



**Gary Wiltz, MD oversees the Franklin Community Health Center and three satellite clinics in rural Franklin, Louisiana.**

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# Health Care's Safety Net

Community health centers exist for one reason—to care for patients regardless of ability to pay, resident status, or cultural differences.

The growing number of uninsured and constant threats to funding are but two of the challenges faced by providers who say the rewards of caring for this population outstrip the hassles.

BY TERESA ODLE

A typical spring day in Anchorage, Alaska finds Dr. Thomas Hunt at Anchorage Neighborhood Health Center, caring for a homeless pregnant patient and a Laotian woman—also pregnant—who is mentally challenged and doesn't speak English. He works nearly 80 hours a week as a family practice physician and the medical director of a community health center that serves both urban and rural patients from a number of cultures with high-risk pregnancies, HIV, diabetes, substance abuse, and other challenging medical needs.

Thousands of miles away, internist Gary Wiltz worries about the state of mental health services in rural Franklin, Louisiana,

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### Providers With a Mission

Gary Wiltz went from his hometown of New Orleans to Franklin, Louisiana in 1982 with the National Health Service Corps to a small community health center that is now the multiple-site Teche Action Board Inc. "I had a three-year commitment that's obviously turned into a lifetime," says Wiltz. He's raised two children, worked, and worshiped in a communal environment. He even holds public office in St. Mary parish. Although Wiltz jokes that something in the water made him stay, it's more likely the small-town life. "The phone book is about one-quarter inch thick, the newspaper is 10 pages thick. I'm one minute and 45 seconds from my office and two minutes from the hospital," he says.

Mostly, it's the people he cares for. "If I had to give the most overriding or compelling reason I've stayed, it would be the gratitude of the patients we serve. It's being given the opportunity to make a difference and see the difference in your lifetime," says Wiltz.

His sentiment is matched by his peers around the country. Long-term CHC providers say they appreciate not only the gratitude they receive from patients, but the ability to practice medicine free of the business headaches that often come with private practice. "Any provider who works at a health center is going to practice 'real medicine,'" says Joe Pierle, the CEO of the Missouri Primary Care Association. "They're not going to deal with all of the [operational] headaches, and they're going to see patients with



"When someone comes into our center, we look at their resources to see not if we're going to treat them, but how," says internist Gary Wiltz, MD.

some of the most complex situations. We're also implementing the chronic care model, which I would argue was started by health centers nationally. I see our care as more than just health care. It's holistic and comprehensive and the future," says Pierle.

Daren Wu of Open Door Family Medical Centers in Ossining, New York says the greatest benefit of six years with his health center is practicing medicine as he was trained in school. It's the idealistic way he and many physicians hopefully still have in their minds. "If a patient doesn't have insurance, we just see him. And it's very liberating from that standpoint. You're taking care of people and it's phenomenally rewarding; it's actually spiritually rewarding to

take care of this patient population," he says.

Thomas Curtin, who serves as the chief medical officer for the National Association of Community Health Centers, says that physicians can practice primary care, move into chief medical officer positions, or become involved at state levels. Primary care associations offer committee involvement in various issues that impact health care in the state. "And you can continue to be involved on the national level," says Curtin. CHC physicians may become involved with Centers for Disease Control or National Institutes of Health research on issues such as HIV, immunizations, or pandemic flu preparation.

For physicians who love to teach, most centers offer involvement in

health professional teaching. "We have medical students and residents and nursing students all of the time and I enjoy that," says Thomas Hunt, the medical director of Anchorage Neighborhood Health Center in Anchorage, Alaska. Hunt also enjoys the many outdoor opportunities his location offers—at least in the "glorious summers"—as well as his involvement in the community. He's been with the center for 12 years.

"I'm passionate about equal access to health care on principle," says Hunt. "This just seems to me a compelling career in that it gives me an opportunity to act on principle and still earn a living. The sense of social justice keeps me here," he says.

Hunt is just the kind of physician fellow Alaskan and recruiter Amy Chang is looking for to fill spots in four northwestern states. "We're looking for mission-driven physicians; that's the bottom line. We want physicians who really have it in their hearts to work for the underinsured and medically underserved," says Chang.

