

NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS

1984

ANNUAL PROGRAM REPORT

Reflections  
on the  
Past

PRIORITIES  
FOR THE  
FUTURE



Presented at  
The 15th Annual Convention and Community Health Institute  
San Antonio, Texas

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## *INTRODUCTION*

This has been a dynamic and fast-paced year, mirroring the health care environment in which we find ourselves. Objectives set by the organization, while ambitious, were by and large achievable. Their focus centered on advocating for the maintenance of federal grant support for health centers, and reauthorization of the programs as categorical programs; keeping health centers informed about legislative, regulatory and policy changes, as well as emerging issues in primary care development; continuing efforts, through research, to better understand health centers and the patients they serve; securing required financial resources for support of the organization's programs; concluding national health promotion/disease prevention project. and, finally, completion of the long-range plan of the organization.

Funding for community health centers and migrant health centers for FY '84 hovered close to the total funds available in FY '83. Total dollars last year incorporated one-time-only "Jobs Bill" funds, thus the difference in total funds between the two years. However, when comparing base funds there was a thirteen (13) percent increase for Community Health Centers, and a (10) percent increase for Migrant Health Centers. Providing testimony to House and Senate Subcommittees at their request provided the members of Congress with information on the documented need for the dollars appropriated.

During the year, Congress (Senate and House Subcommittees) also requested that NACHC work with them on the question of reauthorization of the Community and Migrant Health Center programs. Congress determined to reject the Administration's proposal to renew the Primary Care Block Grant based on the fact that over the past three years only two states ever applied (West Virginia and Georgia), and only one (West Virginia) ever received the Block Grant. As had been reported earlier in the year, West Virginia returned the Block after only six months. Two bills emerged, S. 2308 and H.R. 5602, which call for the reauthorization of Community and Migrant Health Centers as categorical programs. There are several differences between the bills, but it is expected that they will be ironed out in conference.

Keeping centers informed on issues vital to their ability to operate continued as a major activity for NACHC. The issues are large in number, and information concerning them was distributed in numerous ways:

- Publications
  - Bi-weekly "Washington Update"
  - Bi-monthly "Primary Care Focus"
  - Action Memos
  - Position Papers
  - Bi-monthly "Healthbound"
  
- Conferences
  - Community Health Institute

- Health Policy Seminar Series (4)
- Migrant Conference
- Medical Directors Conference

Issues of concern included Medically Underserved Area (MUA), and Health Manpower Shortage Area (HMSA) designations, National Health Service Corps (NHSC) payback requirements, grant-related income and excess revenue, Medicaid amendments (particularly Sec. 1903 (m) (2)(B), corporate diversification, strategic planning, financial management, prospective payment systems, pre-paid Title XIX, clinical issues for treatment of selected problems of migrant and seasonal farmworkers; clinical administration for medical directors and, finally, the development and growth of State Primary Care Associations (SPCA).

Analysis of the data collected in the '83-'84 health center survey is well underway. The response rate was not as good as had been hoped for (33%); however, it provided a statistically sound sampling. The data results are providing good information that can be used to continue to "state the case" for the continuing need for the programs, the impact of the federal cuts in social programs in 1981, the scope of services provided and the configuration of service delivery. There is still much to glean from the data, and it will be reported throughout the year.

Activities for the year were varied, and large in number, but we were able to secure the necessary resources to support them. Although a grant from the Bureau of Health Care Delivery and Assistance (BHCDA) represented the largest portion of the budget (75%), this is declining (71%, '84-'85). Funds generated by NACHC represented 15% of the budget and should increase to 24% during FY '84-'85. The Robert Wood Johnson grant (to facilitate the development of SPCAs) represented 10% and will represent 5% in FY '84-'85. The significance of these numbers lies in the fact that NACHC is increasingly able to generate more of its own revenues, and expand its revenue source. This has long been a goal of the organization, and the trend is well on the way. (FY '79-'80: BHCDA=87%, NACHC=13%, other=0; FY '84-'85: BHCDA=71%, NACHC=24% other=5%). In addition to this positive trend, the organization through the strong support of its membership, has been able to develop a reserve fund (see audit report), thus enhancing its future financial health.

Part of the organization's time this past year has been spent completing tasks, among them the conclusion of NACHC's first national health promotion/disease prevention program (HP/DP), and a long-range plan for the organization. With respect to the former, NACHC has been able to develop a resource center with a wealth of HP/DP material, a yearly calendar display, e.g., national health events, a TA Memo series on a variety of HP/DP programs and ideas, and establish a National Health Center Week with a variety of materials distributed to health centers designed to increase the visibility of the HP/DP programs and activities provided through health centers. Additionally, with the able assistance of a National Advisory Committee, a national strategy to encourage the development of networking between health centers and other organizations involved in health care has been implemented. NACHC is working with a number of national groups to facilitate the growth of this networking. A national report on the HP/DP program will be available in September of this year.

Finally, a plan for the organization for the next five years was completed. Input was broadly solicited from within the organization, and many hours were spent by the Program Planning Committee, a special "Blue Ribbon" panel (assembled by the Board), and staff to accomplish this task. This plan is grounded in the belief that NACHC can and must take charge of its future. Primary care is the focal point for all providers, insurers, and consumers. Health centers who now have fifteen years of experience in delivering these services can and must be in the forefront of the changing health care environment. The long-range plan will be reviewed and acted upon by the House of Delegates in September, and it is hoped that it will be adopted.

Throughout this annual report, you will find detailed information about this past year's work, as carried out through the various departments. The progress that has been made is clearly a reflection of the membership and staff working to ensure that the health needs of the poor and underserved receive the attention and support they require.

# Education & Training

Community-based Health Centers continue to meet the numerous challenges to their ability to operate in a rapidly changing health care environment. In order to assist centers to compete successfully, the Department of Education and Training has continued to provide services and products to appropriately address the needs of the constituency. The following will highlight the Department's activities this past year.

## *COMMUNITY HEALTH INSTITUTE:*

The Community Health Institute (CHI) is the Association's largest educational activity. Each year this activity attracts a broad cross section of health center administrators, Governing Board members, clinical providers and consumers. The CHI provides an opportunity for all participants to interact with their peers, individuals from academia, government and private industry. These individuals are able to assist health centers in strengthening their clinical and programmatic management capability and provide center policy makers with direction regarding the feasibility of their decisions.

The theme for the 1984 Institute is "Reflections on the Past.....Priorities for the Future". Based upon an analysis of returned Institute surveys, the following topical areas were developed into the core curriculum:

- Financial Management
- Management Information Systems
- Programmatic Impact
- Personnel Management
- Identification of Survival Strategies
- Health Promotion/Disease Prevention

A selected Continuing Education Program was developed in cooperation with the University of Texas Health Science Center at San Antonio. Application was made to the University of Texas Health Science Center at San Antonio, Medical and Dental Schools, for Continuing Education Credits and the following selected sessions were accredited and sponsored by the University:

- Nutrition, Aging and the Aged
- The Management of the Cardiovascular Patient in an Ambulatory Care Setting
- Preventive Dentistry In Community Based Programs: New Approaches and Techniques
- Medical Emergencies In Dental Offices

## *MEDICAL DIRECTOR'S CONFERENCE*

The Third Annual Medical Director's Conference was held June 20-22 in Key Biscayne, Florida. Over one hundred-forty clinicians attended the national meeting. This represents almost a 100-percent increase in attendance over last year.

