

Colorado Community Health Network

25 YEARS

of Good Medicine for
Colorado Community
Health Centers

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network

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Dear Friends:

The Colorado Community Health Network (CCHN) represents Colorado's 15 Community Health Centers that together are the backbone of the primary health care safety net in Colorado. Since its inception in 1982, CCHN has made significant strides in ensuring that Colorado's low income residents have access to affordable, high quality primary health care.



How were we able to do that? How did we get to where we are today?

Twenty-five years ago, a small group of 1960s visionaries formed a lifelong friendship around a single cause: providing premium health care to all Coloradans regardless of ability to pay.

Their task was enormous. But they had a plan. They would unite and politically mobilize Colorado's community health centers or CHCs – then, a dozen facilities stretched from farm towns to urban neighborhoods. These independent, community-owned, non-profit or public health centers had been treating working families, including people without medical insurance, since the 1970s, one since 1966. The visionaries saw that to meet the needs in their individual communities, a statewide network of like-minded organizations would be required. They would fill their new network with elite medical talent and adopt a sliding fee scale so that no person was turned away because of their income. They would attract bipartisan support from the Colorado statehouse to Capitol Hill. They would lift the community health center movement in Colorado to the next level by launching an alliance – the Colorado Community Health Network (CCHN).

Over the next quarter century, CCHN and CHCs would reshape the state's health care landscape, growing to include 15 community health centers operating 118 clinics in 33 counties and providing a health care home to One in 12 Coloradans.

Today, the CCHN family annually cares for nearly 400,000 Colorado residents. These health centers are integral parts of their communities. To ensure that services are geared toward the community they serve, each health center is governed by a board of directors, which include local business owners, community leaders and other interested citizens. A unique feature of community health center boards is that more than half of the members are patients of their health centers.

But as medical insurance costs rise and more employers drop health coverage, the CCHN safety net is gaining renewed importance as a health care home for not only the most poor families, but also working families who struggle to balance increasing health care costs with other financial responsibilities.

To ensure that all Coloradans have a health care home, CCHN is committed to 1) educating policy makers and stakeholders about the unique needs of Community Health Centers (CHCs) and their patients, 2) providing resources to ensure that the CHCs are strong organizations, and 3) supporting the CHCs in maintaining the highest quality care.

The staff at CCHN is deeply honored to work on behalf of Colorado's Community Health Centers. By banding together and putting the needs of Coloradans above their own territorial issues, the health centers have served hundreds of thousands of Coloradans who otherwise would not have been able to get the health care they need.

This is the history of CCHN – and the visionaries behind the movement. These are the stories of the health care providers and the patients, the people who are the community health center movement in Colorado.

Sincerely,

A handwritten signature in blue ink, appearing to read "Annette Kowal".

Annette Kowal
Chief Executive Officer
Colorado Community Health Network

On

Friday nights, drained

by their work but stirred by their cause, they gathered around a table at the Landmark Inn in Denver for beers and banter: three front-line soldiers in the new battle for health care equality.

In 1980, one happy hour at a time, they hoped to save the world.

There was Stephanie Thomas, a young Denver General Hospital administrator who drew inspiration from her father's bond with John F. Kennedy. There was Jerry Brasher, who had cashed in his economic resources career to run the tiny Salud Family Health Center in Fort Lupton – a facility born in a converted onion shed. And there was Chuck Stout, who led Colorado's migrant health program.

Individually, their days were jammed with the headaches and triumphs of bringing medicine and healing to thousands of farm workers, laborers and city families, no matter their ability to pay. But Friday evenings were filled with sharing innovations and frustrations. Over frosty mugs of beer at the old hotel on South Colorado Boulevard, their informal gatherings were part pep rally, part therapy session – a sort of support group for a trio of 1960s idealists living in an increasingly class-divided world, where vast numbers of needy people still had little or no access to health care.

"Back in college," Stout recalled,

"you would have all these discussions about how things were so screwed up in the world, how if only *they* would do this or *they* would do that, things would be better. Suddenly, we realized we are the ‘*they*’ we always spoke of, that we can create our own future here, and let’s go do that."

By late 1980, the three had been meeting for months to dissect their medical horror stories and common challenges. Like the 35-year-old migrant woman who already had lived through nine pregnancies, two miscarriages and the death of one infant. Like the panicked parents who took their child to the emergency room for a simple fever because they had no idea how to treat it. The trio swapped new ideas on patient outreach and education, on recruiting and training staff. And they talked constantly about finding more of the federal dollars that fueled their work – a cause that consumed each of them.

"I love the mission," said Thomas, whose father served with Kennedy aboard the Navy ship PT 109 during World War II. "I got to meet Kennedy when he was in the White House and I was seven years

old. He made a real impression on me. After that, I was always driven to do something."

"We were on the front line of



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Allan Webb, Thomas's father, far left aboard PT-109 with John F. Kennedy, far right, 1940s.

knocking down these walls," added Stout. "We said it's not OK to have a two-tiered health system in America. We were not going to have storefront care for poor people and carpeted, high-end medical centers for rich people. We were going to have health care for poor people that's every bit as sophisticated."

In the town of Alamosa, four

"The Peace Corps and community health share a whole series of values – doing something good, doing something right, taking a chance. It's all of that." - Mike Bloom

hours southwest of Denver, Mike Bloom, director of Valley-Wide Health Services, Inc. (now called Valley-Wide Health Systems, Inc.), was having some of the same fiery chats

with his colleagues at other rural clinics.

Like the trio in Denver, Bloom saw value in Colorado's community health center leaders gaining a more collective voice. And like the group in the big city, Bloom's passions were rooted in 1960s social mandates that spanned Kennedy's soulful call to action and Lyndon Johnson's epic War on Poverty. Bloom had served in the Peace Corps in Bolivia. He had come to believe that health care is a

right, not a privilege.

"The Peace Corps and community health share a whole series of values – doing something good, doing something right, taking a chance," Bloom said. "It's all of that."

So in the city and in the hills, Colorado's community health center leaders talked about their future.

"And then in the early 1980s," added Thomas, "there was a change in Washington, D.C. Suddenly, there was a big threat to community and

migrant health centers."

The peril came in the new way national leaders planned to funnel federal money to the states. Block grants were becoming a popular option. As a result, social programs long fueled by their own dedicated streams of federal money now would have to fight for a consolidated chunk of federal funding.

To be able to respond, the group at the Denver bar recognized they would need a statewide organiza-

When Dan Euell was invited to apply for an opening at Eastside – the No. 2 job at the Denver General facility – he wanted no part of it. After all, how could he join a health care system that had killed his brother?

The pain and anger still festered, 28 years after the family tragedy. In fact, Euell hadn't even been born when his mother entered a hospital in St. Louis, ready to deliver an infant son. But what came next would color his life forever. It was about race.

"There were difficulties," Euell recalls. "There were difficulties in terms of providing health care across the board. My brother expired shortly after delivery because of conditions in the hospital." How did it happen? Why did it happen?

"Because at that point in time, we (African Americans) were relegated to the basement. That was something that stuck with me for a long time."

So, in 1970, when Euell became a candidate for the assistant director post at Denver's first community health center, he turned down the interview – twice. His father suggested he at least give the place a look. So Euell did it his way, undercover. He posed as a patient, sat in the waiting room and simply observed how people were treated.

"I didn't want to be associated with a program that might have been a fraud," he says now. "I wanted to find out if it was real."

"And I became impressed."

At the time, the four-year-old facility was still called the Neighborhood Health Center – one of the first two



Dan Euell, 2006



Bernard F. Gipson, Sr. Eastside Family Health Center, 2006

programs in the country to be funded under the federal War on Poverty. Boston was the other one. Housed in a remodeled Wonder Bread bakery, the health center was located in Five Points and half of the 36,000 people in its service area lived below the poverty line. For them, services were free. For folks who had more income but no insurance, the Neighborhood Health Center offered a sliding fee scale.

The waiting room buzzed constantly, Euell saw, as 300 people a day sought treatment there.

"I recognized that this represented a great opportunity to the overall community, which in turn might help to negate the kind of thing that happened to my family," Euell says.

He applied for and got the job. In 1971, he took over as health center administrator. But while working in the neighborhood, Euell witnessed some of the same fierce mistrust he once carried for the health care system – feelings only heightened by 1972 revelations about the Tuskegee Syphilis Study. When African American men in the area were urged to be screened for prostate cancer, many refused, saying: "I know I'll just be another experiment." Work continues, Euell says, to ease those old fears.

Today, the Bernard F. Gipson, Sr. Eastside Family Health Center is located at 501 28th St., about a block from its original location.

Euell works for Denver Health as executive liaison for community and governmental relations but he returns to the facility once in a while... "I never thought my family's situation was a lone thing. And for me, it wasn't a black-white thing. It was the whole health care system – how could it do what it had done?" Euell says. "This was an opportunity to face it, to be in charge of the solution."

tion to boost their collective political muscle – an alliance to help them retrieve the federal dollars needed to support Colorado's growing community health center movement.

As they examined their situation, they realized they had a clear roadmap to a more financially secure place. Health Centers specializing in care for the needy and underserved already had a powerful advocate in Washington, D.C. – the National Association of Community Health Centers (NACHC). Even better, Brasher was deeply con-

nected with NACHC. Community health centers already enjoyed a national movement.

