



MASSACHUSETTS LEAGUE OF COMMUNITY HEALTH CENTERS



COMMUNITY HEALTH CENTERS AS ECONOMIC ENGINES

*An Overview of Their Impact on
Massachusetts Communities and Families*

OCTOBER, 2003

FORWARD

For nearly 40 years, community health centers have had a significant impact on their communities, providing high quality health services and opportunities for human and economic development. So, too, the Massachusetts League of Community Health Centers has grown in size and scope to support health centers in their work to improve the well-being of whole communities. Many of our health center members and their patients contributed to this report. We are grateful to them for their help in telling — at least in part — the story of community health centers. It is a compelling account, filled with hard facts, personal triumphs and a shared vision of what communities can be.

Most sincerely,

A handwritten signature in blue ink that reads "James W. Hunt, Jr." with a stylized flourish at the end.

James W. Hunt, Jr.
President & CEO
Massachusetts League of Community Health Centers
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EXECUTIVE SUMMARY

The first community health center in the nation opened as a pilot site in 1965 at Columbia Point in Dorchester, Massachusetts. Until that time, health services for low and moderate income people in inner cities and isolated areas were often lacking altogether. Forty years later, 50 Massachusetts health centers serve one out of ten people in the Commonwealth. Their mission is unchanged: to provide comprehensive primary and preventive health care, including medical, dental, social and mental health services to anyone in need regardless of their medical status, ability to pay, culture or ethnicity.

In addition to their health and social service roles, health centers are stable community assets that operate as economic development engines within low-income communities by:

- producing goods and services,
- offering critical entry-level jobs, training, and career building opportunities that are community-based, and
- serving as anchors for attracting new businesses and investments into the community.

In 2002, Massachusetts health centers directly contributed \$413 million to the state's economy, generated \$301 million in household income and supported more than 7,700 Massachusetts jobs. When Massachusetts state multipliers are factored in to estimate the spin-off activity from the expenditures of all the community health centers in providing health care services, the health centers' total economic impact is even more substantial. When applying multipliers, in 2002, health centers contributed \$693 million to the state's economy, generated \$487 million in household income and supported nearly 10,600 Massachusetts jobs.

Summary of 2002 Multiplied Economic Activity Stimulated by Massachusetts Community Health Centers¹

	<i>Total Output</i>	<i>Total Employment</i>	<i>Total Value-added (inc. personal income)</i>
DIRECT	\$412,934,223	7,714	\$301,010,480
INDIRECT	\$ 87,575,338	811	\$ 58,708,964
INDUCED	\$192,431,251	2,071	\$127,366,314
TOTAL	\$692,940,812	10,596	\$487,085,758

This economic impact analysis is by no means unique. In fact, it reflects what is generally true about the economic impact of health centers across the country. As a result of the combined effect of their multiple roles as service providers, employers, and local businesses, health centers play a significant economic development role in their communities. To invest in health centers is to invest in the economic development of America's communities

ORIGINS OF COMMUNITY HEALTH CENTERS



“ **The poor get sicker
and the sick get poorer.** ”

This observation was made by Dr. H. Jack Geiger, a Tufts University-trained physician who, along with Tufts colleague Dr. Count D. Gibson, Jr., helped found the first two community health centers in the nation in 1965: one at Columbia Point in Boston and the other in the Mississippi Delta at Mound Bayou.

Their belief — that poverty-causing conditions must be addressed before the health of a community can be sustained — formed the basis of a new model of health care the physician-activists brought before the federal Office of Economic Opportunity (OEO) in the early 1960s. Persuaded by their premise and community-based model, federal officials agreed to fund the Columbia Point and Mound Bayou sites.

In the meantime, President Johnson’s “War on Poverty,” a broad-based social program to promote revitalization and economic development within urban and rural areas, was getting underway. OEO officials embraced health centers as an integral part of the program early on, and began development of new health centers in other parts of the country. By 1971, there were 150 health centers throughout the country; 20 of those were located in Boston.

As a creation of OEO, health centers joined Community Action Programs (CAPs) and Community Economic Development Corporations (CDCs) as part of the “War on Poverty” arsenal, each targeted to intervene at a key point in the cycle of poverty: ill health, unemployment, substandard housing and limited educational opportunity. Because these pilot projects were so successful, the federal government created a permanent structure, the Division of Community and Migrant Health within the Bureau of Primary Health Care (BPHC), for administration of the programs in the early 1970s.

Despite major growth and numerous challenges throughout the program’s history, its stated mission remains the same:

To provide high-quality, family-oriented primary and preventative health care services to people in rural and urban medically underserved communities regardless of their ability to pay. Health Centers overcome economic, geographic, or cultural barriers to primary health care, and they tailor services to the needs of the community.

Today, more than 1,000 community health centers carry on the mission of providing high-quality accessible health care to medically underserved and uninsured people across the country.

MASSACHUSETTS SOCIO-DEMOGRAPHIC SNAPSHOT

Massachusetts is a physically small state with a U. S. Census 2000 population of 6,349,000. The demographics of the Commonwealth have changed markedly over the last decade; these changes were most dramatic at the level of individual communities.²

These changes occurred during a decade that was generally regarded as an economic “boom” for the state. Many statistics related to employment and income suggest that the increase in prosperity was limited to only certain segments of the population and that a significant reversal is well underway.

While the total population increased 5.5% statewide between 1990 and 2000, the poverty population increased 10.1% and the low-income population increased by 8.5%. Statewide, 21.8% of the 2000 Massachusetts population was low-income. Eight Massachusetts cities had percentages of low-income populations which far exceeded the statewide average: Lawrence, 51.5%; Chelsea, 47.6%; Holyoke, 46.3%; Springfield, 43.6%; New Bedford, 42.2%; North Adams, 39.4%; Boston, 37.2%; and Worcester, 36.2%.

Overall, Massachusetts ranked 3rd among the states in 1999 median household income, but ranked 45th in rate of home ownership. The median household income of the poorest 20% of Massachusetts is unchanged from the late 1970s while the median household income of the wealthiest 20% increased by 54%. The “income gap” between the poorest and wealthiest 20% of households increased from \$93,390 to \$149,990 (61%) in this period.³ After several years of declining unemployment rates, Massachusetts had the third highest unemployment rate increase between 2001 and 2002 of any state in the country (1.6 percentage point increase).⁴

As with other parts of the country, Massachusetts experienced a dramatic increase in the racial and ethnic diversity of its population in the last decade. Statewide in 1990, the Census reported that 14.8% of the total population was non-white; in 2000, this percentage increased to 15.5%.⁵ The state's Hispanic population grew from 4.3% of total in 1990 to 6.8% in 2000. In addition, the Hispanic population of Lawrence increased from 40.7% to 59.7% of total over the decade. In Holyoke, the increase was from 33.1% to 41.4%; in Worcester from 9.2% to 15.1% of total; and in Springfield from 16.9% to 27.2% of total.

The linguistic diversity of Massachusetts communities also has increased. Statewide, 13.2% of children in Massachusetts public schools (K–12) speak a primary language other than English. This percentage is much higher in health center communities: Boston, 35%; Worcester, 33%; Lawrence, 82% and Holyoke, 53%. Ten percent of Massachusetts residents are foreign-born, and 20% of Massachusetts children are immigrants or children of immigrants.

Other growing immigrant populations in Boston, Springfield and Worcester include Albanians, Bosnians, Ukrainians and Russians. Asian and Southeast Asian populations, while smaller in total, also increased 54% in the last decade. Springfield, Worcester, Boston, Lowell and Quincy have significant Chinese, Vietnamese, Khmer or Hmong populations.

MASSACHUSETTS COMMUNITY HEALTH CENTERS

The Massachusetts League of Community Health Centers (the League) membership includes 50 health centers which serve more than 600,000 patients through 185 sites across the state. Thirty-three Massachusetts health centers receive federal support through the section 330 health center grant program administered by the Bureau of Primary Health Care (BPHC), Health Resources and Services Administration (HRSA). Health centers also receive state-based support through public health grants and are reimbursed for the care they provide to Medicaid recipients and the low-income uninsured.

MASSACHUSETTS COMMUNITY HEALTH CENTER LOCATIONS



Boston

Boston Health Care for the Homeless Program
 Bowdoin Street Health Center
 Brookside Community Health Center
 Codman Square Health Center
 Dimock Community Health Center
 Dorchester House Multi-Service Center
 East Boston Neighborhood Health Center
 Fenway Community Health Center
 Greater Roslindale Medical & Dental Center
 Neponset Health Center (Harbor Health Services)
 Geiger Gibson Community Health Center (Harbor Health Services)
 Harvard Street Neighborhood Health Center
 Joseph M. Smith Community Health Center
 Martha Eliot Health Center
 MGH Community Health Associates
 MGH Back Bay HealthCare Center
 Mattapan Community Health Center
 North End Community Health Center
 Roxbury Comprehensive Community Health Center
 Sidney Borum Jr. Health Center .
 South Boston Community Health Center
 South Cove Community Health Center
 South End Community Health Center
 Southern Jamaica Plain Health Center
 Upham's Corner Health Center
 Whittier Street Health Center . .

“ **Investments in health centers have paid off over the last 40 years ... in stimulating the sometimes depressed economies of urban and rural neighborhoods.** ”

Outside of Boston

Baystate Medical Center Health Centers, Springfield
Brockton Neighborhood Health Center
Cambridge Health Alliance Health Centers
Community Health Center of the Berkshires
Community Health Center of Franklin County
Community Health Connections Family Health Center, Fitchburg
Duffy Health Center, Hyannis
Family Health Center of Worcester
Great Brook Valley Health Center, Worcester
Greater Lawrence Family Health Center
Greater New Bedford Community Health Center
HealthFirst Family Care Center, Fall River
Hilltown Community Health Centers, Huntington and Worthington
Holyoke Health Center
Lowell Community Health Center
Lynn Community Health Center
Manet Community Health Center, Quincy and Hull
Mid Upper Cape Community Health Center, Hyannis
North Shore Community Health Centers, Peabody and Salem
Outer Cape Health Services
Springfield Health Services for the Homeless
Springfield Southwest Community Health Center
SSTAR Family Healthcare Center, Fall River
Tri-River Family Health Center, Uxbridge

Economic Benefits: Stabilization and Stimulation

Community health centers provide services in nearly all of Massachusetts' larger cities (Boston, Worcester, Springfield, Lowell, Lawrence, New Bedford, Lynn and Fall River) as well as in smaller cities (Fitchburg, Holyoke, Salem and Peabody), and in rural and semi-rural areas (the Berkshire hill towns and the towns of the Outer Cape region on Cape Cod). The essence of the community health center model — a locally-focused and locally-governed nonprofit organization, providing comprehensive primary care services to all who need them — has stood the test of time in Massachusetts and is needed now more than ever.

Investments in health centers have paid off over the last 40 years — not only in the form of improved health outcomes, but in stimulating the sometimes depressed economies of urban and rural neighborhoods. Today, 50 health centers serve one out of ten people in more than 140 communities across Massachusetts. Health centers collectively:

- see more than 600,000 patients;
- serve 43 percent of the state's 1.3 million medically underserved;
- provide more than 3 million visits for people in need of medical, dental and social services;
- employ 7,700 clinical, professional and support personnel, 5,500 of whom are full-time staff;
- contribute an estimated one-half billion in total revenues; and
- generate business for local medical professional services such as pharmacies and labs, local restaurants, convenience stores, and other local service industries.

