


## Introduction to the Community Health Center System

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CHAMPS/NWRPCA  
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“There has to be someone who is willing to do it, who is willing to take whatever risks are required. I don’t think it can be done with money alone. The person has to be dedicated to the task. There has to be some other motivation.” – Cesar Chavez

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## 1962: Migrant Health Act

Established Migrant Health Centers to provide a broad array of medical and support services to migrant/seasonal farmworkers and their families.



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## 1960's

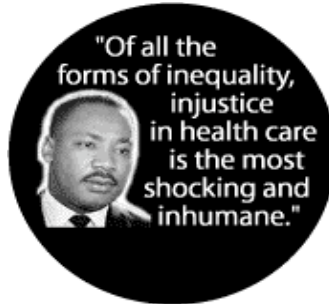
### War on Poverty

- Establishment of the Office of Economic Opportunity (OEO) and the creation of programs such as:
  - VISTA
  - Head Start
  - Job Corps

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## 1960's Continued

- Drs Jack Geiger and Count Gibson met in 1964 during the Freedom Summer in Mississippi.
- Developed idea of providing community health care to the people of disenfranchised neighborhoods.



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## 1960's Continued

- Petitioned federal government for a \$25,000 federal grant to open community health centers in Boston and Mound Bayou, Mississippi.
- Office of Economic Opportunity approved \$1 million for demonstration projects.
- Opened Columbia Point Health Center in Boston in 1965 and Mound Bayou Health Center in Mississippi in 1967.

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## 1960's Continued

- 1966: Comprehensive Health Center Program
  - Established by Economic Opportunity Act amendment
  - Provided \$50 Million
  - Not integrated with Medicaid and Medicare
  
- 1969: Department of Health, Education and Welfare begins to fund neighborhood health centers.

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## 1970s

- By 1971 there were 150 health centers – 100 funded by OEO and 50 by HEW.
- Office of Economic Opportunity dismantles and the health center program is transferred to HEW, (now the Department of Health and Human Services).
- Nixon and Ford administrations attempt to control Federal spending by returning power for a number of programs to the State and local levels and reduce health center funding.
- Carter Administration revitalizes health center program, passing legislation that increases Medicaid/Medicare reimbursement rates.

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## 1980's

- Reagan Administration proposes to block grant CHCs
  - Most existing grantees were protected, nevertheless cuts did force the closure of several grantees.
- Ted Kennedy persuades Orrin Hatch to co-sponsor a repeal of the primary care block.

*“For all those whose cares have been our concern, the work goes on, the cause endures, the hope still lives, and the dream shall never die.” – Ted Kennedy*

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## 1990's

- Health Center Consolidation Act combines the separate authorities (community, migrant, homeless, and public housing) under §330 of the Public Health Service Act (PHSA) to create the consolidated health centers program.
- Health center grantees are often called 330 grantees because of this statutory authorization.
- Within DHHS, the Health Resources and Services Administration (HRSA), Bureau of Primary Health Care (BPHC) administers the program.

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## 2000's

Bush Administration: "President's Health Center Initiative" creates significant Health Center Growth and Expansion:

- Investment has doubled – \$1 billion in FY 2000 to \$2 billion today, resulting in:
  - 630 New Health Centers or Satellite Clinics
  - 570 Expanded Health Centers
  - Additional 6 million patients served

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## 2000's continued

### **The American Recovery and Reinvestment Act**

- ARRA allocated \$2 billion specifically for health center infrastructure and operations, resulting in:
  - More than 2.7 million new patients served
  - More than 1.5 million new uninsured patients served
  - More than 10,000 health center jobs added in 2009

