

NACHC newsletter

National Association of Community Health Centers, Inc.

Winter 1986

Medical Malpractice Crisis: Here We Go Again

Much has been said lately about the current "medical malpractice crisis" and for some of us this great debate has stirred up feelings of *deja vu*. It was just a decade ago that insurance carriers, responding to an alarming increase in the frequency and severity of medical liability claims, put severe limits on the coverage they offered, raised their premiums to a level many health care providers could not afford or dropped out of the liability insurance business entirely. As a result, many health care providers were left without a market in which they could obtain adequate liability coverage.

Today, the number of medical liability claims and award amounts is again on the rise. The insurance industry reports that there were 16.4 claims per 100 MDs in 1984 compared with 2.5 in 1976 and that insurance underwriting losses this year will be in excess of \$25 billion — a record amount.

Responding to this situation as they did ten years ago, insurers are again hiking premium prices to record levels, severely limiting coverage or withdrawing coverage in certain areas. In turn, health care providers, depending upon what services they perform and where they are located, are once again faced with serious problems of affordability and/or availability of adequate medical liability insurance.

While the average cost of malpractice insurance is said to represent a very small percentage of a provider's gross income, those who provide high-risk services have been hit particularly hard with large insurance premium increases. Malpractice coverage for an OB/GYN for example, cost an average of \$3,000 last year while this year the average is \$18,000.

As lawyers, health care provider groups and the insurance industry debate over who should be blamed for this situation, one thing is certain — the lack of appropriate, affordable, medical liability coverage poses some very serious pro-

blems for community and migrant health centers which have traditionally served the health care needs of the poor and near-poor — typically a high-risk group which has little health resources of their own.

Centers Forced to Make Tough Decisions

Although it should be borne in mind that most community and migrant health center physicians may not engage in hospital-based, high-risk medical procedures to the same extent as do other primary care specialists, they nonetheless have had a lower incidence of claims than the national averages in such areas such as obstetrics and family medicine.

Because insurers place greater emphasis on provider specialty rather than claims history in setting premium levels, however, community and migrant centers, by the nature of their services, are seeing their insurance bills double and in some cases triple. Already faced with declining federal dollars, many centers are finding that they simply cannot afford the huge insurance bill that is now required to continue liability coverage. As a result they are having to make some very difficult decisions in terms of their services and their patients.

As an alternative to closing their doors altogether, centers are (1) cutting back or cutting out entirely their high-risk services; (2) cutting back on the number of patients they serve; or (3) going "bare" — practicing without coverage. While community and migrant health centers are not required by law to carry liability insurance, this last choice is a brave one because it not only exposes the center and its staff to lawsuits, but it exposes the board of directors as well. (NACHC attorney Jacki Leiffer says that the federal government is not liable for medical malpractice suits filed against a federally-funded health center.)

The malpractice situation varies from state to state and it is not known exactly how many community and migrant centers are being adversely affected at present. It is known, however, that centers located in New York, California and Florida are experiencing difficulties particularly because the insurance industry has identified those states as being high-risk areas (a disproportionate number of claims have been filed and/or settled in those areas). As a result, insurers are refusing to do business.

On the other hand, some more fortunate centers are reporting no problems to date because they have found a carrier which has agreed to insure just the center and an alternative insurer (i.e. a state joint underwriting association) to insure its physicians. In addition, some centers do not have problems yet because their current insurance policies will not be up for renewal until later in the year.

Patients Caught in the Middle

Clearly, in those instances where centers cannot afford the insurance and thus have to reduce their services and the number of patients they serve, access to quality health care for health center patients will become increasingly limited or non-existent.

One area which poses a particular problem for health centers is prenatal care — an obstetrical service considered by health insurers to be high-risk.

As a case in point, the Anchorage Neighborhood Health Center in Alaska (one of the few centers in the area which offers sliding-scale fees for low-income patients) provided care to 300 expectant mothers last year, most of whom were low- or moderate-income patients.

The center had projected that they would see more than 500 patients this year. However, when estimating how much this would cost them in insurance, the center found that the bill would

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Boston CHCs May Link, Expand Role

by Maureen Dezell
Boston Business Journal

Community health centers, long the overlooked stepchild in Boston's high-powered, high-cost health care system, may soon become a key player in the local health care delivery arena.

