THE NEW MAGAZINE PUBLISHED BY THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS

PRIMARY CARE FOCUS

NOV/DEC 1983

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rimary Care Focus
ISSN 0732 1260)
ublished bi-monthly by the
lational Association of Community Health Centers, Inc., 625 "I" Street, N.W., Suite 420 /ashington, D.C. 20006.
'elephone: (202) 833-9280
ubscription rate:
)rganizational members - $37.50
ndividual members - $40.00
lon-members - $50.00

ON THE COVER

Message From the President

IT IS THE BEST OF TIMES, IT IS THE WORST OF TIMES

Dear Colleagues:

It is particularly significant for me to have the privilege of serving as your President in this year which marks the 20th anniversary of so many events that have served to mold the development of our nation.

In many respects, the events of the past 20 years mirror those described in Charles Dickens, 'A Tale of Two Cities-'

it was the best of times, it was the worst of times,
it was the age of wisdom, it was the age of foolishness,
it was the epoch of belief, it was the epoch of incredulity,
it was the season of Light, it was the season of Darkness,
it was the spring of hope, it was the winter of despair,
we have everything before us, we have nothing before us,
we are all going direct to Heaven, we are all going direct the other way.

Twenty years ago we celebrated the Freedom March in Washington and suffered the assassination of President John F. Kennedy. Twenty years ago approximates the birth of a war that would cause world wide suffering and despair and the birth of a War on Poverty that would lead to a new social commitment and definition of health care with emphasis on access for all.

Little has changed since the 1775 described by Dickens or the 1963 many of us remember so vividly. Congress has given approval to continue war in various parts of the globe, Congress has recognized the impact of the Civil Rights movement through the declaration of Dr. Martin Luther King, Jr.'s birthday as a national holiday.

What we must learn from this is never to assume things will move in a particular direction and to never rest on our laurels. It was clear at the convention in Denver, that we have grown and maintained our strength. We must continue these efforts. The new dues structure passed overwhelmingly by the House of Delegates, expresses the dedication of purpose and willingness of the membership to do what must be done.

Section 330 will be up for reauthorization in 1985. We cannot expect to impact on this process if we act as 600 individual centers. We need NACHC and NACHC needs us - not just as members, but as active members. In the short time since the convention, NACHC staff has successfully delayed the implementation of the new MUA designation process in order that it may be re-evaluated and redesigned.

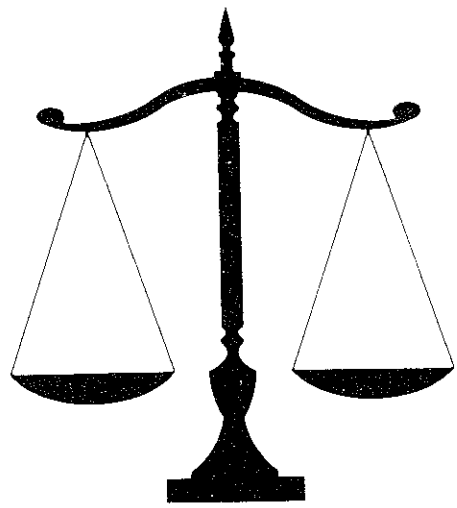
The opportunity is upon us and if we do our job properly, perhaps 20 years from now the NACHC President will reflect back on 1984 and say, "it was the best of times."

Sincerely,

Harvey Holzberg

Harvey Holzberg
President, NACHC

current legal developments



by Jacki Leifer Attorney at Law

Court Cases

The Legal Services Corporation's (LSC) offset of a 1982 carryover fund balance against a 1983 grant award was enjoined by Judge June Green in *East Arkansas Legal Services v. Legal Services Corp.*, Civil Action No. 83-2813 (D.D. C. October 4, 1983). The court held that the offset constituted a partial "termination" of the grantee's authority to spend current funding, an action which cannot be taken under LSC regulations without first affording the grantee prior notice and hearing opportunities.

Does this mean that HHS cannot offset health centers' year-end fund balances against new grants without affording due process protections? As a general rule HHS can probably still offset without giving notice and hearing opportunities, although , as explained later, this issue already is being tested in the primary care block grant context. The major distinction between LSC and the Health Centers programs lies in the area of funding level discretion. LSC provides "annualized funding" to 326 programs nationwide. A program's "annualized funding level" is the amount of money LSC agrees to provide to that program on a continuine year-to-year basis.

Unlike LSC, HHS makes no annualized funding level guarantees. Each year, HHS leaves itself completely free to increase, decrease or altogether deny funding to each and every CHC and MHC, and the courts have consistently acceded to HHS' discretion in this regard. Accordingly the offset of fund balances current funding levels would probably not be viewed as a partial "termination" of the current grant since a health center has no legally recognized right to expect continued funding at any particular level.

HHS' offset/carryover policy is curretnly under review in the *Society for the Advancement of Ambulatory Care v. Heckler* case. In July, Judge Green ordered HHS to ensure that each West Virginia CHC had received or would receive at least the same level of 1983 funding as it received in 1982 in accordance with the block grant statute's guarantees. However, HHS' Report to the Court in this regard revealed that HHS was, in several instances, counting 1982 carryover funding towards fulfillment of the 1983 minimum entitlements. SAAC protested this action and Judge Green has ordered HHS to submit its policy concerning carryover funding to the Court. No such written policy has been submitted by HHS, and SAAC has therefore moved the court to order HHS to ensure that the affected CHCs receive the balance of their entitlements to 1983 funding.

It should be noted that SAAC supports HHS' decision to authorize carryover of prior year funds so as to preserve them for health center use and prevent their lapse to the U.S. Treasury at fiscal year end. However, that does not mean that the carryover mechanism should be used to reduce current CHC funding entitlements (provided, of course, that the center can demonstrate the need for all of the funds in tis annual application).

One final word concerning the LSC case. LSC already has issued proposed rules which would exclude fund balance offsets from the definition of "termination," thereby removing due process protections for grantees which Judge Green insisted LSC had to offer.

For those who haven't heard, HHS' "squeal rules" are dead. Three federal district courts and two courts of appeals have so heald, and HHS recently decided not to request Supreme Court review. Thus, it is now settled that HHS cannot require Title X grantees to notify parents or guardians when unemancipated nimors receive prescription contraceptives. Nor can HHS require the grantees to consider family income in determing the minor's ability to pay for family planning services.

HHS also attempted to require grantees to abide by state laws demanding parental notification or consent for unemancipated minors. Only the Court of Appeals for the D.C. Circuit addressed this aspect of the proposed rules. Essentially, the court held that HHS was not authorized to allow the states to set eligibility criteria for participants in Title X programs. Those criteria

are set exclusively by Congress. (See Planned Parenthood Federation of America v. Heckler, C.A. 83-1232, (D.C. Cir. July 8, 1983).

Following this line of reasoning a federal district court judge has enjoined HHS from awarding all Title X funds allocated to Utah to the state health department. See *Jane Does 1-4 v. Heckler,* Civial Action No. C-83-0379W (D. Utah, Nov. 28, 1983). The state imposes a prior written parental consent requirement in connection with family planning services provided by public agencies, obviously a far more stringent law than proposed by HHS in the squeal rules. As a consequence of the injunction, HHS has awarded grants to Planned Parenthood Association of Utah, Park City Community Clinic, as well as the State health department, on the theory that unemancipated minors can be referred by the State to the nonprofit private grantees, which are not subject to the parental consent law. The issue of whether such a referral arrangement is legitamate has yet to be decided.