The theme of the conference was "Community-Oriented Primary Care" and Paul A. Nutting, M.D., former Institute of Medicine Scholar and current Director of Primary Care Studies, Office of the Administrator, HRSA/DHHS, delivered the keynote address.

The following topics were presented:

- Community-Oriented Care Practice Models
- Quality Assurance in CHCs Utilizing A Life Cycle Approach
- Administrator/Medical Director Roles and Models
- Role of Primary Care Physicians in Health Promotion: Results from Maryland Survey
- Provider Involvement In Networking
- Accreditation of Health Centers
- Computerized Medical Systems

The program was co-sponsored by the University of Miami Medical School and fully accredited.

Edward Martin, M.D., Director, Bureau of Health Care Delivery and Assistance, delivered the luncheon address. Dr. Martin provided insight regarding BHCDA's emerging clinical priorities, and stressed the need for more active involvement of medical directors in presenting the case for health centers (from a clinical perspective).

During this conference, the Medical Directors Committee took on greater shape. The committee proposes to provide feedback to NACHC as well as BHCDA on issues impacting on clinical care, e.g., physician recruitment and retention, support materials development, identification of clinical program models.

It was recommended that there be a state representative to a regional grouping which will in turn select a representative to participate in NACHC's national Medical Director's Committee. The committee will establish an agenda and schedule appropriate meetings for the year.

The clinicians in attendance were most interested in involving themselves in the activities of the Association. This interest will be channeled and increased by the proposed activities of the committee.

#### ***MIGRANT HEALTH CONFERENCE***

The seventh Annual Migrant Health Conference was held in Charleston, South Carolina on April 13-15, 1984. The Conference had broad sponsorship including:

- American Academy of Pediatrics
- American Friends Service Committee
- Children's Defense Fund
- Department of Education  
Office of Migrant Education

- Department of Health and Human Services
  - Bureau of Health Care Delivery and Assistance
  - Office of Migrant Health
  - Office of Human Development Services
  - Administration For Children, Youth and Families
  - Indian and Migrant Programs Division
- Division of Continuing Education
  - Medical University of South Carolina
- Johns Hopkins School of Public Health
  - Tropical Medicine Section
- "Migration Today" Magazine
- National Association of Farmworkers Organization (NAFO)
- National Coalition of Hispanic Mental Health and Human Services Organizations (COSSMHO)
- National Council of LaRaza
- South Carolina Primary Care Association

The theme of this year's meeting was "The Migrant Child", primarily focusing on the clinical care provided to migrant and seasonal farmworker children and their families. Improved coordination of all migrant services emerged as a sub-theme. Representation from Migrant Head Start, Migrant Education, Migrant Housing and Labor enhanced discussions around this theme, and paved the way for future working relationships.

There were in excess of 300 people in attendance, the largest Migrant Conference ever held by NACHC.

Issues addressed included:

- \* Enteric Illness Survey On the East Coast Migrant Stream
- Oral Rehydration Therapy Facilitator Training Session
- Health Care Priorities within the Migrant Health, Migrant Head Start and Migrant Education Programs
- Orientation Session on the Migrant Health Program
- Shared Services
- \* Recognition and Management of Oral Rehydration Therapy (PART I - II)
- Pesticide Poisoning Prevention
- Marketing the Migrant Health Center
- Presentation of Research Papers
- \* Infectious Disease Management In the Migrant Day Care Center
- \* Dental Health In Migrant Health Centers
- Allocation of Funds for the Migrant Health Program
- \* Folk Medicine: Its Use Among the Migrant Population
- \* Migrant Maternity Management
- Utilizing Resources for Increased Service Delivery



- Migrant Childhood Accident Prevention
- \* Quality Assurance: Developing An Effective and Efficient System
- \* Lead Poisoning and Anemia
- School Health and The Migrant Child
- Health Handicap Needs of Migrant Head Start Children
- Interaction with the Farming Community

The Medical College of South Carolina (MCSC) sponsored a CME program for clinicians providing credits for the above referenced (\*) sessions.

Marian Wright Edelman, President of the Children's Defense Fund, delivered the keynote address and Fernando Guerra, M.D., Consultant to the American Academy of Pediatrics, delivered the luncheon address and provided insight into the physical and emotional problems faced by the migrant child and adolescent. In addition, Edward Martin, M.D., Director of the Bureau of Health Care Delivery and Assistance, provided the participants with insight into the policy directions that the Bureau was undertaking for migrant health.

#### *COMMUNITY HEALTH CONNECTION*

NACHC completed its twenty month health promotion/disease prevention project, under the "Community Health Connection" (CHCn) with the assistance of a grant from the Bureau of Health Care Delivery and Assistance, DHHS. The dual goals of the Community Health Connection were to assist health centers in developing and enhancing their HP/DP Programs, and expand their local networking with providers and agencies in their communities.

Between October, 1982 and June, 1984, the Community Health Connection served over 700 Centers and 34 State Primary Care Organizations as they undertook a comprehensive program of networking for improved community health promotion. State and local health departments were also recipients of this service.

As judged by the health centers and Primary Care Organizations served, the Community Health Connection succeeded in delivering an important service. Their evaluation of the usefulness of the Community Health Connection services was overwhelmingly positive (97%). The program evaluation also offered staff valuable suggestions which are being used to chart the "Connections" second program cycle.

Technical assistance to health centers has taken many forms since the inception of the Community Health Connection program. Program staff has worked closely with health leaders and their national organizations to facilitate the development of health center sponsored Health Promotion/Disease Prevention networks in communities across the country.

A National Advisory Committee was developed to assist the CHCn in this networking process. Membership was carefully designed to bring specialized knowledge, and skills to the program. Membership of the National Advisory Committee include Kenneth Woodward, M.D. (Chair), and the following:

- American Academy of Family Physicians
- American Academy of Pediatrics
- American Academy of Physician Assistants
- American College of Prevention Medicine
- American Dental Association
- American Dietetic Association
- American Hospital Association
- American Indian Health Care Association
- American Nurses Association
- American Osteopathic Association
- American Red Cross
- American Society of Allied Health Professions
- Association of State & Territorial Health Officials
- Blue Cross & Blue Shield Associations
- Council on Foundations
- March of Dimes Birth Defects Foundation
- National Association of Social Workers
- National Coalition of Hispanic Mental Health & Human Services Organizations (COSSMHO)
- National Dental Association
- National Health Council
- National Mental Association
- The National Office of Disability
- U. S. Conference of City Health Officials
- YMCA of the USA

Establishment of the Advisory Committee facilitated access of key health organizations whose support of health centers and HP/DP initiative, through their respective local organizations, aided in the development of local HP/DP networks. The advisory committee met three times during the course of the project, and as a result of their meeting in March of 1984, a set of planning strategies was developed, and incorporated into the CHC's planning process. These strategies emphasized networking and encouraged development of on-going relationships utilizing minimal resources (human and financial). Coupled with the evaluation of study findings, these strategies represent important factors in charting a course for continuation of the program. A sampling of the successful networking that has occurred includes:

***MARCH OF DIMES BIRTH DEFECTS FOUNDATION (MOD)***

The Community Health Connection worked with the March of Dimes National Office to establish three community programs in Los Angeles, California (Watts Health Foundation), Dallas Texas (Los Barrios Unidos Community Clinic), and Newark, New Jersey (North Jersey Community Union Health Center). MOD chapters in those cities are working with the health centers in the area of maternal and child health.

