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**THE FUTURE OF COMMUNITY  
CLINICS AND HEALTH  
CENTERS IN CALIFORNIA'S  
SAFETY NET:  
A BLUEPRINT FOR ACTION  
2007 UPDATE**

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**Prepared for:**

**CPCA**

California Primary  
Care Association

*Health Care Access for All*

**Prepared by:**

Jennie Schacht  
Schacht & Associates  
Oakland, California  
510-654-0545

[js@schachtandassociates.com](mailto:js@schachtandassociates.com)  
[www.schachtandassociates.com](http://www.schachtandassociates.com)

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## **EXECUTIVE SUMMARY**

In 1999, Schacht & Associates worked with the California Primary Care Association (CPCA) in a strategic process that resulted in the document, “The Future of California Community Clinics and Health Centers in the Safety Net: A Blueprint for Action.” The Blueprint for Action was intended as a guide for community clinics and health centers (CCHCs) and others committed to understanding and supporting their critical safety net role. It also was intended to alert foundations and other funders to the most critical resource needs facing CCHCs. The report included six strategies along with detailed recommendations for CPCA, clinics, consortia, and funders.

The Blueprint, and this 2007 Update, are part of CPCA’s ongoing effort to facilitate CCHCs in carrying out their mission to provide care to all Californians and to support their critical role in the health care safety net. This update is intended to revisit the original report and to consider the best ways funders can support the critical role played by community clinics and health centers given the current climate in which they are operating and the current challenges they face.

This 2007 Update reviews the findings of the earlier report, updating them to reflect the current environment. We interviewed key informants and surveyed CPCA clinic corporations statewide to seek their input on the challenges they face, as well as the strategies that might be used to address them. Based on this information, we have updated the strategies included in the earlier report to suggest a new Blueprint for Action moving forward.

After reviewing the environmental analysis included in the 1999 Blueprint, we concluded that, the more things change, the more they stay the same. While there have been many changes in the health care environment since 1999, our review of the literature, as well as interviews with key informants and our survey of community clinics and health centers, told us that much remains the same.

CCHCs continue to be an essential ingredient in California’s health care delivery system, especially for the state’s most difficult to reach populations. With 6.5 million Californians remaining uninsured and a statewide network of almost 800 community clinics and health centers providing a great portion of their care, the urgency remains as great as ever to assure a strong and viable health care safety net.

One indicator of how things have changed: Rather than being thought of solely as a safety net for the poor, CCHCs are now well integrated into the fabric of the health care system. Certainly, the clinics continue to care for the state’s poorest and most disenfranchised patients. But at the same time, California clinics have emerged as a model for the delivery of quality health care in an efficient and cost effective manner.

Clinics have outgrown their position as underdog to participate as an equal partner in the health care system—not only as peer, but often as innovator and mentor. They have emerged as a beacon for the ways in which they manage care, provide supportive and

enabling services that allow patients to access care, reduce emergency room usage, integrate mental health and oral hygiene into primary care, and address chronic conditions. They have demonstrated that it is possible to do these things while continuing to care for all segments of the population.

CCHCs have long operated using a model that today is promoted as the wave of the future in health care. They are a natural environment for chronic care management and treatment as they are based on establishing a relationship with clients, closely managing their care, and keeping patients out of the hospital. CCHCs provide a “medical home” for their patients—a true source of primary and preventive care, rather than acting as a treatment source of last resort.

Having a primary physician as a first point of medical contact has been shown to keep patients healthy and out of emergency rooms, where the cost of care is much higher than for routine, preventive, and primary care. Beyond providing a medical home, CCHCs assist patients to navigate a continuum of care that is increasingly complex. CCHCs are at the forefront of chronic disease management, employing chronic disease registries and other methods to support quality care.

Ten-year trend data from the California Office of Statewide Health Planning and Development (OSHPD) show that the total number of clinics grew from 471 in 1995 to 794 in 2005, an increase of 323 clinics or almost 70%. The growth in number of patients served and total number of encounters mirror the growth in the number of clinics, with increases of 66% and 64% in those two categories, respectively. This amounts to a lot of patient care—the total annual number of encounters grew by more than 4 million over the ten-year period, with the average number of encounters per patient holding steady at about 3.1. In 2005, CCHCs delivered more than 11 million encounters to nearly 3 million patients. The proportion of patients with incomes below the federal poverty level grew by almost 5% over the ten-year period, with those in the higher income brackets declining.

Clinics had significant income growth over the ten years, almost doubling their collective income from \$569 million in 1995 to over \$1 billion in 2005. Total operating expenses increased at almost the same rate, leaving the clinics with a negligible net operating gain for 2005.

In consideration of the environmental scan, findings from key informant interviews, and survey findings, the report concludes with five top priority strategies for clinics and those working to assure their continued survival. They are:

- ☑ **Strategy #1: EXPAND PRIMARY CARE CAPACITY.** Clinics serve a large proportion of Californians with incomes at or below 200% of poverty, and nearly half of clinic patients are uninsured. In light of their proven track record in providing cost effective, quality care, funding for their expanded infrastructure should be an important element of any proposal for health care reform. Recognizing this with significant investments in clinic infrastructure and capacity can help not only to increase the volume of patient care, but also to improve the health of communities, reducing the need for care. Key areas for capacity expansion include core support, capital, and technology.

- ☑ **Strategy #2: ENHANCE HEALTH INFORMATION TECHNOLOGY.** Technology has become increasingly essential to the quality of care, efficiency, alliance-building, infrastructure, and financial viability of safety net providers. A key area for HIT in the coming years will be enhancing the ability to use technology to support and document quality improvements. Other areas include broadening implementation of electronic health records; helping clinics to systematize, document, and track the care they already provide; increasing capacity for and use of telemedicine; and participating in regional and statewide health information exchange. While technology requires a significant up-front investment, there is good reason to believe it will pay off in better care and reduced costs. Until that happens, clinics will require external funding.
  
- ☑ **Strategy #3: ADDRESS WORKFORCE OBSTACLES.** Clinics face challenges recruiting and retaining qualified medical and other staff, especially those who are prepared to address the linguistic and cultural needs of their patients. Strategies should address the full spectrum of workforce issues, from provide supply, to adequate salaries and benefits or other incentives, to training and other programs to improve retention. Workforce initiatives should take into consideration the \$3.15 billion in business California clinics and health centers bring to their communities and to the state.
  
- ☑ **Strategy #4: SUPPORT CCHC MODEL PRACTICES IN PREVENTION, POPULATION HEALTH, AND CHRONIC DISEASE CARE.** There is much data to support the efficacy and cost-effectiveness of the clinic model. Support is needed to continue and expand these efforts. At the core of the model is prevention and a population-based health approach that treats the patient as a whole person within a community. Investments are needed to build on these innovations in order to reduce health disparities, as well as to support core services that are not compensated through traditional health care reimbursement systems.
  
- ☑ **Strategy #5: PROMOTE INTEGRATED SYSTEMS THAT LINK SAFETY NET AND OTHER PROVIDERS TO ADDRESS MULTIPLE PATIENT NEEDS.** Integration among providers can help to spread effective practices to promote the best interest of the patient. Integrated systems can help CCHCs and others to develop and achieve shared financial risk, resources, and financial accountability, as well as common medical records, quality standards, and approaches to disease management. One area ripe for integration is facilitating CCHC involvement in local and regional public health efforts.

Clinics are poised to meet the demands of emerging health care reforms. They have already proven their leadership in meeting the challenges of chronic disease management. They have weathered continual changes in the funding climate.

As we saw in 1999, reimbursement for patient care is not sufficient to support the critical role of community clinics and health centers in a healthy California. In order to actualize their capabilities, clinics will need a significant and ongoing infusion of financial resources. The identified strategies suggest a good place to start.

## **BACKGROUND**

In 1999, Schacht & Associates worked with the California Primary Care Association (CPCA) in a strategic process that resulted in the document, “The Future of California Community Clinics and Health Centers in the Safety Net: A Blueprint for Action.”

The Blueprint, and this 2007 Update, are part of CPCA’s ongoing effort to facilitate community clinics and health centers (CCHCs) in carrying out their mission to provide care to all Californians and to support their critical role in the health care safety net. The original Blueprint posed four key questions related to the viability and sustainability of California CCHCs:

1. What does the future hold for California’s CCHCs in their role as critical safety net providers?
2. What key strategies, tools, and resources can help CCHCs best carry out their safety net mission?
3. What can CCHCs, regional consortia, and CPCA do to assure that CCHCs can continue to meet their objectives into the future?
4. What can funders do to assure the future role of CCHCs in the safety net?

The Blueprint for Action was intended as a guide for CCHCs and others committed to understanding and supporting their critical safety net role. It also was intended to alert foundations and other funders to the most critical resource needs facing CCHCs. The report included detailed recommendations for CPCA, clinics, consortia, and funders.

The process for developing the report included a comprehensive review of previous safety net analyses, an informal survey of California CCHCs, and input from both the CPCA Board of Directors and a Safety Net Advisory Task Force called together by CPCA to address these questions. The Task Force included representation from CCHCs, regional consortia, health plans, foundations, provider organizations, public health departments, public hospitals, organizations addressing geographic and population concerns, and CPCA.

This 2007 Update is intended to revisit that report. In particular, the update considers the best ways funders can support the safety net role played by community clinics and health centers given the current environment in which they are operating and the current challenges they face.

The Blueprint concluded by suggesting six key strategies for preserving the role of CCHCs in the safety net. Recommendations were aimed at funders and policymakers for directing resources that could enable CCHCs to do their part in bringing the strategies successfully to fruition. It was recommended that CPCA continue its advocacy efforts aimed at strengthening and preserving the safety net and promoting systems of care that are both accessible and responsive to the health care needs of all Californians.

## **WHAT THE 1999 BLUEPRINT SAID**

### ***Defined the Safety Net***

Safety net providers are the not-for-profit CCHCs, county health departments, public hospitals and other health care providers that share a common mission to serve everybody who walks through their doors, regardless of their ability to pay. Because of their mission, these providers frequently are the only place to turn for people who face obstacles to utilizing mainstream health care services, such as lack of ability to pay for services, fear of repercussions on immigration status, language and cultural barriers, and a lack of knowledge about or comfort with traditional health services and providers.

Community clinics and health centers (CCHCs) are an essential segment of the safety net. In many California counties, they are responsible for providing a significant proportion of comprehensive primary care services to those who are publicly subsidized or uninsured. In some rural areas, they are the only health provider available to the community.

But CCHCs are more than the provider of last resort. Because many originally were organized to address the needs of special population groups, they have an important role to play in providing culturally-responsive services in a variety of languages to those who would not or could not seek or receive care from other sources. Moreover, they are instrumental in reaching out to individuals who otherwise would use only emergency services, offering a broad range of medical, dental and supportive services, and encouraging ongoing preventive and routine care.

### ***Described the Health Care Environment***

The environment in which they operate may be the largest single factor affecting the ability of CCHCs to survive and thrive. The 1999 Blueprint reported on changes in the health care environment over the previous five to ten years that affected the ability of CCHCs to perform their safety net role and fulfill their missions. Key factors at that time included the large growing number of Californians without health insurance, the introduction of Medi-Cal managed care, an increasingly unstable resource base, challenges to access for certain populations, increasing infrastructure demands, and advances in medical and information technologies. This continually shifting environment presented CCHCs their greatest challenge: operating on the margin, calling upon diminishing resources to provide increasingly costly care to growing numbers of un- and under-insured.

Changes in the environment have influenced CCHCs in the way they provide services, in how they are reimbursed (or not) for services, in payer mix, and even in the mix of patients CCHCs serve. At that time, we saw a trend in CCHCs caring for increasingly sick and vulnerable populations, and those with the highest rates of chronic illness. The ethnic distribution of patients served also was changing, with the proportion of White non-Hispanic patients decreasing and Latino patients increasing.

### ***Reviewed Key Accomplishments and Impact of CCHCs***

The 1999 Blueprint reviewed the critical role CCHCs play in promoting and delivering health care for all Californians, especially those located in medically underserved areas. The report discussed the characteristics that distinguish CCHCs from other health care providers and health systems. It spoke about their strengths: being rooted in and responsive to their local communities, sharing a common sense of mission and purpose, having proved resilient in the face of challenges and change, and acting as advocates on behalf of their patients and communities. It was also noted that, beyond providing health care, CCHCs play an important role in the development and empowerment of their local communities. The role of regional associations also was discussed.

The earlier report predicted that CCHCs would continue to be a major player in the safety net, providing increasing numbers of encounters to growing numbers of patients. These patients would likely be increasingly non-white (and largely Latino), immigrants, and either recipients of Medi-Cal or other public insurance programs or uninsured. Consequently, CCHCs would be expected to struggle over the ten years that followed with revenues that do not keep up with the increasing costs of providing care to populations most in need.

### ***Proposed Strategies To Help CCHCs Achieve Their Optimal Role***

From the work of the Safety Net Task Force, groundwork laid by CPCA, and discussions amongst the CPCA Board of Directors emerged a set of six strategies and recommendations aimed at increasing the odds that California CCHCs could achieve and maintain their optimal role.

The strategies were intended to provide a framework for organizing, understanding, and addressing the range of issues discussed in the broader three focus areas, offering a road map for assuring the future of CCHCs in their critical role of preserving locally-driven, community-based safety net health care to underserved populations.

The strategies were ranked in order of relative importance by the CPCA Board of Directors, though in many cases they are deeply interconnected, each reinforcing the others. Included in the 1999 Blueprint for Action were specific action recommendations related to each strategy for CCHCs and regional clinic consortia, and for funders committed to supporting the role of CCHCs in the safety net. An over-arching role was suggested for CPCA: Advocating for a strong and effective safety net, and promoting accessible systems of care for all Californians.

