in meeting long-term and short-term performance goals; and
- ◆ Effectively collaborates with other programs that share common goals.

### Chronic Disease

Health center patients, including low-income individuals, racial/ethnic minority groups, and persons who are uninsured, are more likely to suffer from chronic diseases such as hypertension and diabetes. Clinical evidence indicates that access to appropriate care can improve the health status of patients with chronic diseases and thus reduce or eliminate health disparities.

Controlling blood pressure (hypertension) can reduce the health risk associated with conditions such as heart disease and stroke. However, with increasing rates of hypertension, effective control is a particularly ambitious undertaking as improvements in such a chronic condition often requires treatment with both lifestyle modifications, usually as the first step, and, if needed, with

medications. According to the Centers for Disease Control and Prevention (CDC) data for 2004, only 36 percent of adults nationally demonstrated adequate high blood pressure control while health center patients far exceeded the national rate at 44.4 percent of patients with blood pressure under control.<sup>12, 13</sup>

### Promoting Efficiency

Health centers have a demonstrated track record in providing cost-effective services. Health centers continue to maximize the number of patients served per dollar while keeping cost increases below annual national health care cost increases. In 2005, the average cost per patient served at health centers grew by only 2.1 percent. In 2006, costs grew at a slightly higher rate (4.6 percent), but were still about 33 percent below the 6.8 percent projected growth rate for national health expenditures. In fact, over the past 4 years, cost increases at health centers have been at least 20 percent below national cost increases.<sup>14</sup> By restraining increases in the cost per individual served at health centers below the national per capita health care cost increases, the Program has been able to serve more patients that otherwise would have required significant additional funding to serve annually elsewhere.

Success in achieving cost-effectiveness may in part be related to health centers' use of a interdisciplinary team that treats the "whole patient." This, in turn, is associated with the delivery of high quality, culturally competent, and comprehensive primary and health care services that not only increases access and eliminate health disparities, but promotes more effective care for health center patients.

## External Evaluation

In addition to internal monitoring of health center performance, peer reviewed literature and major reports continue to document that health centers successfully increase access to care, promote quality and cost-effective care, and improve patient outcomes, especially for traditionally underserved populations.

- ♦ Health center uninsured patients are more likely to have a usual source of care than the uninsured nationally (98 percent versus 75 percent).<sup>15, 16</sup>
- ♦ Health centers provide continuous and high quality primary care and reduce the use of costlier providers of care, such as emergency departments and hospitals.<sup>17</sup>
- ♦ Uninsured people living within close proximity to a health center are less likely to have an unmet medical need.<sup>18</sup>
- ♦ Health centers have demonstrated success in chronic disease management. A high proportion of health center patients receive appropriate diabetes care.<sup>19</sup>
- ♦ Medicaid beneficiaries receiving care from a health center were less likely to be hospitalized than Medicaid beneficiaries receiving care elsewhere.<sup>20</sup>
- ♦ Health center Medicaid patients were 11 percent less likely to be inappropriately hospitalized and 19 percent less likely to visit the emergency room inappropriately than Medicaid beneficiaries who had another provider as their usual source of care.<sup>21</sup>
- ♦ Health centers have been found to improve patient outcomes and reduce racial and ethnic disparities in health care.<sup>22, 23, 24</sup>
- ♦ Health center low birthweight rates continue to be lower than national averages for all infants. In particular, the health center low birthweight for African-American patients is lower than the rate observed among African-Americans nationally (10.7 percent versus 14.9 percent respectively).<sup>25</sup>
- ♦ Health center patient rates of blood pressure control were better than rates in hospital affiliated clinics, the U.S. Department of Veterans Affairs health system, or in commercial managed care populations.<sup>26</sup>

# Sustaining the Connections

## Critical Partners in Achieving the Mission

To assist HRSA funded health centers in increasing access to comprehensive, culturally competent, quality primary health care services, HRSA has developed partnerships with State, regional, and national organizations to provide:

- ♦ Training and technical assistance.
- ♦ Operational and administrative support.
- ♦ Program development and analysis.

National and State-level partners play a key role in HRSA's continuing efforts to make more quality health care available to those who need it most. These partners, supported through cooperative agreements, bring a great deal of experience and knowledge to the challenge of serving low-income and underserved people. Because they engage with a variety of safety net organizations throughout the country at the national and State levels, they are well positioned to work with providers, policy makers, program administrators, and communities to advance the goal of improving the health of the Nation's underserved communities and vulnerable populations.

Our national and State partners are involved in a wide spectrum of issues that impact health centers ranging from primary care expansion, community development, workforce development, health information technology, State-based health care

reform, Medicaid waivers, evidence based medicine, and outreach. These partners are key in enhancing administrative operations as well as the quality and performance improvement of health centers.

The work done through these vital partners helps HRSA make the best use of its Federal investment throughout the country, avoid duplication of effort, and better target resources to those most in need.

## Primary Care Associations

Primary Care Associations (PCAs) are private, non-profit organizations whose members represent HRSA supported health centers and other safety-net providers. HRSA supports 52 PCAs across the country that:

- ♦ Provide training and technical assistance to health centers and other safety-net providers;
- ♦ Plan for the growth of health centers in their State; and
- ♦ Enhance the quality of care provided by health centers.

## Primary Care Offices

State Primary Care Offices (PCOs) assist in the coordination of local, State, territorial, and Federal resources that contribute to improving primary care service delivery and workforce availability to meet the needs of underserved populations. Fifty-two PCOs are supported in their work by health centers,

professional organizations, public and private entities, and other community-based providers of comprehensive primary care.

The PCOs' core activities include:

- ♦ Assessing the need for health care and for primary care providers in their State,
- ♦ Applying to have parts of the State designated as health professional shortage areas, and
- ♦ Recruiting and retaining providers to work in underserved areas.

