Community Health Centers: Their Post-Stimulus Role in Health Reform
Alliance for Health Reform
February 23, 2009

[START RECORDING]

ED HOWARD, J.D.: - Okay. We're honoring old Alliance tradition in the breach, we are starting on time in a briefing that is starting 15 minutes sooner than we usually do. My name is Ed Howard with the Alliance for Health Reform. Thank you all for coming. Let me apologize formally for the cramped quarters in which we find ourselves.

We've got a very popular subject and unfortunately a very small room but we actually are pleased to be able to be on the House side for every once in a while and in coming back to my roots in Congressional staff service, I find it very nice to be able to walk down the hallways that I actually know where I'm supposed to go.

On behalf of Senator Rockefeller and Senator Collins, our board of directors, I want to welcome you to this briefing on the condition of community health centers in the United States and their potential role in health reform. Our partner in today's program is the United Health Foundation, which for the last 10 years or so, has been the charitable arm of the United Health Group.

We're pleased to have Dan Johnson, I think in the audience, thank you Dan, who's the head of the Foundation. There's a nice description, by the way, of the Foundation's work particularly the community health center-related work in

your packets. You'll be hearing from Reed Tuckson from United in just a moment.

I'm not going to bother to explain what a community health center is. There are a ton of people here who can do that more capably than I and you're going to hear from them presently but in the interest of some scene setting, I will take this opportunity to lay out for you the basics of what you in Congress actually did in passing the stimulus package that's most relevant for our community health center discussion. I actually have some PowerPoint, unusual for those of you who go to these things, unusual enough that I can't do it very well. There you go.

First, you can see that health care was a major part of the stimulus package especially the spending parts of it, most notably of course on the right hand side, you see almost $90 billion to help meet the increased costs of Medicaid and CHIP but for several other projects too including IT and the community health center bar, which is on the left, actually it looks pretty short when you see it in that kind of context but two billion dollars in the community health center world is still considered real money.

You can see the division on the left, $1.5 billion for construction and renovation, IT acquisition, and other infrastructure purposes and $500 million represented by the bar

on the right for health center operations to help them meet the increased demand in cost by the recession.

Other parts of the stimulus have funding that CHCs might be able to qualify for, $500 million as you see for primary care workforce development, $300 million of it for the National Health Service Corps, the rest for Title VII and VIII, Medicaid incentive payments for providers including centers to get them using health IT systems and finally just about $90 million in funds for volunteer programs including the community health corps that can help staff the centers.

There’s no doubt that CHCs can find a use for these funds in this period of economic slowdown. Let me just show you these are actually 2006 figures from the Health Resources and Services Administration showing that even then two out of every five patients served by CHCs were uninsured and that number is surely higher today as the number of uninsured grows.

There’s little doubt that we should look carefully at community health centers as Congress and the President begin the conversation about broader health reform. The model for care in most centers strongly resembles what a lot of the people in the field are calling the patient-centered medical home idea. They’re usually built around the idea of delivering care using multiple professional teams, physicians and nurses and others. So there may be a very appropriate role for

community health centers to play as we have this larger reform conversation.

Now I want to turn to Dr. Reed Tuckson. I'm sorry, my notes are in error and Dr. Tuckson, who is on my executive committee, has reminded me that we're going to now turn to Dan Hawkins. Dan is the Senior Vice President for Policy and Programs at the National Association of Community Health Centers. He's been at this community health centers stuff longer than almost anybody in town and NAC is in fact co-sponsoring today's briefing and we're very pleased to have you as a co-sponsor and have you with us on the dais. Dan?

DAN HAWKINS: Thank you Ed. Good afternoon everyone. I want to begin by expressing our sincere gratitude to the Alliance, to you Ed, and to United Health for sponsoring and coming together to sponsor today's briefing and in particular, Dr. Reed Tuckson, for his energetic and generous support and involvement with health centers all across the country.

Most of all, I want to thank all the leaders in Congress and the members who, together with our new President and his administration, showed such high confidence in America's health centers by including the significant support that Ed pointed out in the Economic Recovery Act and in the recently enacted Children's Health Insurance reauthorization as well.

I can tell you that every health center in America understands clearly not only the support for their work that underlay these advances but also the substantial responsibility that they and we all have to ensure that those new resources are deployed quickly and effectively not only to stimulate our economy and create job opportunities but also to fundamentally advance the cause of providing high quality, cost efficient, and effective health care to more of the millions who need it today.

Today's health centers are a testament to the vision of their founders, people like Jack Geiger and others who dreamed of a health care system that would be of the community, by the community, for the community and the health centers' movement and it is still a movement today, has for its entire history, focused on bringing health care to underserved communities without regard to income, health insurance coverage, or health status.

So we stand proud to join with the Alliance and with United Health as well as with GlaxoSmithKline/GSK, and Pfizer to celebrate the work of health centers and to look forward to the advance in the future when more of the millions, the 56 million Americans who, today, are medically disenfranchised. They have no regular source of care, no family physician, no medical or health care home, when more of them can count on a health center or some other continuing source of quality care,

to be their health care home in the future. So thank you very much Ed and I turn it back over to you.

ED HOWARD, J.D.: Okay. Thank you Dan. Now let me turn to Dr. Reed Tuckson [laughter]. Reed is the Executive Vice President and Chief of Medical Affairs at the United Health Group. He's a board member of the United Health Foundation and I'm pleased to say a founding board member of the Alliance for Health Reform.

Jay Rockefeller coerced him into joining back in 1991 and he hasn't been able to escape since. He's held, as the biographical information in your packets points out, more prominent posts in health care policy than almost anybody you can imagine. Reed, thank you very much for being with us and thanks for helping us put this briefing together.

REED TUCKSON, M.D.: Great. I will be brief as well but there are a couple of points that we wanted all of you to understand. Number one, you are the most wonderful people in the universe [laughter]. What you did for poor and socioeconomically challenged Americans in this legislation is extraordinary. I hope that you really, really understand how powerful what you did is. This is an unprecedented moment in our nation's history and you are to be totally and thoroughly commended.

Number two, we in the private sector have a responsibility to step up to the plate and be helpful to make

sure that what you have done works as well as it absolutely and possibly can work. So today, I just want to let you know that there are a couple things that you may be interested in that have been announced. We announced, this morning, that United Health Foundation will make available another charge of four million dollars of funding to four community health centers to continue to help them to become centers of excellence, centers of choice not of last resort.

I hope that you are aware but in a very important peer-review published article by Sara Rosenbaum, who is here today, we have been able to prove that health centers, community centers, can and do provide care equal to or better than care in the private sector using the same evidence-based measures of performance as we do for private sector business and by the way folks, that was without adjusting for risk, straight up, head-up competition.

The four health centers that we are involved with, Janelle Getches [misspelled?], here at Unity Clinic, Dennis Johnson, at the Children's Health Fund in the Bronx, are two of them that are here and are available to answer your questions but all those clinics; they equal or beat care in the private sector. So have confidence that the money that you have made available through your hard work is going to be well spent.

We also announced, this morning, that we will be providing significant funding, $100,000, to Capital Link, and

the reason you will hear when the presentation is made by Allison, is that it is important that community health centers have support in spending this money in the way in which you have deemed it to be spent in the legislation. That means spend it well and spend it on time so that this is what Capital Link does.

In addition, we also announced today a volunteer executive program where private sector businesses will be now volunteering our business for example for sure at United, our real estate experts, capital planning experts, our IT experts, loaned executives will be matched up with community health centers around the country so that they will have more resources with which to guarantee that public money is spent the way that the public sector demands. So we are clearly aware that we have a responsibility to do right by the legislation you created.

Lastly, we have also announced today that there will be $100,000 of money given to the work that Sara Rosenbaum does at George Washington to develop the criteria and conduct a tracking analysis on exactly what were the outcomes of these expenditures. Job creation is so important but the issues that health centers are doing are also obviously well beyond jobs. So we'll talk later about some of the things that are on her mind that will happen.

Lastly as we turn and get into the program, I do want to acknowledge that we have also found resources from the private sector here to support the ideas that I just talked about. I want to ask the people from GSK to wave their hand. Joe Kucharski, Steve Stefano, and Poonam Alaigh from GSK and my good friend also from Pfizer, Dr. David Golocker [misspelled?] who is also here from Pfizer.

