community clinic case studies

collaboration

LFA Group
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Established in 2000, 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. They engage deeply with organizations as partners, facilitating processes to draw on strengths, while also providing expert guidance. Their high-quality services are accessible to the full spectrum of efforts, from grassroots, community-based organizations to large-scale international initiatives. To learn more, visit: www.LFAgroup.com

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introduction

context

California community clinics are operating in a complex environment. Because of the economic downturn, Medi-Cal payments to clinics were delayed in 2008, 2009, and 2010. Entire programs, such as adult dental and podiatry, were eliminated. A few clinics have closed as a result of financial hardships over the past two years, and many others have cut staff and services.

The Patient Protection and Affordable Care Act of 2010, also known as healthcare reform, has created a climate of excitement and change mixed with tremendous uncertainty about what is to come. If clinics are to thrive, or even just survive, they must operate at higher levels of efficiency while still providing high-quality services to their patients.

Blue Shield of California Foundation (BSCF) believes that clinics functioning at high levels of capacity in several critical areas – engaging in meaningful collaborations, maintaining good financial health, and providing robust professional development – will be poised to meet the future challenges of the field and provide high levels of access and quality care to their patients. These case studies explore that hypothesis and discuss a vision for the future of the clinic field along each dimension of capacity.

Access to care: The timely use of personal health services to achieve the best health outcomes.

Quality of care: The extent to which care is effective, safe, timely, patient-centered, culturally competent, equitable, and efficient.

background

In 2007 and 2009, the BSCF commissioned LFA Group: Learning for Action to conduct surveys and a small number of interviews to explore the impact of core support funds on California community clinics. The evaluation findings raised questions about the ways in which several core capacities affect access to care and quality of care, and in 2010, BSCF engaged LFA to conduct research on this topic.

This case study on Collaboration is one of three that focus on access to care and quality of care in California community clinics; the other two focus on Financial Health and Professional Development.

collaboration

Collaboration is important because it allows clinics to share resources, information, and coordinate referrals. BSCF believes that collaboration improves access and quality in community clinics and will be increasingly vital in the era of healthcare reform.

Collaboration occurs in a variety of ways: community clinics collaborate with other clinics, local health departments, public and private hospitals, other safety net and non-safety net providers, and can be members of clinic consortia.

This case study explores collaboration in a sample of California community clinics. It describes the ways in which clinics currently collaborate with other clinic corporations, public and private hospitals, county health systems, other safety net and non-safety net providers, and clinic consortia. This case study provides information about the factors that facilitate successful collaborations – and some challenges. It highlights findings that can inform the field in improving quality and access, and presents questions on how collaboration can help meet the demands of an evolving healthcare environment. The case study especially focuses on the role that consortia play in leading local collaborations.

methodology

Clinics were selected to participate in this case study based on their responses to the Community Clinic Survey that LFA implemented in 2009. LFA Group consultants conducted interviews with staff from seven clinics, which were screened and selected to develop a diverse sample. The sample included those who were and were *not* members of clinic consortia, and the clinics varied in type, size, and geography. Four of the seven clinics interviewed were members of clinic consortia, two were Federally Qualified Health Centers (FQHC), three were FQHC look-alikes, and two were non-FQHC clinics. Four of the participating clinics were small clinics (operating budget under $5 million), and three were large (operating budget more than $10 million). Interviewees from the clinics were primarily executive directors/chief executive officers (CEO) and medical directors, but consultants also spoke with a few chief information officers (CIO), chief financial officers (CFO), quality directors, and other clinic staff. An additional four clinics were interviewed about the use of Health Information Technology (HIT). Their input is integrated where it relates to collaboration and consortia membership.

