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Community Health Centers: Vital to Healthcare's Present and Future

By **Nora Haile**

*Contributing Editor
Washington Healthcare News*



“For every one percent increase in unemployment, more than one million people lose their health insurance and another million people enroll in Medicaid and SCHIP.”¹ The final statement of the National Association of Community Health Center’s (NACHC) one-page summary on the economic stimulus probably should be the first. If more people could truly absorb that, perhaps the concept of healthcare reform wouldn’t be so controversial.

While that may be overly optimistic, understanding the demand may help the public appreciate the vital role that Community Health Centers play, and must continue to

play, in healthcare. Consider how hard recession has hit healthcare budgets, with Washington State’s alone seeing over \$1.2 billion in cuts. That’s why the American Recovery and Reinvestment Act (ARRA, aka “the stimulus package”), has allocated \$2 billion to health centers for their infrastructure and ongoing operations, as well as to help them cope with rising patient numbers due to the economic recession. Over two years, grant award distributions will go out, and predictions are that by 2011, an additional 3 million patients will have received care.²

NACHC reports that most health centers indicate a rise in uninsured patient demand. The organization, sharing a recent survey’s preliminary results, finds health centers faced with a growing need for services, in addition to an uptick in patients and uninsured patients from June 2008 to June 2009. Nearly all report a need for at least one new site to meet community need, and half report that unemployment has impacted up to 30 percent of their patients or patients’ families. Fortunately, the ARRA funds let Community Health Centers continue providing services amid rising demand. The funds support new health center sites and workforce development, as well as help the Community Health Centers ac-

quire and implement Health Information Technology (HIT).

Anita Monoian, CEO of Yakima Neighborhood Health Services (YNHS) and NACHC’s newly installed Board Chair, points to YNHS’s near-immediate results from their portion of the allocation. “It let us add a pharmacist, allowing our pharmacy to have Saturday hours for our uninsured patients. We’ve also added behavioral health staff, and at our homeless clinic, a dental operatory.” Over-

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Letter from the Publisher and Editor



Dear Reader,

The **Washington Healthcare News** is mailed monthly to healthcare leaders at hospitals, clinics and insurance organizations in Washington, Oregon, Idaho and Alaska. Having done our best to identify each person in this demographic, and offer them the **Washington Healthcare News**, it was time to spread our wings.

In late August we started a new publication and web site: the **California Healthcare News**. Our goal is to add the same types of readers as the **Washington Healthcare News** over the next twelve months. The population of California is over three times the combined populations of Washington, Oregon, Idaho and Alaska so we anticipate quite an increase in our current base of 6,300 readers.

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David Peel, Publisher and Editor

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all, since the money started flowing in March, YNHS has served 983 new medical patients and 813 new dental patients.

New Patients and New Perceptions

Good thing they were able to ramp up. Health and Human Services Secretary Kathleen Sebelius noted at NACHC's national conference in Chicago that since the economic downturn began, the health center patient population has grown by another one million people – a third of them children. Monoian, who briefly met with the Secretary at the gathering, explains: "We're seeing families who have never known a time without coverage. This is our working middle class, and many have never even been in [a Community Health Center] before."

Health centers are traditionally located in medically under served areas that sometimes, from the outside, appear less than stellar. For many of the new patients, walking in the door can be a pleasant surprise. "So many health centers are state-of-the-art facilities," Monoian says. "After experiencing the reality and receiving quality care from our clinicians, these new patients walk away with a shift in perception and become a voice of support in the community."

Some newly unemployed are uninsured not only because COBRA payments and individual coverage costs are so high, but also because they don't qualify for any of the public options. There is hope that at a minimum, healthcare reform will bring a change in the ability for adults to qualify for care under public options. That means an increase in the percentage of poverty

level that programs use to determine who gets coverage through publicly funded options. "If as a nation we could get that up to even 130% of poverty level for adults, that would make a tremendous difference for the adult population," says Monoian. Right now, children are the most likely to be covered, thanks to SCHIP.

Coverage vs. Care: The Workforce Dilemma

But can health centers sustain caring for any resulting new patient load on top of the one they're currently experiencing? After all, workforce is at the heart of the access problem. Most of the media focus is on coverage issues, not care access issues. If healthcare reform, in some iteration, takes care of coverage issues, what does that mean for actual care?

There's the rub. The number of new primary care physicians is down 50% since 1997, states an article in Kaiser Health News.³ What happens when nearly 47 million uninsured suddenly have coverage? After all, it's the access to preventive care that helps reduce healthcare costs.