So what we do have and we will continue to do, Dan Hawkins, is to recruit private sector resources, Jim, to make sure that the public expenditures are going to be matched with intelligent use so that we can get the best outcome and be able to report well to the American people in a transparent way on how these resources were expenditures. So with that, I'll return it back to you and let's start the program.

ED HOWARD, J.D.: Great. Thanks very much Reed. A couple of logistical notes that those of you who come to our briefings regularly will be bored by and if you'll just bear with us, we'll get through it for those folks who aren't regulars.

By tomorrow morning, you will be able to view a webcast of this briefing on kaisernetwork.org and in a few days, you can also get a transcript on that website and on the Alliance website at allhealth.org. All of the materials that are in your packets will be on both those websites on the landing page for that briefing so you'll be able to share them with your colleagues.

REED TUCKSON, M.D.: I forgot one thing, one real quick thing [laughter]. That's the reason why I was down here. I also want to just let you know that there will be copies floating around of Faces of Hope, which is the first time there's been a documentary done, photographically, of the community health centers including, as someone mentioned, Jack Geiger, the founders are in here as well as legislative supporters such as Senator Kennedy and quite a large number of others.

This is the first time that we've actually had a living history of community health centers. I wanted to let you know that starting on Monday of next week, these pictures from Faces of Hope will be displayed in the Russell Senate office building rotunda and that there will be a reception to bring this to public attention on Wednesday, March the 4th. So just making you aware. I'm going to actually take the chance, I'll probably never see it again but we're going to pass it around while the meeting goes on.

ED HOWARD, J.D.: That's great. What Reed said reminded me of something that I forgot, which is that I wanted to thank Representative Jim Clyburn, the Assistant Majority Leader in the House, who helped arrange for us to be in this space and we look forward to being able to do it a little more frequently in the future.

There are, just to tie together a couple more logistical loose ends, in your packets green cards that you can

use to write a question. We have one microphone, if you can get to use to say your question, otherwise hold it up and we'll bring it up forward and have our panelists address them at the appropriate time.

At the end of the briefing, there is, in your packet, a blue form, an evaluation form that I would appreciate it if you'd take a moment or two to fill out so that we can improve these briefings in the future. I should point out that we were recruiting all last week, finally got Jim MacRae late on Friday afternoon, we'd already printed the evaluations but we don't want him to escape your wrath [laughter]. So write him in. Thanks very much.

Okay, we're through with the preliminaries and as Reed says, it's time to get to the meat of this program. We're going to shuffle the speakers as they're listed in your agenda a little bit. After a consultation among the sponsors, we're going to, the last shall be first and the first, second to paraphrase a famous saying.

We're going to start with somebody who lives and breathes the problems and the potentials of community health centers every day. Paloma Hernandez is the CEO of Urban Health Plans South Bronx and New York City. Under her leadership, Urban Now operates a whole network of CHCs and school health programs, lots of other moving parts that you can read about in the biographical information in your packet.

We've asked her to really share with us how she plans to deal with the challenges and the opportunities that are presented by stimulus package, CHIP legislation, and the increased demand that she's having to cope with as a result of the economic situation. Paloma thank you very much for being with us. We'll look forward to hearing from you.

PALOMA HERNANDEZ: Thank you. Thank you very much for having me today and allowing me to share my story and how I believe the American Recovery and Reinvestment Act is going to affect our health center. I would like to first thank everyone here for having the faith and trust in community health centers and passing this really once in a lifetime opportunity of funds that will be available to all of us.

I come here as one health center. There are 1,200 or 1,199 other health centers with very similar stories and we have a kind of saying within the health center community. If you've seen one heath center, you've seen one health center because as similar as we are, we all have very different beginnings and very different ways that we just operate at who we are.

So what I'd like to do today is tell you a little but about our health center, what we translate to in terms of a medical home. I'd like to share a little patient story with you or two, and then I would like to talk to you about the impact

that the act will have on us and some of the challenges that I see that it also raises for us.

So Urban Health Plan has been in existence since 1974. It was founded by a physician who happens to be my father who started out as a private practitioner on one corner, worked there as a solo practitioner before Medicaid and Medicare was enacted, moved over into a group practice, and in 1974, we became Urban Health Plan. So we've been in the community. He grew up in the community, has been a part of the community for 70 years.

So we have 35 years of service to the South Bronx community. We have currently four primary care sites. We have built our latest, which was built about eight years ago, it is a 40,000-square foot facility that no one ever thought we would fill. In eight years that we've been opened, we've had 110-percent growth in our visits.

We are currently expanding into another borough in Queens. We have five school health programs, four sites at homeless shelters, adult day treatment programs, and in dental clinic and in a boys and girls club. We also have a large support services site that houses our WIC program, community health worker program and that sort of program.

We have a health literacy site that's been funded by the Office of Minority Health at the federal level. It's

located in the Hunt’s Point area and the attempt is really to reduce health disparities by increasing health literacy.

We predominantly serve a Latino population and we provide a broad array of services from primary specialty care, diagnostic services, and support services. We have been fully implemented with our electronic health record since September of 2006. What this has done for us is it actually has increased productivity. It has increased our ability to document properly and it’s increased our efficiency overall.

Lastly, we are an economic engine in our community. We employ over 400 people, many of whom come, get trained and move on to other jobs and that’s great. We understand that that’s part of the mission that we also provide.

Medical home, these are some of the components that make up a medical home and health centers really believe that they’re not necessarily a medical home but more so a health care home because of the type of services that we provide. We provide not only primary care but dental care, behavioral health services.

So when you look at us, it’s a place where people come and get a continuum of services that address not only their primary health care needs but deal with the person as a whole. Through health education, through case management, through our electronic health record, we really are able to provide a continuum of well integrated and coordinated health services.

I wanted to share a story that kind of talks about how we actually do provide health and not only health care but comprehensive services. This is a 72-year old male who resides with his 86-year old wife. Both had traveled to the United States because their niece promised them an apartment upon their arrival.

Once they arrived, they faced the fifth floor walk up and forced to pay the rent as the niece left to a different state. Neither was able to leave the house because of their medical conditions because of the stairs, and lack of transportation. The husband was diagnosed with cancer. He would deny his illness and only show concern for his wife. Not only was medical care provided but case management services assisted in building trust, assisting with housing applications to local senior apartments, and similar things.

A year later, this case manager is still in contact with them. They have been interviewed for new housing arrangements and as of Friday, have been actually moved into a new house. Basic human needs including food, shelter, and clothing were met as the case manager provided assistance in providing home care services. Their lives have improved and they are now empowered to move forward. This is just one example of the type of services that we provide to lots of people.

We've also had the good fortune, because the founder has been in the community for so long, we served as the primary care provider for our former U.S. Surgeon General, Richard Carmona, and we provide services, when she was a little girl, so the second federal court judge, Sonia Sotomayu [misspelled?] and lastly, the presently appointed United White House Director for Urban Affairs, Adolfo Carrion, Jr., actually received services at our health center and when described the why, he says it's the best care possible, much better than private practice and it's like family.

So we really do provide services not only to our community but also people who lived in the community and really have gone on to make a big difference.

I wanted to quickly show you a business case for quality that we've made where we actually show that we've cost health plans less money than the rest of their network in providing health care. So the fact that we could provide quality and cost effective quality really is something that we hold very close to us because we value quality but at the same we understand that there's a balance that has to happen between our finances and what our mission is in trying to improve the quality of care that our community receives.

So what's the impact of the American Recovery and Reinvestment Act? For us, through the infrastructure money, we'll actually be able to expand our main site. Our main site

now is bursting at the seams eight years later. We met our fifth year projection in our first year of operation and we're hoping that we could get some money to build an extension to that site so that we continue providing the kind of services that we are.

Through the operations money, we believe that we could get temporary support for our Queens expansion. We had applied for some federal funds, had a high scoring application but because of lack of funds, we were not funded. It will also allow us to care for a growing, uninsured population that we see.

Through workforce, we'll be able to recruit among a larger pool of applicants, which right now because of the restriction in the National Health Service corps financing, we're really not able to get as many docs as we can. So we believe that we'll be able to accomplish some of that and through the health information technology, we hope that we could continue to support the infrastructure that is required to continuously weigh in on how you support your HER system going forward.

So however, what are some of the challenges? The challenges are that the infrastructure needs, there still is a large amount of capital need out there in spite of all the good work that has been done. We appreciate it. However, there should be a recognition that there more is actually needed.

