

COMMUNITY HEALTH CENTER **GROWTH PLAN**

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ENVIRONMENT & DATA PRIMER

# **KAUA'I COUNTY**



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## NOTES

This primer was developed by the Hawai'i Primary Care Association for exclusive use by its member Community Health Centers. Inquiries related to this material should be directed to:

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Table information tagged with the (†) notation is drawn from 2008 Dartmouth Primary Care Service Data, published by the Dartmouth Institute for Health Policy and Clinical Practice.

Information presented as the Department of Health Assessment is drawn from the 2009 State of Hawai'i Primary Care Needs Assessment Data Book.

Population information for “dentally underserved” is calculated as follows: MED-QUEST + UNINSURED + HALF OF MEDICARE.

The following are drawn from the 2000 Census: Native Hawaiian / Other Pacific Islander Population; People with Language Assistance Needs.

Homeless data is drawn from the Hawai'i Public Housing Authority (April 2007).

Data on a Adults with Poor Mental Health 7 or More Days is from the Department of Health Behavioral Risk Factor Surveillance Data (2008) and Dartmouth PCSA.

# **A COMMUNITY HEALTH CENTER GROWTH PLAN**

Improving the health of the country, the state of Hawai'i, and each of our special communities depends not just on insurance coverage or an ability to pay for needed health care but also on:

- access to care,
- refocusing on primary care,
- integrating care management and behavioral health services with medical care, and
- ensuring the availability of a competent health care workforce.

Community Health Centers (CHCs) have a significant presence in most underserved places in Hawai'i, and in a reformed health care delivery system these health centers continue to be the best option for comprehensive primary health care.

The Hawai'i Primary Care Association, in developing a statewide growth plan for community health centers, aims to identify opportunities for CHCs that will not only enhance their capacity and role in the health care system, but also encourage them to partner and collaborate with each other and the broader public health infrastructure to better serve Hawai'i's population.

This environment and data primer provides an assessment of the region's needs, specific health and demographic information, as well as population trends, so that planners may better understand the full scope of these underlying issues and bring a well-informed perspective to the process for developing a statewide growth plan.

# KAUA'I COUNTY

## COMMUNITY HEALTH CENTER

Kaua'i County has one community health center corporation with three clinical sites dispersed around the island. This CHC is, uniquely, also the Native Hawaiian Health Care System for the island. The health center plans to seize opportunities to expand services and sites significantly over the next 3-5 years.

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### Ho'ola Lahui Hawai'i

*David Peters, Executive Director*

4491 Rice St., Suite 6  
Lihue, HI 96766

NHHS

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Kaua'i Community Health Center      PR | BH | DN  
4643-B Waimea Canyon Dr.  
Waimea, HI 96796

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Kaua'i Community Health Center      PR | BH | DN  
4800-D Kawaihau Rd  
Kapa'a, HI 96778

BH - Behavioral Health Services  
DN - Dental Services  
EC - Elder Care Services  
ER - Emergency Room Services  
HCH - Health Care for the Homeless  
NHHS - Native Hawaiian Health Systems  
NTR - Nutrition  
PED - Pediatric Services  
PN - Perinatal Services  
PR - Primary Medical Services

### WHY COMMUNITY HEALTH CENTERS?

The people in the areas served by CHCs have a variety of health needs, including medical, dental, and mental health. Frequently, patients who have no private insurance or have language or cultural barriers to care neglect to seek care for some time. As a result, clinical visits in CHCs are more intense and need to address a variety of ailments.

Often, they also need assistance with a host of other issues that would interfere with good health including housing, financial assistance, referral to other programs, health education, culturally appropriate language assistance, and transportation. Outreach and follow-up are necessary to ensure that people get the care they need and are able to fully participate in their therapeutic plans.

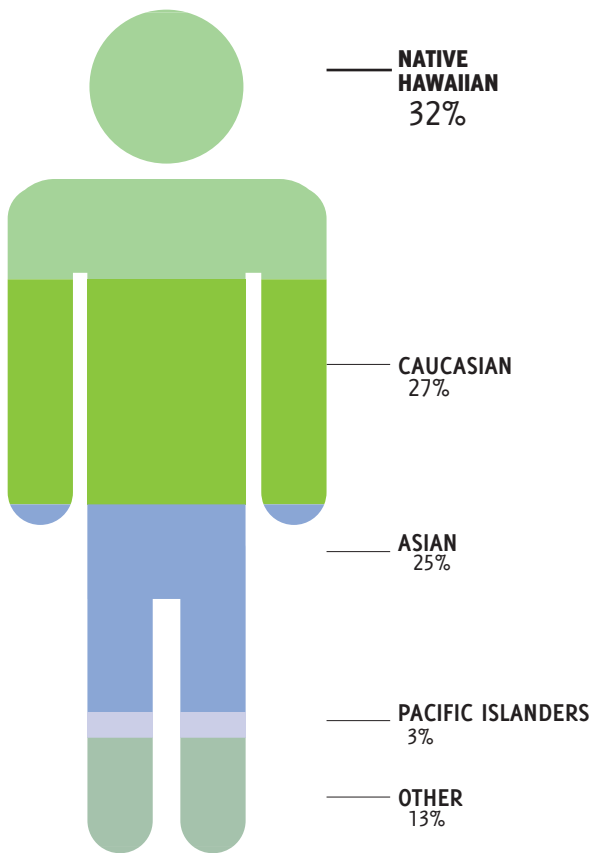
Community health centers typically address all these needs and serve as the health care home for their clients and community.