The strategies included in the 1999 Blueprint for Action were:

**STRATEGY #1: *Expand primary care capacity.*** The growing number of uninsured and disenfranchised patients in California necessitates expanded capacity for primary care, as well as resources to cover the cost of that care. To support primary care expansions, CCHCs will need to upgrade and expand their current facilities, many of which are housed in older buildings sorely in need of renovations. They also will need state-of-the-

art equipment to uphold current standards of care. These “bricks and mortar” improvements can allow CCHCs to provide better care in a more customer-oriented environment, and will enhance their competitive position. Cost-saving measures and effective marketing and communications campaigns can help CCHCs make the most of these improvements.

**STRATEGY #2: *Expand the capacity of safety net providers to address population-based and community health issues.*** An accessible system of quality safety-net care must be community-responsive, comprehensive and population based. CCHCs are eager to participate in joint efforts to assess population-based approaches and to identify and address population health needs. All too frequently, however, they have been excluded from public health discussions. Strategies are needed to encourage health departments and others to include the expertise of CCHCs in local public health efforts.

**STRATEGY #3: *Increase public awareness and improve the public perception of safety net providers.*** CCHCs and safety net patients stand to benefit from public education strategies that raise awareness among funders, government, managed health plans, decision-makers, stakeholders and the general public about the broad role safety net providers play in promoting community health. Resources are needed to support these efforts.

**STRATEGY #4: *Facilitate strategic alliances that enhance community health.*** CCHCs have made great efforts to build and participate in strategic alliances at statewide, regional and local levels. Strategic partnerships should be required to foster and promote the inclusion of CCHCs in order to build on the strengths and diversity of CCHC models.

**STRATEGY #5: *Use technology to improve safety net services.*** New and existing technologies can expand and enhance the quality of care, efficiency, external marketing efforts, alliance-building, infrastructure and financial viability of safety net services. CCHCs need resources to take advantage of these technologies.

**STRATEGY #6: *Promote integrated systems that link safety net and other providers to address multiple patient needs.*** Integrated systems may include alliances, partnerships and relationships, both vertical and horizontal, that coordinate comprehensive care and create access across multiple systems. Integrated systems can help CCHCs and others to develop and achieve shared financial risk, resources and financial accountability, as well as common medical records, quality standards and approaches to disease management.

## **HOW WE UPDATED THE BLUEPRINT**

This 2007 Update reviews the findings of the earlier report, updating them to reflect the current environment in which community clinics and the funders concerned with their welfare are operating. We also spoke with key informants and surveyed clinics statewide to seek their input on the challenges they face, as well as the strategies that might be used to address them.

Based on current information, we have updated the strategies in the earlier report to suggest a new blueprint for action moving forward. Data included in this 2007 Blueprint include:

- A review of the 1999 Blueprint for Action to identify areas in need of updating
- A survey of recent studies and reports on the role of clinics in supporting the safety net
- 5- and 10-year clinic trends based on OSHPD data
- A survey of current funding initiatives available to CCHCs, in particular for the kinds of projects discussed in the Blueprint
- Interviews with six key informants (CPCA staff, a consortium director, a major California health care funder, and three clinic executives) to collect their input and perspectives on perceived challenges and funding priorities for clinics
- An on-line survey of clinic executives to gather their views on challenges currently facing clinics and strategies for addressing them; and
- Input from the CPCA Board of Directors on the recommended strategies included in this report.

## REVISITING THE HEALTH CARE ENVIRONMENT: 2007

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to participate as an equal partner in the health care system—  
not only as peer, but often as innovator and mentor.*

The more things change, the more they stay the same. While there have been many changes in the health care environment since 1999, our review of the literature, as well as our interviews with key informants and our survey of community clinics and health centers, told us that much has remained the same.

CCHCs continue to be an essential segment of California's health care delivery system, especially for the state's most difficult to reach populations. With 6.5 million Californians uninsured<sup>1</sup> and a statewide network of almost 800 community clinics and health centers providing a great portion of their care, the urgency remains as great as ever to assure a strong and viable health care safety net.

One indicator of how things have changed: Rather than being thought of solely as a safety net for the poor, CCHCs are now well integrated into the fabric of the health care system. Certainly, the clinics continue to care for the state's poorest and most disenfranchised patients. But at the same time, California clinics have emerged as a model for the delivery of quality health care in an efficient and cost effective manner.

Clinics have outgrown their position as underdog to participate as an equal partner in the health care system—not only as peer, but often as innovator and mentor. They are viewed as a beacon for the ways in which they manage care, provide supportive and enabling services that allow patients to access care, reduce emergency room usage, integrate mental health and oral hygiene into primary care, and address chronic conditions. They have demonstrated that it is possible to do these things while continuing to care for all segments of the population.

### *Major Environmental Changes Affecting CCHCs Over the Past Several Years*

The environment in which they operate continues to be the largest single factor affecting the ability of CCHCs to survive and thrive. A variety of changes in the health care environment since the 1999 report have affected the ability of CCHCs to perform their critical role and fulfill their missions. This section summarizes key changes in the environment affecting community clinics and health centers.

<sup>1</sup> Yoon, J.E., Brown, R., Glenn, S., Lavarreda, S.A. *UCLA Health Policy Research Brief: One in five Californians were uninsured despite modest gains in coverage*. UCLA Center for Health Policy Research. October 2006.

➤ **High rates of uninsured**

Although the numbers of uninsured are no longer increasing as they were at the time of the original report, those without coverage continue to represent a significant population in need of care and without resources to pay for it. According to an October 2006 study by the University of California-Los Angeles Center for Health Policy Research, one in five Californians—or 20% of the state population—has no health insurance.<sup>2</sup> The study estimates about 6.5 million uninsured Californians, with about 10.7% of children in the state uninsured for part or all of the previous year compared with 14.8% in 2001. A significant portion of uninsured children in California are eligible for public programs but are not enrolled in them.

The economic and demographic forces behind California's large uninsured population are complex:

- California has a higher proportion of uninsured residents and lower rates of employer-based coverage than the nation.
- Almost 40% of California's uninsured work for small employers with fewer than 25 workers.
- Seventy-one percent of the state's uninsured children are in families where the head of household works full time, all year.
- Nearly 1 in 3 uninsured have family incomes of \$50,000 or more.
- Latinos, who represent more than half of California's uninsured residents, are much more likely to be uninsured than any other ethnic group.<sup>3</sup>

What will happen to those without insurance remains very much up in the air at this time. At the same time that California's governor is proposing universal coverage, Washington is threatening to reduce funding for the Federal State Child Health Insurance Program (SCHIP). As a result, the program will not cover all the children who are covered today. An analysis by Families USA found that, in contrast to his 2004 campaign promise, "The President's budget proposal would cut health coverage for children in low- and moderate-income families... Not only will states be unable to enroll more children, but they will be forced to terminate coverage for hundreds of thousands of children, thereby consigning them to the ranks of the uninsured."<sup>4</sup> The proposal includes reductions in SCHIP eligibility in 18 states, including California. Other lawmakers are proposing more conservative, less extensive plans to increase coverage.

<sup>2</sup> Ibid

<sup>3</sup> California Health Care Foundation. *Snapshot: California's Uninsured*. October 2006.

<sup>4</sup> Ron Pollack. *Press Release: President's Budget Cuts Children's Health Coverage, Contrary to His 2004 Promises*, Families USA. February 5, 2007.

While the dust settles, the cost of health premiums and co-payments continues to rise. Many employers are pulling back on the benefits they offer despite pressure on businesses to expand coverage. Some workers are opting out of coverage, even when their employer offers it.

➤ **Rising concern about chronic illnesses**

Chronic disease has emerged as a central concern in health care. An October 2006 study funded by the California HealthCare Foundation found that, “In California, individuals with multiple chronic conditions, 20% of the population, account for 60% of the state’s health care expenditures.”<sup>5</sup> The report focuses on four common conditions that require ongoing care and that they suggest can benefit from disease management: heart disease, hypertension, asthma, and diabetes.

As rates of these conditions rise, clinics have taken a leading role in establishing effective programs to address them. With federal funding, CCHCs have created electronic systems to track patients with chronic diseases and the care they provide to them, as well as to demonstrate program compliance and outcomes.

Strategies to reduce disparities generally take one of two forms. Targeted programs focus on a particular group of patients; for example, improving the quality of care provided to African Americans with hypertension. A more common approach is to implement programs to improve quality more broadly with the expectation that across-the-board improvements in quality will narrow gaps in care.<sup>8,9</sup> Broader programs also may target settings that care for disadvantaged populations.

One of the most important national initiatives for chronic disease care is the Health Disparities Collaboratives program sponsored by the Health Resources and Services Administration (HRSA). The Collaboratives bring together CCHCs for the purpose of learning and disseminating quality-improvement techniques developed by the Institute for Healthcare Improvement. Ultimately, the Collaboratives lead to the refinement and adoption of new practices and procedures aimed at reducing health disparities by improving chronic disease care.

Since the Collaboratives were initiated in 1998, about two-thirds of CCHCs nationwide have participated on a voluntary basis. The first controlled, national evaluation of the Collaboratives found that CCHCs participating in the Health Disparities Collaboratives had considerably more success than did control centers in improving the quality of care

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<sup>5</sup> Gerard F. Anderson and Katherine B. Wilson. *Chronic Disease in California: Facts and Figures*. California HealthCare Foundation. October 2006.

for patients with asthma and diabetes, with significantly improved prevention and screening, as well as disease treatment and monitoring.<sup>6</sup>

Building on this success, CPCA has called for state funding to support the installation of electronic chronic disease management systems in clinics, and for training of CCHC staff to use those systems. Regional consortia are working to assist clinics in building capacity to use chronic disease registries, improve quality improvement (QI) systems, and thereby improve the collection, utilization, and reporting of clinical data measures. Consortia data will be aggregated to the state level to measure the effectiveness of the effort. The Accelerating Quality Improvement through Collaboration (AQIC) project funded by CHCF is supporting this effort. (See *Private Funding Initiatives*, below.)

In December 2006, CPCA received a grant from the California HealthCare Foundation to improve chronic care in California CCHCs by working together with clinics and consortia to implement standardized clinical measures and report on performance. The Community Clinics Initiative of the Tides Foundation supports the effort's Clinical Systems Learning Community and the Clinical Measures Group sets data standards for participating CCHCs.

Clinics are a natural environment for chronic care management and treatment as they are based on establishing a relationship with clients, closely managing their care, and keeping patients out of the hospital. They provide a “medical home” for their patients—a source of ongoing primary and preventive care, rather than acting as a treatment source of last resort.

This approach supports the findings of four major physician groups, who recently proposed a patient-centered medical home (PC-MH) model as a way to reduce cost and increase the quality of care.<sup>7</sup> Endorsed by the American College of Physicians, the American Academy of Family Physicians, the American Academy of Pediatrics, and the American Osteopathic Association, the model is defined by four key characteristics—that each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care; that the physician lead a team that collectively takes responsibility for the patient's care; that care has a “whole person orientation” that attends to all the patient's health needs at all stages of life; and that care is integrated across all components of the health care system as well as the patient's own community. This last point assures that patients get the care they need when and where they need and want it, in a culturally and linguistically appropriate manner.

<sup>6</sup> Landon, Bruce E., Hicks, LeRoi S., O'Malley, A. James, Lieu, Tracy A., Keegan, Thomas, McNeil, Barbara J., Guadagnoli, Edward. *Improving the Management of Chronic Disease at Community Health Centers*. N Engl J Med 2007 356: 921-934.

<sup>7</sup> Press Release: American College of Physicians. *Joint Principles of a Patient-Centered Medical Home Released by Organizations Representing More Than 300,000 Physicians*. 3/5/07.

If this all sounds familiar, it is—the proposal sounds an awful lot like the way care has been provided for decades in community clinics and health centers.

Under the model, each patient would have a primary physician who would be their first point of medical contact. The physicians would assist patients in navigating the continuum of care, and would use health information technology to support care integration across practices and health systems. Technologies to be employed in the model include chronic disease registries, e-mail communications between patients and providers, and electronic health records that have support for clinical decision-making built into them. The proposed system includes incentives for improved clinical outcomes and for adopting the recommended health IT strategies.

➤ **Growing reliance on health information technology**

Advancements in health information technology (HIT) are helping to support chronic disease management and other quality initiatives in CCHCs. Improvements in information technology have contributed to better communications, better quality assurance through data-driven decision-making, increased efficiency, enhanced quality of care, and ultimately to stronger, healthier communities. However, increasing technology demands, coupled with insufficient resources to meet them, make it difficult for clinics to keep up.

Up to this time, the ability of CCHCs to participate in technology has been facilitated to a significant degree by support from the Community Clinics Initiative (CCI) of the Tides Foundation in partnership with The California Endowment. Clinics and funders are currently focusing on four components of health information technology (HIT):

- registries for tracking patients with chronic diseases
- electronic health records (EHR)
- telemedicine, and
- health information exchange (HIE).

HIT is at the center of current strategic efforts to reduce waste, improve the quality and consistency of care, and reduce spiraling health care costs. In October 2006, California Governor Schwarzenegger issued an executive order calling for the convening of the Health Action Forum to develop a statewide policy agenda for health IT. One goal of a proposed \$240 million investment is that all health data be exchanged electronically in California within ten years.

