Washington Healthcare News

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Articles, Interviews and Statistics for the Healthcare Executive

VOLUME 4, ISSUE 10

OCTOBER 2009

Community Health Centers: Vital to Healthcare's Present and Future

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Washington Healthcare News

"For every one percent increase in unemployment, more than one million people lose their health insurance and another million people enroll in Medicaid and SCHIP."[1] The final statement of the National Association of Community Health Center's (NACHC) one-page summary on the economic stimulus probably should be the first. If more people could truly absorb that, perhaps the concept of healthcare reform wouldn't be so controversial.

While that may be overly optimistic, understanding the demand may help the public appreciate the vital role that Community Health Centers play, and must continue to play, in healthcare. Consider how hard recession has hit healthcare budgets, with Washington State's alone seeing over $1.2 billion in cuts. That's why the American Recovery and Reinvestment Act (ARRA, aka "the stimulus package"), has allocated $2 billion to health centers for their infrastructure and ongoing operations, as well as to help them cope with rising patient numbers due to the economic recession. Over two years, grant award distributions will go out, and predictions are that by 2011, an additional 3 million patients will have received care.[2]

NACHC reports that most health centers indicate a rise in uninsured patient demand. The organization, sharing a recent survey's preliminary results, finds health centers faced with a growing need for services, in addition to an uptick in patients and uninsured patients from June 2008 to June 2009. Nearly all report a need for at least one new site to meet community need, and half report that unemployment has impacted up to 30 percent of their patients or patients' families. Fortunately, the ARRA funds let Community Health Centers continue providing services amid rising demand. The funds support new health center sites and workforce development, as well as help the Community Health Centers acquire and implement Health Information Technology (HIT).

Anita Monoian, CEO of Yakima Neighborhood Health Services (YNHS) and NACHC's newly installed Board Chair, points to YNHS's near-immediate results from their portion of the allocation. "It let us add a pharmacist, allowing our pharmacy to have Saturday hours for our uninsured patients. We've also added behavioral health staff, and at our homeless clinic, a dental operatory." Overall, since the money started flowing in March, YNHS has served 983 new medical patients and 813 new dental patients.

New Patients and New Perceptions

Good thing they were able to ramp up. Health and Human Services Secretary Kathleen Sebelius noted at NACHC's national conference in Chicago that since the economic downturn began, the health center patient population has grown by another one million people – a third of them children. Monoian, who briefly met with the Secretary at the gathering, explains: "We're seeing families who have never known a time without coverage. This is our working middle class, and many have never even been in [a Community Health Center] before."

Health centers are traditionally located in medically under served areas that sometimes, from the outside, appear less than stellar. For many of the new patients, walking in the door can be a pleasant surprise. "So many health centers are state-of-the-art facilities," Monoian says. "After experiencing the reality and receiving quality care from our clinicians, these new patients walk away with a shift in perception and become a voice of support in the community."

Some newly unemployed are uninsured not only because COBRA payments and individual coverage costs are so high, but also because they don't qualify for any of the public options. There is hope that at a minimum, healthcare reform will bring a change in the ability for adults to qualify for care under public options. That means an increase in the percentage of poverty level that programs use to determine who gets coverage through publicly funded options. "If as a nation we could get that up to even 130% of poverty level for adults, that would make a tremendous difference for the adult population," says Monoian. Right now, children are the most likely to be covered, thanks to SCHIP.

Coverage vs. Care: The Workforce Dilemma

But can health centers sustain caring for any resulting new patient load on top of the one they're currently experiencing? After all, workforce is at the heart of the access problem. Most of the media focus is on coverage issues, not care access issues. If healthcare reform, in some iteration, takes care of coverage issues, what does that mean for actual care?

There's the rub. The number of new primary care physicians is down 50% since 1997, states an article in Kaiser Health News.[3] What happens when nearly 47 million uninsured suddenly have coverage? After all, it's the access to preventive care that helps reduce healthcare costs.