Community health centers serve people who have disproportionately high rates of diabetes, asthma, hypertension, and behavioral health problems.

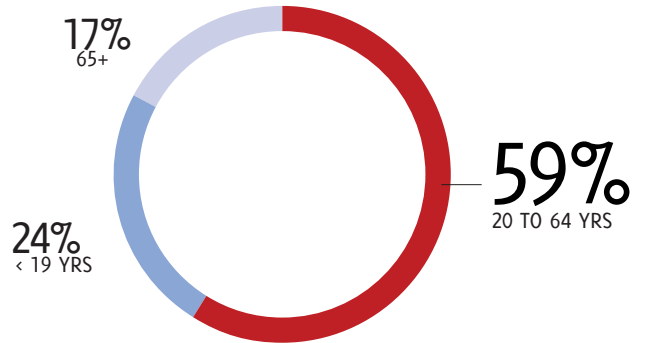
**KAUA'I COUNTY CHC PATIENTS:**

**6,189**

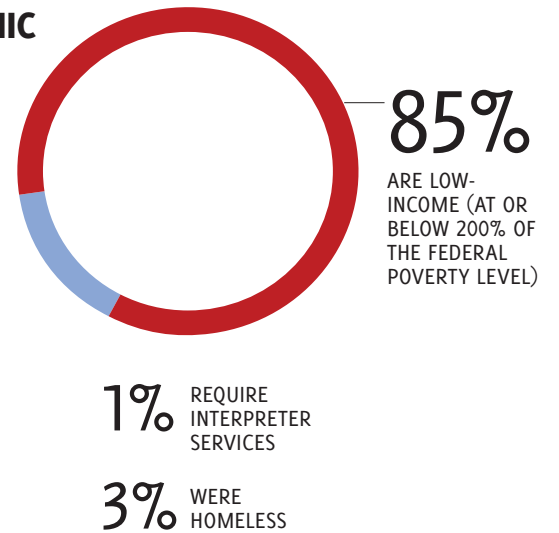
**ETHNICITY**



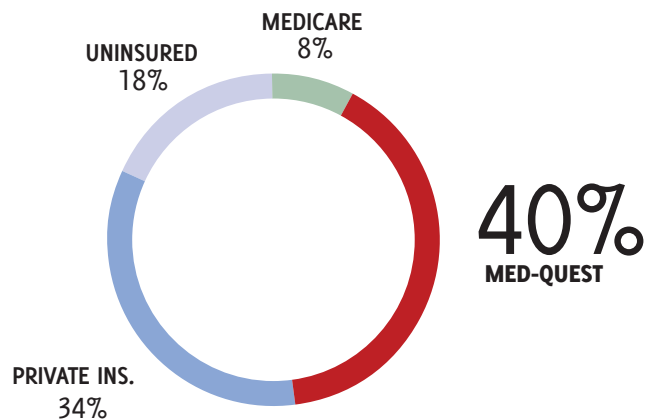
**AGE**



**ECONOMIC STATUS**



**COVERAGE**



## OVERVIEW

### Kaua'i County:

- Approximately one-third of the births in Hanalei, Kapa'a, and Waimea had less than adequate prenatal care.
- The percentage of adults with high blood pressure in Waimea and Lihue are the highest in the state.
- Lihue has the second highest percentages of Filipino residents and the third highest adult population with less than a high school diploma.
- Kaua'i County has the largest percentage of elderly residents. Lihue and Waimea are ranked 4th and 5th, respectively, in the state for population 65 or older.

Per 2006 emergency room utilization data, Kaua'i has the highest per capita rate for utilization in the state (34%) and the highest uninsured rate (24%). Kaua'i also had the state's highest rate of pediatric ER utilization.

During the period 2000-09, Kaua'i had the largest increase in ER use for mental health conditions.

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*Despite its status as the smallest county, Kaua'i leads the state with the highest rate of uninsured and emergency room use per capita.*

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# EVIDENCE OF NEED

This assessment shows community data for Kaua'i County, identifying demographic groups poorly served by our mainstream medical system. Many of these factors coincide with groups at risk for poor health due to socio-economic causes.

