Betsey Cooke

Heading community health centers coalition

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Cancer survivor Betsey Cooke helps insure the uninsured...

It was 10 years ago that a coalition of community health centers was formed in Miami-Dade County with a commitment to provide high-quality, comprehensive preventive and primary care to the uninsured and others with low incomes.

The venture was named Health Choice Network, and someone with more than 20 years' experience in community-based health care and social services around Florida was recruited to head it as chief executive officer.

She is Betsey Cooke, whose career had included holding executive positions in state government in employment, training, and community development; consulting with community-based groups running Tri-County Community Medical Center in Greenville, near Tallahassee. Before taking on her role at Portel-based Health Choice Network — which will commemorate its 10th anniversary Oct. 2 with a benefit dinner at the Sherraton Bal Harbour — Ms. Cooke served as executive director of its predecessor organization, Prime Health Care Consortium of Dade County.

She was interviewed by Miami Today international editor Michael Hayes.

Q: How did Health Choice Network come into being, what is its mission, and what does it comprise today?

A: Health Choice Network is a not-for-profit corporation formed in 1994 by four African-American CEOs who ran community health centers at the time. They believed that together, they would be stronger in operating key business functions and in ensuring that the notion to take care of uninsured and low-income people would be better-served.

But at Health Care Network, we are strong believers in independent community-based boards of directors that must be at least 51% governed by our own consumers. So we were looking for a model that would make the integrity of the individual corporations in the network but allow them, in effect, to do business together to get the economies of scale in critical areas of infrastructure.

As health care has become more of a big business, all mom-and-pop organizations have disappeared, and although community health centers are fairly significant in size, we are not big enough individually to be efficient in the larger marketplace. So our model of a network that is governed by those health centers is one that preserves the neighborhood model as well as allows them to work together to build a centralized infrastructure.

The network now is comprised of 10 community health centers in South and Central Florida, and we also run the information technology for seven centers in Utah and six in New Mexico.

Together in Florida, we serve in excess of 200,000 patients, most of them low-income.

Q: How is HCN structured?

A: The community health centers compose our governing board, usually the CEOs, and as the CEO of the network and our staff, we work for them collectively. Then, in the business functions that are delegated to us to run — information technology, finance, billing, certain managed-care functions and certain programs — we serve as the leadership and the executive.

We have an executive team composed of a chief financial officer and chief information officer for the network who is also the CFO/CIO for the centers. He reports directly to me but also to each center CEO. He has a staff of finance people and IT people.

We centralize all IT here at the network — all the servers, hardware and software are here. Each center has a separate data set that only they and the network staff can get into.

The finance is not quite as centralized.

We have a common accounting system, and all of the big financial issues are dealt with by the CFO — that is, he and the staff drive the audits, the cost-reimbursement report, the big funding report — but we oversee all of the financial statements so as to be able to say to the CEO and to the board, “These are correct. They are done according to correct principles, and we are confident in forwarding them to you.”

We also centralized billing about two years ago, so we have a director of reimbursement at the network level, and we’re able to provide the billing for all of the centers in Florida out of the network here.

We got some savings in cutting a few positions. The reason to do that is to increase revenue because you can have people specialize in a certain area — commercial, Medicare — where they can charge the rules every day, so it’s good to have one person or one group responsible.

Q: You have specialists in other areas?

A: Yes, for example, we have a VP for managed care and clinical. She manages now three risk contracts for Medicaid and Medicare where we are in partnership with an HMO and share full risk.

Q: How is the network funded?

A: Different functions of the HCN are funded by different sources. Overall, close to half of the funding comes from the centers themselves, where they contract with us for operation of these functions. We believe that a corporation like this has to be supported by its members and it must make sense and be competitive in the market.

The other half of our funding comes from a variety of sources. Part comes from the federal government, which has designated us a model of an operating network — they want us to work together because they know for some things, such as those I have described, we are only efficient by working together, so they provide incentive funding. Then we receive grants from local, state and federal foundations and governmental sources.

