



CALIFORNIA
HEALTHCARE
FOUNDATION



Bootstrappers and Mavericks:
A Framework for Understanding
What Drives Community Clinics

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Bootstrappers and Mavericks: A Framework for Understanding What Drives Community Clinics

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CALIFORNIA HEALTHCARE FOUNDATION

by

NCB Capital Impact

Point Forward

About the Authors

NCB Capital Impact (NCBCI) is a national organization committed to helping people and communities reach their highest potential at every stage of life. Over its 30-year history, its Community Development Financial Institution (CDFI), has provided \$1.7 billion in affordable financing to organizations working in underserved communities. Since 1995, NCBCI has provided more than \$610 million in capital for the construction and renovation of community health center facilities, the acquisition of equipment, and working capital needs. This investment has resulted in 3.1 million square feet of additional CHC space serving more than 1.3 million patients annually. Over half of its clinic loan portfolio is in California.

Point Forward is an innovation consultancy based in Redwood City, California that specializes in ethnographic research and need-finding to connect organizations to their consumers and create innovative product and service opportunities. Point Forward uses health care engagements with providers such as Kaiser Permanente and Alegen Health to transform care through patient experience and process innovations.

About the Foundation

The **California HealthCare Foundation** works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit us online at www.chcf.org.

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Prologue

At a large, urban community health center... leadership fosters business practices that it believes lead to high-quality care and efficient operations. But staff feels there is a disconnection between perceptions of clinic needs at the top of the organization and among providers. One person used the term “admin-land” to describe the staff view of leadership.

At a suburban clinic... clinicians embrace the mission to provide high-quality care to all regardless of ability to pay. Yet many feel that the intense pressure from management to maximize billable visits comes at the cost of innovative approaches that could result in better health outcomes.

At a mid-sized, urban community health center... the patient population has changed over the decades since its founding. While many clinics have taken steps to ensure that their staff and programs reflect patient demographics, evolution at this clinic seems stalled.

At a small, rural clinic... there is reluctance to collaborate with organizations outside its walls, despite its limited-resource environment. The clinic feels insular — which constrains its ability to achieve fundraising, patient health outcomes, and other goals.

Community health centers (CHC) respond in widely different ways to their environments — sometimes when the challenges seem similar. The volumes of data available on CHCs do not fully explain such differences in approach. Because CHCs are vital to the interests of communities throughout California, and because clinics are likely to face unprecedented demand and financial pressure in the future, it is useful to understand how they work and what their opportunities might be to improve their performance.

The ethnographic research employed for this study examines the culture and identity of health centers through the lenses of the people who work and receive care there. (Appendix A briefly describes ethnography.) Within their experiences are important ideas about how to secure CHCs’ place at the forefront of this new era of health care.

I. CHCs in California

A STUDY OF CHCs' FINANCIAL HEALTH published in 2010 showed a growing demand for services and pointed to the need for clinics to improve their capacity.¹ It found that, as of 2008, there were 230 health center organizations operating 719 clinic sites serving a total of 3.6 million people in California. The report also indicated that:

- CHCs were heavily dependent on revenues from patient services and especially on those reimbursed by Medicaid;
- CHCs varied widely in terms of financial strength;
- CHCs were not serving the majority of uninsured/low-income Californians; and
- Cutbacks to state-funded health care programs represented a significant threat to CHCs.

Despite substantial federal investments in community health centers, they face constraints in accomplishing their mission of optimizing

community health. One structural barrier is the complex reimbursement system that locks CHCs into a service delivery model that can be inefficient and disconnected from quality patient outcomes. Other challenges include: growth in uninsured populations due to increased unemployment; state reductions in entitlement programs; recruitment and retention of staff — especially medical providers; the need to keep up with rapid advances in technology; and rising costs.

On the immediate horizon, the Affordable Care Act (ACA) could bring many new, previously uninsured patients into CHCs seeking care. But the uncertainty of full ACA implementation leaves clinics and their investors having to plan for a future that is difficult to predict.

To the extent that California CHCs are able to respond positively to their changing environments and embrace growth, they have the potential to serve as engines of innovation that improve the performance of the health care system as a whole.

Overview of Community Health Centers

Community health centers (CHCs) are nonprofit community-directed organizations that provide primary care services to individuals and families living in low-income and medically underserved communities. Health centers serve over 20 million people nationally and provide care to all, regardless of a patient's ability to pay, while offering services tailored to the linguistic and cultural needs of their constituencies. There are more than 7,000 clinic sites in underserved urban and rural areas nationwide. In California, nearly 4 million people are cared for in more than 700 CHC sites.

Nearly 70% of CHC patients live at or below the federal poverty level. More than one-third are uninsured while another one-third depend on Medicaid. CHCs rely on a combination of federal and state grants, Medicaid and Medicare reimbursement, patient fees, private insurance payments, and donations. Most health centers operate from multiple sites around a community, from small school-based clinics to large comprehensive care facilities that provide a combination of primary, dental, and behavioral health care services.

II. An Ethnographic Approach

ETHNOGRAPHY IS A METHOD USED TO understand and describe people and cultures. It is based on fieldwork in which researchers spend time observing and talking with people in their natural environments. The resulting “inside out” view reveals insights that would not be captured by data alone.

Ethnography is particularly effective at stimulating innovative and creative thinking because it uses the insights of an outsider (the researcher) as well as the wisdom of an insider (those being observed). The ethnographer enters the field without the bias of someone entrenched in the system and exits with intimate knowledge of its subject’s strengths, weaknesses, successes, and challenges. Because ethnography reports often contain rich descriptions and broad insights, they are well suited to the collaborative, creative climate of multi-discipline innovation teams used by most institutions today. Ethnography has been used in many kinds of settings, including health care (see Appendix A).

This ethnographic study included field work with seven California CHCs. For some consistency, all clinic participants were Federally Qualified Health Centers (FQHCs). The clinics were diverse in terms of number of sites, budget, number of patient visits, location (rural and urban, Northern and Southern California), age, and communities served (see Appendix B).

