

# **It Takes a Village: Community Health Centers and the Organizations that Support Them**

**Dobson | DaVanzo**

Dobson DaVanzo & Associates, LLC Vienna, VA 703.281.3250 [www.dobsondavanzo.com](http://www.dobsondavanzo.com)

# It Takes a Village: Community Health Centers and the Organizations that Support Them

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Written by:  
**Dobson | DaVanzo**

Joan E. DaVanzo, Ph.D., M.S.W.

Gregory Berger

Audrey El-Gamil

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# *Introduction*

Community clinics and health centers are an integral part of the nation’s health care system. Since the first community health center was founded in 1965, the network of federally qualified health centers (FQHCs) has expanded to over 1,200 organizations serving more than 20 million patients in more than 7,000 clinic locations annually. In addition, many more FQHC “look-alikes” and other safety net providers also deliver health care services in at-risk and underserved communities. Although similar in overall mission and function, health centers vary greatly in terms of size, capacity, tenure, location, clinical expertise, patient population demographics, and funding sources.

As the number and complexity of health centers’ missions have grown over the past four decades, many types of organizations have developed to support health centers in achieving their mission of improving and expanding access to quality, affordable health care for the medically underserved. These support organizations include:

- Primary Care Associations (PCAs), which are state, territory, and regionally-based membership organizations charged with providing various types of technical support to their health centers and representing them through advocacy
- “Sister” corporations to PCAs, which were originally developed in conjunction with (and/or are organizationally linked to) a PCA
- Organizations such as Capital Link, the Community Clinics Initiative (CCI), and the Primary Care Development Corporation (PCDC) (collectively referred to in this study as “independent stakeholder organizations”), which are wholly independent organizations that directly

serve health centers and/or support health centers through strategic alliances with PCAs

- Community health center networks, which are organized and operated at the local level to enhance the ability of health centers in nearby communities to share resources, promote best practices, and operationalize various kinds of efficiencies such as health information technology (HIT) programs and managed care organizations

This study was commissioned by the California HealthCare Foundation to explore the range of services health centers need from supporting organizations in order to fulfill their mission as safety net health care providers. We investigate the organizational structures of and services provided by PCAs, their sister corporations, and three independent stakeholder organizations – Capital Link, CCI, and PCDC. Our goal is to examine the benefits and drawbacks of the different ways organizations provide support to health centers. Although community health center networks are also important vehicles through which health centers receive support, these unique networks were not included in the scope of this study.

Because there are substantial barriers to access for health center patients, which include more than an inability to pay for services, health centers need to offer comprehensive as well as complementary services to patients to enable them to access health care. These enabling services include:

- Referrals to specialty providers of medical services
- Patient case management services (including counseling, referral, and follow-up services)
- Services that assist individuals to use the services of the health center (including community outreach, transportation services, and language services for individuals of limited English-speaking ability)
- Education for patients and the general population served by the health center regarding the availability and proper use of health services<sup>1</sup>

We used a case study methodology to examine how support organizations are structured and how they work together to provide health centers with resources, technical assistance, and other more specialized services essential to achieving the

health centers' mission. Just as the health centers need to provide their patients with supportive and enabling services, these organizations provide supportive services to the health centers. Our case study states include Colorado, Illinois, Massachusetts, Missouri, New York, and Texas. We collected information from a series of key informant interviews, supplemented with reviews of reports, documents, and websites of selected organizations. We interviewed senior staff at PCAs in the six case study states, as well as senior staff from the independent stakeholder organizations Capital Link, CCI, and PCDC, which provide supportive services to health centers across multiple states. Case study summaries are included in Appendices A and B.

Our study objectives were to better understand how support organizations enhance health center performance by:

- Understanding the products/services provided to health centers by each of the case study support organizations in differing state environments
- Understanding how the structure and mission of each type of support organization facilitates (or hinders) the provision of services to health centers
- Examining the opportunities and limitations of how certain types of organizations approach service delivery

# *Findings in Brief*

Our in-depth comparison of how PCAs, sister corporations, and the independent stakeholders Capital Link, CCI, and PCDC provide support services to health centers illuminated several organizational characteristics that may possibly enhance the ability of the organization to serve health centers more effectively in certain circumstances. These characteristics include:

## **Membership Structure**

PCAs provide member health centers with representation, are responsible to their members as a trade association, and respond to the leadership and participation of their members. In some areas, however, these member relations can complicate the ability of PCAs to provide support services to health centers. Some services are better delivered by sister corporations or independent stakeholders.

## **Internal Expertise**

Health centers often receive training and technical assistance from sister corporations or independent stakeholders, often in cases where their PCA may not have staff with the particular specialized knowledge or expertise. PCAs often play a facilitative role in these cases, by connecting their member health centers with outside expertise and access to specialized assistance.

## **Financial Risk**

Many of the services health centers need, from loans for capital development to group purchasing, could place a PCA at serious financial risk. Sister corporations and independent stakeholders are better able to take these risks without placing other health center services in jeopardy. Some PCAs coordinate these services for their members, but do not themselves provide loans or purchase and distribute bulk medical supplies.

# Findings in Brief

## State Government

State governments that have a strong relationship with their state PCAs tend to allow health centers to play a larger role in the primary care delivery and safety net system. Within the state, these relationships can lead to new initiatives and the creation of additional sister corporations that further expand the network of support services, such as training, technical assistance, and quality improvement, available to health centers.

Table 1 below summarizes the link between the type of support organization and the supportive services they provide. As demonstrated in this study, some support organizations are better positioned by their charter, mission, or level of resources to provide specific types of services. However, other services are provided by all three types of support organizations. These services are critical to the success of health centers – each of which has differing needs and abilities.

An indicator of “✓” indicates our finding that the supporting organization type currently provides limited support functions to health centers; an indicator of “✓✓✓” indicates that the supporting organization type is central to the effective functioning of health centers in this regard.<sup>2</sup> Being intimately familiar with health center operations allows organizations to provide the health centers with specialized services in some cases.

**Table 1: Relationship between Supporting Organization and Function**

Type of Service	PCAs	Sister Corporations	Independent Stakeholders
<b>Advocacy</b>	✓✓✓	✓	✓
<b>Health Center Operations</b>			
Operations compliance	✓✓✓	✓	✓
Operations improvement	✓✓	✓✓	✓✓✓
Workforce development and retention	✓✓	✓	✓✓
Group purchasing	✓✓	✓✓✓	✓
Operational capital development	✓	✓✓✓	✓✓✓
<b>Clinical Initiatives and Quality Improvement</b>			
Training	✓✓	✓✓	✓✓✓
Technical assistance	✓✓	✓✓	✓✓✓
<b>Funding</b>			
Government	✓✓✓	✓	✓✓
Funding capital development	✓	✓✓✓	✓✓✓
Foundation grants	✓✓✓	✓✓✓	✓✓✓

✓ = organization provides limited assistance to health centers

✓✓ = organization provides moderate assistance to health centers

✓✓✓ = organization provides many services that are central to health center operations

# *What Health Centers Need*

The level of assistance that a health center needs from the various supporting organizations – whether a PCA, sister corporation, or independent stakeholder – depends on many factors, including the health center size, maturity, staff expertise, leadership, mix of funding sources, and the availability of state and local resources.

Many health centers rely heavily on federal and state funding to finance their operations, and as a result, depend on having strong representation before state legislatures, Congress, and various regulatory bodies in order to successfully maintain and expand their service infrastructures. In addition to advocacy, health centers often need technical assistance and training in a variety of areas, including, but not limited to: health center management and operations, compliance with state and federal regulations, licensure, HIT, fundraising, and capital development. Clinical initiatives, quality improvement, and data collection are another important type of service needed by health centers. Support organizations assist health centers in developing and implementing quality measures to improve care delivery. These measures can be key to health centers' ability to optimize the services they provide to a vulnerable patient population.

Health centers also need a variety of administrative and member services in a variety of areas, which are generally provided by PCAs for that reason.