Administrative Appeals

The HHS Grant Appeals Board has ruled that overhead costs which bear only a "tenuous relationship" to the purposes of a Federal grant are unallowable. In *Mid-America Health Systems Agency*, Docket No. 82-166, Decision No 420, the Board upheld $25,550 in PHS disallowances and reversed the agency only on one item $1,475 for working dinners which were found to be adequately documented, reasonable and necessary to further grant objectives. The following items of cots were among the disallowances:

1. Automobile lease - $3,336

The grantee's executive director argued that the lease was reasonable and necessary because some areas served were inaccessible to public transportation, and because several meetings outside the office required his attendance. The Board held that there was no documentation supporting the need for the car on a full-time basis; occasionally renting a car would have cost less; and the executive director obviously had made personal use of the car (but did not keep a mileage log book). The disallowance of the entire lease cost was upheld.

2. Consultant Fees - $2,460

The grantee's former president was reimbursed for travel expenses to attend AHPA meetings. PHS objected because the executive director also attended, resulting in suplicative costs. The Board upheld the disallowance because the grantee failed to show why attendance of both individuals was beneficial to the grant, and, more importantly because the grantee has never submitted written justification for employing the consultant in the first place.

3. Meal Expenses - $8,935

Expenditures on meals at local restaurants for employees, volunteer workers and the excutive director and his guests were found to be unallowable "personal" expenses, absent documentation that business was conducted over the meals and that such business benefited the grant.

Impact of Federal Policy on CHCs and the Elderly

By Juanita B. Wood, Ph.D.
Public Policy Analyst
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Introduction

Recently the Aging Health Policy Center, University of California, San Francisco, completed the first year of a three-year study on the effects of public policy changes on community-based long term care organizations serving the elderly. Community health centers were one respondent group in that study and will be the focus of this article. While community health centers are not aging-specific organizations, they are important to the concept of a continuum of care. The elderly population does, in fact, use these centers. According to a survey done in 1981 by NACHC, approximately 825,000 of the 1.6 million clients served were elderly. Of the medical users broken down by age and sex, 16.9 percent were males over the age of 65, and 5.4 percent were females of that age group. In the dental user category, 14.8 percent were males over the age of 65 and 12.7 percent were females in that age group. With this proportion of users being elderly clients, it is not only appropriate to include community health centers within the long term care continuum under study, but to monitor the effects of government policy changes upon these organizations.

The long term care study is being conducted in eight states (i.e., California, Florida, Massachusetts, Missouri, Pennsylvania, Texas, Wisconsin, and Washington) and will include 32 communities within those states. Respondents were selected in each of the 32 communities and asked to report how their particular agency had been affected by current federal policy changes. The community health center respondent group was composed of 42 centers. Of the approximately 800 centers in the United States, the study sample represents about 5 percent of the total. While the centers are charged with providing direct, ambulatory care, fifteen of the 42 centers studied indicated that they were multi-service agencies. They offered other services such as transportation, home health, mental health and nutrition. Sixteen of the agencies are ethnically based.

Community health centers had enjoyed a continuous rate of growth each year until 1982. In 1975, for example, there were 309 centers in the United States serving 1.5 million persons, and by 1981 the number of centers had grown to 1,000 and the number of persons served to 5.6 million. However, with changes in federal policy, by 1981 approximately 20 percent of these centers were closed.

The programs under the Bureau of Health Care Delivery and Assistance (BHCDA) include Community Health Centers, Migrant Health, Black Lung Clinics, and the National Health Service Corps, as well as the Maternal and Child Health Block Grant and services to victims of Hansen's Disease. (NACHC positon paper on "Primary Health Care Appropriations: FY 1984," 1983).

All these programs suffered significant reductions in FY 1982. These cuts, as well as cuts in Medicaid and Medicare (which centers rely upon) resulted in the closing of approximately 200 of the 1,000 CHCs. Funding for these programs showed approximately a five percent increase in FY 1983, but the Administration has proposed a freeze on program funding for FY 1984 and a cut of almost $20 million in program support. (NACHC position paper on "Primary Health Care Appropriations: FY 1984," 1983).

One major concern for this category of respondent agencies is the effect of the inclusion of community health centers into the Primary Care Block Grant in the Omnibus Budget Reconciliation Act of 1981. This block grant has not yet been assumed by any state because of a ruling by a federal district judge that the Department of Health and Human Services failed to adhere to legislative provisions approved by congress. (NACHC position paper on "Block Granting of Primary Health Care Programs" 1983). The concern of the CHCs is that they continue to be funded when the states assume responsibility and that they retain control over the delivery of primary care services. The centers are opposed to states having discretion over how the funds are spent. They are also opposed to including other categorical programs, particularly Migrant Health and Family Planning into the block grant. It is not only a question of further reducing funds that would be available to the community health centers, but also the question of federal responsibility for populations and programs that might be considered by some states to be expendable, particularly in times of fiscal stress. This respondent category will be one of the more interesting to observe over the next two years.

Impact of Federal Changes on CHCs

The centers in the sample were asked to respond to questions about both the ways in which their agency had been affected by federal policy changes, and also how they had responded. This first section deals with impacts on the agency and the second section deals with agency response. The major impacts were upon personnel and services as follows.

Personnel

In terms of staff reductions, centers in every state but Massachusetts experienced a loss of personnel, with 40.5 percent reporting losses in full-time staff. As Table 1 indicates, these staff losses were primarily in full-time staff. Massachusetts was the only state that reported no staff losses in any category. In fact, Massachusetts accounted for this by noting an increased demand for their services, due in part to high unemployment and in part to other centers closing and their trying to absorb clientele. One center had to increase their staff to satisfy the requirements of a state grant for children and youth services. Centers in Missouri, Texas, and Wisconsin reported increased in volunteers. These were generally used to help with food programs although one center noted the use of University work-study students for clerical chores.

There was no trend in the community health centers to try to replace full-time staff with part-time staff or volunteers. The centers noting personnel increases generally did so because of either increased demand or funds specified for particular services. The staff losses were far more prevalent than staff gains. Missouri reported the largest loss of staff and attributed it to a cut in funds due to federal funding levels not keeping pace with inflation. The choice was to cut staff to try to preserve services rather than vice versa.

A little over half (22) of the centers had CETA slots and 82 percent (18) of those centers reported the elimination of the CETA program as having an effect on their centers. CETA workers were used as clerical staff and as program assistants. The response to the elimination of the program was to either shift the workers to paid staff, which did happen in half of the cases (50%). For those agencies that elected to transfer CETA workers to paid staff, the effect was to further strrain their budgets. An indirect effect of losing CETA workers was to have lost the investment in training these workers and then not being able to hire them. A number of centers mentioned the increased burden on existing staff by not being able to keep the CETA workers. The use of CETA workers as dental assistants was one specific area mentioned.

TABLE 1

Number of Personnel Lost From Community Health Centers By Type of Personnel and By State

Type	CA	FL	MA	MO	PA	TX	WA	WI
Full-time	43	12	0	123	3	62	115	20
Part-time	5	2	0	6	0	0	1	0
Volunteer	6	0	0	1	2	0	0	3

When the centers had to reduce services as a result of the loss of CETA staff, it was primarily in areas of outreach, health education and some home services.