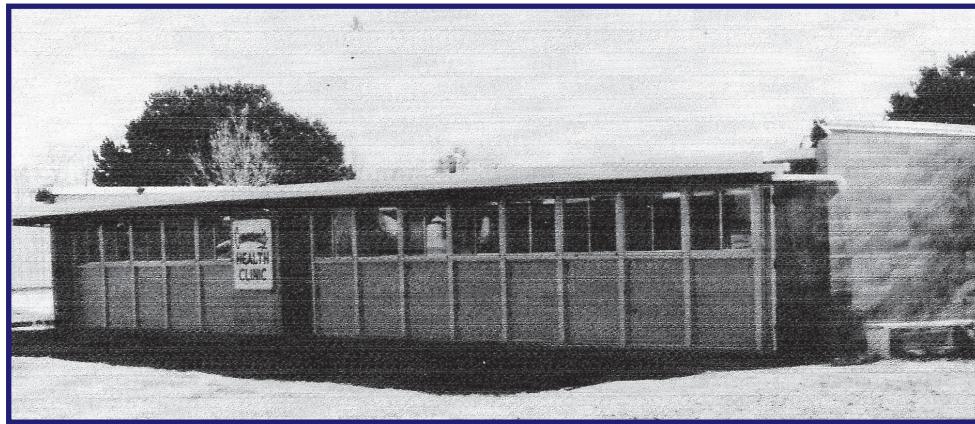
"If these block grants were going to happen," Thomas said, "the state was going to be in the driver's seat. We thought, we'll emulate what NACHC did at the national level and come up with our own association at the state level. That really got us going."

Thomas, Brasher and Stout teamed with Bloom at Valley-Wide and a loose affiliation of several other federally-funded clinics (including Sunrise Community Health Center in Greeley and Clinica Campesina Family Health Services in Lafayette)

and, in 1982, they formed the Colorado Community Health Network (CCHN), a primary care association. Brasher – described by Stout as "everybody's hero" – was the group's first leader.

"No one is denied service because of lack of funds," Brasher said. "That is our cornerstone."

In time, Colorado's new primary care association landed grant funding from the Bureau of Primary Health Care of the U.S. Department



First facility of Dove Creek Community Health Clinic, 1975 (The Dove Creek Press)

of Health and Human Services. Soon, through Thomas's connections, they found room to work. Denver Health offered CCHN office space at the Eastside Health Center in the Five Points neighborhood, already home to thousands of community health center patients who didn't have medical insurance or the cash to pay for care. It was a perfect site to spur the movement even further.

The first days of CCHN in 1982 blended fresh camaraderie with some old rivalries.

After all, there were about a dozen health center directors at the table, each deeply committed to provid-

ing health care to working families in their individual Colorado towns and counties. But there were limited federal dollars available to fuel the movement.

Early CCHN gatherings often were held around scheduled meetings of the federal grantees in the state who for years had been delivering health care to the needy, to rural residents and to migrant workers. Often, the get-togethers were held in Denver, creating long treks for providers on the Western Slope or Eastern Plains. One health center director in Dove Creek, near the Utah border, had to hold bake sales to pay her travel costs to attend the sessions.

"The meetings were pretty rough at the beginning," recalled Stephanie Thomas. "It wasn't a Kumbaya kind of thing."

"It was all intrigue then," added Bloom, "as we competed amongst ourselves for federal money. If the feds had, say, \$2 million in grant money for community health centers, a piece of that would be allocated to Colorado and we're all fighting for it. So, CCHN got into this bizarre role of being both an advocate and a referee amongst us."

The Colorado community health centers had to meet specific criteria to be eligible for those precious federal dollars. Also called "federally qualified health centers," grantees

had to provide care for a medically underserved area or population and had to work under the supervision of a board of directors comprised mostly by patients. They had to offer a sliding fee scale to patients in financial distress. It had to provide primary health care for people in

all life cycles along with emergency care, patient outreach and pharmacy services. These remain the rules today, and dental and mental health service services have since been added.

Despite fears inside the movement that Washington leaders would bring

block-granting to community health centers, it never came. But federal social programs did undergo cuts after 1980. And that helped CCHN gain some early focus.

"We found coming together as health centers, we could learn a lot from each other," Thomas said.

Inez Bugs prays open a bulging blue binder packed with 30 years of healing. She peers at each fading image and, with a soft voice, narrates the journey of her life.

A fuzzy Polaroid picture is taped to page 1: The little white house where Clinica Campesina took its first breath, where a lone nurse practitioner saw her first patient.

"This is 1977, when I started collecting all these," Bugs says. "This is where it began."

Her scrap book is a record, a precious chronicle of what Bugs now describes as her "spiritual calling." But within the pages of newspaper clippings and personal mementos Bugs also has honored – and even eulogized – the work of dozens of others who turned a back-room practice into a \$15 million network that today sees more than 18,000 people in Adams and Boulder counties.

"To be able to look back at the evolution," she says with a hint of wonder, "I guess it's like comparing a pencil and pad to cyberspace. If you had not been here, you wouldn't have seen it."

She flips the pages slowly, soaking in those old, warm moments.

Here is a photo of the original clinic's kitchen, its dark brown cabinets bathed in sunlight, its countertop holding a microscope and a coffee pot.

"Sometimes I would be the receptionist, check the patient in, take the patient back, examine them, do the labs, do the injections."

Here is a newspaper story about Bugs, headlined: "Nurse Practitioner Dispenses Caring Along with Healing." It is accompanied by a photo of Bugs treating an infant. That baby in the picture is now a Marine, she says.

"I still see his mom as a patient. What I love most is just coming to work, being with the patients, touching them. The interpersonal relationships. The bond. And maybe just knowing that I showed some kindness or consideration, or made someone feel worthy."

Here is an article about Alicia Sanchez, the woman who



Inez Bugs, 2006

started Clinica Campesina through her own bond with migrant workers in Lafayette.

"She was a woman of great wisdom. In our culture, education has a value when you have a piece of paper with a bunch of initials by it. But her education was so high in terms of knowing how to motivate people, being sensitive to their needs. And people trusted her, so they trusted the people she worked with. It enhanced the development of this clinic."

Here is an event program from 1989, the night Bugs won the Florence Nightingale Award, given

by Boulder County.

"I didn't think anyone was paying attention."

Here is a clipping about a health fair Clinica Campesina ran a few years ago.

"I had three chances to leave the clinic for jobs in corporate nursing or medical care. Each time, it didn't happen. Each time, I would ask myself, 'What am I going to teach these people? How beneficial am I going to be over there compared to here?'



From left, Alice Juarez-Sanchez, Mario Ruiz and his mother Susie, Inez Bugs, 1980 (Boulder Daily Camera)

She closes the binder. She packs up her belongings and thinks about the patients she will see tomorrow morning at Clinica Campesina.

"I wake up everyday looking forward to coming to work – and I go home wondering

what more I could have done. This is a mission for me. It's not a job. It's more encompassing than the money you take home. I am just driven. It feels like a spiritual calling."

And after the face-to-face meetings, Thomas said, “members could get on the phone with CCHN and ask about some new federal rule – ‘What are they thinking?’ – or ask how you count or define patient visits.”

“They had somebody safe they could call or somebody they could let their hair down to. This was a huge step forward for these directors. Otherwise, they got professionally isolated. The turnover in these positions was pretty high.”

Job training, however, often extended beyond the medical and administrative worlds. With Brasher in place as the first CCHN leader, he gave the group a working lesson on politics. First, he got CCHN members more invested in NACHC, gaining the Colorado directors spots on key committees within the organization. Next, he assembled a CCHN work group for policy forums in Washington D.C. And during those trips, the CCHN members would meet with every representative of the Colorado Congressional delegation.

“We would take a common agenda – this is what’s important and this is what we need from you,” Stout said. “Because we represented the whole state, they would listen. Jerry was everybody’s mentor on the political side of things.”

The CCHN contingent roaming the halls of Congress was simultaneously savvy and colorful. Early health center directors included a former bartender and a director who doubled as his health center’s janitor. Community health always had been a movement of the people, a lunch-bucket enterprise that championed working families, migrant farmhands and small-town residents who lived

pendently in the 1970s all reflected that gritty foundation: a free clinic in Colorado Springs launched by a priest, and a free clinic in Boulder started by former college friends.

“Storefront hippies out of the mainstream,” is how Bloom described the first community health center directors in Colorado.

In the mountain town of Blackhawk, residents opened a community health center in 1977 after the only physician in Gilpin County, “Doc” Peterson, retired and moved away. Peterson often saw patients in his living room or kitchen and delivered babies in his bedroom, using a dresser drawer as a bed for the newborns. In his absence, Gilpin County citizens formed a non-profit corporation and applied for federal funding as a Rural Health Initiative grantee. Columbine Family

Health Center opened in 1978 in the second story of a Blackhawk building owned by the local Veterans of Foreign Wars. Today, the office is part of Mountain



First facility of Clinica Campesina Family Health Services in Lafayette, 1978



First home of Salud Family Health Centers, 1970

hundreds of miles from big hospitals. The Colorado health centers that were alive and working inde-

pendently in the 1970s all reflected that gritty foundation: a free clinic in Colorado Springs launched by a priest, and a free clinic in Boulder started by former college friends.

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Family Health Centers.

Meanwhile, four of Colorado’s early community health centers

opened with a focus on caring for migrant families. They included Salud, Brasher's center in Fort Lupton; Valley-Wide, Bloom's center in Alamosa; Sunrise in Greeley; and Clinica Campesina in Lafayette.

Twenty miles northwest of Denver, Lafayette was filled with commercial farms and Spanish-speaking migrant workers in the 1970s. When the vegetable pickers grew ill, they came to see Alicia Sanchez, the local "medica." Each week, she packed her car with migrants or their families and drove them to University Hospital in Denver where they received low-cost health care.