As Boston-area employee benefit managers seek out cost-efficient health care providers, Boston's neighborhood health centers are positioning themselves to offer employers alternatives to cost-cutting Health Maintenance Organizations (HMOs), preferred provider organizations (PPOs) and the traditional insurance plans.

The health centers next year may establish a corporate network of neighborhood health centers that would operate as a so-called managed care organization similar to an HMO.

Such a corporation could provide hefty competition to other HMOs in Boston, such as Harvard Community Health Plan (HCHP) and Blue Cross/Blue Shield, once the latter opens its HMO operation in the city.

Health insurers are looking at ways of cooperating, rather than competing with the health centers.

Participate with Blue Cross?

Blue Cross/Blue Shield, for instance, "is actively exploring the feasibility of a Boston-based HMO program in which the health centers would be eligible to participate as providers," said Hal Belodoff, director of policy and program development at Blue Cross/Blue Shield.

Some HMOs, such as Bay State, now use health center physicians as providers in their plans.

The state, charged in legislation signed by Gov. Michael Dukakis last week with developing a plan to provide health care for the state's uninsured population, is expected to actively consider funding community health center care for the uninsured—care many of them provide gratis at this time.

Boston's 24 neighborhood health centers, some of which have been in existence for two decades, treat an estimated 250,000 Boston residents per year.

The centers are non-profit ambulatory

health facilities that provide comprehensive medical care, social services and community-based programs, particularly to low-income or medically underserved populations. Some are freestanding and some affiliated with hospitals. There is one health center in almost every Boston neighborhood.

Financially strapped because of federal cutbacks in health care funding in recent years, many community health centers have been forced to deliver care on tight budgets.

Cost Containment

Such restrictions have encouraged cost containment and delivery policies at the centers of the sort that many HMOs, clinics and physicians are now attempting to put in place.

Physicians at the centers are usually salaried—a policy widely considered to be a cost containment measure.

In order to control costs, too, the centers encourage patients to avoid seeking primary health care in expensive hospital settings. In addition, they encourage patients to seek preventive and primary care, which some health professionals say cuts down on medical costs.

Traditionally, the health centers have provided care to Medicare and Medicaid patients and the uninsured. But many also serve employed Boston residents, who pay to see doctors, nurses, social workers and technicians at the centers with employer-provided health insurance.

Yet, for the most part, corporations don't know what community health centers do, said John Cogswell, secretary-treasurer at New England Telephone and a member of the Greater Boston Forum for Health Action, an organization that is looking into setting up new programs for community health centers.

The centers suffer a reputation of operating "as storefront operations," said Cogswell, "[But] many of them are as modern and sophisticated as a Harvard Community Health Plan facility."

"The forum is in the process of tying the health care facilities into a Boston HMO, so that we can offer it as another HMO alternative to employers," added Cogswell. "Many of the centers offer managed care [including preventive programs such as dental plans and eye care],

just like regular HMOs. Some of them need [to develop] management tools.

"But they're located in neighborhoods and serve an area clientele. And a number of businesses we talked to would offer [the proposed community health center participating HMO] as an alternative to their employees," Cogswell said.

Unions and self-insured companies have already started encouraging their employees to use community health facilities, according to Charles Donahue of the Health Planning Council. "Employers and self-insured groups are beginning to recognize that community health centers deliver high-quality health care at incredibly less cost," Donahue explained.

"People who go through these health centers end up being hospitalized less frequently than others. And the quality of care at a center like the East Boston Community Health Center is superb."

But as corporations and insurers turn to the health centers with open arms, not all of them are eager to be embraced. Some centers are eager to maintain ties to hospitals. Others, long ignored by the medical and insurance establishment, aren't eager to join in partnerships with them now.

"We have a number of options open to us, and not all centers may be willing to participate in all of them," said Jim Hunt of the Massachusetts League of Community Health Centers. "We are ready and able to do managed care as a group, in a for-profit or a not-for-profit setting. We may do a linkage with an insurer. But we'll probably have our own can of peas."

Boston Commissioner of Health and Hospitals Lewis Pollack said he expects Boston's neighborhood health centers to "get into some kind of managed care system soon. It's important for them to do that."

