

An Overview of California's Health Centers

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March 2005

Introduction

California has the most health centers of any state in the nation, with 83 health centers serving 1,655,439 patients in 2003. As a major source of agricultural farming, California has an abundant migrant and seasonal farmworker population. Close to 300,000 farmworkers received health care services at California's community health centers and 17 migrant health centers and rural clinics. Always at the forefront of the health center movement, California's health centers are as diverse as the populations they serve. As compared to the national health center average, California's health center patients are younger, poorer, more likely to identify as Hispanic or Latino, more likely to be on Medicaid, and more likely to be uninsured.

In this report, we provide a review of the health center movement nationally, the health center movement in California, migrant health center and rural clinics nationally and in California, and provide a snapshot of health centers in California today and how they compare to health centers across the country. While this report just touches the surface of the history of the health center movement in California, it provides important overview information of California's health centers, which will help provide a context for the individual stories of each health center.

Health Center Overview

Forty years ago, the health center movement arose out of an awareness of unmet need in the local community. Community leaders observed that "health care was still essentially a privilege with a price tag and that for the poor it was unavailable,

inaccessible, inappropriate in its organization and focus, and ineffective in its delivery.”¹

The health center concept was a revolutionary approach to the organization and delivery of medical care to the community. These new providers focused on both treatment and prevention, and were centered around a primary care model that included a wide range of social services and gave the communities they serve a voice in the governance of their health center.

Health centers originated as part of President Johnson’s War on Poverty. They began in 1965 as the Neighborhood Health Center Program (NHCP), funded as a demonstration project by the Office of Economic Opportunity (OEO). The first health centers were established in Mississippi and Massachusetts, and other states soon followed. “Between 1965 and 1971, more than 100 health centers were funded by OEO appropriations totaling \$308 million, and another 50 were funded by \$110 million in HEW funds.”² Of the first government grants in 1965-66, 50% were awarded to hospitals, 37% to medical schools, and 13% to health departments. Curative medicine was making certain it had a stake in this “new medicine.” That soon changed, however, and by 1971, 59% of grants went to new health center corporations, while only 10% went to hospitals, and 7% went to medical schools.³

While open to all patients, Neighborhood Health Centers were created to work in concert with the newly enacted Medicaid program to provide health care to both the

¹ H. Jack Geiger, “Community Health Centers: Health Care as an Instrument of Social Change,” in *Reforming Medicine: Lessons of the Last Quarter Century*, ed. Victor Sidel and Ruth Sidel (New York: Pantheon Books, 1984), 14 -15.

² *Ibid.*, 19.

³ Alice Sardell, *The U.S. Experiment in Social Medicine: The Community Health Center Program 1965 – 1986* (Pittsburgh: University of Pittsburgh Press, 1988).

newly eligible low-income Medicaid populations as well as the uninsured.⁴ In addition to providing health care services, health centers were conceived of as a mechanism for empowering the community to improve its economic and social well-being through job training, political participation, early childhood education, agricultural development, and other means.⁵ While health center requirements changed over time, the basic premise remained the same. The key features of health centers include:

- The provision of comprehensive primary care services;
- The provision of enabling services such as translation, transportation, and community outreach;
- The provision other services targeted to the needs of their community;
- The use of a sliding fee scale which based charges on the patient's income level; and
- A mandate that health center patients make up the majority of the center's governing board.

This last feature, community governance, is unique to health centers and is an essential part of keeping health centers responsive to the needs of their communities. The community board provision gives health center users formal authority and policy-making roles to help shape how their health center participates in and improves their communities.

In 1974, what had been the NHCP demonstration project was expanded and authorized as the Community Health Center (CHC) program under Section 330 of the Public Health Service Act. In addition to keeping the requirements that had been part of the NHCP, the CHC authorizing legislation was designed to expand care to low-income

⁴ D. R. Hawkins Jr, and S. Rosenbaum, "The Challenges Facing Health Centers in a Changing Healthcare System," in *The Future U.S. Healthcare System: Who Will Care for the Poor and Uninsured*, ed. S. Altman, U. Reinhardt, and A. Shields (Chicago: Health Administration Press, n.d.), 100.

⁵ S. Rosenbaum and A. Dievler, "A Literature Review of the Community and Migrant Health Centers Programs," The George Washington University Center for Health Services Research and Policy, 1992, 30-31.

and minority populations who had difficulty accessing traditional sources of care by requiring health centers to be located in urban and rural areas designated as either medically underserved areas or health professional shortage areas.⁶ In addition to the CHC program, Congress authorized other health center programs targeting specific patient populations. The migrant health center program began with the Migrant Health Act of 1962 and the homeless health center program was created through the McKinney Act of 1987. The Health Centers Consolidation Act of 1996 grouped these and other health center programs, so today the term “health center” refers to Community, Migrant, Homeless, Homeless Children, School-based, and Public Housing Health Center programs.⁷ These programs are administered by the Bureau of Primary Health Care, which is part of the Health Resources and Services Administration of the U.S. Department of Health and Human Services.

Nationally, 843 federally funded health centers provided comprehensive primary care to 11.3 million patients at more than 4,600 urban and rural sites in 2002. In addition, almost 100 Federally Qualified Health Center (FQHC) “look alike” health centers provided care to approximately 1.2 million additional patients. Approximately 39% of health centers patients did not have insurance in 2002.⁸ Health centers are also the medical home to about 10% of all Medicaid beneficiaries, serving over 4 million in 2002. These beneficiaries comprise approximately 34% of all health center patients. In 2002, health centers served over 621,000 homeless patients and over 708,000 migrant workers.⁹

⁶ R. M. Politzer, et al., “Inequality in America: The Contribution of Health Centers in Reducing and Eliminating Disparities in Access to Care,” *Medical Care Research and Review* 58 (2001): 234 – 248.

⁷ Health Centers Consolidation Act of 1996, PL 104 – 299.

⁸ S. Rosenbaum, P. Shin, and J. Darnell, “Economic Stress and the Safety Net: A Health Center Update,” Kaiser Commission on Medicaid and the Uninsured, Issue Paper. June 2004.

⁹ B. Siegel, M. Regenstein, and P. Shin, “Health Reform and the Safety Net: Big Opportunities; Major Risks,” *Journal of Law, Medicine, & Ethics*, Fall 2004: 426-432.

Two-thirds of health center patients are members of ethnic or minority groups, with approximately 35% of patients identifying as Hispanic and another 25% identifying as Black. Many health center patients are poor. Overall, 88% of health center patients had family incomes below 200% of the federal poverty level.¹⁰

The Health Center Movement in California

The early history of health centers in California is deeply rooted in the culturally diverse populations of the state as well as the social events of the time. As the federal government enacted the Civil Rights Act of 1964, states began to create legislation to circumvent the new integration laws. In California, this took the form of Proposition 14, which attempted to block the fair housing components of the Civil Rights Act. The racial powder keg exploded on August 11, 1965 during a routine traffic stop in the south central Los Angeles community of Watts. Before the riot was quelled, 34 people were dead, over 1,000 were injured, and hundreds of buildings had been destroyed.

