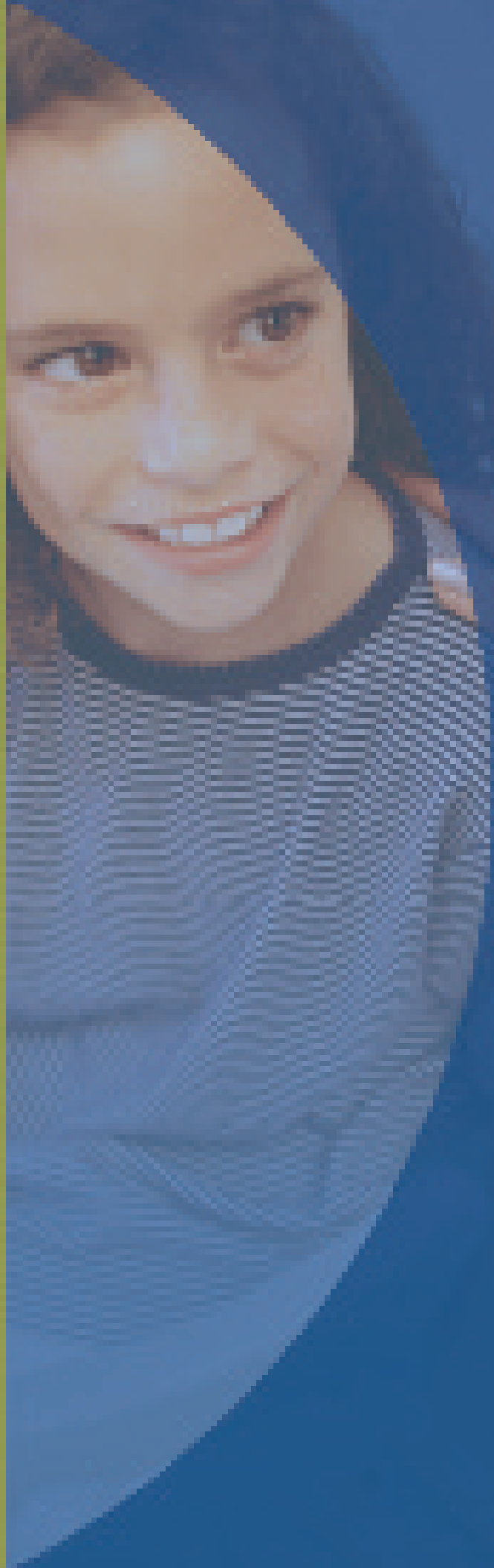


• JUNE 2008

Clinic Consortia Policy and Advocacy Program

Evaluation Executive Summary 2004 - 2006

Grantees:

Community Clinic Consortia

Prepared by:

UCSF University of California San Francisco

A Program of:

The California Endowment

Introduction

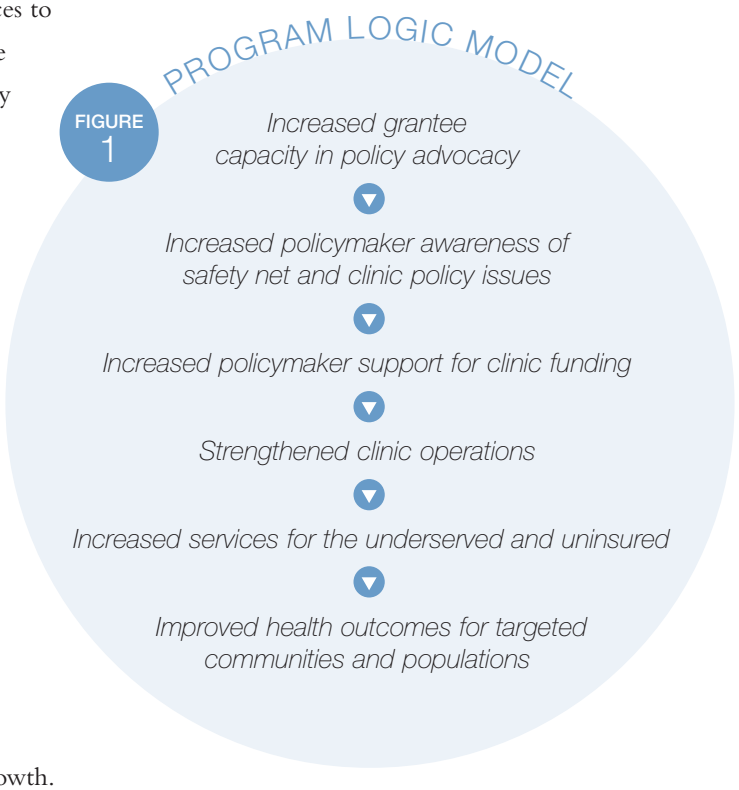
As part of its commitment to increasing access to high quality and affordable health care for underserved Californians, The California Endowment (The Endowment) provided multi-year funding for the Clinic Consortia Policy and Advocacy Program (Program). In early 2001, fifteen California regional community clinic associations and four statewide clinic organizations (referred to as "consortia" or "grantees") received three years of funding (totaling $10 million) to strengthen the role and capacity of consortia in order to support the management, leadership development, policy, and system integration needs of community clinics (Round 1). Funding supported specific activities related to policy advocacy, technical assistance, media advocacy, as well as shared or centralized services. In 2004, The Endowment refunded 18 clinic consortia for a second three-year funding cycle (totaling $8.8 million) to continue policy advocacy activities and improve the quality and financial stability of their member clinics[1] (Round 2). While many Round 1 activities carried over to Round 2, there were some notable differences between the two funding periods. For example, most grantees pursued partnerships with non-health organizations under Round 2 whereas under Round 1 they strengthened the relationships among clinics and consortia. In addition, some grantees worked with member clinics and their patients to strengthen advocacy skills under Round 2.

...fifteen California regional community clinic associations and four statewide clinic organizations... received three years of funding totaling $10 million...

The Philip R. Lee Institute for Health Policy Studies at the University of California, San Francisco (UCSF) has continued its evaluation of these activities by conducting interviews with grantees and partner organizations and collecting data for longitudinal measures used since 2001. In addition, UCSF developed three policy advocacy case studies detailing grantee involvement in three policy issues, and also assembled 17 best practice case studies describing exemplary grantee activities that speak to the achievement of individual grantee and program outcomes.

The Clinic Consortia Policy and Advocacy Program is based on the theory that staffing and resources dedicated to policy advocacy and technical assistance will increase the collective influence of clinics and strengthen a broad base for long-term support of clinic policy issues. As described in the Program Logic Model (see **Figure 1**), these activities are anticipated to contribute to long-term improved health outcomes for targeted communities.

Policy advocacy activities, or activities that mobilize resources to support a policy issue or create a shift in public opinion, are critical for expanding local and state support for community clinic funding. In an era of decentralized decision-making and increased grassroots responsibility for addressing the needs of California's vulnerable populations, clinic consortia have great potential for mobilizing resources and participating in policymaking in ways that are beyond the means of many individual clinics.



The purpose of this Summary is to describe the evaluation results of the second funding cycle of the Clinic Consortia Policy and Advocacy Program for the years 2004-2006. The evaluation focuses on the program outcomes by the grantee population as a whole, particularly the benefits of program-funded activities to clinics and their target populations. Overall, grantees are moving beyond sustaining activities to creating the infrastructure necessary for continued evolution and growth.

Overview of Grantees and Member Clinics

In response to the increasing challenges of shifting health care and political environments, clinics have joined together to form regional consortia and statewide organizations. Clinic consortia are membership organizations for community clinics and related safety net providers, and they are instrumental to ensuring that California's health care safety net remains strong.