A recent New England Journal of Medicine article reports the number of U. S. medical students entering specialty fields rising rapidly, while those entering adult primary care has decreased sharply. Money is one obvious factor in the downturn. Income gaps over a 40-year career average \$3.5 million. Combine more money with the fact that specialists typically have more say over their lives and schedules, and the picture becomes clearer.⁴

Unfortunately, Community Health Centers are very familiar with the physician shortage dilemma. "If we don't have providers – doctors,

nurses, nurse practitioners, PAs, pharmacists – we have nothing," states Monoian. "If you have an insurance card in your pocket, that's a great thing. But it doesn't guarantee access. We have to be able to staff these clinics." She shares that recruiting has become incredibly difficult. Several years ago, resumes came in steadily even though it could take six months to fill a position, but now there are no resumes, and positions take up to two years to fill.

Traditionally, federal programs such as the National Health Service Corps make a crucial difference in access. This year, ARRA money (\$300,000 million over this year and next) has helped dramatically expand the National Health Service Corp, always a good recruiting ground for health centers. Its loan repayment program gives \$50,000 in loan repayments to recipients working in under served areas, in addition to salaries, while they serve two years with the corps.⁵ Of course, Monoian acknowledges, some who complete the two years leave the communities where they serve. "Retention is always a challenge. But it's about 50/50. Some like the challenge and will want to stay. It's great, rewarding work."

But if Community Health Centers are to meet their goal (they currently serve 20 million) of providing care to 60 million people over the next decade, there's a need for 50,000 additional physicians – just to meet the needs of the health centers. The NHSC only provides a gain of about 4,000 providers over the next few years. The other opportunity for workforce improvement is the Residency Training in Health Centers concept set forth in the House's version of the healthcare reform Bill.

If it survives, it would authorize funding provisions to “develop or operate primary care residency programs.”⁶

Where Good Health Begins

Healthcare reform aims to provide coverage and care while saving money, something Community Health Centers already do. “Our lawmakers recognize that health centers currently save the healthcare system up to \$18 billion a year,” Monoian states. “If we could follow the model and reach the goals set forth in the ACCESS for All American Plan, we would save the system up to \$80 billion annually and serve 60 million people a year.”⁷

She takes another tack. “Consider this: even if we just continued doing what we do now, saving \$18 billion a year, that would still be \$180 billion in savings over ten years.” Let’s see, a model – based

on preventive care and a healthcare home– that works, people getting high quality, patient-friendly care, and savings – hard to take issue with that.

Like everyone and every organization in the country, Community Health Centers are paying close attention to the debates on the Hill. Everyone, regardless of party lines, realizes overhauling the current system is a herculean task. It’s a system fraught with inefficiencies. According to the Organization for Economic Cooperation and Development (OECD), our national health spending (15.3% of 2006 GDP) is “higher than all other OECD countries, including Canada, France, Germany, Japan and the United Kingdom.”⁸ Yet we still can’t take care of everyone well.

Until healthcare reform becomes a reality, there is a limit to what

healthcare organizations can do. Community Health Centers and the healthcare home concept set forth in the ACCESS plan is a good beginning. It’s an efficient design with a vision of offering the patient truly integrated care – with access to primary care, dental, behavioral health – all under one roof. According to Monoian, such a design makes things easy and economic, both for the patient and the system.

“Good health begins with access, disease prevention and a primary care medical home,” asserts Monoian. “Good health saves money.”

No argument here. Let’s hope any healthcare reform package coming out of our nation’s capital focuses on those commonsensical outcomes.

¹Community Health Centers and the Economic Stimulus: A One-Page Summary, National Association of Community Health Centers (NACHC), nachc.com/stimulus.

²“Community Health Centers Vital to Any Health Overhaul,” Andrew Villegas, Kaiser Health News, McClatchy Washington Bureau, August 11, 2009.

³“Physician Shortage Could Hinder Health Reform,” www.kaiserhealthnews.org, July 6, 2009.

⁴“Easing the Shortage in Adult Primary Care – Is It All about Money?” by Robert Steinbrook, M.D., The New England Journal of Medicine, Volume 360:2696-2699, June 25, 2009, Number 26.

⁵Ibid.

⁶“America’s Affordable Health Choices Act of 2009,” NACHC, www.nachc.com.

⁷ACCESS for All America Plan, National Association of Community Health Centers, www.nachc.com.

⁸“Trends in Health Care Costs and Spending,” Kaiser Family Foundation, March 2009, www.kff.org.

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Keeping ICE Out of the Workplace: An Update in I-9 Compliance

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By now, most healthcare employers have heard of E-Verify. But many remain uncertain as to whether E-Verify applies to them. And for good reason – the final rule requiring certain federal contractors and subcontractors to use E-Verify has been embroiled in litigation and its implementation delayed no less than four times. Add state legislation mandating the use of E-Verify to the mix, and you have a nationwide patchwork quilt of E-Verify requirements – enough to make any employer dizzy. Yet, now more than ever, it is critical for employers to understand and comply with the I-9 requirements that apply to them.