The Watts Health Center in Los Angeles was established in late 1965 as the first health center in California in the wake of, and in response to, the Watts Riots of 1965. The local community moved to rebuild itself and aimed to strengthen the health and social services network in Watts. The creation of the Watts Health Center was met with great opposition from members of the medical community who feared that this new type of provider would pose a competitive threat to business.¹¹ As racial tensions began to ease and the Watts health center became a success, other health centers opened across California.

¹⁰ Rosenbaum, Shin, and Darnell, 4.

California's health centers were started in a variety of ways, reflecting the varying needs of the communities they served. To meet the healthcare needs of their local community populations, centers were established in abandoned warehouses, fire stations, at night in hospitals, and in offices that were initially only open for one evening a week. Some practitioners were local primary care physicians and others were volunteer physicians from established medical schools.¹² For example, San Ysidro Health Center was established in August 1968 by area residents who recognized a need for quality healthcare in their community. The health center collaborated with the UC-San Diego Medical School to provide the first services. Three years later, in 1971, San Ysidro became a non-profit organization, and opened a new building on the site of the original clinic in 1972. Today, the center operates in a 50,000 square foot facility, and has two satellite clinics.¹³

The geographic and demographic variation in California is mirrored by the distribution of health centers across the state, and at last count, in 2003 there were 83 health centers serving 1,655,439 patients. California's health centers are in both rural and urban areas based on the needs of the communities. More health centers are located in the populous with urban areas due to their disproportionate number of individuals in need.¹⁴

From towns like Weedpatch to cities like Fresno and Los Angeles, clinics arose where people in the community recognized a need. Today, these same clinics are some of

¹¹ Milton Roemer, "Resistance to Innovation: The Case of the Community Health Center," *American Journal of Public Health* 78, no. 9 (1988): 1234-39.

¹² Central Valley Health Network, "Clinic Snapshots," <http://www.cvhclinics.org/snapshots/index.html> (accessed November 18, 2004).

¹³ San Ysidro Health Center, "Our History," <http://www.syhc.org/english/history/index.html> (accessed October 22, 2004).

the largest, most well-established health centers in the state, providing extensive, high quality primary care and many other ancillary health services. In addition, many of today's health centers grew out of the migrant health center movement, which preceded the Neighborhood Health Center demonstration project. Among these is Clinica Sierra Vista, which was founded in 1971 to provide healthcare to migrant workers in San Joaquin Valley, California. Today, Sierra Vista is one of the largest health centers in the state and also provides care from two mobile medical units as well as services tailored to homeless patients.¹⁵

A number of health centers have evolved over time, starting as small scale community efforts, becoming Federally Qualified Health Center (FQHC) Look-Alikes and then applying for and becoming approved FQHCs.¹⁶ For example, Inland Behavioral and Health Services began as a community mental health project in 1978, first provided on-site primary health care in 1993, became a Look-Alike health center in 2000, and received FQHC status in 2002. Nationwide, some 40 FQHC Look-Alikes have successfully applied for FQHC status.¹⁷

The establishment of new health centers across the state continues to this day, as new needs are recognized in communities statewide. When Shasta County General Hospital in Redding, California was closed in 1988, the community responded, creating

¹⁴ Appendix B lists the distribution of medically underserved areas and medically underserved populations located throughout California by county, revealing the approximate need for health centers.

¹⁵ Clinica Sierra Vista, "Overview," http://www.clinicas ierravista.org/AboutUs_Overview_En.php (accessed October 23, 2004).

¹⁶ "Look Alike" health center refer to those that meet a variety of federal requirements but do not receive federal funding under §300 of the Public Health Service Act. These requirements include having a public or private non-profit status, serving a MUA or MUP, meeting all statutory requirements of §330 of the Public Health Service Act, and compliance with the Balanced Budget Act of 1997 requirement that FQHC look-alikes not be under the authority of any other entity. http://bphc.hrsa.gov/chc/CHCInitiatives/fqhc_lookalike.asp

Shasta Community Health Center, which now serves nearly 40,000 patients (1 out of every 4 residents of Shasta County) and is a valuable option for low-income patients who need access to specialty care in a six-county region in northern California.¹⁸ The Ravenswood Family Health Center in Palo Alto, CA was incorporated in May 2000 and has taken advantage of the expertise in the local community by establishing a relationship with Stanford University.¹⁹

These are just a few of the stories of California Health Centers. Although part of a larger movement, each health center has its own unique story. Regardless of how they got started or have grown over the years, each of California's health centers provides a much-needed safety net of care for vulnerable populations throughout the state.

California's Rural Health Clinics and Migrant Health Centers

With a large rural and migrant and seasonal farmworker population, California's migrant health centers and rural health clinics²⁰ are a key part of the state's safety net. California's rural population is an estimated 3.8 million residents, approximately 10% of California's total population. Over 75% of California's 99.8 million acres is considered

¹⁷ Barbara Bailey, "Experts with Experience," Bureau of Primary Health Care, http://bphc.hrsa.gov/CHC/CHCDocuments/pdf/tenyear_report.pdf (accessed February 20, 2005).

¹⁸ Shasta Community Health Center, "A Visit to Shasta County," <http://www.shastahealth.org/index.cfm> (accessed October 22, 2004).

¹⁹ The Volunteer Center, "Ravenswood Family Health Center," <http://www.volunteersolutions.org/thevolunteercenter/org/1269793.html> (accessed October 23, 2004).

²⁰ Rural Health Clinics were authorized in 1977 (PL 95-210) for the purpose of improving access to care for Medicare and Medicaid beneficiaries. The clinics receive reasonable cost reimbursement under Medicare, and can be either provider based or free-standing. They must be located in a rural area that is either a Health Professional Shortage Area or a Medically Underserved Area. Detailed information about the RHC program, including links to statutory requirements regarding staffing, reimbursement, quality assurance, and other RHC issues can be found at the National Rural Health Association website, <http://www.nrharural.org/pagefile/RHCs.html>.

located in the state's agriculturally rich Central Valley area and extend from northernmost Siskiyou, Del Norte, and Modoc counties to southernmost Riverside and Imperial counties.²⁵

Rural health clinics in California, as in other parts of the country, provide a wide variety of health services to children, adolescents, adults, and elderly persons. For example, they provide access to gynecology and obstetrical care, well-child visits, and adult preventive and treatment services for acute and chronic conditions that promote health and reduce costly avoidable hospitalizations. Rural health clinics serve people covered by employer-sponsored health insurance, Medicare, Medicaid, and SCHIP, as well as those who are under- or un-insured. Rural health clinics also perform an essential role by providing occupational health services for rural employers and workers in California's important agricultural industry, including migrant and seasonal farmworkers.²⁶

Many rural Californians are poor and rely on public programs to finance their health care. Poverty rates are higher among rural populations²⁷ and an estimated 1 in 5 children in California's nonmetropolitan areas lives at or below the federal poverty level.²⁸ Federal Medicaid law requires that Medicaid enrollees have access to rural health clinics and health center services as part of the mandatory federal basic coverage

²⁴ Connecticut, Delaware, Maryland, Massachusetts, and New Jersey have no RHCs. Kaiser State Health Facts Online, <http://www.statehealthfacts.org> (accessed February 20, 2005).