“ **The work of health centers is intrinsically tied to progress in communities ...** ”

And their mission remains the same. Community health centers are:

- Mission-based organizations that provide comprehensive primary and preventive health care and social services;
- Community-based — serve urban and rural communities through 185 sites from Provincetown to the Berkshires;
- Accessible to everyone, regardless of financial barriers, linguistic barriers, cultural barriers, geographical barriers and age;
- Non-profit 501(c)(3) organizations; and
- Governed by community boards.

But it is the indirect and induced economic impact that is difficult to measure. The work of health centers is so intrinsically tied to the infrastructure of progress in communities, that setting apart their full economic impact is challenging. Health centers are not only providers of high quality health care, they are also important contributors to the economic base of each community in which they are located. As local businesses, health centers stimulate the economy in many ways:

- Providers of essential health care — by addressing the public health of their communities and the individual health status of community members, health centers contribute to a healthier local workforce. This impact can be measured in higher numbers of jobs held and retained by community residents and lower rates of illness-related work absence.
- Purchasers of goods and services — health centers are often one of the largest purchasers of goods and services within their service area. By purchasing in the community through organizational expenditures and individuals' use of disposable income, health centers support the development and growth of other small neighborhood businesses (groceries, restaurants, supply stores and various service suppliers). In concert with these business partners and over time, health centers both revitalize urban neighborhoods and maintain the core business infrastructure of small rural communities.
- Employers of community residents — health centers are often one of the largest employers within their immediate service area. By hiring from the community, health centers often offer the first professional employment opportunities for members of disadvantaged communities. The income from health center employment stabilizes and supports families. Health centers also offer career ladders to their employees, supporting professional development and increased educational attainment of both the employees and their families and children.
- In some cases, health centers have played a significant role in revitalizing business districts in which they are located and have been key players in efforts to strengthen all aspects of their communities. Community health centers act as “Economic Engines” spurring local economic development through:
 - Enhanced health care services
 - Referrals to other health providers
 - Employment training
 - Community-based employment
 - Infusion of spending into the community



- Acting as an anchor to attract new businesses and investments into the community
- Community-based development

Community health centers are the foundation of the state's primary care safety net, caring for more than 43% of Massachusetts' low-income patients. The League recently commissioned a study to validate the capacity of health centers for ensuring primary care access to a larger number of vulnerable state residents in a time of fiscal crisis. The study found that with the proper state investments, health centers could extend their reach to an estimated 300,000 more medically underserved patients. However, the study also identified a number of critical success factors that must be addressed before that can happen, including insufficient reimbursement for the cost of health center care, lack of resources for technology needs and competitive barriers in recruitment of staff.

Codman Square Health Center: A Study in Community Revitalization

It was 1978 and Codman Square in Dorchester was experiencing riots, racial tension and a high crime rate. More than 70 percent of the storefronts were vacant, there was no local food market and residents avoided walking through the square. Frustrated by the neighborhood's blight and economic decline, community leaders helped to establish the Codman Square Health Center (CSHC) with a mandate to rebuild the community.⁶

CSHC opened its doors in a converted library branch in 1979. As the health center grew in scope to meet the health, social and civic needs of its community, it also grew in size. In 1993, a \$5.5 million expansion and relocation of the health center tripled the amount of space available for providing services. In 2001, the health center completed a second capital project totaling \$7 million and increased its clinical space by 20,000 square feet. This expansion allowed the health center to add eye care and urgent care services to its clinical programs, double its dental visits, triple its medical visits and augment the specialty care it offers.

More recently, the health center purchased two neighborhood houses and acquired 21,000 square feet from a nearby vacant building, transforming it into a technology and youth center. Other new community programs include a job training center; a civic health institute, a charter high school, a copy business run by local teen-aged girls, adult education classes and free music lessons for youth.

This expansion has helped catalyze other economic gains in the community. In the year following the health center's 1993 expansion, 32 new businesses opened in Codman Square — more new business starts than in any other neighborhood of the city of Boston. Today, the neighborhood continues to thrive with several restaurants patronized by CSHC staff and two pharmacies that have benefited from the health center's growing patient base. CSHC is the largest employer in central Dorchester, providing jobs for 275 people and brings more than 16,000 people per month into the Codman Square business district.

WORKFORCE DEVELOPMENT

As the nation grapples with a shortage of health care professionals at every level in the system, Massachusetts health centers play a direct role in strengthening the state's health care workforce. Because of their longstanding human and

“GNBCHC’s commitment to the community is mirrored by its strong commitment to higher education and continued education for its employees.”

economic development missions, many health centers provide innovative education and job training programs for community residents. These programs run the gamut from sponsoring GED preparation classes, to training nurses' aides and medical billing clerks to helping employees advance their skills and careers. In addition, health centers offer primary medical care instruction to a range of health care practitioners — nurses, optometrists, dentists, social workers — and in some cases, medical residents. And with an eye to the future, health centers continue to provide a wide range of support and training to ethnically diverse populations who represent the state’s future health care workforce.

Greater New Bedford Community Health Center’s Workforce Initiative

With the help of one U.S. Public Health Service physician and two support staff, the Greater New Bedford Community Health Center (GNBCHC) began its mission “to provide programs and services that improve the health of individuals and the entire [New Bedford] community” in 1981.⁷ Since 1981, the community health center has continued to expand its services and to provide a medical home and continuous care for the residents of New Bedford. A radiology program and urgent care clinic were implemented in 1996. In that same year, laboratory and pediatric services were expanded. The dental program, added in 2001, has more than doubled since it began operations. Today, GNBCHC serves nearly 30% of the 94,000 residents (42% of whom are low income) of New Bedford and conducts more than 80,000 visits through all its programs and services, including primary medical, dental and nutritional services.⁸ With a workforce of 180 employees, GNBCHC has also grown into one of the largest employers in the city.⁹

GNBCHC’s commitment to the community is mirrored by its strong commitment to higher education and continued education for its employees. And, as a major employer in the community and with 70%¹⁰ of its staff from the community, GNBCHC’s education and training programs significantly enhance the skills of community residents. To advance its commitment to higher education and continued education, GNBCHC requires that staff complete ten hours of in-service education each year and ties this requirement to raises. To help staff meet this requirement, the community health center provides various opportunities in-house. Each year GNBCHC provides training to employees in continuous quality improvement practices and techniques and each year 98% of its staff complete the training. The benefit to this program is two-fold: employees constantly learn new skills and patients continue to receive high quality care. Additionally, in 1996, GNBCHC became a long distance learning center via satellite link to the University of Dallas and the Southeastern Massachusetts site for the Health System’s Television Network (HSTN). Through this partnership, employees can receive CEU credits for courses provided by the university. These credits and the training provided by GNBCHC are applicable to the ten hours of required in-service education.

To further enhance its workforce development activities, GNBCHC has implemented a career ladder program for medical assistants and plans to implement a similar program for its nursing staff. GNBCHC is also an active participant in the League/Suffolk Program, and recently established a senior level position to focus on workforce development issues. As a testament to its successful workforce development program, more than 30 staff members have been promoted within GNBCHC over the last decade.



Dimock Community Health Center's Workforce Initiative

Focused on helping community residents advance in employment and education, Dimock Community Health Center (Dimock) provides a series of educational programs designed to prepare students for their next challenge.

Their Adult Basic Education program helps improve rudimentary reading, writing and math skills. The health center's GED program is designed to prepare students for all five subject areas of the GED exam. Long-term Skills Training programs are also available for students who are interested in entering the hospitality and health care fields. In addition, Dimock offers certification training courses for nurses' aides and medical/clinical assistants.

Over the years, Dimock has trained more than 4,000 people, many of whom have found fulfilling work at health centers, local hospitals, and other health care facilities.¹¹

In 2003, the number of skills training programs at Dimock was reduced by 50%; the health center currently offers two skills training programs and three adult education programs. In the past year, the Dimock Workforce Development staff was also reduced by 50% in order to survive the current fiscal climate and lack of funding opportunities. As a result of these changes, the emphasis has shifted to more intensive training for fewer students.

While Dimock is an exceptional direct provider of formal adult career education, all community health centers are integrally involved in bringing individuals from the community into health care related careers. Whether it is through mentoring, formal training programs or an entry level job opportunity, the lives of many families have been affected by seeking work at their local community health center.

Ruth McSharry, Neponset Health Center

Until she moved to senior housing two years ago, Ruth McSharry lived next door to the community health center that she and some of her equally committed neighbors helped to found in 1970. Ruth, mother of five, and grandmother of six, spent 25 years supervising and mentoring the work of entry-level staff in reception and patient accounts at Neponset Health Center. Following in their mother's footsteps, her daughters have each worked in a variety of roles at a number of community health centers in the Boston area. One worked her way through a nursing certificate program, and then continued as a part-time student to complete an associate's degree and become a registered nurse. Two others have worked at community health centers in medical billing and outreach. Three of the children are college graduates — the first generation of this family to attend college. Having literally grown up at the community health center whose board first met around their kitchen table, these young adults benefited from role models and early employment opportunities afforded them by their community health center — opportunities they have repaid with service and commitment to their neighbors.

Christine Reyes-Rivera, Family Health Center of Worcester

Passionate, committed and driven are only a few of the words that can be used to describe Christine Reyes-Rivera. Chris was born into one of the first three Latino families in Worcester and raised in Main South, one of the poorest sections of the city. She was born at Worcester City Hospital, the site to which the community health center, Family Health Center of Worcester (FHCW),



moved its operations in 1995. Chris has had a close relationship with FHCW since her birth in 1960 and, over the years, she and her entire family (including grandparents, aunts, uncles and cousins) have received their health care at FHCW. Her mother, Lydia Reyes, was hired as a receptionist at FHCW in 1973 and nine years later Chris began her career at FHCW as a receptionist in the Social Service Department. Working at FHCW, Chris said she “felt at home” because it provided an environment where she could be herself as she saw the “community walking through the doors” as both patients and staff of the community health center.¹² By the time she left FHCW in 1986, Chris had been promoted to medical assistant.

In 1986, Fran Anthes, who later became the President & CEO of FHCW, hired Chris as a counselor at Health Awareness Services of Central Massachusetts. In Chris' own words, Ms. Anthes “saw the light in her eyes, took the chance and gave her the opportunity” to become a counselor though Chris had lacked any formal training. Under Ms. Anthes' tutelage, Chris grew both professionally and personally and was encouraged to continue her education. Although no longer employed by FHCW, Chris maintained her ties with the health center. As a member of a multi-disciplinary team, she provided advocacy, case management, mediation and counseling to pregnant and parenting teens that were patients at FHCW. At Health Awareness, Chris was instrumental in developing a successful GED program for pregnant and parenting teens, many of whom were below a 6th grade math level. The program provided case management services to address the psychosocial needs of these young mothers and day care services while they completed courses to attain their high school diploma.

While working full-time at Health Awareness, Chris undertook a second job as an overnight supervisor at the Friendly House Shelter of Worcester for personal and financial reasons. Her experience at the homeless shelter was one of her greatest challenges and proved to be a pinnacle in her life. Charged with the responsibility of “keeping the peace” in the shelter, as she describes it, among 13-14 families with different ethnic and cultural backgrounds, Chris began ad hoc group sessions with the residents that helped make them aware of their cultural biases, helped them understand and work through their differences, and gave them the tools and skills to redirect their stresses. For Chris, “their therapy was [her] therapy and their involvement was [her] involvement.” Five years of working two jobs and maintaining a family life with her three children and long-time partner eventually took an emotional and physical toll on Chris and, in 1997, she left her job at the shelter. Motivated by the lives she had touched at the shelter and throughout her career and by her passion to make positive changes in the community, Chris committed herself to getting a college degree to help her accomplish her goals. In 1997, she began taking courses at Quinsigamond Community College and made the Dean's List.

