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Partnership Strategies of Community Health Centers: Building Capacity in Good Times and Bad

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"Partnerships are a foundation CHCs can build on, even in uncertain times."

SUMMARY: Federally Qualified Health Centers—commonly referred to as Community Health Centers (CHCs) —serve as critical safety net providers for those who are uninsured or who may become uninsured. This policy brief reports the findings from the Remaining Uninsured Access to Community Health Centers (REACH) research project, which sought to identify the impact of the Affordable Care Act (ACA) on the ability of CHCs to serve the remaining uninsured.

We examined strategies undertaken by CHCs in four states to reinforce the local safety net through partnerships, improvements to the local health system, and advocacy. With the uncertainties about whether Medicaid expansion will be continued or will be handed over to the states with limited oversight, partnerships both among CHCs and between CHCs and others in the health care system and beyond may become even more important.

Since passage of the ACA, CHCs have been operating in an environment of change. CHCs participating in the REACH project reported that while they have continued to serve high numbers of uninsured patients, they have lacked clinical and administrative capacity, have had limited options for specialty care, and have had to contend with policies and political environments unfavorable to the safety net.[1]

In the face of both challenge and opportunity, CHCs have looked beyond their own organizations to develop partnerships with other CHCs and with allies in other sectors to increase their capacity, explore ways to improve the care they provide to patients, and gain leverage within the policy and funding environment. The results are strategies aimed at developing referral and information-sharing systems with other providers, working directly with other CHCs, joining forces with county policymakers and health departments, and leading broader

policy efforts to support health care access for the uninsured. These strategies have directly addressed some of the ongoing challenges and have been implemented at the local, regional, and state levels, allowing CHCs to address gaps in the health systems in which they operate. The strategies employed in the ACA era, summarized in Exhibit 1, provide insights into the factors that can support CHCs in the face of future uncertainties.

Connection: **CHC-Hospital Collaboration to Streamline Referrals in Atlanta, Georgia**

In Atlanta, with a relatively robust publicly supported hospital, one CHC established a formal system for electronic referrals via interconnected EMR systems with the local nonprofit hospital. This agreement was the result of an evolving relationship between the hospital and the CHC. A new hospital CEO initially reached out to the CHC for partnership opportunities. The hospital then granted admitting privileges to the CHC physicians; the partners jointly participated

Exhibit 1   **CHC Strategies: Partners, Key Elements, and Factors for Success**

Strategy	Partners	Key Elements	Factors for Success
Direct specialty referral system with local hospital	1 CHC and local nonprofit hospital	• CHC and hospital link EMRs so that providers can directly place referrals, see medical records, and provide needed follow-up. • CHC providers can make direct electronic specialty referrals to the hospital. • Hospital providers can refer patients directly back to their PCP for follow-up after receiving ED care.	• Local hospital recognized the value of partnering with CHC to reduce ED visits and provide preventive services. • Partners had built a relationship through previous smaller projects.
Regional collaboration of CHCs	4 CHCs in the same region	• CEOs meet regularly for informal and formal discussions. • Agencies share organizational knowledge, such as policies and procedures and successful grant proposals. • Funding is obtained for shared pharmacy, psychiatry, and other services, while maintaining each CHC as the medical home for its patients. • Grants are provided for CHC to work with law firm regarding legal aspects of joint services and resource sharing.	• The agencies and their leadership and staff "matched on a lot of values." • The leadership recognized their shared mission and developed trust. • Funders recognized the value of supporting the collaborative by providing programmatic and unrestricted funding, allowing for arrangements in which one served as fiscal sponsor and the other housed services and supported planning efforts.
County-level coverage program for uninsured	204 CHC sites and county department of health services	• County government funds used to cover primary care services for uninsured. County residents must be ineligible for other forms of public coverage. • CHCs serve as medical homes and receive payment for each enrolled patient. • CHCs engage in initial planning process and in ongoing planning and refinements to program.	• The county had been contracting with CHCs under different programs for the past 20 years to provide primary care, creating existing relationships and trust between partners. • Policymakers and health care leaders recognized that CHCs were well suited to providing services for the remaining uninsured population and included CHCs in the planning of the program.
CHCs leading local and state policy advocacy	CHCs and local and state advocacy organizations	• CHCs are active in supporting health and other public policies that advance fair social conditions, such as immigrants' rights or transportation access. • CHCs foster relationships with state and federal legislators. • CHCs partner with non-health sectors and are "at the table" on issues beyond CHCs (e.g., immigrant rights).	• CHCs are responsive to quickly changing political environments. • CHCs successfully built a shared sense of mission with non-CHC partners. • CHCs educated policymakers and other partners about the contributions of CHCs and the need to both support CHCs and include them in policy discussions.

in a funded planning project for a 1115 waiver; and, eventually, the CHC adopted the same EMR as the hospital to facilitate mutual referrals. At the time of the interview, the CHC and the hospital had both successfully streamlined their systems: the CHC could make a direct referral to the hospital, and any CHC patient seen in the hospital's emergency room could be referred back to the primary care provider through the hospital, all through the shared EMR system.