### **National Cooperative Agreements**

HRSA also supports national training and technical assistance through 18 National Cooperative Agreements (NCAs). NCAs are important partners in enabling HRSA to achieve its mission because they are uniquely positioned to work nationally with providers, policy makers, program administrators, and communities to improve the health of underserved communities and vulnerable populations. NCAs are organizations that represent crucial connections with targeted stakeholders: organizations focused on health centers issues at both the national and State levels as well as organizations focused on special populations and programs.

### **Who are HRSA's Health Center Partners?**

In 2007, HRSA's national cooperative agreement partners included the following organizations.

- ♦ Association of State and Territorial Health Officials
- ♦ Association of Asian Pacific Community Health Organizations
- ♦ Capital Link, Inc.
- ♦ Farmworker Health Services, Inc.
- ♦ Farmworker Justice Fund, Inc.
- ♦ Institute for Healthcare Improvement
- ♦ Migrant Clinicians Network, Inc.
- ♦ Migrant Health Promotion
- ♦ National Academy for State Health Policy
- ♦ National Assembly on School-Based Health Care
- ♦ National Association of Community Health Centers, Inc.
- ♦ National Association of County and City Health Officials
- ♦ National Center for Farmworker Health, Inc.
- ♦ National Center for Health Care for Public Housing Residents
- ♦ National Conference of State Legislatures
- ♦ National Health Care for the Homeless Council
- ♦ National Network for Oral Health Care Access
- ♦ National Rural Health Association

# Unprecedented Growth: Health Center Expansion 2002-2007

In 2001, President Bush launched the Health Center Growth initiative and set a goal to significantly impact 1,200 communities across the Nation by supporting new or expanded health center sites. This initiative received support from Congress. A few years later in 2007, High Poverty grants were awarded to further ensure health centers expanded to locations where there

had previously been none. Since the launch of the initiative in 2002, the goal to significantly increase access has not only been reached but surpassed. With broad support, Federal investments in the Health Center Program have nearly doubled, growing from a little more than \$1 billion in 2000 to nearly \$2 billion today.

Table 7. Federal Funding for the Health Center Program, 2002-2007

	Fiscal Year					
	2002	2003	2004	2005	2006	2007
<b>Appropriations (in billions)</b>	\$1.34	\$1.51	\$1.62	\$1.74	\$1.79	\$1.99
<b>Number of Grantees</b>	848	895	914	954	1,006	1,076

### Health Center Growth Initiative

**Purpose:** Increase health care access for low-income people

**Goal:** 1,200 new or expanded health centers

**Status:** Goal reached with over 1,200 new and expanded health center access points funded and nearly 6 million additional patients served

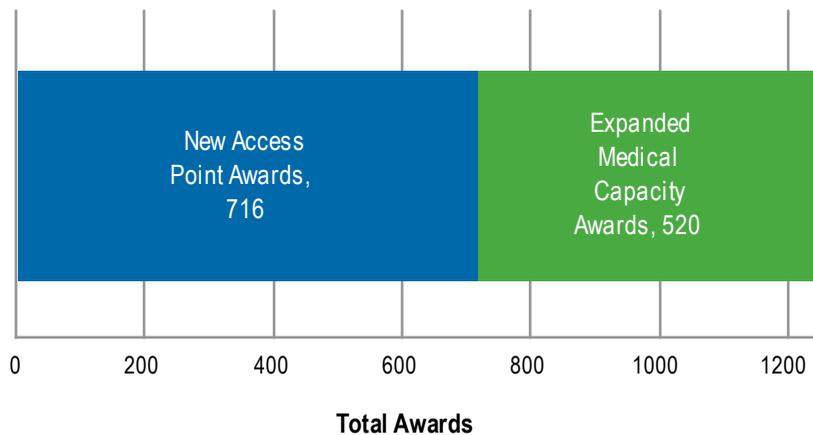
### High Poverty County

**Purpose:** High Poverty County grants put health center sites in more low-income counties than ever before stretching America's health care safety net to places it's never been

**Goal:** Significantly impact 200 high poverty counties through the support of new access points or planning grants

**Status:** 80 new health center sites and 25 planning grants

Figure 4. Goal Met: 1236 New and Expanded Access Points



### Opening More Doors to a Health Care Home

- ♦ In 2007 the number of patients served passed the 16 million mark for the first time.
- ♦ Between 2001 and 2007, the number of patients treated at health centers has increased by nearly 5.8 million, representing a 56 percent increase in just 6 years.
- ♦ Looking back even further—over 10 years (1997–2007)—the number of patients served has nearly doubled (increased by 95 percent) while the number of health center grantees grew by almost 60 percent over the same period.
- ♦ As a key source of local employment and economic growth in many underserved and low-income communities, health centers have seen their staff grow to over 103,000 full time equivalents, leveraging over \$9 billion in needed health services.
- ♦ Health centers are also serving an increasing number of special populations, including people experiencing homelessness and migrant and seasonal farmworkers.
  - The number of homeless patients served during this time period (2001–2007) rose by over 428,000, a 75 percent increase.
  - And the number of migrant and seasonal farmworkers during this time (2001–2007) increased by over 140,000, a 20 percent increase.

Table 8. Percent of Patients Uninsured and Below Poverty, 2007\*

	Percent of Patients	
	Uninsured	Incomes Below 200% of the Federal Poverty Level
<b>All Health Centers</b>	39	92
<b>Health Care for the Homeless Program</b>	69	98
<b>Migrant Health Centers</b>	54	98
<b>Public Housing Primary Care Health Centers</b>	39	97

\* Based on preliminary estimates

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care. Uniform Data System. Rockville, Maryland: U.S. Department of Health and Human Services, 2007.