On April 30, 2009, the Department of Homeland Security (DHS) announced a shift in its enforcement focus from work site raids in which undocumented workers are the target to employers of undocumented workers. Immigration and Customs Enforcement (ICE) agents were given specific instructions to

“obtain indictments, criminal arrest or search warrants, or a commitment from a U.S. Attorney’s Office to prosecute the targeted employer, *before* arresting employees for civil immigration violations at a work site.” This shift in enforcement policy was illustrated on July 1, 2009, when ICE issued 652 Notices of Inspection to employers, an increase from the 503 notices issued in all of 2008. Given this shift in enforcement policy and the changes in state and federal legislation, how does an employer avoid a visit from ICE?

Ensure Proper I-9 Verification

Employment is one of the strongest magnets drawing unauthorized individuals to the United States. In 1986, Congress attempted to weaken the magnetic pull of employment by passing legislation requiring all employers to verify the identity and employment authorization of each newly hired employee.

Employers comply with this re-

quirement through the use of the Form I-9, which they must ensure is timely and properly completed. Within three business days of the date employment begins, an employer must review documents selected by an employee from the current List of Acceptable Documents, and complete the form by verifying that the documents presented appear genuine on their face and relate to the employee presenting them.

Understand E-Verify’s Mandatory Application

In 1996, an electronic component was added to the I-9 verification process. E-Verify is a free, internet-based system used to electronically confirm employment authorization. According to DHS, an independent research firm found that 96.9% of all queries run through E-Verify result in employment verification within 24 hours. The remaining 3% of queries result in electronic responses that either require employers to take additional steps to verify work authorization or to terminate an employee based on the system’s inability to verify work authorization.

Although initially only available to employers in five states on a voluntary basis, E-Verify is now available to employers nationwide. And it is no longer strictly voluntary; many states, although not Washington, have enacted legislation mandating the use of E-Verify. To complicate matters, cities and counties in numerous states have passed ordinances mandating the use of E-Verify for certain em-

ployers. For example, the City of Lakewood recently enacted an E-Verify ordinance which mandates use by the city as well as city contractors and subcontractors, subject to a limited exception.

On September 8, 2009, a new group of employers will be added to the list of those required to use E-Verify as a result of a recent federal court decision upholding a regulation requiring covered federal contractors and subcontractors to use E-Verify. In light of this decision, all employers should review whether they are federal contractors or subcontractors subject to the E-Verify requirement. Although many healthcare entities receive reimbursement for services to Medicare or Medicaid beneficiaries, reimbursement alone does not require healthcare employers to use E-Verify.

But change may be coming. This

year, a coalition of activist groups in Washington State lobbied, albeit unsuccessfully, to get a form of E-Verify legislation on the ballot. At the federal level, two competing bills requiring all employers to use E-Verify or a similar electronic database have been reintroduced in Congress. Bottom line – some form of mandatory electronic verification for all employers is likely on its way.

Tips for Employers


Until then, healthcare entities can reduce the likelihood of an ICE visit by following the below steps:

- Properly and timely complete the current version of the Form I-9 for all new hires;
- Ensure documents appear genuine, pertain to the employee providing them, and are on the current List of Acceptable Documents;
- Re-verify applicable docu-

ments prior to expiration;

- Store Form I-9s for three years or one year after employment ends, whichever is later;
- Consider adopting an I-9 compliance policy and designating an “expert” to complete all Form I-9s;
- If errors are discovered, consider conducting an internal I-9 audit;
- Follow procedures uniformly and document steps taken; and
- Stay apprised of the applicable requirements, including E-Verify, and consult counsel with questions.

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Retirement Plan Management Part 4: We have a Report, Now What?

By **Ward M. Harris**

Managing Director

McHenry Partners



Compare to Plan

The concept of benchmarks should be very familiar to healthcare professionals whether they are in medical, financial or operational functions. In managing a retirement plan, benchmarking your expenses and risk adjusted results can provide similar benefits as in other healthcare practice areas.

Last month, we talked about a retirement plan's written investment policy as a "recipe" to help plan fiduciaries manage the assets of the retirement program. We also introduced the concept of an objective, standards-based analytic report that compares the investment results of the plan's assets relative to the returns produced, risks taken and expenses incurred.

