The Future of California's Community Clinics and Health Centers

Planning for Change

VIEWPOINT LEARNING

2013

Support for this project was provided by:

blue of california foundation

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ON JANUARY 29 2013, AN INVITED GROUP including community clinic directors and staff, health care advocates, business leaders, government officials and staffers, faith leaders, policy experts, community leaders and other leaders with an interest in health care in San Diego, Riverside and Imperial counties attended a dialogue to discuss the future of the region's Clinics and Community Health Centers under the Patient Protection and Affordable Care Act (ACA). The meeting was sponsored by the Blue Shield of California Foundation and conducted by Viewpoint Learning. Part of a series of dialogues dating back to 2011, its goal was to understand clinics' current and future role in the health of the community and to identify specific challenges and opportunities facing San Diego's community clinics under health care reform.[1]

In the January dialogue, the 29 participants—many of whom had attended the 2011 session—considered the results and recommendations of the earlier report in light of the current health care landscape, now that the ACA is the law of the land. In particular they explored:

- ***What steps regional Clinics and Community Health Centers have taken thus far;***
- ***What uncertainties still remain;***
- ***Where there is a need for action and collaboration to address the approaching transition.***

Participants began by identifying changes brought about by ACA that they found especially exciting. At the same time, they noted that many of these exciting developments also presented challenges for clinics.

COVERAGE EXPANSION

Exciting developments

- Extension of coverage to young adults.
- Guaranteed coverage regardless of health status or pre-existing conditions.
- Increased access for low-wage workers and immigrants.
- Inclusion of reproductive health.
- Greater coverage of preventive care.
- Increased attention to chronic illness.

Continuing challenges

- Clinics will face an influx of new patients: is the provider workforce sufficient, and can clinics maintain quality of care with an increased number of patients (many of whom have chronic illness and/or deferred health care needs)?
- There are still many obstacles to people getting enrolled in coverage and finding a provider.
- "Panic" among employers, who worry what ACA will mean to their bottom line.
- Can clinics maintain the cultural proficiency needed to meet the social, cultural and linguistic needs of their increasingly diverse and complex population?
- Many people—especially the undocumented—are left out of the ACA expansion altogether: how will their needs be met, and how can clinics help address this ongoing social justice concern?

IMPROVED INTEGRATION OF SERVICES LEADING TO BETTER PATIENT CARE

Exciting developments

» Integrating services offers many opportunities for innovation, especially around patient-centered medical homes (PCMH), accountable care organizations (ACO) and efforts to reduce medical errors.

Continuing challenges

» Do clinics have strong enough networks to implement this integration of services effectively?

» Low reimbursement rates make it difficult for clinic patients to get access to specialists.

» The need for increased coordination comes at the same time that clinics are seeing more chronic illness, more dual eligibility.

INCREASED ACCOUNTABILITY

Exciting developments

» The introduction of well-defined quality and accountability metrics.

» Using quality measures as a factor in reimbursement can provide a helpful push towards better care.

Continuing challenges

» Will reimbursements keep up with the increased costs of meeting these standards?

USING DATA AND INFORMATION TO IMPROVE PATIENT OUTCOMES AND FACILITATE RESEARCH

Exciting developments

» Greater integration of electronic health records and other data into primary care.

» Greater efficiency in the exchange of information.

Continuing challenges

» Do clinics have the capacity and analytic tools needed to deal with the volume of data coming in?

OPPORTUNITIES FOR COLLABORATION

Exciting developments

» Expanded partnerships between clinics and County and Mental Health Systems.

» Clinics coming together to be a stronger force in making policy and advocating for improved care.

Continuing challenges

» Pace of change is very fast; can clinics keep up?

» Building collaborative relationships takes time and bandwidth; will clinics be able to take advantage of this opportunity while meeting the increased patient load?

COMMUNITY ENGAGEMENT

Exciting developments

» Emphasis on and support for new communications strategies.

Continuing challenges

» Do we have the cultural competency needed to effectively engage our communities?

» Will the story of community clinics be told well enough to bring people in?

INCREASED CERTAINTY

Exciting developments

» Increased certainty brought about by the Supreme Court's ruling upholding ACA was a major advance: after many months of uncertainty, clinics at last felt free to move forward decisively.

Continuing challenges

» Months spent in a holding pattern waiting for the ruling have compressed a tight calendar even more—the pace of change (always an issue) is now even faster.