Services

It would be misleading to talk about the community health center sample studies here without stressing that this sample consists of thos centers still in operation after the 25 percent across-the board reduction in federal funds to community health centers in 1982. This resulted in the closing of 200 centers. the least economically viable centers are obviously not included, so the picture presented here must be understood in that context.

Respondents were asked to indicate whether their current (FY 1983) budget could support more, less, or about the same number of services than could their previous year's budget. Table 2 records the responses to that question along with whether they felt their next year's budget (FY 1984) would be able to support more, less or the same number of services than this year's budget. In general, the reports seem to display an expected stabilization in the coming year, with a slight shift toward a perception of being able to provide more or about the same number of services as were provided in 1983. At a minimum, drastic reversals are not expected. The exception is California, which is the only state that reported a real shift to being able to offer fewer services in FY 1984. One explanation may be that the California sample includes a larger number of ethnically based centers (6) than those of the other states, and these centers report drastic reductions in funding.

The Indian health centers in t sample all report cutbacks in fede funds and anticipate further federal cu This fear is based on real actions at t federal level that imply an intent to e minate funding for these centers entirel The Indian Health Care Improveme Act was initially passed in 1976 a reauthorized in 1980. It is schedul to expire in 1984. According to NACI (Position paper, "Indian Health," 198 the Reagan Administration has omit the budget for Urban Indian Health fr its proposed budgets for the last th years and the FY 1984 budget simil does not include this item. Centers the sample receiving Urban Indian He funds report a 21 percent cut in fed funds in 1981 and continuing reducti every year. In 1983, approximat 8 3 percent was further cut back in funding.

Other policy changes also have an impact on the Indian health cent ability to deliver services, as well as community health centers in gene Reductions in the funding for the tional Health Services Corp (NHS as well as the movement of NHSC pec to the rural areas, has meant a loss medical personnel for the urban cent Medicaid eligibility changes that m non-Indian spouses ineligible for cover affect some members of this client as do Medicaid reimbursement char that not only reduce the amount M caid will cover, but also what serv will be covered.

In California, where the state adop a policy of making county facili responsible for Medically Indigent Ad (MIAs), Indian health centers have option of referring their clients to s facilities or to continue treating t without being reimbursed. This m

a continuing drain on the Indian health centers should they choose one option or an increased burden on county facilities if they do not.

As for community health centers in general, one concern about the policy of block granting primary care and giving responsibility to the states is that the state may also try to eliminate some community health centers, particularly centers werving an ethnic population, and transfer funding for services (if funding is transferred) to other public health providers. This fear, too, may be grounded in real events. The state Attorney General in Texas has ruled that Texas does not have responsibility for urban Indians and that the state of Texas cannot give special treatment to existing reservations.

Another area of reported cutbacks in service funds for community health centers is in the Maternal and Child Health (MCH) funding. This, among other things, has meant a reduction in nutrition programs. Family planning monies have also been cutback through Title XX reductions and there were reductions in alcohol abuse funds. However, the major reductions in federal funding were in the public health funds for community health centers.

Agency Response

Administrative Response

The respondent agencies did not report many administrative changes. Those that were reported were primarily the cutting of staff, the reduction of staff hours, or the diversification of staff responsibilities. There was some attempt to computerize to reduce the number of personnel needed or to increase efficiency reported. One center in an entrepreneurial move, actually felt they had "capitalized" on the federal cutbacks, since they had hired a professional fundraiser and had managed to replace lost federal funding with corporate funding. This, however, was not a general response. Of the 42 CHCs seven had hired progessional fundraisers, but only this one reported such a measure of success.

TABLE 2

Percent Reporting CHC Budget Capacity for Services
For FY 1983 and FY 1984, By State

	CA	FL	MA	MO	PA	TX	WA	WI
FY'83								
Less	20.0%			50.0%	20.0	40.0%	16.7%	40.0%
About the Same	50.0	50.0		50.0	40.0	60.0	16.7	60.0
More	30.0	50.0	100.0		40.0		66.7	
FY'84								
Less	50.0%			25.0%		20.0%		20.0%
About the Same	30.0	25.0	33.3		60.0	20.0	16.7	20.0
More	20.0	50 0	66.7	25.0	40.0	20.0	33.3	
Don't Know		25.0		50.0		40.0	50.0	60.0

Source: AHPC Private Nonprofit Survey. Service Delivery Instrument.

TABLE 3

Number of CHCs Reporting Policy Changes
By State

	CA	FL	MA	MO	PA	TX	WA	WI	Total: (N=4
Tightening Eligibility	5	1	0	0	2	1	2	2	13 (30.8%)
Initiating Fees/ Co-payments	4	1	0	3	1	2	2	2	15 (35.7%)
Increasing Fees/ Co-payments	6	2	3	4	2	5	3	3	28 (66.7%)
Reduce Services	2	0	0	1	2	1	2	2	10 (23.8%)
Eliminate Services	4	1	0	1	1	3	2	2	14 (33.3%)
Increase Services	5	2	2	2	3	2	6	3	25 (59.5%)

Source: AHPC Private Nonprofit Survey. Service Delivery Instrument.

Policy Response

At least two thirds of the centers indicated policy changes of some form. Table 3 illustrates the types of policy changes reported by state. Two thirds (66.7%) of the centers reported increasing fees or co-payments and a little less than two thirds (59.5%) reported increasing services. The increased services response primarily reflects reports of increased demand which were attributed to the generally poor economic stiuation that has resulted in a high unemployment rate.

Seventy-eight percent of the centers had experienced an increase in clientele and 51.5 percent of those centers attributed the increase to unemployment which resulted in people losing medical benefits.

The federal policy change that now covers refugees under Medicaid for 18 months, rather than 36 months as had been the case previously, resulted in a small number (2) of the centers reporting increased caseloads of refugees. Six centers reported increased caseloads due to the closing of other clinics.

The overall experience, then, has been for centers to report attempts to solve their fiscal crisis by initiating or increasing fees, but they are hampered in this by an increasing demand from a clientele that cannot afford to pay on a sliding scale due to loss of jobs. These clients may sometimes be able on pay on a sliding scale fee schedule, but frequently not. Some centers have reported that when faced with fees, some clients do not come back.

When fiscal constraint is present, one other option is to start prioritizing services. Twenty-eight (66.7%) reported they had indeed established a list of service priorities. Primary medical care remained their first priority, but when distinctions were made within that category, priorities were given to dental care, maternal and child health services, and mental health services.

While it is difficult to ascertain what services are most used by the elderly in this setting, since records are not generally kept in this fashion, the question was nevertheless asked and the responses were varies. Essentially, the elderly use the same services as the rest of the population. We also asked, however, if these services used most by the elderly were in danger of being cutback and 38.1 percent said "yes." This is not to indicate any targeting of elderly services, but rather an overall concern that centers will be cut and that the elderly, along with everyone else, will be affected.