Three years after FHCW began a satellite operation in the former Worcester City Hospital, Chris returned to FHCW as Coordinator of the Home Visiting Program in 1994. Since then Chris has been the Interim Director of the Social Service Program and has been promoted to her current position as Program Manager of Maternal and Child Health/Outreach Services. In 1999, Chris petitioned the Massachusetts Board of Registration of Social Work to take the Licensed Social Worker exam as a non-traditional student. Having met the requirements, Chris was allowed to sit for the exam. She passed the exam

“ **Passionate about her work, committed to her community and driven by the difference she has made in peoples’ lives, Chris has made major strides in her professional development.** ”

and became licensed as a social worker that same year. Chris remains determined to “putting a name to what she has done and what she knows” from her more than 20 years of community work experience by attaining a bachelor’s degree. Through an opportunity afforded by FHCW and the ongoing mentoring by Ms. Anthes, she has continued to work towards her educational goals. Staff education and workforce development has been a priority for FHCW; to that end, FHCW has participated in the Next Step Program. In this program, made possible through an educational partnership among Quinsigamond Community College, Worcester State College, and the University Without Walls/UMass Amherst, individuals can receive credit towards a bachelor’s degree in community health for their work experience. To be accepted into the program, individuals must have accumulated a specific number of college credits towards a degree and developed a portfolio based on their experience. The portfolio is reviewed and evaluated for university credit by a committee of faculty chosen by the program. As of this writing, Chris was well on her way to successfully completing the program and receiving a Bachelor of Arts in Community Health by December 2003.¹³

Passionate about her work, committed to her community and driven by the difference she has made in peoples’ lives, Chris has made major strides in her professional development. She began her career as a young woman who arrived at her first job interview in stiletto heels, using the phrase “lookin’ like all that” to describe herself, and is now a polished, articulate health care professional and mentor. She attributes a large part of her success to the opportunities, encouragement and support she has received from FHCW. And, as a long-time member of the community and employee of the community health center, Chris can only wonder, “if Family Health (FHCW) hadn’t taken City (Worcester City Hospital) over, what would our lives be like; where would we be; what would this community be like?”

Wanie Joe Pierre, Brockton Neighborhood Health Center

Born in Haiti, Wanie Joe Pierre came to this country when she was twelve years old. She attended Brockton High School and graduated from Bridgewater State College in 1996. Wanie, who speaks and uses three languages, was immediately drawn to the diversity of cultures at Brockton Neighborhood Health Center (BNHC). “It’s fun to learn about all the cultures here. What a great experience it is to get to know people from all over. We have Portuguese, African Americans, Cape Verdeans, Asians, Haitians, Belgians, and Latinos from Guatemala, Peru, Puerto Rico, Cuba, and the Dominican Republic.”

Wanie began her career at BNHC in 1997 as a registration clerk earning \$8.00 per hour. With a bachelor’s degree in communications, Wanie was clearly overqualified for this entry-level position but jobs were scarce and she needed to pay the bills. Finding a job that was stable and near her home in Brockton was her top priority. She saw her job at the health center as a stepping-stone as she searched for a position in radio or television she could utilize her degree.

Wanie’s skills and leadership abilities quickly became apparent and BNHC promoted Wanie in 1998 to an administrative assistant position paying \$10.25 per hour. Later that same year, the health center had grown enough that it needed someone to supervise the registration department on a full time basis. Wanie was promoted into this position at a salary of \$13.00 per hour. She has continued to grow within this position and her current salary is \$16.94 per hour.

“ We are a community of scholars, committed to apply ourselves to learning together. Success recognizes each person’s individual effort toward our mutual goal. ”

Wanie's rapid growth within BNHC was supported by frequent educational opportunities offered to her by BNHC. She was sent to seminars on conflict management, interpreter certification, and supervision and management, to name just a few. Most recently, BNHC paid Wanie's salary while she attended an intensive 25-day Suffolk University certificate program in Community Health Center Management. Wanie said the Suffolk University program was broadened her horizons and self-esteem and allowed her to learn how other departments at her health center function.

As her career has evolved, Wanie's vision of the value of her communications degree has expanded. She now sees that her interaction with the community and patients utilizes the public relations skills she developed in college. Her goal for the future is to take a more active role in informing the community about services available at BNHC. She sees herself growing into a more expanded role with the community over the next five years with a transition in her health center role to focus more on patient and community education.

By working up from a registration clerk position, Wanie has been able to set a good example for her staff and encourages them to be responsible workers and to improve their skills and education. "I tell new people that there is a lot of opportunity here to develop a sense of responsibility, to gain leadership skills, and learn much from fellow workers," Wanie said.

Wanie feels she has helped BNHC in many ways, especially by ensuring a better-educated registration staff and by educating the community about vital information such as the availability of insurance programs. "The days are so busy that we're always running," she commented. "I don't even have an office. I just go where my team needs me. I do whatever it takes to get the job done because the patients come first."

Greater Lawrence Family Health Center's Family Practice Residency Program

Frustrated with what he viewed as the "competing interests of service and education" in traditional medical training, Dr. Scott Early, a graduate of Dartmouth Medical School, set out to build a better model. Attracted to the challenge of training residents in an urban underserved community, Dr. Early came to the Greater Lawrence Community Health Center in 1993 to help shape and oversee a medical residency program that was still in the early stages of development.

The Lawrence Family Practice Residency program is the first accredited community health center-based residency program in the country. The program is focused around a single goal: "to educate and encourage physicians in a way that maintains their commitment to service and caring." Launched with funding and support from the Lawrence General Hospital, every aspect of the curriculum is linked to the mission of serving Lawrence's predominately underserved Latino population. Medical residents are required to enroll in an intensive Spanish course at the beginning of their first year and to attend weekly classes thereafter. The expectation of each resident who graduates from the program is that they speak Spanish and are familiar with the cultural aspects of providing care to Latino patients. In addition, students gain an understanding that genuine health access is achieved only when both the medical and social service needs of a patient are addressed.



To date, the program has graduated 51 Family Practice Physicians and has made a significant impact on the Merrimack Valley. Seventeen graduates have set up practice in the city of Lawrence, 14 of whom work at the health center. In 1993, before the residency program was started and providers were recruited, the patient to provider ratio was 4,355:1. In 2002 that ratio had improved to 3,008:1 — even while the service area population increased from 57,924 to 72,000.¹⁴

League/Suffolk University Certificate Program

Health centers have joined forces with other hospitals and academic institutions, including the Center for Community Health Education, Research and Service (CCHERS) at Northeastern University and the University of Massachusetts Medical School to provide learning experiences for health professions students in underserved communities throughout the state. However, community-based medical training represents only one side of the workforce challenge health centers face. Building capacity and developing expertise within the health centers' management ranks are equally important.

In the dynamic health care environment, community health centers are faced with multiple challenges everyday. Providing affordable, accessible, quality health care to vulnerable populations has been the cornerstone for community health centers. But, as the health care environment evolves, health centers are faced with more competition, more stringent accountability for every dollar earned and spent, and keeping pace with advancing technology; and, as traditional funding sources become limited or depleted, health centers are forced to search for new and innovative funding sources.

To remain viable and competitive, health centers require managers who are savvy about the business of providing health care within a community health setting. Unfortunately, many health centers lack the resources to establish comprehensive workforce development programs for their managers, many of whom have received little or no management training. Recognizing the need and demand for better-trained managers within health centers, the League in collaboration with Suffolk University established the Certificate Program in Community Health and Community Health Center Management¹⁵ — commonly referred to as the League/Suffolk Program — in 2001.

The League/Suffolk Program provides high quality formal management training, at low cost to both the sponsoring agency and employee, for mid-level managers who work in community-based organizations. It is designed to address barriers such as lack of financial resources to pay for an education, lack of time to pursue an education and lack of programs that specifically address issues faced by community health agencies.

With support from Neighborhood Health Plan, the Massachusetts Association of Community Health, and Health and Human Services HRSA/BPHC, the League/Suffolk Program, valued at more than \$4,000 per student, is available to the League organizational members at a greatly reduced cost. For the 2003-2004 program, members can send an employee to the intensive one-year training program for a nominal \$50 agency application fee and a \$500 tuition fee per student. In return, the student agrees to a one-year commitment to the sponsoring agency after graduation from the program. The cost to the student is limited to course material and is generally no more than \$100.



The program is conducted in five training blocks spread throughout the year. To minimize the impact of the employees' time away from their job, each block is held on five consecutive Fridays with a four to five week break between each block. The curriculum includes courses in community health service management, human resources, marketing, management information systems, grant writing and financial management. The program is further enhanced by the broad experiences of its diverse mix of students representing a range of departments from administrative to clinical and a range of responsibilities from clerical to senior level management.

Upon successful completion of the League/Suffolk Program, students receive a Certificate in Community Health and Community Health Center Management issued jointly by the League and Suffolk University. In addition, students receive six to nine graduate level credits that can be applied towards one of four Masters programs or a Certificate of Advanced Studies in Public Administration at Suffolk University. In each of the first two years of the League / Suffolk Program, an average of 30 students representing 22 community health centers successfully completed the program. Thirty-two students from 24 community health centers are currently enrolled in the class of 2003-2004.

Recently, two students from the 2002-2003 program sponsored by the Lowell Community Health Center were highlighted in a press release from the agency. Charlotte Hermann, Clinical Director of Behavioral Health Services, holds a Master's Degree in Social Work and Paulette Renault-Caragianes, Manager of Adolescent Health, is a nurse. Both praised the program and described it as a confidence builder and a positive peer learning opportunity that provided practical information that could be applied within their workplace and perspective jobs. Both agreed that the program broadened their understanding of the community health center movement and was an important component of staff retention at health centers.¹⁶

Through this innovative program, the League and Suffolk University provide a unique opportunity for health centers to enhance their workforce development efforts. By providing staff with intensive management training, community health centers help staff develop the skills needed to meet the on-going challenges posed by a dynamic health care environment. And, by improving and enhancing their management skills and understanding the business of operating a community health organization, employees are more prepared to climb the proverbial career ladder when opportunities arise.

SUPPORT FOR FAMILIES

Traditionally, health centers have provided primary medical care, dental care and mental health services as well as social and support services, but as the needs and demands of their patients become more complex, health centers have broadened their services to meet these challenges.

Today, health centers across the state are able to serve patients in almost 40 different languages either through interpretation services or bi-/multi-lingual staff. Many health centers have added specialty care services including cardiology, ophthalmology and geriatrics and some have added on-site pharmacy services, radiology and mammography. HIV/AIDS counseling and testing, as well as, domestic violence and smoking cessation programs are now commonplace among health centers. In addition, a few health centers offer non-traditional treatments, such as acupuncture and massage therapy. Through health cen-

“ **Today, health centers are able to serve patients in almost 40 different languages ...** ”

ters' eligibility and enrollment services, patients can also be enrolled into Medicaid on the same day as their health care visit. And, the list of services continues to grow.