Teams of four to five researchers spent two full days at each clinic, often at multiple sites. They talked to employees at every level of the organization, interviewed patients, and observed waiting rooms, nursing stations, and back offices. The research methods included:

- Semi-structured interviews with management and staff on a wide range of topics, from daily operations to long-term goals;
- Observations of CHC operations and shadowing of key individuals, including back-office tasks, meetings, appointments, other patient interaction and interactions with outside entities; and
- Interviews with patients to understand the CHC experience from their perspective.

Participating clinics were given a grant of \$1,500 and were ensured anonymity to encourage open, honest dialogue. Patient participants were given \$25 gift cards.

The data gathered were examined from the multiple perspectives of operations, organization, goals, environment, cultural meaning, and identity. A major goal of the research was to identify specific gaps or opportunities between CHCs’ ideal and existing characteristics.

The Polarity Framework

The analysis and synthesis of the data led to the development of a new framework for characterizing the primary forces shaping the performance of CHCs. The framework is based on the theory of “polarity management,” a system of thinking that can be applied to complex challenges that do not lend themselves to simple solutions. By understanding their orientation within the polarity framework, clinics may be able to identify their strengths, weaknesses, successes, and challenges, and more fully realize how best to use their resources to innovate solutions.

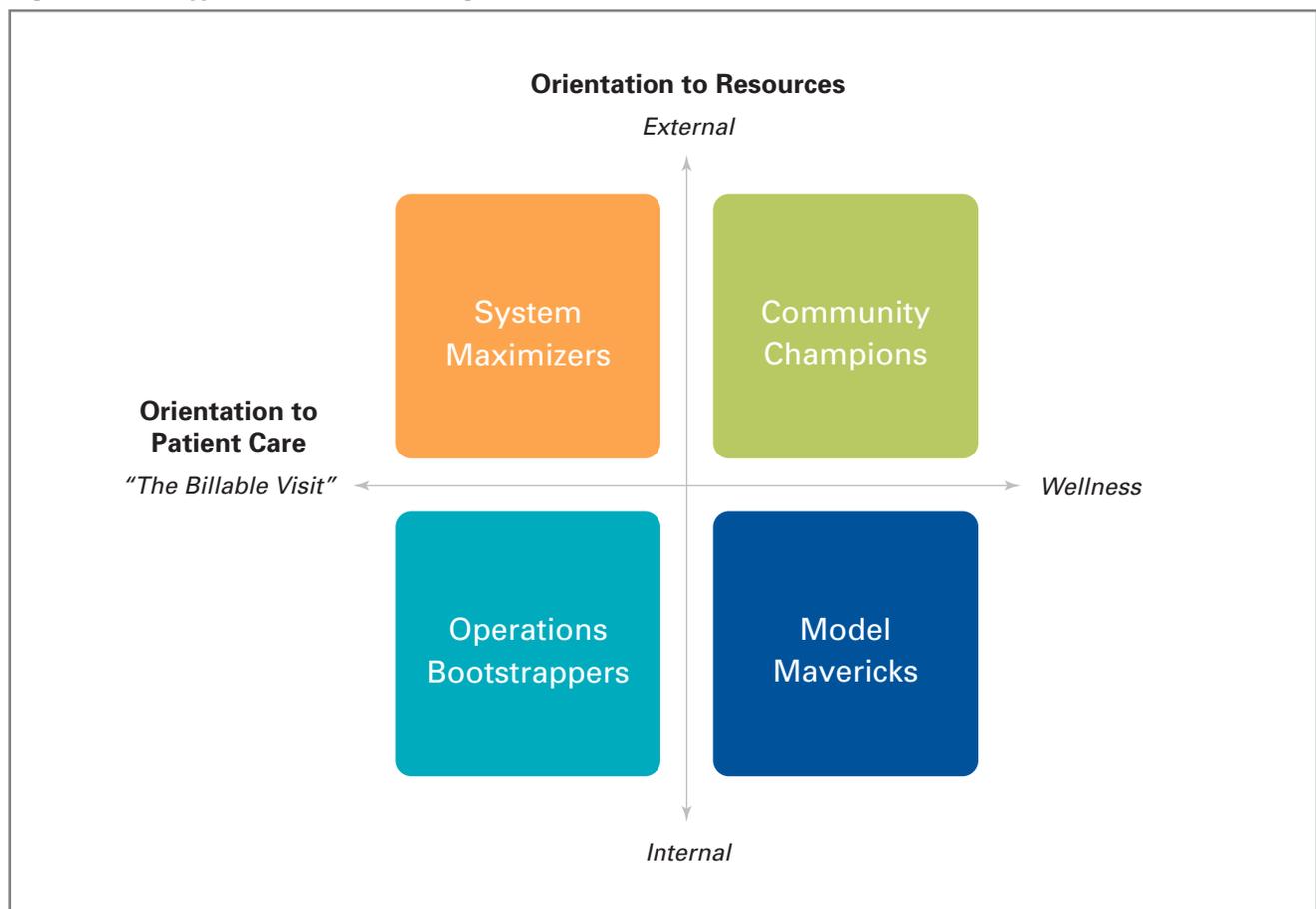
The research uncovered two sets of polarities within the CHC framework: (1) external and internal orientation to resources; and (2) an orientation toward patient care characterized by emphasis on “the billable visit” and emphasis on wellness. An intensive examination of how each clinic balanced these polarities enabled the researchers to identify four “types” of clinics based on their orientation to the four poles (see Figure 1).

Each clinic’s point of view, as oriented within the framework, helps explain the multitude of decisions and activities that clinics accomplish every day, as well as to reveal the possibilities for change or growth that might strengthen the organization.

To understand polarities, it is important to know that the two poles depend on each other to exist: Both are required over time.

- **Polarities** are not problems to be solved, but are ongoing and involve interdependent alternatives that must be managed together to optimize a given situation. Focusing too much on one and neglecting the other will eventually undermine efforts to move toward the organization’s highest purpose.
- **Problems** are not ongoing, are solvable, involve independent alternatives, and often contain mutually exclusive opposites (an either/or solution).

Figure 1. Four Types of Clinics According to Orientation to Resources and Patient Care



All of the participating clinics demonstrated at least some awareness of the four poles, although most were oriented more toward one pole or another. As a result, the clinics varied in their capacity to function well among — or, at least, cycle regularly through — all four. Importantly, the clinics’ ability to innovate and the type of innovation pursued were tied directly to their orientation among the four polarities.