The Programs identified, incorporated MOD's "A Full Time Job", (a program examining teen pregnancy issues) into their on-going clinical programs. Outcomes will be highlighted through training workshops, CHC TA Memo series, and through MOD publications.

### *AMERICAN RED CROSS (ARC)*

On January 30, 1984 the Chief Executive Officers and staff of the NACHC and American Red Cross met to sign a "Memorandum of Understanding", formalizing the relationship which had developed as part of NACHC's Community Health Connection program.

Highlights of NACHC - ARC cooperative activities include:

- Community Health Connection presentations as part of the Red Cross Health Services Symposia Series
- Formal and informal national planning meetings of senior staff
- Red Cross participation in NACHC and State Primary Care Association conferences
- Community Health Connection participation in Red Cross national forums including the Home Health Care Symposium and the Task Force on Hispanic Health Issues
- Placement of news releases and related stories in "Healthlines" (ARC) and "Healthbound" (CHCn) (national newsletters of each organization).

Plans call for increased coordination and cooperation on the national level in order to foster development of jointly sponsored community-level HP/DP programs. Staff of both organizations will continue to foster, where feasible, the establishment of community programs across the country, with other national groups.

Similar activities are ongoing with the American Dietetic Association, American Academy of Physician Assistants, National Coalition of Hispanic Mental Health and Human Services Organizations, National Association of Social Workers and the National Urban League. Additionally, the program has developed on-going relationships with the American Cancer Society and the National Health Screening Council.

### *GETTING THE WORD OUT*

The Community Health Connection developed a campaign to inform the general public and key decision makers about the HP/DP initiative, and to foster development of increased participation, cooperation and support in local communities for health promotion programs and services.

### *HEALTHBOUND YEAROUND*

NACHC's Calendar of National Health Events was designed to increase the visibility of health centers among health professionals and health organizations. Developed with a companion piece, the Resource Guide to 1984 Annual Health Events, the calendar fills a long-standing void, and should assist health centers and others in coordinating cooperative activities around national health events.

## ***MINORITY MEDIA COVERAGE***

The Community Health Connection continues to work with Minority Media Syndicate, Inc., to place stories about health center HP/DP accomplishments in the print and electronic media. Through these mechanisms, approximately 520 radio stations, 160 television stations, and 900 newspapers serving minority communities were reached.

## ***REPORT TO THE NATION: "Community Health Centers: Promoting Health, Reducing Costs"***

This publication is a Report on HP/DP activities being carried out by health centers across the country. Its purpose is to better inform the public and decision makers about the valuable HP/DP services and programs offered through health center-sponsored community networks.

This report offers a concise, engaging summary of the HP/DP programs health centers are conducting, and:

- emphasizes health center HP/DP and networking successes
- informs the reader of recent research showing the cost-effective nature of centers and
- describes the BHCDA HP/DP initiative, NACHC's Community Health Connection program.

With its human interest approach and emphasis on readability, the report should help communicate the health center story nationally. The planned distribution of 5,000 copies includes health centers, Primary Care Associations, national voluntary organizations, DHHS officials, members of Congress, and state and local health departments. In addition, efforts are being made to place articles about the Community Health Center HP/DP initiative in national health publications.

## ***TECHNICAL ASSISTANCE (TA) MEMOS:***

Through the Community Health Connection's National Resource Center, Advisory Committee members and state health departments have joined Primary Care Associations and health centers in receiving these memos. They are designed to provide health centers with program ideas in each of the 12 BHCDA priority areas, and to offer insight into HP/DP management areas such as planning, implementation, evaluation and networking. Over 50 TA Memos have been distributed to date.

## ***HEALTHBOUND***

"Healthbound" is the program's newsletter published bi-monthly and distributed to health centers, national voluntary organizations, primary care associations, state and local health departments, and Federal agencies. The newsletter features the accomplishments of the health centers nationally and provides a mechanism for exchanging information.

“Healthbound” has attracted the interest of a variety of audiences including universities, hospitals, HMO’s, many of whom are now subscribers.

### ***PROGRAM GUIDES***

The purpose of the program guides are to provide examples of effective HP/DP programs, e.g., content development, implementation, replicability. Also, summarize things learned by experienced HP/DP practitioners and list resources health centers can use to plan and evaluate HP/DP programs.

Program guides were developed in the following categories:

- Evaluating HP/DP Activities in Community Health Centers
- Local Networks and Linkages for HP/DP
- Generating Financial Support for HP/DP
- Program Ideas and Resources
  - Smoking, Drug Abuse, Alcohol Abuse
  - Healthy Mother, Healthy Children, Healthy Families
  - Disabled Persons
  - Hypertension
  - Nutrition, Weight Control, and Exercise
  - Dental Health
  - Injury Prevention
  - Diabetes

The Community Health Connection staff has participated as planners, moderators and presenters in national, regional and state HP/DP conferences across the country. This participation has featured HP/DP network building, while helping to improve HP/DP program skills and competencies among health center staff.

With the formation of the National HP/DP Resource Network, Primary Care Associations and health centers have enhanced capability to identify and share program information, and skill-building opportunities. The Network was formed with the assistance of State Primary Care Associations, national voluntary organizations, health centers, health departments, churches, and DHHS Regional Offices.

### ***INTERNSHIP PROGRAM***

The Association continues to work with systems of education in promoting health centers as a viable employment and training option. NACHC acted as a preceptor for a student majoring in nutrition at Howard University, who did a four-month practicum with the Association this past Spring. She worked on several HP/DP programs that focused on her area of interest. She also gained valuable practical experience in proposal development.

Once again, the Association participated in the District of Columbia’s “Summer Youthworks Program”. This program provides work experience for young people during the summer, while providing them with greater insight into various career opportunities.

# Communications

The Communications component of NACHC strives to disseminate information not only on the activities of the Association and its members but also on the primary health care field as a growing entity. The major vehicle utilized thus far has been the magazine, "The Primary Care Focus."

The "Primary Care Focus" completed its third year of publication this year. The magazine is published bi-monthly and is distributed on a subscription basis. The goal of the Association is to make the magazine self-supporting through advertisements and subscriptions. Currently, there are 211 subscribers, which represent an eight percent increase over last year.

Revenue generated through subscriptions represent 83 percent of costs incurred for printing and postage. Currently a proposal is being completed for submission to various sources seeking financial support for the magazine for at least two years. It is projected that during this two-year period sufficient advertisers and subscribers would be solicited to make the publication become not only self-supporting, but to generate a small surplus as well.