# What Health Centers Need

Health centers' major needs can be categorized into the following four functional areas:

1. Advocacy
2. Health Center Operations
3. Clinical Initiatives and Quality Improvement
4. Funding

Examples of activities included in each functional area are shown in Table 2.

**Table 2 – Health Center Support Organization Activities**

Functional Area	Description
Advocacy	Representation before local, state, and federal legislative and regulatory bodies to maintain and increase funding and inform policy debate around primary care, as well as public education campaigns to raise awareness about the importance and impact of health centers.
Health Center Operations	Training, technical assistance, and general support on health center operations, including: <ul style="list-style-type: none"> <li>• Operations compliance, such as accreditation, facility licensure, regulatory compliance, accounting, and budgeting;</li> <li>• Operations improvement, such as quality improvement, practice management, and emergency preparedness;</li> <li>• Workforce development and staff recruitment/retention; and</li> <li>• Group purchasing.</li> </ul>
Clinical Initiatives and Quality Improvement	Programs on clinical topics such as improving cancer detection and prevention, providing comprehensive diabetes care, <sup>3</sup> cultural competence, and reducing health disparities, provided through: <ul style="list-style-type: none"> <li>• Training;</li> <li>• Technical assistance; and</li> <li>• Other general support</li> </ul> <p>Many quality improvement initiatives overlap with HIT operations, such as: collection, aggregation, and dissemination of data; development of clinical guidelines; implementation of electronic medical records; and construction of disease registries.</p>
Funding	Obtaining funding from different sources including: <ul style="list-style-type: none"> <li>• State and federal government, including appropriations and reimbursement;</li> <li>• Loans for capital development;</li> <li>• Foundation grants; and</li> <li>• Other funding sources, such as private donations.</li> </ul>

# *Overview of Supporting Organizations*

Our case studies showed that there are three main groups of organizations that provide support to health centers: PCAs, “sister” corporations of PCAs, and independent stakeholder organizations such as Capital Link, CCI, and PCDC.

## **PCAs**

PCAs are nonprofit membership organizations, described as a “special type of health care association.”<sup>4</sup> All states and U.S. territories have one designated PCA that is responsible for advocating on behalf of its member health centers as well as supporting its members in providing affordable health care to uninsured and medically underserved patients. We found that every PCA is uniquely designed to meet the needs of its members within different state environments. According to a report comparing the structures of PCAs, “If you’ve seen one PCA, you’ve seen one PCA.”<sup>5</sup>

## **Sister Corporations**

Health centers also receive valuable services from PCA sister corporations, which we define as either: a) an organization originally developed as a program within a PCA, or b) an organization formed through the cooperative efforts of one or more PCAs. Sister corporations can form when a PCA-based program becomes too large to continue to be housed internally, or when health centers need services that are outside of its PCA’s core competencies and/or mission. In some cases, the sister corporation works in collaboration with the PCA to serve the membership, but most often these organizations provide services directly to health centers.

# Overview of Supporting Organizations

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Examples of sister corporations are from group purchasing organizations, capital development programs, health maintenance organizations for health center patients, and HIT consulting companies.

## **Independent Stakeholder Organizations**

Unlike sister corporations, which are intimately linked with a PCA through some formalized relationship, independent stakeholder organizations, such as Capital Link, CCI, and PCDC, work outside of the health center-PCA infrastructure to advance the mission of health centers by complementing the services available from PCAs. These organizations, like sister corporations, have a wide range of missions and purposes.

## **Community Health Center Networks**

Over the past two decades health centers have increasingly organized into regional community health center networks, which provide members with access to more sophisticated business and HIT services, allow the sharing of best practices, and increase various types of efficiencies (as in group purchasing) through collective action. Such health center networks have developed in response to funding opportunities with the Bureau of Primary Health Care (BPHC) and the movement toward Medicaid managed care, among other trends in health care policy and delivery.<sup>6</sup> Due to the scope of work, community health center networks were not included in this study.

# *Profile of Support Services*

Based on our communication with the case study PCAs and other organizations in benchmark states, we identified key areas in which health centers need services from PCAs and areas in which sister corporations and independent stakeholder organizations provide services that effectively complement the offerings of PCAs.

The major categories of support in which these organizations provide services are:

1. Advocacy
2. Health Center Operations
3. Clinical Initiatives and Quality Improvement
4. Funding

## **Advocacy**

The primary means by which health centers are represented before their local and state (and federal, to a lesser extent) governments is through the advocacy activities of their PCA. In their role as state-level trade associations for member health centers, PCAs are charged with representing their members' interests and ensuring that health centers receive adequate funding, are reimbursed by public payers (such as Medicaid) at a sustainable level, and are appropriately regulated as publicly funded primary health care providers. Through the advocacy activities of PCAs, health centers are able to determine their legislative priorities and collectively make their voices heard.

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Each of the PCA case studies presented in this study has a legislative or government affairs division dedicated to conducting a wide variety of activities, including tracking legislation, providing health centers with policy updates through emails and newsletters, advocating before state and local government officials, and conducting statewide public education campaigns. Some PCAs also have specifically focused advocacy programs, which include: the Covering Kids and Families project of the Colorado Community Health Network (CCHN); the Access Illinois multi-year campaign to create medical homes for over 2 million Illinois residents by 2015 of the Illinois Primary Health Care Association (IPHCA); the Insure Texas Kids Campaign of the Texas Association for Community Health Centers (TACHC); and the New Health Professionals Shortage Areas initiative of the Community Health Care Association of New York State (CHCANYS).

All of the PCAs included in this study are located in their state capitals, in part to increase their access to state lawmakers. Several years ago, CHCANYS, which was historically located in New York City, opened a satellite legislative affairs office in Albany to improve its ability to represent its members. Each of the case study PCAs also has a government affairs committee on their Board of Directors to drive their legislative agendas. The Massachusetts League of Community Health Centers (MLCHC) created a sister corporation—the Massachusetts Association of Community Health—as a 501(c)(4) organization specifically dedicated to additional legislative advocacy activities.

In addition to state PCAs, health centers are represented at the federal level by the National Association of Community Health Centers (NACHC). NACHC is also a nonprofit membership organization, but primarily concerned with a national health care legislative and regulatory agenda. Some independent stakeholder organizations—such as the PCDC—also conduct advocacy activities on behalf of health centers, though this is not their primary function. In general, health centers look to their PCAs first for collective representation, and as members, they are able to ensure their specific needs are being met.

### Health Center Operations

Assistance in various aspects of health center operations from supporting organizations can be critical for health centers. PCAs, sister corporations, and independent stakeholders are all positioned to provide services to health centers in

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different ways. Health center operations can be subdivided into the following service categories, which we discuss in this section:

- Operations compliance
- Operations improvement
- Workforce development and retention
- Group purchasing

## **OPERATIONS COMPLIANCE**

To adequately provide quality and low-cost care to the underserved, health centers must effectively manage their administrative operations and ensure compliance with state and federal regulations. Examples of these include accreditation, licensure requirements, HIPAA compliance, and billing and financial services. Because of their varying nature, these types of services are often provided by PCAs, sister corporations, and independent stakeholders. Support services that are state-specific (e.g., licensing) are best provided by PCAs. As state-wide organizations, PCAs are in the best position to train health centers on how to incorporate statewide requirements into their daily activities. In addition, PCAs are informed by their role in compliance oversight, and can effectively advocate for changes to licensure requirements and other regulatory issues that might adversely affect their members.

With operational issues that often extend beyond the scope of individual state regulation, sister corporations are able to play a collaborative role in offering more comprehensive support than some PCAs can by themselves. IPHCA, for example, provides financial and operational services through a partnership with two other PCAs and NACHC. This partnership, referred to as the Financial Management Infrastructure Development Partnership (FMIDP), addresses financial and operational issues in health centers by using the NACHC finance professionals program as a resource. By seeking support from NACHC and others, PCAs are able to enhance their programs with validated methods and expert materials that otherwise might not be available to their members.