### Expanding Health Center Services

During this tremendous period of growth, health centers have provided more mental health and substance abuse treatment than ever before. In 2007, more than 613,000 patients received mental health and/or substance abuse services at health centers, representing more than triple the number of patients seen over 2001 and a 31 percent increase in substance abuse visits over 2001.

For oral health, in 2007, over 2.8 million patients received dental services at health centers, nearly double the number of dental patients seen in 2001. Health centers provided over 6.7 million dental visits, more than doubling such visits over 2001.

### Health Center Growth Opportunities Opening More Doors to a Health Care Home: New Access Points

New Access Points support the establishment of new service delivery sites for medically underserved populations. Through these grants, organizations offer access to comprehensive primary and preventive health care (including mental health, substance abuse, and oral health care services) and social services to populations currently with limited or no access to such services. Federally funded health centers may offer services to the general community; migrant and seasonal farmworkers and their families; homeless people, including children and families; and public housing residents. All services must be provided to all persons without regard to an individual's ability to pay. Each application for support to establish a new access point must identify a population in need of primary health care services and propose a specific plan to increase access to care and reduce disparities identified in the population or community to be served.

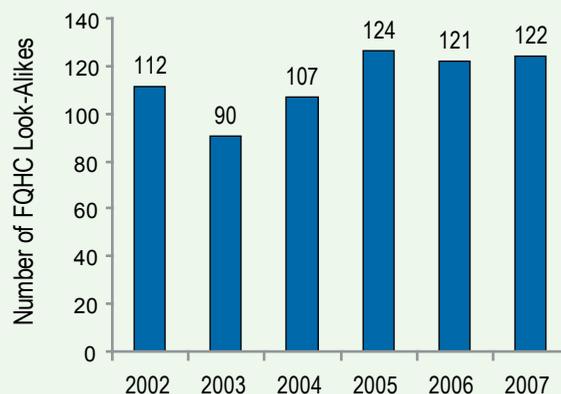
### Federally Qualified Health Center Look-Alikes

In 1990, Congress authorized the FQHC Look-Alike Program as a result of limited Federal funding to support the increased demand for health centers to serve the millions of uninsured and underinsured populations throughout the country. Organizations that are approved for FQHC Look-Alike designation do not receive grant funding under section 330 of the Public Health Service Act; however, they operate and provide services similar to grant funded programs. FQHC Look-Alikes are required to meet the statutory, regulatory, and policy requirements of section 330 and demonstrate a commitment to providing primary health care services to medically underserved populations regardless of their ability to pay.

FQHC Look-Alikes receive the following Federal benefits in lieu of section 330 grant funding: (1) enhanced Medicare and Medicaid reimbursement; (2) eligibility to participate in the 340(b) Federal Drug Pricing Program; (3) automatic Health Professional Shortage Area designation; and (4) eligibility to receive National Health Service Corp personnel. These benefits support FQHC Look-Alikes in improving access to culturally-competent, high quality primary health care services for the medically underserved in their community.

The FQHC Look-Alike Program has been an effective additional resource in meeting the increased demand for primary health care delivery systems. What started with 28 organization designated as FQHC Look-Alikes in 1991 has grown to 122 Look-Alikes operating in 2007. As a key primary care resource, FQHC Look-Alikes have also successfully competed for section 330 grants due to their increased experience in meeting section 330 program requirements. From 2002 to 2007 there were 286 applications for New Access Point funding from FQHC Look-Alikes; 36 percent were successful in obtaining New Access Point awards during the 5-year period. HRSA anticipates that the number of FQHC Look-Alikes will vary each year based on demand for service and availability of Federal funds.

Figure 5. Number of FQHC Look-Alikes, 2002-2007



### Strengthening Existing Health Care Homes: Expanded Medical Capacity

Supporting the expansion of medical capacity at existing health center sites allows grantees to significantly increase the number of people with access to comprehensive primary and preventive health care services. Strategies may include but are not limited to expanding existing primary care medical services, adding new medical providers, expanding hours of operations, or providing additional medical services through contractual relationships (e.g., obstetric/gynecological services). Applicants for expanded medical capacity funds must ensure that the proposal will increase access to comprehensive primary and preventive health care and improve the health status of underserved and vulnerable populations. Further, applicants must address the major health care needs of the target population and ensure the availability and accessibility of essential primary and preventive health services to all individuals in the service area.

### Expanding Existing Health Care Homes: Service Expansion

Mental health/substance abuse, oral health and comprehensive pharmacy services are critical to improving the health status of communities and patients served by health centers and eliminating disparities in access to health care. Applicants for service expansion funding are expected to describe the target population and its need for mental health/substance abuse services, oral health, and comprehensive pharmacy services and present a service delivery plan that demonstrates responsiveness to the identified needs of the target population.

Table 9. Trends in Health Center Program Funding by Type, 2002-2007

	Number of Grants						Total
	2002	2003	2004	2005	2006	2007*	
<b>New Access Points</b>	171	100	63	94	86	202	716
<b>Expanded Medical Capacity</b>	131	88	66	64	36	135	520
<b>Total New and Expanded Funding</b>	302	188	129	158	122	337	1236

\*Includes High Poverty New Access Point awards.

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration. Rockville, Maryland: HRSA Electronic Handbooks (EHB) Grants Data, 2002-2007.

# Moving Forward

**R**ooted in a commitment to civil rights and social justice, the Health Center Program's creation was a landmark event in U.S. health care. What began with Jack Geiger and Count Gibson's founding of the Nation's first two health centers in 1965, has evolved into a network of more than 1,000 Health Center Program grantees that continue this proud tradition and today serve over 16 million people in urban and rural medically underserved communities.

While the past 6 years have been an unprecedented period of sustained expansion and quality improvement for health centers, looking ahead, there are a number of challenges for HRSA as it continues to support and improve access to health care services for people who are uninsured, isolated, or medically vulnerable.