But, cautioned Pollack, "health centers should not lose sight of their public health mission, which is to provide health care to people in a neighborhood."

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BHCDA Update

Primary Care

This year's Primary Care Program management strategy will continue to focus on improving the posture of community and migrant health centers. The basic strategy began in FY 85 with an emphasis on building both state-based service networks and cost-effective community based systems of care. Efforts this year will be directed toward effectively relating each center's objectives and resources to available and potential opportunities in its area. Each health center will experience an in-depth review of its organizational structure and performance capabilities. The purpose of the review is twofold:

- (1) to identify those organizations that based on governance, clinical and administrative capacity are a priority for funding; and
- (2) to determine the appropriate federal subsidy to support an organization's programs and services.

Program Objectives

The mission of community and migrant health centers remains unchanged. Their purpose is to combat three types of access limitations to health care—geographic, population and financial. While each center's operations should be continually reassessed in the context of the changing environment, it is essential that the basic mission and uniqueness of community and migrant health centers be maintained.

With an unchanged mission, BHCDA's activities, therefore will reflect the following programmatic objectives:

- Support for delivery systems that are organized, structured and operated in a manner that is consistent with legislative requirements and program priorities, particularly governance and clinical operations.
- Support for programs and services that are efficiently and effectively managed.

Funding Priorities

In addition to compliance with standard eligibility criteria for community and

migrant health center grants, priority for funding will be based on consistency with the following expectations:

- **Governance:** health centers that are operated by a community-based, user majority governing board that has full responsibility for the functions set forth in the Public Health Service Act Section 330 law.

The intent of the 330 law is that governing boards of health centers be responsive to the communities they serve. The statute stipulates that each governing board must represent the population of the catchment area, with users of center services comprising a majority of the membership of each board. The board is expected to exercise its authority to control the budget and resource decisions, set priorities for the center and appoint/dismiss the executive director.

Public agencies may receive up to five percent of the total available funding in a fiscal year. Where a public entity is the recipient of the grant, however, a community-based board must maintain all authorities except general policymaking. Long-term funding of public agencies is not considered a preferred option.

It is also desirable to have boards for which operation of the center is their sole responsibility, although boards that supervise other health and social services in addition to the health center may be funded on a limited basis.

- **Clinical:** health centers that have an organized system for the delivery of basic health services tailored to the population-at-risk, provided by an appropriate number of well-trained providers with hospital privileges and practices.

In order to be a funding priority, a center is expected to have full-time providers who offer continuous, comprehensive primary care, including after-hours coverage and hospitalization of their patients. They should also have, or plan for, an appropriate specialty representation, board elig-

ible or certified physicians with adequate continuing education, appropriate leadership, and an adequate quality assurance system.

- **Financial/administrative efficiency:** health centers that provide essential health services in a cost-effective manner designed to control expenditures while maximizing revenues.
- **Need-demand:** health centers located in an area with a significant need for federally subsidized primary care capacity and serve a population with a significant number of persons who are at or below poverty and/or have no alternative access to public or private providers of primary care.

Center Reviews

Centers that meet the above criteria and thus are identified as priorities for funding will undergo a review and zero-based assessment (ZBA) of their costs, revenues and need for services to determine the level of investment of migrant and/or community health center funds. A variety of indicators, outliers, screens and guides will be used to assist in the ZBA process. Each center will be assessed individually within the context of its own environment using relevant available information.

State Activities

As in fiscal year 1985, BHCDA's state-based activities will focus on continuing coordination with states of specific strategies for expansion of primary care capacity in priority urban and rural areas. State and regional primary care associations will continue as important partners in this process.

Regional Activities

Each regional office will have its own management strategy for carrying out BHCDA's FY 86 priorities and initiatives. These strategies will complement the Bureau's and will focus on in-depth reviews of grantees funded under Sections 329 and 330 of the Public Health Service Act.