## **OPERATIONS IMPROVEMENT**

Beyond meeting regulatory requirements and managing day-to-day operations, health centers need help improving their care delivery model to achieve better patient outcomes, expand patient access and further reduce costs. These services,

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across all supporting organizations, are predominately provided through group trainings and one-on-one technical assistance. While most PCAs develop their own trainings based on the expertise of their staff, others facilitate training sessions through arranging for and coordinating presentations by subject matter experts. TACHC has constructed a Learning Network, connecting half of its over 300 centers with voice, video, and data streams. TACHC also provides frequent web-trainings with staff and outside experts that are broadcast from their very own studio. As Texas is one of the largest states in the country, and it would be both difficult and time consuming for health center staff to travel across the state to attend training sessions, the Learning Network makes training sessions accessible to a majority of TACHC's members.

Other PCAs focus on in-person trainings, which rely on health center staff to travel to a central location. For example, the recently built IPHCA Institute for Learning is a large, modern, and fully-outfitted training and conference center that IPHCA uses to host two trainings per month for member health center staff. Located in Springfield, which is the state capital and in the center of Illinois, the Institute for Learning is accessible to all of IPHCA's members, and can also be rented to outside organizations as a source of revenue. While time away from the health center for staff can be difficult, in-person meetings facilitate a different level of interaction and networking across health centers that can be difficult to achieve through web-based trainings.

Operational improvement activities overlap significantly with quality improvement and clinical initiatives, and both sister corporations and independent stakeholder organizations offer consulting services to assist health centers in improving their clinical operations. Through the development and expansion of information technology and public health expertise, CQuest America, Inc. is able to provide a host of health care support services as a sister corporation to IPHCA. CQuest implemented and provides ongoing support for Illinois' statewide practice management system called "i-net," which includes hosting operations, managing telecommunications equipment, and coordinating system upgrades. In addition to i-net, CQuest has developed an "e-net" or electronic health information network for all of IPHCA's member health centers, which integrates enterprise practice management, electronic health records, and electronic dental records. IPHCA and other PCAs often do not have the specific expertise or advanced technological

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capacity to provide this type of specialized HIT service, which is very beneficial to clinical quality and information systems.

As an independent stakeholder, PCDC provides performance improvement programs and consulting services to health centers both inside and outside of New York. These services include consulting on practice redesign, medical home development, implementation of HIT, and emergency preparedness. While all PCAs provide training and technical assistance on health center operations, PCDC focuses intensively on the implementation and incorporation of best practices at each site. Many PCAs do not have the resources to do this.

### **WORKFORCE DEVELOPMENT AND RETENTION**

Workforce development and retention is critical to the success of health centers and is directly related to access to care for the underserved. PCAs have demonstrated strong abilities to train health center staff to better care for the diverse populations served by health centers and provide effective administrative support. By housing these support services within a PCA, member health centers can easily develop a support network to answer questions and help handle issues. MLCHC's workforce development programs provide training for health center executives, managers, clinicians, administrative staff, board members, and community residents in Massachusetts, as well as a national student-volunteer corps. By developing trainings for all levels of health center staff positions (i.e., clinical, managerial, and administrative staff), PCAs can concentrate trainings in one place for health centers. Additionally, MLCHC has been awarded a Student/Resident Experiences and Rotations in Community Health (SEARCH) contract that places health professions students and residents in multidisciplinary health care teams in underserved communities. This program benefits health centers by strengthening the links between community-based sites and academic institutions—potentially introducing the upcoming workforce to available employment opportunities in community health centers.

The Missouri Primary Care Association (MPCA), in collaboration with the Missouri Department of Health and Human Services (MDHSS), developed Missouri Health Professional Placement Services to recruit clinicians for a wide variety of health care facilities across the state free of charge. CCHN also provides workforce development in the form of health center training and technical assistance, scholarship programs, educational loan repayment, and

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continuing education. These programs provide additional benefits and incentives for current and potential clinicians and health center administrative personnel, and are critical to linking qualified practitioners with health centers in need.

Although there are independent stakeholder organizations that provide assistance to health centers around the issues of workforce development and retention, none of the ones featured in this study offered such programs.

### **GROUP PURCHASING**

Health centers often seek membership in group purchasing organizations (GPOs) to avail themselves of volume discounts for medical, pharmaceutical, and administrative supplies. These GPOs are often arranged through a PCA, and allow health centers to obtain needed supplies at deeply discounted rates. Both CCHN and TACHC organized GPOs to maximize savings on laboratory, dental, and pharmaceutical supplies for their member health centers. Coordinating GPOs at the PCA level takes advantage of a large and already-organized potential membership pool, and further optimizes benefits to individual health centers through their collective influence. Reductions in supply cost further help the health centers keep expenses down and free up more resources for providing care.

Through three separate GPOs, CCHN members are able to purchase laboratory services 63 percent below published prices, dental supply and equipment 27 percent below published prices, and pharmaceuticals at reduced prices as well. TACHC provides similar group purchasing opportunities to its member health centers. TACHC is able to provide discounted prices to its members, while at the same time generating revenue for its own operations. This revenue is returned to the PCA budget to help the PCA expand its offerings.

Sister corporations are also created by PCAs to manage and operate their GPOs. For instance, MLCHC created the Commonwealth Purchasing Group, a wholly owned subsidiary of MLCHC. This limited-liability corporation provides group purchasing, shared services, and strategic sourcing solutions for 300 community health centers and related non-profit organizations concentrated in Massachusetts and the eastern region of the country. Externalizing the GPO through a sister corporation protects the PCA from financial risk. It also allows the PCA more direct control over the purchasing and distribution of supplies on behalf of its members, and provides member health centers with more direct representation in the GPO through the PCA relationship.

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Independent stakeholder organizations also operate GPOs for health centers around the country. These GPOs are not typically targeted to a specific geographic locale, and generally provide the same types of benefits to member health centers.

### **Clinical Initiatives and Quality Improvement**

Evidence in the research literature documents that health center patients are among the highest risk populations in the nation, including, for example, migrant farm workers and homeless persons. These patients have been described as, “significantly poorer, in significantly worse health, and . . . more likely to be members of racial and ethnic minority groups,” than patients of other providers.”<sup>7</sup> Health centers are required to serve all patients in their communities, regardless of the patients’ ability to pay.

There are a myriad of barriers to access for health center patients which include more than an inability to pay for services. These include a lack of transportation to a facility and lack of language fluency and/or health literacy, and need to be addressed by health center staff. Vulnerable populations are characterized, in part, by sporadic health seeking behaviors and greater use of more costly services. Because health centers serve as medical homes for medically underserved and often hard to reach patients, they need a wide range of support services to achieve their clinical mission of providing comprehensive health care under one roof.

Sister corporations and independent stakeholders are often useful in supplementing the services offered by PCAs. For example, CCHN is a member of the Community Health Association of Mountain/Plains States (CHAMPS), which assists FQHCs in Region VIII (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming) with workforce development and clinical quality programs, as PCAs in Region VIII have varying levels of resources available to do this. CHAMPS is also a nonprofit membership association of community, migrant, and homeless health centers, and was founded in 1985 to unite Region VIII health centers in an advocacy and mutual support network.

The services and resources described in this section are categorized as:

- Training (e.g., intensive Continuing Professional Education ((CPE))
- Technical assistance (e.g., practice redesign to better incorporate a “team approach” to care)

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- Member services (e.g. other general support in clinical and quality improvement programs)

Initiatives to support health center clinicians include, but are not limited to: improving cancer prevention and detection, providing comprehensive diabetes care,<sup>8</sup> assistance with recruitment and retention of clinical staff, and efforts to increase cultural competence. Many quality improvement initiatives overlap with activities like HIT introduction and the collection, aggregation, and dissemination of clinical data. An example is the CHAMPS Evidence Based Clinical Guidelines that are reviewed and compiled for Region VIII clinicians.

