Community Health Center
Big Picture

The Civil Rights Movement

- In the “Freedom Summer” of 1964, the Civil Rights Movement reached a peak
- The Medical Committee for Human Rights sent physicians, nurses, and other health workers from around the country to Mississippi to provide protection and emergency healthcare for the civil rights workers
- This focused attention on the appalling health status of the state
The Civil Rights Movement

- In December 11, 1964, civil rights workers met to consider how to follow on the work of “Freedom Summer”
- At that meeting, Jack Geiger, serving as the Mississippi Field Coordinator with the Medical Committee for Human Rights suggested they “use health as an entry point for broader social change”
- More specifically, he recommended they implement an American adaption on the South African community health centers

Jack Geiger

- Jack Geiger was a pre-med student just back from WWII in 1947 when he chaired a civil rights committee which carried out protest strikes against the refusal of the University’s hospital to admit black patients
- As a physician, Jack secured a Rockefeller Foundation fellowship in 1957 and went to South Africa to learn about community-oriented primary care
Jack Geiger

- He returned from his fellowship experience and wrote a thesis proposing a comprehensive contemporary community health center model in the United States based on his experience in the Pholela Health Center.
- This thesis is often considered the founding document of the Community Health Center movement and Jack is often referred to as the “father” of CHCs in the U.S.

Community-Oriented Primary Care

- COPC is an approach to health care delivery where the health center takes responsibility for the health of a defined population.
- COPC combines epidemiologic study and social interventions with clinical care of individual patients, so that the primary care practice itself becomes a community medicine program.
The Civil Rights Movement

- Also in 1964, LBJ declares an unconditional war against poverty in his state of the union address
- The Economic Opportunity Act, Civil Rights Act, Migrant Health Act and Medicare/Medicaid legislation are signed into law in 1965
- Jack Geiger and Count Gibson take their proposal to the Office of Economic Opportunity (OEO) and ask for $30k grant to do a “feasibility study” ...

The Civil Rights Movement

- This national focus on domestic poverty and the creation of a safety-net for the poor (with legislative support) paved the way for health centers to focus on more than just health care
- The social determinants of health (circumstances in which people are born, grow up, love, work and age and a wider set of forces including economics, social policies, and politics) are all part of how the Health Center Program was designed and how it operates today
Fundamental Principles

- A new model of healthcare delivery, serving defined areas or populations in greatest need and removing barriers to access by providing primary care regardless of the inability to pay
- The targets of intervention are both individual patients and their community, the goals are to provide both personal curative and preventative medical care and to provide community-targeted public health interventions to address such social determinants of health

Fundamental Principles

- Community participation is an explicit component of the community health center, and community empowerment and community development are implicit goals
- Community control of their own health services is the ultimate goal
Fundamental Principles

- The focus on defined areas and populations facilitates the use of epidemiologic methods to identify major health problems in each health center’s service area and guide clinical and public health interventions to address them
- Community health centers will require new combinations of clinical and public health personnel, including community organizers, health educators, public health nurses, social workers, psychologists, and others in addition to traditional healthcare providers

History of TPCA

Tennessee Primary Care Association (TPCA) evolved out of the national community health center movement begun in the 1970s as part of President Lyndon Johnson’s “War on Poverty.”

The Association began in 1976 following organizational meetings in East, Middle and West Tennessee.
### History of TPCA

The organizing issue was a conflict between rural centers staffed by nurse practitioners or physician’s assistants and the Board of Pharmacy. NPs and PAs were prescribing, and in some cases dispensing, medications under standing orders from physicians. The Board of Pharmacy took exception to this practice.

The Pharmacy Board issue made it clear that community health centers needed a statewide voice to represent their interests with regulatory boards as well as the state legislature.

<table>
<thead>
<tr>
<th>History of TPCA</th>
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<tr>
<td>In 1977 TPCA held its first annual conference, approved its by-laws, and elected its first board. The following year it began to seek 501(c) (3) status.</td>
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<td>A technical assistance grant came in 1978 from the Lyndhurst Foundation and more monies from the Foundation followed in 1981.</td>
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<td>The first Bureau of Primary Health Care Grant was received in 1984. Grant funding, membership, and programs have grown through the years.</td>
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About TPCA

The Tennessee Primary Care Association improves access to primary health care through leadership, advocacy, and support as the voice of Community Health Centers.

