The National Association of Community Health Centers, Inc.

Special Topics Issue Brief #2

The Role of Health Centers in Reducing Health Disparities

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“Of all forms of inequality, injustice in health care is the most shocking and inhuman.”
-Dr. Martin Luther King, Jr.

INTRODUCTION

The health centers program is committed to delivering care to the nation’s underserved, a large proportion of whom are minorities. Through this commitment, health centers play a major role in addressing health disparities. In recognition of this, last year Health and Human Services Secretary Tommy Thompson told an audience of health center representatives “One of our top priorities at the Department of Health and Human Services is to reduce racial disparities in health care in America. We are committed to providing access to quality care for all Americans, and…community health centers are among the very most effective tools at accomplishing that goal.”

The 2002 landmark report from the National Academy of Sciences’ Institute of Medicine (IOM), Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare, recognized the importance of health centers in increasing access to care and in improving health outcomes for all patients, including minorities. The report concludes American minorities receive poorer health care than non-minorities, even when income, insurance status and medical conditions are considered. This inequality contributes to higher minority morbidity and mortality rates than those of non-minorities. For example:

- African Americans and Hispanics are less likely than non-minorities to receive appropriate cardiac medication or undergo coronary artery bypass surgery;
- African Americans with end stage renal disease are less likely than non-minorities to receive hemodialysis and kidney transplantation; and
- African American and Hispanic patients with bone fractures seen in hospital emergency departments are less likely than non-minorities to receive pain medication.

According to the IOM report, this disparity in the quality of healthcare is the result of racial or ethnic differences rather than due to access-related factors, clinical needs, preferences, or appropriateness of intervention. Factors causing disparities identified by the IOM include language barriers; inadequate coverage; bias, stereotyping, prejudice, and “clinical uncertainty” on the part of providers; and lack of minority doctors. These factors exist in all aspects of the health care system.

Through its review of literature, as well as discussions with minority healthcare consumers, professionals, researchers, providers, advocates, federal agency representatives, and American Indian and Alaska Native tribal leaders, the IOM concluded with a series of

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3 Ibid, page 19.
recommendations for eliminating racial and ethnic disparities in the United States. These recommendations are listed below in Box 1.

**Box 1**

**IOM Recommendations to Address Health Disparities**

**General Recommendations**
- Increase awareness of racial and ethnic disparities in healthcare among the general public and key stakeholders.
- Increase healthcare providers’ awareness of disparities.

**Legal, Regulatory, and Policy Interventions**
- Strengthen the stability of patient-provider relationships in publicly funded health plans.
- Increase the proportion of underrepresented U.S. racial and ethnic minorities among health professionals.

**Health Systems Interventions**
- Enhance patient-provider communication and trust by providing financial incentives for practices that reduce barriers and encourage evidence-based practice.
- Support the use of interpretation services where community need exists.
- Support the use of community health workers.
- Implement multidisciplinary treatment and preventive care teams.

**Patient Education and Empowerment**
- Implement patient education programs to increase patients’ knowledge of how to best access care and participate in treatment decisions.

**Cross-Cultural Education in the Health Professions**
- Integrate cross-cultural education into the training of all current and future health professionals.

**Data Collection and Monitoring**
- Collect and report data on health care access and utilization by patients’ race, ethnicity, socioeconomic status, and where possible, primary language.
- Include measures of racial and ethnic disparities in performance measurement.
- Monitor progress toward the elimination of healthcare disparities.
- Report racial and ethnic data by OMB categories, but use subpopulation groups where possible.

**Research Needs**
- Conduct further research to identify sources of racial and ethnic disparities and assess promising intervention strategies.
- Conduct research on ethical issues and other barriers to eliminating disparities.