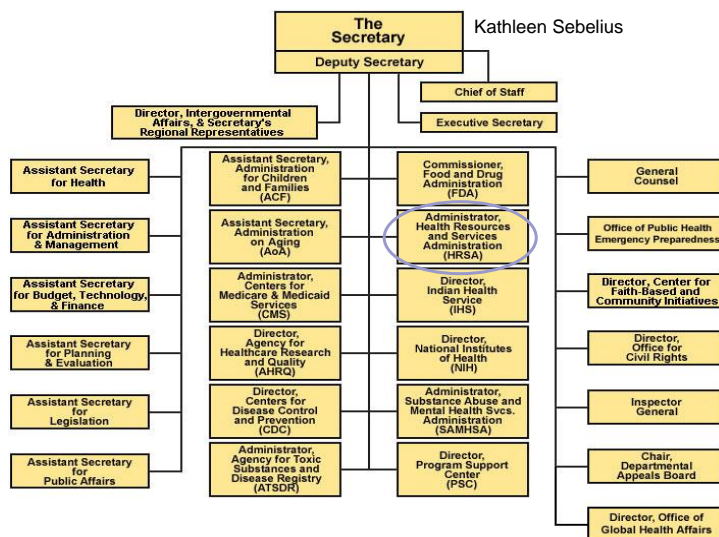
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2010

## The Patient Protection and Affordable Care Act

- The Affordable Care Act provides \$11 billion in funding over the next 5 years for the operation, expansion, and construction of health centers throughout the Nation.
- \$9.5 billion is targeted to:
  - Create new health center sites in medically underserved areas.
  - Expand preventive and primary health care services, including oral health, behavioral health, pharmacy, and/or enabling services, at existing health center sites.
- \$1.5 billion will support major construction and renovation projects at community health centers nationwide.
- This increased funding will enable health centers to nearly double the number of patients seen.

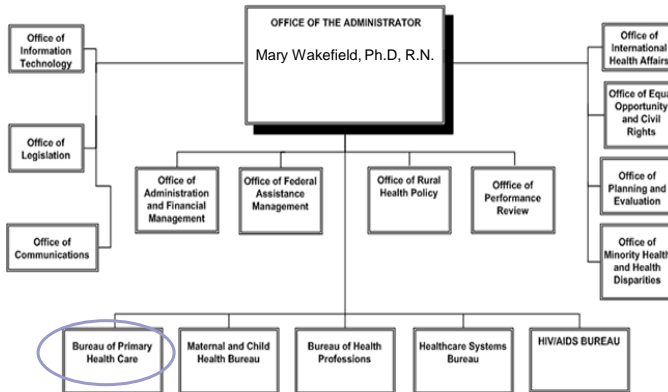
## US Department of Health & Human Services



# Health Resources and Services Administration

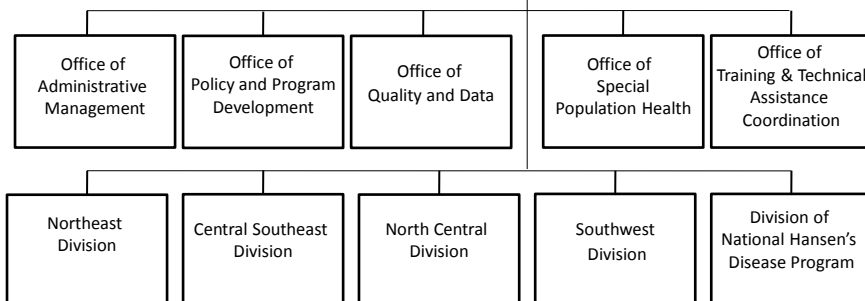
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH RESOURCES AND SERVICES ADMINISTRATION

ORGANIZATION CHART (HRSA)



