Restoring the Healthcare Workforce for Equity Project

Funded by the Center for Disaster Philanthropy

HEALTHCARE READY

Fortifying Community Health Centers: Fostering Community Resilience, Equitable Response, and Disaster Preparedness

Each year, more than 31.5 million patients receive care from among more than 14,000 community health center locations operating across the U.S. Health centers play a vital role in addressing health disparities, providing comprehensive primary healthcare to medically underserved rural and urban communities and populations.

Disasters profoundly influence the management and treatment of patients with chronic conditions and others who are medically vulnerable. No-notice events, such as tornados and other extreme weather events, can force patients to flee their homes without life-saving medications or equipment to manage chronic and acute conditions. **The role of health centers in addressing a disproportionate share of populations with complex needs underscores the critical significance of health center operations and maintaining continuity of care for vulnerable populations during crises.** H1N1, mpox, and other infectious disease outbreaks can lead to medical surges that overwhelm health systems, and healthcare supply chains. Health centers commitment to provide preventative and comprehensive primary care to patients—as well as other support to enhance access to insurance and transportation—fosters greater individual and community-level resilience, and functions as a critical offset to medical surges in hospitals and emergency rooms.

Health centers provided indispensable care to millions, rapidly scaling and changing operations, and administering more than 22 million vaccines, with 69 percent administered to people of color during the COVID-19 pandemic.[1]

Health centers are essential to community resilience

1

Patients are incredibly diverse

Community health centers serve individuals experiencing homelessness, those residing in public housing, individuals who require care in languages other than English, and agricultural workers and their families.

For many racial and ethnic minorities, community health centers are a primary source of healthcare, providing culturally competent care, and reducing disparities. Of patients in health centers, 63% identify as a member of a racial and/or ethnic minority community, compared to 42% of the general U.S. population.

2

Health centers are an essential source of low-cost, high-quality care

One in three patients treated at community health centers is living in poverty, with 90% of patients residing at, or below, 200% of the Federal Poverty Level (FPL).

A significant proportion of health center patients face insurance and coverage challenges. Eighty percent of patients are either uninsured or publicly insured.

One in five patients (20%) is uninsured, double the national average of 9% of the U.S. population being uninsured.

3

Medicaid beneficiaries find vital support at community health centers, with 48% of patients relying on Medicaid, in contrast to 15% of the general U.S. population covered by Medicaid.

Health centers serve a disproportionate share of populations with complex needs

Health centers have a 35% higher likelihood of caring for patients with any chronic condition and a 31% higher likelihood of treating patients with two or more chronic conditions than private practices.

Key Barriers to Health Center Disaster Preparedness and Resilience

Health centers are essential in helping communities withstand disasters, especially where public health is a concern. While health centers may receive some funding for disaster response and recovery for major, federally-declared disasters, funding is limited and specific to the event at hand. Below are examples of key barriers health centers face, limiting their capacity for preparedness and response and making it more difficult for communities to navigate recovery following a disaster.

Limited Resources

Available funding is primarily dedicated to ongoing operational costs, leaving little room for proactive disaster planning and preparedness measures.