Health centers have already put many of these recommendations into practice, and serve as an example on how to eliminate health disparities. This issue brief:

- Reviews how health centers reduce, and even eliminate, many racial and ethnic disparities in access to health care as well as health outcomes for their patients;
- Describes the Health Disparities Collaboratives which have successfully improved health outcomes and narrowed the disparities gap for health center patients with chronic conditions; and
- Presents a summary of findings from literature measuring the performance of health centers and demonstrating that they successfully improve access to and quality of care among minorities.
THE ROLE OF HEALTH CENTERS

The health centers program was created to deliver health care to the underserved, of whom minorities are disproportionately represented. In 2000, while Latinos represented less than 13 percent of the U.S. population, they made up 30 percent of the uninsured. During the same year, African Americans represented about 12 percent of the population and 17 percent of the uninsured. Nationally, racial and ethnic minorities are projected to grow from 28 percent of the U.S. population in 1998 to 40 percent by 2030.

Health centers consistently meet the needs of minorities. For almost 40 years, health centers have been providing high quality, cost-effective, primary and preventive health care to the medically vulnerable, regardless of insurance status or ability to pay. The health center mission as established by the federal agency that oversees the health center program, the Bureau of Primary Health Care (BPHC) within the Department of Health and Human Services, is to “provide family-oriented primary and preventive health care services for people living in rural and urban medically underserved communities regardless of their ability to pay. Health centers overcome economic, geographic, [and] cultural barriers to primary health care, and they tailor services to the needs of the community.”

By 2002, there were approximately 1,000 community, migrant, and homeless health centers in the U.S. in over 3,500 urban and rural communities in every state and territory. Health centers are an important part of the safety net system, serving as the family doctor and medical home for over 13 million people, including 4.9 million low-income children, 5 million uninsured people, and 8 million people of color. As can be seen in Figure 1 below, two-thirds of all health center patients in 2001 were members of minority groups, with Latinos making up the largest minority group at 35% of all health center patients, while African Americans make up a quarter of all patients.

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7 Based on calculations by NACHC, 2003.
HEALTH CENTER REQUIREMENTS AND HOW THEY ADDRESS DISPARITIES

All health centers are characterized by five essential and unique requirements that are central to their mission and success. Health centers must meet these requirements in order to be funded under Section 330 of the Public Health Services Act. Moreover, these factors contribute to their role in reducing or eliminating racial and ethnic health disparities.

First, health centers must be located in high-need areas. Health centers must, by law, be located in areas that have been identified as “medically underserved” – typically economically distressed inner-city neighborhoods and isolated rural communities, where low-income individuals and families live and work, and where few available health providers exist. Accessibility of patient-centered care is a priority in increasing access to care. Many health centers operate during evening or weekend hours, at multiple sites, and through mobile clinics to reach rural and homeless patients. Health centers eliminate disparities by improving access for people who traditionally confront geographic barriers to health care.

Second, health centers must provide comprehensive health and “enabling” services. They make it their mission to deliver early and effective primary and preventive care, as well as other health and social services. Health centers tailor their services to fit the special needs and priorities of their communities. Many provide health education programs on a variety of topics, including parenting classes and nutrition. Additionally, health services are provided in a linguistically and culturally appropriate setting, meaning that staff are often bi- or multi-lingual, patient materials are written in multiple languages, and staff are sensitive to the specific needs and cultural beliefs of their patients. Table 1 below lists examples of services health centers provide.
Table 1
Examples of Services Provided at Health Centers

<table>
<thead>
<tr>
<th>Health Services</th>
<th>Enabling Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Primary and Preventive Health Care</td>
<td>• Case Management</td>
</tr>
<tr>
<td>• Obstetrical and Gynecological Care</td>
<td>• Health Education</td>
</tr>
<tr>
<td>• Dental Services</td>
<td>• Parenting Education</td>
</tr>
<tr>
<td>• Mental Health/Substance Abuse Services</td>
<td>• Nutrition Education</td>
</tr>
<tr>
<td>• X-Rays and Lab</td>
<td>• Outreach</td>
</tr>
<tr>
<td>• Pharmacy</td>
<td>• Interpretation/Translation</td>
</tr>
<tr>
<td>• Hearing/Vision Screening</td>
<td>Services</td>
</tr>
<tr>
<td>• Testing for Blood Lead Levels</td>
<td>• Transportation</td>
</tr>
<tr>
<td></td>
<td>• Home Visiting</td>
</tr>
</tbody>
</table>