Many health centers, as Allison could tell you, have been living in facilities that are very old with the average one being something like 36 years old. So additional funding is needed.

The operations money, although it's great, it ends after two years. So that's a real challenge for us as we start investing and making the changes that are needed. What happens once that money ends. In terms of workforce, an addition into National Health Service corps is great. However, there has to be a pipeline and there has to be some policy around bringing more primary care docs into medicine as well as incentivizing primary care so that it's seen as an appropriate profession for them.

Lastly, health information technology, there's lots of need for technical assistance to get these EHRs up and running. There's also a need to continue the infrastructure support that's required to maintain them. Thank you.

ED HOWARD, J.D.: That's terrific. Thank you

PALOMA HERNANDEZ: Thank you. Thank you. Thank you. I wanted to thank you again for all that you've done. This is the most important job, however it's not yet done, community health centers are a critical component of our health care delivery system in the United States. If you could see the commitment and resources that makes us are very well used and we are very cost effective.

So we not only provide cost effective care, we provide outstanding quality care and we have excellent access to care. The care our patients receive are incomparable to any other anywhere else. Thank you very much.

ED HOWARD, J.D.: Thank you Paloma. We turn now to Jim MacRae for almost three years now, Jim's been the Associate Administrator of the Health Resources and Services Administration within HHS and head of HRSA's Bureau of Primary Health Care. Most of you know HRSA is responsible for overseeing and distributing the funds to, among others, community health centers in this country.

We're very pleased that, on short notice, Jim was able to join us, give us a sense of how HRSA plans to deal with the new resources, Congress and the President have provided and make sure they're allocated and spent in the wisest way possible. Jim thanks very much for being with us.

JIM MACRAE, M.A., M.P.P.: Sure. Thank you very much. Good morning everyone. I really want to thank, first and foremost, the Alliance for Health Care Reform for having this session in particular your partners with United Health Care and the National Association of Community Health Centers. I also would like to thank our colleagues from Capital Link as well as GW. They are great supporters in terms of what we do and without them, we would not be as successful as an organization or as a program. They really are tremendous.

Lastly and even most importantly, I'd like to thank Paloma and really all the health centers out there because they're the ones that really make the difference in terms of taking the money, the resources that we provide and really turning that into health care, quality health care for patients out there who really need it. So a big thanks to Paloma and everything out there that they do out in the centers.

It's great to be here this afternoon. It's been a little hectic. We are incredibly appreciative of the support that we've gotten from the Congress for our program and for all the resources that are going to be made available to people out there. We do take it incredibly seriously but first and foremost just really want to thank you for the opportunity.

We know we've got a lot to do. I'm going to spend a little bit of time talking about some of our initial thoughts and I would say initial at this point although initial is much shorter timeframe in terms of getting the resources out there than we've traditionally had. So I'll talk a little bit about that also.

Before I get into that, I just really want to echo a couple of things that Paloma said about health centers and why we really think they are critically important. Right now, health centers serve as a medical home, a health home, for over 16 million people across this country. The statistic that really jumps out at me, however, is that right now, health

centers are a health care home for about one in three people in poverty in this country. They are the source of care where people go who really need it. We really take that responsibility seriously.

In addition, we serve almost a million people who are homeless, who are at risk of homelessness. We also serve almost a million migrant seasonal farm workers across this country. So we have, I think, an incredible responsibility to make sure that the care that's provided is of the highest quality, produces the best health outcomes, and is done in a cost effective manner.

The reason why I really do believe that the health center program is successful is because it's built on a few core principles and I won't drag this out but I really do want to emphasize these because I think it's what makes the health center what the health center is.

First and foremost, the health center is directed by its patients. It actually is governed by a board that is 51-percent patients of the health center. So they really make sure that the health center response to the needs of the patients and even more importantly the response and the needs of the community.

Being grounded in the community really makes you accountable because they are the ones that will come back and

say no this isn't right or you need to do this. So it makes a huge difference.

The other thing is that the health center program must provide all of its service regardless of a person's ability to pay. No matter what a person's financial circumstance is, the services are available regardless of their ability to pay. The services that we provide are comprehensive, culturally competent, and quality in terms of the services that are provided at a primary health care level.

We also attempt, from where we sit, to target the neediest communities out there as well as the neediest populations so that our resources really get to those communities and those populations that need it. About 90-percent, I think it's 92-percent is the most recent statistic, of our patient population, is below 200-percent of poverty. That maintains and that is our focus.

Then finally, the last pieces that we really are focused on improvement. As Paloma said, each health center is its own unique circumstance. You've seen one health center, you've seen one health center. However, I think all health centers are committed to making sure that they get as many people into the door as they possibly can, that the services that are provided are of the highest quality, and that even more importantly that it produces better health outcomes and eliminates health disparities. That's really what we're

grounded in and, at the same time, be as cost effective as possible. That really is critical and given the shoestring budgets that most of our health centers operate on, it's a necessity in terms of how we operate.

In terms of the recovery itself, we are incredible excited about the opportunity. We have spent an enormous amount of time, I won't say just in the past week but trying to determine what's actually going to happen from the previous weeks in terms of the recovery monies.

We do see it as both a great opportunity as well as a recognition of really the value of the program but we also acknowledge that there's incredible responsibility associated with it from us, from where we sit, from the health centers, from all of our partners to really make sure that we spend the money both quickly to make an impact in communities that are currently hurting but also spend it wisely so that we make sure that it's used to the best effect.

In terms of the resources that are available, there are about $500 million that is available for health center services. It talks about, in the Congressional language, about new sites and new communities. We do see this as critical in terms of making sure that the reach of the health center program continues and really is an infrastructure that is out there.

It also talks about the increased need for services. I will just tell you then we have had a number of health centers that have called, I would say begged, pleaded for additional resources from where we sit. They are experiencing significant increases in the number of patients that are needing services now. A number of folks have become recently unemployed, have lost their insurance, and the health centers are doing their best to try to address it. They really have welcomed the opportunity to have some resources from you all to help support that.

Just to give you a couple of examples, several health centers, you may have seen it in the newspaper, in Saint Louis, they're experiencing 10, 15, 25-percent increases in the number of patients that are just showing up. There are health centers nearby, Unity, I know I've talked to Vince and the folks, that they've experienced definitely an increase.

Even where it's not necessarily an increase in the number of patients, the percentage of people who are uninsured has gotten greater. So definitely addressing that need is critical.

In addition, we're hearing from a number of our health centers that folks are needing some of the other services that we provide. Behavioral health has been a big issue. A lot of folks who were previously employed now are really needing some help to deal with the economy and some issues at home in terms

of how do they move forward, so definitely that need. Oral health care services are critical, pharmacy services, transportation. Even though there's been lessening in terms of where the gas is, in terms of the price, people are still needing help with transportation and cost there. So really recognizing that is key for us in terms of the $500 million.

In terms of the $1.5 billion for construction, Allison Coleman will definitely talk more about the need. I think it's significant and we're really excited about this opportunity. The way I look at it is that it's really an opportunity to upgrade and modernize our facilities across the country and really make sure that where we provide services is the best place where people can get it and is not only the highest quality in terms of the services that's delivered but also the facilities reflect that. The need is also tremendous. I've already gotten several proposals.

I was joking with Allison earlier that I received a proposal already for somebody for $10 million and another person on Friday just gave me one for $40 million. I'm like wait, wait we're not there yet but I hear you. Thank you very much, clearly some needs out there.

The bottom line, for me, is that if we can really create a place and a home where people can go, whether they have insurance or they don't. to me, this is really a down payment and an investment in communities across the country,

underserved communities, making sure that they have a good place, a safe place, a wonderful place to go to receive health care.

The other thing that's exciting about the money that's available under this $1.5 billion is the opportunity to help our health centers become more electronic. We estimate that between 10 and 15-percent of our health centers currently have electronic health records but many more need it. we really believe, at the end of the day, this will help improve the quality of the care that's provided and really make a difference in terms of the patients.

Then finally in terms of where we are, we think at the bottom, at the end of this time, we really need to demonstrate about the economic impact of health centers in terms of direct jobs, whether those are construction or in the health center but also that larger economic impact. We also have to demonstrate how we really will make a difference in terms of getting services to people who need it now. Then finally, really demonstrating how we're being effective in terms of improving the quality of care.