CPCA has assessed that, “additional significant funding is needed for clinics to successfully overcome the financial barriers that stand in the way of achieving the vision for electronic health information outlined by Governor Schwarzenegger.”<sup>8</sup> In response, in

<sup>8</sup> California Primary Care Association. *Advancing health information technology for California’s community clinics and health centers*. November 2006

coordination with regional clinic consortia and CPCA member clinics, CPCA has initiated an effort to secure public and private funding to support the advancement of HIT in California CCHCs. In particular, the effort is focused on technology-enabled quality assurance—those quality assurance measures that give providers and patients the information they need to follow best practices in prescribing medications, assuring that immunization protocols are followed, and otherwise managing health care. Technology is used both to systematize and to document this care.

A commentary on HIT and quality improvement for CHCs concluded that, “...selection, acquisition, and implementation of HIT for quality improvement are beyond the means of many federally supported community health centers. In the absence of federal leadership and investment, adoption of HIT will be slow, haphazard, duplicative, and wasteful. HHS should actively support HIT to improve quality in CHCs.”<sup>9</sup>

In the area of electronic health records for CCHCs, an analysis of the costs and benefits reported in *Health Affairs* found that “EHR-related benefits for most study CHCs did not pay for ongoing EHR costs, yet quality improvement (QI) was substantial.” The study points out that clinics are not able to recoup costs in the way private practices may. For example, while private practices may use EHRs to capture information about reimbursable services, CCHCs must live with a fixed per-visit reimbursement rate that can’t be increased by capturing additional services provided during a visit. The report concludes that, in light of the potential for improved quality, “policies are needed that help CHCs to afford EHRs and produce more EHR-related QI gains, including through grants and QI performance rewards.”<sup>10</sup>

CCHCs are learning that technology may be their best hope for efficiently and effectively managing chronic care. As they increasingly assume responsibility for managing chronic illnesses, so are they increasingly dependent on government and private funding to finance the additional levels of service that are not reimbursable through Medi-Cal or other sources.

➤ **Workforce challenges**

Shortages in the health care workforce persist, making it difficult for CCHCs to recruit and retain staff. There is particularly heightened competition for culturally and linguistically competent staff to serve California’s increasingly diversified population. This challenge affects all levels of clinic employees, from line staff to providers to chief executives.

<sup>9</sup> Kevin Fiscella and H. Jack Geiger. *Health information technology and quality improvement for community health centers*. Health Affairs, March/April 2006; 25(2): 405-412.

<sup>10</sup> Robert H. Miller and Christopher E. West. *The value of electronic health records in community health centers: policy implications*. Health Affairs, January/February 2007; 26(1): 206-214.

A report by the Center for California Health Workforce Studies at the University of California, San Francisco, named under-representation of minorities in the health professions a public health crisis. An example is the Latino population, where approximately one-third (32%) of the state's population is Hispanic, yet only 3% of physicians and 4% of registered nurses represent that population group.<sup>11</sup>

Clinical staff may be especially difficult to recruit, with even more acute challenges in rural areas. There are shortages of primary care physicians and providers at all levels throughout California. To increase the supply and interest among new providers in CCHCs, clinics will need to remain active in addressing pipeline issues, beginning to generate interest among high school students and introducing potential clinical staff to the clinics and to health care careers in general and the benefits of working in a CCHC in particular. Beyond provider shortages, it is difficult to convince providers to adjust to the challenges of living and practicing in a rural area. Retention is likewise difficult in these areas. Hiring staff with training in information technology is another growing challenge.

Medical Directors face particular frustrations as they move from their role as provider to a more administrative role. A 2003 study commissioned by CPCA found that many Medical Directors were new to their jobs, with almost 45% in their current positions for fewer than two years. Mean tenure was five years; median three. For two-thirds of those surveyed, this was their first time in the role. Top challenges included Managing personnel, limited financial resources, senior staff turnover, balancing multiple duties, and communicating effectively with the executive management team. Many respondents felt under-prepared for their transition from solely clinical to administrative and managerial work. The report calls on funders to provide access for Medical Directors to management and business training to complement their clinical knowledge; invest in professional development and planning initiatives where CEOs, Medical Directors, and CFOs are encouraged to work together; and support the clinic infrastructure necessary for Medical Directors to focus on priority responsibilities.<sup>12</sup>

Succession planning is another concern. A 2003 report commissioned by the regional and state clinic associations of California looked at preparedness of clinic chief executives for the inevitable changing of the guard. About one in four clinic CEOs planned to leave their job within the following two years, and 38% expected retirement to be their next career step. Only half of current clinic CEOs had identified a potential successor. Clinic chief executives—many of whom played founding roles in the community health movement in

<sup>11</sup> Center for California Health Workforce Studies. *Strategies for improving the diversity of the health professions*. UCSF. August 2003.

<sup>12</sup> Catalina Ruiz-Healy and Jeanne Peters. *Bridging Medicine and Management. A Profile of Community Clinic and Health Center Medical Directors in California*. A Study Commissioned by the California Primary Care Association. Compass Point: December 2003.

the 1960s and 1970s—will need to plan for the next generation of leaders if the clinics are to retain their key role.<sup>13</sup>

➤ **Challenges to access for certain population groups**

CCHCs serve populations that frequently are shut out from other health providers and systems because of cultural barriers, language, health coverage, geographic access, age, and other reasons. Immigrants have been fearful of perceived and real threats associated with receiving health care.

Racial and ethnic disparities highlight the critical role of CCHCs in providing care to those most in need as these populations often have few or no choices for care. A recent report by the Kaiser Family Foundation reviews key data and concludes that the nation's diversity is growing, with nearly one-third of the population identifying themselves as a member of a racial or ethnic minority group in 2005, with the numbers expected to increase to nearly half by 2050.<sup>14</sup> Minority representation is even greater in California, with nearly half (46%) of the coming generation (children age 0 to 18 years) being Hispanic compared to 20 percent of the nation as a whole.<sup>15</sup>

The Kaiser Family Foundation report concludes that, "People of color are more likely than non-Hispanic Whites to have low-incomes, which may have implications for both their health and insurance status." These implications include greater risk of not having health insurance and of having poor health status. "Racial and ethnic minority Americans are less likely than Whites to have a usual place to receive care or to have a health care visit; for Hispanics, these differences persist even when accounting for income."<sup>16</sup>

The Kaiser Family Foundation data review found that "minority Americans frequently report higher prevalence of specific health problems, such as diabetes or obesity, which can have serious consequences for health and longevity." Death rates for many common diseases, such as cancer and heart disease, are higher for some minorities than for Whites. These findings reinforce the key role of the CCHC efforts to address chronic disease discussed above.

A new obstacle is the requirement implemented in July 2006 as part of the Deficit Reduction Act of 2005 that states must ask all Medicaid applicants for documentation of

<sup>13</sup> Jeanne Peters and Catalina Ruiz-Healy. *Securing the safety net: A profile of community clinics and health centers in California*. A study commissioned by the Regional & State Clinic Associations of California. CompassPoint Nonprofit Services. October 2003.

<sup>14</sup> The Henry J. Kaiser Family Foundation. *Key facts: Race, ethnicity & medical care*. January, 2007.

<sup>15</sup> Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2005 and 2006 Current Population Survey (CPS: Annual Social and Economic Supplements).

<sup>16</sup> Henry J. Kaiser Family Foundation, op. cit.

citizenship status. Under the new law, applicants must present proof of citizenship and identity when applying for or renewing their Medicaid coverage. Since the law was implemented, states have reported marked declines in Medicaid enrollment, particularly among low-income children. At the same time, the administrative burden means funds are being used to pay for the significantly increased cost rather than for coverage.<sup>17</sup>

While the requirement was intended to prevent undocumented immigrants from falsely participating in the Medicaid program—and while it may indeed intimidate those concerned about their citizenship status, even if they are documented—it turns out that it is affecting U.S. citizens most. Many are eligible for Medicaid but for various reasons aren't able to produce the required documents. Difficulties securing birth certificates or other proof of citizenship means longer periods without coverage for those who legitimately qualify.

That's bad news for CCHCs, who lose out on Medicaid payments for services provided to these patients, while at the same time inflating their uncompensated care costs. In fact, the changes are unraveling progress in streamlining eligibility and improving access for those who qualify. Children in particular are at risk for losing coverage, and it means lost income for the working poor, who cannot afford to miss work time to apply for or renew their coverage in person to present the required documentation.

➤ **Demonstrated cost effectiveness of care in CCHCs**

Studies by the National Association of Community Health Centers have demonstrated that clinics improve access to, and quality of, care while reducing health disparities and maintaining high user satisfaction. The average total annual cost of care per patient is \$455 in CCHCs compared to \$657 for office-based medical providers. Clinics reduced Medicaid spending by 30%.<sup>18</sup>

Nationwide, compared with Medicaid patients treated elsewhere, Medicaid patients served at CCHCs are between 11% and 22% less likely to be hospitalized for avoidable conditions; 19% less likely to use the emergency room for avoidable conditions; and have lower hospital admission rates, shorter lengths of hospital stays, less costly admissions, and lower outpatient and other care costs. Together, this amounts to 30% to 33% in total cost savings for each Medicaid beneficiary served in a CCHC<sup>19, 20</sup>. California alone could save \$1.8 billion annually by preventing avoidable emergency room visits.<sup>21</sup>

<sup>17</sup> Donna Cohen Ross. *New Medicaid Citizenship Documentation Requirement Is Taking A Toll*. Center on Budget and Policy Priorities. March 2007.

<sup>18</sup> Proser, M. *Quality and Cost Effective Care at Community Health Centers*. National Conference of State Legislatures, 2004 Health Care Series. February 11, 2004.

<sup>19</sup> Falik, et.al. "Comparative Effectiveness of Health Centers as Regular Source of Care." (2006) *Journal of Ambulatory Care Management*. 29(1):24-35.

In a 2006 Field Poll examining California voters' views on the health care system, “greater than eight in ten (86%) support the idea (53% strongly) of increasing the number of community health clinics to provide care for uninsured residents instead of at more expensive emergency rooms or trauma centers.”<sup>22</sup>

A 2006 Economic Impact Analysis performed by Capital Link in collaboration with CPCA found that CCHCs benefit their communities economically in many ways beyond the direct economic effect of the health care they provide.<sup>23</sup> These benefits accrue from providing employment for local residents, purchasing goods and services from local businesses, and engaging in capital development projects. Capital Link used data from the California Office of Statewide Health Planning and Development (OSHPD) to analyze the impact of 794 CCHCs on the state’s economy.

Together, in 2005 these CCHCs had an overall economic impact of more than \$3.15 billion, directly injecting almost \$1.6 billion into their local economies and supporting more than 26,500 jobs: 13,953 full-time jobs directly and indirectly supporting another 12,254 full-time jobs through their operating expenditures.

The study demonstrates the important role CCHCs play in their communities beyond their role as health provider. Findings bolster the argument for clinic expansions, which in addition to supporting needed service capacity also serve to stimulate economic activity and generate employment opportunities.

➤ **Changes in the managed care environment**

The Medi-Cal managed care experiment in California continues to evolve. Governor Arnold Schwarzenegger’s administration has been vocal in its belief that managed care will contain health care costs in California. The 1115 Medicaid waiver between the state and federal governments provides for the expansion of Medi-Cal Managed Care to thirteen additional counties; three rural counties are scheduled to transition to managed care by March 2007. Some rural counties have struggled with managed care largely due to the lack of an adequate network to secure access. The administration is also pursuing the expansion of statewide mandatory managed care enrollment of seniors and persons with disabilities, its most costly population.

<sup>20</sup> Duggar BC, et al. *Utilization and Costs to Medicaid of AFDC Recipients in New York Served and Not Served by Community Health Centers*. Center for Health Policy Studies, 1994.

<sup>21</sup> National Association of Community Health Centers. *2006 Databook*.

<sup>22</sup> Mark DiCamillo and Mervin Field. The Field Poll. Release #2222: *California voter views of the health care system* (Part 2 of 2). Field Research Corporation. January 3, 2007

<sup>23</sup> *Economic Impact Analysis: The economic impact of California’s community clinics & health centers*. Capital Link. October 2006.

Managed care, coupled with competition from private providers, has forced CCHCs to build infrastructure and improve customer responsiveness over the last ten years in order to attract and retain patients. To do this, CCHCs increased consumer involvement in designing systems of care. While some small CCHCs have given up on managed care because the infrastructure requirements were too daunting, the challenges of managed care have proved beneficial to many clinics and the patients they serve.

➤ **Constant state of change**

In the 1999 Blueprint, clinics pointed to the continual changes in patient eligibility, insurance coverages, reimbursement mechanisms, and other environmental factors as an enormous burden on their administrative and health care delivery systems. Interestingly, the clinics seem to have become accustomed to this environment. While changes continue to bring with them challenges, the CEOs and others we talked to no longer pointed to this as a major obstacle to moving forward. Nonetheless, clinics continue to operate on the margin, with diminishing resources available to provide increasingly costly care to an increasingly complex population base.

**THE DATA: UPDATED TEN-YEAR TRENDS**

Changes in the environment continue to influence CCHCs profoundly: in the way they provide services, in the ways they are reimbursed (or not) for services, in payer mix, and even in the mix of patients served. We revisited data from the Office of Statewide Health Planning and Development (OSHPD) over a 10-year period, from 1995 to 2005, with a focus on changes over the two five-year intervals and over the full ten-year period. These data are presented in Table 1, below, which shows trends among community clinics and health centers for the period 1995 to 2005.

Because the California Office of Statewide Health Planning and Development (OSHPD) modified the way in which their data was collected and reported in order to remain consistent with Census data, the 2000 data is most comparable to 1995 while 2001 is most comparable to 2005. We show all four years below.