Third, health centers must be open to all residents, regardless of income, with sliding scale fee charges for out-of-pocket payments based on an individual’s or family’s income and ability to pay. They must serve all patients seeking care, regardless of insurance status or inability to pay. Because of their mission, the patient population at health centers is heavily uninsured or publicly insured. As Figure 2 below illustrates, 40 percent of health center patients were uninsured and 37 percent had Medicaid or SCHIP in 2001. Only 16 percent had private coverage.

Figure 2
Insurance Status of Health Center Patients, 2001

Fourth, health centers, the vast majority of which are Section 501(c)(3) federally tax-exempt, non-profit organizations, must be governed by community boards, and at least 51 percent of the membership of these governing boards must consist of patients. Consumer-majority boards assure responsiveness to local needs.

Finally, health centers must follow rigorous performance and accountability requirements regarding their administrative, clinical, and financial operations. The Uniform Data System (UDS) is an integrated reporting system used by health centers to report clinical and performance outcomes to the BPHC. This system establishes a means of health center accountability regarding cost effectiveness and quality of care. Section 330 grantees are required to report information each year on utilization, patient demographics, insurance status, managed care, prenatal care and birth outcomes, diagnoses, and financing.

APPLYING IOM RECOMMENDATIONS TO ADDRESS DISPARITIES

Not only do health center grant requirements address disparities, health centers also have historically applied many of the IOM report’s recommendations. As a result, minority health center patients experience better health outcomes than non-health center minorities. Given the fact that health centers minimize and even eliminate disparity in access to care, a recent study sought to examine the disparity in health status among health center patients of different racial and ethnic groups and compare those findings to non-health center patients. The study compared self-reported healthy life indicators from the 1994 Health Center User Survey and the 1994 National Health Interview Survey, including in the later survey set only those identifying a usual source of care other than a health center. The study found that while there were significant racial and ethnic health disparities in healthy life among the general population even after controlling for socio-demographic factors, these disparities did not exist among health center users. In fact, the study found that non-white Hispanic health center users experienced healthier life than both African American and white users, and no significant differences were found between white and African American users. Conversely, among non-health center users, whites experienced significantly healthier life than both African Americans and Hispanics. The study concludes that the absence of disparities at health centers may be related to their culturally competent practices and community involvement, features that are often lacking at other primary care settings.

The remainder of this issue brief discusses the ways in which health centers have reduced disparities for their patients through practices that closely parallel the recommendations from the IOM.

IOM Recommendations: Legal, Regulatory, and Policy Interventions and Health Interventions

Effective Provider-Patient Communication. According to the IOM report, positive provider-patient relationships are related to positive health outcomes, especially for minority patients. The report suggests that greater racial and ethnic diversity among health professionals

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would strengthen patient-provider relationships. The IOM also found that many racial and ethnic minority Americans experience language barriers because of limited proficiency in speaking, reading or comprehending English. Linguistic barriers can present significant challenges to both patients and providers, particularly for Asian Americans/Pacific Islanders and Latino populations. In fact, many studies have shown that low-income patients often report significant difficulties in communicating with their providers. These problems can lead to serious under-use of preventive services and substantial treatment disparities.

Health centers recognize their patients’ diverse backgrounds and provide services in a linguistically and culturally appropriate setting. Clinicians often speak other languages, and staff commonly provide trained interpretation. In 2001, 28% of health center patients were best served in a language other than English. A 2001 survey of health center patients found that 95 percent reported their doctor speaks the same language as they do, and of those reporting their doctor does not speak the same language, over half stated someone at the health center translates.

