

Public Health and Community Health Centers 101

Overview of Community Health Centers

Community health centers (CHCs) are nonprofit private or public entities that provide affordable health services to underserved and at-risk populations.¹ Authorized under the [Health Center Program Statute: Section 330 of the Public Health Service Act \(42 U.S.C. §254b\)](#), CHCs serve the primary healthcare needs of over 24 million patients in more than 1,300 health centers at over [9,000 locations](#) across America.² CHCs serve predominately low-income, minority, and uninsured or underinsured patients in medically underserved areas, including migrant and seasonal farmworkers, homeless individuals or those in public housing, and through many school-based health centers.³ To meet the needs of the populations they serve, CHCs typically offer a range of supportive services that extend beyond those traditionally offered in a primary care physician's office.

HRSA's Bureau of Primary Healthcare, the federal agency that provides oversight to the [Health Center Program](#), has outlined 19 program requirements that CHCs must meet to be eligible for federal grant funding. These requirements define CHC services, the targeted needs of the patient population, management and finance, and governance. The core requirements mandate that CHCs must:^{4,5}

- Offer services to all persons regardless of ability to pay.
- Establish a sliding fee discount program.
- Be a nonprofit or public organization.
- Be community-based, with the majority of their governing board of directors composed of their patients.
- Serve a medically underserved area or population.
- Provide quality comprehensive primary care services for patients of all age groups—including medical, oral, mental and behavioral health, and substance abuse and pharmacy services—regardless of insurance status, with fees adjusted based on ability to pay.
- Provide enabling or supportive services that support access and engagement in health, such as patient and community health education, transportation, outreach, translation, eligibility assistance, and case management, as illustrated by the National Association of Community Health Centers (NACHC) in Figure 1.
- Have an ongoing quality assurance program.

How CHCs Differ from Other Providers

- Their patients are disproportionately poor, uninsured, and publicly-insured.
- They disproportionately serve minorities.
- They receive subsidies in the form of federal grants and enhanced Medicaid reimbursement.
- They are located in underserved rural communities and central cities, where other providers are unable economically or unwilling to locate.

Source: National Association of Community Health Centers (NACHC). "A Sketch of Community Health Centers." Available at http://www.nachc.com/client/Chartbook_2014.pdf. Accessed 4-27-16.

There are a variety of healthcare organizations that may be called CHCs; however, this document refers specifically to federally qualified health centers (FQHCs) and FQHC "look-alikes." FQHCs are ambulatory care clinics that qualify for specific reimbursement systems under Medicare and Medicaid and receive federal Health Center Program grant money intended to finance care for uninsured populations. Health

centers receive FQHC status and funding by submitting applications to specific HRSA open funding opportunity announcements.⁶

When there are no open funding opportunities available, health centers may apply for the “look-alike” designation, which is a non-competitive process and is open for continuous review. FQHC look-alikes must meet the core requirements but they do not receive HRSA’s grant funding or supplemental funding for capital investments of health information technology (HIT) incentive payments. They are, however, eligible for material advantages that include enhanced Medicaid reimbursement and access to the [340B drug pricing program](#) in the same manner as federally funded health center grantees.

