



California Health Care Foundation



Partnering to Succeed: How Small Health Centers Can Improve Care and Thrive Under Value-Based Payment

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About MacColl at KPWHRI

Kaiser Permanente Washington Health Research Institute (KPWHRI) is the nonproprietary, public-interest research center within Kaiser Permanente Washington, a nonprofit health system based in Seattle. Its mission is to improve health and health care for everyone through leading-edge research, innovation, and dissemination. Within KPWHRI, the MacColl Center for Health Care Innovation has a 25-year history of developing and disseminating models to improve care delivery, patient experience, and clinical outcomes, especially for vulnerable populations.

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The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

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Executive Summary

Since their inception in the 1960s, community health centers (CHCs) have provided access to care for millions of Americans, including some of the most vulnerable individuals and families. As the economic environment of CHCs has changed, most recently with the expansion of Medicaid under the Affordable Care Act (ACA), these institutions have had to adapt quickly.

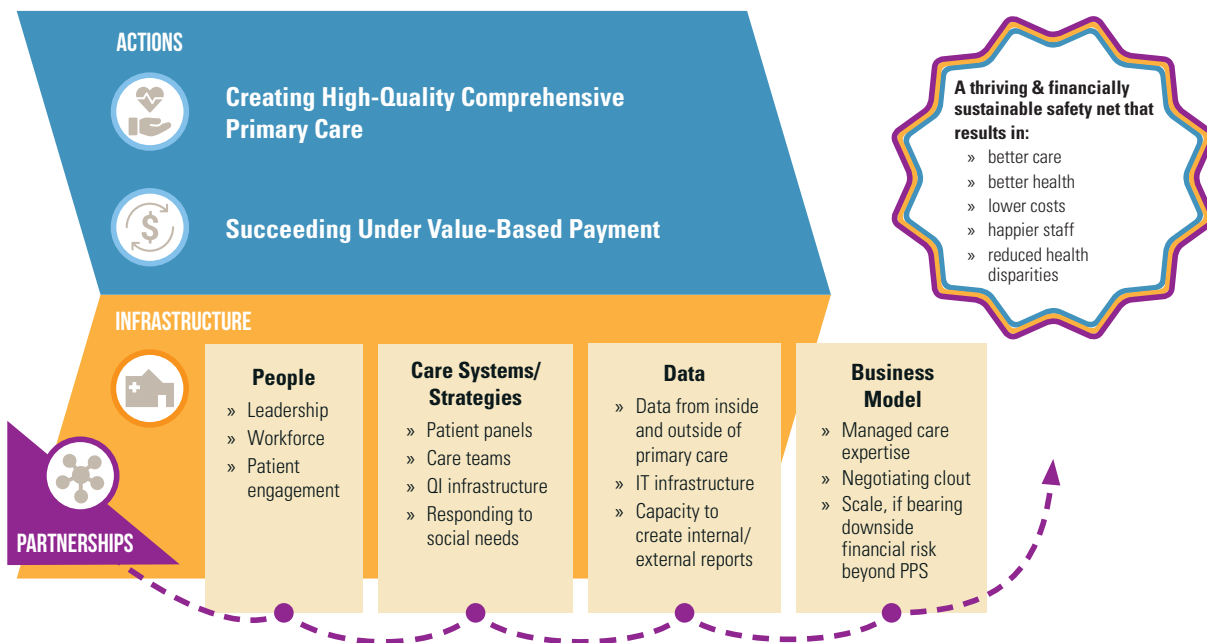
In California, CHCs serve more than 4 million people annually. Many CHCs in California and nationally are experimenting with strategies to improve and expand care, such as finding ways to integrate behavioral health, bolster team-based care, and proactively reach out to patients with unmet preventive or chronic care needs. In tandem, health centers are increasingly participating in value-based payment. These actions require considerable infrastructure, with many components necessary for both endeavors. All health centers struggle to put this infrastructure in place, but small health centers — defined for the purposes of this paper as having fewer than 10,000 patients or an annual budget of \$10 million or less — face unique challenges in securing access to capital, building strong data capabilities, and negotiating favorable rates with vendors and contracts with health plans.

To help clarify the way forward for small health centers, this paper presents a Model for Advancing High Performance (MAHP) (see Figure 1). Based on research and expert opinion, it describes the actions and infrastructure CHCs will need to thrive in this new environment and contribute to a sustainable primary care safety net that achieves the quintuple aim — better care, better health, lower costs, happier staff, and reduced health disparities.

As Figure 1 shows, engaging in the actions required to achieve the quintuple aim necessitates supportive infrastructure in four major areas: people, care systems/strategies, data, and a business model. Infrastructure elements such as meaningful patient engagement in care, well-defined patient panels, and the ability to create actionable data reports are important to support both care transformation and value-based payment.

For small health centers that are not in a position to create extensive infrastructure on their own, partnerships and alliances can be critical. When done well, such collaborations can help health centers fulfill their missions by supporting and supplementing primary care activities to leverage resources and improve health.

Figure 1. A Model for Advancing High Performance (MAHP)



This paper presents seven types of partnerships:

1. Partnerships with community-based agencies and organizations (local government and nonprofit).

Health centers can offer patients comprehensive care that addresses medical, behavioral, and social needs by partnering with public agencies and community-based organizations.

2. Partnerships with hospitals. A local hospital partnership can serve many functions, including care coordination; data sharing; access to specialists, lab services, and pharmacy services; additional funding for staff positions; and potential grants from a hospital community benefit program.

3. Consortia. Consortia can help individual health centers to monitor and influence policy, engage in quality improvement, share best practices, and centralize select nonmedical functions such as training or managing volunteers.

4. Management services organizations (MSOs) and clinically integrated networks (CINs). MSOs and CINs are designed to assist health centers with needed nonmedical functions. For some, these functions extend to collective clinical quality work and negotiations for incentive payments (upside risk) with payers.

5. Health-center-led independent practice associations (IPAs). IPAs allow health centers to contract collectively for risk-based payments and to distribute savings, if they occur, based on quality and cost outcomes of an assigned member population.

6. Partnerships with health plans. Partnerships with health plans, often in the form of contracts for value-based care and payment, such as pay-for-performance incentives or care management payments, can help health centers secure additional flexibility or revenue to innovate in care delivery.

7. Mergers and acquisitions. A merger or acquisition strategy can stabilize health centers by increasing economies of scale. The right partnerships can enhance services to the community.

Individual small health centers may make use of one or many of these partnerships depending on an array of factors. This white paper provides a detailed review of these factors, along with the advantages and disadvantages of each partnership type. In addition, four case studies highlight the experiences of small health centers partnering in these ways.

To be ready for potential partnership opportunities, CHCs can take the following concrete steps to get started.

- ▶ **Assess health center infrastructure.** Make an honest assessment of the CHC's internal infrastructure in terms of people, systems and strategies, data, and business model.
- ▶ **Understand the local context.** Each community operates with different partners and politics. What partnerships are available in the area? Which partners are the best cultural fit and most mission aligned? What are the managed care contracting practices in the region?
- ▶ **Weigh the options.** Not all partners offer the same breadth, depth, and quality of services, regardless of their organizational type. A partner may be strong in one area but weak in another.
- ▶ **Reach out.** Starting conversations with potential partners can result in collaborations and partnerships that take shape through exploratory discussions.
- ▶ **Build readiness.** Even if a health center is not ready to partner, it can build infrastructure and improve care now. Health centers are undertaking a broad range of activities that are achievable under a prospective payment system (PPS) and that also prepare them for value-based pay.

Health centers have a history of working well together on advocacy and other policy-related topics. The demands of care transformation and value-based payment increase the need for collaboration and partnerships, especially for small organizations. In this dynamic environment, partners that bolster a health center's capabilities will be a key ingredient for success. There are opportunities for consortia, health center-led IPAs, policymakers, health plans, and funders, among others, to support partnerships and accelerate progress.

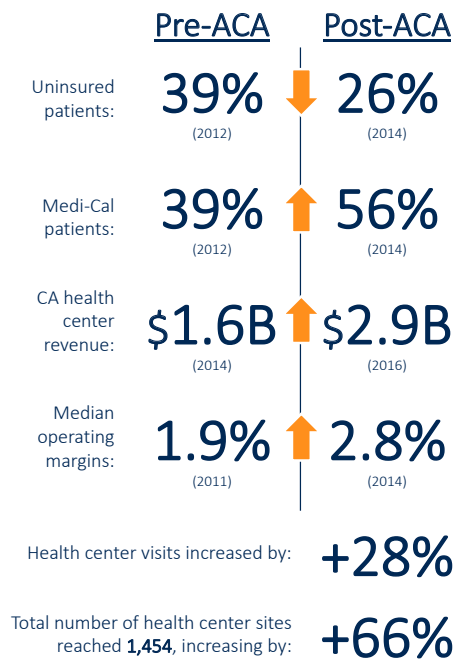
Introduction: Advancing the Health Center Mission of Providing High-Quality Care for All in a Value-Based Environment

Community health centers (CHCs) provide access to care for millions of Americans, including some of the most vulnerable individuals and families,¹ and they have done so since their inception in the 1960s. The health care environment has changed dramatically in the intervening years, particularly in California, with the advent of managed care, and, more recently, with the rapid expansion of the Medicaid program under the Affordable Care Act (ACA). Medicaid expansion accelerated the pace of care delivery experimentation² and ushered in a wave of financial stability for many health centers, with improvement demonstrated across a wide range of indicators (see Figure 2).³

However, this stability may be jeopardized if Medicaid expansion is rolled back or if Medicaid becomes a block grant or per capita capped program. Health centers would likely see an increase in the number and proportion of uninsured patients, and to continue fulfilling their missions, they may need to do more with less.⁴

Regardless of these uncertainties, the care delivery innovations that CHCs have undertaken during this period — including proactive, population-based care; behavioral health integration; and team-based care — are likely to stay. Research continues to emphasize the importance of a strong primary care system and the crucial role CHCs play in improving health.^{5,6}

Figure 2. Health Centers in California, Pre- and Post-ACA



Sources: Health Resources and Services Administration, Uniform Data System, 2012-2015. Blue Shield of California Foundation, "California Community Health Centers: Financial & Operational Performance Analysis, 2011-2014," 2016, www.caplink.org (PDF).

Additionally, under a wide range of future political scenarios, the shift from volume-based to value-based payment is predicted to continue. This is evidenced by increased activity in California through pay-for-performance programs through Medi-Cal managed care,⁷ state plans to implement Health Homes⁸ in 2018, and continued explorations of a health center Alternative Payment Methodology (APM). The changes to payment represent a fundamental shift for health centers that have long relied on volume-based reimbursement through the prospective payment system (PPS). New payment methodologies promise more flexibility, but they require health centers to assume greater responsibility for their patients' care experiences and health outcomes.

CASE STUDIES

Included at the end of the report are four case studies from diverse geographic regions across California. These case studies show how small health centers have taken advantage of partnerships to enhance their ability to sustain high-quality, comprehensive care for their patients and/or better position themselves for participation in value-based payment. They represent the wide range of partnership options discussed in this paper. The sites were recommended as compelling examples of relationships that can support small health centers.

California's CHCs, which serve more than 4 million patients annually, must evolve to keep up with these changes.⁹ Many of these organizations are accustomed to adapting to change; however, the pace and breadth of change now confronting both care delivery and payment infrastructure raises the stakes. Small health centers — defined in this paper as having fewer than 10,000 patients or an annual budget of \$10 million or less — may face particular challenges succeeding under emerging value-based payment models and the practice transformations these models require.

This paper presents a Model for Advancing High Performance (MAHP) that describes the capabilities and infrastructure California CHCs will need to thrive in this new environment (see Figure 1, page 4). The paper specifically explores how partnerships can help small health centers advance their care and contribute to a sustainable primary care safety net that achieves the quintuple aim — better care, better health, lower costs, happier staff, and reduced health disparities.¹⁰

The following sections of this paper explain the content and activities set out in the MAHP model:

- ▶ A close look at California's small health centers
- ▶ What it takes to create high-quality, comprehensive primary care that achieves the quintuple aim
- ▶ New skills needed to financially sustain care and succeed under value-based payment
- ▶ Infrastructure elements needed to support both care and payment: people, care systems/strategies, data, and business models
- ▶ Partnerships that can support small health centers to build or share those critical infrastructure elements
- ▶ A road map for small health centers as they consider potential partnerships
- ▶ Recommendations for organizations that support health centers
- ▶ Case studies demonstrating how various partnerships are supporting small health centers

Methods

This paper is based on expert opinion and research, including summary findings from a semi-structured literature review of 113 articles and an environmental scan. In addition, executive teams from 22 "bright spot" organizations were interviewed; these included small CHCs in California and throughout the United States, independent practice associations (IPAs), and consortia. Finally, an all-day meeting with a team of expert advisors from across the health care landscape was convened to provide feedback on early analysis and generate new ideas on how to best support small health centers and strengthen the capacity and efficiency of the primary care safety net.

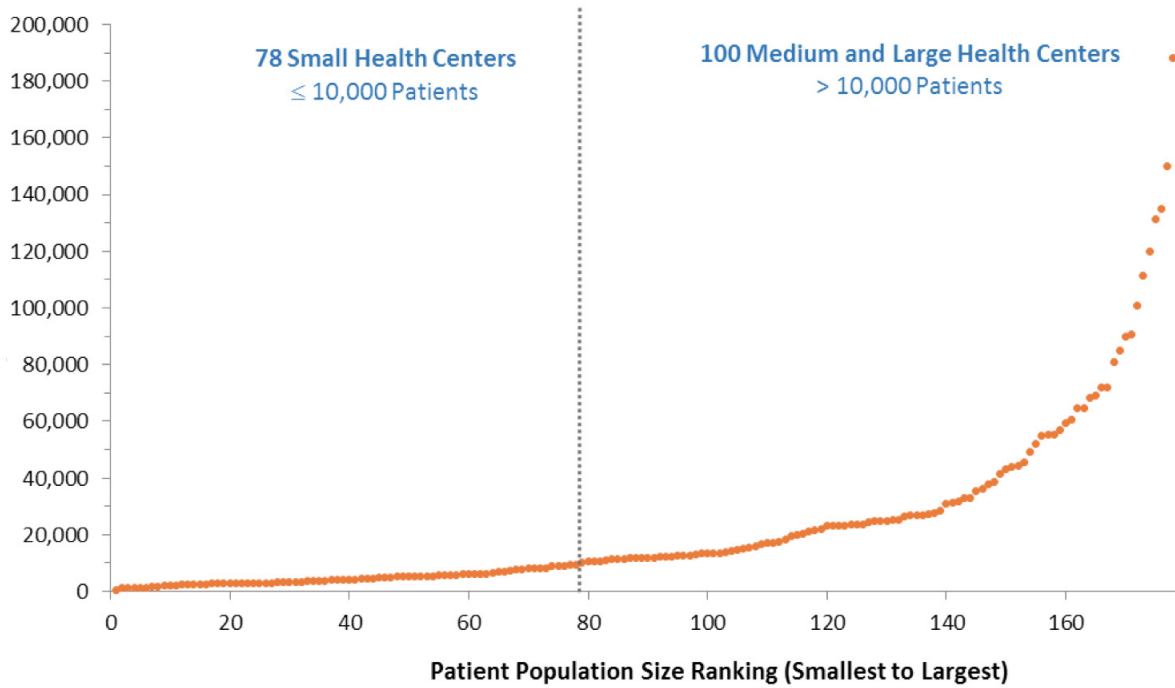
A Close Look at California's Small Health Centers

This paper focuses on what small health centers need to have and what they have to do to thrive in the changing health care environment.¹¹ In the absence of a consensus definition of a "small" health center, this paper defines it as having fewer than 10,000 patients or an annual budget of up to \$10 million. Defining size is complex because a health center can be variously measured by number of patients, total budget, or number of providers. Each of these descriptors is a continuum, and the presence of extreme outliers makes creating natural groupings difficult. For example, in 2015, one California health center served 656 patients whereas another served 188,122. Further, size is not static and cannot be understood in isolation; it is in dynamic relationship with other factors such as organization maturity, number of physical locations/sites, and total population. Figure 3 shows how small health centers compare with medium and large health centers in terms of patients served and budget size (see page 8).

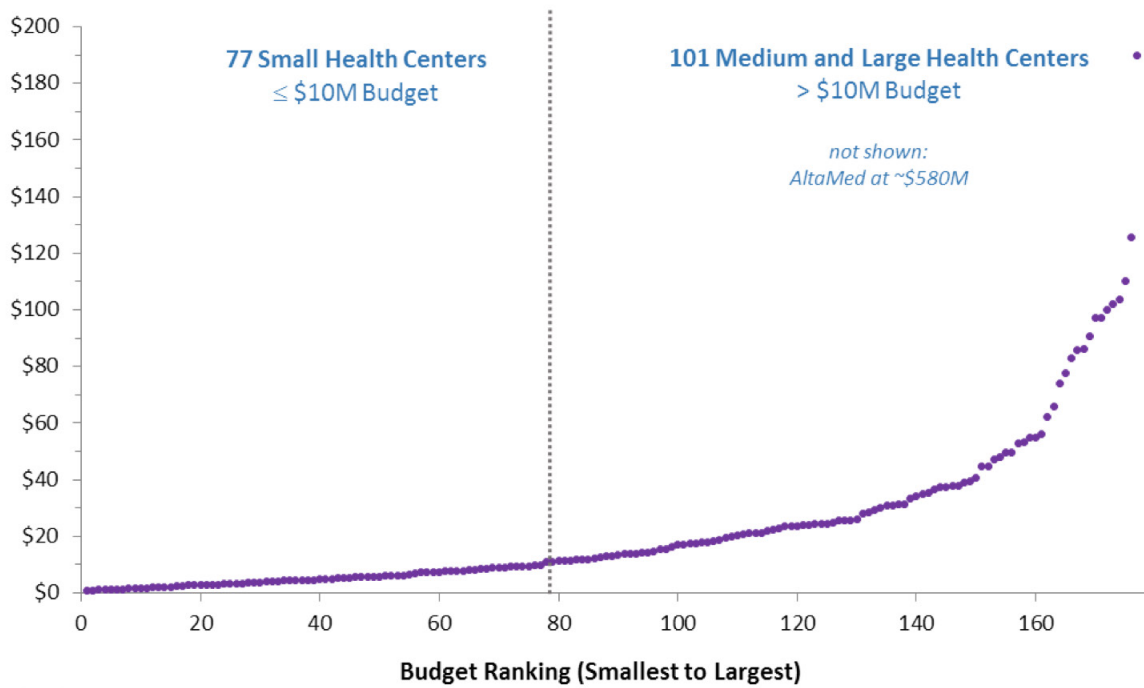
Approximately 44% of California health centers meet this paper's definition of "small" (78 health centers by patients served and 77 by budget). These two groups are not all the same health centers, although there is overlap between them (see Figure 4, page 9). Among these two groups of health centers, approximately 85% (66 health centers) overlap and fit into both categories of small.