Some readers asked about the best way to create such a report and in those conversations, we suggested that there are three options available to plan trustees: 1) "Borrow" the

reporting system of your broker or vendor and rely upon that perspective to ensure that you are meeting your objectives; 2) "Build" your own data collection and reporting process using Morningstar, Excel or some other tool; or 3) "Buy" the services of an objective third party who has no "dog in the fight" and is not selling you something other than an objective professional opinion – like your doctor.

Each of the three options involves some degree of effort and expense, but the results of a diligent and objective analysis of your plan can be significant. These results include better decisions, improved investment returns and lower expenses. In our experience, the nominal effort and expense of an objective benchmarking program for employee retirement plans often provides an immediate return on investment (ROI) equal to the cost of the benchmarking program – several times over.

Standards-Based

A written investment policy provides minimum standards for consideration, selection and retention of investment products for use in your 401(k), 403(b), 457 or other retirement plan.

Let's also assume that the written objectives for risk, return and expense of plan investments can be referred to as the "Lake Wobegone Standard" where all of the measures are "better than average."

With a formal policy in place and a quarterly benchmarking report in hand, you can compare your in-

vestment return, risk and expense results period by period, compared to various peer groups – other investment alternatives and other plan sponsors of a similar size and plan.

Reviewing the Report

The most important part of the report is the summary of exceptions for the current and prior periods. Did any of your managers fail to meet all standards? Is the failure part of a continuing trend? What is the cost of the failure? These are all the questions to be asked and answered in reviewing the report and managing your fiduciary responsibilities.

The next step is to monitor any exceptions and develop procedures for escalation, remediation and possible replacement of investment options.

To receive a model investment policy statement (IPS) and a sample of a standards-based quarterly report for your use in managing plan investment operations, call or email the author of this column.

Next Month: "Retirement Plan Management: Exception Management & Replacement"

Ward Harris is Managing Director with McHenry Partners, a regional investment consulting firm. He is a Seattle native with 30 years of experience in investments for corporate and not-for-profit organizations. Call him at 1-800-638-8121 or ward.harris@mchenrypayers.com.



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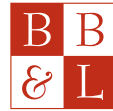
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What Employers Should Know About Employment Screening

By Jeff Sears

Director of Sales

Intelius Screening Solutions



With the Summer season drawing quickly to a close, I find myself reflecting on what an interesting year this has been for healthcare organizations as it relates to employment. In the 2009 monthly employment report published by the U.S. Department of Labor, healthcare was one of only two industries that experienced employment growth for the month of July – adding 20,000 to its ranks nationally.

While some might think statistics like this paint a rosy picture for healthcare, HR and staffing professionals are still faced with difficult recruitment challenges including: high employee turnover, managing the massive influx of resumes from a growing national unemployment rate (9.7% in the month of July) and increased resume scrutiny on every potentially qualified candidate identified in the recruitment process. In times like this, HR and staffing professionals need to be extra diligent and overly cau-

tious as they identify candidates for their open positions. Why? In 2009 alone, resume falsification has skyrocketed. For example, a recent survey conducted by the Society for Human Resource Management (SHRM) found that 52% of job seekers admitted to “making some sort of false claim on their resumes.”

The good news is healthcare recruiters can and are taking action to overcome these challenges. By following simple employment screening best-practices, healthcare organizations can reduce turnover, cut costs, increase efficiency and improve hiring compliance, while reduce significant risk to their organizations and those they serve.

Intelius’ Best Practices for Healthcare Employment Screening

1. Commit To Screening – It’s Proactive, Cost-Effective Risk Management: Employment screening is a simple and cost-effective step any organization can take to mitigate risk against unqualified or unsafe individuals becoming part of their workforce. For what can be as little as 1-2 hours pay per new hire, healthcare organizations can instill a first line of defense quickly to protect their staff, patients and customers.
2. Define Your Employment Screening Policy – By Committee: Leading organizations, in all industries, have defined, documented and instituted formal policies around employ-

ment screening. Increasingly, the policies are being “built by committee.” Meaning, HR and staffing leadership are working closer with their business-unit counterparts to define strategy and policy requirements. By doing so, HR and staffing professionals are gaining greater buy-in on their policies and programs and are seeing them embraced more often organization-wide.

3. Brush Up on Industry Regulation To Ensure Legal Compliance: HR and staffing practitioners in leading healthcare organizations spend time staying current on the latest regulations to ensure their organizations are compliant. Screening your employees as governed by industry, state and federal regulations reduces the risk of litigation and potential fines that could have a detrimental impact on your bottom line.

Following these simple screening best-practices can go miles in avoiding costly hiring mistakes. Working with a solution provider, you’ll be able to quickly and cost-effectively streamline your processes to cut costs, improve compliance and mitigate organizational risk – and who knows, you could even make your organization a little greener along the way.