Health centers go above and beyond the traditional provision of primary and preventive care, often providing dental, behavioral health, pharmacy, and community outreach services. The continued engagement in quality improvement initiatives and the delivery of patient-centered care have led to improved screening rates and outcomes in health centers, as well as reduced health care disparities for their patients.<sup>9,10</sup>

### TRAINING

Health center staff receive training from each type of support organization, and often the sessions are very specialized. One example of a didactic training is the CHAMPS Intensive Spanish Language program for clinicians in Colorado. Webcasts are also a popular way to reach a large audience, and can involve any or all of the organizations, such as the CHAMPS *Health Center Preparedness for Emerging Infections and Bioterrorism* webcast.

Other types of training are more experiential, such as the educational and networking events that surrounded the 2009 National Primary Care Network Week. As part of this week, MLCHC teamed up with Tufts University School of Medicine to sponsor a conference entitled *A Caring Community: Community Health Centers as Primary Care Medical Homes*. Other activities involved MLCHC partnering with Beth Israel Deaconess Medical Center's Community Benefits Program and Harvard Medical Center.

In each instance, the PCA serves a facilitative role in bringing in the best clinical expertise for symposiums, panels, and other activities. This collaborative approach could be considered a “best practice,” as each organization is operating in its “sweet spot,” or areas of core competencies.

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## **TECHNICAL ASSISTANCE**

There are many areas in which health centers need different types of technical assistance to deliver the best care to patients. For example, health centers are required to assess the health needs of the population to be served as well as what resources are available in the community to meet those needs. Centers must ensure that basic primary care services are coordinated with enabling services and other levels of care; this package as a whole must be appropriate to the communities' health care needs. CHAMPS provides a coordinating structure for assisting health centers in this function.

A major area in which health centers receive technical assistance is the process of selecting and implementing an electronic health record (EHR) system that is appropriate for the needs of the health center. This can be a complex, costly, and labor-intensive undertaking, particularly for health centers that are small and often lack the time, staff, and technical expertise necessary to search for and select an appropriate EHR.<sup>11</sup> The wrong system or poor integration of the system into the health center's workflow can be devastating. PCAs, sister corporations, and independent stakeholder organizations can all be sources of assistance in this area. MPCA, for example, has been a pioneer in the field by attempting to be the first state (Missouri) to implement EHRs in all of its member health centers.

Another important area of clinical technical assistance is practice redesign, which is an area well suited to the expertise of independent stakeholders. One example is a program run by PCDC to redesign the patient visitation process. PCDC works through learning collaboratives (group learning) or with individual health centers to redesign their scheduling systems and workflow, in order to shorten patient wait-times, reduce no-shows, and increase clinician productivity. This type of assistance is best provided by an outside organization like PCDC, as often health center staff members have become entrenched in particular work processes that may be inefficient. The PCA can be too close to the health center, and this member relationship may need to be delicately managed; whereas PCDC—or another organization outside of the health center structure—is better able to provide intensive coaching and/or facilitation.

## **MEMBER SERVICES**

There are numerous member services that take the form of general support and clinical resources, and include live and Internet-based conferences, seminars, and

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workshops. These sessions often include the provision of Continuing Professional Education (CPE) hours and the development of both print and electronic educational materials. These services are all provided by each of the organization types, and depend upon the needs of the health center and the resources available to the organization.

Health centers can also receive some general support services through PCA sister corporations and PCA strategic partnerships with other organizations. The Oral Health Network of Missouri (OHNM) is a sister corporation of MPCA, originally organized as a coalition at the request of MDHSS and the Missouri Dental Association to improve oral health care delivery across the state. OHNM provides the same types of services to dental health centers as MPCA provides to primary care health centers, from quality improvement guidelines and workforce development support to clinical education programs.

### **Funding**

Health centers are funded through a variety of sources, including reimbursement for health care services paid by a mix of public, private, and individual payers (the majority of their revenue), as well as federal and state appropriations, foundation grants, private donations, and other local fundraising efforts.

### **GOVERNMENT**

All community health centers receive funding from the Health Resources and Services Administration (HRSA) under Section 330 of the Public Health Services Act (PHSA). Many health centers, both community health centers and other safety net providers, receive additional state funds. As member organizations driven by health centers, the state PCAs and NACHC are most involved in protecting and increasing state and federal allocations and public payer reimbursement rates for health centers. CCHN is notable for receiving half of its budget from state funds, indicating that the organization maintains a strong relationship with the state government. The close relationship between CCHN and the state has elevated the role of health centers in providing quality primary care within the state.

Since 2002, MPCA has served the unique role of fiscal agent for the state of Missouri in administering health center funds. MPCA's members are content with this role, as each health center is included in the distribution process and

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guaranteed a share in the resources. MPCA's budget, staff, and offerings to health centers have grown considerably as a result. This role for MPCA also developed out of a strong relationship with the state government and may not be directly transferable to other states. In addition, the size of MPCA may relate to its ability to carry out this function: of the case study PCAs, MPCA has the smallest population served, fewest sites, fewest annual visits, and second-fewest number of members.

In another instance where health centers benefited from PCA collaboration with a state government, the nonprofit corporation CQuest grew out of a program started by IPHCA and the Illinois Department of Human Services in the early 1990s. IPHCA developed and implemented a statewide system that integrated the delivery of maternal and child health services, such as WIC, family case management, and immunizations, all funded by the state government. Through the acquisition of another company in 2007, CQuest now manages the automated public health case management systems for Kansas, New Hampshire, the Inter Tribal Council of Arizona (ITCA), Washington, and Puerto Rico, and is continuing to expand its business. CQuest now offers a myriad of technology services to health centers across the country, and is also able to improve services offered to IPHCA's member health centers by reinvesting the revenue it earns from state contracts and consulting back into IPHCA. CQuest now has approximately 100 employees.

### **CAPITAL DEVELOPMENT**

Capital development is critical for health centers to increase accessibility, expand their sites of service, and update necessary medical equipment. Financing capital development projects for health centers through grants and loan-making is too risky and otherwise not financially feasible for PCAs. While some private foundations do provide grants for capital projects, these opportunities can be limited. Recognizing the difficulties health centers face in obtaining capital financing, several supporting organizations emerged to assist health centers in funding their renovation and expansion projects. Capital development is also better handled by sister corporations or independent stakeholders, and not by PCAs directly, as PCAs generally do not have the in-house expertise necessary to advise and assist health centers in this type of project. Our study examined Capital Link, which evolved into a national PCA-driven organization from a sister corporation, and PCDC, an independent stakeholder organization.

## *Profile of Support Services*

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Capital Link, which emerged in its current form in 1998, is a national nonprofit organization that grew out of collaboration between the Community Health Center Capital Fund (a subsidiary of the Massachusetts League of Community Health Centers), the Massachusetts League of Community Health Centers (MLCHC), the Illinois Primary Health Care Association (IPHCA), the Texas Association of Community Health Centers (TACHC), the North Carolina Primary Health Care Association (now the North Carolina Community Health Center Association), and the National Association of Community Health Centers (NACHC), with the assistance of funding by the Health Resources and Services Administration (HRSA).

Capital Link connects health centers to lenders by assisting them in identifying and accessing capital for building and equipment projects. Its staff members are primarily professionals with experience in the lending, banking, and financial market sectors, which are skills not typically part of a PCA's core competencies. Capital development is a very specialized area and only needed by any given health center once every 5 to 10 years. This has allowed Capital Link to be successful in providing a service that is very difficult and not necessarily efficient—in terms of expertise or resources—for individual PCAs to replicate. Capital Link's close connection to the PCAs allows it to be very responsive to health center needs, build trusting relationships with the health centers it serves, and operate on a national level through its network of regional offices.

Capital Link primarily provides one-on-one technical assistance to health centers in accessing capital for building and equipment projects. These services can include risk assessments of capital expansion, business plan development, and even debt crisis management. Additionally, Capital Link collaborates with other PCAs and NACHC on strategic development issues, generally focused on capital needs surveys, financial analysis, and assistance in creating strategies to leverage capital funding for health centers. Capital Link also provides targeted loans to health centers to assist them in leveraging other forms of capital and provides educational sessions at NACHC and PCA conferences on capital development, which increases health centers' awareness of their options.