Figure 3. Distribution of California Health Centers, by Patients Served and Budget (N=178*)

UNDUPLICATED PATIENTS



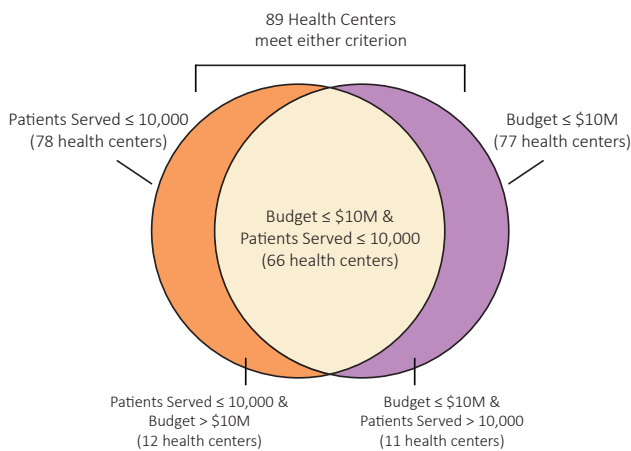
BUDGET (IN MILLIONS)



*180 identified health centers excluding Community Medical Wellness Centers USA and Behavioral Health Services. These two health centers were missing data — either number of patients or budget.

Source: Unaudited financial data obtained from the Health Resources and Services Administration's Bureau of Health Professions, the Office of State Health and Planning Department, 2015 and 2016.

Figure 4. Identifying California’s Small Health Centers by Patients Served and Budget



Source: Unaudited financial data obtained from the Health Resources and Services Administration’s Bureau of Health Professions, the Office of State Health and Planning Department, 2015 and 2016.

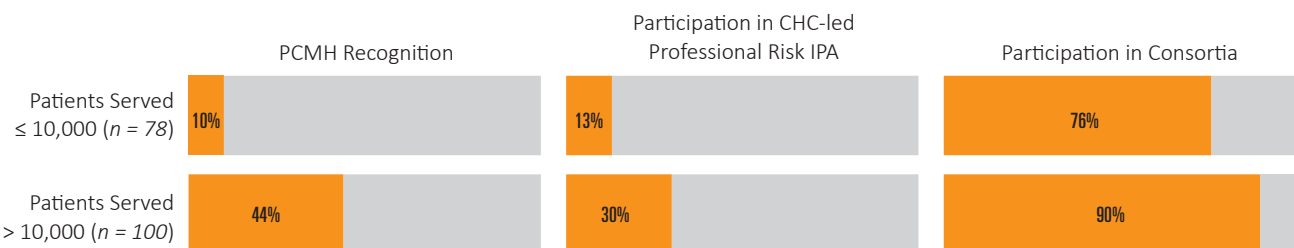
Together, California’s small health centers serve more than 350,000 people.

About half of all 178 health centers (89) that were studied meet either criterion. Together, these small health centers serve more than 350,000 Californians, approximately 9% of all of the state’s health center patients.

Small health centers provide vital access to underserved communities throughout California. Some offer care for distinct ethnic communities in urban settings, others are new access points, and still others serve rural areas. Although some of these organizations are thriving, many face challenges with regard to capacity and sustainability, two concepts explored in more detail in this paper.

Larger health centers outperform smaller ones on a range of financial measures associated with viability, and those that perform better financially may also score higher on some standardized measures of clinical quality.^{12,13} However, additional research is needed to understand the relationships among size and other important indicators, such as patient experience, per capita cost, and provider/staff satisfaction. As shown in Figure 5, large health centers (by patients served) in health-center-led IPAs and consortia are more likely to have internal resources for quality improvement (QI) activities and participate more often in care transformation recognition programs such as the Patient-Centered Medical Home (PCMH) Recognition Program of the National Committee for Quality Assurance (NCQA). (This pattern is similar using the budget cutoff; among health centers with a budget up to \$10 million, 12% report PCMH recognition, 13% participate in CHC-led IPAs, and 75% participate in consortia.)

Figure 5. Patient-Centered Medical Home Recognition and Participation in Selected Partnerships, by Patients Served



Note: CHC is community health center. IPA is independent practice association.

Source: Unaudited financial data obtained from the Health Resources and Services Administration’s Bureau of Health Professions, the Office of State Health and Planning Department, 2015 and 2016.

Creating High-Quality, Comprehensive Primary Care

In the 60 years since the founding of the CHC movement, much has been learned about how to deliver care that improves health, addresses social and behavioral needs, and puts patients at the center of their care.¹⁴⁻¹⁶ Research has demonstrated the centrality of primary care in creating more effective and efficient health care systems^{17,18} and has shed light on the core components of primary care — first-contact care, continuity of care, comprehensive care, and coordination of care.¹⁹ Primary care practices, including many CHCs, have experimented with moving from a largely reactive, physician-centered model of care based on individual face-to-face office visits to a more proactive, team-based approach based on addressing the health needs of a patient population. This move has resulted in substantive improvements in care, especially for people living with chronic illness.²⁰ Care delivery transformation initiatives like the Chronic Care Model or PCMH have helped to spread these changes beyond the vanguard. Recent studies of high-performing clinics are providing more granular insights into how high-quality, comprehensive primary care is created.^{21,22}

We know that the provider team relationship with patients and their families is the core of all value in the health system.

“Never before in our nation’s history has there been such a large-scale attempt to change clinical health care delivery while placing the patient in the forefront of redesign efforts.”

— Ben F. Miller et al.
“Payment Reform in the Patient-Centered Medical Home: Enabling and Sustaining Integrated Behavioral Health Care”
American Psychologist, 2017

The provider team relationship with patients and their families is the core of all value in the health system. Finding ways to strengthen that relationship by supporting long-term continuity of care is critical to addressing the social and medical needs of patients.²³ The box below outlines an emerging consensus — from across the health care sector, including commercially insured practices and CHCs of varying size — about how best to bolster that relationship.

Community health centers are committed to providing access to preventive, chronic, and acute care for their patients. Ensuring that all patients get the care they need can be daunting; one study estimated it would take 22 hours per day to deliver all the care a panel of 2,500 patients would need.²⁴ Team-based care enables a wider range of professionals to be involved during and between visits, better supporting patients and enabling health centers to manage complex acute needs with targeted resources. Having a defined panel of patients allows the care team to use data and identify patient care gaps, and to reach out to those who may need follow-up or are due for important preventive or chronic care services. It also fosters a long-term relationship between care teams and



Creating High-Quality, Comprehensive Primary Care

In collaboration with informed, activated patients, a prepared, proactive practice team does:

- » Planned Care
- » Medication Management
- » Self-Management Support
- » Behavioral Health Integration
- » Oral Health
- » Enhanced Access
- » Population Management
- » Referral Management
- » Clinic-Community Connections
- » Care Management
- » Communication Management

patients. When patients come into the clinic for care, the team is ready to address their needs, knowing both the patients' priorities and what labs or procedures are due. Care teams are prepared to offer and follow up on referrals to other medical specialties and leverage oral health, behavioral health, and connections to community services to address other social needs. Care teams can also address polypharmacy and medication reconciliation. Finally, they take a proactive role in engaging patients as equal partners in care, facilitating behavior change and self-management support.

For health centers in which these activities are not regularly occurring, the research sheds light on how to best undertake improvements. Experimentation has led to some important insights:

- ▶ Practices and health centers *can* change to implement the features of high-performing primary care.²⁵
- ▶ There is a sequence of changes that facilitates transformation,²⁶ specifically:
 - ▶ Engage leadership at all levels.
 - ▶ Match providers and patients together to create panels so patients have a continuous relationship with the care team of their choice. Regularly adjust the size and complexity of those panels to make good access and continuity possible.²⁷
 - ▶ Choose and use a QI strategy, including putting in place a data collection infrastructure that supports proactive population outreach, panel management, and creative improvement.
 - ▶ Pair medical assistants with providers. Create a core team that works together regularly to ensure that the social and medical needs of patients are met.
 - ▶ Systematically build care processes to ensure the conduct of the activities shown in box on page 10.
- ▶ Many of these changes require a long-term commitment to training and improvement.²⁸
- ▶ When clinics implement these features well, patients are healthier and more satisfied with their experience, provider burnout declines, and inappropriate and expensive utilization is reduced.²⁹ Incomplete or symbolic implementation — such as pursuing PCMH recognition without truly transforming care practices — does not result in meaningful changes³⁰ and can destabilize organizations.³¹

- ▶ Payers are interested in authentic practice transformation and are willing to pay primary care differently to achieve these goals.³²
- ▶ Both practice change and payment reform require new capabilities, infrastructure, and ways of working, much of which is not currently reimbursable. This is a challenge for small health centers or those with narrow operating margins.³³

Succeeding Under Value-Based Payment

Health centers have long received the majority of their revenue based on volume of visits through the PPS. Yet new payment reforms emphasize the value of care rather than volume of services. Though health centers continue to struggle with broadening the care team to include staff who are not eligible for reimbursement through the PPS, widespread value-based payment is changing that equation. Value-based payment for primary care comes in three main forms for health centers:

- ▶ Additional payment — or in some cases potential financial loss — contingent on outcomes (e.g., pay for performance and/or financial arrangements with both upside and downside risk)³⁴
- ▶ Supplemental payment for providing care management and coordination services that are not included in the base payment
- ▶ Conversion of the PPS base payment from a volume-based payment into a capitated equivalent under an APM that meets federal requirements for being voluntary and at least equal to what would have been received under PPS

Both the California Primary Care Association (CPCA) and the National Association of Community Health Centers (NACHC) have articulated how these multiple forms of value-based payment could work together in a comprehensive health-center payment reform model.³⁵ In recent years, both the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and the American Academy of Family Physicians have put forward similar multilayered alternative payment models for primary care.³⁶⁻³⁸ Although each of these types of payment reform could be pursued independently, together they can provide a health center with increased flexibility to deliver care, new resources for care management and

coordination services, and incentives for achieving cost and quality outcomes.

The goal of exploring payment reforms for health centers is to create financial structures that incent and support improved health and reduced costs. Similar to other primary care payment reform models aimed at improving outcomes,³⁹ the notion of pairing multiple reforms together could support high-quality, comprehensive care both within the current PPS system and under a scenario without PPS protections. Explicitly or implicitly, payment demonstrations are operating on the assumption that high-quality, comprehensive primary care — facilitated in part by payment reforms — will respond to most social and medical needs for patients and will involve the coordination of care across settings.

Many California health centers are pursuing or are participating in all three categories of payment reform depicted in NACHC and CPCA comprehensive payment reform models:

- 1. Most California health centers are participating in at least one of two arrangements that tie payment directly to outcomes.** First, 18 of 22 managed care Medi-Cal plans have implemented or plan to implement pay-for-performance programs with their providers.^{40,41} Second, health-centered professional risk-bearing IPAs are providing incentive payments to member health centers for performance on quality outcomes and total cost of professional services.
- 2. Additional dollars for care management and coordination services are a new and growing aspect of payment reform for California health centers.** For instance, Medicare recently instituted

new payments to health centers for care management for Medicare beneficiaries.⁴² California is also slated to begin a phased implementation of Health Homes in 29 counties starting in July 2018. Under Health Homes, plans will contract community-based care management entities to manage and coordinate care for individuals with multiple chronic conditions in exchange for supplemental payment. In addition, in both instances, these payments are considered supplemental to PPS.

- 3. California health centers and the state proposed a Federally Qualified Health Center (FQHC) APM demonstration that would translate PPS rates into PPS-equivalent per-member-per-month (PMPM) payments for health centers volunteering for the demonstration.** The goal was to align health center financial incentives with the managed care system and give health centers more flexibility to use nontraditional providers and modalities of care to address patient needs. It was essential to the state that health centers also bear some financial risk. In 2017, the Centers for Medicare & Medicaid Services indicated that the state's desire to have health centers bear even limited financial risk could be done only through a Medicaid waiver, which was not pursued. CPCA and interested health centers continue to explore future directions for payment reform that do not involve waiving PPS protections.

The payment reform initiatives described above show that value-based payment is already here for many health centers in California, and they provide the opportunity to understand how participation in value-based pay changes life day-to-day activities for health centers. To create high-quality, comprehensive primary care and to succeed under value-based payment (see box), health



Succeeding Under Value-Based Payment

- » Population-based mindset based on members
- » Care management/coordination to reduce costly hospital utilization
- » Value of care articulated using data

centers must do some things differently from how they have done them in the past. These actions include:

- ▶ **Shifting to a population-based mindset based on members, not just patients.** Within California's ubiquitous managed care context, value-based payment requires health centers to manage the health of an assigned member population, regardless of whether those members come into the health center for primary care. This includes understanding who assigned members are and then proactively reaching out to ensure that all members have received preventive screenings, disease management, and appropriate referrals to specialists or social services. Most pay-for-performance contracts calculate incentive payments based on quality outcomes and sometimes hospital utilization rates for all assigned members.
- ▶ **Providing care management and coordination services for the purpose of reducing costly hospital utilization and preventable morbidity.** Many health centers have long provided care coordination and some care management for patients between visits. Value-based payments, such as supplemental payment under Health Homes, require that providers demonstrate to the state and managed care plans that this payment reform results in reduced hospitalizations, skilled-nursing facility stays, and emergency department visits. For many health centers, this means expanding their care management and coordination skillsets and workforce to be able to stratify their population and then provide intensive care management services to individuals at the greatest risk for experiencing high-cost utilization. This also means a health center must have the real-time data and processes in place to respond when a member goes to the emergency department or the hospital. For example, whether a health center receives supplemental care management payments, has a shared savings contract, or participates in a professional-risk-bearing IPA, being able to obtain and act on admission/discharge/transfer (ADT) data from hospitals becomes an essential capability.

- ▶ **Articulating the value of the care provided, based on data.** Delivering high-quality, comprehensive primary care is necessary but not sufficient for success under value-based payment. Health centers must be able to prove that their care results in better outcomes. Depending on the payment arrangement, such outcomes could include quality outcomes (often measured by Healthcare Effectiveness Data and Information Set [HEDIS] scores), reduced total costs (via reducing utilization of high-cost services), and improved patient experience (often measured by the Consumer Assessment of Healthcare Providers and Systems [CAHPS], a patient satisfaction survey required by managed care Medi-Cal plans). Being able to track, improve upon, and report outcomes requires increased sophistication around data analytics. It also requires being intentional and systematic about measuring and improving the effectiveness of interventions that have long been part of the fabric of health centers but in a variable or fluid way (see Response to Social Needs sidebar on page 16).

Delivering high-quality, comprehensive primary care is necessary but not sufficient for success under value-based payment. Health centers must be able to prove that their care results in better outcomes.

Infrastructure: Four Pillars


Creating high-quality, comprehensive care and succeeding under value-based payment are not independent efforts. In fact, there are four major areas — or pillars — of infrastructure that health centers need to support both care and payment: people, care systems/strategies, data, and business model (see box below). Some health centers may need to strengthen these elements or develop them from scratch. For small health centers that are not well positioned to strengthen or develop infrastructure on their own, partnerships can play a key role. The four pillars can be broken down as described below.

People

Leadership. Leadership is essential for creating the kind of change necessary to improve care and succeed under value-based payment.⁴³ For small health centers with limited administrative resources, organizational leaders must do it all — champion improvement and maintain a strategic vision while managing day-to-day operational demands. A notable shared characteristic of the high-performing small health centers interviewed as part of this project was the presence of an informed and creative leader — or team of leaders — who were meaningfully engaged in continuous learning and championing improvement in care and the patient experience. These leaders also had a long-term strategy that incorporated financial creativity, ensuring that resources were in place to sustain the gains they were making.

Workforce recruitment, retention, and training. These are essential to developing the care teams, workflows, and analytics required to create high-quality, comprehensive primary care and succeed under value-based payment. Although they can be challenging for all health centers, workforce issues can be particularly hard for small organizations. With limited patient volume for primary care and behavioral health, small health centers may not be able to afford the array of skilled staff needed (e.g., a full-time diabetes care manager). Thin operating margins make it difficult to create competitive compensation packages that attract quality leadership and providers, and these margins may not be able to support full-time staff in key roles, such as a chief technology officer (CTO). Attracting talent is particularly challenging in rural areas. Training presents another challenge; sending providers and staff to a training can mean foregoing critical revenue, whereas building in-house training expertise may be difficult to sustain.

Engaging patients. Actively engaging patients in the design, improvement, and governance of the health center — as well as in the decisions that impact their own care — is essential to good care and payment reform.⁴⁴ Patients can help prioritize organizational changes as members of focus groups or ongoing quality-improvement teams. They can participate in governance as members of boards. Health centers that have developed the capacity to engage patients at multiple levels are able to better invest limited dollars in ways that address patient needs. For example, patients who have strong relationships with their care teams are less likely to use



Infrastructure

What health centers need to have to support care and payment redesign

| People | Care Systems/ Strategies | Data | Business Model |
|---|---|---|---|
| <ul style="list-style-type: none"> » Leadership » Workforce » Patient engagement | <ul style="list-style-type: none"> » Patient panels » Care teams » QI infrastructure » Responding to social needs | <ul style="list-style-type: none"> » Data from inside and outside of primary care » IT infrastructure » Capacity to create internal/external reports | <ul style="list-style-type: none"> » Managed care contracting expertise » Negotiating clout » Scale, if bearing downside financial risk beyond PPS |

the emergency department and other expensive downstream services.⁴⁵ Partnerships may be helpful in building these capacities, especially for small health centers with limited administrative overhead.

Care Systems/Strategies

Patient panels. Prioritizing health outcomes and preparing for value-based payment means shifting toward proactive care for populations — rather than the traditional reactive mode. Health centers work together with patients to define panels so that patients and care teams recognize each other as partners in care. Under value-based payment, this includes reaching out to patients who have been assigned to the health center by a health plan. When a patient needs care, health centers promote continuity by scheduling patients with their provider team as often as possible. Access is preserved by closely monitoring panel size and composition. Thinking in terms of patient panels is a radical change for many health centers, but it is critical to achieving both quality and financial success. Without partners, it can be hard for health centers with low patient volume to justify the technology and time investment needed to initiate or maintain patient panels.

Care teams. This work requires a team effort. In fact, for health centers to compete for payment or to improve care, clinicians and administrative staff must contribute meaningfully to patient care activities, be willing to take on new work and new roles, and spend time meeting and coordinating with one another. In payment models that give providers additional flexibility to provide care, using a well-defined care team to support patients can be both financially sound and patient centered. Small health centers that find it difficult to recruit and support behavioral health counselors, care management nurses, and clinical pharmacists can experiment creatively with sharing a single staff member between sites, cross-training existing staff, or leveraging alternative visit types like phone or virtual visits.

QI infrastructure. Teams need a strategy for making change. Choosing and using a QI strategy (e.g., Lean, Six Sigma, and Model for Improvement) is essential to improving care. Along with leadership, care teams, and patient panels, QI infrastructure is one of the four building blocks of high-performing primary care, the foundation for value-based pay.^{46,47} Working closely with other health centers to share best practices and leverage external QI expertise can be transformative, especially for small health centers without an in-house QI department. See Case Studies 2 and 3 for more on how health centers leverage partnerships to build QI capacity, improve care, and generate additional revenue.

