blue of california
foundation

community clinic core support initiative: 2011 evaluation findings

LFA Group: Learning for Action
July 2012

Established in 2000 and with offices in San Francisco and Seattle, LFA Group: Learning for Action provides highly customized research, strategy, and evaluation services that enhance the impact and sustainability of social sector organizations across the U.S. and beyond. LFA Group's technical expertise and community-based experience ensure that the insights and information we deliver to nonprofits, foundations, and public agencies can be put directly into action. In the consulting process, we build organizational capacity, not dependence. We engage deeply with organizations as partners, facilitating processes to draw on strengths, while also providing expert guidance. Our high-quality services are accessible to the full spectrum of social sector organizations, from grassroots community-based efforts to large-scale national and international foundations and initiatives. To learn more, visit: www.LFAgroup.com.

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executive summary

Blue Shield of California Foundation (BSCF) engaged LFA Group: Learning for Action in 2007, 2009, and 2011 to conduct assessments of Clinic Core Support Initiative grantees with the goal of tracking trends in the field of community clinics. (The initiative was renamed the Community Health Center Core Support Initiative in 2012.) Community health centers and parent corporations who received funding in 2006, 2008, and 2010 were invited to complete the surveys, and the subsequent data have contributed to a growing body of knowledge for the Foundation and the field about how community health centers in California are changing over time. The Foundation will continue to monitor trends in the field in the future.

Findings from the 2011 assessment of 2010 BSCF Clinic Core Support Initiative grantees provide a profile of community health centers' current capacity to serve uninsured patients and highlights other trends. Key observations from 2011 and of trends over time include:

Community health centers continue to experience moderate growth. Community health centers report they are expanding services, hours of operation, and locations. However, these indicators have not changed significantly between 2007 and 2011. Total patient encounters, unduplicated patients, staff, and operating budgets have grown significantly since 2007, while the percent of uninsured patients seen by community health centers has remained mostly the same. Taken together, this suggests an overall pattern of moderate growth in the field over the past four years. This is consistent with expectations expressed by community health center leaders in 2009, who predicted slow growth due to the economy in the coming years.

There is a widening gap in resource levels among community health centers. Consistent with the growth in other areas, community health centers' annual revenues, expenses, and operating surpluses have increased on average since 2007. However, there is evidence of a widening gap between large and small community health centers – those community health centers with budgets of $2 to $5 million experienced a decrease in their annual operating surplus, while community health centers with annual budgets of $5 million or more experienced an increase in their annual operating surplus. The percentage of community health centers with more than 90 days of cash on hand increased over the past four years, while the percentage of community health centers with 30 days or less of cash on hand has also grown. More community health centers have either healthy reserve funds or almost no reserve funds, with fewer community health centers falling in the middle.

Acceptance and adoption of Health Information Technology has grown. Average community health center expenditures on Health Information Technology (HIT) increased by more than 90 percent since 2007, representing the widespread purchase and adoption of new practice management systems (PMS), electronic health records (EHR), and chronic disease registries (CDR). Eighty-four percent of community health centers now have a PMS, 73 percent have an EHR, and 56 percent of community health centers have a CDR. In addition to having more systems in place, community health centers are gathering more information and using these data more frequently to make decisions about patient care and strategic organizational issues. The Patient Protection and Affordable Care Act (ACA) has placed an increased emphasis on efficiency and patient care outcomes, and community health centers that were reluctant to adopt new systems in prior years have responded by increasing their HIT capacity to meet these new demands.

Community health centers are working on Continuous Quality Improvement (CQI) initiatives and Patient-Centered Medical Home (PCMH) recognition. Nearly all community health centers are engaging in CQI processes, with 86 percent reporting on these processes to their Boards, and 69 percent having a dedicated CQI staff member. However, only 11 percent of community health centers have achieved any level of PCMH recognition. The ACA is catalyzing community health centers to seek PCMH recognition – over 60 percent of community health centers say they are planning for PCMH implementation in the coming year.

Collaboration is vital in the post-ACA environment. Community health centers report an average of 20 partnerships with other community health centers and safety net providers. Most partnerships are informal, with only verbal agreements in place, but an average of 3.5 partnerships are contractual relationships that generate revenue for the community health center. The ACA and a move to PCMH models are encouraging partnerships, as community health centers find that increased collaboration with hospitals and specialty care practices is necessary to meet demand for new services. Partnering with other organizations and strengthening referral networks within the community are expected to be critical in supporting changes in care delivery.

Community health centers are investing less in policy and advocacy activities. The resources that community health centers devote to policy and advocacy – both money and staff time – have declined steadily since 2007. A smaller percentage of community health centers include policy and advocacy work in their mission or engage in such activities outside of their clinic consortia membership.

Preparing for a new healthcare environment is having a significant impact on operations and services. The ACA brings increased accountability for financial and patient care outcomes, which is leading community health centers to invest in new technology to track their ability to meet these new standards. Most community health centers anticipate increased demand for services and increased revenues due to the expected large numbers of newly insured patients. To meet the demand for services, including increased specialty care, community health centers anticipate increased collaboration with hospitals and specialty care practices. Some community health centers believe they will be negatively impacted by the ACA, either because they will not be successful in attracting newly insured populations or because they will not receive enough in reimbursement for patients who are still left uninsured.

introduction

Blue Shield of California Foundation's mission is to improve the lives of Californians, particularly underserved populations, by making health care accessible, effective, and affordable for all Californians, and by ending domestic violence. For the past eight years, the Foundation has provided core support funding to community health centers in California through the Core Support Initiative.

Over the last nine years, the Foundation has contributed more than $58 million in core support funds to more than 200 community health centers, clinic parent corporations, and clinic consortia/networks throughout California. The goal of these grants is to strengthen the network of those providing health care on the front lines to low-income and uninsured Californians.

The Foundation engaged LFA Group: Learning for Action in 2007 to create a multi-year evaluation plan and conduct a baseline assessment of community health center and parent corporation grantees. In 2009 and again in 2011, LFA Group conducted follow-up assessments. The primary goals of this multi-year assessment and evaluation are to:

- Capture trends over time within the field of community health centers in California; and
- Inform the field of philanthropy about the impact that core operating support can have over time.