Jeff Sears is the Director of Sales for Intelius Screening Solutions. Email Jeff at jsears@intelius.com or visit www.hr.intelius.com.

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Lessons From Ike: Healthcare and Highways - There is a Relationship

By Peg Hopkins

Chief Executive Officer

Community Health Association of Spokane

On a hot afternoon in late June, 1956, President Eisenhower lay in bed at Walter Reed Army Medical Center recovering from a bout with Ileitis. He roused himself to sign the bill he would later describe as the crowning domestic achievement of his presidency: The Dwight D. Eisenhower National System of Interstate and Defense Highways. We call it the interstate highway system and usually just the interstate. It is the largest highway system in the world (46,876 miles) and remains the largest public works project in our history. It took 35 years to complete and cost \$114 billion dollars.

Imagine a health delivery system for America that's like our interstate highways. Everyone has access to one and you can get on or off in any state. It is designed primarily from a safety and security perspective. The commercial value is secondary. The signs will look pretty much the same so you can figure out how to maneuver wherever you are, but the speed limits vary somewhat and the surface and maintenance is different from state to state. The states and the Feds share the burden of financing.

America's Community Health Centers (CHCs) are already providing universal access to more than 18 million users across all 50 states, territories and the District of Columbia, and have been doing so over the last 40 years. CHCs

provide access to an integrated health service delivery model, including medical, dental and behavioral health. Everyone is eligible for care regardless of their ability to pay for services. Patients pay on a sliding fee, with Medicaid coupons, Medicare, and every type of coverage in between. All CHC organizations are consumer controlled not for profit organizations.

The healthcare reform discussion shifts significantly if one basic principal is adopted: *If you're breathing you qualify for healthcare in America.* That is, whatever the out come of healthcare reform, no additional healthcare dollars will be spent on "determining eligibility." It is difficult to isolate the costs embedded in our system related to determining who's in and who's out literally millions of times every day. Adopting this simple rule will begin to drive many decisions about how to build a system around this new paradigm. And that leads me back to my buddy Ike and the similar barriers he faced in creating the interstate highways system we all take for granted today.

It wasn't actually the financing model that finally pushed the idea from concept to reality with the highways, though much like today there was plenty of noise about the money. In fact, one opponent described the idea as "another ascent into the stratosphere of New Deal jitterbug economics". Like today's healthcare debate, there were innumerable vested interests with vast

war chests.

Eisenhower's vision was derived from his personal observations of the effectiveness of the German autobahns during the war. He knew that a comprehensive interstate highway system was essential to our security. There are obvious parallels to the current risks we face in the global market place due to our second tier health status. Ike used his influence to shift the discussion toward the idea of necessary investment in our national security and away from which industry or state deserved to benefit the most from the endeavor. Other countries have already crossed the universal access threshold and we can learn things from each of them, but our solution must be a uniquely American model, like our highways. For instance, Ike realized early on that he would be in a close partnership with the states every step of the way. He commissioned the Clay Committee to work with the nation's governors to devise a unique model of financing that included the creation of the Highway Trust fund to ensure a dedicated source of funding for the entire project. The fund is also unique because most of the dollars come from user fees and gas taxes. In healthcare we call them premiums, deductibles and co-pays. They altered the ratio of state to federal match (10/90) to encourage the states to move aggressively. It worked.

Partnership with the states is a

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A New MBA Program in Healthcare Management for the Pacific Northwest

By James J. Huntzicker, PhD

*Head, Division of Management
OHSU School of Medicine*

In January 2009, Oregon Health & Science University (OHSU) and Portland State University (PSU) launched their joint MBA in Healthcare Management. This program evolved from the existing graduate Certificate in Healthcare Management offered by the OHSU Division of Management (a unit in the OHSU School of Medicine) and the MBA+ degree offered by the PSU School of Business Administration. The need for this program was discerned through a series of interviews that were conducted with healthcare executives in the Portland metropolitan area, focus group studies with potential candidates for healthcare management graduate studies, and the expressed wishes of a number of graduates from the Certificate in Healthcare Management program. In developing the program, we established several design criteria:

- The program had to deliver the fundamental business knowledge, skills, and tools that would be found in any MBA program.
- Healthcare would be thoroughly integrated throughout the curriculum. Specifically, healthcare would be the primary source for cases, examples, and guest speakers and not just an add-on via electives.
- The program must recognize that healthcare in the United States is greatly in need of

transformation and that effective management has an important role to play in that transformation. For us this meant that the graduates of the MBA in Healthcare Management must be equipped to be change agents within both their own organizations and within the broader healthcare system. This also meant that where appropriate we would incorporate best practices from other industries.

