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The Johnson City Community Health Center: A Qualitative Analysis of the Center's Strengths, Weaknesses, Opportunities, and Threats in Johnson City, Tennessee

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Thesis submitted in partial fulfillment of Honors

By

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Abstract

The Johnson City Community Health Center is one of over 1200 community health centers serving over 22 million patients across the United States. Community health centers primarily serve patients with low income or without health insurance, but most serve all the members of their communities. These centers provide many services and treat health problems in a holistic manner in order to improve the health of their communities and also allow the members of those communities to progress. The Johnson City Community Health Center is compared to successful CHCs from across the nation to determine if it has characteristics to be successful in this community. A SWOT Analysis is conducted by evaluating the Marketing Mix, or the Product, Price, Placement, and Promotion, of the center and also by examining the Political, Economic, Social, and Technological environments it operates in. This research determines the internal Strengths and Weaknesses and external Opportunities and Threats of the Johnson City Community Health Center and concludes that it does have the characteristics needed to be successful in the community. This research can be used by center management to improve services, but it can also be used by other researchers to continue evaluations of community health centers across the nation.

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Chapter 1

Research Objective

The Johnson City Community Health Center (JCCHC) is a Federally Qualified Health Center (FQHC) located on 2151 Century Lane, Johnson City, Tennessee. It is administrated by the College of Nursing of East Tennessee State University. Formerly known as the Downtown Clinic, this healthcare facility has focused on providing “exceptional, individualized care for all” no matter a person’s income status (“Johnson City Community Health Center”). The JCCHC has increased its services rapidly and has been trying to increase the amount of patients it serves. The center would like to keep serving its primary population, the underserved and uninsured, but would like to know if it has the potential to become competitive in the broader environment of Johnson City and to serve a broader patient pool.

Therefore, the objective of this research is to create one of the most prominent tools within marketing, a SWOT Analysis. Analyzing the center’s internal Strength and Weakness and the external Opportunities and Threats and comparing them to other community health centers will aid the Johnson City Community Center in determining its current position and competitive potential in Johnson City, Tennessee. Afterwards, executives at the center can use the information to determine competitive strategies.

Literature Review

In order to determine how successful and competitive a community health center (CHC) can be, it is crucial to look at community health centers from across the United States that have become successful and to understand the history of them as a whole. The source of literature which contributes the most to this research is Bonnie Lefkowitz’s 2007 book, *Community Health Centers: A Movement and the People Who Made It Happen*. Bonnie Lefkowitz is “a writer and a consultant working on socioeconomic status and health, health care for low income and minority populations, community health issues and the determinants of health policy" and has worked for the U.S. Department of Health and Human Services (Consultants, 2014). This book demonstrates the history of the community health centers since their creation in the 1960s due to the Civil Rights Movement and President Lyndon B. Johnson's War on Poverty. Lefkowitz explains the struggles different centers from five different parts of the country had to endure and what each of them did to survive and become successful.

Community health centers were meant, and are still meant, to serve the community where they are located and more specifically the underserved, low-income populations. The original model of community health centers

> "featured personal health care from teams of physicians and other health professionals, often assigned to follow specific families; convenient locations and a focus on the community to be served; outreach, child care, and transportation to help the severely deprived patients use the services; attention to the economic and environmental factors that contribute to ill health; and involvement of the patients themselves in how the programs were set up and run" (Lefkowitz, 2007).

The different centers, Delta Health Center in Mississippi, Geiger Gibson Community Health Center (formerly Columbia Point) and East Boston Neighborhood Health Center in Boston, Beaufort-Jasper-Hampton Comprehensive Health Services in South Carolina, William F. Ryan

Community Health Center and its associated centers in New York, and Su Clinica Familiar in Texas, all had various challenges but were based on the same model.

Along with this book, scholastic studies, marketing and management textbooks, news articles, government information and statistics, various business statistics and research, and press releases contribute to the literature of this study. Since the community health centers have changed over time due to governmental policies, culture, expansion, management changes, and most importantly the changing needs of the communities they serve, the literature mentioned will be used to assess them and the Johnson City Community Health Center and to understand their current positions.

Introduction to Community Health Centers

The following section will give a brief history of community health centers. It is crucial to understand the past because it will give insight on the purpose of community health centers. Moreover, companies must know the struggle and challenges from the past in order to adapt and face similar, future challenges if they arise again.

The Birth of Community Health Centers

The concept of community health centers was originally developed in South Africa in 1942 by doctors Sidney and Emily Kark, who "recognized that poverty played a key role in the health problems," so they "expanded their medical work to include improving housing, sanitation, and access to food" and established the Pholela Health Center (*A Model for the World*). Soon, Jack Geiger, a student at Western Reserve Medical School, decided to do some clinical rotations alongside the Karks at their site, where he "was hooked" instantly (Lefkowitz, 2007).

Later in 1965, Geiger, working with the Medical Committee for Human Rights, along with Dr. Count Gibson, chair of the Preventative and Community Medicine Department at the Tufts Medical School, were the two men who made the concept of community health centers in the United States possible (Lefkowitz, 2007). After talking to Lee Schorr, a worker transitioning into the Office of Economic Opportunity, they were to schedule a meeting with Dr. Sanford Kravitzs, the director of the Community Action Research and Demonstration Programs at the OEO. With a budget of $125 million dollars at his disposal, he helped them set up the first community health centers (*Dr. Sanford Kravitz*, 2004).

Geiger and Gibson were able to secure $1.3 million dollars to help set up the first two community health centers. The first was built in "Columbia Point, an isolated and troubled housing project in South Boston where tufts had been operating a home health program" (Lefkowitz, 2007). The other, the Tufts-Delta Health Center, was located in Mound Bayou, Bolivar County, Mississippi, in an area that had "a black hospital in desperate need of financial and professional support,…a black power structure interested in a health center,…[and] the surrounding area offered good potential for community support" (Lefkowitz, 2007).

Many other projects that gave medical care to the lower income population had been started across the nation, but in order to get more federal support for CHCs, Schorr, under Kravitz authorization, secured a visit from Senator Ted Kennedy to the Columbia Point Community Health Center. Kennedy later became a big proponent for community health centers. Senator Kennedy's leadership in Congress allowed the community health centers to receive separate funding of $51 million in 1967 and by allowing them to be independent from "administrative decisions, the centers had a life of their own." (Lefkowitz, 2007)

Changes in Government Equal Changes for Community Health Centers

The idea for community health centers in the U.S. was conceived under Lyndon B. Johnson's administration and his War on Poverty. His administration was fertile ground on which these centers could take strong root. However, community health centers have had to prove themselves and stand firm time after time with different administrations, some of them more supportive then others.

The OEO's first director, Sargent Shriver, created the Office of Health Affairs (OHA) in order to "coordinate OEO's health efforts," which included the health centers (Lefkowitz, 2007). Towards the ends of Johnson's term in office, all the health programs under the OEO were gathered into OHA.

Another administrative agency, the Department of Health, Education, and Welfare (HEW), which was established well before the Johnson administration, began to create community health centers of their own. However, these centers were administered by personnel who were "uncomfortable with the provision of comprehensive care [used by the centers run by OEO, and] favoring 'categorical,' or disease specific, education and screening programs run by state and local health departments" (Lefkowitz, 2007). Like the community health centers from OEO, these centers had to have grantees, such as community development agencies, hospitals, or educational institutions.

Between OEO and HEW, a total of 150 community health centers existed in 1971. The majority of them were under the control of the OEO; the office, though, was now under threat of the new Nixon administration. Donald Rumsfeld, a man supporting the OEO, was appointed director of the office. He tried to convince President Richard Nixon to expand community health centers, but Nixon decided for Health Maintenance Organizations (HMOs). Afterwards, Rumsfeld began changing the control of most health center from OEO to HEW. (Lefkowitz, 20007)

Within Nixon's two terms, the OEO was downsized into becoming the Community Services Agency. Then in 1972, HEW determined that health centers no longer needed federal funding because "centers could collect reimbursements from Medicare, Medicaid, and private insurers and becoming self-sufficient" (Lefkowitz, 2007). Once more Senator Kennedy, the head of health for the Senate's Labor and Public Welfare Committee, along with Representative Paul Rogers, the chair for the House subcommittee of health, came to the aid of the centers. The Senate's General Accounting Office investigated HEW's determination and concluded that it was not practical. A major point which helped come to this conclusion is "Medicaid was then and remains today a federal-state program allowing states to set many of the parameters, including payment rates, eligibility, and some covered services" (Lefkowitz, 2007). In other words, eligibility of people covered, services covered, and the amount of coverage could vary among states, leaving many people still uncovered. Hence, the need for community health centers. (Lefkowitz, 2007)

A bill strengthening the centers was then proposed by Senator Ted Kennedy. It "gave the program its own section in the Public Health Act, delineated required and optional services, and mandated that all centers have a consumer majority governing board" (Lefkowitz, 2007). This last portion greatly reinforced the fact that the community had to have involvement of the actions of the centers, a concept those centers whose grantees were hospitals, universities, or other state institutions struggled to grasp.

Unfortunately, even after Nixon's resignation, Gerald Ford continued his downsizing of health centers and vetoed the bill twice, but Congress overrode the veto in 1975. Then Ford, by appointing Ed Martin to lead “HEW’s Bureau of Community Health Services, where the centers where administered,” gained more control of the centers (Lefkowitz, 2007). Martin implemented measures and systems, some of which are still used, requiring community health centers to report finances, performance and service numbers, and staff information in order to check their efficiency and effectiveness in their communities. He also increased the number of centers operating in the nation, reaching 872 by 1980, but did not increase funding for them. Finally, the centers’ institutional overseers, their grantees, were cutting back non-medical services from the centers. (Lefkowitz, 2007)

Later, HEW, who now was controlling all the centers, saw changes once President Jimmy Carter took office. Two major decisions President Carter took were to increase funding for community health centers and assign Joe Califano as HEW secretary. Califano “had served as Lyndon Johnson’s domestic policy advisor and was sympathetic to at least some War on Poverty programs” (Lefkowitz, 2007). Califiano, after knowing a family member used the services of a community health center, used his position to put together a team from across the nation to help promote and aid community health centers. Under Carter’s administration, community health centers worked with Farmers Home Administration to renew rural centers. (Lefkowitz, 2007)

Later in 1977, the Rural Health Clinic Services Act was “enacted to address an inadequate supply of physicians serving Medicare patients in rural areas and to increase the utilization of non-physician practitioners such as nurse practitioners (NP) and physician assistants (PA) in rural areas” (*Rural Health Clinic*). This act increased the reimbursement amount of Medicare and Medicaid to the sites. Finally, centers with medical hospitals as their grantees once more lost a battle of governance allowing the community members to keep control of center governing boards instead of relinquishing it to the hospital members and their boards. (Lefkowitz, 2007)

Yet, the CHCs faced threats once more during the Reagan era. Ronald Reagan took a more conservative approach to healthcare and was determined to reduce the community health centers fearing “that these programs were stalking horses for a nationalized healthcare system” (Lefkowitz, 2007). HEW had been transformed into the Department of Health and Human Services in 1980 after the “Department of Education Organization Act was signed into law, providing for a separate Department of Education” (*Historical Highlights*, 2006).

With this being done, Reagan cut 25 percent of center funding and proposed a block grant for health services that include health centers. The block grant was a huge threat for centers because it had been proven that programs receiving block grants were less likely to get funding increases in the future. Furthermore, the block grants would be given directly to states to manage. This would have been detrimental since they would not know how to appropriate funds causing them to use them in other areas not intended for health care and away from the poorer communities. (Lefkowitz, 2007)

Congress decided on a compromise in which states would apply for the block grant but “had to maintain current funding levels for existing grantees and ensure that they continued to meet all federal requirements” (Lefkowitz, 2007). Reagan’s administration did not honor this compromise and imposed the original proposed block grant, resulting in the community health centers going to court opposing the measure. Attorney Jacqueline Leifer took the case on behalf of the community health centers after West Virginia took the block grant; a state had to accept the block grant and studied before the judge presiding over the case, June Green, would allow the case to proceed. It was concluded that the health care services and the families utilizing them would suffer from the block grant. Afterwards, West Virginia gave back the grant when they realized their residents were missing the opportunity of receiving more funding from the federal government by having the block grant. (Lefkowitz, 2007)

Due to this, Reagan's further efforts to reduce funding or alter the structure of community health centers through Congress were fruitless. Therefore the administration focused on individual performance of centers and deemed necessary to close 187 of them and cut funding for others. Soon, the community health centers expanded once more. They also "began to network; form alliance; come together in new, more equal partnerships with hospitals; and provide the management of care outside their walls so important to continuity." This expansion continued to the George H.W. Bush's years in office. (Lefkowitz, 2007)

Under the Bush administration, money allocated to the centers reached $150 million and they were established to receive cost-based payments from Medicaid and Medicare as Federally Qualified Health Centers (FQHCs). Furthermore, the Drug Pricing Program (340B) was implemented by Congress and it required "pharmaceutical manufacturers to sell medicines to health centers and other safety net providers at deeply discounted rates," allowing the 6 million people served by the centers to benefit from the reduced pricing of medicine. (*1987-1992*, 2011)

Becoming FQHCs and being able to receive almost full reimbursements from Medicaid were the major positive impacts during Bush's administration. On a national average, payments from Medicare surpassed "the federal grants as the largest source of income for the centers." But Bill Clinton's time in office posed challenges once more for community health centers. President Clinton had his own healthcare reform idea, and appointed Ira Magaziner, an academic, to lead a task force and consolidate health care programs into "health alliances," which turned out not to have constitutional powers. Yet, the administration tried to consolidate programs granting money through individual states, but failed due to similarities from the Reagan era. (Lefkowitz, 2007)

Under the Clinton administration, a piece of legislation was proposed that had some benefits for community health centers: the Clinton Health Security Act of 1994. Community health centers were given "the certification of essential community providers" under the bill, and it authorized

> "the Secretary [of Health and Human Services] to make grants and enter into contracts with qualified community health groups to provide enabling services such as transportation, community and patient outreach, patient education, and translation services in order to increase the capacity of individuals to utilize the items and services under title I of this Act." (*H.R. 3600 (103rd): Health Security Act*, 1994)

In other words, these now essential centers would receive funding for activities that weren't necessarily medical services but were needed to promote patient health. However, this bill failed in Congress. Throughout the rest of Clinton's time in office, the health centers had trouble guaranteeing increased funding directly from his administration. It was Congress who increased funding for the centers and by 2001 federal spending on centers reached $1.2 billion (Lefkowitz, 2007).

