Testimony before the Health and Human Services Appropriations Subcommittee
Tuesday, February 15, 2005

Theodore J. Boesen, Jr.
Executive Director, Iowa/Nebraska Primary Care Association

Thank you for the opportunity to address the committee today.

My name is Ted Boesen and I am the Executive Director of the Iowa/Nebraska Primary Care Association. I have the pleasure of working with the 13 Federally Qualified Health Centers in both states.

Federally Qualified Health Centers or CHC's provide a medical home offering comprehensive primary and preventive health care. In Iowa, there are seven community health centers with 41 delivery sites (located in Burlington, Council Bluffs, Davenport, Des Moines, Keokuk, Marshalltown, Ottumwa, Sioux City, and Waterloo) providing care to nearly 90,000 patients through more than 300,000 annual encounters.

An eighth CHC located in Decatur County was awarded federal funding in December 2004 and will begin seeing patients in April of this year. It is anticipated the Decatur County center will add another 11,000 patients with 27,000 annual encounters.

CHCs are open to all regardless of ability to pay and address barriers such as transportation and language. By eliminating these barriers, CHCs provide a medical home for many of Iowa's underserved and thus have tremendous impact on improving the health status of these individuals.

In some centers, the amount of uninsured can be as high as 40% of the patient population. While a sliding fee schedule helps the centers recover some of this cost, it falls far short of meeting the total cost of patient care. To help offset some of these expenses, Community Health Centers receive funding through the U.S. Department of Health and Human Services, but this is relatively level funding and does not grow with the pace of the growing numbers of uninsured.

The community health center program has consistently demonstrated its ability to provide quality, cost-effective care to those in greatest need. This year the White House Office of Management and Budget cited the health center program as one of the ten most successful

federal programs and the most successful one in the U.S. Department of Health and Human Services.

Several studies, including one conducted by the Kaiser Commission on Medicaid and the Uninsured, have found health centers save significant amounts of money for state Medicaid programs due to reduced specialty care referrals and fewer hospital stays. **In Iowa this savings has been estimated at $5.8 million per year.**

In 2001, community health centers received unprecedented support when President Bush announced a five-year initiative to double the number of individuals served through new or expanded health centers. Since this initiative began, Iowa has seen its community health center network expand with the addition of sites in Burlington, Lamoni, Leon, Keokuk, and Marshalltown. During the State of the Union address earlier this month, the President again stressed the importance of funding community health centers as part of his comprehensive health care agenda.

Since the President's initiative began, competition for funding has increased dramatically. In each of the last three years, the number of applications submitted has far exceeded the federal funding allocated to the program. Since 2001, more than 2,000 applications were received and only 410 have been funded. In the first round of FY2005 funding, of the 180 applications received, it is anticipated only 15 will be funded.

The application process is rigorous. Applicants must demonstrate significant community support and involvement in the development of the application. They must validate the need for a community health center by detailing barriers and health disparities in the target population. They must outline a comprehensive plan for providing care that includes primary, preventive, oral health, and mental health services, as well as enabling services such as transportation, interpretation, and outreach services. Applicants must also demonstrate the services they will provide will complement and work in cooperation with the existing health care delivery system.

This process is extensive with most applicants investing several years and considerable resources into the development of a competitive application. Three Iowa communities – Dubuque, Fort Dodge, and Storm Lake – have all undertaken such efforts and have succeeded in developing strong applications. While each of these communities has received very high scores on their applications, they have not received federal funding because of the intense competition.

If all three of these communities were funded, an additional 17,445 patients would be served through Iowa's community health center network.

Several other communities, including Cedar Rapids and a group of counties in extreme Northwest Iowa, have efforts underway to submit applications this summer.

Numerous other state governments also recognized the value of community health centers and have directed state funds to CHC's. As of August 2004, 32 states provide funding to health centers and four additional states are considering allocating funds to centers.

In the Health Care Access legislation offered by Senator Hatch there is funding for existing CHC's to meet the growing number of uninsured patients receiving care. There is also a provision for a CHC Incubator Program so communities who have unsuccessfully applied for federal funds and have scored a minimum of 86 points out of 100 total points in the federal competition would be eligible for State funding. The 86 point threshold indicates the application has achieved an "Excellent" designation through the federal review process. This threshold will ensure that eligible applicants have the same community support and meet the same rigorous criteria required by the federal government. These communities receiving State funding will also continue to apply for federal funds. If awarded federal funding, the state funding they receive will then be reallocated to another community meeting the scoring criteria.