- Provide leadership in implementation of care coordination, quality improvement, and integration initiatives.
- Advocate effectively in the interest of member clinics by serving as the voice of Tennessee’s community health centers on a state and national level.
- Support member health centers across the state with high-quality, timely training and technical assistance.

Today’s Community Health Center

For more than 50 years, health centers have delivered affordable, accessible, quality, and value-based primary health care to millions of people regardless of their ability to pay.

The Health Center Program is leading the nation in driving quality improvement and reducing health care costs for America’s taxpayers.

The health center network is also called upon to support public health priorities such as the opioid crisis and the White House initiative, Ending the HIV Epidemic.
2019 Annual Conference
Health Center Board Member Boot Camp

VALUE + IMPACT of HEALTH CENTERS
Tennessee Federally Qualified Health Centers

Tennessee's 30 Federally Qualified Health Centers provide tremendous value and impacts to their communities, including access to care for vulnerable populations; savings to the health care system; jobs and economic stimulus to local communities; state-of-the-art, comprehensive, coordinated care, with a focus on chronic disease management and quality health outcomes. Highlights of their 2017 contributions are shown below:

**Tennessee Health Centers Provide...**

- 4,835 TOTAL JOBS
- 2,817 HEALTH CENTER JOBS
- 2,018 OTHER JOBS IN THE COMMUNITY
- $557,005,500 TOTAL ECONOMIC IMPACT of current operations.
- $277,744,652 DIRECT HEALTH CENTER SPENDING
- $279,260,848 COMMUNITY SPENDING
- $74 Million ANNUAL TAX REVENUES
- $58 Million STATE AND LOCAL TAX REVENUES
- $56 Million FEDERAL TAX REVENUES
- $323 Million SAVINGS TO MEDICAID
- $688 Million SAVINGS TO THE OVERALL HEALTH SYSTEM

**Savings to the health system**

- 24% LOWER COSTS FOR HEALTH CENTER MEDICAID PATIENTS

**Access to care for vulnerable populations**

- 457,532 PATIENTS SERVED
- 1,527,072 PATIENT VISITS
- 105,316 patients are CHILDREN AND ADOLESCENTS
- 332,216 patients are ADULTS
- 94% of patients are LOW-INCOME (below 200% of the Federal Poverty Level)
- 41% of patients identify as an ETHNIC OR RACIAL MINORITY

**Comprehensive Coordinated Care**

- 387,107 patients received MEDICAL CARE
- 41,151 patients received DENTAL CARE
- 56,044 patients received MENTAL HEALTH CARE
- 664 patients received VISION CARE
- 48,817 patients received at least one EMERGING SERVICE to overcome barriers to care

**Preventive Care and Chronic Disease Management**

- 14,846 patients were diagnosed with ASTHMA
- 16,589 patients were diagnosed with CORONARY ARTERY DISEASE
- 49,517 patients were diagnosed with DIABETES
- 108,598 patients were diagnosed with HYPERTENSION
- 39,339 children received WELL CHILD VISITS
- 90,901 patients received IMMUNIZATIONS and SEASONAL FLU VACCINES

**State-of-the-Art Practice**

- 90% of health centers have installed and currently use an ELECTRONIC HEALTH RECORD (EHR)
- 67% of health centers are currently participating in the Centers for Medicare and Medicaid Services (CMS) EHR INCENTIVE PROGRAM “MEANINGFUL USE”

**Quality Health Outcomes**

- 97% of health centers met or exceeded at least one HEALTHY PEOPLE 2020 GOAL FOR CLINICAL PERFORMANCE

For more information, visit us online: www.tnpca.org/
VALUE IMPACT of HEALTH CENTERS
Tennessee Federally Qualified Health Centers

REFERENCES AND DATA SOURCES
4. Economic and Employment Impacts: Calculated by Capital Link using 2016 IMPLAN Online with forecasts as years multipliers.
5. Comprehensive Care-Based Care: Bureau of Primary Health Care, HRSA, DHHS, 2017 Uniform Data System.
6. Preventive Care and Chronic Disease Management: Bureau of Primary Health Care, HRSA, DHHS, 2017 Uniform Data System.

