MODULE 1: AN INTRODUCTION TO THE COMMUNITY HEALTH CENTER MODEL

Unique Model of Care that Facilitates Research

The Federal Health Center Program, also known as Community, Migrant, Homeless, and Public Housing Health Centers,[1] began as a "War on Poverty" program targeting medically underserved communities. From their founding under the Public Health Services Act of 1965, health centers were designed to remove entrenched barriers to care, improve population health, narrow health disparities, and generate system-wide health care savings. In fact, a wealth of literature demonstrates their successes along these lines, as well as their capacity constraints.[1]

Health center program requirements are grounded in federal statute and regulation, touching on governance, need, services, financing, and management – which in combination establish a unique, patient- and community-centered approach to care that sets health centers apart from other providers. These include:

- *Community governed*. At the heart of the health center model is the requirement that at least 51% of health center governing board membership be made up of active patient users, thereby ensuring that health center programs are responsive to community needs and priorities. This governance structure oversees all areas of health center operations – including the hiring and firing of health center Directors – thereby functioning as something much more than advisory boards.
- *Locate in or serve medically underserved areas.* These areas are designated by the Health Resources and Services Administration (HRSA) as having: too few primary care providers, high infant mortality, high poverty, and/or high elderly populations.[2] These areas tend to have high risk for health disparities and poor health outcomes and have high need for health care services.
- *Serve all without regard to insurance status of ability to pay.* Health centers provide services to anyone and everyone who walks through their doors. They provide discounts to uninsured patients in need with fees adjusted based on an individual's ability to pay.
- *Provide comprehensive, coordinated primary and preventive care services.* Health centers must provide a broad array of primary and preventive care, as well as "enabling services" designed to remove barriers to care. Health centers are also encouraged or in some cases required to provide behavioral health, dental, vision, and pharmacy services. Health centers are also required to collaborate with other local health and social services providers, though strong referral networks in many places do not exist.
- *Provide culturally competent care*. Services are required to respect and respond to their patient population's cultural preferences.
- *Conduct ongoing needs and quality improvement (QI) assessments.* Health centers must have QI and quality assurance programs, and must conduct regular, formal assessments of community needs.
- *Report data.* Health centers must report data annually to the federal Health Resources and Services Administration (HRSA) on patients, services, quality, and finances.

These requirements are designed to ensure that health centers improve access to high quality, affordable care in communities at high risk for health disparities. They also lead to diverse patient populations, unique staffing, and community expertise – all of which make health centers prime vehicles for community-driven research.

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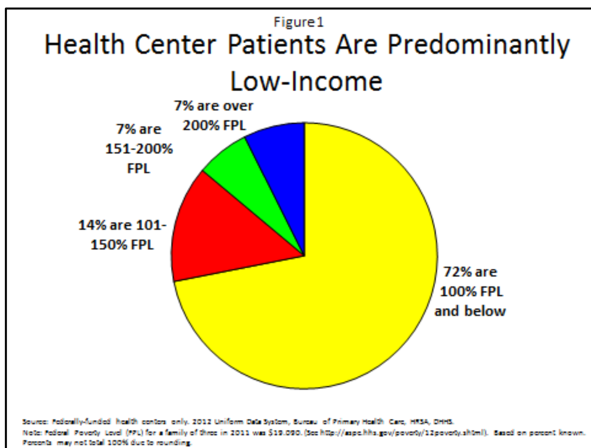
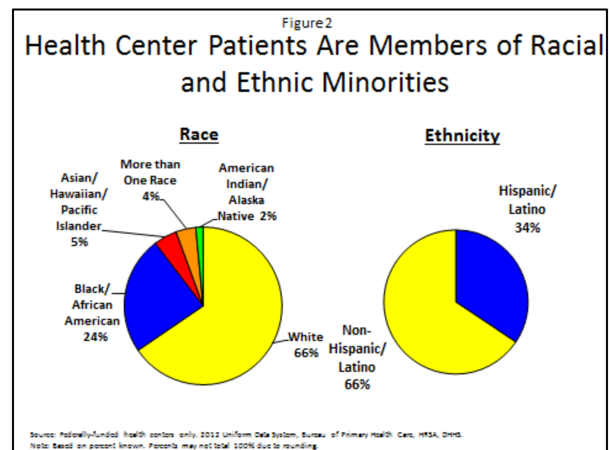
[1] Health centers are also commonly referred to as Federally-Qualified Health Centers (FQHCs), which refers to a Centers for Medicare and Medicaid Services payment designation.