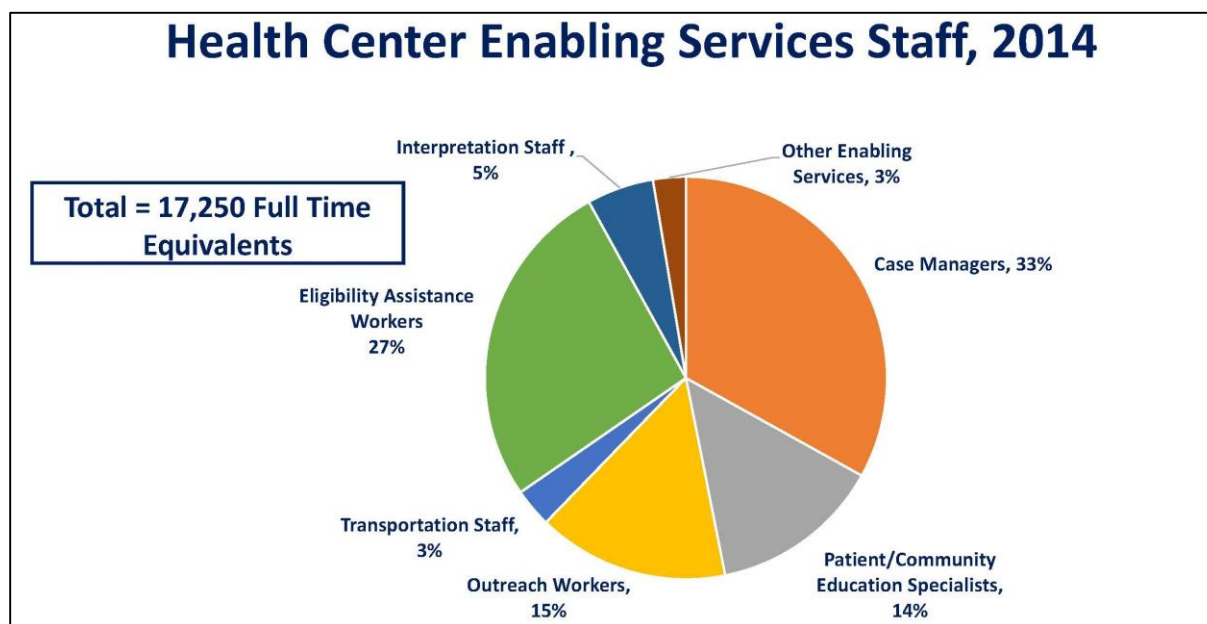


Figure 1: NACHC Analysis of 2014 Health Center Data, Bureau of Primary Health Care, HRSA. Available at: <http://bphc.hrsa.gov/uds/datacenter.aspx?q=t5&year=2014&state>

What Public Health Should Know about Health Centers

History of Health Centers

In the early 1960s, millions of Americans living in inner-city neighborhoods and rural areas suffered from deep poverty and lacked access to healthcare. President Johnson’s [War on Poverty proposals for CHCs](#) to serve this population began with two demonstration projects: one in Boston and the other in Mound Bayou, Mississippi.⁷ The demonstration health centers were unique in that they allowed community representation on the governing boards and empowered individuals to participate in decisions about their health and healthcare.

The Economic Opportunity Act of 1964 expanded these demonstrations to additional rural and urban communities and represented a national commitment to addressing the roots of intergenerational poverty through affordable healthcare. Today’s health center model emerged, which prioritizes community involvement in decision-making and uses federal funds to address locally determined needs. The Health Centers Consolidation Act of 1996 combined several authorities under Section 330 of the Public Health Service Act to create the [Consolidated Health Centers Program](#), which HRSA administers

today. Studies have shown that the health center model reduces health disparities, lowers infant mortality, and reduces chronic disease.⁸

Health Center Infrastructure

CHCs must maintain facilities, staff, and medical provider infrastructure for primary, preventive, and supportive services that include:⁹

- Medical (19.5 million patients).
- Dental (4.8 million patients).
- Mental health (1.3 million patients).
- Substance abuse (100,238 patients).
- Vision (433,086 patients).
- Enabling services (2.2 million patients).
- Specialty referrals.

Understanding Reimbursement

FQHCs receive funding from federal grants, patient fees on a sliding scale, insurers, Medicare, and Medicaid. Private insurers pay at the prevailing rates for a given service, but HRSA mandates enhanced funding for Medicaid and Medicare.

For Medicaid, federal law requires that FQHCs and look-alikes be reimbursed at a minimum rate. This payment baseline is based on a historical average unique to each CHC, and is adjusted based on the [Medicare Economic Index](#). States are not required to use this methodology, but it constitutes the minimum reimbursement allowable.¹⁰

Medicare pays FQHCs and look-alikes a national encounter-based rate per beneficiary per day, with some adjustments. Payment is 80 percent of either the prospective payment system (PPS) rate of \$158.85 or the total charges for services furnished, whichever is less. FQHCs and look-alikes can bill for separate visits when mental health and medical visits occur on the same day. The FQHC and look-alike PPS rate is adjustable based on geographic differences in the cost of services. In addition, the rate increases by 34 percent when a FQHC or look-alike furnishes care to a new patient or beneficiary receiving a comprehensive initial Medicare visit or annual wellness visit.¹¹

Health Center Governance

Every CHC is governed by a community board with a patient majority, which is one of the five core statutory requirements that FQHCs must meet to receive federal funding. Through their board representatives, the patients have a voice in determining how their healthcare is delivered, and governance is therefore responsive to the individual and evolving needs of the community.