This case study was designed according to the principles of the “small sample case study” method. Researchers selected clinics that are “typical” of the population as a whole (i.e., California community clinics that meet licensing requirements). The clinics also represented *diversity* with respect to the independent variable of interest: the dimensions of collaboration. Using careful case selection that takes into account both representativeness and variation on the independent variable allows researchers to make inferences about the field that these clinics represent, even in the absence of a large random sample. A more complete discussion of the methodology for choosing clinics can be found in the Methodological Appendix.

state of collaboration

collaboration with other clinics and safety net providers

Community clinics described the various ways in which they collaborate, and strategies range by the type of resources and time required. Clinics and their collaborative partners – within and outside of the safety net – work together to share best practices, apply for funding, streamline referrals, and share appropriate patient information. Interview findings illustrate how clinics' relationships with other community clinics, local public and/or private hospitals, local health departments, and clinic consortia support them and the patients that they serve.

Community clinics collaborate frequently with other clinics, sharing best practices around the implementation and use of HIT, staff training, operations, and cultural competency. The quality director at one clinic shared that "we are improving our care and our system by finding out what's working and who's doing it better, and adopting some of those practices."

Clinics shared examples of collaborating with other clinics, such as visiting and interviewing other sites to inform their selection and implementation of HIT products. Clinics also reported leveraging support from other partner clinics in their applications for 330 grants or FQHC status through letters of support or technical assistance during the application process.

Clinics work closely with local hospitals, specialists, and private physicians, as these entities often care for mutual patients. Understanding one another's scope of services, when and how to make appropriate referrals, and effectively sharing patient information helps ensure that patients receive the appropriate care and avoid "falling through the cracks."

One clinic chief medical officer noted that staff went to the local hospital and met with a specialist to gain understanding about which patients should be referred and when. The CEO of another clinic described a collaboration formed to strengthen the healthcare system in the

> “I think that by collaborating we defined our roles better; [it] reduces duplicative services.”
>
> *Medical Director*

community: “We meet on a monthly basis to determine the scope of services that each agency provides. We have gone through this assessment process…the next step is to identify and address gaps.”

Sharing staff is another way that community clinics collaborate with other providers. One clinic had a contractual relationship with an OB provider from the local hospital, allowing the clinic to provide OB-GYN services at their clinic. Another clinic employed a chief information officer who split his time, providing part-time support at a smaller, neighboring clinic.

Local health departments provide clinics with resources and information. During the H1N1 epidemic, health departments equipped clinics with doses of vaccine, guidelines for vaccine administration, and treatment recommendations for suspected cases. Many clinics also reported using their county’s immunization registry to track immunization rates against benchmarks.

Another area where clinics and County Health Departments collaborate is in emergency preparedness. One clinic explained that they have access to an emergency alert system through the county that notifies the clinic of outbreaks, disasters, or other emergencies.

collaboration through consortia

Clinic consortia play an important role in collaborations both as a partner as well as a facilitator among members. Consortia functions and roles that clinics say are invaluable include coordinating training opportunities, sharing grant funds with clinics, and conducting advocacy work. One clinic staff person commented, “We rely heavily on our contact with the consortia that we belong to, and I can’t imagine not having that resource.”

The clinic consortia bring members and other safety net providers to the table to coordinate different aspects of their organizations’ work.

Clinics report that consortia gatherings bring together specific staff (e.g., clinic directors, human resource directors, medical directors, and CFOs) to strategize about targeted initiatives. One clinic CEO noted that the consortium provides trainings to staff focusing on specific areas, such as quality, human resources, front-office operations, or accounting. These trainings allow staff from different clinics to network, share ideas, and learn new skills together.

Consortia provided other resources and supports that aid training. One clinic reported having access to video conferencing provided by the consortia, which facilitated training across sites spanning a wide geographic area. However, for clinics that do not qualify for consortia membership or have not joined their local consortia, opportunities to engage in this type of networking and learning are limited.

Numerous clinic staff shared that one of the most important contributions of their clinic consortium was the policy and advocacy work that they undertake. These activities give community clinics a voice in the legislative arena and are instrumental in advocating for funding that supports clinic services. Clinic staff expressed how important it is to have the provider voice at consortia meetings and in advocacy efforts. However, this does mean taking the provider away from seeing patients, which can also decrease access to care if the provider is less available to see patients, and can reduce revenue producing activities. Staff also expressed that it is necessary to have sufficient resources and a commitment to support clinical staff in engaging in policy advocacy and consortium activities.