## Profile of Support Services

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PCDC, in contrast, was founded in 1993 to bring much-needed capital to New York primary care providers, who needed to construct new facilities to expand capacity and make critical improvements to existing ones. Unlike Capital Link, PCDC provides loans to health centers directly rather than connecting health centers to third party lenders. By actually serving as the lender and servicing the loan, PCDC is able to resolve rejected applications, loan defaults, and other financial hardship issues directly with the recipient health center. Furthermore, this process ensures that any PCA member health center in financial distress does not become a liability to the PCA, and does not place the PCA in the role of deciding which members receive loans (which can be further complicated by the member-based Board of Directors). While PCDC's practice redesign and HIT consulting services are available nationally, PCDC's loan-making activities are limited to New York State due to its funding sources and the state-specific nature of key health center revenue streams, including Medicaid and indigent care funding.

### **FOUNDATION GRANTS**

Foundations can play a major role in providing the funding that health centers need to expand their service offerings. While foundations tend to avoid providing health centers with funds for overhead or general operating expenses, they create opportunities for health centers to update equipment and technology, or embark on new programmatic initiatives. This study examined one foundation-based program, the Community Clinics Initiative (CCI).

CCI, created in 1999, is a collaboration between Tides and the California Endowment designed to complement the services that health centers receive from the California Primary Care Association (CPCA) and the network of regional consortia (unique to California) that also support them. CCI operates as a program within a larger foundation to provide grants itself (as opposed to loans) to health centers, in addition to providing support in implementing the programs for which health centers receive grants. Over the years, CCI has provided grants and highly complex technical assistance regarding HIT and infrastructure development through a series of targeted campaigns, including Building Capacities (facilities and management development), Strategic Investments in Technology, and Networking for Community Health.

## *Profile of Support Services*

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One advantage of CCI's funding is that it is grant-based and health centers need not pay it back. Another is that the development approach in both grant-making and learning has been one of building one capacity on the prior one, with a long-term (ten year) horizon rather than episodic trainings. One major drawback is that the funding is awarded competitively, and that the funding is restricted to the scope of the grant. But while the specific focus of CCI has evolved over time, depending on the availability of funds, the interest of funders, and the evolving needs in the field, CCI's overall mission to develop technological infrastructure, learning across the field, and networking capacity for health centers has remained consistent throughout.

# *Lessons Learned*

Community health centers are charged with delivering quality, cost-effective care to the most vulnerable and underserved populations in their communities. On an individual level, health centers have needs as varied as the patients they serve.

We have identified a number of characteristics that affect how PCAs, sister corporations, and independent stakeholders provide support to health centers. Our comparison of the case study organizations in benchmark states illustrates that, while health centers at a state and national level do have similar needs, there are opportunities for and limitations on the services each type of organization is best suited to deliver.

## **Membership Structure**

PCAs are by definition membership organizations, and therefore have a particular mission and structure as it relates to their member health centers. Member health centers drive PCA activities through serving on the Board of Directors, participating in conferences and trainings, requesting assistance with the full range of health center activities, and providing feedback to the PCA. PCAs are responsible primarily for meeting the full range of their members' needs in delivering and expanding access to affordable, quality primary care services through providing a wide range of technical assistance services in support of their member health centers' mission. PCAs also advocate on behalf of their members before state legislative and regulatory bodies, and conduct broad public education campaigns. This relationship between health centers and their PCA works very well in regards to advocacy, member services, health center operations compliance, workforce development, and clinical initiatives (depending on the PCA).

## Lessons Learned

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In some areas, however, the member relationship can complicate the ability of PCAs to provide certain services. For example, operations and quality improvement services can in some cases be more effective when provided by a sister corporation or independent stakeholder because these types of organizations can be more objective, bring a fresh perspective, are not structurally controlled by or accountable to the health centers they are serving. The same conditions apply to loan processing and grant-making, or any type of activity that involves choosing between organizations.

### **Expertise**

Many health centers turn to their PCA first for training and technical support. In some cases, a given PCA may not have the resources or in-house expertise on a particular issue to provide health centers support at the level desired, which has created an opportunity for many sister corporations or independent stakeholders to provide these complementary services. Sister corporations and independent stakeholders have been very successful in providing health centers with assistance in operations and quality improvement, clinical programs, HIT implementation, capital development, and other types of services that require a very specialized body of knowledge and expertise or the ability to work closely with each individual health center.

PCAs, however, often play a facilitative role in these cases by connecting their member health centers with outside expertise and access to this specialized type of assistance. Many PCAs arrange for outside experts to lead in-person and web-based training sessions, and some PCAs collaborate with sister corporations or independent stakeholders to meet member health center needs. In addition, some PCAs collaborate with universities and medical schools to be able to provide CPE offerings that could otherwise be logistically inconvenient or cost-prohibitive to health center clinicians.

### **Financial Risk**

As 501(c)(3) membership organizations, PCAs are limited both by tax status and mission in their programs and activities. PCAs cannot place their organization at financial risk because of their responsibility to ensure adequate health center representation and provide all of the member services necessary to help maintain and expand the safety net. However, there are services that health centers do need

## Lessons Learned

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that often require some financial risk. These services include grant-making, loans for capital development, and group purchasing. Sister corporations and independent stakeholders like CCI, PCDC, or the Commonwealth Purchasing Group are able to provide these at-risk financial services without threatening the stability of other health center services. PCAs can then play a facilitative role for their members by connecting them to other organizations that provide such services, such as when PCAs work with Capital Link, or manage an arrangement themselves, in the case of the GPOs being overseen by CCHN.

### **State Governments**

Health centers located in states in which the PCA and the state government have a strong relationship appear to play a larger role in primary care delivery, and this relationship often leads to expanded support services for health centers. State government funding is critical to a PCA and its member health centers for continuing and expanding operations. It is also important for being able to implement new statewide programs. In addition, collaborations between a PCA and a state government have led to the creation of many successful sister corporations, such as the Oral Health Network of Missouri or CQuest in Illinois.

# *Conclusion*

The needs of health centers are as diverse as the needs of the populations they serve, and no single organization or type of organization can provide all of the support, assistance, and funding necessary for a health center to continue operating, improve its care delivery. Health centers receive support, training, and technical assistance from a variety of support organizations at the local, state, and federal level. As critical elements of the U.S. health care safety net, health centers are able to play a unique role in increasing access to care for the most vulnerable patients. Tasked with the dual role of policy advocate and member organization, PCAs balance the interests and needs of their members with their missions and ability to provide support services.

In cases where a PCA does not have the specialized expertise or available resources, may be placed at risk financially, or membership issues could hinder quality improvement, sister corporations and independent stakeholders provide support to health centers that complement PCA offerings. These supporting organizations, whether created independently or through the collaborative efforts of a PCA, state government, and/or national organization, form in unique ways to meet the particular local needs of health centers. Health centers benefit the most when the various support organizations that serve them—PCAs, sister corporations, and independent stakeholders—collaborate with each other and with state governments to ensure that health centers are better able to meet their mission.

This study was commissioned by the California HealthCare Foundation to explore the range of services health centers need from supporting organizations in order to fulfill their mission as safety net health care providers.

# Appendix A

## PCA Case Studies

Interviews with PCA staff and others were conducted over August and September, 2009. Table 1 presents summary characteristics of PCAs in the six benchmark states we reviewed: Colorado, Illinois, Massachusetts, Missouri, New York, and Texas. We attempted to select a diverse group of states, with PCAs of varying tenure, size, geographic location, and patient populations served. Benchmark states were selected after in-depth discussions with representatives from the National Association of Community Health Centers (NACHC).

