NATIONAL HEALTH SERVICE CORPS (NHSC) VIGNETTE

FINAL REPORT

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National Health Service Corps
Community Story ("Vignette") of National Health Service Corps Program Impact

Introduction

As a complement to a series of community-based information gathering activities conducted by the National Health Service Corps (NHSC) in 1997-1998, a method was devised for rapidly and telephonically gathering information from a community to determine its history and relationship with the National Health Service Corps, and the impact of that relationship on the community.

This document summarizes the information gathered using this method. It summarizes the "story" of NHSC clinician impact on communities, as told by one community in each of the fifty states, and Puerto Rico. In addition, this document summarizes community challenges to serving the underserved (current and future) and catalogs advice offered by communities contacted to the NHSC. A discussion of the benefits and application of the information from this project conclude the document.

There are several appendices to this summary report. These include completed data sheets from each interview, poster panels from Vignette communities displayed at the NHSC 25th Anniversary Conference Celebration, administrative tracking sheet used in the project, and a template for all materials used in the information gathering process. These documents can be referenced for additional information.

Purpose

The purpose of the NHSC Community Vignette Process was to:

- compile short stories/testimonies of how NHSC clinicians, and/or the facilities where they work, have had an impact on the health of underserved communities (rural, suburban, and urban);
- obtain a historical overview of NHSC presence in the participating communities;
- identify local examples of policies and processes that influence how the NHSC meets primary care needs in underserved communities; and
- gather advice and recommendations from communities for the NHSC.

Method

- Sites for this project were identified via NHSC Regional Program Consultants (RPC) in each HRSA Field Office (Regions 1 through 10).
- The Central Office of the NHSC forwarded a list of forty-four (44) sites identified by the RPCs to FBA. The sites chosen represent a range of NHSC placement sites (grant/non-grant, rural/suburban/urban), NHSC provider fields/specialties, and populations served.
- Eight states around the country had a site which participated in a community site visit process as part of the NHSC Community Assessment Project. Results from those visits served as the source for their community vignette.
- FBA staff placed an introductory phone call to the site to verify the contact name, facility name, address and location, and to obtain a fax number. In some cases this contact was a current NHSC clinicians, or an alumnus; in most cases, the Executive Director or Chief Executive Officer of a facility was the contact.

- An introductory letter and materials were then faxed to the site contact. A follow-up phone call was placed to: 1) confirm receipt of materials; and 2) establish a one-hour interview for the site contact with an FBA staff person. These interviews were conducted between February and June, 1998.
- The "Vignette Data Sheet" was used as an interview guide, and was completed by the FBA interviewer at the time of the interview.
- The completed sheet was faxed to site contact for verification and changes. Changes were sent by the site to FBA via fax or mail. FBA incorporated changes and the final version of data sheets are included with this summary report.

The method used for this project is as important as the results obtained from each community that participated. We learned that a phone interview is a cost-effective approach for learning about the demographics of the communities where NHSC clinicians are practicing; the mission and vision of facilities where NHSC clinicians base their practice; the characteristics of local health delivery systems; the community "story" and history of providing care for the underserved, including its past and future challenges; and other institutional or community policies that impact the practice patterns of NHSC clinicians.

Sample Description

The following is a description of the overall "sample" of communities that participated in the Community Vignette project.

- A total of 255 delivery sites were represented. The facility representing the state of New Mexico, had the largest number of sites with 17 in its "system."
- A total of 132 counties were represented, with each facility having an average service area covering 3 counties. The facility representing the state of Michigan had the most counties with 14 as part of their service area.
- A total population of all counties served by sites in the sample is 36,280,000.
- A total of 415 NHSC clinicians have been identified (former and current) with an average of 8 NHSC clinicians per facility. The facility representing the state of Georgia had the most identified NHSC clinicians who served the community - former and current - with 33.
- In 1997, the sites interviewed had over 1,100,000 patients "on file" with an average of 22,000 patient files per facility (system totals). The facility representing the state of New Jersey had the most patients on file with 85,000 and the facility representing the state of Delaware had the fewest, with 3,000 patient files.
- In 1997, the facilities interviewed had over 2,300,000 patient encounters with an average of 55,000 encounters per facility (system totals). The facility representing the state of Washington had the most encounters in 1997 with 150,000 and the facility representing the state of Iowa had the fewest with 4,200.