²⁵ Rural Policy Research Institute. Community Information Resources Center. Maps available at: <http://circ.rupri.org>.

²⁶ Nancy Oliva, Director, Oak Valley Hospital District Board of Directors, Oakdale, CA. November 4, 2002. Letter to Tom Scully, Administrator, DHHS Centers for Medicare and Medicaid Services. Available at California State Rural Health Association, Health Advocate. Sacramento, CA. <http://www.csrha.org>.

²⁷ Daniel T. Lichter and Martha L. Crowley, "Poverty Rates Vary Widely Across the United States," Population Reference Bureau, <http://www.prb.org/Template.cfm?Section=PRB&template=/ContentManagement/ContentDisplay.cfm&ContentID=7083> (accessed February 20, 2005).

definition of Medicaid services.²⁹ Eligibility rates for Medi-Cal, California's Medicaid program, are higher in rural areas: 18% as compared to 15% in urban areas. In addition, rural areas in California mirror other rural areas around the country, having higher percentages of rural elderly persons covered by Medicare as compared to their urban counterparts.³⁰ According to recent national data, rural health clinics derive 24.4% of their revenues from Medicaid, 29.9% from Medicare, 29.5% from employer-sponsored health insurance, and 14.7% in the form of people who self-pay or receive free care.³¹

Rural health clinics can be organized as for-profit or not-for-profit and freestanding or affiliated with other providers (typically rural hospitals). Across California, they range greatly in size from a large San Bernardino County rural health clinic that employs 40 physicians and 80 administrative staff to a small rural health clinic in Tulare County with one physician and one administrative staff person.³² Many rural health clinic health services are also provided by physician assistants, nurse practitioners, and other allied health professionals. The average number of full-time employees (FTEs) employed in California rural health clinic is 5.6, slightly under the U.S. average of 6.7 FTEs.³³

²⁸ Mark Mather and William O'Hare, "One in Five Children in Rural America Lives in Poverty," Population Reference Bureau, <http://www.prb.org/Template.cfm?Section=PRB&template=/ContentManagement/ContentDisplay.cfm&ContentID=10189> (accessed February 20, 2005).

²⁹ Centers for Medicare and Medicaid Services. U.S. Department of Health and Human Services, "Medicaid Services," <http://www.cms.hhs.gov/medicaid/mservice.asp> (accessed February 20, 2005).

³⁰ California State Rural Health Association, "Stats and Facts."

³¹ John A. Gale and Andrew F. Coburn, "The Characteristics and Roles of Rural Health Clinics in the United States: A Chartbook," University of Southern Maine, Rural Health Research Center, <http://muskie.usm.maine.edu> (accessed February 20, 2005). Also, S. Rosenbaum and P. Shin, "Health Centers as Safety Net Providers: An Overview and Assessment of Medicaid's Role," The Kaiser Commission on Medicaid and the Uninsured, <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&pageID=14342> (accessed December 4, 2004).

³² From special analysis of the data from the Centers for Medicare and Medicaid Services Online, Survey, Certification, and Reporting (OSCAR) database.

³³ *Ibid.*

Rural areas in California experience shortages of both primary and specialty care providers (e.g., dentistry, pharmacy, mental health and substance abuse). The ratio of doctors to patients in rural areas is 1 to 935 patients versus 1 to 460 patients in urban areas. The dentist shortage in rural areas is a particularly urgent matter, given that there are as few as 1.8 dentists per 5,000 rural population compared to 3.1 per 5,000 urban population.³⁴

Given the provider shortage in rural areas, rural health clinics provide much needed access to care for rural residents. For example, the Oak Valley Hospital District Rural Health Clinic network that operates in San Joaquin and Stanislaus counties in the agriculturally rich Central Valley area has a service area that includes 76,000 migrant and seasonal farmworkers and 59,000 rural residents.³⁵ San Joaquin County³⁶ has approximately 47,000 migrant and seasonal farmworkers in addition to 37,000 year-round household members in rural areas of the county. As such, it ranks fifth among California's counties in the number of migrant and seasonal farmworkers. Adjacent Stanislaus County³⁷ ranked sixth in the state in numbers of migrant and seasonal farmworkers, has an estimated 29,000 of these workers in addition to another 22,000 year-round rural household members. The Oak Valley Hospital District operates three rural health clinics in these two counties, providing an estimated 22,000 annual visits to

³⁴ California State Rural Health Association (undated). "Major Health Issues Facing Rural California." Available at: <http://www.csrha.org/advocate/3.3/caissues.pdf>.

³⁵ Oliva, N. (November 4, 2002). Letter to Tom Scully, Administrator, CMS. (Ms. Oliva was Director, Oak Valley Hospital District Board of Directors). Available at: <http://www.csrha.org/advocate/1.22/oakvalley.html>.

³⁶ Population 625,000. California Department of Finance, Demographic Research Unit, "E-2 California County Population Estimates and Components of Change July 1, 2000-2003," <http://www.dof.ca.gov/HTML/DEMOGRAP/E-2text.htm> (accessed February 20, 2005).

³⁷ Population 489,000 *Ibid*.

its patients. In addition, three other freestanding, private-practice based rural health clinics serve patients in need within Oak Valley's 400-mile service area.

Migrant Health Centers

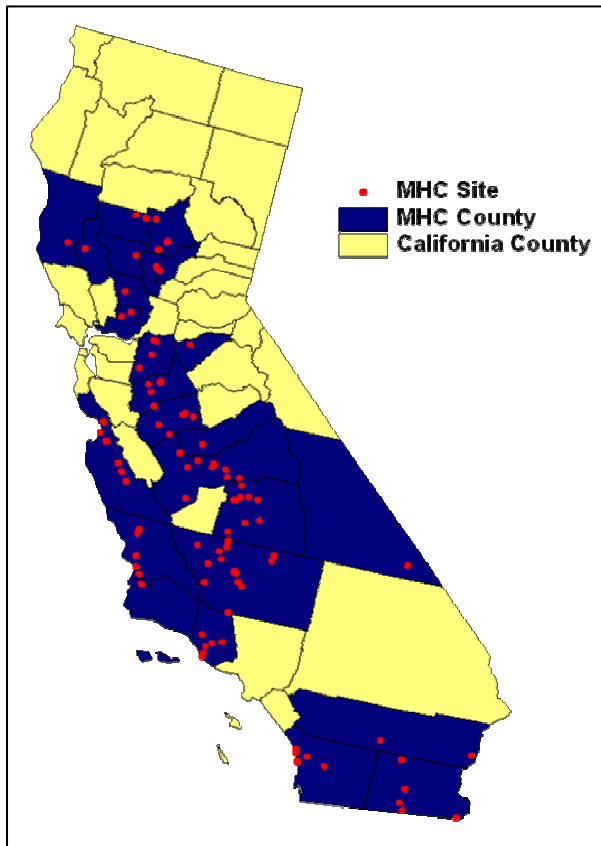
Migrant health centers were established by the Migrant Health Center Act of 1962 to provide health care to migrant and seasonal farmworkers.³⁸ Migrant health centers are required to provide services similar to other community health centers, including primary and preventive medical care and a wide variety of ancillary healthcare services, with a focus on the particular needs of the migrant and seasonal farmworker population. It is estimated that 3 to 5 million farmworkers lived in the United States and Puerto Rico in the early 1990s.³⁹ In 2001, over 650,000 migrant farmworkers received care at 125 migrant health centers.⁴⁰

³⁸ Under the Act, a seasonal farmworker is defined as: "An individual whose principal employment [at least 51% of time] is in agriculture on a seasonal basis, who has been so employed within the last twenty-four months," and a migrant farmworker as a seasonal farmworker who "establishes for the purposes of such employment a temporary abode."