Welcome New Members

Organizational Members

Bucksport Regional Health Center
Bucksport, ME

Centerville Clinics, Inc.
Fredericktown, PA

Central Florida Community Clinic
Sanford, FL

Centro de Salud Familiar La Fe, Inc.
El Paso, TX

Community Health Services
Hartford, CT

Community Health Systems, Inc.
Sprague, WV

Delta Health Center
Mound Bayou, MS

Erie Family Health Center, Inc.
Chicago, IL

Goshen Medical Center
Faison, NC

Hamilton Avenue Family Health Center
Flint, MI

Konawa Health Improvement
Association, Inc.
Konawa, OK

Lake Powell Medical Center
Page, AZ

Lunenburg Medical Center
Victoria, VA

Manet Community Health Center
Quincy, MA

Memphis Health Center
Memphis, TN

Monongahela Valley Association of
Health Centers, Inc.
Fairmont, WV

Plainfield Neighborhood Health
Services Corp.
Plainfield, NJ

Roxbury Comprehensive Community
Health Center, Inc.
Roxbury, MA

Sioux River Valley Community
Health Center
Sioux Falls, SD

Sto-Rox Health Council, Inc.
McKees Rocks, PA

West Berkely Health Center
Berkeley, CA

Associate Members

Alabama Primary Health Care
Association, Inc.
Montgomery, AL

Associated California Health Centers
Merced, CA

Association for Utah Community Health
Salt Lake City, UT

Coalition of Manhattan Health Centers
New York, NY

New Mexico Primary Care Association
Albuquerque, NM

Individual Members

Lillie C. Anderson
Yellowstone City/County
Health Department
Billings, MT

Jose Camacho
Texas Association of Community
Health Centers
Austin, TX

Ron Crawford
Mississippi Primary Health Care
Association
Newton, MS

Myrtle H. Davis
St. Louis Comprehensive Neighborhood
Health Center
St. Louis, MO

E. Frank Ellis
Swope Parkway Comprehensive &
Mental Health Center
Kansas City, MO

John D. Esselink
Samaritan Health Center
Detroit, MI

David L. Fink, MD
San Francisco Medical Center
San Francisco, CA

Iris Hernandez
Hidalgo County Health Care Corp.
Pharr, TX

Sandral Hullett, MD
West Alabama Health Services
Eutaw, AL

Rick Jacobson
Hartford Neighborhood Health
Center Consortium
Hartford, CT

Case Kolff, MD
Sea-Mar Community Health Center
Seattle, WA

Tom Lucas
Primary Care Association of
South Carolina
State Park, SC

Marie E. McCarthy
Joseph M. Smith Community
Health Center
Allston, MA

Ellouise Melton
New Madrid County Group Practice
New Madrid, MO

Leida A. Nazario
Puerto Rico Community Health
Centers Association
Loriza, PR

Carol Perfin
Tug River Health Clinic
Gary, WV

Michael Rashid
West Baltimore Community
Health Care Corp.
Baltimore, MD

Maurice Reid
Brownsville Community
Development Corp.
Brooklyn, NY

Arthur E. Shapland
Family Health & Social
Service Center
Worcester, MA

Raymond L. Standard, MD
Howard University College of
Medicine
Washington, DC

Lynne J. Steinberg
Mays Landing, NJ

Gail Anne Stevens
Delmarva, Rural Ministries, Inc.
Dover, DE

William R. Van Osdol, MD
Methodist Hospital —
Neighborhood Health Centers
Indianapolis, IN

Charles White
Franklin Memorial Primary
Health Center
Mobile, AL

New RWJ Foundation Management Program

The Robert Wood Johnson Foundation, with the assistance of NACHC, has developed a management program to help selected non-profit health centers strengthen their overall financial and managerial operations.

Established as a matching grants initiative, the *Primary Care Health Center Management Program* will be open to primary care health centers which have salaried professional staffs or voluntary professional staffs. Only established health centers with fewer than six full-time equivalent physicians are eligible to apply.

Program applicants will be required to outline a strategic plan showing how

grant funds would be used to enhance their existing management operations. Such plans could include a combination of the following: (1) steps to improve the center's marketing strategy; (2) ways to increase center revenues; (3) steps to improve billing and collection procedures; and (4) ways to make the best use of staff time and talent.

Under the program, The Robert Wood Johnson Foundation will provide selected centers with one-time non-renewable matching grants of up to \$75,000 each over a three-year period. Payments will be calculated annually, with the Foundation providing three dollars for every dollar raised from other sources by a

participating health center.