Operational Efficiency

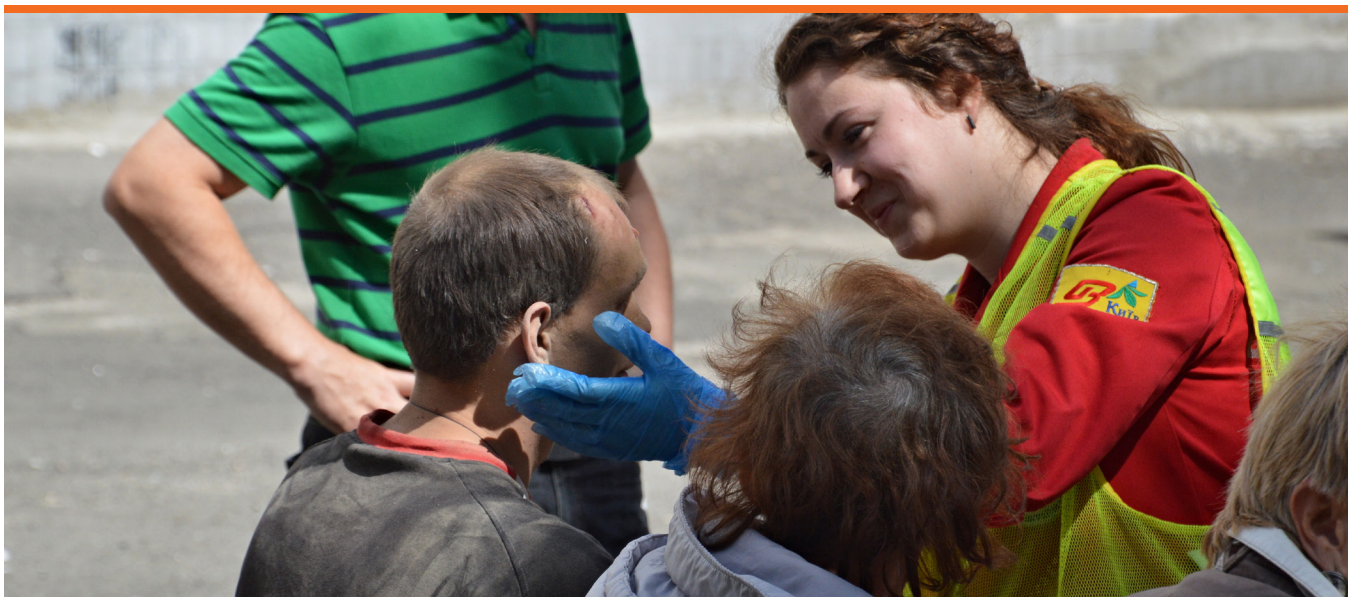
Health centers are known for their efficiency in delivering healthcare services, but the constant pressure to optimize daily operations can hinder the allocation of resources for disaster planning.

Limited Supplies

Health centers may have smaller physical footprints and fewer resources on-hand compared to larger healthcare facilities, which can present as a barrier when it comes to stockpiling necessary supplies (e.g., medical equipment, pharmaceuticals). In a disaster, having adequate supplies is vital and resource constraints can severely impact the center's response capabilities.

Geographic Challenges

Forty-two percent of health centers are located in rural or remote areas, making them harder to reach and more isolated from other healthcare resources. Geographic isolation can limit the rapid deployment of resources and staff to provide immediate assistance.



Disaster Response: Primary Needs and Stages of Response

Effective planning, preparedness, and coordination are essential to ensure that healthcare services are provided to the community during and after a disaster event. A typical response can viewed across four distinct stages.

Assessment of Damages

Facility and Equipment Assessment

- Involves assessing the extent of damages to the health center's facility and equipment, including ultrasound and X-ray machines, and durable medical equipment. Damage to critical tools must be identified and addressed promptly to resume essential medical services.

Wrap-around Services Interruption

- Involves assessing interruption of wrap-around services such as Women, Infants, and Children (WIC) programs, and identifying what other services have been affected is crucial for comprehensive patient care.

Staffing Assessment

- It is essential to evaluate the impact of the disaster on the staff, including personal impacts to employees, identifying transportation needs, etc. both in immediate response and during the recovery period.

Communication and Coordination

Local Partners and Official Channels

- Needs should be shared with local partners, such as the State Primary Care Association (PCA) or healthcare coalition.
- PCAs can help escalate major concerns through to appropriate federal entities like the Health Resources and Services Administration (HRSA) and the Administration for Strategic Preparedness and Response (ASPR).

Role of State PCAs

- State PCAs are non-profit organizations that are responsible for gathering data from health centers regarding the impacts of the disaster and reporting this data to HRSA. The specific process for reporting may vary by health center and state.

Preparedness Investments

- Unfortunately, not all health centers and states have the necessary resources to adequately prepare for disasters. Preparedness investments are vital for ensuring that community health centers can effectively respond to disaster scenarios.
  These investments enable staff to participate in training and exercises that build awareness among staff for such situations.

