Addressing California's Community Clinic Infrastructure Needs: Strengthening and Implementing The Community Clinic Grant Program of 2005

Prepared by:
Annette L. Gardner, PhD
The Philip R. Lee Institute for Health Policy Studies
University of California, San Francisco (UCSF)

Elia Gallardo, Esq
California Primary Care Association
June 2010

SUMMARY

This case study describes an initiative undertaken by the California Primary Care Association (CPCA) to secure beneficial regulations for the allocation of funds ($40 million) under The Community Clinic Grant Program of 2005. One hundred and forty six grants were awarded to expand clinic facilities and services. The benefits of securing this funding on behalf of community clinics include a stronger safety net and increased access to care for underserved populations. The following are key findings that emerge from the analysis of this initiative:

- Expanding clinic facilities and services results in an increase in the number of patients served by community clinics. Every $1 million of infrastructure investments translates into 23,000 additional patient visits;
- It is critical to combine technical expertise in negotiating the funding allocation guidelines with advocacy expertise in working with decision makers in the drafting of legislative rules and regulations; and
- Clinic facility expansion funding is critical for expanding clinic programs and services and for positioning clinics to attract additional financial support.

INTRODUCTION

In 2001, The California Endowment (The Endowment) provided funding to 15 local and regional community clinic associations and four statewide community clinic organizations (referred to as "consortia") through the Clinic Consortia Policy and Advocacy Program to strengthen the capacity of consortia to engage in advocacy on behalf of their member clinics. Clinic consortia are statewide, regional, and local associations of primary care clinics that undertake activities that individual clinics may not be able to do on their own. In 2004 and 2007, 18 grantees were refunded for three years to undertake or continue a similar set of activities.

To achieve their goals, clinic consortia engaged in multi-year initiatives during the grant period to:

- Expand coverage (insurance and/or services) to low-income adults and/or children;
- Strengthen the local or regional health care delivery system, such as securing local funding under the Mental Health Services Act to integrate mental health and primary care; and
- Target policies to strengthen California's safety net, such as averting cuts to statewide and local public funding.

CPCA is a membership organization of 444 community clinics and health centers. Member clinics operate in nearly all California counties. In 2007, CPCA member clinics provided over 12.5 million visits for nearly 4 million patients.

CPCA's efforts to represent member clinics before and during the implementation stage of a statewide policy to direct funding to clinics that serve medically underserved populations is an example of the many ways that advocacy organizations influence decision making. It has resulted in increased access to care more broadly while serving as a stepping-stone for clinic growth.

METHODS

In 2009, UCSF staff reviewed background documents and conducted open-ended interviews with a sample of member clinics, clinic consortia staff, and partner organizations that were involved with each initiative. Informants were asked to describe their involvement in the initiative, challenges encountered, and benefits to clinics and their target populations. (*Please note that lobbying activities were not funded under this program, and are assumed to be funded by other funding sources*.)

FINDINGS

ISSUE: SECURING CLINIC FACILITY FUNDING

Community clinics and health centers face significant challenges in securing infrastructure funding in the face of growing demand for services by the insured and uninsured. It is estimated that California clinics will require an additional $989 million in capital funding through 2011(1). There are other sources of funding, including the federal funding under the President's Initiative and the Tides Foundation Building Capacities Program. However, these programs were limited and failed to meet the overall demand. The problem is particularly acute for smaller clinics that do not have a loan repayment history or large financial base.

In 2000, the California state legislature authorized the creation of the Cedillo-Alarcon Community Clinic Investment Act of 2000 (AB 2875). The one-time contribution of $50 million was distributed to 226 health centers throughout the state to fund capital outlay projects, such as purchasing new facilities and renovating existing facilities. The intention of the legislation was to expand clinic capacity to meet the needs of the underserved and uninsured and those in shortage area designations. In 2004, an additional $35 million was allocated to community clinics and health centers as part of the merger negotiations of WellPoint and Anthem, two large managed care companies. In 2005, the reauthorization of the Cedillo-Alarcon Community Clinic Investment Act (SB 190) was passed, authorizing the California Health Facilities Financing Authority (CHFFA) to develop regulations for disbursing the funds. However, instead of replicating the original Cedillo-Alarcon Act regulations, CHFFA made changes to the original regulations, some of which improved upon the original process and some of which were likely to detract from the original intent of the Act. For example, the draft regulations included new administrative requirements, such as documentation of project completion, and the maximum grant amount was reduced from $1 million to $600,000. Moreover, the regulations did not limit the grant program to non-profit organizations and included the Rural Health Clinics (RHCs), some of which do not necessarily serve all underserved individuals.