Participants next saw and discussed two brief presentations. The first, presented by Viewpoint Learning, outlined the conclusions of the earlier round of dialogues sponsored by the Blue Shield of California Foundation. The second, presented by the CCC, discussed the steps that have been taken in the San Diego region since those earlier dialogues.[2]

Using those presentations as a springboard, participants put together a list of elements that are not in place now but would help clinics move forward in this new environment. As they brainstormed, their ideas grouped around several key areas:

- ***Network/workforce adequacy/payments:***
  - ***Plan for increased demand.*** Participants saw a clear need to plan for increased demand on all front-line staff at clinics, including nurses, nurse-practitioners, mental health practitioners, non MD providers and others. This would need to include not only managing an increased workload but also directly addressing increased stress and the risk of burnout.
  - ***Improve access to specialists.*** Participants also noted the challenge of ensuring adequate access to specialists—already a challenge, and only likely to become more serious with an influx of new patients with long-term unmet health needs.
  - ***Payment reform.*** This led to a discussion of the need for payment reform and payment parity, especially where specialists are involved. Specialists are often reluctant to work with clinics because of low compensation rates, which forces low-income patients to wait for months to see a specialist or else seek out emergency room care. Several participants also noted that there needs to be provision in the payments system to account for the cost of caring for the undocumented.

One thing I think is critical is network adequacy and payment parity. With our low-income health program, we are having difficulty getting our patients access to specialists. Specialists are not interested in getting low pay for services when they can get higher pay. And if the patients don't have access to specialty care, they're going to show up in the ER, and that will be more expensive for us as a system. If we're looking at it from the advocacy level, that's almost as critical as immigration reform because we've got people who are really, really sick who have to wait six months, seven months to get access to specialists.

- ***Covering the undocumented:***
  - ***Need for an open discussion.*** Participants strongly emphasized the need for an open discussion about covering the undocumented. This requires not only thinking about how the payments system might reflect the cost of caring for undocumented residents (as mentioned above), it also requires an explicit effort to understand the very different values and concerns at stake around who "deserves" care and how that care should be paid for.

Everybody comes at these issues from … a different philosophical and political framework. Some people are going to say, "Why extend benefits to the undocumented? They broke a law, they're here illegally. They forfeited any moral claim to service." Then the other camp is going to say, "They're here. There's a million in our region. They provide the work that no one else would do. They're not paid for it. They have families. They're good neighbors. As a society, we should provide care." We're going to go back and forth. If we don't understand the differences up front then we're not going to get anywhere.

- ***Managed/Integrated care:***
  - ***Better ways of integrating care.*** Participants noted that long-term support services are now being shifted into a managed care model. This requires much more attention to finding ways of integrating care, especially for people who are at high risk of being institutionalized. Better ways of stabilizing these patients' care would not only improve their outcomes but also reduce costs overall.
  - ***A CCTP for clinics?*** Some participants suggested establishing a Community Care Transitions Program (CCTP) for clinics, like that used by hospitals and other organizations to help provide patients with continuity of care and support as they transition from one care setting to another.
  - ***From "medical" home to "health" home.*** More broadly, participants also suggested following CMS's lead in shifting away from a patient-centered "medical" home to a patient-centered "health" home that also incorporates needed social and behavioral supports—an especially valuable approach for patients with complex needs.

- ***Innovation/best practices:***
  - ***Better use of shared expertise.*** Like all other health organizations, community clinics have inefficiencies. Rather than struggling with them individually as they have in the past, participants suggested making better use of shared expertise and best practices. They noted that foundations have done good work helping clinics connect to technological expertise and existing best practices and they hoped this work would expand and continue. They suggested a more concerted effort to help health centers collaborate on problem solving and best practice, and suggested that organizations like the Council of Community Clinics and the California Primary Care Association could play a leading role.
  - ***"Live Well, San Diego!"*** Participants also noted the Health and Human Services campaign "Live Well, San Diego!" as a particularly strong effort currently underway in the region. This program, aimed at promoting wellness and health behavior, is being promoted at the city level (Oceanside recently joined). Several participants

suggested working with Live Well and leveraging its resources into a more regional effort that brings together cities, health centers, hospitals, Independent Practice Associations (IPAs), health plans, schools, and more.

- ***Collaboration among providers:***
  - ***Increase collaboration.*** Across the board, participants saw a need to increase collaboration among hospitals, clinics, health systems and social services to make sure all available resources are being identified and used efficiently. An important first step would be to engage the community of providers—including doctors, dentists, mental health professionals and others—to bridge silos and clarify common goals as they plan for and design a new model of care.
  - ***Make best use of data.*** In particular, participants saw a role for shared learning through collecting and effectively understanding data to help improve outcomes. Whatever data system is put in place, they noted, must be robust enough to deal with the highly mobile population that clinics serve, including people who are homeless, as well as those who are moving between counties and/or across national borders.