Wu knows that those physicians who contemplate joining a CHC will find their reward. He admits that the work is not particularly glamorous or outrageously compensated. What it is: satisfying, despite the challenges of navigating patients through the complicated health-care system. Wu says, "You just go home at the end of a tough day and look in the mirror and say, 'I really did something wonderful for a lot of people today.'" ■

a town 100 miles southwest of New Orleans. As the CEO of Teche Action Board Inc., he oversees the Franklin Community Health Center (CHC) and three satellite clinics. When Wiltz arrived in 1982 as a National Health Service Corps provider, he had a staff of 10 or 12 and worked out of a crumbling old house in a practice he humbly referred to as

"Southern Exposure," in reference to a 1990s CBS show "Northern Exposure" about a family practitioner and the challenges he faced in the fictitious town of Cicely, Alaska. Today, Wiltz oversees a staff that includes two ob/gyns, a family practitioner, four

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nurse practitioners, a physician assistant, a pharmacist, and is in desperate need of a pediatrician. The CHC serves 15,000 area residents. “When someone comes into our center, we look at their resources to see not if we’re going to treat them, but how,” says Wiltz.

Therein lies the primary mission of community health centers: to care for all who enter, regardless of ability to pay or any other barrier, whether it’s financial, cultural, or related to citizenship status. From the U.S. Virgin Islands and Maine to Hawaii and Pohnpei (six hours west of Hawaii), CHCs serve people in 12 time zones. “When I look at the globe, I realize we’re on about a quarter of the planet,” says Dr. Thomas Curtin, the chief medical officer for the National Association of Community Health Centers (NACHC). Curtin also serves on the board of his local health center—the one in East Jordan, Michigan, which he joined in 1978 as a National Service Health Corps scholarship student.

### A presidential initiative

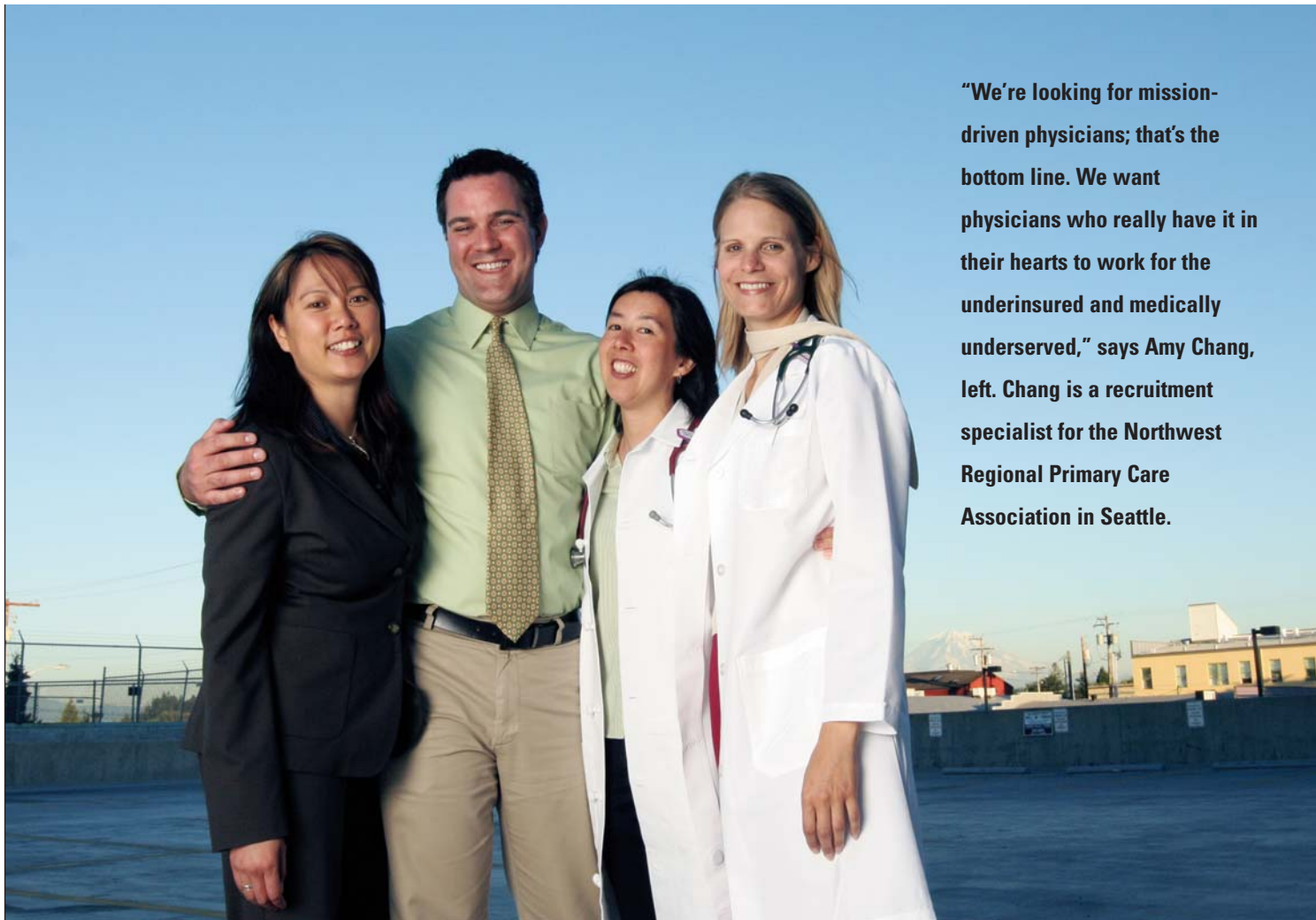
The number of CHCs and the communities and patients they serve has grown in recent years. Much of the growth can be attributed to an initiative signed in October 2002 by President George W. Bush, expanding the role of CHCs. Community health centers are one type of Federally Qualified Health Center (FQHC) and the terms often are used interchangeably. FQHCs also include Migrant Health Centers, Healthcare for the Homeless Health Centers, and Public Housing Primary Care Centers. The designation also includes FQHC look-alike programs and outpatient clinics operated by tribal organizations, though grant funding differs. The nonprofit CHCs must meet four core statutory requirements, including targeting of resources in high-need areas, ensuring services to all regardless of ability to pay, offering access to comprehensive primary care service, and governance by the community being served. The president committed funding that would ensure growth in the numbers of CHCs and to expand their reach into previously unserved areas.