Political Response

As previously mentioned, only one center reported successfully assuming the entrepreneurial role through the hiring of a professional fundraiser even though seven of the centers reported hiring such. Thirty of the centers (71.4%) indicated they were actively trying to reduce reliance on government funds. When asked to indicate in what way they were attempting to do so, the following were the major categories of action:

Increase fees	86.7% (26)
Apply to Foundations	76.7% (23)
Apply to United Way	36.7% (11)
Pursue 3rd Party Paymts	30.0% (9)
Consider Private For-profit status	23.3% (7)

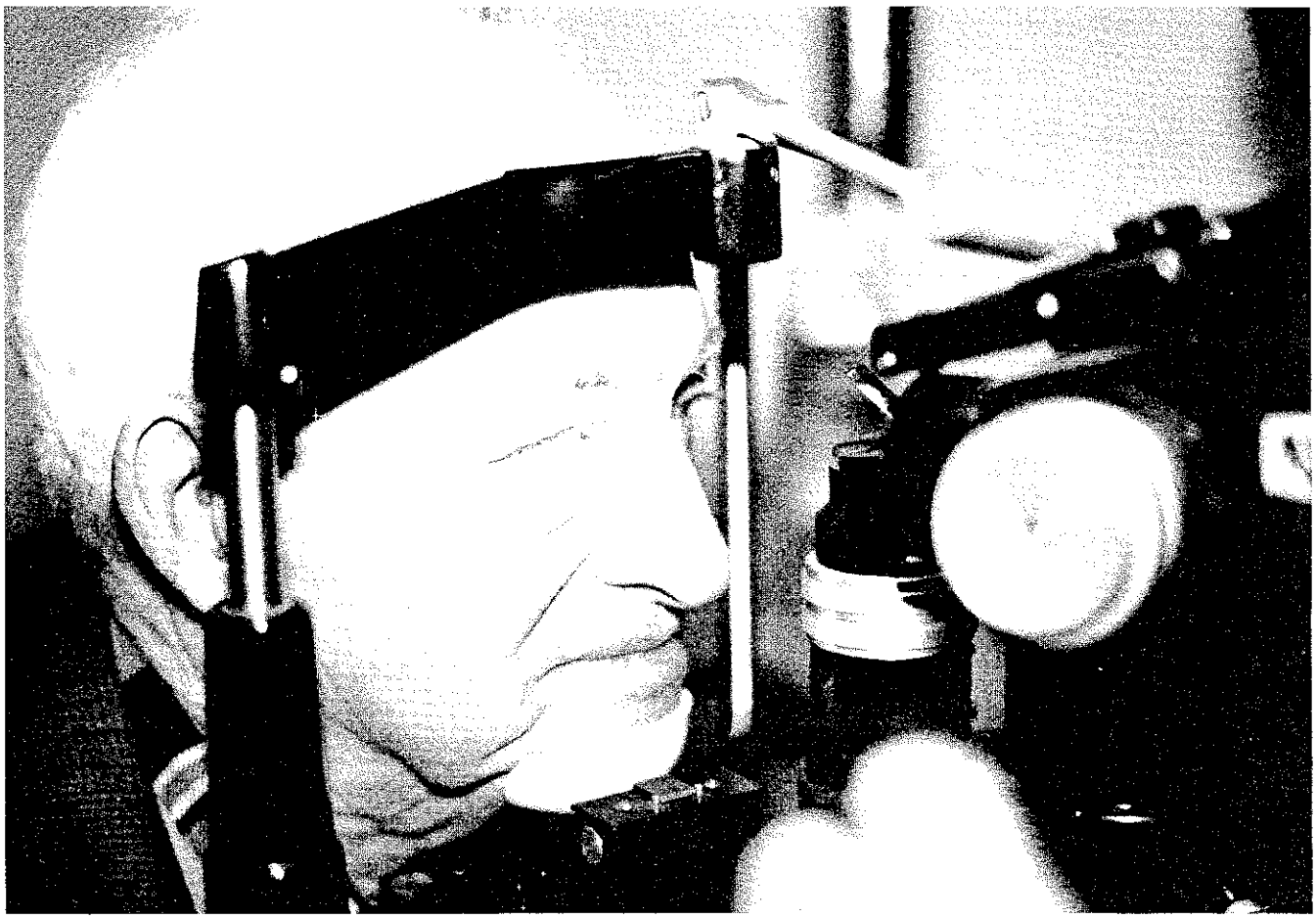
The options are to change the source of funds to either private sector funding agencies or to private citizens, and the responses indicate that both are being pursued with almost equal intensity.

In order to estimate a rough way whether community health centers might be successful in their bid to private foundations for support, the foundations sampled in this study were asked whether they had made awards in the current year to community health centers. Thirty-seven percent (98) of the 265 foundations interviewed indicated that they had made awards to community health centers in the current year and 29.2 percent (77) indicated they had plans to make awards to community health centers in the coming fiscal year. While there is no way of knowing if the foundations and the community health centers in the sample correspond, indications are that there is some interest on the part of foundations we studied to respond to requests from community health centers, at least in the current year.

In terms of whether community health centers had followed up on their interest and intent to apply to the private sector for funding, they were asked to indicate whether they had actually done so.

Twenty-nine of the 30 centers who had indicated an active attempt to reduce reliance on government funds reported that they had applied to private organizations for funding. Twenty of the 29 centers reported they were successful in receiving funding from the organizations they applied to for funds and six did not yet know if they would receive the funds. Relative to where they applied, 17 applied to foundations and 11 to United Way. Thus, it appears that not only are these centers actively moving to secure private funding, but they are enjoying a measure of success in doing so.

(cont. on page 12)



Eye Care for the Elderly

by Walter Ostergren
Arturo G. Aglubat, M.D
Morton Spind, O.D.
Bernard M. Weinstein, O.D.

In 1978 the Robert Wood Johnson Foundation created a national demonstration in the delivery of primary health care services through substantial grants to five major municipalities. As a part of the demonstration, the Health Care Financing Administration of the then Department of Health, Education and Welfare agreed to provide Medicare Waivers for the purpose of creating access to care for the elderly and handicapped. In addition to providing care to Medicare Part B patients without the restrictions of the deductible and co-insurance payments, they also agreed to pay for health care services not normally covered under the Medicare Program. Among thos services to be provided under the insurance system was total eye care consisting of routine diagnostic services, all ophthalamologic and other treatment services and one-half payment for eye glasses.

The Baltimore City Municipal Health Services Program, as a part of the national demonstration, has created five primary health care centers to provide complete and comprehensive primary care services to the citizens of Baltimore. Included in the scope of services is a comprehensive eye care department. At the outset the program used traditional municipal service arrangements. During the second year of the program we decided to contract with a private eye care group. In making arrangements it was decided that the eye care department would function as a private practice, within the confines and restructions of the Municipal Health Services Program.

The private eye care service includes an Opthalmologists, who will diagnose and treat eye diseases as well as perform surgical procedures; a staff of Optometrists. who provide the services of prescribing glasses, contact lenses, and diagnosing eye disease, and a competent staff of Opticians, who fabricate, fit and dispense eye glasses. These physicians are complimented by a staff of clerks and secretaries who labor with records, statistics and other clerical duties.

The uniqueness of this arrangement centers around the team of professionals whose total efforts and expertise are in providing a system for the detection, early referral, maintenance and control of visual and medical pathology in a practice that principally provides care to the elderly. The locations for the eye group are a series of five health centers administered and maintained by the City of Baltimore. These municipal health facilities are in long established neighborhoods of blue collar and elderly people. In addition, within each primary health care center exists a functional linkage to facilitate immediate referral of patients with abnormalities to the appropriate on-site medical specialist. For example, if a patient in his middle sixties comes to the center with the complaint of a severe change in refraction and diabetic changes are suspected, an immediate referral to the Internist is made. There also exists an economic incentive for the elderly to seek services via Medicare. In addition, these patients have the pleasure of camaderie among themselves when the congregate under one roof.