This summary focuses on the themes and findings from the 2011 evaluation, which includes community health centers that received Core Support grants in 2010. Complete survey results from the 2011 survey can be found in the appendix. Throughout the report, comparisons are made between the data from prior years' evaluations. Please reference the reports completed in 2007 and 2009 for detailed questions about the methods and findings from those years.

evaluation methods

This report includes information collected from a series of three online surveys administered to Core Support grantees in 2007, 2009, and 2011, as well as data collected by the Foundation through grant applications and reports. Across the three survey administrations, 79 community health centers completed two of the three surveys, and 49 completed all three surveys. Additional information about each survey administration includes:

grant year	community health centers or parent corporations that received grant	responded to survey (following year)	percentage of participation
2006	178	126	71%
2008	184	142	77%
2010	180	117	65%

patient characteristics

exhibit 1: 2011 patient gender

gender	average percentage of patients
Female	61% (n=103)
Male	39% (n=103)
Transgender	1% (n=60)

Note: One hundred percent of community health centers ask for information on patient gender.

exhibit 2: 2011 patient age

age	average percentage of patients
Pre/perinatal (nine months before birth to one month after birth)	3% (n=83)
Infants and toddlers (0-5)	9% (n=93)
Children (6-11)	9% (n=92)
Adolescents (12-17)	10% (n=98)
Young adults (18-24)	15% (n=99)
Adults (25-64)	47% (n=100)
Seniors (65+)	9% (n=96)

exhibit 3: 2011 patient race/ethnicity

race/ethnicity	average percentage of patients
White/Caucasian	29% (n=99)
Asian/Pacific Islander	10% (n=96)
Black/African American	9% (n=94)
Latino/a	43% (n=97)
Native American/ American Indian	9% (n=87)
Multi-racial	3% (n=74)
Other race	5% (n=72)

Note: One hundred percent of community health centers ask for information on patient race/ethnicity.

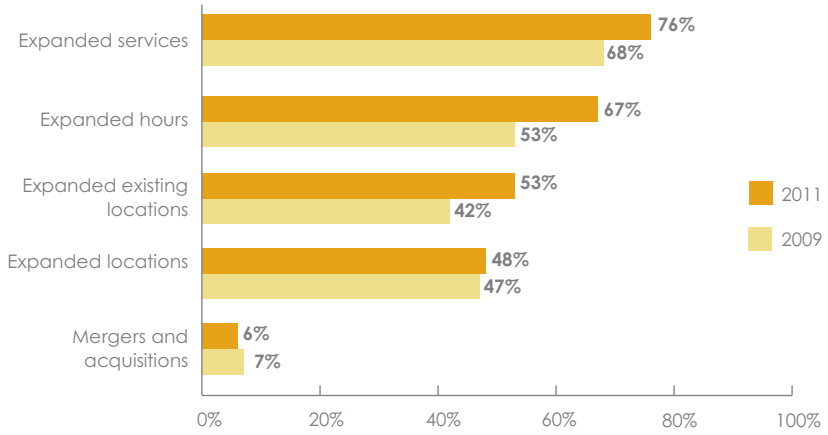
key findings

community health center operations

Hours and Locations

Many community health centers report that they are expanding services, hours of operation, and locations. Smaller percentages of community health centers report being part of mergers and acquisitions. However, the average hours of operation per week and number of community health center locations have not increased substantially since 2007. This indicates that while many are growing, they are not growing dramatically.

exhibit 4: percent of community health centers with expanded hours, locations, and services, and mergers and acquisitions in past two years*



*These survey questions were asked only on the 2009 and 2011 surveys; comparison data are not availble for 2007.

"We expect to have more paying patients [after ACA implementation], especially Medi-Cal, which is our best payer. We will add staff and hours, and are building a new, larger facility in one of our communities to expand access to care."

2011 survey respondent

Patient Services

The average number of total patient encounters per community health center has grown significantly since 2007. The average number of unduplicated patients per community health center declined between 2007 and 2009 but then increased significantly in 2011. The percentage and number of uninsured patients has varied over the same period.

exhibit 5: average number of unduplicated patients served per community health center

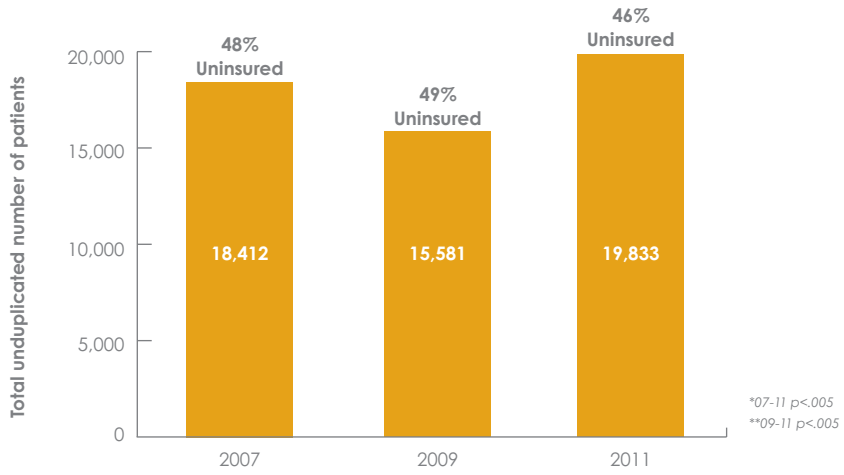
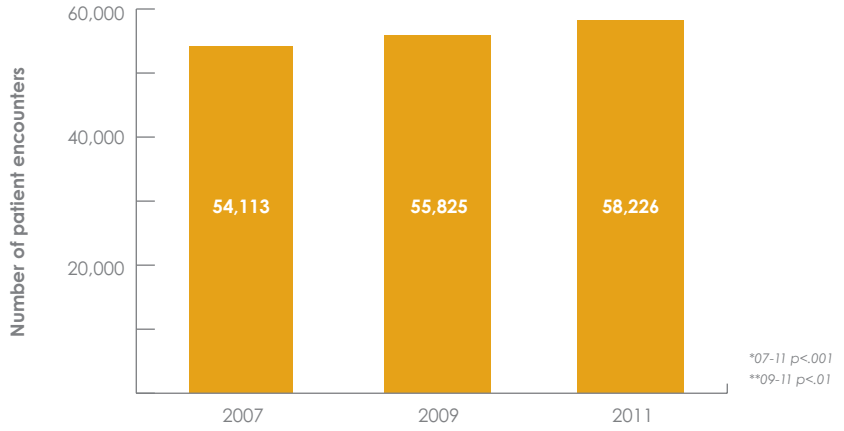


exhibit 6: average number of patient encounters per community health center



Most community health centers continued to offer the same types of services from 2007 to 2011. However, there was a notable decrease in the percentage of those that offer family planning, and an increase in the percentage of those that offer mental health and substance abuse services. See the appendix for a complete list of service offerings between 2007 and 2011.