³⁹ National Center for Farmworker Health, "Migrant and Seasonal Farmworker Demographics Fact Sheet," <http://www.ncfh.org> (accessed February 20, 2005).

⁴⁰ Bureau of Primary Health Care, "National Rollup Report, 2003," Uniform Data System, <http://bphc.hrsa.gov/uds/data.htm> (accessed February 23, 2005).

Locations of Migrant Health Center Sites in California



There are 17 migrant health centers in California, which operate 116 clinical delivery sites in 26 counties, as shown on the map at left.⁴¹ In 2003, California's migrant health centers provided services to an estimated 270,838 migrant and seasonal farmworkers and their dependents, or approximately 24.2% of the estimated 1,118,654 migrant and seasonal farm worker population located in their counties.⁴²

One of the largest and most well-established migrant health center networks

in California is Clinica Sierra Vista in the San Joaquin Valley, which has expanded from a storefront warehouse in 1971 to 15 clinical sites with more than 600 employees today.⁴³ Its migrant health centers provide a variety of primary care and specialty services, including behavioral health and social support services. It also operates a mobile medical van and a mobile dental van. These units provide comprehensive primary health care and dentistry, including operative, fixed and removable prosthodontics, endodontics, oral surgery, limited orthodontics, and minor periodontal surgery. Mobile vans, in

⁴¹ National Center for Farmworker Health, "December 2003 Presentation," <http://www.ncfh.org/GIS/CA%20MSFW%20PPT.ppt#269,1,MSFW> (accessed February 20, 2005).

⁴² *Ibid.*

⁴³ Clinica Sierra Vista, http://www.clinicasieravista.org/home_En.php (accessed October 23, 2004).

combination with telemedicine, are an indispensable means of meeting the needs of populations who are unable to travel long distances to obtain health care services.

The use of migrant and seasonal farmworkers in California began over 140 years ago. The racial/ethnic profile of these workers has changed markedly in that time, originally consisting of mostly Chinese and Japanese workers and then transitioning to Mexican, East Indian and Filipino workers. Currently most farmworkers are Latino, 95% of whom come from Mexico and Central America.⁴⁴ Nationally, the farmworker population is primarily foreign-born (81%), young (average age 31), poorly educated (85% have difficulty processing written information in their native language) and male (80%).⁴⁵ Furthermore, the farmworkers are overwhelmingly poor, receiving an average hourly wage of only \$5.94. The majority (75%) earns less than \$10,000 a year and are impoverished (61%). Only 5% receive employer-sponsored health coverage and 70% are uninsured.⁴⁶

California has the greatest concentration of migrant farmworkers in the U.S., which is not surprising given that the state is the largest single agricultural supplier in the country, accounting for over 50% of U.S. agricultural production. In addition, California farming relies heavily on hand-picking methods because of the types of produce farmed (whereas other farming has been largely mechanized.)⁴⁷ It is estimated that between 23% - 33% of all migrant farmworkers in the U.S reside and/or work in California.⁴⁸ The

⁴⁴ Michael Rodriguez, Jennifer L. Toller, and Patrick Dowling, "Health of Migrant Farmworkers in California," California Research Bureau 2002 Educational Tour Series, Policy Brief Number 4, <http://www.library.ca.gov/crb/03/05/03-005.pdf> (accessed January 28, 2005).

⁴⁵ National Center for Farmworker Health, "Migrant and Seasonal Farmworker Demographics Fact Sheet," <http://www.ncfh.org/docs/fs-Migrant%20Demographics.pdf>

⁴⁶ *Ibid.*

⁴⁷ Rodriguez, Toller, and Dowling.

⁴⁸ Author's estimate based on statistics from Alice Larson and Luis Plascencia, "Migrant Enumeration Study," Washington, D.C.: Office of Minority Health, 1993; "An Atlas of State Profiles Which Estimate

actual figure is likely at the upper end of this range, considering that there are a number of crops that have year-round growing seasons in California.⁴⁹ Geographically, the migrant and seasonal farmworker population is concentrated in California's Central Valley region, with Fresno County having by far the largest share of such farmworkers.

California's migrant health centers serve not only migrant and seasonal farmworkers themselves but also their family members and non-farmworker patients. When including their families, California's migrant farmworker population is estimated to be between 1.3 million⁵⁰ and 1.67 million persons.⁵¹ Migrant and seasonal farmworkers and their families experience lack of access to safe food and clean water, occupational hazards, and sun exposure, which produce a disproportionate share of "tuberculosis, diabetes, back pain, extremity pain, arthritis, headaches, dermatitis, dental problems, allergies, eye irritation, depression" and poor nutrition.⁵² Agriculture is a dangerous occupation, representing a host of significant safety issues to its workers. One report notes that the "occupational fatality rate for all private sector industries is 4.3 per 100,000 full-time employees, [while] the rate for the broad category of agriculture, forestry, and fishing was 23.9 [per 100,000 full-time employees]."⁵³ Only mining is considered a more dangerous occupation than agriculture.⁵⁴

Number of Migrant and Seasonal Farmworkers and Members of Their Families", Rockville, MD, U.S. Department of Health and Human Services, 1990.

⁴⁹ Alice C. Larson, "Migrant and Seasonal Farmworker Enumeration Profiles Study: California, 2000," <http://bphc.hrsa.gov/migrant/Enumeration/final-ca.pdf> (accessed December 14, 2004).

⁵⁰ *Ibid.*

⁵¹ *Ibid.*

⁵² Rodriguez, Toller, and Dowling.

⁵³ National Center for Farmworker Health, "Overview of America's Farmworkers: Occupational Safety and Health," http://www.ncfh.org/aaf_003.php (accessed February 20, 2005).

⁵⁴ Migrant Clinician, "The Migrant/Seasonal Farmworker," http://www.migrantclinician.org/migrant_info/migrant.php. (accessed February 20, 2005).