The eye care department is structured in the following manner. Under normal conditions, clerks will schedule the patient with the Optometrist. Upon termination of the exam, the Optometrist will have the following options: 1) refer the patient to the Optician for glasses; 2) refer the patient to Medicine, Podiatry, Dentistry, Opthalmology, as need exists; or 3) terminate the exam and request the patient return in a specified time period for another regular exam.

The eye care department also has two main specialities within the Municipal Health Centers. To begin, we provide a highly sophisticated contact lens service. The requirements of contact lenses have been developed for the age bracket we deal with, where a great deal of aphakia or post cataract surgery occurs. As a result, we prescribe, maintain, and service extended soft contact lenses for aphakia. This device had made aphakia a manageable and tolerable condition, allowing the patient to experience binocular vision, (a privilege not enjoyed prior to the development of this device). We also dispense a full spectrum of contact lenses, including bifocal contacts, soft contacts, and gas permeable contacts.

The second speciality is in the area of visual fields. The instrument we use is a topcon perimeter which is an exact copy of the Goldman perimeter, In addition, we

The second specialty is in the area of visual fields. The instrument used is a topcon perimeter which is an exact copy of the Goldman perimeter. In addition, we have a well trained technician to perform our field examination. Having the Ophthalamology and Optometry services working so closely, we have had no choice but to purchase this instrument. We find the instrument is important in definitively diagnosing pathology such as glaucoma, optic tract obstruction, and retinopathies. This instrument is unique to the private Optometrist's office as many private practitioners find the need to send this type of test to major eye centers.

The Opthalmology service is structured in following manner. Upon receiving a referral from the Optometrist or medicine, the Ophthalmologist will classify and treat a pathology. In addition, he will work up pre-surgical candidates. Post surgically, the Ophthalmologist will continue to follow patients on-site.

There is present a staff of well trained Opticians who take a great deal of pride in their work. They are trained to fit, measure, dispense and fabricate glasses to best suit the cosmetic tast and facial requirements of the geriatric patient. They offer the most contemporary lens systems as well as a full line of fashionable frames.

In analyzing the eye care service, we found that it proved to be effective in controlling geriatric morbidity in its referral procedure, due to a well structured standard vision screening mechanism developed to screen, diagnose, and refer patients by the Optometric staff. The following example will demonstrate the advantages to the geriatric patient in our eye program compared to most other eye facilities in dealing with specific common geriatric diseases.

To begin, many times diabetics are originally diagnosed in the eye department because of a severe refractive change that subsequently follows a body sugar change. This patient is immediately sent to medicine where further diagnosis and treatment are offered. Long standing diabetics of twelve to fifteen years are many times seen in our center as a retinopathy. These patients are immediately sent to Ophthalmology for analysis. Severe and proliferating cases are frequently treated with laser therapy.

Secondly, hypertension and vascular changes, which are observed upon examining the fundi, can be seen in their first ocular stages as a disproportionate and abnormal relationship between the arteries and veins. Upon this detection the patient is sent to medicine.

One of our main concerns in the geriatric patient is neural disorders. Neural neoplasms often create pressure behind the optic disc, manifesting itself in a pathology known as papaladema. The disease is obvious upon examining the grounds of the eye by noting the elevation of the optic disc.

Another neural problem, usually first picked up on the eye department, is the complaint of the geriatric patient with a recent onset of diplopia, which could denote a cranial nerve disorder. Additionally, neural tract obstructions are detected with our perimitry device which accurately plots out the field of vision. This device also aids in observing neural defects from stroke patients. All of these very serious neural problems are immediately referred to medicine, without the patient having to worry about transportation. Many times differential diagnoses are made within minutes at our varying sites.

Our visual fields department is also very important in the detection of glaucoma. As pressure build in the eye, visual field and optic disc changes become apparent. The patient's pressure is routinely taken by applanation devices.

At this point we must stop and ask the following questions. What is the significance of our Eye Care Department findings, and what follow-up occurs after a patient leaves our office? In the case of a referral to Ophthalmology a differential diagnosis has already been made by the Optometrist and the patient receives his follow-up care as the severity of the situation dictates. This care can range from minutes to the next available appointment. On the other hand, the Ophthalmologist can begin directing and preparing for his potential options. For example, in glaucoma cases the patient benefits by receiving immediate therapy to reduce his eye pressure thereby, limiting damage. Generally, when dealing in geriatric practice, we alert ourselves to the high risk presented; be it vascular, high eye pressure or whatever, the patient will profit from our efforts by having maximal vision restored or minimal vision lost.

(cont. from previous page)

The follow-up on patients who are referred to Medicine can have many ramifications. However, the patient will benefit because in severe cases the physician is immediately briefed and diagnostic tests and treatment options are at his disposal. The urgency of this process can limit damage and reduce mortality. As an example, we can recollect observing a lippoidal placque lodged in a vessel upon examining the eye grounds. The Ophthalmologist who was on-site noted the same findings with his stethoscope, listening to the vessels of the neck. He immediatley called upon the Internist to do the same. Subsequently, the patient became a surgical candidate and a stroke was probably prevented.

During a recent survey of one hundred eleven patients, the following results were noted. Twenty-two patients were referred to Opthalmology, representing approximately nineteen percent. Seven patients were referred to Medicine, basically for diabetic and cardiovasular problems, representing approximately six percent. Furthermore forty eight patients were in need of refractive changes, representing forty three percent. The other thirty two percent (or thirty four patients) had received no further actions.

Another smaller study in our centers was conducted for the purpose of following what kind of precise problems were confirmed and the following resuts occured. Of the total number of patients seen, 24.1% pathology was confirmed by our physicians, which corresponds to the above study. The percentage of glaucoma patients as well as advanced cataracts totalled 3.4% in each case Early cataracts totalled 10.4% and retino-vascular disease totalled 6.9%.

In summary, I find that sixty-eight percent of all geriatric people are in need of some eye care on a yearly basis. Without our Municipal Health Services environment, ths may not have been realized.

(cont. from page 8)

In terms of future funding, 27 of the 42 centers indicated they would apply for private funds in the future, and 24 felt they would be successful in procuring these funds. As we monitor these agencies, it will be possible to see if they continue to be successful or whether the increased demand on the private sector will begin to reduce their initial success experience. Another important issue for further study is the extent to which the private sector funding actually replaces the lost resources from other sources, such as government funding reductions.

Conclusion

Community health centers suffered their major cutbacks in federal funding in 1982 when they received a 25 percent across-the-board cut in funding. This resulted in the closing of 200 centers in the United States. The major response to this by the centers in the sample was to reduce personnel and to initiate or increase co-payments. They have also begun to move to procure private funding from foundations and United Way agencies.

Of great concern to this group of respondent centers is that legislative safeguards be maintained in the Primary Care Block Grant to ensure that the states, in assuming this responsibility, protect existing CHCs. Of particular concern are the ethnically based centers. The Urban Indian centers appear to be at particular risk of being defunded altogether.

The national economic situation that has resulted in high unemployment has increased the caseloads of these centers at a time when they are experiencing a reduction in personnel. Other federal policy changes, such as reduction in what Medicaid covers as well as reimbursement rates. also have an effect on community health centers. The lowering of the length of time Medicaid will cover health care for refugees from 36 months to 18 months means that in many cases the health center will not be reimbursed for care given, even though the center may have a sliding scale policy for fees.