Findings

The Story

The Hamakua Health Center (HHC) in Hawaii is located in the rural, northwestern corner of the island of Hawaii. The island has a population of approximately 23,000 and the Hamakua Health Center has 7,000 of these residents as patients; in 1997, the Hamakua Health Center had over 13,000 patient encounters.

The story of HHC begins in 1994, when the closing of a large sugar plantation forced many of the island's northern residents out of work. When the plantation closed, so did the infirmary, which was the only source of care for workers and their families. Gail Walker, a Registered Nurse who grew up in northern Hawaii, and Chris Danzer, a local community activist, co-wrote a 330 grant application to secure funding for a community health center. Chris Danzer continues to write grants for Hamakua Health Center today.

With the closing of the sugar plantation, there was a great need to attend to depression, suicide attempts, and substance abuse. Dr. Brace, a NHSC Scholar, and others from the Hamakua Health Center played an important role in meeting this need, and spent time with patients to address medical needs, assist in job placement, and enroll people in programs which could financially assist them to obtain the services they required. Dr. Brace's presence also provided stability to the new community health center. His continuous service has allowed for services, particularly community education programs to extend into the schools and in the local senior center.

Dr. Brace's wife, has been giving free dance lessons to local girls and boys for their self-esteem and physical health: "something positive kids can turn to instead of drugs and sex," Dr. Brace asserts. The response to Mrs. Brace's dance lessons has be overwhelming. With the assistance of parents and neighbors, the Brace's are now converting and expanding a historic auto-body garage on their property into a dance studio where Mrs. Brace can teach dance. Until the conversion is complete, Mrs. Brace will continue to give free dance lessons at the local Methodist Church.

Dr. Brace, and other active residents, have also established a not-for-profit information/visitor center for Hamakua at the historic service station adjacent to the garage, in order to promote the local tourist industry to help boost the local economy.

The story of the Hamakua Health Center does not differ greatly, in terms of the impact of NHSC clinicians, from the other communities interviewed during for this project. We learned about the NHSC's impact (and the stories) from specific questions asked during the interview:

- When or why did your organization first turn to NHSC for support?
- What do you believe has been the impact of your facility on your community? Key accomplishments of NHSC clinicians (Impact of NHSC program on facility/community)?
- If you were given 2 to 3 minutes of air time to tell the story of your facility/local program, what would you say?

In sum, the stories of NHSC clinician impact can be categorized into three areas:

- contributions to the ability of facilities and practices to expand services and programs;
- contributions to the social and cultural dimensions of communities; and
- development of policies that help communities meet the needs of the underserved.

Stories and examples of impact in these areas are discussed below.

Expansion of Services and Programs
NHSC impact has often been described as "critical," "significant," "integral," and "key" in the planning, development, implementation or expansion of services and programs relative to:

- primary care (preventive, acute, and long term primary health care - including mental health services and programs);
- maternal and child health (OB/GYN services, prenatal programs, breast feeding, mammographies and pap smears, immunizations, lead screenings, and parenting programs);
- special populations (diabetics, HIV/AIDS populations, homeless, migrant)
- dental health;
- health promotion and disease prevention; and
- innovative community health programming.