The total number of clinics grew from 471 in 1995 to 794 in 2005, an increase of 323 clinics or almost 70%. The largest growth was among Federally Qualified Health Centers (FQHCs), which increased steadily from 148 in 1995 to 376 ten years later. FQHC look-alikes grew by only 5 clinics during the ten-year period; however, this is likely an undercount as some clinics converted from look-alikes to FQHCs while new look-alikes took their place. This is illustrated by the fact that there were 17 more look-alikes in 2001 than in 1995, with the number declining to 71 in 2005.

The growth in number of patients served and total number of encounters mirror the growth in the number of clinics, with increases of 66% and 64% in those two categories, respectively. This amounts to a lot of patient care—the total annual number of encounters grew by more than 4 million over the ten-year period, with the average number of encounters per patient holding steady at about 3.1. In 2005, CCHCs delivered more than 11 million encounters to nearly 3 million patients.

Ten-Year Change 1995-2005	1995	2000	2001	2005	1995 - 2005 Increase or Decrease (#)	1995-2005 Increase or Decrease (%)
TOTAL CLINICS	471	744	677	794	323	68.6%
TOTAL FQHCs	148	235	237	376	228	154.1%
TOTAL FQHC LOOK-ALIKES	66	72	83	71	5	7.6%
<b>TOTAL PATIENTS</b>	<b>2,200,156</b>	<b>2,827,889</b>	<b>2,897,469</b>	<b>3,645,740</b>	<b>1,445,584</b>	<b>65.7%</b>
<b>TOTAL ENCOUNTERS</b>	<b>6,869,492</b>	<b>8,266,388</b>	<b>8,626,575</b>	<b>11,286,312</b>	<b>4,416,820</b>	<b>64.3%</b>

Ten-Year Change 1995-2005	1995	2000	2001	2005	1995 - 2005 Increase or Decrease (#)	1995-2005 Increase or Decrease (%)
<b>RACE</b>						
WHITE*	33.7%	25.5%	54.2%	75.7%	2,018,718	42.0%
BLACK	7.8%	6.2%	5.8%	6.2%	53,835	-1.6%
HISPANIC	47.4%	55.0%	52.6%	54.1%	931,317	6.8%
NATIVE AMERICAN	2.5%	2.1%	2.2%	1.8%	8,858	-0.8%
ASIAN/PAC ISLANDER	5.9%	6.3%	6.1%	6.7%	113,445	0.8%
OTHER/UNKNOWN	50.0%	59.9%	31.7%	9.6%	(749,272)	-40.4%
<b>FEDERAL POVERTY LEVEL</b>						
BELOW 100%	57.2%	63.9%	59.8%	62.0%	1,001,380	4.8%
100 – 200%	26.5%	24.9%	24.1%	21.1%	186,713	-5.4%
ABOVE 200%	15.4%	11.2%	7.8%	6.9%	(88,615)	-8.5%
<b>AGE</b>						
0-19 YRS					403,484	-4.6%
20-64 YRS					973,243	4.4%
65 AND OVER					70,818	0.2%
<b>FISCAL DATA:</b>						
TOTAL REVENUES	\$568,693,360	\$1,008,995,388	\$1,090,618,563	\$1,651,749,555	<b>\$1,083,056,195</b>	190.4%
TOTAL OPERATING EXPENSES	\$569,117,282	\$992,784,083	\$1,067,626,292	\$1,604,820,099	<b>\$1,035,702,817</b>	182.0%
NET OPERATING	-\$423,922	\$16,211,305	\$22,992,271	\$46,929,456	<b>\$47,353,378</b>	

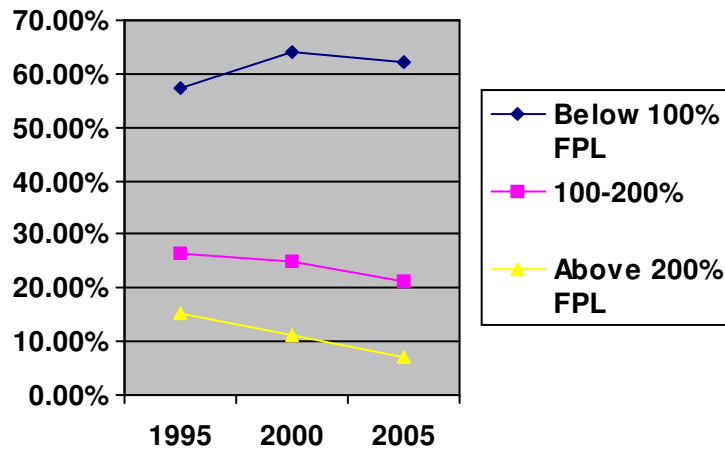
Data Source: California Office of Statewide Health Planning and Development (OSHPD), compiled by California Primary Care Association (CPCA)

\* See text regarding changes in which race and ethnicity were reported between 2000 and 2001.

One major change is the way in which OSHPD collected race data. Until 2000, Hispanics were reported solely in the Hispanic category. Beginning in 2001, Hispanics are included in that category as well as in a second category (White, Black, Native American, Asian/Pacific Islander, or Other). This created a double count of Hispanic individuals when comparing data with earlier years.

Regardless, the proportion of Hispanic clinic patients grew by 7% over the ten-year period. While it is impossible to tease out how many in each of the other categories are also reported as Hispanic, this reporting change no doubt accounts in large part for the great increase in White clinic patients, who made up only 25.5% of the clinic patient population in 2000 but comprised 54.2% in 2001. Still, the 21.5% increase in White patients from 2001 to 2005, when they were counted the same way, does indicate growth in this population among clinic patients. Asian and Pacific Islanders were the only other ethnic population among clinic patients to increase over the ten-year period.

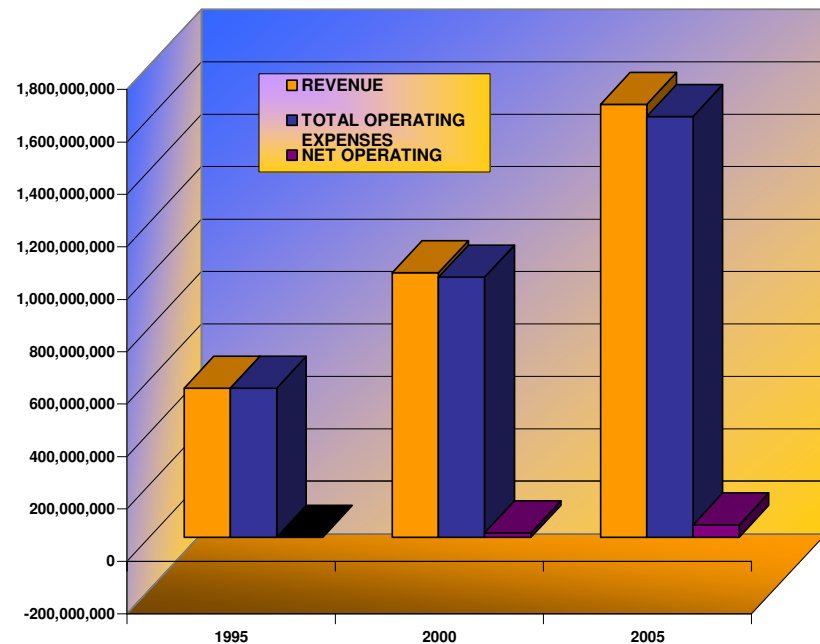
**% Patients by Federal Poverty Level**



Clinics had significant income growth over the ten years (right), nearly doubling their collective revenues from \$569 million in 1995 to over \$1 billion in 2005. Total operating expenses increased at almost the same rate, leaving the clinics with a negligible net operating gain for 2005.

The proportion of patients with incomes below the federal poverty level (left) grew by almost 5% over ten years, with those in the higher income brackets decreasing. Patient age also shifted, with more patients between the ages of 20 and 64 years, and fewer age 19 and below. The proportion of patients age 65 and older remained about the same.

**OPERATING REVENUE**



Looking at particular patient revenue categories, those with the greatest revenue increases were in Medi-Cal, Sliding Fee Scale, and Medicare. With write-offs and adjustments, clinics increased their net patient revenues by less than four percent over the ten-year period.

REVENUE CATEGORY	CHANGE IN REVENUE 1995-2005	PERCENTAGE CHANGE 1995-2005
<b>GROSS PATIENT REVENUE</b>	<b>\$1,131,681,241</b>	<b>263.4%</b>
MEDICARE	97,271,200	3.9%
MEDI-CAL	470,050,883	9.7%
COUNTY/STATE PROGRAMS	83,065,513	-0.5%
HEALTHY FAMILIES	N/A	N/A
PRIVATE INSURANCE	77,671,295	2.9%
SLIDING FEE SCALE/FREE	157,829,521	4.3%
CANCER PREVENTION PROGRAMS	N/A	N/A
CHDP	14,026,375	-0.9%
EAPC	50,861,370	2.1%
FAMILY PACT	N/A	N/A
OTHER	31,033,692	1.1%
<b>TOTAL WRITE-OFFS / ADJUSTMENTS</b>	<b>\$372,033,003</b>	<b>263.4%</b>
<b>NET PATIENT REVENUE</b>	<b>\$759,648,238</b>	<b>3.9%</b>

Data Source: California Office of Statewide Health Planning and Development (OSHPD), compiled by California Primary Care Association (CPCA)

Among operating expenses, the largest category across the ten years was Salaries, Wages, and Employee Benefits, which held steady at about 59% of total clinic operating expenses for the entire period. “Other expenses” accounted for between 12.5% and 26.3% of operating expenses over the period.

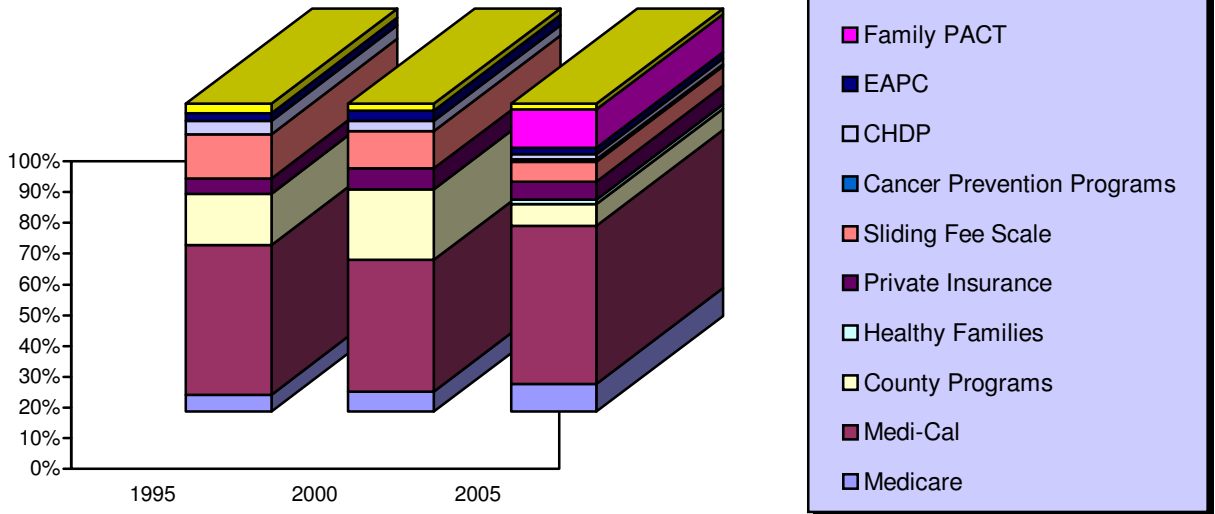
**FUNDING SNAPSHOT**

Community clinics and health centers rely on a patchwork of funding that includes federal section 330 funding, Medi-Cal and private insurance reimbursements, sliding fee scale payments, foundation grants, and other sources. In seeking to fulfill their mission, CCHCs must overcome enormous challenges in navigating an ever-changing funding landscape. Over the years, CCHCs have endured numerous changes in health care financing and delivery. The resources on which CCHCs once relied are increasingly unstable.

***Sources of Public and Private Funding***

In 2005, clinics raised 65.4% of their total income (after write-offs and adjustments) through patient fees and the remaining 34.6% through federal, state, and county programs; private foundations; and donations. The largest single contribution of funds came from federal dollars at 15.6%. Of patient revenues, the largest sources were Medi-Cal (51% of patient revenues received), Family PACT (12%), Medicare (9%), county reimbursement programs (7%), and sliding fee scale payments (6%).<sup>24</sup>

**Proportional Net Patient Revenues  
 (reporting year encounters only)**



For services they provided to the uninsured, in 2005 clinics received reimbursements from Family PACT, county programs, sliding scale payments, EAPC, CHDP, and cancer

<sup>24</sup> Unless otherwise noted, all data in this section is OSHPD data, compiled by CPCA.

screening and prevention programs. Over the ten-year period from 1995 to 2005, the area of largest growth was in Medi-Cal payments (up 9.7%, with all the growth occurring in the most recent five years), self-pay (up 4.3%), Medicare (up 3.9%), and private insurance (up 2.9%). In the case of county/state reimbursement programs, private insurance, and sliding fee scale payments, revenues increased from 1995 to 2000 but then decreased over the most recent five-year period. CHDP revenues fell slightly over the ten years, which may reflect, in part, changes in Healthy Families, California's SCHIP program.<sup>25</sup>

State, federal, and county operating revenues all declined over the ten-year period, with state revenues falling 5.3% and federal 2.9%.