# Bureau of Primary Health Care

OFFICE OF THE  
ASSOCIATE ADMINISTRATOR  
Jim Macrae

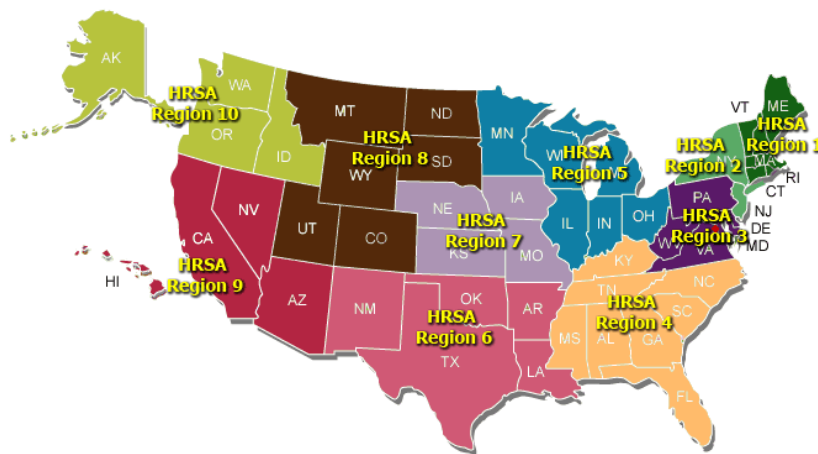


## North Central Division - Regions: 5, 8, 10

Director: Margaret Davis

- Five Branches:
  - Central Mid-West Branch: Illinois and Indiana
  - East Mid-West Branch: Michigan and Ohio
  - Northern Mid-West Branch: Minnesota, Montana, North Dakota, South Dakota, Wisconsin and Wyoming
  - Northwest Branch: Alaska and Washington
  - West Central Branch: Colorado, Idaho, Oregon and Utah
  
- # of Health Centers - 290
- # of Primary Care Associations - 15
- # of FQHC Look-Alikes - 17
- # of Health Center Controlled Networks - 17

## U.S. Map of HRSA Regions



## Region VIII

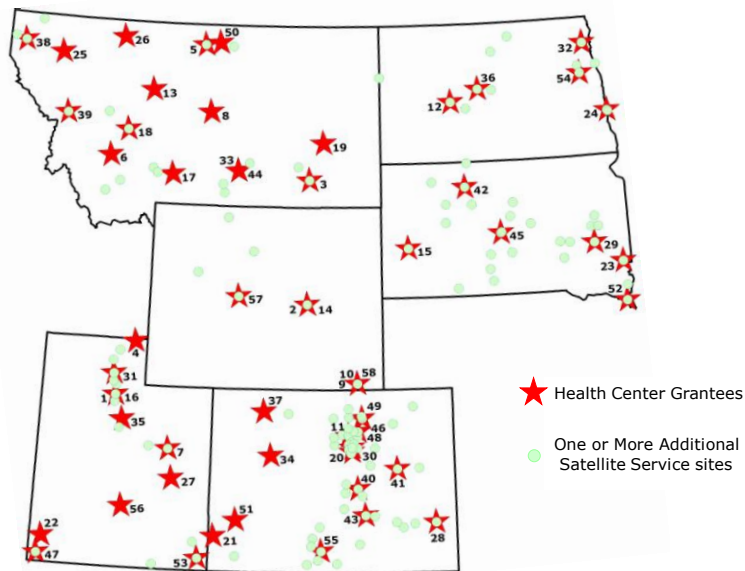
58 Community, Migrant, and Homeless Health Center Grantees in CO, MT, ND, SD, UT, and WY with over 285 service sites

Number of health centers has increased over 41% from 2000 (from 41 to 58)

Total users/patients has increased 81% since 2000, from over 421,000 to over 762,600