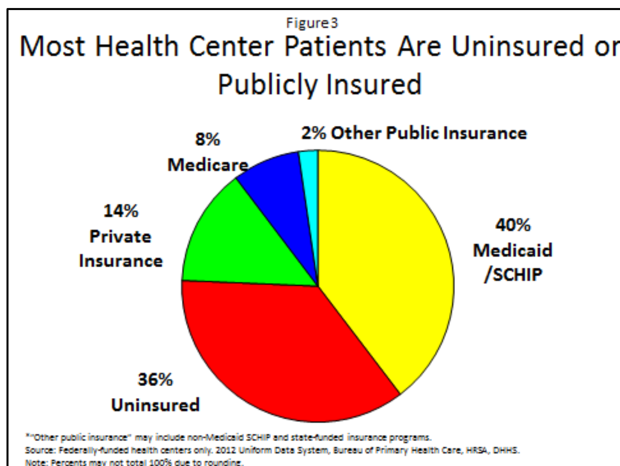
Health Center Patients Make Up Priority Populations

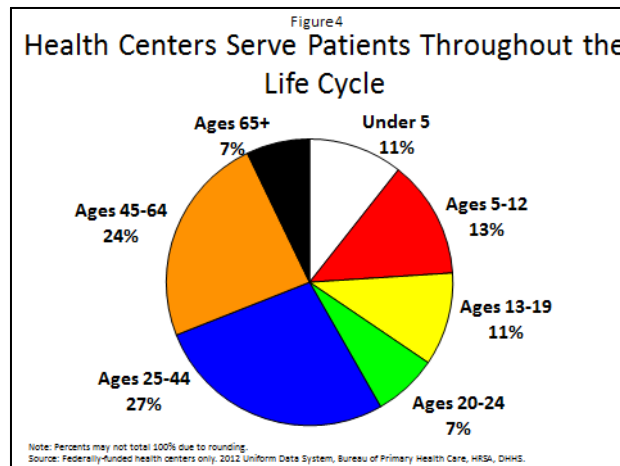
Health centers currently serve over 22 million medically underserved populations at high risk for acute health disparities. Nearly all health center patients are low income (below 200% of the Federal Poverty Level) with 72% having incomes at or below poverty (Figure 1). Patients also tend to be members of racial and ethnic minority groups (Figure 2). At the same time, 36% of health center patients are uninsured and another 40% depend on Medicaid (Figure 3). About half of health center patients reside in rural areas while the other half tend to live in economically depressed inner city communities. In addition, they serve over one million homeless patients, and another million migrant and seasonal farmworkers.

Because of the mandate to serve all patients regardless of insurance or ability to pay, health centers serve disproportionately more Medicaid and uninsured patients than mainstream providers. Furthermore, they have extensive data on these populations that most providers do not. They currently serve 1 out of every 7 Medicaid beneficiaries in the U.S. and 1 out of every 5 low-income uninsured.[3] The following figures provide an overview of the populations served by health centers nationally, but the characteristics of a population served by a particular health center may differ from others and be driven by the unique characteristics of the geographic setting they serve. Overall, working with health centers offer insights and potential understanding of populations under-represented in mainstream populations.









Health centers serve populations that often experience high levels of chronic conditions. Top health conditions diagnosed at health centers are hypertension, diabetes, overweight and obesity, depression, and asthma—many of which are considered priorities for research and action by Healthy People 2020 and the Agency for Healthcare Research and Quality (AHRQ) as Table 1 below shows.[4] They also serve patients who experience co-morbidities and face compounding social determinants of health, such as homelessness, language barriers, poverty, and lack of social support. Few health center patients have access to innovative research occurring in other practice-based settings. Patient and community engagement is critical so that patients are informed and are aware of opportunities to participate in research.