Clinical Quality

There is some evidence that quality of care at FQHCs and look-alikes is comparable, if not superior, to private primary care practitioners. In a 2012 *American Journal of Preventive Medicine* study, researchers wrote:

“FQHCs and look-alikes demonstrated equal or better performance than private practice PCPs on select quality measures despite serving patients who have more chronic disease and socioeconomic complexity.”¹²

There are significant indications of quality improvement apparent in the reduction in health disparities among at-risk FQHC patients, including reduced disparities among Hispanic, African American, Medicaid, and uninsured populations by comparison to national averages. The examples below are for African American populations, but comparable improvements are seen among the groups seeking FQHC services.¹³

- Eighty-two percent of FQHC patients receive mammograms versus the national average of 66 percent for low-income populations.
- Ninety-two percent receive pap smears versus the national average of 81 percent for low-income populations.
- Sixty-two percent receive colorectal cancer screening versus the national average of 44 percent for low-income populations.
- Eleven percent of babies whose mothers received prenatal care at a CHC have a low birthrate versus the national average of 15 percent for low-income populations.

Healthcare Savings and Cost Effectiveness

Due to their locations and mission to reach the underserved, CHCs provide a viable and cost-effective alternative to episodic care. Their availability to the underserved and success in providing preventive services result in considerable savings, which NACHC estimates at \$1,263 per patient per year, as illustrated in Figure 2.¹⁴ CHCs help lower expensive visits to emergency departments, as well as assist patients in effectively managing chronic disease, which reduces the need for more expensive specialty care down the road.

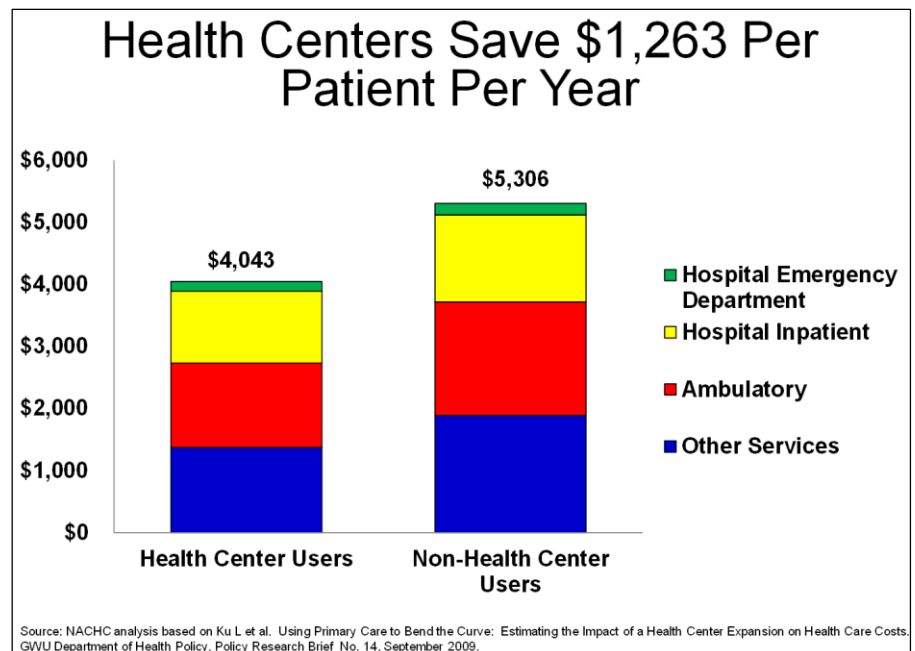


Figure 2: NACHC. "A Sketch of Community Health Centers." Available at http://www.nachc.com/client/Chartbook_December_2014.pdf. Accessed 5-27-16.

Opportunities for Public Health Partnerships with CHCs

Although public health services vary widely across state health departments and within state jurisdictions, the fundamental goal is consistent: to prevent disease and promote health. Public health departments provide laboratory, environmental, licensure, and regulatory services, which tend to be legally mandated, as well as categorical clinical services in WIC, family planning, immunization, and

disease control. Patients seen in specialized public health clinics are often uninsured and at-risk and need the services of a culturally competent primary care practitioner. CHCs offer such a resource, and many also play an important role in referrals to community-based social services or enrollment in health insurance exchanges.

Public health and healthcare often provide direct services that complement each other. The American Academy of Family Physicians has detailed the overlap of primary care and public health activities and their individual contributions in improving both individual and population health.¹⁵ Both the primary care physician and public health officer are actively involved in chronic disease management, care coordination, immunizations, preventive care screenings, maternal and child health, transitions of care, and social determinants identification. Meanwhile, the surveillance, epidemiological analysis, and service planning and health impact studies provided by public health departments can complement primary care delivery and help broaden the reach of clinical care services. A close, cooperative relationship between public health services and local CHCs facilitates referrals between agencies and allows providers to allocate their time and resources more effectively.