Responding to behavioral and social needs. Comprehensive care means responding to the most common needs of patients.⁴⁸ For safety-net health centers, that involves addressing behavioral needs around mental health and substance use as well as connecting patients with social services that focus on housing, employment, and food security. Because patients' health and well-being are often deeply impacted by poverty, racism, poor housing, lack of education, and limited job opportunities, many health centers view responding to patients' social needs as central to their care model despite limited ability to bill for these services through traditional fee-for-service mechanisms.

The expectation of health centers to systematically respond to behavioral and social needs is increasing as more is known about the impact of social needs on health, and as providers "go upstream" to intervene in the hopes of improving health. Health plans are becoming involved in identifying and addressing patients' social needs as means to reduce the long-term cost of care. One CHC leader with years of experience taking financial risk advised health centers interested in pursuing risk-based payment to view working to address patients' social needs as a prerequisite for risk-bearing because addressing social needs can control costs and result in better quality outcomes. For small health centers, partnering may be crucial to addressing patients' social and behavioral needs.

Response to Social Needs

Services to address patients' social needs are of great interest to health centers. Best practices have not yet coalesced, but a great deal of experimentation is going on. Because patient populations are diverse, and health centers vary widely in size, funding sources, and location, there is a range of approaches for addressing social needs. Activities in urban areas include partnering with a local gang outreach organization to implement a mobile health unit, and developing relationships with opioid assistance/needle exchange sites, homeless shelters, and supportive housing to deliver health care at these sites. Rural health centers are addressing the barrier of distance to care, including home-to-clinic transportation and community-based mental health and primary care outreach.

Key informants described a range of services they provide to address patients' social needs. These include:

- ▶ Linkage services like transportation, translation, and benefits enrollment
- ▶ Housing, rental assistance
- ▶ Literacy, tuition scholarships, backpack programs
- ▶ Legal advocacy and immigration services
- ▶ Nutrition, food pantry
- ▶ Substance abuse treatment
- ▶ Funeral planning services

Some health centers are trying universal screening for social needs or adverse childhood events; referrals are then made to external agencies or more formal partnerships through regular deployment of a mobile unit to a social service agency. Others are trying full co-location and integration with social service providers.

Health centers are positioned to play a key role in building the field's understanding of the value of social needs interventions. Still required are systematic collection and reporting of social needs data and solid documentation of interventions and their impacts on health. These data could help shape care, payment, and policy.

Data

Data from inside and outside primary care help to bridge some of the most costly and dangerous gaps in medical care — between the primary care provider and the hospital, and between the lab and the specialist. Comprehensive primary care and value-based payment models envision that data from within primary care will be used for clinical decision support to help clinicians see gaps in care for the patients on their daily schedule, as well as for members who may be assigned but not yet seen. Clinical decision support can be used to improve cancer screening,⁴⁹ immunization,⁵⁰ and chronic illness management.⁵¹

Examples of clinical decision support that support all members of the care team include a dashboard displaying each patient's care gaps used by clinical assistants when preparing for a huddle,⁵² templates prompting clinical assistants when rooming a patient to document information that merges with the clinician's chart note,⁵³ and data entry forms to gather condition-specific

structured data reflecting the strategic priorities of the health center. (These forms might include the Patient Health Questionnaire [PHQ-9], cardiovascular risk calculation, asthma control test, and SBIRT [Screening, Brief Intervention, and Referral to Treatment] forms.) Closing such care gaps can help a health center perform better on pay-for-performance measures and prove the value of primary care services to payers in negotiating for supplemental payment. Value-based payment that aligns financial incentives with reducing total cost of care requires that health centers also use data from outside primary care to identify high-risk patients, especially during care transitions, to ensure linkage with primary care for follow-up and care management.

Information technology infrastructure. Comprehensive primary care under value-based payment requires information technology (IT) infrastructure that optimizes electronic health records (EHRs) and population health management systems and that facilitates data interfaces with other providers. This allows for communication with

respect to referrals or knowing when a patient is going to be discharged from the hospital. IT infrastructure may include clinical data stored in a reporting server or cloud-based data warehouse that is accessible via robust and flexible analytics software. Small health centers that lack the economies of scale needed to diffuse the upfront and ongoing costs of IT infrastructure may look to partnering to achieve their goals.

Analytic capacity to create internal and external reports. Health centers benefit from the ability to generate meaningful information from data at the provider and patient level for guiding care, QI, and reporting over various time periods and for different patient populations. Data should feed into an organized QI strategy. To be helpful in value-based payment, health centers need the data and the analysts to understand and track assigned members by health plan and to monitor and act upon clinical quality data tied to financially incentivized outcome measures. For payment contracts that hold financial reward and/or risk for managing specialty costs and/or total cost of care, health centers also need the analytic capacity to stratify and the clinical capacity to manage high-risk patients. Reporting functionality should include both automated and customizable reports that can be run at a local level, including an ability to “drill down” to the care team level and to “roll up” to the clinic or system level.⁵⁴ Such functionality can be used for both internal efforts to close care gaps or analyze health disparities and for external reports to health plans or government entities.

Regardless of the internal or external nature of the reports, health centers need staff who can make information out of data. Analytic capacity covers a broad range of functions including managing incoming data, maintenance of data, data extraction, basic and complex analysis, and data governance. Each of these functions requires an increasing level of training and experience. Small health centers report having trouble recruiting and retaining the necessary workforce of analysts who know the questions to ask of the data regarding health and financial outcomes, and who also have the programming and analytics acumen to answer the questions.

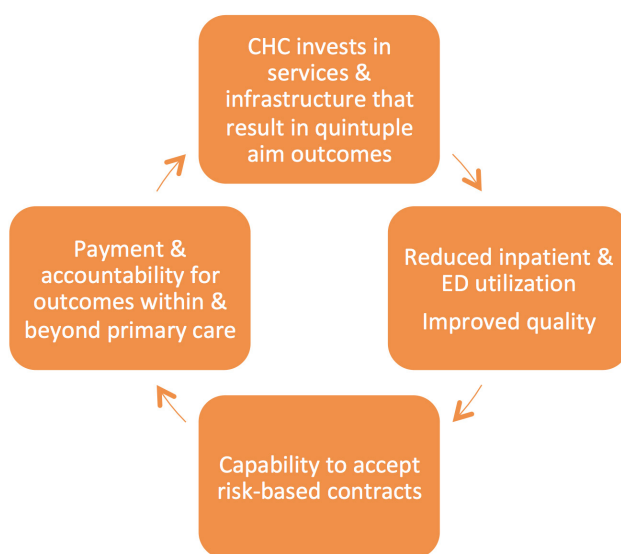
Business Model

Because most health centers still receive the majority of their revenue through the PPS, making wholesale changes to care delivery and investing in infrastructure can be difficult and financially risky. Going forward, health centers can benefit from expanding their business model from one relying largely on PPS to one that leverages value-based payment in order to:

- ▶ Change care delivery, such as adding intensive care management at the primary care level
- ▶ Sustain high-quality, comprehensive care services where PPS does not
- ▶ Build capacity in an organization so that it can take on additional value-based pay arrangements and/or perform better under value-based payment contracts

For example, IPAs and consortia that participate in value-based payment described “a virtuously reinforcing cycle of payment and delivery system reform” that can be entered either through changes in payment or care (see Figure 6). They observed that some health center networks with value-based payment contracts reported using performance incentive payments to invest in the capacities needed to deliver care that was not reimbursed

Figure 6. Cycle of Payment and Delivery System Reform



Note: CHC is community health center. ED is emergency department.

by PPS, such as care management and coordination services. This kind of performance-driven care produced outcomes that resulted in increased pay and the confidence to negotiate for more value-based contracts. The additional value-based payment dollars were then used to sustain the capacities for delivering high-quality, comprehensive care, such as maintaining care managers and behaviorists on staff and investing staff time to engage in ongoing QI activities. In California, fewer small health centers participate in health-center-led IPAs than large health centers (see Figure 5, page 9).

Regardless of the exact form of value-based pay in which a health center might participate, all California health centers will contract with Medi-Cal health plans for some, if not all, of their value-based payment arrangements. Thus, health centers need the ability to understand the goals and regulatory frameworks that guide managed care plans and translate the value that health centers bring to the managed care system into contracted payments. Having such expertise can support relationships with plans and can be an essential element of a business model for sustaining high-quality, comprehensive primary care. To achieve the cost reductions and quality improvements that plans are interested in paying for, health centers will need specially trained staff and managers who are monitoring and improving utilization and quality outcomes. For example, health-center-led IPAs that showed that their utilization management techniques lowered ambulatory-sensitive hospitalizations were able to translate that value into dollars in the form of a partial capitation payment for care management. Health centers need a business model that includes the necessary expertise to align health center value with the goals of the managed care system.

A business model that supports ongoing operational and financial stability is another key component of infrastructure for care and payment. Having size and scale — whether as an individual organization or as part of a network of other health centers — can be advantageous if it supports stability. Size and scale are particularly important when assuming financial risk and for having the negotiating clout to obtain favorable contract terms with a payer. When it comes to risk-based contracting, most experts agree that assuming risk is actuarially advisable

only if an organization has a threshold amount of financial reserves and a minimum number of lives over which to spread the risk. Multiple sources have estimated that taking downside risk as a single organization or a network requires at least 20,000 lives.⁵⁵ In addition, health centers and payers have indicated that providers have less negotiating power when they approach plans individually. If a health center represents a small slice of a plan's market share, it is easier for the plan to exclude them from value-based contracting. Similarly, health plans can also find the process of contracting with many small health centers burdensome and may be interested in fostering health center networks to reduce the cost of negotiating and managing contracts with many small health centers.

Small size can be a challenge when engaging with payers. For example, payer representatives indicated a preference for working with larger entities that they perceive as having a greater capacity to implement change. Networks or health-center-led IPAs reported many more examples of implementing novel payment and care programs with their plans compared with individual health centers. Size was also mentioned as a factor when seeking capital funding to invest in care and infrastructure changes. Research also illuminated a connection between size and financial stability; a 2016 Capital Link study found that larger clinics tend to have stronger operating margins and perform better on other key financial metrics.⁵⁶ Furthermore, small health centers explained how staffing changes, unexpected absences, new regulations — or even sending providers to training — could be financially destabilizing.

Developing new administrative skillsets, care teams, clinical functions, analytical capabilities, and business models involves, at a minimum, redesigning work flows, retraining existing staff, and reworking job responsibilities. In most cases, it also involves securing additional staff, technology, and data infrastructure. Although there are a few activities that can be done in-house and can generate revenue while preparing for the future, most small health centers will need to explore partnerships with other health centers or entities in order to have the necessary infrastructure to support high-quality, comprehensive primary care and success under value-based payment.

Partnerships

For many small health centers, executing such changes on their own is neither efficient nor feasible, particularly if their financial and operational infrastructure is already strained. Partnerships and alliances can be critical to securing resources and leveraging the skills of another entity. In fact, participating in partnerships emerged as a promising strategy for small health centers for attaining the infrastructure needed to deliver high-quality, comprehensive care and succeed under value-based payment (see box below).

Partnerships fall on a wide spectrum that includes linking to community agencies to ensure needed social and behavioral health services, working with other health centers individually or through consortia to share clinical or administrative services, and networking through IPAs to exert market pressure on health plans and negotiate shared savings or other financial benefits.

Individual small health centers may make use of one or many of these partnership strategies. When done well, such collaborations can help health centers and the community by supporting and supplementing primary care activities to leverage resources and improve health. The partnerships described by the bright spot interviewees for this project shine a light on the path forward for other small health centers in California.

Interviews with bright spot health centers revealed examples of ways that small health centers' challenges can lead to opportunities:

- ▶ Several small health centers collaborated to share a full-time bilingual diabetes care manager that neither could support on their own.
- ▶ A small rural health center forged a close partnership with the county behavioral health organization (see Case Study 1).
- ▶ IPAs and clinically integrated networks helped health centers to obtain, analyze, and use data in ways they had not been able to do alone. This enabled the health centers to proactively manage their member populations, including outreach to people who were assigned but never seen in primary care (see Case Study 2 and 3).
- ▶ IPAs and health plans helped health centers to close care gaps through care management and case coordination while also helping to garner funding for these activities.
- ▶ Two health centers merged in order to leverage each of their strengths, preserve their missions, and achieve better financial and operational stability (see Case Study 4).

Health centers engage in many types of partnerships for a wide range of reasons, including to advance their missions, improve patient care, and strengthen their business model. Nonmerger partnerships might involve linking to community agencies or schools for services

» Partnerships with Community-Based Agencies and Organizations
» Partnerships with Hospitals
» Consortia
» Management Services Organizations (MSOs) and Clinically Integrated Networks (CINs)
» Health Center-led Independent Practice Associations (IPAs)
» Partnerships with Health Plans
» Mergers/Acquisitions

PARTNERSHIPS

like behavioral health, working with other health centers through consortia to share clinical or administrative services, and networking through IPAs to negotiate risk-based contracts and/or other financial benefits. Much work has been done to characterize the variety of collaboration types that nonprofit organizations pursue.^{57,58} This paper does not detail every potential partnership type nor does it cover ways that health centers grow capacity by expanding geographically or to new populations. Rather, it focuses on a subset of partnerships that emerged most prominently in the research about what health centers must do and must have in terms of infrastructure to support and sustain their performance.

It is important to note that the partnership strategies that emerged from the literature and interviews are not mutually exclusive; many health centers pursue multiple strategies concurrently. This section presents seven partnership strategies organized roughly in order of ease of initiation by small health centers. Because the requirements (cost, data, relationship, sophistication) to begin or sustain these partnerships varies greatly by the individual organizations in a given market, the order is not identical for each health center.

1. Partnerships with community-based agencies and organizations (local government and nonprofit)
2. Partnerships with hospitals
3. Consortia
4. Management services organizations and clinically integrated networks
5. Health-center-led IPAs
6. Partnerships with health plans
7. Mergers and acquisitions

In deciding on partnership strategies, each health center needs to weigh internal considerations, such as capabilities of staff and the culture of the board and leadership, as well as external factors, such as the local competitive market, the local managed care plans, the policy context, and other service providers in the catchment area.

Below are key questions a health center might answer when considering each partnership type. (A more detailed look at factors to consider is provided in the Partnering to Succeed: A Road Map for Health Centers section on page 34.)

In deciding on partnership strategies, each health center needs to weigh internal considerations, such as capabilities of staff and the culture of the board and leadership, as well as external factors, such as the local competitive market, the local managed care plans, the policy context, and other service providers in the catchment area.

Partnerships with Community-Based Agencies and Organizations

Health centers recognize that their patients have health-related needs far beyond direct medical care. With limited capacity to serve these needs, health centers are partnering with community-based agencies and organizations — both local government and community-based nonprofits — to leverage expertise and resources.

What Is It?

Health centers are forming a wide range of partnerships with community-based agencies and organizations. They tend to be driven by two primary goals: addressing the behavioral health and social needs of their patients. Interviewees reported that partners include entities such as:

- ▶ County mental health agencies
- ▶ Substance use providers (and the local Drug Medi-Cal Organized Delivery System)
- ▶ County social services agencies
- ▶ Food banks and nutrition assistance (e.g., Women, Infants, and Children [WIC])
- ▶ Public housing, homeless shelters, and housing/rental assistance
- ▶ Literacy programs
- ▶ Job-training programs
- ▶ Legal advocacy organizations
- ▶ Transportation service providers
- ▶ Domestic violence organizations
- ▶ Funeral planning services

Across interviews and the literature, integration with behavioral health — including mental health and, increasingly, substance use treatment — was widely viewed as one of the highest priority partnerships for providing high-quality, comprehensive primary care.

Advantages

Health centers can offer patients comprehensive care that addresses medical, behavioral, and social needs by pursuing partnerships with public agencies and community-based organizations (CBOs). Through these arrangements, the patient's needs can be addressed by the organization that best delivers that service. Community-based partners can also help health centers expand their footprint to serve to new populations or new geographic areas. For small health centers that cannot support all such services in house, partnering with public agencies and/or CBOs can be critical. (See Case Study 1 about how Hill Country has partnered with community organizations to improve access to a wide range of essential services.) It should be noted that although addressing social needs reflects all health centers' missions to best serve their community, health centers that are in risk-bearing arrangements have additional incentives to address them. In fact, having partners to support patients' social needs was cited by several interviewees as a prerequisite for taking risk for Medicaid populations.

Clinics "need to have the self-knowledge to say, 'I know what I'm good at, and I know what I'm not . . . so I need to bring in a partner.'"

— Louise McCarthy, CEO
Community Clinic Association of Los Angeles County

Key Considerations and Challenges

Forming partnerships with public agencies and CBOs to address behavioral and social needs requires strong leadership, ability to navigate fragmented funding streams, identification of limited resources in the community, and coordination and navigation services for patients. Furthermore, although screening for social needs and referrals have been shown to result in improved outcomes,⁵⁹ more research needs to be done to establish which social interventions in the clinical setting are effective and cost-efficient. Finally, other partners, such as consortia, might be in a better position than individual small health centers to reach out to and build relationships with CBOs and public agencies. See Table 1 on page 22 for more details.

Table 1. Areas of Consideration When Establishing Partnerships with Community-Based Agencies and Organizations

| | INTERNAL CONSIDERATIONS (ORGANIZATIONAL CAPACITY) | EXTERNAL CONSIDERATIONS (ENVIRONMENT/MARKET/POLICY) |
|---|--|--|
| Leadership and Staffing | <ul style="list-style-type: none"> ▶ Are leaders committed to responding to social needs as part of the health center’s approach to care? ▶ Is there leadership/staff time dedicated to developing and maintaining the partnership? ▶ Does your health center use community participatory-based research to assess what social needs of the community should be prioritized? ▶ Do you have social work staff who can coordinate and track referrals to CBOs? | <ul style="list-style-type: none"> ▶ Has there been a community needs assessment done recently that addresses social needs of the community? ▶ Might your local consortia help you and other small health centers to establish relationships with CBOs and public agencies? |
| Care Delivery and Infrastructure | <ul style="list-style-type: none"> ▶ Do you provide integrated behavioral health for individuals with mild to moderate behavioral health needs? Do you provide primary care services to those with serious and persistent mental illness? ▶ Do you have a process in place to screen for behavioral and social needs? ▶ What are your relative strengths for meeting nonmedical needs of patients? | <ul style="list-style-type: none"> ▶ Do you have a shared care plan or way to know when a referral to a CBO or county agency has been fulfilled? ▶ What CBOs exist in your service area? ▶ What are the relative strengths of local CBOs for meeting nonmedical needs of patients? (For example, are there CBOs skilled in providing services for substance use treatment in your community?) |
| Financial | <ul style="list-style-type: none"> ▶ Are you addressing some social needs within your health center using grant funds that could be addressed more sustainably by a community partner? | <ul style="list-style-type: none"> ▶ Would the county contract with you for behavioral health services for individuals with serious and persistent mental illness? ▶ Are there opportunities in your county to contract for care coordination services under a whole-person care pilot? ▶ Are there opportunities to approach payers for a joint contract to address health and social needs? |
| Data and Analytics | <ul style="list-style-type: none"> ▶ Are you capturing behavioral and social needs using standardized data that can be leveraged for evaluation, payment reform, and identifying needs for new partners? | <ul style="list-style-type: none"> ▶ Is there a local directory of resources available in your community (e.g., Purple Binder)? ▶ Is new data infrastructure being established under a Whole Person Care demonstration that allows sharing data between health, housing, behavioral health, and other county data systems? |

Partnerships with Hospitals

Health center partnerships with hospitals have the potential to improve care coordination and specialist access. However, health centers are cautious about entering financial arrangements that involve shared risk with hospital partners.