We appreciate this committee's efforts in bringing attention to the exceptional work performed by community health centers, rural health clinics, and free clinics and the potential that exists to use their combined resources to increase access to cost effective health care services. By supporting this legislation the State will strengthen Iowa's health care safety net and provide basic health care to thousands who would otherwise go without. Now Mark Prosser, Chief of Police in Storm Lake, and Mary Rose Corrigan from the City Health Department in Dubuque will speak briefly about the importance of these efforts to their communities

We appreciate the opportunity to address the committee today and will be pleased to answer any questions.

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National Conference of State Legislatures

LEGISBRIEF

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Community Health Centers: An Update

By Laura Tobler and Hy Gia Park

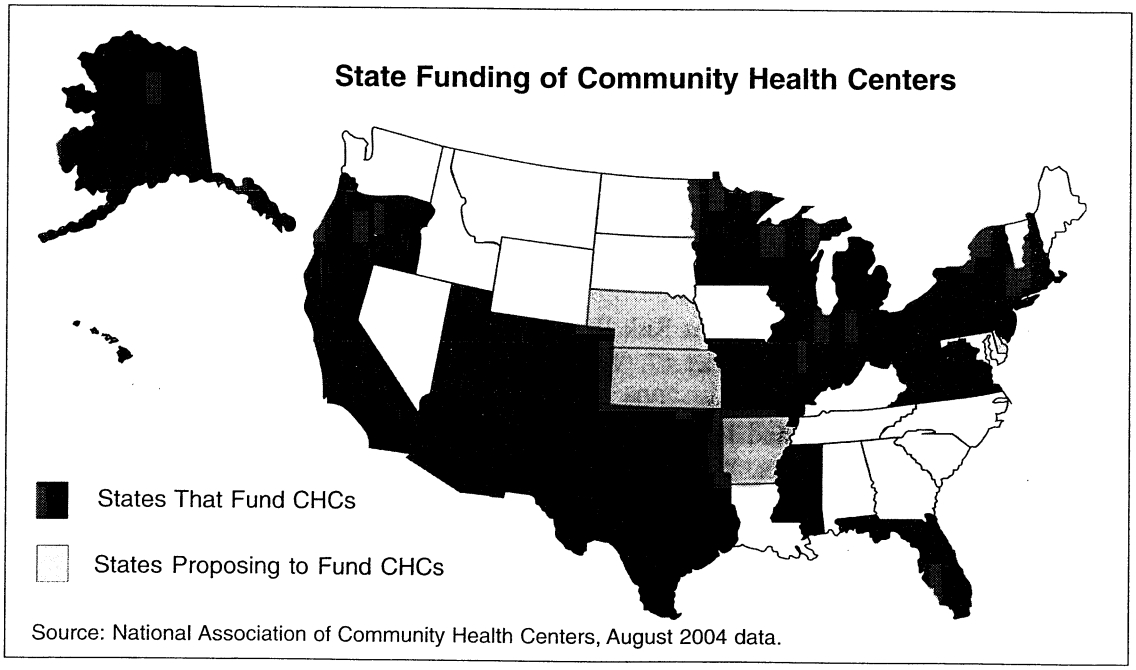
Health centers serve our nation's poor and underserved people.

Since the first one opened its doors 40 years ago, community health centers have specialized in providing affordable primary and preventive care services to our nation's poor and underserved people, regardless of insurance status or ability to pay. They serve nearly 3,600 communities across the country—about 15 million people. These health centers are local, community owned and operated facilities financed by Medicaid, Medicare and private insurance payments as well as federal, state and local contributions.

In 2003, 69 percent of community health center patients had incomes at or below the federal poverty level, 39 percent were uninsured, 35 percent were insured by Medicaid, and about 65 percent belonged to an ethnic or racial minority group. Given this patient mix, an economic downturn creates fiscal challenges when the number of uninsured rise while states cut back on Medicaid program eligibility and benefits.

Health centers are successful at improving the health of patients while reducing costs.

This year, the White House Office of Management and Budget cited the health center program as one of the 10 most successful federal programs and the most successful one in the U.S. Department of Health and Human Services.



Source: National Association of Community Health Centers, August 2004 data.

National Conference of State Legislatures

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Accomplishments of health centers include:

- **Lower Cost and Higher Quality Care.** Studies on cost-effectiveness show that money invested in health centers reduces Medicaid expenditures and national health care spending. For example, in 2003, the average cost of serving one health center patient annually was about $479. This is 10 times less than average annual per capita spending on personal health care and $250 less than the average cost of care at a medical office. Health care costs for Medicaid clients are also lower—as much as 36 percent less. Similar savings can be seen with other services such as pharmaceutical drugs and treatment of people with diabetes or asthma.