As mission-driven health care organizations, health centers continue to provide these services to everyone, many of whom represent the most vulnerable populations in the state, without hesitation or barriers. Many of the successes of health centers are quantifiable, such as improved health outcomes or reduction in infant mortality. But the full impact of how health centers help individuals and families overcome obstacles and challenges in life that ultimately affect their health and ability to contribute economically cannot easily be quantified and depicted in charts and graphs. Below is a sampling of stories from the patients' perspective:

Stella from Saugus

With her mother dead of a heart attack at age 44 and her brothers both gone by their early 60s from heart trouble, Stella Selvage had always assumed that she, too, would die early. Living on Social Security, she can't afford the \$648 worth of drugs she needs each month to control her diabetes, hypertension, and asthma. But she also makes too much on Social Security to qualify for Medicaid. She used to fill prescriptions only when she had the money.

Luckily, Stella found the Lynn Community Health Center's pharmacy program that allows patients with inadequate insurance to get their medications for a minimal co-payment. The program was established because doctors and nurses at the Health Center were so upset about trying to treat patients with chronic illnesses without access to the medications that could help them. Now, Mary has regained health and strength, thanks to the medications she obtains through the program at the health center. "Without the program, I'd die," the 65-year-old Saugus resident says simply.

Mark from Lynn

Forty-seven year old Lynn resident Mark G was very sick in 1997. He feared he had HIV and, wanting to assure confidentiality, went to the Fenway Community Health Center in Boston where his fears were confirmed. Mark was underweight and weak, and decided to move back in with his parents where he would also have the support of nearby siblings. In need of care closer to his parents' home, Mark was able to receive his ongoing care at nearby Lynn Community Health Center. There he met the HIV care team of providers who continue to take care of him today. Initially it was discovered that Mark's T cell count was only 11 (a count of 1200 is normal) and that he had a very high viral load. The physician's assistant told him : "I don't know how you are walking around." Mark was placed on medications immediately and remained bedridden for close to one year.

Over the next year and a half Mark was able to regain his health through the support of his team and learning to be an active participant in his treatment and sharing "a lot of laughs" with his health care team and others. He remembers times when he missed appointments that his case manager would call to tell him that the appointment was rescheduled and to let him know that he really needed to come in. "They were watching my back," he says. "They set up weekly appointments for medical care, acupuncture and massage to try to rebuild my immune system. They knew I was getting depressed and isolated

“ I am, and will continue to be awed by the resiliency of these women. ”

and told me to get up and out of the house.” His T cell count went up 1489 points to 1600. He gained weight, strength and hope.

Six years later Mark is working 3 days a week and volunteering at Cornerstone for Life, a local drop-in center for people with HIV, and spending quality time with his two grandsons. “People at the health center smile even though they are stressed; they must really like their jobs. And this inspired me to find the strength to get back my health.”

A Mother from Springfield

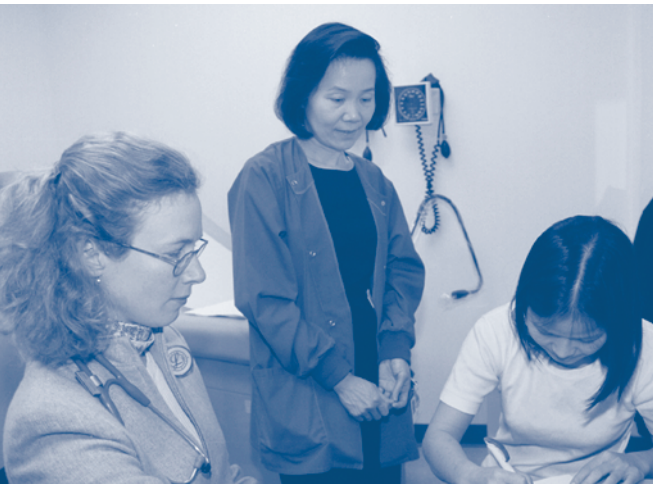
This is a story from a staff nurse at Springfield Health Services for the Homeless:

I had promised a young woman with bi-polar disorder some information on the illness. She had a 2-month old daughter and four other children and was new to the shelter. Her therapist was very forthcoming on the phone and was at first hesitant to consider DMH eligibility for this woman. The therapist shared that the woman wasn't trusting. With this in mind, I put some information together for the client on bi-polar disorder and also sent a personal note. The nurse practitioner informed me that day that this client's infant daughter had died of an apparent SIDS. I immediately called this woman's therapist to make sure that she was aware of the situation.

I am, and will continue to be awed by the resiliency of these women. I asked the therapist if there was anything I could do to help the situation and she told me that this woman had requested transfer to another shelter, as she could not bear to stay there. I requested the DTE number and called the office and did manage to get through to the person in charge of making a decision. We had a very frank discussion about her concerns for this woman moving because of the issues with the boyfriend and the fact that she did not want to act inhumane by not allowing this man to accompany this woman to another shelter. She thanked me for calling and said she would call me back.

Later that week, I was at A Family Place and was speaking to the staff about this client. Staff was telling me how bad they felt that she had lost her baby but that she was a cold person that was not very approachable. The client was upstairs in her apartment clearing out 'her things'. When I saw the client, she had just carried down a basket of clothes and was placing them inside a van. She was alone and looked exhausted. I reminded her of who I was and just stood with her to offer my sympathy and support. She began crying and telling me how her heart and arms ached for her daughter; that she did not know how she was going to go on. She said that the baby's father just couldn't return to the site. She and her grandmother were left to pack and move everything down stairs to the van. I told her of my experience with other women who had lost children and how they told me if they could get one foot on the floor in the morning then that was a good day. I accompanied her back up to her apartment to pack all the baby toys and stroller and jump seat. Her grandmother looked tired and sad. I offered to help move more things but they had to wait for DTE to call them and let them know if they were approved to move.

I sat with them in that lonely place and offered what support I could. She had gotten my note and the information I gave her. I found her to be not cold or aloof, but another broken-hearted mother. I went home and cried for all I had known who have lost children.



Rooted in the community, health centers are natural collaborators. Determined to make a difference in the lives of local residents, health centers partner with community-based groups, including other health centers, social service agencies, local government and faith-based organizations to find ways to remain viable and to serve the needs of their patients in more effective and efficient ways.

Health Services Partnership of Dorchester

Health centers, like other providers, have had to look for new ways to manage costs while upholding their missions to improve the health of their patients. Responding to the challenges of an increasingly competitive health care marketplace, Codman Square Health Center (CSHC) and Dorchester House Multi-Service Center (DHMSC), located just a few miles apart, formed the Health Services Partnership of Dorchester (HSP) in August 1998. HSP is a mission-driven management service organization.

HSP was created to manage selected clinical services to maximize performance, minimize financial risk, and reduce administrative costs for both health centers; today HSP has also become the vehicle for jointly managed public health, civic education, youth, and family support services. During uncertain economic times and with shrinking public funding, HSP's past savings are today's reserves — reserves that allow both CSHC and DHMSC to continue offering their high-quality services to those who are increasingly left without a safety net.

A joint venture of the two health centers, HSP is structured as a separate entity with its own board of directors. Led by a Chief Operating Officer, the objectives of HSP are to develop the following:¹⁷

- a single medical practice with common leadership;
- common, high-quality clinical and behavioral health systems;
- comprehensive quality improvement systems;
- effective managed care while managing risk;
- joint clinical and administrative systems to support managed care;
- a strong market presence and negotiating power from a combined patient population;
- advocacy for public policies that support the communities served by CSHC and DHMSC;
- joint management of community-based non-clinical programs; and
- joint development of grant funded initiatives in public health, research, youth development, environmental health, and civic health.

Since its inception, HSP has made progress in several areas of medical leadership and management. Clinical guidelines have been revised and expanded; physician productivity has increased by 13.3 percent. Successful pilot programs aimed at improving patient visits and overall patient satisfaction are being implemented. Special attention has also been given to expanding access for patients to specialists, including orthopedics, adult cardiology, acupuncture/pain management, dermatology, eye care, and radiology.

By centralizing information technology, the partnership provides a high level of day-to-day technical support as well as opportunities for long-term strategic planning for each health center. In particular, the partnership's data analysis and



reporting capabilities provide critical information and data services for many of HSP's clinical initiatives.

Joint coordination of care continues to be an important function of HSP. A more thorough assessment of patients has been put in place as have new clinical protocols, patient information materials, and improved clinical tracking tools. Nurse case managers, who are shared by the health centers, are now available to all health center patients.

The partnership has had an impact on clinical outcomes for patients, including a dramatic increase in mammography screenings and a significant reduction in emergency room use and hospitalization for asthma patients. Joint management of behavioral health services has resulted in improved patient access and financial performance at both health centers. To further enhance its medical programs, HSP oversees clinical research at CSHC and DHMSC; a systematic evaluation process by which all programs and services will be measured for both clinical and financial outcomes is being developed.

Manet Community Health Center

For over 20 years, Manet Community Health Center, Inc. (Manet) has been providing health care to Massachusetts' South Shore communities from Quincy to Hull.¹⁸ In recent years, Manet has partnered with local service agencies and a large hospital institution in creating new services and programs to better serve area residents. These community partnerships have resulted in more appropriate delivery of care, greater awareness of chronic disease management and more efficient and effective management of resources.¹⁹

In 2001, Manet opened a primary care site at the Quincy Medical Center to divert patients presenting for episodic, non-emergent care at the medical center's emergency room. To date, Manet has served 2,500 patients at the new site of which over 90% are new to the health center. Another collaboration with Quincy Medical Center resulted in a successful grant application to the Blue Cross Blue Shield Foundation of Massachusetts in 2003. As the primary collaborator on a cultural competency grant awarded to Quincy Medical Center by the foundation, Manet is working with QMC to develop and enhance services to the growing Asian populations in Quincy and surrounding communities.

To enhance its current diabetes management program that serves 800 diabetic patients, Manet is currently developing a public awareness campaign in collaboration with the local YMCA and the city of Quincy. The campaign seeks to increase awareness about the importance of diet and exercise in preventing and managing diabetes. A key proposal of the campaign is the placement of mile markers around a major recreational area in Quincy. The concept behind the mile markers, which will include the program logo, is to encourage people to walk and jog and to get more information about assessing their risk for diabetes by contacting the program.

In partnership with South Shore Mental Health, a local mental health and social service agency, Manet recently launched the "Building Bridges" program to identify local families who are the highest users of mental health and social services in the city of Quincy. This joint venture began in 2003 and focuses on better management of these cases. By identifying these families, Manet and partnering community agencies seek to 1) aggressively manage their care to ensure that family members are getting the services they need and 2) manage limited program resources more effectively.

Mattapan Community Health Center

The Mattapan Community Health Center (MCHC) has been serving the Mattapan, Dorchester, Hyde Park and Roxbury neighborhoods and adjacent suburbs for 31 years and is the only comprehensive community health center in the Mattapan and Hyde Park service areas.²⁰ In 2002, MCHC reached over 8,000 patients and conducted more than 24,000 visits.²¹ In recent years, MCHC has engaged in proactive and innovative partnerships to reach and improve the overall health of Mattapan residents and to advance the economic development of the Mattapan community.