At the time the president launched the initiative, CHCs served about 10 million people. The goal was to increase that number by about 6 million by the end of 2007. In 2001, a year before the legislation was signed, there were 748 federally funded health centers. The initiative aims to reach more people by adding access points, or actual clinic locations in communities. “The president wanted to expand the number of access points by 1,200,” says Dr. Donald Weaver, the deputy associate director for Primary Health Care at the Health Resources and Services Administration (HRSA). “We now have more than 1,100 and hope by the end of the year to achieve that goal [of 1,200 more],” he says. To that end, federal health center funding was close to \$1.8 billion in 2006.

Touting CHCs as the answer for health coverage for the poor and uninsured, the president also looks to them to lower health-care costs. NACHC data shows that while national per capita spending rose 49 percent from 1999 to 2005, health-center costs per patient increased only 26 percent. According to NACHC, the average annual cost of medical and dental care for a CHC patient is \$515, or about \$1.40 a day. Perhaps more telling are outcomes data. A study in the May 16, 2007, on-line version of *Health Services Research* reported on the cost-effectiveness and improvements in diabetes care among CHCs. Hunt says that based on his benchmark comparisons, the Anchorage CHC does a better-than-average job in diabetes and HIV care. “And I think one reason we are better than average in those two diseases is that we have wrap-around services. It would be very hard to accomplish without them,” he says. Also termed enabling services, these services include translation, transportation, case management, health education, home visitation, and extras that help improve patients’ access to care.

Community health centers, staffed mainly by primary care physicians and mid-level providers and supported by administrative staff members, generally provide care during regular Monday-through-Friday hours. Many also offer some sort of 24-hour call. Dentists, pharmacists, mental health providers, and other profes-

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**“We’re looking for mission-driven physicians; that’s the bottom line. We want physicians who really have it in their hearts to work for the underinsured and medically underserved,” says Amy Chang, left. Chang is a recruitment specialist for the Northwest Regional Primary Care Association in Seattle.**

sionals may assist to provide comprehensive primary care. Because of the employment/contract arrangement, physicians leave much of the business details to their CEOs, support staff, and governing boards.