What Is It?

Partnering with local hospitals takes a number of forms, including data sharing, funding a workforce for care coordination and transitions, access to specialists, philanthropy, and in some cases shared financial-risk arrangements. Because of the importance of managing care across settings, receiving real-time ADT data from hospital partners can be essential for ensuring coordinated and timely follow-up in primary care for health center members. CHCs also reported having hospitals fund care managers and coordinators to serve as a point of contact in order to link hospital and emergency department patients back to a PCMH. Some health centers described being the recipient of hospital community benefit funds. In markets such as Los Angeles there are examples of health-center-led IPAs and hospitals splitting capitated risk from health plans with a shared risk pool if quality and utilization outcomes are achieved. Although Medicaid accountable care organizations (ACOs) comprising hospitals and health centers are emerging in some states, there has been no movement toward this type of partnership in California.

“I don’t think we would be able to achieve the kind of results we have in terms of seven-day follow-up for inpatient visits if we didn’t have care coordinators here who actually knew the patients, who could literally walk over to the hospital and meet the patients while they were in the hospital to generate those kinds of relationships.”

— Dan Fulwiler, CEO
Esperanza Health Center

Advantages

A local hospital partnership can be essential for a wide variety of functions: care coordination; data sharing; access to specialists, lab services, and pharmacy services; additional funding for staff positions; and potential grants from a hospital community benefit program. Some health centers achieve these benefits by co-locating with a hospital partner. Hospitals have also provided health centers with a shared EHR — and prorated licensing fees — that can facilitate care coordination and boost provider satisfaction. Many providers are accustomed to working within large hospital-system EHRs and feel they are state of the art. In certain cases, hospital partners have provided health centers with information technology and legal support.

“I think the biggest benefit of participating in consortia is learning from each other. Other members try things first and they have the funding to do that, and we get to learn from things that work and things that don’t.”

— Deborah Howell, CEO
Alexander Valley Healthcare

Key Considerations and Challenges

Health centers in states that have participated in ACOs with hospitals found that hospitals tend to take the larger share of the financial benefit from these partnerships, whereas primary care takes on a disproportionate share of the clinical and administrative burden. Although vertical integration with a hospital, or acquisition by a hospital, may be of interest to some health centers, such arrangements must carefully consider the Health Resources and Service Administration (HRSA) policy for independent FQHC boards. See Table 2 on page 24 for more details.

Table 2. Areas of Consideration When Establishing Partnerships with Hospitals

| | INTERNAL CONSIDERATIONS (ORGANIZATIONAL CAPACITY) | EXTERNAL CONSIDERATIONS (ENVIRONMENT/MARKET/POLICY) |
|---|---|--|
| Leadership and Staffing | <ul style="list-style-type: none"> ▶ Do you have a leader who acts as the liaison to your local hospitals? ▶ Are there any staff positions that your hospital would be interested in funding? | <ul style="list-style-type: none"> ▶ Do you have a clinical point of contact for the emergency department or inpatient discharge to link a patient back to primary care? ▶ Is there alignment of your mission and the missions of the hospital or hospital system to serve the uninsured and underinsured in your community? |
| Care Delivery and Infrastructure | <ul style="list-style-type: none"> ▶ Are there opportunities to have closer coordination with specialty consultants to promote community-based rather than hospital-based specialty care? | <ul style="list-style-type: none"> ▶ Are there opportunities to build innovative access to specialist services for your patients (e.g., e-consult)? ▶ Have you appealed to your local hospital community benefit department for nonmedical programs addressing social needs? |
| Financial | <ul style="list-style-type: none"> ▶ Do you have a need for capital that your hospital might be interested in helping you to meet via a low-cost loan? | <ul style="list-style-type: none"> ▶ Do you have more than one hospital where patients can be referred? If so, is there a hospital known for providing higher value care (better outcomes for lower price)? |
| Data and Analytics | <ul style="list-style-type: none"> ▶ Do you receive and act on a daily ADT feed from your local hospitals? | <ul style="list-style-type: none"> ▶ Would your hospital consider funding implementation of a second generation EHR in your CHC that both meets your needs and links with their EHR systems? |

Consortia

By participating in consortia, health centers have a collective voice in national and regional advocacy and can benefit from a range of technical assistance and shared functions. Consortia vary in their roles, capacity, and offerings; some are predominantly advocacy entities, whereas others may offer robust support and many of the functions of a management services organization (MSO).

What Is It?

Consortia are the primary form of health center collaboration in California. There are 13 consortia — organized predominantly by geographic region — in addition to the statewide CPCA. Some began as early as the 1970s, whereas others started as recently as 2010.⁶⁰ Health center consortia serve as “hubs for information, technical assistance, and shared functions in areas including general administrative and billing services, managed care contracting, management, fundraising, developing EHRs, clinical assistance (such as care management approaches), and advocating for and adjusting to policy changes,” as well as giving health centers a stronger, collective voice.⁶¹

Advantages

Consortia can help individual health centers to monitor and influence policy at the local and state levels, engage in QI, share best practices, and centralize select nonmedical functions such as training, managing volunteers, and building partnerships with hospitals. Some consortia also serve in the role of a health-center-specific MSO, helping health centers to access services, particularly administrative ones, that would be difficult or more costly to develop on their own. Strong consortia reported providing the following key functions and services to member health centers:

- ▶ National and regional advocacy
- ▶ Helping health centers stay informed on policy change
- ▶ QI programs
- ▶ County contract negotiations
- ▶ Serving as a grant recipient and administrator

- ▶ Peer/affinity groups (chief financial officer [CFO], chief medical officer [CMO] roundtables)
- ▶ Workforce training programs (e.g., motivational interviewing, security, Health Insurance Portability and Accountability Act [HIPAA])
- ▶ Uniform Data System reporting
- ▶ Engaging hospitals to align community benefit resources with health center priorities
- ▶ Facilitating memoranda of understanding (MOUs) with other members for shared services (e.g., ob/gyn and dental)
- ▶ Sharing best practices
- ▶ Pharmacist of record
- ▶ Interacting with medical education and volunteer workforces (e.g., AmeriCorps)
- ▶ Compliance
- ▶ Credentialing
- ▶ Recruitment

- ▶ Technology procurement (vetting and negotiating with EHR and population health management system vendors)
- ▶ Serving as Health Center Controlled Networks (HCCNs) under HRSA

Key Considerations and Challenges

Depending on a consortium as a key partner requires that it have sufficient capacity and that there is a good fit between what the consortium provides and what the individual health center needs. Some health centers described consortia membership as positive and helpful. Others were less clear about the benefits. In one case, health centers were actively participating in a neighboring consortium because of their own consortium's limited capacity. See Table 3 for more details. For more information on developing consortia, see Recommendations for Organizations That Support Small Health Centers on page 37.

See Case Study 2 for an example of how Health Center Partners' work with local consortia helped them improve quality and secure additional resources.

Table 3. Areas of Consideration When Establishing Partnerships Through Consortia

| | INTERNAL CONSIDERATIONS (ORGANIZATIONAL CAPACITY) | EXTERNAL CONSIDERATIONS (ENVIRONMENT/MARKET/POLICY) |
|---|--|---|
| Leadership and Staffing | <ul style="list-style-type: none"> ▶ Do you feel informed about local policy and do you feel that health centers are being adequately represented in local politics? | <ul style="list-style-type: none"> ▶ Are there local advocacy opportunities (e.g., town halls) where more coordinated efforts among health centers could benefit all CHCs and the communities they serve? |
| Care Delivery and Infrastructure | <ul style="list-style-type: none"> ▶ Are there clinical services that you would prefer to outsource to allow your CHC to deliver higher quality care to patients (e.g., pharmacist of record, QI, clinical protocols)? | <ul style="list-style-type: none"> ▶ What centralized and support services does your consortia offer? ▶ Are there opportunities to build partnerships and/or negotiate data-sharing agreements with local hospitals (e.g., getting ADT data) that would have more promise if a consortium initiated the effort? |
| Financial | <ul style="list-style-type: none"> ▶ Are there services that you are doing internally that might be more efficiently outsourced to your consortia (see list under the Advantages subsection above)? | <ul style="list-style-type: none"> ▶ Is there opportunity to build capacity — and economies of scale in certain administrative functions — at your consortia for the benefit of multiple CHCs? |
| Data and Analytics | <ul style="list-style-type: none"> ▶ Do you struggle to get responsiveness from your EHR vendor for change requests? ▶ Would it be helpful to understand best practices from other CHCs and/or negotiate vendor requests collectively? | <ul style="list-style-type: none"> ▶ Do you and other health centers share a common health plan partner(s) for whom studying the value of CHCs in the region would be beneficial for negotiating payment reform? ▶ Are there external resources available for HCCNs for which your consortia could apply? |

Management Services Organizations and Clinically Integrated Networks

Engaging with MSOs might offer health centers greater administrative efficiency, competitive pricing for services and supplies (including negotiating with health IT vendors), and collective contracting — while enabling them to maintain autonomy. MSOs can assist with many of the nonmedical functions of running a health center and clinically integrated networks to build shared clinical and operational capacity without assuming downside risk.

What Is It?

MSOs are designed to assist health centers with needed nonmedical functions. These can include centralized administrative functions such as human resources, payroll, billing and collections, procurement of supplies and services (using the consolidated volume of multiple health centers to negotiate better pricing), and leasing office space. MSO functions can also include individualized services such as financial analytics, staff training, compliance, credentialing, operations consulting, vendor selection, risk management, contracting with payers, and tracking and analyzing data for value-based payment contracts.

An MSO can charge health centers a single membership fee for a package of services or offer an a la carte menu. For instance, Health Center Partners of San Diego uses this model with its group purchasing and sharing QI services across member health centers (see Case Study 2). For commercial private practices, MSOs sometimes hold an ownership stake in a practice. Even though MSOs can provide much of the infrastructure needed under value-based care models, they do not enter into risk-based contracts with payers.

Health center clinically integrated networks (CINs) often fulfill MSO functions but also perform collective clinical quality work and collective negotiations for incentive payments (upside risk) with payers. The one health center partnership that described itself as a CIN (see Case Study 2) assisted member health centers with improving performance on outcomes through data analytics and QI activities.

“We now have data that indicate networked health centers outperform non-networked health centers clinically, including UDS data that indicates our HCCN outperforms others across the country in 10 of 13 clinical measures, and HEDIS data that indicates our CIN is posting the highest minimum performance level scores Molina Healthcare has ever posted in California, by any provider group. What that says to me is that the time has come for FQHCs to work together in networks, locally and regionally, to ensure the delivery and continuity of high-quality health care and the highest possible outcomes, at reduced cost, for the patients entrusted to their care. How one does that, through an IPA or a CIN or other vehicle, will have its own pros and cons depending upon the business model and the business goals of the organization.”

— Henry Tuttle, President and CEO
Health Center Partners

Advantages

An MSO can help an individual health center to pay the best prices for services and supplies, to have access to pre-vetted vendors for services and technology products, and to focus on clinical care and developing strategic relationships in the community. An MSO or a CIN may also aggregate data and use it for QI. A CIN can leverage negotiating power, data, and quality work to bring more resources to a health center through collective contracting for pay-for-performance from health plans.

Table 4. Areas of Consideration When Establishing Partnerships with MSOs and CINs

| | INTERNAL CONSIDERATIONS (ORGANIZATIONAL CAPACITY) | EXTERNAL CONSIDERATIONS (ENVIRONMENT/MARKET/POLICY) |
|---|--|---|
| Leadership and Staffing | <ul style="list-style-type: none"> ▶ Are there staffing-related functions, such as credentialing or training, that might be more efficiently outsourced? | <ul style="list-style-type: none"> ▶ What administrative services does your consortia offer? Is there opportunity to build MSO-like capacity at your consortia? |
| Care Delivery and Infrastructure | <ul style="list-style-type: none"> ▶ Are there clinical or administrative services, such as technological expertise or data analytics for population health management, that you do internally that might be more efficiently outsourced? | <ul style="list-style-type: none"> ▶ What care delivery infrastructure and QI does your consortia offer? ▶ Are there other health centers that you trust that could work with you on QI activities? |
| Financial | <ul style="list-style-type: none"> ▶ Are you not ready to take downside risk through an IPA but interested in collectively negotiating upside payments? | <ul style="list-style-type: none"> ▶ Would your health plans prefer to have a single point of contact and negotiate with a network of health centers rather than individual CHCs? |
| Data and Analytics | <ul style="list-style-type: none"> ▶ Are you considering a second-generation EHR? Would it be helpful to negotiate with vendors collectively? ▶ Do you need assistance with data analytics for QI? | <ul style="list-style-type: none"> ▶ Is there a health information exchange in your community? |

Key Considerations and Challenges

An MSO approach requires buying services from a trusted MSO that can perform the health center’s nonmedical services under a clear contractual arrangement. One area in which group contracting has proven challenging is with IT support and EHR hosting, given individual health centers’ IT needs. Key challenges for a CIN doing collective contracting include building in mechanisms to ensure that all members are contributing to quality outcomes and establishing a fair way of distributing performance payments from a payer. (For example, would members see it as more fair to distribute payments based on member lives or degree to which a member influenced the group’s quality scores?) See Table 4 for more details.

Health-Center-Led Independent Practice Associations

As a mechanism for risk-based collective contracting, health-center-led IPAs offer health centers a way to enter the virtuous cycle of increased revenue linked to improved care and outcomes. However, there are challenges to both formation and participation, including regional managed care Medi-Cal contracting practices, the demands of managing utilization outside of primary care, and building trust and discipline among members.

What Is It?

IPAs are corporations that contract with managed care health plans on a capitated basis for either all primary care services or, more frequently, all professional services (both primary and specialty care). IPAs effectively allow health centers to contract collectively for risk-based payments and to distribute savings, if they occur, based on quality and cost outcomes of the assigned member population.

Some health-center-led IPAs have been functioning as “virtual Medi-Cal ACOs”⁶² in that they assume limited financial accountability and risk for a defined member population and reward providers if cost and quality outcomes are achieved. Some thought leaders have posited that the presence of IPAs within managed care Medi-Cal are a reason that there has been no movement toward Medicaid ACOs in California to date, despite the emergence of ACOs in the commercial and Medicare markets in California and in Medicaid markets in other states. Some health-center-led IPAs are also functioning like ACOs in that they actively help health centers transform care through data analytics, care management, and coordination of care between settings.

IPAs pay health centers either on a fee-for-service basis or via primary care capitation for primary care services. It should be noted that health centers are protected from financial risk for FQHC services by virtue of the state paying a “wraparound” and conducting an annual reconciliation to make up any difference from what the health center would have received under PPS. These processes can delay cash flow for health centers but ultimately ensure that health centers receive their PPS rate for all eligible visits.

“I think the clinics are really leaning on us to make them smarter with their managed care participation. They value what we’ve done so far. We have a very active board, active strategic planning committee We offer support as an IPA, such as access to patient navigators or certified coders, for things that maybe clinics can’t afford on their own.”

— Iris Weil, Executive Director
Health Care Los Angeles Independent Practice Association

Advantages

Being part of a health-center-led IPA can bring additional revenues to health centers through shared savings-type payment arrangements while also fostering efforts to redesign the care system. For example, health centers within risk-taking IPAs tend to engage in advanced data analytics and in care management and case coordination for their members; they are financially rewarded when such efforts are successful in preventing unwarranted hospital utilization and achieving quality outcomes. These additional dollars can be used to sustain the care management functions, creating a virtuous cycle of payment and improvement in care delivery. Both health center members and Community Health Center Network (CHCN) leaders described this virtuous cycle. See Case Study 3 for an example of how CHCN has helped its member health centers to build capacity in providing comprehensive primary care and to negotiate with plans and local hospitals to help sustain improved care.

IPAs allow health centers to keep their autonomy while achieving many of the benefits from increased size.

IPAs reported conducting data analytics, including analyzing claims, supporting complex care management, and facilitating specialty care access. Health center and health-center-led IPA leaders reported that participating in IPAs has resulted in financial benefit to health centers. Although health-center-led IPA contracts are technically both upside and downside risk, none of the health centers interviewed for this project reported incurring financial losses as a result of IPA participation.

Key Considerations and Challenges

Pursuing an IPA strategy requires having a managed care Medi-Cal plan that is willing to contract with an IPA, a minimum number of lives to take collective risk safely (often estimated at about 20,000 lives,⁶³ and trust and discipline among IPA members. Health centers reported that forging new financial risk-taking partnerships within the entrenched managed care infrastructure and contracting habits of a given region can be a barrier. Despite interest among health centers in forming IPAs in certain regions, some payers have dictated whether health centers can contract through IPAs.

Forming a health-center-led IPA also requires leadership, administrative bandwidth, managed care expertise, and a deep sense of mutual trust and discipline among members. Taking collective risk can create an incentive for IPAs to admit only new health centers that meet quality-of-care standards and demonstrate a commitment to QI, including a clear commitment and capacity to manage utilization outside of primary care. For small health centers, the lack of capacity to manage utilization outside of primary care, including behavioral health integration and care management and coordination, can pose a barrier to participation.

IPAs may not be interested in having health centers with a small number of additional lives and the unknown capacity to manage care of members. This may be particularly challenging if a small health center brings a high-risk population without commensurate capacity to manage the utilization of high-risk members outside the primary care setting. It is perhaps owing to these challenges that small health centers are less likely to participate in health-center-led IPAs compared with their larger counterparts. Some interviewees suggested that small health centers might gain entry into an IPA by bringing a unique care approach that other members can use, such as having a robust system for caring for homeless individuals. See Table 5 on page 29 for more details.