In 1977, Sanchez and other Lafayette residents formed Clinica Campesina in a tiny white house that doubled as a travel agency. Beyond the cramped waiting room, the old kitchen contained a coffee pot on one side of the sink and a microscope on the other. In back, a lone nurse practitioner, Inez Buggs, saw patients in a bedroom that had been divided into two tiny exam rooms.

In 1984, Stephanie Thomas took the CCHN reigns from Jerry Brasher and the two community health pioneers each dug into fresh

chores. Brasher was about to open a fifth facility in

his Salud network, this one in Commerce City. Thomas, meanwhile, was trying to grow something else for CCHN: momentum.

"Keeping that organization going, that was the big thing," Thomas recalled. "Standing it up. Getting it

"Keeping that organization going, that was the big thing." - Stephanie Thomas

Dr. Kris Steinberg has now delivered one quarter of Alamosa's residents. But her baby, her labor of love, just might be a 10,000-square-foot swath of brick and mortar near the middle of town.

Not long after Steinberg arrived in 1986 to work as a family physician at Valley-Wide, she discovered a cramped, aging facility that was "badly busting out at the seams." To solve the problem, she literally mortgaged her future.

Without funds for capital construction, community health centers could not construct new buildings. Worse, Alamosa offered no pre-existing structures to house a bustling medical clinic. So, Steinberg and three other Valley-Wide doctors simply went to the bank.

"We had the wherewithal. We shopped for mortgages together and all of us pitched in what seemed like a big sum of money at the time to build a new clinic," Steinberg said. "Those four of us who went into it were the four who intended to have a career here."

After securing the construction cash, the doctors then helped design the new clinic, sketching out a system of hallways, exam rooms, bathrooms and labs that allowed for easy communication and efficient movement. Once the project was completed, they leased the building to Valley-Wide and moved in. Nineteen years later, Steinberg still practices medicine at the Alamosa Family Medical Center on First Street.

She has followed her career blueprint to the letter.

"Many physicians move every three years," she says. "But I can't imagine getting to know your patients all over

again every three years."

That down-home philosophy – and community health calling – is almost certainly genetic. Her father, Dr. Thomas Steinberg, was Vail's first physician, launching a health clinic and helping start the hospital in that resort town. He treated jetsetters and skiers but connected more with the locals, his daughter says.

"The people he still talks about are the ranchers down the valley or the hotel workers. My parents were never concerned about what they weren't blessed with. My dad is the youngest of six, my mom the youngest of 12. Even though I grew up in Vail, if your dad had to work, it was 'poor you.' Once I got here to Alamosa, the political concept of community health clicked with me immediately."

After 30 years on the job, she has delivered about 2,000 of Alamosa's residents – including the babies of several moms she delivered a generation ago.

"I call myself an obstetrical grandmother," Steinberg says. "It's really kind of cool."

Her community roots have spread to local causes – launching the town's recycling program, volunteering at the radio station. And as she helped bring new life to Alamosa, the town has wrapped itself around Steinberg.

"The longer you stay in a community, you feel appreciated, that people like you, love you. I didn't do this because I wanted to feel like the queen. But I sure do feel like the queen. I feel so appreciated here."



Valley-Wide's Alamosa Family Medical Center in Alamosa

to the point where we could walk into the state legislature and have credibility."

To help accomplish that task, CCHN broadened its powerbase in the 1980s and added three new members to its family: Pueblo Community Health Center in 1983, Stout Street Clinic (part of Colorado Coalition for the Homeless) in 1984 and, in 1989, the Metro Denver Provider Network (today called the Metro Community Provider Net-

work, MCPN). Thousands of Coloradans, including the working poor



Denver Health's original Eastside building as it looks today.

and uninsured, were slowly gaining routine access to doctors, nurses and medicine.

The glue for the organization, Thomas said, remained its cadre of older health centers near Colorado's capitol: Eastside in Denver (part of Denver Health), Sunrise in Greeley, Salud in Fort Lupton and Clinica Campesina in Lafayette, along with one strong voice in rural Colorado – Mike Bloom at Alamosa's Valley-Wide health center.

"The 1980s mark the first of three time periods for community health centers in Colorado," said Bloom. "In

One of the early offshoots of MCPN's swift expansion was the creation of the Aurora Teen Pregnancy and Prevention Project (ATP3). Through the initiative, teens learn how to form healthy relationships, make smart decisions and avoid pregnancy. For girls who do get pregnant, ATP3 helps them complete school, find safe housing and ultimately, learn how to parent.

Once or twice a day, teen girls with bulging tummies walk into the Parker Place Clinic in Aurora for a checkup. With a ready smile and sweet touch on the arm, a medical assistant escorts them from the lobby to an exam room, checks their weight, records their vital signs and often, whispers some encouragement.

"There's a program in our network that can help you," Misha Diawara tells them softly. "They'll help you with Medicaid. They'll show you how to pay the bills. They'll tell you some places you can afford to stay if your parents put you out."

"You're scared. You're young. You're pregnant. Wouldn't it be nice to have an adult you can talk to who's not going to judge?"

Diawara is something of an expert on ATP3. It probably saved her life six years ago.

She was 17, a student at Overland High School in Aurora, a girl with a scholarship to attend the University of Tennessee, a person with a future. In a blink, she was a teenager with a baby inside. College was out. She was dropped from her mother's insurance provider. And there was no place in her mom's cramped apartment for a new baby.

"I felt like my life was crushed at that moment. To go from having a scholarship to having to grow up, to having to be a mom, to having to get a job, I was so scared."

At ATP3, case manager Jo English showed Diawara how she could complete school – even attend her senior prom, while eight months pregnant. She got into MCPN's Hoffman Heights Clinic for medical supervision and graduated on time. She found alternative housing. She had her baby – a girl named Zahla. She got into College America and earned a medical assistant degree.

"I wanted to give back what I got at MCPN. That's why I wanted to be an employee there. When I was pregnant and first walked in the door, I was already so scared, no insurance, and I thought I wasn't going to get the best care. But I walked into smiling faces and people who really did want to help me, a doctor who wanted to help me."

Today, Diawara works as a medical assistant at MCPN's Parker Place Clinic in Aurora. She is married to Mohamed and has since had another daughter, Nevaeh, 2. Through MCPN, she has earned a scholarship to nursing school. She'll attend in 2007.

And after that?

"I'll be back with MCPN," she says. "Right now, I can't see myself without MCPN. I probably would have dropped out of school. I would have started working to pay the rent. I never would have thought about college."

"MCPN gave me inspiration to do better, to go to school, to keep bettering myself and keep doing all the things I need to do to make a healthy life for my daughters. MCPN gave me a life."



Misha Diawara with husband Mohamed and daughters Nevaeh, left, and Zahla, 2006

the 1980s, we were all virtually 100 percent grant-funded. We thought like grant-funded organizations."

The federal bureaucracy was their master, laying down the strict rules under which community health centers would qualify for vital dollars. Within that competitive environment, the group of diverse entities came together and worked together to obtain those federal dollars.

But the daily challenges facing Colorado's urban cluster of community health centers were a world apart from the political and economic realities that swirled through CCHN's more rural centers, like those in Dove Creek and Norwood on the Western Slope, and Alamosa in the San Luis Valley.

For starters, there was vocal, local opposition to some rural health centers – a resistance often fueled by private physicians and dentists who worried that charity-based competition would cut into their bottom line. Sometimes, though, the friction was racial, Bloom recalled.

"I remember a front page story in the Alamosa newspaper that said something like, 'We don't need any stinking community health center here,' and it was signed by all the doctors in town," Bloom said. "I remember a front page story in Greeley, when Sunrise started, in

which a top health official said, 'We don't need any place that takes care of Mexicans.'

Beyond those tensions, some smaller community health centers were strained by their far-flung locations. In Norwood, 128 miles from Grand Junction, the Uncompahgre Medical Center clinicians sometimes



High Plains Community Health Center, Lamar, 2002

had to shoo cows off the concrete helipad outside the building. When setting up appointments for patients to go see Western Slope medical specialists, Uncompahgre often had to foot the gasoline bills associated



Uncompahgre Medical Clinic, Norwood, 2006

with those long drives.

Today, private physicians and specialists on the Western slope commonly cut community health patients a break on their medical

bills, said Michelle Haynes, executive director of the Uncompahgre Medical Center, which became a federal funded community health center in the 1970s.

"The private doctors (in the region) realize we're out here stranded. They will always take our phone calls," Haynes said. "Out here, it has

to not be about the money."

Another modern casualty of small-town medicine can be confidentiality. A community health center's parking lot is often perched on a primary street and everybody knows what everybody drives. Your doctor visit can

be detected by all who pass by. For this reason, many rural community health centers have tucked their behavioral health services into a single building that also houses the medical exam rooms, dental suites,

pharmacies and administrative offices. It allows patients seeking private therapy some cover from prying eyes. In Limon, that has helped the behavioral health team flourish. Today, after three years as a community health center, Plains Medical Center has three full-time counselors who deal with domestic violence, parenting and substance abuse issues, along with conditions like depression.

"Even though our area has about 20,000 to 25,000 peo-

ple, word spreads fast (about anything). And there is a stigma attached to coming to behavioral health," said Dr. Ray Kessler, a licensed professional counselor at Plains Medical Center, which serves a patient base that stretches across 4,000 square

miles in five counties. "I've had some patients who will not come through the front door. They always come in a side door and wait in the hallway here for our session."