When President George W. Bush took office, the community health centers had found an ally in him. President Bush "proposed to add 1,200 new and expanding sites and increase the number of people served to sixteen million over the next five year [beginning in 2001], and eventually to double the centers' capacity" (Lefkowitz, 2007). Bush's and Congress's support for the community health centers resulted in a budget total of $1.6 billion for the 2004 fiscal year, and appropriations from the states reached $350 million (*2002-2004*, 2011). Due to deficits and Hurricane Katrina, budget increases were less than the administration had expected. None the less, towards the end of Bush's second term in the White House, the CHC program was twice as big, with over 18 million people being served, a federal budget of over $2 billion, and state funding of $590 million (*2005-2008*, 2011).

Current Position of the Community Health Centers

According to the National Association of Community Health Centers, currently over 1,200 community health centers serve more than 22 million patients from 9,000 communities across the U.S. (*Federal Appropriations*). For the 2014 Fiscal Year, Congress approved the Consolidated Appropriations Act which would give funds to health centers of $3.7 billion, which included "$1.495 billion in discretionary funding and $2.2 billion in mandatory funding originally appropriated by the Affordable Care Act (ACA)" (Farber, 2014). President Barack Obama has been supportive of community health centers, even before taking office, and has appropriated funds since securing the Oval Office, allowing the continued expansion of community health centers.

Chapter 2

Methodology

Research Design

This research, while using secondary, quantified data, is qualitative in nature because it seeks to "provide insights and understanding of the problem setting," which is the Johnson City Community Health Center (Malhotra, 2010). In this research, the JCCHC is being compared to other community health centers. As it is designed, this study, by evaluating the external and internal environments of the center and not specifically the quantitative variables gathered, will lead to a better understanding of the JCCHC but will not determine any conclusive findings. The findings, however, will be used to produce a SWOT analysis which can later be used in a marketing plan by center executives. This analysis will only help explain "the current marketing situation [in which the health center is in] as well as potential threats and opportunities" but alone will not help determine what direction or strategy the center should follow (Armstrong and Kotler, 2012).

Data Collection

Only secondary data collected from diverse sources is used in this research. The collected data is used to evaluate the center itself and compare it to other healthcare institutions. As mentioned, some of the data collected will be quantitative. Some information, such as news articles gathered, will be opinioned based, but it is necessary in order to fully understand community health centers.

Government and financial information on JCCHC and other community health centers is gathered from the U.S. Department of Health and Human Services, the White House, the National Association of Community Health Centers (NACHC), the Tennessee Primary Care

Association (TPCA), and the Office of Practice at East Tennessee State University College of Nursing. In order to make comparisons to other types of CHCs, public information obtained from their websites and news media is used. These include news reports and annual reports made public. Demographic information needed is gathered from the JCCHC and U.S. Census Bureau. Information from research entities, such as the Pew Research Center, has also been collected for this research. Various online new websites and their articles are also used in this research. This type of data is collected in order to analyze the external environment.

To understand the internal environment and the center's strengths and weaknesses, information provided by the Johnson City Community Health Center is incorporated into the study. News articles in which the center is featured are also gathered in order to understand the center more profoundly. Information gathered from the NACHC and the TPCA about the JCCHC is obtained to investigate the internal environment as well.

Data Analysis

The SWOT situational analysis's duo components are the internal environment, analyzing the strengths and weaknesses, and the external environment, investigating the opportunities and threats. In order to make the research flow better, the external portion will be analyzed first for a better understanding of how the JCCHC's internal environment fits into it. The first segment will objectively analyze various outer environments in the health care industry in which community health centers operate and more specifically in which the JCCHC operates. The internal portion will view the internal situation of the JCCHC and compare it to other health centers to find similar characteristics among them.

In order to analyze the external atmosphere, the PEST (Political, Economic, Social, and Technological) analytical framework must be used. In any company, "marketers must understand the macroenvironmental factors that operate in the external environment" because all of these influence consumer, competitor, and the company's decisions for action (Grewal and Levy, 2012). The internal review of the Johnson City Community Health Center will consist of appraising the marketing mix, or the four Ps (Product, Price, Place, and Promotion) of it. These four Ps are "the controllable set of activities that the firm uses to respond to the wants of its target markets" (Grewal and Levy, 2012). They will be compared to other CHCs that have flourished in their respective environments.

The criteria imposed on these centers to be deemed successful by the analytical frameworks are the following: they should have increased the number of patients they served in their communities, and they should have flourished in competitive environments ruled primarily by other healthcare institutions and facilities.

Hypothesis

Based on the objectives of this research and the criteria for success, the hypotheses that will be examined are:

H_o: No significant relationship can be demonstrated between the Johnson City Community Health Center and other community health centers categorized as successful, and the JCCHC does not have the similar characteristics required to be competitive and successful in Johnson City, Tennessee.

H_1: A significant relationship can be demonstrated between the Johnson City Community Health Center and other community health centers categorized as successful, and the JCCHC does have the similar characteristics required to be competitive and successful in Johnson City, Tennessee.

Chapter 3

External Environment Analysis: Opportunities and Threats

PEST: Political, Economic, Social, and Technological Environments

Political

In *Community Health Centers: A Movement and the People Who Made It Happen*, Bonnie Lefkowitz examines the history of several community health centers in five different states, but also focuses on the community health centers as a whole. In order to determine the present political environment of the Johnson City Community Health Center, it is crucial to focus on both, national and state levels.

Lefkowitz writes that "clearly, skilled advocacy and bipartisan support played a role in the centers' survival," and Congressmen from both parties, such as Democrat Senator Ted Kennedy and Republican Representatives Henry Bonilla and Senator Susan Collins, showed support for them. White House administrations from both parties have rejected or supported CHCs. They began with the Democrat President Johnson and saw growth under the Republican President George W. Bush. However, Republican and Democrat presidents Ronald Reagan and Bill Clinton, respectively, tried to impose block-grant style funding for the centers, a move shown to harm them. (Lefkowitz, 2007)

Various health care reforms under the different administrations have affected the community health centers. Some presidents, such as Nixon, preferred Health Maintenance Organizations, and others, as mentioned, tried to seek block grants for the centers, fearing the threat of a nationalized health care system. Then during George W. Bush's administration, some argued, "that the aspirational, value-driven, and community-based nature of the program allowed it to bridge the gap between liberals and conservatives." (Lefkowitz, 2007)

By analyzing today's national, state, and local politics, it is possible to determine if the Johnson City Community Health Center has support or opposition on those levels. First off on the national level, President Barrack Obama has expressed support for community health centers ever since he was a candidate for the 2008 presidential elections, and under the Affordable Care Act, also known as ObamaCare, has tried to materialize this support. The Affordable Care Act, which is "a long, complex piece of legislation that attempts to reform the healthcare system by providing more Americans with affordable quality health insurance and by curbing the growth in healthcare spending in the U.S.," has provided an increase in funds for community health centers and services not originally provided by them (Affordable Care Act Summary).

On June 20th, 2012, the U.S. Department of Health and Human Services gave a press release entitled "Health care law expands community health centers, serves more patients," in which it stated that under the new law, 219 health centers were going to be awarded grants to increase their services to over 1.25 million new patients and generate 5,640 employment positions.

Furthermore, Congress and its members seem to be supportive of community health centers in general. The Consolidated Appropriations Act of 2014 passed by Congress early in January 2014 was a piece of bipartisan legislation approving governmental spending; the first bipartisan bill passed of this kind in years (Farber, 2014). There are Tennessee congressmen who support the centers. For example, the Tennessee representative for the 5th district, Jim Cooper, is a member of the Community Health Center Caucus (Jim Cooper). In 2008, TPCA awarded the Distinguished Community Health Superhero Award to Senator Lamar Alexander, Representative Marsha Blackburn, Representative Lincoln Davis and Representative Bart Gordon for their support in Congress to community health centers throughout the nation (Crumley, 2008).

Then, the Tennessee House member for Johnson City's district Phil Roe has demonstrated support for the community health centers in the past. In 2010, Representative Roe voted in favor of the Family Health Care Accessibility Act, a piece of legislation allowing "any health care volunteer who provides services eligible for funding under the community health center grant program would be considered an employee of the Public Health Service for purposes of any civil actions that may arise" (Vote History, 2010). However, Representative Roe has been opposed to the Affordable Care Act, which grants $11 billion between 2010 and 2015 to the community health center program (Community Health Centers in an Era of Health Reform, 2013).

On the state level, Tennessee's decision to opt out of Medicaid expansion from the ACA shows lack of support for the centers. The Supreme Court ruled that states could opt out of the expansion established by the ACA. Governor Bill Haslam is trying to negotiate an agreement with the U.S. Department of Health and Human Services and the Tennessee General Assembly to create a "Tennessee Plan" (Wilemon, 2014). Even though the state has received $87.5 million dollars from the $11 billion granted, centers in the state will miss out on money from the revenues from the Medicaid expansion (Wilemon, 2014). According to a study by the George Washington University School of Public Health and Health Services, Tennessee, the state "with the highest percentage [at 82%] of community health center patients [having] incomes below the federal poverty level," will currently forgo about $555 million, but on the contrary, Tennessee would receive $2 billion from the federal government if it were to expand Medicaid (Vestal, 2013).

Community Health Centers must also be supported by the local government in order to be successful. Being part of ETSU's College of Pharmacy, the JCCHC can find support in the college community and the city of Johnson City. When it first opened, the “clinic…brought together [the disciplinary departments of] medicine, pharmacy, audiology and speech language pathology, nutrition and dental hygiene” (Barber, 2012). The city has also shown support for the clinic by appropriating $26,640 towards it, but the funds have decreased for the third year in a row from $37,000 in 2011 (Annual Budget for Fiscal Year 2014, 2014). None the less there is still support from the city.

<u>Economic</u>

As it can be seen in the Political section, the economic environment and the political environment are very connected. Community health centers, such as the Johnson City Community Health Center, depend primarily on government funding along with insurance, private and governmental, to survive. Still, since not all patients are covered by insurance, some still have to pay out of pocket, so the economic environment in Johnson City must be solvent.

Community health centers will have received a total of $11 billion from the ACA by September 30, 2015, from which Tennessee has received $87.5 million (Wilemon, 2014). However, as mentioned, instead of the $555 million it is currently missing out on, the state will miss out on $2 billion from the federal government because it will not expand Medicaid (Vestal, 2013). The Consolidated Appropriations Act of 2014 gives funding to CHCs of $3.7 billion for the 2014 fiscal year. Additionally, the municipal government of Johnson City, TN, allocates $26,640 for the JCCHC.

Among some grants received during the 2010 through 2012 fiscal years are the following. They received a $1.4 million Nurse-Managed Health Center grant, a $6.89 million grant for a Capital Improvement Project for JCDC (Johnson City Downtown Clinic), a Successful Community Health Centers Competition grant of $6,125,090 distributed over 5 years, a Health

Resources and Services Administration (HRSA) Patient Centered Medical Home grant of $35,000, and a HRSA Quality Cervical Cancer Screening grant of $60,000. (ETSU College of Nursing Nurse-Managed Clinics, 2012)

While the center receives funding from government, they still receive revenues from insurances and patients' pockets. But many of the patients are uninsured and have low income. According to the East Tennessee State University 2012 Health Center Profile, the most recent information from the HRSA, percentage of known patients at the JCCHC with income that is below 200% of poverty is 97.5% and the ones below 100% of poverty is 79.6%. The center has a total of 5,471 patients, but of those, 53.3% are uninsured. 26.8 percent have Medicaid or CHIP (Children's Health Insurance Program), 4.1% have Medicaid, and15.8% have a third party insurance. Of the uninsured patients, 18.9 percent are at or below the age of 19. The 2012 expenses from the Health Center Service Grant was $1,208,426 and the total costs for medical services were $3,035,694. This led to a cost per patient of $554.87, an increase of 13.7% since 2010. (East Tennessee State University, 2012)

National averages for community health centers are the following: percentage "of patients with known income" below the 200% poverty line for 2012 is 92.6% and below the 100% of poverty is 71.9%. The national percentage averages for uninsured, Medicaid/CHIP, Medicare, and Third Party insurances are 36%, 40.8%, 8%, and 15.2%, respectively. The percentage of uninsured patients below 19 years of age is 17.6%. The health center service grant expenditures for 2012 were above $2.3 billion and the total cost of care for 2012 was almost $14.5 billion. This made the 2012 national average for the total cost per patient of $686.68, up from $629.67 in 2010. This information can be seen in Appendix A (2012 Health Center Data, 2012)

The percentage of uninsured patients at the JCCHC is well above the national average, meaning that more patients have to pay out of pocket if they have any type of income. It is therefore important to review Johnson City's economy to verify if there is employment from which patients can receive income. After the Great Recession which ended in June of 2009, Johnson City has been recovering gradually. While the unemployment rate peaked at 10.5% on January, 2010, it has now dropped to approximately 7.0% in February, 2014 (Local Area Unemployment Statistics, 2014). This unemployment rate is slightly higher than the national rate of 6.7% in February (United States, 2014). These percentages can be seen in Appendix B.