A recent New England Journal of Medicine article reports the number of U. S. medical students entering specialty fields rising rapidly, while those entering adult primary care has decreased sharply. Money is one obvious factor in the downturn. Income gaps over a 40-year career average $3.5 million. Combine more money with the fact that specialists typically have more say over their lives and schedules, and the picture becomes clearer.[4]

Unfortunately, Community Health Centers are very familiar with the physician shortage dilemma. "If we don't have providers – doctors, nurses, nurse practitioners, PAs, pharmacists – we have nothing," states Monoian. "If you have an insurance card in your pocket, that's a great thing. But it doesn't guarantee access. We have to be able to staff these clinics." She shares that recruiting has become incredibly difficult. Several years ago, resumes came in steadily even though it could take six months to fill a position, but now there are no resumes, and positions take up to two years to fill.

Traditionally, federal programs such as the National Health Service Corps make a crucial difference in access. This year, ARRA money ($300,000 million over this year and next) has helped dramatically expand the National Health Service Corp, always a good recruiting ground for health centers. Its loan repayment program gives $50,000 in loan repayments to recipients working in under served areas, in addition to salaries, while they serve two years with the corps.[5] Of course, Monoian acknowledges, some who complete the two years leave the communities where they serve. "Retention is always a challenge. But it's about 50/50. Some like the challenge and will want to stay. It's great, rewarding work."

But if Community Health Centers are to meet their goal (they currently serve 20 million) of providing care to 60 million people over the next decade, there's a need for 50,000 additional physicians – just to meet the needs of the health centers. The NHSC only provides a gain of about 4,000 providers over the next few years. The other opportunity for workforce improvement is the Residency Training in Health Centers concept set forth in the House's version of the healthcare reform Bill. If it survives, it would authorize funding provisions to "develop or operate primary care residency programs."[6]

Where Good Health Begins

Healthcare reform aims to provide coverage and care while saving money, something Community Health Centers already do. "Our lawmakers recognize that health centers currently save the healthcare system up to $18 billion a year," Monoian states. "If we could follow the model and reach the goals set forth in the ACCESS for All American Plan, we would save the system up to $80 billion annually and serve 60 million people a year."[7]

She takes another tack. "Consider this: even if we just continued doing what we do now, saving $18 billion a year, that would still be

$180 billion in savings over ten years." Let's see, a model – based on preventive care and a healthcare home– that works, people getting high quality, patient-friendly care, and savings – hard to take issue with that.

Like everyone and every organization in the country, Community Health Centers are paying close attention to the debates on the Hill. Everyone, regardless of party lines, realizes overhauling the current system is a herculean task. It's a system fraught with inefficiencies. According to the Organization for Economic Cooperation and Development (OECD), our national health spending (15.3% of 2006 GDP) is "higher than all other OECD countries, including Canada, France, Germany, Japan and the United Kingdom."[8] Yet we still can't take care of everyone well.

Until healthcare reform becomes a reality, there is a limit to what healthcare organizations can do. Community Health Centers and the healthcare home concept set forth in the ACCESS plan is a good beginning. It's an efficient design with a vision of offering the patient truly integrated care – with access to primary care, dental, behavioral health – all under one roof. According to Monoian, such a design makes things easy and economic, both for the patient and the system.

"Good health begins with access, disease prevention and a primary care medical home," asserts Monoian. "Good health saves money."

No argument here. Let's hope any healthcare reform package coming out of our nation's capital focuses on those commonsensical outcomes.

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[1]Community Health Centers and the Economic Stimulus: A One-Page Summary, National Association of Community Health Centers (NACHC), nachc.com/stimulus.

[2]"Community Health Centers Vital to Any Health Overhaul," Andrew Villegas, Kaiser Health News, McClatchy Washington Bureau, August 11, 2009.

[3]"Physician Shortage Could Hinder Health Reform," www.kaisierhealthnews.org, July 6, 2009.

[4]"Easing the Shortage in Adult Primary Care – Is It All about Money?" by Robert Steinbrook, M.D., The New England Journal of Medicine, Volume 360:2696-2699, June 25, 2009, Number 26.

[5]Ibid.

[6]"America's Affordable Health Choices Act of 2009," NACHC, www.nachc.com.

[7]ACCESS for All America Plan, National Association of Community Health Centers, www.nachc.com.

[8]"Trends in Health Care Costs and Spending," Kaiser Family Foundation, March 2009, www.kff.org.

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