**Table A-1: Characteristics of PCA Case Study Sites**

	Colorado Community Health Network	Illinois Primary Health Care Association	Massachusetts League of Community Health Centers	Missouri Primary Care Association	Community Health Care Association of New York State	Texas Association of Community Health Centers
<b>Year Formed</b>	1982	1982	1972	1984	1971	1983
<b>Number of Members</b>	15	54	52	21	112	68
<b>Number of Health Center Sites</b>	138	300	280	120	508	300
<b>Population Served</b>	419,000	1,100,000	Over 750,000	310,000	1,200,000	814,000
<b>Number of Annual Primary Care Visits</b>	1.7 million	4 million	Over 3 million	1.1 million	5.6 million	2.9 million
<b>Number of PCA Staff</b>	26	21	32	15	30	23

**Table A-2: Number of Membership Tiers and Range of Membership Dues per Year**

PCA	Number of Membership Tiers	Structure of Dues
Colorado Community Health Network	1	Based on annual budget
Illinois Primary Health Care Association	4	Tiered based on annual budget
Massachusetts League of Community Health Centers	7	Percent of annual budget with ceiling/floor
Missouri Primary Care Association	2	Percent of annual budget with flat rate component
Community Health Care Association of New York State	4	Tiered based on annual budget
Texas Association of Community Health Centers	4	Tiered based on annual budget

**Table A-3: Proportion of Total Budget by Funding Source, Fiscal Year 2009**

PCA	Membership Dues	Federal Grants	State Grants/Contracts	Foundation Grants	Private Grants	Other Revenue
Colorado Community Health Network	8%	15%	50%	25%	0%	5%
Illinois Primary Health Care Association	2.4%	17.8%	59.6%	0%	0%	20.2%
Massachusetts League of Community Health Centers	3.5%	16.5%	16%	3%	52%	9%
Missouri Primary Care Association	0.5%	1.9%	96.3%	0.7%	0%	0.6%
Community Health Care Association of New York State	18%	37%		20%	0%	25%
Texas Association of Community Health Centers	14%	36%	13%	~1%	0%	36%

Note: Total do not sum to 100% due to rounding. The relative distribution of funding across these sources can vary greatly from year to year due to changes in government funding and the awarding of foundation grants, etc. This table shows a snapshot of the current proportion of funding for each PCA by source for illustrative purposes.

In this section, we present brief descriptions of our six case study sites, including examples of unique attributes or activities of each PCA.

## **Colorado Community Health Network**

The Colorado Community Health Network (CCHN) was created in 1982 and now represents 15 community health centers across the state. All current members of CCHN are FQHCs funded under Section 330 of the Public Health Service Act (PHSA), though FQHC look-alikes are also eligible; there is a single membership category, and each member health center has the same voting rights on the Board of Directors.

Below the Chief Executive Officer, there are 25 staff members divided into five divisions. There are seven staff in the policy and advocacy division, five staff in the health center operations division, eight staff in the clinical quality division, and two staff in both the finance and operations (administrative) divisions. Every year CCHN conducts a member satisfaction survey, based on the Bureau of Primary Health Care (BPHC) annual survey (as it relates to PCAs), to identify areas in which members believe CCHN can improve services.

Member dues are determined by the previous year's budget for each health center, and are distributed proportionately across the smallest and largest member health centers. While dues and federal funding were the original financial foundation of the organization, the majority of the current budget comes from state funding and foundation grants, with the small remainder comprising both private donations and unrestricted revenue allocated by CCHN's group purchasing organization (GPO). Trainings provide very little revenue.

The Board of Directors meets quarterly and consists of 20 representatives: the CEO of each member health center and four section leaders. The sections include the Colorado Operations Directors Advisory Network (CODAN), the Colorado Clinicians

### **Unique Attributes of CCHN**

- Colorado health centers are moving toward a regionalized model, as smaller and more rural health centers have begun to merge with larger neighbors due to financial pressures and the need to create efficiencies
- One health center corporation in Denver (15 sites) serves over 100,000 patients annually (25 percent of total patients served by health centers in Colorado)

Advisory Network (CCAN), the Colorado Dental Health Network (CDHN), and a Fiscal Directors Advisory Section (named FISCAL), which make recommendations to the full Board. Community health center Development Directors, Billing Directors, Human Resource Directors, and Outreach and Enrollment Coordinators also meet throughout the year. Standing committees unique to CCHN include the Strategic Workforce Committee and Strategic Data Committee. The Board itself has been surveyed to rate its own effectiveness in leading and representing the mission and activities of CCHN. There has been very little turnover in Board membership as most Board members are health center directors and have been serving for more than 10 years.

CCHN maintains three GPO agreements to negotiate discounted goods and services on behalf of its members. CCHN partners closely with its sister corporation the Colorado Community Managed Care Network (CCMCN)—a network of health centers dedicated to improving health information technology and managed care contracting for community health centers. Additional sister corporations include the Community Health Association of Mountain Plain States (CHAMPS), which provides workforce development and clinical quality improvement services to health centers in federal Region VIII.

### **The Illinois Primary Health Care Association**

The Illinois Primary Health Care Association (IPHCA) was founded in 1982, and has since grown into a large network housing multiple corporate entities that serve health centers in Illinois and Iowa, do business with health centers, and manage the Women, Infants, and Children (WIC) programs in several states.

There are 57 members in IPHCA, divided into four categories: organizational, associate, coalition, and business. Of the total membership, 46 qualify as organizational, due to their status as either FQHCs or FQHC look-alike health centers. The nine associate members are health centers in the process of becoming an

FQHC or look-alike in order to obtain full organizational membership status. In addition, there is one coalition member and one business member. A system of regional caucuses—formally organized by IPHCA—was disbanded two years ago in favor of regional representation on the Board of Directors, though the health centers in Chicago and the southern region of Illinois continue to meet regionally on a less formal basis.

Under the President and CEO, the 21 staff members of IPHCA are divided into three major groups. The Chief Financial Officer oversees the seven staff in the accounting, administrative, facilities management, and human resources departments. The Chief Operating Officer manages ten staff in the community health services division, separated into communications and member services and data activities. The Vice President of Governmental Affairs also oversees one staff member.

Member dues comprise a very small portion of the IPHCA’s annual budget, are collected based on the financial size of the health center, and are normally distributed into roughly four or five classes. IPHCA receives funding from HRSA, accepts very little state funds, and rarely pursues foundation grant opportunities. A significant portion of IPHCA’s budget (on average 20 percent annually) is allocated from CQuest America, Inc., a sister corporation with 501(c)(4) status that owns and operates the WIC systems in Illinois, Kansas, New Hampshire, and the Inter Tribal Council of Arizona and employs approximately 100 people. CQuest also hosts a practice management system and health information network for all IPHCA members, and builds contract management systems, and provides other information technology services for health centers across the country.

The IPHCA Board of Directors is a representative board consisting of 13 organizational members and 6 regional representatives, including the President and CEO, and six officers. Unique standing committees include: Access to Care, Compliance and Risk Management, Senior Health Care, and Managed Care. Both the full

## **Unique Attributes of IPHCA**

- Outreach initiatives:
  - President/CEO visits every health center once every two years
  - Program staff visit 1-2 health centers per year
- Sister corporation funds IPHCA through managing state WIC programs and providing HIT consulting services
- The IPHCA Health Source Newsletter is published monthly and distributed to member health centers, government officials, other PCAs, hospitals, and organizations involved in health care

Board of Directors and the committees meet four times per year. In addition, the Assembly of Delegates is composed of one representative from each organizational member, and meets three times per year.

## **The Massachusetts League of Community Health Centers**

Founded in 1972, the Massachusetts League of Community Health Centers (MLCHC) is the second oldest primary care association. MLCHC is composed of 52 organizational members, including every FQHC in the state. Of the total membership, 36 health centers are FQHCs, four health centers are FQHC look-alikes, and 12 are hospital-licensed or affiliated. In addition to organizational members, MLCHC has five primary associate members, three network members (which are community health center-based networks or community health center-based health plans), and one business member. Other member categories include community health center health system members, individual members, and honorary individual members.

Out of a total staff of 32, there are roughly ten divisions in which MLCHC staff members are organized. There are five staff working in finance and administration, five staff in clinical health affairs, four staff in technical services, three staff in health resources and policy, two staff in public affairs, and three staff in workforce programs and training. There is one staff member in each of the following departments: legislative affairs, member services, administrative and business systems, oral health affairs, and programs and policy. In addition, there are three staff of the Commonwealth Purchasing Group. Staff are generally organized at MLCHC by operational function rather than departmentally, and can be roughly organized into four categories: communications, technical assistance, promotion, and government affairs.