But the need for behavioral health care in rural America far outweighs fears of the stigma of seeking help.

"I get the sense that people are very happy with us here," said Kes-

sler, who was hired by Plains in 2004. "We get a lot of our referrals through word of mouth. That is a good sign."

Attracting full-time clinicians like Kessler can be tricky for rural health centers.

"You recruit one, you lose two," said Brenda Higgins, the executive director of Plains Medical before

After three office moves in 30 years, Dr. Peg Latourette is growing a bit weary of packing and unpacking boxes. But the books, the medical notes, and all the photos of little boys and girls from days gone by: how could she ever leave those behind?

After treating three generations of patients, Dr. Latourette is growing ever more attached to all the kids she cared for in illness and befriended in health.

"This is my life. From the time I was 4 years old, I wanted to be a doctor," she says, now ensconced in her new office at the Wellington E. Webb Center for Primary Care in Denver. "I love these people."

The pediatrician has carved her own cozy medical style – part doting grandmother, part tough-love doc – while working her way through every era of the community health movement in Denver.

Her memories reach back to her days as a resident at Denver General Hospital in the mid-1960s, before any community health clinics had opened in Colorado. Families without health insurance had few options when their kids got sick.

"They would end up coming to the emergency room. We had kids walk in with pneumonia, so dehydrated from diarrhea we had to do cut-downs on their veins just to get needles in so they could get fluids," she recalls.

In 1967, La Mariposa Family Health Center opened in a small house at 12th Avenue and Mariposa Street with a basement pediatric office that flooded during heavy rain and a rear entrance best suited for people who stood 5-foot-2-inches or shorter. The hearing and vision screening area was located in an old shower room and backed up to a bathroom. Each time someone flushed the toilet, pipe noise drowned out the hearing checks.

Latourette loved it, because she got to know the neighborhood and its children.



Peg Latourette, 2006

She taught parents with 6th grade educations how to properly feed their babies. She urged them to read to their children. Her exams began to transcend medicine, turning Latourette into an enthusiastic counselor, social worker and friend. She gave out her home number and asked worried mothers to phone her at night to update her on a kid's fever. Or she urged parents to call if they just needed to talk about life's latest twists.

The facility moved about two blocks east to its own building in 1975. In Latourette's office, squeezed between two exam rooms and separated by pocket doors, she collected snapshots and school photos of her patients. She also stockpiled hundreds of children's books which she handed out to incoming families as rewards for coming in regularly.

The phone calls to her home kept coming – worried parents, moms who just needed to vent. But in time, those calls were followed by invitations to graduations and weddings. Her first generation of patients was growing up. One invitation took Latourette to a Lakota Indian sweat lodge.

Most of the kids she saw came from poor households – about 85 percent were on Medicaid.

"These people, they need somebody desperately. They need some time with me. I can do an uncomplicated well-child visit in 20 minutes no problem. But if they have problems it isn't going to take 20 minutes. I take the time they need and the next patient waits. And when that patient gets in, I take the time for them. And at the end of the day, we work overtime."

She continued preaching to parents about good health and good reading habits. But in the 1990s, Latourette began focusing on a new epidemic in her neighborhood – childhood obesity. She taught parents better nutrition, analyzed their eating diaries, discussed the contents of their cupboards, and encouraged families to walk together.

Several months ago, she and the entire staff at La Mariposa moved again, this time to new facilities at the Webb Center for Primary Care.

Of course, the photos and snapshots went with her.

"Lots of people ask me, 'Why don't you retire? You could go volunteer somewhere.' But I like what I do. I just can't imagine doing anything else."

retiring to her family ranch in 2006.

To fill that gap, small-town clinics often tap into big-city residency training programs that rotate young physicians and pharmacists into remote health centers for a month of work – or young dentists for



From left, Valley Wide's Kirk Kritner, physician assistant, patient Lorena Andrews, and Virginia Stuber, nurse, 2000

one-year stays.

"It gives them a rural experience and tries to influence where they will practice medicine – hopefully here or someplace like this," said Konnie Martin, vice president and chief operating officer at Valley-Wide.

So far, that tactic has paid off for the Alamosa-based network. It landed one full-time pharmacist and two permanent physicians through residency programs.

"For them, the difference between here and the city is in the workload," Martin said. "In the city, you have a specialist for everything, backup for everything. Here, you are it. You are the doctor. To some people, that's very attractive."

As the 1990s dawned, a community-driven mission powered by a civil rights energy continued to flow into distant and

impoverished corners of Colorado. CCHN and its member health centers were providing top-drawer health and dental care to a rising number of working families who couldn't otherwise afford this basic slice of the American pie.

But the new decade also brought a new, buttoned-down reality for health center workers long ago drawn to a blue-jean social movement. They had to understand and work within the Medicaid bureaucracy. Costs had to be documented, tracked and reported.

Over time, revenues at the nonprofit health centers were shifting from federal grants to Medicaid payments. Managing those revenues meant clinics had to adopt



Dave Myers, CEO of Metro Community Provider Network, at the United States Capitol, 2000

a more businesslike approach. And that triggered new ways of managing throughout the CCHN family.

"We all realized we were becoming very serious enterprises, in terms

of our size and our impact in our respective communities," recalled Mike Bloom, who was finishing his Valley-Wide tenure in 1990.

"Throughout the 1990s, people were beginning to understand that our growth into the future was not going to be driven by federal money, it was going to be driven by our ability to deliver care efficiently and to document that that's what we're doing," Bloom said.



Ribbon cutting at MCPN Hoffman Clinic-Aurora in 1997 - from left: Ray Quereshi, board member, Sandra Ocampo, front office staff David Myers, CEO, and Gloria Salinas, LPN

For the first time, a number of community health centers hired CFOs and COOs with MBAs. Along the way, many of those 1960s idealists and health-care pioneers turned out to be expert number crunchers who quickly learned how to play the business game, who could understand and speak the corporate lingo central to fundraising, medical administration and, just as important, state and federal politics. Some facility directors (including the Metro Community Provider Network and Pueblo Community Health Center) would launch their own endowments. Others became experts on keen real estate acquisitions, turning corner churches

and empty K-Marts into workable space for the community health cause.

Their free clinics and storefront health centers – many launched in leaky basements, in the kitchens of old homes, in converted onion sheds and bakeries – were slowly built into complex networks

filled with sophisticated medical talent and equipment. The expansion of the community health center movement eventually would cover nearly 400,000 of Colorado's nearly 1 million medically underserved people.

Indeed, growth was the answer.

"It was the challenge of going from an idea and a vision to a business," said David Myers, president

and CEO of the Metro Community Provider Network (MCPN). "You always need the energy, the commitment, the mission. But you also have to know how to run a business. You have to meet payroll. You've got to have a human resources department that knows how to deal with personnel issues."

"Every health center started out with the idea, 'Golly gee, we really

Marty Martinez teaches a bit of responsibility whenever he has a chance.

Hispanic people, who face a higher rate of diabetes in their community, must make changes in their traditional meals in order to prevent or control the disease, Martinez often says.

"Sometimes, they don't want to," Martinez says. "They think diabetes is caused by eating sugar, candy, pastries. But they don't think about the tortillas and the chili, especially the lard in the chili. They are staples of their diet. But those carbohydrates turn to sugar. We're trying to reeducate people about their diet."

Martinez knows this truth in his soul. He was diagnosed with diabetes more than 20 years ago, not long after he spent two tours in Vietnam as a medevac helicopter pilot.

In addition to staying current on the latest lifestyle recommendations for people with diabetes, Martinez serves as a board member for Mountain Family Health Centers. In that role, he provides personal advice to Hispanic people, including Spanish-speaking immigrants. He was featured in an October 2006 cover story about diabetes in La Tribuna newspaper, illustrating in several photos how to properly inject insulin and how to monitor blood sugar. He also talks to immigrant classes about managing diabetes.

"They want to know. And then they will tell me, 'Oh, my mother has it, my sister has it, and I'm worried about my kids because they're overweight.' Some people in the Hispanic community never had anybody tell them things like this," Martinez says. "They may go to a private doctor, but they can't communicate with them, and they leave. They can't afford to pay another doctor's fee, they don't have insurance, so they don't go back there. But here, at Mountain Family, they get that care. The staff here doesn't let them leave without getting care."

That brand of patient self-management is part of an innovative effort at the core of the community health

center movement – the federal Health Disparities Collaborative. Under that strategy, teams of clinicians are working to eliminate health care gaps that affect many people in poverty or those who deal with cultural or geographic barriers. Health centers have made creative changes in how they deliver care to groups of patients – like the diabetic population and those diagnosed with depression.

In Colorado, health centers like Mountain Family and Clinica Campesina have chipped away at the traditional mold of diabetes treatment to more strongly emphasize prevention at home and reduce the long-term costs of the disease. For example, patients are invited to come to group sessions to share their nutritional challenges or discuss their exercise habits. Patients enrolled in the collaborative also are given in-depth hemoglobin tests at selected, 90-day intervals to more closely track blood glucose levels – a more precise indication of how they are fighting the disease. What's more, people like Martinez continue to drive home the point that patients should take greater interest in their own health treatment.

"If you're a diabetic, you're going to be more closely managed here than you probably will be in any private practice," says David Adamson, executive director of Mountain Family. "No matter who you are, you need to understand this illness. You need to make some of your own decisions.

You need to take some responsibility. You need to watch what you eat. At the same time, we're going to hook you up with some dietary advice and check your hemoglobin. But this is all a step ahead in terms of prevention."

Adds Martinez: "They keep a lot of people from eventually having to go to the emergency room."