Delays in accessing initial and follow-up care to treat injuries and illness are related to the lack of insurance, lack of awareness of insurance and health care resources, and lack of continuity of care.⁵⁵ While many migrant and seasonal farmworkers are categorically ineligible for governmental assistance because of their immigration status, there are some exceptions. Legal immigrants, and some undocumented immigrants with special circumstances, are entitled to receive Medi-Cal benefits. For example, refugees and anyone granted political asylum on or after June 15, 2000 is eligible for at least eight months of regular Medi-Cal regardless of their age, immigration status, or ability to pay. Certain undocumented immigrants can receive restricted or “emergency” Medi-Cal. Coverage is limited to treatment under EMTALA, prenatal and post-partum care for pregnant women, kidney dialysis, long-term care, and breast and cervical cancer.⁵⁶ In addition, U.S.-born children of immigrant farmworkers are entitled to assistance. Yet, many do not receive care due to language barriers, illiteracy in their the native language and/or English, fear of repercussions such as deportation or setbacks in the citizenship process, inadequate access to transportation, and the difficulty of accessing Medicaid because their parents’ jobs require them to move among states with some frequency.⁵⁷

The provision of culturally competent care is paramount when working with this population, and the need for translators skilled in numerous languages is essential. The Federal government requires under Title VI of the Civil Rights Act of 1964 that health

⁵⁵ Rodriguez, Toller, and Dowling.

⁵⁶ Various sorts of presumptive eligibility mechanisms exist to assist immigrants in accessing healthcare services with the assistance of Medi-Cal. Immigrants have the longer of 30 days or however long it takes the Medi-Cal office to determine eligibility, to produce their immigration documents, and that the immigrant, after swearing to their eligibility, must be covered under Medi-Cal until the Immigration and Naturalization Service (INS) determines the individual’s immigration status. The Health Consumer Alliance, “Immigrants and Health Care,” <http://www.healthconsumer.org/cs019ORimmigrantsEng.PDF> (accessed November 21, 2004).

⁵⁷ *Ibid.*

centers that receive federal funding provide free interpreter services and translated written materials.⁵⁸ A new program known as *La Familia Sana* attempts to address these issues through the use of *promotoras*, who are Latinos (some former migrant farmworkers) trained to provide outreach to increase awareness of availability of migrant health center services, as well as availability of government assistance to other Latinos. *La Familia Sana*, supported by funding from The California Endowment, is currently networking throughout Ventura County, California. It links agricultural workers with expanded health care services in four rural health centers in Santa Paula, Fillmore and Piru. It also collaborates with Ventura County Public Health, Santa Paula Clinic, Santa Paula Rural Health Center and Sespe Rural Health Center.⁵⁹

In light of California's rural geographic and demographic characteristics and community health needs, rural health clinics and migrant health centers are essential community-based providers of safety net health care services to vast numbers of Californians who live and/or work in rural areas. Their roles in providing access to care for people who otherwise would have to forego or delay essential health care services, or travel inordinately long distances to access them, is of paramount importance to the state's financial and population health and well-being.

California Health Centers and the Patients They Serve

In some ways California health centers mirror the nation's health centers in terms of patients served and revenues received, and in other ways California has its own distinct health center populations. While all health centers, California's included, serve

⁵⁸ *Ibid.*

⁵⁹ Rodriguez, Toller, and Dowling; *See also*, Ventura County Medical Resource Foundation, <http://www.vcmrf.org/Grants-1.asp>

many minority and low-income populations, California serves a higher than the national average group of health center patients who are young, identify as Hispanic or Latino, are at or below the Federal poverty level, receive Medicaid, or are uninsured. In addition, California has a significant number of migrant and seasonal farmworkers among its health center patients. Clearly, California has a strong need for the culturally competent quality of care provided to its vulnerable populations by health centers.

California leads the nation in number of health centers and patients served. In 1997, California's 46 health centers are the most located in any one state.⁶⁰ In 2000, there were approximately 55 health centers in California, which treated 1,244,014 persons, 60% of whom were Latino, and 68.2% of whom had income levels below 100% of the federal poverty level.⁶¹ These numbers grew, by 2003, to encompass over 83 health centers, and 1,655,439 persons treated, 61% of whom were Latino, and 65.7% of whom had income levels below 100% of the federal poverty level.⁶²

Patient Age

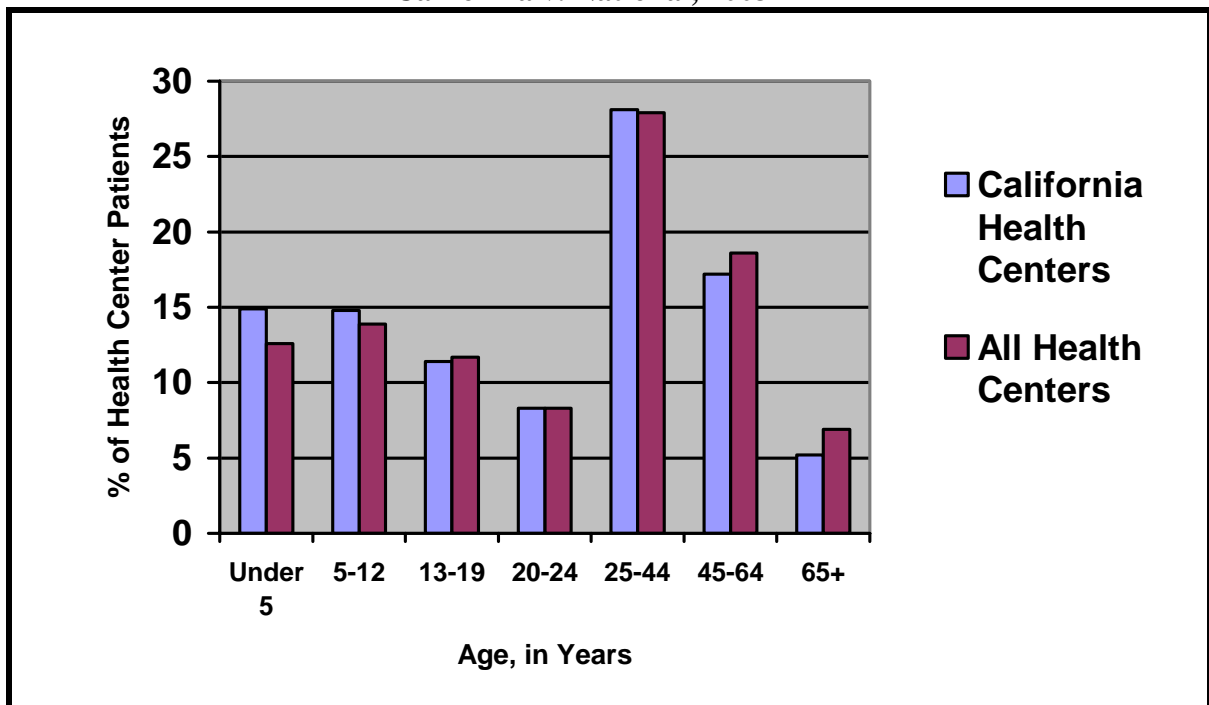
As shown in Figure 1, in 2003 California's health centers provided care to a larger proportion of children under the age of 12 and a lower proportion of care to those ages 45 and over than the national health center average. Health center patients ages 13 – 44 represent approximately the same proportion of health center patients in California health centers as they do in all health centers nationwide. This is consistent with the state's overall demographics. A greater percentage of California's population is under age 18

⁶⁰ Marion Ein Lewin and Stuart Altman eds., *America's Health Care Safety Net: Intact but Endangered*. (Washington D.C.: Institute of Medicine, National Academy Press, 2000).