CHC resources focus on primary medical and dental services, and their patient loads are growing rapidly. Public health preventive services align with CHC's primary care services, particularly along the lines of the mandated clinical quality improvement standards. HRSA evaluates federally funded health centers on a set of performance measures emphasizing health outcomes and the value of care delivered, as well as additional categories covering health outcomes, disparities, and financial viability/costs. The 12 quality measures are listed below along with potential public health interfaces where applicable.

1. *Access to Prenatal Care.* Reducing infant mortality is a key public health goal, and access to prenatal services is crucial in the underserved populations that CHCs serve. County and state health departments can facilitate referrals through maternal and child health programs, health education materials, and outreach to CHCs with prenatal services.
2. *Childhood Immunization.* There are two major avenues of cooperation on childhood immunization: (1) the public health statewide immunization registry that provides primary care centers and other providers with current immunization status, and (2) the federal Vaccines for Children program, which provides vaccines without cost. Many county health departments provide immunizations, and effective health information exchanges (HIE) and immunization registries help ensure both efficient communication of immunization status and allow CHCs to appropriately report successes.
3. *Cervical Cancer Screening.* Through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), CDC provides low-income, uninsured, and underserved women access to timely breast and cervical cancer screening and diagnostic services. Currently, NBCCEDP funds all 50 states to provide breast and cervical cancer screening services. Once cancer is diagnosed, women become Medicaid-eligible for treatment. Effective HIEs facilitate communication of health status and help FQHCs meet required standards of patient care.¹⁶
4. *Adolescent Weight Screening and Follow Up.* The HHS Healthy People Initiative has established weight control as a major area of emphasis for public health.¹⁷ Most public health departments have health promotion programs dedicated to impacting this critical health marker. The initiative provides materials for clinicians' use and facilitates cross referrals between CHCs and public health providers.

5. *Adult Weight Screening and Follow Up*. See “Adolescent Weight Screening and Follow Up.”
6. *Tobacco Use Screening and Cessation*. Many states have tobacco quitlines and provide health education materials and tobacco replacement products to assist in smoking cessation.
7. *Cholesterol Treatment (Lipid Therapy for Coronary Artery Disease Patients)*. CDC provides federal grant funds to all 50 states to prevent chronic disease. Funding targets epidemiology and surveillance activities, environmental improvements, health system interventions, and clinical-community relationship building.¹⁸ Many health departments also offer cholesterol screenings and heart disease risk assessments to individuals, which could also facilitate cross-referrals.
8. *Ischemic Vascular Disease (IVD) and Aspirin or Other Antithrombotic Therapy*. See “Cholesterol Treatment.”
9. *Colorectal Cancer Screening*. In 2015, CDC’s Colorectal Cancer Control Program awarded \$22.8 million to 24 state health departments to improve colorectal screenings, particularly targeting low-income, underinsured or uninsured groups, and other at-risk populations.¹⁹
10. *Depression Screening and Follow Up*. CDC has recommended that public health address depression through data collection and tracking, evaluation, and dissemination of evidence-based initiatives.²⁰
11. *HIV Linkage to Care*. The [National Alliance of State and Territorial AIDS Directors](#) (NASTAD) has surveyed CHCs to identify areas for collaboration regarding HIV/AIDS prevention and treatment. NASTAD identified existing challenges, such as lack of funding and perceived complexity of care by practitioners. As a result, NASTAD recommends health departments conduct outreach and leverage existing sister programs in family planning, tuberculosis, or substance abuse in order to enhance the effectiveness of both clinical and public health services and to improve continuity of care among providers.²¹
12. *Oral Health*. Many state health departments have oral health programs that focus on community and school-based education and prevention, and oral health is also included as a top priority in the HHS Healthy People Initiative. The [Association of State and Territorial Dental Directors](#) also provides resources to connect with state dental health programs.

Mechanisms for Cooperation

An effective HIE is an important tool for communication and collaboration because it facilitates seamless transmission of referral data and ensures medical records are updated. Ninety-two percent of FQHCs use electronic health records (EHRs).²² As these EHRs are linked to public health surveillance systems through HIEs and other mechanisms, they add to public health’s population surveillance and health analytics capacity.