The first set of data pertains to Federally-Designated Underserved Areas, which demonstrate statistical evidence of need. The federal government's Health Resources & Services Administration (HRSA) designates areas that are underserved or lack health professionals. The following table shows the number of Kaua'i residents who live in areas that are designated as Medically Underserved Areas or Populations (MUA/P) or a health professional shortage area (HPSA), which may be for primary care providers, dentists, or mental health professionals.

	POPULATION	MUA / P	HPSA		
			PRIMARY CARE	DENTAL	MENTAL HEALTH
<b>Kaua'i County</b>	63,581	63,581	63,581	63,581	8,840

## POPULATION DATA

### ALL KAUA'I COUNTY Versus CHC Service Area

	REGION	SERVED BY KAUA'I CHC	% OF REGION SERVED
Total Population †	63,581	6,198	10%
Population <=17 †	15,141 24%	1,358 22%	9%
Population >=65 †	9,236 15%	1,052 17%	11%
Estimated Uninsured †	6,788 11%	1,108 18%	16%
Med-QUEST enrollees	13,698 22%	2,502 40%	18%
Medicare enrollees †	8,095 13%	516 8%	6%
Dentally underserved	23,534 39%	3,315 53%	14%
Population at or below 200% FPL †	16,272 26%	5,236 84%	32%
Native Hawaiian / Other Pacific Islanders	13,511 23%	2,121 34%	16%
People with Language Needs	1,661 3%	49 1%	3%
Homeless Individuals	257 <1%	168 3%	65%
Adults with Poor Mental Health	7,169 15%	782 13%	11%

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## HEALTH ASSESSMENT

The following data from the Department of Health identifies populations with increased health access needs or health risks, and compares statewide populations to the county and its smaller components.

	STATE	COUNTY	SUB-COUNTY				
			HANALEI	KAPA'A	KOLOA	LIHUE	WAIMEA
Percentage of Native Hawaiians	19.8%	23.1%	13%	30%	18%	18%	29%
Percentage of Filipinos	22.8%	31.7%	13%	25%	30%	45%	33%
Households receiving Financial Aid (TANF or TANOF)	2.2%	1.5%	1%	2%	1%	2%	2%
Births with Inadequate Prenatal Care, 2003-2008 (Healthy People Goal: 10%)	29.2%	29.5%	34%	33%	26%	25%	32%
Estimated Annual Adult Diabetes Prevalence, 2003-2008 (Healthy People Goal: 2.5%)	8.6%	8.6%	4%	9%	9%	11%	7%
Estimated Annual Percent of Adults Who Smoke, 2003-2008 (Healthy People Goal: 12.5%)	16.9%	17.9%	13%	19%	16%	18%	23%
Heart Disease Mortality, 2003-2008 (per thousand)	197.9	174.8	164	237	163	180	136
Estimated Number of Adults Who Did Not Visit a Dentist, 2003/2004/2006	24.4%	29.3%	27%	34%	26%	26%	32%

## UNMET NEEDS (GAP ANALYSIS)

Based on the preceding data sets, the populations that call for CHC growth are indicated below by region. The 'gap' identified represents the difference between the underserved population present in each region and the number of individual served by the health center in that region (2009).

	<b>GAP / UNMET NEED</b>
Uninsured	5,680
Med-QUEST	11,454
Medicare	2,182
Population Below 200% of Poverty	11,036
Needs Language Assistance	1,612
Dentally underserved	21,219
Need Mental Health services	6,387
Need Perinatal care	1,482

In addition, the following services are in high demand at health centers: diabetes management, chronic heart disease management, smoking cessation, and obesity reduction (includes nutrition/exercise support).

## GROWTH TRENDS

KAUA'I COMMUNITY HEALTH CENTER

	2004	2009	INCREASE	GROWTH RATE
<b>Patients</b>	2,334	6,198	3,864	166%
Receiving Medical Care	1,110	2,799	1,689	152%
Receiving Dental Care	939	3,315	2,376	253%
Receiving Behavioral Health Care	276	782	506	183%
<b>CHC Sites</b>	2	4	2	100%
Employed Physicians	1.6	2.3	.7	41%
Employed APRNs/PAs	0	0	0	-
Employed Dentists / Hygienists	1.6	4.7	3.1	187%
Employed Behavioral Health Providers	1.8	1.8	0	-
<b>Total Employees</b>	52	61	9	18%