The Staff of the Association met on several occasions throughout the course of the year to provide recommendations for improving the magazine. In order to improve the quality of the magazine, thus its marketability, several recommendations were made which included the establishment of an editorial board and a detailed advertising and subscription campaign.

An editorial board, external to the staff, possessing expertise and knowledge in publishing, as well as in primary health care, would significantly enhance the magazine content and it is projected that the editorial board will be in place by November of 1984. Although there has been continuous solicitation of advertisers for the magazine, few have been received. It is difficult to present a prospective advertiser with a package that appears advantageous when the volume of subscribers is so low. A more precisely planned and rigorously executed advertisers campaign will be carried out.

Thought was given to encouraging health center directors to obtain advertisements for the magazine from organizations from whom they have purchased goods and services. Incentives for centers to be involved in such a campaign might incorporate a prize of value to be awarded for the most advertisements solicited. In order for the circulation to increase, the number of subscribers must increase, which in turn enhances the organization's ability to increase advertisers.

Possible changes in the magazine design, layout and content, have been discussed, and a concerted effort has been undertaken to provide a more attractive publication, that will keep people abreast of the changing primary care environment. The activities required for this task are numerous and will be undertaken with great thought and care and assistance from the editorial board. It is anticipated that this should result in positive results by Spring, 1985.

The "Clearinghouse" section of the magazine continues to expand. It has been updated, and efforts continue to solicit articles and publications from the constituency. There have been a number of requests from organizations and various university programs for the information featured in the Clearinghouse.

# Policy Analysis

The Department of Policy Analysis' major goal is to ensure that health policy related information is analyzed and communicated in a timely fashion to our nation's health centers and their users, to conduct research, and to transmit relevant findings to key policymakers at the federal and state levels.

During the 1983-84 fiscal year, a number of key issues surfaced for the Legislative and Health Policy Committees, State Primary Care Associations, State Coordinators, and the department.

The most pressing issue faced by Community Health Centers and our department was the reauthorization of Sections 330 and 329 programs. The existing optional Block Grant legislative authority expires September 30, 1984.

Major FY 1983-84 issues included:

- Reauthorization of Community and Migrant Health Centers
- Reauthorization of the National Health Service Corps
- FY85 appropriations for primary care
- FY84 Supplemental appropriations
- National Health Service Corps:
  - payback policy provisions
  - placement opportunity lists
  - conversion plans
- State Memoranda of Agreement
- Final Regulations, Cost Principles for Nonprofits (OMB A-122)
- Migrant Health Funds (used to repay FmHA loans)
- Immigration Reform Bill
- Medically Underserved Areas / HMSA Revisions
- Shared Services Contracts
- Strategic Planning Guidance
- Title XIX Medicaid:
  - expanded services for mothers and children
  - prepayment options under Section 1902.

In an effort to meet NACHC's goals and objectives, the following activities were conducted under plans formulated by the Legislative and Health Policy Committees.

## I. HEALTH POLICY SEMINAR SERIES (HPSS)

Two and one-half day, intense training seminars were conducted through five (5) regional conferences. The theme, "Keys to Survival in the New Competitive Era," explored this new environment in detail. Participants examined the history and evolution of primary care programs, future trends for primary care in general, and community-based primary care centers in particular. Detailed analyses focused upon changes in the reimbursement system, strategic planning, and anticipated increases in health manpower. Participants examined options necessary for future survival.

A highlight of some of the topics covered:

- Development of provider networks and primary case management systems;
- Increasing role of employer groups, insurers and governments, particularly Medicaid/Medicare programs as major purchasers of health care;
- Use of group contracts and "freedom of choice" waivers in negotiating closed service agreements;
- Legal, technical and managerial issues in forming alliances or networks with other providers; and,
- Presentations of detailed case histories of successful health center networks.

A Seminar Guidebook was published to facilitate the HPSS and to serve as a permanent resource document. Evaluation surveys indicated that seminar topics and issues were both important and timely.

The conferences were conducted at the following times and locations:

### Regions VIII, IX, X

November 2, 3, 4, 1983  
Las Vegas, Nevada

### Regions V, VII

November 9, 10, 11, 1983  
Indianapolis, Indiana

### Region IV

November 30, December 1, 2, 1983  
Orlando, Florida

### Region VI

December 7, 8, 9, 1983  
South Padre Island, Texas

### Regions I, II, III

January 11, 12, 13, 1984  
Atlantic City, New Jersey

We extend appreciation to the State Coordinators and State Primary Care Association representatives for their assistance in bringing about yet another successful series of seminars. We also appreciate the assistance of Attorney Jacki Leifer, BHCDA staff, and Regional Office staff.



## II. POLICY AND ISSUES FORUM

The 9th Annual Policy and Issues Forum was held at the Hyatt Regency Hotel, Washington, D.C., March 4-7, 1984. Over 550 representatives from community, migrant, and Indian health agencies participated in the conference.

Educational workshops were extremely well-attended and covered a variety of topics, including:

- BHCDA Priorities
- NHSC Issues (placement priorities and conversions, and payback policies)
- HMSA/MUA Issues
- Migrant Health Issues
- Innovative Delivery Systems Development
- Needs Assessment / Demand Analysis
- Developing Health Promotion / Disease Prevention Programs for the Aged
- Strategic Plan Implementation
- Issues for Community Health Center Boards of Directors
- Legal Issues Impacting on Health Centers.

Health center issues and priorities were shared with invited guests during sponsored receptions. Speakers in attendance were:

Senator Lowell Weicker -- Connecticut  
Senator Edward M. Kennedy -- Massachusetts  
Senator Robert C. Byrd -- West Virginia  
Senator Jennings Randolph -- West Virginia  
Congressman Al Gore -- Tennessee  
Congressman David Obey -- Wisconsin  
Congressman William Gray -- Pennsylvania  
Congressman William Hill Boner -- Tennessee

Special group sessions were held with:

Senator Alfonse D'Amato -- New York  
Senator John Heinz -- Pennsylvania  
Senator Arlen Specter -- Pennsylvania  
Congressman Brian Donnelly -- Massachusetts  
Congressman William Richardson -- New Mexico

Dr. Edward Martin, Director of the Bureau of Health Care Delivery and Assistance, addressed the general session on BHCDA priorities and new policies/directions for health centers, further detailing his views of what health centers needed to do to survive and compete successfully in the future.

A Policy and Issues Guidebook, consisting of over 300 pages, was distributed to all registrants. The participants also received "Issue Papers" outlining background information, recommendations and rationale on the following issues:

- Reauthorization of CHCs and MHCs
- National Health Service Corps

- FY85 Appropriations
- Medicare/Medicaid
- FY85 USDA Health-Related Programs and Reauthorization of Indian Health Care Improvement Act, Title V Urban Indian Health Services.

### *III. STATE PRIMARY CARE ASSOCIATION FORUM (SPCA)*

State Primary Care Association representatives around the country expressed to us a need to interact with other SPCAs in an effort to share experiences, determine priorities, and develop activity plans for the upcoming year. Accordingly, we conducted a Forum, July 8-11, 1984, in Seven Springs, Pennsylvania, in conjunction with the Pennsylvania Forum for Primary Health Care annual meeting.