In working with the San Diego Community Clinics for a long time, it's clear that there are strengths and skill sets here that don't necessarily [exist in] other community clinics and other networks across the state. I think sometimes the San Diego Community Clinics get painted with a brush of … less robust networks. I know within our health plan structure we run across people who have preconceived notions about community clinics that are based on other places. The unevenness in community clinic development across the state hurts you guys. It's another really big job but it does affect how you guys are perceived.

- ***Engaging the community:***
  - ***Tackle the perception problem.*** Participants also noted that community clinics continue to have something of a perception problem—and several found it very frustrating that while the region's clinics actually perform quite well compared to others statewide, all are painted with the same brush. They felt it was important to improve the public's perception of community clinics through good word of mouth, and they hoped to engage the community in dialogue to support clinics and improve patient experience/community health.
  - ***Build bridges with employers.*** They suggested that clinics develop stronger relationships with the employers in their area. The launch of the health insurance exchange (Covered California) in 2014 will give more working Californians access to coverage, and clinics stand to benefit if employers see them as a good value and encourage employees to consider clinics and associated plans.
  - ***Up our game.*** Participants also noted that it's not enough for clinics to talk about themselves more effectively, they also need to consistently improve their performance. If patients are choosing to visit the

emergency room rather than a community clinic it is important to understand why and address the barriers and concerns that lead people to make that choice.

As participants discussed these themes (both in pairs and as a large group), they coalesced around four broad areas that they felt would be both feasible and effective in helping clinics thrive in the coming months and years:

1. ***Using immigration reform debate to expand boundaries of health care reform***
2. ***Shared learning/collaboration among clinics and providers***
3. ***Expanding community health promotion efforts like Live Well San Diego.***
4. ***Community engagement/branding***

Participants each selected one of these four areas and worked as a group to draft an action plan. Four action plans emerged from these working groups:

1. Link Health Care Reform and Immigration Reform

OBJECTIVE: Use the vehicle of the immigration reform debate to put those who were left out of the ACA back in. Make sure that the advantages of health reform can be extended to people who will be newly regularized (or on a path to citizenship) by the immigration bill expected to hit Congress this March. Because this legislation is currently making its way through Congress, time is of the essence. This group came up with a fast-paced timeline:

- ***ASAP: Develop list of immigration/health related questions that need to be addressed***
  - Pay special attention to terminology: "Employment-authorized" includes Dream Act, Deferred Action, otherwise eligible.
  - Find data: immigrants healthier than non-immigrants
- ***ASAP: Identify which Senator will carry this through the Senate***
  - Talk with Senator Feinstein and Senator Boxer's offices.

One of the most important things that the Council does for and with our clinic members is policy and advocacy. The political will appears to be there now at the federal level to make something happen in regards to immigration reform. And if we're going to get our concepts and policy ideas in there, we've got to be active.

- ***Within a week: Develop Immigration Reform Coalition***
  - Identify (with Rabbi Coskey) members of coalition, including but not limited to:
    - Interfaith Committee for Worker Justice (ICWJ);
    - Service Employees International Union (SEIU);
    - National Council of La Raza (NCLR);
    - San Diego Immigrants'Rights Consortium (SDIRC);
    - Hospitals.
- ***Within 2 weeks: Schedule Consortia Policy Group discussion***
  - Get project onto agenda for next meeting.
  - Arrange for regular updates to Clinic CEOs.
- ***Within the month: Denise Ducheny meets with Bob Ross (CEO of The California Endowment)***

Link Health Care Reform and Immigration Reform

WHAT'S HAPPENED SINCE:

The immigration reform group has taken many of the concrete steps listed above, including:

» Contacting State Senator Ducheny, Senators Boxer and Feinstein and identifying key players in the state and national legislatures.

» Discussing the need for healthcare coverage within the Immigration Reform legislation with members of congress and staff of all delegations as part of the Policies and Issues Forum (National Association of Community Health Centers).

» Initiating conversations with the San Diego chapters of Interfaith Coalition for Worker Justice (ICWJ) and the American Friends Service Committee to identify and network with local groups advocating for immigration reform.

» Discussing need for advocacy with leaders and policy staff at the California Primary Care Association (CPCA). Conversations focused on the possibility of forming a regional advocacy group of state Primary Care Associations outside of the National Association of Community Health Centers (NACHC) process, as NACHC has decided to remain neutral on this issue.

» Placing this issue on the agenda to be discussed with the statewide Consortia Policy Group (representative of each clinic consortia).