# PRIORITIES

PREVIOUSLY IDENTIFIED FOR KAUA’I COMMUNITY HEALTH CENTER

	EXPANDED MEDICAL CAPACITY OR NEW/EXPANDED MENTAL / ORAL HEALTH	NEW ACCESS POINT	FACILITIES & EQUIPMENT
Health Center	Increase Primary Care and Integrate with HHSC/HPH: \$2,500,000 BH Expansion: \$950,000 OH Expansion: \$625,000 Enabling Services: \$225,000	Urgent Care in Lihue: \$2,750,000	Replace Kapa’a Facility: \$12,000,000 Equipment (incl. IT): \$1,500,000
<b>HEALTH PROFESSIONS TRAINING</b>			
Native Hawaiian Health Care System	Family Practice Residency (Wilcox): \$750,000		
	<b>\$5,050,000</b>	<b>\$2,750,000</b>	<b>\$13,500,000</b>

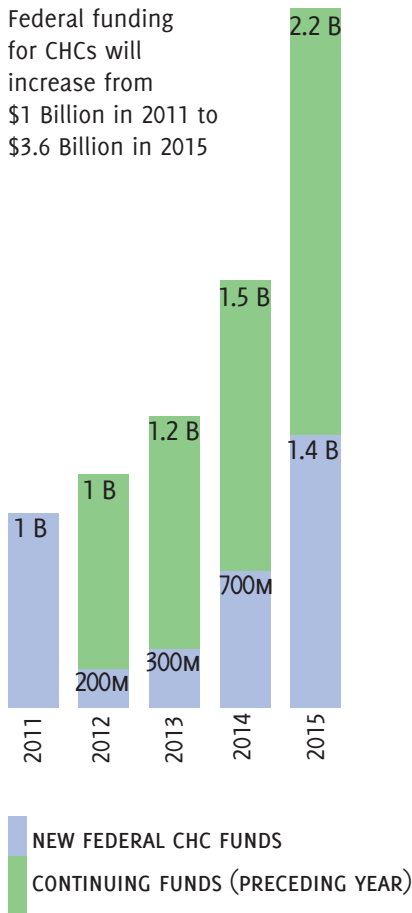
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# APPENDICES

# OPPORTUNITIES FOR GROWTH

## Federal Resources

Federal funding for CHCs will increase from \$1 Billion in 2011 to \$3.6 Billion in 2015



Likely programs for HRSA/BPHC growth will be:

- New access points (i.e., new service sites in MUA/P areas)
- Expanded medical capacity
- New/expanded dental capacity
- New/expanded behavioral health capacity
- Expanded enabling services
- School-based health clinics (these have met with limited success in Hawai'i because of DOE policy).
- Facility construction or renovation. \$1.5B for capital will be available as soon as 10/10 but will be allocated over the next 5 years.

Community need is expected to become more of a factor in obtaining funding. This will include poverty, health status, cultural/language barriers to care, and possibly provider shortages. There will be less emphasis on numbers of uninsured. Expect continued reporting requirements on clinical outcomes and possible improved health status for communities served.

Funding for the National Health Service Corps will also increase. CHCs should take advantage of NHSC for recruitment and retention of providers of all types.

Other HRSA opportunities not yet detailed are likely to include health professions training and implementation of the patient-centered medical home model.

Besides opportunities for HRSA funding, CMS will be making funds available for essential providers for meaningful use of EHRs.

- Providers must care for 30% needy individuals which might be Medicaid or uninsured (20% for pediatricians).
- Physicians, NPs, CNMs, PA, and Dentists are all eligible providers.
- CHCs can get incentive payments up to \$63,750 per provider over 5 years to acquire, update, and implement EHRs for meaningful use. CHCs in Hawai'i could realize more than \$11 million in EHR incentive payments.
- Meaningful use includes using EHRs for e-prescribing, exchanging data to improve quality care, and using patient information to improve outcomes.
- Funds are 100% federal but will come through the State Medicaid program.

## Patient Fees

Additional considerations for CHC growth include the variability of reimbursement.

- **Medicaid/QUEST.** Medicaid is the best payer for CHCs.
  - Children and pregnant women will continue to be the most reliably covered under Medicaid.
  - Dental benefits may continue to be limited for adults. Providing more children's dental services (possibly including school-based sealant and fluoride programs) contribute both to CHC mission and solvency.
  - In future, more adults should become eligible for Medicaid under federal health care reform.
  - Patients with Medicaid coverage may still encounter barriers to care in the private market, which may make CHC referrals for specialty care increasingly difficult.
  - Medicaid will be providing incentives to states to enroll chronically ill patients in patient-centered medical home programs.
- **Medicare** changes in federal health care reform will make caring for patients with that coverage more attractive. There will be opportunities to develop PCMH demonstration projects in Medicare.
- **Private insurance** is currently the least desirable third-party payer for CHCs. Insurers (and policy-makers) will be looking at reimbursement changes to encourage PCMH models and outcomes-based systems.
- CHCs may find that fewer people will be uninsured although those who remain uninsured will likely continue to be immigrants, migrants, and homeless people and should continue to be a key target group for CHCs.