However, the economic trend for the Tri-Cities Metropolitan area, which includes Johnson City, Bristol, and Kingsport, is not optimistic. Employment rates have been declining while unemployment rates have been escalating. According to the ETSU Bureau of Business and Economic Research's Tri-Cities Labor Market Report of the 2013 fourth quarter prepared by Dr. F. Steb Hipple, "employment in the metro area decreased by 1.6% to 225,589, well below the figures for 2011 and 2012…[, yet] the number of jobless workers only increased 0.5% to 18,157" (2014). The report also mentions that the decrease of residents because of the lack of employment is causing an outward migration from the area.

In Johnson City, the top five employment categories are Government, Education and Health Services, Trade Transportation and Utilities, Leisure and Hospitality, Professional and Business Services. They make up 16.2%, 13.5%, 13.1%, 8.9%, and 8.5%, respectively, of the total amount of nonfarm wage and salary employment (Economy at a Glance, 2014). The Tri-Cities Labor Market Report demonstrates that of the top five business sections mentioned, Leisure and Hospitality, Professional and Business Services, and Government showed a job growth, Trade showed a loss, and in Transportation & Utilities and Education & Health Services stayed unchanged (2014). The JCCHC must keep monitoring the economic environment in the area because it will affect revenues if the uninsured do not have jobs.

<u>Social</u>

Community health centers were developed to aid a diverse group of underserved patients. They were created in the 1960's, a time in which "many Americans [lived] on the outskirts of hope -- some because of their poverty, and some because of their color, and all too many because of both" (Johnson, 1964). It was a time in which President Johnson proposed, during his inaugural address of 1964, better education, health care and prevention, jobs, and overall better opportunities for the success of Americans, and he wanted to do it in a collaborative effort among the Federal government, local governments, and communities.

The 60s were also an era of great social activism. The African American community fought for and won their battle for Civil Rights in 1964. The Civil Rights Act of 1964…"ended segregation in public places and banned employment discrimination on the basis of race, color, religion, sex or national origin," and the following year the Voting Rights Act was passed prohibiting discrimination when voting (Civil Rights Act, 2010).

Many community health centers flourished under the war of poverty because they were committed to the improvement of the poor and underserved, to treating the community problems and not just the medical illnesses, and to the development of a better future. According to Tom Van Coverden, the president of the National Association of Community Health Centers, "[There was] the energy, the leadership, the people steeped in traditions of civil rights and helping others, social justice and positive action," and it was them who helped make the difference. (Lefkowitz, 2007)

For example, the CHCs in South Carolina, Beaufort-Jasper-Hampton Comprehensive Health Services, helped change the power-structure in the communities from a primarily white governed system to a more African American representative system. The Delta Health Center in Mississippi took health care, education, and job training to an area that had “conditions somewhere between slavery and a company town where the boss owned your house, the store where you shopped, and, as the song says, even your soul.” In Boston, the Geiger Gibson Community Health Center and other CHCs in the area demonstrated that governing boards composed of community members who are also patients could make these centers successful. (Lefkowitz, 2007)

However, the CHC leaders who struggled to make the programs take root, survive, and succeed now “fear that young people lack the same level of commitment [towards the underserved communities]” and that “many of these young men and women are unaware of how health centers and the people who founded them anchored their work in historic social movements” (Lefkowitz, 2007). These leaders feel America’s youth will not continue with the same support they have demonstrated for the community health center program; thus threatening the progress of the programs. Some of these fears are not without good reason.

The Millennial Generation, which is the generation between the current ages of 18-33, seems to show fewer tendencies towards social activism (*Millennials in Adulthood,* 2014). According to 2010 Demographic Profile Data produced by the United States Census Bureau, the total population between the ages 15 to 34 in Johnson City is 20,210 or 32.1%. The majority of this population is between ages 20 to 24, making up 11.2% of the population. Appendix C will show this information. This group is college age students, and it makes sense that it is a large group because ETSU is located in the city.

Since a significant portion of the city's population is represented by Millennials, it is important to understand their social characteristics and values. Based on the February, 2010, PEW research report *Millennials: Confident. Connected. Open to Change*, Millennials are a very expressive, educated, inter-connected, confident, diverse, and independent generation. However, not many seem interested in helping the ones in need. For example only 21 percent of those sampled "say that helping people who are in need is one of the most important things in their life." This also reflects on their focus on the poor. The PEW survey results indicated in 2009 that 51% of this age group thought government should help those in need even if the nation's debt increased; this was an 8 percent drop from 2007 findings.

The PEW research report found Millennials ousted other generations of American internet and cell phone usage. They are the most likely to have social media, text more often, view technology as beneficial, and think technology helps them become more efficient (*Millennials: Confident. Connected. Open to Change*, 2010). While technology and the use of social media can help stir and advance social movements, it appears Millennials are not producing results out of their movements. First of all, they do not have a definite social cause identified. Larissa Faw, contributor for Forbes, says in her 2012 article "Are Millennials Lazy Or Avant-Garde Social Activists?" how in 2007, Millennials' top causes they supported were cancer, animal rights, and education, but in 2012, the focused changed to education, ending poverty, and environmental causes.

Secondly, the approach for social movements is different with technology. The same article mentions the Occupy Wall Street movement, a movement in which the youth occupied Wall Street to declare "Rebellion will not stop until the corporate state is extinguished" (Cohan, 2011). Faw comments how youth participants did not accomplish anything because all they sought was attention and a journey, not outcomes. That's the main difference between this generation and older generations; older generations "focused on results, effecting change, and a material end result" (Faw, 2012). The use of technology reflects this. Millennials use digital technology for social awareness and involvement, are portrayed as "slackavists" due to this form of advocacy instead of actively going to demonstrations. However, no matter how socially active you are, true social change only comes with outside engagement and participation. (Faw, 2012)

Health care trends must also be analyzed as part of this social environment section. Part of the community health center movement is to help the community with their health problems but in a holistic manner. For example, Su Clinica Familiar in Texas worked on "a water project…to deal with the constant gastrointestinal problems" in the area and "and built a potable water and sewer system for the outlying colonias along the U.S. side of the Rio Grande. Over 2,500 families were served, and disease was substantially reduced" (Lefkowitz, 2007). Su Clinica Familiar observed the health environment in the community, did something about it, and obtained positive results. Observed health care trends can serve as opportunities or threats in which the JCCHC can act on or avoid.

In 2012, 24% and 10.3% of the JCCHC patients suffered from hypertension and diabetes, respectively (East Tennessee State University, 2012). Hypertension, otherwise known as high blood pressure, "is a common condition in which the force of the blood against your artery walls is high enough that it may eventually cause health problems, such as heart disease" (Mayo Clinic Staff, 2012). Diabetes is a disease in which the human body has too much glucose in the blood stream, and insulin, the hormone that helps glucose enter blood cells, is either being destroyed by the immune system (Type 1 Diabetes) or blood cells are resistant to insulin and the pancreas can't produce enough of it to counteract the resistance (Type 2 Diabetes) (Mayo Clinic Staff, 2013).

According to the "Lifestyle and home remedies" section of each disease written by the Mayo Clinic Staff in 2012 (Hypertension) and 2013 (Diabetes), in order to treat or control either disease, patients should change their lifestyles to eating healthier foods and exercising more often. The JCCHC knows the two major conditions its patients suffer, so if it wants to maintain its mission to "optimize health and reduce health disparities through the provision of innovative and high quality care and services in partnership with our patients, communities, and regional health and services agencies," it must be aware of health trends in 2013 ("ETSU Community Health Centers", 2012). The Huffington Post's January 1st, 2013, article "Health Trends 2013: What To Expect" mentions that in 2013 gluten-free option will become more common in fast food restaurants, and fresh-squeezed juices, the ones without preservatives, will enter mainstream consumer markets. Also during the same year, high intensity interval training, gyms specializing in specific activities, such as yoga, body weight workouts not requiring equipment, and functional workouts that "improve balance, coordination, force, power and endurance to perform activities of daily living" will become more common and trendy.

However, there are trends that can be harmful to anyone, no matter their overall health conditions. Towards the end of the year, in December 2013, K. Aleisha Fetters reported in "The Best and Worst Health Trends Of 2013" for the Huffington Post a list of worst trends in 2013. Eating gluten free foods was on the list as a bad trend. This is because the Journal of the Academy of Nutrition and Dietetics demonstrate no health benefit with this diet "and can even harm gut health -- in people without celiac disease or a gluten intolerance." Another 2013 dietary trend which was unhealthy was the Whole30 Diet. This diet consisted of solely plants and meat for 30 days, and it excluded products whole grains, dairy products, alcohol, coffee, and honey. People did lose weight but when they regained it, it was all fat.

She also counters high intensity interval workouts if a person is not in proper form to do them. Fetters argues it can be “counterproductive and dangerous” if a person is pushing themselves over their physical limit and suggest to first consult a trainer. Finally if people are recommended to go to gyms, there is also a possibility certain locations could do more harm than good. It became trendy for some gyms to increase temperatures to 115 degrees Fahrenheit, to give the client the perception of working out more. Yet, in reality clients are getting about the same work out but running a higher risk of dehydration. By knowing these trends, their benefits, and their dangers, the healthcare providers at the JCCHC can make better decisions when treating their patients. (Fetters, 2013)

<u>Technological</u>

Social trends can be interrelated with the Technological environment and trends. Hence demographics with regards to technology must be understood. The following information can be seen in Appendix D. Based on the PEW Research Internet Project’s “Mobile Technology Fact Sheet,” in January of 2014, 90 percent of adults in the U.S. had cell phones, and 58% of all adults classify their cell phone as a smartphone. Between the ages of 18-29, 98% have a cell phone and 83% are classified as smartphones; between 30-49 years of age, cell phone and smartphone ownership is 97% and 74% respectively; and ages 50-64 percentages in the same categories as mentioned in that order are is 88% and 49%. Finally, the above 65 years of age have the least percentage of owning a cell phone, at 74% of the population, or a smartphone, at 19% of that population. Since 63.4% of the patients seen at the JCCHC are between the ages of

18-64, a significant amount, it is very likely that these patients will have a regular cell phone or a smartphone (“East Tennessee State University”, 2012).

The Johnson City Community Health Center serves primarily the underserved or low income populations in an urban environment. 97.5 percent of patients served at the center are at or below the 200% federal poverty threshold (“East Tennessee State University”, 2012). In other words, this means a household of one individual earns $23,340 per year (“Federal Poverty Guidelines, 2014”). According to the fact sheet by the PEW Research Internet Project, the cell phone ownership percentage of the population that has a household income of less than $30,000 per year is 84%, while the smartphone ownership percentage for that group is 47%. The percentages in both categories rise as the household income increases. This still makes it likely that patients might have cellphones or the more advanced smartphones.

Based on the U.S. Census Bureau, computer ownership and use is also very high. The infographic from 2012 entitled “Computer & Internet Trends in America” estimated that in 2012, “78.9% of all households had a computer at home” and “94.8% of households with a computer use it to connect to the Internet.” Furthermore, computerrepaircircuit.com, a website listing computer repair businesses in different states and cities, reports 28.8 percent of the female population in Johnson City own a computer compared to 48.7 percent of the male population in the city. However, the year this information was published was unknown.

The information gathered, if correct, makes it likely that a decent amount of the population at the JCCHC has access to a communication format, such as a computer, cell phone, and smartphone, and has access to internet. Thus, it is now important to look at technological trends. Millennials, are the most likely to have smartphones and be connected online. When it comes to being social activists, 1 in 3 Millennials began by being involved through an online format, and 2 in 3 believe that spreading the word in an electronic format “can create more change than a person on the street, rallying or protesting” (Faw, 2012). This is partially true. Syria is an example of how social media has been used by youth and opposition in that country to show the atrocities resulting from biochemical weapons used by the government. The U.S. used “thousands of photos and videos that the rebels uploaded detailing the attack” as proof to strike against President Bashar Assad’s oppressive government (Dinan, 2013). However, while Syrian advocates are using technology to spread their message of opposition, they are also physically fighting for change. As Faw argues, that is something Millennials in the U.S. are not doing.

In healthcare, there are also technological trends occurring. In “Health Trends 2013: What To Expect,” reported by the Huffington Post in January, 2013, health care apps focusing on exercise and nutrition will be downloaded more frequently. In fact more than one billion of these apps for mobile devices will be downloaded by 2016. If used correctly, these apps can be very beneficial for a patient’s health. Even baby boomers could benefit since “60% are most likely to use an app recommended by a doctor” and thus use it to improve their health (Dolan, 2012). Along with healthcare apps and tech trends, the Huffington Post sees self-monitoring becoming trendy. In other words, people will download apps to monitor their daily eating, sleeping, movements, and overall living behaviors. Finally for the trends from 2013, various classes, such as yoga classes, will become virtual.