External and Internal Resources

It is crucial for community clinics to identify, obtain, and maximize resources — both external and internal.

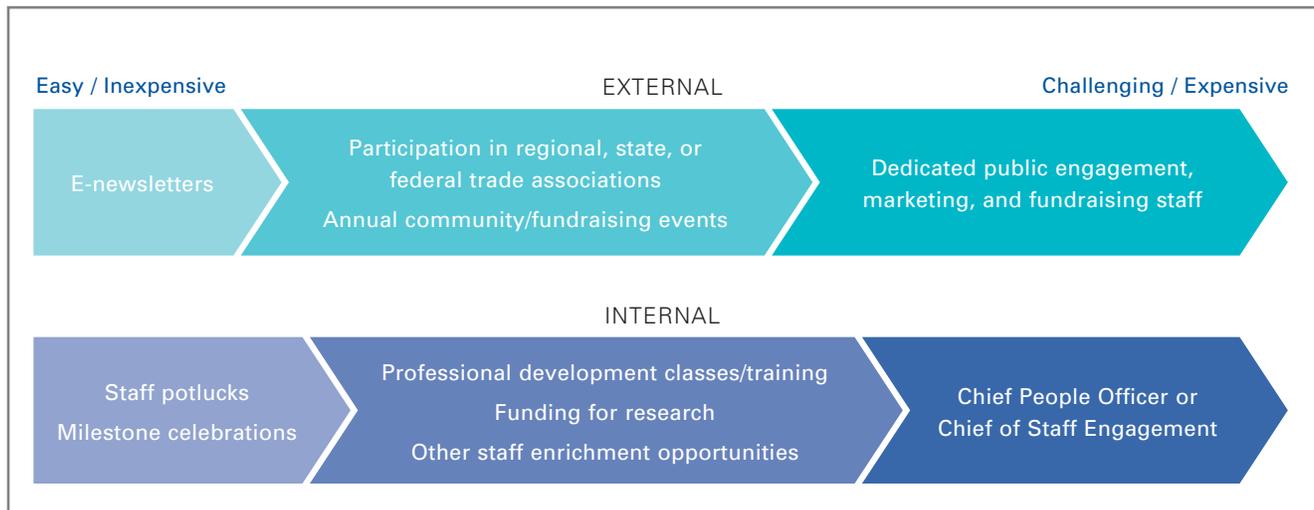
External resources-oriented activities include fund development, community relationships, policy engagement, and development of hospital partnerships. External orientation is key to a clinic’s visibility in the community and access to the resources that visibility can bring. Most clinics know that patients are only one part of their stakeholder base and that they must be adept at telling their story and marketing their successes to attract diverse partners to support and expand their work. Clinics with this orientation demonstrate an ability to

forge external collaborations to fill resource gaps and ensure positive external perceptions of the organization.

Internal resources-oriented activities include development of meaningful staff engagement, professional growth opportunities, and a clear and compelling culture. Because clinic environments can be challenging workplaces due to lower wages, sub-par facilities, and a challenging patient population, a positive culture is crucial to recruiting and retaining high-quality staff and inspiring excellence in every aspect of care.

Clinics operate in a lean, regulated, and rule-oriented environment. Meeting the day-to-day demands of a clinic is essential but cannot be the only goal. It is incumbent on management to seek opportunities both to grow and appreciate employees; this is an effort that will benefit the clinic as well through higher job satisfaction and lower staff turnover. However, most clinics do not have ample internal resources to spur innovation on their own. Partnerships and collaborations external to the clinic are necessary to support innovative practices.

Figure 2. Examples of Activities to Strengthen Clinics’ Orientation to Resources



Wellness and “The Billable Visit”

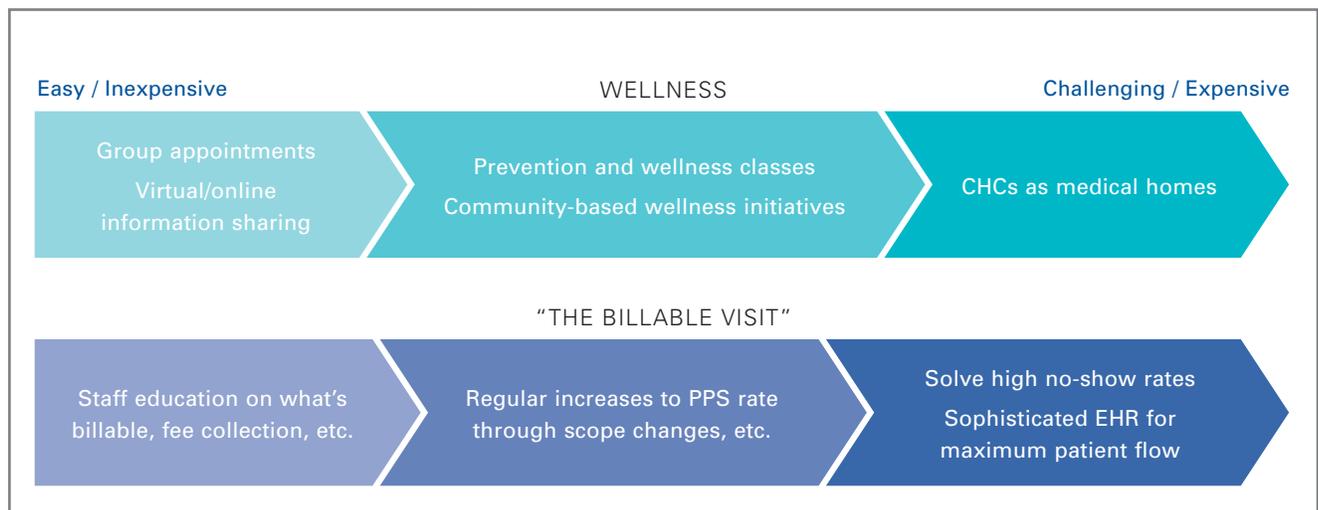
A healthy tension between a CHC’s medical mission and its financial health must be carefully managed. The current payment model of cost-based reimbursement emphasizes traditional approaches to treatment and maximization of the number of certain kinds of patient visits over innovative treatment models or prevention efforts. Clinics therefore must spend time focused on productivity aimed at maximizing financial return within the current system. Some use skilled finance and accounting staff who are expert at navigating the state and federal bureaucracies on which clinics must depend for most of their revenue. In many cases, it takes years for clinics to obtain retroactive payments from cost reconciliations.

