

Community Health Centers in the Dakotas, 2018

By H. Bruce Vogt, MD, FAAFP; Jennifer Tinguely, MD, MPH;
Jill Franken, MS; and Shelly Ten Napel, MSW, MPP

Abstract

Community health centers (CHCs) are a critical component of the healthcare safety network. The modern era of CHCs began in the mid-1960s although their origin can be traced back as far as the first two decades of the 20th century. Over 24 million people receive their healthcare in CHCs. North and South Dakota are home to nine centers and provided care to nearly 110,000 medical and dental patients in 2017. All CHCs use a uniform data set to report annually on demographics, scope of practice, and clinical measures to assure that they remain true to their original mission to provide quality healthcare to the most vulnerable of our population.

Background

Community health centers (CHCs) are a critical component of the healthcare safety network for the most vulnerable in our country. This includes the impoverished, the uninsured or underinsured, and those who would otherwise lack access to healthcare. Across the nation, over 24 million people receive their healthcare in community health centers. North and South Dakota are home to nine CHCs. The purpose of this article is to briefly review the origin of the U.S. Public Health Service and community health centers and to discuss the impact of CHCs in North and South Dakota.

U.S. Public Health Service

The U.S. Public Health Service (USPHS) was founded in 1798 through legislation titled, “The Act for the Relief of Sick and Disabled Seamen,” and signed into law by President John Adams. The act created the U.S. Marine Hospital Service (MHS), a loosely controlled group of hospitals at sea and river ports. In 1870, administration of the MHS was centralized with headquarters in Washington, D.C., under direction of its first Supervising Surgeon (later, Surgeon General), John Maynard Woodworth, appointed in 1871. By 1889, Dr. Woodworth established a commissioned corps, which Congress formalized as the agency’s uniformed services component. The MHS’s name changed to the USPHS and MHS in

1902, reflecting its growing responsibilities. In 1912, the powers of the agency were expanded but the name shortened to the USPHS.¹ The Public Health Service Act of 1944, signed by President Franklin D. Roosevelt, was a major step, which gave a more formal structure to the USPHS, streamlined its administration, and both consolidated and revised legislation pertaining to the USPHS.²

Even before the Public Health Service Act was signed in 1944, President Roosevelt was laying the groundwork for poverty relief. The New Deal of 1933-36 was a monumental effort led by the President to guide the country out of the Great Depression. The New Deal resulted in an explosion of public works projects, financial reforms and new federal programs, including the Civilian Conservation Corps and the Social Security Administration. Throughout the following administrations (Truman, Eisenhower, and Kennedy), parts of the New Deal were expanded upon and there was a push to address civil rights in the United States. When President Lyndon B. Johnson took office, the national poverty rate was around 19 percent and, in response to that, he introduced legislation that unofficially became known as the “War on Poverty.”³ This is where community health centers truly found their origins.

Development of Community Health Centers

Although the origin of CHCs can be traced to “infant

milk stations” (1901) and “district health centers” (1914) in New York City,⁴ the modern era of CHCs began in the mid-1960s. Through President Johnson’s ambitious “War on Poverty,” the Office of Economic Opportunity (OEO) was developed in 1965. Neighborhood health centers (NHCs), now called CHCs, were created as part of the OEO to provide access to healthcare and social services in poor and underserved communities and to promote community empowerment.

The first two CHCs in the U.S. were the Columbia Point Health Center, which opened in a public health housing project in Boston on Dec. 11, 1965 and the Delta Health Center, Bolivar County, MS, which opened in 1967.⁵ The extraordinary effort to establish these centers was led by Dr. Jack Geiger who initially approached the OEO in January of 1965, and helped organized community residents.⁶ Today, over 24 million people receive health care in more than 1300 CHCs modeled after these original two centers.⁷

Although the OEO dissolved by the end of the 1970s, the program moved to the Department of Health, Education, and Welfare (now, known as Health and Human Services). NHCs were eventually merged with Migrant Health Center programs in 1975⁸ and subsequently with health care programs for residents of public housing and the homeless in 1996. The Health Centers Consolidation Act of 1996 authorized these programs as one under section 330 of the Public Health Service Act. Section 330 grants are the major federal funding mechanism for CHCs.⁹ Section 330 funds can account for between 15 and 50 percent of a CHC’s total revenue, depending on the payer mix of the patient population. CHCs also get revenue from insurance reimbursement, sliding scale payments from patients, and grants and donations.