Grantee Profile

California is unique in that it has upwards of 18 community clinic consortia, with the oldest consortium, the California Rural Indian Health Board (CRIHB), being launched in 1969. Many grantees met informally for years prior to incorporation, reflecting a grassroots origin and long-time commitment to clinics and their clients (see **Figure 2**).

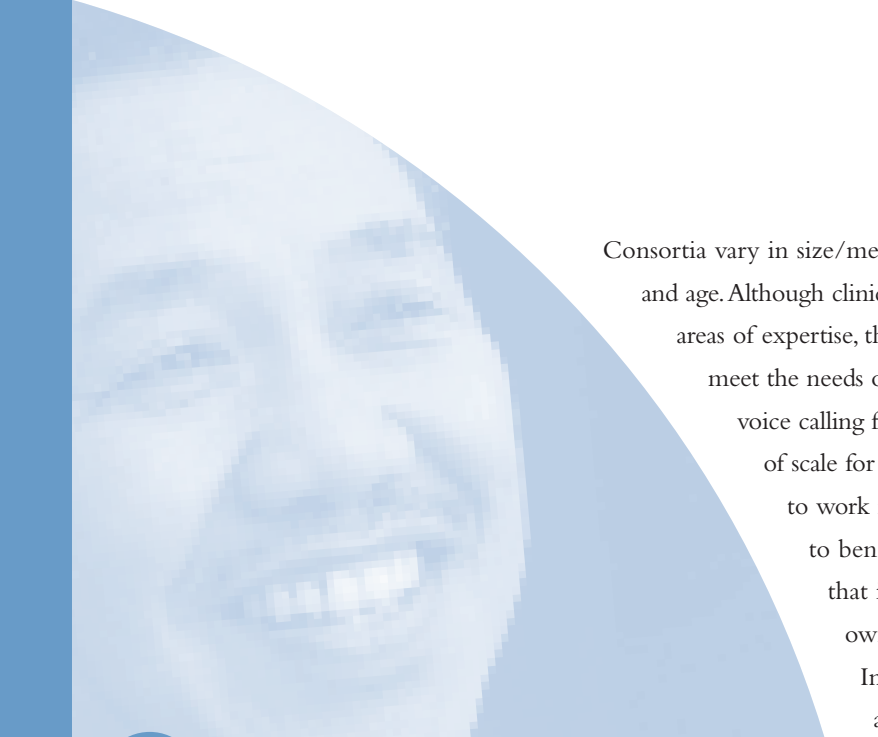


FIGURE 2

GRANTEES

AHC	*Alameda Health Consortium*
ARCH	*Alliance for Rural Community Health*
CFHC	*California Family Health Council*
CPPEF	*California Planned Parenthood Education Fund*
CPCA	*California Primary Care Association*
CRIHB	*California Rural Indian Health Board*
CCHN	*Capitol Community Health Network*
CVHN	*Central Valley Health Network*
COCCC	*Coalition of Orange County Community Clinics*
CCALAC	*Community Clinic Association of Los Angeles County*
3C	*Community Clinic Consortium Serving Contra Costa and Solano Counties*
CHPSCC	*Community Health Partnership of Santa Clara County*
CCC	*Council of Community Clinics*
NCCN	*North Coast Clinics Network*
NSRHN	*Northern Sierra Rural Health Network*
RCHC	*Redwood Community Health Coalition*
SFCCC	*San Francisco Community Clinic Consortium*
SCCHC	*Shasta Consortium of Community Health Centers*

Consortia vary in size/membership, staffing, scope of services, geographic focus, and age. Although clinic consortia are diverse in their membership focus and areas of expertise, they are similar in that they all help individual clinics meet the needs of their patient populations. They provide a unified voice calling for increased services to the uninsured, offer economies of scale for business and program shared services, and allow clinics to work in partnership on local health improvement programs to benefit clients. In short, consortia undertake activities that individual clinics may not be able to do on their own. For example, some consortia have launched major Information Technology (IT) expansions, including an electronic health record across multiple clinics.[2]

Member Clinic Profile

There are approximately 794 primary care clinics in California that serve 3.6 million low-income and uninsured Californians.[3,4] Some clinics specialize in particular areas, such as Planned Parenthoods or mental health clinics. Most clinics provide comprehensive primary care services. Clinics also may have different designations, such as a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC). Clinic needs vary, with smaller, individual rural clinics having very different support needs compared to large, multi-clinic corporations. Consortia must be flexible organizations that can accommodate clinic diversity while striving to find common needs that can be readily addressed through centralized services, support, and/or grant writing.