> " We started getting together and saying, 'We can make a bigger impact collectively.' "
>
> – Houston CHC director

Capacity: **Regional CHC Collaboration to Strengthen Local Health System in Houston, Texas**

A collaborative of four CHCs in Houston is in the early stages of testing ways to partner in order to create a more integrated regional health system. The four midsized CHCs in the collaborative jointly served more than 35,000 patients in 2014. Each CHC had a

strong mission to serve vulnerable populations and improve health outcomes in the region. Further, their geographical proximity facilitated development of a regional approach to collaboration. The directors first met for initial conversations about how to leverage resources. From these discussions they turned to actively sharing ideas and resources, such as internal documents on organizational policies and procedures, content and lessons learned from successful funding applications, and quality measures and benchmarks. Small grants for shared pharmacy services and a shared psychiatrist position provided the opportunity to conduct formal planning and implementation of shared services. Both efforts involved initial assessment of their respective infrastructures and overlap in services to determine the following: which organization would house the newly funded service; which one would serve as the fiscal sponsor; how their different EMR systems would be handled; and how they could most effectively refer patients to different shared services while ensuring that these patients then returned to their medical home. The group has successfully secured funds from a private foundation to support planning efforts, as well as to retain a law firm to provide counsel regarding legal compliance as the CHCs explore the possibility of establishing an administrative services organization. Today, each CHC maintains its own organizational plans and practices, but as a group the four achieve economies of scale that allow each to benefit from pooled resources and the sharing of knowledge.

Coverage: County Policymakers and CHCs Implement a Coverage Program in Los Angeles, California

My Health LA is a no-cost health care program for low-income residents of Los Angeles County who are uninsured and not eligible for public health insurance programs. The program has made primary care available to many undocumented county residents.[2] My Health LA emerged from two previous iterations of a similar program in which the county dedicated funds to contract with CHCs to serve as primary care medical homes to the

> "You cannot start this planning process and not have the people providing the services around the table. They are serving the remaining uninsured, so they need to be in the planning process."
>
> – L.A. County Official

uninsured, with the goal of ensuring that Los Angeles County residents who were not eligible for health coverage under the Affordable Care Act (ACA) or other publicly financed programs had a medical home and could access needed services. The program also sought to encourage better health care coordination, continuity of care, and patient management within the primary care setting. In 2014, the Los Angeles County Board of Supervisors authorized a $61 million budget for My Health LA to provide care for up to 146,000 people.

Soon after passage of the ACA, the county began conversations with its community providers, advocates, and other stakeholders about how to prepare for ACA implementation, recognizing that a sizable population of residents was likely to remain uninsured. Program enrollees choose a medical home at one of 204 participating CHC sites. The program, administered by the county's Department of Health Services, covers primary care, prescriptions, and labs and ancillary services at CHCs. Individuals must fall within specific income guidelines to qualify, but once enrolled they receive all covered services free of charge. My Health LA increased funding to the CHCs from prior iterations of the program. CHC participation requires data collection, reporting, and adherence to managed care regulations. The local CHC association has been working with the county to address the challenges experienced by participating CHCs.

> *By working together, CHCs and local hospitals more efficiently serve their patient populations.*

> "We have a very good relationship with our local city council representative, and I think for us it starts there."
>
> – New York State CHC director

Advocacy: Health and Immigration Advocates Coordinate Efforts to Influence Changes in the Health System in New York State

CHCs around New York State are engaged in different forms of advocacy on behalf of their patients. At the local level, advocacy efforts are generally led by small partnerships of CHCs. These efforts sometimes involve encouraging patients to attend local government meetings to express support for the services they receive. At some CHCs, the leadership participates in local councils and committees focusing on issues such as transportation or housing. All respondents reported maintaining relationships with local policymakers, such as city council members or the board of supervisors, as well as with other stakeholder groups, such as chambers of commerce. CHCs are engaged in advocacy on a range of state and federal policy issues as well, either directly or through the state primary care association. The primary policy issues facing CHCs are related to funding for health care for the remaining uninsured. These issues include funding for uncompensated care, the involvement of CHCs in New York State's Delivery System Reform Incentive Payment (DSRIP) program,[3] and negotiating with hospitals on indigent care funds. In addition, due to recognition that the broader political environment has an impact on social determinants of health, CHCs are pulled into other policy issues (e.g., transportation and zoning regulations) and immigration issues (which can affect the mobility and safety of patients and staff).