## Workforce

In response to recent reports highlighting the critical workforce needs in health centers as well as the ongoing challenges of recruiting and retaining high quality health care providers, HRSA is working with a variety of local State and national partners on shared solutions, including:

- ♦ Identifying health centers with “best in class” workforce planning strategies and activities, including superior hiring, retention, and training of staff to assist other health centers in developing a more stable, viable workforce.
- ♦ Maximizing health center linkages with the National Health Service Corps, Area Health Education Centers, health professions schools, academic and professional associations, etc.
- ♦ Continuing to develop and identify resources that can be shared with health centers to improve workforce planning.

## Health Information Technology

HRSA is working to:

- ♦ Develop a strategy and supportive policy that leverages the power of health information technology and telehealth to meet the needs of people who are uninsured, underserved and/or have special needs.
- ♦ Identify, disseminate, and provide technical assistance to health centers and other HRSA grantees in adopting model practices and technologies.
- ♦ Disseminate appropriate information technology advances, such as electronic medical records systems or provider networks.
- ♦ Promote grantee health information technology advances and innovations as models.
- ♦ Work collaboratively with foundations, national organizations, the private sector, and other government agencies to help HRSA grantees adopt health information technology.

## Emergency Management

HRSA is working to:

- ♦ Foster collaboration with key stakeholders to ensure that health centers and other HRSA grantees are prepared to respond and recover from emergencies.
- ♦ Identify, disseminate, and provide technical assistance to health centers and other HRSA grantees related to emergency management.

## Quality and Performance Measurement

A key component of the success of the Health Center Program has been its ability to demonstrate to payers and patients the value of care delivered to those receiving health center services. The expansion of the Health Center Program and the resulting growth in the number of health center patients and services, along with technological advances and the development of provider incentive programs in the private and public health sector market, have underscored the importance of demonstrating that health centers continue to deliver high quality care to underserved populations.

In concert with the quality initiatives occurring within the broader health care community, HRSA is incorporating quality-related measures that place greater emphasis on health outcomes and demonstrate the value of care delivered by health centers funded under Health Center Program.

Through the implementation of these new measures HRSA will be able to publicly report on key successes of the Health Center Program in providing quality care to the underserved community. Further, individual health centers will have additional data to support ongoing performance and quality improvement.

## Measuring Health Center Performance

In 2008, health centers will begin program-wide collection of core quality of care and health outcome data in the following areas:

- ♦ Early entry to prenatal care
- ♦ Childhood immunizations
- ♦ Cancer screening—Pap tests
- ♦ Diabetes control
- ♦ High blood pressure control
- ♦ Reductions in low birthweight

## Continuing the Mission

HRSA is proud to have supported and assisted the many dedicated health center staff, local, State, and national partners that have made the accomplishments highlighted in this report possible. These organizations have not only expanded, but strengthened the primary care base of this Nation.

As health centers face these and other new challenges, HRSA will continue its support of this proven model which has opened thousands of doors to a comprehensive, high quality health care home that is patient-driven and culturally and community-responsive.

Health centers will be an essential part of HRSA's mission of providing national leadership, program resources, and services necessary to improve access to culturally competent, quality health care to the Nation's neediest communities.

# Reflections on Success: Health Center Voices

Providers that serve uninsured, Medicaid, and other underserved and vulnerable patients constitute the primary care safety net. These providers typically are public hospitals, health centers, local health departments, various public and private outpatient and emergency departments, and free or charity clinics.<sup>27</sup>

Health centers—whether they are supported at the Federal, State, and/or local levels—have been a critical component of our Nation’s safety net for more than 40 years. While there is no model health center, all health centers share common attributes: the mission to provide primary and preventive health services to underserved populations; the ability to adapt and survive the challenges of a dynamic health care environment through strong leadership and infrastructure; and the delivery of high quality, cost-effective clinical services that have a measurable impact on health outcomes. Today, health centers continue to deliver high

quality, primary care to those most in need and continue to be an integral part of the service delivery system and primary care safety net.

From Connecticut to South Dakota to Micronesia, health centers have made incredible strides in increasing access to care, promoting quality, eliminating health disparities, and improving patient outcomes in many of the Nation’s neediest communities. Behind the impressive body of academic research highlighting health center success in these areas are thousands of individual stories of growth, achievement, and excellence. HRSA is pleased to highlight a small sample of these inspiring voices from the field as health centers continue to not only expand but strengthen the Nation’s primary care safety net.



## CONNECTICUT

**East Hartford Community HealthCare, Inc.**  
East Hartford

The center began with one building in East Hartford, Connecticut. At that time there was 1.0 full time equivalent (FTE) family practice physician and 0.5 FTE Advanced Practice Registered Nurse. The dental department consisting of two operatories had just been completed and 1.0 FTE dentist and 1.0 FTE dental hygienist were hired.

Since the original funding award East Hartford Community HealthCare (EHCHC) has accomplished the following:

- ♦ Grown to three sites—East Hartford Community HealthCare, Manchester Community Health Services, and Vernon Community Health Services.
- ♦ Grown from 11 employees in 2002 to over 80 employees in 2008, including 13 medical providers (pediatrics, family practice, internal medicine, obstetrics/gynecology), 6 dentists, and 6 dental hygienists.
- ♦ In 2002, services were provided to 1,837 unduplicated clients in 4,814 visits; in 2007 services were provided to 12,341 clients in 39,076 visits.
- ♦ Provide mobile dental hygiene services to 20 elementary schools in East Hartford and Manchester.
- ♦ Implemented electronic health records in the dental department in April 2008 and will be operational for the medical department by July 2008.
- ♦ Completing renovations to the newest building in East Hartford for pediatrics and obstetrics/gynecology by June 2008.
- ♦ Currently uses digital radiography.