Health care technological trends for 2014 are similar to the ones in 2013. Leyl Master Black, reporter for Mashable, writes in “5 Health Tech Trends to Watch in 2014” about the daily behavioral information tracked by apps. The next step is to allow doctors to gather that information, analyze it, and set health goals based on that info. However, HIPAA (Health

Insurance Portability and Accountability Act) privacy guidelines must be met when information is gathered by the provider. This patient information must remain secure, and a "technology that's already addressing this issue is TrueVault, which provides HIPAA-compliant storage for all the protected health information (PHI) that comes from apps." Also, tech devices, such as the AIRO wristband which are devices that can accurately monitor the calories and types of food you eat, will become more popular. The digital revolution has changed how patients and doctors interact. Virtual house calls will become more popular with sites or apps such as HealthTap or Google Helpouts Health. Finally, patients will have the opportunity to be rewarded for being healthy and partaking in healthy lifestyles. For example, the mobile application GymPact uses a device's GPS system to track a person while visiting a gym and monitors the person's exercises. The app user is penalized monetarily if a workout is missed, but rewarded if goals are reached. (Black, 2013)

All these trends, whether they are in the Political, Economic, Social, or Technological environments must be monitored by the JCCHC to know if it has the ability to capitalize on an opportunity presented to them or if they should avoid or prepare for a potential threat. Some trends found exist independently from each other in different environments. However, many have proven to be interrelated among each other and often cross over into multiple environments.

Chapter 4

Internal Environment Analysis: Strengths and Weaknesses

4 Ps of Marketing: Product, Price, Placement, and Promotion

Product

The Johnson City Community Health Center's product is essentially health and well-being for its patients and it offers it through the services of Family Nurse Practitioners, certified midwives, interpreters, students, and healthcare providers in various clinical specialties. CHCs do not only focus on the immediate health problem or concern. They treat health symptoms by also having a holistic view of the situation. In other words, providers working in these centers look at community and household dynamics and needs. For example, if families are suffering from gastro-intestinal problems, the healthcare providers look at their nutrition habits, they look at their household economic status to see if they are being fed, or they look at problems in their communities to see if it's an environmental issue.

In order to be successful in a community, they must offer various services which allow for the overall improvement and well-being of the patients they serve. If they do not offer certain services, they must have partnerships with other health care facilities or providers in order to keep the best interest of the patient in mind. However, many health centers have been more successful by offering more services themselves and by providers a more comprehensive health care experience.

For example, the William F. Ryan Community Health Network of centers in New York offers many types of services. They offer general health care, pediatrics, and woman's healthcare; services fairly common among CHCs. However, they also offer specialties which include "allergy, cardiology, dermatology, endocrinology (pediatric), gastroenterology, neurology, ophthalmology/optometry, podiatry, pulmonology (pediatric), and urology" (Ryan Network Services, 2013). However, according to Lefkowitz, the Ryan centers' services offer a wellness center with additional, less traditional services such as yoga and massages (2007).

In South Carolina, the Beaufort-Jasper-Hampton Comprehensive Health Services (BJHCHS) centers offer various services as well. The BJHCHS was originally "established to provide health care to the underserved," but has now become "one of the largest and most respected health care providers in the state of South Carolina" (Beaufort Jasper Hampton Comprehensive Health Services, Inc.). In Lefkowitz's book, *Community Health Centers: A Movement and the People Who Made It Happen*, she describes how the BJHCHS offers general medical treatment, women's health, and HIV/AIDS clinic, dental, and "pharmacy services as well as home health care." These centers are also working closely with Beaufort Memorial Hospital. There is collaboration between the staffs of both facilities to help make the birth of babies and the process more smoothly.

In Boston, Roxbury Comprehensive Community Health Center had been encountering financial issues as of late and unfortunately closed its operations; it is estimated that around $900,000 were owed to the center by the government and health insurance companies (Walker, 2013). Furthermore, the Massachusetts Attorney General Martha Coakley noted after an investigation that the center had errors and violations within the administration, the health care procedures, and as stated, the finances, so Whittier Street Health Center was set as the receiver of funds normally given to Roxbury (Loh, 2013). However, Whittier provides many services as well. Besides quality healthcare, they also provide healthcare education, assistance for insurance enrollment, and transportation services in a new, modern center ("Whittier Street Health Center", 2013). Whittier Street Health Center demonstrates how it is important to have various services because then the center can be prepared to take on additional patients, if required.

In Boston, though, the South End Community Health Center (SECHC) has been successful. This community health center, like the others, offers many different services and specialties. According to their website, sechc.org under the Services and Programs section, the SECHC offers general healthcare, dentistry, behavioral health, women's health, nutrition, eye care, and a pharmacy. All of these services are provided in a three-story tall building with services such as optometry on the first floor, general medicine on the second floor, and dentistry and behavioral health on the upper-most floor. (Lefkowitz, 2007). This all-in-one care has proven to be very beneficial for the center as well as the community.

Currently, the Johnson City Community Health Center offers various medical services. It provides general health treatment for adults and children by Nurse Practitioners (NPs). NPs and certified nurse-midwives also offer women's health and prenatal care. "The JCCHC is one of only a few nurse-managed CHCs in the nation to be designated as a Federally Qualied Health Center and is a unique CHC in the nation through its operation in conjunction with a College of Nursing," which is the receivership ("Johnson City Community Health Center"). When they shifted to their new location, they began to work together with the ETSU College of Clinical and Rehabilitative Health Sciences. This was done in order to offer patients "physical therapy, radiography, nursing, dental hygiene, nutrition, audiology, sociology, psychology and pharmacy" (Barber, 2012). Furthermore, the center offers health care clinics to migrant workers in the area, and as of 2013, a specialist for the Federal Insurance Marketplace was hired to help with the outreach programs to help uninsured patients apply for health insurance required by the ACA ("JCCHC celebrating first anniversary with open house", 2013)

However, dental hygiene and an on-site pharmacy have not yet been fully operational, even though they have the space built into the facility. The JCCHC currently works with Keystone Dental Care Inc. to provide dental hygiene services, such as cleanings ("ETSU working with area professionals to provide dental care for low-income families", 2001). The center also works with the Northeast Tennessee Dispensary of Hope to help its patients with low income receive medication (Egerváry, 2013). The Dispensary of Hope is a pharmacy offering free medication to qualified patients, and it is staffed by a full-time pharmacist and volunteers, some of which have been ETSU students (Wachter, 2009). Since there are some services the JCCHC cannot provide, it has partnered with Mountain State Health Alliance to receive the services of laboratories and volunteer physicians ("Social Responsibility Plan", 2011).

Nurse Practitioners form a crucial part of the services offered by the JCCHC. NPs are the perfect type of health care providers for community health centers. This is because the "core philosophy of the field is holistic, individualized care that focuses on patients' conditions as well as the effects of illness on the lives of the patients and their families" (Lyder, 2012). They focus on what is going on in their environment and how it is affecting the people around them. This is, in essence, what CHCs do for the community.

However, while there are many similar things NPs can do resembling a physician, such as perform physical exams, prescribe medications, order lab analysis, and diagnose illnesses, there is a very crucial activity some regions prohibit: admitting patients into hospitals. This is detrimental because some insurance companies are starting to have this as a requirement to be a primary care provider for a patient. Also, research shows that admitting and hospital privileges for NPs "may decrease readmission rates and errors, speed recovery, and improve health for consumers" while lowering health care related costs. Unfortunately, the NPs at the Johnson City

Community Health Care do not have these privileges. None the less, the JCCHC is still able to offer many services. (Brassard and Smolenski, 2011)

Price

The promise of the Johnson City Community Health Center is that “All patients receive treatment regardless of income or ability to pay” (“Johnson City Community Health Center”). However, in order to continue operations the clinic must have revenues and funds. Most CHCs receive government funding, but many also operate primarily from medical insurance reimbursements. There are also payment plans or sliding scale fees available. All these forms of funding or payments are used to offset the individual cost per patient at each center.

Under the “Payment Options & Registration” information section of Su Clinica Familiar in Texas, the website lists Medicare, Medicaid, CHIP, and private insurances such as Humana, BlueCross, and TexCare, as insurance plans they accept. They offer sliding scale discounts as well based on household size and income. Based on the “Su Clinica Familiar 2012 Health Center Profile” by HRSA, the 34,465 patients served by Su Clinica have some form of the insurance listed or fall under the sliding scale. 50.6% are uninsured, so most likely they apply for the sliding fee. 34.4%, 5.7%, and 9.3% have either Medicaid/CHIP, Medicare, or a third party insurance, respectively. Overall the cost of health care per patient at Su Clinica Familiar is of $825.62. The HRSA information for this center and the following centers can be found in Appendix A. (2012)

HRSA’s 2012 Health Center Profile information on the South Boston Community Health Center lists the demographic info and the cost per patient. The center has 14,293 patients. They have a very low population of uninsured patients at 12.5%. Medicaid/CHIP patients make up 27.1% of the population; Medicare patients form 9.9%. The rest of the population, 50.6% to be exact, has third party insurance. However, the total cost per patient is higher, $973.65. On South End's website under the "Frequently Asked Questions" section, the center accepts insurance coverage like MassHealth, Tufts, and Harvard Pilgrim. Also if patients do not have insurance, and they are eligible, it is possible "to make arrangements for you to pay for services on a sliding scale." (2013)

The William F. Ryan Community Health Center profile is different from the rest, yet they are still successful. 58.4 percent of the 48,981 patients served have Medicaid/CHIP. 23.6% are uninsured, 10.3% have Medicare, and 7.8% have private or other type of insurance. However, the cost per patient is $997.34 (William F. Ryan Community Health Center, Inc., 2012). Examples of the third party insurance companies this CHC accepts are Cigna, Affinity, and Guardian, and uninsured families also receive the opportunity for a sliding fee based on household size and income. These uninsured patients also have the uncommon additional incentive of getting a discount if they pay for the visit on the day of their appointment ("Become a Patient", 2013).

In the Economic trend section of the external analysis, the 2012 Health Center Profile for ETSU from HRSA was analyzed. To recap the information, of the 5,471 patients, 53.3% are uninsured, 26.8 percent have Medicaid or CHIP, 4.1% have Medicaid, and15.8% have a third party insurance. The cost per patient, though, is $554.87. The cost per patient is by far lower than the previous three centers, but it also has the highest uninsured rate. The percentage of uninsured patients is 2.7% higher from Su Clinica Familiar uninsured stats, and that entity also had an $825.62 cost per patient. It appears the JCCHC is doing well so far.

The JCCHC has "contracts with many insurance companies" but it also offers a sliding scale fee program for uninsured patients ("ETSU Community Health Centers", 2012). On

February 14th, 2013, the health center changed its sliding fee program. The JCCHC gives out the "Annual Income Threshold by Sliding Fee Discount Pay Class and % of Poverty" informational sheet to all its patients. On this sheet the payment scale is broken up based on income and household size and income. This sheet can be seen in Appendix E. There are five levels of payment. For those who are at or below 100% of poverty, the nominal fee per visit is $25. From 101% to 133% of poverty the charge is $40. It costs $55 per visit if the household income is 134% to 175% of poverty. From 176% to 200% of poverty is $70. Finally, there is no discount for those greater than 200% of poverty levels. The income amounts vary depending on household size. The sheet informs that the table is "based upon 2013 Federal Poverty Guidelines (January 24, 2014)."

<u>Placement</u>

Armstrong and Kotler have suggested that the three most important things to remember when dealing with placement are: "*location, location,* and *location*!" (2012). It is one of the fundamentals of marketing, and community health centers have made sure they know this by heart. Since the origins of the CHCs, they have been strategically placed to be near the underserved populations who need the most medical attention. They would be located in areas accessible to the patients, and if the patients had to travel, they would sometimes provide transportation or work with public transportation. (Lefkowitz, 2007)

For example, the first ever built community health center, Geiger Gibson Community Health Center, formerly Columbia Point CHC, was located in an area without medical attention and it was an odyssey to get to a medical facility where a patient had to then wait for a long time. Sometimes, "young mothers had to take three different trains and buses to the only source of care, wrestling the baby carriage on and off each one." Therefore it was very important to have a site near the patients and where they could get transportation. (Lefkowitz, 2007)

In Boston, Massachusetts, the South End CHC expanded into a fully renovated block. $30 million were used to redevelop the block to include "thirty-nine condos, office space, a pharmacy, cafés, green space, and, of course, a new health center facility" (Lefkowitz, 2007). This renovation helped bring in more patients. The site can now be easily reached by automobile or public transportation, such as bus and subway ("Locations", 2013).