CHC Fundamentals

CHCs are administered by the Bureau of Primary Care of the Health Resources and Services Administration (HRSA), a division of the Department of Health and Human Services (HHS). Statutory requirements are extensive. A Compliance Manual provides a consolidated resource regarding eligibility to establish a CHC and detailing center requirements.¹⁰

CHCs differ from other healthcare centers in that their patients are disproportionately poor and uninsured or underinsured or they live in medically underserved parts of the country, including rural and frontier areas. CHC

practices typically serve a significantly higher percentage of minorities. Many refugees receive their healthcare in CHCs.^{7,11}

CHCs are eligible for federal grants authorized under Section 330 of the PHSA (i.e., often referred to as “330 grantees.”) To receive 330 grant funds, CHCs must meet 19 statutory requirements. The requirements address needs assessment, CHC services, management, financial issues, and center governance. Among the 19 statutory requirements, it is mandated that CHCs:

- Be located in a medically underserved area or serve a medically underserved population
- Be nonprofit, public, or tax exempt
- Provide quality, comprehensive primary health care services to all age groups
- Provide dental, behavioral health, and substance abuse care and pharmacy services
- Provide supportive services including health education, translation, transportation, and social services such as case management (including counseling regarding supportive services)
- Provide services regardless of ability to pay or insurance status and establish a sliding scale for fees based upon family income
- Have a governing board of directors with the majority of members being patients of the center
- Develop an ongoing quality assurance program⁷

The statute in regard to governing board membership is consistent with the original intent of the legislation providing for Neighborhood Health Centers (now CHCs) to promote community empowerment. Ongoing needs assessment requires CHCs to conduct annual reviews of the boundary of their service area and identification of the medically underserved population or populations they serve. The review must assess the availability of health resources in the area relative to its size and population, the ratio of primary care physicians to the population, health indices, economic factors affecting the population’s access to health services (e.g., population below poverty level), and demographic factors such as population over 65 years of age. At least every three years, the center must review the major causes of morbidity and mortality in the service area; factors associated with access to care (e.g., transportation, educational attainment, employment status, etc.); and other unique healthcare needs or

characteristics impacting health status or access to primary care (e.g., cultural/ethnic factors, language needs, housing status, etc.).¹²

CHCs must provide primary health services as defined in section 330(b)(1) of the USPHS Act either directly or through formal written contracts or agreements with other providers. The USPHS Act defines primary health services as those related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology that are furnished by physicians, and where appropriate, physician assistants, nurse practitioners, and nurse midwives. The required care encompasses preventive dental services and pharmacy services as may be appropriate for particular centers. In addition, provisions need to be made for referral to specialists, as well as for substance abuse and behavioral health treatment; patient case management; transportation; interpretation services as necessitated for the population; and patient education.¹³

CHC providers must have hospital privileges or formal agreements must be made with other entities for the care of center patients requiring hospitalization. Similarly, after hour coverage must be available to patients either by center staff or through agreements with other providers.^{14,15} An example of such arrangements is that of the contract between Falls Community Health (FCH) in Sioux Falls and the Sioux Falls Family Medicine Residency Program (Center for Family Medicine) for after hours coverage and hospital care of FCH patients.

CHCs in the Dakotas

There are nine CHCs in North and South Dakota. The five centers in North Dakota have 20 delivery sites in 18 communities; South Dakota has four CHC organizations with 42 delivery sites in 33 communities. (See Figures 1 and 2).