Money invested in health centers reduces Medicaid expenditures and national health care spending.

- **Fewer Hospitalizations and ER Visits.** Improving access to regular preventive and diagnostic services reduces the number of avoidable hospital admissions and unnecessary emergency room visits. In fact, studies find Medicaid beneficiaries served at health centers are 22 percent less likely to be hospitalized. Estimates from the National Association of Community Health Centers suggest that providing access to primary and preventive care can reduce non-urgent emergency room visits for a savings of $1.6 billion to $8 billion annually.

Providing primary and preventive care can reduce emergency room visits.

- **Improved Health.** Communities with health centers have lower infant mortality rates, lower rates of low-birthweight babies, higher rates of women obtaining mammograms and pap smears, and higher rates of women receiving early prenatal care.
- **Reduced Racial and Ethnic Disparities.** A 2003 report indicates that as health centers serve more poor people in a state, disparities among whites, blacks and Hispanics decline for infant mortality, prenatal care, tuberculosis case rates and age-adjusted death rates.

State Action

Today, community health centers can be found in all 50 states and U.S. territories. Thirty-two states provide funding. Budget woes in the states, however, resulted in 18 states cutting their level of dedicated financing for health centers last year. Every state has cut Medicaid somewhat in the past few years with a significant impact on health center operating capacity. Medicaid is the single most important source of revenue for community health centers. Recent cuts—to eligibility and benefits—coupled with a rising number of uninsured patients, reduced revenue and the ability to provide care.

Community health centers are in all 50 states.

Federal Action

About a quarter of community health center financing comes from federal grants through the Consolidated Health Center Program. The Bush administration has announced a five-year $2.2 billion initiative that will add an additional 1,200 new health center sites serving at least 6 million new patients by 2006.

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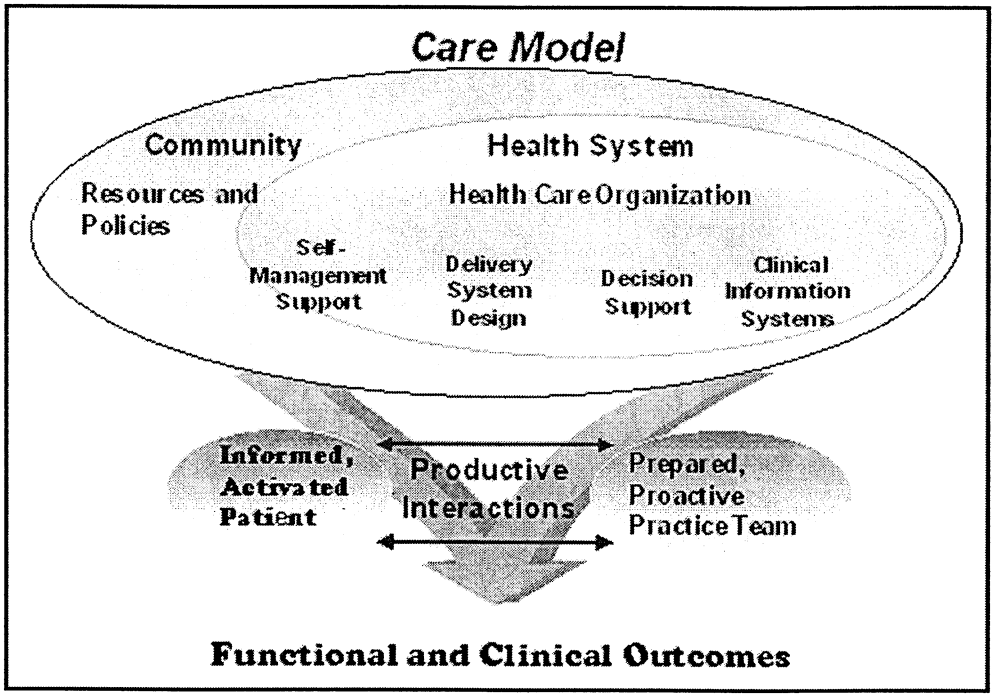
IA/NEPCA *Iowa Nebraska Primary Care Association*

Health Disparities Collaboratives – Changing Practice, Changing Lives

Vision - Reduce disparities in health outcomes for poor, minority, and other underserved people
Dedication - Of health center staff, clinicians, patients themselves, and their communities.
Tools – A tested model that changes how we provide health care.