It's a little hectic now. I'll try to answer as many questions as I can when we get the opportunity. I have told Ed that I have to leave a little bit early because we're still working on plans. I see some of my colleagues even here who I've been working with to finalize these but we hope to get

resources out quickly but in a responsible manner that really makes an impact for communities across the country. So again thank you for the opportunity.

ED HOWARD, J.D.: Terrific. Thanks very much Jim. Both Jim and Reed have mentioned our next speaker, Allison Coleman. Allison runs a non-profit technical assistance firm, Capital Link. I thought that had to do with the seat of government. It actually has to do with the money that government and others sometimes provide as in capital. That firm helps CHCs and primary care associations nationwide. She also runs a non-profit program offering tax exempt bonds and loans for community health centers in Massachusetts. She's going to help us, I'm sure, understand some of the challenges being faced by the centers that she and Capital Link work with. Allison?

ALLISON COLEMAN: Thank you. Good afternoon. I'm delighted to be here today on what really feels like the cusp of a historic opportunity for health centers and echoing what Jim said, I can tell you for sure that there are 1,100 or almost 1,200 health centers out there who are very, very excited about this opportunity.

Really from several weeks before the legislation actually passed when there became sort of some real hope that Congress would support this initiative, we began getting nonstop phone calls, nonstop streams of emails that have just accelerated over the last week with health centers all across

the country really incredibly excited about being able to move ahead on projects that many have had planned for years that they've just really have not had resources to undertake.

So I can tell you that the watchword among health centers and all of us I think supporting health centers, for us is really stand and deliver. This is the time and we intend to do whatever we can to help make that a success for health centers. I really want to thank the Alliance for this opportunity to get the word out and especially to United Health Foundation for really stepping to the plate very quickly to help support this tremendous opportunity for health centers.

So I'm going to first tell you a little bit about Capital Link then talk about the capital needs of health centers as it relates to the economic stimulus, funding that's coming down the pike and then talk a little bit about what Capital Link will be doing to help support health centers' efforts.

First of all, Capital Link, as Ed said, is a non-profit organization. We really work only with community health centers focused specifically on helping them plan and obtain financing for building and equipment projects. We also work with PCAs and with NAC to help leverage available resources from a variety of sources both grants and loans. We were founded originally from within the health center movement by NAC and a number of primary care associations. We're located in nine states.

Since 1998, we've helped health centers all across the country, obtain grants and loans for building and equipment projects totaling about $550 million and then have worked with primary care associations to leverage an additional $341 million in capital. So you'll see that this $1.5 billion investment is just an order of magnitude beyond what we or health centers have really had the opportunity to work with.

We also work very closely with our partners at HRSA and with NAC and primary care associations to document the capital needs of health centers across the country. So in December of 2007, we completed a study that was funded by HRSA to look at the current needs or the needs within five years of health centers related to capital. These needs totaled about $4.4 billion.

They are focused really on the current infrastructure of health centers so improving and modernizing existing facilities but basically just to maintain the existing infrastructure not really so much about expansion but more about just dealing with the often deferred needs that health centers have.

We also then, in March of 2008, worked with NAC to look at what the capital needs would be for health centers in order to meet the larger goal of serving 30 million people by 2015. So that need is estimated at about $10.5 billion. That includes

the $4.4 billion that is the current financial need for capital.

You'll see sort of an order of magnitude that the $1.5 billion is an incredible down payment but it is not everything that health centers need to grow in the way that we think they can and should.

This is an incredible opportunity, $1.5 billion represents the largest investment in health center infrastructure in the history of the health center program. it is coming on very fast and health centers are incredibly interested in figuring out how to use the funds as effectively as they can to build their capacity.

I think that many health centers really view this as a spring board not only to just kind of take care of deferred needs but to really build on their capacity to play a larger role within what may be an environment that supports health reform so that health centers really can be an important piece or continue to expand their important role within health reform.

So regarding shovel ready projects, HRSA actually has funded Capital Link for about the last 11 years and we've been working with many health centers to get their projects ready not knowing that we would have this tremendous opportunity in front of us. As a result, there are a lot of health center

projects that are ready or that could be ready in very short order.

It’s highly likely that some of these projects that are particularly the smaller ones, will likely be 100-percent grant-funded. It would really allow an immediate acceleration of projects that have really been on the drawing board for a while but just have not had the funding available. Other larger projects, very likely, will use the economic stimulus funds to leverage other sources of financing as well ranging from tax exempt bonds to a lot of health centers are using the new markets tax credit program. Other grant funding, both from foundations and in some cases from states, and from conventional loans from banks.

So what’s really great about all of these projects is that not only are we expanding the health center infrastructure but health centers, by their nature, are incredible job creators. The health center itself creates jobs but their construction projects create jobs. So just a word on that.

We did some initial modeling of what we think the impact, that job creation impact, will be as a result of spending $1.5 billion over two years. We think that the concept of economic stimulus is that the dollars that you directly put into the economy then circulate through the economy and have a larger economic impact than just the dollars themselves.

So we think that $1.5 billion in construction projects will result in about three billion in overall economic impact and will result in about 20,000 construction-related jobs. Then once the health centers themselves have expanded, when they have new space to serve patients, inevitably it means they also hire new staff and those staff are estimated, in addition from the capital projects as well as the $500 million operating funding, should provide about 48,000 new permanent health center jobs within two years.

As health centers grow in their communities, it also supports other local businesses that work with the health centers. We estimate that about 28,000 additional jobs will be created as a result of health center expansion.

We expect Capital Link to be very busy certainly over the next 90, 120 or 180 days in helping health centers prepare applications to HRSA but then we'll be continuing to work with them both to leverage other sources of funding as they need it and to help make sure that the projects are successful. We'll be doing a lot of training and kind of up front information dissemination to health centers. We'll be working directly, one on one, with individual health centers to help them prepare to spend the money effectively.

We will be working with HRSA to provide whatever advice and assistance we can provide to help them in their process of developing the way to get $1.5 billion out quickly to health

centers. We will also be working with United Health Foundation on this effort to see if we can get professionals, both from United Health Foundation and other businesses, engaged and involved in community health centers to help them successfully really respond to this opportunity.

We hope also, over the long-term, to continue to study the economic impact of health centers. I think it's an incredibly important aspect of the stimulus package to be able to really document the jobs that are created and we intend to help with that as well.

So I want to thank, once again, United Health Foundation for assisting Capital Link in developing our ability to work very quickly with health centers. I want to thank Jim MacRae for the bureau's ongoing support of Capital Link. I like to think, for 11 years, we've been getting ready for this Jim and that now we're on the cusp of doing something really remarkable. So we look forward to working with all of our partners, with NAC, and the United Health Foundation, and obviously with individual health centers. So thank you very much.

ED HOWARD, J.D.: Okay. That's great. Thank you Allison. Finally, we're going to hear from Sara Rosenbaum. Sara chairs the Department of Health Policy at George Washington's School of Public Health and Health Services. She's one of the

country's preeminent health services researchers overall and the go-to person when the subject is community health centers.

Sara's probably in a better position than anybody to look at how CHC funds are being or will be spent and we've asked her to share some of that insight with us today. Welcome back Sara.

SARA ROSENBAUM: Thank you very much Ed. Good afternoon everybody. First of all, I want to thank Ed and the Alliance, of course, for hosting this terrific meeting and of course express our gratitude to the United Health Foundation, United Health Group for what will be our second project with United, our second community health center project.

This research will be undertaken by a special research collaborative, which is part of the department that I am privileged to chair. The collaborative was established with a major gift that we received a couple of years ago from the RCH and Community Health Foundation and Feygele Jacobs who is the Executive Vice President of the foundation is here today. Thank you very much for schlepping down from New York. It's great to have you here.

The collaborative itself is part of the department's Geiger Gibson program in community health policy. The program was named after Jack Geiger and Count Gibson who, of course, are prominently featured. Jack certainly is, in the Faces of Hope and Count, unfortunately, died several years ago. They

were the great pioneers of this, what can only be described as a movement really.

Let’s try and move through the slides quickly, move quickly because I’m aware of Jim’s time constraints and I know people may have lots of questions for him. I’m not going to bother going over all of this information. You have heard it all. It is an unprecedented investment in health centers and what makes the investment so extraordinary is not just its size but the multiple dimensions of the investment.