» Gathering statistical information regarding the health of non citizen immigrants in California with the help of Dr. Hayes-Bautista, Director of the Center for the Study of Latino Health and Culture at UCLA.

» Contacting Nathan Fletcher about San Diegans United for Commonsense Immigration Reform.

2. Collaboration

OBJECTIVES:

1. Countywide collaboration between healthcare and social service providers to identify common issues, goals, solutions, and opportunities;
2. Eliminate inefficiencies and maximize effectiveness and revenue.

OBSTACLE: Providers do not collaborate well

How to address:

- Identify common issues/goals/priorities that all share.
- Create incentives for provider participation (something individual organizations cannot get/accomplish by themselves); possibilities include financial incentives, or even penalizing those who do not participate.

OBSTACLE: Bandwidth/Time/Deadlines/Resources. Providers are often isolated in their silos, focusing on meeting the enormous challenges they face in providing care on a day-to-day basis. They do not feel they have the resources (time, money, staff) to do more than meet the immediate needs of the day.

How to address:

- Identify commonalities that providers share.
- Communicate the need to join together to solve issues, and the benefits of doing so.

OBSTACLE: Communications

- Often different provider groups have difficulty coomunicating, have different priorities.
- Sometimes there is communication and commitment at top levels, but it doesn't translate well to action at lower levels of the organizations.
- Clinics are undervalued by others but also sometimes by themselves—they are unwilling to promote themselves.

Different provider groups talking to each other are really speaking different languages and have different imperatives. They may be talking at different levels—there may be a commitment at the CEO level but translating that to action at another level can be difficult.

How to address:

- Identify convener to get people together: should be independent.
- Identify champions from key sectors who can influence their organizations.
- Make sure that communication is high-low, bringing in both CEO's and other layers of clinic staff, so that actions identified are feasible and are implemented.
- Promote the many successes achieved in recent years (i.e. improvement of chronic conditions).

TIMELINE:

By 8/21/13:	Identify conveners (both financial sponsor and champions). CCC will have a role to play, but champions may come from outside health care as well. (Bob Ross was mentioned as possible champion/funder, as were foundations, the United Way, Red Cross and others)
By 10/31/13:	Identify issues and commonalities Identify success stories, old and new
By 12/31/13:	Set priorities/solutions
By 3/31/14:	Identify value and incentives for each party Set common action steps and responsibilities
Ongoing:	Monitor progress

Collaboration

WHAT'S HAPPENED SINCE:

A large number of collaborative projects that bring together healthcare and social service providers are taking place in San Diego County. These collaborative projects—led by San Diego County's Health and Human Services Agency—offer many community stakeholders new and innovative ways to collaborate and eliminate inefficiencies. The Council and its members will look for opportunities to participate in these collaboratives as appropriate. Below is a listing of some of the key collaborations:

- Beacon Communities
- Bridges to Employment in Healthcare
- Communities Putting Prevention to Work
- Community Nutrition Expansion Project
- Community Transformation Grant
- Low Income Health Plan
- Public Health Infrastructure Grant

3. Expand HHS Campaign (*Live Well, San Diego!*) to a Broader Regional Effort

OBJECTIVE: Expansion of existing *LiveWell* Program to be a county-wide, multi-disciplinary integrated effort. The expanded program should include not only cities (like Oceanside, which has recently joined) but also other communities, as well as hospitals, health plans, health centers, their IPAs, and medical groups.

Participants identified several important obstacles, as well as some ways those obstacles might be addressed:

OBSTACLE: Funding. Getting this effort started will probably require up to $100,000/yr.

How to address:

- In-kind contributions, grants, corporate support.
- In particular, look at corporations that are currently sponsoring health promotion and health education initiatives.

OBSTACLE: Need for champions to get the ball rolling

How to address:

- The county, which has already achieved critical mass in this effort, will take the lead in identifying potential partners.
- Networking and fundraising will help identify and recruit champions, especially from the ranks of community leaders and professional groups.

OBSTACLE: How to implement this idea, get buy-in from leaders and key stakeholders

How to address:

- Highlight return on investment.
- Start with low-hanging fruit (e.g. putting LiveWell materials in clinics, exam rooms, mental & oral health clinics, so that providers can refer to it and offer it to patients).

Not too many people talk about health promotion. They get stuck on the cost of care. Well, you don't need a big grant [to do this]. I have about six promotores already working on diabetes, hypertension, cardio, whatever. If I had [these] materials in every clinic, every exam room, mental health, oral health and provider office, they could just refer to it in their discussions with the patients. I don't need a huge grant for that.