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### Region VIII CHCs



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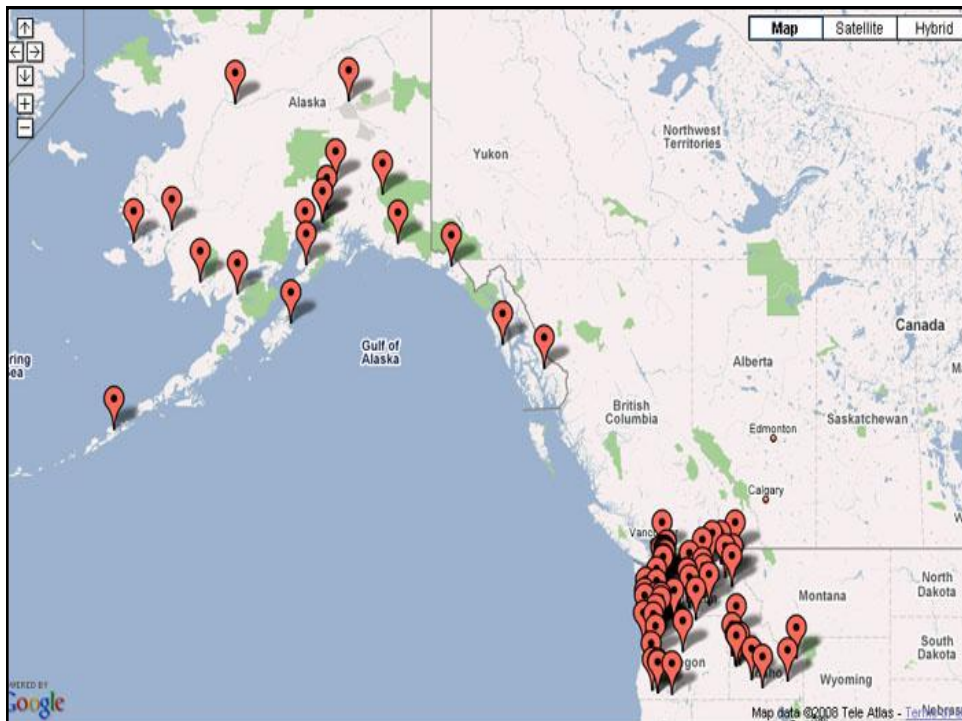
## Region X

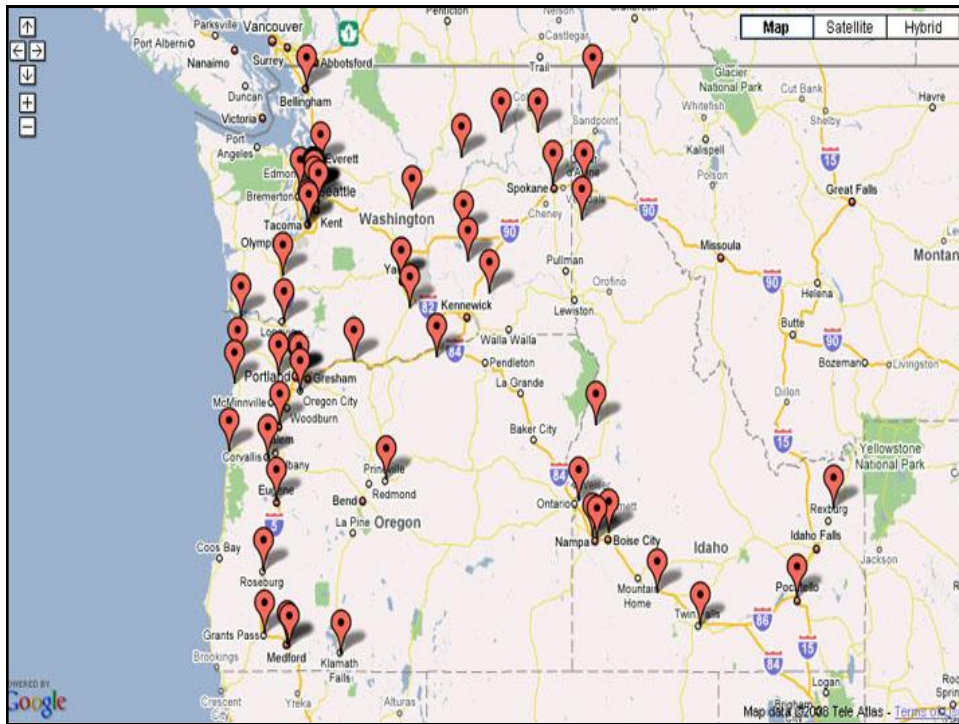
85 Community and migrant health centers  
with 800 sites

Number of health centers nearly doubled  
since 2001 (43 to 85)

Serve 1 million people

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## In 2009, Health Centers Cared for:

More than 18.7 million patients, including:

- 3.4 million who received dental services.
- 758,131 who received mental health care.
- 1,720,626 who received enabling services.