⁶¹ Bureau of Primary Health Care, "California Rollup Report, 2003," Uniform Data System, <http://bphc.hrsa.gov/uds/data.htm> (accessed February 23, 2005).

than in the United States as a whole, and that a smaller percentage of California’s population is age 65 and over than in the United States as a whole.⁶³ However, this is significant in that it reveals the composition of health center patients in California and the types of medical care and services they are more likely to need. Children of school age need not only such age-appropriate treatments as immunizations, dental care, hearing and vision screening in disproportionate amounts to older adults, but also they need age appropriate delivery of care.

Figure 1. – Age of FQHC Patients as a Percentage of Total Patients, California v. National, 2003



Source: National Association of Community Health Centers, “Health center fact sheet: California,” <http://www.nachc.org/advocacy/files/californiafactsheet.pdf>; “Health center fact sheet: United States,” <http://www.nachc.org/advocacy/files/Usfactsheet.pdf>

Note: Does not include data from FQHC look-alikes.

⁶² *Ibid.*

⁶³ U.S. Bureau of the Census, “California Quick Facts,” <http://quickfacts.census.gov/qfd/states/06000.html> (accessed February 21, 2005).

Patient Race/Ethnicity

It is apparent from Figure 2 below that California's health centers provide an overwhelming majority of their services to those who identify as Hispanic or Latino and the proportion of Hispanic/Latino patients served by California health centers is nearly double the national average. Consequently, the proportion of those receiving care at California health centers composed by Blacks is only one-third of the national average. The proportion of White patients seen at California health centers is equivalent to approximately two-thirds of the national average.

Census estimates project that the proportion of the minority population will grow from 52% of the population in 2000 to 66% in 2025.⁶⁴ Currently, one in four Californians are foreign-born immigrants.⁶⁵ In an effort to best serve this diverse patient population, health centers offer a wide array of translators. Ninety-four percent of health centers in California provide interpreters.⁶⁶ Studies have shown that by providing appropriate and culturally competent care, health centers are successful at reducing disparities in health outcomes between racial and ethnic groups.⁶⁷

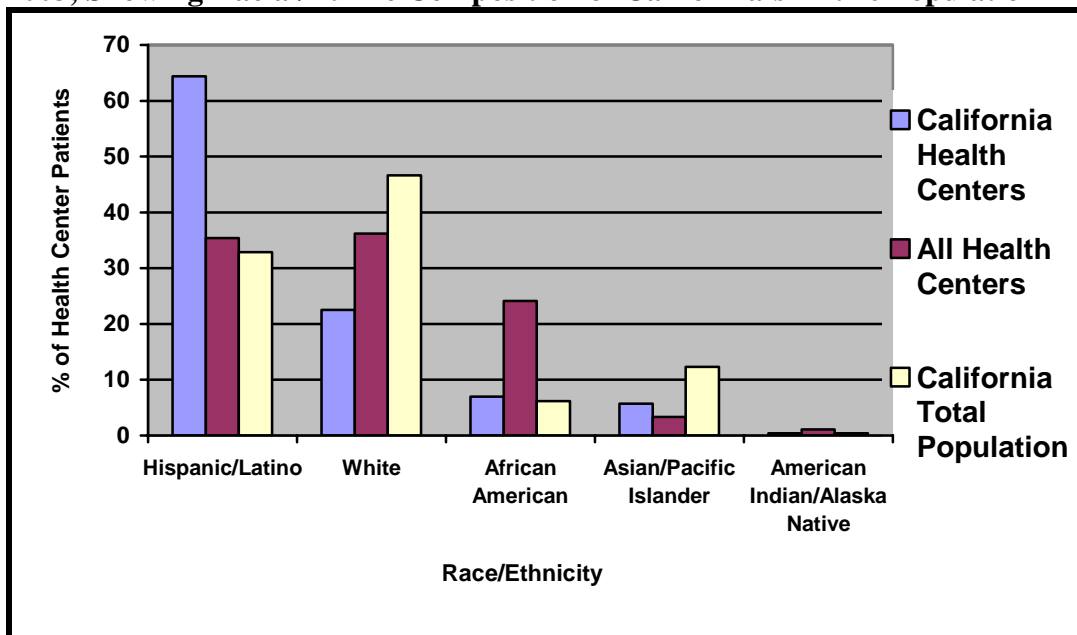
⁶⁴ U.S. Census Bureau, "Projected State Populations, by Sex, Race, and Hispanic Origin: 1995 – 2025," <http://www.census.gov/population/projections/state/stpjrace.txt> (accessed November 21, 2004).

⁶⁵ Kevin Starr, 1.

⁶⁶ Bureau of Primary Health Care, "California Rollup Report, 2003," Uniform Data System, <http://bphc.hrsa.gov/uds/data.htm> (accessed February 23, 2005).

⁶⁷ Politzer et al.

Figure 2. – Race/Ethnicity of FQHC Patients as a Percentage of Total Patients, in 2003, Showing Racial/Ethnic Composition of California’s Entire Population in 2004.



Source: National Association of Community Health Centers; Tadese Alemu, 2004.

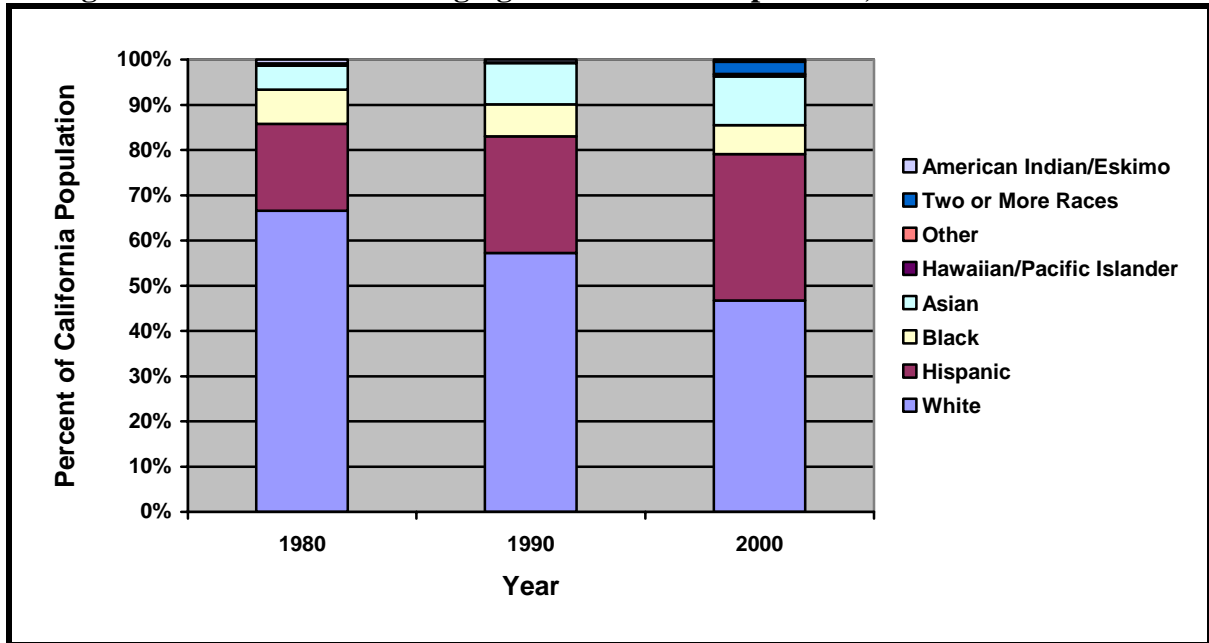
Note: Does not include data from FQHC look-alikes.