Adjustment of Operations

Patient and Staff Communication

- Includes general communications about the status of the health center and rescheduling procedures for appointments or treatments that may have been disrupted due to the disaster, to both patients and staff.
- In rural areas, where communication infrastructure may be less robust, additional considerations and funding sources for telecom support may be necessary.
- In cases where regular communication channels are down, health centers should have contingency plans for communicating with patients and staff. This may involve the use of alternative means such as satellite phones or community-based networks.

Resource Availability

- Health centers need resources to communicate rapidly with patients and staff if services have changed due to impacts to equipment and supplies.

Managing Surge

Surge Response

- As the disaster subsides, there may be a surge in demand for healthcare services, especially as evacuation shelters close down, and people start rebuilding their lives.
- Health centers should be prepared for an increased patient load and have strategies in place to manage this surge effectively.

Collaboration

- Collaboration with local authorities, relief agencies, and neighboring healthcare facilities is crucial during this phase to ensure that healthcare services are available to those in need.

The fields of health and emergency preparedness operate in a greater context that demands consideration of structural and systemic inequities contributing to disparate impact on communities of color, low-income, medically fragile, and other vulnerable communities. Community health centers often serve populations with more complex health needs and patients receiving care through these centers are more likely to live in areas with limited access to medications and other healthcare resources. These vulnerabilities are the product of a complex interplay of factors and policies that have affected public health and pushed certain communities in areas with greater disaster risk.

Historic Policies and Structural Racism: Impact on Communities

Historical policies play a significant role in current day public health. Increased vulnerability and risk among certain communities is particularly pronounced among communities of color, who face higher disaster risks today as the result of historical policies that systemically shape communities' access to public health resources.

Structural racism, evident in housing policies and discriminatory practices, has led to communities of color residing in high-disaster risk areas. These areas are often more susceptible to the adverse effects of climate change, including more frequent and severe natural disasters. The communities impacted by these historical and current-day practices are more likely to black, brown, and indigenous communities. As a result, certain communities face more severe and lasting impacts from disasters, further driving healthcare disparities and prolonging disaster recovery.

Housing Policies: Housing policies can disproportionately affect vulnerable populations. Communities residing in low-income housing or areas with substandard housing conditions may be at increased risk during disasters due to the lack of structural resilience and safety measures.

Environmental Regulations: Environmental policies can also influence disaster vulnerability. Areas with lax environmental regulations may be at risk of pollution or exposure to hazardous materials during and after a disaster, impacting the health of community health center patients.

Business Decisions: The location and availability of critical healthcare services, such as pharmacies, can be influenced by business decisions. If pharmacies are concentrated in wealthier or urban areas, patients in underserved communities may face significant challenges accessing necessary medications during disasters.

Public Transportation: The availability and reliability of public transportation can be a critical factor in ensuring that community health center patients can reach healthcare facilities and obtain essential medical care in disaster situations.

Existing Policies Related to Community Health Center Resilience

There are several ways policy can be used to support resilience of community health centers to help address health disparities within communities.

Currently proposed legislation (As of January 2024)

The **Bipartisan Primary Care and Health Workforce Act** is a proposed act that holds increased funding for THCGME, CHCF, NHSC, and other policies that support the healthcare workforce in community health centers and lookalikes.[1] The Bipartisan Primary Care and Health Workforce Act

[1] https://www.nachc.org/bipartisan-primary-care-funding-legislation-to-be-considered/

intends to expand the nations' access to community health centers that provide a full breadth of healthcare as well as mental health services, dental care, behavioral healthcare, and other wrap around services to patients. The bipartisan legislation aims to address nursing and primary care shortages, workforce retention and resilience programs, financial supports, as well as save Medicare and Medicaid billions of dollars in the process. This bill's efforts to strengthen health center resources nationwide would help these centers prepare for, respond to, and recover from emergencies and disasters.

Health center funding policy

Beginning in 2010 as part of the Affordable Care Act (ACA), the **Community Health Center Fund (CHCF)** provides around 70% of federal funding ($4 billion per funding period) to community health centers throughout the US. This ensures stable, multiyear base grant funding for community health centers receiving this funding. Since CHCF is a main source of annual funding for health centers, a reduction in funding would majorly impact the healthcare workforce, patient safety, and health center resources. Decreased funding would also negatively impact health center's abilities to effectively prepare for, deal with, and recover from emergencies and disasters.