Findings

This section describes key macro-level outcomes resulting from the second funding cycle of The Endowment's Clinic Consortia Policy and Advocacy Program. Overall, grantees made considerable progress, accomplishing many short and longer-term outcomes.

Outcome 1: Increased policymaker awareness and/or support for clinic policy issues

From 2004-2006, grantees engaged in new types of advocacy activities, such as facilitating or advocating for systems change and increasing their focus on local advocacy. For example, grantees are helping to develop allocation plans in several counties to disburse Proposition 63 funding for mental health services, and statewide grantees, such as CPCA, worked with stakeholders at the state level to develop implementation guidelines. Grantees also are working directly with policymakers, such as helping to draft rules, regulations, and guidelines, consulting with policymakers on clinic policy issues, and hosting clinic tours. Policymakers have responded by initiating contact with consortia to ask for their expertise and opinions, readily participating in consortia activities, and offering their support for clinic policy issues. Grantees continued to achieve short-term outcomes, such as increased policymaker knowledge of clinic policy issues while securing longer-term policy changes. The capacity differences between newer (post-1990) and older (pre-1990) consortia almost have disappeared, with newer grantees engaging in a similar percent of activities, achieving similar policy gains, and securing similar clinic funding.

Similar to Round 1 (2001-2003), many grantees are engaging in diverse media advocacy activities to increase policymaker and public awareness of clinic policy issues and the role played by community clinics. Although grantees continue to rate media advocacy as less effective compared to other policy advocacy activities in achieving policy change, media advocacy has served many grantees and clinics well, such as regular TV coverage of health issues in San Diego and ongoing coverage in California's major daily newspapers and local papers. Grantees also are leveraging their media work from earlier years, building on existing relationships with the media and serving as a source of information about the safety net. Some grantees are experimenting with different strategies, such as aggressively engaging the media in dialogue (versus passively distributing materials) and serving as a sponsor for a public radio station. Continued involvement in media advocacy may result in increased ability of consortia to undertake a major media campaign when needed.

Grantees also are working collectively to expand their reach and coordinate their policy agendas. During Round 2, all grantees worked in partnership with the California Primary Care Association (CPCA) in order to develop a coordinated approach to achieving state-level policy change. As a result, an increased number of grantee staff are serving on CPCA committees and are involved in planning and promoting a state health policy agenda. Moreover, there is an improved flow of information and resources between CPCA, consortia, and clinics.

Local funds were the most significant funding source for grantees during 2004-2006 (40 percent)...

Outcome 2: Increased clinic financial stability

Grantees continue to engage in a wide variety of activities related to clinic financial stability, such as advocacy activities, conducting trainings or providing technical assistance to help clinics generate funds, helping clinics attain designations that generate funds, and developing strategies that ensure the long-term sustainability of the consortium and its member clinics.

From 2001-2006, grantees reported securing over $2.2 billion, with $753 million (34 percent) of that attributable to Endowment funding. Compared to Round 1, grantees secured significantly more funding during Round 2—$482 million vs. $270 million (see **Figure 3**).

Local funds were the most significant funding source for grantees during 2004-2006 (40 percent); followed by federal (33 percent), then state sources (23 percent), and then private sources (4 percent). Similar to previous years, grantees have had to contend with a less than ideal funding environment and have had to balance wins and losses at the federal level, such as increased federal funding for the 330 health center program and stagnant Medicare reimbursement rates. The current challenge is to maintain funding as well as identify new sources of funding.