Summary of 2017 Total Economic Activity

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<th>Direct</th>
<th>Indirect</th>
<th>Total</th>
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<tr>
<td>Economic impact</td>
<td>$377,704,052</td>
<td>$2,637</td>
<td>$379,341,689</td>
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<tr>
<td>Employment (# of FTEs)</td>
<td>2,637</td>
<td>585</td>
<td>3,222</td>
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<tr>
<td>Total</td>
<td>$138,953,188</td>
<td>585</td>
<td>$140,138,373</td>
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Direct FTEs (employment) based on HHS 2017 U.S. data source for IMPLAN.

Summary of 2017 Tax Revenue

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<th>Federal</th>
<th>State</th>
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<tr>
<td>Direct</td>
<td>$26,794,216</td>
<td>$6,416,896</td>
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<tr>
<td>Indirect</td>
<td>$34,969,046</td>
<td>$10,947,344</td>
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<tr>
<td>Total</td>
<td>$61,453,946</td>
<td>$17,364,240</td>
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Total Tax Impact: $78,818,186

*Full-Time Equivalent (FTE) of 1 means that the person is equivalent to a full-time worker. In an organization that has a 40-hour work week, a person who works 40 hours per week (e.g., a 50% time) is reported as “0.5 FTE.” FTE is also based on the number of months the employee works. An employee who works full-time for four months out of the year would be reported as “0.33 FTE” (4 months/12 months).

VALUE IMPACT of HEALTH CENTERS
Tennessee Federally Qualified Health Centers

HOW ECONOMIC IMPACT IS MEASURED
Using IMPLAN, integrated economic modeling software, this analysis applies the “multiplier effect” to capture the direct, indirect, and induced economic effects of health center business operations and capital projects. IMPLAN generates multipliers by geographic region and by industry combined with a county/state database. It is widely used by economists, state and city planners, universities and others to estimate the impact of projects and expenditures on the local economy. This analysis was conducted using 2016 IMPLAN Online with forecasted multipliers.

WHAT ARE DIRECT AND COMMUNITY IMPACTS?
Direct impacts result from health center expenditures associated with operations, new facilities, and hiring.

Community impacts can be indirect, resulting from purchases of local goods and services, and jobs in other industries.

Community impacts can be induced, resulting from purchases of local goods and services at a household level made by employees of the health center and suppliers.

A health center purchases medical devices from a local medical supply store.

The medical supply store purchases paper from an office supply store to print receipts and hires a local delivery service to transport the medical devices.

These purchases are indirect economic impacts of the health center’s operations.

As local industries grow and household income increases, employees of the health center, medical supply stores, office supply stores, and delivery service spend their salaries in the community.

These purchases are induced economic impacts because they are the result of a ripple effect through the entire community.
Bipartisan Support


- President Bush proposed health center expansion, increasing federal funding by more than $150M
- 1989 and 1990 marked the development of the Federally Qualified Health Center act for Medicaid and Medicare which created cost-based reimbursement
- Congress also extended FTCA coverage to Health Centers (the time the only non-governmental entity with FTCA) and created 340B drug pricing

Bipartisan Support

President Bill Clinton (1993-2001) and President George W. Bush (2001-2009) both presided over expansion in funding for health centers during their tenure:

- President Bush called for a 5-year initiative to increase health center funding by $700M
- Congress unanimously reauthorized the Health Center Program boosting federal funding for health centers by $175M in the first year
Bipartisan Support

President Bush’s health center initiative doubled the size of the program, reaching 18M people, as federal funding for CHCs surpassed the $2B mark.

President Barack Obama (2009-2017) made unprecedented investments both through ARRA and the ACA.

Resources

- Tennessee Primary Care Association [www.tnpca.org](http://www.tnpca.org)
- National Association of Community Health Centers [www.nachc.org](http://www.nachc.org)
- Health Resources Services Administration [https://bphc.hrsa.gov/about/index.html](https://bphc.hrsa.gov/about/index.html)