The SPCA Forum was sponsored under a grant from the Robert Wood Johnson Foundation which, along with NACHC, felt that health centers, if they were to survive, had to be more responsive to state issues.

The Forum was well-attended with over 40 people representing 24 states. Pertinent discussions surrounded:

- state association development
- resource development and membership services
- policy analysis techniques
- case studies/innovation for state associations
- contract development under Medicaid and Blue Cross / Blue Shield
- shared services contracts
- recruitment and retention of health professionals
- strategic planning goals and objectives.

### *IV. STATE ASSOCIATION SEMINARS AND TECHNICAL ASSISTANCE*

As in the previous year, our staff's participation was requested by state organizations and health centers for institutes around the country. Presentations were made at 44 such meetings. Seventeen documents and papers were developed for use at the various meetings as well as a comprehensive analytical document presented for use at the Tri-Regional Cluster Training Center in New York. NACHC staff participated in two capacities: (1) presenting updated technical information on a wide variety of policy issues (laws, regulations, etc.), and (2) providing technical advice on state association development.

Again, this effort was supported in part by the Robert Wood Johnson Foundation.

## *V. INDIVIDUAL TECHNICAL ASSISTANCE / CASEWORK*

Increasingly, technical assistance has been requested by our constituency. Over 1800 requests for information, analyzing data, and dialogue with BHCDA staff were handled in the past year.

Areas requiring individual assistance included:

- preparation of grant applications
- policy interpretations
- physician placements
- shared services contracts
- Jobs Bill policies and applications
- grant review procedures
- funding determinations
- FmHA loan applications
- prepaid arrangements/regulations
- interpretation of laws, regulations for programs under the PHS Act as well as Titles XVIII and XIX of the Social Security Act.

In addition, individualized technical assistance was given to over 250 health centers regarding MUA/HMSA designation and NHSC physician placements.

## *VI. COALITION BUILDING*

With the respect and confidence NACHC has gained from health policymakers and from Congress, over 200 requests for information on primary care health issues were received this year from Congressional staff, state legislatures, and local officials on a wide range of primary care issues. Other national organizations around the country have relied on NACHC for information and assistance. Listed are a few:

### *Coalition for Health Funding*

Coalition on Block Grants	Children's Defense Fund
Independent Sector	National Governors' Association
National Rural Primary Care Association	Rural Study Group
Joint Center for Political Studies	COSSMHO
Congressional Black Caucus	Congressional Hispanic Caucus
Congressional Rural Caucus	National Health Council

## *VII. STATE COORDINATION*

The Policy Analysis Department maintains ongoing communication with State Coordinators and Legislative and Health Policy Committee members to assess the impact of new policies. Correspondence accompanied by in-depth analysis was mailed on an as-needed basis.

### *VIII. WASHINGTON UPDATE*

The "WASHINGTON UPDATE" is a publication of timely information on changes in government policy affecting a broad range of health issues. The publication is disseminated to organizational members and subscribers on a bi-weekly basis (while Congress is in session) throughout the year. Twenty issues were published during the year.

### *IX. ACTION MEMOS*

When issues are of top priority, Action Memos are sent to health centers. This process is done on an as-needed basis. Ten such issues were mailed out this year, on subjects including: reauthorization, OMB Circular A-122, Notice of Availability of Funds, and NHSC placement lists.

### *X. ANALYTICAL DOCUMENTS*

A total of five analytical documents were published. These documents, the result of extensive research, included:

- Analysis of the Primary Care Block Grant
- Index of Medical Underservice
- MUA and the Index of Medical Underservice: A Reappraisal
- Community Health Centers and State Governments: Cooperation in Change
- An Analysis of Base Level Funding for CHCs.

### *XI. TESTIMONIES*

Through NACHC's officers, staff, and health center representatives, testimony was given on seven occasions to Congressional Committees which had extended an invitation for testimony. Committees included: Budget, House and Senate Appropriations, Energy and Commerce, and Senate Finance.

Testimony centered on primary care, physician manpower, and financing of health care for the uninsured/poor. Testimony was also given before the House Committee on Agriculture on the Farmers' Home loan program and the Department of Labor's Occupational Safety and Health Administration concerning safety standards for migrants.

***XII. FY 1985 SCHEDULE OF HEALTH POLICY SEMINAR SERIES***

Work was begun on the FY85 HPSS. Selected sites are:

Regions V, VII

November 15 - 16, 1984  
Inn of Chicago  
Chicago, Illinois

Regions IV, VI

December 12 - 13, 1984  
Royal Orleans Hotel  
New Orleans, Louisiana

Regions VIII, IX, X

November 28 - 29, 1984  
Desert Inn  
Las Vegas, Nevada

Regions I, II, III

January 9 - 10, 1985  
Resorts International Hotel  
Atlantic City, New Jersey

# Membership

NACHC membership continues to represent the most important base of the Association's strength and influence. While NACHC programs and activities attract a sizable number of new organizational members each year, an analysis of membership growth activity for the past few years showed that the ratio of centers which join the Association versus centers which drop membership averages approximately one-to-one. From year to year, the Association loses as many many members as it gains. After taking non-renewal memberships into account, total membership growth levels off, resulting in little or no net increases each year. This trend emerged again during FY 1983-84.

Specifically, as of the close of the fiscal year (June 30, 1984), the Association's total organizational membership count stood at 322 -- 57 of which were new members. However, after taking into account those members which did not renew their memberships, the Association experienced a net loss of three (3) members in FY 1983-84. Individual membership, however increased by 9%.

In light of this trend, Departmental activities during FY 1983-84 focused not only on recruiting new members, but efforts were made to improve the Association's ability to retain existing members as well.

One such activity was the improvement of the Department's management of information through utilization of the Association's in-house computer. All member and non-member records were input into the computer and the Department gained the capability to generate more efficiently, mass solicitation and informational mailings, member and non-member statistical data, conference confirmations and mailing labels and lists. Also, the Department began to respond to member and non-member information requests more quickly and efficiently and a follow-up system was developed.

To better promote the Association's activities among members and potential members, the Department designed three new attractive brochures which detail NACHC's goals and programs and organizational and individual membership benefits. All three brochures have been widely distributed by NACHC staff members attending conferences and meetings around the country, and they have been included in various informational mailings to members and potential members. Attached to each brochure is a tear-off return reply card, and its convenience has greatly increased the number of information requests received in the Department. NACHC's potential member mailing list has also grown substantially since the brochures were first printed and used. In addition to increasing the interest of potential members in the Association, the brochures have served to describe more clearly and concisely for existing members, the benefits they receive through membership.

During the year, the Department also designed an in-depth survey to define more accurately Association member 1) characteristics, 2) likes and dislikes in regards to programs and member benefits and 3) the level of member participation in program activities. The survey will be mailed after the 1984 Annual Meeting and the findings will be used to pinpoint specific strengths and weaknesses in the Association's membership program.