Table 1. Health Center Data by AHRQ Priority Populations

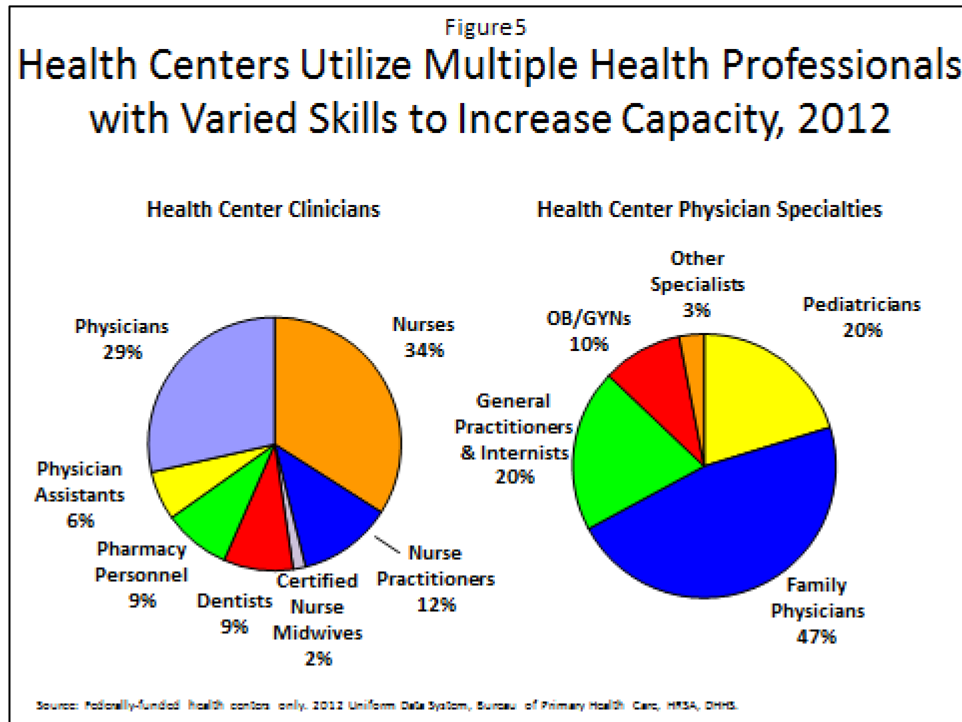
AHRQ Priority Populations	Health Center Demographics
Low-Income	93% of patients are ≤200% FPL 72% of patients are ≤100% FPL
Female	59% of patients are female
Chronic Illness	More than 40% of encounters concern a chronic illness*
Rural	48% of health center grantees are in rural communities
Minority	62% of patients are racial/ethnic minorities
Children	32% of patients are under age 18
Elderly	7% of patients are age 65 and older

Source: 2012 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS.

Health Centers' Broad Array of Services and Staffing

Health centers already have much of the "foundational" infrastructure for researchers to develop varying proposals for study. Health center staff consist of multi-disciplinary team of health care professionals, who are engaged in quality improvement activities and who use health information technology to track and evaluate performance measures. However, few health centers have staff whose duties solely include research[5]; therefore, infrastructure often does not include research administrative infrastructure.

Given their patients' broad health care needs, health centers provide services not traditionally seen in other primary care settings, such as dental, behavioral health, pharmacy, and enabling services that facilitate access to care. These include case management, outreach, translation, transportation, health education, exercise programs, nutritional assistance, insurance enrollment, home visitations, housing assistance, job training, and support groups. Health centers achieve such comprehensive care through a diverse staff model that utilizes multiple health professionals with varied skills, such as physicians, nurse practitioners, physician assistants, community health workers, and case managers (Figure 5).



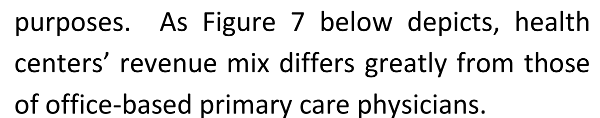
Health center staff work in teams to ensure the complex health care needs of their patients are met. Health centers consistently work to improve their performance. As of March 2014, 73% of health centers are participating in a Patient-Centered Medical Home (PCMH) Initiative and 44% had achieved PCMH recognition.[6] This presents both opportunities and challenges for engaging health centers in research. Health centers are eager to evaluate

their progress in serving as PCMHs and improving performance, particularly on the value they generate to payers, patients, and communities, but often lack dedicated research staff and expertise to effectively engage in evaluation studies. Transforming care often requires changing how care is delivered and coordinated, as well as infrastructure enhancements, and therefore generates many research or evaluation questions. It also means that health centers are eager to translate proven innovations – another area in which research can assist.

Health Centers' Revenue Streams

Health centers run on tight operating margins and all rely on grants to ensure services provided are comprehensive and to ensure they meet their mandate to serve all without regard to ability to pay. In fact, health centers currently serve 1 in 5 low-income, uninsured individuals. Current funding sources make it difficult for most health centers to engage in research studies. For example, many health centers do not have indirect rates. Therefore, researchers should be prepared to provide some level of financial and staff support to health centers directly for their involvement.