*HRSA 2009 Uniform Data System (UDS)*

## Patient Demographics\*

- 24.7% best served in language other than English
- 38.0% racial/ethnic minority
- 71.4% below poverty level
- 38.2% uninsured
- Special Populations:
  - 864,996 Migrant and Seasonal Farmworkers
  - 1,018,084 homeless persons
  - 360,655 school-based health center patients
  - 165,000 public housing patients

*HRSA 2009 Uniform Data System (UDS)*  
*\*Percentages are of known, not of total*

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## Health Center Program Fundamentals

- Located in or serve a high need community (designated Medically Underserved Area or Population).
- Governed by a community board composed of a majority (51% 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.

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## Types of Health Centers

- Community Health Centers [Section 330 (e)] serve a variety of underserved populations and areas.
- Migrant Health Centers [Section 330 (g)] serve migrant and seasonal agricultural workers.
- Healthcare for the Homeless Health Centers [Section 330 (h)] reach out to homeless individuals and families and provide primary care and substance abuse services.
- Public Housing Primary Care Centers [Section 330 (i)] serve residents of public housing and are located in or adjacent to the communities they serve.
- Federally Qualified Health Center Look-Alikes

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## Program Expectations

“The program expectations are intended to ensure that health centers not only survive but thrive as they move into the twenty-first century.”

- Governance
- Clinical Services
- Management
- Financial

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## Governance

“An essential and distinguishing element of the Health Center Program is governance by and for the people served.”



## Governance

### Health Center Board of Directors:

- Must have between 9-25 members
- 51% or more must be patients or “consumers” of the health center
- Consumer board members must be representative of patient demographics
- Non-consumer board members (49% or less) must be representatives of the community served and be selected for expertise in areas such as accounting, health administration, business, finance, etc.
- No more than half of the non-consumer board members can derive more than 10% of their income from the health care industry

## Clinical Services

Must provide, directly or through contracts or cooperative arrangements, basic health services including:

- primary care;
- diagnostic laboratory and radiological services;
- preventive services including prenatal and perinatal services;
- cancer and other disease screening; well child services;
- immunizations against vaccine-preventable diseases;
- screening for elevated blood lead levels, communicable diseases and cholesterol;
- eye, ear and dental screening for children;
- Family planning services;
- preventive dental services;
- emergency medical and dental services; and
- pharmaceutical services as appropriate to a particular health center.

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## Clinical Services

Must also provide enabling services, specifically:

- case management services;
- services to assist the health center's patients gain financial support for health and social services;
- referrals to other providers of medical and health-related services including substance abuse and mental health services;
- services that enable patients to access health center services such as outreach, transportation and interpretive services; and
- education of patients and the community regarding the availability and appropriate use of health services.

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## Clinical Services

Must have written policies and procedures which address at least the following elements:

- hours of operation;
- patient referral and tracking systems;
- the use of clinical protocols;
- risk management procedures;
- procedures for assessing patient satisfaction;
- consumer bill of rights; and,
- patient grievance procedures.

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## Management

- The governing board must select, dismiss and directly employ the Chief Executive or director of the health center.
- The Chief Executive should have the authority, responsibility and skills to:
  - communicate with the board and management team;
  - operationalize board policies;
  - manage personnel and systems;
  - allocate resources and operate within available resources;
  - identify and resolve problems;
  - interact with the community and providers and payers in the marketplace;
  - respond to opportunities and; plan for future events.

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## Financial System

- Must maintain financial systems which provide for internal controls, safeguard assets, ensure stewardship of federal funds, maintain adequate cash flow to support operations, assure access to care, and maximize revenue from non-federal sources.
- Must have written, board approved, billing, credit, and collections policies and procedures which, at a minimum, include:
  - a fee schedule for all billable services covering reimbursable costs and comparable to prevailing local rates
  - a method of discounting or adjusting fees based upon the patient's income and family size from current Federal Poverty Guidelines
  - and, a system of billing patients and third-party payers within a reasonable period of time after services are provided, typically within 30 days.
- Must ensure that an annual independent financial audit is performed in accordance with federal audit requirements.