So trying to capture the impact of the investment, something that everybody is eager to do here and I know that those of you who are percent Congressional offices are most eager to hear about the impact of the investment. It’s going to be a major challenge but I have to say probably one of the nicest challenges we’ve ever had.

There are a number of expected effects when the, of course, the legislation was only signed a few days ago and so in a little bit of a daze when Dr. Peter Shin who leads the collaborative, who’s here today, and the other researchers in the collaborative and we began sort of banding about what might be some of the effects, kinds of things that you have to think about.

The issues are just what you heard from Reed, from Jim, from Allison, more sites, more patients, different kinds of patients served, and wider range of services available. in our

research for United and others, we have noted again and again that dental and mental health and pharmacy are, of course, some of the major pressing needs.

All of the kinds of increased investments in HIT and capital that you've heard about, which should ultimately result in certain kinds of measurable improvements particularly as health centers adopt HIT and are able to be more efficient in their management of patients at not only in the four walls of the centers but of course, as Paloma underscored, in the communities themselves being able to link overtime with other programs and services.

Of course, the issue that I think is high in everybody's mind, this influx of money into a community translates as we have found in our own work, we have a major forthcoming study of economic impact of a group of health centers in Indiana, which we think can be extrapolated to the nation, that is clusters can be studied around the country, a tremendous economic effect that comes from the presence of a health center in the community.

The key questions that we think are really uppermost in our mind are questions that go not only to health centers in their capacity as clinical care providers and outstanding clinical care providers but questions that go to health centers at their very roots. If you watch this program over time or worked in this program, you know that health centers were

designed to be more than the sum of their parts. Their externality has been a major feature of this program since it began as a demonstration back in the mid 1960s.

We think that we would do the program a disservice if we didn't measure the externality. So that is we want to develop clear measures that look at what happens over time when direct investments are made through a legislation into very specific federal agencies that deal with health centers, how those agencies translate, what are some of the benchmarks for translating these investments into actual investments into particular communities. Very importantly in this case, how some of the parallel Medicaid reforms also affect health centers.

Don't forget, it's not just their own direct investment in, for example, HIT adoption. It is this huge surge and need for Medicaid and an investment not directly in health centers but, of course, indirectly in health centers because Medicaid is the single biggest source of funding. It is the engine behind health centers but the HRSA grant funds are wonderful but I'm sure that Jim would be the first to tell you that it is Medicaid that has given the program its great lift.

So what happens when simultaneously Congress pushes money into Medicaid. The Medicaid roles are expanding. CHIP is reauthorized with major new outreach provisions for eligible but unenrolled children. All of this has to be captured as well as does measures that capture the tremendous workforce

investment that’s been made here, translation of workforce into actual recruitment. How do health centers on the ground combine these multiple investments.

So it’s not just capital. It’s not just operating funds. It’s not just HIT. It’s not just the surge in patient need of potentially more Medicaid. It is the strategic choices that health centers make to try and combine these changes into a single dynamic engine that in turn has lots of spillover effects, not just in the quality of care for patients but in communities.

Some of the key questions have to do with quality outcomes. Another group will have to do with sustainability, another group with value. I just want to close by noting that one of the things that we think has been very poorly captured over the years, we’ve done a little bit of work on this, Peter authored a very good study that provides a little bit of insight into this issue several years ago now, is what’s the population health impact of health centers.

At this point, health centers have reached enough of a critical mass in many states so that their combined force with their joint effect and their spillover effect begins to potentially result in small but measurable movement for the health of a population particularly chronic conditions that can be managed in primary care, pregnancy outcome, measures of child health.

We think if there is a way in this next several years to begin to lay the ground work for measuring the population health effects of health centers that this will be a major contribution. Thank you.

ED HOWARD, J.D.: Okay. Terrific. Thank you Sara. That's very helpful. Now you get a chance to join the conversation directly. Let me remind you, if you have a question and you want to write it on a card, do that and as this lady on my right has just done, hold it up and someone will make their way to you and bring those cards forward. If you have a question you want to ask orally and given the volume of cards, you may want to take that opportunity if you can. There's a microphone right there that you can use. I would ask you to keep your questions short and identify yourself and I would also ask you to forebear while I make the following observations.

As a couple of folks have noted including Jim himself, Jim MacRae has to leave at 1:30 so if you have questions particularly aimed at him, you might want to be aggressive in getting those asked up front. Secondly, I want to note that he is fortunate to have had named, over the weekend, a new nominee as a Director of the Health Resource and Services Administration, Mary Wakefield, whom some of you here on the Hill might know from her days as Chief of Staff to Senator Conrad, as I recall.

Third, I wanted to not forget that Sara didn't mention it but she and he staff have put together the best summary I have seen of all of the health-related provisions in the stimulus package. I know we don't have it in our packets, that wouldn't fit but it is up on the web, and I would commend that to you as a source for good information about this and other provisions in the stimulus package.

Now with that in mind, Neal why don't you identify yourself.

NEAL NEWBERGER: Thank you Ed. I'm taking your advice. I'll go real quick. Picking up on Sara's, I'll just comment. I'm Neal Newberger from the Institute for EHealth Policy and I do some work with the RCHN Community Health Foundation. If you look at all the externalities, there's even more than the $1.5 billion for infrastructure for CHCs, the Medicaid money, the primary care training money because if you look at, for example, rural broadband, technology money that's available through NTIA and through the rural utility service, that's another $7.2 billion right there or for worker retraining money through the Economic Trade Administration, that's four billion dollars that can be used for dislocated workers and training and retraining of folks especially in underserved urban areas.

I think the opportunity and the problem is going to be for you Sara is how do you model all of that on top of the problem you just said but there is actually much more available

for the CHC community in that bill than we've even give credit for. Thank you.

ED HOWARD, J.D.: Harvey?

HARVEY SLOANE: Harvey Sloane. I was the director of a health center back in the 60s and Dan, when the amendment of OEO of $60 million for Ted Kennedy, we thought it was the sky. Congratulations. I wonder if Reed or anybody might talk about the recruitment of physicians. We've got a problem with primary care physicians not graduating as much. If you're going to double the population, obviously the manpower, womanpower needed is going to be terrific.

REED TUCKSON, M.D.: Yes, very briefly, this question of recruitment of physicians and other health professionals is one that is of concern. I was really glad that you just mentioned that there is money in the bill for training of primary care. That's going to be key.

The reason we did the Faces of Hope book, in large measure, was to capture who these people are who had chosen these careers. How did they get to the community health center? Almost every time you ask a young physician how did they wind up working in a community health center, it was because they trained in medical school in a community health center, that it was a part of their regular curriculum.

So one of the things that we're going to have to do now is to work continually with the Association of American Medical

Colleges to really push hard to make sure that the traditional training programs in medical schools are giving students rotations through community health centers. That's more than, by far, the most important thing.

The second thing, of course, will be and this is why that legislation is so important, is going to be the loan forgiveness. I think we get the loan forgiveness done and give these young people a chance then to work in the clinics, whether it is a part of the National Health Service Corps giveback or independent of that, that's also going to be also key.

Lastly, what I think is going to be really important will be as we are doing with our private sector business is enrolling community health centers in the networks for private sector care thereby ensuring that the physicians and other health professionals who are working in these clinics, will get a chance to see a wide variety of patients from a wide variety of challenges therefore giving them a full and complete clinical experience, which we think is also important. Great question.

ED HOWARD, J.D.: Before we do anything else with the microphone, let me activate, effectuate the suggestion that I made. Several of you have questions directed to Jim or Jim and others and actually this one, Dan, also mentions you as a potential responder. They're asking about dental needs in

health centers both dental workforce needs and the need for dental services.

JIM MACRAE, M.A., M.P.P.: I was going to say I think the need for dental services is tremendous. We, just to give you a sense, we have a competition out there currently for our health center program and we had estimated that we would be able to fund about 30 expansion grants. We put that out in the announcement and we always try to sometimes temper based on the amount of money that we have. We've received almost 300 applications for expanded oral health services.

It is the number one or number two need that our patients identify and that our centers identify really needing help with. So definitely oral health is critical. I think then making sure that the workforce is there is critical. I think in terms of just workforce generally, we're also very excited about the opportunity to have resources available for the National Health Service Corps to deal with some immediate needs and the investment in both Title VII and Title VIII to build towards the future in terms of a primary care and dental work force situation where we can actually have more people go out there.