Other sites in which clinics were opened near the areas with severe health concerns were in South Carolina. The various centers from the Beaufort-Jasper-Hampton Comprehensive Health Services were located in the state's Low Country where hunger was the main concern, and they were set across the mainland and the surrounding islands. However, "Transportation was the 'Achilles' heel' of [the] rural preventive health care program," so more and more sites were opened with the help of the community. Later transportation services were able to be provided to the patients. These transportation services later developed into complete bus services for the community. These clinical sites demonstrate how important it is to have the services near the population being served and to be in an area where transportation can be accessed. (Lefkowitz, 2007)

The Johnson City Community Health Center is a 23,000 sq. ft. facility currently located on 2151 Century Lane in Johnson City, Tennessee ("Johnson City Community Health Center"). This site is a huge upgrade from the previous site in downtown Johnson City. It now has 23 exam rooms as opposed to the eight rooms on the East Myrtle Ave. site (Barber, 2012). Based on the East Tennessee State University map provided by HRSA which tells where patents come from, the majority of the patients served in 2012 by the JCCHC came from the following zip codes: 37601, 37604, 37615, and 37659. The quantity of patients in each of the zip code areas in the same order are 1487, 908, 180, and 340. These are followed by the zip codes 37692, 37650, and 37643 with the quantity of patient each being 172, 145, 143, respectively. The rest of the patients are from the rest of the Tri-Cities regions and surrounding counties. This map can be viewed in Appendix F. In essence, they are from eastern Greene County, Kingsport, and Bristol areas. Based on the map, the JCCHC is located in a central location to all the areas it serves. The map also features an area around Hancock County, TN, which has school based clinics served by ETSU. The JCCHC does not serve this area, so the numerical data of patients served from that area must be ignored.

Therefore, it is important that patients have access to transportation in order to get to the center. Fortunately, there are public and private transportation services in and around Johnson City. First, Johnson City Transit (JCT) is a bus service covering the entire city with “seven buses on 13 fixed routes” (“Johnson City Transit Ride Guide”, 2014). A map of the routes served can be found in Appendix G. This service is very beneficial for the JCCHC because when compared to the map by HRSA, the JCT map covers the major part of the four zip codes where the centers’ patients reside. Additionally, JCT has an integrated technology system and has partnered with Google Transit, among the first in the state to do so, in order to better serve the residents of Johnson City. These two systems will help residents with smartphones and text services get real-time information on bus locations and also help pre-plan their travels more easily (Janutolo, 2013).

Secondly, Johnson City has two taxi services which cover the city and some parts outside of it. The first, W.W. Cab Company, has 12 cars serving the area while the second service, Trinity Taxi, which opened in 2011, has three vehicles (Gray, 2011). Finally, a third service offering transportation services is Net Trans. This company serves patients outside the Johnson City area through means of shared shuttle bus rides. For example their purple route serves Greeneville, Limestone, and Jonesborough (“Greeneville – Purple Route 4”, 2014). Meanwhile, their Teal Route Serves Rogersville, Church Hill, and Kingsport (“Rogersville – Teal Route 8”, 2014). Altogether Net Trans offers services in “Carter, Greene, Hawkins, Johnson, Sullivan, Unicoi and Washington counties” (“The Connection”). It appears all the counties around the JCCHC service area are covered by transportation, but the Bristol area is the one with least transportation service. Overall, the JCCHC is fairly well served by transportation, allowing patients to go to the center for care.

<u>Promotion</u>

Basically, the fourth P of marketing, Promotion, refers to the communication of a product or service and the related activities undertaken to “persuade target customers to buy” or use the product or service. Any company must have a good marketing mix consisting of advertising, sales promotions, Public Relations (PR), direct marketing, and digital marketing in order to be successful. Some community health centers have a good mix while others do not. (Armstrong and Kotler, 2012)

The William F. Ryan Community Health Network in New York contains a varied pallet of promotional tools. By navigating the website, www.ryancenter.org, it is possible to learn about these various tools. For example, it is possible to join an email list for patients. This community health center network also has a YouTube channel which shows the different centers. These are forms of regular advertising, digital marketing, and direct marketing. Furthermore, they appear to have a good PR department because they promote events such as their 47th Anniversary Gala on June 11th, 2014, and the 2014 Revlon Run/Walk for Women’s Cancers in partnership with the Entertainment Industry Foundation. Finally, as mentioned in the Price section, this CHC network offers discounted rates when patients pay on the day of their visit. This last example is an example of a sales promotion.

The Harbor Health Services, Inc., the network which the Geiger Gibson Community Health Center also has a good marketing mix set. Many can be found through their website, www.hhsi.us. On their homepage, it is possible to see links to various social media, such as Facebook, LinkedIn, Twitter, and YouTube. They also seem to have a good PR department. Under the Media and Events tab, subsection Events, they show the different events they have had for the community, such as Free Flu Clinics, a diabetes education event, and free dental screenings. It appears they also host 5k runs and walks. Finally, they have also had traditional print and video advertisement.

However, there are some CHCs that have less promotional tools. Su Clinica Familiar only seems to have website for digital marketing, www.suclinica.org. Yet, one of their promotional tools is Public Relations. Under the community services tab, they promote themselves by participating in programs such as the “Willacy County Health Network: A grass-roots, community driven group of concerned citizens, health care providers, and government working to improve community health in Willacy County, Texas” or Reach Out and Read, a service which gives books to children to promote reading (2005). PR and the website seem to be the only promotional tools used by Su Clinica.

Promotion is the weakest P for the Johnson City Community Health Center. For starters, the JCCHC does not even have an independent website like the other health centers. The closest thing to a website they have is https://www.etsu.edu/nursing/practice/sites/johnsoncity.aspx, which is an extension of the East Tennessee State University Website. However, the JCCHC has promoted itself through social media. It currently has a Facebook account, but no posts have been added to it since January 27, 2014. The center also seems to have some PR in its promotional mix.

For example, on October 17, 2013, the center celebrated its first year anniversary at its current location by having an Open House even. At this event people were able to receive a "tour [of] the facility, learn about the array of services available and enjoy refreshments" (Diamond, 2013). Also on August 15, 2013, the center hosted the JCCHC Community Health Block Party to celebrate National Health Center Week. In this event, there were "free health screenings" which included

> "blood pressure and blood sugar checks, body mass index (BMI) measurements, and screenings for vision, hearing and speech. Various information booths [offered] visitors facts and tips for healthy living, and Reflections of Health School of Massage [provided] free massages. Games and face-painting [were] available for children. Refreshments and lights snacks [were] available" as well ("JCCHC celebrating National Health Center Week with Block Party", 2013).

These events, along with the open house, were the only two events the center has hosted as promotion. The lack of promotion and promotional tools is something that can negatively affect the center.

Chapter 5

Results

The SWOT Analysis

The analysis of the internal and external environment research will now be synthesized into the four parts of the SWOT analysis. Each of the four parts, Strengths, Weaknesses, Opportunities, and Threats, will be explained separately. These four parts, together, will then help determine if the Johnson City Community Health Center is similar to other CHCs and if it has the characteristics to be competitive and successful in Johnson City, Tennessee. The finalized SWOT Analysis diagram can be found in Appendix H.

Strengths

When analyzing the 4 Ps of Marketing, Product, Price, Placement, and Promotion, for the internal environment, the JCCHC demonstrated to have various strengths. Under the Product section, one of the major strengths for the center is the fact that Nurse Practitioners are the primary care providers. Since NPs' philosophy of health care is a holistic approach, which take into account not only the problem itself but how it affects others around the patients, they are a perfect reflection of the type of health care community health centers try to convey. The next major forte found under this section is the fact that the JCCHC offers many different types of services. It offers general health care, pediatrics, women's health, radiology, physical therapy, nutrition, behavioral health, and audiology. Offering a variety of services, such as the ones offered by the South End CHC in Boston and the centers in the William F. Ryan Community Health Center, increases the likelihood of being successful.

Analyzing the P of Price determined further strong points. Compared to other community health centers, the JCCHC has a low cost per person at $554.87. Furthermore, having a sliding scale program with different payment levels based on income and household size will help patients pay the least possible while still having affordable health care. Researching the third P of Placement helped determine the location of the center to be a big asset to the clinic. It is conveniently located in a central location accessible to its patients. It is located in a city which offers several means of transportation for those without their own transportation. There is the Johnson City Transit bus system, which can be synchronized with smartphones and text messages to make a resident's commuting experience better. There are also two taxi services, and a shuttle bus system, Net Trans, which cater to patients outside the city limits.

Weaknesses

The major weakness for the Johnson City Community Health Center can be found under the section of Promotion. While the JCCHC has had promotional events such as an Open House commemorating the first anniversary at the current location and the JCCHC Community Health Block Party, they are not significant enough on their own in order to constitute a good promotional mix. There is also the JCCHC Facebook page, but if not used regularly, it will not be an effective promotional tool. Not having a website of its own is also very negatively affecting the center. As researched, successful health centers, like the Harbor Health Services, Inc., network have a strong promotional mix, which include, video and print advertising, digital marketing (including the website), and PR events.

A key weakness concerning the Product is the fact that the NPs do not have hospital privileges. While the JCCHC works with the Mountain State Health Alliance and its hospitals, by not allowing NPs to have admitting privileges, patients' readmitting rates may stay up, recovery times may be lower, and healthcare costs could stay high. Other weaknesses concerning the center's Product is the lack of all the potential services that could be offered. For example, the center doesn't have dental hygiene and its own on-site pharmacy yet. These services have to be referred to outside the clinic to its partners, Keystone Dental Care Inc. and the Northeast Tennessee Dispensary of Hope. Finally, under the Price section of the external analysis, the high uninsured population of 53.3% is a weakness because more people have to pay out of pocket and the funds obtained by the government must be used to offset the cost. These funds could be used for other value-adding services, such as outreach, marketing, and center expansion.

Opportunities

Analyzing the various external environments, Political, Economic, Social, and Technological, has revealed many opportunities and threats for the Johnson City Community Health Centers. In the Political environment, there are numerous opportunities which would benefit the center. Nationally, CHCs have much political support from President Barrack Obama and Congress. The Affordable Care Act allotted grants to numerous centers to expand services. Congress passed the Consolidated Appropriations Act granting $2.2 billion for direct funding to centers from the ACA. Various Tennessee Representatives and Senators have shown support for CHCs in several occasions. On the local level, the JCCHC receives funding from the city of Johnson City, and it also has support due to its affiliation to ETSU's College of Nursing.

The economic environment did reveal some potential opportunities. For example, the ACA has allocated a total of $11 billion to be distributed to CHCs until September, 2015. Furthermore, Johnson City continues to give additional funding for the JCCHC. The center also has a good track record of grants awarded to it. The JCCHC can take this into account when applying for future grants. Since the Great Recession, unemployment levels have generally been dropping. Additionally, data from the 2013 fourth quarter showed an increase in job growth in three of the top five employment categories in Johnson City: Leisure and Hospitality, Professional and Business Services, and Government. Education and Health Services stayed the same. The Johnson City Community Health Center can keep this in mind when serving their patients and understanding where their potential employment can be.

There are opportunities found in social trends in that can be used to offer better service and increase patients' health. The Millennial Generation is a very educated, diverse, expressive, and energetic. These are the type of personalities needed to stir social movements, just like in the 60s. Furthermore, in 2012, their social movement focuses included ending poverty and environmental causes.

In health care social trends, the main diagnoses by the JCCHC in 2012 were hypertension and diabetes, two conditions which can be effectively controlled with a good diet and exercise. In 2013, opportunistic trends were body weight workouts, gyms specializing in certain activities like yoga, functional workouts, and nutritional trends like fresh-squeezed juices without preservatives. Body weight workouts are beneficial to the low-income population because there is not a charge related to them. Specialized gyms in yoga are beneficial for behavioral health patients, and functional workouts can be recommended to the elderly patients. Finally, freshly-squeezed juices are generally inexpensive to make, benefiting the uninsured population.

There are also many opportunities in the technological environment. The likelihood of JCCHC patients having smartphones and computers gives the ability of offering more services. Millennials are the generation with the most connectivity to the internet. This has allowed this age group to become more involved as social activists, the key to the future leaders of community health centers. Smartphones and technology advances also allow for opportunities for health care. Nutrition and exercise apps are among the most download types of apps. This will help achieve the JCCHC's goal of providing high quality health care to its patients.

Furthermore, it will benefit the older generations to achieve better health if primary care providers recommend these apps to them. Health care app information can also be monitored by providers and allow them to help set goals for patients. Nurse Practitioners and other providers can also recommend patients to watch online fitness classes, which are becoming more popular. They can also recommend lower-income patients to subscribe to apps such as GymPact in which they will earn rewards and improve their health by staying dedicated to going to a gym.

Threats

These various environments also pose significant threats to the JCCHC. In the Political environment, the state and local level positions give the greatest threat, but there is some threat in the national level as well. Nationally, Representative Phil Roe, representing the district in which Johnson City is at, is against the Affordable Care Act. By opposing the act, he also opposes the funding granted by the act. Funds are greatly in trouble at the state level, though. The U.S. Supreme Court had ruled that states could opt out of Medicaid expansion, and Governor Bill Haslam decided Tennessee should opt out. Since Tennessee has the highest level of patients below poverty lines compared to any other state, these patients will now miss out even more on money used to care for them. In fact up to $2 billion could be gained if the state were to expand Medicaid. Moreover, the trend for the city of Johnson City is to decrease funding for the JCCHC, meaning the center will continue to have fewer funds.

The economic environment is also demonstrating threats. The uninsured rate of patients is significantly higher than the national percentage, 53.3% compared to 36%. This means more funds from grants are used to offset costs for uninsured patients. Also, the unemployment rate has been increasing slightly in the last fiscal quarters. Employment has decreased “well below the figures of 2011 and 2012” (Hipple, 2014). Out of the top five employment categories in

Johnson City, one showed a drop in employment. These economic threats must be monitored, especially when serving low-income populations who pay out-of-pocket.

In the social environment, certain social trends must be given consideration. It has been mentioned that the Millennials' personality characteristics and 2012 social causes focus on ending poverty were opportunities. However, research has also proven Millennials' support has dropped for government assistance to the poor. Support for this issue dropped from 59% in 2007 to 51% in 2008. Additional research has also shown how the focus on social causes this age group supports is continuously changing. Finally, when Millennials seek social change, like during their Occupy Wall Street movement, they do not necessarily seek outcomes. They seek an opportunity for a journey. This poses a threat to community health centers because centers focus on actual change and betterment for their patients and communities, and their future leaders must seek the same thing.