One such partnership is the Health Care Revival (HCR) Initiative, established in 1997 by MCHC and a steering committee composed of community leaders, health advocates and church leaders. HCR is an internationally recognized faith-based, data-driven collaboration that incorporates a unique approach to providing health education and engaging residents in a dialogue focused on the health issues in the Mattapan community. In an article published in the February 2002 issue of the American Journal of Public Health, it is described as a “combination of Southern revival meeting and community health fair...[that] consists of inspirational singing, survivor testimonies, dissemination of health information, and screening.”²²

Each year since 1997, MCHC has conducted the all day HCR meetings that intertwine spiritual leaders, inspirational singing and prayer with health screenings and discussion of key health issues affecting Mattapan residents — determined by data collected from the Boston Public Health Commission and MCHC’s own database.²³ Approximately 300 - 450 Mattapan residents and other participants have attended the Health Care Revival each year.

Evaluation of the meetings has shown that this forum has been an effective health outreach strategy for MCHC. Ninety-five percent of the participants reported that they were better informed of the health issues in the community and the services provided at MCHC. Additionally, MCHC experienced an increase in use of services after the meetings and community health improvement projects were implemented to address the concerns of residents raised during discussion of specific community health issues. An example of a community health improvement project implemented by MCHC was a comprehensive program for teens that included a campaign encouraging early and continuous prenatal care. A direct result of the program was a decrease in the infant mortality rate in Mattapan.²⁴

Another significant community partnership is the Mattapan Community Partnership (MCP). MCP, founded in 1999, is composed of community residents and representatives from a cross-section of community organizations, including health and human service organizations, neighborhood associations, local businesses and faith-based organizations.

*The mission of the Partnership is to improve the quality of life for people of Mattapan by working together to build a stronger, safer, healthier, and a more vibrant community. MCP is committed to building on the strengths of families by honoring ethnic, religious and cultural differences; maximizing community involvement and resources for Mattapan; and working together for the common good of the community.*²⁵



MCHC has been a Collaborating Partner of MCP since 1999 and served as the Coordinating Partner in the development and release of the *Mattapan Community Partnership, Strategic Plan, 2002 - 2005* that outlines seven strategic priority goals:²⁶

1. Community Development, Housing and Economic Development
2. Youth Development and Education
3. Community Health
4. Community Education and Awareness
5. Community Participation and Involvement
6. Strengthening the Infrastructure of the Mattapan Community Partnership
7. Community Funding Strategies

As a member of the Community Health Work Group, MCHC served as the Coordinating Partner of the 2001 and 2003 Cross-Cultural Picnics sponsored by MCP that focused on nutrition counseling and physical activity. And, as the only comprehensive community health center member of MCP, MCHC will have a key role in meeting the objectives of the MCP Strategic Priority: Goal 3 — Community Health “to promote the health of the Mattapan community through health education and outreach that address data-driven health issues such as Nutrition, Fitness and Obesity; Breast Cancer; Prostate Cancer; HIV/AIDS; and Infant Survival.”²⁷

These are just two examples of the community partnerships established by MCHC. Through its role as a provider of health care and its partnerships with other community organizations, MCHC has become, and will continue to be, a major force in improving the overall health of Mattapan residents and shaping the economic future of the Mattapan community as a whole.

LOCAL DOLLARS & LOCAL JOBS: THE ECONOMIC IMPACT OF HEALTH CENTERS

Overview of Economic Multipliers

The goal of this economic impact analysis is to demonstrate the role of health centers as “Economic Engines” in the local economy and as viable community platforms for economic development. The analysis calculates the economic impact of a community health center and/or its capital project on its community.

Realities:

- The economic role of health centers is overshadowed by their historical origins and commitment to providing quality care to at risk populations.
- There is limited economic data collection and analysis at the local level.

Goal:

- To demonstrate that investments in community health centers are investments in the community.

Recourse:

- Use economic modeling and analysis to determine the economic benefits of health centers.

The Multiplier Effect:

- Macro-economic modeling to estimate the economic impact of spending on a defined (region) economy.
- Concept and application of the multiplier effect of dollar turnover.

Before measuring the economic impact health centers have on the community, one must understand the concept and application of what is known as the multiplier effect.²⁸ Within the field of economics, the multiplier effect is used to determine the impact of spending or investing in a defined economy (industry and community). By bringing employees and patients into a defined area, a health center creates indirect and induced business effects, which make the economic impact larger than the direct effects (total expenses) by themselves.²⁹

This economic impact analysis uses IMPLAN³⁰ to construct a regional economic model. IMPLAN generates multipliers by geographic region and by industry combined with a county/state database³¹ which allows the assessment of change in overall economic activity. IMPLAN can be used to estimate the impact of organizational projects and expenditures by industry on regional output (expenditures), household earnings and jobs both inside and outside of a given industry. Consequently, IMPLAN (and similar economic databases) has been used nationally by economists, state and city planners, universities and others to gauge the impact of both for-profit and not-for-profit organizations' programs and projects on the local economy.

Standard Economic Multiplier Definitions

Within the IMPLAN database, the total effect (direct, indirect, and induced) is examined from the perspective of output (dollars), earnings (purchasing power) and employment (job creation). IMPLAN determines the multiplier effect of these three areas by generating an "Output Multiplier", "Value-Added (Earnings) Multiplier" and "Employment Multiplier" for each industry within a defined geographic area.

- Output Multiplier: measures the total increase in dollars of total output generated for each dollar spent by a given industry
- Earnings/Value Added Multiplier: measures the purchasing power generated through payroll
- Employment Multiplier: measures the number of jobs generated per \$1 million spent

Every dollar spent on a community health center capital project results in the additional generation of dollars that circulate in the community and additional employment.

CAPITAL PROJECTS

Community health centers have been involved in significant capital development activity. Because most health centers were built between 20 and 30 years ago, many were operating in inadequate and outgrown facilities. Several health centers have renovated existing buildings or built new ones with local, state and federal support as well as philanthropic help. This recent growth and replacement of facilities has been a source of economic stimulation, leading to new jobs during construction, creation of permanent jobs resulting from the health center's expansion of space and services, and direct investment in local communities. In addition, these projects have helped to eliminate blight and reverse



long-term trends of dis-investment, and to provide incentives for the opening of other businesses that provide goods and services to health centers, employees and patients.

When a health center undertakes a capital expansion project, a significant economic revitalization occurs within the local community. This economic impact has been demonstrated by health centers within various Massachusetts communities where additional “units of health care,” new jobs, and stimulated local business served as the immediate outcomes. These areas contribute directly to increased economic activity, household earnings and jobs and are briefly described below:

- Local businesses provide pre-development technical assistance in areas such as feasibility studies, financial planning, capital campaign development, government approvals, architectural design and engineering assessments.
- Local construction companies are contracted to build the new/expanded site.
- The purchase of equipment and supplies for clinical services, programs and administrative support will be located in the newly constructed space.
- An increased number of employment opportunities will be available in health care and other industries.
- Increased revenues and reserves will result from providing additional “units of health care.”

By engaging in facility development projects to meet the growing health care services needs of their communities, community health centers increase this impact. During the planning, construction and fitting out of new buildings, the purchasing and hiring impacts of the centers increase. Once the facility is complete, the economic development impact of health centers as employers and purchasers continues at a new higher level. A few health center capital projects are highlighted below:

South End Community Health Center

The South End Community Health Center (SECHC) was established as a non-profit pediatric facility in 1969 when local residents and city officials acknowledged that a serious gap existed between the medical requirements of South End children and the local public and private institutions available to meet those needs. Their goal was to provide the most efficient delivery of quality medical care to patients in need. This model was successful, allowing SECHC to grow from a pediatric unit in 1969 to a full-service, primary care and health maintenance facility.³²

In 1994, Boston was designated as one of the nation's Enhanced Enterprise Communities (EEC) under the federal Empowerment Zone Initiative launched by President Clinton and Vice President Gore. The program provided enhanced financial assistance, tax incentives and other support to stimulate the self-revitalization of communities in economically depressed urban and rural areas. Funding and support for empowerment zone projects was awarded based on strategic collaboration among community-based businesses, agencies and organizations.

In 1998, SECHC, located in the heart of one of Boston's most ethnically diverse communities, undertook a joint venture real estate development project at 1601 Washington Street (corner of Washington and Rutland Streets).

Leveraging the EEC initiative, SECHC sought \$6.23 million from the City of Boston as part of the Empowerment Zone Initiative. Specifically, SECHC requested and received a Section 108 loan of \$3.33 million and an Economic Development Initiative grant of \$2.9 million. The project proposed to create 110 permanent jobs, 60% of which were targeted to community residents.

The resulting health center facility, located within Boston's EEC, is part of a unique, mixed-use development project of which SECHC is a partner with South Park Associates and the Blackstone/Franklin Square Neighborhood Association. In addition to the new three-story, 35,000 square-foot health center; the development includes three additional floors for market rate condominiums, commercial/retail space, underground parking and community gardens.

Within this joint venture, SECHC project costs totaled \$10.44 million. Based on an economic analysis assessing the SECHC portion of the project, the SECHC's estimated impact of all the capital project components (pre-development assistance, construction, medical and office equipment purchases and increased health services' expenditures) is outlined below:

Summary of 1997 Multiplied Economic Activity Stimulated by South End Community Health Center's Capital Project³³

	<i>Direct</i>	<i>Total Output</i>	<i>Total Employment</i>	<i>Total Earnings</i>
CAPITAL PROJECT	\$10,440,000	\$22,520,000	308.2	\$9,210,000

Applying the industry multipliers to assess the overall economic change, these totals suggested that the aggregate effect of SECHC's \$10.44 million capital expansion project on the local economy was \$22.5 million in increased output across all contributing industries, \$9.2 million in increased household earnings across all contributing industries and 308 additional jobs across all contributing industries.

Founded in 1969, the new facility allowed SECHC to respond more effectively to the health care needs of all South End families - especially low-income Latino and African-American families - by consolidating operations from five locations to a single entity, doubling the current combined square footage and increasing preventative care services. The project allowed SECHC to:

- expand medical programs (especially in areas of pediatric, adolescent and geriatric care) through additional examination rooms and staff;
- enhance mental health/social services through significant growth in counseling space and staff;
- improve delivery of care through consolidation of clinical sites;
- increase economic stability through additional patient visits and diversification of revenue sources;
- provide community meeting and education space to allow South End residents and organizations to address health, social, cultural and economic issues before the neighborhood; and



- promote neighborhood economic development through use of neglected land to create housing and jobs.³⁴

The SECHC capital expansion project provided:

- substantial economic impact to the Boston economy;
- significant number of jobs to residents in the EEC area;
- increased health services to “at risk” and ethnically diverse populations; and
- long-term stimulation for economic revitalization along the Washington Street corridor:

According to Reginald Nunnally, executive director of the Boston Empowerment Center, “It’s a project we think has a major impact on the South End. It will attract people to the area, and that will be good for the other businesses that dot the street.”

In July 1998, Vice President Al Gore came to Boston to mark the groundbreaking of a new South End Community Health Center on Washington Street. The health center project was hailed by the Vice President as a true economic development catalyst for the South End neighborhood.