Regarding funding, we have another main division, program development. We used to do a lot of outreach education and prevention in the community, but now we are very hard to find, and the centers said to us, “We want you to find a way to fund prevention on an ongoing basis, work with faith-based partners — churches particularly in the African-American and Hispanic communities have a way of reaching into communities — develop a partnership and find a way to fund it.”

That is what our program development unit does in a program that we call Healthy Body, Healthy Soul. We have several projects underneath that program. They have the unenviable task of finding the money to run that from the network and at the center and church levels because this country does not fund prevention — we fund acute care — and part of our challenge is to change that policy over time.

We also run some clinical programs that funders want us to run because they need critical mass. For instance, we run disease management, a special senior immunization program and a sexually transmitted-disease program where the funder needs to fund a larger group, not a single center.

Q: You have recently been awarded a $4 million federal government grant?

A: It is a grant from the Health Resources and Services Administration of $1 million each year over four years. It’s called Improving Communications with Technology. At the end of the four years, we would have all 200 providers in all 10 health centers completely on electronic health and oral-health records. We are interfaced to hospitals, labs and pharmacies, and we have about 40 providers up already.

It’s important to point out that although the grant is $4 million, the centers themselves will have to contribute at least $8 million.

Q: What would you respond to those who might ask why the government rather than the not-for-profit sector shouldn’t handle the services you are providing?

A: As a private not-for-profit corporation, we can be entrepreneurial as well as provide service. I believe that there are some areas where the private not-for-profit sector, if it is entrepreneurial, can provide services more efficiently, more effectively and closer to the community.
PROFILE

...with Health Choice Network, approaching 10th anniversary

than can the government sector. The gov-
ernment sector is constrained by its own
size and bureaucracy. If it supports pro-
grams like this at all. If the philanthropic
community does, what you find is that
money will go further.

We see ourselves as entrepreneurs. It is
important for us not to spend money but
to save it and to give it more effectively. We
work in the areas where the profit margin
is not enough to attract private business,
but a business that can be a break-even
business — which is what we are — can
survive with help from year to year. It
challenges us and makes us be creative, to
find new and better ways to serve the
uninsured.

Q: You serve not only the uninsured
but also the under-insured?

A: Yes, both. Many of them are work-
ing but are not covered by health insur-
ance. We also accept Medicaid and Medi-
care. We have some commercial insur-
ance, but very small. We serve patients on
a sliding fee scale, where their income is
taken into account. If it is very low, they
pay only a minimum fee of anywhere from
$75 to $125 per visit. We are a slightly high-
income but still qualifying for reduced fees,
the fees are applied on a percentage
basis — that is, our charges might be $150
for a physical, and they may pay 30%, 60% or 80%, based on their income. That
way, we can cover people that need to be
seen but often go to emergency rooms.

Q: How many patients do you cur-
rently serve?

A: Over 300,000 throughout Florida,
New Mexico and Utah. In Florida, it's
around 200,000, predominantly Hispanic
and African American, including Carib-
bean American and Haitian, but also
a number of Angles — it depends on the
community that is served.

Q: You have been engaged in com-
munity-based health care and social
service for more than two decades?

A: Yes. I started my career in Florida
state government with a program called
CHEAT — Comprehensive Employment
Training. I was responsible for fund-
ing programs throughout the state to im-
prove the employment situation of people
who were unemployed or under-employed.

After the eight years of that, in the
1970s, it was called to me that there are
some areas of the state that were under-
developed, and I made a career move. I
chose to go out into some of those commu-
nities to help develop non-profit infra-
structures both to improve communities
and to be available to contract for local,
state or federal dollars, believing that there
were things that non-profits could do in
communities that neither the private sec-
ctor nor the public sector could do.

So I did that and worked for awhile for
the National Governors Association on
the same issues. It was in that consulting
work that I came into contact with health
care. All I had known about health care
before that was to stay away from the
doctors. But I learned, by working in a
poor north Florida community, that doctors
were an important fabric in that com-
devolution in this particular community.
I was not serving poor, and especially black,
people and made a conscious decision not
to serve them. Consequently, the whole com-
nunity was affected because it had real
high infant-mortality rates, like Third World
rates.

