Community Health Centers

A Quality System for the Changing Health Care Market

What is a Community Health Center?

There are about 600 federally supported community health centers (CHCs) in the United States, located in every territory and State except Wyoming. Serving over 5 million people, they are a major component of the health care services industry in America. The purpose of these centers is to provide high quality managed care for those people who are most likely to lack access to health services because of geographic isolation, lack of providers or financial barriers.

Central direction for federally funded CHCs is located in the U.S. Department of Health and Human Services, Bureau of Health Care Delivery and Assistance in Rockville, Maryland. Line administration is vested in the department's 10 regional offices. The centers themselves are governed by representatives of the communities they serve.

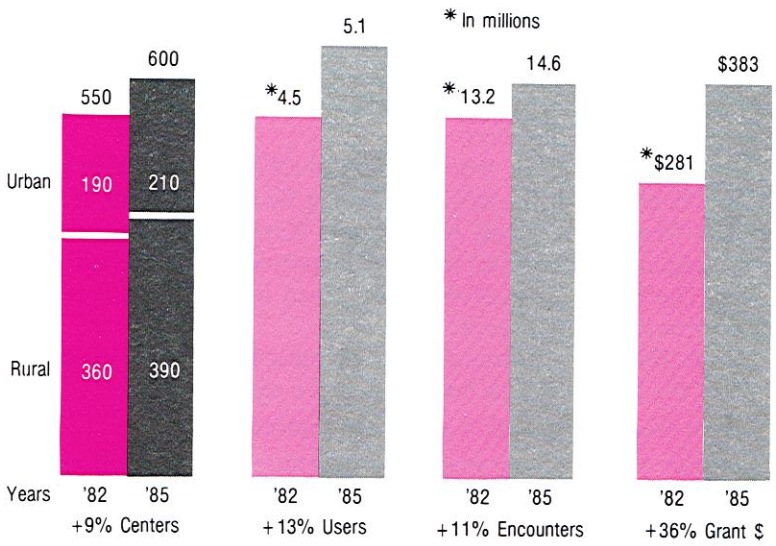
To fulfill the provisions of their enabling legislation, Section 330 of the Public Health Service Act, the centers must:

- serve areas designated as medically underserved
- provide basic primary medical care services plus support and facilitating services appropriate for the target population
- have a governing board the majority of whose members are users of their services
- adjust the cost of services to the patient's ability to pay.

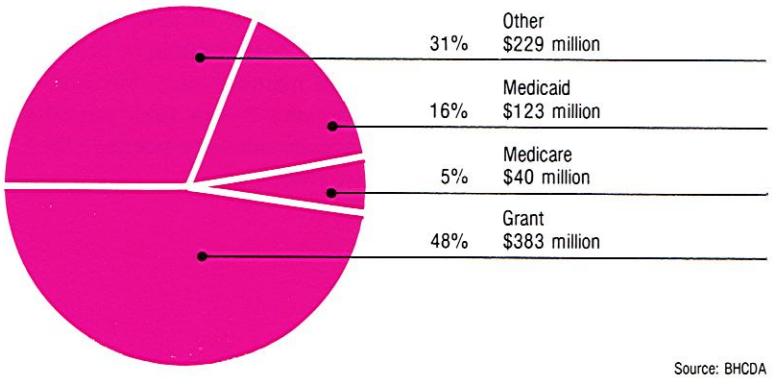
Over the years, CHCs have pioneered and developed the concept of managed care. Starting with knowledge of their population's health needs, they directly provide comprehensive primary care services and manage speciality and hospital care. Health center physicians are required to admit and follow their patients in the hospital and, where tertiary care services are needed, they maintain contact with patient and provider.

Community Health Centers Today

Community Health Centers
1982-1985



Community Health Centers Sources of Revenue
1985



Source: BHCDA

Of the 5.1 million users of CHCs approximately half are in urban areas and half in rural areas. Sixty percent of the patients are female and 40 percent male. Approximately 64 percent are members of minority groups— Black, 31 percent; Hispanic, 28 percent; and other, 5 percent. Forty-five percent of these served are children under age 20; 46 percent are in the 20 to 64 age group and 9 percent are 65 or over. About 60 percent of CHC users have incomes under the poverty level and another 25 percent are between 100 and 200 percent of poverty.