In social trends in health care, there are threats health care providers must be aware of regarding diets and types of exercises. For example, a popular diet in 2013 was the Whole30 Diet, which severely restricted the dieter to only plants and meat without whole grains or dairy products. Furthermore, restaurants began offering more gluten free products. However, this type of diet could harm patients' gut health if they were not gluten intolerant or had celiac disease. Providers should make sure to inform patients of this threatening diet trends in order to keep them healthy. Exercise trends that also pose a threat to the JCCHC's patients include high intensity interval workouts if patients are not quite fit for them and also gyms which commonly set high temperatures during workouts.

Finally, there are not some technological trends posing a threat to the JCCHC or community health centers. Social media has actually allowed social change to occur at a greater pace, but Millennials, the ones using technology the most, must learn to be more physically active in movements. With technology, the biggest threat is against patient information privacy. Information from apps shared with a health care provider must be guaranteed to be kept safe. Fortunately, services such as TrueVault, help maintain this information secure and HIPAA compliant.

Chapter 6

Conclusions

For this research, the null hypothesis being examined was:

H_o: No significant relationship can be demonstrated between the Johnson City Community Health Center and other community health centers categorized as successful, and the JCCHC does not have the similar characteristics required to be competitive and successful in Johnson City, Tennessee.

After analyzing the JCCHC using the PEST analytical framework and evaluating the marketing mix, Product, Price, Placement, and Promotion, and comparing it to other community health centers around the United States, the conclusion is to reject the null hypothesis and accept the alternative hypothesis. A significant relationship can be demonstrated between the Johnson City Community Health Center and other community health centers categorized as successful, and the JCCHC does have the similar characteristics required to be competitive and successful in Johnson City, Tennessee.

Overall, the JCCHC has similar characteristics which have made other CHCs like the William F. Ryan Community Health Network in New York, the Harbor Health Services, Inc. in Massachusetts, East Boston Neighborhood Health Center in Boston, the Beaufort-Jasper-Hampton Comprehensive Health Services in South Carolina, and the Delta Health Center in Mississippi successful. The JCCHC has a great location, offers many services to its patients along with the right health care providers, has low costs per patients, and is operating in macroenvironments that are generally favorable for it.

However, to improve outcomes the center should work on the characteristics it does not have that other successful CHCs do. For example the JCCHC should strive to get health insurance to more of its patients. It should also create a better promotional mix, which includes traditional advertising, digital marketing, sales promotions, direct marketing, and Public Relations. Finally, the community health center must promote the importance of CHCs and gain support in the various levels of government that are opposed to certain legislative acts that would benefit the centers.

Mostly, though, the Johnson City Community Health Center must always remember it is there to serve the community, specifically the underserved communities, improve not only their health but their quality of life. Community health centers were founded to give representation to these communities and to meet their needs to allow them to progress in life. This, the JCCHC must remember to truly be successful.

Limitations and Recommendations for Future Research

This SWOT Analysis only shows a snap shot of current events related to a business. As environments and the internal structure of business change, so does the strengths, weaknesses, opportunities, and threats. Due to the static essence of this model, it is important to continually be analyzing the macroenvironments and internal strengths and weaknesses.

As part of the external analysis of the model, a business's competition must also be evaluated. This can be done by using Porter's Five Forces of Competition Model. It is a strategic management tool that researches the supplier power, buyer power, threats of new entries, threats of substitute products, and the level of competition in a given industry. Due to time constraints, these variables were not studied. This weakens the results of the SWOT Analysis, but it opens up the possibility for future research.

It is important to understand that SWOT analyses are used as an initial framework to later develop a marketing strategy and plan. Hence, this analysis must be followed by further research in order to develop a comprehensive marketing plan. For example, consumer behaviors can be researched, market segmentation studies must be conducted, target markets must be chosen, differentiating factor must be analyzed, studies demonstrating the current market position must be conducted, and competitors and their movements must be investigated. These are future studies the Johnson City Community Health Center can conduct.

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Appendix A

2012 Health Center Data

Extracted from U.S. Department of Health and Human Services:
Health Resources and Services Administration

National Program Grantee Data

2012 Health Center Data

National Program Grantee Data

View Information by Criteria Reported:
Table 3A through 9E
View Full 2012 National R ▼ Go

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View National, State and Program Grantee Data

Total Number of Reporting Program Grantees: 1,198

Total Patients Served: 21,102,391

EHR 79.3% PCMH 46.6%

Age and Race/Ethnicity

	2010	2011	2012	2010 - 2012 Trend %Change
Total Patients				
Total Patients	19,469,467	20,224,757	21,102,391	8.4%
Age (% of total patients)				
Children (< 18 years old)	32.1%	32.0%	31.6%	-1.6%
Adult (18 - 64)	61.0%	61.1%	61.3%	0.3%
Geriatric (age 65 and over)	6.8%	6.9%	7.2%	4.6%
Minority Patients By Race & Ethnicity (% known)				
Racial and/or Ethnic Minority	62.3%	62.2%	61.9%	-0.7%
Hispanic/Latino Ethnicity	34.4%	34.5%	34.4%	0.1%
Black/African American [1]	25.8%	25.2%	24.2%	-6.2%
Asian [1]	3.3%	3.4%	3.5%	4.5%
American Indian/Alaska Native [1]	1.4%	1.5%	1.5%	7.2%
Native Hawaiian / Other Pacific Islander [1]	1.3%	1.2%	1.3%	-0.5%
More than one race [1]	4.2%	3.9%	4.1%	-3.2%
Language (% known)				
Best Served in another language	24.3%	23.0%	22.9%	-5.7%

Patient Characteristics

	2010	2011	2012	2010 - 2012 Trend % Change
Income Status (% of patients with known income)				
Patients at or below 200% of poverty	92.8%	92.5%	92.6%	-0.2%
Patients at or below 100% of poverty	71.8%	71.8%	71.9%	0.1%
Insurance Status (% of total patients)				
Uninsured	37.5%	36.4%	36.0%	-4.1%
Children Uninsured (age 0-19 years)	20.3%	18.6%	17.6%	-13.4%
Medicaid/CHIP [2]	39.7%	40.4%	40.8%	2.6%
Medicare	7.5%	7.8%	8.0%	7.0%
Other Third Party	15.2%	15.4%	15.2%	0.0%
Special Populations				
Homeless	1,051,750	1,087,431	1,121,037	6.6%
Agricultural Worker	862,775	862,808	903,089	4.7%
Public Housing	172,731	187,992	219,220	26.9%
School Based	398,754	434,607	434,833	9.0%
Veterans	226,019	249,548	251,188	11.1%
Gender of Patients by Age (% Female)				
Women's Health (ages 15-44)	27.9%	27.5%	27.2%	-2.6%
Patients Under 15 Who are Female	49.5%	49.5%	49.4%	-0.6%
Patients 15-64 Who are Female	62.4%	62.3%	62.3%	-0.4%
Patients 65 and Over Who are Female	60.6%	60.7%	60.6%	-0.2%

Cost Data

	2010	2011	2012	2010 - 2012 Trend %Change
Cost Data				
Health Center Service Grant Expenditures	$1,984,633,941	$2,167,306,962	$2,331,290,193	17.5%
Total Cost	$12,259,284,149	$13,224,572,705	$14,490,666,198	18.2%
Total Cost Per Patient	$629.67	$653.88	$686.68	9.1%

East Tennessee State University JCCHC

2012 Health Center Profile

EAST TENNESSEE STATE UNIVERSITY
JOHNSON CITY, TENNESSEE

Total Patients Served: 5,471

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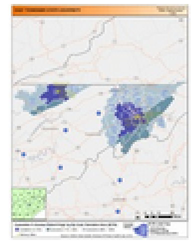
View all Tennessee Program Grantees

View National and State Program Grantee Data



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Age and Race/Ethnicity

	2010	2011	2012	2010 - 2012 Trend %Change
Total Patients				
Total Patients	4,358	5,610	5,471	25.5%
Age (% of total patients)				
Children (< 18 years old)	37.0%	33.9%	33.6%	-9.2%
Adult (18 - 64)	61.0%	63.3%	63.4%	3.8%
Geriatric (age 65 and over)	2.0%	2.8%	3.0%	55.6%
Minority Patients By Race & Ethnicity (% known)				
Racial and/or Ethnic Minority	30.8%	33.6%	31.3%	1.8%
Hispanic/Latino Ethnicity	23.9%	25.8%	24.0%	0.5%
Black/African American [1]	6.0%	6.4%	5.9%	-1.3%
Asian [1]	0.6%	0.7%	0.8%	28.7%
American Indian/Alaska Native [1]	0.2%	0.2%	0.2%	0.9%
Native Hawaiian / Other Pacific Islander [1]	0.0%	0.1%	0.2%	685.0%
More than one race [1]	0.3%	0.4%	0.3%	35.6%
Language (% known)				
Best Served in another language	19.6%	21.4%	17.6%	-10.1%

Patient Characteristics

	2010	2011	2012	2010 - 2012 Trend % Change
Income Status (% of patients with known income)				
Patients at or below 200% of poverty	97.8%	98.4%	97.5%	-0.4%
Patients at or below 100% of poverty	79.5%	83.7%	79.6%	0.1%
Insurance Status (% of total patients)				
Uninsured	54.2%	56.5%	53.3%	-1.7%
Children Uninsured (age 0-19 years)	17.6%	19.0%	18.9%	7.3%
Medicaid/CHIP [2]	29.1%	28.0%	26.8%	-8.0%
Medicare	3.2%	3.0%	4.1%	28.7%
Other Third Party	13.5%	12.6%	15.8%	17.5%
Special Populations				
Homeless	371	376	352	-5.1%
Agricultural Worker	60	121	192	220.0%
Public Housing	-	-	-	-
School Based	0	-	1,417	-
Veterans	50	49	15	-70.0%

Cost Data

	2010	2011	2012	2010 - 2012 Trend %Change
Cost Data				
Health Center Service Grant Expenditures	$1,211,454	$1,202,626	$1,208,426	-0.2%
Total Cost	$2,126,957	$2,918,793	$3,035,694	42.7%
Total Cost Per Patient	$488.06	$520.28	$554.87	13.7%

Su Clinica Familiar

2012 Health Center Profile

SU CLINICA FAMILIAR
HARLINGEN, TEXAS

Total Patients Served: 34,465

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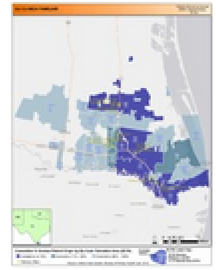
View all Texas Program Grantees

View National and State Program Grantee Data



Click to enlarge

Age and Race/Ethnicity

	2010	2011	2012	2010 - 2012 Trend %Change
Total Patients				
Total Patients	29,749	31,415	34,465	15.9%
Age (% of total patients)				
Children (< 18 years old)	41.2%	38.5%	37.6%	-8.5%
Adult (18 - 64)	53.0%	56.0%	57.0%	7.5%
Geriatric (age 65 and over)	5.8%	5.5%	5.3%	-8.4%
Minority Patients By Race & Ethnicity (% known)				
Racial and/or Ethnic Minority	95.8%	96.5%	97.1%	1.4%
Hispanic/Latino Ethnicity	94.7%	95.9%	96.6%	2.0%
Black/African American [1]	0.2%	0.2%	0.1%	-35.4%
Asian [1]	0.2%	0.0%	0.0%	-100.0%
American Indian/Alaska Native [1]	-	0.0%	0.0%	
Native Hawaiian / Other Pacific Islander [1]	0.1%	0.0%	0.0%	-36.8%
More than one race [1]	0.0%	0.0%	0.0%	
Language (% known)				
Best Served in another language	50.0%	50.0%	51.0%	2.0%

Patient Characteristics

	2010	2011	2012	2010 - 2012 Trend % Change
Income Status (% of patients with known income)				
Patients at or below 200% of poverty	95.8%	96.1%	95.1%	-0.7%
Patients at or below 100% of poverty	75.8%	77.3%	77.3%	1.9%
Insurance Status (% of total patients)				
Uninsured	49.4%	51.2%	50.6%	2.6%
Children Uninsured (age 0-19 years)	26.5%	27.5%	24.9%	-6.2%
Medicaid/CHIP [2]	35.5%	34.9%	34.4%	-3.0%
Medicare	6.1%	5.6%	5.7%	-7.1%
Other Third Party	9.0%	8.4%	9.3%	2.7%
Special Populations				
Homeless	5	5	12	140.0%
Agricultural Worker	989	973	1,007	1.8%
Public Housing	-	-	-	-
School Based	876	1,537	1,721	96.5%
Veterans	173	173	241	39.3%

Cost Data

	2010	2011	2012	2010 - 2012 Trend %Change
Cost Data				
Health Center Service Grant Expenditures	$7,365,344	$7,170,630	$8,646,810	17.4%
Total Cost	$26,582,197	$27,174,644	$28,454,937	7.0%
Total Cost Per Patient	$893.55	$865.02	$825.62	-7.6%