However, the study found that clinics with the strongest focus on maximizing reimbursement rates and patient visit throughput were sometimes less effective at meeting patient needs and seemed

less open to innovation. While efficiency and productivity are important attributes of a successful clinic, overemphasis on these efforts seemed to undermine staff morale and the creation of a cohesive and compelling clinic culture. Many clinic staff members expressed frustration with the “factory-like” approach that the reimbursement model seemed to demand.

Some clinics found creative ways to work around the reimbursement system by taking a population management approach to promoting wellness. These clinics focus on long-term, preventive, comprehensive care. There are challenges to this strategy. Health education, disease prevention, nutrition counseling, even some behavioral health care are not reimbursable services under the current payment structure. Also, teaching patients disease self-management can be difficult and time-consuming.

Figure 3. Examples of Activities to Strengthen Clinics’ Orientation to Patient Care



III. Opportunities Within the Poles

FOLLOWING IS A DETAILED DESCRIPTION of the different types of clinics that emerged in relation to the polarity framework, along with some identified opportunity areas for clinics, funders, and policymakers. Among all four poles there are best practices that range from simple and relatively inexpensive to more difficult and resource-intensive to implement. See Figures 2 and 3.

Within the polarity framework, clinics can develop blind spots from over-emphasis on one set of needs while neglecting another. A key strategy for any clinic, then, is to recognize its current strengths or assets as well as the “white space” or areas ripe for improvement and growth.

“Community Champions”

Focused on long-term, preventive, comprehensive care coupled with an external orientation to resources, these participating clinics were dubbed “Community Champions” for purposes of the study. For these CHCs, community engagement is key and a means to innovation. While traditional sources of revenue remain important, Community Champions work hard to identify other funds and resources to



maximize the organization’s ability to focus on disease prevention and wellness promotion.

Strong and varied external partnerships are hallmarks of the Community Champions. For example, Clinic A has forged a valuable partnership with a local, highly regarded teaching hospital. This affiliation brings the clinic expertise in medicine and technology and access to business and operating systems that most clinics lack. Importantly, it also expands Clinic A’s access to employees, as those who choose to work in the clinic are not required to relinquish their university tenure or benefits. This innovative partnership is a powerful means to recruit and retain high-quality providers. In addition, Clinic A’s successful history has been built on its ability to capture the interest and enthusiasm of its community to support its operation and growth. The clinic appears to have a fundraising campaign that is in perpetual motion and that harvests ideas and energy from an army of volunteers that far outnumber paid staff. Most notably, these resources seem to be coordinated and focused from every level of the organization on innovations in patient care.

Clinic B has a long history with the federally funded AmeriCorps program, using AmeriCorps members to provide outreach and patient enrollment assistance, as well as offer health education that helps patients maintain and pay for medications. Such self-care training helps patients live healthier lives, especially those with chronic conditions. Clinic B has also established a successful partnership with a large hospital that allows clinic staff to take professional development courses sponsored by the hospital free of charge and to participate in teaching rotations in the surrounding area. Finally, this clinic manages

partnerships with public schools to bring health programs inside the school walls. Going beyond clinical care, Clinic B offers before- and after-school programs as well as supervised homework periods. Students can take classes in art and music and participate in recreational sports. The clinic also provides individual and group counseling, and consults with faculty and staff to address social issues in class or at play. They conduct educational programs to motivate and educate students to make healthier life choices. Clinic leaders believe that working with children through the school system is a powerful tool to create wellness habits that last a lifetime.

At Clinic E, innovation is limited. However, many years ago the health center established a groundbreaking partnership with Kaiser Permanente. Due to the wide distance between Kaiser's nearest facility and many of its clients, it began allowing the clinic to provide primary care services to Kaiser members living in the health center's service area. Recently, Kaiser has begun to research and test the possibility of building a technological bridge between its own EMR system and that of the CHC. The goal is to improve continuity of care to clients receiving care at the health center. Apparently, Kaiser sees the health center as a pilot for this technology and, given that most clinics face the challenge of being unable to access medical records of its patients outside clinic walls, this long-standing partnership now has the potential to give rise to an innovation of value to all CHCs.

Two "counter examples" offer contrasts to these clinics' orientation. Clinic C, for example, appears to have become weaker than it once was in its ability to harness external resources. When this CHC commenced operations several decades ago, it relied on an army of organizers to reach out and stay connected to its community. This allowed the

clinic to be especially adept at providing culturally appropriate care while leveraging its deep community connections to bring additional resources to support its operations. Today, the ethnic make-up of Clinic C's community has shifted dramatically while the size of the staff devoted to outreach has shrunk significantly. Importantly, only a small minority of the outreach staff reflects the linguistic and cultural identity of the community.

Another counter example can be seen in Clinic G. Though the benefits of this health center's strong internal focus are many — high job satisfaction, low staff turnover, organization-wide alignment with the mission — this emphasis has resulted in a relatively low profile outside the clinic walls and immediate community. Signage for the health center was poor, and was explained with the comment that "patients know where we are and we don't have capacity to grow our patient base much in any case." Though the health center enjoys a good relationship with one of the local hospitals, the CMO said that, generally, the clinic's profile outside the medical community is weak.

Likely due to a primary focus on development of staff — and a generally frugal mentality — Clinic G's CEO is not as engaged in state or national health care forums as some others. There is a general feeling among the staff of distance from the CHC "establishment" and skepticism of outsiders. Management's focus on its staff and current patient population may reflect a limited view of its stakeholder base, and they might be missing opportunities to identify additional external resources and partnerships that could help advance their mission. An overemphasis on these particular poles leaves room for improvement in the health center's ability to engage and attract outside support for its mission and, possibly, increase its reimbursement rate without sacrificing patient care.

Lessons Learned

- Clinics should leverage external relationships and resources to help advance their strategy.
- Creating and maintaining strong community ties and a recognized brand positively affects a clinic's ability to effectively serve its patient population, recruit and retain quality providers, and raise critical financial resources.