In an effort to provide rural based members with a vehicle by which experiences, information and resources can be shared in approaching health care problems which are unique to rural areas, the Department published the first two issues of the Rural Health Quarterly. The newsletter focuses on news, national legislation and other matters relating to rural issues. The Department experienced some difficulty in obtaining contributing articles from rural members and other experts in rural health care, however, it will continue to solicit articles more aggressively in the coming months.

Finally, as in previous years, the Department sought out additional member benefits which will enhance the overall benefits packages for both organizational and individual members. Departmental staff met with various service industry representatives to discuss potential new services and the findings will be reviewed with the Membership Committee at the coming Annual Convention.

### *ANNUAL CONVENTION*

The Annual Convention represents one of the major activities of the Association and through coordinated activities with the Department of Education and Training, the Membership Department devoted a significant portion of its efforts during FY 1983-84 to preparation for the Fifteenth Annual Convention in San Antonio, Texas. The Association's in-house computer was used for the first time in processing convention pre-registrations and confirmations and generating statistical reports.

Convention planning during the year includes:

- site selection
- hotel, room rate and airline negotiations
- Convention Bureau support
- preparation of promotional materials
- letters of invitation to dignitaries
- educational workshop scheduling
- pre-registration and on-site registration management
- coordination and support of the NACHC House of Delegates
- coordination of exhibits
- solicitation of sponsors and advertisers
- on-site management
- post convention follow-up

This year's Annual Convention promises to be one of the most exciting and rewarding ever held.

# Research

The 1983-84 Work Plan for the NACHC Research Department continued and extended the process of development of the Association's capabilities in the area of research. The set of five (5) research protocols mandated by the Board of Directors and the Executive Director continued to be a viable and useful framework for organizing and guiding the Association's research efforts. Following is a report on the 1983-84 program year in the context of these protocols:

## A. Productivity

Objective I.A.1. - to analyze the data gathered pursuant to the 1983-84 NACHC Survey of General Characteristics of Health Centers and report findings. The survey data are organized into six (6) data pools.

### I. *Identity/Accessibility data:*

- location - including region, county, state
- years established
- years Sec. 330/329 funding
- hours of service
- number sites/number mobile sites
- type of area served (rural, urban)
- provision of transportation

### II. *Service Area Demographics*

- users primary language other than English
- staff bi-lingual capacity
- age, sex profile
- median family income
- % below poverty level
- % 1-parent headed households
- % female-headed households
- median number school years completed
- age-specific fertility rates
- average number persons/family
- average number persons/household
- % unemployed
- 20 most frequently encountered diagnoses for 1981 and 1982
- total encounters for 1981 and 1982
- total users for 1981 and 1982

### III. *Finances*

- sources by amount - sources include federal, state, local, foundations, churches
- participation in a pre-paid health plan
- number users by pay status
- % total reimbursement by sources for CY 1981, 1982



- participation in HMO
- joint purchasing agreements with other CHC's, physicians, hospitals
- participation in reimbursement research
- total billings 1981 and 1982
- total bad debt 1981 and 1982
- total sliding fee write-off 1981 and 1982
- average annual accounts receivable by account for 1981 and 1982

**IV. Staffing**

- by number filled
- by NHSC assignees

**V. Services**

- provided in facility
- provided via contract
- provided via referral
- hospital linkages - inpatient, primary care, administrative
- CHC activities as a clearinghouse/developmental entity for:
  - environmental services
  - housing
  - business
  - food
  - education/training
- funding sources/amounts for clearinghouse activities
- CHC program linkages (clinical, contractual or administrative) with community agencies/entities:
  - correctional facilities
  - industry/commerce
  - universities/colleges
  - local public school systems
  - city/county health departments
  - long term care facilities
  - funding sources/amounts for program links maintenance

**VI. Health Promotion/Disease Prevention**

- program focus (illness prevention, health protection, health promotion) by how activity was undertaken (patient education, health fair, screening programs, business/industry impacts etc.)
- HP/DP program links
- HP/DP priorities

The survey instrument design has enabled isolation of several "keys" which structure the analytical combinations used to describe the CHC program. The keys are:

- survey instrument number
- DHHS Region
- BCRR number
- NACHC member
- years established
- Sec. 330
- Sec. 329
- type of area served
- 1982 encounters
- 1982 number persons served
- pre-paid health plan activity

Each data pool has been cross-tabulated by one or more keys. For example, projects serving rural areas can be profiled for all six data pools. Thus, rural health centers services can be derived. The funding mix for small or large health centers can be described. The top twenty diagnoses are profiled by region, by type of project funding and by type of area served.

The over-all survey response rate was 33% of all health centers. The "spread" of responses, urban vs. rural, closely approximates the actual observed distribution, 61% rural, 39% urban. The survey generated 1,209 separate variables (compared with 265 variables generated from 1981 NACHC survey). Complete survey results and preliminary analyses are being presented at the 15th Annual CHI, September 1984. Further potential analyses include correlation with BCRR data (aggregated) for those health centers responding to the NACHC survey.

Highlights of findings:

**Part I. Accessibility/Availability**

- health centers provide services on weekends, even Sundays
- Sec. 330 projects generally maintain one (1) site
- Sec. 329 projects are more likely to maintain multiple sites
- Sec. 329 projects generally operate one (1) mobile site
- Sec. 330/329 projects are more likely to provide transportation than to arrange or reimburse for it
- When an urban vs rural perspective is taken, the above patterns persist.

**Part II. Service Area Pop/User Characteristics**

- Spanish is the predominant other language among health center users
- Most Sec. 330s and all Sec. 329s are capable of speaking the users primary language if other than English
- This pattern persists across type of funding, but not for all regions (I, III, IV, and VI report less than a majority) nor for type of area served (urban centers are more conversant than not.)

- Elderly persons (65+) are 11.4% of health center service area populations (see also Objective IV - User Characteristics)
- Nearly one half (43.5%) of all women in health center service area are women of child-bearing age, vs 28.6% of female users population
- The pediatric age (<15 yrs) population is 26.3% of health center service area populations and 36.2% of the health center user population
- The majority of health centers report that their service area populations have median family incomes below the poverty level at the rate of 21-40% of the families. This pattern persists across the regions regardless of types of area served and type of funding received.
- Health centers most frequently report that 21-40% of their service area populations are families headed by single parents. This pattern persists across rural and urban areas
- Hypertension, upper respiratory infections, pre-natal care and diabetes mellitus are among the top ten diagnoses encountered by health centers in every region in 1981. This pattern did not persist into 1982, regardless of type of funding or type of area served.

**Part III. Finances**

- the average health center grant under Sec. 330 was \$664,000 and was \$317,000 under Sec. 329 for 1981-82
- nearly 30% of health centers are engaged in a prepaid health plan. Region IX reports 70% of its health centers so involved
- the majority of users are sliding fee eligible, followed by medicaid eligible users. This pattern persists regardless of type of project funding. This pattern did not persist when type of area was considered. For urban areas, medicaid users constitute the majority.
- the majority of health center reimbursement from third parties comes from self-pay patients when type of funding (Sec. 330 v 329) is considered, however, for urban areas medicaid is the largest source of reimbursement.