Also, to help overcome linguistic and cultural barriers, many health centers employ *promotoras* or community health workers. *Promotoras* are persons from health center patient communities who speak the common language and are sensitive to the specific needs of the community. For example, the Centro San Vicente Community Health Center in El Paso, Texas relies on direct community involvement to serve a primarily Hispanic, working poor population without health insurance or the financial means to pay for needed services. The Center's Community Health Workers (*Promotoras*) serve as liaisons for the Center staff to the community. Centro San Vicente uses *promotoras* to provide a number of community health services, such as:

- Educating community members on how to access health care and social services;
- Motivating community involvement;
- Advocating for individual and community needs;
- Providing culturally and age appropriate health education;
- Interpreting medical and other terminology for clients; and
- Promoting the importance of self-care and prevention.

_Multidisciplinary Delivery of Health Services._ The IOM recommended wider use of multidisciplinary team approaches because they effectively optimize patient care. These teams save costs and improve efficiency of care by reducing the need for face-to-face physician visits

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and improving patients’ day-to-day care between visits. In addition to providing culturally and linguistically appropriate services, health centers use a team-effort approach to care for their patients. Multidisciplinary teams of physicians, nurses, dietitians, and social workers coordinate and streamline care, enhance patient adherence to health care plans through follow-up techniques, and address multiple behavioral and social risks faced by patients. More on multidisciplinary teams will be discussed below under Patient Education and Empowerment.

**Continuity of Care.** Health centers provide continuity of care, or “one-stop caring.” One recent study found that health centers provide better continuity of care than in either hospital outpatient departments or physician offices. The study also examined preventable hospitalizations among medically underserved communities and found that in communities served by Federally-Qualified Health Centers, rates of preventable hospitalizations were lower than in communities not serviced by these centers. Patients in underserved areas served by these centers had 5.8 fewer preventable hospitalizations per 1,000 population over three years than those in underserved areas not served by a Federally-Qualified Health Center.

**IOM Recommendation: Patient Education and Empowerment**

**Patient Education.** Patient education improves patients’ understanding of their health and health care needs, as well as encourages their participation in care decisions. Patient education may include reading materials such as books and pamphlets, as well as classes on disease management and proper nutrition. In 2001, 96 percent of federal health center grantees provided some type of health education program, and 73 percent provided parenting education separate from other health education programs.

**Eliminating Disparities for Chronic Conditions Through Empowerment.** At least 20 percent of all health center visits in 2001 were for chronic conditions – most notably diabetes, hypertension, asthma and other respiratory illnesses, and heart conditions – or for mental health problems. Many health centers are participating in a nationwide initiative known as the Health Disparities Collaboratives, which aims to improve health outcomes for chronic conditions among the medically vulnerable. Developed by the BPHC in 1999, the initiative is structured around the chronic care model, defined as “a population-based module that relies on knowing which patients need care, assuring that they receive knowledge-based care and actively aids them to participate in their own care.” It was designed to cover all chronic illnesses and, ultimately, prevention as well. Currently, participating health centers focus on diabetes, cardiovascular disease, asthma, depression, prevention, cancer, and HIV.

The Collaboratives seek to *transform* care through a chronic care model that identifies and tracks which patients need care for each health condition, *apply* the most current clinical

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16 Ibid.
17 For more information, see the Health Disparities Collaborative website, [www.healthdisparities.net/index.html](http://www.healthdisparities.net/index.html).
knowledge and practice guidelines to the care that is provided, and actively involve patients in their own care by educating them on their condition and encouraging them to set their own health improvement goals. To achieve this last objective, Collaboratives stress planned individual and group visits to help patients track their improvement and to continue meeting their goals. Self-management education has been shown to be more effective than simply providing information to patients in improving clinical outcomes, and possibly reduces costs associated with caring for the chronic condition.\(^{19}\)

Health centers operating Collaboratives participate in intensive, year-long learning and improvement activities. Multi-disciplinary health center teams attend three learning sessions conducted by the Institute for Healthcare Improvement under contract to HRSA, using a performance-based method of learning that supports teams from several health centers to apply, adapt, share, and generate knowledge about best practices, and to spread these best practices to other health centers. The Collaboratives are created to be implemented in care delivery systems quickly and efficiently. In the years following their intensive learning experience, health center clinical teams disseminate best practices to other health centers and continue to report progress on nationally shared measures.