It was that type of collaborative philosophy between clinicians and patients that helped convince Martinez to volunteer his time to the Mountain Family board of directors.

"My interest came," he says, "because I am a diabetic."



Marty Martinez, 2006

need a clinic here. Let's go get a clinic.' Then some financial realities hit. There's usually someone who steps in and brings a sense of business there, but somebody who can meld business with that original mission."

When Myers arrived at MCPN in 1993, the health center had two locations, Aurora and Jefferson County. He had just completed 10 years of work at Salud which by the early

1990s boasted six clinics across the northern Front Range and Estes Park. Myers understood that MCPN, which was sputtering financially, also had to get bigger.

"There was some suggestion as to whether it would survive. And I was actually brought in under the thought, 'Well, we'll give it one more chance to see if it can stabilize and move forward.'

With gaps in the community health safety net in the towns just east, south and west of Denver, Myers scanned the horizon and saw shining opportunities. The local hospital at the time (Aurora Presbyterian Hospital) and Jefferson County Schools each wanted to partner with MCPN to fill health care niches. A community planning group in Aurora called and asked MCPN to

At the height of college turbulence in America, 19-year-old Mary Lynn Sheetz decided to take a year off from the University of Colorado and see what was happening in the world.

Her friend, Father Steve Handen – a young priest who was running a soup kitchen and trying to lure doctors to a new free clinic in Colorado Springs – suggested that Sheetz volunteer her time to the place.

"After one year at the free clinic, pretty quickly it was clear to me that I was learning more there than in school," Sheetz recalls. "I wasn't going back."

In 1971, a few doctors began donating their own hours on Monday and Thursday nights to see pregnant women and sick kids. Sheetz, meanwhile, gave her time too, sitting at the top of the entryway stairs where she supervised a sign-in book and a coffee can for donations.

"As time went by we were having so many patients and the docs were staying so late, they wanted to start triage. They asked me. I didn't want to tell them I didn't know what triage was," Sheetz says. "So I went home and looked it up in the dictionary."

"Then, that became my job. I looked at the people coming in each night, did the initial interviews, asked what was wrong and would coordinate the patients."

Eventually, Handen left the priesthood and married Sheetz. They began running hospitality houses for impoverished people in Colorado Springs, giving them food and shelter – and bringing them to the free clinic for medical care. For their own checkups, Sheetz and her husband went there too.



Mary Lynn Sheetz and Steve Handen, 2006

"When you're living with poor people and working with the poor, our thought was we had to accept the medical care that was available to them," Sheetz said. "You can't go off and get medical care somewhere else. It also allowed us to really stay in touch with how they were being treated."

"But it never felt risky to us. At the free clinic – and later at the community health center it became – we had really excellent medical care, better than that we could have purchased."

As the health center expanded, moved and became Peak Vista, Sheetz and her husband continued their medical treatment there. Then, out of the blue, the health center saved two of its founders.

At the end of 1999, Sheetz was diagnosed with breast cancer. It was the first time she had seen the nurses and doctors at Peak Vista respond to a serious illness.

"Once my mammogram came back with problems, they were scheduling me to see a surgeon and an oncologist, totally coordinating the full thing. Emotionally, I was on automatic pilot. So it was helpful to have the people at Peak Vista take over."

"And in the middle of my treatment, my husband was having his routine maintenance visits at Peak Vista and they determined he had a (coronary) blockage. They sent him to a specialist, got him in the hospital immediately and he had a triple bypass. That was all in one year."

The facility to which Sheetz and her husband devoted their lives had stepped in to extend theirs. Both are healthy today.

"We've just had wonderful treatment."



Ribbon-cutting ceremony for Divide Health Clinic, Peak Vista's Teller County facility, August 2006

serve as the fiscal agent for a new teen pregnancy program. "That all happened in about 12 months – three



Two MCPN patients with an MCPN volunteer who coordinated the clinic reading program for young patients, 1995

entities that said, 'We'll give you some money if you do something around the uninsured.' That established our credibility," Myers said. "We jumped at the opportunities and were able to respond to what the community saw as its needs."

Throughout the 1990s, MCPN opened more clinics in Aurora, Littleton, Englewood, Lakewood, Arvada

"When these places go under and when these towns lose clinics, we all pay. People end up going to the emergency room when they get sick. The cost is huge to all Coloradans."
- Marguerite Salazar

and Bailey. Other CCHN members were booming as well. Valley-Wide was invited to set up shop or take over financially sinking clinics in

18 locations near three of Colorado's four borders, including the towns of Burlington, Rocky Ford, and Mancos.

"Our success is due to the failure of the larger health care system," said Marguerite Salazar, president and CEO of Valley-Wide. "If things were going OK, we wouldn't be in all these places. Every place we've been asked to go into, or any small-town private doctor we've been asked to bolster, has been on the verge of failure."

"When these places go under and when these towns lose clinics, we all pay. People end up going to the emergency room when they get sick. The cost is huge to all Coloradans."

Growing up in Wyoming – where his mother worked as a nurse, wanted to be a physician and urged her kids to go into medicine – Paul Melinkovich knew his career choices were fairly limited.

"I had two options," he said with a grin, "I could have been a doctor – or a priest."

Like his brother, a pediatrician, and his sister, a nurse, Melinkovich fulfilled his mother's dream. Thirty years ago, he joined Denver Community

Health Services as a pediatrician, working at four clinics. In 1995, he became director of Denver Health's school-based health centers, which

numbered only two on his first day in that role.

Over the next 10 years, Melinkovich opened 10 more school-based health centers, finding the necessary funds and building partnerships with community organizations and the Denver schools to expand the system at a fever pitch. Just as critical, he encouraged the partners to integrate their clinics with Denver Health, giving students better access to the community health centers, the emergency department and the urgent care center. In contrast, other school-based clinics around the country are often stand-alone entities, and some are even privately owned.

"We are now a national model," Melinkovich said. "Every month, I get a call from someone at another school district around the country who wants to come out and see how we did it."

At Denver's school-based clinics, the medicine is comprehensive and ranges far beyond tummy aches and hallway scrapes – from preventive care and immunizations to mental health and substance abuse counseling. Case management is applied with a parental tone.

"When we can't provide a service in the schools, and we refer a student elsewhere for something, we'll follow up with them to see if they made it," Melinkovich said. "If they didn't, we ask, 'What happened, why you didn't make it? Need another referral?'"

"With asthmatic students, it's: 'We gave you your medicine; you had

another attack, what's wrong? Are you taking it?" It may sound like a parent: 'Why didn't you use your inhaler?' But at this age, our saying it may be more effective than parents," added Melinkovich, who today heads Denver Health's Community Health Services.

Next, Melinkovich wants to expand the health education in the school clinics to cover obesity, pregnancy prevention, suicide prevention and automobile safety.

Inoculations against disease also remain a critical piece of school-based health care in Denver. In fact, boosting immunization rates has been a CCHN priority since the 1980s when Colorado still lagged behind most other states.

A 2004 CCHN assessment showed that 11 community health centers have achieved up-to-date immunization rates of 90 percent or better for 1-year-olds. At the Pueblo Community Health Center, where case managers remind and cajole parents to keep their kids' immunizations current, that rate is 99.6 percent for 1 and 2-year-olds. By comparison, Colorado's rate for fully immunizing the state's children from birth to 35 months was 83.4 percent in 2005, according to the U.S. Centers for Disease Control. In fact, with CCHN pushing the immunization agenda, Colorado has moved from the 44th ranked state in 2004 to 16th highest in 2005 in terms of the percentage of immunized children.

Today in Pueblo, in a stuffed basement office shared by four women working four phones, medical as-

sistant Juanita Torres has the task of tracking the 350 clients who are age 2 or younger.

"She's a bulldog," said Janet Fieldman, PCHC's chief foundation officer. "She's on the phone, finding people, getting new moms to bring their kids in for their 1-year and 2-year immunizations. We got the CCHN award for the top immunization rate in Colorado. In fact, we've got a track record of seven years in a row for that."

Before her death, retired Pueblo District Judge Patti O'Rourke made a change to her will and invested in the community health center movement in Colorado.

The mother of six children added a seventh heir: Pueblo Community Health Center, to which she left about \$100,000. Her gift in 2003 was steeped in a stark memory that O'Rourke had carried since the days she lived in the Uncompahgre Valley, back when she watched small children and migrant workers struggling to survive.

"She saw young women getting



Judge Patti O'Rourke speaking at O'Rourke Dental Clinic grand opening, Pueblo, October 2000

pregnant and not getting prenatal care. And their kids were dying," recalled Fieldman. "And she said,

'Nobody should ever have to go through this because they cannot afford a doctor's visit.' So that was her passion. That's what drove her."

Migrant health is a backbone of the community health center movement in Colorado, with roots running as deep as the crops in the fields. Pueblo Community Health Center, which became so near to O'Rourke's heart, launched a farm worker program in 1994. During peak growing seasons, Pueblo extends its hours and its clinicians visit migrants in the fields of eastern Pueblo County, encouraging preventive and routine exams along with appropriate immunizations. Similar work has gone on around the state for generations.

In the 1980s, Valley-Wide Health Systems assumed administration of the Federal Migrant Health Program for the San Luis Valley and received money to open a migrant health center in the town of Center.



Dr. Ricardo Velasquez, Valley-Wide's medical director, with patient at San Luis Health Clinic, San Luis, 2001

"It started in a little house. Everybody would go to this house for care and they would also pick up blankets, jackets and maybe some food," said Val-

ley-Wide's Salazar. "That was our hub. Then we went full force."



