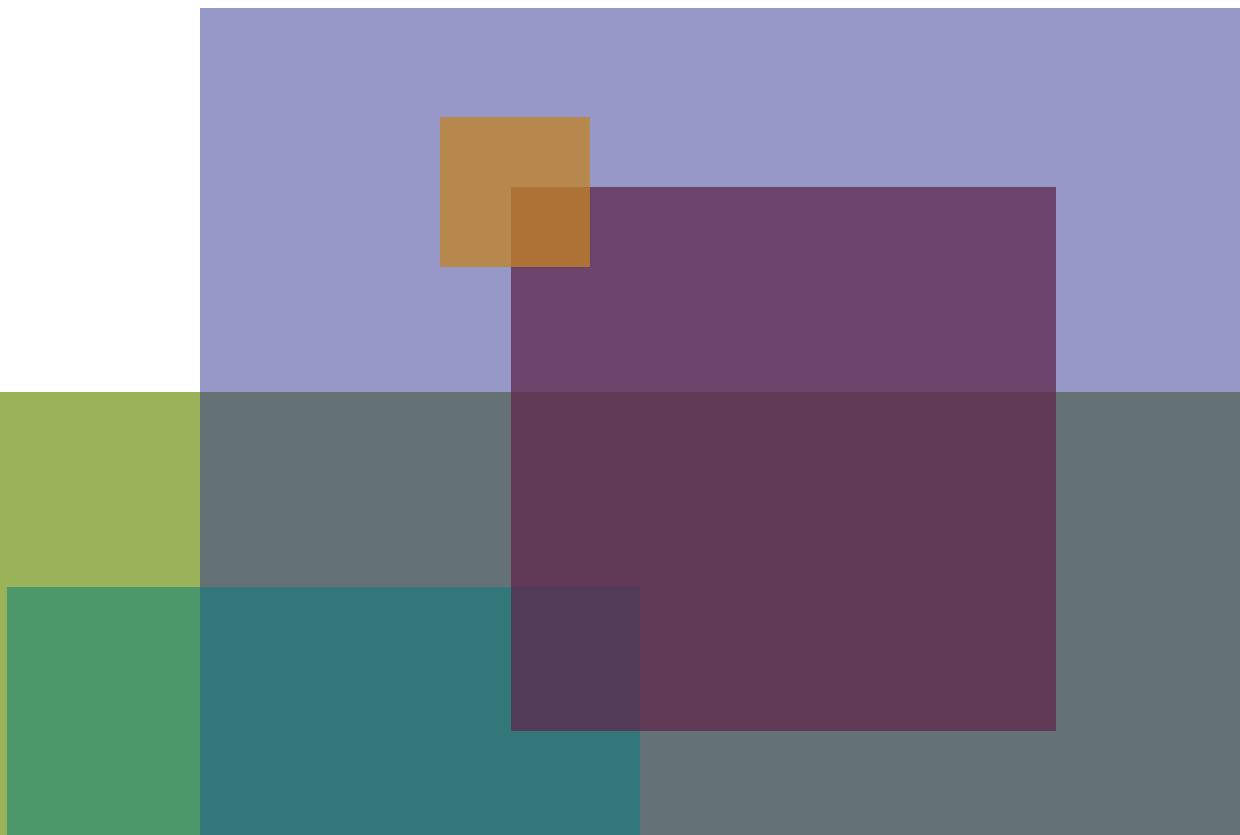


# Developing Centers for Community Health

A report on the CCI Futures Group Process



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Community Clinics Initiative  
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The work of the Community Clinics Initiative (CCI) over the past eight years has laid the foundation for a broader conversation about the role of community clinics and health centers as leaders. As clinics have been able to collect data about the quality of care they provide, it is clear that they are innovators in caring for diverse, multicultural populations and they have an important role to play in any effort to reorganize the way care is provided.

With the Governor targeting health care access as a priority and the emergence of health care reform as a key issue in the upcoming presidential election, we anticipate a window of opportunity at the policy level for dialogue and action over the next few years. It is critically important that the voices of clinic leaders be heard in that process, not just in their traditional role of arguing for more resources for the underserved, but also in the larger conversation about system redesign. Even if the goal of “universal” coverage is achieved, we know that will not guarantee access to quality care for traditionally underserved populations.