Here is just one of EHCHC's success stories. An uninsured female with no health care for years presented to the center for a physical. She had an intrauterine device (IUD) inserted years earlier and wanted it removed. The physician removed the IUD. The patient also stated that she had a rash on her breast; a punch biopsy was done and sent to lab. It was later determined that she had inflammatory breast cancer (mortality rate is 80 to 90 percent) which is the most aggressive type of breast cancer. The health center referred the patient to a specialist for surgery and 2 years later she is doing great.



## Federated States of Micronesia

### Wa'ab Community Health Center Yap

**W**a'ab Community Health Center is located in Yap in the compact Nation of the Federated States of Micronesia, an island Nation located in the Pacific Ocean located northeast of Papua New Guinea. Yap has 7,391 people living in its main islands, with more than 98 percent of the population living below the U.S. Federal poverty level.

Before the health center was awarded health center funding in March 2006, the only health care provided in Yap was through the one hospital. Due to traveling distances to the hospital, many people did not access health care at all. With the funding of the Wa'ab Community Health Center, there are now five sites in the various villages on the island. The health center has developed health councils that

work in conjunction with the village chiefs and those health councils have input and representation on the governing board of the health center. Some of the Yapese have never seen a doctor—now they have access to medical providers in their own villages.

One of the success stories are the health professionals working in Yap. Four of the five medical providers working in the health center are Yapese and trained in the Pacific medical officer training program. The fifth provider is a family practice physician, a National Health Service Corps (NHSC) provider, trained at the University of Hawaii. Dr. Hancock grew up with an adopted Yapese brother and has made it his life's mission to work with the Yapese. When he

finished his residency 2 years ago and was preparing to serve his NHSC obligation, he could have gone anywhere in the United States and easily made a salary over \$100,000 a year. However, Dr. Hancock remained steadfast in his dedication to serve the Yapese, moved from the United States to Yap taking a salary of less than \$25,000 a year working at the health center. Dr. Hancock is a shining example of the NHSC and is a key health leader in Yap.



## GEORGIA

### East Georgia Healthcare Center Swainsboro

As a resident of Emanuel County, Linda Newham works in Metter/Candler County, Georgia—where East Georgia Healthcare Center (EGHC) submitted a New Access Point application to open a facility. Like many other residents, Linda called EGHC her medical home, but working in Candler County made it hard for her to get to the center for treatment. Linda traveled from Candler County to Emanuel County to be seen and in her words, “Had it not been for the alert medical attention that I received from EGHC in Swainsboro, and the early diagnosis of my breast cancer, I may not have been here to offer my sincere request on behalf of the residents of Candler County.”

She commented that she wanted Candler County residents to have the same level of needed and affordable medical attention offered through EGHC.

“I wholeheartedly want to thank you for giving us hope and for giving us a facility (EGHC) for the sake of all our citizens.” As it was before the health center expansion initiative, the travel distance placed an undue burden on underserved patients from accessing care; the new health center has improved their quality of life.



## Hawaii

### Waikiki Health Center Honolulu

In Honolulu, Waikiki Health Center's Youth Outreach Project (YO) is the only source of help and guidance available for the estimated 200 homeless youth who live in Waikiki's parks, abandoned buildings, or on the streets at any given time. YO offers counseling, medical care, mental health services, and most of all unconditional support. Brandi, a YO client, was smoking ice by age 12. She first visited YO at age 14 when she was homeless. Over the years, YO referred Brandi to a treatment center for pregnant women with drug abuse problems; she struggled to "stay clean." YO helped Brandi get her GED. She eventually enrolled at a local community college taking courses in social work. Brandi is now working for the agency that she feels gave so much to her—Brandi is a YO Outreach

Worker at Waikiki Health Center. "YO saved my life," Brandi says. "If I can touch one life and do for that person what YO did for me, then everything I went through will be worth it."

Waikiki Health Center also provides HIV Early Intervention Services which has been delivering primary medical care to people living with HIV/AIDS since 1986 and offers one of the most comprehensive HIV programs in Hawaii. Paul Kaleolani Smith is an HIV/AIDS advocate and has been an AIDS patient since 2001. Waikiki Health Center has provided Paul with the medical nutrition therapy and food supplements he urgently needs often with the help of grants from the M•A•C AIDS Fund (established by M•A•C Cosmetics) and others. "I wouldn't be

alive today if I didn't have dietary and nutritional supplements. When I had very little choices with HIV meds and needed to wait for new ones to get approved, I needed food and supplements to heal me...I had many digestive problems and worked closely with the (Waikiki Health Center) dietitian who gave me supplements provided by a MAC grant to stay alive." Paul is currently a member of Waikiki Health Center's Board of Directors.



# INDIANA

## NorthShore Health Centers Portage

NorthShore Health Centers operates at three sites located in Portage and Lake Station, Indiana. In 2006, Randy, an uninsured patient, scheduled his first appointment and presented with symptoms of skin allergies to a blood pressure medication he had been taking. Upon the examination the physician noted a nodule on the right side of Randy's neck. The physician ordered a series of diagnostic tests which confirmed a diagnosis of tongue and neck cancer. Due to Randy not having insurance and living on a fixed income, it was very difficult to find a specialist who would take him as a patient. With a lot of effort and hard work, the Medical Director and CEO were able to find a surgeon in the area who was willing to see Randy at a reduced fee. With great success due

to the comprehensive care facilitated by the health center, Randy is cancer free and is still continuing his care at NorthShore. If it was not for health centers providing care for the medically underserved and low income individuals like Randy, they would not get the health care desperately needed.



## IOWA

Primary Health Care, Inc.  
Des Moines

A family of six arrived at Primary Health Care, Inc.'s Health Care for the Homeless Center in Des Moines, Iowa, desperate and homeless. The father spoke for the family stating that the gangs in his hometown were threatening the safety of his four children; so he relocated his family to Des Moines in search of a less violent place to live. Their plan was to stay with relatives until he found work; but that fell through because his family was asked to leave.