Health centers have diverse funding streams that include grants and third party payers (Figure 6). Reflecting their predominately publicly insured and uninsured patient mix, health centers' largest source of revenue nationally is Medicaid and their second largest source is federal health center grants[7] (Section 330 under the Public Health Service Act). These federal grants are part of their core program infrastructure and are not intended for research purposes. As Figure 7 below depicts, health centers' revenue mix differs greatly from those of office-based primary care physicians.



Despite the mix of revenue sources, health centers' operating margins are less than other providers', with some health centers running on negative operating margins. This is because health centers' financing is structured around their mission of improving access to care and decreasing health disparities. Federal grants have not kept up with the costs of health care (Figure 8), and health centers actually lose money in all their third party transactions (Figure 9).

Their tight operating margins (Figure 10) and the fact that revenue is generally already directed at continuing or expanding patient care, mean that research should not distract health centers from their mission of providing care to the medically underserved and should help them leverage new resources that have a community benefit. Research activities must cover the costs of participation.

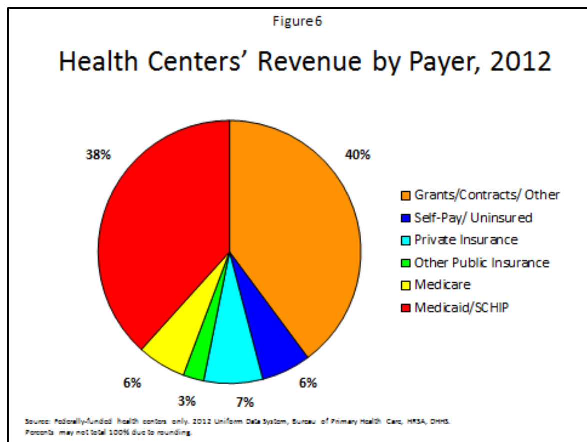


Figure 6
Health Centers' Revenue by Payer, 2012
38%
40%
6%
3%
7%
6%
Grants/Contracts/ Other
Self-Pay/ Uninsured
Private Insurance
Other Public Insurance
Medicare
Medicaid/SCHIP
Source: Federally-funded health centers only. 2012 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS.
Percents may not total 100% due to rounding.

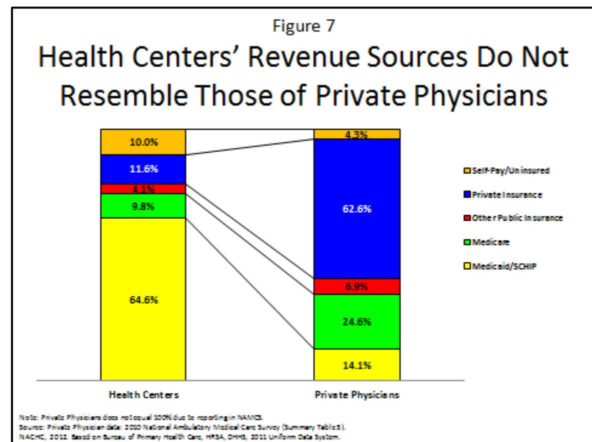


Figure 7
Health Centers' Revenue Sources Do Not Resemble Those of Private Physicians
10.0%
11.6%
4.1%
9.8%
64.6%
4.3%
62.6%
6.9%
24.6%
14.1%
Health Centers
Private Physicians
Self-Pay/Uninsured
Private Insurance
Other Public Insurance
Medicare
Medicaid/SCHIP
Note: Private Physicians does not equal 100% due to reporting in NAMCS.
Source: Private Physician data: 2010 National Ambulatory Medical Care Survey (Summary Table 5).
NACHC, 2012. Based on Bureau of Primary Health Care, HRSA, DHHS, 2011 Uniform Data System.