### ***Reimbursements for Care***

Federally Qualified Health Centers are reimbursed for services provided to their Medi-Cal patients using a formula that is intended to cover the cost of providing those services. Beginning in 2001, the federal government began to phase out cost-based reimbursements to FQHCs and Rural Health Clinics for care they provide to Medi-Cal patients. In place of calculating a clinic's actual cost of providing care, the government instituted a Prospective Payment System (PPS) that pays a per-visit rate calculated using the facility's average cost during fiscal years 1999 and 2000. For subsequent years, the PPS rate is based on the preceding year's rate, adjusted using the Medicare economic index (MEI) as a cost-of-living increase. Increases have been minimal, about 3 percent per year.

Restrictive policies limit the clinics' ability to raise PPS rates as circumstances change, and many argue that the MEI underestimates actual increases in cost. This means a widening gap each year between the actual cost of providing care and the PPS rate, which in many cases does not cover even the basic costs associated with traditional medical care for covered services.

That gap is exacerbated by the cost of enhanced services such as case management, nutrition, psychosocial counseling, patient education, transportation, and translation. These are the very services that have been demonstrated to make clinics so effective in bringing in and caring for hard-to-reach populations, and shielding them from preventable conditions requiring more costly care.

If covering the cost of care provided to patients with Medi-Cal or insurance is difficult, covering the cost of care to patients with no pay source is even more challenging. Yet by their mission and health center status, CCHCs must serve all who walk through their doors, even when they have no payer source. While the uninsured are asked to contribute

<sup>25</sup> The Family PACT program was previously labeled as State Office of Family Planning (SOFP) and was not tracked separately.

on a sliding scale basis, those with no coverage cannot realistically be expected to have the resources to cover the cost of services they receive. Instead, CCHCs rely on reimbursement from Medi-Cal and other state and federal insurance programs to cover the cost of uncompensated care. OSHPD data show that the uninsured—as represented by sliding fee scale patients—increased by 4.3% from 1995 to 2005.

Ongoing reductions in reimbursement levels, coupled with continual changes in reimbursement and eligibility mechanisms, make it difficult for clinics to maximize reimbursements for the care they provide. The California HealthCare Foundation describes the dilemma this way:

*Safety net clinics are further strained by the initiative to move more people eligible for Medi-Cal into managed care, to limit the number of Medi-Cal eligibles through altered eligibility determinations and to limit benefits for those beneficiaries. This will result in higher levels of the uninsured and a greater level of uncompensated care.*<sup>26</sup>

### ***Universal Coverage and State Financing***

The ongoing need to identify and solicit other funding sources to cover the gap between the cost of care and reimbursement levels will persist until a system of universal coverage is put in place with reimbursements that fully cover the cost of care at California CCHCs.

Recently, Governor Schwarzenegger proposed a plan to require insurance for all Californians, including undocumented immigrants. The Governor's stated goal is to ensure medical coverage for all of the 6.5 million Californians who now lack it. Experts say this could cost upward of \$10 billion a year. California is embarking on what is likely to be a long process toward implementing universal coverage.

In the plus column, in Spring 2006, the California Health Facilities Financing Authority (CHFFA) awarded over \$35 million in grant awards to California CCHCs for capital projects such as land and equipment acquisition, including information technology equipment and construction and renovation of facilities. This funding was made available through concessions to the State of California as a result of the \$18.4 billion merger of private health care providers, Anthem and WellPoint Health Networks. This funding built on an earlier significant state investment, the Cedillo-Alarcon Community Clinic Investment Act of 2000, which brought clinics \$50 million. Together, these two programs amount to a significant investment in clinic infrastructure with a focus on physical plant and medical equipment.

<sup>26</sup> California HealthCare Foundation, *California's Safety Net: A Primer*, November 2005.

### ***Federal Financing***

In 2002, President Bush proposed a multi-year initiative for the Federal Consolidated Health Centers Program authorized under section 330 of the Public Health Service Act. The President's Initiative sought to substantially expand and strengthen the health care safety net for those most in need by improving and increasing access to primary health care services. Section 330 funding is essential to many CCHCs for the base annual support it provides for primary care operations, stabilizing a portion of the clinic's budget, particularly for uncompensated care. The federal Office of Management and Budget ranked the section 330 program one of the ten most effective federal programs.

The President's Initiative significantly improved the capacity of California section 330 health centers to serve the state's low-income communities. In the first five years of the Initiative:

- 79 new health center sites were added.
- 49 health centers substantially expanded their patient capacity.
- 7 health centers expanded and improved their mental health and substance abuse programs.
- 23 health centers expanded and improved their dental programs.<sup>27</sup>

As California is home to 14% of the nation's uninsured, the program addressed a historically disproportionate funding equation that previously had not reflected the state's high rate. Yet even with the first President's Initiative, California health centers receive only \$199 in federal dollars per uninsured patient served, significantly less than the national average of \$309 per uninsured patient and less than other states with large uninsured populations such as New Mexico (\$362) and Texas (\$247).

Recent federal budget challenges have made section 330 funding more elusive. According to a July 2005 report by the General Accounting Office, competition for section 330 funding increased over the first three years of the Initiative. Funding for New Access Point (NAP) grants for new health care sites decreased by 53% from 2002 to 2004, while at the same time the number of applicants for NAP grants increased by 28%. As a result, the proportion of funded NAP applicants declined from 52% in FY 2002 to 20% in FY 2004. The situation worsened by 2005 and 2006, when several consecutive NAP funding cycles were cancelled or postponed, often after health centers had invested significant resources in preparing applications. In Fall 2006, the first NAP opportunity in about a year and a half was issued.

In February 2007, the President signed a \$463.5 billion funding bill that included a Continuing Resolution boosting Community Health Center funding by \$207 million. Funding increase will strengthen and expand health center efforts to reach more people in

<sup>27</sup> California Primary Care Association

need of life-saving preventive health care services. The funding increase includes \$25 million designated for Base Grant Adjustments to help existing health centers cover the costs of caring for a burgeoning patient population.

According to the Bureau of Primary Health Care, \$52 million of the new \$207 million funding expansion for CHCs is targeted for the 2007 Poor Counties Initiative, which aims to place a health center in every poor county in the nation. A CPCA analysis shows that the Poor Counties Initiative would seriously disadvantage low income communities in the west, midwest, and northeast because counties in these regions are significantly larger than counties in the east and midwest.

With an average county size of about 2,700 square miles and the highest population density per county in the nation, a single health center cannot possibly serve the health care needs of an entire county's low-income population. Despite California's large population and disproportionate share of uninsured, many of the state's counties will not be eligible to apply for Poor County funds. CPCA has proposed a more equitable definition of geographic area that allows for realistic health center coverage in the larger, more densely populated communities typical of California's large communities.

### ***Private Funding Initiatives***

In recent years, many private funders have stepped in to fill these gaps by helping CCHCs to resolve funding challenges in targeted areas. Key among these funders are:

**BLUE SHIELD OF CALIFORNIA FOUNDATION.** Blue Shield works in strategic partnership with health care providers to provide care for low-income people. With annual grants of nearly \$30 million, Blue Shield provides funding in three areas: Health Care and Coverage, Health and Technology, and Domestic Violence. Under Health Care and Coverage, the foundation strives to strengthen safety net providers that care for the uninsured. The foundation has been a generous donor of general operating support to licensed community and free clinics to help provide primary care services to the uninsured. Blue Shield is developing a Clinic Leadership Institute to address workforce needs. (See also *California Network for Electronic Health Record Adoption*, below).

**THE CALIFORNIA ENDOWMENT.** The Endowment has been the largest long-term funder of CCHCs in California. Their current funding is organized around three goals shared by CCHCs: Access to Health, Community Health and the Elimination of Health Disparities, and Culturally Competent Health Systems. This third area provides opportunities for CCHC workforce development, including training of health care interpreters, implementing new models of health promotion tailored for a particular underserved population, or advocating for increasing recruitment, retention, and promotion of racial and ethnic minorities in a health care organization. TCE also has made grants totaling \$29 million to the regional associations for advocacy and other programmatic areas.

The Endowment has partnered with the **Tides Foundation** and **Tides Center** from 1999 to 2008 to create the **Community Clinics Initiative** (CCI). The purpose of CCI is to

strengthen the infrastructure, leadership, and organizational capacities of the community clinic safety net system. As of 2006, CCI had made \$52 million in grants to 164 clinics, or over 90% of nearly 200 nonprofit clinics and their clinic associations in California, together operating nearly 600 practice sites. Initially, CCI focused on helping CCHCs to develop information technology capacity in order to enhance business operations and care delivery. Subsequently, the initiative expanded to include capital facilities grants, leadership development programming, and extensive technical assistance associated with those programs.

**THE CALIFORNIA HEALTHCARE FOUNDATION (CHCF).** In an ongoing commitment to improving the way health care is delivered and financed in California, CHCF commissions research and analyses; publishes and disseminates information; convenes key health care stakeholders and groups; and funds development of programs and models aimed at improving health care in California. CHCF also often funds initiatives that support the mission of CCHCs.

A November 2005 Patient Self-Management Initiative allowed CCHCs to apply for funding to promote self-management approaches to improving chronic disease care, such as diabetes self-management. CHCF also supports the *Step by Step: Local Coverage Expansion Initiative* to fund county-based efforts and local coalitions (which include CCHCs) seeking to expand coverage to uninsured populations ineligible for public coverage.

In December 2006, CHCF awarded grants totaling more than \$3 million to both CPCA and the Safety Net Institute at CAPH to accelerate chronic care improvements in California's safety net. A portion of this funding supports quality improvement infrastructure at CPCA and the clinic consortia. As a part of this initiative, CPCA will build a statewide system for electronic collection of clinical data. Clinics, consortia, and CPCA will implement standardized clinical measures and regularly report on performance. The measure development is supported by CCI for the Clinical Systems Learning Community and the Clinical Measures Group, which sets the data standards to which clinics will conform. This new clinic initiative has been dubbed AQIC, or Accelerating Quality Improvement through Collaboration.

The California HealthCare Foundation and The California Endowment jointly support the Frequent User of Health Services Initiative, which aims to help frequent users of hospital and emergency department services get care and supportive services up front that can keep them from seeking emergency room care for preventable conditions. A number of clinics have participated in these community collaborations.

The Foundation's most recent strategic plan, adopted by the Board in December 2006, may result in more funding for community clinics. Two of the Foundation's three new objectives focus on the underserved: Better Chronic Disease Care and Innovations for the Underserved. In addition to improving the quality of chronic disease care, the Foundation is now focusing on dental care, specialty access, and innovations in efficiency and affordability for the underserved.

The Foundation previously supported two cohorts of non-federally-funded CCHCs to participate in a parallel collaborative to the Bureau's Health Disparities Collaborative, which was aimed at improving the quality of chronic disease care delivered by clinics. A number of the clinics that participated subsequently received section 330 funding from HRSA.

**THE CALIFORNIA WELLNESS FOUNDATION (TCWF):** TCWF is a major funder of CCHCs and clinic associations. TCWF's responsive grantmaking program prioritizes eight issues for funding: diversity in the health professions; environmental health; healthy aging; mental health; teenage pregnancy prevention; violence prevention; women's health; and work and health. CCHCs, as well as clinic associations, have received substantial core operating support for activities in these areas.

**KAISER PERMANENTE:** Kaiser Permanente's Community Benefit Programs in Northern and Southern California award grants for general operating support to increase access to care, quality improvement initiatives, health information technology, and special projects.

In 2002, Kaiser Permanente entered into a formal partnership agreement with CCHCs, clinic consortia, and CPCA articulating the shared mission to provide comprehensive, affordable, high-quality health care and to improve the health of the communities Kaiser serves. The partnership institutionalizes a stable, long-term relationship whereby Kaiser Permanente supports CCHCs through a combination of grant funding and internal resources.

In December 2006, Kaiser Permanente North made \$7 million in grants to Northern California safety net hospitals and clinics for quality improvement programs, including chronic disease management tools, panel management, and population health advances. Nearly \$5 million of that funding came from Kaiser's Health Information Technology initiative. This effort is intended to feed into California HealthCare Foundation's investment in QI. In Southern California, KP has collaborated with UniHealth Foundation and LA Care to support Building Clinic Capacity for Quality (BCCQ), described below.

Clinics also receive funding from private foundations with a national scope, including the **W.K. Kellogg Foundation** and the **Robert Wood Johnson Foundation**, among others.

**FUNDING PARTNERSHIPS.** Especially in the area of technology, funders have created joint strategies to address the needs of CCHCs. Three are described here.

**California Network for Electronic Health Record Adoption (CNEA).** As CCHCs have become better equipped with technology, they have begun to explore new ways to use technology to uphold their safety net mission. In June 2006, the Blue Shield of California Foundation, the California HealthCare Foundation, and the Community Clinics Initiative announced the CNEA, a \$4.5 million grantmaking program to speed the adoption of electronic health records in California CCHCs. The funders are providing grant support and technical assistance to develop partnerships and collaborative strategies for community-based technology models that can improve the quality and efficiency of care.

**Funders Fostering Technology for Quality (FFTQ).** FFTQ began as the California Health Funders Strategy Group, a group of 16 private and public funders who came together in 2005 to develop a set of common principles related to grantmaking in the areas of information technology and quality improvement. Members include Blue Shield of California, the California HealthCare Foundation, the Community Clinics Initiative, Kaiser Permanente, and other funders. In June 2006 the group set out funding principles and objectives for technology-enabled quality improvement and strategies for achieving them.<sup>28</sup> The report lays out six objectives: Advance clinic readiness; Spread success and avoid repeat failures; Promote consumer-centric care; Foster communities of care; Attain quality improvement goals; and Achieve sustainability. FFTQ will continue through 2008 as a “community of practice” to share programs, learn together, and develop common analyses and frames for how to advance quality improvement work in the safety net utilizing the tools of information technology, technical assistance, and grantmaking. FFTQ is staffed by CCI and overseen by a steering committee of member funders.