- The program must be designed for working professionals in healthcare, including clinicians (physicians, nurses, physician assistants, dentists, etc.) with managerial roles and non-clinicians with roles in the business aspects of healthcare delivery (e.g., finance, IT, safety, operations, logistics). Moreover, the program should be applicable to the broad spectrum of the healthcare industry, including provider organizations (hospitals, clinics, private practices, etc.), health insurance companies, pharmaceutical and medical device manufacturers, etc.

The criterion related to transformation was particularly important, and we relied heavily on what the Institute of Medicine had to say in this regard—specifically *To Err is Human* (IOM, 2000), *Crossing the Quality Chasm* (IOM, 2001), and *Health Professions Education—A Bridge to Quality* (IOM 2002). According to the IOM,

American healthcare must become safe, effective, patient-centered, timely, efficient, and equitable. To achieve these aims, healthcare professionals must embody five specific core competencies: provide patient-centered care, work in interdisciplinary teams, employ evidence-based practice, apply quality improvement, and utilize informatics. All of this is embodied in what Don Berwick, CEO of the Institute for Healthcare Improvement, calls the Triple Aim, which is to enhance the individual patient experience, promote the health of the population, and control or reduce costs. (Berwick et al, 2008)

The MBA curriculum that was ultimately developed weaves these ideas throughout the curriculum and trains individuals to manage to the Triple Aim. The curriculum is composed of six themes:

- Understanding the healthcare industry
- Leadership and management in healthcare
- Financial management in healthcare
- Operations and quality management in healthcare
- Marketing, business planning, and strategy
- Application projects and capstone

The program is designed to serve busy, working professionals, who will complete the degree on a part-time basis over a three-year period.

Please see> MBA, P16



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<Lessons, from P12

missing element of the current healthcare proposals. Just like the highway system, every state and locality has unique and specific challenges to meet in providing access. Universal access doesn't require absolute Federal control. It can be a shared responsibility, like the interstates. CHCs already offer models for local solutions that operate within federal expectations, but are controlled by citizens themselves. We are creating innovative solutions to universal access everyday in 7,000 communities around the country. America should leverage the strength of this time-tested model to build its healthcare superhighway.

Peg Hopkins is the Chief Executive Officer of Community Health Association of Spokane (CHAS). To learn more about CHAS visit www.chas.org.

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<MBA, from P14

The learning modality is a hybrid of online and face-to-face learning. Over an eleven week quarter, students gather at OHSU's South Waterfront campus for two weekends while participating online for the remainder of the quarter through OHSU's online learning platform. This makes the program accessible to anyone within a day's travel of Portland. The online part of the program is highly interactive and promotes collaborative learning among participants. In large measure, the role of the formal instructor is more one of facilitation than teaching, and

adult learning principles guide the program. Our experience to date has indicated that the hybrid learning format is highly effective and user friendly.

The first cohort of the program launched in January 2009, and subsequent cohorts will begin each September. The September 2009 cohort will be full at 30 participants—a size which was chosen to optimize learning. Participants in the first two cohorts represent both

the breadth of roles found in the healthcare industry as well as the breadth of organizations. Complete details about the program can be found at www.HealthcareMBA.pdx.edu. Interested individuals are also welcome to call 503-346-0370 for further information.

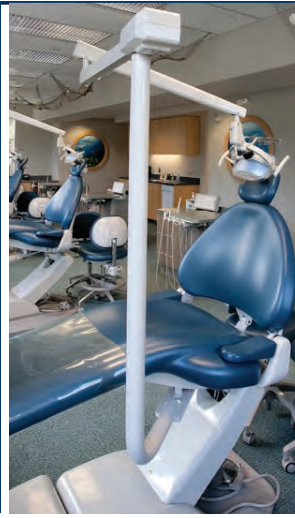
James J. Huntzicker, PhD, is Head of the Division of Management in the Oregon Health & Science University (OHSU) School of Medicine.

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Community Health Center La Clinica: Playing a Foundational Role in Keeping Our Community Healthy

By Carl I. Walters II

Chief Executive Officer

Community Health Center La Clinica



Community Health Center La Clinica (health center), a Federally Qualified Health Center with locations in Pasco and Kennewick Washington, has been serving as a primary care services home for Tri-Cities families for over 27 years. Our health center offers Family Practice, Pediatrics, OB/GYN, Urgent Care, Behavioral Health Services, Psychiatric Services, WIC Services, Dental Services and a wide array of enabling services. We employ close to 200 employees and produce over 105,000 patient encounters annually. With an annual operating budget just under \$15 million, our health center serves the entire Tri-Cities geographical area by ensuring anyone in need of cost-effective, high-quality primary care services has access to such services.