Wait Time for Patient Appointments

Community health centers report accommodating urgent care visits with little to no wait, while new patient visits may take longer to schedule.

exhibit 7: 2011 wait time by appointment type*

type of appointment	no wait time at all	less than one week	one to two weeks	more than two weeks
Urgent care	81%	18%	0%	1%
Chronic disease management	12%	41%	37%	10%
New patient visit	13%	34%	31%	22%

**This survey question was added in the 2011 survey; comparison data are not available for 2007 and 2009.*

Staffing

Total paid full-time equivalents (FTEs) have increased significantly since 2007, another indicator of growth. In 2007, community health centers had an average of 91 FTEs, which grew to 92 in 2009 and to 121 in 2011. See the separate appendix for FTE changes of all medical and non-medical staff between 2007 and 2011.

There were some notable differences in staff growth by community health center characteristics:

- Federally Qualified Health Centers (FQHCs) experienced greater increases in management team and case manager staff size than non-FQHCs and look-alike community health centers. FQHCs reported an average increase of five management team FTEs and three case manager FTEs between 2007 and 2011. This was significantly higher than the corresponding changes experienced by other community health center types.
- Those with larger budgets experienced greater increases in doctor FTEs than smaller community health centers. Community health centers with budgets of $10 million or more increased their doctor staff by an average of four FTEs between 2009 and 2011, which was a significantly greater increase than community health centers with budgets of less than $10 million.

Anticipated Impact of the ACA on Community Health Center Operations

Changing the landscape of patient services. Community health centers anticipate that the ACA will increase demand for healthcare services because a majority of the formerly uninsured population will have access to health care through expanded Medi-Cal eligibility and the Exchange. Community health centers also anticipate that the ACA will increase patient choice in their healthcare providers, fueling competition for patients among community community health centers and with other types of providers.

Growing and adapting to meet increased patient numbers and needs. Community health centers anticipate the need to increase their number of providers, hours, and locations to accommodate the expanding patient population. Many community health centers discussed plans to become Patient-Centered Medical Homes and to better integrate primary care and behavioral health services to create a seamless system of patient care.

"We expect to see more patients, restructure services to be more patient-centered, establish patient panels, and increase the number of providers, sites, and services."

2011 survey respondent

Patient-Centered Medical Home (PCMH)

According to the National Committee for Quality Assurance, the PCMH is a healthcare setting that facilitates partnerships between individual patients, their personal physicians, and, when appropriate, the patient's family.

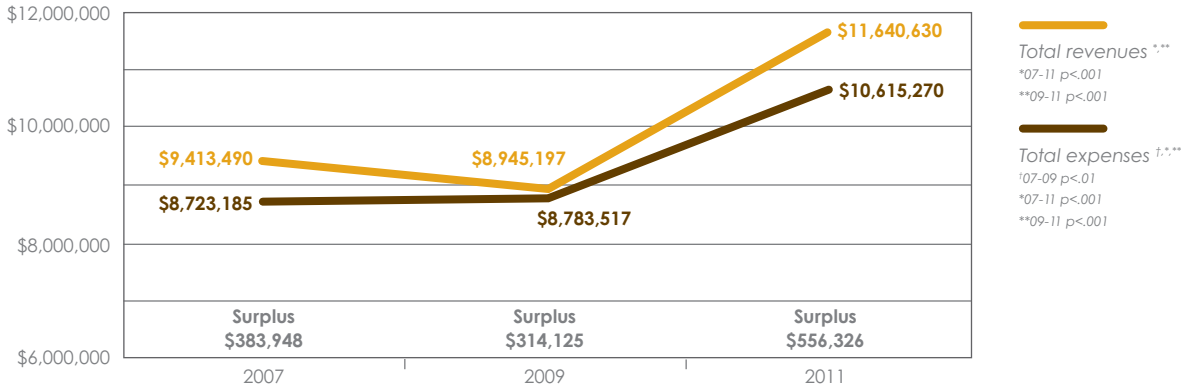
finances

Community health center operating budgets have grown steadily since 2011. The average community health center operating budget grew from $8.7 million in 2007 to $10.6 million in 2011. Over the same period, the average budget surplus[1] grew to over $500,000, a relatively small percentage of an average community health center's annual budget. Community health centers may use surpluses for a variety of purposes, including reinvestment in their facilities or contributions to an endowment or "rainy day" fund. There were significant differences in the average surplus/deficit by community health centers with different budget sizes. For example, between 2009 and 2011, community health centers with annual budgets of $2 to $5 million experienced an average *decrease* in their surplus, while those with annual budgets of $5 million or more experienced an *increase*.[2]

[1] *A community health center's surplus (or deficit) was calculated by subtracting reported annual expenses from revenues.*

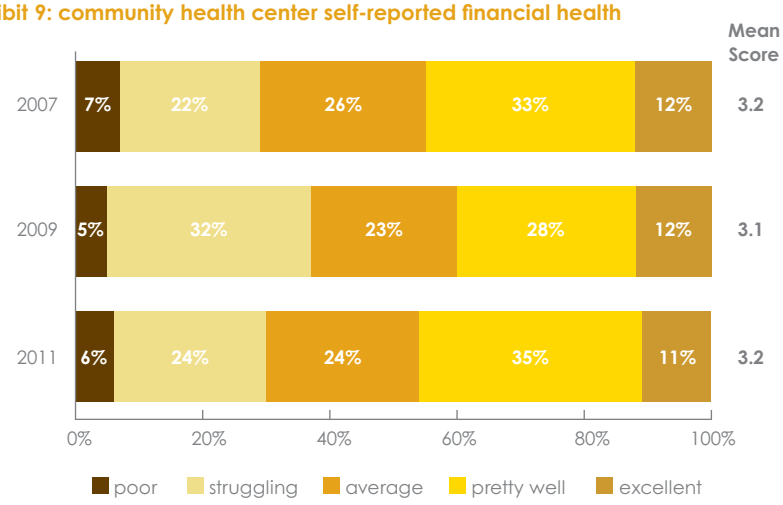
[2] *This information is provided to show trends in community health center financial health, not to draw conclusions about financial management.*

exhibit 8: average community health center annual operating revenues and expenses



While budgets have grown, community health centers report that their financial health has remained about the same since 2007.

exhibit 9: community health center self-reported financial health



Community health centers have experienced significant changes in the percentage of their revenues from different sources since 2007. The percent of revenue from state and local government funding sources (e.g., Family PACT and county health programs) has increased significantly from 14 to 20 percent, while the percent of revenue from Medi-Cal, Medicare, and private insurance combined has decreased significantly from 44 to 36 percent.

Seventy-one percent of community health centers have accessed new revenue streams since 2009, with the most commonly cited new source of funding being other foundation support.