This category of respondent agencies, perhaps more clearly than others, brings to light the philosophical problem being grappled with my many. That is, will the federal level, in shifting from responsibility for the health care of the poor and underserved to states, communities, and the private sector, place that population at further risk?

References

NACHC "Primary Health Care Appropriations: FY 1984" Washington, D.C. NACHC 1983.

Ibid., "Blocki Granting of Primary Health Care Programs", NACHC 1983.

Ibid., "Indian Health", NACHC 1983.

THE ROBERT WOOD JOHNSON FOUNDATION

AND

THE PEW MEMORIAL TRUST

HEALTH CARE FOR THE HOMELESS PROGRAM

Co-Sponsored by the U.S. Conference of Mayors

"The Health Care for the Homeless Program offers as many as 14 four-year grants of up to $1.4 million each for the development and implementation of demonstration projects to deliver health services to homeless people."

"Experience has shown that community-based services will be heavily utilized when made available in an accessible and non-threatening manner."

For details contact:

Philip W. Brickner, M.D., Director
Health Care for the Homeless Program
St. Vincent's Hospital
and Medical Center of New York
153 West 11th Street
New York, New York, 10011
(212) 790-7065

Deadline for receipt of letters of interest, March 1, 1984.
Application deadline June 1, 1984.

National Institute on Aging

Age Page

Heat, Cold, and Being Old

As you get older, your body becomes less able to respond to long exposure to heat or cold. In cold weather, some older people may develop accidental hypothermia (hi-po-thur-mee-uh), a drop in internal body temperature that can be fatal if not detected and treated promptly. During hot and humid weather, a buildup in body heat can cause heat stroke or heat exhaustion in the elderly. This is especially true of those with heart and circulatory disease, stroke, or diabetes.

Accidental Hypothermia

Hypothermia is a condition of below-normal body temperature—typically 95 °F (35 °C) or under. *Accidental* hypothermia may occur in anyone who is exposed to severe cold without enough protection. However, some older people can develop accidental hypothermia after exposure to relatively mild cold.

Those elderly most likely to develop accidental hypothermia are: the chronically ill, the poor who are unable to afford enough heating fuel, and those who do not take the normal steps to keep warm. The small number of aged persons whose temperature regulation is defective face the greatest danger. For unknown reasons, these people do not feel cold or shiver, and thus cannot produce body heat when they need it. It is interesting to note that many people who have "felt cold" for years may actually have a lower risk of accidental hypothermia.

The only sure way to detect hypothermia is to use a special low-reading thermometer, available in most hospitals. A regular thermometer will do as long as you shake it down well. If the temperature is below 95 °F (35 °C) or does not register, get emergency medical help. Other signs to look for include: an unusual change in appearance or behavior during cold weather; slow, and sometimes irregular, heartbeat; slurred speech; shallow, very slow breathing; sluggishness; and confusion. Treatment consists of rewarming the person under a doctor's supervision, preferably in a hospital.

Heat-Related Illnesses

Heat stroke is a medical emergency requiring immediate attention and treatment by a doctor. Among the symptoms are: faintness, dizziness, headache, nausea, loss of consciousness, body temperature of 104 °F (40 °C) or higher, measured rectally, rapid pulse, and flushed skin.

Heat exhaustion takes longer to develop than other heat-related illnesses. It results from a loss of body water and salt. The symptoms include: weakness, heavy sweating, nausea, and giddiness. Heat exhaustion is treated by resting in bed away from the heat and drinking cool liquids.

Protective Measures

In Cold Weather: There is no strong scientific basis for recommending room temperatures for older people. However, setting the heat at 65 °F (18.3 °C) in living and sleeping areas

should be adequate in most cases, although sick people may need more heat.

Measures you can take to prevent accidental hypothermia include:

- ☐ Dress warmly even when indoors, eat enough food, and stay as active as possible.
- ☐ Because hypothermia may start during sleep, keep warm in bed by wearing enough clothing and using blankets.
- ☐ If you take medicine to treat anxiety, depression, nervousness, or nausea, ask your doctor whether the medication might affect the control of body temperature.
- ☐ Ask friends or neighbors to look in on you once or twice a day, particularly during a cold spell. See if your community has a telephone check-in or personal visit service for the elderly or homebound.

In Hot Weather: The best precaution is to remain indoors in an air-conditioned room. If your home is not air-conditioned, you might go to a cool public place (like a library, movie theater, or store) during the hottest hours.

Other good ways to cool off include taking baths or showers, placing icebags or wet towels on the body, and using electric fans (being careful to avoid getting an electrical shock). In addition, it is wise to:

- ☐ Stay out of direct sunlight and avoid strenuous activity.
- ☐ Wear lightweight, light-colored, loose-fitting clothing that permits sweat to evaporate.
- ☐ Drink plenty of liquids such as water, fruit and vegetable juices, and iced tea to replace the fluids lost by sweating. Try not to drink alcoholic beverages or fluids that have too much salt, since salt can complicate existing medical problems, such as high blood pressure. Use salt tablets only with your doctor's approval.
- ☐ Above all, take the heat seriously, and don't ignore danger signs like nausea, dizziness, and fatigue.

Contact for Assistance

Anyone trying to save on fuel costs can protect against hypothermia by dressing warmly and heating only one or two rooms of the home. There are government-funded programs to help low-income families pay high energy bills, weatherize (insulate) their homes, or even get emergency repairs of heating/cooling units. Your local community action agency or area agency on aging should be able to direct you to the proper source of assistance.

Caution, common sense, and prompt medical attention can help older people avoid illnesses due to heat and cold. For the brochure *A Winter Hazard for the Old: Accidental Hypothermia,* check your supermarket information rack or write to: NIA/AH, Expand Associates, 8630 Fenton Street, Suite 508, Silver Spring, Maryland 20910.

'AGE PAGE' is availabe in bulk for distribution to patients. For information contact:

Information Office
National Institute on Aging
Building 31, Rm 5C36
Bethesda, Maryland 20205

MEDICARE MEDICAID NOTES

PREPARED BY THE OFFICE OF BENEFICIARY SERVICES FOR MEDICARE AND MEDICAID BENEFICIARIES

PART B ASSIGNMENT RATE ON THE RISE

For the fifth straight year there has been an increase in the percentage of Medicare medical insurance (Part B) claims paid under the assignment method. This is good news for Medicare patients because a higher assignment rate means that doctors (and other suppliers of covered medical services) are accepting with greater frequency Medicare's approved charges as payment in full for their services. When the assignment method is used, the patient's out-of-pocket costs are greatly reduced and sometimes eliminated altogether if there is supplemental health insurance coverage.

In FY 83, Medicare's nationwide net assignment rate rose to 53% -- the highest it has been since 1972. The assignment rate reached its low point in 1976 and 1977 when it bottomed out at 50.5%. Before then, the national percentage of claims taken on assignment had been in a steady decline since 1969. The national assignment rate from 1969 - September 30, 1983 is shown in the table below:

Year	Net Assignment Rate
1969	61.5%
1970	60.8
1971	58.5
1972	55.1
1973	52.7
1974	51.9
1975	51.8
1976	50.5
1977	50.5
1978	50.6
1979	51.3
1980	51.5
1981	52.3
1982	53.0
1983	53.5

However, not all areas of the country experienced increases in the assignment rate. The East, South and Midwest posted gains, but the Mountain and Pacific regions reported slight reductions in the percentage of claims taken on assignment. Throughout Medicare's history, the Eastern states have reported generally higher assignment rates than the West. In calendar year 1982 Rhode Island recorded the highest rate with 82.9%. Wyoming's 19.4 % was the low for that year.