South Boston Community Health Center

2012 Health Center Profile

SOUTH BOSTON COMMUNITY HEALTH CENTER
BOSTON, MASSACHUSETTS

Total Patients Served: 14,293

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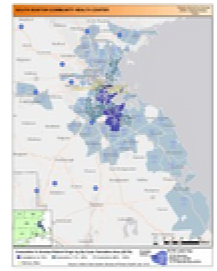

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Age and Race/Ethnicity

	2010	2011	2012	2010 - 2012 Trend %Change
Total Patients				
Total Patients	14,079	14,297	14,293	1.5%
Age (% of total patients)				
Children (< 18 years old)	18.0%	17.4%	16.7%	-7.4%
Adult (18 - 64)	71.2%	71.7%	71.3%	0.2%
Geriatric (age 65 and over)	10.8%	10.8%	12.0%	11.0%
Minority Patients By Race & Ethnicity (% known)				
Racial and/or Ethnic Minority	15.8%	15.6%	18.1%	14.7%
Hispanic/Latino Ethnicity	8.8%	8.0%	10.0%	14.1%
Black/African American [1]	5.6%	5.0%	5.0%	-11.0%
Asian [1]	1.3%	1.4%	1.4%	5.2%
American Indian/Alaska Native [1]	0.2%	0.2%	0.2%	21.7%
Native Hawaiian / Other Pacific Islander [1]	0.2%	0.5%	0.6%	285.1%
More than one race [1]	0.0%	6.1%	8.5%	-
Language (% known)				
Best Served in another language	16.6%	17.1%	17.9%	7.6%

Patient Characteristics

	2010	2011	2012	2010 - 2012 Trend % Change
Income Status (% of patients with known income)				
Patients at or below 200% of poverty	91.2%	73.0%	70.0%	-23.2%
Patients at or below 100% of poverty	76.8%	59.9%	50.5%	-34.2%
Insurance Status (% of total patients)				
Uninsured	7.5%	12.0%	12.5%	65.3%
Children Uninsured (age 0-19 years)	6.5%	11.0%	7.4%	14.2%
Medicaid/CHIP [2]	28.2%	27.0%	27.1%	-4.0%
Medicare	11.3%	10.4%	9.9%	-12.3%
Other Third Party	53.0%	50.6%	50.6%	-4.5%
Special Populations				
Homeless	40	28	36	-10.0%
Agricultural Worker	0	2	0	
Public Housing	-	-	-	-
School Based	0	0	0	
Veterans	244	337	332	36.1%

Cost Data

	2010	2011	2012	2010 - 2012 Trend %Change
Cost Data				
Health Center Service Grant Expenditures	$615,314	$711,817	$681,049	10.7%
Total Cost	$11,277,214	$11,073,044	$13,916,394	23.4%
Total Cost Per Patient	$801.00	$774.50	$973.65	21.6%

William F. Ryan Community Health Center, Inc.

2012 Health Center Profile

WILLIAM F. RYAN COMMUNITY HEALTH CENTER, INC.
NEW YORK, NEW YORK

Total Patients Served: 48,981

EHR PCMH

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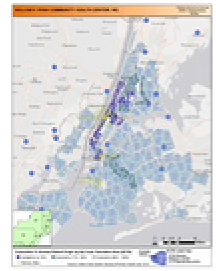
View all New York Program Grantees

View National and State Program Grantee Data



Click to enlarge

Age and Race/Ethnicity

	2010	2011	2012	2010 - 2012 Trend %Change
Total Patients				
Total Patients	45,873	49,192	48,981	6.8%
Age (% of total patients)				
Children (< 18 years old)	29.7%	30.5%	30.0%	1.1%
Adult (18 - 64)	61.4%	59.8%	60.1%	-2.1%
Geriatric (age 65 and over)	8.9%	9.7%	9.9%	10.8%
Minority Patients By Race & Ethnicity (% known)				
Racial and/or Ethnic Minority	80.0%	85.0%	85.4%	6.7%
Hispanic/Latino Ethnicity	41.6%	47.6%	47.4%	13.8%
Black/African American [1]	33.2%	50.3%	51.8%	55.8%
Asian [1]	2.8%	5.1%	4.8%	74.3%
American Indian/Alaska Native [1]	0.6%	0.8%	1.0%	57.7%
Native Hawaiian / Other Pacific Islander [1]	0.3%	5.2%	3.2%	897.3%
More than one race [1]	6.8%	0.4%	2.5%	-63.6%
Language (% known)				
Best Served in another language	18.8%	19.8%	19.4%	3.2%

Patient Characteristics

	2010	2011	2012	2010 - 2012 Trend % Change
Income Status (% of patients with known income)				
Patients at or below 200% of poverty	89.6%	88.0%	91.4%	2.0%
Patients at or below 100% of poverty	75.2%	74.2%	81.9%	8.8%
Insurance Status (% of total patients)				
Uninsured	28.6%	26.8%	23.6%	-17.7%
Children Uninsured (age 0-19 years)	18.6%	17.4%	11.0%	-40.5%
Medicaid/CHIP [2]	53.0%	56.2%	58.4%	10.2%
Medicare	10.7%	9.9%	10.3%	-4.0%
Other Third Party	7.7%	7.1%	7.8%	1.5%
Special Populations				
Homeless	1,498	2,648	2,690	79.6%
Agricultural Worker	90	118	205	127.8%
Public Housing	-	-	-	-
School Based	3,356	1,796	1,867	-44.4%
Veterans	242	360	381	57.4%

Cost Data

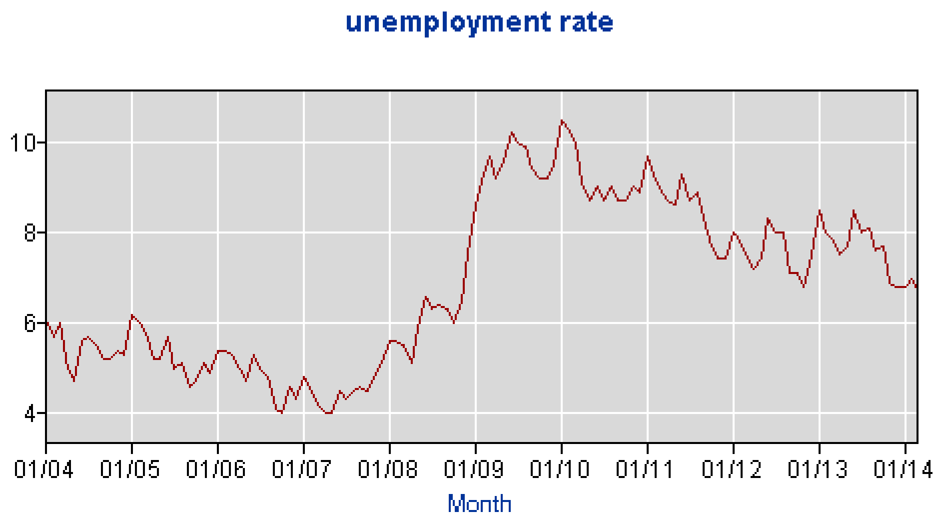
	2010	2011	2012	2010 - 2012 Trend %Change
Cost Data				
Health Center Service Grant Expenditures	$7,157,027	$7,524,335	$7,581,686	5.9%
Total Cost	$45,134,366	$47,119,690	$48,850,642	8.2%
Total Cost Per Patient	$983.90	$957.87	$997.34	1.4%

Appendix B

Economic Information

Johnson City Unemployment Rate

Extracted from Local Area Unemployment Statistics, 2014



Johnson City Economy at a Glance

Extracted from the Bureau of Labor Statistics

Johnson City, TN

Johnson City, TN

Data Series	Back Data	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014	Mar 2014
Labor Force Data							
Civilian Labor Force (1)		(4) 95.6	(4) 95.4	(4) 95.0	93.8	94.5	(P) 94.9
Employment (1)		(4) 88.3	(4) 88.8	(4) 88.5	87.5	87.9	(P) 88.5
Unemployment (1)		(4) 7.3	(4) 6.6	(4) 6.5	6.4	6.7	(P) 6.4
Unemployment Rate (2)		(4) 7.7	(4) 6.9	(4) 6.8	6.8	7.0	(P) 6.7
Nonfarm Wage and Salary Employment							
Total Nonfarm (3)		78.5	79.1	79.3	76.6	77.4	(P) 77.9
12-month % change		-2.1	-1.6	-0.9	0.1	0.0	(P) 0.1
Mining, Logging, and Construction (3)		2.7	2.7	2.7	2.4	2.5	(P) 2.6
12-month % change		0.0	0.0	3.8	-4.0	0.0	(P) 0.0
Manufacturing (3)		7.4	7.3	7.3	7.3	7.2	(P) 7.2
12-month % change		-5.1	-3.9	-3.9	-2.7	-4.0	(P) -4.0
Trade, Transportation, and Utilities (3)		13.4	13.7	13.8	13.3	13.1	(P) 12.9
12-month % change		2.3	2.2	3.0	3.9	1.6	(P) 0.8
Information (3)		1.4	1.4	1.4	1.3	1.3	(P) 1.3
12-month % change		0.0	7.7	7.7	-7.1	0.0	(P) 0.0
Financial Activities (3)		3.8	3.8	3.8	3.8	3.8	(P) 3.8
12-month % change		5.6	2.7	2.7	2.7	2.7	(P) 2.7
Professional and Business Services (3)		8.6	8.6	8.7	8.4	8.5	(P) 8.7
12-month % change		6.2	4.9	4.8	5.0	7.6	(P) 6.1
Education and Health Services (3)		13.1	13.2	13.5	13.4	13.5	(P) 13.6
12-month % change		-5.1	-3.6	-0.7	-0.7	0.0	(P) 0.7
Leisure and Hospitality (3)		8.9	9.0	9.0	8.8	8.9	(P) 9.1
12-month % change		3.5	4.7	3.4	6.0	3.5	(P) 4.6
Other Services (3)		2.4	2.4	2.4	2.4	2.4	(P) 2.4
12-month % change		0.0	0.0	0.0	4.3	0.0	(P) 0.0
Government (3)		16.8	17.0	16.7	15.5	16.2	(P) 16.3
12-month % change		-10.2	-9.6	-9.2	-6.1	-5.3	(P) -4.7

Footnotes
(1) Number of persons, in thousands, not seasonally adjusted.
(2) In percent, not seasonally adjusted.
(3) Number of jobs, in thousands, not seasonally adjusted. See About the data.
(4) Reflects revised inputs, reestimation, and adjustment to new state control totals.
(P) Preliminary

United States Economy at a Glance
Extracted from the Bureau of Labor Statistics

United States

United States - Monthly Data

Data Series	Back Data	Nov 2013	Dec 2013	Jan 2014	Feb 2014	Mar 2014	Apr 2014
Unemployment Rate (1)		7.0	6.7	6.6	6.7	6.7	6.3
Change in Payroll Employment (2)		274	84	144	222	(P) 203	(P) 288
Average Hourly Earnings (3)		24.15	24.17	24.22	24.29	(P) 24.31	(P) 24.31
Consumer Price Index (4)		0.1	0.2	0.1	0.1	0.2	
Producer Price Index (5)		0.0	(P) 0.0	(P) 0.2	(P) -0.1	(P) 0.5	
U.S. Import Price Index (6)		-0.9	0.1	(R) 0.4	(R) 0.9	(R) 0.6	

Footnotes
(1) In percent, seasonally adjusted. Annual averages are available for Not Seasonally Adjusted data.
(2) Number of jobs, in thousands, seasonally adjusted.
(3) Average Hourly Earnings for all employees on private nonfarm payrolls.
(4) All items, U.S. city average, all urban consumers, 1982-84=100, 1-month percent change, seasonally adjusted.
(5) Final Demand, 1-month percent change, seasonally adjusted.
(6) All imports, 1-month percent change, not seasonally adjusted.
(R) Revised
(P) Preliminary

Appendix C

Johnson City Demographic Distribution by Age

Extracted from the U.S. Census Bureau

DP-1 | Profile of General Population and Housing Characteristics: 2010

2010 Demographic Profile Data

NOTE: For more information on confidentiality protection, nonsampling error, and definitions, see http://www.census.gov/prod/cen2010/doc/dpsf.pdf.

Geography: Johnson City city, Tennessee

Subject	Number	Percent
SEX AND AGE		
Total population	63,152	100.0
Under 5 years	3,353	5.3
5 to 9 years	3,417	5.4
10 to 14 years	3,284	5.2
15 to 19 years	4,835	7.7
20 to 24 years	7,078	11.2
25 to 29 years	4,657	7.4
30 to 34 years	3,640	5.8
35 to 39 years	3,688	5.8
40 to 44 years	3,773	6.0
45 to 49 years	4,078	6.5
50 to 54 years	4,232	6.7
55 to 59 years	3,922	6.2
60 to 64 years	3,514	5.6
65 to 69 years	2,713	4.3
70 to 74 years	2,153	3.4
75 to 79 years	1,832	2.9
80 to 84 years	1,458	2.3
85 years and over	1,525	2.4
Median age (years)	36.9	(X)
16 years and over	52,425	83.0
18 years and over	51,081	80.9
21 years and over	46,717	74.0
62 years and over	11,700	18.5
65 years and over	9,681	15.3

Appendix D

2014 Cell Phone Ownership
Extracted from the Pew Research Center

Cell owners in 2014

Among adults, the % who have a cell phone

		Have a cell phone
	All adults	**90%**
	Sex	
a	Men	93[b]
b	Women	88
	Race/ethnicity*	
a	White	90
b	African-American	90
c	Hispanic	92
	Age group	
a	18-29	98[cd]
b	30-49	97[cd]
c	50-64	88[d]
d	65+	74
	Education level	
a	High school grad or less	87
b	Some college	93[a]
c	College+	93[a]
	Household income	
a	Less than $30,000/yr	84
b	$30,000-$49,999	90
c	$50,000-$74,999	99[ab]
d	$75,000+	98[ab]
	Community type	
a	Urban	88
b	Suburban	92
c	Rural	88

Source, Pew Research Center Internet Project Survey, January 9-12, 2014. N=1,006 adults.
Note: Percentages marked with a superscript letter (e.g., [a]) indicate a statistically significant difference between that row and the row designated by that superscript letter, among categories of each demographic characteristic (e.g., age).
* The results for race/ethnicity are based off a combined sample from two weekly omnibus surveys, January 9-12 and January 23-26, 2014. The combined total n for these surveys was 2,008; n=1,421 for whites, n=197 for African-Americans, and n=236 for Hispanics.