In several cases, these expansions or new ideas have documented outcomes. For example:

- Alaska: In 1989, Anchorage Neighborhood Health Center was seeing about 25% of the low income patients from community. With technological advancements (computer tracking system) and NHSC resources (clinicians), the facility was able to expand its services and is projected to see 85% to 90% of low income persons in the facility's service area by the year 2000.
- Massachusetts: Since 1980, Greater Lawrence Family Health Center through its programs, services and providers, has lowered infant mortality rates from 15/1,000 live births to 5/1,000 live births. The rate of hospitalization for "ambulatory-care sensitive conditions" for Family Health Center patients is also better than the private sector rate, particularly for asthma. In addition, NHSC clinicians played a critical role in decreasing the C-section rate and increasing the immunization rate of children.
- South Dakota: The Isabel Community Clinic (ICC) was able to open and operate a site in Eagle Butte, staffed entirely by NHSC clinicians. This site, which provided 3,900 visits in 1997, is the only source of care for 60 miles. The ICC, because of this expansion, is transitioning to a system, Prairie Health Providers, and operates an additional site in Faith, South Dakota.
- South Carolina: NHSC clinicians played significant roles at Beaufort-Jasper Comprehensive Health Services in the Ridgeland community in the reduction of infant mortality, increasing nutritional education, decreasing paralyzation caused by stroke through early screening processes, and increasing blood pressure/diabetes management.

Dental health was a specific area of service expansion or outreach that communities described the contribution of NHSC dentists and dental hygienists as critical.

- Michigan: NHSC clinicians at Health Delivery are the only source of dental care for the indigent in a 14-county service area.
- New Mexico: The NHSC clinician at La Clinica de Familia is the only dentist serving the poor in a 1,500 mile radius.
- Utah: With the NHSC as a resource, Community Health Center was able to secure a dentist who now sees approximately 1,300 patients a year and provides a service that would otherwise not be available.

- West Virginia: In 1995, Dr. Lynn Gilbert, a NHSC Scholar, and her staff applied sealants to "as many kids as possible" in Calhoun County. According to a 1997 survey, 46% of children had a sealant on at least one tooth. This figure is better than the Ohio State total of 27%, and nearly attains the Healthy People 2000 goal of 50% for the entire county). Dr. Gilbert is currently brokering a relationship with the State Department of Health and the Centers for Disease Control and Prevention for a statewide oral health needs assessment.

Contribution to Social and Cultural Dimensions of Communities

Many interviewees shared that the NHSC provides not only culturally competent clinicians, but clinicians that are often from diverse cultural backgrounds themselves. These clinicians can help to meet the need for bi-lingual or bi-cultural providers in communities. For example, described by the Executive Director as a place of "courageous patients and courageous providers," all NHSC nurse-midwives at Alivio Medical Center in Illinois are bi-lingual, specifically to serve the minority Latino community surrounding the center.

A story from Mississippi illustrates the contribution of NHSC clinicians to the fabric of community life: The City of Gulltort has a clinic located in the heart of an inner-city neighborhood. According to a Gulfport City Council Member, prior to the clinic's establishment and the presence of NHSC clinicians, rarely, if ever, would you see a white person in this particular neighborhood. Today, the center is a "magnet" for all of the people in the neighborhood and surrounding area. White and black people seek care at the clinic and as a result, there is a marked improvement in social interaction between whites and blacks.

Developing Policies That Help Meet the Needs of the Underserved

Facilities shared the role and impact of NHSC clinicians in shaping the local health care delivery system, particularly around practice, process and policy. For example, in New Jersey, Howard Smith, PA and NHSC Scholar and his facility administrator met with a state senator to discuss Physician Assistants practice regulations. They were able to have legislation sponsored that will allow PA's to prescribe in the outpatient setting, increasing their ability to provide access to underserved patients.

Challenges

To complement these stories of NHSC clinician service, we also asked participants to describe for us the challenges they currently face, or anticipate facing the future, around serving the underserved.

- Many community contacts shared that recruiting quality providers to rural, isolated areas in addition to serving underserved populations, remains a challenge.
- The implementation of Medicaid and Medicare managed care and its impact on community health centers (and all facilities that provide services to poor persons) was almost universally described as challenge. Specifically within this framework, lack of reimbursement for supportive and case management services from Medicaid managed care approaches, and the phase-out of "cost-based reimbursement" as passed in the 1997 Balanced Budget Amendment were highlighted as challenges.
- Welfare reform was described not only as a financial challenge for community organizations that serve poor persons, but also as a barrier to trusting relationships between these organizations and the community members they are intended to serve.
- Communicating effectively was a challenge for many communities, particularly to patients and others in the community about the availability of services, and about the impact of rules or regulations that influence eligibility for services.