**Part IV. Staffing**

- health centers generally employ physicians in general and family practice and pediatrics
- there is a one to one physician to LPN ratio in most health centers
- health centers continue to use community health workers and family health workers to affect outreach
- Sec. 329 health centers staff physician assistants, more extensively than Sec. 330 health centers
- Sec. 330 health centers staff family health workers more extensively than Sec. 329 health centers
- Sec. 329 health centers staff nutritionists more extensively than Sec. 330 health centers

- urban health centers staff obstetricians, internists and pediatricians more extensively than rural health centers
- the NHSC assigns predominantly physicians, family nurse practitioners and dentists to health centers
- health centers in Regions IV and VI are most dependent on NHSC assignees. Health centers in Regions VIII, II, IX and X are least dependent on NHSC assignees.

*Part V. Services*

- health centers provide a broad, comprehensive program of services generally in their own facilities
- health centers contract out most often for OB deliveries, complicated lab and x-ray procedures, home health/chore-worker services and for pharmaceuticals
- health centers refer to specialists most often for home health care, oral surgery, adult day care, legal counseling, vocational counseling, optometric services
- the majority of health center dental encounters are for restorative, preventive and emergency care
- Sec. 329 health centers see a greater proportion of emergency care dental encounters than Sec. 330 health centers. This pattern persists for rural vs urban health centers.
- few health centers are sponsored by hospitals
- a large majority of health centers (greater than 70%) are affiliated with hospitals
- the majority of health centers report that their physicians have staff privileges at the hospitals for internal medicine, OB deliveries and emergency care. A minority report that their physicians have surgical privileges.
- of health centers serving as the hospital's specialty clinic for primary care services, most health centers are providing pre- and post-natal care, diabetes, hypertension, family planning and nutrition/weight control services
- of health centers having links to a hospital's administrative services, those linkages are in the areas of a health center Board member serving also on the hospital's board of directors, as well as the centers participating in purchasing, management information and billings/collections systems of the hospital.
- health center clearinghouse/development activities most often involve brokering education and training services, food distribution, water fluoridation, and private and senior citizens housing development.
- health centers most often develop program linkages (of a clinical, contractual or administrative nature) with other health/social service agencies, the city/county health department, local public schools, nursing homes and colleges and universities

*Part VI. HP/DP*

- most health centers use patient education as the predominant mode of disease prevention/health promotion

- health centers relate most frequently to area health education centers (AHECs), pharmacies, the local Red Cross, local department of recreation, the Society for the Prevention of Blindness, local Police department, and the Cystic Fibrosis Foundation in HP/DP program activities.
- health center HP/DP priorities in the future in rank order are:
  - hypertension
  - healthy moms/healthy families
  - nutritional deficiencies
  - diabetes mellitus
  - dental health
  - alcoholism/drug abuse
  - smoking cessation
  - pre-natal care
  - health education
  - family planning
- this pattern changes slightly when type of funding and type of area served are considered

Objective I.A.2. - Research impact of policy changes on CHC's

- changes in Medicaid reimbursement policy enabled a significant number of health centers (nearly 30%) to engage in prepaid health plan activities.
- federal and state medicaid cut-backs resulted in significant reductions in the proportion of health center third party reimbursement from Medicaid. This pattern was consistent regardless of type of project funding or type of area served.

Objective I.A.3. - To support/monitor the development of State Primary Care Associations, consortia among health centers specifically as regards:

- shared services
- needs assessment
- strategic planning
- innovative financial models

In the areas of shared services, strategic planning and innovative financial models, site visits were made to the Tennessee Association of Primary Health Care Clinics (IFM), the Central Seattle Community Health Centers consortium (SP) and the Primary Care Development Unit of the Bronx Committee for the Community's Health (SS) to observe program planning, development and implementation. The results of these investigations are contained in the book entitled: 'Case Studies in Community-Oriented Primary Care: The Health Center Experience'.

The research director served as a member of the BHCDA Task Force for Review/Revision of the Needs Assessment/Demand Analysis Methodology. The panel reviewed extant methodologies employed by other entities (states, HSA, etc.) and recommended revisions to the current guidance. The revised guidance will include definitions of terms and standardized work sheets.

Objective I.C. — System interrelationships

These objectives were accomplished in part with the development of a book of case studies of health centers entitled: "Case Studies in Community-Oriented Primary Care: The Health Center Experience." The book, published in September 1984, includes 13 cases:

- Primary Care Health Services, Inc. - Pittsburgh, PA
- Primary Care Development Unit - NYC
- Jackson-Hinds HHC - Jackson, Miss
- Wake Health Services - Raleigh, NC
- Lincoln CHC - Durham, NC
- Tennessee State Primary Care Association, Nashville, Tenn
- Florida CHC's - W. Palm Beach, Fla
- Park DuValle CHC - Louisville, KY
- Watts Health Foundation - Los Angeles, CA
- North East Medical Services - San Francisco, CA
- California Health Federation - Sacramento, CA
- Central Seattle CHC's - Seattle, WA
- Rural Health Corp. of N. Eastern Penn. - Wilkes-Barre, PA

Each case addresses the model and techniques employed by the health center in addressing one or more of the following eight (8) issue areas:

- shared services
- health promotion/disease prevention
- strategic planning
- diversification
- networking
- services to the unemployed using "Jobs Bill" support
- quality assurance
- innovative financial models

Interviews were conducted on-site with key program personnel including the Board chairperson, CEO, staff managers of key functional areas within the corporate structure and extra-organizational representatives where appropriate. Questions were designed to elicit and elucidate fully the techniques used by the health center in addressing an issue area(s). The descrip-

tive techniques are preceded by an individual program profile (where appropriate) and followed by an analysis of the impact of relevant factors on the health center's efforts. These factors include image impact, implications for replication, impact on provider relations and others.

These case studies reveal health centers as the organizational entity most reflective of the concepts of community-oriented and community-based primary care. Health centers are important, integral components of the institutional framework and environment in their communities, offering leadership, stability and career opportunities as well as health care. Health centers broker access to other important services such as housing for senior citizens in urban areas and water fluoridation services in rural communities. In those communities where health centers are serving, they are one of the only visible, viable means for accessing services for the un-served and underserved, especially the poor elderly and foreign refugees.

In a dynamic, constantly changing financial and policy environment, health centers are in the forefront of positive, innovative change in development and delivery of primary care services.

The book of case studies is designed to be a useful technical assistance document. It describes the reasons models were successful as well as identifying techniques and factors which hindered the efforts described.

#### *B. To Research Issues That Affect The Fiscal Viability of Health Centers*

Pursuit of this objective was addressed in part by the book of case studies which describes demonstrations in primary care case management, prospective/capitated payment systems and other demonstrations pursuant to waivers allowed under P.L. 97-35. Other activities included analysis of the financial profiles developed from the 1983-84 NACHC survey and on-going monitoring of changes in federal or state policies regarding payment for primary care services and their impact on health centers.