Table 5. Areas of Consideration When Establishing Partnerships with Health-Center-Led IPAs

| | INTERNAL CONSIDERATIONS (ORGANIZATIONAL CAPACITY) | EXTERNAL CONSIDERATIONS (ENVIRONMENT/MARKET/POLICY) |
|---|--|--|
| Leadership and Staffing | <ul style="list-style-type: none"> ▶ Do you have managed care contracting expertise within your team? ▶ Are leaders amenable to entering into a risk-bearing arrangement? ▶ Do you have care managers and case coordinators on your care teams? | <ul style="list-style-type: none"> ▶ Does your Medi-Cal plan(s) contract through IPAs? ▶ Is there a health-center-led IPA in your area or are there other local health centers interested in forming an IPA? |
| Care Delivery and Infrastructure | <ul style="list-style-type: none"> ▶ Do you have a demonstrated commitment to and practice of QI that has been proven to reduce avoidable hospital utilization (a valuable skillset to payers)? ▶ Do you have clinical capacity to manage and coordinate care outside of primary care? ▶ Do you have a system for sending specialty referrals to high-quality, low-cost specialists? ▶ Have you established partnerships with CBOs to address social factors for your patients to help you perform under risk-based payment? | <ul style="list-style-type: none"> ▶ Are local payers open to delegating care management and coordination services? ▶ Would a local health plan be willing to make upfront investment in staffing and data infrastructure necessary to manage utilization outside of primary care? ▶ Do your patients have a choice of hospitals and specialists? |
| Financial | <ul style="list-style-type: none"> ▶ Do you have the financial stability to take on downside risk? ▶ Would a health-center-led IPA have at least 20,000 lives? ▶ Do you have the financial resources to invest in the necessary data systems and new staff to manage financial risk? | <ul style="list-style-type: none"> ▶ Is there money to be made in risk-based IPA contracts in your region given the competitive IPA environment and hospital environment? (For example, would a hospital or specialty group with monopoly power likely raise prices if utilization goes down?) |
| Data and Analytics | <ul style="list-style-type: none"> ▶ Do you have data on your members' utilization and cost outside of primary care? ▶ Do you have the analytic capacity to review cost and utilization trends of services rendered outside primary care? ▶ Do you have the ability to report on IPA quality metrics? | <ul style="list-style-type: none"> ▶ Have you established data linkages with hospitals (e.g., ADT feeds) that would allow you to manage care transitions and coordinate care? |

Partnerships with Health Plans

Partnering with payers for value-based payment can yield the financial resources to achieve and sustain care transformation but may require sophisticated data and contracting capabilities. The local managed care context heavily shapes potential opportunities for health centers to engage with plan partners. In counties with only one Medi-Cal plan or a local initiative, health centers may be able to leverage aligned missions to improve care and outcomes for their community.

What Is It?

Health center partnerships with health plans often take the form of contracts for value-based care and payment. Pay-for-performance incentives and care management/case coordination payments are the most common forms of value-based payment that health plans use. A 2015 survey showed that 18 of 22 Medi-Cal plans had a pay-for-performance program. Within these 18 programs, five domains for measurement were most prevalent: clinical quality (e.g., HEDIS), utilization (e.g., readmissions, avoidable emergency department visits); encounter

submission (i.e., records of health care services for which plans pay in capitated arrangements); access to care (e.g., extended office hours); and patient experience.⁶⁴ Medi-Cal managed care plans in 29 California counties are planning to implement Health Homes in 2018-2019. Health centers have an opportunity to contract as community-based care management entities to provide care management/case coordination services for high-risk members with multiple chronic conditions.

Plans were also envisioned as a critical partner in the proposed California FQHC APM demonstration, in which volunteer health centers would receive a PPS-equivalent capitation rate from their plan(s) for all assigned Medi-Cal beneficiaries. The APM was designed both to give health centers more flexibility in delivering care and to align payment with the way managed care is paid — for members, not just patients who are seen for visits. In the wake of the Centers for Medicare & Medicaid Services not allowing the APM to proceed without a waiver, select plans and CPCA continue to explore how to achieve many of the goals of the APM without pursuing a waiver of PPS.

In certain markets, plans are even more collaborative. For example, Partnership Health Plan of California piloted an intensive outpatient care management program, worked with clinics on provider recruitment, and provided innovation grants to health centers to address community-level social determinants of health. In another example, Inland Empire Health Plan invested in new staff and training for delivering integrated behavioral health in health centers.

Advantages

Partnering closely with a plan can help a health center to initiate care transformation that is not supported by their current payment model and sustain that care by earning financial rewards related to keeping members healthy and out of the hospital. In many regions, consortia and/or health-center-led IPAs can play a key role in facilitating such infrastructure and care improvement opportunities between plans and health centers. For example, Health Center Partners of Southern California was instrumental in building capacity in data and QI in a small member health center. This led to the health center improving quality outcomes and receiving improved pay-for-performance payments from health plans that could sustain its new data and QI infrastructure (see Case Study 2).

Key Considerations and Challenges

Partnering more closely with health plans for value-based payment requires that health centers modify data systems to understand who their assigned members are and how to reach out to those needing care. For health centers to negotiate for supplemental payment for care management and coordination of care inside and outside primary care, they will need to demonstrate capacity to perform such functions. For example, CHCN and its member health centers demonstrated to their health plans that a novel care management and coordination program they piloted improved quality outcomes and reduced hospital utilization; the plans were convinced by the results to pay to sustain the new program (see Case Study 3).

Partnering directly with a health plan might not be an option for individual small health centers. Many Medi-Cal health plan payers in California prefer to negotiate with larger medical groups that assume accountability for significant numbers of health plan members. This includes QI initiatives, training, and capacity-building for providers. In such cases, small health centers can still work through other organizations (e.g., IPAs, CINs, consortia) to partner with their health plan(s). See Table 6 on page 31 for more details.

“As an HCCN, we have traditionally worked with UDS data as we test population health management strategies. But with 100% of our Medicaid market in capitated managed care, and the formation of our CIN two years ago, our members have made the move from fee-for-service to value-based care, using HEDIS data to measure quality. However, since we function as both HCCN and CIN, we are always evaluating our performance based on both the UDS and HEDIS value sets.”

— Nicole Howard, Executive VP
Health Quality Partners of Southern California

Table 6. Areas of Consideration When Establishing Partnerships with Health Plans

| | INTERNAL CONSIDERATIONS (ORGANIZATIONAL CAPACITY) | EXTERNAL CONSIDERATIONS (ENVIRONMENT/MARKET/POLICY) |
|---|--|--|
| Leadership and Staffing | <ul style="list-style-type: none"> ▶ Do you have a leader who acts as the liaison for your health plan(s)? | <ul style="list-style-type: none"> ▶ Could your plan be a partner in advancing workforce policy change as a way of increasing access? |
| Care Delivery and Infrastructure | <ul style="list-style-type: none"> ▶ Do you have capacity to provide care management and coordination services to high-risk individuals? If not, what training do you need? Have you discussed Health Homes with your health plan? | <ul style="list-style-type: none"> ▶ Are you located in a county that plans to implement Health Homes? ▶ Have you asked your plan if there are services such as care management and coordination that they would delegate and pay for? |
| Financial | <ul style="list-style-type: none"> ▶ Have you reviewed your pay-for-performance program with your plan to determine where there are opportunities? ▶ Are you interested in converting your PPS rate into a capitated equivalent that would allow more flexibility to provide care through nonbillable providers and modalities (e.g., email or phone) in exchange for limited risk under an APM? ▶ Do you address social needs in a care management/coordination program that a plan might be willing to fund? | <ul style="list-style-type: none"> ▶ Does your plan prefer to contract directly or through IPAs/networks? ▶ Do your payers have programs that pay for performance outcomes and/or reward providers for lowering total cost of care? ▶ Are your pay-for-performance measures and targets changing in response to the California court case ruling against double payment for services in pay-for-performance? ▶ Is the proposed California health center APM moving forward? ▶ Are you located in a whole-person care pilot county where payers (the plan or the county) may have additional funding for housing navigation, care coordination, and so on? |
| Data and Analytics | <ul style="list-style-type: none"> ▶ Can you prove the financial value of your current services by showing that your members utilize fewer hospital services than the health plan average? ▶ Are you able to assign all members to a panel in your EHR for the purposes of outreach for preventive services and measuring quality metrics for all members (to improve HEDIS measures)? ▶ Do you have the data-reporting capability and QI practices in place to monitor and improve the outcomes for which you receive performance payment? | <ul style="list-style-type: none"> ▶ Is your plan willing to share hospital and specialty utilization for your patients? ▶ Is your plan sharing monthly membership assignment with you? ▶ What HEDIS measures matter most to your plan? |

Mergers and Acquisitions

Health centers that are able to come together through a merger stand to gain economies of scale in staffing (including attracting leadership talent) and administrative functions. They also achieve greater clout in developing partnerships or negotiating contracts and increased capital to invest in infrastructure needs.

What Is It?

Mergers and acquisitions are strategies for increasing size, economies of scale, breadth of services, and market clout by fusing two or more distinct organizations into a single entity. Other industries, including the nonprofit sector, pursue them to stretch administrative capacity and leadership talent over more service provision.⁶⁵ Some CHCs use mergers to achieve the benefits of size and expand services for their patient population. For example, HealthRight360 in San Francisco is the result of a series of mergers of multiple CHCs, behavioral health, and community-based organizations. It leverages the strengths of each of the small organizations that came together to provide a comprehensive set of services, including primary care, dental care, substance use disorder treatment, and mental health services.

“The future requires mergers. We can’t support 40 small health centers to each have a piece of the population. Maybe small specialized little hubs, but we can’t have 40 [distinct] primary care clinics. We won’t get efficiencies of costs, won’t use HRSA dollars appropriately, or be able to make public private partnerships because people won’t invest in 40 small things. Health centers should embrace bold innovation.”

— Karen McGlinn, CEO
Share Ourselves Corporation

Advantages

A merger or acquisition strategy can bring about rapid growth in lives and revenue, increase economies of scale for administrative functions and negotiations on payment, and result in a health center that maintains autonomy going forward. Combining the service offerings of two small organizations can also be a pathway to offering comprehensive primary care using an expanded care team. Further, mergers and acquisitions can leverage top leadership talent in the safety net by having strong, visionary leaders take charge of larger organizations using the combined resources. For example, given that California health centers are having to compete with Silicon Valley for CTOs, one thought leader commented, “When competing with tech companies, it might be possible to find 50 high-level CTOs, but unlikely to find 176.” Additionally, mergers and acquisitions can responsibly maintain access points by allowing underperforming or financially at-risk organizations to remain open and improve via buyer support. When a larger, stronger organization results from a merger, a community can benefit from expanded services available in more locations.

Key Considerations and Challenges

Some CHCs resist the idea of merger unless driven to it by financial distress, and some local board structures favor local control. Other institutional barriers include strong organizational culture and the need for approval by lenders or oversight agencies such as HRSA. Despite these obstacles, merger may be the best option — or only viable option — for struggling CHCs or those in areas that lack other partnership organizations capable of providing shared services. Indeed, some mergers have further advanced individual health centers’ missions in their communities through leveraging the strengths of both organizations. See Table 7 on page 33 for more details.

See Case Study 4 for an example of how Parktree — created through an organizational acquisition — preserved access and expanded services for patients.

Table 7. Areas of Consideration When Establishing Partnerships Through Mergers and Acquisitions

| | INTERNAL CONSIDERATIONS (ORGANIZATIONAL CAPACITY) | EXTERNAL CONSIDERATIONS (ENVIRONMENT/MARKET/POLICY) |
|---|--|--|
| Leadership and Staffing | <ul style="list-style-type: none"> ▶ Would your board be amenable to exploring a merger as a strategy for sustainability and/or improving quality of care? ▶ Are you struggling to hire and retain leadership talent? Would a larger organization with more resources at the administrative level help recruit the talent you need? ▶ Are there staffing capacities that would be easier to leverage over more lives (e.g., bilingual disease management, finance, data analyst)? | <ul style="list-style-type: none"> ▶ Is there another local health center that has a similar mission and/or target population and has strong leadership capable of managing an expanded organization? ▶ Would health plans and other key stakeholders support a merger? ▶ Are you close enough geographically to another CHC that sharing staff would make sense? |
| Care Delivery and Infrastructure | <ul style="list-style-type: none"> ▶ Is using a care team to manage population health inhibited by small panel size? | <ul style="list-style-type: none"> ▶ Is there a strong local health center that has clinical and administrative infrastructure that would benefit your health center and your patients? ▶ Would a local hospital be more likely to collaborate with a single larger health center? |
| Financial | <ul style="list-style-type: none"> ▶ Would investing in new infrastructure, administrative staff, technology, and training be more viable if the cost could be spread over more patient lives? | <ul style="list-style-type: none"> ▶ Is capital available at reasonable rates to fund integration of administrative and IT systems, to cover potential losses of an acquired clinic, and to do necessary work to bring teams together? ▶ Would local payers be more interested in partnering with a larger health center organization for value-based payment? |
| Data and Analytics | <ul style="list-style-type: none"> ▶ Is there data infrastructure, analytic capacity, or technology savvy that seems unaffordable for the size of your health center? | <ul style="list-style-type: none"> ▶ Would hospitals or health plans be more likely to share data with your health center if you had more patient lives? |

Partnering to Succeed: A Road Map for Health Centers

The questions in Figure 7 can help a health center select which partnerships to pursue. It can serve as a road map for making the most appropriate partnership decisions.

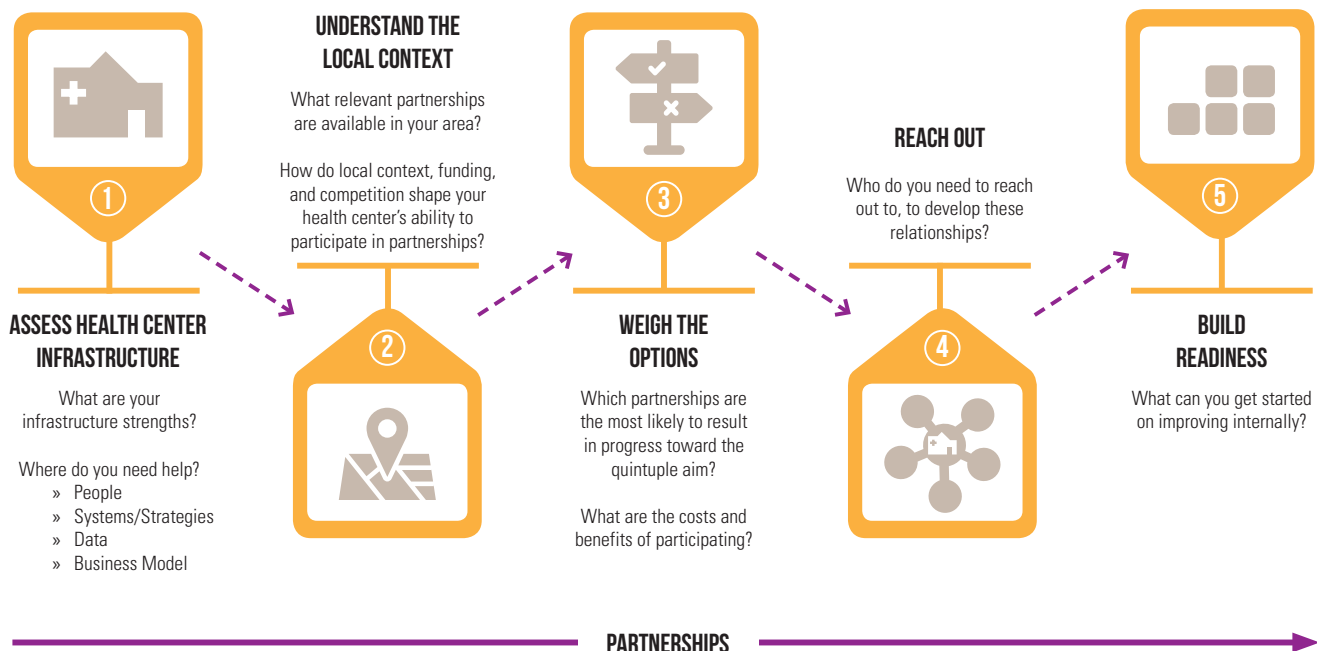
Assess health center infrastructure. Health centers interested in creating financially viable organizations that deliver high-quality, comprehensive primary care need infrastructure in terms of people, systems and strategies, data, and a business model. It is important for a health center to make an honest assessment of its strengths as well as the areas that would benefit from additional support. Does the health center have the right scale and scope of services to match patient needs? Is the right team in place to deliver those services?

Understand the local context. Each community operates with different partners and politics. The table below shows the key advantages of different kinds of partnerships. Health centers need to consider the following: What partnerships are available in your area? Which make the most sense for you to pursue based on cultural fit and mission alignment? What are the managed care contracting practices in the region? Is there a natural hospital partner? What history or politics might need to be confronted?

Weigh the options. Partnering can bring tremendous benefit to small health centers that may otherwise struggle to acquire the resources for adequate infrastructure. But not all partners offer the same breadth, depth, and quality of services, regardless of their organizational type. A partner may be strong in one area but weak in another. Health centers need to be clear on what their biggest gaps are in order to find the best fit. Because partnerships take time and often require relationship building, it may be wise to reach out before circumstances compel a change. This gives the health center some time to engage its board and ensure that a partner is well aligned with the mission.

Reach out. The only way to really know which partnerships would work best is to start building relationships. The case studies in the last section of this paper show how varied the path to partnership can be. Simply starting conversations with potential partners can result in collaborations and partnerships that take shape through the exploratory discussions. Reaching out to potential partners requires a health center to solidify its own case as a desirable partner organization. The strengths that it brings to the table — from a particular expertise, or unique patient population, or strong community reputation — need to be well understood and shared.

Figure 7. Road Map for Partnering: Key Questions



Build readiness. Even if a health center is not ready to partner or has limited opportunities to do so in its area, it can build infrastructure and improve care now. Health centers are undertaking a broad range of activities that are achievable under PPS and also prepare them for value-based pay. For example, some health centers

are using medical assistants to act as scribes in order to improve efficiency and boost patient volumes. Others leverage volunteers or students through AmeriCorps or other professional training programs to do proactive outreach to patients.

Table 8. Key Advantages of Each Partnership Type

| KEY ADVANTAGES [THIS PARTNERSHIP CAN HELP A HEALTH CENTER TO...] | |
|--|--|
| Community Agencies | <ul style="list-style-type: none"> ▶ Better respond to and/or address social and behavioral health needs ▶ Expand access to care by engaging with patients in the community (e.g., the YMCA, the school, a food pantry or farmers' market) ▶ Expand grant-funding opportunities |
| Hospitals | <ul style="list-style-type: none"> ▶ Improve care coordination by: <ul style="list-style-type: none"> ▶ Establishing contact points between hospital and primary care staff to manage care transitions ▶ Providing data when patients are in the hospital (to ensure follow-up in primary care and decrease avoidable hospital utilization) ▶ Embedding and funding nursing and other staff in health centers to provide care coordination (in select cases) ▶ Leverage hospital community benefit requirement for grants |
| Consortia | <ul style="list-style-type: none"> ▶ Leverage shared best practices, centralized technical assistance, and a collective health center voice in policy discussions and advocacy efforts. A consortium can also fulfill multiple other partnership roles in select cases: <ul style="list-style-type: none"> ▶ Connect peers to share and spread best practices related to infrastructure through training and technical assistance (TA) ▶ Facilitate introductions among likely partners; help facilitate partnership discussions ▶ Provide QI and health IT technical assistance and explore health information exchange (HIE) infrastructure through their role as an HCCN ▶ Provide reporting and analytic capacity for members |
| MSOs and CINs | <ul style="list-style-type: none"> ▶ Outsource infrastructure and nonmedical functions to an entity that specializes in such infrastructure and functions. An MSO can do the following: <ul style="list-style-type: none"> ▶ Optimize health IT infrastructure — both related to human resources (e.g., analysts) and capital investments (e.g., EHR, HIE) ▶ Provide services such as billing, physician recruitment, credentialing ▶ Provide QI infrastructure such as training in specific QI methods and data for evidence-based practice change ▶ Negotiate better pricing on purchased supplies and services ▶ Additionally, some MSOs serve a collective QI and group contracting function (sometimes termed clinically integrated network) by doing the following: <ul style="list-style-type: none"> ▶ Conducting data analysis and coaching to improve outcomes ▶ Negotiating performance payments with greater clout while allowing member health centers to maintain independence |

Table 8. Key Advantages of Each Partnership Type, continued

KEY ADVANTAGES [THIS PARTNERSHIP CAN HELP A HEALTH CENTER TO...]

| | |
|---------------------------------|---|
| IPAs | <ul style="list-style-type: none">▶ Collectively contract for risk-based payments designed to give health centers access to more of the Medicaid dollar▶ Build clout with managed care plans and hospitals while maintaining health center independence▶ Centralize expertise in data analytics, care management, and coordination of care outside of primary care (in select cases)▶ Enhance specialty access and management of high-cost hospital services through relationship-building with hospitals |
| Health Plans | <ul style="list-style-type: none">▶ Provide contracts for value-based pay — for care management payments, performance payments, and proposed APM payments▶ Leverage plan capabilities with data infrastructure and analytics to stratify member data by risk, measure quality outcomes, and manage utilization outside of primary care▶ Build capacity in care managing high-need members through either directly funding health center staff (e.g., care managers, behaviorists) or covering these responsibilities through additional payment |
| Mergers and Acquisitions | <ul style="list-style-type: none">▶ Leverage economies of scale to do the following:<ul style="list-style-type: none">▶ Recruit and retain leadership expertise▶ Spread administrative costs over a larger patient population▶ Expand the care team to include new roles that are more efficiently shared among multiple patient panels (e.g., pharmacist, behavioral health)▶ Preserve and/or expand access to, and range of, services |

Recommendations for Organizations That Support Small Health Centers

The MAHP presented in this paper is intended to help small health centers identify and actualize partnerships that will enable them to deliver excellent patient care and thrive in the transition to value-based payment. In California, many different organizations have a role to play in supporting the development and/or expansion of partnerships that can meet the needs of small health centers. These include consortia, IPAs, MSOs and CINs; health plans; regional and state associations; and foundations. Although some of these organizations already excel at addressing the needs of small health centers, there is variation across the state. The research gathered for this paper identified several opportunities for improvement, as listed below.