NACHC will provide technical assistance to the program and its project sites.

The management program will close when a maximum of \$1.5 million has been granted, or on June 30, 1987, whichever occurs first. Proposals will be considered on an individual basis as they are received.

Program brochures were sent to non-profit health centers during the latter part of last year. For additional copies and/or a grant application, contact Delores Price, Primary Care Health Center Management Program, The Robert Wood Johnson Foundation, POB 2316, Princeton, NJ 08540, (609) 452-8701.

Focus on NACHC Staff

Welcomes are in order for three new staff members: **Rowena Gregory**, Senior Administrative Assistant in Education & Training; **Darline Arnone**, Administrative Assistant in Administrative Services; and **Jennifer Johnson**, Administrative Assistant in Program Development.

Congratulations to **Chaye Wise**, having been promoted to Senior Administrative Assistant in Policy Analysis.

Members

Dr. Aaron Shirley, director of the Jackson-Hinds Comprehensive Health Center, Jackson, MS, and a member of the NACHC Health Policy Committee, appeared on a January 14th *CBS Evening News* broadcast on hunger in America to discuss conditions in Holmes County, Mississippi.

Cheryl P. Artis, a member of the NACHC Membership Committee, has been elected as Board Chairperson of the East Bronx Community Health Center Association, Bronx, NY. Ms. Artis has been a member of this board for the past six years and has served as Chairperson previously. At 27 years old, it is believed that Ms. Artis is one of the youngest persons in the country to have ever been elected as Board Chairperson on a community-based health center governing board.

Mark Your Calendar

March 23-26...32nd Annual Meeting of the American Society on Aging — "Aging: A Celebration of Life? The Paradox of Living Longer", Westin St. Francis Hotel, San Francisco, CA. Contact: American Society on Aging (ASA), 833 Market Street, Suite 516, San Francisco, CA 94103, (415) 543-2617.

April 17-20...NACHC 9th Annual Migrant Health Conference — "Migrant Health... America's Third World", Amfac Hotel, Minneapolis, MN. Contact: NACHC, 1625 I Street, NW, Suite 420, Washington, DC 20006, (202) 833-9280.

May 21-24...National Rural Health Care Association 9th Annual Meeting — San Diego, CA. Contact: NRHCA, 2220 Holmes, Kansas City, MO 64108, (816) 421-3075.

June 17-21...NACHC 1986 Clinical Directors Conference, Wyndam Franklin Plaza Hotel, Philadelphia, PA. Contact: NACHC, 1625 I Street, NW, Suite 420, Washington, DC 20006, (202) 833-9280.

Job Openings

Primary care center serving migrant and indigent families in the Orlando, Florida area has an opening for a **family practice physician**. Good salary and benefits. EOE. Send CV to: Gil Walter, POB 1249, Apopka, FL 32703 or call collect (305) 889-8427.

An **executive director** is needed for the overall administrative responsibilities of the Providence Rhode Island Ambulatory Health Care Foundation. The Foundation is a large multi-site community health center providing ambulatory care to low income patients. Candidate requirements include: MA in hospital administration, public health or related areas from an accredited institution. Experience in a hospital, community or public health setting preferred. EOE. Resume to: Dr. Stanley Block, Medical Director, Acting Executive Director, 469 Angell Street, Providence, Rhode Island 02906.

Do you have a staff opening and wish to advertise? If so, send position description to NACHC Newsletter, 1625 I Street, NW, Suite 420, Washington, DC 20006. Listings are free for NACHC members and \$12 per ad/per issue for non-members. NACHC reserves the right to limit ad space.

MEDICAL MALPRACTICE

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be somewhere between \$200,000 and \$400,000 for less coverage than was obtained for \$40,000 in the past. Because they cannot afford the cost, they have had to reject new obstetrics patients and have had to shift approximately 170 pregnant women from the care of six physicians to two.

Community and migrant health centers have been credited with making a significant dent in the nation's infant mortality rate by providing prenatal care to low-income women. In many situations, these women would not receive this vital care if it were not for the health center. As health centers are forced to cut back in these services, it is feared that many women will have to forgo prenatal care and simply show up as drop-in deliveries at hospital emergency rooms. It is also troubling to imagine what will happen to women in those rural communities where limited access to obstetrical care is already a problem.