Community health center membership dues are calculated as a standard percent of the member's annual budget, excluding any lines of business unrelated to health centers. The correct level of dues is ascertained each year through an annual audit, and

### **Unique Attributes of MLCHC**

- Staff work collaboratively by operational function across divisions rather than internally by department
- Have wide range of sister corporations, including a group purchasing organization, a capital development corporation, a managed care organization, and an advocacy organization

accelerators are set every three to five years to adjust for inflation. Funding comes mainly from private grants and donations, in addition to state and federal grants. Membership dues and foundation grants proportionally make up little revenue in the annual budget.

As part of a new corporate structure, MLCHC last year created an Assembly above the Board of Directors, composed of four representatives—one designated as the “voting representative”—from each member health center, and one voting representative from each network member and each community health center health system member. The Board transitioned from a representative body composed of 35 members to a body with one representative of each health center, network member, and community health center health system member; one designated clinician and one designated consumer; and any current Massachusetts members or officers of NACHC. The Board has five officers and several unique standing committees including Education and Boston Conference of Community Health Centers. The Assembly meets annually, while the Board meets quarterly and the Executive Committee meets monthly. MLCHC also convenes many informal committees, such as task forces on capital and workforce development, multiple disease collaboratives, and networks for the Chief Medical Officers, Chief Financial Officers, and Chief Information Officers for each community health center.

In addition to housing the Commonwealth Purchasing Group, MLCHC also works closely with several sister corporations: Capital Link (a national organization facilitating capital development that was once housed within MLCHC), the Community Health Center Capital Fund, the Massachusetts Association of Community Health (a 501(c)(4) organization dedicated to legislative advocacy), Neighborhood Health Plan (a managed care organization founded by Massachusetts health centers), and the Massachusetts Coalition of School Based Health Centers.

## Missouri Coalition for Primary Health Care, Missouri Primary Care Association

Formed in 1984, the Missouri Primary Care Association (MPCA) is Missouri’s leader in shaping policies and programs that improve access to high-quality, community-based, and affordable primary health services to the medically underserved.

MPCA has two membership categories – organizational and associate members. There are currently 21 organizational members, which are all FQHCs. There are currently no associate members, which would include FQHC look-alikes and other community based organizations. These members are supported by approximately 15 MPCA staff members, who are divided into three separate divisions: six within the Access to Care division, four within the Missouri Center for Quality Care and Excellence division, and five within Administration, including the CFO, an accountant, and HR representative. The Access to Care division focuses on government relations, health care development, Medicaid outreach/enrollment, oral health services, and workforce development. The Missouri Center for Primary Care Quality and Excellence works with Missouri’s community health centers on quality improvement activities to improve overall patient health.

MPCA is funded through a combination of membership dues and grants. Membership dues are structured differently for associate and organizational members. Associate member dues are based on a flat-rate, while organizational member dues are formula based, including a flat-rate plus a portion based on total expenses for the specific FQHC. MPCA also receives a large amount of funding through 12 grants. MPCA is the association responsible for distributing state funding to health centers. Every organizational member receives state funding through MPCA based on a formula which includes a flat-rate plus additional funds based on patient case-mix and center growth.

MPCA is managed under a Board of Directors. The Board, with currently 21 members, is comprised of one CEO from each of the

### Unique Attributes of MPCA

- Distributes state funding to FQHCs
  - \$10.5M distributed to health centers annually
  - Serves as “fiscal agent of the state”
- Developed centralized data warehouse
  - Hope to have all health centers across the state linked using EHRs

organizational members. The Board of Directors meets quarterly in addition to ad hoc meetings, as necessary. A unique standing committee in operation is their Nominating Committee. Additional specialty committees are established by the Board and currently include Workforce Development and Medicare Policy Regulation.

To help pursue MPCA's mission, it has created strategic alliances with the Oral Health Network of Missouri, Missouri Coalition for Community and Mental Health Centers, Missouri Hospital Association, and Missouri Dental Association. MPCA's focus is to provide technical assistance, support and advocacy for its members, rather than engage in business ventures like group purchasing through a sister corporation.

### **Community Health Care Association of New York State**

Formed in 1971, the Community Health Care Association of New York State (CHCANYS) is the oldest state PCA in the country. Beginning in 2005, CHCANYS implemented a completely new set of programs and services to better support community health centers in New York State.

Of the 112 total members, 52 are organizational members and 60 are associate members. These members are supported by approximately 30 CHCANYS staff members (a large increase from the five staff members four years ago), who are divided into six main programmatic divisions across two offices, including: four staff members within government affairs, five staff members each within technical assistance and training, member services, clinical and quality improvement, and technology, and six members within general and administration. The government affairs division serves as the foundation of the organization's activities and is under the direction of the Public Policy Team.

CHCANYS is funded through a combination of membership dues, funding from the New York City, State, federal governments, and foundation grants. Membership dues are determined by referencing the current cost reports, and represent approximately 18 percent of

#### **Unique Attributes of CHCANYS**

- Only PCA under the direction of a CEO who served as a CEO of a health center first
- CHCANYS supports approximately 425 community health centers in the state, with 40 percent of them located in New York City

the total budget. Under the old structure of CHCANYS, government grants were not regularly received. Under the new structure, these grants represent approximately 37 percent of the total budget. CHCANYS supplements these increased government grants with foundation grants to support their new organizational structure, which represents approximately 20 percent of their budget. Currently, private donations do not contribute to the total budget.

The Board of Directors for CHCANYS is comprised of 29 members which includes a consumer at-large representative from an organizational member and the immediate past president of the Board of Directors. The remaining 27 directors represent the six regions of the State. In addition, two directors must be clinicians who have served in community health centers in New York State for over three years. The Board of Directors meets at least six times a year, with additional meetings as needed. Unique standing committees include their By-laws Committee. Other committees can be established on an ad hoc basis as well.

CHCANYS has a strong strategic alliance with the Primary Care Development Corporation (PCDC), which works with CHCANYS and directly with its member health centers to provide loans for capital development. Furthermore, PCDC also provides performance improvement services to individual health centers on issues including practice redesign, medical home development, implementation of HIT, and emergency preparedness.

### **Texas Association of Community Health Centers**

Formed in 1983, the Texas Association of Community Health Centers (TACHC) represents safety-net health care providers in the state of Texas. TACHC provides support services, technical assistance, and training for its members, in addition to operating many of the IT services on which its members rely.

TACHC has four membership categories. Full organizational members include FQHCs and FQHC look-alikes; interim

organizational members include organizations seeking FQHC or FQHC look-alike status; network members are associations that support FQHCs and FQHC look-alikes; and individual members, which support and are committed to TACHC's mission.

Of the 68 total members, 61 are full organizational members and six are interim organizational members. These members are supported by approximately 23 TACHC staff members (more than double the staff from 10 years ago). The staff are divided among four main programmatic divisions, including planning and policy analysis, clinical, information technology, and development. There is also an Executive division that includes the Executive Director, administrative staff, group purchasing staff, and compliance officers. Planning and policy analysis focuses on strategic planning, special projects, and legislative analysis. The clinical department coordinates the training and technical assistance related to clinical and quality provided through the PCA and promotes quality improvement and efficiency initiatives. This department is closely linked to the IT department, which supports the local and wide area network, EHR implementation, and the learning network. The community development department helps get new health centers established and supports recruitment and retention efforts within health centers. Additionally, it provides financial analyses for health centers.

TACHC is funded through a combination of membership dues, and state, federal, and foundation funding. Membership dues are based on health center budget size, and combined with shared services such as member networks. The revenue generated from the group purchasing program represents a sizeable part of the total budget. TACHC receives federal funding, but barely any funding through foundation grants. Additional funding is secured through other business, such as conference registrations, and trainings.