## State Resources & Policy

CHCs should continue to benefit from the CHC Special Fund but this may produce less money than expected when it was set up both because the State may continue to restrict spending due to the economic situation and/or decreased smoking rates may produce less revenue.

Other POS funds that CHCs get from the State may be subject to reductions or elimination including perinatal, family planning, and homeless outreach.

Because of cuts in the overall state budget, DOH and DHS resources to support providers or deliver care directly continue to shrink and shouldn't be expected to be revived over the next 3-5 years. Among the cuts:

- Adult Mental Health Division changes leave CHCs with more demands by people with more critical mental illnesses. Planned transfer of MH treatment responsibility to QUEST plans will result in more strain on CHCs.
- The PCO is not adequately funded or staffed to keep up with designations, deal with NHSC, or provide assistance to communities or CHCs.
- Dental health division is no longer doing anything in the way of preventive service for children.
- DHS has already cut funds for outstationed eligibility workers and is poised to cut other outreach funding.
- The Administration may attempt to restrict benefits for adults who are not categorically eligible. FQHCs/PPS rates would still be good if adults were covered under Med-QUEST but the number of visits, among other services, might be restricted.

## **Other Opportunities**

### **Oral Health**

CHCs may be the sole entities in the state that can expand the application of dental sealants and fluoride varnishes in settings other than the CHC dental operatory. This could be the only viable effort available to improve children's oral health status and could be a good strategy for CHC growth and financing in areas with high rates of Med-QUEST coverage for children.

### **Hospitals and ERs**

- CHCs may want to work with local hospitals on ER diversion services, especially in urbanized areas with busy ERs.
- Hospitals should also seek greater collaboration with CHCs to reduce readmissions for the same condition, since Medicare (and other insurers) will be reducing or eliminating payment for readmissions.

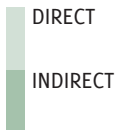
### **Provider Shortages**

Rural CHCs are in a particularly good position to negotiate with private insurers to support growth in areas with access limited by provider shortages. CHCs are better able than any other provider type to expand OB services in underserved areas since virtually every patient will have coverage and FTCA makes CHCs uniquely able to afford the service.

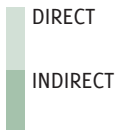
# ESTIMATED ECONOMIC IMPACT OF CHCs

Community health centers help make communities livable by supporting jobs, attracting resources, and providing high quality health care that residents in vulnerable and otherwise economically-depressed communities need.

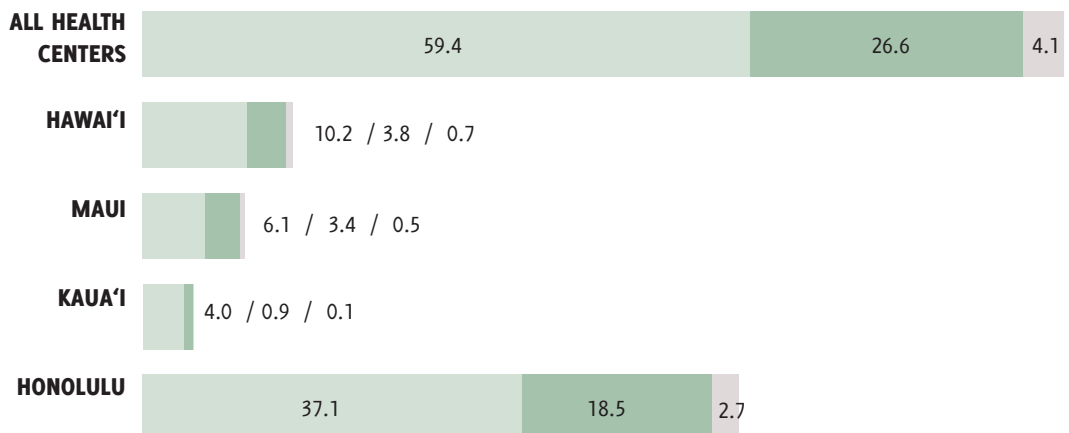
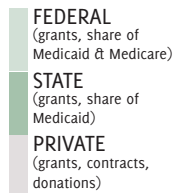
## OUTPUT IN MILLIONS



## JOBS



## FUNDS



## HEALTH CARE SYSTEM COST SAVINGS

The CHC model produces not just good clinical outcomes but significant savings to the overall health system. This is because CHCs serve as the “health care home” for their patients, emphasizing on-going relationships between patients and providers that allow for early diagnosis and treatment of emerging health problems, easy access to care, integration of behavioral health with medical care, and the provision of support services to address socio-economic factors that inhibit healthy lifestyles and use of health care.