As seen in Figure 3 below, the last two decades reveal a substantial increase in the proportion of Hispanics in California. Most of this increase is due to a constant influx of Mexican and El Salvadorian immigrants.⁶⁸ This growing population presents a significant concern for health centers, as Hispanics are found to have the highest rate of uninsurance and account for nearly fifty percent of the uninsured in the state.⁶⁹

⁶⁸ Children Now, “Poverty status of children of immigrants (ages 0 – 11) by parents’ ability to speak English, 2001,” *California Report Card 2004*, <http://www.childrennow.org/assets/pdf/policy/rc04/ca-rc-charts-poverty-english-proficiency.pdf> (accessed December 4, 2004).

⁶⁹ Jennifer Aguayo et al., “Important health care issues for California Latinos: Health insurance and health status,” *UCLA Center for Health Policy Research, FactSheet*, http://www.healthpolicy.ucla.edu/pubs/files/FS_LCHC_012403.pdf (accessed December 5, 2004).

Figure 3. – California’s Changing Racial/Ethnic Population, from 1980 - 2000



Note: In 1980 and 1990 "Asians" includes Hawaiians and Pacific Islanders.

Source: Census 2000 analyzed by the Social Science Data Analysis Network (SSDAN)

Patient Income Level in 2003

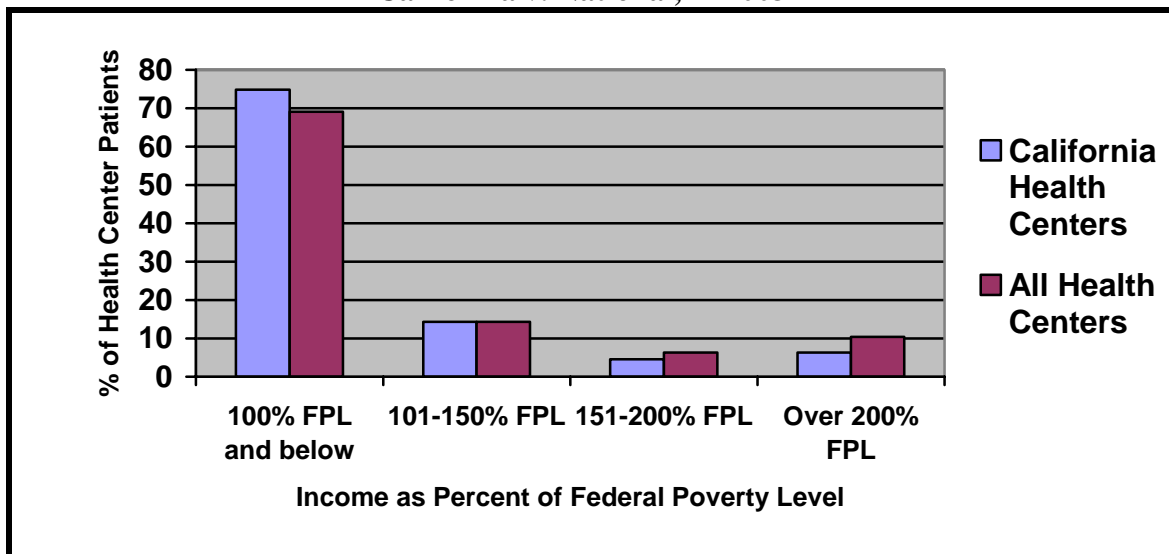
Figure 4 shows that a greater proportion of health center patients in California are at or below the Federal poverty level than the national average. Over 4.6 million people in California earned less than 100% of the Federal poverty level in 2003, and nearly 33% of Californians earned less than 200% of the Federal poverty level that same year.⁷⁰ The distribution of poverty across the state varies, with higher concentrations of poverty located in Southern California, and lower levels around the San Francisco Bay Area.⁷¹

Poverty level is also associated with other factors, such as immigration status and its associated characteristics, such as ability to speak English. Recent findings reveal that among children of immigrants ages 0 – 11 years, 33% of children were below 200% of

⁶⁸ California Budget Project, "New census data reveal that the economic recovery has resulted in few gains for Californians and the nation," <http://www.cbp.org/2004/040826censusdata.pdf> (accessed November 23, 2004).

the federal poverty level if their parents spoke English very well, compared to 96% of children below 200% of the poverty level whose parents spoke no English at all.⁷² Income and poverty level also vary by race/ethnicity. In 2004, the mean income for whites in California was \$90,246, while it was \$76,889 for Asians, \$54,478 for Blacks, and \$48,938 for Hispanics. Only 7.5% of Whites were below the Federal poverty level in California in 2004, compared to 11% of Asians, 20.5% of Hispanics, and 21.9% of blacks.⁷³

Figure 4. – Income Level of FQHC Patients as a Percentage of Total Patients, California v. National, in 2003



Source: National Association of Community Health Centers, 2004.

Note: Does not include data from FQHC look-alikes.

Insurance Status in 2003

As shown in Figure 5, a larger proportion of health center patients in California are either uninsured (43.9%) or enrolled in Medicaid or SCHIP (37.4%) than the national

⁷¹ *Ibid.*

⁷² Children Now.

⁷³ Tadese Alemu, “California current population survey basic report March 2004 data,” *California Department of Finance*, http://www.dof.ca.gov/HTML/DEMOGRAP/CPS_2004_CA_basic_profile.pdf (accessed December 4, 2004).

average. The proportion with private insurance is only 7%, which is half of the national average. Managed care enrollment has increased among health center patients over the past decade. In 1991, only 8% of health centers reported treating MCO patients, but by 1997, that figure had risen to 64%, and has remained at this level since then.⁷⁴

More than 6.3 million Californians were uninsured at some point during 2001, and more than 3.3 million were uninsured for all of 2001.⁷⁵ This was a slight improvement from the 7.3 million uninsured in 1998,⁷⁶ but in 2003, approximately 20% of Californians remained uninsured.⁷⁷

Among the general population, the percentage of uninsured is higher in California (21%) than it is nationally (16%), a gap that has remained in place for over a decade. Only Texas, Louisiana, and New Mexico have a greater percentage of uninsured persons in their population than California.⁷⁸ There is a tremendous amount of variation in the distribution of the uninsured geographically across the California, with the greatest number of uninsured persons residing in Southern California and the Central Valley, and the least number residing in San Francisco and Sacramento.⁷⁹

⁷⁴ *Ibid.*

⁷⁵ E. R. Brown and S. A. Lavarreda, "Health Policy Fact Sheet: Over Half of California's 6.3 Million Uninsured Lacked Health Coverage for More Than a Year," UCLA Center for Health Policy Research: Los Angeles, http://www.healthpolicy.ucla.edu/pubs/files/SHIC_FS_032003.pdf (accessed November 21, 2004).