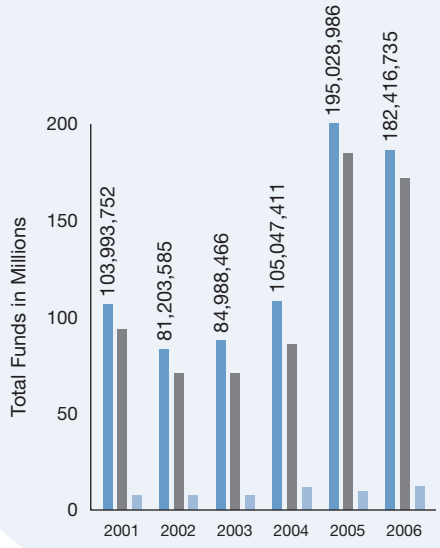
Outcome 3: Policy "wins" benefiting clinics and their target populations

A useful indicator of the impact of grantee policy advocacy activities is the number and type of policies that are proposed and ultimately signed into law. During the second funding cycle (2004-2006), grantees were involved with 72 pieces of legislation at the federal and state levels; six federal policies (18 percent) were passed and 20 state bills (55 percent) were passed. *Please note that lobbying activities were not funded under this program, and are assumed to be funded by other funding sources.*

Round 2 could be characterized as a modestly successful period for passage of federal and state legislation. Many federal policy issues, such as federal reauthorization of 330-clinic funding and reauthorization of SCHIP remained unresolved at the end of 2006. However, many important health bills were passed at the state level and signed into law, such as the "Safe Harbors" bill that protects Federally Qualified Health Centers (FQHCs) from anti-kickback statutes. Many grantees attributed their specific policy wins to direct policymaker education efforts, including funding for prenatal services for community clinics in Contra Costa County and direct services for the seriously mentally ill in San Diego County.