**Building Clinic Capacity for Quality Readiness (BCCQR) Assessment Program.** Kaiser Permanente, LA Health Care Plan and UniHealth Foundation are providing funding to Southern California clinics through the program, which has helped two-thirds to three-quarters of clinics and three clinic consortia in Southern California to assess their readiness to adopt more sophisticated IT systems, including electronic health records and chronic disease management system technologies. Phase II of the program is under development with announcements scheduled in 2007.

<sup>28</sup> *A Strategic Framework: Technology-Enabled Quality Improvement for California’s Community Clinics.* Object Health. June 2006.

## **WHAT THE KEY INFORMANT INTERVIEWS REVEALED**

Schacht & Associates interviewed six key informants for their thoughts about how things have changed since the previous Blueprint for Action. Key informants were:

- Carmela Castellano-García is President and Chief Executive Officer of the California Primary Care Association, the federally recognized association of primary care health clinics in California.
- Carl E. Coan is President and Chief Executive Officer of the Eisner Pediatric & Family Medicine Center, a federally qualified health center (FQHC) in Los Angeles, California. Mr. Coan is a member of the CPCA Board of Directors.
- Jane Garcia is Chief Executive Officer of La Clínica de La Raza Health Center, a federally qualified health center (FQHC) based in Oakland, California with 23 clinic sites in Alameda and Contra Costa counties. Ms. Garcia is a member of the CPCA Board of Directors.
- C. Dean Germano is Chief Executive Officer of Shasta Community Health Center, an FQHC in Redding, California. Mr. Germano is a member of the CPCA Board of Directors.
- Laura Hogan is Vice President, Program at The California Endowment.
- Ralph Silber is Executive Director of the Alameda Health Consortium and Chief Executive Officer of the Community Health Center Network in the same county.

The overwhelming consensus was that the issues identified in the 1999 Blueprint, and the strategies developed to address them, remain relevant today. Some have become more critical while others have been largely met. Still, that document remains a working Blueprint, now and into the future. That said, the issues have shifted to some degree, and new issues have moved to the forefront. The following outlines the gist of the conversations.

### ***What are the Major Challenges Currently Facing Health Centers?***

Reviewing the challenges enumerated in the 1999 Blueprint, those interviewed agreed that, while the numbers of uninsured are no longer growing, the problem of so many Californians having no health insurance continues to pose a major burden to the health system in general, and to community clinics and health centers in particular. A difficulty that has emerged since the earlier report: reduced employer benefits, leading to large numbers of people who actually do have coverage, but who, due to high deductibles, are unable to pay for the kinds of primary care and preventive services available in the clinics. There is also the perception that, although there are fewer total uninsured, the proportion of uninsured presenting at the clinics has actually increased. This leaves clinics with the continuing problem of finding revenue sources to cover the cost of care they provide to this population.

When caring for patients who are insured, reimbursement levels have not kept up with increasing costs. In some areas, programs are in place to help make up for the shortfalls. In Los Angeles, for example, a long-standing Public-Private Partnership includes a mechanism for providing primary care and disease management to uninsured adults.

The face of patients presenting at the clinics also has shifted. Interviewees mentioned that patients today are more likely to be middle class, sophisticated about their health needs, and to have more complicated health problems requiring a complex web of primary, specialty, and mental health care.

The unstable resource base for safety net care continues to be a challenge. While clinics are in a better financial position today than they were in 1999—largely owing to increased section 330 funding and state infrastructure initiatives—Medi-Cal still does not cover the cost of patient care. In fact, with increasing costs and slow rising reimbursements, the gap between the cost of care and reimbursement levels may be increasing. Barriers to care continue to create obstacles for immigrants. Most recently, citizenship verification requirements could prevent the most vulnerable Medi-Cal eligibles—immigrant or not—from receiving benefits.

In many cases, clinics are successful in caring for their patients because they provide a broad range of enabling services such as transportation, child care, case management, outreach, and other resources that typically are not reimbursed. This is especially true in caring for patients with chronic conditions, who require more intensive management. The Prospective Payment System that has become the standard for reimbursement is based on a retrospective accounting system which leaves clinics a little farther behind each year. New regulations requiring re-enrollment in Medi-Cal means more patients losing their coverage, or fluctuating from covered to not.

Access to care continues to be an issue, particularly with regard to specialty care. As one interviewee pointed out, “If you bring more people into primary care, you have more need for specialty care.” While the supply of specialty care for the uninsured may have remained stable, the demand for it is increasing. Likewise, the clinics’ success in providing chronic care management has led to the identification of new needs that CCHCs may not be equipped to provide, or for which they cannot draw adequate reimbursement to support.

With the increased demand for specialty care comes another problem: the difficulty of recruiting and retaining providers to deliver that care in all areas of the state. Recruitment is especially difficult in remote rural areas.

Funding for infrastructure improvements has provided great benefit to clinics, allowing them to upgrade facilities long in need of repair, and to build new facilities in response to geographic areas that previously had an insufficient supply of providers. Upgrades have helped some facilities to be more competitive in attracting Medi-Cal patients where private providers also are available to serve that population.

Perhaps the biggest, and fastest growing, infrastructure issue is the increasingly complex demands placed on clinics with growing reliance on health information technology. Developing the technology to keep up is an enormous resource drain on clinics, and there are few sources of funding to address it. Funding disseminated through a partnership between The California Endowment and the Tides Foundation has helped clinics to make enormous strides, but there is still great unmet need in this area.

“One thing that’s really hurting us is that every payer wants so much information for compliance.” In some cases, information demands “takes clinicians away from clinical time.” “The bigger we get, the more complicated medicine gets, the more educated our clients get via internet, the more we need to adapt.” Electronic health records, quality improvement initiatives, credentialing, and compliance all place great demands on clinics, requiring expensive and sophisticated systems, and skilled personnel to operate them.

Interestingly, while those participating in the previous Blueprint complained about the impact of living with constant change, clinics now see it as “a way of life; we have to get used to it.” Indeed, it seems they no longer are fazed by constantly changing reimbursement systems and funding mechanisms, ever changing reporting requirements, even shifting demographics and population needs. Perhaps a byproduct of a life of change is that clinics have learned to roll with the punches.

Emerging challenges since the earlier report include:

- **Workforce:** Clinics continue to struggle to recruit personnel and providers at all levels. Obstacles include the ability to offer competitive salaries, inadequate supply of experienced providers, diminishing pipeline of new providers, closing of residency programs, inadequate supply of clinicians who are culturally and linguistically prepared to serve clinic populations, competition from other providers, and the high cost of living in California. With the impending retirement of many clinic CEOs and managers, clinics also are concerned about succession planning. “There may not be a sufficiently skilled workforce in the wings ready to take over these positions.”
- **Technology:** Clinics face a broad array of obstacles to implementing new technologies, including financial barriers. A new frontier is using technology to enable and support quality improvement and chronic disease management efforts.
- **Changes in clinic placement:** Retail clinics, school-based clinics, hospital outpatient clinics, and other new sites have the potential to create competition with CCHCs for patients or interruptions in care as patients move between one system and another. One concern is that these clinics will care for patients with the least complicated medical histories, leaving the most complex—and expensive—cases to the clinics.
- **Changing face of the uninsured:** Rising deductibles and decreasing benefits are creating a new class of uninsured. Clinics are seeing patients with new and differing health needs. Increasing awareness of the impact of mental health issues on primary care also is changing the way clinics deliver care.

- **Increasing focus on chronic disease:** Chronic illness is growing among clinic patients, forcing clinics to rethink their delivery systems. “The registries we’re creating for chronic care management are having an influence on how we’re managing our care; for example, increasing group visits.” Clinics have a key role to play in developing and implementing new practices in the treatment of chronic disease. For the most part, clinics see this as an opportunity and are poised to meet the challenge.
- **Integrating mental health into primary care:** Increasingly, clinics are recognizing that mental health issues often go hand-in-hand with physical health. For example, depression is not uncommon with chronic disease. Many clinics are not prepared to address the psychosocial aspects of health conditions, and are not adequately reimbursed to do so.
- **Changing compliance and quality assurance requirements:** “As clinics have become bigger we’re more under the microscope.” CCHCs have had to become much more sophisticated. “Our mission-driven nature is no longer an excuse,” said one respondent. Moreover, clinics are concerned about a new federal requirement that clinics taking in more than \$5 million in federal funds must train their employees on how to uncover and report questionable billing practices. “Becoming a whistle-blower is the new retirement plan.”

### *What Forces Are Likely to Affect Health Centers Over the Next Ten Years?*

Looking into the future, interviewees pointed to a number of issues expected to affect the delivery of health care in community clinics and health centers.

- **Consolidation in entitlement programs:** It is difficult to know the fate of these programs going forward. The push toward consumer-driven health spending, such as health savings accounts, may lead to a reduction in entitlement programs
- **Restructuring of county health services:** County health systems recognize the clinics as meeting an important need. However, their expectations of what the safety net can accomplish is sometimes unrealistic, with county systems expecting the clinics to pick up the slack where they are unable to meet a community’s needs. Moreover, as counties are increasingly strapped for resources, their partnerships with clinics may “fray at the edges.”

Increasing debate about the role of public health—for example, the public-private partnership in Los Angeles—means that “we need to be a leader in advancing this kind of model.” According to one interviewee operating in a rural area, “Public health departments, at least in our area, have gotten out of almost all direct services.” The same person indicated that they are currently negotiating to move all mental health care to their clinic corporation, as the county has gotten out of that business, as well. He anticipates more counties turning to the clinic system to be their mental health delivery system. The challenge: Clinics haven’t previously been in the business of caring for the severely mental ill, and it may be difficult to find sufficient qualified staffing to deliver the services.

- **Privatization:** Looking back seven years ago, there was great concern about the emergence of for-profit medical groups and hospital chains. Going forward, privatization doesn't appear to be so much of a concern. "The question is going to be, 'who or what is going to emerge to take care of uninsured? Will it be a private or public model?'"
- **Mergers and acquisitions:** Clinics will have to carefully navigate these in a way that maintains their mission and strengths, being careful not to lose their "edge" values of integration, creativity, running lean, and community responsiveness that other institutions they partner or network with may not share. At the same time, clinics have been benefiting financially from monies made available to them as a condition of large-scale mergers, including the Anthem-Wellpoint merger and possibly PacifiCare. Another big change is that "those who never thought they'd become a [section] 330 clinic have been willing" to take that step. Hospitals and counties, for example, are seeing section 330 status as a way to increase their funding. For clinics, one potential challenge is the move to change section 330 requirements to eliminate the community board requirement. This could potentially bring hospitals, counties, and other entities to compete with clinics for a piece of the shrinking section 330 pie.
- **Shifting demographics:** More patients are taking catastrophic coverage only, or have huge deductibles that make it unrealistic to seek care. No coverage means no reimbursement for the clinics that serve them.
- **Changing models of health care delivery:** While clinics are poised to lead in innovation, they are limited by programs like Medicaid that are not designed to be flexible. Likewise, they are increasingly dependent on static forms of reimbursement. There exists a "threat to the underpinnings of clinics, which are founded on innovation while funding sources want a stable approach to care." For example, clinics are realizing that many visits—even when presenting with physical symptoms—are based in behavioral health issues, which require a different approach.
- **New quality improvement measures:** This is increasingly an issue, with the clinics and Kaiser "leading the pack" in meeting the need more effectively than many other segments of the health system. QI changes include new methods for data collection and reporting, as well as changes in how data are used. There is "way more focus on health outcomes," including pay for performance, HEDIS measures, and clinical outcomes. Some interviewees mentioned that their health disparities work have put clinics ahead of the curve in the use of clinical measures. Still, challenges persist in data collection and management, with the clinic associations providing important assistance to their member clinics. As one person put it, "I hope some day we will be recognized and paid for providing better care." This leads to the need to clearly document the fact that the clinic model works; that clinics provide care that keeps people out of hospitals.

- **Information and medical technologies:** This may be the biggest single challenge to clinics because it touches so many areas, with implications for cost, workforce, clinical care, and quality all requiring the appropriate use of emerging technologies. Clinics are changing not only the ways in which they operate, but also how they link electronically with partnering hospitals and referral sources. “Every day is an increasing challenge as technologies and costs increase.” As one interviewee put it, “IT is a freight train coming.” One concern is the possibility of federal and state IT mandates, such as the Governor’s health proposal mandating that all health providers be e-prescribing by 2010.
- **Legislative and regulatory changes:** Increased regulation of health care increases the cost and complexity of doing business. There is emerging a serious discussion in California, and nationwide, about universal coverage, making it critically important that clinics are involved proactively. Until meaningful health reform is enacted, interviewees believe we are likely to see increasing regulation. In the existing system, “the only way to get a hospital or health system to do anything is to mandate it.” Federal and state legislation, as well as voter initiatives, also may help to direct funding to clinics.
- **Reimbursement rates:** The gap is widening between Medicaid reimbursement rates and the increasing cost of providing care. One respondent posed the question, “Will Kaiser and the clinics become the only private providers to take patients with Medi-Cal?”
- **Hospital cut-backs and closures:** As public hospitals close they leave in their wake patients who use emergency departments as their primary source of routine health care. Because they are largely uninsured, these patients turn to the clinics. Likewise, hospitals are shedding programs “that made a difference in the quality of life,” such as Alzheimer’s, pain, prenatal, and dental clinics. These, too, will increase the burden on CCHCs.
- **Community health vs. episodic care:** Clinics increasingly see themselves as purveyors of health rather than of treatment. Said one interviewee, “I can’t think of a better movement to trust with this than clinics—it’s the most pressing challenge of the next 25 years.”