The Collaboratives are supported by both the BPHC and state Primary Care Associations, which work with state health departments to support health centers’ efforts to implement the chronic care model. Health centers are also partnering with local and state organizations, including local businesses, YMCAs, and faith-based organizations, as well as with national partners such as the National Association of Community Health Centers (NACHC), the Centers for Disease Control and Prevention (CDC), and the Bayer Corporation. These partnerships have increased access to expertise, computer software, discounted pharmaceuticals and laboratory equipment, direct community resources for patients, health education materials, and community level marketing and educational resources.

Since 1998, more than 450 health centers have participated in the program, and by the end of 2003 the number will exceed 600, two-thirds of all health centers, marking significant progress toward meeting the federal goal of having all health centers participate in one of the Collaboratives by 2005. To date, more than 75,000 health center patients with chronic disease have been enrolled in the Health Disparities Collaboratives’ electronic registries that drive proactive, planned care for patients and document their outcomes.\(^{20}\)

The ability of the Collaboratives to improve the health of center patients will undoubtedly assist in closing the health gaps for racial and ethnic minorities as well as the poor in the U.S. The experience of two health centers described below that participate in the Health Disparities Collaboratives help to illustrate the success of the program, as well as how they have improved health outcomes for minority populations.


\(^{20}\) Based on personal communication with the BPHC.

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**Clinica Campesina (Colorado)**

Clinica Campesina provides care to a largely uninsured Hispanic population in the Denver, Colorado area. As of 2001, Clinica’s three facilities provided care to almost 17,000 people, with 58,000 patient visits. Seventeen percent of their patients suffer from a lifelong or chronic disease. Clinica implemented its diabetes Collaborative in 1999. The clinic established multidisciplinary teams of doctors, nurse practitioners, health educators and medical assistants, as well as a diabetes registry and commenced a monthly review of patients due for appointments for needed visits or tests. In addition, patients participate in self-management programs where they are provided health education and information on choosing self-improvement goals such as daily exercise or stopping tobacco use.

Clinica Campesina reports that the average HbA1c level of its diabetic population dropped from nearly 11 percent in October 1998 to under 9 percent in March 2000. The health center also reports that the percent of diabetic patients with self-management goals increased from 3 percent in February 1999 to 65 percent by March 2000. Table 2 below highlights the increases in the rates of diabetic patients receiving certain necessary services.

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Percent of Diabetic Patients at Campesina Clinica Receiving Necessary Exams, Pre- and Post- Health Disparities Collaborative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Exam</td>
<td>Pre-Collaborative, October 1998</td>
</tr>
<tr>
<td>At least 2 HbA1c tests within a year</td>
<td>11%</td>
</tr>
<tr>
<td>Eye examinations</td>
<td>7%</td>
</tr>
<tr>
<td>Foot examinations</td>
<td>15%</td>
</tr>
</tbody>
</table>


**Bedford-Stuyvesant Family Health Center (New York)**

The Bedford-Stuyvesant Family Health Center (BSFHC) located in Brooklyn, New York began its diabetes Collaborative in April 2001. BSFHC serves 13,000 patients annually, 85 percent of whom are African American and 13 percent are Hispanic. Approximately 600 of their patients have been diagnosed with diabetes mellitus. While comparative data pre- and post-implementation are not currently available, the health center reports that of their diabetic patients:

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23 Hemoglobin A1c levels are used to measure blood sugar among individuals with Diabetes.
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- 68% have A1c levels <8.0;
- 76% have two HgbA1c tests at least three months apart;
- 74% have at least one annual retinal eye exam; and
- 65% have at least one annual dental exam.²⁵

Whether measured in terms of individual health center patients or large populations, the Collaboratives demonstrate that it is possible to transform the health care system from one of sickness care to one that is truly about health care. Collaboratives are powerful drivers for positive change, through generating improved outcomes faster than traditional models of training or individual patient-doctor consultation, and efficiently and effectively translating research into practice. For example, only two months after the results of a clinical diabetes prevention trial were reported in the medical literature, health centers were busy learning how to put the knowledge gained from the trial into practice.²⁶

As a result of the work of the health centers Collaboratives, the IOM commended health centers in another recent report, *Fostering Rapid Advances in Health Care: Learning From System Demonstrations*, saying that their “strong record in chronic care management, electronic patient registries and performance measurement…contribute to providing care that is at least as good as, and in many cases superior to, the overall health system in terms of better quality and lower costs,” and recommended health centers as models for reforming the delivery of primary health care.²⁷

**IOM Recommendation: Data Collection and Monitoring**

The IOM report notes that standardized data collection is critically important in the effort to understand and eliminate racial and ethnic disparities in health care. However, standardized data on racial or ethnic inequality in care are not readily available from non-health center institutions. Federal and state-supported data collection efforts are sporadic and unsystematic. Also, many healthcare delivery institutions do not collect data on enrollees’ race, ethnicity, or primary language.²⁸

In contrast to these other health care institutions, the BPHC collects data annually from health centers on their administrative, clinical and financial operations, and patient characteristics through the UDS reporting system. Through the use of UDS, numerous studies using objective and comparative measures of performance have documented that health centers deliver effective, high quality health care.²⁹

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²⁵ Based on personal communication with Dr. Monica Sweeney, Medical Director, Bedford-Stuyvesant Family Health Center. Dr. Sweeney also presented this information in September 2002 at the Black and Puerto Rican Caucus Conference in Washington, DC.
²⁶ Based on personal communication with the BPHC. For the article on the diabetes prevention trial, see Diabetes Prevention Program Research Group. 2002. “Reduction in the Incidence of Type 2 Diabetes with Lifestyle Intervention or Metformin.” *New England Journal of Medicine* 346(6):393-403.
²⁸ IOM, March 2002.
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Not only does UDS provide a helpful look into the operations of health centers, it also allows for comparisons of health measures between health center patients and the general U.S. population. The most recent review of literature comparing health center and national health outcomes looked at UDS data from 1998, as well as survey information of health center and non-health center individuals, to demonstrate the success of health centers in reducing or eliminating health disparities. Because health centers serve a disproportionate number of minorities, improved access for all health center patients results in reductions in racial or ethnic health disparities. Some examples discussed in the article are described below.

- **Access to Care.** Of uninsured individuals who participated in a 1998 national survey, 55 percent reported that they delayed seeking care because of costs, 30 percent reported going without needed care, and 24 percent did not fill prescriptions for needed medicine. According to a 1995 survey of health center patients, those who were uninsured reported rates for the same measures that were half those of the nation’s uninsured (25, 16 and 12 percent, respectively).

- **Prevention Services.** Health centers have been instrumental in reducing racial/ethnic disparities in access to screening and prevention services. In fact, for mammograms, clinical breast examinations, and up-to-date Pap smears, health center women have far exceeded the national rate for comparable women, and have met or exceeded the Healthy People 2000 goal for those categories. Figure 3 shows that 76 percent of Hispanic health center women needing mammograms received them compared to 49 percent nationally, and 61 percent of African American health center women patients needing mammograms received them compared to 49 percent nationally.