PROMISING SOLUTION: INFORMING DECISION MAKING EARLY AND OFTEN

California's community clinics were well served by having CPCA represent their interests on multiple fronts. Pre-passage of the legislation, CPCA responded to inquiries from the Insurance Commissioner's Office on the impact of the 2000 legislation on the 226 clinics that received funding. While passage of legislation is a key advocacy goal, attention on and participation in the crafting of the rules and regulations that flow from legislation is critical. CPCA was intensively involved in a series of discussions with CHHFA in 2005, the lead agency in developing regulations, on clinic eligibility, grant amounts, and grant reporting requirements.

MAJOR MILESTONES: PERSISTENCE AND PARTNERSHIPS PAY OFF

CPCA involvement with securing and allocating health facilities funding dates back to 2001 when it provided two technical assistance sessions to clinics applying for funds under the Cedillo-Alarcon Community Clinic Investment Act of 2000. Additionally, CPCA had hoped to augment this funding from $50 million to $100 million. However, the state was facing a significant deficit that precluded additional funding. However, it was also a time when the $50 million targeted to clinics was the more affordable option to shoring up the safety net.

The Anthem/Wellpoint merger in 2004 provided another opportunity for CPCA to educate decision makers on clinic infrastructure needs. At the request of the state Insurance Commissioner, CPCA provided documentation of the importance and impact of the Community Clinic Investment Act of 2000. It estimated that clinics had provided approximately one million more patient visits after 2000. These efforts proved effective: the merger included a new $35 million contribution to community clinics in underserved communities–something that had never been done before.

Since the new funds were to be used in a similar fashion to the 2000 Act to finance clinic expansions and infrastructure, then Insurance Commissioner John Garramendi decided that the funds would be made available through procedures that mirrored the process used under the 2000 Cedillo-Alarcon Act. However, the CHFFA, an office under the state Treasurer Office, developed draft regulations that deviated significantly from the original Act. Passage of SB 190 was intended to mandate the existing framework to administer the new funds. However, CHFFA chose to continue to pursue some of its original regulations, such as reducing the maximum grant amount to $650,000, prompting CPCA to work more directly with CHFFA on revising the remaining regulations that deviated from the original regulations. CPCA brought to bear its negotiating skills and technical expertise in proposing regulation amendments, including a longer project timeline of 18 months and preservation of a grant scoring system. Ultimately, this alliance benefited clinics and CHFFA. CPCA was able to preserve many of the original provisions of the 2000 regulations and CHFFA had CPCA's support on the final regulations. In May 2006, 146 grant requests totaling more than $40 million were approved.

CPCA turned its attentions to ensuring that clinics were informed of the new funding opportunity and successfully navigated the application process. It provided technical assistance, such as assisting clinics that did not get their applications scored correctly. Additionally, it publicly acknowledged the decision makers who supported the program and the clinics that

expanded their facilities, such as, holding ribbon-cutting ceremonies.

The resources required to represent member clinics during the drafting of rules and regulations vary with the legislation. In the case of the 2005 Act, two CPCA staff worked part-time for 3-4 months to negotiate the final regulations. Communicating with member clinics and providing technical assistance in preparing grant applications required similar staffing over two months, such as explaining the grant process and making sure that applications were in compliance with the RFP.