Opportunities for Consortia, IPAs, MSOs, and CINs Led by Health Centers

Compared with their larger counterparts, small health centers are less likely to participate in consortia, IPAs, MSOs, and CINs (see Figure 5 on page 9). To enable small health centers to participate in *existing* networks and partnerships, supporting organizations should do as follows:

1. Conduct outreach, needs assessment, and intentional welcoming for small members.
2. Create governance that provides small health centers with an equal vote for strategic direction setting, even if financial rewards are prorated based on the number of patient lives.
3. Adjust membership fees for small health centers.

Supporting organizations should also consider what services they can offer to help small health centers excel. For example, they can do the following:

1. Ensure that small health centers are optimizing group purchasing from vendors.
2. Tailor support and coaching for small health centers.

3. Leverage regional relationships with health plans and hospitals to help small health centers access data.
4. Identify opportunities for adding new centralized services, such as data analytics, contracting, credentialing, and evaluation.
5. Assist small health centers in assessing and brokering new partnerships.

Opportunities for Policymakers, Health Plans, State and/or Regional Associations, and Funders

Other types of organizations can help build capacity within existing partnerships or cultivate the development of new partnerships. For example, they can do the following:

1. Support the development of regional IPAs in markets where they do not exist. This may start with identifying regions where health plans (local initiatives, in particular) have interest in contracting with health centers collectively but where no health-center-led IPA or CIN exists. It would also include assessing interest of local health centers in forming an IPA or clinically integrated network to contract collectively with the plan(s) and provide health centers with support in improving quality outcomes.
2. Form a statewide MSO for health centers that do not have access to centralized, nonmedical functions. One key area of focus would be data analytics and, in particular, risk stratification and understanding total cost of care.
3. Expand high-functioning consortia through targeted investments.
4. Help small health centers build tighter relationships with county health systems and local initiative health plans. A natural starting place could be around advancing care management of high-risk populations, including potential collaborations related to the recently launched Whole Person Care pilots and the Health Homes initiative.

Conclusion

Creating high-quality, comprehensive primary care is core to the mission of community health centers that aim to improve the health and well-being of low-income and vulnerable persons. Doing this work well, and in a financially sustainable way, increasingly means understanding and participating in value-based payment arrangements. Improving care and succeeding in value-based payment requires considerable, shared infrastructure. All health centers struggle to put this infrastructure in place, but small health centers face unique challenges in securing access to capital, building expensive data capabilities, and negotiating favorable rates with vendors and contracts with health plans.

Health centers have a history of working well together on advocacy and policy, but the recent infrastructure requirements for value-based pay and care redesign invite new kinds of partnerships. Sharing infrastructure, clinical approaches, and data openly with partners represents a new way of thinking for many health centers. The following case studies demonstrate some partnering strategies that have opened up new doors for small health centers and effectively stretched their limited resources. In this health care environment, finding partners to share resources and infrastructure will be crucial to success.

Case Studies

The following four case studies — from diverse geographic regions across California — show how small health centers have taken advantage of partnerships to enhance their ability to sustain high-quality, comprehensive care for their patients and/or better position themselves for participation in value-based payment. They represent the wide range of partnership options discussed in this paper. The sites were recommended as compelling examples of relationships that can support small health centers.

CASE STUDY 1

Hill Country Community Clinic

Leveraging a county partnership to bring behavioral health and community resources to a rural setting

This small, rural health center used a variety of partnerships to provide more comprehensive, whole-person care to their community. Hill Country Community Clinic's story demonstrates how partnerships involve serendipitous timing, relationship building, and the ability to mold a cohesive program from work supported by different partner organizations.

Interviewees

Lynn Dorroh, CEO

Nick Cutler, CFO

Bridget Schafer, CIO/COO

Susan Foster, Medical Director

Organizational Profile

Located in Round Mountain, a small town about an hour east of Redding in Northern California, Hill Country Community Clinic (HCCC) has been working toward the integration of behavioral health, dental care, and primary care since 1982. Responding to unmet needs for primary care, HCCC opened a satellite clinic in Redding in 2015, and it also runs a number of community-based wellness programs. The health center provides a wide array of services including dental care, behavioral/mental health care, substance abuse treatment, complementary and alternative treatments, supportive services, and community linkages.

HCCC has grown from serving about 3,700 people in 2013 to more than 6,000 in 2016. The payer mix changed dramatically during that period, from 35% uninsured in 2010 to 8.5% uninsured in 2016, a change largely attributable to Medicaid expansion. Of HCCC's patients, 66% are age 18 to 64, and 20% are under 18. HCCC has had very stable leadership; the current CEO has served for over 13 years and is well known and respected in the community.

Partnering to Support Physical, Mental, and Social Wellness

HCCC developed its unique approach to providing holistic care in response to patients' behavioral and social needs through several innovative partnerships and funding streams. Its most significant partnership is with the Shasta County Mental Health Department (SCMHD), a department under Shasta County Health and Human Services. In 2006, SCMHD stopped direct provision of mental health services and closed several outpatient and inpatient mental health facilities. In response, community providers convened a coalition to decide how to best address mental health service needs. This coalition work allowed HCCC to respond the following year when the county received funds through the Mental Health Services Act (MHSA, also known as California Proposition 63). As a result, HCCC was able to offer a variety of mental health services to a larger population and work more intensively with the severely mentally ill.

HCCC also opened the Circle of Friends Wellness and Recovery Center, a wellness and peer-support program for families experiencing mental illness. Circle of Friends offers classes and activities such as knitting, quilting, and painting; workshops on topics such as boundary-setting and dealing with loneliness; and group social activities such as movie days and volunteering at local parks. HCCC simultaneously expanded its intensive case management program to serve teens with serious mental illness and to implement an after-school wellness program.

Recent funding from SCMHD helped initiate the CARE (Counseling and Recovery Engagement) Center in March 2017. Open 24 hours a day, seven days a week, the CARE Center's goal is to reduce inappropriate emergency department use for mental health crises and provide intensive case management to those with serious mental illness. The CARE Center also supports foster children and families and has space for community members to connect with each other. A mental health counselor is on call to deal with crises.

HCCC participates in Shasta County Health and Human Services Agency's Whole-Person Care pilot, a Medi-Cal program to coordinate care for Medi-Cal beneficiaries who are high utilizers of services. Through this pilot, HCCC provides intensive case management for qualified homeless individuals and is exploring the creation of a mobile crisis unit. To support whole-person care, HCCC integrated a comprehensive panel of mental and behavioral health screening tools (e.g., PHQ-9, Generalized Anxiety Disorder-7 [GAD-7], Adverse Childhood Experiences [ACEs], SBIRT, and opioid risk assessment) and documentation and referrals to related services. These activities have put HCCC in the top quartile of all community health centers in the country for tobacco use screening and providing a cessation intervention, as well as screening for depression and providing a follow-up plan.

In addition to the partnership with SCMHD and Shasta County Health and Human Services, HCCC has many other alliances that expand its capacity to address the social determinants of health and serve high-needs and at-risk populations. These include participation with the Special Education Local Planning Agency (SELPA), Partnership Health Plan, Alliance Chicago, Shasta Health Assessment and Redesign Collaborative (SHARC), and Health Alliance of Northern California (HANC).

These partnerships, especially the funding partnership through SCMHD, enable the health center to target specific populations that need specialized support. Other partnerships allow access to QI and IT technical assistance. HCCC benefits from their ability to knit resources into a cohesive whole of sustainable programs.

HCCC works with their partners to plan for the future. One example is the City of Hope, an ambitious collaborative project aimed at providing holistic care including primary care, dental care, behavioral health, support services including wellness recovery action plans and résumé building, and housing for homeless and transitional youth. The City of Hope will engage numerous community partners.

Caveats

HCCC initiated a relationship with the county based on a large gap in care and a real need to find services for a vulnerable population. This ready-made partnership opportunity might not exist in other regions.

Close-knit communities where many people have long-standing relationships helped the CEO and her team develop important partnerships and gain a well-deserved reputation; some of these components would not be feasible in large, urban centers.

Key Takeaways

HCCC, while a relatively small health center, has built a comprehensive set of services for their clients by looking outside standard clinic funding mechanisms and engaging with partners. The following are some of the strategies HCCC has used to maximize the overall effectiveness of their partnerships and build a comprehensive set of services around multiple partnership activities:

- ▶ **Relationships are critical.** HCCC is known as a good partner that is friendly, flexible, and easy to work with and has demonstrated several times throughout its history the importance of relationships.
- ▶ **Develop a clear mission.** HCCC chose early on to focus on behavioral health integration and the mental health needs of at-risk populations. This move positioned it to respond to recent funding and partnership opportunities targeted at whole-person care and the social determinants of health.
- ▶ **Listen to the needs of the community and community partners.** Listening and planning around the needs of the people served allows a clinic to focus efforts on areas of high need and the potential for high impact.
- ▶ **Develop a reputation for being good collaborators and partners.** By garnering respect in the local and regional community, HCCC's CEO leveraged many important partnerships and funding opportunities.
- ▶ **Demonstrate the organization's mission statement on a regular basis.** This underscores commitment to core goals and values.
- ▶ **Base actions and decisions on a clear mission.** This attracts similarly mission-driven employees who see the long-term sustainability of the organization as a joint effort that they are willing to commit to for the long term.

CASE STUDY 2

Health Center Partners of Southern California and Community Health Systems, Inc.

Partnering to improve administrative efficiencies and build an infrastructure for value-based payment and care

For Community Health Systems, Inc., a midsize health center in Southern California, joining Health Center Partners of Southern California was a game changer. This case study describes the experience of participating in a consortium that includes a QI-focused nonprofit, a clinically integrated network of health centers operating under a master contract with health plans, and a nationwide purchasing organization.

Interviewees

- HCP Henry Tuttle, CEO
Nicole Howard, EVP, CAO
Sabra Matovsky, former EVP
- CHSI Lori Holeman, CEO

Organizational Profile

Community Health Systems, Inc. (CHSI), with five sites in Riverside, San Bernardino, and North San Diego counties, serves about 25,000 unduplicated patients annually with a budget of just over \$20 million. CHSI joined Health Center Partners of Southern California (HCP), a consortium of 17 community clinic and health center organizations. HCP members operate 133 medical and dental practices in San Diego, Riverside, and Imperial counties, collectively serving 868,000 patients. HCP fulfills many of the same functions as other consortia in respect to policy, advocacy, and training. It serves

as the umbrella organization for a family of the following three companies.

Health Quality Partners (HQP) develops and implements innovative, collaborative programs that focus on access to care, patient engagement, and quality and performance improvement support for members. It serves as an innovation hub and incubator to improve primary care. Historically, HQP has provided managed care contracting and other services that are available for purchase by all members.

Integrated Health Partners (IHP) is HCP's clinically integrated network. Eleven of 17 HCP members currently operate under a group contracting model, where members maintain their discrete organizational identities but work together to achieve clinical integration; the goal is to implement the same clinical protocols and provide the same level of care across all sites. IHP is governed by an independent board of directors that includes up to five of the 11-member health centers' CEOs and HCP leadership. Additionally, IHP members are eligible for performance incentives if they reach quality and access metrics negotiated with the plan (most are HEDIS measures).

CNECT is a nationwide group purchasing organization (GPO) that optimizes member operations through a robust 2,200+ GPO contract portfolio and consultative supply chain support. Membership in this organization is broader than the consortium membership at more than 6,500 members to date. CNECT is a source of innovative external revenue streams for the consortium.



Consortium Meets Multiple Needs of an Unaffiliated Health Center

With the Affordable Care Act, many health centers invested in EHRs. CHSI chose instead to use a capital investment grant to expand its sites. But with the expansion accomplished, CHSI worried that they were four years behind their peers in EHR adoption and optimization. As a midsize health center, CHSI also struggled with being deprioritized by vendors for optimization, training, and technical assistance.

These factors led CHSI to join the HCP family of companies, which offered access to training, consultants to provide technical assistance, and opportunities to learn from other health centers that had already been through this transition. For CHSI, the dues and fees associated with joining were a significant investment. However, CHSI CEO Lori Holeman described this decision as “a game changer.”

The benefits of the partnership — including improved care quality and increased revenues — have outweighed the costs. CHSI improved its ability to collect and analyze data through its EHR, enhanced its performance across several quality measures, and was able to achieve Level 3 PCMH recognition for all of its sites in 12 months. HCP described being able to “fast track” CHSI’s progress in a number of areas. Benefits to joining have positively impacted CHSI’s quality of care as well as its financial stability.

“When we began with this, we would see our HEDIS scores — . . . the different measures colored red, yellow, and green — I just stared at two pages of red [lower than a desired performance level]. In a little over a year and a half . . . we went from mostly red to all yellow and green on every measure! With the improvement in the data, we have improvement in the incentive monies that come in.”

— Lori Holeman, CEO
Community Health Systems, Inc.

Improving Quality Through Culture Change and Data

Changes in staffing for QI were implemented prior to joining HCP, but improving data systems and analytics was an infrastructure challenge that HCP helped CHSI to overcome — ultimately improving care and outcomes.

CHSI viewed HCP as a key facilitator in providing technical assistance to the QI team as they made the changes necessary to become PCMH recognized. CHSI was able to draw on other health centers in the network to help solve problems — through a one-on-one call between medical directors or by having an expert from another health center come and give an in-service training to staff. CHSI staff also regularly participate in HCP peer learning committees. About peer learning, Lori Holeman observed, “Information is shared freely — you can easily find someone who has had a similar problem.” Such interactions with other health centers have helped CHSI to feel less isolated. Prior to joining HCP, CHSI leaders described feeling like it was just “swimming upstream the whole time” and that it was much easier to be a part of “a whole pool of fish.”

Changing its care model and enabling the additional data collection and analysis associated with being part of HCP required CHSI to make significant staff changes. This included expanding its QI group and training all staff to be accountable for data quality.

Participation in IHP and HCP’s technical assistance in EHR optimization (in its role as a health-center-controlled network) gave CHSI access to new data and analytics for QI. An important piece of data that CHSI was newly able to access was the assigned member population that hadn’t previously been a point of focus for staff or providers. Using the new QI team, CHSI is now actively managing these patients, including those who are assigned but have not yet been seen, leading to notable improvements in quality outcomes. Because many of these “assigned but not seen” members are included in HEDIS denominators, reaching out to ensure that they receive preventive screenings and to engage them in primary care is key to improved care. CHSI leaders believe the technical assistance, transparency in committee members, and effective communication around data verification processes have greatly bolstered performance on quality metrics. CHSI described this as one of many ways that its decision to engage with HCP helped the health center to deliver value-based care and improve performance under value-based payment arrangements with payers.

Financial Benefits Rooted in Negotiating Power

As part of larger entity, CHSI sees increased clout with payers, hospitals, and local decision-makers. Negotiating with payers as a group with IHP has led to higher pay-for-performance and incentive payments than CHSI achieved alone. In addition, hospitals in the community have been more willing to talk about emergency department diversion programs and other initiatives.

As a result of having data on all assigned members from IHP, CHSI has also been able to increase revenue by actively engaging all assigned members in primary care. It has done this by inviting patients to a face-to-face visit and making sure that they are using the full range of CHSI's services in addition to primary care.

"We increased the staffing in our QI team. Before we could run on one or two people, a QI nurse and the CMO. Now we have 10 different people looking at data, IT structure, provider care, watching all the measures. We've invested in trainers and train full time at all clinics. With staff turnover and continued systems improvement, there is a need for continued training to ensure that data is as clean and accurate as possible."

— Lori Holeman, CEO
Community Health Systems, Inc.

Improving quality and the IHP-negotiated group contract are enabling CHSI to receive significant and consistent performance payments for the first time. Prior to joining IHP, any performance payments were earned "by accident" because the health center had such limited data to understand their practice model and outcomes. CHSI leadership sees this new consistency in care, and the financial rewards received for high-quality outcomes, as contributing to the health center's financial stability.

Investment in IHP and other services from the family of companies in terms of dues and investment in technology licensing fees is substantial for a health center the size of CHSI. However, leaders estimate that the increased performance payments financially balance these costs. When taking improved patient and staff experience into account, CHSI leadership believes these are worthwhile investments for maximizing revenue under current and future value-based pay arrangements.

Implications for the Field

FOR HEALTH CENTERS:

- ▶ **It is worth being deliberate about the objectives sought in joining a consortium or network.** Consider questions such as the following: What is the main focus (e.g., is it more politically focused or more QI driven)? Who are the other members and are they like-minded? CHSI did this research and found that convincing clinic leadership to make the initial investment in joining the consortium was bolstered by HCP's strong reputation and like-minded leadership.
- ▶ **The transition from the status quo to more data-driven care is a pain point for some health centers.** Cleaning and validating data is a painful but necessary step toward improved care and successful participation in value-based contracting.

FOR CONSORTIA:

- ▶ **Consortia may have an opportunity to build on their experience in providing training, best practices sharing, and technical assistance with QI to explore group contracting opportunities with payers.**
- ▶ **Consortia can fulfill their mission of supporting a thriving safety net by expanding their membership to include motivated small and medium health centers that can benefit from such supports.** CHSI noted several potential ways to facilitate this expansion, including lowering dues and fees to be more affordable for small health centers and expanding geographic membership.