### *Have the Clinics Developed New Areas of Competency?*

The 1999 Blueprint pointed to areas in which clinics have distinguished themselves, namely that they are rooted in and responsive to their local communities; share a common sense of purpose; act as advocates for their clients and communities; and continually demonstrate resiliency in the face of change.

The clinics have maintained and added to that list of competencies, with improvements that include the following.

- **Organized system of health care:** Clinics have successfully organized themselves into local, regional, state, and federal networks, and have increased their sophistication in drawing on each level for a variety of functions, including sharing best practices, spreading innovations, and advocating for policy reforms. Clinic associations and networks have helped CCHCs to move from fragmentation and reinvigorate the clinic movement.
- **Growing practice competencies:** Clinics have continued to develop new competencies in dental care, mental health, specialty care, emergency preparedness, terrorism response, and other areas. Clinics have helped to establish dental care as a public policy priority in California.
- **Values-driven:** As clinic have become increasing sophisticated, they have not lost sight of the key values that have always driven them. They remain unique in their approach to care, responsive to their communities, and creative in meeting emerging challenges while preserving their core mission.
- **Data driven:** Clinics have grown significantly in their ability to collect and apply data to improve the quality of care, as well as to make sound business decisions.
- **Cutting edge:** CCHCs are creative. In many ways, they have surpassed the private physician's office in developing infrastructure that allows them to provide good and responsive care. A sense of entrepreneurial spirit has helped clinics to be successful in expanding their scopes of practice, patient populations, and geographic boundaries.
- **Leaders in chronic disease management:** Clinics are at the forefront of caring for patients with chronic illnesses, pushing the boundaries of the health care model to explore new and promising practices. These efforts have led to the development of learning communities and new standards of practice in public health. "Out of the chronic disease collaboratives have come a greater consciousness of practice and visit redesign."
- **Cost effective:** Studies show that clinics offer a less expensive way to provide care, cutting costs by providing case-managed, comprehensive services that prevents chronic conditions from accelerating and keeps patients out of emergency rooms.
- **Economically beneficial to their communities:** Clinics have begun to document the impact that accrues to their local communities beyond improving the health of their patients. Because they frequently hire from their communities—often from within their own patient base—clinics directly benefit their communities economically. Often, the clinics serve as a community center as much as a health clinic, keeping their patients connected to the community and addressing social and mental health as well as physical problems.

### *Revisiting the 1999 Blueprint Strategies*

Of the strategies identified in the previous Blueprint, interviewees felt that much has been accomplished, and that all remain relevant and important to some degree.

- **Expand primary care capacity:** Although clinics have made huge strides in this area—building clinic infrastructure and adding mental health, oral health, and other services—their capacity needs have become increasingly complex. The next frontier may be addressing infrastructure issues related to serving patients with chronic diseases and that address population health. Although clinics have benefited from state and other infrastructure monies, there still remains much need for capital resources.
- **Expand ability to address population-based and community health issues:** This is an area that was still considered critically important, although “we’re still figuring out what it means to do that.” Clinics are essential to strengthening the safety net in communities. In many areas, public health departments are using the clinics as their public health system. While public health departments in some areas involve clinics in their thinking about health care planning and delivery, in others they are kept out of the public health discussion. Health departments and others could benefit from including CCHC expertise in the design and implementation of local public health efforts.
- **Increase public awareness of and public perception about CCHCs:** There was a high level of consensus that this is an area where clinics have improved “monumentally,” with clinics moving from an underdog position to becoming the provider of choice in many communities. Government health plans and policy makers now better understand who the clinics are and how dependent communities are on their primary care capacity. The general public may be somewhat less aware of the clinics and the role they play. The logical next step is to better document and disseminate the unique contributions clinics make to the health of Californians; for example, in their chronic disease work efforts, in order to objectively demonstrate the efficacy of the clinic model. “We have achieved more credibility but need to be more articulate about what our needs are.”
- **Facilitate strategic alliances that enhance community health:** Clinics have forged successful alliances amongst themselves and with similar organizations. However, fewer enduring strategic alliances have been developed between clinics and other entities such as the business community, faith community, and others beyond health care. Alliances with other organizations and systems may be critical to the ability of clinics to keep pace with new challenges in an ever-changing environment.
- **Use technology to improve safety net services:** Clinics have had no choice but to come up to speed in the use of technologies, and they have done so impressively. Turning from a focus on using technology to improve business efficiencies at the time of the earlier report, clinics have very much come on board with efforts to use technology to track and improve health outcomes and health care. Technology plays a role in clinics’ ability to communicate across counties,

share capacity, access specialty care, and to provide services that are not available locally through telemedicine.

- **Promote integrated systems that link safety net and other providers to address multiple patient needs:** While CCHCs have made considerable progress in working collectively and collaboratively, this remains an area where more can be achieved. Clinics continue to integrate services within their own systems; for example, integrating behavioral health into the primary care setting. Still needed are joint strategies with larger health systems, hospitals, and private providers; for example, sharing medical records for the planning and delivery of quality patient care. Especially in rural areas, CCHCs are dependent on private providers for specialty care and other services they are not equipped to provide themselves. To provide optimal care, all segments of the health care system will need to work together as a community for the good of the patient and the health of the community.

## HOW CLINICS “VOTED” ON KEY CHALLENGES AND RECOMMENDED STRATEGIES

A survey was sent to the Chief Executive Officers of all CPCA member clinic corporations. Of 160 recipients, 41% (65) completed the survey, with representation from all parts of the state (north, south, central; urban, rural). Nearly all respondents (56 of 61 who answered that question) were Executive Directors and CEOs, with one Associate Director, a Chief Operating Officer, an Administrator, an Outpatient Services Director, and one Clinic Manager responding. The survey included three questions directly related to the 1999 Blueprint plus an open-ended question to solicit any additional comments. Two questions collected information specifically about capital improvements and planned projects at the clinics.

1. *The 1999 Blueprint included challenges facing community clinics and health centers (CCHCs). Please tell us which are the top 3 challenges at your clinic today.*

Reviewing the top challenges facing CCHCs included in the 1999 Blueprint, the largest portion of respondents—65.1%—selected the **growing number of uninsured** as one of the top three challenges facing their clinic today. Close behind at 63.5% was **increasing infrastructure demands**. The third most common response was **inadequate reimbursement rates**, at 54%. Health information technology followed at 36.5% and “expanding service areas beyond primary care (mental health, dental)” at 27%. All other responses had response of less than 20%. Of least concern were the “Privatization of health care / emergence of clinics in retail locations” (nobody selected this choice), “New and changing quality assurance requirements,” and “Changing demographics and health needs of your patient population.” For the last, presumably this is because clinics are specialists in addressing these issues.

2. *The 1999 Blueprint concluded with six recommended strategies. Please prioritize the strategies you think CPCA and funders should pursue now.*

Respondents ranked the strategies, with 1 being their top priority ranking and 6 the lowest priority of the six strategies. Cumulatively, the strategy given the highest priority by respondents was **expand primary care capacity** with an average ranking of 1.73 out of 6. The second highest priority was **use technology to improve safety net services** at 2.98. The remaining priorities were fairly tightly clustered, in this order: “Promote integrated systems that link safety net and other providers to address multiple patient needs,” “Expand ability to address population-based and community health issues,” “Facilitate CCHC involvement and application of the clinic model in local and regional public health efforts,” and “Increase public awareness of and public perception about CCHCs.” It is worth noting that at least one respondent ranked each strategy at each priority level. Each strategy was the number one priority for at least four respondents. In fact, “expand primary care capacity” was the only priority that stood strongly out from the pack, with 61% of respondents ranking it at the top. The only other strategy receiving more than 20 endorsements was the ranking of “Increase public awareness of and public

perception about CCHCs” at the bottom, selected by 34.3% of respondents. Interviews suggest that this reflects the great strides CCHCs have already made in achieving this objective since the original strategies were set in the 1999 Blueprint for Action.

3. *In which of the following areas is funding insufficient to address your current and emerging needs?*

The two highest ranked areas in which funding is insufficient to address current and emerging needs were **health information technology** (90.8% selected this response) and **workforce** (78.5%). Still, “**Quality improvement**” and “**Medical technology**” were on the minds of many respondents, at 38.5% and 35.4%, respectively.

4. *Is there anything else you would like to share about the challenges you face, your funding needs, or your suggested strategies for CPCA or funders to consider?*

Over half (36 of 65 respondents) shared additional comments about the challenges they face, funding needs, and suggested strategies for CPCA and funders to consider. The following summarizes the concerns mentioned by respondents.

- **Funding challenges.** The widening gap between the cost of providing care and reimbursement rates requires clinics to increasingly pursue private fundraising efforts. PPS rates are increasing by about 3% per year while costs are increasing by about 10% per year, and already they do not cover the full cost of most visits. Yet private foundation grants have become so competitive that many clinics find themselves unable to access adequate funding. Moreover, most programs pay clinics in arrears, requiring them to spend monies up front to provide care despite their often limited financial capacity.

Said one respondent, “Medicaid FQHC remains the basis for our business and service model. We have to find creative ways to be adequately reimbursed for providing more access to uninsured.”

Another said, “HRSA money does not adequately cover the amount of uncompensated care being provided by CHCs. On average, CHCs in California spend 142% of their federal grant on direct patient services, [meaning that] we ‘overspend’ our grant in support of our mission of access to quality medical services regardless of ability to pay. Other foundations need to assist CHCs, as community safety nets become more dependent on the CHCs.” Clinics also expressed concern about pending legislation to eliminate the consumer board requirement, which could reduce FQHC funding to clinics through increased competition with hospitals and other entities.

One respondent suggested that, “single payer universal health coverage should be a priority of CPCA, but the key will be rates that cover costs.” Still, core operating funding is needed to support uncompensated care.

One respondent noted that the dependence on grant funding to augment patient revenues is a special problem in small, rural clinics in isolated areas, where limited staff don’t have the time and capacity to constantly seek funding. At the

same time, these clinics often do not qualify for section 330 funds. Another suggested that “because of low critical mass, county and state governments do not readily respond to the needs of the rural and frontier communities. The lack of infrastructure and public services in rural areas affects the residents’ ability to access services.”

- **Workforce** issues were mentioned by several respondents, including “recruitment of all health professionals.” Rural areas face increased challenges. “Being rural we add the issue of good help is hard to find locally, so we have to train and train and pay people enough to commute, and then watch them be recruited away and start over. It is harder for us in that we have so few support staff, due to short funding, that every vacancy is agony until a new person is hired and trained.”
- Several mentioned the cost of **capital improvements**, including medical and dental equipment, diagnostic equipment, technology, and facilities. For clinic expansions, it was noted that real estate and construction costs are prohibitive in many California markets.
- **Technology** is another growing area that requires a significant financial investment, making it difficult for clinics to climb on board.

CCHCs lack funding for infrastructure development needed to use information technology for electronic health records and for disease management. As one respondent put it, “We need an equitable financial system to reimburse CHCs for technological improvements like EMR. There is much payback to payers (i.e., the state) and to patients (more preventive care, etc.) but little for the CHC except more costs, especially in the short-run.”

- Clinics expressed concern about **immigration reforms**, which may interfere with clinic outreach and eligibility screening. “On one hand, government encourages us to sign up families for Healthy Families. On the other hand, people are reluctant to sign up for any government sponsored program if they have family members who are undocumented or if they intend to apply for citizenship later and do not want to have a record with the perceived ‘public charge.’ Public attitude towards Latinos is becoming more outwardly hostile.”

These concerns and priorities closely mirror those identified in the key informant interviews, with primary care capacity, reimbursement for uncompensated care, workforce issues, infrastructure demands, technology, quality improvement, and chronic disease management, topping the list.

## WHAT CLINICS REPORTED ABOUT THEIR CAPITAL NEEDS

California clinics play a vital safety net role in California. Based on the 2004 Uniform Data System (UDS), 84% of all California clinic users have income levels at or below 200% of poverty. In addition, 46% of all users are uninsured. CCHCs must be able to expand their facilities and infrastructure if they are to continue meeting the healthcare needs of California's underserved.

Over the past few years, California clinics have benefited from many new financing programs for capital development. Among them are The California Endowment / Tides Foundation's Community Clinics Initiative, the Healthy California Loan Program, and the Wellpoint-Anthem bond program. As a result, clinics in California have expanded to meet growing population needs, with 72% of California clinics implementing capital projects in the past five years. Despite the recent growth in funding sources and building projects, there remains considerable need for capital expansion to accommodate growing population demands.

As part of the survey of CPCA member clinic corporations described in the previous section, Capital Link asked CCHCs about their capital needs. Capital Link is a nonprofit organization that assists health centers nationally in planning and obtaining financing for capital projects. As of January, 2007, Capital Link helped 104 health centers obtain \$305 million in grant and debt financing for capital projects totaling \$446 million. The organization has developed a database of health center financial and statistical data for benchmarking purposes and currently holds the largest database of health center financial information.

The vast majority of survey respondents (85%) indicated plans for capital expansion projects during the next five years, with a median 15,000 new square footage planned for each clinic corporation. Extrapolating the survey response to CPCA's full membership, Capital Link projects that California clinics have a total expansion need of approximately 2.475 million square feet over the next five years. Capital Link estimates the cost to support this infrastructure expansion at *\$990 million* based on recent cost estimates for health clinic construction.