When Dad informed the intake worker that he was a certified mechanic, the worker gave him the classified/employment section of the newspaper. Dad found two job openings and scheduled immediate interviews. The intake worker also called area family shelters to assess bed availability since the family would need temporary shelter—an opening was found.

The next day the family returned to the health center to express their appreciation for the services they received and to inform staff that Dad was hired by an auto dealership at a pay rate equal to his previous salary in the big city.

# Community Elementary School

Coffeyville Public Schools

USD 445

"Truly A Community Project"

Board of Education Members

Debbie Beeson	Jerry Hamm
Tim Brant	Larry Loffer
Fred Brown	Mike Mason
Janie DeVore Gillis	Cathy Shald, President
Denise A. Gates	Corey Taylor

Dr. Rod Allen, Superintendent  
Wes Dreyer, Assistant Superintendent / Project Manager

City of Coffeyville  
Funding & Promotion Support

PBA Architects, P.A.  
Architect

Crossland Construction  
Construction Manager

And the many other Community Partners  
and unique collaborations that brought  
meaning to the name  
"Community" Elementary School



## KANSAS

### Community Health Center of Southeast Kansas

Pittsburg

Little nine-year-old Michael was carried into the Community Health Center of Southeast Kansas (CHCSEK) dental clinic in Pittsburg, Kansas with a high temperature and an abscessed tooth. He hadn't eaten solid foods in weeks—the lunch ladies at his elementary school in Coffeyville had fixed him oatmeal to make sure he had nourishment. The school nurse also visited with his disabled grandmother with whom he lived. She had no transportation and there was no dentist in the community that accepted Medicaid. Although the CHCSEK clinic was 77 miles and 90 minutes away, the school nurse called and the staff told her to proceed immediately to the health center. Crying and so very afraid when he arrived, he was bundled into blankets and taken into a quiet corner where the dental assistant held him while the dentist examined him.

The problem was obvious and, as staff said later, the amount of pain he must have endured for weeks greatly moved the staff. He was within hours of being admitted to a hospital. After being given a large dose of antibiotics, the tooth was extracted. His relief was instantaneous and while still uncomfortable due to the infection, the look in his eyes said it all.

We continue to provide care for Michael—he had extensive decay throughout his mouth. When staff went to his school a few months later to screen 700 other children, he took the hands of CHCSEK staff, led them into his classroom and announced "These are my friends and they will help you."



## MISSISSIPPI

### Picayune Family Health Center (Southeast Mississippi Rural Health Initiative, Inc.) Hattiesburg

Picayune, Mississippi is located only minutes away from Louisiana, which was devastated by Hurricane Katrina. Many hurricane victims fled to Picayune and became residents of that area; however, most of them did not have access to health care due to loss of insurance coverage. Prescription coverage was also a huge issue.

Southeast Mississippi Rural Health Initiatives, Inc. received funding in July 2007 and purchased a 3,400 square foot facility. A family practice physician and nurse practitioner were recruited. With open arms, the providers and staff welcomed those in need of quality medical services at a discount. Full support with a complement of ancillary services unique to health centers was also made available to the community. The clinic is a huge success and is growing even faster than projected. The local medical community has

welcomed the health center and is assisting in creating awareness of the clinic and the services that are available.

The Board of Directors has been very involved in the progress of the health center. A new board member from Pearl River County has been highly instrumental in promoting the clinic. The clinic is a testament to the “process” working. Without this clinic many residents in Pearl River County, and as well as from neighboring locales in Louisiana would not have access to a clinic that provides services with a sliding fee scale.



## NEW YORK

### Morris Heights Health Center Bronx

Morris Heights Health Center (MHHC) serves more than 48,000 patients annually and provides a wide range of primary, specialty, dental, mental health, educational, and social services at five locations throughout Bronx, New York. In addition, the health center maintains school-based health facilities in four New York City Public Schools, providing health care for the students.

Gail Jackson-Kelly is a resident of the Mott Haven area and lives in the Mill Brook Housing Complex. Prior to becoming a patient of MHHC at St. Ann, she had to travel several miles to find a doctor for her chronic conditions. When she discovered St. Ann, she felt relieved that she found a great, clean, respectable health center in her own backyard. She is so happy with her coordinated care that she applied for and was accepted into the Patient Advisory Council (PAC). She dutifully attends meetings (except when she had foot surgery) and has referred family members to

the center. Gail believes that having a good center so close to home has helped her in dealing with her poor health. She no longer has to take several buses and the train to get good care—health care is now just a few steps from home. The added bonus is participating on PAC where she feels she has a voice in what services are offered.

MHHC strives to meet the health care needs of its community. MHHC at St. Ann is situated in one of the poorest districts in the Bronx. MHHC provides primary care for adults and children, HIV, dental, case management, and facilitator enrollment services. At a health screening fair as part of the center's health promotion and outreach efforts, a 52-year-old Hispanic male asked to have his blood pressure and diabetes screenings done. The patient and his family benefited from the screenings that were offered at the fair. Staff conducted a glucose screening for the 52-year-old; the results yielded a reading of over

500. The doctor saw him immediately and was able to stabilize his blood sugar level. Free lunch was provided and the doctor showed him what he should eat, especially the portion size. The patient was not working, had no insurance, and thought he could not afford care. Using the sliding scale fee payment system for self pay patients, the man was able access care. He purchased a glucose meter and the doctor showed him how to use it daily to monitor his blood sugar levels. He and his family are extremely grateful for the medical care they received. MHHC center is now their medical home.