TIMELINE:

Step 1 (March-June 2013): Funding

What: Develop work plan; reproduce educational, promotional materials.

Who: County of San Diego/Health and Human Services takes the lead.

Step 2 (by June 2013): Champions

What: recruit small group of key leaders and organizations to act as champions.

How: Build on process of fundraising from Step 1.

Step 3 (by September 2013): Implementation

Core group of leaders meets to establish goals/metrics/markers of success.

Expand HHS Campaign (Live Well, San Diego!) to a Broader Regional Effort

WHAT'S HAPPENED SINCE:

At a future Council of Community Clinics Board meeting the LiveWell San Diego proposal will be discussed to determine if the Council could be involved as a Champion in expanding the program.

4. Community Engagement/Branding

OBJECTIVES:

1. Rebranding Community Clinics and Health Centers toward community engagement. Keeping the patient at the center
2. Create the best patient care experience to retain and grow the patient population of clinics.

OBSTACLE: Lack of awareness among patients and businesses

How to address:

- Social Media/Outreach/Promotores.
- Employee champion for clinics to engage with Wellness coordinators for employer.
- Create opportunities to engage with businesses (coffee meetings w/chamber reps, business improvement districts).

We grow by reaching out to the employers that are out there in the community. At the county we've spoken about having a wellness coordinator speaking to their colleagues at Target, at Wal-Mart or any of these retail centers, talking to them about the prevention efforts that we have, and putting the plug in for community clinics.

OBSTACLE: Provider burnout

How to address:

- Shifting model from illness to wellness (prevention) can reduce caseloads.
- Ensure providers have tools to deal with staff burnout.
- Customer service trainings (patient-centered).
- Employee of the Month (newsletter).

OBSTACLE: Not enough resources for staff

How to address:

- Group purchasing power (like system used by CCC).
- Investigate other sources.

OBSTACLE: Inconsistent customer experience

How to address:

- Re-emphasize mission to employees.
- Reduce caseload though wellness efforts.
- Publicize victories, emphasize staff appreciation.

Important steps to advance this initiative:

- ***CCC convenes a conversation among community health centers/clinics to talk about branding efforts***
  - Do we want to align the region's branding efforts with statewide and national efforts, or do we want to differentiate them?
  - Requires rethinking historical prohibition on community clinics doing marketing—is this best decision for the current environment?
  - Review national and CPCA marketing efforts—are they working for us now, can we piggyback on them, do we need to make local clinic marketing a higher priority?
  - Vision is of CCC playing a convening/coordinating role
    - Do not re-invent the wheel; could partner with Live Well San Diego to support prevention and wellness activities.
    - Use small group of community connections.
    - Could have a shared staff person (housed at CCC?) who would be focused on community engagement, recruiting promotores, etc.
    - Even if person is housed at CCC, staff time from community clinics will be essential.
    - Clinics need more money and more staff to do this better.

Community Engagement/Branding

WHAT'S HAPPENED SINCE:

» At a recent CCC Board of Directors meeting attended by 16 health center CEOs a discussion took place regarding the branding for local health centers. The board decided that they would wait until the California Primary Care Association's branding pilot program is complete. Some of the local health centers are participating in the statewide branding program.

» Channel 8 KFMB has aired a weekly segment called "What's Going Around," featuring the Council of Community Clinics and local health center Medical Directors sharing what illnesses they are treating. The CCC moniker was improved, providing positive visibility for our health centers.

Closing Remarks

At the close of the session, many participants said they were inspired by the diversity of perspectives in the room, the creativity being shown by clinics today, and the common commitment to helping clinics fulfill their potential and serve their communities in this time of change and transition. Participants saw this dialogue as a valuable opportunity to learn from each other and deepen connections across the community, and they thanked BSCF and the regional consortium for making it possible.

Several noted that time is short—changes are coming soon, and clinics must continue to move forward. Most stressed the need to maintain and build on the momentum created in the dialogue to be able to meet that challenge.

> *I just want to thank you all for spending the evening with us. I know this is a lot of time and we appreciate that time. We have some clinics represented in this room but by and large, this is the San Diego community. And hearing from you about what our role should be and what we could do better is really, really important. So, we look at all of you as partners and we look at all of us working together. We have a lot to do.*

ENDNOTES

1. The results of the 2011 San Diego dialogue and other similar sessions across the state are outlined in the report *California's Community Clinics and Health Centers: Taking initiative in a new health care landscape* (http://tinyurl.com/al2epbg).,
2. Presentations can be viewed at: http://www.ccc-sd.org