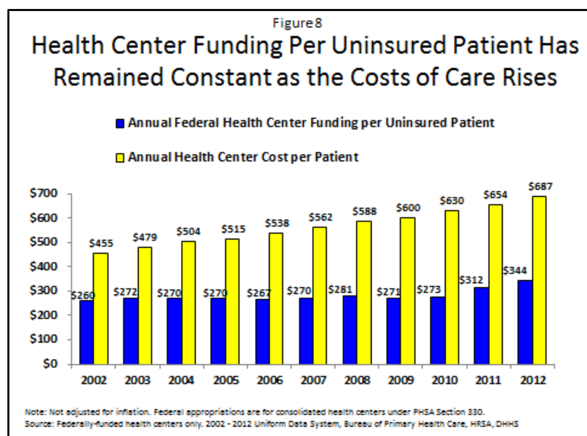


Figure 8
Health Center Funding Per Uninsured Patient Has Remained Constant as the Costs of Care Rises
Annual Federal Health Center Funding per Uninsured Patient
Annual Health Center Cost per Patient
$700
$600
$500
$400
$300
$200
$100
$0
$260 $455
$272 $479
$270 $504
$270 $515
$267 $538
$270 $562
$281 $588
$271 $600
$273 $630
$312 $654
$344 $687
2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012
Note: Not adjusted for inflation. Federal appropriations are for consolidated health centers under PHSA Section 330.
Source: Federally-funded health centers only. 2002 - 2012 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS

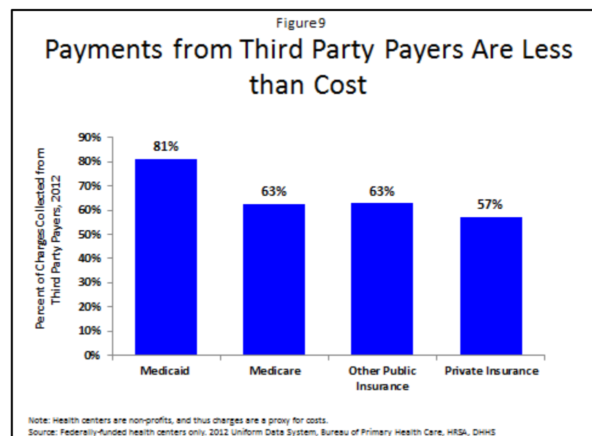


Figure 9
Payments from Third Party Payers Are Less than Cost
Percent of Charges Collected from Third Party Payers, 2012
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
81%
63%
63%
57%
Medicaid
Medicare
Other Public Insurance
Private Insurance
Note: Health centers are non-profits, and thus charges are a proxy for costs.
Source: Federally-funded health centers only. 2012 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS

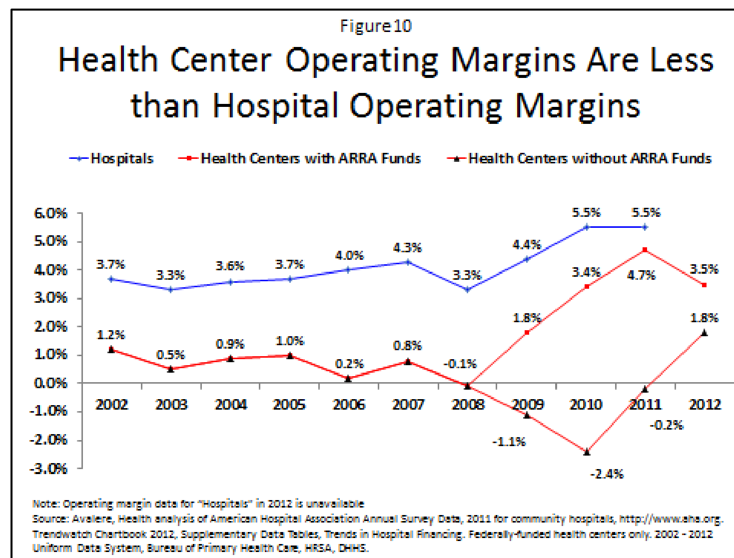
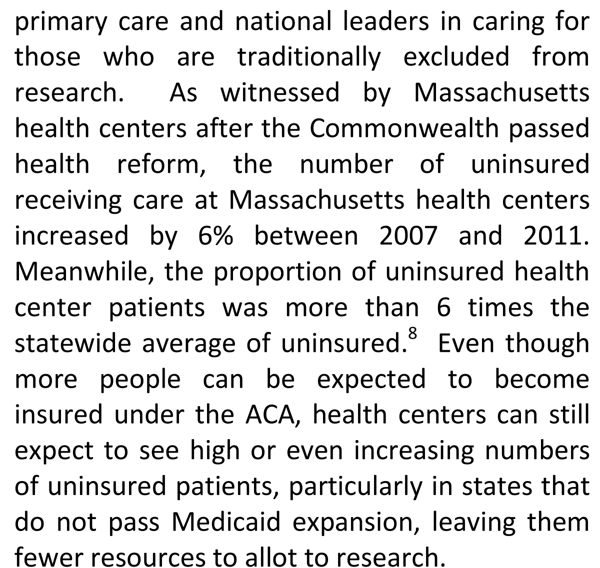