I do think it is key to get people exposure, get residents exposure, get medical students early on out there to really see what it is about to practice in a community, to be a part of something larger than themselves because that's the

best recruitment and retention tool that we have but definitely oral health and dental services is probably number one or number two in terms of the needs that we see.

REED TUCKSON, M.D.: One of those amazing things in this whole area has been a program at AT Still University out in Arizona where the community health centers around the country can recruit young people who want to be dentists and serve this population. They can send them straight from the community health center and the interest almost without a whole lot of rigor moral and a lot of jumping through hoops and getting them straight to AT Still.

AT Still will train those young people to be dentists and then ship them back to the communities that they came from to work for a number of years in trade for paying for their training. This is a really, really important model that's sort of exciting and a lot of people want to build on it.

DAN HAWKINS: Ed I was only going to add one point. I think numbers tell a story in their own right. There are about 8,000, a little over 8,000 now Jim right, FTE physicians working in health centers today and about 4,500 nurse practitioners, PAs, nurse midwives. There are only 3,000 physicians and about 1,500 hygienists. Of the 16 million people on the, by the way there are 18 million served by health centers because there are lookalikes that look just like federally funded health centers but don't get a grant located

all across the country serving a million and a half people and there are some newer starts that haven't reported yet but of the 16 million reported, in the health center reports, only about is it 3 ½ to four Jim? It's less than four million is there an indication that they actually received oral health care.

So the need is significant and thank God for the National Health Service Corps program and for AT Still in its work. We need more dental schools, need more support for oral health training and need more amount in underserved communities.

ED HOWARD, J.D.: Okay. Also let's start with Jim on this one. The questioner wants to know if you see expansion of health centers creating pressure on the 340B program and pushback from the manufacturers that provide 340B discounts. I might ask what's a 340B [laughter]?

JIM MACRAE, M.A., M.P.P.: I could probably let Dan get into that more in more detail but 340B basically allows community health centers, federally qualified health centers and other safety net providers to get access to pharmaceuticals, drugs at a discounted price.

Depending on the size of the expansion, there's always concerns that are raised. However, I think generally speaking, the program has been seen as a very positive step, I know especially from the health center side but I would say also

from the manufacturer side in terms of really meeting a need that's out there.

With any expansion there are increased pressures that you're going to feel. However, I don't anticipate that that will be a tremendous impediment at all in terms of 340B but I don't know if Dan or Sara want to comment.

DAN HAWKINS: I mean the one thing I would say is that separate and apart from the 340B program, Pfizer, which is I think also here today, has been an incredibly generous supporter of health centers over the last 10 years providing more than a billion and a half dollars and today, running what $200 million a year in totally free, their entire product line of pharmaceuticals for health center uninsured patients. That is above and beyond the call.

It's an example of the perfect kind of corporate citizenship and support that we think others can and should show. That's above and beyond 340B. Health centers are not the biggest users of the 340B pharmaceutical programs. It's more public hospitals and others. I don't think we have not gotten any sense that the manufacturers are pushing back on that.

REED TUCKSON, M.D.: No I don't think so and also it gives us a chance to note that Mike Andre, who runs the center of excellence in the ninth ward of New Orleans and they have been adopted by GSK in a similar sort of way. So you're seeing these sort of partnerships between companies in the

pharmaceutical space who are adopting community health centers around the country.

SARA ROSENBAUM: If I could just add as a 340B health center, what we do is we combine the 340B with pharmacy assistance programs so that we maximize the resources that are available for the patients and even reduce even further the cost to the patients because the pharmacy assistance programs are less expensive. It works very, very nicely.

ED HOWARD, J.D.: Jim, we don't want you to get out of here without being pummeled with as much as possible. So there's yet another question directed to you. Keying off Sara's comment about sustainability, can you speak to what HRSA sees as sustainability of the growth stemming from these funds?

JIM MACRAE, M.A., M.P.P.: It's a great question. It's one of the questions that we're actually really grappling with right now is how do we take a significant and meaningful investment in terms of the programs but how do we make sure that it's not just a one-time thing?

We really do see this investment as creating a down payment on whatever happens with respect to health care reform to really set the stage in terms of having a place for people to go.

In addition, however, we don't want to set up false expectations for the health centers. So one of the things we want to do is really work with them to develop plans to show

how they're going to be able to sustain this investment especially on the capital side. What I mean by that is really working with them on their business plans.

There have been recent expansions with the CHIP program, which we think are going to make a big difference for health centers. We also see the increased FM.A.P is going to help in terms of on the Medicaid side. We want to work with our health centers to make sure that whatever investment we make especially on the construction, renovation, repair side can actually be sustained.

Do we anticipate still requests for ongoing operational support? Absolutely. The need is definitely out there. We're experiencing it and we're able to fund, right now, between 10 and 20-percent of the applications that actually come in but we really are going to try on the front end as best we can to deal with the issue of a sustainability making sure that we invest in things that really will produce that best outcome in the future.

SARA ROSENBAUM: Ed?

ED HOWARD, J.D.: Yes? Go ahead Sara.

SARA ROSENBAUM: It's much too early to say this is why God created research but if I had to just based on experience take a guess as to what will be the single biggest determinant of sustainability, it will be how states implement their Medicaid policies because of this extraordinary dynamic between

Medicaid and health centers. It’s not just obviously the augmented FM.A.P, which is most wonderful for the next couple of years but it’s the, if you look at the breakdown of who uses health centers, the CHIP expansions cannot be overstated in their importance not so much because health centers see children at the higher end of the income scale.

Actually, very few children seen by health centers receive coverage under CHIP because they’re so poor that they’re generally Medicaid eligible but what CHIP has built into it is a tremendous incentive for outreach, outreach and enrollment. This is coming at a time when the need for the program is great.

So one of the things that we will be paying a lot of attention to is this dynamic between Medicaid policies, CHIP policies, and health center investments to be able to look at key measures of interactivity between these two parallel sets of investments.

ED HOWARD, J.D.: Let me just follow up actually by asking something that was triggered by what Sara said, in my mind anyway. There’s been a lot of rumbling, over the last few days, about some states not wanting some of this money and I wonder if any of the funds that we’ve been talking about are dependent on state approval to get the money into the hands of the community health centers or others.

DAN HAWKINS: Not the infrastructure or the operating support. I don't believe, Jim, the workforce money either. The only funding that would be subject to state action would be the HIT money, the Medicaid payments for electronic health records. That clearly is going to have to flow through the states but I believe it's 100-percent federal funding. There's no state match required. I can't imagine that that's going to be a problem.

ED HOWARD, J.D.: Okay. We've got a question for Paloma and Sara. Speaking of electronic medical records, does the EHR implementation include the ability to see patient information on other facilities' records besides your own and making observation that the record may also allow you to move more quickly to population-based research?

PALOMA HERNANDEZ: Our EHR system does not permit that. That has all kinds of issues around security and privacy and sharing of information. We do participate with the Bronx Regional Health Information where the idea is that certain information can be shared among providers.

So if a patient comes to our facility and was seen at one of the local hospitals, we'll be able to go into the system and pull out discreet information. As a board member of that REOs, it is so expensive to build that we're not really sure of the sustainability of the REOs over time.

I think, from a health centers' perspective, it's important that we do that. I think it reduces duplication in visits, in procedures, in all kinds of things that could really provide good efficient care but I also think it has to be broadened so that health centers across the country are linked together so that we could really compare our data and see how effective we are in the work that we do.

So one is, from a policy perspective, really understanding our impact across the country and then the other one is really on the ground where we are really able to share information and the affordability of that, I think, is really what gets in the way of getting that implemented.

SARA ROSENBAUM: Our research collaborative actually does a good deal of work on HIT issues in health centers and use of electronic health information. One of the directions that health centers clearly are moving in and this is something that the RCHN Foundation spends a lot of time on and we do in our own work is very large networked groups of health centers in regional groups.

I, too, think that the long-term future lies not just in health centers becoming integrated and interoperable with their community health systems, which will come over time, but as a group being able to be fully integrated so that one can begin to look at the ecology of health centers in ways that we can't now other than through the very important and very useful

UDS data but it's really the only data anybody has. It's, by nature, just somewhat limited in what can be measured.

I do think that the most important development, putting on now my HIT adoption hat, one of the most important developments that will drive a lot of what health centers are able to accomplish, over time, in terms of being able to link to others in their communities is the growth and the use of public health registries.