Early Valley-Wide doctors, from left: Robert Linden, Mike Firth, Allen Ramsey, Don Jacobs and Ricardo Velasquez, all National Health Service Corps, late 1970s

Salazar obtained a low-interest loan to pay for construction of the Cesar Chavez Family Medical Center – also located in the town of Center – to bring health care to migrant farm workers and their families.

"The United Farm Workers, the lettuce workers, organized in Center in the mid-1970s, so Cesar Chavez had a history here in the San Luis Valley. Migrant health has always been a big piece of what we do," Salazar said.

The ties between migrant workers and Colorado's burgeoning community health center movement first took hold in the 1970s. One of CCHN's founders, Chuck Stout, worked for the state's migrant health program at that time. And in 1977, Clinica Campesina was launched in



The building today in which Valley-Wide started in 1978, Alamosa

Twenty-three years ago, Linda Tope stopped seeing the world and, just as sadly, stopped painting the rich Colorado landscape splashed outside her back door. Diabetes had stolen her eyesight. Soon, it would claim her kidneys.

That's a lot of loss.

But she and her family did hang on to something critical – their home near Dove Creek in southwestern Colorado. The community health center three miles from their house gave the Topes the freedom to stay put.

"Without them, we wouldn't be able to live here," Tope says.

When Tope went blind in her mid 20s, clinicians at Dove Creek helped her gain referrals to nephrology and bone specialists in Grand Junction, Durango and Farmington, New Mexico. And when it came time to find her a new kidney, the local health center put her in touch with a transplant surgeon in Albuquerque.

After the operation, Tope returned home and visited the Dove Creek Community Health Clinic every day for lab work to track how her body was handling the anti-rejection medicines.

"If not for that, we would have had to move to Denver or somewhere," she says.

Tope's blindness, her increasingly brittle bones and her bouts of insulin shock forced her husband, Jerry, to find a series of part-time jobs so he could spend more hours at

home near his wife. He repaired computers, drove a school bus, and worked at a local low-frequency TV station. His shorter hours further drained the family's finances. And not surprisingly, Jerry Tope began suffering stress-related symptoms.

Again, the Dove Creek facility was the answer, offering the Topes a sliding fee scale so they could afford treatment and buy cheaper prescriptions.

"As a result of her more-than-enormous medical expenses, and not having any insurance to start with, I could never afford insurance in my own right," Jerry Tope says. "If it hadn't been for the clinic, I don't know how we would have made it."

Today, Linda Tope is on a transplant waiting list again. She needs another kidney and a pancreas. But she remains hopeful that a donor will be found soon.

Instead of painting, she now plays the flute. She also bakes bread to sell in Dove Creek to help cover her medical costs. And she still remembers the last painting she ever created.

"It was for the doctor who delivered our second boy," she says. "It was a water color of his home that he built, and the flowers his wife had planted, on the side of a mountain in Durango."

Tope gave that doctor her final creation for a good reason. He personally donated some of the blood she needed during her kidney transplant.



Linda and Jerry Tope, 2006

Clinica Campesina was launched in Lafayette by migrant activist Alicia Sanchez.

In Greeley, Sunrise Community Health Center opened in 1973 when local residents and doctors raised money and recruited volunteers to start a health facility for migrant workers, many of whom were Spanish speaking. A few years later, Sunrise hired dentist Kent Day to run a two-chair oral health facility then housed in a trailer in Gil, Colorado.

"We saw a lot of migrant work-



Sunrise dentist Kent Day, 2006

ers in those days, people who were going back and forth from Texas working the crops in different seasons," said Day, who still works as a Sunrise dentist. "In those early days, we saw a lot of kids. Many had never been to the dentist before."

These days, Day continues to treat a large number of Spanish-speaking families – folks who have settled in or near Greeley and earn money in service jobs. But the dental work is similar to what Day saw in the 1970s.

"Acute toothaches, infections, things that indicate these folks have

not had access to dental care," Day said. "We want to get them in the

eventually left that job and entered medical school.

"Acute toothaches, infections, things that indicate these folks have not had access to dental care. We want to get them in the habit of coming back to see me." - Kent Day

habit of coming back to see me."

The community health center with perhaps the oldest ties to migrant health in the nation is the Salud Family Health Centers, headquartered in Fort Lupton. That network began as a single site in a converted onion warehouse in 1970, mainly meeting the health care needs of farm workers and their families in north central Colorado.

Salud's associate medical director,

Dr. Virgilio Licona, is himself deeply connected to history of migrant workers in America. A self-described former "Chicano radical" with an arrest record for protesting, Licona helped launch and then ran the community health facility in Rocky Ford in 1973. But he became so frustrated with his inability to attract doctors to the remote farming town, he

"I went into medicine for political reasons," Licona said. "The civil rights movement has always been a guiding force in my life. But I think I've changed. I've evolved. We all have. The way we dress is different, the vocabulary we use, the level of sophistication."

"What isn't different, however, is our commitment to serve the people we care for, the empathy we provide, yet still pushing the movement."

For Licona, some of that work goes on behind closed doors in the exam room.

"One of the things I'm doing individually is really pushing my patients to become bilingual. I don't want to coddle people who have been here 10 years and refuse to learn the language. The reason I don't is because the anti-immigration movement is not anti-immi-



Jerry Brasher, Salud's executive director, left, and Dr. Virgilio Licona, Fort Lupton, 2006

grant, it's anti-Mexican."

"If you can't understand what's being said

about you
on the streets
or on TV or in
the newspaper,
how are you going
to defend yourself?" Licona
asked.

"We have to be more responsible
as individuals. In that sense, it's a
very different me."

A generation ago, CCHN was built on the spirit of charity – the free-spirited sharing of ideas, expertise and time by a small group of health center directors.

Across the movement today, those themes still flourish.

In Greeley, CCHN founder Mike Bloom and Mitzi Moran, president and CEO of Sunrise Community Health Center, have joined with other local health care providers to fill widening gaps in patient care. They have formed a rare alliance, borrowing a piece of the blueprint that helped launch CCHN 25 years ago. Another slice of CCHN nostalgia: Some of the rudimentary plans

even were drawn up on napkins at a martini bar.

"We've all had too much demand, not enough supply," said Moran. "Whether you are talking about Sunrise, the mental health agencies,

"We could have all gone, 'Wow! Crisis! Panic!' Instead, we said, 'Maybe we have an opportunity here.'" - Mitzi Moran

the health departments or the people hitting the emergency room without insurance, community-wide the demand is growing faster than we've been able to keep up."

"We could have gone, 'Wow! Crisis! Panic!' Instead, we said, 'Maybe we have an opportunity here.'"

With Bloom and Moran in the lead, many of those players came to the table to take stock of the situation. They performed a community-wide needs assessment – an across-the-board audit of available space and equipment, of provid-

ers and paying patients in northern Colorado. They opened up about their strengths – and their weaknesses in areas like primary medical and dental care, mental health and substance abuse counseling, staff development and outreach services.

"We asked each other, 'How many exam rooms do you have? How many providers? How do you fund them? How does it really work?' " Moran said. "We saw one entity over here had capacity that we don't. Or that another had resources that we don't. Or that this one has x-ray, this one has an onsite lab, this one a pharmacy."

"We said, 'OK, how can we do this better?'" Moran said. "Then we developed the North Colorado Health Alliance." Bloom is CEO of this new nonprofit group.

From hospitals to clinics, all the partners remain independently operated with their own budgets and own boards of directors. But within the alliance, subcommittees

He remembers planting the onions and harvesting the cucumbers at the age of 9.

He remembers weeding the beans and thinning the beets with his mom and dad and eight siblings working the green rows close by.

Mostly, though, Francisco Gonzalez remembers the night his brother, Jaime, went to the hospital in Greeley with a fever. Jaime was 4 years old. His family had no medical insurance. And because of that, no doctors would look their way for hours.

"He wouldn't be seen. He wouldn't be seen. Finally," Gonzalez recalls, "he was seen. But the end result was terrible, because he ended up with some chronic back issues. They lasted for three or four months. My parents were not happy."

That was the last time the Gonzalez family went to the local hospital for any care. After that, they all came to the Sunrise Family Health Center for checkups, immunizations,

the flu, sprains or strains. And they have been going there ever since.

Today, Gonzalez' parents are still Sunrise patients at the Greeley clinic. Gonzalez is a board member there, scrutinizing the care that others get.

"I want people treated like how I want my parents treated," said Gonzalez, who today works in the finance industry. "My family moved here from Mexico for the same reasons as a lot of our patients here – for the agricultural work, to live the American dream, not to be a distraction. Ninety percent of the people who come here from Mexico are trying to make a better life for their family. And it's not easy. We were able to succeed at that. We were very lucky."

"Now," Gonzalez said, "I do anything I can do to help other people, to give an opportunity so that the next family can be successful."

were formed to patch specific flaws in the local safety net by expanding primary and mental health care and sharing support services, outreach and case management.

The results already are tangible. Sunrise and the Weld County Department of Public Health and Environment came together to start an integrated electronic health record system – one patient, one chart, no matter where they go for care. It cuts out duplicate immunizations or unnecessary and expensive tests for illnesses already diagnosed within the system. Alone, neither agency could have afforded an electronic health record program. Together, they secured a grant from the U.S. Bureau of Primary Health Care.

Sunrise and McKee Medical Center also partnered to expand a community health center in Loveland. The hospital, its foundation and some local donors contributed \$6.9 million to build and renovate the facility while Sunrise put in \$14.3 million for operations spanning 10 years.