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*Using the cost savings methodology described (at right) in the George Washington University report, community health centers in Hawaii saved the health care system over \$135 million in 2009.*

### BY COVERAGE

Med-QUEST	\$64.0 M
Private Insurers	\$29.4 M
Medicare	\$ 9.7 M
Uninsured Care	\$32.4 M

### BY COUNTY

Hawai'i	\$34.4 M
Maui	\$14.2 M
Kaua'i	\$ 6.8 M
Honolulu	\$80.4 M

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*[W]e analyzed data from the 2006 Medical Expenditure Panel Survey to compare the medical expenditures of people who receive the majority of ambulatory care at health centers and those who do not. It found that, after adjusting for health status, age, gender, race/ethnicity, and health insurance coverage, the average patient receiving care at a community health center had annual medical expenditures \$1,093 lower than an average patient who did not use health centers. This estimated savings includes both reduced ambulatory costs as a result of health center efficiencies as well as reduced inpatient medical expenses, which may be due to the prevention of more severe health problems requiring hospitalization. These findings are consistent with numerous prior studies showing that health centers are efficient providers of quality primary care and that more effective use of primary care can reduce hospital and specialty care costs.*

Ku, Leighton, PhD, MPH; Rosenbaum, Sara, JD; Shin, Peter, PhD, MPH (2009). Using Primary Care to Bend the Cost Curve: The Potential Impact of Health Center Expansion of Senate Reforms. George Washington University School of Public Health and Health Services.

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## ADVANTAGES FOR GROWTH IN THE COMMUNITY HEALTH CENTER MODEL

### **Delivery Model**

CHCs provide a complete array of primary medical, mental health, and (usually) dental services in convenient locations in underserved communities. Their clinical services are supplemented with a variety of supplemental services that help patients with complex health conditions and socio-economic barriers get the care they need.

CHCs use a team of professionals that includes physicians, dentists, psychologists, nurse practitioners, physician assistants, social workers, dentists, substance abuse counselors, outreach workers, health educators, and others, working in concert for the benefit of each patient.

Almost all CHCs have advanced electronic medical records and billing systems to improve clinical care, reduce duplication and errors, and better manage their business systems.

CHCs are leaders in embracing quality improvement systems and encouraging patients to be active participants in improving their own health and reducing health issues that stem from socio-economic disparities.

## **Federal Funding**

FQHCs get on-going grants from the federal Bureau of Primary Health Care (Health Resources & Services Administration, DHHS), ranging from several hundred thousand to over one million dollars. These federal grants, often referred to as Section 330 grants, are operating subsidies. Periodically, FQHCs are able to apply for expanded 330 funding for special populations, new sites, or additional services, such as dental, mental health, or pharmacy services. FQHCs may also apply for Health IT or other kinds of network grants.

## **Tort Claims Coverage**

FQHCs don't have to purchase significant medical malpractice insurance policies because their providers are covered under the Federal Tort Claims Act (FTCA), which provides their defense and any compensation in the event of a claim against an FQHC. FTCA coverage is available for all primary care and related clinical services, such as labor and delivery and inpatient coverage.

## **Enhanced Public Insurance Reimbursement**

**Medicaid /QUEST.** FQHCs are paid on a prospective payment system (PPS) basis for Med-QUEST services. Each FQHC has a unique PPS rate based on its overall costs, which is adjusted annually in accordance with the Medicare Economic Index. Other rate adjustments are made when an FQHC adds, subtracts, or changes a service or location that results in a substantial change in cost.

**Medicare.** FQHCs are paid a per visit rate based on cost, which is capped at about \$115 for urban FQHCs and \$100 for rural centers.

## **Outstationed Eligibility Workers**

The federal Centers for Medicare and Medicaid Services (CMS) mandates that states either pay for at least one worker at each FQHC or station a State worker on each health center site to assist patients with Medicaid applications. In Hawai'i, the Department of Human Services Med-QUEST Division provides partial reimbursement to FQHCs for outstationed eligibility workers.

## **340B Prescription Drugs**

FQHCs are entitled to purchase and provide prescription drugs for their patients at substantial discounts, established under the federal 340B Federal Drug Pricing Program.

## **National Health Service Corps (NHSC)**

This federal Health Resources and Services Administration Program provides loan repayments for physicians, dentists, nurse practitioners, physician assistants and other health professionals who then work in federally designated Health Professional Shortage Areas (HPSA). Every FQHC is automatically a HPSA although the availability of loan repayment opportunities varies for Hawai'i's health centers. Fortunately, resources have increased for the NHSC under federal health care reform so every CHC can take advantage of this program for provider recruitment and retention needs. The NHSC also has a modest budget that provides scholarships to students of the health professions who then have an obligation to serve in a HPSA for specified number of years.