In conjunction with community health centers, several programs are operated for persons with special needs—coalminers with respiratory and pulmonary impairments, the elderly and other people who are confined to their homes because of medical conditions, and migrant or seasonal farmworkers. Roughly 450,000 of the latter group living in 35 States and Puerto Rico receive health and environmental services in migrant health centers, most of which are operated together with CHCs.

Between 1982 and 1985, the number of CHCs increased by 9 percent, from 550 to 600; 20 urban and 30 rural centers were added. The number of users increased by 13 percent, from 4.5 million to 5.1 million. Federal grant dollars increased by $102 million, from $281 to $383 million ($31 million in real growth). The total cost of operating CHCs in 1985 was $775 million. The $383 million in Federal grant funds covered 48 percent of the cost. Medicaid covered 16 percent; Medicare, 5 percent; other third parties, 6 percent; patient fees, 11 percent; and State, local, and other sources, 14 percent.

HOUGH NORWOOD Cleveland—James G. Turner (L.), executive director of the Hough Norwood Family Health Care Centers in Cleveland, Ohio, joins with board members and community representatives to open the Collinwood Health Center, one of two new centers established under the 1985-86 urban expansion strategy. Hough Norwood further increased its services by renovating two other

The Environment

In recent years, there have been major changes in the health field—in patient demographics, in physician supply, and the organization of the health care industry.

- Despite the existence of Medicare and Medicaid, about 25 million persons, the majority of them poor, lack any health insurance coverage. States, however, are playing a growing role in indigent care. Increasingly, the people in need of care are not only poor; they are also new to this country or elderly. Moreover, while the number of people in poverty has remained relatively constant, the poor are no longer confined to sharply defined neighborhoods.
- The supply of physicians has increased significantly. In some cases this helps meet needs of previously underserved areas but in others, recruitment and retention of physicians remain major problems. In addition, family physicians are in great demand by health centers and other providers because of their case management orientation.
- The increasing supply of physicians and attempts to control health care costs have contributed to many changes in the way services are organized, delivered, and paid for and in intense competition for the health dollars. More care than ever before is being provided in organized settings, and more and more health care dollars are capitated.

ST. JOSEPH FAMILY HEALTH CENTER Detroit—St. Joseph Family Health Center in Detroit is one of five health centers renovated by the Sisters of Mercy Health Corporation in 1985-86, and the Corporation now plans to establish a new center. By expanding its facilities and adding nineteen physicians to its staff, Sisters will be able to serve almost 20,000 additional patients.

The challenge for CHCs is to continue to serve well those with the greatest needs while adjusting to the new health care environment. To meet this challenge, the health center program has focused on using its financial resources to create and expand systems of care in needy areas and on developing Statewide plans to avoid duplication of efforts. Clinical management and financial analysis by cost center are emphasized. Special assistance is provided to centers where market forces dictate participation in contracting and/or prepayment.

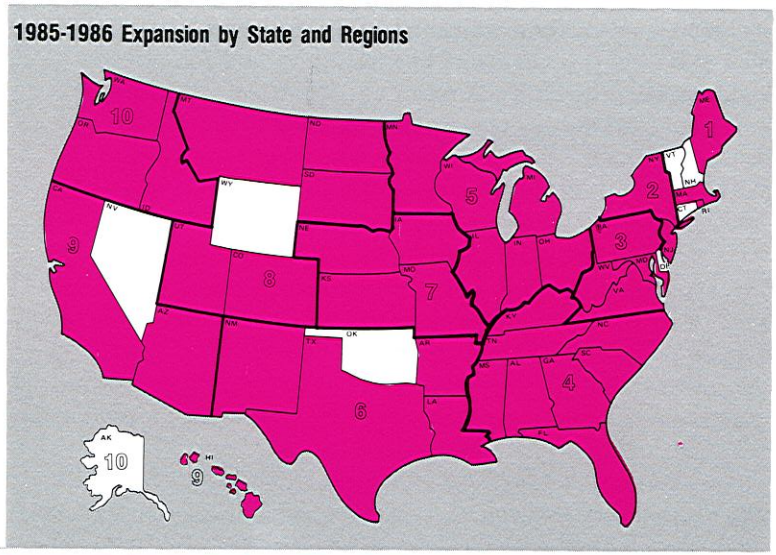
Urban and Rural Strategies. In 1985 and 1986, community health centers helped provide better services for more people through rural and urban strategy initiatives. By establishing systems of care; integrating Federal, State, local and private foundation funding; sharing professional services; buying supplies together in quantity, and establishing compatible information systems the centers have been able to use more effectively their limited resources.