“We do see more patients now. In the past, we had outreach events, but we didn’t have an organized fashion to use the data from the plans to see what patients we are seeing and what patients are not coming in.”

— Lori Holeman, CEO
Community Health Systems, Inc.

Caveats

HCP was careful to note that several factors helped facilitate its success. These include:

- ▶ A history of more than 40 years of partnership among health centers in San Diego County that formed a critical foundation of trust. Member health centers have long-tenured CEOs who already knew each other well.
- ▶ A high-level of pre-existing capacity among health centers and supporting organizations.

The availability of significant internal and external financial resources to fund planning and readiness activities. The founding members of IHP each contributed \$10,000 to cover initial legal and planning costs, and \$200,000 each in loans to cover IHP start-up costs. These loans will be repaid when IHP builds sufficient reserves to meet its reserve policy. In addition to these resources from members, HCP administers over \$6 million of grant funding annually, including a federal HCCN grant from HRSA.

Every member in a collective contracting arrangement — large or small — needs to bring a benefit to the collective and must be ready for a high level of transparency about individual health center results. For health centers without a significant number of patients or those lacking strong baseline outcomes, this benefit may be in the form of a specialized skill, such as care managing a special population, or in demonstrating the ability to rapidly improve outcomes.

Key Takeaways

- ▶ **Consortia, consider expanding your role.** HCP has expanded its role to include a wide range of services and support that help members improve care and succeed under payment arrangements with health plans. These offerings include a clinically integrated network, group purchasing discounts, training and technical assistance, managed care contracting support, and other services.
- ▶ **Recognize the related effects of improving data systems and QI, and of participating in value-based payment.** As a midsized health center, CHSI was able to benefit from this partnership and the multiple services offered by a high-functioning consortium. The partnership as a whole facilitated a chain of events starting with EHR optimization, through QI, and ending with dollars attached to improvements in quality performance.
- ▶ **Take advantage of benefits consortia can offer.** CHSI accelerated its transformation to PCMH by joining the consortium and taking advantage of staff training, data and analytics, new QI infrastructure, and more favorable value-based payment contracting. CHSI went through a change process that it had taken other health centers a decade to achieve.

CASE STUDY 3

Community Health Center Network

A partnership for analytical support and participation in value-based payment through managed care

This case study profiles the Community Health Center Network (CHCN), a health-center-led managed care organization (MCO), through the perspective of two of the smaller health centers in the group (Axis Community Health and Tiburcio Vasquez Health Center).

This partnership model centralizes managed care functions and has proven successful in improving care and accessing additional funding from payers.

Note: CHCN refers to itself as a managed care organization (MCO) to best reflect its core functions, and this term is used throughout this case study. However, other organizations that serve similar functions use the term “health-center-led IPA”; this term is used in this paper to refer to these types of organizations overall, including CHCN, in its typology of partnerships.

Interviewees

| | |
|------------------|--|
| CHCN | Ralph Silber, CEO Laura Miller, CMO |
| Tiburcio Vasquez | David B. Vliet, CEO |
| Axis | Sue Compton, CEO |

Organizational Profile

Axis Community Health was founded in 1972 to provide health care in Eastern Alameda County. It has five sites serving about 14,000 unduplicated patients with a budget of \$18 million. In contrast to other clinics in the network, Axis Community Health is in a suburban/rural location that is somewhat geographically isolated — some patients travel 10 miles to the nearest health center, and many make the trip into Oakland, 25 miles away, for specialty or hospital care.

“There’s always little fear of getting run over, but in general we have a good understanding amongst ourselves of equality in decision making — we just have to be sure to speak up about what it means to be small.”

— Sue Compton, CEO, Axis Community Health

“I would highly recommend this model. The administrative structure is key. . . . It’s important that everybody, regardless of size, has a fairly equal say in whatever the decisions may be.”

— Sue Compton, CEO, Axis Community Health

Tiburcio Vasquez Health Center is described as a “classic-model” health center by CEO David B. Vliet. It was founded in 1971 to serve migrant workers and other marginalized groups in southern Alameda County. Tiburcio Vasquez is a midsized organization with a budget of about \$35 million serving approximately 25,000 unduplicated patients. Patients are largely Spanish-speaking families in Union City, Hayward, and San Leandro. In addition to medical services, Tiburcio Vasquez has a robust promotor program as well as state and county contracts with CalWorks and CalFresh. Tiburcio Vasquez is also one of the larger WIC providers in the area.

The Community Health Center Network was established in 1996 in response to the advent of managed care in Alameda County. CHCN currently has eight member health centers, and takes full professional risk for 141,000 Medi-Cal members. It contracts for primary care services with all eight health centers and contracts and pays claims for specialty care and lab services. If there is a surplus after paying out these claims, CHCN shares it prorated to patient population size and contingent on achieving defined performance outcomes. CHCN also fulfills a host of community leadership, administrative, and analytic tasks for member health centers paid for through a management services organization fee. CHCN evolved from the Alameda Health Consortium, through which these same eight health centers had already been collaborating on advocacy and policy work for many years.

The CHCN governance structure, a board comprised of the CEOs of each of the member health centers, was replicated from the consortium structure. The eight health centers differ in terms of patient demographics and geographic distribution, and they are intent on remaining independent. They nevertheless see the benefit of working together and have overcome barriers to collaboration through a sense of shared mission and a board structure where all members have a voice. The

interviewees emphasized the importance of making sure the perspective and the unique needs of small organizations are heard.

Axis and Tiburcio Vasquez CEOs see CHCN as serving multiple functions including providing financial returns, both in terms of current and future contracts; operating as a mechanism for improving care, including building understanding and capacity to manage utilization outside primary care and managing social complexity; and providing economies of scale in centralized administrative functions.

“Sweet spots — where you just have to know a lot of detail and sometimes very specialized information that you have to keep up with. . . . Increasingly, there’s a lot of complexity on the business end that isn’t very different by clinic and the population/community they serve.”

— Ralph Silber, CEO
Community Health Center Network

Centralizing Managed Care Expertise and Data Analytics Capacity

Centralized managed care expertise, administrative functions, and analytic capacity are integral to the success of value-based payment arrangements. Axis and Tiburcio Vasquez CEOs see CHCN as an efficient way of centralizing managed care contracting expertise (and headaches) and meeting health plan needs. Over the years, CHCN has realized that there are many areas of specialized knowledge involved in taking risk in California’s managed care regulatory environment, and that it makes sense to have one central expert rather than having each health center house this expertise. For CHCN leadership, the network has a clear function of centralizing administrative functions so that health centers can focus on patient care. CHCN provides particular support in data analytics, compliance, and credentialing, but it is always looking for ways to shift functions that can be lifted from member health centers and streamlined.

In terms of exploring future value-based payment, CHCN has been at the forefront of state negotiations to shape health-center-specific APMs. Indeed, health center leaders cited continued reliance on the PPS rate as a barrier to truly transforming clinical practice. CHCN has helped its interested member health centers to evaluate their capacity to participate in the APM, including data-driven exploration of the financial risks and opportunities associated with a shift away from volume-based pay.

Axis and Tiburcio Vasquez CEOs see CHCN’s capacity to analyze data across health centers, as well as the incorporation of data from other parts of the health system, as a key benefit of participation. Health centers receive detailed clinical reports on quality measures in addition to financial reporting. CHCN has also leveraged its centralized data analytic capacity to demonstrate the impact to health plans on metrics they value. For example, health plans are motivated by opportunities to improve HEDIS measures, and CHCN is partnering with their member health centers to help them meet this health plan goal. When HEDIS scores improve, the health centers benefit under pay-for-performance contracts held with the plans. CHCN’s analytic capacity has also been essential in ongoing professional risk-contracting negotiations and in securing supplemental funding for innovative programs such as its intensive outpatient care management program, Care Neighborhood.

Though members are not currently sharing medical protocols, data is shared for risk management and quality purposes. This includes transparently looking at individual health center results on a host of quality process and outcome metrics. Comparison of health centers was described as a positive process that prompts the unveiling of best practices and areas for growth.

Health center leaders saw clear financial benefits rooted in negotiating clout and in the upside of bearing risk. CHCN represents 141,000 lives, and has been able to wield the corresponding clout with both payers and partners. For example, CHCN successfully negotiated with plans for supplemental payment for the social determinants of health-focused Care Neighborhood intervention. In another example, CHCN is a contracted partner under Alameda County’s Whole Person Care Pilot as the county strives to better coordinate behavioral health, social, and health care services for some of the county’s most vulnerable residents.

During 20 years of operating in a capitated risk environment, CHCN has been able to effectively manage the financial risk it has taken for the benefit of its members. For a small health center, participation in CHCN was seen as essential for negotiating contracts and data analytic capacity. CHCN provides the data for health centers to actively manage assigned members, both in terms of making sure all assigned members have had at least one visit at the health center (to establish a relationship between members and their PCMH) and making sure that established patients are receiving timely and appropriate care. In terms of risk sharing, small health centers noted advantages in sharing risk with other larger health centers in the network.

Health center leaders anticipate an increasingly value-based payment and care going forward, and they cite many of the functions of CHCN (data sharing, QI support) as critically important for this future.

“If you’re small and you’re taking risk on your own, and you have a couple of really high need patients, it stings. Risk sharing is always a good thing.”

— Sue Compton, CEO
Axis Community Health

Building Care Management Capacity and Focusing on Social Needs

CHCN supports building care management capacity with a social determinants focus and expanding access to specialty and primary care. It takes an active role in improving care quality and supporting care transformation. CHCN has developed innovative pilot programs such as Care Neighborhood, an intensive outpatient care management effort. Care Neighborhood is a hybrid program with centralized program development and administration through CHCN and implementation through health center-employed community health workers. The program is focused on addressing the social determinants and behavioral health issues that contribute to repeated hospitalizations and episodes of post-acute care — including housing; food insecurity; transportation and mobility issues; access to health care; loneliness and social isolation; and the intersection of trauma, behavioral health, and poverty. CHCN used data to demonstrate the value

of Care Neighborhood in reducing utilization and costs; this has prompted health plan investment, which in turn allows CHCN to continue to do this work.

Health centers, particularly small members like Axis, have benefited from the increased gravitas afforded by the CHCN partnership. Being well known in the community, and having the credibility to collaborate with others, has facilitated the member health centers’ participation in a range of community initiatives, including improving care coordination and transitions of care. For example, CHCN leaders negotiated with a local private hospital to fund health center nurses to manage hospital transitions. Using CHCN data analytics, this program has demonstrated reduced readmissions and emergency department use, which has helped the hospital to sustain the program.

CHCN has also supported innovation in specialty care through building relationships with hospitals and implementing an e-consult platform. Because the expansion of Medi-Cal has taxed existing specialty connections, CHCN is seeking to build trust between its 500 primary care physicians and public hospital specialists by hosting dinners and facilitating specialist shadowing. CHCN partnered closely with the county health system to offer a number of county health system specialists as first responders to e-consults sent out by CHCN primary care providers to a national network. Going forward, CHCN plans to continue to build on its experience with care management with a social determinants focus through a number of initiatives. CHCN leaders see their MCO future as increasingly including HEDIS QI work, improved care transitions, and potential expansion into confronting the opioid epidemic in primary care. CHCN is also exploring taking risk for mild to moderate behavioral health and continues to be at the forefront of coordinated health and behavioral health care through its participation in Alameda’s Whole Person Care pilot (Alameda County Care Connect).

For small and medium health centers interested in taking professional risk and building capacity for care management and coordination, a health-center-led MCO model can help to improve care and gain access to additional funding from payers. In many ways, health-center-led MCOs are taking on the role that Medicaid ACOs are playing in other parts of the country in terms of helping providers transform care, and they benefit financially from those transformations.

Caveats

Plan and managed care structure may preclude the formation of health-center-led MCOs. In some counties, health plans will only contract directly with health centers. In other counties, contracting has evolved in such a way that it would be difficult for health centers to start an entity like CHCN.

The formation of an MCO may require third-party assistance from experts in multiple parts of the arrangement on both the clinical and legal aspects.

Key Takeaways

- ▶ **Be sensitive to issues of equality.** A board structure where each member has an equal vote was seen as a key element in the success of CHCN. Health centers that vary across a number of factors, including size and patient demographics, have been able to work collaboratively under this governance structure.
- ▶ **Use shared commitment and strong leadership to build trust.** A collaboration of this nature relies on trusting relationships and leadership. At times, health centers may need to compromise when there is a benefit to the group that might not be an individual health center's first choice. For this kind of arrangement to be successful and sustainable, members must share a commitment to the overall benefits of collaboration and draw on talented leadership to foster trust and collegiality.
- ▶ **Look for ways to centralize.** There are infrastructure components and administrative functions that can be successfully centralized. As the business side becomes increasingly complex for health centers, having a dedicated and trusted central entity for some functions can help them take advantage of revenue opportunities that require a certain level of infrastructure (e.g., data analytics or managed care contracting expertise).

CASE STUDY 4

Parktree Community Health Center

An acquisition to preserve and expand services

This successful “merger of missions” between a small, independent community clinic and a community health center was technically an acquisition. The case study highlights how thoughtful leadership and dedication to the same mission can lead to the formation of a combined organization that preserves the mission and vision of the original, separate entities.

Interviewees

Parktree Ellen Silver, CEO
Cynthia Prendiz, Chief Engagement Officer
PVHMC Rich Yochum, President/CEO
Chris Aldworth, VP of Planning

Organizational Profile

Parktree Community Health Center (CHC) consists of four Southern California clinics in Pomona and Ontario. It is the combined vision of Kids Come First (KCF), a non-profit, state-licensed independent community clinic led by Cynthia Prendiz, and the Pomona Community Health Center (PCHC) led by Ellen Silver. Though the merger is just over a year old, Parktree CHC has already realized significant advantages.

The original KCF dental program served as the starting place for a new dental expansion grant awarded in 2016; 800 patients have now received oral health services as part of their primary health care. In 2017, Parktree CHC received one of only 75 federal New Access Point expansion grants and has opened a second site in Ontario. These expansions, which resulted in increased access for the Ontario community, were facilitated by the successful transition of PCHC and KCF to a unified Parktree CHC.

A Partnership in the Making

This story began at Pomona Valley Hospital Medical Center (PVHMC) a nonprofit, 437-bed acute care community hospital at the far eastern edge of Los Angeles (LA) County. It served eastern LA and western San Bernardino counties for more than a century. According to the CEO of PVHMC, the hospital has always had a mission to serve the community and has been a longtime provider of care for patients in these two communities who are uninsured or covered by Medi-Cal or Medicare. PVHMC's leadership understood the importance of providing health care to the entire community and recognized that primary care clinics were vital to the PVHMC population health goals.

In the mid-1990s, the hospital found itself treating patients in the emergency department for primary care needs. Recognizing the potential to deliver better primary care in more appropriate settings, they began exploring public and private partnerships. The hospital partnered with a local pediatrician to fund a school-based clinic to provide care for uninsured children where there were few pediatricians willing to see children covered by Medi-Cal. This practice grew to become KCF.

During this timeframe, a PVHMC family medicine resident Dr. Jamie Garcia and PVHMC CEO Rich Yochum implemented their vision to combine LA County funding and PVHMC funding to create an outpatient primary care clinic in Pomona. Under the hospital's guidance, the clinic eventually became the Pomona Community Health Center (PCHC). PCHC incorporated with the assistance of PVHMC capital dollars and LA County funding and became an FQHC in 2013. Originally, PCHC staff were hospital staff, but gradually they transitioned to become PCHC employees. In 2012, PVHMC, along with LA County and LA Care Health Plan, provided capital dollars for expansion to a 13-exam room clinic in a second PCHC Pomona site.

Increased Financial Strain

PVHMC remained an active participant in the solvency of both KCF and PCHC through various community benefit activities and with key leadership from the hospital serving on the governance boards of each clinic. In 2015, KCF was facing increased financial strain and unforeseen key staffing turnover that led their CEO, Cynthia Prendiz, to the decision that KCF needed to consider joining another organization. She connected with Ellen Silver, the CEO of PCHC, and they identified potential ways to partner in the management of operations and recruitment challenges at KCF and PCHC. They found synergy in their leadership vision and values that set the stage for the personal and organizational evolution that came next.

“My biggest role was to make a way for the clinic to survive and thrive. It was important for the community that we were still there.”

— Cynthia Prendiz, Chief Engagement Officer
Parktree Community Health Center

A Merger of Missions

Though legally an acquisition, the message to staff and patients was that the move was a “merger of missions.” To make this real, both organizations’ boards worked with a facilitator to establish the mutual benefit of the arrangement and to align governance. One KCF board member joined the 10-member PCHC board. In addition, an Ontario Advisory Committee, which includes leadership from both KCF and PCHC and reports to the board, was formed to ensure organizational focus on their community. Though required for one year by the acquisition agreement, Parktree CHC leadership has continued this committee to stay in touch with the Ontario community originally served by KCF. A significant part of the strategy was to merge the cultures on an equal footing, and so the combined clinic was renamed and marketed as Parktree Community Health Center.

Throughout the acquisition there was a strong focus on staff and patient engagement and communication throughout the merger process. Most KCF staff received upward adjustments of their salaries and benefits and new access to the PCHC retirement plan. Significant effort was put into training staff in the EHR, work flows, and clinical competencies. Patients were notified of the merger of missions through staff talking points, flyers, and posters. Information stressed the advantages of the acquisition, which included expanded services, locations, and hours. In the transition period, the call center answered the phones with both clinic names to reassure patients that they had reached the correct number.

Leadership was intentional about noting and assimilating the best parts of both organizational cultures. PCHC CEO Silver continued in the role of CEO at Parktree CHC, but she recognized KCF’s long engagement in Ontario and wanted to maintain the “voice and vision” KCF had for that community. The role of chief engagement officer was created for KCF CEO Prendiz, in part to demonstrate continued commitment to staff and the Ontario community and to emphasize the centrality of Prendiz’ leadership. Prendiz is currently in charge of patient outreach and in-reach efforts, managing the call center, and responsible for both patient and staff satisfaction.

KCF brought a passionate culture of “finding the yes” when serving patients regardless of the job description. This commitment to teamwork to meet the patients’ needs is a treasured asset now modeled by all staff at Parktree CHC. To this patient-centered approach, PCHC added competencies in risk management and patient safety as well as finance expertise and financial stability to the culture of KCF.

Kids Come First / Parktree Community Health Center Merger Transformation

| | KCF 2014 | PCHC 2014 | PARKTREE 2016 |
|-----------------------------|-------------|--------------|------------------|
| Patients | 2,910 | 2,511 | 7,610 |
| Visits | 7,433 | 10,271 | 22,535 |
| Clinic Sites | 1 | 2 | 4 |
| Employees | 10 | 14 | 76 |
| Annual Budget (in millions) | >\$1 | \$2.4 | \$7.6 |

Source: Kids Come First.

Caveats

The success of this acquisition that looks like a merger depended on a strong shared vision, an already established relationship, and a willingness to bring leadership from the acquired organization to the table in a continued prominent role. Silver credited Prendiz’s selfless commitment to put the community first as a key facilitator in the successful merger.