What Health Centers Can Do

The medical malpractice crisis is a complex legal, monetary and moral problem that is having an adverse effect at every level of the nation's health care delivery system. While no one group alone can be blamed for causing the problem (and consequently no one group can solve

it), there are several things which health centers can do to ultimately improve the situation. These steps include:

- Assist in determining the exact impact the crisis is having on community and migrant health centers by reporting problems immediately to NACHC and their state association.
- Work closely with the state association, local medical society and other groups in reviewing and recommending changes in state laws and insurance regulations and with NACHC on federal laws which will benefit health centers.
- Work closely with the state association in soliciting alternative insurers (i.e. joint underwriting associations (JUAs) and provider-owned mutual companies) for possible coverage of health centers in the state. (At present, most of these insurers will only insure individual physicians.)
- Enlist the help of community leaders in educating legislators and public health agency officials about the problem and its effects because it is the consumers who are ultimately affected the greatest by the insurance crisis.
- Institute a formal risk management program at the center to better protect the center from lawsuits, and at the same time, make the center a more attractive prospect to insurance carriers.
- Assist NACHC in examining alternative insurance systems (i.e. self-insurance)

by answering completely and quickly all surveys sent to you.

Malpractice Task Force

NACHC has established a special Malpractice Task Force which met with the Bureau of Health Care Delivery and Assistance to discuss the malpractice issue and BHCDA's position. The task force also met to examine data taken from two recent NACHC surveys on malpractice and recently submitted recommendations to the NACHC Board of Directors on a course of action for the National Association and its constituency. Its recommendations included the following:

- Select a qualified consultant to act as an advisor on health center insurance options.
- Follow-up on malpractice surveys sent to health centers to assure that accurate and up-to-date information on the malpractice situation is readily available.
- Explore the possibilities of linking with other groups to form larger risk-sharing pools.
- Work with other health provider groups in pursuing legislation that will enhance the availability of malpractice insurance.
- Establish NACHC as a clearinghouse for health centers and state associations on state and federal insurance legislation and rulings.

New Pentagon Policy Provides Possible Opportunity For CHCs

Community-based health care providers could benefit from a new Department of Defense (DOD) policy to "keep in-house those medical specialties that relate to wartime military readiness and farm out those services that don't" because DOD has begun to look at the civilian health care provider as an alternative to its Civilian Health and Medical Care Program (CHAMPUS).

CHAMPUS, a self-insurance health care system, currently provides medical care at U.S. military medical facilities across the country and overseas to approximately 3 million dependents of active military personnel, 3.7 million retirees and their dependents and 300,000 survivors of retirees. These facilities have a million admissions and 56 million outpatient visits a year and it is estimated

that it costs the Pentagon \$12 billion annually.

Under their new policy, the Defense Department will seek arrangements with community health care providers, such as HMOs, PPOs and other contract medical programs, to provide retiree and family-oriented services (non-wartime related such as pediatrics and obstetrics) to its 7 million retirees and dependents. As a result, DOD is offering a multibillion-dollar health care contract for a single provider. (The *NY Times* reports that Hospital Corporation of America (HCA) is aggressively seeking the contract.)

A formal request for information (RFI) will go out in March of this year, followed by a request for proposals sometime in the fall. A contract will not be awarded until 1987. While the RFI has not yet

been drafted, Defense officials say that bidders will be told the number of patients to be served and the specific services they require and asked how much it will cost to provide the services.

Defense Department officials say that while this new policy will significantly reduce the military resources that are presently available for military dependents and retirees, use of civilian health care providers would be "less-costly, more efficient and more accessible than the current CHAMPUS program."

Community-based health care providers who are interested in receiving more information about the RFI should write the Office of the Assistant Secretary of Defense for Health Affairs, The Pentagon, Washington, DC 20301.

From the President . . .

Adolescent Family Life Demonstration Project

Timely and substantive communication continues to be a primary goal of the National Association of Community Health Centers. Accordingly, I am pleased to present the new *NACHC Newsletter* to you, a publication that will serve as an additional information source of our Association. In the coming months the National Association will keep you



abreast of funding opportunities, federal and local policy developments, and current topics of technical interest including malpractice updates, physician and administrative recruitment, and other technical information through this medium.