Partnerships and collaborations*:* While CPCA can do much of the legwork to develop alternative regulations and respond to decision maker inquiries, it relied heavily on its partnerships with high-level supporters of community clinics. Key partners included:

Insurance Commissioner's Office: CPCA had a long-standing relationship with John Garramendi, who was the treasurer of CHFFA going back to the 2000 initiative. Since then, CPCA partnered with the Commissioner's office on other occasions, including securing clinic representation on the investment in the Healthy California Program Advisory Committee, which provided input on the allocation of Anthem/Wellpoint merger funding more broadly. Solid relationships with Commissioner John Garamendi and his staff were essential in facilitating the CHHFA/CPCA partnership, as well as directing funding to clinics under the 2005 Act.

California Health Facilities Financing Authority (CHFFA): CHFFA is the vehicle for allocating state subsidized loans to community clinics. The initial allocation of funding under the 2000 Act was considered a model process and CHFFA was the logical site for allocation of 2005 Act funding. Differences in the regulations for the second round of funding may have had more to do with staff turnover and a different vision of eligible clinics. In the end, CPCA and CHFFA were able to work through their differences, with concessions on both sides.

Overcoming challenges: As described above, CPCA had to contend with draft regulations that had the potential to work against the goal of creating investments for the public good. Passage of legislation to require adherence to the original guidelines developed under the 2000 Act was not enough to ensure a straight reauthorization. CPCA had to maintain pressure and employ strong administrative advocacy expertise to achieve its goals. Second, the funding from the Anthem/Wellpoint merger was an innovative opportunity but it may have been a one-time opportunity. Efforts to secure an investment fund from the PacifiCare/UHG merger in 2006 were unsuccessful due to a change in staff and departure of John Garamendi. Nor is it an easy approach to securing new funding. Initially, Anthem was reluctant to commit funds to programs for the public good and negotiations were difficult.

ACCOMPLISHMENTS AND BENEFITS

The short and long-term outcomes of securing and allocating funds from the Anthem/WellPoint merger for clinic facilities and services included:

E*xpanded CPCA advocacy capacity:* CPCA expanded its expertise in the areas of bonds and financing. It leveraged its in-house expertise in negotiating the technical details of administrative rules and regulations, specifically clinic eligibility and development of the grant guidelines. CPCA negotiated the details while clinics provided input on the regulations and why they would or would not work.

***Increased policymaker awareness of safety net and clinic policy issues*:** CPCA built on prior decision maker support for clinics under the 2000 Act, maintaining its role as a credible source of information on the role of clinics in meeting the needs of the uninsured in California. CPCA sought the support of Senators Cedillo and Alarcon, as well as adopted a bipartisan approach to educating decision makers on 2000 dollars and their impact. There was not a lot of opposition since the funds had already been allocated and CPCA was just seeking to allocate the funds using the original framework.

***Increased policymaker support of safety net and clinic policy issues*:** CPCA efforts to cultivate and maintain relationships with top-level decision makers contributed to these decision makers sponsoring legislation as well as intervening on CPCA's behalf in the drafting of the rules and regulations. As a result, $40 million ($5 million from the 2000 Act and $35 million from the 2005 Act) was allocated to 146 community clinics statewide. While for many recipients, individual grants represented part of the total funding required for a facility expansion, the funding was important for meeting capital campaign goals and securing the additional funding needed to complete clinic expansions.

Strengthened clinic operations*:* The $40 million in new funding for clinic facilities and services greatly contributed to clinic operations on multiple fronts: expanding clinic facilities allows for increased clinic staffing, including providers and support staff; installing equipment is useful for clinic operations later on, such as information technology that can be used for quality improvement activities; expanding physical space allows for restructuring and streamlining of services, such as co-locating behavioral health and primary care services; and, having a larger facility attracts more patients that in turn generates additional revenue for the clinic.

Increased services for the underserved and uninsured: For the $30 million secured under the 2000 Act, CPCA estimates that every $1 million in clinic facility funding resulted in 23,000 patient visits, for a total of 700,000 visits. While a comparable analysis was not done for the 2005 funding, individual clinics interviewed for this case

study report significant expansions in services and consequently expanded access to care for existing and new services. For example, CommuniCare Health Centers was able to expand its facility in West Sacramento and bring all its services under one roof, including medical, dental, ob/gyn, and mental health. Logan Heights Family Health Center added 23,000 square feet to an existing clinic and it anticipates an increase in 28,000 visits or 20 percent increase in capacity.