LFA Group also examined where there were significant differences in revenues by FQHC status and found, notably, that non-FQHCs:

- Increased revenue from state and local governments significantly more than FQHCs and look-alikes between 2007 and 2011;
- Decreased revenue from third-party reimbursements (Medi-Cal, Medicare, and private insurance), while FQHC and look-alikes increased their revenue from these sources between 2007 and 2011; and
- Experienced a decrease in revenue from patient fees, while FQHCs and look-alikes saw an increase between 2009 and 2011.

exhibit 10: average composition of operating budget

revenue source	2007	2009	2011
Medi-Cal	44%*	28%	27%
Medicare		5%	4%
Private insurance		5%	4%
Federal government grants	12%	14%	16%
Foundation support	8%	10%	11%
In-kind support	3%	4%	4%
Patient fees/self pay and earned income	11%	8%	9%
State or local government, including EAPC grants, Family PACT **Significant change from 07-09 (p<.01) and 07-11 (p<.05)*	14%	20%	20%
Donations from individuals and events	5%	4%	4%
Other	1%	3%	2%

** In 2007 Medi-Cal, Medicare, and private insurance were combined in a "third-party reimbursement" category.*

Cash on Hand

Almost one in three community health centers had more than 90 days of cash on hand in 2011, an increase from 2009 and 2007. However, the percentage of community health centers with 30 days or less has also increased over the same period, and four percent reported no cash on hand during this period. One interpretation of these findings is that there could be a widening gap between those community health centers that are financially secure and those that are less financially secure. However, it is also possible that some community health centers are investing more in HIT or facilities improvements, leaving less cash on hand during this period.

exhibit 11: days of cash on hand

days of cash on hand *average days of cash on hand significantly changed from 2009 to 2011 (p<.005)*	**2007**	**2009**	**2011**
None	1%	3%	4%
Less than 30	22%	19%	21%
30	23%	17%	26% (31-60 days)*
60	24%	30%	17% (61-90 days)*
90	8%	9%	
More than 90	22%	24%	31%

**Categories were different in 2011 than in 2007 and 2009. For the purposes of this table, 31-60 days = 30 days, and 61-90 days = 60 days.*

Anticipated Impact of the ACA on Community Health Center Finances

Community health centers reported on a wide range of impacts they anticipate the ACA will have on their finances and related systems. These sometimes contradictory opinions indicate that there is little agreement on the ultimate impact.

Increased patient volume and revenues. The majority of community health centers expect they will experience an increase in patient volume and consequent revenues due to the increased number of patients with access to insurance. They anticipate a more diverse payer mix with fewer self-pay patients.

Decreased revenues. Some community health centers believe their finances will be negatively impacted by the ACA, either from losing patients to competing providers or because of scarce reimbursement sources for undocumented populations that have few other options for care.

Increased cost of services. Many community health centers admit trepidation about meeting accountability and transparency standards. They believe higher standards will result in an increase in the cost of their services and are unsure if increased patient volumes and revenues will fill this gap.

Increased administrative burden. Many organizations anticipate increased administrative costs and burden due to a variety of factors: needing more finance staff, more sophisticated HIT systems, more training for existing staff (due to complicated reimbursement methodologies), and increasing insurance costs for their own staff.

Great uncertainty. Many community health centers are still unsure of how the ACA will affect them, either because they have not adequately assessed their environment or are confused by how regulations will affect their particular situation. With the upcoming Supreme Court decision[3] (June 2012) and presidential election creating uncertainty about ACA implementation, the changing landscape will require community health centers to continue to adapt.

"Accurately projecting the financial health of the organization is essential with the expansion under healthcare reform. Changing course needs to be timely and strategic; financial leadership in conjunction with the entire management and clinic leadership is key."

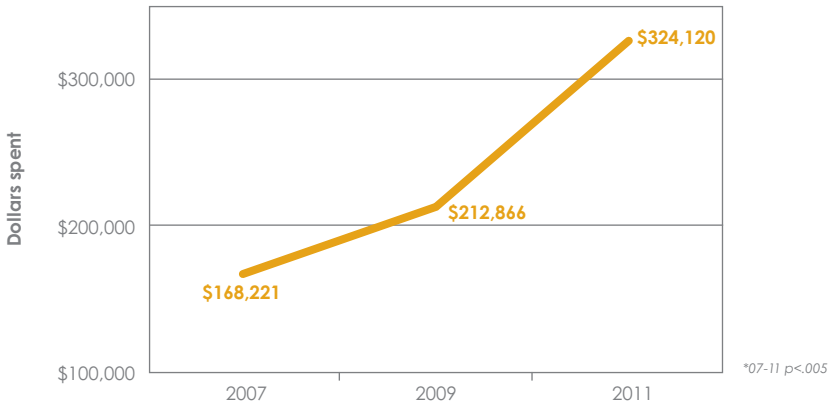
2011 survey respondent

[3]*This report was developed before the Supreme Court's decision on the constitutionality of the ACA.*

health information technology

California community health centers are expanding their access to and use of Health Information Technology (HIT). They are investing in new technology to support patient care, organizational efficiency, and planning. Average community health center spending on HIT has risen steadily since 2007.

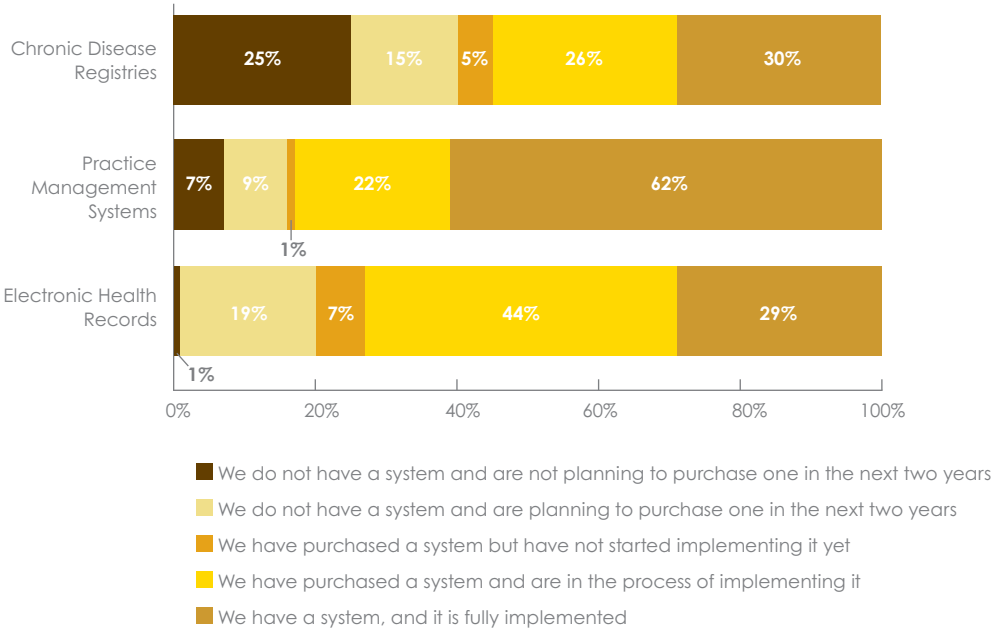
exhibit 12: average annual spending on HIT per community health center