CHCs' advocacy involves both direct and indirect methods. The primary care associations organized CHCs across the state that at times had different interests, bringing a united voice to advocacy efforts. Two respondents served on the executive board of the state's primary care association, providing another platform for speaking about the specific needs of the CHC patient population. Using online advocacy tools created by the state and national CHC associations, the CHCs are able to send mass email communications to their constituents and request support for messages and phone calls to policymakers. Some respondents take part in direct discussions with state and national health care agencies (e.g., the Centers for Medicare and Medicaid Services) and policymakers. In addition to engaging in advocacy for specific legislation, CHCs also find themselves in the position of engaging with local institutions, such as hospitals or law enforcement agencies, to change organizational practices in order to benefit CHC patients.

Factors That Support Successful Partnerships Across Strategies

Regardless of the specific processes involved in efforts of CHCs, common factors were critical to their initiation, development, and success. All strategies required long-term relationship building through both formal (e.g., projects) and informal partnerships (e.g., "being at the table"). Common factors that supported successful partnerships included identifying a shared mission, being responsive to the political context, starting partnerships with funding for smaller projects, and increasing recognition of partnership benefits.

A Foundation of Shared Missions

Many CHCs reported that the shared mission was a prerequisite to working with other partners. When there was not a shared mission, CHCs found it difficult to find partners with the same priorities. For example, in Georgia, many CHCs struggled to find private specialists who were willing to make accommodations for the uninsured. In New York State, CHC advocates found effective ways to overcome

> " I already knew the other CEOs, and there was a level of trust, and philosophically we have the same approach in that we put people first. In theory, FQHCs should have that, but some treat it more as a business model. "
>
> – Houston CHC director

differences in priorities, such as when working with advocates focused on different issues, by developing a shared issue-based mission around common concerns about the populations they represented. This is distinct from alliances of convenience or strategy, because the relationships around an issue generally lasted beyond a single campaign or policy battle. Because many potential supporters, allies, partners, or funders did not understand the role of the CHC within the larger health care system, many CHCs had to dedicate time and resources to the additional task of educating individuals and institutions in their communities regarding the purpose and focus of CHCs.

> " The political will is great, but also having a budget line item that you're protecting is critical. "
>
> – L.A. County Official

Understanding and Responding to Opportunities (and Limitations) Within State and Local Political Environments

CHC leadership stayed up to date on local and state political opportunities and limits. For example, in New York State, policy advocacy regularly shifted based on emerging local and state issues – from state funding of uncompensated care to providing training to the local police department to prevent

racial profiling. CHCs had to work within the reality of these environments. As a result, they were keenly aware that their strategies would only be as successful as the level of political will and funding to support them. In Los Angeles, respondents reported that their efforts to create a coverage program for the uninsured were possible due to the county government's long-standing commitment to funding services for those not eligible for other forms of insurance. A respondent noted that because of this support, the issue was not whether the program could be created, but "more an issue of how we can do this."

Secure Funding, Start Small, and Grow for Long-Term Effect

For the strategies highlighted here, it was critical that the CHCs first receive smaller or program-specific grants to help them build relationships with potential partners. This lay the groundwork for securing and working together on larger grants for significant projects. Relationship building required funding for staff time and for discretionary activities, such as attending planning meetings.

Often, local foundations saw the strategic importance of helping these relationships develop. The collaborative of CHCs in Houston received small foundation grants, each focused on supporting a step in the effort for the four agencies to test, strengthen, and formalize their collaborative relationships. The CHC in Atlanta partnered with a local hospital, having developed a relationship with hospital leadership through two smaller previous projects. Los Angeles County had contracted with a number of CHCs for primary care services since 1995, when a fiscal crisis led the department to increase primary care capacity and reduce public hospital use for the uninsured through public-private partnerships.[4] This evolved into contracts with community clinics for the Health Care Coverage Initiative (HCCI), which was a pre-ACA (Medicaid) expansion for uninsured adults. Most of the clinic contractors under the HCCI eventually became CHC contractors for the My Health LA program.