CHCs’ enabling services provide another mechanism for cooperation. According to the roundtable report *Enabling Services at Health Centers: Eliminating Disparities and Improving Quality*, enabling services are “nonclinical services that aim to increase access to healthcare and improve health outcomes.”²³ They include health education, transportation, translation, and case management, among other services.^{24,25} Case management services may be a particularly effective tool to coordinate care between public health agencies and CHCs.

Addressing the Social Determinants of Health

According to CDC, the social determinants of health include economic stability, neighborhood and built environments, health and healthcare, social factors, and education.²⁶ Enhanced cooperation between

CHCs and public health may have a direct impact on health and healthcare. However, public health's partnerships with other governmental and nongovernmental entities can address barriers to health in nontraditional settings, such as through housing or school-based initiatives.

Existing Partnerships in Emergency Response

As a condition of their federal grants, FQHCs are [required to develop a strategy for emergency management](#) (such as in response to natural/environmental disasters, civil disturbances, or infectious disease outbreaks), doing so in concert with community partners, including public health. At the state level, health centers work with their primary care association (PCA), which helps integrate them into statewide and community preparedness and response plans. Cooperation between state and local health departments, PCAs, and FQHCs is essential to effective emergency response, particularly to ensure that all providers can respond to changes in demand for healthcare, disruptions in service delivery, or protecting FQHC staff and patients.²⁷

One existing partnership takes place in Harris County, Texas, where local health officials confirmed cases of the Zika virus. As a result, Legacy Community Health, a FQHC, is offering pregnant patients a clinical screening for the Zika virus and is launching new patient communications through letters and a radio ad to educate the public on CDC guidance.²⁸

Recommendations for Where to Start

Public health outreach to CHCs can begin the process of collaborating to increase access to care and comprehensive services. To establish a relationship that will include public health considerations, public health must be cognizant of potential avenues for collaboration that benefit both entities. Effective cooperation can then begin with something as simple as picking up the phone and beginning a dialogue.

CHCs have a state association that is a key partner in the development of a relationship. [NACHC](#) provides a wealth of information about CHCs and [links to state and regional PCAs](#). State health agencies will find that an effective way to coordinate with the programs is to establish a relationship with NACHC.

At the community level, the best way to start a relationship is to have something to offer and reach out. First, identify the CHCs serving your jurisdiction and determine the services they provide. This information is typically available on their websites. Personal contacts to establish communication will be essential. Some suggestions to work with the association include:

- Asking to speak at the state association meeting.
- Including local health departments in contacts and discussions.
- Visiting CHCs to see their work firsthand and build relationships with locals.
- Putting a CHC representative on your board of health or community advisory council.
- Seeking their support on population health initiatives.
- Inviting representatives to your office to talk about priorities.

Conclusion

Public health and CHCs have a mutual interest in improving the health status of underserved communities. Public health cannot provide direct primary care services to underserved populations, but CHCs are dedicated to them, which creates opportunities for public health and CHCs to complement one another. CHCs need public health data and preventive services to fulfill their fundamental mission and federal grant requirements. Thus, public health and CHCs can develop meaningful partnerships to address health and healthcare disparities through mutual assistance in service delivery and preventive care, the collection and sharing of health data and HIE, and community outreach through coordinated enabling services.

¹ HRSA Health Center Program. "Program Requirements." Available at <http://www.bphc.hrsa.gov/programrequirements/index.html>. Accessed 4-27-16.

² National Association of Community Health Centers (NACHC). "America's Health Centers." Available at <http://www.nachc.com/client/documents/America's%20Health%20Centers%20March%202016.pdf>. Accessed 4-27-16.

³ HRSA Health Center Program. "Program Requirements." Available at <http://www.bphc.hrsa.gov/programrequirements/index.html>. Accessed 4-27-16.

⁴ Illinois Primary Healthcare Association. "HRSA Program Requirements." Available at <http://www.nachc.com/client/documents/HRSA%20Program%20Requirements.pdf>. Accessed 4-27-16.

⁵ Rural Health Information Hub. "Federally Qualified Health Centers (FQHCs)." Available at <https://www.ruralhealthinfo.org/topics/federally-qualified-health-centers>. Accessed 4-27-16.

⁶ HRSA. "How to Become a Health Center." Available at <http://www.bphc.hrsa.gov/programopportunities/howtoapply/>. Accessed 5-20-16.

⁷ NACHC. "Press Kit: Intro to Health Centers." Available at <http://www.nachc.com/press-kit.cfm>. Accessed 4-27-16.