Adoption of Health Information Technology Systems

Community health centers are widely purchasing and implementing HIT systems, as there is growing emphasis on the value of electronic data to support efficient operations, planning, and patient outcomes. Larger community health centers, as indicated by budget size, and FQHCs were significantly more likely to have adopted Practice Management Systems (PMS), Electronic Health Records (EHR), and Chronic Disease Registries (CDR) than small community health centers and non-FQHCs.

exhibit 13: community health centers' implementation status of EHR, PMS, and CDR tools in 2011



Satisfaction with HIT systems

Community health centers with HIT systems in place report being very satisfied with those systems in 2011, and satisfaction with their PMS increased significantly between 2007 and 2011. This steady increase may be due to improvements in the capabilities of community health centers' systems and HIT infrastructures, such as having more computers, faster systems, or upgraded software. Another factor may be increased community health center ease with utilizing the systems; early implementers have been using their PMS longer in 2011 than they had been at the time of previous evaluations, and therefore likely have greater mastery and smoother implementation.

exhibit 14: degree to which EHR, PMS, and CDR tools met community health center needs in 2011

HIT system	mean response	not very well 1	2	moderately well 3	4	extremely well 5
		percentage of community health centers				
Electronic Health Records	3.8	3%	0%	33%	42%	21%
Practice Management Systems	3.8	1%	7%	20%	49%	23%
Chronic Disease Registries	3.9	3%	3%	32%	37%	35%

Factors Influencing Community Health Center Satisfaction with HIT Systems

Increased efficiency and implementation challenges. While many community health centers reported very high satisfaction with their EHRs, other users were not completely satisfied. Some are still working to optimize their system and improve procedures for working with the EHR. Initial decline in productivity is common with EHR adoption, and survey responses indicate that a number of community health centers are still on the learning curve. Additionally, numerous users felt that the reporting capabilities of their EHR system did not meet all their needs. As community health centers strive to meet Meaningful Use[4] criteria, reporting capabilities are an important element for EHRs.

Integrated systems. A desire for a PMS to be compatible with EHR systems was a common remark among community health centers that were less satisfied with their PMS system – or a reason for changing to a new system. Many community health centers expressed frustration with limited or overly complex reporting capabilities of their PMS. Those providing high satisfaction ratings express that the investment of time and resources to customize the PMS helps to develop reporting tools and increase efficiency. Community health centers recognize the value of CDRs (for supporting patient care and community level prevention) and acknowledge that effective utilization of the system takes time. Integrated systems require less duplicative data entry, reducing the burden of using the system.

"The Electronic Medical Record system will allow the clinic to provide more efficient care to patients. Records will be retrieved much faster and will be readily available to clinic staff. This will also allow for more availability of physical space as records will be stored in computer systems."

2011 survey respondent

[4]Meaningful Use (MU) guidelines, specified in the American Recovery and Reinvestment Act of 2009, specify HIT use criteria for supporting coordinated patient care, electronic exchange of information, and reporting of clinical quality and other measures. Community health centers meeting MU criteria are eligible to receive payments from the Medicare and Medicaid EHR incentive program, and can achieve one of three levels of recognition.

HIT for Information Tracking and Strategic Decision Making

Since 2007, there has been a steady increase in the percent of community health centers using HIT to track patient referrals, follow-up on referrals, patient care outcomes, and provider productivity.

exhibit 15: percent of community health centers that use HIT systems to track information

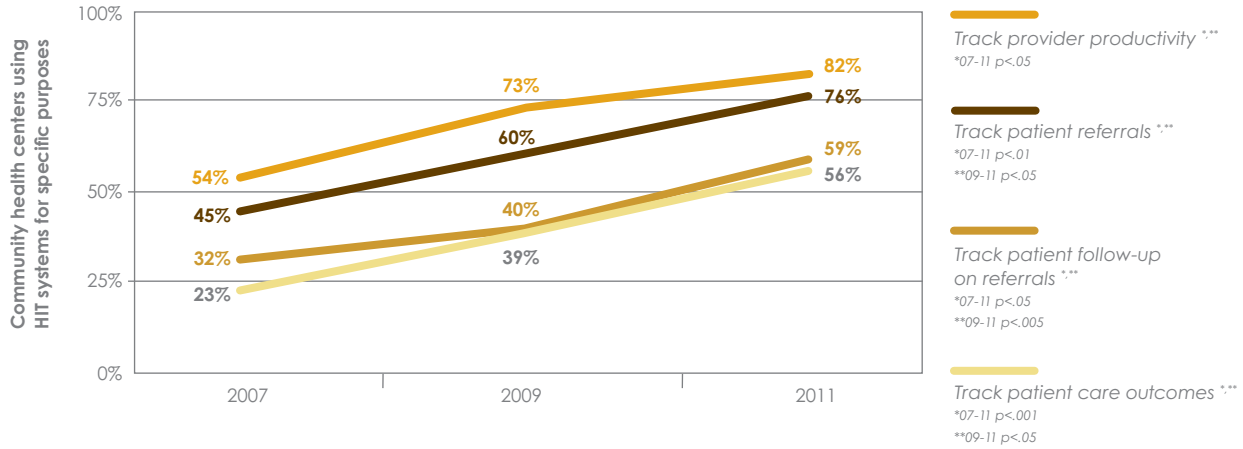
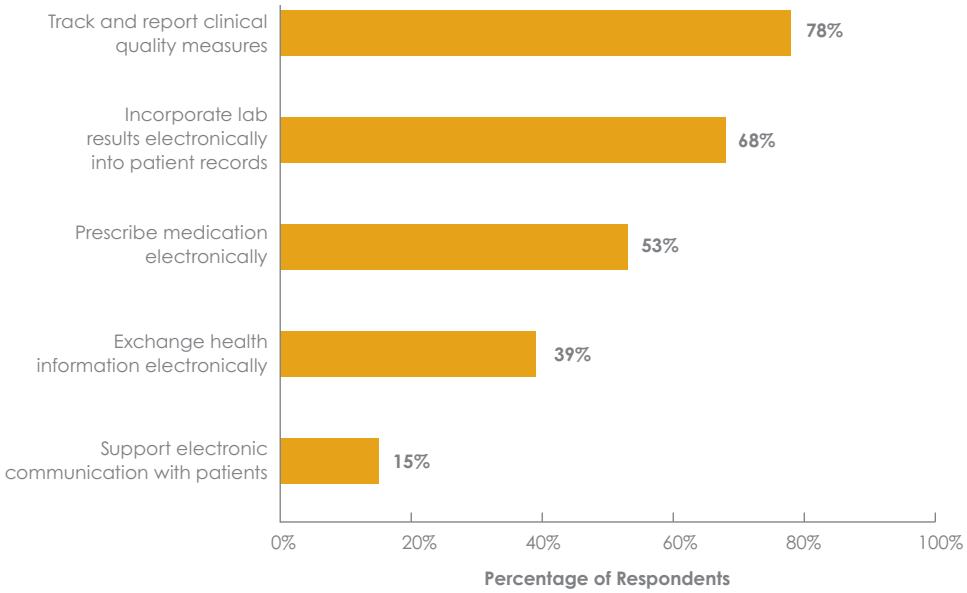