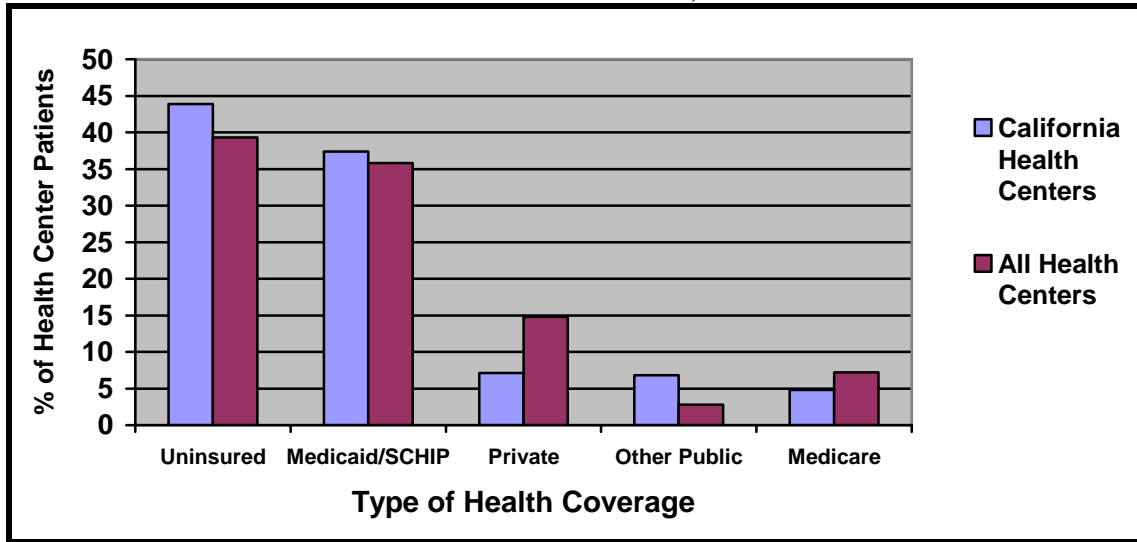
⁷⁶ Veronica Richardson, "Legislature considers proposals to cover the uninsured," *California Budget Project: Budget Brief*, <http://www.cbp.org/2003/bb030807LegUninsured.pdf> (accessed November 23, 2004).

⁷⁷ Anna D. Sinaiko, "Employer's Responses to a Play-or-Pay Mandate: An Analysis of California's Health Insurance Act of 2003," *Health Affairs*, web exclusive, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.469v1> (accessed November 21, 2004).

⁷⁸ California Budget Project, New census data, 2004.

⁷⁹ Carolyn Mendez et al., "California's New Assembly and Senate Districts: Geographic Disparities in Health Insurance Coverage," UCLA Center for Health Policy Research, Policy Brief, http://www.healthpolicy.ucla.edu/pubs/files/UCLA_LegisDistr_PB_FINAL2.pdf (accessed November 21, 2004); Agnes Lee, "Medi-Cal Program," California Budget Project, *Budget Backgrounders*, <http://www.cbp.org/2004/0402medical.pdf> (accessed December 4, 2004).

Figure 5. – Insurance Status of FQHC Patients as Percentage of Total Patients, California v. National, 2003



Source: National Association of Community Health Centers, 2004. Does not include FQHC look-alikes.

Conclusion

California has a long and rich health center history with many stories to tell. From migrant health centers to the Neighborhood Health Program demonstrations, to the Community Health Center program, California has been at the forefront of the community health movement. With such a large and varied state, diverse population, and geographical challenges, health centers are an integral part of California’s safety net. In light of the number of migrant and seasonal farmworkers, Latino/Hispanic patients, and uninsured individuals in the state, the culturally competent care and tools to reach the community that are part of the health center mission are vital to ensuring that health care is affordable and accessible.

As state economies around the country have fluctuated over the years, downturns and recessions are often felt strongly in California, the nation’s most populous and diverse state. It is particularly in times of tight fiscal budgets, rising unemployment, and growing populations that California’s health centers are most called upon to serve more

people utilizing services that are simultaneously cost-effective and “health-effective.” Ongoing support and monitoring are needed to ensure that they have the resources needed to continue to improve the vital role they place in California’s health care safety net.

**Appendix A – An Overview of Health Centers in
California’s Central Valley Region**

CLINIC	SITES	NUMBER OF PATIENTS	Number of Annual Visits	% of Uninsured Patients	% of Medi-Cal Patients	% of Farmworker Patients	% of Other Patients
Clinica Sierra Vista	14	67,048	309,345	32%	56%	63%	12%
Community Medical Centers	10	35,000	106,000	34%	63%	19%	3%
Darin M. Camarena Health Centers	3	15,956	53,014	27%	55%	63%	N/A
Del Norte Clinics	15	61,000	200,695	14%	61%	38%	25%
Family HealthCare Network	11	72,774	254,000	7%	76%	87%	5%
Golden Valley Health Centers	15	58,557	185,403	30%	80%	42%	10%
Inland Behavioral and Health Services	1	9,633	17,452	57%	39%	0%	4%
Livingston Medical Group	1	12,221	39,990	44%	41%	27%	15%
National Health Services	9	26,188	113,538	34%	54%	44%	N/A
Sequoia Community Health Foundation	5	20,887	75,347	38%	46%	45%	6.7%
Tulare Community Health Clinic	1	13,646	52,420	6.5%	78%	41%	N/A
United Health Centers of the San Joaquin Valley	7	35,786	116,630	25%	54%	71%	21%
Valley Health Team	3	12,000	36,000	47%	37%	70%	16%

Source: Central Valley Health Network, 2004.

Appendix B – California Counties Containing at Least One Designated MUA/MUP

(Number of MUAs/MUPs in parentheses.)

COUNTY	Number of MUA/MUPS	COUNTY	Number of MUA/MUPS
Alameda	7	Riverside	20
Amador	1	Sacramento	3
Butte	3	San Benito	1
Contra Costa	1	San Bernardino	12
Del Norte	1	San Diego	18
El Dorado	2	San Francisco	7
Fresno	12	San Joaquin	1
Glenn	1	San Luis Obispo	2
Humboldt	6	San Mateo	1
Imperial	2	Santa Barbara	1
Inyo	1	Santa Clara	3
Kern	12	Santa Cruz	2
Kings	2	Shasta	4
Lake	2	Sierra	2
Lassen	2	Siskiyou	6
Los Angeles	53	Solano	1
Madera	1	Sonoma	7
Marin	3	Stanislaus	1
Mendocino	1	Sutter	2
Merced	3	Tehama	1
Modoc	1	Trinity	1
Monterey	5	Tulare	7
Napa	2	Tuolumne	1
Nevada	1	Ventura	1
Orange	5	Yolo	1
Plumas	1	Yuba	3

Source: U.S. Dept. of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care. (2004). Available: <http://bphc.hrsa.gov/databases/newmua/default.cfm>

Appendix C – California County Level Map



Source: U.S. Census Bureau, 2004 Available: http://quickfacts.census.gov/qfd/maps/california_map.html