Most recently, our health center

was awarded a Federal Increased Demand for Services grant of \$408,000 that we plan to utilize to strengthen our Pediatric and Internal Medicine service lines. Additionally, we were awarded a Federal \$1.1 million Capital Improvement grant which we plan to use to add an additional dental operatory, expand our growing Urgent Care operations and purchase a new practice management system and several pieces of medical equipment to enhance the quality of services we provide. We recently applied for \$7.5 million in Federal Facility Improvement grant dollars and, if awarded, plan to build a new 30,000 sf facility to consolidate our Behavioral Health Services operations, and expand our Call Center, WIC/Community Outreach and Dental Services operations. We have also applied for \$439,000 in federal grant funding to identify and enroll children eligible for Medicaid insurance.

While we are grateful for the grant dollars received to date, as well as those we hope to receive in the near future, it should be noted that these grant dollars are not the sole solution to our funding issues. We also need to push more paying business through our health center because we anticipate increased utilization of our services and the need to hire more providers. Not an unattainable task, but certainly a challenging one that we see as critical to stabilizing and repositioning our health cen-

ter for stronger financial viability moving forward.

To keep pace with where the Obama Administration is heading as it relates to holding federally sponsored Programs more accountable, Community Health Center La Clinica is working hard to strengthen our Quality Program. Whether we like it or not, the reality is that we live in a time where Federal and State-sponsored programs are going to be required to quantify the clinical and financial “bang for the buck” the Federal and State governments are getting by investing dollars into health centers. I don’t believe we are far out from the time where Health Centers unable to quantify their Federal and State financial and clinical “bang for the buck” are either placed on funding restrictions or have their funding cut off altogether.

The Community Health Center system, including organizations like Community Health Center La Clinica, have become a vital part of our national healthcare system. Mary Looker, CEO of the Washington Association of Community and Migrant Health Centers, Washington’s Primary Care Association observes, “Federally Qualified Health Centers serve as the nation’s primary care catchment system serving over 18 million patients across the nation during 2008. There are roughly 1200 such organizations across the country

Please see> Foundational, P20



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<Foundational, from P18

dedicated to ensuring a growing number of uninsured and under insured have access to affordable, high-quality healthcare." She continues, "Community Health Center La Clinica is one of these organizations on the front lines every day. The face of America's growing uninsured is also changing. Today the face of people utilizing Federally Qualified Health Centers increasingly looks like the face of our families."