NACHC reports that community health center needs currently outpace health center allotted funding as CHCF remained static or decreased from budget sequestration over the last five years. Over the past three to four years, the COVID-19 pandemic has shown how an unprecedented healthcare emergency strains health centers' resources and workforce. These sites have seen growth in patient populations, increase in treatment and care deliveries to patients, higher need of PPE, increase in need of mental healthcare, and other services, without seeing an increase in the CHCF.

Though funding through the CHCF has been a stalwart support for health centers in the past, federal funding for health centers has dropped 9.3% and the number of patients has increased 24%, in inflation-adjusted terms.

Adequate funding is critical to community health centers delivering quality care in steady state times and becomes paramount for health centers when experiencing emergencies and disasters. Impacts of uncertainty and/or reduced funding in community health centers can be detrimental to the healthcare workforce and patient health experience and outcomes. The community health center mission centers on whole-person care and comprehensive, community-based care for patients of any needs, especially in treating social determinants of health. CHCF, and other policies, are critical to providing that type of care and full breadth of services to any patient in need, particularly in disaster and emergency events when, typically, needs increase and supplies/resources decrease.

Workforce expansion policies

For over 50 years, the **National Health Service Corps (NHSC)** has supported over 69,500 providers, over 20,000 of whom serve in Health Professional Shortage Areas (HPSAs), in every U.S. state and territory to provide primary care medical, dental, and behavioral health through loan repayments and scholarships with an annual mandatory funding budget of $310 million. NHSC provides financial, professional, and education resources to medical, dental, mental, and behavioral health care providers. Loan repayment for these providers can be up to $50,000 or a full-time service

of two-year term and $25,000 for half time service of two-year term and supplemental rewards can cover up to $120,000 in scholarships. By placing a provider for two to two and a half year full-time clinical practice at an NHSC approved site (more than 9,000 health center sites seeing over 21 million patients), NHSC contributes to building a robust and diverse workforce in health centers and incentivizes providers to work in areas of high need (rural, underserved, etc.).

The NHSC program is mutually beneficial for providers and health centers alike. Studies show that the use of NHSC supported providers increases capacity of community health centers without increasing cost of services for patients or health centers in underserved areas, rural areas, and urban health centers. While always important, increased health center capacity is a core tenet of being effectively prepared to respond to an emergency or disaster. Emergency and disaster preparedness, response, and recovery is made more successful with a full and complete healthcare workforce, often provided, in part, by NHSC providers.

Teaching Health Center Graduate Medical Education (THCGME) provides training of over 1,096 residents in 81 community-based residency programs. THCGME residents treated over 792,000 patients during over 1.2 million patient encounters in 2022-2023, and directly increased the number of physician trainees in the past 25 years. Increasing physicians and dentists trained in community-based settings, improves health outcomes for underserved communities, expands healthcare access, especially in rural and underserved areas, and enhances access to primary care for underserved communities. An increased number of providers strengthens recovery and resiliency when disasters strike.

Note: The previously mentioned provisions and funding goals must be signed into law to adequately resource health centers. If currently proposed legislation is not passed or is passed with less than the requested funding amount, health centers will be stunted in their ability to prepare for, respond to, and recover from disasters, which ultimately reduces the quality and accessibility of patient care. Long term, sustainable funding is necessary to combat existing and growing needs in health centers that are already under significant pressure to support a variety of emergencies.

Telehealth Access in Health Centers

Telehealth is a critical tool for community health centers to provide increased/sustained access to care, particularly during disasters and emergencies. To do so, policies that expand telehealth access must be prioritized and supported. COVID-19 is a key example of how telehealth usage played a role in providing care especially to underserved communities. During the COVID-19 public health emergency, Medicare and Medicaid agencies expanded telehealth policies to improve patient health outcomes. Medicare and Medicaid (1) allowed health centers to provide services as distant site providers in Medicare and Medicaid programs, (2) waived geographic requirements for health centers serving as originating sites and allowing patients to receive care directly from their homes, (3) allowed health centers to provide audio-only services in Medicare in some states, and (4) eased HIPAA requirements to allow for providers to use new technologies to communicate with their patients via telehealth.