CHCs in South Dakota first emerged 40 years ago when two organizations, the Miner-Hamlin Health Care Project

Figure 1. Locations of North Dakota community health centers



Figure 2. Locations of South Dakota community health centers



and Tri-county Health Care, each received a grant from the Bureau of Primary Health Care to establish and assist communities in opening clinics and recruiting healthcare professionals. The Miner-Hamlin Health Care Project was comprised of citizens from Howard and Bryant, South Dakota, who sought funding because the healthcare provider in their community was retiring, leaving residents at risk of losing local health care. Tri-county Health Care included citizens of Wessington Springs, Plankinton, and Woonsocket, South Dakota. The first clinics to develop from this effort were the Howard Clinic, which opened in February of 1978, the Bryant Clinic, which opened in March of 1978, and the Jerauld County (Wessington Springs) Clinic, which opened in August of 1978. The Miner-Hamlin Health Care Project subsequently changed its name to East River Health Care and in 1998 merged with Tri-county Health Care to become Horizon Health Care.¹⁶

CHCs in North Dakota can trace their origin to a homeless center, which opened a clinic at the Salvation Army in Fargo in 1990 funded by a Homeless Health Care (section 340) Grant. CHC 330 non-profit status was obtained in 1993. The clinic’s name was changed to Family Health Care Center in 1994. Family Health Care now has clinics in Fargo, West Fargo, South Fargo, and Moorhead, Minnesota.¹⁷

CHCs in North Dakota served 41,075 medical and dental patients (133,714 total visits) in 2017.

South Dakota CHCs served 68,601 medical and dental patients (230,575 total visits).

Figures 3 and 4 provide demographics for patients served by North and South Dakota CHCs.

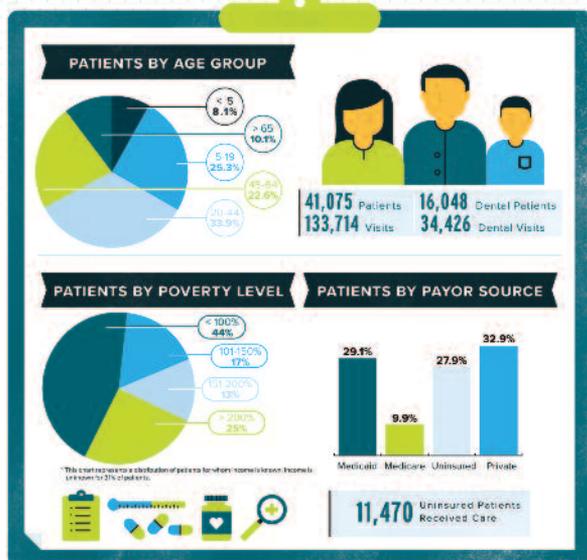
Quality Metrics for CHCs

All community health centers across the country are monitored for quality by HRSA through use of a uniform

Figure 3. 2017 snapshot of North Dakota community health centers

2017 SNAPSHOT

NORTH DAKOTA COMMUNITY HEALTH CENTERS



Coal Country Community Health Center
Family HealthCare

Northland Health Centers
Valley Community Health Centers



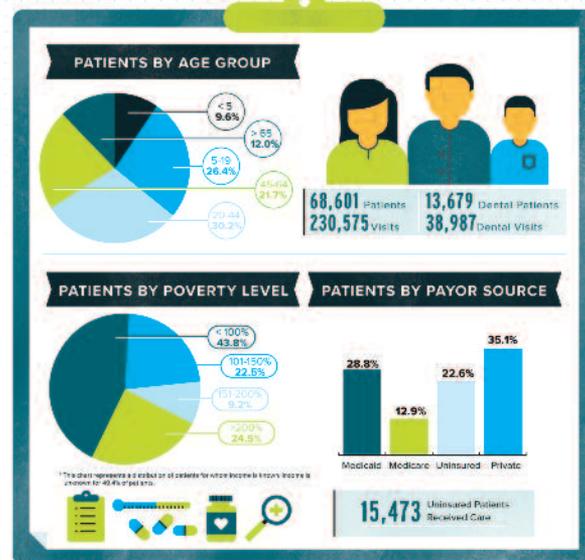
Source: 2017 North Dakota UDS Data

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Figure 4. 2017 snapshot of South Dakota community health centers

2017 SNAPSHOT

SOUTH DAKOTA COMMUNITY HEALTH CENTERS



Community Health Center of the Black Hills
Falls Community Health

Horizon Health Care
Rural Health Care



Source: 2017 South Dakota UDS Data

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data system (UDS). Data is submitted electronically to HRSA on an annual basis. Some of the clinical measures reported on are:

- Percentage of patients with a diagnosis of hypertension who are controlled with a blood pressure of less than 140/90
- Percentage of patients with diabetes mellitus who are poorly controlled (hemoglobin A1c greater than 9 percent) or who have not been tested during the year
- Percentage of patients with asthma using appropriate medication for treatment of the disease
- Percentage of patients with coronary artery disease receiving lipid therapy
- Percentage of eligible patients who have been screened for cervical cancer
- Percentage of eligible patients who have been screened for colorectal cancer

The UDS also reports on demographics, services provided (called the scope of practice), costs, and revenues. Table 1 compares CHAD centers to national centers in meeting several clinical outcomes measures during 2016. As can be discerned, our centers compared favorably. Comparison data for 2017 are not yet available.

Community HealthCare Association of the Dakotas

The Community HealthCare Association of the Dakotas (CHAD) is the Primary Care Association for North and South Dakota. Established as a 501c(3) membership organization in 1986, CHAD supports the nine CHCs in the Dakotas through training, technical assistance, and advocacy. With offices in Sioux Falls and Bismarck, CHAD provides CHCs with resources for key operations including: clinical, human resources, finance, regulatory compliance, outreach, and marketing.¹⁸

In addition to as needed daily supportive services it

Table 1. Selective clinical outcomes measures for community health centers of North Dakota/South Dakota (aggregate)* vs. national center averages – by percentage of patients, 2016

	CHAD Centers	National
Patients with controlled hypertension (Blood pressure less than 140/90)	65.1%	62.4%
Patients with diabetes mellitus who are poorly controlled (hemoglobin A1c greater than 9 percent) or who have not been tested during the year	31.4%	32.1%
Patients with asthma using appropriate medication for treatment of the disease	77.4%	87.4%
Patients with coronary artery disease receiving lipid therapy	79.0%	79.5%
Eligible patients who have been screened for cervical cancer	48.9%	54.4%
Eligible patients who have been screened for colorectal cancer. *Community HealthCare Association of the Dakotas (CHAD) – Nine Centers	41.7%	39.9%

provides, CHAD organizes an annual conference for the membership to facilitate collaboration, foster leadership development, and inform members of legislative and other important developments affecting CHCs. It also helps to arrange and coordinate meetings with state and national officials including advocacy efforts.

An example of a major effort coordinated by CHAD was the 2017-18 advocacy efforts to help avoid the “funding cliff,” which would have placed community health centers throughout the nation in a dire financial situation had it not been resolved. The potential financial impact on North Dakota and South Dakota centers would have resulted in a budgetary shortfall of over \$7 million for North Dakota and \$13 million for South Dakota if critical 330 funds, the primary mechanism of federal funding for CHCs, were lost. More importantly, it would have adversely affected the care of tens of thousands of the most vulnerable of our population in the Dakotas and millions nationwide. It would also have placed an enormous stress on emergency rooms and resulted in a much higher cost of care, which would have ultimately been borne by the public. Re-authorization of CHCs will next be addressed by Congress in 2020.

Conclusion

Community health centers remain a critical component of the healthcare safety network throughout the United States, including the Dakotas. They remain true to their

original mission to provide quality healthcare to the most vulnerable of our population, whether they are impoverished, uninsured, or would otherwise lack access to healthcare.

Acknowledgment

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Please note: Due to limited space, we are unable to list all references. You may contact South Dakota Medicine at 605.336.1965 for a complete listing.

About the Authors:

H. Bruce Vogt, MD, FAAFP, Professor Emeritus, Department of Family Medicine, University of South Dakota Sanford School of Medicine, Sioux Falls, South Dakota.

Jennifer Tinguely, MD, MPH, Medical Director, Falls Community Health, Sioux Falls, South Dakota; Clinical Assistant Professor, Department of Family Medicine, University of South Dakota Sanford School of Medicine.

Jill Franken, MS; Sioux Falls Public Health Director, Department of Health, Sioux Falls, South Dakota; Executive Director, Falls Community Health, Sioux Falls, South Dakota.

Shelly Ten Napel, MSW, MPP, Chief Executive Offer, Community HealthCare Association of the Dakotas, Sioux Falls, South Dakota.