FIGURE 3

TOTAL FUNDS ATTRIBUTED TO CLINIC CONSORTIA POLICY AND ADVOCACY PROGRAM ACTIVITIES



Funding due to a grant from The Endowment

Clinic Funding

Consortia Funding

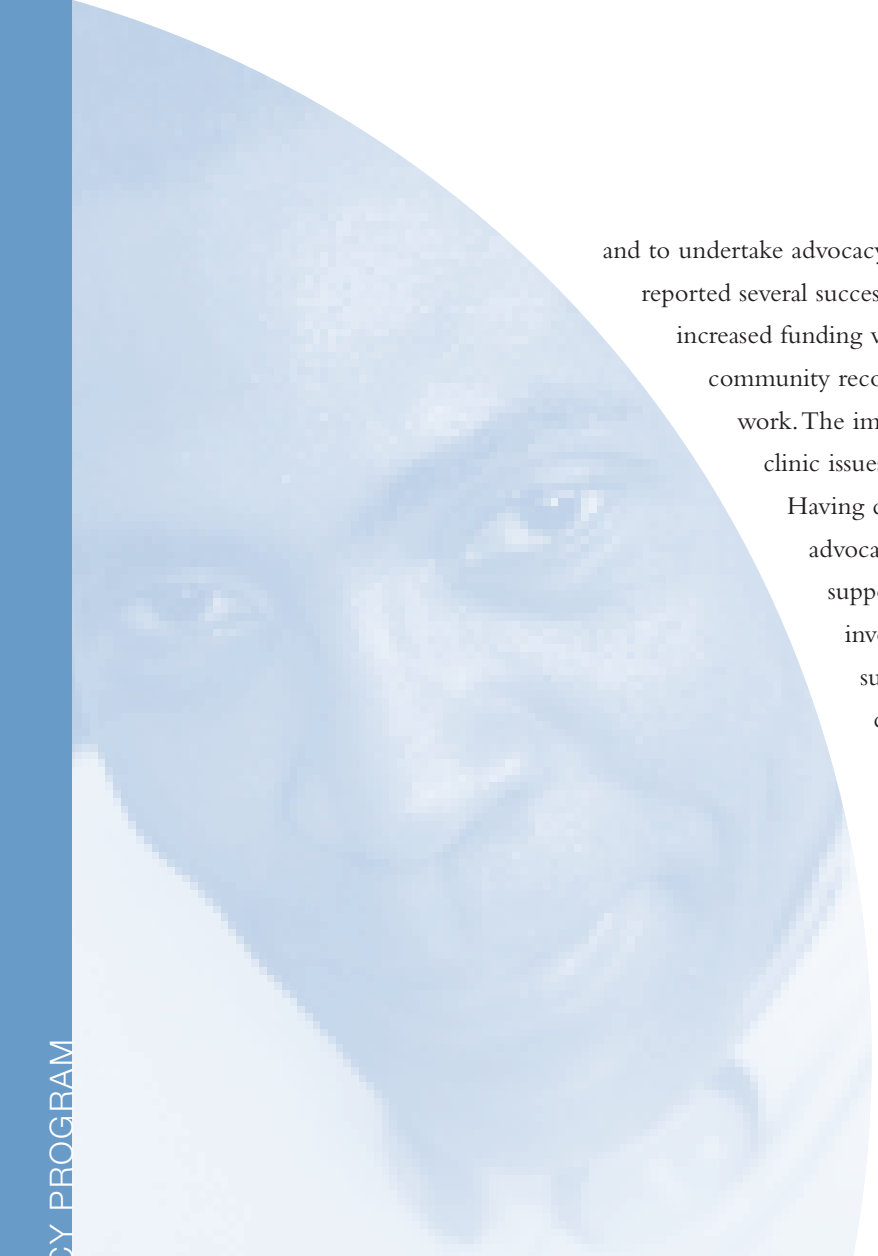
UCSF developed case studies of three different policies-state Prospective Payment System (Medi-Cal), Measure A in Alameda County, and local Mental Health Services Act funding in two counties-in order to provide a detailed look at how expanding grantee policy advocacy capacity resulted in significant gains on behalf of member clinics. Key factors contributing to these policy "wins" included:

- staff expertise;
- the ability to participate early and often during the planning and implementation phases;
- business acumen and the ability to make financial projections;
- the ability to build coalitions and mobilize stakeholders; and
- the ability to leverage partnerships with member clinics.

Outcome 4: Benefits to member clinics and their target populations

Member clinics have benefited greatly from Quality Improvement (QI) activities undertaken by grantees during the second funding cycle. Consortia continue to leverage their ability to launch and manage QI projects that individual clinics could not otherwise undertake on their own. Over the last three years, grantees have reported greater buy-in and enthusiasm from clinic members to participate in these QI activities and to use data to improve the delivery of care. Grantees also are achieving longer-term outcomes, such as development of IT systems that are being used to document improved quality of care, integration of QI data in their policy advocacy, and expansion of emergency preparedness activities.

In addition to QI activities, consortia increasingly are training clinic staff and patients to advocate in different venues, resulting in tangible benefits to clinics. Advocacy technical assistance (TA) is a new activity funded under Round 2 with the goal of strengthening clinic operations and expanding clinic capacity to engage in dialogue with policymakers



Consortia and clinics continue to be successful despite the ongoing challenge of educating policymakers...

and to undertake advocacy activities, such as media advocacy. Grantees reported several successes attributed to their advocacy TA efforts including increased funding via policy wins, registering new voters, and community recognition through awards for consortia advocacy work. The impact of advocacy TA on policymaker interest in clinic issues and actual policy successes has been considerable. Having clinic allies at the table strengthened consortia advocacy messages and shows the depth of community support for clinics. Finally, grantees that have been involved with advocacy TA for several years have succeeded in sustaining clinic staff and patient capacity for advocacy, including Speaker's Bureaus to respond to media inquires and continuing clinic-based advocacy efforts.