> " *L.A. County supervisors helped CHCs provide health care to noncitizens left out of ACA reforms.* "

> *"Health advocacy is a policy tool that strengthens the state and local safety nets."*

Recognition of the Benefits of CHC Partnerships

The efforts of CHCs to pursue strategic partnerships were, in part, dependent on potential partners' recognition of the unique expertise of CHCs. For example, the leadership of the hospital in Atlanta recognized that collaboration with local CHCs would advance their efforts to focus on prevention and population health. Similarly, in its efforts to achieve the goal of providing access to care for the uninsured, the Los Angeles County health department recognized that CHCs were experienced in providing care to vulnerable populations. CHCs, however, often had to educate others, such as local hospitals and policymakers, about the mission and role of CHCs, as well as the ongoing challenges in the safety net. Many dedicated time and resources to educate potential partners and allies about CHCs' contributions to health systems and the safety net. In advocating for their patients, staff from CHCs in New York met directly with policymakers to describe their role in the health system, as many elected officials did not understand the mission of CHCs nor the ongoing need for them in the post-ACA era.

Recommendations

There are many factors supporting CHCs in developing partnerships in their regions and states. There are also concrete steps that policymakers and funders, as well as CHC leadership, can take to give CHCs the needed resources, flexibility, and organizational infrastructure to develop partnerships that will strengthen the safety net.

CHCs should include fostering partnerships as part of their strategic plans. It is hard to predict what opportunities or threats might arise that help or hinder CHCs' efforts to provide primary care. Forming partnerships only when opportunities or threats arise will not lead to the lasting and productive relationships needed. CHCs should be proactive in seeking to partner with neighboring CHCs, other medical providers, and community organizations that have common missions and complementary strengths. In doing so, they can start with small efforts that can grow over time.

Support and formalize CHC-driven partnerships. While CHCs develop many partnerships due to policy or funding requirements, our findings suggest that the strongest partnerships are those that CHCs have the opportunity to pursue and foster over the long term. CHCs should be given the policy and funding support they need to develop partnerships that best serve their organizational mission and needs.

Foundations should provide small grants to foster new collaborations. Funding for smaller, specific, and one-time collaborative projects creates a foundation for strategies that are larger and more sustained. Planning and relationship building must start on a smaller scale, and the effort requires time and resources that many CHCs do not readily have available in their day-to-day operations. While not all projects will lead to long-term collaborations, such collaborations are less likely to occur without this start-up experience.

Increase awareness about and highlight the value of CHCs. CHCs have demonstrated their ability to develop strategic partnerships by educating potential partners about the value of their inclusion in partnerships. To foster these efforts, funders and policymakers should incentivize non-CHC agencies (e.g., hospitals) in state and local health care systems to develop relationships with CHCs by rewarding improvements in prevention and reduction of hospital utilization. This represents an opportunity for CHCs to show off their strengths in providing patients with primary care services that can help local hospitals lower their readmission rates, decrease waiting times in their emergency departments, and help shorten hospital stays by providing patients with a medical home for follow-up care.

Provide funding for staff dedicated to developing community partnerships and advance advocacy efforts. Dedicated funding for these essential duties is needed in order to allow CHCs the flexibility to adapt responsively with local strategies. Being stretched thin is a common problem that limits CHCs' abilities to be a voice for patients and to benefit from changes to the health care system. One respondent commented, "It would have been nice to have a staff person doing advocacy who could have stayed on that [funding] issue more diligently."

Conclusion

With the uncertainties about whether Medicaid expansion will be continued or will be handed over to the states with limited oversight, partnerships among CHCs and between CHCs and others in the health care system and beyond become even more important. Local foundations and health departments are well positioned to encourage budding partnerships and should take the initiative to encourage them. Strong networks that include CHCs are important for both CHCs and the safety net overall, enabling CHCs to make optimal use of new opportunities and respond most effectively to policies that could reduce access to care for their communities.

Methodology

Between October 2015 and October 2016, the REACH project conducted interviews with 42 CHCs and their stakeholders in California, New York, Texas, and Georgia. Stakeholders included health departments, local hospitals, primary care associations, and community-based organizations. Initial interviews with CHCs identified the major financial and capacity challenges that CHCs faced post-ACA implementation. Based on findings, we identified four promising partnership strategies that represented the range of types of partnerships that CHCs developed to serve the uninsured. Follow-up interviews were conducted to examine the elements of each strategy and identify what organizational, institutional, and policy factors supported these efforts.

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Endnotes

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2   Los Angeles County Health Services. *My Health LA: Annual Report to the Los Angeles County Board of Supervisors, Fiscal Year 2015-16. http://file.lacounty.gov/SDSInter/dhs/1010204_2015-16MHLAAnnualReport%28final%29.pdf.*

3   The DSRIP program is part of the Section 1115 Waiver programs and offers state funding for collaborative efforts to support payment and delivery system reforms. *See:* The Commonwealth Fund. 2016. *Implementing New York's DSRIP Program: Implications for Medicaid Payment and Delivery System Reform. http://www.commonwealthfund.org/publications/fund-reports/2016/apr/new-york-dsrip-medicaid.*

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