COVID-19 Example: Telehealth expansion was critical for effective emergency response

Telehealth coverage expansion during the COVID-19 pandemic offers a prime example of how access to care improved during a major emergency. During the COVID-19 pandemic, 95% of health centers provided visits virtually. Healthcare services delivered virtually through telehealth were reimbursed at national rates set by CMS, so a majority of states paid community health centers as they would for in-person visits. This allowed CHCs to continue receiving reimbursements and thus providing care to patients. Many health centers use telehealth services in general to address geographic, economic, transportation, and language barriers in providing comprehensive services to underserved areas and these needs heighten during disasters and emergencies.

There are critical benefits in helping community health centers stay prepared and resilient in the face of emergencies and disasters.

Telehealth access and reimbursement flexibilities are useful tools to keep health centers nimble so they can best respond to patient needs during any disaster event.

The Federal Tort Claims Act (FTCA) and Portability

The FTCA, enacted in 1946, is federal legislation providing compensation, through legal means, for individuals who have suffered personal injury, death, or damage caused by negligent acts of an employee of the federal government. Its place in healthcare delivery rests in how its coverage was expanded to malpractice liability protection for health centers through the Federally Supported Health Centers Assistance Act of 1992 and 1995. The FTCA has critical application for health centers and lookalikes in the face of emergencies and disasters. During a disaster or emergency, health centers may rely more heavily on volunteers or temporary healthcare workers to meet the needs of medical surges. Beyond providing support in an emergency event, health centers are considered federal employees and the federal government acts as their primary liability insurer, helping save health centers millions of dollars annual on liability protection. This added savings can be put into health center funding to maintain quality and care.

COVID-19 Example: FTCA portability supported emergency response

During COVID-19 public health emergency, HHS expanded the scope of FTCA coverage to include in-scope care/services provided through community health centers at temporary locations and the individuals providing care/working at the temporary locations.

Expanding FTCA regulations would provide increased, easier coverage for healthcare workers during disasters and emergencies. For the purpose of FTCA coverage, the patient-provider relationship must be previously established, however in emergency situations, health center triage services are provided by telephone/in person even when the patient is not yet registered with the covered entity, but intends to register. Additionally, FTCA redeeming application for coverage must be submitted annually, which can present a barrier to health centers that are already under resourced.

The funding sources and policies listed in the above sections are critical to the success of community health center providers ability to meet the demand for affordable health care and the needs of their communities.

Find More Resources and Ways to Support Community Health Centers

To learn more about ways to support community health centers.

Workforce Resources

- Publication: Building a Resilient & Trauma-Informed Workforce Factsheet
- Resource: C-Suite Toolkit: HPET for Recruitment and Retention
- Publication: Health Center Onboarding Checklist

Sign up now to become an ACU Advocate and get the latest news on how to support increased funding for community health centers and for essential primary care workforce programs –- the National Health Service Corps and Teaching Health Center Graduate Medical Education programs, which support residents and providers who practice in underserved communities.

Further community health center resources

- https://healthcareready.org/community-health-centers-and-clinic-resources/
- https://healthcareready.org/telehealths-applications-for-preparedness-and-response/
- https://healthcareready.org/cdrt/
- https://healthcareready.org/resource-center/

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ACU leads advocacy, clinical, operational and equity excellence to develop and support clinicians and the healthcare workforce caring for America's underserved communities. The Association of Clinicians for the Underserved is a uniquely transdisciplinary membership organization striving to establish a robust and diverse workforce to help transform communities to achieve health equity for all. To support clinicians and organizations caring for medically underserved communities, ACU provides professional education, training and technical assistance, clinical tools, and more.

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Healthcare Ready builds resilient communities that are prepared for, can respond to, and recover from disasters and disease outbreaks. The health of all, especially those most impacted by these crises, depends on strong infrastructure, seamless emergency response and supply chain coordination to ensure continuity of care. Healthcare Ready leverages unique relationships with government, nonprofit and medical supply chains to build and enhance the resiliency of communities before, during and after disasters.