UCSF also worked with each grantee to develop unique, individualized best practice case studies in order to present a more detailed perspective of successful grant-funded activities that had a direct benefit for clinics and their target populations. These case studies illustrate how Endowment funding has afforded grantees an opportunity to develop novel solutions to pressing problems, such as unmet mental health needs and access barriers to health care. Grantees have experienced many successes benefiting consortia, clinics, and their communities, including maintained funding, implementation of new programs, and increased community visibility.

A primary goal of the Consortia Policy and Advocacy Program is to increase access to health care for underserved populations. All grantees are involved in initiatives to reduce barriers to health care by spearheading efforts to expand services for the underserved. For example, consortia have substantially expanded clinic facilities and increased enrollment of children in public health insurance programs. Grantees are attentive to the impacts of legislation, rules, and guidelines on access to care and have helped offset the potentially negative impacts of some legislation, such as citizen verification, while identifying gains to clinics.

Outcome 5: New partnerships

In previous years, UCSF assessed grantee capacity to form and maintain relationships among member clinics, consortia, and other health care stakeholders—their traditional allies. During the second funding cycle, grantees have prioritized partnerships with non-health organizations, including advocacy groups, academic institutions, non-health government agencies, business organizations, religious organizations, media organizations, and labor groups. Grantees initiated partnerships with 117 non-health organizations during Round 2.

Both grantees and partner organizations have a high regard for one another, rating their partnerships as very useful. There is good alignment in organizational missions and moderate partner familiarity of clinic policy issues. These new partnerships provide access to new resources, increase consortia and/or clinic visibility, and lay the groundwork for future activities. Partnerships with government agencies are considered to be the most beneficial, particularly county agencies and the county Board of Supervisors. Ongoing partnerships with academic institutions are increasingly common and have the potential for significant long-term change benefiting clinics, such as an increase in health care professionals trained in primary care. Lastly, while many partnerships with non-health organizations focus on advocacy, grantees are making inroads in new areas such as workforce development, emergency response, and local economic development. Although cultivating these partnerships requires ongoing education and staffing, it appears to be a worthwhile effort for grantees, their partners, and clinics.

Conclusions

The second round of the Clinic Consortia Policy and Advocacy Program benefited from the capacity gains of Round 1, resulting in continued achievement in many areas. Consortia and clinics continue to be successful despite the ongoing challenge of educating policymakers, clinic members, and the broader community about clinics and clinic policy issues, while also working to improve clinic operations and patient care. Their success can be attributed to the development of a policy advocacy infrastructure, their acumen to cultivate and nurture mutually beneficial relationships with policymakers as well as health and non-health partners, and their ability to respond to clinic member needs, such as improvements in clinic operations through QI initiatives.

Evaluation findings indicate that individually and collectively, grantees are achieving not only short-term outcomes, such as increased policymaker awareness of safety net and clinic policy issues, but also longer-term outcomes including increased access to care and improved health outcomes for targeted populations. Though there are annual differences, the longitudinal data on funding and policy advocacy activities points to sustained effort

and continued gains to clinics during uncertain times. The challenge is to leverage these gains and seek new opportunities, such as being ready to represent clinics when new funding becomes available.

The findings speak to the ability of consortia to branch out and be agents for systems change, creating lasting improvements to their health care delivery systems. Partnerships both with existing allies as well as new, non-traditional partners are an essential mechanism for bridging the gap between individual grantee accomplishments and achieving community-wide change. In summary, grantees are moving beyond sustaining activities to creating the infrastructure necessary for continued evolution and growth.