This is an area that tends to get less attention. In HIT adoption. Most people are focused on clinical records but as more and more state and local health agencies begin to build health registries around certain conditions in certain patient populations that are designed for secure and private use by clinical providers and then across systems, for example, ultimately with school systems or nutrition programs or whatever. This is where the future lies and I think for a program like health centers that is, by its nature, geared to be external, this will be of critical importance.

REED TUCKSON, M.D.: I think also that the real challenge that I think that HRSA has right now is in this new stimulus package there was so much energy put into trying to coordinate health information technology and make it interoperable across the full delivery system.

The stimulus package does speak to the creation or really the revitalization of some efforts that were already

ongoing specifically America's Health Information Community and that sort of thing to try to stitch together the whole fabric of care at a regional level.

HRSA will have to be very attentive to how it plays in that game so that health centers do not become in its health information technology an island unto itself but something that is integrated into the larger fabric of the delivery system in their environment. I think this mirrors another and related challenge that HRSA has and that is around being able to have standard measures for assessing performance.

As I mentioned earlier, Sara Rosenbaum and them did a study on our four centers of excellence. We use the industry standard performance measures that everybody else uses. HRSA hasn't quite gotten there yet and I think that's a real challenge here especially because the health information technology systems will enable the collection of a new kind of data, which it will augment the traditional claims-based, encounter-based quality information.

So I think this is real key and I think we really are looking to HRSA to provide a more enhanced leadership in these areas.

JIM MACRAE, M.A., M.P.P.: If I can just to echo on that. I think in terms of the HIT piece, clearly interoperability is going to be key. That's going to be one of the expectations in terms of the systems. We also have been

supporting efforts around networks of health centers but also vertical integration in terms of really making sure that it’s connected up and down the system, not just horizontally across.

In the whole area of performance measure, I couldn’t agree with you more. In fact, this year we’ve actually have just begun to collect data on real health outcomes. We are looking at controlled diabetes, control of hypertension, as well as impact on low birth weight.

We’re actually going to be able to collect that information not only for all of our health centers but also by race and ethnicity so we can really see how we’re making an impact on disparities because we really do think we have a great story to tell but we haven’t had the data as much. we’re going to get it actually in March. So we’re going to be really excited to be sharing that. it’s all aligned with NQF and all the quality data-

REED TUCKSON, M.D.: That’s the key thing because what’s also key and I think we heard today, which is pretty exciting. So I hadn’t thought about it at all was that as you push more, as Sara says, you push more Medicaid dollars out there and you do all that, what you’re going to wind up with is not having very many people to take care of all those folks who now have access to Medicaid.

So where are they going to go? They're going to wind up in the community health centers, which is terrific. The notion then is, is that the performance measures that accompany the expectations of Medicaid, which are again because CMS is a part of the national standards that everybody's trying to do from a public/private point of view, it's even more of a stimulus for, so this is very encouraging, your comment.

ED HOWARD, J.D.: And speaking of somebody with a very low level of understanding of these IT questions, it does seem to me that the population that you're serving is much more likely to have been somewhere else on another record system before they came into the center and maybe going somewhere else afterwards and thus making the kind of communication that we're talking about even more important.

Reed just alluded to the question of potential shortages in personnel and a couple of you have written questions about that. I'm told there's a personnel shortage particularly in health care providers that would prevent community health centers from serving the additional people if they're going to reach that 30 million expansion target. How might that provider pipeline issue be resolved and I might add, there's a separate question that asks how do you deal with the specific problems that are presented in rural areas-

JIM MACRAE, M.A., M.P.P.: I won't go into great detail about it except to say that I do recognize and I think we would

recognize that there is a current workforce crisis out there in terms of really making sure that the primary health care needs are met of our populations.

I am really excited about our new administrator, Mary Wakefield, coming in because this is one of her focuses of her work and in particular around rural health care issues. So we're excited about working with Dr. Wakefield around really developing some strategies about how do we move forward.

I think one of the keys for us with the whole recovery effort really, it goes back to a point, I think it was the first question that was raised, is there are so many different parts of this and we can't just think about where we sit in the community health center program but we have to think about what we do with health centers, what we're doing on the workforce side, what's going on with HIT, what's going on with Medicaid but what's also going on in terms of rural broadband, some of these other efforts that are going on there.

How do we really make sure that the investments we're making are for the long term, make the biggest impact, and really make a difference for the people out there. That's some of the stuff that we're grappling with and really trying to address but I think, first and foremost, is we want to make sure that people have a place to go, having great facilities, having the staffing be there, and making sure that we can

document it at the end of the day is critical. We know that and that's what we're attempting to do.

ED HOWARD, J.D.: Dan?

DAN HAWKINS: Ed, a couple of things. for those especially who work here on the Hill, last year there were 3,200 applicants for national health service for loan repayment. Only 800 were able to be assisted with the regular funding that was provided. So there's a whole group of applicants, some of whom apparently never even finished the application but they can be reached out to, to see if they still have interest. One assumes they're in first or second year residency now.

There were actually 1,000, almost 1,000 applicants for scholarships and only about 100 could be assisted. So in terms of need or from a demand perspective, the interest is there.

The second thing I want to note Reed mentioned AT Still dental school. That was a collaboration with my organization that actually created, at that time, the newest dental school in the nation, kicking out 60 dentists a year now and work is underway to establish one or perhaps two more campuses to grow that program even more but the most recent collaboration is the AT Skill medical school, which now has, it's in its third year or operation with 100 students a year taking didactic learning at the Arizona campus, again this is a school of osteopathic

medicine, which is by the way, the only discipline that shows any real continuing interest in primary care.

Allopathic medicine seems to have gone to hell in a hand basket on that front but with 100 students a year who spend one year in Arizona on didactics and the next three years in one of ten, what are known as contextual learning hubs, which are community health centers including one just up the road from Paloma in New York and in rural areas as well. The whole state of Alabama is one network. They'll have 30 students.

We're hopeful that this program can expand as well. the bottom line is a big of solving the workforce problem is going to be to grow our own. That's what has to happen.

ED HOWARD, J.D.: One final note on workforce before we leave it, somebody's actually trying to channel Mary Wakefield I'm sure by asking how the stimulus funding for centers will specifically affect nurse-managed community health centers.

JIM MACRAE, M.A., M.P.P.: Well I was going to say I think in terms of the issue, it's definitely something that we want to work with Mary on in terms of making sure that our health centers are adequately staffed. Nurse-managed clinics have been a key source of care for a number of folks out there.

We really want to work collaboratively with them to make sure that resources are available both in terms of staffing and everything. So we're looking forward to that. I

apologize that I have to run but I really thank you for the opportunity. So thanks everybody.

ED HOWARD, J.D.: Thanks for making the time [applause]. We've let Allison Coleman off the hook for the first part of this conversation. I don't want her to feel that she shouldn't be subjected to the same scrutiny. The questioner asks what you consider to be a smaller project, fully stimulus grant-funded versus a larger project using stimulus grant and other leverage funds if there is a cap for example, on the grants that would be given to smaller projects.

ALLISON COLEMAN: Well Jim is leaving at just the right point on that [laughter].

ED HOWARD, J.D.: Nice timing.

ALLISON COLEMAN: We don't know what parameters HRSA will place on the grant awards. So I can't really say with any level of authority what that will be though I think when I talk about a smaller project, in part, it depends on the context. In rural areas, a fairly substantial size project for a rural health center might be five or $600,000. For an urban health center, a small project might be five million.

So we have a series of issues related to context that need to be resolved. I think that virtually every health center out there has projects that they have been kind of warehousing because there just isn't any support for it.

A number of health centers have called up and said well how much are the grants going to be? I could do a small project. I could renovate four exam rooms and buy dental equipment and upgrade my HIT. I could spend $500,000 in two months but I also have these other projects. I've got a couple million dollars. I want to do an add-on to another clinic. Then I have my dream clinic of $20 million.

So health centers have a lot of sort of tiers of projects. I think part of the decision that comes down from HRSA in terms of how much are health centers able to apply for will, in part, depend on which projects they are able to activate immediately.

REED TUCKSON, M.D.: The next question, I'll read because Ed can't read the writing [laughter]. I guess mine is so bad that I can do it. Capacity, how many patients are being seen now? How many will be served extra with the new money and how will the dollars come from over time particularly interested also in the payment structure for the new dollars coming forward.