**Emphasizing access**

The mission of a CHC is not just about serving the uninsured, but about access to care. Curtin says that even if the country someday comes up with a universal health plan, “It won’t deal with some of our rural areas, some of our frontier areas in Alaska. It won’t deal with some of our most urban areas where no one will set up a practice,” he says. Access to care remains a huge barrier for uninsured patients and affects the total cost of care. More than \$18 billion was wasted on emergency department visits in the United States in

**With Chang at right and above are, from left, Jeffery A. Harvey, PsyD, Lillian Wu, MD, and Cristina Covert, MD, all of whom work for Auburn Community Health Center in Auburn, Washington.**

**Chang recruits for community health centers in Oregon, Washington, Idaho, and Alaska.**



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2006 for problems that could have been handled by a primary care provider. NACHC data says that health-center patients with Medicaid are 19 percent less likely to use the emergency department for avoidable conditions; they’re appropriately seeing their primary care physicians at

CHCs for non-emergent care.

Transportation, language, and geographic barriers remain for patients accessing care, but financial barriers still present the biggest hurdles—both for patients and for health centers’ viability. According to NACHC, the

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typical health-center patient mix is about 40 percent uninsured, 36 percent Medicaid, 15 percent private insurance, and 8 percent Medicare. A typical private physician practice compares at roughly 5 percent uninsured, 10 percent Medicaid, 56 percent private insurance, and 21 percent Medicare. Approximately 70 percent of CHC patients have family incomes at or below poverty level. With the sliding fee scale, only six percent of total revenue comes from self-paying patients.

One of the biggest challenges for providers comes when a patient must be referred to a specialist. One program has addressed the need for access to specialist care for CHC patients. The Anchorage Project Access has signed up 350 specialists who will see CHC patients in their offices through a coordinated program that schedules the visits and provides patients with a card that looks much like a typical private insurance card. The project has trained personnel in the specialists' office to submit a bill to Project Access, eliminating front-desk confusion and adding to patient dignity. Though the project technically doesn't pay for the care, records are kept on how much charity care each physician gives. "The patient gets seen and everybody is happier. Most importantly, the physicians who really want to do charity care know they're not the only ones providing it," says Hunt. Anchorage Project Access was modeled after a similar volunteer provider network developed by the medical society in Asheville, North Carolina.

### Financial matters

Health centers have to make up the money somewhere, and federal grants

help. Since Medicaid is the largest insurer of FQHC patients—about 37 percent of their total revenue—Medicaid payments also are essential to keeping the centers afloat. Medicaid reimburses FQHCs on a cost-per-visit basis. According to a 2003 Kaiser Family Foundation report, the number of Medicaid patients served by health centers nearly tripled from 1980 to 2001, topping out that year at 3.6 million people. By comparison, total Medicaid growth for this period was 50 percent. Health centers and Medicaid have a complex and fundamental interrelationship—the dynamics in one are bound to affect the other.

Community health centers have become the mainstay of health-care delivery for countless Medicaid beneficiaries. Weaver and Curtin say the point is to ensure that the cost of providing care for those patients enrolled in the program is covered by Medicaid dollars and not absorbed by the grant dollars allocated to provide care for the uninsured and underinsured. "These community organizations get their funding from a variety of sources and the way I look at it, each payer is trying to make sure they are paying their portion," says Weaver. The Deficit Reduction Act of 2005 likely will impact states' Medicaid funding and eligibility benefits; Medicaid funding remains volatile for CHCs in 2007.

Joe Pierle, the CEO of the Missouri Primary Care Association, based in Jefferson City, says, "We have to have a good payer mix in order to take care of the uninsured. If we didn't see any private, Medicare, or Medicaid patients, we wouldn't be able to care for the uninsured because we don't get enough grant dollars to offset all of

the care we provide to them." The Missouri Primary Care Association assists CHCs in this mostly rural state by helping with provider recruitment and retention, developing local programs, offering technical assistance and provider networking opportunities, and conducting legislative advocacy. Most states and regions have similar associations.