exhibit 16: percent of community health centers that use HIT systems to track information, 2011 only*



**This question was added in the 2011 survey; comparison data are not available for 2007 and 2009.*

Data drives strategic decisions. Community health centers show an upward trend in their use of data to make strategic decisions in four areas: organizational strategic planning, improvement of patient care and coordination, service planning, and financial planning. Ratings increased in all areas between 2007 and 2011.

exhibit 17: extent to which community health centers use data to make strategic decisions
(Mean ratings on a scale of 1-5, where 1 represents "not at all" and 5 represents "extremely often")

areas of strategic decision making	2007	2009	2011
Organizational strategic planning **Significant change from 07-11 (p<.01)*	3.7	3.9	4.1
Improve patient care and coordination **Significant change from 07-09 (p<.01) and 07-11 (p<.05)*	3.5	3.8	3.8
Service planning (expansion or reduction in services)	3.9	4.0	4.0
Financial planning	4.2	4.3	4.4

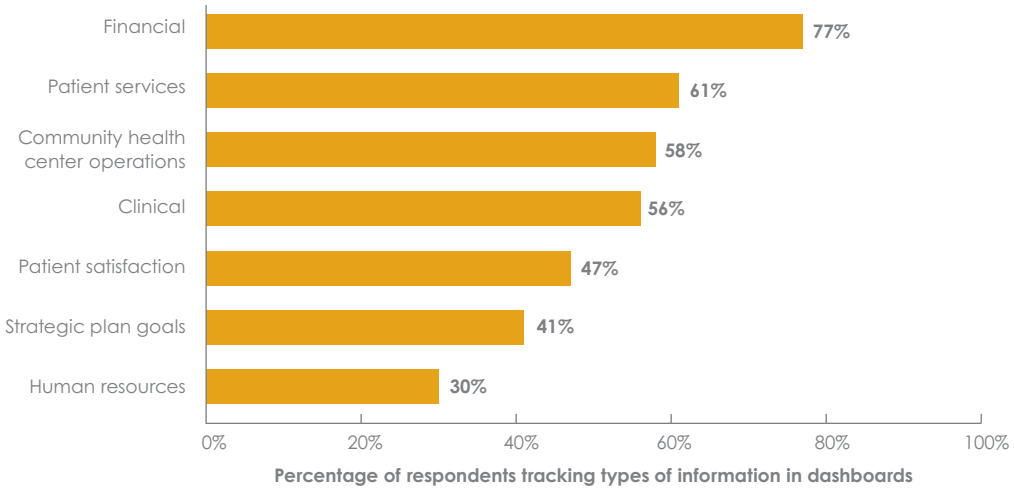
Anticipated Impact of the ACA on HIT Use

Improved productivity and patient outcomes, but concerns about costs. Community health centers believe that HIT systems will facilitate the increased collaboration required by the ACA, but they are concerned about the expenses of purchasing and maintaining new equipment as well as losing revenue because of decreased productivity as they launch and learn new HIT systems. Some community health centers note that Meaningful Use incentives will help to offset the cost of HIT systems, while others are determining how to manage the financial impact of HIT implementation or expansion. Most community health centers embrace HIT implementation and expansion as a critical component of ensuring high-quality, accessible care, however, and one respondent noted that regardless of the ACA, HIT systems are necessary tools to be effective and stay competitive.

organizational improvements

Approximately half (52 percent) of community health centers maintain a dashboard to track and monitor high-level information about their key trends. Dashboards provide an at-a-glance view of performance indicators relevant to organizations' business functions, and community health centers most commonly report tracking financial and patient services information.

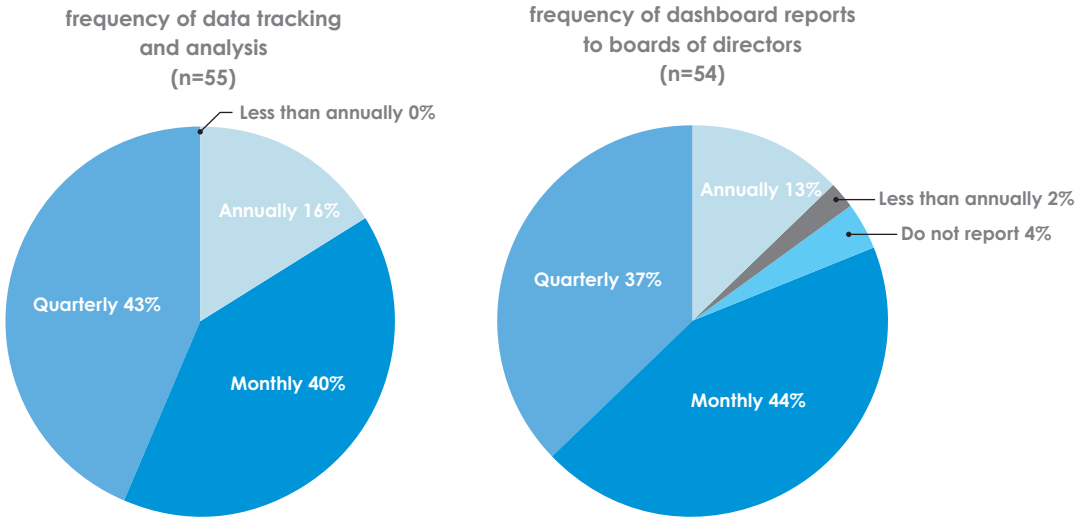
exhibit 18: percent of community health centers that include different types of information in their dashboard, 2011 only*