“Give the people in the neighborhoods the tools they need to help themselves and the access to resources to build their dreams,” Gore declared. He stressed that as the national economy continues to surge, empowerment zones provide a proven means for ensuring that “cities don’t get left behind,” adding that, “Once again, cities are becoming the pride of America; just like the USS Constitution, the wind is in their sails again.”³⁵

Family Health Center of Worcester

In 1990, Family Health Center of Worcester (FHCW) was in a unique position. It was the largest provider of outpatient health services in downtown Worcester. In the meantime, Worcester City Hospital (WCH), another local provider of outpatient primary care, was slated to close. WCH provided over 20,000 visits in 1990; without WCH, area residents, which included some of the most vulnerable populations in the city, would have been left without essential community and primary health care services. To avoid such a crisis, FHCW quickly organized a campaign to continue to provide these services. FHCW worked closely with local providers and city and state officials to move into the six-story hospital building and operate a satellite facility to fill the void of providing necessary ambulatory health care services to the community. And in 1991, when WCH closed its door at 26 Queen Street, FHCW opened its satellite at the site and continued services to residents with minimal disruption. With support from the University of Massachusetts and the state, \$4.8 million in renovations at Queen Street were completed in 1995 and FHCW consolidated its modest facility at 875 Main Street from which it had operated since 1973 and its WCH satellite into the new state-of-the-art facility.³⁶

Since 1990, FHCW has increased in size from 11,000 square feet to 55,000 square feet, users have grown from 5,000 to 18,000, and visits have increased from 20,000 to over 80,000. Throughout the years, FHCW has worked continuously to enhance its primary health care and social services. In 1992, the former emergency room of WCH was converted into an urgent care center. FHCW opened its first school-based health center in 1994; and, by 2001, three additional sites were opened. An on-site pharmacy operated by FHCW

was opened in 2001; then, in 2002, dental services were expanded to include oral surgery.³⁷ In addition to its main facility and the school-based health centers, FHCW also operates three off-site Women, Infants and Children Supplemental Nutrition Programs (WIC). FHCW has enhanced its diagnostic services with the addition of radiology, including ultrasound and mammography, and has added a number of specialty services such as orthopedics, urology and podiatry. FHCW also continues to operate its legacy programs, such as the Getchell-Ward Tuberculosis Program that is operated in conjunction with the city of Worcester.

According to Frances M. Anthes, President & CEO of FHCW, “the most significant impact FHCW has made on the community is its vision to turn what could be a vacant six-story building in the middle of downtown Worcester into a viable economic opportunity for goods and services in one of the poorest communities of Worcester.” Its growth since 1990 is a testament of this vision. To meet the increased demand for services and to continue to expand services, FHCW staff has almost quadrupled in size and has grown from 65 employees in 1990 to more than 250 in 2003. With approximately 60% of the staff residing in the community, FHCW is truly a “community” health center. And as a result of its growth and expansion since 1990, the community health center is now the largest employer within the inner-city neighborhoods of Piedmont, Elm Park and Main South in the city of Worcester. By continuing to provide essential health care services within the community, FHCW has not only contributed to the overall health of the downtown Worcester community, it has greatly contributed to its viability.

Based on an economic analysis assessing the FHCW \$4.8 million capital project, the FHCW’s estimated impact of all the capital project components (pre-development assistance, construction, medical and office equipment purchases and increased health services’ expenditures) is outlined below:

Summary of 1995 Multiplied Economic Activity Stimulated by Family Health Center of Worcester’s Capital Project³⁷

	<i>Direct</i>	<i>Total Output</i>	<i>Total Employment</i>	<i>Total Earnings</i>
CAPITAL PROJECT	\$4,800,000	\$8,986,874	86.8	\$4,711,944

Applying the industry multipliers to assess the overall economic change, these totals suggested that the aggregate effect of FHCW’s \$4.8 million capital expansion project on the local economy was almost \$9.0 million in increased output across all contributing industries, \$4.7 million in increased household earnings across all contributing industries and 87 additional jobs across all contributing industries.

Hilltown Community Health Centers

Located in the western foothills of the Berkshires, the Hilltown Community Health Centers, Inc. (HCHC) has been providing both medical and dental health care services to residents of several rural communities located in the counties of Hampshire and Hampden for over 50 years. Over the years, HCHC has also added behavioral health care to its growing list of



services offered. In 1950, HCHC, then operating as the Worthington Health Association, began providing medical care to the residents of Worthington and other Hampshire County towns of Chesterfield, Cummington, Goshen and Plainfield. The Worthington Health Center was later built in 1965. In 1976, HCHC became a federally-funded rural community health center; and, in 1981, opened the Huntington Health Center and expanded its services into the southern Hampshire County hilltowns of Huntington and Middlefield and the Hampden County hilltowns of Blandford, Chester, Huntington, Middlefield, Montgomery and Russell.³⁹ The total population of these 11 towns that constitute the primary service area for HCHC was slightly more than 12,500 in 2000.⁴⁰ In 2003, HCHC served approximately 8,000 residents (equivalent to 64% of the total population of these rural towns), provided 33,500 health care visits, employed 59 full-time equivalents (FTEs) and expended \$3.6 million to provide services. These figures represent increases of 10% in total visits, 34% in FTEs and 20% in total expenditures between 2002 and 2003.

According to Joyce H. Toth, Executive Director of HCHC, the most significant impact HCHC has had on the community has been its continued commitment to serving the residents in the hilltowns of Hampshire and Hampden Counties through which it has enhanced residents' quality of life by effectively providing accessible, affordable care and eliminating economic and geographical barriers to care faced by residents. To better serve and meet the health care needs of these remote towns, HCHC has continued to expand its services and has become the primary provider of health care services in the area.

In 1998, HCHC opened a school-based health center at the Gateway Regional Middle and High School and currently more than 90% of the student body. In October 2002, HCHC completed a \$1.23 million renovation of its Worthington Health Center. Through a successful capital campaign, HCHC completely funded the renovation with a generous Community Development Block Grant of \$660,000 from the town of Worthington, other public funds and private donations. The renovation provides 5,300 square feet of additional space for the health center doubling the capacity for medical, dental and behavioral health services. The waiting rooms, reception, on-site laboratory and medical records room were also redesigned and enlarged to more amply accommodate its growing patient population. Additionally, expansion of the Huntington Health Center has begun. Through a \$100,000 grant from the UMass Medical School, HCHC recently completed expansion of its dental program at the Huntington Health Center, effectively doubling dental capacity at the site. Complete expansion of this health center is a priority for HCHC in the upcoming year.

As HCHC has worked to expand services to area residents, its workforce has expanded to keep pace with its service delivery. As a result, HCHC has grown into the largest employer in the area with a workforce of 90 staff totaling 59 FTEs. A human resources department has been recently developed to better serve employees and formal policies for career advancement at HCHC have been developed. Through its commitment to the residents it serves and the staff it employs, HCHC has become, and will continue to be, a major health care and economic force in this western region of Massachusetts.

Based on an economic analysis assessing the HCHC's \$1.33 million capital project, the HCHC's estimated impact of all the capital project components (pre-development assistance, construction, medical and office equipment purchases and increased health services' expenditures) is outlined below:

Summary of 2002 Multiplied Economic Activity Stimulated by Hilltown Community Health Center's Capital Project⁴¹

	Direct	Total Output	Total Employment	Total Earnings
CAPITAL PROJECT	\$1,330,000	\$2,074,569	20.3	\$1,013,135

Applying the industry multipliers to assess the overall economic change, these totals suggested that the aggregate effect of HCHC's \$1.33 million capital expansion project on the local economy was \$2.1 million in increased output across all contributing industries, \$1.0 million in increased household earnings across all contributing industries and 20 additional jobs across all contributing industries.

Brockton Neighborhood Health Center

The Brockton Neighborhood Health Center provided primary health care to approximately 9,700 individuals in fiscal year 2002; over 99% of these patients had incomes below 200% of the federal poverty level.

Currently, BNHC has four sites: the main clinic at 157 Main Street, administration and dental offices at 231 Main Street, a satellite clinic at 795 Pleasant Street and a clinic at Mainspring House Homeless Shelter. As a direct result of the health center opening its doors in 1994, the following businesses have opened in the area:⁴²

- Plaza Pharmacy: Dontun Diyaolu opened Plaza Pharmacy in 1997 directly across the street from Brockton Neighborhood Health center. He said his decision on the location of the pharmacy was easy. He wanted to locate near the health center. Dontun says his relationship with BNHC is "a marriage made in heaven". He said, "The health center's business gave Plaza Pharmacy the impetus to really branch out as we saw the difficulty patients had returning to the pharmacy." This led Plaza Pharmacy to expand beyond traditional pharmacy to start a pharmacy home delivery service and a home infusion program. Plaza Pharmacy currently is working with BNHC to move the pharmacy to BNHC's new building. Plaza Pharmacy plans to invest approximately \$900,000 purchase a 5,000 square foot condo within the new building. This will allow the pharmacy to maintain its close proximity to BNHC, will allow Dontun to own his space rather than continuing to rent, and will allow him to significantly expand his retail business. Dontun estimates the joint expansion of BNHC and Plaza Pharmacy will allow him to hire four additional full time pharmacy technicians. Plaza Pharmacy's revenues for the most recent year was \$1.9 million, of which approximately \$375,000 in revenue were generated by filling prescriptions for BNHC patients. Plaza Pharmacy's revenues have been increasing steadily since it opened. First year revenues were approximately \$1.1 million.
- Caritas Good Samaritan Medical Center estimates it will add 25 full time employees, in a variety of positions, to its staff to accommodate the doubling of the business it receives from BNHC. BNHC's expansion should bring an additional \$3 million in revenues to the hospital annually. BNHC's business currently supports about 25 FTEs and brings in \$3 million in revenues.
- Gateway Lab plans to add 3.5 FTEs, an investment of \$300,000 annually, to accommodate BNHC's growth. New staff would include .5 FTE lab tech, one billing person and two lab assistants. Billing and lab assistants are

trained on the job or through a one- or two-year technical school; Lab technicians complete a two-year technical school.

- Drobni Dental Lab plans to add two full time technicians at a total cost of \$66,000. They hire employees with no skills and provide on the job training, thus contributing to the development of a skilled workforce.
- CleanLink, a Brockton-based medical facility cleaning company, plans to add two full time staff at a cost of \$36,000. Staff will be minorities from the local community.

Recently, BNHC purchased land in downtown Brockton and plans to construct a new health center at that site. Tentative plans are for a building of approximately 44,000 square feet on four floors. This will more than double BNHC's current capacity. The doubling of space will enable BNHC to continue its phenomenal growth in terms of health services provided to the community, in terms of new jobs created, and in terms of revenues generated in the local economy. In addition, the consolidation of the two current sites will create operational efficiencies that will enhance the long-term stability of the organization.

This project also addresses an important economic need for downtown Brockton in that it will replace a blighted vacant lot in the heart of downtown with a beautiful, functional building that will enhance the ongoing revitalization of the downtown area. Brockton Mayor John T. Yunits, Jr. has stated on numerous occasions that the overgrown vacant lot is an impediment to attracting businesses and developers of residential property. In his 2003 State of the City Address, while outlining his economic revitalization plan, Mayor Yunits said, "During recessions, the weak wilt but the creative flourish by inventing collaborations that sustain development, enabling great communities to lead the recovery. I envision a new Health Center on Main Street surrounded by new privately developed market rate apartments that will increase the housing supply and relieve pressure on prices."

BNHC has estimated that this capital project will cost a total of \$7,728,000. Based on an economic impact analysis assessing the BNHC capital project, BNHC estimated impact of all the capital project components (pre-development assistance, construction, medical and office equipment purchases and increased health services' expenditures) is outlined below:

Summary of 2003 Multiplied Economic Activity Stimulated by Brockton Neighborhood Health Center's Capital Project⁴³

	<i>Direct</i>	<i>Total Output</i>	<i>Total Employment</i>	<i>Total Earnings</i>
CAPITAL PROJECT	\$7,728,000	\$12,845,234	111.5	\$6,324,617

Using IMPLAN, these totals suggest that the aggregate effect of BNHC's \$7.728 million capital expansion project will be \$12.8 million in increased output in all contributing industries, \$6.3 million in increased household earnings across industries and 111 additional full- and part-time jobs.