"We went from one clinician and two support staff there to now 49 staff members serving 6,452 patients," Moran said. "The point is, over the course of nine or 10 years, that initial \$6.9 investment would have built and funded a three-doctor clinic – instead of the 49-clinician center we now have. And our money alone wouldn't have ended in this. It took the coming together to get the better result."

Meanwhile, another old CCHN principle continues to propel the Peak Vista Community Health Centers in Colorado Springs: volunteerism.

In 1971, volunteer staffers from the Pikes Peak Action Agency decided to form a free clinic to help bring medical care to people in the area who had no health insurance and who couldn't afford to see a doctor. They loaned some employees and put

together exam space in two tiny rooms on South Wasatch Street. A few local physicians volunteered their time two nights a week.

"It was

so small, they didn't even have the whole address," said B.J. Scott, the current president and CEO of Peak Vista. "It was 722 and ½ S. Wasatch."

"It started as a free clinic – a total volunteer effort. And today, we still have a very rich professional volunteer base. We have over 100 specialty docs (in private practice) that volunteer to see our patients. We have never had a problem with a specialty referral."

Those specialists agree to see Peak Vista patients in their own offices or they come to Peak Vista to donate their time, Scott said. The medicine they offer ranges from psychiatry

and neurology to cardiology, gastroenterology, nephrology, oncology, urology and podiatry.

"Literally," Scott said, "it's head to toe."

Pete Leibig, President and CEO of Clinica Campesina, swiveled his chair to the right and gazed at the map tacked to the wall behind his desk.

With shaded swaths and dark borders, the map of Clinica Campesina's service area more resembled a war-time battle plan. And sometimes, Leibig fears he is losing that war.

In 2000, Clinica Campesina's service area in Lafayette and neighborhoods northwest of Denver included 62,000 people whose family income

"Even with doubling our capacity, the need grew away from us faster than we grew."
- Pete Leibig

was 200 percent below federal poverty guidelines. The health center's capacity at the time was 12,000 people a year – a gap of 50,000 folks in need.

Today, after adding new clinics and hiring new clinicians, Clinica can care for 25,000 people a year. But the health center's service area now contains 92,000 people living 200 percent below

the poverty line – a gap of 67,000 people. “Even with doubling our capacity, the need grew away from us faster than we grew,” said Leibig, president and CEO of Clinica Campesina, where more than half of the patients are uninsured. “Pretty discouraging stuff.”

There are hard reasons. In the most simplistic terms, America’s rich are getting richer, the poor are getting poorer. Look closer at the ledger and you’ll see that Clinica’s service area is gaining more people who have taken lower-paying service jobs – for employers who can’t afford to supply health insurance.

That dynamic can be seen from border to border in Colorado, where 770,000 people live without medical insurance. The average health insurance premiums have jumped by more than 45 percent since 2000. At the same time, real earnings for Colorado residents have grown at a rate of less than 15 percent.

The crisis is no less true in rural areas. In Lamar, home of the High Plains Community Health Center, there were 10,236 medical and dental

visits in 1997. Last year, there were about 28,000 visits. One-third of the patients are uninsured.

The population in southeastern Colorado is stagnant, “but we continue to see about 100 new patients

see their doctors even quicker when they call in. Two other cornerstones of the plan are better treatment – including preventive medicine – and to ultimately serve more people in each community.

In Lamar, Brooke and his staff have spent three years studying “patient-visit redesign” ideas in California, recently implementing measures like same-day appointments.

“We have a ‘sick call’ for kids under 18, a walk-in clinic for parents who have been up all

night,” Brooke said. “They can come first thing in the morning, from 8 to 9. And we keep other appointments

unfilled so people can come in same day for pap smears or other preventive things.”

“We have worked on efficiency in terms of staying on schedule, getting people in and out. We keep our average

walk-in-the-door, walk-out-the-door time at about 30 minutes. It’s really out-of-the-box thinking, not how traditional clinics operate.”

At People’s Clinic in Boulder, simi-

In Lafayette

Clinica has soaring caseload

By DAVE HALBROOK
Times-Call Staff Writer

LAFAYETTE — Fatigued, overworked staff and soaring caseloads have triggered major expansion plans at Clinica Campesina. In the next year, the Lafayette clinic for low-income patients will be forced to hire another full-time physician and substantially expand its office and medical facilities.

“Our staff is totally overamped,” said Pete Leibig, executive director of Clinica. “It’s just a matter of time before the rod flies through the engine.”

Since 1987,

when Leibig took over the reins at



Article in Longmont Daily Times-Call, July 29, 1990

every month who we have never seen before,” said Jay Brooke, executive director of High Plains.



From left: Dr. Mark Olson; Robyn Horner, director of nursing, and former executive director Brenda Higgins, Plains Medical Center, Limon, 2006

The rising need gap has spurred community health centers across Colorado to invent new methods of providing care. Those include refined appointment systems so patients can

lar streamlining has slashed appointment lag times from an average of 24 days to less than three days from the point at which patients call. The health center also has set up patient "panels," grouping people with assigned doctors. Today, when patients come in, they see their personal physician 84 percent of the time.

"It was thought before that the best way, the most effective use of time, was when you came in you saw the first doc available. That's not true," said Lois Lacroix, a patient and board member at People's Clinic.

"It turns out you can do more clinic visits if you have an assigned doctor because the doctor knows you, doesn't have to ask a lot of questions and learn all about you again and again," Lacroix said. "Also, the patient is more forthcoming with information with a familiar doctor."

At People's Clinic, patients come in an average of 35 times a year, but the tighter system is expected to reduce that number, freeing up space and exam time, allowing the health center to see even more people in the community. So far, the strategy is working. In June and July of 2006, People's Clinic saw six percent more patients than it did during those same months in 2005. In August, overall visits were up by 11 percent over 2005. In September and October, patient visits rose nine and 20 percent respectively compared to 2005.

In Lafayette – where Leibig has been fighting the growing needs gap – Clinica Campesina is evolving into a national model for its efficient in-

novations. Patient self-management has shifted some of the responsibility for care from the clinicians to the people.

"You can do more to improve your health status than we can," Leibig said. "We spend a lot of time helping people set goals for themselves – like diet and exercise – and then tracking those goals with them."

As part of that, the health center has added group visits, for example, inviting nine diabetic patients to come in and talk about their illness together, educate each other, take cooking classes, and cheer each other on.

"They actually give each other more grief over their foot care than the clinicians do," Leibig said.

And under this drive for maximum efficiency, Clinica Campesina is now coated in new colors. The health center has set up pods of medical clinicians, case managers, nurses, medical assistants and social workers with whom each patient works. Each pod is color-coded.

"So when you come in, you always see the same person at the front desk and you have your team," Leibig said.

"For example, we have the red team, the red pod. The wall of the pod is red, the charts are red, the appointment card is red, the people who are the red pod people know they are the red pod people. And when patients come in for an appointment, they go to the red pod and get served by the red pod cli-

cians."

The ideas – colorful and novel – are helping health centers across Colorado pull in more patients. But in some places, the lines remain long. Places like Stout Street Clinic in Denver, a CCHN member that serves homeless people.

"The number of homeless people just keeps going up in concert with the number of uninsured," said Dr.

"We spend a lot of time helping people set goals for themselves – like diet and exercise – and then tracking those goals with them." - Pete Leibig

Ed Farrell, medical director at Stout Street Clinic.

According to a 2005 survey by the Colorado Division of Housing, there are 12,000 homeless people in Colorado, some scraping by in rural towns and remote areas. Survey takers believe that number is probably even higher because the count didn't touch people in the most secluded nooks or many women in domestic violence shelters. When the last statewide survey was conducted, advocates counted 3,637 homeless people in Colorado.

On a recent winter morning, people already were lined up from the front counter to the front door at 8 a.m. The chilly outside air wafted off their bodies as they waited to see Farrell. Their

illnesses typically range from acute infections to more chronic disorders – asthma, hypertension, diabetes, coronary artery disease, congestive heart failure, renal failure and an array of complex mental health problems like schizophrenia and bipolar disorder.

"It really does feel to me that we are seeing ever sicker people than previously," said Farrell who began working at Stout Street Clinic in 1994. "The lives of homeless people are unspeakably hard and everything is getting worse for them in terms of access to livable wages, housing, and disability benefits."

"But I'm just truly inspired every day by these people. Despite all of this, they have upbeat attitudes and hope for the future, and kindness and caring and love and dignity for their fellow people in the moment. And if people who are coming through the door here can do that," Farrell said, "then we darn well better do that."

When Annette Kowal was 11 and growing up in New Mexico, her father suggested an after-school job: Go work in the chili fields near their home on the Mexican border.

Most days, Kowal was the only English-speaking woman plucking pods in the 110-degree temperatures. For 10 summers, she toiled happily under the sun.

"At the time, I never would have

thought that shaped me in any way," said Kowal, who joined CCHN in 1996, serving as its chief executive officer.

For starters, Kowal doesn't fear the heat – politically, or otherwise.

Today, CCHN has entered its third and most important era as a leader on the Colorado health care landscape. The modern CCHN is rooted in service delivery, powered by smart business sensibilities, and the network continues to develop its own potent brand of political muscle on the state and local level.

"Annette coming in was, symbolically and actually, a statement that we are going to be a professional organization," said CCHN founder Mike Bloom.

And that truly bloomed under Amendment 35, which evolved into a centerpiece of CCHN's long commitment to the medically uninsured and underserved people in Colorado.