**This survey question was added in the 2011 survey; comparison data are not available for 2007 and 2009.*

Most community health centers with dashboards analyze and track trend data either monthly or quarterly. Similar percentages report to their Board on their dashboard either monthly or quarterly.

exhibit 19: frequency of dashboard analysis and reporting*



**These survey questions were added in the 2011 survey; comparison data are not available for 2007 and 2009.*

Community health centers reported on the extent to which they made improvements in efficiency and patient care. On average, community health centers reported between moderate and significant improvements in all areas during the two prior years. Community health centers provided the highest ratings for improvement in accessibility of patient records and implementation of new strategies that have successfully improved quality of care.

exhibit 20: areas of community health center improvements in the prior two years*
(Scale: 1-5, 1=not at all, 3=a moderate amount, 5=a significant amount)

areas of community health center improvements	2009	2011
Effective communication systems around individual health	3.6	3.6
Effective treatment team case planning	3.3	3.2
Coordination of timely patient follow-up care	3.6	3.5
Accessibility of patient records to all providers in the community health center **Significant change from 09-11 (p<.05)*	3.5	3.8
Overall efficiency and provider productivity **Significant change from 09-11 (p<.01)*	3.8	3.5
Implementation of new strategies that have successfully improved quality of care	3.8	3.7
Use of specific guidelines (e.g., HEDIS measures) to guide appropriate patient care	3.2	3.2

**These survey questions were asked only on the 2009 and 2011 surveys; comparison data are not availble for 2007.*

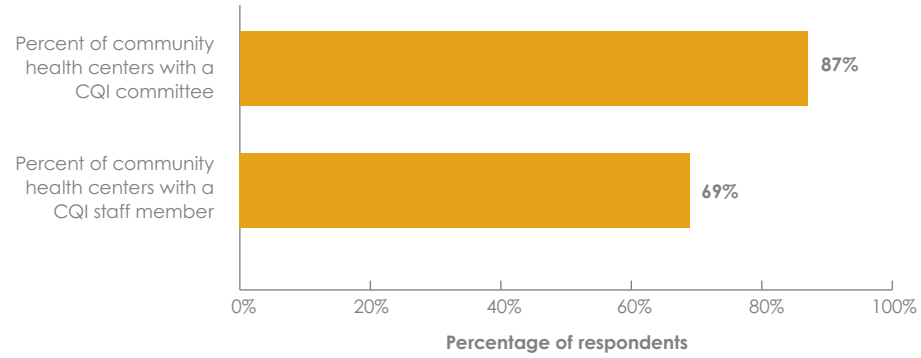
"We are adding EMRs and portals to effectively communicate with patients. We're adding exam rooms…and are re-engineering patient intake and flow. We're doing extensive staff training so as to make our service operation as efficient as possible."

2011 survey respondent

continuous quality improvement

Nearly all community health centers report engaging in Continuous Quality Improvement (CQI) processes either through a CQI Committee or with a dedicated CQI staff member. Of community health centers with CQI Committees, 86 percent report that their Boards of Directors receive CQI reports. Community health centers with a CQI committee are more likely to have a dedicated CQI staff member than those without a committee.

exhibit 21: continuous quality improvement*



**These survey questions were added in the 2011 survey; comparison data are not available for 2007 and 2009.*

Continuous Quality Improvement (CQI)

CQI is an approach to improving operational and clinical quality in community health centers through a process of assessing performance using data and scientific methods to continually improve. Community health centers measure and assess the performance of their services, take action where indicated, and empower employees to engage in continuous improvement of operational and clinical processes.

Community health centers note that the improvements to their HIT capacity, spurred by federal legislation, support their ability to track and monitor quality indicators. Respondents anticipate an increased emphasis on quality and patient satisfaction among community health centers.

patient-centered medical homes

Only a small number of community health centers (11 percent) have currently achieved any level of Patient-Centered Medical Home (PCMH) recognition. However, more than half of respondents report planning for PCMH implementation in the upcoming year. Community health centers reported that achieving PCMH recognition will help them meet increased demand for patient-centered care and coordination that result from ACA implementation.

"We have added quality components to all meeting agendas from the Board to senior management team to clinicians to team meetings – and provide monthly in-services on quality and customer service."

2011 survey respondent

exhibit 22: patient-centered medical home levels of achievement* (n=117)

levels of PCMH recognition	2011
Achieved Level 3 PCMH recognition	2%
Achieved Level 2 PCMH recognition	6%
Achieved Level 1 PCMH recognition	3%
Planning for PCMH implementation in the next year	61%
No PCMH implementation at the community health center	29%

**This survey question was added in the 2011 survey; comparison data are not available for 2007 and 2009.*

Relationship Between PCMHs and the ACA

Operational changes community health centers implement in order to pursue PCMH recognition complement other efforts stimulated by the ACA. For example, PCMH requirements about the use of HIT align closely with Meaningful Use requirements that many community health centers are striving to fulfill. Achieving PCMH recognition may also help position community health centers to weather some of the anticipated challenges associated with the ACA. Some note that they are expanding services or increasing primary care access for their patients as a part of their efforts to achieve PCMH recognition. Comprehensive services, in addition to increased focus on patient satisfaction, may give some community health centers a competitive edge for attracting and retaining patients, since patients will have more choices in providers after ACA implementation.

"Through the PCMH model, [we] see opportunities to integrate additional services that will improve overall health outcomes of our patients. The emphasis on provid[ing] a wide range of services and fully coordinat[ing] care for individual patients through a multidisciplinary care team mandates that we approach primary care differently."

2011 survey respondent

collaboration

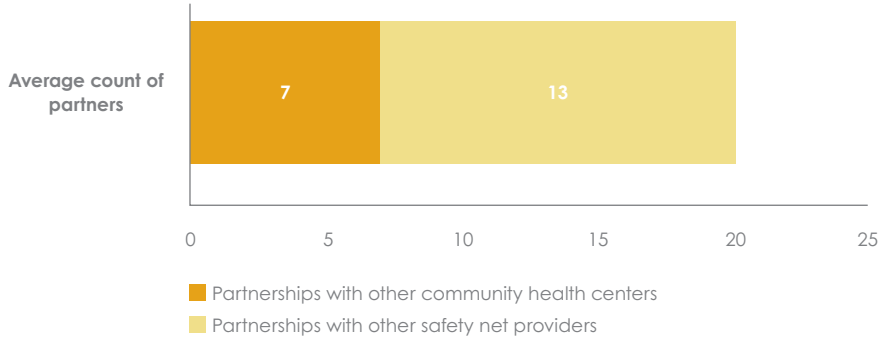
Community health centers report collaborating with an average of 20 other organizations. These partnerships range from informal verbal agreements to formal contracts with a financial exchange. On average, 3.5 contractual relationships generate revenue for the community health center.