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## Key Documents and Resources

- What is a Health Center?
  - <http://bphc.hrsa.gov/about/>
- Policy Information Notice 98-23: Health Center Program Expectations
  - <http://bphc.hrsa.gov/policy/pin9823/>
- Section 330 of the Public Health Service Act (42 USCS § 254b)
  - <http://bphc.hrsa.gov/about/legislation/section330.htm>

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## **The Community Health Center Support System**

- Funding and regulation
  - Health Resources and Services Administration
  - Bureau of Primary Health Care
- Advocacy, training, and technical assistance
  - NACHC
  - Primary Care Associations
  - Primary Care Organizations
  - Special populations grantees

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## **Advocacy, training, and technical assistance**

- Membership Associations
  - NACHC
  - Primary Care Associations
    - Community Health Association of Mountain and Plains States
    - Northwest Regional Primary Care Association
    - State PCAs

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## National Association of Community Health Centers, Inc.



Founded in 1970, the **National Association of Community Health Centers, Inc.**, is a non-profit organization whose mission is to enhance and expand access to quality, community-responsive health care for America's medically underserved and uninsured. In serving its mission, NACHC represents the nation's network of over 1,000 Federally Qualified Health Centers (FQHCs) which serve 16 million people through 5,000 sites located in all of the 50 states, Puerto Rico, the District of Columbia, the U.S. Virgin Islands and Guam.

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## Community Health Association of Mountain/Plains States



### Mission

To provide opportunities for education and training, networking, and workforce development to Region VIII (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming) community health centers so we can better serve our patients and communities.



### Vision

All patients and communities benefit from the impact of the resources that CHAMPS provides to community health centers.

### Values

Support  
Excellence  
Responsiveness  
Vision  
Integrity  
Collaboration  
Effectiveness

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## CHAMPS Programs & Services

- Promotion of collaboration, networking, and the sharing of best practices
- Workforce Support
  - Online Job Opportunities Bank (JOB)
  - Job Fairs
  - Salary/Benefits/Vacancy/Turnover Survey
  - JOB Data Summary
  - Regional R&R Collaborations



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## CHAMPS Programs & Services

- Educational Resources and Training
  - Fall Primary Care Conference (w/NWRPCA)
  - Continuing Professional Development via Live and archived Distance Learning Events (webcasts and teleconferences)
  - Spanish Language face-to-face trainings and teleconferences
  - Online clearinghouse of resources:
    - Boards, R&R, Clinical, Cross-Disciplinary



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## CHAMPS Programs & Services

- Strengthening Clinical Quality
  - Mountain/Plains Clinical Network (MPCN)
  - Clinical focus to resources and trainings
- Regional Publications
  - Quarterly Newsletter, Health Center Directory, Regional Data Summaries
- Monitoring the environment and needs of Region VIII



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## Northwest Regional Primary Care Association

### Mission

Northwest Regional Primary Care Association is a member organization that strengthens community and migrant health centers in the Northwest by leveraging regional power and resources on their behalf.

### Vision

With the support of NWRPCA, our community health centers will be exemplary professional homes for their staffs and serve their communities well.



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## Education and Training

- Learning Connections: A competency-based approach to quality training for CHC staff and board members
  - Primary Care Conferences: Spring (Region X), Fall (Regions X & VIII)
  - Western Migrant Stream Forum
  - Stand-alone trainings
    - UDS Reporting
    - Harvard Ambulatory Care I
    - Community Health Leadership Institute
  - Distance Learning
    - Webinars webcast live from conferences
    - Coding and billing webinars
    - CFO Certification webinars series
    - HR webinar

## Workforce Development

- Provide community health experience and training for interested medical students and residents
  - A.T. Still University program
  - Education Health Center Initiative (EHCI)
- Recruit clinicians and senior administrators for vacant positions
  - Direct clinician recruitment
  - Free posting of senior administrative jobs
- Support clinicians at CMHCs through education, training and networking opportunities



## Farmworker Health

- We work with migrant health centers and allied organizations
- Goal: to maintain and strengthen services for migrant and seasonal farmworkers through
  - coordination
  - community organizing
  - information sharing
  - partnerships
  - training