### Diversity and sensitivity

Serving a diverse mix of patients seems characteristic of CHCs, whether in an underserved urban location or a small rural town. From the Anchorage Neighborhood Health Center to Westchester County—just north of Metropolitan New York City—CHC physicians seem to enjoy the diversity and the opportunity the clinical, language, and even "social work" challenges their jobs present. Daren Wu serves as the chief medical officer of Open Door Family Medical Centers in Westchester County. With more than 40 clinicians in four offices and two school clinics, including primary care physicians, podiatrists, optometrists, and a nutritionist, the CHC serves patients who have a hard time accessing care in Westchester County. It's not that physicians and hospitals are scarce. "But for those lacking economic means or those having language barriers, the services are not accessible," he says.

That population includes a fair number of immigrants from Central America, Mexico, and South America, predominantly Brazil. Wu says about half of his staff is bilingual. In border states and throughout the country and territories, health centers such as Wu's are opening their doors to all residents.

Amy Chang is a recruitment special-

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ist for the Northwest Regional Primary Care Association in Seattle. The association is a collaboration of state care associations in Oregon, Washington, Idaho, and Alaska, broadening provider recruiting resources. Her understanding of CHCs comes not only from her current position but previous experience visiting migrant camps and from growing up uninsured. Her father was a founding member of a health center and her mother was on the board of a health center for three years. Today, she works to overcome stigmas about community health centers when recruiting providers.

Wiltz, the Louisiana internist, also serves as secretary of NACHC's board of directors. He says the mission of the CHC in Franklin originally was to care for sugar cane workers. "There is a big misperception in the country about the uninsured—that they're not working people," he says. "These are some of the hardest working people. Most of them are employed; they just can't afford [health insurance] premiums." Still other CHC clients may work two or three part-time jobs because their employer intentionally keeps them below 40 hours to avoid having to provide benefits. Franklin and other rural communities feel the crunch suffered by small employers who can't offer affordable family coverage.

CHCs take in those who work, those who don't, and those who live in their communities illegally, no questions asked. It's a fundamental part of their mission and of public health—to provide care without regard to income, health insurance status, race, culture, or legal status. The NACHC has adopted a policy opposing legislation that would limit access to health center services in any form. Further, the

association has supported efforts to expand Medicaid coverage to eligible migrant workers who cross state lines. They also have opposed any effort to criminalize humanitarian assistance, regardless of immigration status. The association points out that ignoring any part of the community or any single health problem, whether natural or man-made, risks the entire community's health.

Serving all members of the community means that CHCs are largely ahead of their peers in cultural competence. Although federal regulations set the core principles, Pierle of the Missouri Primary Care Association says local communities have flexibility on how to design their programs to serve their populations. Wiltz agrees. "We take pains to hire personnel who are culturally competent and sensitive," he says. Bilingual staff, translators, outreach workers, and a variety of providers all add up to a more culturally-sensitive health experience.

It's also a recent push with the Joint Commission. Wiltz knows all about that, too. His center was the first Joint Commission-accredited CHC in the state of Louisiana. The HRSA says that nationally, about one-third of CHCs are accredited, most by the Joint Commission and a few by the Accreditation Association for Ambulatory Health Care. Curtin says the quality of CHCs is an attraction for many physicians. He mentions other benefits, most notably malpractice coverage under the Federal Tort Claims Act. "If you sue one of us, you're suing the federal government," says Curtin.

Another financial benefit for physicians is possible loan repayment. All FQHCs qualify as health professional shortage areas (HPSAs), making

providers eligible to apply for loan repayment under the National Health Service Corps for two years, renewable for two more. "If you're a primary care physician and you want to do rural health care in Michigan, you could find a CHC job that will pay you \$125,000 a year and up to \$35,000 a year to pay off your loans," says Curtin. "And we would hope that after four years, we've convinced you to stay with our system." ■

Teresa Odle is a free-lance writer in Albuquerque, NM. She has edited national medical practice newsletters and written for trade magazines.