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Figure 3

Percent of Women Receiving Mammograms, at Health Centers vs. Nationally, 1995 and 1997*

<table>
<thead>
<tr>
<th>Race</th>
<th>Health Centers</th>
<th>Nationally</th>
<th>Healthy People 2000 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>76%</td>
<td>48%</td>
<td>61%</td>
</tr>
<tr>
<td>African American</td>
<td>61%</td>
<td>49%</td>
<td>58%</td>
</tr>
<tr>
<td>White</td>
<td>58%</td>
<td>44%</td>
<td>49%</td>
</tr>
</tbody>
</table>


- **Low Birth Weight.** Nationally, thirteen percent of African American women give birth to low birth weight infants, compared to 9.9 percent of all African American women at health centers and 7.4 percent of rural African American health center patients in 1998. This statistic is noteworthy, considering the fact that health center women are more likely to be at greater risk for adverse pregnancy outcomes.

- **Avoiding Hospitalization.** Medicaid beneficiaries who sought care at health centers were 22 percent less likely to be hospitalized for potentially avoidable conditions than beneficiaries who obtained care elsewhere. Moreover, these patients were 16 percent more likely to have outpatient visits for such conditions. Compared to non-health center users, health centers are able to reduce Medicaid costs by 30 percent to 34 percent.

- **Health Education.** Uninsured adults at health centers were more likely than other US uninsured adults to be counseled on nutrition (54 percent vs. 43 percent), physical activity (57 percent vs. 49 percent), smoking (75 percent vs. 64 percent), drinking (68 percent vs. 52 percent), drug use (55 percent vs. 39 percent), and sexually transmitted diseases (54 percent vs. 36 percent).

- **Chronic Care.** Health centers meet or exceed nationally accepted practice standards. Ninety percent of African American and Hispanic health center patients with hypertension reported that their blood pressure is under control. This is more than triple that of a comparable national group and nearly double the Healthy People 2000 goal of 50 percent. Also, health center diabetics were more then twice as likely to have their glycohemoglobin tested on schedule than the national population.
CONCLUSION

Health centers deliver savings to all payers, especially Medicaid. Several studies have found that health centers save the Medicaid program at least 30 percent in annual spending for health center beneficiaries due to reduced specialty care referrals and fewer hospital admissions. Based on that data, it is estimated that health centers already save almost $3 billion annually in combined federal and state Medicaid expenditures – $1.2 billion in state spending alone. That amount is more than four times the current national total of state-appropriated funding provided to health centers.31

Both the Bush Administration and Congress recognize the contribution made by health centers. President Bush made a substantial commitment to the nation’s health centers by proposing a five-year initiative to increase federal funding for the health centers program by at least $2.2 billion through Federal Fiscal Year 2006. The President’s initiative has received overwhelming bipartisan Congressional support. For the past three years, Congress has approved the three largest funding increases over the program’s history, enabling health centers to serve more than 2 million additional people.

Over the full five-year period, the President’s proposal would support new and expanded sites and services designed to serve an estimated 6.1 million additional patients, while a bipartisan Congressional REACH (Resolution to Expand Access to Community Health) initiative seeks to extend care to an additional 10 million patients over the same period. If the demographics of these new health center patients under the Bush and REACH initiatives parallel as expected those of the 13 million Americans served by health centers in 2002, then by 2006 health centers will be the family doctor and health care home for:

- Between 30 and 38 percent of all low-income Latinos;
- Between 30 and 36 percent of all low-income African Americans; and
- Between 12 and 15 percent of all low-income Asian/Pacific Islanders.32

As the nation confronts the unsettling findings in the Institute of Medicine’s report, Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare, health centers provide a model for how health disparities can be successfully eliminated. They play a vital role because of their expertise in serving large numbers of minorities and the medically underserved. Moreover, they provide comprehensive and culturally sensitive medical and social services, as well as constantly endeavor to expand their services to improve access for those who are underserved. The Health Disparities Collaboratives demonstrate how health centers have successfully integrated their services to improve health outcomes. Additional federal and state support would allow health centers to continue to eliminate disparities while yielding cost savings.

31 Based on calculations by NACHC, 2003.