While high-functioning consortia are clearly quite valuable, clinics did discuss challenges. One of the most significant challenges is that not all clinics were able to participate in a consortium. One clinic reported that they did not meet data collection requirements for local consortium membership. Another had applied for consortia membership multiple times but was told that the consortium was not accepting new members. One clinic was applying for grants in order to join their local consortia, since the membership dues were out of their reach.

Another challenge was that not all consortia were able to consistently offer all the benefits that their members wanted. One consortium member confided, "As dollars ebb and flow for the association, those activities ebb and flow. There are times when [support and relevant activities] don't happen on a consistent basis."

access and quality

Collaboration contributes to improved access and quality in community clinics. Clinics provided examples of how collaborations strengthen the system of care for patients, and they articulated ways in which the lack of inclusion in a consortium limited access to and the quality of care. This section includes examples of how collaboration supports financial health, securing the resources needed to maintain access and quality within the clinic.

coordinated referrals

One important outcome of collaborative relationships is streamlined referral processes. The CEO of one clinic explained: "Collaborators know how each other's schedules work, how to gain access, and how to complete a meaningful referral. There are expectations about how information will flow back and forth."

Having relationships that facilitate co-managing patient care improves continuity of care and access to a full scope of services. For example, a small clinic providing a limited scope of services had a relationship with a local behavioral health provider. Being able to refer patients to this community partner was crucial to meeting the needs of local patients. Many small clinics echoed that they valued having partners who offered the types of services that they did not, ensuring that their patients have access to the full continuum of care.

Consortia membership facilitates relationships that help streamline referrals. The clinic director of a small clinic that was not a consortia member shared that being part of the local consortia would allow them to be more integrated into the network of community providers: "It would be more seamless for our patients to be seen here and in other places."

With increasing numbers of insured people and growing utilization of health care services in a reformed healthcare environment, it will be increasingly important to manage patients in the most appropriate settings in order

> “The concept is brilliant and simplistic. The major hospitals and medical centers will refer ER patients who don’t really have emergencies to the community clinic to become their medical homes. The clinics can serve those patients at a fraction of the cost. And when the clinics have a need for specialty care, we can refer to the hospitals and they will be seen in a timely way.”
>
> *CEO*

to maintain open and timely access – and reduce overall cost. Currently, many specialty clinics and emergency rooms are overburdened with clients whose needs could be appropriately managed in the primary care setting. Ensuring timely access with extended hours of services, knowing how and when to make appropriate referrals, sharing clinical information, and establishing medical homes can help patients receive high-quality care in the timeliest manner.

health information technology (HIT)

Collaboration and consortia membership support increases in HIT infrastructure and the ability to effectively use HIT systems, which increase access to and quality of care. Clinic collaborations supported the acquisition and use of HIT as well as the effective use of HIT. It also supported organizations’ abilities to collaborate with one another. Additionally, electronic collection and exchange of health information is a key tenet of a reformed healthcare environment.

Clinics collaborated on HIT expansion by purchasing equipment jointly, or being added as a user to a partner’s existing system. Partners also collaborated to support the successful implementation of HIT systems, sharing best practices to minimize the burden to access and productivity. Effective use of HIT systems – such as Practice Management Systems (PMS), Electronic Health Records (EHR), and Chronic Disease Management Systems (CDMS) – improves access and quality of care. Clinics staff shared some examples of how these systems were used to benefit patient care, as well as to facilitate meaningful collaboration.

Sharing best practices with partners helps clinics adopt and effectively utilize information systems. One clinic’s IT director shared an example of visiting other clinics to help inform the clinic’s selection of HIT products and seek advice about implementation: “We did site visits with a couple of sites

that had each product... When we were going live, we were put in touch with clinics that were using the [same] system. We're not figuring things out on our own."

Clinics articulated ways in which EHRs facilitate collaboration, improve the quality of and effectiveness of care – and save the healthcare system money. EHRs enable providers to view patient information at a glance, and clinics whose collaborative partners use information systems that communicate with each other are able to view visit records and labs from specialty or hospital visits.