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2014 Smartphone Ownership
Extracted from the Pew Research Center

Smartphone owners in 2014

Among adults, the % who have a smartphone

		Have a smartphone phone
	All adults	58%
	Sex	
a	Men	61
b	Women	57
	Race/ethnicity*	
a	White	53
b	African-American	59
c	Hispanic	61[a]
	Age group	
a	18-29	83[bcd]
b	30-49	74[cd]
c	50-64	49[d]
d	65+	19
	Education level	
a	High school grad or less	44
b	Some college	67[a]
c	College+	71[a]
	Household income	
a	Less than $30,000/yr	47
b	$30,000-$49,999	53
c	$50,000-$74,999	61[a]
d	$75,000+	81[abc]
	Community type	
a	Urban	64[c]
b	Suburban	60[c]
c	Rural	43

Source, Pew Research Center Internet Project Survey, January 9-12, 2014. N=1,006 adults.
Note: Percentages marked with a superscript letter (e.g., [a]) indicate a statistically significant difference between that row and the row designated by that superscript letter, among categories of each demographic characteristic (e.g., age).
* The results for race/ethnicity are based off a combined sample from two weekly omnibus surveys, January 9-12 and January 23-26, 2014. The combined total n for these surveys was 2,008; n=1,421 for whites, n=197 for African-Americans, and n=236 for Hispanics.

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Appendix E

JCCHC Sliding Scale Chart

Extracted from the JCCHC Sliding Fee Packet given to patients

Schedule of Income Thresholds Based upon 2013 Federal Poverty Guidelines (January 24, 2014)

Annual Income Thresholds by Sliding Fee Discount Pay Class and % of Poverty

Family Unit Size	(A) $25.00 Nominal Fee	(B) $40.00	(C) $55.00	(D) $70.00	(E) 100% Pay No Discount
Poverty	100%	133%	175%	200%	>200%
1	0.00	11,670	15,521	20,423	23,340
2	0.00	15,730	20,921	27,578	31,460
3	0.00	19,790	26,321	34,633	39,580
4	0.00	23,850	31,721	41,738	47,700
5	0.00	27,910	37,120	48,843	55,820
6	0.00	31,970	42,520	55,948	63,940
7	0.00	36,030	47,920	63,053	72,060
8	0.00	40,090	53,320	70,158	80,180

Note: *The income ceiling for the nominal fee pay class is equal to the federal poverty level.*
The 2013 federal poverty guideline increase by $3,960 for each family member.

Monthly Income Thresholds by Sliding Fee Discount Pay Class and % of Poverty

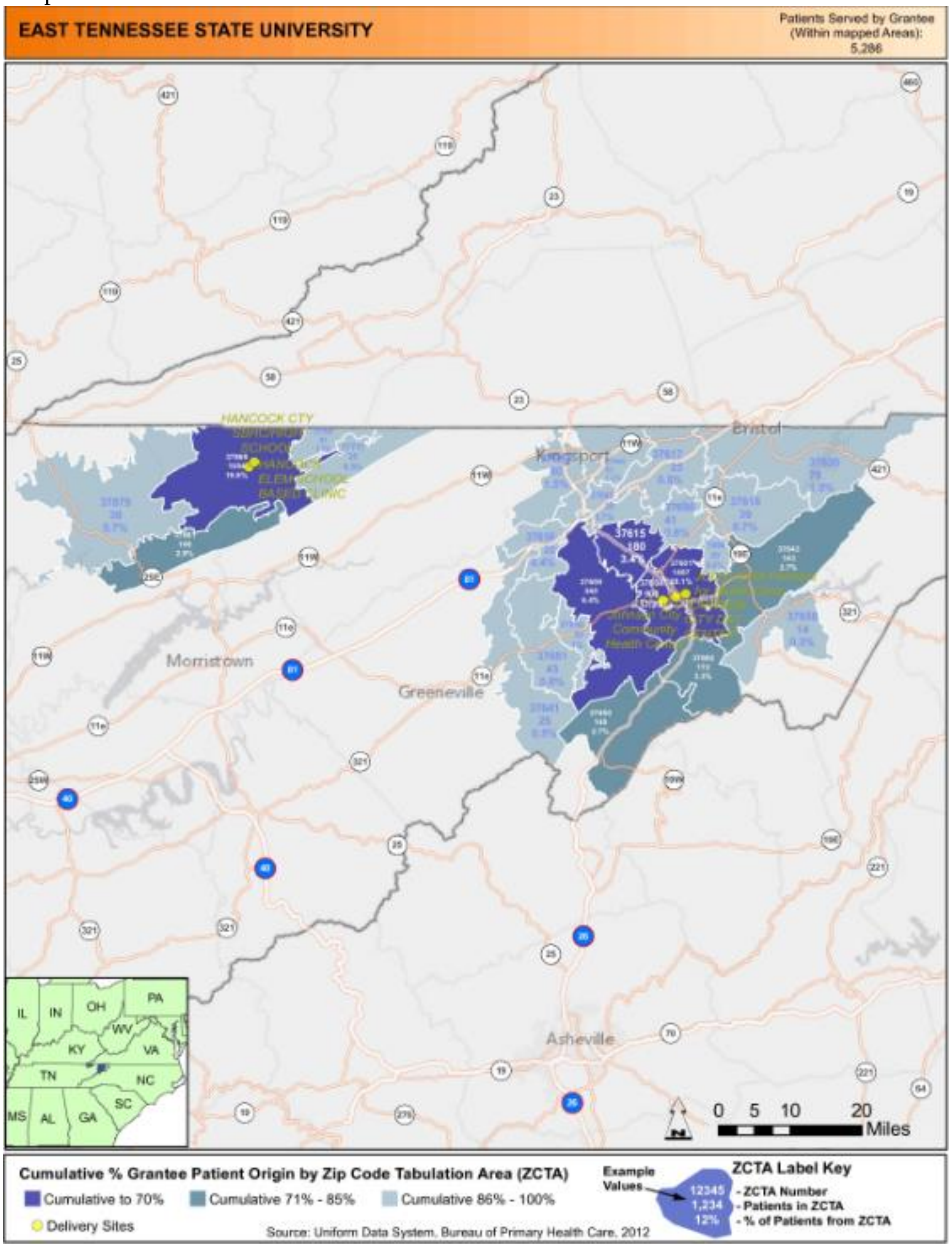
Family Unit Size	(A) $25.00 Nominal Fee	(B) $40.00	(C) $55.00	(D) $70.00	(E) 100% Pay No Discount
Poverty	100%	133%	175%	200%	>200%
1	0.00	973	1,294	1,703	1,945
2	0.00	1,311	1,744	2,294	2,622
3	0.00	1,649	2,193	2,886	3,298
4	0.00	1,988	2,644	3,478	3,975
5	0.00	2,326	3,094	4,071	4,652
6	0.00	2,664	3,543	4,662	5,328
7	0.00	3,003	3,994	5,255	6,005
8	0.00	3,341	4,444	5,847	6,682

Note: *The monthly schedule is equal to the annual schedule divided by 12 months.*

Appendix F

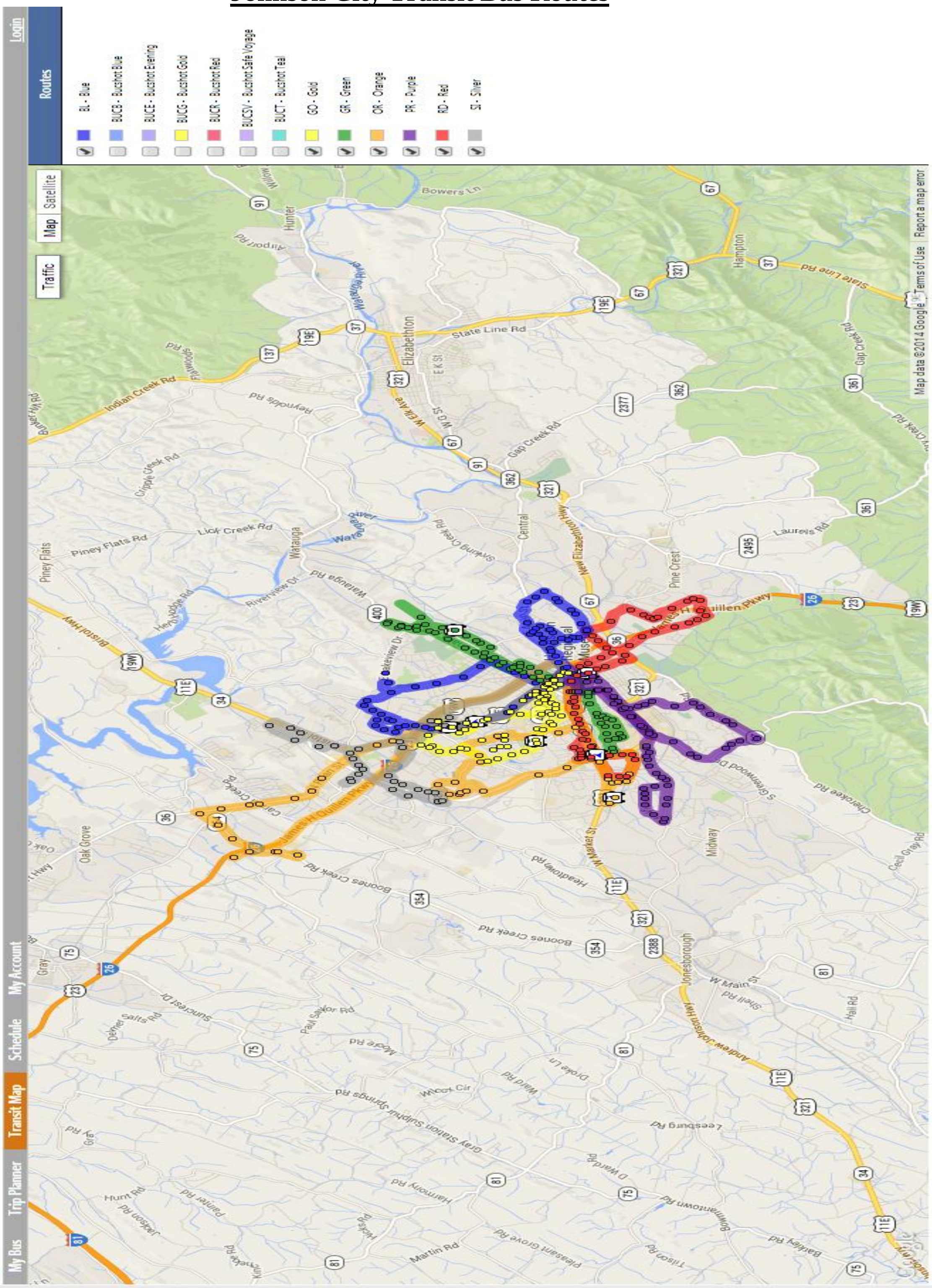
JCCHC Service Area

Extracted from the
U.S. Department of Health and Human Services: Health Resources and Services Administration



Appendix G

Johnson City Transit Bus Routes



Appendix H

SWOT Analysis

Strengths (Internal)	Weaknesses (Internal)
• Family Nurse Practitioners and their philosophies. • Various services are offered. • Low cost per patient. • Sliding fee scale is offered. • Convenient location accessible by different forms of transportation.	• The center does not have a strong promotional mix. • Family Nurse Practitioners do not have hospital admitting privileges. • There is a lack of certain services, such as dental hygiene and an on-site pharmacy, even though it has space for both of these services. • High uninsured population
Opportunities (External)	**Threats (External)**
• There is strong political support in the national, state, and local level of government. • The Consolidated Appropriations Act and the Affordable Care Act. • Good record of grants being awarded to the JCCHC. • In general, unemployment has been decreasing. • Job growth in three of the top five employment sectors in Johnson City. • The Millennials' personalities are the right ones needed to stir social movements. • Body weight workouts, specialized gyms, functional workouts, and healthy nutritional trends. • Increase in cellphone and smart phone ownership. • Health care and nutritional apps for smartphones.	• Tennessee Representative Phil Roe opposes the Affordable Care Act. • Tennessee Governor Bill Haslam did not expand Medicaid in the state. • Uninsured population of patients is very high compared to the national average for community health centers. • Unemployment rates have been increasing slightly. • One of the top five employment categories in Johnson City has shown a drop in employment. • Millennials' support for the poor has dropped. • Millennials' focus on social causes is constantly changing. • Millennials' social movements focus on the journey of a movement as opposed to actual change. • Unsafe diets and unhealthy weight loss methods. • HIPAA privacy violations when patients share mobile information with health care providers.