exhibit 23: 2011 partnerships with other community health centers and safety net providers*

partner type	partnerships with verbal contracts	partnerships with MOUs in place	partnerships that have formal contracts but no financial exchange	partnerships that have formal contracts and a financial exchange
Partnerships with other community health centers	5.3	3.5	2.7	1.5
Partnerships with other safety net providers	9.3	6.6	2.2	3.9

**This survey question was added in the 2011 survey; comparison data are not available for 2007 and 2009.*

exhibit 24: average number of community health center partnerships*



**This survey question was added in the 2011 survey; comparison data are not available for 2007 and 2009.*

Anticipated Impact of the ACA on Collaboration

Greater collaboration. Collaboration will be necessary to meet the anticipated increased demand for services resulting from expanded insurance coverage. The ACA has provided an impetus for collaboration while strain on the economy has also pushed community health centers towards consolidation and joint partnerships.

Increased access to specialty care and more comprehensive care for patients. It is anticipated that partnerships will be more formalized and more collaborations will involve contractual relationships. As some community health centers shift towards a Patient-Centered Medical Home model, they are undertaking efforts to provide more comprehensive care and to increase patients' access to services that community health centers are unable to provide. Partnering with hospitals and specialty care practices – and strengthening referral networks within the community – are expected to be critical to supporting these changes in care delivery.

"Healthcare reform is helping drive the Medical Home model, with collaboration being at the heart of the Medical Home."

2011 survey respondent

policy and advocacy activities

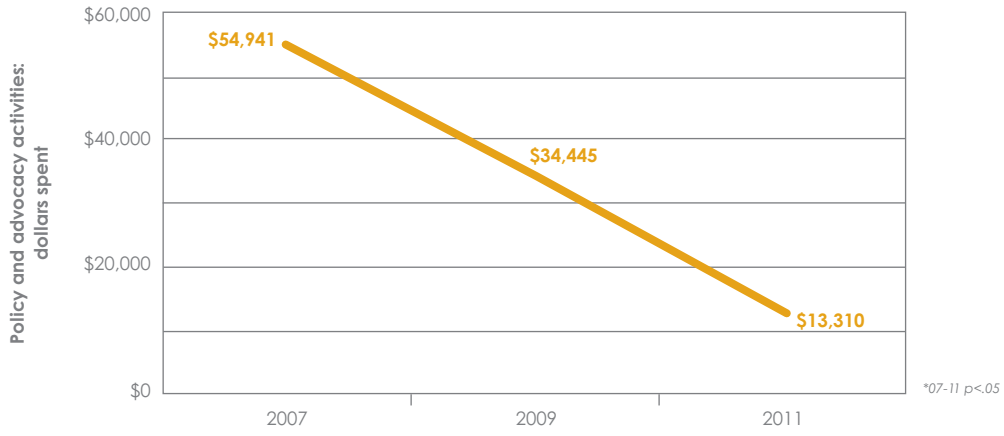
The percentage of community health centers engaging in policy and advocacy activities has declined since 2007. Community health centers reported on the specific types of policy and activities that they participate in. Approximately 80 percent report participating in coalitions, while 70 percent forward policy updates to staff and participate in community planning and organizing. A complete list of policy and advocacy activities – and the percentage of community health centers who engage in each type – can be found in the separate appendix.

exhibit 25: percentage of community health centers engaged in policy and advocacy activities

policy and advocacy activities	2007	2009	2011
Percent of community health centers with policy and/or advocacy in their mission	73%	62%	63%
Percent of community health centers that engage in mission-related policy and/or advocacy activities apart from those done through a consortium **Significant change from 07-11 (p<05)*	78%	72%	67%

The resources that community health centers devote to policy and advocacy have declined steadily since 2007. Respondents report both spending less money and staff time on these activities.

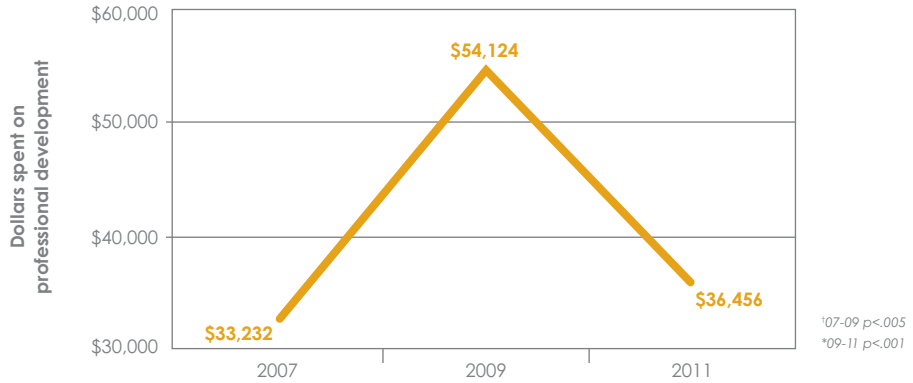
exhibit 26: average annual spending on policy and advocacy per community health center



professional development

The average annual community health center expenditure on professional development increased significantly from 2007 to 2009. In 2011, the expenditure amount returned to approximately the same level as 2007. The change in funds spent on professional development from 2007 to 2011 differed by FQHC status. FQHCs increased the amount spent on professional development significantly more than non-FQHCs and look-alikes.

exhibit 27: average annual spending on professional development per community health center



Succession Plan. In 2011, 57 percent of community health centers reported having a succession plan in case of transition at the senior leadership level.

Complete results of the percentage of community health centers that offer professional development to each position type and the average amount of professional development offered can be found in the appendix.

conclusions

The 2011 survey contributed a third year of longitudinal data on California community health centers. Findings from the surveys demonstrate ways in which the field is changing over time, and signals future changes that will result from the ACA. Specifically, community health centers:

- Have experienced continued growth since 2007 in a few key areas: expansion of services, hours of operation, and locations;
- Continue to accommodate increasing numbers of unduplicated patients and patient encounters, and are increasing staff size to meet increased needs;
- Report growing operating budgets since 2007;
- Anticipate that the ACA will change the healthcare landscape and are actively planning their processes to adapt to that new landscape;
- Are adopting new HIT systems and expanding the ways in which they use HIT to improve access to care and quality of care; and
- Are embracing CQI initiatives to systematically improve the quality of care, and are either planning or working toward PCMH recognition.

The Foundation is committed to continuing to track trends in the field with the goals of understanding how community health centers adapt and change, and uncovering best practices that contribute to the provision of high-quality health care for all Californians.

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