⁸ Community Health Network of Washington. "Community Health Center Model." Available at <http://chnw.chpw.org/about-us/community-health-centers/community-health-center-model>. Accessed 4-27-16.

⁹ HRSA Health Center Program. "2014 Health Center Data." Available at <http://bphc.hrsa.gov/uds/datacenter.aspx?year=2014>. Accessed 5-27-16.

¹⁰ NACHC. "2014 Update on Implementation of the FQHC Prospective Payment System (PPS) in the States." Available at <https://www.nachc.com/client/2014%20pps%20report%20LE%20Edits%202%2020%2015.pdf>. Accessed 4-28-16.

¹¹ CMS. "New Medicare Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHCs) MLN Connects National Provider Call." Available at <https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2014-05-21-FQHC-Transcript.pdf>. Accessed 4-28-16.

¹² Goldman L, Chu PW, Tran H, *et al.* "Federally Qualified Health Centers and Private Practice Performance on Ambulatory Care Measures." *American Journal of Preventive Medicine*. 2012. 43(2): 142-148. Available at <http://www.ncbi.nlm.nih.gov/pubmed/22813678>. Accessed 5-4-2016.

¹³ NACHC. "A Sketch of Community Health Centers." Available at http://www.nachc.com/client/Chartbook_2014.pdf. Accessed 4-27-16.

¹⁴ NACHC. "Cost Effectiveness of Care Provided at Health Centers." Available at <https://www.nachc.com/client/documents/CostEffectivenessFS.pdf>. Accessed 4-27-16.

¹⁵ American Academy of Family Physicians. "Integration of Primary Care and Public Health (Position Paper)." 2014. Available at <http://www.aafp.org/about/policies/all/integprimarycareandpublichealth.html>. Accessed 4-27-16.

¹⁶ CDC National Breast and Cervical Cancer Early Detection Program. "About the Program." Available at <http://www.cdc.gov/cancer/nbccedp/about.htm>. Accessed 4-27-16.

¹⁷ Office of Disease Prevention and Health Promotion. "Leading Health Indicators." Available at <https://www.healthypeople.gov/2020/Leading-Health-Indicators>. Accessed 4-27-16.

- ¹⁸ CDC. "State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health (DP13-1305)." Available at <http://www.cdc.gov/chronicdisease/about/state-public-health-actions.htm>. Accessed 4-27-16.
- ¹⁹ CDC. "Colorectal Cancer Control Program." Available at <http://www.cdc.gov/cancer/crcccp/>. Accessed 4-27-16.
- ²⁰ CDC. "CDC Promotes Public Health Approach to Address Depression Among Older Adults." Available at http://www.cdc.gov/aging/pdf/cib_mental_health.pdf. Accessed 4-27-16.
- ²¹ NASTAD. "Health Department-Community Health Center Collaborations." Available at <https://www.nastad.org/sites/default/files/IB-CHC-HD-Collaboration-September-2013.pdf>. Accessed 4-27-16.
- ²² Ryan J, Doty M, Abrams M, *et al.* "The Adoption and Use of Health Information Technology by Community Health Centers, 2009-2013." *The Commonwealth Fund*. May 2014. Available at http://www.commonwealthfund.org/~media/files/publications/issue-brief/2014/may/1746_ryan_adoption_use_hlt_it_chcs_rb.pdf. Accessed 4-28-16.
- ²³ Park H. "Enabling Services at Health Centers: Eliminating Disparities and Improving Quality." *New York Academy of Medicine*. 2006. Available at <http://www.aapcho.org/wp/wp-content/uploads/2012/03/ES-Metlife-Report.pdf>. Accessed 4-27-16.
- ²⁴ Ibid.
- ²⁵ NACHC. "A Sketch of Community Health Centers." Available at http://www.nachc.com/client/Chartbook_2014.pdf. Accessed 4-27-16.
- ²⁶ Office of Disease Prevention and Health Promotion. "Social Determinants of Health." Available at <http://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>. Accessed 4-27-16.
- ²⁷ HRSA Bureau of Primary Healthcare. "Policy Information Notice: Health Center Emergency Management Program Expectations." Available at <http://bphc.hrsa.gov/about/pdf/pin200715.pdf>. Accessed 5-13-16.
- ²⁸ African American News. "Legacy Community Health to Screen Pregnant Women for Zika Virus." Available at <http://www.aframnews.com/legacy-community-health-to-screen-pregnant-women-for-zika-virus/>. Accessed 5-9-2016.