Presently the health care delivery system is experiencing significant changes, particularly with the thrust of competition and HMOs on virtually every agenda. Public policy directions are also in transition and uncertain. Community-based health centers must maintain a strong posture on the forefront of these and other trends to maximize our effectiveness. The National Association of Community Health Centers will be assessing these trends and providing timely information to member health centers for their use.

Concerning health policy, several key actions are expected this year by the Congress, including the reauthorization of the community and migrant health center programs and the National Health Service Corps. It remains uncertain what impact the President's 1987 Budget will have on community health centers, how-

ever, our Association's position regarding the budget is crystal clear and will be communicated to both the Department of Health and Human Services and Congress.

Centers must maintain adequate funding to continue their services to those at highest risk. Cuts in Medicaid, Medicare and other block grant programs have placed an unfair economic strain on centers, a strain that can only lead to reduced services and fewer patients served. One recent estimate on the effects of Gramm-Rudman legislation and the President's 1987 budget showed that the impact on community health centers nationally will be 550,000 less patients served and the possible closing of fifty centers.

On the local scene many states are focusing on the growing malpractice dilemma and the establishment of approaches to the burgeoning uncompensated care population. NACHC staff is working closely with state-based Primary Care Associations in tracking and reporting legislative action on these issues so that all may benefit from the experience of others. When appropriate, NACHC technical staff will also provide direct assistance to state associations and local community health centers.

All of this technical work, information dissemination, and patient advocacy is made possible by the involvement of dedicated individuals in the National Association and the organizational commitment of centers through membership. If your center is currently not a member of the National Association of Community Health Centers, now is the time to join. If your center is presently a member you may also join as an individual member. Please call the membership department of the Association for more information.

I look forward to seeing many of you at the upcoming Migrant Health Conference in April, at our Medical Directors meeting in June, our State Associations meeting in July or the Annual Convention and Community Health Institute in Seattle this September. Please feel free to contact either myself or the staff if we may be of service.

James W. Hunt, Jr.

James W. Hunt, Jr.
President

The Health and Human Services Office of Adolescent Pregnancy Programs is seeking applications from 28 states and territories for community-based demonstration projects to discourage teen pregnancy and provide counseling for pregnant teens. Funds will be available for projects in prevention and care. Prevention projects are defined as those which emphasize ways in which adolescents can be reached before they become sexually active and which encourage postponing sexual activity. Care projects are those which promote adoption as an alternative to adolescent parenting and which test new methods of service delivery.

Any public or private non-profit organization or agency is eligible to apply. Under the announcement, funds are available for local demonstrations only.

It is estimated that about \$1.3 million will be available to fund 15 projects. Project grants will range between \$40,000 and \$150,000.

The application deadline is March 21. For more information, contact Nabers Cabanis, Office of Adolescent Pregnancy Programs (202) 245-7473.

The *NACHC Newsletter* is published four times per year as a primary care information resource, exclusively for members of the National Association of Community Health Centers, Inc. Story and photo contributions are welcome. Comments, questions and employment notices should be sent to *NACHC Newsletter*, 1625 I Street, NW, Suite 420, Washington, DC 20006. (202)833-9280.

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NACHC Annual Convention Set for September

NACHC's Seventeenth Annual Convention and Community Health Institute will be held at the Westin Hotel in Seattle, Washington, September 13-17. This year's theme is "Community and Migrant Health Centers: Two Decades of Achievement."

It was in 1966, when President John F. Kennedy made an amendment to the 1964 Economic Opportunity Act for federal support in the development and implementation of a comprehensive health service program to provide quality health care services to the nation's medically underserved peo-

ple. As a result of the Kennedy Amendment, the Neighborhood Health Center Program was born.

Now called the Community and Migrant Health Center Programs and funded under the Department of Health and Human Services, this creation has grown and matured over the past two decades into a strong network of nearly 800 primary care health centers providing comprehensive primary care to nearly six million poor and underserved Americans in 50 states, Puerto Rico and the District of Columbia.

With an unchanged mission since 1966, Community and Migrant Health Centers have made a significant contribution to the nation's health care delivery system and this year's annual conference is dedicated to their achievements.



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