According to Medicare officials a number of factors influence assignment rates. Regional differences in attitudes toward government programs may be one factor, but a difficult one to measure. Also, assignment rates tend to be lower in areas where Medicare approved charge reductions or denial rates are higher. Several studies suggest that the single most important factor influencing a physician's decision to accept or reject assignment is the patients financial situation. Where the patients are better able to apy, the assignment rate is lower. The recent upturn in the Medicare assignment rates may reflect a growing awareness that those among the nation's elderly who are on fixed incomes are less able to cope with the continuing inflation of physician fees and other health care costs.

NRPCA Annual Awards

National Conference on Rural Primary Care is presently accepting nominations for Annual Awards to be presented in Albuquerque, New Mexico at their 7th Annual National Conference, March 18-21, 1984. The awards, which honor accomplishments and leadership in the field of rural health care delivery will be given in the following categories:

Outstanding Rural Health Project

Rural Health Practitioner of the Year

Most Significant Contribution to Rural Health Care by a Public Service Employee

The Louis Gorin Award for Outstanding Achievement in Rural Primary Care

* * * * * * * * * * * * * * * * * *

Community Service Discretionary Grants

HHS has announced that it is accepting applications for new grants under the Office of Community Services discretionary grant program. Fiscal '84 grants will be awarded in three areas:

urban and rural economic development
rural housing and comnty. facilities development
assistance for migrants and seasonal farmworkers

OCS expects to make approximately 75 new awards, which will range from $50,000 to $1 million. Approximately $25.3 million was appropriated for this program.

Public and private, nonprofit or for-profit organizations are encouraged to apply.

For further information contact: OCS, Office of State and Project Assistance, Division of Discretionary Grants, 1200 19th St., N.W., Room 518, Washington, D.C. 20506. Or call (202) 632-6634.

APHA Annual Awards Nominations

The American Public Health Association is currently accepting nominations for awards to be presented at their 112th Annual Meeting in Anaheim, California, November 11-15, 1984. Those awards are:

Jay S. Drothman Memorial Award

Martha May Elliot Award

Sedgwick Memorial Medal

Nominations must be received by April 1, 1984. For further information contact APHA, at 1015 Fifteenth Street, N.W. Washington, D.C. 20005.

* * * * * * * * * * * * * * * * * *

NACHC's 7th ANNUAL MIGRANT HEALTH CONFERENCE, April 13 - 15, 1984

This year's conference will be held in Charleston, South Carolina, at the Sheraton Charleston.

The conference theme is, "The Migrant Child," and will focus on health, social, and political issues that impact on this population group. The conference is sure to be most educational, public health workers, educators, policy makers, clinicians and everyone interested in migrant health issues are encouraged to attend. For details contact, Francine White or Rudy Arredondo at NACHC, 1625 "I" Street, N.W., Suite 420, Washington, D.C. 20006
(202) 833-9280

* * * * * * * * * * * * * * * * * *

ORDER FORM

1983 HEALTH POLICY SEMINAR SERIES GUIDEBOOK
"KEYS TO SURVIVAL IN THE COMPETITIVE ERA"
A Resource Book for Primary Care Providers

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PRICE: $15 - NACHC Members $20 - Non-Members

Please send me _____ copies of the HPSS Guidebook. Enclosed is my check for $_____
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Mail this form and your check (made payable to NACHC) to:
National Association of Community Health Centers

ACRONYM'S ANONYMOUS

When people ask me what I do, I don't know how to say
Administering acronymns of health care every day.
My alphabet vocation is a maze through which I'm lead;
For example, with deficit funding the only color I need is red.

The Block Grant is mortared upon us troweled down from levels above.
Determining the dollars has been passed to SIR, with love.
Block advantages were outlined; less paper, speedier funds,
No, politics, flexibility, as compared to the way it now runs.

BCRRs are filed twice for PHS when due --
You must be in compliance with the Fed's indicators too.
If MUAs are deleted, then you have to start anew.
If you need to build staff toilets, then there's OON review.

The local does squash HMSAs but refer AFDC's;
Getting Medicaid capitation is as slow as end stage disease.
You must write grants for RHI or CHC with flair,
And hope your needs assessment meets the guidelines that are there.

NHSC's gone private, there're two types of PPOs.
Concerned citizens wanting access can add to a grantee's woes.
Our physicians aren't sure about DRGs --'fraid they will have to get
Old folks out of hospitals fast, before they go in debt.

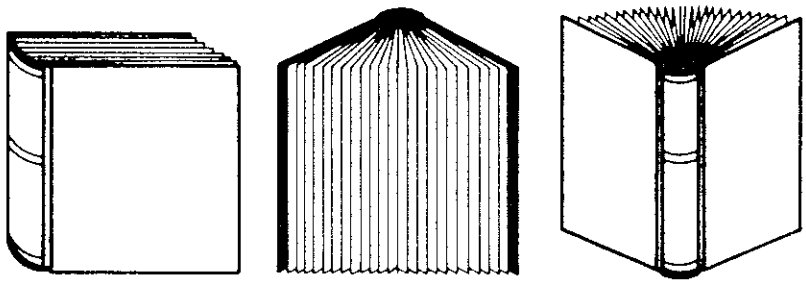
Bring on the WIC, let's bring on MIC, have EPSDT for every child.
Who wants to do the paperwork that later gets misfiled?
These alphebetic buzz words can make heads spin about
Until at last "oh, SCHEC," you very loudly shout.

Someday our SHPDA will come in and hearald minimized
Reports, reviews and FSR's that DFAC's analyzed.
But if block grants turn out to be another pain in the neck,
It's time to pack it up, throw in the towel and say, "AWHEC."

by Ray Alvarez
Monongahela Valley Association of
Health Centers, Fairmont, W Va.

* *

Congratulations to the National Migrant Referral Project on the publication of their newsletter, *Migrant Health Newsline*. We think it looks great !



New Book News

NACHC has recently developed the following reference materials which are available at the prices listed through the NACHC office 1625 "I" Street, N.W. Suite 420, Washington, D.C. 20006.

1) $15 -- a detailed description of how a community health center must develop in order to accommodate prospective payment and/or capitation arrangements for its Title XIX patitents.

2) $10 -- developed as an educational aid for the NACHC Board Training Seminars, this booklet covers all areas of Board responsibility.

3) $10 members, $15 non-members --a directory of some 200 health centers, compiled from survey results, contains basic key information such as CHC location, size, key personnel and services rendered.

4) $15 members, $20 non-members-- a step-by-step description of how a community health centers assesses the need and demand for primary care in its area. It is also a marketing tool and an internal/external management analysis tool.

The following two publications are available *free* by contacting, BCHDA, Liz Hickey, Division of Primary Care Services, 5600 Fishers Lane, Rockville, Md. 20857.

1) revised January 1983.

2) May 1982.