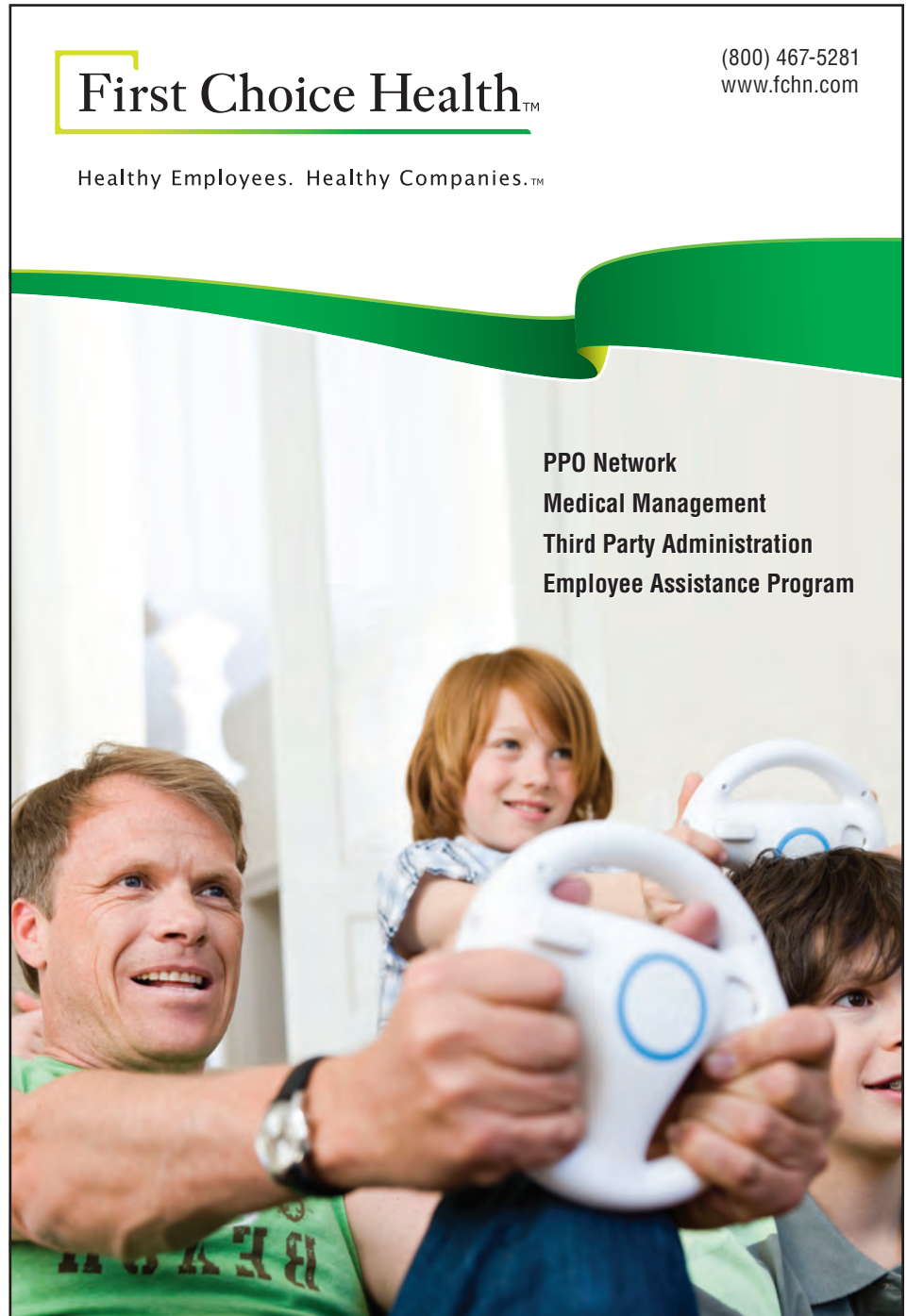
Honest, hard-working people who have lost their jobs, lost their health insurance, or who have simply fallen on hard times need systems such as ours to not only survive but thrive. No longer can or should we say that people who need services from Federally Qualified Health Centers are "those people," for "those people" today represent our families, neighbors and friends. The simplest thing our nation can do to help drive the total cost of healthcare down across the country, is to continue strengthening our nation's Federally Qualified Health Centers and to advocate for more people to be serviced through our health centers. Numerous studies suggest that it is more cost-effective to provide core primary care services in an outpatient primary care arena, as opposed to through extended hospital stays and inappropriate Emergency Room and Urgent Care utilization. It is not a question of whether we are going to pay for healthcare in our nation, but rather what is the most cost-effective way to pay for such care and *how* do we desire to pay for it. Federally Qualified Health Centers already play a pivotal primary care services leadership role and are capable of pro-

viding an expanded leadership role ensuring our nation's constituents receive the right care, at the right time and in the right treatment platform. We believe that we are moving in the right direction in our mission, goals and vision of where the nation is headed as relates to the healthcare system. Community Health Center La Clinica has always seen their mission as being cutting edge and playing a foundational role in helping to keep their

community healthy. It is a mission that has not changed in 27 years.

Carl I. Walters II is the Chief Executive Officer of Community Health System La Clinica in the Tri-Cities area of Washington State. To learn more about Community Health System La Clinica visit www.laclinicnet.org.

Opinions expressed in this article are not necessarily those of the Washington Healthcare News.

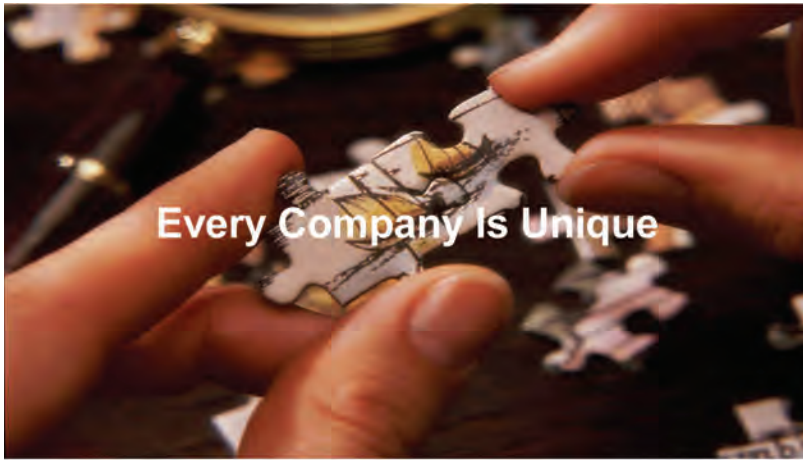


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Director, Plant Operations

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Director, Quality

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We are currently seeking the following position.

DIRECTOR QUALITY: A terrific opportunity to impact our evolving, specialized environment. Help us achieve our mission of quality of care for every patient, family member and employee! Previous experience in an acute care hospital as an RN and manager of Quality Program. Bachelor's degree and current Oregon RN license required.

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