On the urban side, 420 physicians were added to 84 centers in 47 cities representing 29 States. The annual cost of these added resources to the Federal government is $31.5 million. In addition, a total of $29.8 million was spent on facilities, equipment and other one time costs to accommodate the expansion.

On the rural side, 272 providers were placed in 197 centers representing 36 States. The annual Federal cost of these added resources is $34 million. These expansions were accomplished largely through increased efficiency and redistribution of funds to the neediest areas.

State Based Activities. States have been key actors in formulating the plans on which urban and rural strategies were based. Initially they were brought into the allocation process by commenting on proposed grants. State based activities are now formalized in two ways. States receive funding through cooperative agreements to participate in needs assessment and system development. In addition, State primary care associations facilitate the sharing of services and expertise among centers and other

1985-1986 Expansion by State and Regions



Regions	Annual Cost of Resources Added ($ millions)*	Number of Physicians Added
I	1.6	22
II	3.5	25
III	6.7	66
IV	21.2	222
V	13.7	151
VI	7.3	70
VII	1.5	18
VIII	2.3	19
IX	5.7	83
X	2.0	16
Totals	65.5	692

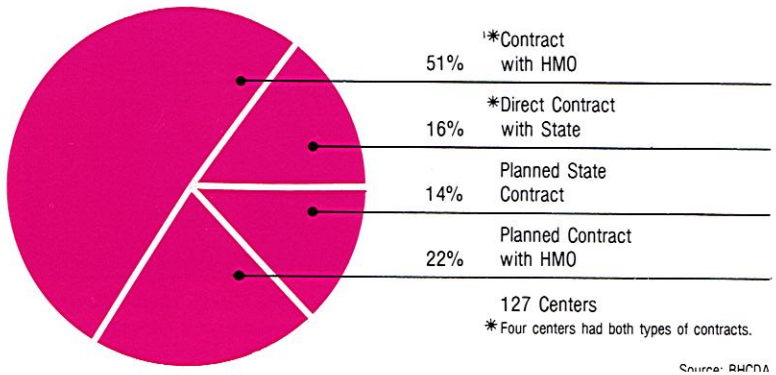
*Federal grant funds only. Federal share of total cost varies with center revenue.

and seven contracts with States, as well as 31 State primary care associations.

Clinical Management. Health centers are focusing on the prime elements of a well-managed, well-organized clinical system—strong leadership and an appropriate number and mix of qualified full-time health professionals. This enables them to provide managed care, assuming responsibility for the total health care of each patient. Clinical plans are based on a *Life-cycles* concept, recognizing the health care needs of those in each basic age group—prenatal, pediatric, adolescent, adult, and geriatric—and stressing health promotion and disease prevention at every age.

Prepayment. The number of CHCs involved with prepayment is increasing, largely because of the interest of Medicaid, Medicare, and private firms in containing medical costs. And the number is expected to keep growing. By the end of June 1986, 127 CHCs were involved in prepayment and about 317,000 persons were enrolled. Twenty of the centers contracted directly with States for Medicaid enrollees; 61 contracted with health maintenance or-

Community Health Centers Prepayment Activities
June 1986



Source: BHCDA

ganizations (HMOs) or intermediaries to provide services to Medicaid or Medicare beneficiaries or employer groups; and four had both types of contract. Prepayment contracts were planned by 46 more centers.

About a fourth of the centers involved in prepayment operate like health maintenance organizations and, in fact, some are licensed HMOs. They are at risk for a full range of services including hospital care. The remainder are usually at risk for primary care and specialty physician services.

The community health center program aids CHCs involved in prepayment through training seminars, individualized consultation with experienced HMO managers, and support for startup costs.

ERIE FAMILY HEALTH CENTER Chicago—The Erie Family Health Center has grown, in the past two years, from a small clinic located in a Chicago settlement house to two handsome, well equipped health centers. The Chicago Avenue clinic (shown) opened in the spring, and the Humboldt clinic will open in late

In 1987 and beyond, community health centers will continue to have as their basic mission the provision of high quality managed care to those most in need. The activities undertaken in the last few years to maximize revenues, ensure sound clinical management and create or expand health systems will also continue.