In the late 1990s, Kowal began to see an opportunity for CCHN around the tobacco settlement dollars. According to Bloom, Kowal helped "stimulate the thinking" that the organization could tap those funds for Colorado's community health center patients. And after CCHN accomplished that task, it caused the entire organization to set its goals even higher.

"That threw us really into the political arena," Bloom said. "It moved us from very informal contacts with our legislators and a very narrow agenda – usually around something to do with Medicaid – to a place where we will set an agenda with

objectives to create something even bigger."

"It gave us hope and optimism," Kowal agreed.

Bigger things indeed were coming.

"At that time, through some of the boards I was sitting on, I knew there was a small group of tobacco control people who were looking potentially at running a tobacco tax bill in this state," Kowal said. "I basically came back to the office and said, 'We're going to get a spot at that table.' "

The designers of Amendment 35 aimed to increase the tax on cigarettes by 64 cents per pack and boost the tax on other tobacco products by 20 to 40 percent of the price. The measure would be taken to the voters in November 2004 and was expected to generate about \$172 million a year.

Well before that, Kowal sealed her seat at the Amendment 35 planning table by committing that CCHN would help pay for a statewide opinion poll on a potential tobacco tax. The price for that survey was \$30,000; CCHN contributed \$5,000 to \$6,000.

"Now, we were part of the process," Kowal said. "And, of course, the proposal we brought forward was to fund health centers. But with 50 or 60 people around the table – some of them very powerful docs and providers – it was like, who knows what we're going to get?"

"But I was a persistent little bulldog. And consensus-wise, everybody supported our proposal. The voters passed Amendment 35 and it was written into our state constitution."

the Amendment 35 proceeds that went into the Primary Care Fund. This fund will bring an estimated \$29 million annually to community health centers. The money sparked a variety of health initiatives to improve health care for some of the state's poorest people, and to welcome more folks into the community health center safety net.

At Valley-Wide in Alamosa, directors invested some of the money into a 36-foot RV that will serve as a mobile health and dental facility for San Luis Valley schools, Head Start programs, migrant workers and community corrections sites.

At several community health centers, including Plains Medical Center in Limon, the money will pay for electronic health record systems – perfect for a provider serving a scattered population of patients who may show up at any one of four clinics spread across five counties.

Amendment 35 dollars also sparked several brick-and-mortar projects designed to grow the community health center patient base. At Clinica Campesina, which has a waiting list numbering about 2,000 people, there are plans to hire two medical clinicians and two more dentists while expanding facilities in Westminster and Thornton.

Mountain Family Health Centers, based in Glenwood Springs, spent some of the tobacco tax money it received on a new electronic health record program.

But Mountain Family executive director David Adamson plans to use

most of the Amendment 35 revenues in his coffers to expand services into Rifle during the next two years.

Mountain Family must grow to keep up with the rising population near Glenwood Springs – growth partly fueled by immigrants from Mexico, many of them undocumented workers. That surge has put Mountain Family on the front line of a thorny public topic. Adamson, who says he “won’t hide from the issue,” has installed a culturally sensitive staff complete with bilingual clinicians.

“But both for humane reasons and for economic reasons of keeping people healthy and productive, it makes sense that people get access to health care.”

- David Adamson

“The reason I’m vocal about it is kind of a no-brainer. If you have people in the community, whether they are here legally or not, is not our issue. That’s an INS issue,” Adamson said. “They live in the community, they work with us, go to our churches, go to our schools.”

“But both for humane reasons and for economic reasons of keeping people healthy and productive, it makes sense that people get access to health care,” Adamson said.

“Because the thing you’ve got to realize is, if anybody gets really sick

and goes to emergency room, they are going to get taken care of. And that is at everybody’s cost.”

A quarter century after a series of Friday night chats between friends sparked a statewide movement, CCHN continues to boost access to quality health care for working families and people in need across the state.

From the Eastern Plains to the Four Corners, clients are drawn to the good medicine practiced by CCHN’s 15 member community

health centers. At 118 community, migrant, homeless, and school-based health centers, Colorado health centers care for one in 12 Coloradans and serve as the health care home for 44 percent of the state’s low-income, uninsured, 33 percent of all Medicaid recipients, and 31 percent of all kids enrolled in the Child Health Plan Plus (CHP+).

This “good medicine” includes ground-breaking prenatal care, a children’s dental initiative and an innovative working partnership between chronically ill patients and clinician teams for management of diabetes, asthma, depression and other long-term conditions. ■

The CCHN model envisioned by its founders 25 years ago has spawned a litany of success stories:

- Community health centers in Colorado meet or exceed national up-to-date rates for childhood immunizations. Low-birth-weight rates for health center patients are better than the state average.
- By emphasizing preventive care, community health centers are helping keep people out of the ER and saving money. In communities with community health centers, emergency room usage rates for Medicaid and uninsured patients are lower than in communities without community health centers.
- Lawmakers and leaders are paying close attention. One of the most enthusiastic backers of community health centers is President George W. Bush, who made expanding America's community health system a national priority. Since his arrival at the White House, the number of community health centers receiving federal health care grants has grown from about 700 to 950, while the number of patients those facilities serve each year has risen from 38 million to more than 55 million.
- A 2005 study published in the journal *Health Affairs* found that medical quality continued to improve at community health centers even as they treated a higher number of chronically ill, near-elderly and uninsured patients. At the same time, researchers found no health disparities when they examined ethnicity or insurance status in the delivery of that medicine.

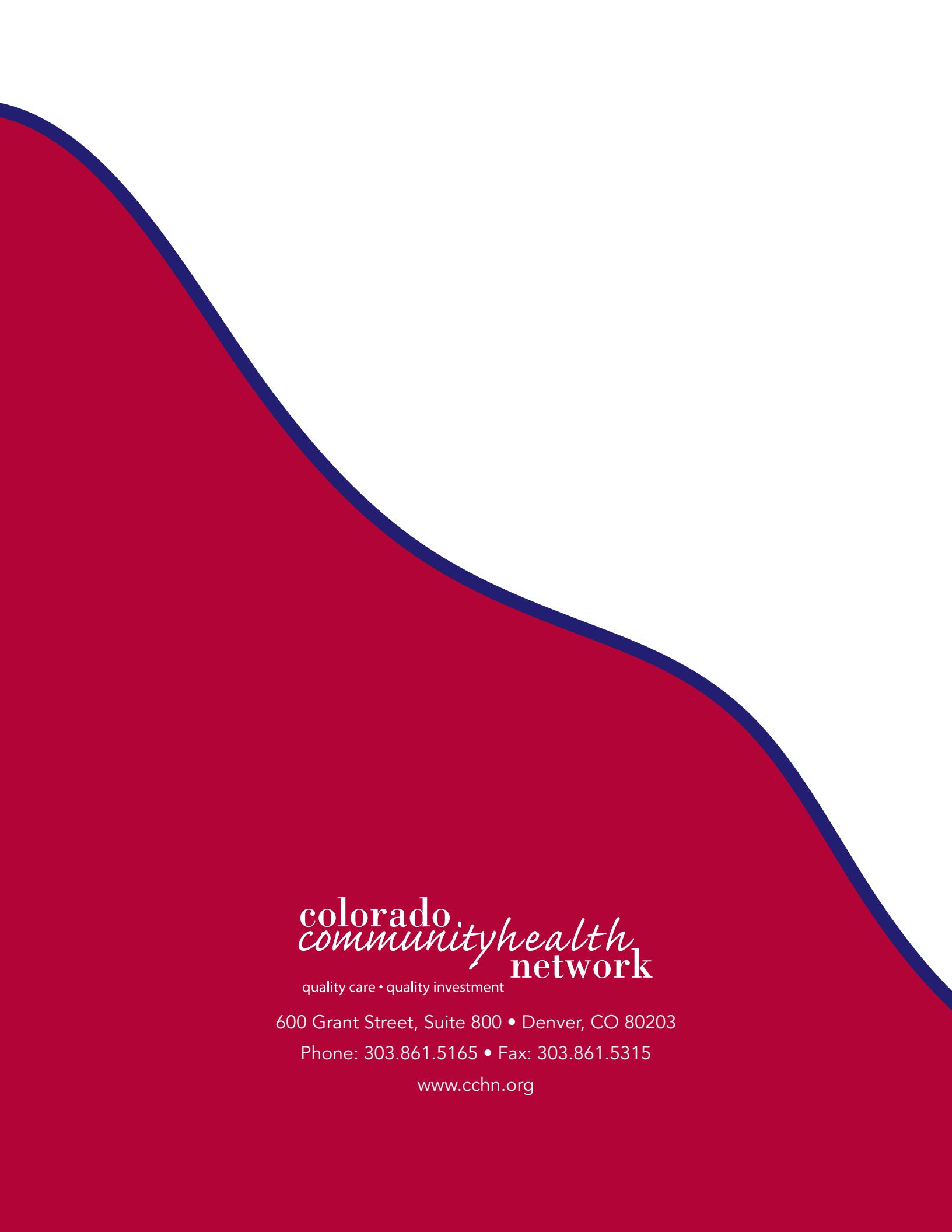
These proven results have allowed Colorado's community health centers to set an example for the entire health care system. Patient-visit redesigns allow people to see their doctors sooner after calling for an appointment. An emphasis on cultural sensitivity and family-friendly care are helping attract and retain more patients, leading to better management of their long-term health. With these innovations and a sliding fee scale that keeps care affordable, CHCs provided 1.59 million patient visits in 2005. Indeed, the central philosophy at community health centers in Colorado isn't simply "do more with less." It is: "do better with less."

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