How much will be, in terms of as you look at how much of this will be insured people versus not insured and the ratio and does that affect a priority of being seen whether you are insured or not insured? So basically who has a good handle on that?

DAN HAWKINS: I'll try with some numbers but I think Sara might have some information also. In fact, I'm going to cite her and take her name in vane on this. Today, it costs about a little over $500 a year for care at a health center for an individual but the grant dollars really only represent about 20-percent of that or about $110-115 per person.

The rest comes from Medicare or Medicaid, private insurance, state and local funding, and the like so that if you were to take that $500 million, now remember it's over two years, so it's over $250 million a year, and divide it by that number, it would tell you about a million additional individuals would be served.

Then again, as I remember it, George Washington did a piece on an investment in health centers earlier, no last year, about a year ago, that indicated that with a $250 million investment with leverage, an additional $750 million from other sources, producing a billion dollars in total operating revenues that would actually translate into care for, Peter, was it not 1.8 million, 1.8 million people, almost twice as many. It's the leveraging aspect of those grant dollars that does that.

So I'm going to say somewhere between one million and two million people and that assumes that 40-percent of them are uninsured, so 400 to 800,000. Now if the proportion who are uninsured is higher then it will affect the overall number

because more grant dollars, it will cost more to serve those people in order to do that. I think that obviously would have an impact then on their ability to serve additional numbers of people.

SARA ROSENBAUM: Well the only thing I would add, Dan then obviously is totally correct, he's citing our work [laughter] but I'm not sure whether we're not going to have to go back and revisit some of these models at least for the next several years because with the federal government pumping additional funding into Medicaid, the number of people who have Medicaid, obviously again this is a big driver here, and as the federal government puts more money into Medicaid, the take-up rate of eligible individuals to enrolled people may also begin to go up some.

Because with more money to spend, states are able to be more efficient in getting people into the program and keeping them into the program so to the extent that the estimates looked at a certain proportion of the patients who are Medicaid-eligible, we may have to go back and rethink whether that number stays where it is or goes up a little bit. Of course, if it goes up a little bit then you get even a greater leveraging effect.

PALOMA HERNANDEZ: If I could just comment on prioritizing patients. Health centers do not prioritize patients. So we see everyone who comes to our doors

irrespective of ability to pay or insurance. That's really one of the bigger features that we have and our physicians are totally, it's transparent to them whether they're treating an uninsured patient, a Medicare patient, a Medicaid patient, a managed care patient. We really have one system of care throughout.

SARA ROSENBAUM: I should note that when I refer to the Medicaid numbers, the other thing that our research shows that's very important to understand is it's not that you get a greater surge just in the proportion of patients who are on Medicaid because it's more available to them but you get an overall surge in the number of patients served because of the economics of health care, that is if health centers have more revenues to work with, they're able to do more across the board. So it's not simply more insured patients. It's more patients.

REED TUCKSON, M.D.: Finally, on the question of sustainability, one of the key things now is to be able to enroll more health centers in the commercial networks of private insurance. So like in our United Health Care business, we are doing that. We're trying to make sure that every community health center and anywhere near what we're doing is enrolled in the network there.

Also because we know that community health centers provide such good quality care and especially for certain

patients, it’s the ideal place to be because of the expertise that they have in managing some of the more comprehensive and complex problems where disease is comingled with socioeconomic challenges.

The example that Paloma gave earlier in her talk is the perfect example. That’s where you want a person getting care in that environment. So it just makes sense to not only enroll community health centers in your networks but to actively try to match people who have those kinds of needs into those centers thereby also giving you a much better sustainability model in the out years.

ED HOWARD, J.D.: We’re going to take another five to eight minutes’ worth of questions and we have someone at the microphone. As we do that, I would ask that you take the time to fill out the evaluation form before you go. with that, I will recognize the gentleman in the blue blazer.

BOB GRISS: Bob Griss with the Institute of Social Medicine and Community Health. All of the presentations have emphasized cost effectiveness and quality in the care provided at community health centers and that community health centers don’t want to just be islands within the health care delivery system.

I’m wondering what kinds of lessons we can learn from community health centers that can be applied to the larger community health care delivery system through regulations,

through state and federal regulations, so that the health care delivery system functions more like a system.

Reed just mentioned how certain patients in certain socioeconomic conditions might actually be better served in a community health center than the way they're served right now in the highly fragmented health care marketplace. I'm wondering what lessons there are for health planners and regulators to make our whole system more efficient, effective, and equitable.

ED HOWARD, J.D.: Okay, let me just say that put that in the context of Congress about to being what most people think will be a serious conversation on broadening coverage, improving delivery, raising quality over time. Sara?

SARA ROSENBAUM: I'll take the first shot. I would say the most important lesson and I wish our colleague, David Stevens who's on our faculty and also works very closely with the National Association, were here. Is David not here? Is David here?

ED HOWARD, J.D.: No, he's not.

SARA ROSENBAUM: No?

DAN HAWKINS: He just sends his fellow gym rat.

ED HOWARD, J.D.: He's doing push-ups at the Bethesda Health and Sport at the moment.

SARA ROSENBAUM: Well David is actually really key to a question like this. Seji Hyashi [misspelled?] from our faculty is also here and works on similar issues. I think one of the

interesting things about health centers is that long before as much attention was paid to it as is the case today, they function with the attributes of a medical home.

So whether it's a regulatory intervention or the use of third party payments to incentivize the attributes of a medical home meaning a team approach to care and the ability of the health care entity to essentially go above and beyond to go a little bit, if not as much as health centers, health centers are really social creatures as well as health care entities, but to take on that social role as well as a specific clinical role and where that balance gets dropped for a traditional group practice, for example, I'm not sure but I think that it's that approach to delivery of clinical services that may be of greatest transferable interest.

PALOMA HERNANDEZ: I think another lesson that can be learned form health centers is our ability to learn to use community resources that exist. So we're very good at bringing in a visiting nurse service or a farmer's market or a whole series of services that we understand if we were going to undertake ourselves, would cost us a lot of money.

So what we've been able to do very well is network within the community and identify all those resources that our community needs and then link them up together.

ALLISON COLEMAN: It is interesting Paloma's story, the health center that grows out of a traditional practice is not

an unusual story and of course, over time, you also can see physicians who may maintain their own practices in the community but begin to affiliate quite formally with health centers. So it's clearly a practice style but appeals.

ED HOWARD, J.D.: Yes Sara?

SARA ROSENBAUM: And I might just say I'm from Massachusetts and there's been a lot of discussion in general, anyone looking at health reform is looking at what's going on in Massachusetts. One of the things that we've seen is that right now, 96-percent of Massachusetts residents have a health insurance card but just because you have a health insurance card does not mean that you have a place for care.

One of the next things we're looking at tackling is the issue of costs. I think one of the drivers of, there's been a tremendous expansion of health centers in Massachusetts because they provide primary and preventive care and it's much less costly.

So I think a lot of the payers are really seeing the need to invest in that level of the health center, of the health infrastructure as a complement and a balance to hospital and specialty care. Obviously we need all three but I think that's one of the lessons from health centers is that if you don't have primary and preventive care, costs go up and access is obviously not there.

REED TUCKSON, M.D.: The last thing I would just, as we bring to closure, I think the key thing that I've observed that whether you have regulations or not but I know that from how we are learning to operate our private sector business is clearly having an integrated, coordinated set of key functions. I think what health centers do is they address the psychosocial very effectively. You need to have that in place.

What they do is they look at things holistically and bringing dental services into the mix. That is very important but the key and I think the biggest is, is trying to be able to coordinate care and having care coordination services married directly with the clinical services so that the person's needs, medically, are so often dependent upon a non-medical social support that has to be integrated into a model.

So what you see in private sector health care, for example, and some of the things that, for example, we're doing at United is very much integrating care coordination, disease management as supplements integrated with the clinical care delivery. That's what health centers really have taught us. I think it's a very important lesson.

ED HOWARD, J.D.: And a pretty good way to bring this briefing to a close as a matter of fact. Let me just ask one last time if you would take a moment to fill out the evaluation but also to thank you for being part of a very useful discussion. I want to thank Dan Johnson and his colleagues at

the foundation for their support and Dan Hawkins at NAC for their co-sponsorship. I'd ask that you join me in helping to thank our panelists for a very useful discussion [applause]. Don't try to run off with that picture book [laughter].

[END RECORDING]