In addition, health centers will be pursuing a number of new directions consistent with their basic mission.

- *Maximizing opportunities for partnerships*. As competition for all insured populations increases, hospitals, HMOs, employers, and other providers are indicating a willingness to accept health centers as partners in cooperative ventures. Centers should use this trend to forge the relationships which will ensure availability and continuity of care for their users.
- *Diversification*. Some health centers have the size, expertise and solid base needed to diversify—into home care, for example, or prepayment or industrial medicine and fitness programs.
- *Capital formation*. Dollars are a crucial element in plans for expansion, new ventures and diversification. In a time of limited Federal funds, health centers need to pool their resources, as have hospitals, to access sources of financing. Solid relationships with the private sector are key to capital formation.
- *Retention and recruitment*. 1987 is the last year a significant number of National Health Service Corps physicians will be available for placement in underserved areas. Health centers must recruit their share of the burgeoning number of new physicians, offering them organized settings with cross coverage and professional interaction. Although doctors make the system work, the clinical system is what attracts, and keeps, the doctors.

- *Expanded State focus*. Increasingly, States are the geo-political units that make decisions about health centers' revenue sources, including indigent care programs, Medicaid rates, and prepayment contracts. States can also provide access to capital, through loan or mortgage guarantees, and to health manpower, through their own scholarship or loan forgiveness programs. The community health center program and the centers themselves need to establish links with all parts of State government that can contribute to their mission.
- *Institutional marketing*. Health centers have always marketed themselves to users through community outreach and traditional advertising techniques. They also need to communicate their advantages to groups or institutions responsible for decisions about large numbers of users, revenues, other resources or cooperative ventures.

GOSHEN MEDICAL CENTER Goshen, Ohio—With the addition of the Goshen Medical Center (shown) last year and the Batavia Center this year, the Southern Ohio Health Services Network now has eleven health centers serving over 20,000 patients in southeastern Ohio. To further expand its services, the network is planning to provide prepaid care for Medicaid, Medicare, and private patients.

The advantages that community health centers offer are important ones. CHCs improve health status and their patients have a lower incidence of hospitalization than patients cared for in other settings. Less hospitalization means less medical cost.

- A nationwide study indicated that in counties with at least one CHC the reduction in Black infant mortality attributed to the centers amounted to 1 death per 1000 live births. In counties with 4 or more CHCs a reduction in the Black infant mortality rate of 2.9 deaths per 1000 was attributed to the centers.

- Site specific studies showed that infant mortality decreased by 50 percent after the establishment of primary care centers in the rural south, and Denver's CHC program brought about a 25 percent reduction in infant mortality.

WATTS Los Angeles—Mayor Walter Tucker of Compton, California, reads a proclamation to Dr. Clyde Oden (L.), President of the Watts Health Foundation, and Frank Sotelo, Chairman of the Board, at the opening of the Compton Health Center. The center was one of two established in Los Angeles by Watts in 1985-86 to serve multi-ethnic communities. Medical services offered at the comprehensive medical facilities include general medicine, adult medicine, obstetrics

- A 60 percent decrease in rheumatic fever between 1960 and 1970 in Baltimore neighborhoods served by CHCs was attributed to early detection and treatment of health centers and similar organizations.
- Total Medicaid costs (primary care, ancillaries, referral and inpatient services) were 6 to 45 percent lower for users than for nonusers at specific CHC sites in Minnesota, Kentucky, Michigan and Colorado.
- Center users in 13 cities had 25 percent fewer hospital days than all nonusers and 22 percent fewer hospital days than comparable patients obtaining care from a private physician. The cost of ambulatory care in CHCs was lower than in hospital outpatient departments and similar to that in private practices.

In sum, community health centers provide real value—care that is effective in terms of impact and efficient in terms of cost. They also exert an economic impact in the communities they serve. Health centers upgrade neighborhoods, return Federal tax dollars to areas of need, attract other businesses and draw customers for those businesses. Their knowledge and experience with case management make them good prepayment providers. Their relative stability and community connections make them a good risk for lenders. Their systems of care, cross coverage and backup, plus the opportunity to feel good about one's work, make them attractive to providers. As they look to the future, community health centers bring a record of high quality and able performance in their part of the health care market.