## Member Services

- *QuickNotes* monthly e-newsletter
- Member visits on site
- Side meetings at conferences
- Annual Membership Meeting and Awards
- Online community listservs
- Orientation calls for new members & new CMHC leaders
- Member discounts on all registrations & exhibitor fees
- Regional leadership & sponsorship opportunities

## State Primary Care Associations (SPCAs)

### Region VIII

- Colorado Community Health Network (CCHN)
  - [www.cchn.org](http://www.cchn.org)
- Montana Primary Care Association (MPCA)
  - [www.mtpca.org](http://www.mtpca.org)
- Community Health Care Association of the Dakotas (CHAD)
  - [www.communityhealthcare.net](http://www.communityhealthcare.net)
- Association for Utah Community Health (AUCH)
  - [www.auch.org](http://www.auch.org)
- Wyoming Primary Care Association (WYPCA)
  - [www.wypca.org](http://www.wypca.org)

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## State Primary Care Associations (SPCAs)

### Region X

- Alaska Primary Care Association (APCA)
  - [www.alaskapca.org](http://www.alaskapca.org)
- Idaho Primary Care Association (IPCA)
  - [www.idahopca.org](http://www.idahopca.org)
- Oregon Primary Care Association (OPCA)
  - [www.orpca.org](http://www.orpca.org)
- Washington Association of Community & Migrant Health Centers (WACMHC)
  - [www.wacmhc.org](http://www.wacmhc.org)

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## Primary Care Offices (PCOs)

- Assessing the need for health care and for primary care providers in their state
- Determining health professional shortage areas (HPSAs)
- Working to recruit/retain providers in underserved areas (loan repayment programs, J-1 Visa Waiver program, etc.)

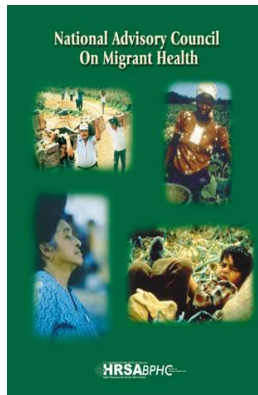
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## Special Population Health

- National Advisory Council on Migrant Health
- Farmworker Health Network
- National Health Care for the Homeless Council

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## National Advisory Council on Migrant Health



The Council is legislatively mandated to advise, consult with, and make recommendations to the Secretary of Health and Human Services on the health and well-being of migrant farmworkers and their families. Fifteen members are appointed by the Secretary to serve four-year terms.

<http://bphc.hrsa.gov/nacmh/>

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## Farmworker Health Network

The Farmworker Health Network (FHN) is comprised of 6 National Cooperative Agreements funded through the US Department of Health and Human Services to provide training and technical assistance to current and potential Migrant Health Centers. The FHN is committed to supporting the development of leadership within Community and Migrant Health Centers and increasing access to care for the farmworker population. The members of the FHN are:

- Farmworker Justice, [www.farmworkerjustice.org](http://www.farmworkerjustice.org)
- Health Outreach Partners, [www.outreach-partners.org](http://www.outreach-partners.org)
- Migrant Clinicians Network, [www.migrantclinician.org](http://www.migrantclinician.org)
- Migrant Health Promotion, [www.migranthealth.org](http://www.migranthealth.org)
- National Association of Community Health Centers, [www.nachc.com](http://www.nachc.com)
- National Center for Farmworker Health, [www.ncfh.org](http://www.ncfh.org)

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## National Health Care for the Homeless Council



<http://www.nhchc.org>

The National Health Care for the Homeless (HCH) Council is a home for those who work to improve the health of homeless people and who seek housing, health care, and adequate incomes for everyone. In the National HCH Council, agencies and individuals, clinicians and advocates, homeless people and housed people come together for mutual support and learning opportunities, and to advance the cause of human rights.


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## Final Thought

“Civil Rights and the War on Poverty were key to the program’s birth. The need to care for the underserved is the key to growth. But the real reason for success has always been the communities’ feeling of ownership over their centers. That’s what has sustained and nurtured us through it all.”

--Dan Hawkins, Senior Vice President, NACHC

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## Thank You!

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