## **State Funding**

**CHC Special Fund.** In 2006, the legislature imposed a new cigarette tax and designated some of the revenue for FQHCs. Beginning in September 2008, a portion of these tax receipts were deposited to the CHC special fund, and the money was available for the health centers in FY 2010. The cigarette tax funds were intended to support the growth and stability of FQHCs and pay for capital and infrastructure not otherwise available through state contracts. Unfortunately, thus far, the CHC special fund has been used to supplant general funds that previously supported CHC needs.

**Federal Pass-Through Funds.** The State contracts with FQHCs to provide WIC Nutrition, Family Planning, and some other services using designated federal funds.

## ADDITIONAL CONSIDERATIONS TO IMPROVE HEALTH & EXPAND CHCs

### **Social Determinants of Health**

Communities with the poorest health also tend to be those with the greatest poverty, homelessness and inadequate affordable housing, and whose residents are from groups that face high levels of racial, linguistic, and cultural discrimination. Poor educational opportunities, inadequate facilities and unsafe conditions for exercise, and inconveniently located or unaffordable healthy foods are also aspects of communities with poor health. These communities have the highest rates of smoking, poor nutrition, inadequate physical exercise, violence, and chronic stress, which, in turn, result in high rates of chronic and communicable diseases, injury, and infant mortality.

### **Public Health**

Public health programs ordinarily address health promotion, disease prevention, mental health, safety, and disaster management. As public health resources shrink, community health centers, with other non-profit agencies, are an increasingly important part the public health system. Their functions go far beyond those provided by private practice providers and include: promotion of good nutritional and exercise practices, maternal/child health and family planning, smoking cessation, mental health services, chronic disease management and reduction, vaccine campaigns, outreach, case management and assistance with public benefits, and disaster preparedness.

### **Prioritize Primary Care**

While a range of health care services are needed for Hawai'i, investment in advanced primary care that promotes timely, appropriate, and well-managed care saves lives and saves money. This is especially true for the higher risk patients typically served by community health centers. Advanced primary care is the kind of delivery system - proven effective in many other countries - that is needed in the United States. As practiced by community health centers, this model includes the outpatient medical services most needed for children and adults of all ages, mental health services that are well-integrated with medical care, and dental care. These clinical services are supported by a robust array of so-called "enabling services" that address the socio-economic needs that interfere with improved health. Care management is a specialty of CHCs and essential to cost savings as patients are monitored for improvements, referrals are tracked, and timely patient information is shared appropriately with all the providers involved in care.

## Workforce Development

Ensuring access to health care requires an increased workforce. The most obvious need is for additional clinicians and some of the tools for building an adequate supply of clinicians for advanced primary care delivery include:

### **Training and residency programs.**

The training of clinicians – especially physicians – needs to be reoriented to prioritize primary care. This is currently not the case as most medical students choose specialty practices because of associated prestige and higher reimbursements.

- While changing the practices of medical schools is a long-term goal, in the immediate term, Hawai'i has a medical school training program affiliated with the A.T. Still Medical School in Arizona which is emphatically oriented to the needs of community health centers. The Wai'anae Coast Comprehensive Health Center manages this excellent program and invites all CHCs to identify appropriate students for the school from their communities and participate in practical on-site training.
- Medical family practice residency programs should be provided public support and linked with community health centers.
- Community health centers are affiliated with a training program in Brooklyn that supports accredited CHC-based general and pediatric dental residency training. This program is a very important resource to Hawai'i as it gives CHCs access to well-trained dentists upon the completion of their training. This program is also increasing access to specialized dental services, such as hospital-based oral surgery, for our vast dentally underserved population.
- Students in advanced practice nursing, dental hygiene, psychology, and more primary care fields must be supported through higher education funding and linked to practica and residencies at CHCs.

### **Loan repayment programs.**

While community health centers are automatically included as appropriate places for loan repayments to be placed, in years when the budget for the National Health Service Corps was limited, most of Hawai'i's health centers and other underserved areas were not highly prioritized enough to qualify for a loan

repayment slot. For this reason, Hawai'i also needs a State Loan Repayment Program (SLRP). SLRPs not only provide the state more flexibility in addressing Hawai'i's needs, but are eligible for matching federal resources.

**Retention.**

After attracting clinicians to work at CHCs, the centers also need the means to keep them there. Adequate affordable housing is one of the largest challenges faced by health centers in Hawai'i. Since there's little we can do about that, CHCs need to be able to offer clinicians better compensation packages, including higher pay, subsidized continuing education opportunities, and opportunities to interact with peers, train residents, and engage in research. All these can be accomplished by all CHCs but require increases in operational funds.