Due to the size of Texas and the number of health centers, the Board of Directors is chosen based on regional districts. The resulting board is comprised of 13 members, which include CEOs,

## **Unique Attributes of TACHC**

- Provides nearly 28 web-trainings per year with approximately 300 health centers connected via voice, video or data
  - Develops own trainings with subject matter experts in their own broadcast booth/studio
  - Internal staff participate in virtually all trainings even if external speaker provides the training
- TACHC conducts an annual evaluation of member health center Executive Directors to assess job performance

Executive Directors, and at least one Provider Representative. The Board of Directors meets quarterly and in additional ad hoc meetings, as necessary. A unique standing committee in operation is the Recruitment and Retention Committee.

TACHC coordinated a group purchasing program to support their members. TACHC members and other FQHCs across the country can participate in the group purchasing program at no additional cost for supplies and services. The group purchasing program includes pharmacy, laboratory services, dental, and medical/surgical supplies. Additional affiliates created by TACHC include an insurance agency, a community development corporation that provides low-interest loans to community health centers for capital projects, and a Purchasing Group corporation that provides Federal Tort Claims Act gap insurance coverage options for community health centers.

# Appendix B

## **Independent Stakeholder Organization Case Studies**

In addition to our six PCA case studies, the project team interviewed three independent stakeholder organizations: Capital Link, the Community Clinics Initiative (CCI), and the Primary Care Development Corporation (PCDC).

### **CAPITAL LINK**

Capital Link, which emerged in its current form in 1998, is a national nonprofit organization that grew out of collaboration between the Community Health Center Capital Fund (a subsidiary of the Massachusetts League of Community Health Centers), the Massachusetts League of Community Health Centers (MLCHC), the Illinois Primary Health Care Association (IPHCA), the Texas Association of Community Health Centers (TACHC), the North Carolina Primary Health Care Association (now the North Carolina Community Health Center Association), and the National Association of Community Health Centers (NACHC), with the assistance of funding by the Health Resources and Services Administration (HRSA).

The mission of Capital Link is to provide technical assistance to health centers in accessing capital for building and equipment projects. In fiscal year 2009, Capital Link provided services to health centers in 51 states and territories due to the availability of funds appropriated through the American Recovery and Reinvestment Act of 2009, and to date has assisted health centers in obtaining \$423 million in grants and loans for 164 capital development projects. Capital Link also provides targeted loans to health centers in order to assist them in leveraging other forms of capital. While some of Capital Link's technical assistance services for health centers are subsidized by HRSA, the United States

Department of Agriculture, and foundations, other services are offered on a fee basis.

About two-thirds of Capital Link’s assistance is provided directly to health centers on a one-to-one basis, and is driven by understanding individual health centers’ market and needs; assessing the size, scope, and affordability of the project; determining available grant and lending sources; writing a business plan; and conducting associated activities. The remaining one-third of Capital Link’s services are conducted through collaboration with the PCAs and NACHC. This strategic development focuses more on capital needs surveys, financial analysis, and assistance in identifying strategies to leverage capital funding for health centers. Capital Link also provides educational sessions at NACHC and PCA conferences in the area of capital development. Capital Link is governed by a Board of Directors composed of 13 members, eight of whom are appointed by MLCHC and five who are appointed by NACHC, and are required to be geographically representative.

### **COMMUNITY CLINICS INITIATIVE**

CCI, created in 1999, is a collaboration between Tides and the California Endowment designed to provide technical assistance, strategic planning, and evidence-based programming and evaluation to health centers in California. Over time, other funders have turned to CCI for help to implement grant-making and learning programs for health centers in California. CCI complements the services that health centers receive from the California Primary Care Association (CPCA) and the network of regional consortia (unique to California) that also support them. Since CPCA and the regional consortia are membership organizations—and ultimately provide information at a level that pertains to and reaches the majority of their members—CCI is able to push health centers in a number of areas which are not member-driven concerns and to set aspirational goals for the field not derived out of consensus but out of scanning future trends in health care. CCI works with all health centers licensed by the state, independent of their membership with CPCA or their respective regional consortia.

In comparison to other strategic alliances, CCI is unique in that it is entirely funded through foundation grants and major gifts, and operates as a program within a larger foundation to provide grants itself (as opposed to loans) to health

centers, in addition to providing support in implementing the grant programs. Over the years, CCI has provided grants and highly complex technical assistance regarding HIT and infrastructure development through a series of targeted campaigns, including Building Capacities (facilities and management development), Strategic Investments in Technology, and Networking for Community Health. While the specific focus of CCI has evolved over time, depending on the availability of funds, the interest of funders, and the evolving needs in the field, CCI's overall mission to develop technological infrastructure, learning across the field, and networking capacity for health centers has remained consistent throughout.

### **PRIMARY CARE DEVELOPMENT CORPORATION**

PCDC is a multi-faceted organization that provides loans for capital development and a variety of programs and consulting services to primary care providers, including FQHCs, hospitals, and special needs providers. PCDC was founded in 1993 to expand primary care capacity by bringing much-needed capital to New York primary care providers in order to construct new and expanded facilities and make critical improvements to existing ones. PCDC is funded through a wide range of avenues: federal, state, and local government; private foundations; and corporate gifts. In addition, PCDC generates revenue by charging fees for its services. While it began with capital financing, since its founding PCDC's mission has grown in two directions: 1) improving the quality of care provided through technical assistance in the areas of practice redesign, HIT, and other services, and 2) influencing policy and state funding to primary care providers through advocacy efforts.

PCDC also provides performance improvement services to health centers both inside and outside of New York. These services include practice redesign, medical home development, implementation of HIT, and emergency preparedness. PCDC staff facilitate, coach, and train health center staff to implement the desired changes, either in learning collaborative (group learning) or individually. PCDC assists health centers in becoming "change oriented" in order to expand and improve services. PCDC has also assisted other PCAs, including the District of Columbia Primary Care Association and the Community Health Center Association of Connecticut, in developing capital lending and/or quality improvement programs.

<sup>1</sup> Paraphrase of 42 USCS § 254b. Emphasis added.

<sup>2</sup> Our findings do not attempt to comprehensively assess the field of support organizations, but rather to highlight examples through the use of a case study methodology.

<sup>3</sup> Chin MH, et al. (2000). Quality of diabetes care in community health centers. *American Journal of Public Health* 90(3): 431-4.

<sup>4</sup> Hunt JW. (2006). Guidebook for the Primary Care Association Executive, Staff, and Board Members, National Association of Community Health Centers.

<sup>5</sup> Ray & Associates, LLC. Study of Governance of Primary Care Associations, Summary Report Provided to NACHC. Steamboat Springs, CO.

<sup>6</sup> Gaylin D, et al. (2005). Final Report, Community Health Center Information Systems Assessment: Issues and Opportunities. NORC at the University of Chicago, October 2005.

<sup>7</sup> Dor A, Pylypchuck Y, Shin P, Rosenbaum S. (2008). Uninsured and Medicaid Patients' Access to Preventive Care: Comparison of Health Centers and Other Primary Care Providers. Research Brief #4, Geiger Gibson Program/ RCHN Community Health Foundation Research Collaborative, August 13, 2008.

([http://www.gwumc.edu/sphhs/departments/healthpolicy/chsrp/downloads/RCHN\\_brief4\\_8-13-2008.pdf](http://www.gwumc.edu/sphhs/departments/healthpolicy/chsrp/downloads/RCHN_brief4_8-13-2008.pdf))

<sup>8</sup> Chin MH, et al. (2000). Quality of diabetes care in community health centers. *American Journal of Public Health* 90(3): 431-4.

<sup>9</sup> Frick KD and Regan J. (2001). Whether and where community health centers users obtain screening services. *Journal of Healthcare for the Poor and Underserved* 12(4): 429-45. 25(6):1713-1723.

<sup>10</sup> Proser M. (2005). Deserving the spotlight: Health centers provide high-quality and cost-effective care. *Journal of Ambulatory Care Management* 28(4):321-330.

<sup>11</sup> Fiscella K, Geiger HJ. (2006). Health information technology and quality improvement for community health centers. *Health Affairs* 25(2): 405-411.