Financial solvency was buoyed by the involvement of PVHMC both before and after the acquisition.

It is common that small and medium community clinics serve a defined segment of their community. There is often strong staff, leadership, and governance commitment to the founding mission to serve this key group of patients. Losing connection to this mission and control over the business are significant barriers for clinics considering partnerships, mergers, and acquisitions to grow their organization and patient panel.

Key Takeaways

- ▶ **Find the “wins” for the organizations and the community.** This merger was a win-win-win for the three partners. PVHMC, with continuing capital and in-kind support, has realized increased stability in its primary care safety-net partners, bringing better access and more comprehensive services for the community. KCF, with improved financial and operational stability, is able to spread its patient-centered passion to adult family members of the pediatric population it has always served. PCHC has increased access to care for children, more sites, dental services for patients, and highly committed patient-centered staff.
- ▶ **Find synergy in mission.** KCF and PCHC, the two primary care organizations, shared an overall mission of providing excellent care to their community. This allowed both organizations to be flexible in negotiating financial modeling strategies, organizational structure, and workflow tactics.
- ▶ **Leverage existing community partners, especially hospitals and health plans.** The shared history of working alongside a third partner, PVHMC, with its extraordinary community focus, represented a financial and leadership asset for this acquisition. The hospital’s vision to ensure stable access to primary care for the community was crucial in developing the clinics and supporting the culture for the partnership.
- ▶ **Build on a foundation of trust.** KCF had a history of referring adult family members to PCHC and had already developed trust in the alignment of its mission to serve patients and the community. Further, the CEOs developed trust, which enabled them to share and resolve fears and concerns as the process developed.
- ▶ **Lean on your leaders.** The vision, commitment, and continuity of leadership present in these three organizations created the foundation for the successful merger. With its team in place, the organization anticipates forming other new partnerships in the near future.

Appendix A. Expert Advisors and Key Informants

Expert Advisors

Veenu Aulakh, MSPH
Executive Director
Center for Care Innovations

Robert Beaudry, MS
Chief Operating Officer and Executive Vice President
California Primary Care Association

Doreen Bradshaw
Executive Director
Health Alliance of Northern California

Bridget Hogan Cole, MPH
Executive Director
Institute for High Quality Care

Naomi Fuchs, MBA
Chief Executive Officer
Santa Rosa Community Health Centers

Alan Glaseroff, MD
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Laura Gottlieb, MD, MPH
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Megan Haase, FNP
Chief Executive Officer
Mosaic Medical

Bob Harrington, MSW
Principal
La Piana Consulting

Louise McCarthy, MPP
President and Chief Executive Officer
Community Clinic Association of Los Angeles County

Bob Moore, MD, MPH
Chief Medical Officer
Partnership HealthPlan of California

Erica Murray, MPA
President and Chief Executive Officer, California
Association of Public Hospitals and Health Systems

Jennifer Sayles, MD, MPH
Chief Medical Officer
Inland Empire Health Plan

Ellen Silver
Chief Executive Officer
Parktree Community Health Center

Judith Steinberg, MD, MPH
Chief Medical Officer, Bureau of Primary Health Care
Health Resources and Services Administration

Winston Wong, MD, MS
Director, Disparities Improvement and Quality Initiatives
Kaiser Permanente

Ron Yee, MD, MBA, FAAFP
Chief Medical Officer
National Association of Community Health Centers

Key Informants

ALEXANDER VALLEY HEALTHCARE
Deborah Howell, Chief Executive Officer
Leah Sanchez, FNP
Jenine Saunders, Chief Finance Officer

ONE COMMUNITY HEALTH
Bob Styron, Chief Finance Officer
Paolo Troia-Cancio, MD, Chief Medical Officer
Christy Ward, Chief Executive Officer

**COMMUNITY CLINIC ASSOCIATION OF LOS ANGELES
COUNTY**
Louise McCarthy, MPP
President and Chief Executive Officer

COMMUNITY HEALTH CENTER NETWORK
Ralph Silber, MPH, Chief Executive Officer
Laura Miller, MD, Chief Medical Officer

COMMUNITY HEALTH PARTNERS MONTANA
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Hannah Pulaski, MSN, RN, Nursing Director
Amber Traxinger, Human Resources Manager

ESPERANZA HEALTH CENTERS
Daniel Fulwiler, MPH, Chief Executive Officer
Wayne Sottile, Chief Finance Officer
Andrew Jacob Van Wieren, MD, Medical Director
Carmen Vergara, MPH, Director, Quality and
Practice Transformation

HEALTH ALLIANCE OF NORTHERN CALIFORNIA
Doreen Bradshaw, Executive Director

HEALTH CARE LOS ANGELES INDEPENDENT PRACTICE ASSOCIATION

MedPOINT Management

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Sandy Hazel, RN, Vice President, Medical Affairs

Derek Schneider, Chief Financial Officer

Iris Weil, MHA, Executive Director

HEALTH CENTER PARTNERS OF SOUTHERN CALIFORNIA

Nicole Howard, MPH, Executive Vice President and Chief Advancement Officer

Sabra Matovsky, MBA, former Executive Vice President

Henry N. Tuttle, Chief Executive Officer

HEALTHRIGHT 360

Vitka Eisen, MSW, EdD, Chief Executive Officer

Ana Valdés, MD, Chief Executive Officer

HILL COUNTRY HEALTH AND WELLNESS CENTER

Nick Cutler, Chief Finance Officer

Lynn Dorroh, MS, Chief Executive Officer

Susie Foster, FNP, Medical Director

Bridget Schafer, Chief Information Officer and Chief Operations Officer

LA MAESTRA COMMUNITY HEALTH CENTERS

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Michael Pendarvis, Chief Finance Officer

Sal Saldivar, Chief Information Officer

Sonia Tucker, QI Director

LIFELONG MEDICAL CARE

Eric Henley, MD, MPH, Chief Medical Officer

Marty Lynch, PhD, Chief Executive Officer and Executive Director

Kanwar Singh, Chief Finance Officer

LOS ANGELES CHRISTIAN HEALTH CENTERS

Lisa Abdishoo, MD, President and Chief Executive Officer

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PETALUMA HEALTH CENTER

Daymon Doss, Chief Operations Officer

Nurit Licht, MD, Chief Medical Officer

Kathie Powell, MSHA, MA, Chief Executive Officer

Pedro Toledo, JD, Chief Administrative Officer

SAN DIEGO FAMILY CARE

Roberta Feinberg, Chief Executive Officer

Manuel Quintanar, Chief Executive Officer

Liliana Uribe Herrera, Operations Director

Aaron Zaheer, MD, Chief Medical Officer

SAN FRANCISCO COMMUNITY CLINIC CONSORTIUM

John Gressman, former Chief Executive Officer

David Ofman, MD, Chief Medical Officer

SHARE OUR SELVES

Eric Huang, MD, Chief Medical Officer

Karen L. McGlenn, Chief Executive Officer

Sergey Sergejev, MPA, Chief Finance Officer

Philip Velasco, MBA, Chief Information Officer

SONOMA VALLEY COMMUNITY HEALTH CENTER

Carol Ahern, MD, Medical Director

Cheryl Johnson, Chief Executive Officer

Susan Torres, Controller

Julie Vlasis, CQI/Compliance Consultant

ST. JOHN'S WELL CHILD & FAMILY CENTER

Helen DuPlessis, MD, MPH, former Chief Medical Officer

Jim Mangia, Chief Executive Officer

Elizabeth Meisler, Chief Finance Officer

WESTSIDE FAMILY HEALTH CENTER

Debra A. Farmer, President and Chief Executive Officer

Marie McKinney, Chief Operations Officer

Rebecca Rodriguez, MD, Medical Director

YAKIMA VALLEY FARM WORKER'S CLINIC

Glen Davis, MHA, Chief Operations Officer

Kevin Heidrick, PA-C, Chief Medical Officer

Carlos Olivares, Chief Executive Officer

Endnotes

1. "Health Center Program: Impact and Growth," Health Resources and Services Administration, 2017, bphc.hrsa.gov.
2. B. F. Miller et al., "Payment Reform in the Patient-Centered Medical Home: Enabling and Sustaining Integrated Behavioral Health Care," *American Psychology* 72, no. 1 (2017): 55-68, doi:10.1037/a0040448.
3. B. D. Sommers et al., "Changes in Self-Reported Insurance Coverage, Access to Care, and Health Under the Affordable Care Act," *JAMA* 314, no. 4 (July 28, 2015): 366-74, doi:10.1001/jama.2015.8421.
4. Haleigh Mager-Mardeusz, Cosima Lenz, and Gerald F. Kominski, A "Cap" on Medicaid: How Block Grants, Per Capita Caps, and Capped Allotments Might Fundamentally Change the Safety Net, UCLA Center for Health Policy Research, April 26, 2017, healthpolicy.ucla.edu.
5. Leiyu Shi, "The Impact of Primary Care: A Focused Review," *Scientifica* 2012: 432892, doi:10.6064/2012/432892.
6. Dana B. Mukamel et al., "Comparing the Cost of Caring for Medicare Beneficiaries in Federally Funded Health Centers to Other Care Settings," *Health Services Research* 51, no. 2 (April 2016): 625-44, doi:10.1111/1475-6773.12339.
7. Sarah Lally and Jill Yegian, *California's Medi-Cal Managed Care Pay for Performance Landscape*, Integrated Healthcare Association, July 2015, www.ihc.org (PDF).
8. More information about California's Health Homes Program is available at: www.dhcs.ca.gov (PDF).
9. Nonaudited financial data obtained from the Health Resources and Services Administration's Bureau of Health Professions, the Office of State Health and Planning Department, and/or other sources, 2015 and 2016. Publication forthcoming.
10. Thomas Bodenheimer and Christine Sinsky, "From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider," *Annals of Family Medicine* 12, no. 6 (November/December 2014): 573-76, doi:10.1370/afm.1713.
11. Based on non-audited financial data obtained from the Health Resources and Services Administration's Bureau of Health Professions, the Office of State Health and Planning Department, and/or other sources, 2015 and 2016.
12. *Hallmarks of High Performance: Exploring the Relationship Between Clinical, Financial, and Operational Excellence at America's Health Centers*, Health Resources and Services Administration, January 2016, caplink.org.
13. *California Community Clinics: A Financial & Operational Performance Profile, 2008-2011*, Blue Shield of California Foundation, 2013, caplink.org.
14. Thomas Bodenheimer et al., "The 10 Building Blocks of High-Performing Primary Care," *Annals of Family Medicine* 12, no. 2 (March/April 2014): 166-71, doi:10.1370/afm.1616.
15. Melora Simon et al., "Exploring Attributes of High-Value Primary Care," *Annals of Family Medicine* 15, no. 6 (November/December 2017): 529-34, doi:10.1370/afm.2153.
16. Jonathan R. Sugarman et al., "The Safety Net Medical Home Initiative: Transforming Care for Vulnerable Populations," *Med Care* 52, no. 11 Suppl. 4 (November 2014): S1-S10, doi:10.1097/mlr.0000000000000207.
17. Shi, "Impact of Primary Care," 2012.
18. Barbara Starfield, Leiyu Shi, and James Macinko, "Contribution of Primary Care to Health Systems and Health," *Milbank Quarterly* 83, no. 3 (2005): 457-502, doi:10.1111/j.1468-0009.2005.00409.x.
19. Barbara Starfield, *Primary Care: Concept, Evaluation, and Policy* (New York: Oxford University Press, 1992).
20. Edward W. Gregg et al., "Changes in Diabetes-Related Complications in the United States, 1990-2010," *New England Journal of Medicine* 370, no. 16 (2014): 1514-23, doi:10.1056/NEJMoa1310799.
21. Katie Coleman et al., "Evidence on the Chronic Care Model in the New Millennium," *Health Affairs* 28, no. 1 (January/February 2009): 75-85, doi:10.1377/hlthaff.28.1.75.
22. George L. Jackson et al., "The Patient-Centered Medical Home: A Systematic Review," *Annals of Internal Medicine* 158, no. 3 (February 5, 2013): 169-78, doi:10.7326/0003-4819-158-3-201302050-00579.
23. Susan Dorr Goold and Mack Lipkin Jr., "The Doctor-Patient Relationship: Challenges, Opportunities, and Strategies," *Journal of General Internal Medicine* 14, Suppl. 1 (January 1999): S26-S33, doi:10.1046/j.1525-1497.1999.00267.x.
24. Kimberly S. Yarnall et al., "Family Physicians as Team Leaders: 'Time' to Share the Care," *Preventing Chronic Disease* 6, no. 2 (April 2009): A59, PMC2687865.
25. Coleman et al., "Evidence on Chronic Care Model," 75-85.
26. Edward H. Wagner et al., "The Changes Involved in Patient-Centered Medical Home Transformation," *Primary Care* 39, no. 2 (June 2012): 241-59, doi:10.1016/j.pop.2012.03.002.
27. Kevin Grumbach and J. Nwando Olayiwola, "Patient Empanelment: The Importance of Understanding Who Is at Home in the Medical Home," *Journal of the American Board of Family Medicine* 28, no. 2 (2015): 170-2, doi:10.3122/jabfm.2015.02.150011.
28. Paul A. Nutting et al., "Transforming Physician Practices to Patient-Centered Medical Homes: Lessons from the National Demonstration Project," *Health Affairs* 30, no. 3 (March 2011): 439-45, doi:10.1377/hlthaff.2010.0159.
29. Robert J. Reid et al., "The Group Health Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction, and Less Burnout for Providers," *Health Affairs* 29, no. 5 (2010): 835-43, doi:10.1377/hlthaff.2010.0158.
30. Anna D. Sinaiko et al., "Synthesis of Research on Patient-Centered Medical Homes Brings Systematic Differences into Relief," *Health Affairs* 36, no. 3 (March 2017): 500-8, doi:10.1377/hlthaff.2016.1235.

31. Patricia Bromley and Walter W. Powell, "From Smoke and Mirrors to Walking the Talk: Decoupling in the Contemporary World," *Academy of Management Annals* 6, no. 1 (June 2012): 483-530, doi:10.1080/19416520.2012.684462.
32. Jay Bhatia, Rachel Tobey, and Michael Hochman, "Value-Based Payment Models for Community Health Centers: Time to (Cautiously) Take the Plunge?," *JAMA* 317, no. 22 (June 13, 2017): 2275-76, doi:10.1001/jama.2017.5174.
33. *AHRQ New Models of Primary Care Workforce and Financing*, Agency for Healthcare Research and Quality, 2016, www.ahrq.gov.
34. *Using Data to Manage Population Health Under Risk-Based Contracts*, Health Information Technology, Evaluation, and Quality Center, July 2017, hiteqcenter.org.
35. *Health Centers and Payment Reform: A Primer*, National Association of Community Health Centers, 2013, www.nachc.org (PDF).
36. *Comprehensive Primary Care Plus (CPC+): Practice Frequently Asked Questions*, Centers for Medicare & Medicaid Services, August 1, 2016, innovation.cms.gov (PDF).
37. *Accelerating and Aligning Population-Based Payment Models: Patient Attribution*, The MITRE Corporation, 2016, www.mitre.org (PDF).
38. *Response to the Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models*, American Academy of Family Physicians, November 9, 2015, www.aafp.org (PDF).
39. *Health Centers and Payment Reform*, 2013.
40. Lally and Yegian, *California's Medi-Cal*, 2015.
41. Personal communication between Sarah Lally (project manager, Integrated Healthcare Association) and Rachel Tobey (director, John Snow Inc.), August 2017.
42. *Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016*, National Archives and Records Administration, July 15, 2015, www.federalregister.gov.
43. Bodenheimer et al., "10 Building Blocks," 166-71.
44. "Health Policy Brief: Patient Engagement," *Health Affairs*, February 14, 2013, doi:10.1377/hpb20130214.898775.
45. Nadereh Pourat et al., "In California, Primary Care Continuity Was Associated with Reduced Emergency Department Use and Fewer Hospitalizations," *Health Affairs* 34, no. 7 (July 2015): 1113-20, doi:10.1377/hlthaff.2014.1165.
46. Bodenheimer et al., "10 Building Blocks," 166-71.
47. Wagner et al., "Changes Involved in Patient-Centered," 241-59.
48. Katie Coleman et al., *Redefining Primary Care for the 21st Century*, Agency for Healthcare Research and Quality, October 2016, www.ahrq.gov (PDF).
49. Gloria D. Coronado et al., "Using an Automated Data-Driven, EHR-Embedded Program for Mailing FIT Kits: Lessons from the STOP CRC Pilot Study," *Journal of General Practice* 2 (2014), doi:10.4172/2329-9126.1000141.
50. Jessica S. Ancker et al., "Associations Between Healthcare Quality and Use of Electronic Health Record Functions in Ambulatory Care," *Journal of the American Medical Informatics Association* 22, no. 4 (July 2015): 864-71, doi:10.1093/jamia/ocv030.
51. Jason C. Goldwater et al., "Open Source Electronic Health Records and Chronic Disease Management," *Journal of the American Medical Informatics Association* 21, no. e1 (February 2014): e50-e54, doi:10.1136/amiajnl-2013-001672.
52. Christina Miller and Mary Takach, *A Medical Home Framework for Increasing Cervical Cancer Screening Rates: Best Practices for FQHCs*, National Academy for State Health Policy, August 2013, nashp.org (PDF).
53. Mark Earnest and Barbara Brandt, "Aligning Practice Redesign and Interprofessional Education to Advance Triple Aim Outcomes," *Journal of Interprofessional Care* 28, no. 6 (November 2014): 497-500, doi:10.3109/13561820.2014.933650.
54. Erica A. Smith et al., "Using Health Information Technology and Data to Improve Chronic Disease Outcomes in Federally Qualified Health Centers in Maryland," *Preventing Chronic Disease* 13 (December 29, 2016): E178, doi:10.5888/pcd13.160445.
55. *Accelerating and Aligning Population-Based Payment Models*, 2016.
56. *Hallmarks of High Performance*, 2016.
57. "The Collaborative Map: Making Sense of Nonprofit Partnerships," La Piana Consulting, December 7, 2015, lapiana.org/blog.
58. James Maxwell, Rachel Tobey, and Christine Barron, "Community Health Center Strategies for Pursuing Accountable Care," *Health Affairs Blog*, 2015, doi:10.1377/hblog20150902.050307.
59. Laura M. Gottlieb et al., "Effects of Social Needs Screening and In-Person Service Navigation on Child Health: A Randomized Clinical Trial," *JAMA Pediatrics* 170, no. 11 (November 7, 2016): e162521, doi:10.1001/jamapediatrics.2016.2521.
60. Laurie Felland, *Stepping Up to the Plate: Federally Qualified Health Centers Address Growing Demand for Care*, California Health Care Foundation, 2016, www.chcf.org.
61. Felland, *Stepping Up to the Plate*, 2016.
62. Rachel Tobey et al., *Health Centers in the Era of Accountable Care*, John Snow Inc., July 2015, www.jsi.com.
63. *Accelerating and Aligning Population-Based Payment Models*, 2016.
64. Lally and Yegian, *California's Medi-Cal*, 2015.
65. "The Collaborative Map," 2015.