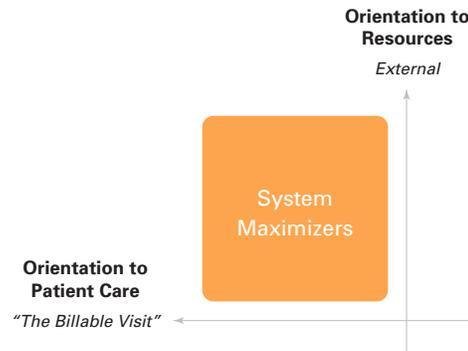
Practice Innovations for Community Champions

Wellness outreach. Many CHCs already do some patient wellness education and counseling (such as nutrition and chronic disease management), but much of this work takes place inside clinic sites. Offering more of these outside of the clinic — in libraries, cafes, church basements — would make connections within the community. Mobile vans could allow full educational programs to be brought to schools and community centers. Beyond the benefit to community health, these efforts would also increase a CHCs' visibility and help validate or establish their role as places where anyone can receive high-quality, culturally competent care.

The challenge to efforts like these is cost. It is difficult for clinics to secure funding to support these non-billable services and to “prove” their beneficial effects. Funding to support the design, implementation, data collection, and evaluation of a comprehensive, off-site, outreach program could provide a powerful platform from which clinics could advocate that the cost of these services should be reimbursable, too.

“System Maximizers”

The leadership of CHCs focused toward these poles is often the strongest voice at the state and federal level for public policies that will benefit community clinics. These clinics concentrate their focus on



maximizing reimbursement within the current payment model, resulting in PPS (Prospective Payment System) rates that are the highest among their peers.² They are well known to communities external to the clinic. However, innovation tends to be more incremental and these clinics are not as skilled at maximizing internal resources.

Of the seven clinics included in the study, Clinic D was the only one that chose a person on the development staff to host the researchers' initial tour of the main facility. It was a first indication that this clinic is particularly aware of its public image, adept at telling its story to “outsiders,” and focused on the important tasks of business development and fundraising. The CEO is quite visible in state and national forums, playing a leadership role in advocacy for CHCs.

Clinic D's successful external orientation to resources has resulted in excellent relationships with local hospitals, allowing an effective continuum of care for patients receiving treatment in both settings. The clinic's leadership is justifiably proud of its performance on standard measures of productivity and efficiency. Yet, it appears that this emphasis causes some strain. During the interviews, several references were made to the divide between leadership and the rest of the staff on this issue. Although one doctor commented that Clinic D was, for the most part, provider-friendly, others felt

there lacked a good understanding of the pressures providers face working in the clinic environment and at Clinic D specifically.

Most of the interviews contained multiple references to the importance of maximizing billable visits, the number of visits a provider must fit into each day, and the challenge of giving good health care under these constraints. In describing this pressure, one provider said, “We are crunched for productivity.”

The clinic’s low emphasis on behavioral health fits its focus on the billable visit. Only one psychiatrist supervises all behavioral health services at this large CHC. The psychiatrist is dual-boarded in primary care, so there is some value placed on the integration of behavioral and primary health care. However, actual integration is constrained by the minimal level of investment in behavioral health staff. While many patients seeking primary care services in a health center might also benefit from behavioral health care, true integration of these two types of services can be seen by clinics as a challenging distraction from their more easily reimbursable treatment offerings.

At Clinic C, the focus is laser-like as staff work to hone the delivery of services, maximizing capacity to capture any and all payment sources that enable it to mount and sustain primary care and related health services. The CEO is well-known and respected in statewide and national clinic forums and works hard to maximize all available public funds in support of the CHC. Employees are intensely focused on raising the PPS level; one staff member referred to it as “dialing for dollars.” Not surprisingly, Clinic C had the highest PPS rate in the study. There is a strong loyalty to patients at Clinic C, and all rules are strictly followed with respect to patient care and clinic operations. However, some staff expressed concern that the culture at the clinic can

feel bureaucratic and limiting in terms of fostering innovation from within.

Clinic G and Clinic E offer counter examples. At Clinic G, a major theme of all interviews was the focus on patient wellness and, particularly, on the full integration of primary and behavioral health care. The health center employs several full-time dual-boarded family medicine and psychiatric specialists who help manage the behavioral health specialty practice. Patients with more acute behavioral health needs receive care in this setting. However, case managers and counselors also work in the clinic itself so that patients with less acute behavioral health needs can receive counseling in the same place they receive primary care. The next phase of integration is to bring primary care treatment rooms into the behavioral health specialty care offices. Ultimately, patients will be able to access both primary and behavioral health care services no matter where their initial visit takes place.

At Clinic E, focus on outside resources has shown a downside. When clinic leadership saw an urgent need to streamline by closing or limiting one of its sites, there was strong resistance from the board and community. Since its founding, this CHC has enjoyed a great deal of local community support, and several individuals have given generous financial gifts to the clinic. However, one staff member commented that some in the community “feel like they own the clinic” — even wanting to be involved in decisions about day-to-day operations. Clinic leadership works hard to balance community involvement with what is best for the sustainability of the business. To that end, an outside consultant has recently been engaged to conduct an operational assessment and feasibility study of all clinic sites. The hope is that the recommendations will be more accepted because they will originate from an impartial third party.

Lessons Learned

- A conscientious emphasis on external resources can bring valuable inputs — financial and otherwise — to support both sustainability and innovation inside CHCs.
- External resources and relationships must be carefully managed so that balance is maintained between community involvement and the business needs of the CHC.
- An overemphasis on maximization of cost-based reimbursement can stifle creativity and innovative approaches to patient wellness.

Practice Innovations for System Maximizers

A new PPS “pie.” For now, health centers must live within the PPS structure, but there may be opportunities to reassess the division of reimbursements to create opportunities to subsidize and emphasize wellness programs. The aims would be to reduce visit times and increase overall encounter volume, keeping revenues high, while providing care that is closer to a holistic model. It will take extensive research to show which wellness activities provide the most benefit in terms of reduced patient visits or less complicated, time-consuming diagnoses.