Greater Lawrence Family Health Center

The Greater Lawrence Family Health Center (GLFHC) began operations as a community health center in 1980 with ten health care professionals working above a former funeral home. In that first year, GLFHC provided services to 3,000 patients. With a current staff of over 400 providing care to more than 35,000 patients annually, GLFHC is now the largest independent community health center in northeastern Massachusetts⁴⁴ and serves nearly half the population of the city of Lawrence with slightly more than 72,000 residents.⁴⁵ According to Bill Dow, Deputy Director of GLFHC, it is the third largest employer in its business district following the city of Lawrence and the Lawrence General Hospital.

GLFHC has undergone tremendous capital development to accommodate the demands of its patients and the needs of staff that are expected to conduct almost 150,000 visits in 2003.⁴⁶ Once a modest community health center operating above a former funeral home, GLFHC has evolved into an innovative, multi-site health care organization. By 1996, GLFHC had three primary care sites in operation. A fourth site was added in 2001. Currently, GLFHC occupies over 70,000 square feet that includes four primary care sites and two school-based health centers as well as administrative offices and community services programs. In recent years, GLFHC has expended nearly \$6.6 million for facility renovations and equipment that increased capacity by more than 50%. Plans are now underway to relocate and expand one of its facilities. The new site is scheduled to open in 2004 and will increase GLFHC total capacity by almost 15%.⁴⁷

As an employer of over 400 staff, GLFHC is one of the largest employers in the area and a significant contributor to the local economy. Each year GLFHC sponsors a vendors' fair that attracts local suppliers and businesses seeking to sell services and products to the community health center as well as its employees. Over 65% of its employees are local residents. In addition, its 10-year operation of the Lawrence Family Practice Residency program has produced over 75 family practice physicians many of whom continue to work in Lawrence or at other community health centers in eastern Massachusetts. And with more than \$25 million of annual expenditures in 2003, GLFHC has become a major purchasing power in the community.

Based on an economic analysis assessing GLFHC's \$6.6 million capital project, the GLFHC's estimated impact of all the capital project components (pre-development assistance, construction, medical and office equipment purchases and increased health services' expenditures) is outlined below:

Summary of Recent Multiplied Economic Activity Stimulated by Greater Lawrence Family Health Center's Capital Project⁴⁸

	<i>Direct</i>	<i>Total Output</i>	<i>Total Employment</i>	<i>Total Earnings</i>
CAPITAL PROJECT	\$6,600,000	\$11,233,573	88.3	\$5,804,912

Applying the industry multipliers to assess the overall economic change, these totals suggested that the aggregate effect of GLFHC's \$6.6 million capital expansion project on the local economy was \$11.2 million in increased output across

all contributing industries, \$5.8 million in increased household earnings across all contributing industries and 88 additional jobs across all contributing industries.

Capital Projects Summary

These individual capital projects are just a sampling of the substantial impact health centers have on their communities. The total economic impact resulting from the pre-development, construction and equipment purchases are summarized below:

Summary of Multiplied Economic Activity Stimulated by Massachusetts Capital Projects

	<i>Direct</i>	<i>Total Output</i>	<i>Total Employment</i>	<i>Total Earnings</i>
South End CHC	\$10,440,000	\$22,520,000	308.2	\$ 9,210,000
FHC of Worcester	\$ 4,800,000	\$ 8,986,874	86.8	\$ 4,711,944
Hilltowns CHC	\$ 1,330,000	\$ 2,074,569	20.3	\$ 1,013,135
Brockton NHC	\$ 7,728,000	\$12,845,234	111.5	\$ 6,324,617
G. Lawrence FHC	\$ 6,600,000	\$11,233,573	88.3	\$ 5,804,912
Total	\$30,898,000	\$57,660,250	615.1	\$27,064,608

Using IMPLAN, these totals suggest that the aggregate effect of these \$30.9 million capital expansion projects was \$57.7 million in increased output in all contributing industries, \$27.1 million in increased household earnings across industries and 615 additional full- and part-time jobs.

TOTAL ECONOMIC IMPACT

Massachusetts Community Health Centers

Massachusetts, according to the 2000 United States census, has a population of 6,349,000. Within the state, 50 community health centers operate at 185 access points located in Massachusetts' low-income communities. Both individually and as a whole, they make a concentrated economic impact on the state. In 2002, Massachusetts health centers saw more than 600,000 medical patients and provided more than 3 million visits for people in need of medical, dental and social services.

This section of the economic impact analysis looks at Massachusetts health centers most recent fiscal year performance and estimates their current economic impact on their communities. When Massachusetts' state multipliers are factored in to estimate the spin-off activity from the expenditures of all the community health centers in providing health care services, their economic impact is substantial.

In 2002, Massachusetts health center members directly contributed \$413 million to the state's economy, generated \$301 million in household income and supported more than 7,700 Massachusetts jobs.

Summary of 2002 Multiplied Economic Activity Stimulated by Massachusetts Community Health Centers⁴⁹

	Total Output	Total Employment	Total Value-added (inc. personal income)
DIRECT	\$412,934,223	7,714	\$301,010,480
INDIRECT	\$ 87,575,338	811	\$ 58,708,964
INDUCED	\$192,431,251	2,071	\$127,366,314
TOTAL	\$692,940,812	10,596	\$487,085,758

Applying the industry multipliers to assess the overall economic change in Massachusetts, Massachusetts community health centers current operations stimulated \$693 million in total economic output and \$487 million in personal income, fueling an estimated 10,600 full- and part-time jobs in the Massachusetts area in FY2002. More importantly, most of these jobs and personal income (payroll) go to residents of this low-income area.

Boston Community Health Centers

Boston is the largest city in both Massachusetts and New England. The 2000 population of over 589,141 residents represents just under 10 percent of the total population of the state. Within the city, 26 community health centers operate at 40 service sites which are located in Boston's low-income communities. Both individually and as a whole, they make a concentrated economic impact on the city. In 2002, Boston health centers saw more than 270,000 medical patients and provided more than 1.5 million visits for people in need of medical, dental and social services.

This section of the economic impact analysis looks at Boston health centers most recent fiscal year performance and estimates their current economic impact on their communities. When Boston's county (Suffolk County) multipliers are factored in to estimate the spin-off activity from the expenditures of all the Boston community health centers in providing health care services, their economic impact is substantial.

In 2002, Boston health center members directly contributed \$252 million to the state's economy, generated \$187 million in household income and supported more than 5,000 Boston area jobs.

Summary of 2002 Multiplied Economic Activity Stimulated by Boston Community Health Centers⁵⁰

	Total Output	Total Employment	Total Value-added (inc. personal income)
DIRECT	\$252,465,347	5,030	\$186,821,874
INDIRECT	\$ 48,817,311	421	\$ 33,473,132
INDUCED	\$116,007,748	1,146	\$ 77,546,600
TOTAL	\$417,290,406	6,597	\$297,841,606



Applying the industry multipliers to assess the overall economic change in Suffolk County, Boston community health centers current operations stimulated \$417 million in total economic output and \$298 million in personal income, fueling an estimated 6,600 full- and part-time jobs in the Boston area in FY2002. More importantly, most of these jobs and personal income (payroll) go to residents of this low-income area.

Massachusetts Homeless Programs

Within the state, two Homeless Programs operate at several sites located in Boston and Springfield's low-income communities. Both individually and as a whole, they make an economic impact in those cities and surrounding communities. In 2002, Massachusetts Homeless Programs saw more than 9,000 medical patients and provided more than 66,000 visits for people in need of medical, dental and social services.

This section of the economic impact analysis looks at Massachusetts Homeless Programs' most recent fiscal year performance and estimates their current economic impact on their communities. When Massachusetts' state multipliers are factored in to estimate the spin-off activity from the expenditures of all the Massachusetts Homeless Programs in providing health care services, their economic impact is substantial.

In 2002, Massachusetts Homeless Programs directly contributed \$16 million to the state's economy, generated \$11 million in household income and supported more than 350 Massachusetts jobs.

Summary of 2002 Multiplied Economic Activity Stimulated by Massachusetts Homeless Programs⁵¹

	Total Output	Total Employment	Total Value-added (inc. personal income)
DIRECT	\$15,754,786	355	\$11,547,983
INDIRECT	\$ 3,129,384	28	\$ 2,136,322
INDUCED	\$ 7,487,159	75	\$ 4,992,297
TOTAL	\$26,371,329	458	\$18,676,602

Applying the industry multipliers to assess the overall economic change in Massachusetts, Massachusetts Homeless Health Center Programs current operations stimulated \$26 million in total economic output and \$19 million in personal income, fueling an estimated 460 full- and part-time jobs in the Massachusetts area in FY2002. More importantly, most of these jobs and personal income (payroll) go to residents of this low-income area.

Worcester Community Health Centers

The city of Worcester is the second largest city in Massachusetts with a 2000 population of almost 173,000 residents. Within the city, two community health centers operate at five service sites which are located in Worcester's low-income community. Both individually and as a whole, they make a concentrated economic impact on their city. In 2002, Worcester health centers saw more than 29,000 medical patients and provided more than 212,000 visits for people in need of medical, dental and social services.

This section of the economic impact analysis looks at Worcester health centers most recent fiscal year performance and estimates their current economic impact on their communities. When Worcester's county (Worcester County) multipliers are factored in to estimate the spin-off activity from the expenditures of all the Worcester community health centers in providing health care services, their economic impact is substantial.

In 2002, Worcester health center members directly contributed \$35 million to the state's economy, generated \$22 million in household income and supported more than 500 Massachusetts jobs.

Summary of 2002 Multiplied Economic Activity Stimulated by Worcester Community Health Centers⁵²

	Total Output	Total Employment	Total Value-added (inc. personal income)
DIRECT	\$35,207,212	505	\$ 22,531,165
INDIRECT	\$12,577,550	114	\$ 7,581,698
INDUCED	\$13,651,518	167	\$ 8,921,051
TOTAL	\$61,436,280	785	\$39,033,914

Applying the industry multipliers to assess the overall economic change in Worcester County, Worcester community health centers' current operations stimulated \$61 million in total economic output and \$39 million in personal income, fueling an estimated 785 full- and part-time jobs in the Worcester area in FY2002. More importantly, most of these jobs and personal income (payroll) go to residents of this low-income area.

CONCLUSION

Massachusetts community health centers have demonstrated their value as community assets for nearly 40 years. As they have grown in number and reach, their value has appreciated. More than just health care providers, community health centers have become integral to the social and economic health of the communities they serve. They are stable community assets that:

- assess health risk and contributes to community-oriented primary health care;
- provide high quality, accessible, community-based health care services in a respectful manner; and
- operate as an economic development engine within the communities it serves to leverage its resource and impact both the economy and the care of patients who would otherwise go without health care.

With continued investment, health centers are poised to ensure health access for the state's most vulnerable, to help train the state's future health care workforce and to bring about profound, positive change for hundreds of thousands Massachusetts residents.