Clinics without the capacity for electronic exchange of information provided examples of how efficiency and the ability to collaborate were hampered: "They [local consortia members] have access to the same database in their clinics…so there is a seamless transition. They can pull out notes of labs that have been done. We work around it…but it takes much more time." The clinic director explained that the local public hospital runs their labs, but the results do not get interfaced with the patient record and cannot be viewed by others.

"Electronic Medical Records are no small feat. It just makes a lot of sense, since our business tools are going to be the same, that we communicate and try to problem solve together."

CIO

Information sharing eliminates having duplicate patient records in multiple sites, ensuring comprehensive records and reducing duplication of services. Having quick and easy access to all patient information enables more informed medical decisions, improving the quality of care. The increased efficiency means providers can spend more of their time seeing patients, increasing access and revenue.

Chronic Disease Management Systems (CDMSs) are one of the leading tools in efforts to improve quality. While a good EHR is able to perform many of the functions that CDMSs offer, CDMSs may supplement an EHR in some clinics or may be used without an EHR in others. Tracking patient

health indicators and assisting providers with managing the care for patients with chronic diseases helps provide individualized care, with close attention to progress and outcomes. Being able to successfully capture and use this data improves individual health outcomes and provides data to demonstrate that impact. Some clinic collaborations use the CDMS set clinical benchmarks and compare outcomes for diabetes, asthma, immunizations, and more. As healthcare reform seeks to create a health delivery system that rewards outcomes rather than the delivery of services, the ability to collect and use data will become increasingly important. Additionally, prevention-focused, effective management of patients with chronic diseases will reduce their usage of certain health services, improving cost savings and allowing for increased access for patients.

Consortia support their members' HIT needs by providing training and technical support for the use of CDMS (in addition to EHRs and other HIT systems) and engage clinics in quality improvement initiatives to monitor health indicators using the CDMS. This training and support helps increase the capacity of organizations to effectively utilize the HIT systems that they have in place.

"We share comparison data and outcomes. Most consortia members have the same disease registry system. We talk about how it can be used to get new data, and how that can be used to raise the bar."

Medical Director

A number of clinics expressed struggles with their CDMS initiatives around gaining buy-in from staff, achieving proficiency, and being able to use the CDMS to its full potential. One clinic described this struggle by saying, "I think it is a wonderful tool, but we haven't been able to manage it to fully utilize it," citing lack of sufficient planning as a limitation.

This example highlights an area where clinic consortia may be able to support their members. Those clinics that are not consortia members (or who are members of consortia that provide limited benefits) are disadvantaged compared to consortia members that can receive support and assistance in this area. In a reformed healthcare environment that

values collaborative, evidence-based care, and measurable quality outcomes, this disadvantage will be exacerbated for clinics that fall behind in their capacity to assess and measure health indicators and outcomes.

collaboration supports financial health

Clinics provided examples that illustrate how effective collaboration and a supportive clinic consortium can help clinics sustain high-quality care and open access while maintaining a sustainable business model that delivers low-cost services. In order to remain viable and competitive, collaboration will continue to be essential for managing costs, access, and quality.

"With referral services...there is a divvying up of who will pay for the testing that needs to be done. For Hepatitis patients, [the clinic we refer patients to] will tell us not to bother testing for that, because they will test for it when [the patients] get to the specialist. We are relieved of that financial burden."

Medical Director

Clinics saved money and increased revenue through collaborations with other safety net providers. Partners shared costs for items such as HIT expenses, and effective use of HIT has the potential to provide clinics with additional cost savings through increased efficiency and access to data that can be used in strategic planning.

Many clinics shared examples of how they use HIT to improve their financial health. They use data to monitor show rates, productivity, and service utilization to inform operations, staffing, hours of operation, and strategic expansion to maximize resources. One clinic COO shared that data "allows you to manage by numbers rather than by feelings."