Better utilization of MAs. Given that medical assistants (MAs) outnumber providers by at least 2:1, there could be both cost and time efficiency gained by allowing or training MAs to perform more tasks. Some clinics rely on MAs to provide IT and other technical support. In other clinics, MAs are effectively cross-trained so that they can also serve the needs at the front desk when they are not needed by providers to perform medical tasks. And in some CHCs, staff that had started as MAs had been encouraged to take on additional responsibilities and offered training opportunities that had advanced

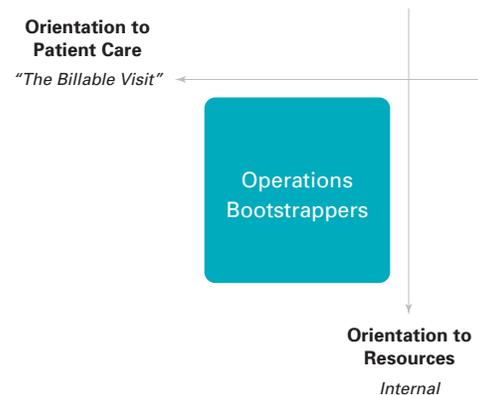
their careers. However, in some of the clinics, MAs appear to be underutilized.

Because many of the MAs live in the communities served by the clinic, they might be among the best to communicate effectively with patients. Greater investment in MAs could help clinics retain these valuable staff members with close community ties, provide a potential pipeline for more advanced medical staff, and a means to offer more efficient medical care.

“Operations Bootstrappers”

These clinics, by necessity or design, place a high priority on optimizing their internal operations. Management is focused on efficiency and maximization of reimbursement, but with a view that a thoughtfully cross-trained staff and appropriate organizational structure are the best means to that end. The Operations Bootstrappers are smaller and more isolated than others in the study, necessitating a “bootstrap” approach to their own survival and success. They do not appear to have much time for innovation.

Recently, Clinic E experienced several staffing changes at the leadership level, and the current leadership is operating in “survival mode” and focusing on the basics: increasing patient visits (all sites have excess capacity); maximizing the PPS rate and increasing the number of insured patients; cross-



training and better aligning staff with clinic needs; improving customer service and communication; improving waiting room flow; monitoring expenses; and creating a strong management structure. These focus areas are those identified by staff as being in greatest need of improvement. A member of the leadership team noted that, historically, the health center has lacked a sense of self-determination.

Appropriate staffing and staff training were repeated themes at Clinic E. Interviews and observations revealed a cultural norm of hiring someone every time a new set of tasks needed to be performed, rather than assessing whether existing staff might have additional capacity and a desire to learn new skills. This practice has, according to the leadership, resulted in overstaffing, inefficient silos between job functions, and a fractured staff that was not operating entirely in alignment with the clinic's mission. On a positive note, the vast majority of the patient population is Spanish-speaking and most staff members, including all primary care providers, are bilingual Spanish/English speakers. It is apparent that this health center values its ability to provide culturally and linguistically competent care.

The primary goal of Clinic E is to move the organization from mere survival to a thriving clinic, but it currently has little time or resources to focus on broad community engagement. Importantly, staff displayed confidence in the organization's future growth under the new leadership, with most individuals who were interviewed indicating the clinic is already operating more strategically.

Another Bootstrapper is seen in Clinic F, which struggles in a poor economy to find and retain quality practitioners, build adequate management infrastructure (for example, it has no CFO or technology officer), and find adequate resources to treat everyone in need. Specialty care is extremely limited in the area, making primary care delivered

by the CHC an essential point of access for the community.

Despite these challenges, Clinic F staff — both operational and clinical — report high levels of job satisfaction that they attribute to strong executive leadership and a caring, supportive, and empowering work environment. The CEO is well respected for a tireless commitment to the mission of the organization. Small measures, such as celebrating each employee's birthday in some way, and staff potlucks that are famous for the quality of the food, are simple, inexpensive, but effective morale builders. "Family-like" was a description used often by staff to describe this clinic.

While the CEO is engaged and well regarded in the community, this clinic is relatively more isolated geographically and, therefore, limited in terms of organizations with which to partner. Regarding innovation, the CEO said, "We don't have the resources to invest in innovation, but we are early adopters. We're happy to have others pave the way and then replicate what's successful." Evidence of this approach could be seen in the telemedicine machine that sat idle because funding for the program dried up. It was evident throughout the organization that patient care is a top priority, yet they seem bound by the "billable patient visit" model and its sub-optimal results.

Lessons Learned

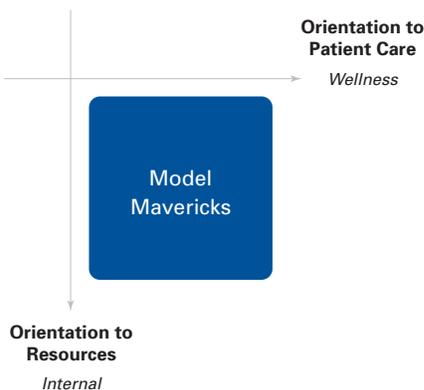
- For clinics with limited external resources, creating and maintaining strong internal culture and infrastructure is critical.
- Maximizing reimbursement is a critical achievement for these clinics, but they should also cultivate opportunities to promote patient wellness and to establish strategic external relationships.

Practice Innovations for Operations Bootstrappers

Externalize back-office operations. For some clinics, it might prove more efficient if an external organization provided back-office services such as billing, claims, and reconciliations, enabling the health center to focus on fulfilling its mission. The charter school sector provides a model, in which several organizations exist exclusively to provide specialized back-office support. Alternatively, health centers that are particularly good at managing these functions could create a new business venture selling services to other CHCs. Initially, a philanthropic organization could consider piloting this kind of structure for several smaller clinics.

“Model Mavericks”

Characterized by willingness to push the boundaries of the current CHC model, these clinics might be called “Model Mavericks.” They place primary emphasis on maximizing patient wellness while demonstrating a particularly strong commitment to internal cultural cohesion and staff development. Their focus on internal resources means that these clinics may be less well known and understood externally, and thus not as strongly supported by those outside the clinic walls. The leaders of Model Maverick clinics value time spent developing staff more than marketing their successes or



advocating for financial resources. Consequently, they can sometimes miss opportunities to forge valuable external partnerships.