Clinic Experience: Expansion of the Bolinas Community Health Center

The Coastal Health Alliance, a three-site community clinic, received $750,000 under the 2000 Act, which allowed it to build a new clinic in Bolinas. This funding was instrumental in helping the clinic secure the additional funding required to undertake the multi-million dollar expansion. The existing facility did not meet ADA or federal access standards. The Bolinas clinic would have had to close if a new site had not been developed. The Bolinas Community Health Center expanded its provider time and clinic users increased from 970 users/year (2,750 visits) to 1,060 users/year (3,036 billable visits). It also expanded its mental health services in Fall 2009. Being a successful CHFFA grantee also provided the Coastal Health Alliance the expertise to approach other lending institutions.

Improved health outcomes for targeted communities and populations: An increase in clinic space allows for an increase in providers, which in turn leads to an increase in access to services (medical, dental, pharmacy, lab, and mental health). Moreover, additional providers are the means for implementing programs and services that have a positive impact on the community, such as expanding clinic hours and offering wellness services. Additionally, increased clinic capacity translates into increased ability to meet community unmet needs. For example, the Coastal Health Alliance expanded its provider capacity to meet the needs of an aging population in West Marin.

FACTORS FOR SUCCESS:

CPCA is the lead membership organization for California's community clinics and is able to bring skilled staff and resources to bear on multiple policy issues in multiple arenas. It played an ongoing and active role in securing and preserving state clinic infrastructure funding on behalf of its member clinics. In addition to being a vigilant advocate that positioned itself at the beginning of process in 2000, CPCA remained involved and was proactive in negotiating the technical details of legislation post-passage. Throughout the process, CPCA was mindful of its partners and was strategic in bringing its influence to bear. Creating clinic champions at the top level provides a window of opportunity. It is hard to know when the window will open but it is important to lay the groundwork, develop the relationships, and have the visibility. Decision makers need to be thinking of you. It is important to take seriously every communication – the window may open without a lot of advance notice. Also, connections may benefit you when you least expect. Key people who were highly familiar with CPCA were in the position to target $140 million for clinics.

LESSONS LEARNED:

While the staffing and time requirements are modest, maintenance of effort and building on previous policy experience are essential. Also, contextual factors, such as the right people in the right place at the right time, are important to the success of an initiative. It is important to lay the foundation to allow for opportunities to occur as well as enhance an organization's strategic advantage.

THE FUTURE:

There are no mergers or acquisitions of insurance companies on the horizon. However, the CHFFA funding mechanism may have applicability in other allocation situations, such as disbursing of federal stimulus dollars. CPCA research is focused on identifying permanent funding sources for clinic infrastructure costs, such as penalties and fees.

CONCLUSIONS

In short, this advocacy initiative was successful in expanding clinic facilities and services and helping clinics meet the unmet needs in their communities. Partners were important for ensuring adoption of guidelines that preserved the original intention of the Act. The benefits of securing and preserving Cedillo-Alarcon funding are a stronger safety net and increased access to care for underserved populations.

FOR MORE INFORMATION:

California Primary Care Association
Elia V. Gallardo, Esq.
Director of Government Affairs
California Primary Care Association
1231 I Street, Suite 400
Sacramento, CA 95814
Phone: (916) 440-8170 ext. 1083
egallardo@cpca.org
URL: www.cpca.org

UCSF Evaluation
Annette L. Gardner, PhD, MPH
Evaluation Director
Philip R. Lee Institute for Health Policies Studies
University of California, San Francisco
3333 California Street, Suite 265
San Francisco, CA 94118
Phone: (415) 514-1543
Annette.gardner@ucsf.edu
URL: http://ihps.medschool.ucsf.edu/

CITATIONS

1. Schact & Associates, "The Vital Role of Community Clinics and Health Centers: Assessing Access for All Californians." March 3, 2008.