Partners

- Community Health Centers, Migrant Health Programs, Healthcare for the Homeless programs in Iowa, Nebraska, and nationally
- Bureau of Primary Health Care
- Institute for Health Care Improvement
- National Association of Community Health Centers, Inc.



The **Chronic Care Model** is a population-based model that relies on knowing which patients have the illness, assuring that they receive evidence-based care, and actively aiding them to participate in their own care. It is recommended that a sub-group of the entire population be the focus of change in practice for the duration of the Collaborative. The Model as shown above has six components:

Health Care Organization

- Goals to improve chronic care are part of the organization's business plan
- Senior leaders visibly support improvement in chronic illness care
- Benefit packages designed by the health care organization promote good chronic illness care
- Provider incentives encourage better chronic illness care
- Improvement strategies that are known to be effective are used to achieve comprehensive system change

Community Resources and Policies

- Effective programs are identified and patients are encouraged to participate
- Partnerships with community organizations are formed to develop evidence-based programs and health policies that support chronic care
- Health care organizations coordinate chronic illness guidelines, measures and care resources throughout the community

Self-management Support

- Providers emphasize the patient's active and central role in managing their illness
- Standardized patient assessments include self-management knowledge, skills, confidence, supports, and barriers
- Effective behavior change interventions and ongoing support with peers or professionals are provided
- The care team assures care planning and assistance with problem solving

Decision Support

- Evidence-based guidelines are embedded into daily clinical practice
- Specialist expertise is integrated into primary care
- Provider education modalities proven to change practice behavior are utilized
- Patients are informed of guidelines pertinent to their care

Delivery System Design

- Team roles are defined and tasks delegated
- Planned visits are used to provide care
- The primary care team assures continuity
- Regular follow-up is assured

Clinical Information Systems

- There is a registry with clinically useful and timely information
- Care reminders and feedback for providers and patients are built into the information system
- Relevant patient subgroups can be identified for proactive care
- Individual patient care planning is facilitated by the information system

Current disease collaboratives include:

- Asthma
- Cardiovascular disease
- Cancer
- Depression
- Diabetes

The Future of Health Disparities Collaboratives

- Work is underway to develop a primary health care collaborative
- BPHC goal is 16 million patients by 2010

For more information about HD Collaboratives in Iowa and Nebraska, contact:

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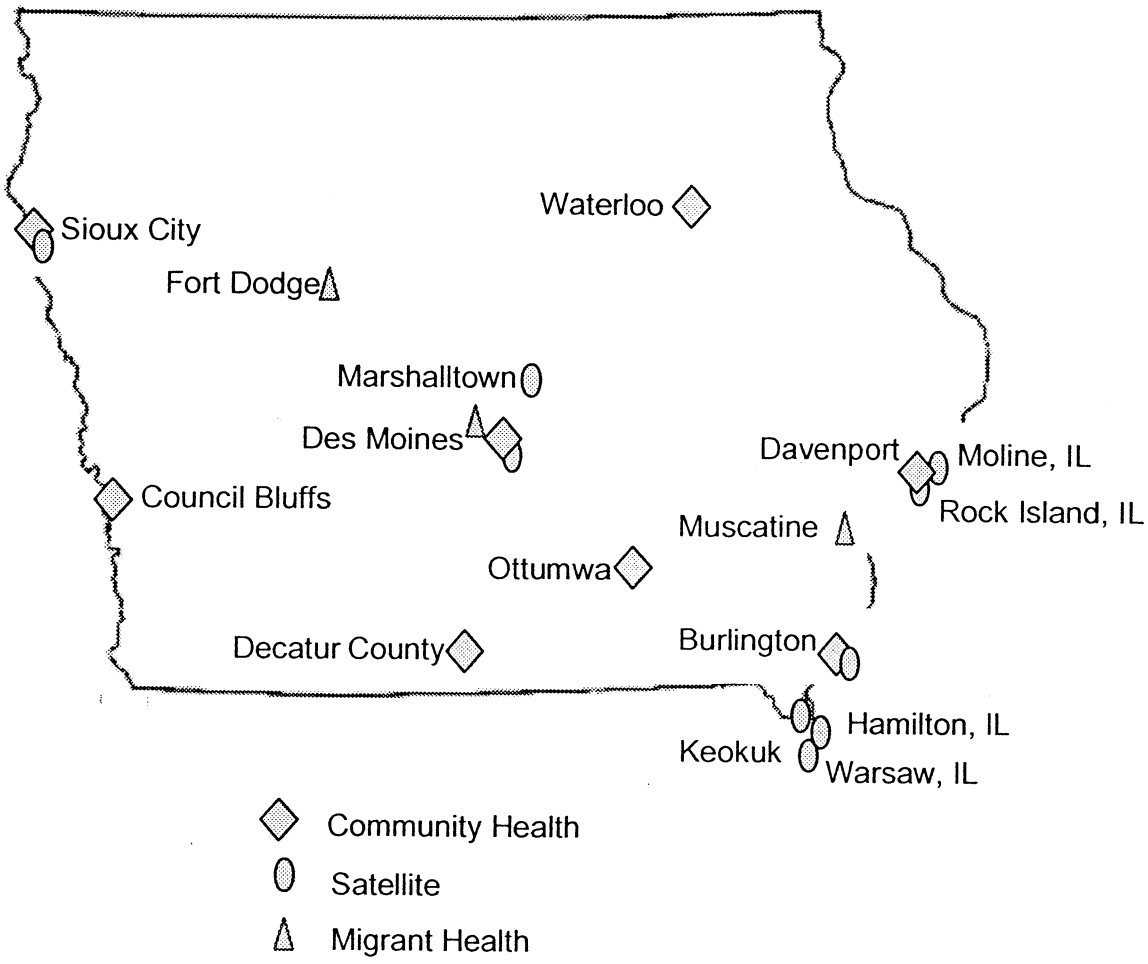
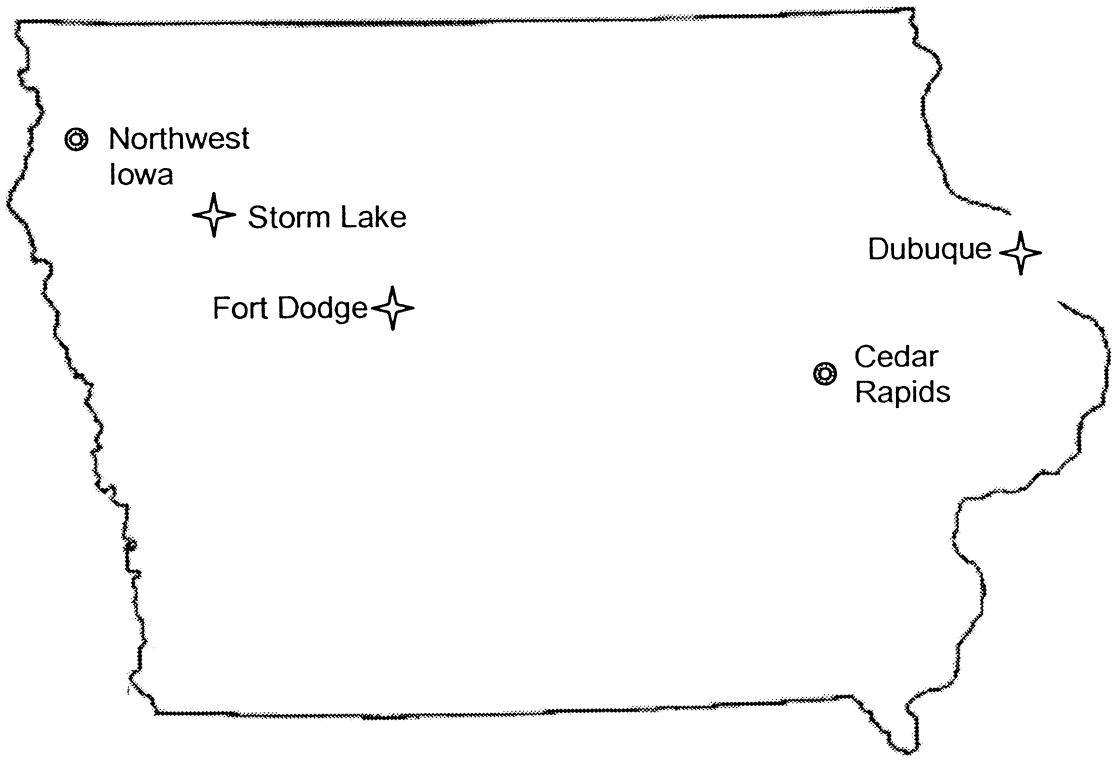
Iowa Community Health Centers Map



Iowa Community Development Efforts



Communities that have submitted CHC applications

Communities with active efforts (anticipate submitting CHC applications in May '05)