Clinic G provides an example. The internal culture can be described as “family-like.” Employees at all levels expressed feelings of being connected to one another and valued. Interviews at Clinic G provided several examples of staff being given opportunities to advance to positions of increasing responsibility. Leadership was repeatedly described as accessible to staff. The CEO was praised often by both front line staff and upper management for a willingness to listen to and help resolve staff concerns. Several wall signs reflected staff appreciation and the CMO indicated that the organization makes an effort to hire individuals who are mission-oriented. Employee turnover at this health center is extremely low.

Nevertheless, some interviewees at Clinic G identified gaps in training and professional development opportunities. Also cited was a need for language and cultural training to address changing patient demographics.

The clinic’s emphasis on internal resources may have resulted in missed opportunities. One staff person explained the lack of marketing efforts with the observation that “We can’t squeeze in all the patients we have right now!” This viewpoint ignores the critical resources that an intentional and focused external campaign can bring – beyond attracting patients. A senior staff person acknowledged that “We’re not as well-known in the medical and professional community as I would hope sometime. So we’re like the best kept secret around here.”

Clinic G’s orientation within the polarity framework is intentional. The CEO noted the health center’s conscious decision to “...move away from every visit being billable, and move toward being more patient-centered.” While the clinic’s PPS rate

was the lowest among those in the study, its financials were as strong as any.

Clinic G would prefer to be compensated based on patient outcomes (i.e., wellness) versus a per-visit basis. Like most health centers, they would like more flexibility within the payment system to be creative with group visits, providing patient education by staff whose services are not currently reimbursable. The CMO spoke of the clinic's intention to use their new EHR system to take a population management approach and track patient outcomes related to various interventions (not exclusively medical). They hope the data collection will demonstrate that patient health and wellness are best served by allowing clinics to provide much more than the traditional reimbursable patient visit.

Model Mavericks strategies can differ. Clinic A, as noted above, has a valuable relationship with its local teaching hospital. In addition to offering access to a talented pool of providers, this link helps remove the administrative burdens that providers carry in some other clinic operations.

Clinic D, while primarily externally oriented, has recently restructured its operations team to better manage this polarity. The CHC has expanded the role of the CMO who is perceived as being particularly interested in staff concerns, job satisfaction, and a wellness orientation to patients. The CMO spoke of the importance of taking a “village” approach to health care, stating, “If we don't focus on relationships, we will not survive.” The CMO would like to see medical assistants take on the role of health coaches and would also like to take advantage of patient navigators (members of the community acting as peer health advocates for patients). The CMO spoke of re-training providers to interact with patients, with an emphasis on “the 4 Es” — empathy, engagement, education, and enlistment.

Clinic B also focuses on innovations that lead to better health outcomes and a better patient experience. They will experiment with new ideas that are not yet funded and make an argument later, once the idea has been proven, to add coverage for new programs or services through PPS. One clinic site has three social workers who provide case management. For elderly patients, this is key to their ability to age in community. As one staff person noted, “Case management is an integral part of the services provided to our clients. Case managers here consider ourselves public service brokers.”

Lessons Learned

- The most innovative clinics may have to sacrifice reimbursement rates in the short term in order to achieve greater patient outcomes over the long term.

Practice Innovations for Model Mavericks

Comprehensive marketing/branding. The widespread belief that clinics do not have to compete for patients has led to complacency inside many CHCs and a limited view of their potential base of stakeholders. CHCs have a compelling story to tell and data to demonstrate the high-quality, cost-effective care they provide. But they must develop more sophisticated and coordinated marketing and branding efforts to achieve multiple goals: attract private payers; erase the perception of being merely medical care of last resort; increase fundraising capacity; and attract and retain high-quality providers and other staff. Foundation support may prove valuable, since most CHCs do not have the financial resources to hire marketing and communications staff. This may be an opportunity for clinics to grow the capacity of existing staff (in the development department or elsewhere) to gain the necessary skills to share the clinic story with a broader audience.

IV. Opportunities for Innovation: Clinic Funders and Advocates

THE RESEARCH IDENTIFIED A NUMBER of opportunities for clinic funders and advocates.

For Funders

- **Support strategic external partnerships.**

Innovation cannot come exclusively from inside a clinic or from within the clinic sector. All organizations benefit from ideas outside their own ecosystem. Funders could support innovation within the larger health sector (with providers, insurers, medical schools, or medical equipment manufacturers, for example) and beyond it. The California HealthCare Foundation established the Health Innovation Fund, which can serve as a model for other potential funders.³

- **Polarity diagnostic tool.** For the polarity framework to become a truly useful planning tool, CHCs need a means to identify their current position among the polarities and opportunities to grow along the other poles. Funding to develop a diagnostic tool based on the polarities would be potentially valuable. Such a tool might be administered by a third party or possibly self-administered by clinics. The tool would ideally be electronic or online and would immediately connect clinics to resources to help strengthen operations at whichever poles the diagnostic reflects as having the greatest room for improvement.

- **Peer benchmarking.** To address the improvement of internal clinic operations, investment could be made in the development of a peer benchmarking program as a platform for best practices and collective innovation. The

creation of such a system could be achieved with a combination of outside expertise and a group of clinic leaders interested in learning from one another's experiences.

- **Design thinking, strategic planning.** Most clinics are opportunistic when it comes to growth; typically, they follow the money. However, CHCs would benefit from engagement in strategic planning, including scenario planning, and design thinking to help them manage growth more intentionally.

Strategic planning could involve regular in-depth scans of external environments (including economic and political factors); self-assessments of weaknesses and strengths; and analyses of potential sources of competition. Scenario planning would involve the identification of possible future scenarios and specific tactics for sustainability and growth. Scenario planning can help clinics react quickly and adjust course, if necessary, in response to a changed environment.

A group of health center leaders could be brought together in a collaborative design thinking process to re-imagine the future of community health care. A funder or group of funders could provide financial support and guidance, tools, facilitation, and access to expertise to assist CHCs in devising a sector-wide strategy to reach the desired state.⁴

- **Technological bridges between/among EHR systems.** Because clinic patients receive care in a variety of settings, the CHCs noted they are significantly hindered by the lack of access to complete patient medical records. Funders

might consider investments in organizations and products aimed at addressing the technical challenges involved in sharing records across various medical providers.