Advice

Interviewees offered the following advice to the NHSC:

- Educate program recipients about rural challenges, expectations, cultures, and opportunities.
- Make better matches in rural areas. Consider the impact of placing an "urbanite" in a rural area on the ability of the community to retain that individual.
- Increase NHSC presence at teaching institutions.
- Expand programs to include surgeons that might assist with OB/GYN services.
- In growing the NHSC program, the transition to a loan repayment system was a good idea, and one that will keep the NHSC politically strong, because it will produce better matches, and better history.
- The NHSC should provide ongoing support to clinicians placed in underserved areas. This should include education and professional networking opportunities, and it would work to increase retention in underserved areas.
- Provide training and technical assistance around the Health Professional Shortage Area (HPSA) designation/site development process. What and who is involved? What is the timeline? When a site applies for NHSC assistance for the first time, it would be useful to have someone walk them through the process.
- HPSA's should be determined by service area or patient "destination."
- Do not de-designate a site before coming on-site to see/appreciate the environment. Get people "in the field" to visit communities who are in jeopardy of losing their designation and those who want to be designated.
- Encourage the development of providers that are already in place by exposing them to best health practices.
- Incentives may be required for providers to stay in underserved areas after their obligation.
- Mid-level practitioners are more likely to stay in a rural community longer and provide services; use this to make better matches in rural/frontier communities (e.g., instead of trying to place 3 physicians in a community, try one physician and two mid-levels).

- NHSC could advocate for local and state financial support of community health centers, which save money in health care by preventing use of emergency rooms.
- Work with states and state PCAs/PCOs as a means to establish a foundation/template for state loan repayment programs and share NHSC "lessons learned."
- Provide regular listings/updates on NHSC clinicians in a standard format, so sites have an idea of who the NHSC clinicians are (geographic, medical, and social preferences); code list for sites that have current position available, position that will be vacant in "X", and position filled.
- NHSC regional conferences should focus on what is working and how to overcome challenges - use participants in conferences as resources.
- Field Offices need to give information consistent with the Central Office to NHSC program enrollees.

Conclusion

As an "agent" of the NHSC, FBA helped to establish contact with communities served by NHSC clinicians; in some cases this contact was with alumni that have not had direct communications with the NHSC in many years.

This project served as an outlet for communities to share their story and challenges. The examples of NHSC impact from communities which participated can be called forward in the re-authorization process; the up-to-date contact information contained in the appendix to this report will assure that representatives interviewed can be reached accurately and directly.

The method and results of this project have multiple applications:

- The interview format and data collection tool used by FBA in this project can be used to obtain a picture of the community, by phone, in a way that captures pertinent market, practice, and clinician information. This approach can be used by any staff person/organization interested in monitoring the community conditions where NHSC clinicians practice.
- The names of clinicians and the history of NHSC clinician service in each community gathered in this project will benefit for the Association of Clinicians for the Underserved (ACU), which is building its membership base of NHSC alumni clinicians.
- An abbreviated story format to describe the NHSC impact to policy makers will be useful in the re-authorization process.
- Completed data sheets for each state provide a resource for testimony or additional evidence of NHSC impact that can be used in the Federal re-authorization effort.
- The description of market conditions in fifty one locations that can be used to complement the information being gathered in the Office of State and External Affairs' Marketplace Analysis project.
- Six (6) sites were selected to be highlighted as posters during the NHSC 25th Anniversary Conference in April 1998. The states chosen for illustration in this venue included: New Jersey, Illinois, Indiana, Idaho, South Dakota, Hawaii. These states were chosen based on the following criteria: states represented regions not visited during the NHSC Community Assessment Project; diversity of interaction and populations served; practice models represented; NHSC clinician types represented; and length of history with the National Health Service Corps.