Pre-Registration Form

9th Annual
POLICY and ISSUES FORUM

MARCH 4 - 7, 1984

HYATT REGENCY HOTEL
400 New Jersey Avenue N.W.
Washington, D.C. 20001
(202) 737-1234

NACHC

1625 I Street, N.W., Suite 420
Washington, D.C. 20006

PRE-REGISTRATION FORM: 1984 POLICY and ISSUES FORUM, Washington, D.C., March 4-7, 1984

NAME _____

ORGANIZATION _____

ADDRESS _____

_____ TELEPHONE _____

Additional registrants from the same center:

(Name) _____

(Name) _____

(Name) _____

TOTAL ENCLOSED $ _____

ALL FEES LISTED ARE PER REGISTRANT.

	NACHC Members	Non-Members
EARLY REGISTRATION (Prior to February 17)	$200	$250
AFTER FEBRUARY 17 & ON-SITE	$230	$280

SPECIAL GROUP RATE FOR 3 OR MORE REGISTRANTS FROM THE SAME CENTER, IF REGISTRATIC IS RECEIVED PRIOR TO FEBRUARY 17: DEDUCT $30 FROM EACH FEE. GROUP RATE DOES NOT APPL TO REGISTRATIONS RECEIVED AFTER FEBRUARY 17 OR ON-SITE.

REVISED PRELIMINARY SCHEDULE

9th ANNUAL HEALTH POLICY AND ISSUES FORUM

FRIDAY, MARCH 2

6:00 p.m.	-	9:00 p.m.	Migrant Task Force Meeting

SATURDAY, MARCH 3

8:00 a.m.	-	3:00 p.m.	Registration
9:00 a.m.	-	2:00 p.m.	NACHC Committee Meetings
3:00 p.m.	-	6:00 p.m.	Executive Committee/Board of Directors Meeting
8:00 p.m.			Mid-West Association of CHCs–Open Board Meeting

SUNDAY, MARCH 4

8:00 a m.	-	9:30 a.m.	State Coordinators Meeting
8:00 a.m.	-	5:00 p.m.	Registration
10:00 a.m.			**General Session**
10:00 a.m.	-	12:30 p.m.	Issues & Orientation (Dr. Ed Martin, Guest Speaker)
1:30 p.m.	-	3:00 p.m.	Analytical Techniques & Guest Speakers
3:00 p.m.	-	5:00 p.m.	State Coordination With All Attendees
8:00 p.m.	-	1:00 a.m.	SAAC Fundraiser ($25.00 Contribution per person)

MONDAY, MARCH 5

9:00 a.m.	-	4:30 p.m.	Registration
8:30 a.m.	-	5:30 p.m.	Congressional Appointments
10:00 a.m.	-	4:00 p.m.	EDUCATIONAL SESSIONS
6:00 p.m.	-	8:00 p.m.	Congressional Awards Reception

TUESDAY, MARCH 6

8:00 a.m.	-	11:00 a.m.	Registration
8:00 a.m.	-	9:30 a.m.	Breakfast Program (with guest speaker)
8:30 a.m.	-	5:30 p.m.	Congressional Appointments
10:00 a.m.	-	4:00 p.m.	EDUCATIONAL SESSIONS
6:00 p.m.	-	9:30 p.m.	Congressional Awards Reception

WEDNESDAY, MARCH 7

8:30 a.m.	-	5:30 p.m.	Congressional Appointments
9:00 a m.	-	11:00 a.m.	EDUCATIONAL SESSIONS
11:00 a.m.	-	12 Noon	General Session -- Wrap-Up

**LEAVE YOURSELF TIME TO REGISTER **

BADGES WILL BE REQUIRED TO ATTEND ALL SESSIONS/MEETINGS

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MAIL FORM TO:

National Association of Community Health Centers, Inc.
1625 I Street, N.W. -- Suite 420
Washington, D. C. 20006

MEMBERSHIP INFORMATION

PURPOSE

The National Association of Community Health Centers, Inc. (NACHC) seeks to assure the the continued growth and development of community health care programs, including community health centers, family health centers, Indian health centers, migrant health programs, rural health programs and maternal and infant care programs.

NACHC strives to meet its objectives through a broad range of program activities designed to promote and facilitate community health center development. These activities include education and training, research, policy analysis, technical assistance, and membership services.

PROGRAM ACTIVITIES AND SERVICES

Education and Training

The principal component of NACHC's education and training activity is the Community Health Institute (CHI). Through the Institute, community health center administrators, health care providers, board members and consumers are provided opportunities for continuing education in a broad range of health related subject areas.

Research

Research issues currently being studied include: twelve most common diagnoses in Migrant Health Centers, systems productivity in health centers and Medicaid reimbursement policies across the country.

Policy Analysis

The Department of Policy Analysis is responsible for the evaluation of federal legislation and implementing rules and regulations. Major emphasis is placed on policy matters relating to health care delivery and financing public health service programs and health manpower. The Department also plays a vital role in educating the general public as well as members of Congress about the problems relating to health care delivery and financing; access to quality health care and the role of community-based health centers in providing quality health care services.

Technical Assistance

The Department of Rural Affairs arranges for technical assistance to members in the following areas: financial management, grants management, administration, continuity of care and program evaluation.

Primary Care Malpractice Insurance Program

Organizational members of NACHC are eligible to participate in the Primary Care Malpractice Insurance Program; a program designed for ambulatory care programs only. The program provides malpractice insurance coverage at a price which reflects the lower risk faetors present in the special and limited market represented by Association members. For additional information contact Sobel Affiliates at (800) 221-2834.

Publication

NACHC publishes, on a bi-monthly basis, a news magazine entitled "*Primary Care Focus.*" The magazine includes the Legislative Status Report which informs the membership of developments in legislative and administrative policy. Also included are articles focusing upon current health and social issues of interest to the general public.

MEMBERSHIP

There are three ways in which you may participate in the development of this dynamic organization; through organizational, individual and associate membership.

Organizational Membership

Organizational membership is available to any organization actively engaged in the operation of a health care program and that is committed to the purpose of the National Association of Community Health Centers.

Individual Membership

Individual membership is open to all persons who support the purposes and objectives of the NACHC. Individual members are entitled to hold office and also to become committee members.

Associate Organizational Membership

Associate organizational membership is open to all organizations that do not qualify for organizational membership but do support the purposes and objectives of NACHC. Examples of organizations that might quality for membership in this classification are voluntary agencies, insurance companies, drug companies, etc.

AWARDS

The following awards are presented to Individual members, nominated by their peers, each year at the Annual Convention and Community Health Institute.

John Gilbert Award--recognizes excellence in community health leadership.

Samuel U. Rodgers Achievement Award--recognizes outstanding contributions made by health care providers.

Ethel Bond Memorial Consumer Award--recognizes dedication to and support of the consumer role in community health care.

Public Service Award--recognizes significant contributions to community health center development made by individuals in the public sector.

NACHC IS CURRENTLY THE ONLY ORGANIZATION WORKING FOR THE CONTINUED GROWTH AND DEVELOPMENT OF COMMUNITY BASED AMBULATORY CARE CENTERS

Please send me additional information regarding:

☐ Organizational Membership
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Date _____

☐ Primary Care Malpractice Insurance Program
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Name _____ Title _____

Organization _____

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Please send me the application for:

☐ Individual Membership

Date _____

Name _____ Title _____

Organization _____

Address _____

City _____ State _____ ZIP _____