- Medicaid cutbacks resulted in reductions in the proportion of reimbursement health centers received from Medicaid from 1981 to 1982. Preliminary analyses extend this trend into 1983.
- Seventy-two percent (72%) of health centers report median family incomes below \$14,999 per year for their service area populations (150% of poverty level). Forty-two percent (42%) of health centers report median family incomes below the poverty level.
- the number of full pay users of health centers decreased by 2% between 1981 and 1982.
- Medicaid users are the majority of users of urban centers when pay status is considered, followed by sliding fee eligible users. For rural centers, sliding fee eligible users are the majority, followed by Medicaid eligible users.
- while health centers increased their billings collected by 16% between 1981 and 1982, bad debt and sliding fee write-offs increased by a combined 39%.
- health centers reduced their self-pay accounts receivable by 208% between 1981 and 1982.

*C. To Support NACHC Departmental Activities with Timely, Relevant Research*

Pursuit of this objective has been on three levels:

Examples included:

Administration: Family planning, health center financial profile

Policy Analysis: Workshops at Policy and Issues Forums impact of federal budget reductions on CHC's; other program impacts - Migrant Health, NHSC, Rural Health; acquisition/analysis of census demographic data.

Education and Training: CHI - average 4 workshops per CHI; CME/CDE; CHCn

Membership: Membership survey design, analysis; PCF articles

- generation of a flexible, but comprehensive data base for NACHC activities in Membership, Policy Analysis, Education and Training and Administration. The data base has been a useful program evaluation and planning tool.
- foster development of a "research perspective" and integration of that perspective into routine Departmental approaches. This has been successfully accomplished thru development of close working relationships with Department heads and the Executive Director.

*D. To Research The Characteristics of Users of CHC's*

A survey of health center user characteristics was completed in August 1984. The characteristics surveyed included:

- % distribution of users by number school years completed
- % users by age and sex
- % users by family size
- age-specific fertility rates
- users by ethnicity
- users by family income
- users by insurance coverage
- users by employment status
- number patient days by type of admission CY 1983
- number admissions by type for CY 1983

User characteristics survey instruments were collected from 141 health centers. A subset of 33 responses was randomly chosen for 10 of 11 questions. For one question, the ethnicity of users, a larger random sample of 76 responses was chosen.

The random sample of responses for each question closely approximates the actual distribution of health centers.

- urban vs rural
- proportion of health centers by region
- rural/urban distribution within regions



## FINDINGS

### I. *Distribution Of Users (%) By Number School Years Completed:*

1 - 8 years = 45.36%  
9 -12 years = 39.63%  
12+ years = 15.03%

### II. *% Of Total Users By Age and Sex*

	MALES	FEMALES
0 - 4	8.9	8.7
5 - 14	9.0	9.6
15 - 34	11.6	23.5
34 - 44	3.5	5.1
45 - 64	4.8	7.8
65+	3.2	4.5

### III. *Total Number Users By Sex = Not Enough Valid Responses*

### IV. *Distribution (%) of Users By Ethnicity*

Black = 27.5%  
White = 44.9%  
Hispanic = 22.6%  
American  
Indian = 1.3%  
Asian = 1.4%  
Haitian = 0.3%  
Other = 0.4%

### V. *% Users By Family Size*

0 - 1 members = 15.6%  
2 - 4 members = 37.8%  
5 - 8 members = 40.0%  
8+ members = 6.6%

### VI. *Age-Specific Fertility Rates* (N=21, 13=R, 8=U)

15 - 19 years = 36.74 births/1000 women  
20 - 34 years = 79.35 births/1000 women  
35 - 44 years = 11.83 births/1000 women

**VII. Distribution (%) of Users' Family Income vis a vis The Poverty Level**

100%	Poverty Level	=	60.8%
100 - 150%	Poverty Level	=	15.7%
151 - 200%	Poverty Level	=	9.8%
200%+	Poverty Level	=	13.7%

**VIII. Distribution (%) of Users By Type of Insurance**

None	=	47.5%	(note: health centers report large (80%) majority are sliding fee eligible)
Medicaid	=	24.5%	
Private	=	16.1%	
Medicare	=	11.5%	

**IX. Distribution of Users By Employment Status of Head of Household**

Currently Employed	=	55.8%
Recently Un-Employed	=	23.3%
Chronic Un-Employed	=	21.2%

**X. Distribution of Patient Days By Type for CY 1983**

(Note: These numbers represent the mean number (average) of days for the projects in the sample.)

Medical/Surgical	=	1,200.5 days
Obstetrics/Delivery	=	326.5 days
Pediatrics	=	225.2 days

**XI. Distribution of Admissions By Type for CY 1983**

(Note: These numbers represent the mean number (average) of admissions for the projects sampled.)

Medical/Surgical	=	227.3 admissions
Obstetrics/Delivery	=	68.9 admissions
Pediatrics	=	67.2 admissions
M/S ALOS	=	5.3 days
OB/DEL ALOS	=	4.7 days
PEDS ALOS	=	3.4 days

***E. To Emphasize and Follow-Through on the Commitment to Continuing Education as regards Evaluation Research Methodologies***

The Research Director has applied for admission to the doctoral studies program at Johns Hopkins School of Hygiene and Public Health.

**Other Departmental Activities:**

- Technical Assistance
  - to member health centers as requested in the areas of needs assessment, survey design, data analysis and brokering access to consultants
  - to chartered state associations as requested in the areas of survey design data analysis, data sharing, and brokering access to consultants especially regarding prepayment activities
- NACHC representative/organizational interface
  - National Library of Medicine
  - BHCDA Needs Assessment Task Force (see Objective I.A.3 above)
  - District of Columbia SHPDA Primary Care Technical Advisory Panel  
The research director served as a technical consultant to the Advisory Panel's primary care study design, assisting in the design of policy issues and alternative means for improving access to primary care in Washington, D.C.
  - APHA Research Study Group  
participated in Research Study Group activities in cost-benefit/cost effectiveness methodology development, issues related to physician supply and distribution and the impact of case mix on the implementation of DRGs in hospitals
- Proposals for Research Projects
  - National Primary Care Information Clearinghouse (with JRB Associates)  
The research director had a major role in the conceptualization and writing of the proposal submitted to BHCDA to establish an information clearinghouse and to produce a directory of federally-funded health centers.
  - Needs Assessment (with Orkand Corp.)  
The research director served as technical consultant to the development of the proposal and was bid by Orkand Corp., as their technical resource for development of a revised needs assessment guidance.
  - Participation via provision of NACHC data, in study of health center MIS systems (with JRB Associates)  
The JRB Associates contractors, with assistance from the research director, reviewed the results of a NACHC research department survey of health center MIS ability as a pre-cursor to the BCHDA-sponsored study.
  - Proposals to John A. Hartford, Commonwealth, Robert Wood Johnson Foundations  
These proposals, developed by the research director, sought support for research into cost containment, productivity and prepayment systems development.

With the exception of two (the clearinghouse and needs assessment efforts) proposals, all proposals were unsuccessful because research is not presently a high priority for foundations. Foundations are currently interested in service demonstrations. The clearinghouse needs assessment contracts were awarded to other entities with significantly lower bids.