## OHIO

### Allen County Health Partners Lima

Jill attended the Hepatitis C health event at Allen County Health Partners (ACHP) on June 14, 2007. During this event she heard about the risk factors of Hepatitis C and decided to get the free screening test that was being offered. During her follow up visit 1 week later with Dr. Gregory Parranto, Jill heard the devastating news—her Hepatitis C test had come back positive! Jill was tearful and physically shaking with this news. Dr. Parranto called the health center's counselor, Daphne K. Lindo, LISW over to help talk to Jill about her fears.

With this team approach, Jill was able to gain a better understanding about Hepatitis C and its treatment. Although Jill was glad to hear that Hepatitis C was treatable, she did not think that

she would be able to afford the medication because she did not have health insurance and only made \$19,000 a year. Dr. Parranto informed Jill that ACHP had a prescription assistance program that could help her get the medicine for free.

Lane Guy, Patient Advocate, worked with Jill to help her complete all the necessary paperwork. Her medicine arrived 3 weeks later and treatment began.

Throughout the past year Jill has continued to receive her medication, follow up visits, and counseling as she battles living with Hepatitis C. Last month she had routine lab work completed and the Hepatitis C virus is now completely undetectable!



## Oklahoma

### Family Health Center of Southern Oklahoma

Tishomingo

With nearby Blue River and plentiful lakes, Johnston County, Oklahoma residents have always enjoyed beautiful surroundings. It was not until Family Health Center of Southern Oklahoma (FHCSO) received funding in August 2003 that Tishomingo and neighboring community residents could enjoy access to affordable health care. Linda, who suddenly lost her job and health insurance coverage after 30 years of continual employment, began to have panic attacks knowing she needed care for diabetes and heart problems. FHCSO's sliding fee scale and pharmacy discount program provides Linda with affordable health care delivered in a professional, respectful manner.

Last September, Tishomingo resident Ed went to FHCSO feeling ill. FHCSO providers immediately ran tests, diagnosed Ed with acute myeloid leukemia (AML) and secured oncology services for him. FHCSO even assisted in the treatment by coming to his home

to draw blood when his immune system was too low to be among the public. Ed is thankful for FHCSO and the way its doctors and staff went above and beyond to provide him with excellent care.

FHCSO will soon move into a new facility secured with funding from the U.S. Department of Agriculture and local support that includes a drive-through pharmacy—further increasing access and improving patient outcomes.



## SOUTH DAKOTA

Falls Community Health  
Sioux Falls

Falls Community Health is located in Sioux Falls, South Dakota. Falls Community Health received expansion grant funding to increase access to health care for homeless or near homeless individuals of Sioux Falls. While conducting outreach, workers encountered one gentleman staying at the local homeless shelter. He was introduced to the center by an employee of the shelter. This gentleman was diabetic and had been without health care for 5 years. He began receiving services through Falls Community Health and was able to obtain diabetic education and medication. With the support of Falls Community Health staff, he was able to obtain glasses, new diabetic shoes, and have extensive dental work completed. Today this gentleman is no longer living on the streets and he has become very proactive in the management of his health care.

With the expansion grant that Falls Community Health received, the center has been able to reach and touch the lives of individuals like this gentleman and is positioned to “providing an open door to medical and dental care.”



## TEXAS ASSOCIATION OF COMMUNITY HEALTH CENTERS

### Comprehensive Community Development from the Ground Up

As a Primary Care Association, the Texas Association of Community Health Centers (TACHC) provides a wide variety of support to communities throughout Texas in need of new and expanded health center services. Over the last few years, TACHC's focus has been both on starting new health centers or new sites as well as helping organizations attain FQHC Look-Alike status. As part of its comprehensive approach to health center development, TACHC has periodically surveyed member health centers as well as interested communities and organizations to develop a statewide strategic development plan and then worked directly with communities to prepare and assist them in increasing access to health center services.

As patient-driven and community responsive organizations, health centers require buy in and support from the ground up. TACHC has assisted Texas communities new to the Health Center Program

by facilitating meetings and providing education sessions on the benefits of the program. It has also supported the essential health center governance functions by providing training sessions for boards of directors and assisted with the other "nuts and bolts" of starting a new or expanded organization such as developing bylaws as well as policies and procedures for human resources, information management, quality improvement, and even lease agreements.

One of the most successful approaches employed by TACHC has come from its innovative method of combining community development efforts in coordination with the Texas FQHC Incubator Program. The Incubator, started in September 2003, has provided \$5 million each year for health center development through planning, operational support, capital acquisitions, and statewide training and technical assistance.

#### Texas Health Center Growth Snapshot

As of August, 2007, Texas health centers have applied for and received:

- 31 New Access Point awards totaling approximately \$16,336,000 in annual grants with additional FQHC Incubator grant support to 21 of these organizations;
- 34 Expanded Medical Capacity awards totaling approximately \$13,087,000 in annual grants with additional FQHC Incubator grant support to 15 of these organizations; and
- 8 Service Expansion grants totaling approximately \$996,000 in annual grants.

The State FQHC Incubator Program has also provided awards to 10 of 11 organizations that have received FQHC Look-Alike status since the beginning of the health center expansion initiatives. Today, seven of those organizations are grant-supported health centers.



## VIRGINIA

### Martinsville Henry County Coalition for Health and Wellness (dba Bassett Family Practice) Martinsville

A new start health center, The Martinsville Henry County Coalition for Health and Wellness (dba Bassett Family Practice) was funded September 2007. Bassett Family Practice serves the Henry County, Virginia area and opened in January 2008.

Laura, who is unemployed, has no health insurance and cannot afford to see a regular physician. She recently experienced chest pain and sought care at the local free clinic, only to discover that the care she needed was beyond what they were able to offer. Her mother learned about Bassett Family Practice through an article in the local newspaper. Laura was seen by a physician and referred to a cardiologist at the University of Virginia, where she also received magnetic resonance imaging (MRI) and follow up neurology care. Bassett Family Practice helped her obtain the chronic medication she needed. Laura

noted “I received more helpful care at Bassett Family Practice in 2 hours than I’d had in the past 2 years.”