Clinics were also able to secure funding by applying jointly for grants that they would not have had the capacity to apply for individually. When clinics, hospitals, and specialists have clearly defined roles, it reduces duplication of care, which also saves money. One clinic medical director commented that their clinic was "going to be contracting with an infectious disease specialist who will be coming to our site and managing the more complicated cases. That helps us avoid unnecessary testing."

Clinics provided examples of how consortia membership supported their clinic's financial health. In addition to sharing financial support and resources, consortia provide trainings and technical support that help clinics operate more efficiently and increase revenue. One example is training on billing that helped clinics improve charge capture in order to ensure reimbursement for services.

conclusion: a vision for collaboration

looking ahead to healthcare reform

The direction that the safety net is moving will necessitate collaboration, and HIT is one of the biggest drivers of this change. "Meaningful use" grants available to community clinics under the American Recovery and Reinvestment Act will provide funds for HIT infrastructure to eligible clinics. Satisfying these requirements will prepare clinics to collaborate using electronic information exchange. Those that do not equip themselves to boost their HIT infrastructure will likely be left behind in a future of more coordinated care within the safety net.

Healthcare reform will incentivize coordinated care models such as the patient-centered medical home and will reward positive patient outcomes. With increasing numbers of insured patients (estimated at 3.4 million more Californians insured by 2016[1]), more patients will be seeking regular access to primary health care, rather than seeking care on an episodic basis, as is traditionally characteristic of safety net populations. Having streamlined processes to transition patients between levels of care (e.g., emergency room, primary care, specialty care) and being able to provide high-quality care in the least costly setting will be crucial to meeting this increased demand.

"The result [of healthcare reform] will mean more demand on safety net providers, and to meet that demand there will have to be increased collaboration to do it well."

CIO

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[1] P. Long, and J. Gruber, "Projecting The Impact Of The Affordable Care Act On California," Health Affairs, 30 (1) (2010): 63-70.

collaboration in the future

For clinics to remain financially viable, competitive, and effective in providing quality care to their patients, collaboration is vital. Clinics are urged to establish meaningful collaborations with other clinics, county health systems, public and private hospitals, and non-safety net providers and to dedicate the resources and supports needed to maintain those relationships.

Those clinics that are members of high-functioning and active consortia will be better poised to thrive in a post-healthcare reform environment. Members of consortium benefit from direct technical assistance and support as well as the collaborations between members. Member organizations also value the advocacy efforts and trainings organized through their consortium. Consortia should:

- Continue to provide services and supports that demonstrate the value of consortia membership – value that is otherwise lacking in informal collaborations among clinics;
- Consider membership criteria to determine if there are mutual benefits to expanding membership; and
- Consider consolidating operations. Each year, the number of consortia (regional and/or statewide) seems to increase, but there appears to be a steep learning curve for smaller consortia to provide the depth and scope of services offered by more established consortia – and needed by clinics.

questions for the field

While this case study provided some concrete examples of how clinics are successfully engaging in collaboration, it also raises questions about how to establish meaningful collaborations – and what the role of collaboration will be in a reformed healthcare environment.

- **What incentives do clinics need to collaborate intensely with each other and other safety net providers?** Collaboration may become near necessity as community clinics adapt to increased demands in a post-reform environment. Collaboration will likely provide needed supports for clinics to be financially viable, to maintain standards of quality, and to participate in networks needed to maintain open access to a full scope of care. The field of community clinics should consider how to remove barriers that impede collaboration and what incentives will promote effective collaborations within the safety net and with new partners. Models of care (such as Accountable

Care Organizations and payment systems that are restructured to incentivize efficiency and outcomes) provide examples of how the field may adapt to promote effective collaboration.

- **Are new consortia sustainable? Should high-functioning consortia expand to provide their high-quality member services to expanded regions?** High-functioning consortia play an important role in providing technical assistance, training, and financial resources to clinics. Not all consortia have the same resources, and new consortia may not be able to provide support equal to their high-performing counterparts. An important consideration for the field is whether high-performing consortia can expand to provide support to wider regions–and accept more members – in a time when the support is most critical under healthcare reform. The field should also consider whether consortia should specialize in areas of expertise and technical assistance support in order to refine their service offerings and maximize efficiencies.

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