**Scope of practice.**

While it is necessary to create and attract clinicians to work in our community health centers, we must also recognize that there is a serious national shortage of primary care physicians. Moreover, psychiatrists, dentists, and some other essential care givers are frequently not drawn to work at CHCs. Fortunately, the advanced primary care system is also a model for expanding the clinical workforce in the most appropriate way. Because it emphasizes a team approach to care and is supported by health information technology that provides clinical decision support, reduces errors, and assesses patient improvement, the CHC system can confidently offer extensive services with nurse practitioners, psychologists, clinical social workers, and dental hygienists. Training and education of other workers. Accordingly, we applaud the expansion of scope of practice for APRNs and PAs in 2009 and urge prescriptive authority for appropriately trained psychologists who work at CHCs.

**Non-clinical workforce.**

Many other well-trained staff members are critical to the success of community health centers and advanced primary care delivery, including excellent managers, health information technicians, medical and dental assistants, outreach workers, health educators, interpreters, and more. Hawai'i depends on high quality public education and support for training community college certificate and degree programs linked to community health centers. The Hawai'i Primary Care Association also provides a variety of training programs targeted to the needs of CHCs including general training for supervisory staff, training for eligibility workers, and support for in-service training for CHC peer networks.

## **Adequate Payment for CHC Model**

While research demonstrates the cost savings rendered by community health centers, their compensation levels rarely reward this virtue. The major funding sources for CHCs are as follows:

**Medicaid/QUEST.** CHCs derive more funds from Med-QUEST than any other source because 47% of their patients are covered by this public insurance. CHCs are paid on a prospective payment system basis. Every CHC has a unique rate that approximates its costs. Problems sometimes associated with Med-QUEST include slow payments and lack of timely attention to changes services and associated costs.

**Medicare.** Medicare doesn't cover 100% of the cost of CHC care and, when patients are covered both by Medicare and Medicaid, billing processes and payment delays are confusing and frustrating. CHCs are an excellent provider for Medicare patients, though, because they can waive the patient co-pay for services, if necessary.

**Private Insurance.** Health centers, especially those in rural areas, are significant providers for commercial insurers. Right now, these insurers do not compensate the CHCs for the extra work they do to ensure that all patients, including those with commercial insurance, are well managed and receive enabling services they need. Poor levels of private insurance reimbursement are one of the greatest threats to adequate CHC operations.

**State funding.** Prior to FY 2010, the State provided general funds that subsidized a majority of uninsured visits. In 2010, the general funds were supplanted with cigarette tax funds earmarked for CHCs. We believe that State general funds should be restored for uninsured services while the earmarked funds are used for the purpose for which they were created: to ensure that the state's network of community health centers expanded to meet needs, remained stable and reliable, and provided care of reliable quality and effectiveness. In fact, even the earmarked funds are not enough to ensure appropriate CHC expansion; accordingly, the State would be well-served to increase funds to CHCs that will save tens of millions of dollars in health care costs that need to be addressed elsewhere in the system through Med-QUEST or subsidies to hospitals.

**Federal funding.** Nationally, CHCs have been funded by the federal government for more than 40 years. Federal funds account for about 18% of CHC funding in Hawai'i. This critically important funding source supports the ability of CHCs to provide the many clinically effective and cost-saving services they do for all patients regardless of insurance status. While additional federal funds are periodically available, increases in federal funds do not automatically follow when CHCs increase their capacity, sites, and services.

## Capital Funds

Due to the high cost of land and construction in Hawai'i, one of the most problematic challenges to community health center growth here is the development of adequate facilities.

**Private funding.** While fortunate to have the Weinberg Foundation and several other funds, Hawai'i is relatively disadvantaged when it comes to private foundations and large corporate givers.

**Federal Funds.** The federal Health Resources & Services Administration provides the operating funding lifeline to community health centers but does not typically fund capital projects (an exception is currently underway with ARRA funds). The US Department of Agriculture provides funds and loans for various projects, sometimes including community health centers. Of course, such funds are not available in areas not recognized as rural. The US Department of Commerce and Economic Development periodically provides funds for CHC capital projects but only as they pertain to job security and workforce development.

**State Grants.** State grants-in-aid have been instrumental in supporting many CHC building and maintenance projects. Unfortunately, the process does not provide equal access for all CHCs nor is funding available in poor economic times when CHCs might need funds the most.

**County Funds.** Counties also contribute to CHC building projects through federal Community Block Grant Grants. It should be noted, though, that not every county uses its CDBG funds to support CHC capital needs and that processes differ by county and may make access to these grants too cumbersome to be of use.

**Revolving Loans.** Some states, foundations, and banks individually or in concert operate revolving loans for CHC capital needs. In some case, part of the principle can be forgiven based on care for the indigent.

**Public Lands.** Making available to CHCs land that's held by the State or Federal governments may also assist CHCs while being consistent with supporting the public good.