As in the past, California clinics will need a diversified funding strategy that includes both grant and debt financing sources to pay for their capital projects. Capital Link estimates the median debt capacity for California clinics at approximately *\$3.5 million*<sup>29</sup> based on fiscal year 2005 financial reports. In the aggregate, Capital Link estimates the total debt capacity of California clinic corporations to be \$575 million, which represents 58% of the total capital budget requirement of \$990 million.

<sup>29</sup> This estimate from audited data collected from 41 clinic corporations assumes an 8% interest rate and a 20-year term.

Although California clinics are positioned to borrow significant funds for their capital projects, there remains a **capital project funding gap of roughly \$414 million** or 42% of the clinics' overall capital needs. Clinics will need to fund this amount through a combination of grants, fundraising, cash reserves and other equity sources. This capital needs analysis is summarized in the following chart:

<b>CAPITAL FUNDING REQUIRED BY CALIFORNIA CLINICS THROUGH 2011</b>	
Median expansion requirements per clinic corporation over the next 5 years as reported in Blueprint Survey (sq. ft.)	15,000
Estimated construction cost per sq. ft. (2007)	\$ 400
Median 5-year capital budget per CA clinic corporation	\$ 6,000,000
Estimated CA clinic corps with pending capital expansion needs (85% of total)	165
Aggregate 5-Year capital budget of CA clinic corporations	\$ 989,400,000
Total Debt Capacity (FY05)	\$ 575,326,205
<b>FUNDING (EQUITY) GAP</b>	<b>\$ 414,073,795</b>

Capital projects enable health centers to expand services and employ more people, many of whom are residents of the local community. In fact, the growth of services for health centers with capital projects far surpasses that of other health centers.

For those California clinics that had capital projects in the last five years that responded to the December 2006 CPCA survey, Capital Link documented the growth in annual visits, users (patients), employment (full-time equivalent employees or FTEs), and Total Revenues using information from the UDS. By comparing the growth rates of these categories to the state-wide average as reported by UDS, Capital Link is able to demonstrate the significant impact of a capital project on a clinic's ability to grow its primary care capacity in terms of utilization, staffing, and financial growth. Compared to the average health clinic, clinics that completed capital projects delivered nearly ten times as many annual patient encounters and added six times the number of FTE staff. The chart that follows summarizes this analysis.

Average Growth per Clinic	Total Average Annual Growth of Clinics in Years of and following Capital Project <sup>30</sup>	Statewide Average Annual Growth per CHC (2002-05) <sup>31</sup>
FTEs	18.9%	3.3%
Encounters	20.4%	2.4%
Users	16.4%	0.9%
Total Revenues	16.8%	5.0%

***Economic Impact***

Due to capital project expansion, California clinics have generated an increasing level of direct, indirect, and induced economic impact on their low-income communities. A recent economic impact report issued by Capital Link on behalf of CPCA illustrates that California clinics and health centers had an overall economic impact of more than \$3.15 billion and supported more than 26,500 jobs in 2005<sup>32</sup>. The analysis clearly demonstrates that, as a result of the combined effects of their multiple roles as service providers, employers and local businesses, California CCHCs play a significant role in the economic development of their communities and of the state as a whole.

In addition to the economic effects generated by community clinics through their regular business operations, these clinics generate significant economic effects through their capital investments and the corresponding expansion of service capacity. Many community clinics operate in inadequate or outgrown facilities — many of which were not originally designed to provide medical services. As a result, clinics and health centers continue to be engaged in significant capital development activities as they pursue the replacement or expansion of their existing buildings. Every dollar spent on the capital expansions of California clinics and health centers is directly tied to additional economic activity and employment opportunities within their communities.

***Low Income Employment***

The majority of health center employees are residents of the surrounding community. In fact, for many individuals, health centers serve as their first job, providing opportunities for career development and advancement. Investment in health centers and clinics

<sup>30</sup> Based on UDS data of 26 clinic corporations reporting capital projects 2001-2005

<sup>31</sup> Based on UDS Roll Up Reports for CA 2002-2005

<sup>32</sup> Economic Impact Analysis of California Clinics and Health Centers. (10/06). The analysis incorporated data provided by the California Office of Statewide Health Planning and Development (OSHPD) of 794 community clinic and health center sites.

stimulates economic development in their respective communities by increasing the household incomes of low-income persons employed by the centers. The nature of the jobs that are created—such as outreach worker, maintenance worker, receptionist, and medical records clerk—make it possible to recruit individuals for employment from a broad spectrum of low-income backgrounds. Capital Link estimates that roughly 36% of the overall FTE positions offered by health centers and community clinics are filled by low-income employees. As highlighted by Capital Link’s study of the economic impact of California clinics, these clinics and health centers directly employed 13,954 FTE positions in 2005. Capital Link therefore estimates that 5,023 FTE positions are filled by low-income individuals.<sup>33</sup>

### *Survey Findings*

Two questions on the CCHC survey allowed clinics to report their past and planned capital projects. The vast majority of clinics surveyed anticipated undergoing a capital project to increase their capacity within the next five years.

#### **Survey Highlights**

- Clinics that have completed a major capital project in last 5 years: **73%**
- Clinics that anticipate capital project in next 5 years: **85%**
- Clinics that indicated “Expand Primary Care Capacity” as either its number 1 or 2 priority strategy of 6 proposed strategies: **83%**

<sup>33</sup> Each federally funded health center must report information on the composition of its staffing on Table V of its UDS reports. This table contains 34 staffing categories, including doctors, dentists, nurses, and other professional staff. Five of those staffing categories include positions that would typically go to low-income individuals. Those staffing categories include Other Medical Personnel; Dental Assistants, Aides, and Technicians; Transportation Staff; Personnel Performing Other Enabling Services; and Patient Services Support Staff. Those five staffing categories account for 36% of the overall FTE’s employed at health centers, according to data obtained from national UDS reports from 2000 through 2004.

***CCHC Capital Projects***

	#	%
<b>Total Respondents</b>	63	100%
Indicated "infrastructure demands" as clinic priority	40	63.5%
Clinics mentioning infrastructure/capital/expansion under "other"	7	11.1%
Clinics selecting "Expand Primary Care Capacity" as <b>#1 priority strategy</b> for funders and CPCA	39	<b>62.0%</b>
Clinics selecting "Expand Primary Care Capacity" as <b>#2 priority strategy</b> for funders and CPCA	11	<b>17.5%</b>
<b>Clinics COMPLETING a major capital project in last 5 years</b>	46	<b>73.0%</b>
Total number of projects listed	71	
Total number of projects listed with year 2004 or before	34	
Total number of clinics with project complete before 2004	27	
Total number of projects complete after 2004	36	
<b>Clinics ANTICIPATING a capital project in next 5 years</b>	51	<b>85.0%</b>
<b>Average</b> size of capital projects over next 5 years per clinic corporation (sq. ft.)	18,579	
<b>Median</b> Size of capital projects over next 5 years per clinic corporation (sq. ft.)	15,000	

These findings support the need for additional funding to support clinic capital expansions, which not only can contribute to increased patient services capacity, but also to the growth and well-being of communities in which CCHCs operate.

## **REVISITING THE BLUEPRINT STRATEGIES: STRATEGIC RECOMMENDATIONS FOR 2007 AND BEYOND**

### *A Strategic Consensus*

Five strategies clearly emerged as top priorities for clinics and those advocating for their continued survival as a key element of a healthy safety net.

#### **☑ Strategy #1: EXPAND PRIMARY CARE CAPACITY**

While the growth in the number of uninsured has slowed, California's large population of un- and under-insured and other disenfranchised individuals puts the need for expanded primary care capacity once again at the top of the list. Clinics serve a large proportion of Californians with incomes at or below 200% of poverty, and nearly half of clinic patients are uninsured. CCHCs must be able to expand their facilities and infrastructure if they are to continue meeting the healthcare needs of California's underserved.

Despite the availability of funding over the past few years, CCHCs still have much unmet need for expansion of physical infrastructure: buildings and equipment. Capital Link has estimated that California clinics have a total expansion need of approximately 2.475 million square feet over the next five years at a cost of \$990 million, with a funding gap of \$414M after debt financing.

Clinics are critically important to the economic success in their communities. In light of their proven track record in providing cost effective, quality care, funding for their expanded infrastructure should be an important element of any proposal for health care reform. Recognizing this with significant investments in clinic infrastructure and capacity can help not only to increase the volume of patient care, but also to improve the health of communities, reducing the need for care. Key areas for capacity expansion include core support, capital, and technology. (The latter is discussed separately, below.)

#### **☑ Strategy #2: ENHANCE HEALTH INFORMATION TECHNOLOGY**

In the time since the 1999 Blueprint, technology has become even more essential to the quality of care, efficiency, alliance-building, infrastructure, and financial viability of safety net providers. Health information technology (HIT) is essential to the clinics' ability to provide safe and affordable health care to their clients. Our survey showed that CCHCs believe HIT is important and that they are ready to move forward in implementing technological advances.

One key area for HIT in the coming years will be enhancing the ability to use technology to support and document quality improvements. Technology-enabled quality improvement supports the recent proposal of four physician groups to promote a patient-centered medical home (PC-MH) model as described in the section above on chronic illness. Such a model incorporates much of what CCHCs already are known for: assuring patients have a primary physician as their home base, assisting patients in navigating the

continuum of care, and using health IT to support care integration, including the expanded use of chronic disease registries.

Other areas for enhanced HIT include:

- Broadening implementation of electronic health records to enable providers to make quick and accurate diagnoses and clinic decisions using real-time information.
- Helping clinics to systematize, document, and track the care they already provide for both internal (cost and quality) as well as external (contract reporting, information exchange) purposes.
- Increasing capacity for and use of telemedicine.
- Participating in regional and statewide health information exchange.

Technology is expensive. It cannot be funded through patient services or cost savings, at least not in the short term. But while technology requires a significant up-front investment, there is good reason to believe that it will pay off eventually in better care, ultimately leading to reduced costs. Until that happens, clinics will require external funding in order to meet this essential need.

**Strategy #3: ADDRESS WORKFORCE OBSTACLES**

Workforce issues have emerged as a growing concern among clinics, which have experienced reduced availability of qualified medical and other staff, especially those who are prepared to address the linguistic and cultural needs of their patients. To be successful, workforce strategies will need to address the full spectrum of issues, from the supply of physicians and other providers, to adequate salaries and benefits or other incentives to attract them, to training and other programs that can improve retention rates. Workforce obstacles are particularly challenging in rural areas and in patient populations with cultural and linguistic barriers to care. Workforce initiatives should take into consideration the \$3.15 billion in business that California clinics and health centers bring to their communities and to the state. This includes providing 26,500 jobs, many offering lower income opportunities for advancement.

**Strategy #4: SUPPORT CCHC MODEL PRACTICES IN PREVENTION, POPULATION HEALTH, AND CHRONIC DISEASE CARE**

There is much data to support the efficacy and cost-effectiveness of the clinic model. Support is needed to continue and expand these efforts, which have been proven to improve the health of communities while reducing costs. At the same time, more and better data are needed to document and widely disseminate these innovative practices. At the core of the clinic model is prevention and a population-based health strategy that treats the patient as a whole person within a community, providing comprehensive primary care and preventive services in one setting along with case management and supportive services that allow patients to access and actively participate in their care. CCHCs have taken a leadership role in using this approach to manage the chronic conditions that disproportionately affect their patients through their participation in chronic disease registries and other quality initiatives. Investments are needed to support

the technology and infrastructure required to build on these innovations to reduce health disparities, as well as to support core services that are not compensated through traditional health care reimbursement systems. In the long term, supporting effective clinic models can lead to shifts in public reimbursement programs to better cover the actual cost associated with the expanded and supportive services CCHCs provide.

**☑ Strategy #5: PROMOTE INTEGRATED SYSTEMS THAT LINK SAFETY NET AND OTHER PROVIDERS TO ADDRESS MULTIPLE PATIENT NEEDS**

Clinics already do a good job of addressing the complex needs of their patient populations in an integrated way. Integration among providers can help to spread effective practices between clinics and other entities to promote the best interest of the patient. Such relationships may include alliances and partnerships that coordinate comprehensive care and create access across multiple systems, including between CCHCs and private providers. Integrated systems can help CCHCs and others to develop and achieve shared financial risk, resources, and financial accountability, as well as common medical records, quality standards, and approaches to disease management. One area ripe for integration is to facilitate CCHC involvement in local and regional public health efforts.

## CONCLUDING COMMENTS

As one survey respondent commented, “Community clinics deserve a long-term partnership [with funders] that responds to their needs. I wish more funders were driven by a philosophy of long-term engagement, progressing along a pathway rather than putting out an RFP for XYZ.”

The strategies identified in this report all contribute to a health care system that is responsive to the environmental factors clinics and Californians face today. In order to remain effective, clinics need resources to support capacity expansion, to implement health information technologies that support quality care, to overcome workforce obstacles, to support and further document the important contributions clinics make to the health of their patients and communities, and to promote integrated systems that can help clinics as they serve an increasingly complex patient population.

Clinics are poised to meet the demands of emerging health care reforms. They have already proven their leadership in meeting the challenges of chronic diseases. They have weathered continual changes in the funding climate.

As we saw in 1999, reimbursement for patient care is not sufficient to support the critical role of community clinics and health centers in a healthy California. In order to actualize their capabilities, clinics will need a significant and ongoing infusion of financial resources. The identified strategies suggest a good place to start.

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We would be delighted to hear your feedback on this updated Blueprint for Action. Please send your comments by email to Jennie Schacht at [js@schachtandassociates.com](mailto:js@schachtandassociates.com). Comments may be forwarded to CPCA or elsewhere, as appropriate.