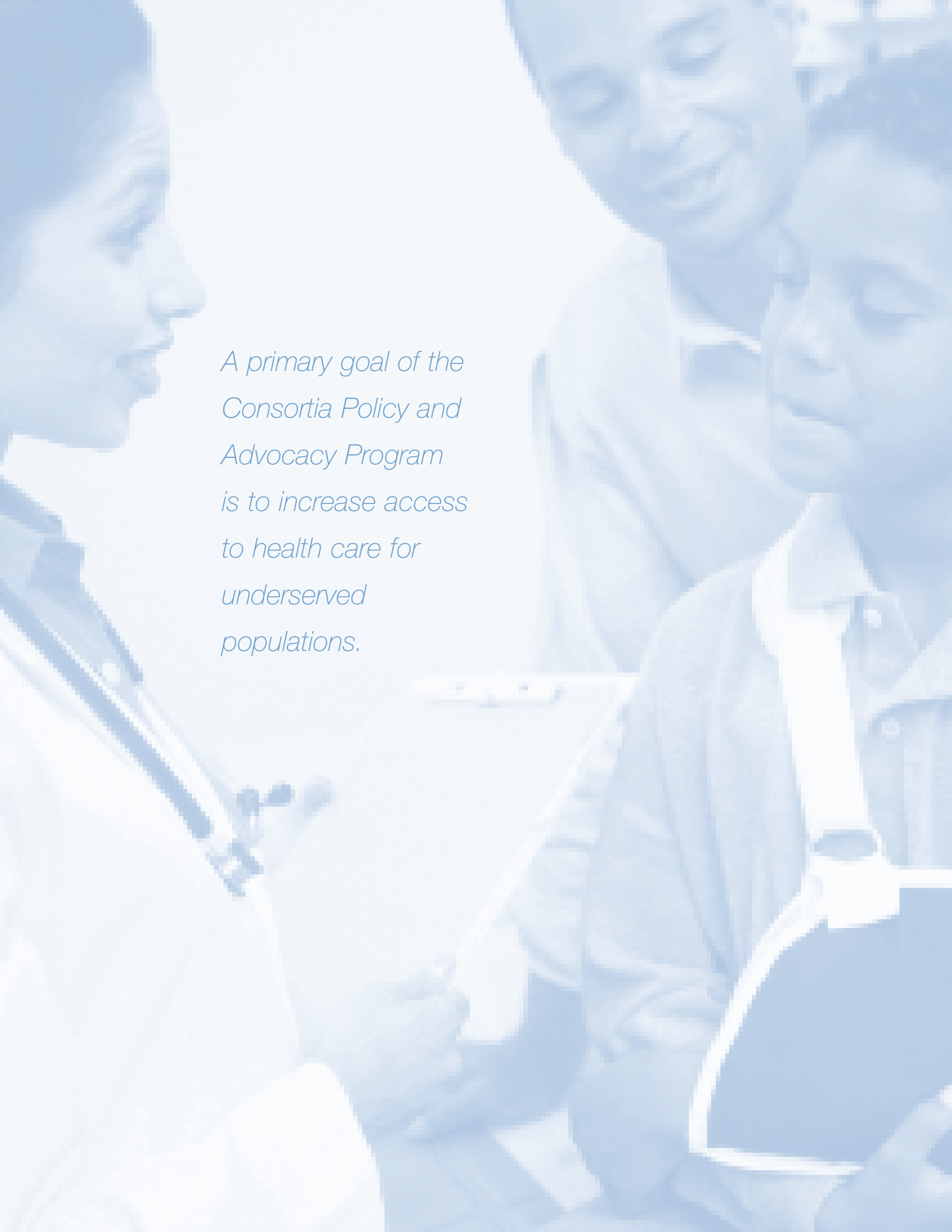
Endnotes

[1] Eighteen grantees were refunded for three years in 2007 (Round 3), undertaking or continuing a similar set of activities.

[2] These are general activities performed by consortia, and not all activities are funded via The Endowment's Clinic Consortia Policy and Advocacy Program.

[3] California State Primary Care Association (CPCA). 2005 OSHPD data reported in "California State Profile."

[4] These 794 primary care clinics are not all members of the 18 consortia grantees.



A primary goal of the Consortia Policy and Advocacy Program is to increase access to health care for underserved populations.

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