Figure 10
Health Center Operating Margins Are Less than Hospital Operating Margins
Hospitals
Health Centers with ARRA Funds
Health Centers without ARRA Funds
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
-1.0%
-2.0%
-3.0%
3.7% 3.3% 3.6% 3.7% 4.0% 4.3% 3.3% 4.4% 5.5% 5.5%
1.2% 0.5% 0.9% 1.0% 0.2% 0.8% -0.1%
1.8% 3.4% 4.7% 3.5%
-1.1% -2.4% -0.2% 1.8%
2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012
Note: Operating margin data for "Hospitals" in 2012 is unavailable
Source: Avalere, Health analysis of American Hospital Association Annual Survey Data, 2011 for community hospitals, http://www.aha.org. Trendwatch Chartbook 2012, Supplementary Data Tables, Trends in Hospital Financing. Federally-funded health centers only. 2002 - 2012 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS.

Federal Investments to Expand the Health Center Program

Health centers enjoy broad bi-partisan support, given their unique and successful model of community-directed care. Congress established a Trust Fund under the Affordable Care Act (ACA) to accelerate health center growth to serve new communities and new patients through fiscal year 2015.

As health centers grow, they will serve larger numbers of the nation's most medically underserved and at-risk, reinforcing their role as the nation's largest national network of primary care and national leaders in caring for those who are traditionally excluded from research. As witnessed by Massachusetts health centers after the Commonwealth passed health reform, the number of uninsured receiving care at Massachusetts health centers increased by 6% between 2007 and 2011. Meanwhile, the proportion of uninsured health center patients was more than 6 times the statewide average of uninsured.[8] Even though more people can be expected to become insured under the ACA, health centers can still expect to see high or even increasing numbers of uninsured patients, particularly in states that do not pass Medicaid expansion, leaving them fewer resources to allot to research.



Key Resources for More Information:

- Bureau of Primary Health Care, Health Resources and Services Administration, HHS, "Health Center Program Requirements," http://www.bphc.hrsa.gov/about/requirements/index.html.
- Geiger J. The First Community Health Centers: A Model of Enduring Value. JACM. 2005; 28(4): 313 – 320.
- NACHC, *A Sketch of Community Health Centers: Chartbook*, 2013, http://www.nachc.com/client//Chartbook2013.pdf.
- NACHC 'Community Health Centers at a Glance," Infographic, March 2012, http://www.nachc.com/client//Infographic--CHCs.pdf.

- NACHC state fact sheets, http://www.nachc.com/state-healthcare-data-list.cfm
- NACHC, *Powering Health Communities: Community Health Centers Address the Social Determinants of Health*, August 2012 Issue Brief. http://www.nachc.com/client/documents/SDOH1.pdf
- NACHC's Weekly Washington Update: http://www.nachc.com/washington-update.cfm

- For more information and data on health centers, visit www.NACHC.com/research.

[1] National Association of Community Health Centers. Health Centers in the Literature: Study Summaries. 2013. Accessed on February 2, 2013 at http://www.nachc.com/literature-summaries.cfm.
[2] US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care. Medically Underserved Areas and Populations. Accessed October 30, 2013 at http://bhpr.hrsa.gov/shortage/muaps/.
[3] NACHC, 2013. Includes patients of federally-funded health centers, non-federally funded health centers, and expected patient growth for 2013.
[4] Agency for Healthcare Research and Quality. Priority Areas for National Action: Transforming Health Care Quality. National Academies Press: 2003. Edited by Karen Adams and Janet M. Corrigan, IOM Committee on Identifying Priority Areas for Quality Improvement, Healthy People 2020, Topics and Objectives. Accessed on November 1, 2013 at http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx.
[5] Jester, et al. 2013. National Survey of Health Centers' Research Participation: Activities and Needs. (forthcoming publication in CES4Health).
[6] Bureau of Primary Health Care Update. March 19, 2014 Presentation by Jim Macrae at the National Association of Community Health Centers Policies and Issues Conference.
[7] Section 330 under the Public Health Service Act.
[8] Ku L, Jones E, Shin P, Byrne FR, and Long SK. Safety-net providers after health reform: Lessons from Massachusetts. Arch Intern Med. 2011; 171(15):1379-84.