In addition to providing critically needed, high-quality, community-based health care to low-income residents of the Commonwealth, community health centers provide training and employment for significant numbers of local residents,

creating a foundation for local economic investment and stability. Economic expansion, coupled with improved access to health care, makes investment in health centers one of the most productive possible uses of capital dollars.

Industry standard economic research and data analysis, when applied to health center capital expansion and health services activity, demonstrate the significant economic impact of investments in these community-based institutions. The resulting information strongly suggests that:

- models for depicting and accurately predicting the economic impact of health centers and related capital expansion projects can be generated by using reliable economic statistics and applying knowledge of health care, health centers and real estate development; and
- health centers provide significant economic stimulus to the communities where they are located through involvement with businesses, other health and human service provider organizations and hiring of local residents.

Because Massachusetts community health centers use their resources to provide care to individuals who are low-income, they operate with narrow financial margins and reinvest the majority of their operating profit back into new services that treat additional uninsured/underinsured patients. Despite these financial constraints, and as a result of the combined effect of their multiple roles as service providers, employers, and local businesses, health centers serve a significant human and economic development role in their communities. Expanding their scope and reach over the last 40 years, community health centers have proven their resiliency and power in helping to transform the health, social, and economic well-being of communities. Investing in health centers is investing in the future of our communities.

MASSACHUSETTS LEAGUE OF COMMUNITY HEALTH CENTERS



The Massachusetts League of Community Health Centers (the League) is a statewide association representing and serving the needs of the Commonwealth's 50 community health centers. The League continues to strengthen the Massachusetts community health center network through:

- **Comprehensive Technical Assistance:** The League provides technical assistance leadership to health center administrators, clinicians and board members, and to other agencies that support or work in community-based health care. League staff render support to health centers on both an individual and group basis, focusing on state and federal health regulatory and policy issues. In addition, technical assistance is provided in a range of administrative areas that include financial and personnel management, capital development, grant writing and managed care systems.
- **Training & Education:** As part of its Training and Education program, the League develops seminars, workshops, and conferences designed to provide useful and timely health care operations, management, and clinical information to senior managers, board members, physicians, mid-level providers, administrators, and support staff.
- **Workforce Development:** Targeting physician and mid-level clinicians, the League's Clinical Recruitment and Retention program serves as a role model for primary care associations across the country. In addition, the League is working to address the recruitment and retention of non-clinical health center staff through new workforce initiatives that include publication of a monthly personnel referral bulletin and the recent launching of a certificate program to advance the skills of health center middle managers.
- **Information Dissemination:** The League works to keep health center staff and patients up-to-date on the economic and political changes within the primary health care system through newsletters, bulletins and general information notices. Information on the issues affecting community health centers also is provided to policy makers, the media, potential clinical staff, and the public. The League has developed a series of technical publications that address issues such as the roles and responsibilities of boards of directors, credit and collection policies and wage and compensation levels for health center employees.
- **Community Development:** Focused on expanding health access to new communities and new patient populations, the League participates in statewide health planning activities. In addition, the League renders assistance to locally-based health committees and organizations seeking to open health centers in their communities.
- **Advocacy:** The League works to promote the improvement and expansion of primary health care access by providing information to policy makers, public and private agencies, and the media on the key issues that affect uninsured and underinsured populations across the state.

The League is also a co-founder and member of the health-center based HMO, *Neighborhood Health Plan*, *Community Health Center Capital Fund*, established in 1994 to assist Massachusetts health centers in developing and funding capital projects, and *Capital Link*, established in 1998 to provide similar assistance to health centers nationally.

ENDNOTES

- ¹ Data compiled by Massachusetts League of Community Health Centers Survey of Health Centers, 2003. Economic impact analysis constructed by IMPLAN, an analysis tool for economic planning efforts.
- ² Massachusetts is made up of 351 cities and towns (US Census “Minor Civil Divisions”); in this discussion, community is used to mean “city and town”.
- ³ “Pulling Apart: A State by State Analysis of Income Trends”, Center on Budget and Policy Priorities, April, 2002.
- ⁴ US Department of Labor, Bureau of Labor Statistics, February 2003.
- ⁵ While changes in 2000 Census categories (and addition of “other” and multiple self-identification) make census comparisons more complicated, aggregate changes are quite obvious.
- ⁶ William Walczak, CEO of Codman Square Health Center, response to Massachusetts League of Community Health Centers survey, September 2003.
- ⁷ Greater New Bedford Community Health Center, Greater New Bedford Community Health Center: Our History, www.gnbchc.org.
- ⁸ U. S. Census Bureau, Census 2000, Massachusetts – Place and County Subdivision, City of New Bedford, factfinder.census.gov/servlet/BasicFactsServlet.
- ⁹ Stuart Forman, President & CEO of Greater New Bedford Community Health Center, response to Massachusetts League of Community Health Centers survey, August 2003.
- ¹⁰ Ibid.
- ¹¹ Dimock Community Health Center, www.dimock.org, September 22, 2003.
- ¹² Christine Reyes-Rivera, LSW, interview held at the Family Health Center of Worcester, Worcester, Massachusetts, September 2003.
- ¹³ University of Massachusetts, Amherst, University Without Walls, Next Step Program, www.umass.edu/uww/nextstep.htm.
- ¹⁴ Greater Lawrence Family Health Center, Welcome to Greater Lawrence Family Practice Residency, www.lawrencefpr.org.
- ¹⁵ Massachusetts League of Community Health Centers and Suffolk University, Certificate Program in Community Health and Community Health Center Management, application, 2003-2004.
- ¹⁶ Lowell Community Health Center, press release “Professional Development Opportunities Improve Staff Retention”, August 2003.
- ¹⁷ Health Services Partnership of Dorchester, HSP News, Spring 2002.
- ¹⁸ Manet Community Health Center, Inc., Manet Community Health Center, Inc.: Welcome, www.manetchc.org.
- ¹⁹ Toni McGuire, CEO of Manet Community Health Center, response to Massachusetts League of Community Health Centers survey, September 2003.
- ²⁰ Mattapan Community Health Center, 2002 Annual Report.

- ²¹ Massachusetts League of Community Health Centers, 2003 Fact Sheet Survey, February 2003.
- ²² Emma Lawson, RN, PhD and Azzie Young, PhD, MPA, "Health Care Revival Renews, Rekindles, and Revives," American Journal of Public Health, February 2002.
- ²³ Since September 2000, MCHC has developed and released health data (Health of Boston, Boston Public Health Commission) to the community for 14 health indicators in an annual Community Health Report Card for Mattapan and Hyde Park. The Report Card depicts data in colorful bar graphs and grades of Good Progress or Needs Improvement are assigned for each health indicator. In the same document, MCHC highlights the programs and services that are available to address each of the health indicators.
- ²⁴ Ibid. Lawson and Young.
- ²⁵ Mattapan Community Partnership, Strategic Plan: 2002-2005, 2002.
- ²⁶ Ibid.
- ²⁷ Ibid.
- ²⁸ The multiplier effect is based on the principles of dollar turnover entering and impacting on the economy, and serves to qualify the economic impact and activity that results from each dollar entering, impacting and eventually leaving a defined economy (industry and community). This results in increased production and expenditures, employment opportunities and creates an attractive environment (and/or long-term investment) for new residents, businesses and investments.
- ²⁹ Indirect — represents the response by all local industries caused by "the iteration of industries purchasing"; Induced — represents the response by all local industries caused by the expenditures of new household income generated by the direct and indirect effects.
- ³⁰ IMPLAN — IMPact analysis for PLANning — the US Department of Agriculture, in conjunction with the Minnesota IMPLAN Group (MIG), developed a complete a integrated analysis tool for economic planning efforts.
- ³¹ Multipliers by industry with a county/state database uses the Standard Industry Classification (SIC) system developed by the federal Office of Management and Budget (OMB). The SIC codes (multipliers) used in this analysis are: 490: Doctors and Dentists; 462: Real Estate Related Costs — real estate; 49: Hard Costs — New construction (new industrial and commercial buildings); 56: Hard Costs — Renovation (maintenance and repair other facilities); 407: Equipment Costs — Medical equipment (surgical & medical instrument) and 506: Soft Costs — Engineering, architectural services.
- ³² South End Community Health Center website, www.sechc.org, September 22, 2003.

- ³³ Before converting to IMPLAN, the League ran this analysis using: used the U.S. Department of Commerce, Bureau of Economic Analysis, Regional Input-Output Modeling Systems (RIMS II), and FY97 information supplied by South End Community Health Center and estimated capital project costs and projected budget increases supplied by South End Community Health Center, May 1997.
- ³⁴ South End Community Health Center website, www.sechc.org.
- ³⁵ South End News, p. 3, June 12, 1997.
- ³⁶ Frances M. Anthes, President & CEO of Family Health Center of Worcester, phone interview held at the Massachusetts League of Community Health Centers, Boston, Massachusetts, August 2003.
- ³⁷ Family Health Center of Worcester, Inc., Family Health Center of Worcester Annual Report 2002, 2002, p. 4.
- ³⁸ The League ran this analysis using: IMPLAN Pro version 2.0.1021, 2000 structural matrices, the 2000 (deflated to 1995) Worcester County, Massachusetts multiplier, and 1995 capital project costs supplied by Family Health Center of Worcester, September 2003.
- ³⁹ Hilltown Community Health Centers, Inc., "Health Professions Shortage Area Designation Application, for the Hampshire and Gateway Regional Districts, Located in the Western Massachusetts Counties of Hampden and Hampshire", September 1998.
- ⁴⁰ U. S. Census Bureau, Census 2000, Massachusetts – Place and County Subdivision, <http://factfinder.census.gov/servlet/BasicFactsServlet>.
- ⁴¹ The League ran this analysis using: IMPLAN Pro version 2.0.1021, 2000 structural matrices, the 2000 (inflated to 2002) Hampshire County, Massachusetts multiplier, and 2002 capital project costs supplied by Hilltown Community Health Centers, September 2003.
- ⁴² Background supplied by Brockton Neighborhood Health Center, July 2003.
- ⁴³ The League ran this analysis using: IMPLAN Pro version 2.0.1021, 2000 structural matrices, the 2000 Plymouth County, Massachusetts multiplier, and FY02 capital project costs supplied by Brockton Neighborhood Health Center, April 2003.
- ⁴⁴ Greater Lawrence Family Health Center, Inc., Greater Lawrence Family Health Center Programs, <http://www.glfhc.org/Programs.html>.
- ⁴⁵ U. S. Census Bureau, Census 2000, Massachusetts – Place and County Subdivision, City of Lawrence, <http://factfinder.census.gov/servlet/BasicFactsServlet>.
- ⁴⁶ Bill Dow, Deputy Director of Greater Lawrence Family Health Center, response to Massachusetts League of Community Health Centers survey, August 2003.
- ⁴⁷ Robert Ingala, President & CEO of Greater Lawrence Family Health Center, response to Massachusetts League of Community Health Centers survey, August 2003.

⁴⁸ Ibid.

⁴⁹ The League ran this analysis using: IMPLAN Pro version 2.0.1021, 2000 structural matrices, the 2000 Middlesex County, Massachusetts multiplier, and capital project costs supplied by Greater Lawrence Family Health Center, September 2003.

⁵⁰ Data compiled from Massachusetts League of Community Health Centers Survey of Health Centers, 2003. Economic impact analysis constructed by IMPLAN, an analysis tool for economic planning efforts.

⁵¹ Ibid.

⁵² Ibid.

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