The community at that time wanted to
put together a health center, and I helped
organize it while working as a consult-
ant and borrowing money to do that. I
borrowed from my parents because no-
body was going to pay you to develop an
organization where there was not one but
the community of poor people wanted it.

Q: Where was that community?

A: Greenville, just east of Tallahassee.
The group came together as a health cen-
ter. We competed for grant funding and
were funded. For about eight years, I
served as CEO. It was a group called Tri-
County Community Medical Center, and it
operated in Jefferson, Madison and Tay-
lor counties.

It was that experience and participation
in health care around the state that got me
eventually to Miami. I was recruited by
the centers here — particularly by Jessie
Trice from Economic Opportunity Family
Health Center — to use my organizational
skills to put together a new type of organi-
ization. Jessie Trice died of lung cancer in
stage 4, and during her treatment, which
she knew would not work because she
was diagnosed so late, she asked me to help
develop a program where we would
screen people and get them into treatment
early. So we have a program called the
Jessie Trice Cancer Prevention Project
under the Healthy Body, Healthy Soul
program as a sacred responsibility to her.

Q: Who were the others who recruited
you?

A: They were Brodes Hartley Jr., who
is the CEO of Community Health of South
Dade — he is still here and serves as the
chairman of our group — and Carl Davis,
CEO of the Helen B. Bentley Family Health
Center. They knew me from our state
association and recruited me down here
with the idea of the health centers
working together.

Q: That was in 1994?

A: They actually recruited me in '91, just
before Hurricane Andrew, to work with
the predecessor corporation, called the
Primary Health Care Consortium. That
group had never been well-funded and had
ebbed and flowed. We did a planning out-
put of that corporation that then created
the Health Choice Network. One principle
on which we are based and learned from
the consortium is that this corporation had
to belong to consumers, that the centers
did not have to invest in them in order to value it — we
must invest, it must be ours.

Another principle is that we believe in
the power of community-based boards of
directors, and we want to preserve those
to work and to learn from communities
while at the same time being able to run
certain business functions as a group rather
than as an individual entity. In addition, we
feel we need to be in partnership with
community agencies in our community,
including the faith-based community, in
order to get the word about prevention of
disease into the community.

Our communities have huge disparities
in health outcomes. Part of that is the
access to care, part of it is education and
prevention.

Q: While you have been at the fore-
front of such advocacy, you have been
fighting a hard battle of your own.

A: That is true. I am both a cancer
survivor from 1996 and have had a recur-
rence of breast cancer. I am fortunate that
it was caught very early because I do my
screening and prevention. I am probably
misinformed in that I have a very rare
disease where in fighting the disease, your
body makes antibodies to fight the cancer,
with the good news being that the cancer
is often defeated because the antibodies
are so powerful. But the antibodies also
attack your cerebellum cells, affecting
your motor skills — walking and speaking
particularly.

I believe that this gave me an opportunity
to talk about cancer openly. In our commu-
nities, we are afraid to talk about cancer or
we don’t talk about it. Cancer treatment
has come so far in the past 10 years that it's
very different than what it was even in '96.
The fear of cancer keeps people learning
about it and from seeking treatment.

I am certainly talking about it, to my
staff and to anybody that will listen. You
can live with cancer. You may die from it,
but we all die and what is important is how
we live. I want to encourage people that
we have nothing to fear but fear itself.

What’s important is that every day we
are learning more things about cancer, and
as people, we need to learn more and not
be afraid. So the extent to which I can
carry that message, I will. I’m lucky that
I can still work part-time in my office and
part-time from my home. I’m fortunate
that the board allows me to do that. And
over time, I believe that I will gain back
some of the working and talking skills.

Cancer may close a door, but it opens
other doors. One of the doors that opens
for me is that I’m 54 now, I need to be
mentoring and developing my team to carry
us for the next 10 years — we are just
nearing our first 10-year anniversary.