For Advocates

■ **Incentives for public/private collaborations.**

An idea from the public education sector could inspire a federal “Race to the Top” for community health centers. In this model, states forged diverse partnerships to support large-scale improvements in the public education system. Collaborations brought together organizations from a variety of sectors — both public and private — working toward a common good. The financial incentives were significant. Something similar for CHCs could help clinics find new ways to work with one another and with other partners — traditional and not — to improve the overall safety net.

- **Getting beyond PPS.** A breakthrough innovation for CHCs would be a business model alternative to PPS that would incentivize cost control by the most expensive providers without sacrificing quality of care.⁵ It would allow clinics to offer a full spectrum of both primary and behavioral health care provided by a wider array of professionals. Education, disease management and prevention, and counseling would be part of the spectrum of allowable costs in addition to medical treatment. Same-day visits would be permissible under appropriate circumstances. And, in general, CHCs would have much greater flexibility and autonomy to design the best course of care for their patients and communities.

Though most participating clinics are eager for a system like this, all were concerned that it not be implemented without a financial safety net. Though PPS is restrictive, it is also a primary source of revenue that many have come to depend on.

There may be an opportunity to pilot clinic operations with a model that more closely approximates managed care or PACE⁶ wherein a CHC can benefit financially if it can control the cost of patient care. This opportunity requires further research and data analysis. A sector-wide strategic planning process would involve specific policy recommendations to support the continuing ability of CHCs to meet their mission. Input and feedback from policymakers would need to be solicited during the planning process. With health centers’ significant reliance on public funds, they must ensure buy-in from public policymakers to achieve successful implementation of their goals.

V. Conclusion

THIS ETHNOGRAPHY PROJECT PROVIDED a new perspective on community health centers. With interviews and observations over a relatively brief period, the research led to a deeper understanding of what motivates these organizations.

During the project, CHCs revealed a strong desire to provide excellent patient care, contribute to patient and community wellness, and maintain sustainable business models. Individual clinics gravitated toward certain positions on the polarity framework to achieve their goals. The research uncovered some opportunities to be found through activation of the other polarity orientation — potentially opening doors to innovations that had not been considered. Similar research of more clinics, both inside California and in other states, would enrich the findings.

Appendix A: Ethnography and Health Care Innovation

Ethnography is a method used to understand, interpret, and describe people and cultures. It is based on fieldwork that involves observing and talking with people in their natural environments, trying to understand activities and culture from their perspective.

In the early 20th century Franz Boaz, the father of American anthropology, studied immigrants and indigenous people, arguing that they were distinct societies, not groups lacking in “civilization.” He fought discrimination and supported an agenda of social reform in America. Focus on underserved people is still a strong tenet of today’s applied anthropology studies.

In the 1950s, medical anthropology emerged as a subfield of anthropology to better understand factors that influence health and well-being. Medical anthropologists study a wide variety of topics, including how people experience illness, prevention, and treatment; healing processes and therapy; and the use of pluralistic medical systems. For example, medical anthropologist Byron Good of Harvard is noteworthy for his work on how culture and society shape psychiatric disorders.

Today, ethnographic fieldwork is used by many disciplines to support innovation efforts because the findings produce insights often overlooked by other forms of research. In the high-tech sector, for example, Intel uses ethnography to understand medical technologies and their implementation in home settings. Their Health Guide device resulted from years of research to understand the needs of the aging population and how technology can support them in their daily lives.

Many large health care providers employ ethnographers and design researchers to improve quality, efficiency, and the patient experience. The Mayo Clinic Center for Innovation’s Jack and Jill rooms were born from the observation that only a small part of a clinical visit involves a physical exam, yet traditional exam rooms are dominated by the tools needed for that activity. The new rooms are designed to create the kind of collaborative communication that benefit today’s clinical encounters.

Kaiser Permanente’s Innovation Consultancy engaged a team of ethnographers to identify opportunities to increase the time nurses spend directly caring for patients. Kaiser’s research team spent one week in each of three hospitals shadowing and interviewing staff and patients. The eventual result was a patient-centered shift change program that increased time at the bedside by over 20%.

Appendix B: Participating Clinic Summary Statistics

	# SITES	# ANNUAL VISITS	LOCATION	FY10 REVENUES
Clinic A	5 to 8	> 100,000	Urban	\$10.0 to \$30.0MM
Clinic B	9 to 12	> 100,000	Urban	> \$30.0MM
Clinic C	5 to 8	50,000 to 100,000	Urban	> \$30.0MM
Clinic D	9 to 12	> 200,000	Urban	> \$30.0MM
Clinic E	1 to 4	< 50,000	Rural	< \$10.0MM
Clinic F	1 to 4	< 50,000	Rural	< \$10.0MM
Clinic G	9 to 12	> 200,000	Urban	> \$30.0MM

Endnotes

1. “Financial Health of Community Clinics,” California HealthCare Foundation.
www.chcf.org
2. A prospective payment system (PPS) is a method of reimbursement in which Medicare and Medicaid payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, diagnosis-related groups for inpatient hospital services). The Centers for Medicare and Medicaid Services (CMS) uses separate PPSs for reimbursement to acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long term care hospitals, and skilled nursing facilities.
3. CHCF Health Innovation Fund.
innovations.chcf.org
4. A joint effort of the Community Clinic Initiative (CCI) and The California Endowment supports the development of Centers for Community Health. It developed from a convening of clinic leaders in a Futures Group to do work very similar to what is recommended in this paper (scenario planning, etc.) CCI is currently in its second round of grant funding to clinics through the resulting “Networking for Community Health” program. Similarly, CCI has just launched its “Health Home Innovation Fund.” Both of these efforts seem well positioned to result in innovations in effective network/partnership creation, advancements towards the creation of medical homes, and implementation of strategies resulting in long-term health improvement.
www.communityclinics.org
5. See “Transforming Community Health Centers into Patient-Centered Medical Homes: The Role of Payment Reform,” a 2011 Commonwealth Fund report. It examines how changes in the way federally qualified health centers (FQHCs) are financed could support the transformation of these critical safety-net providers into high-performing patient-centered medical homes.
www.commonwealthfund.org
6. PACE is Program for All-inclusive Care for the Elderly.
www.npaonline.org



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