Another patient at the health center, Deb moved to the area with her husband as a result of a job change. Things did not work out as planned and they soon found themselves with less income than expected and without health insurance. Deb was unable to find a physician accepting new, self-pay patients. She was very depressed and did not know what to do. A neighbor recommended Bassett Family Practice and she had an appointment within the week. Deb soon had her much needed medication and a follow up appointment for laboratory blood work. Deb noted that she is “grateful that Bassett Family Practice is available and that the staff is so kind, caring, and efficient.”



## WEST VIRGINIA

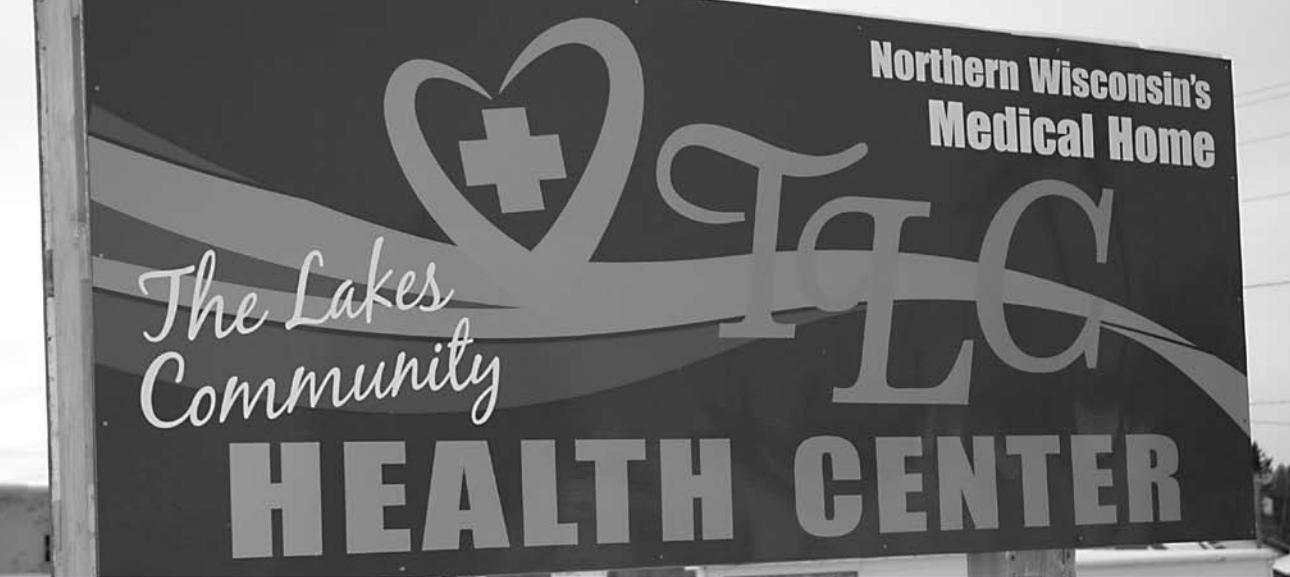
### Primary Care Systems, Inc. and Tri-County Health Clinic, Inc.

Clay and Rock Cave

Primary Care Systems, Inc. (PCS), located in Clay, and Tri-County Health Clinic, Inc. (TCHC), in Rock Cave, collaborate to provide care for over 15,000 users in central West Virginia. In 2007, PCS and TCHC implemented a new model of care using a modified version of the care model supported by electronic health records. The new workflow, reassignment of job duties, and reminder tracking-system resulted in more effective preventive care and outreach to center patients whose needs range from routine care to support in managing chronic illness. Imbedded in this new model is an emphasis on self-management.

David was a hypertensive, diabetic, hypercholesterolemic, obese patient who rarely sought preventive services or followed up on chronic illness care. With the implementation of a new workflow and electronic health records, the centers have been able to contact David when he is due for a test or an office visit. David receives education from clinic

coordinators and care managers. With these tools, David has made significant lifestyle modifications: losing 85 pounds and stopped needing his diabetic and anti-hypertensive medications. Through the marriage of the new care delivery, collaboration between centers, and the electronic health record these goals have been achieved.



## WISCONSIN

### Bayfield County Community Health Center (dba The Lakes Community Health Center) Iron River

A veteran undergoing chemotherapy came to the clinic one day, too weak, too exhausted, and too sick to make the long drives to either U.S. Department of Veterans Affairs (VA) medical facility in Superior, Wisconsin, or Minneapolis, Minnesota. He could not even muster the energy to see the physician in charge of his chemotherapy for help. At The Lakes Community Health Center (TLC), the first step was to draw a blood sample to check for abnormalities. “His hemoglobin was 8.5—about half the normal count,” said Lynn Hall, R.N., the Lakes Community Health Center Clinical Coordinator. “I called his physician treating with the chemotherapeutics and we discussed treatment. After a round of the red blood cell stimulating hormone treatment, erythropoietin, the patient returned 10 days later with a hematocrit of 10.5—a wonderful response.”

At that visit, he told Hall that if TLC hadn't been so conveniently located, he would have stayed in bed, not eaten, and just become sicker and sicker. “He was so impressed that the center not only was here, but they knew what to do and acted quickly. Now, the patient talks to staff every week or two, and he updates them on his condition,” says Hall. “He continues to stay in touch with us and has shared that even though his care at the VA is free, he'll become one of our patients for his primary care as soon as he completes chemotherapy—even though it'll cost him something out of his own pocket. It's worth it, he says.”

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### **For More Information**

The Health Center Program is administered by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), the primary Federal agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable. To find out more about the Health Center Program, please visit the HRSA Web site [www.bphc.hrsa.gov](http://www.bphc.hrsa.gov).

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