The next year of the Community Clinics Initiative offers an opportunity to help focus and support the voices of clinic leaders in those policy deliberations as well as practical demonstrations of the value clinics can bring to health reform. To that end, we convened the CCI Futures Group in February, 2007. We brought a small group of provocative thinkers together with staff from CCI and The California Endowment for a series of conversations over the first six months of the year. Our charge to the Group was to articulate a leadership vision and a strategy for the field that CCI can support with its remaining uncommitted grant funds.

The Futures Group process has included two levels of dialogue. First, the Group met twice on its own with CCI and TCE staff to sketch out a vision and to develop a set of key questions that must be addressed in order to craft a leadership strategy for the field. Then, we invited a larger group to come together for an intensive two-day planning process. That group included additional clinic leaders as well as potential allies from across the health care system (e.g. counties, public hospitals and HMOs) as well as others engaged in movement building with low-income populations (e.g. community organizers, housing advocates and local media experts) to seek common strategic ground. We then reconvened the Futures Group to reflect on that process and to formulate recommendations for CCI’s next steps in grantmaking. The participants found the process to be so useful for their own thinking that we have decided to share this report summarizing those conversations with the broader field.

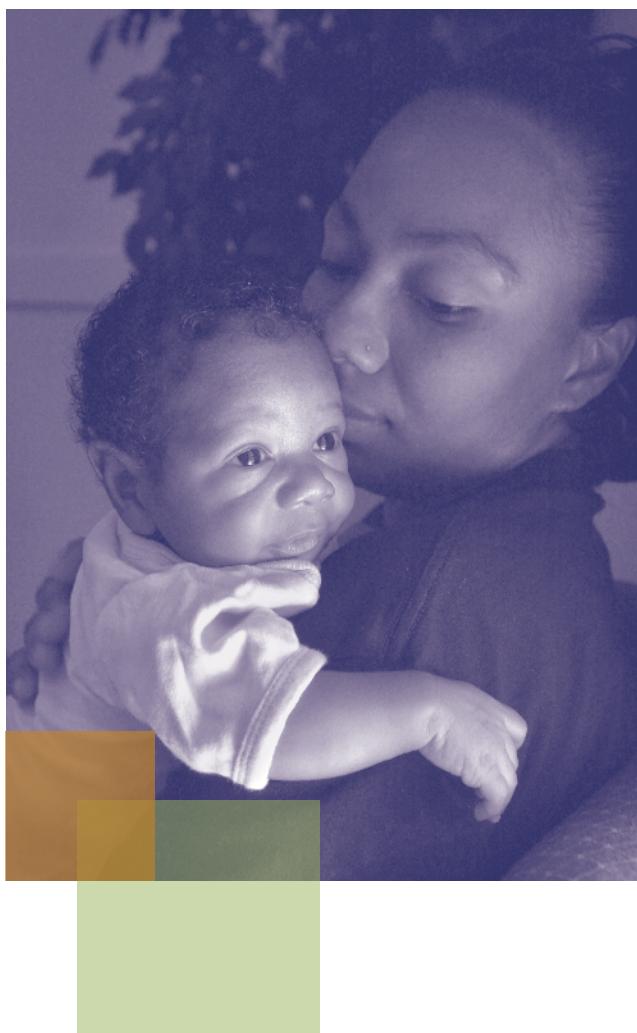
# Opening Discussion

Clinics confront a changing landscape on all fronts, yet there is a tendency for many of them to cling to traditional models that may no longer be relevant. Some clinics are still operating out of a scarcity mentality when they have long since earned the right to see themselves as innovators and leaders in the conversation about reform of the health care system. California's profound ongoing shift in demographics is a key driver of change, yet not many clinics have explored let alone implemented models of care that address this. The many changes facing clinics require a different way of thinking and a new image of leadership.

The social fabric of communities in which many clinics are located has deteriorated, even as clinics have grown to become significant local assets. A core strength of clinics is their strong value base and commitment to patient-centered, culturally-competent care. How can those values be successfully realized in this changing context?

The image that emerged from our initial discussion was that of a **Center for Community Health**. While the Center might take the form of a particular physical facility, what we talked about is more of a fundamental reframing of the role of Community Health Centers as central nodes in networks of community resources and connections.

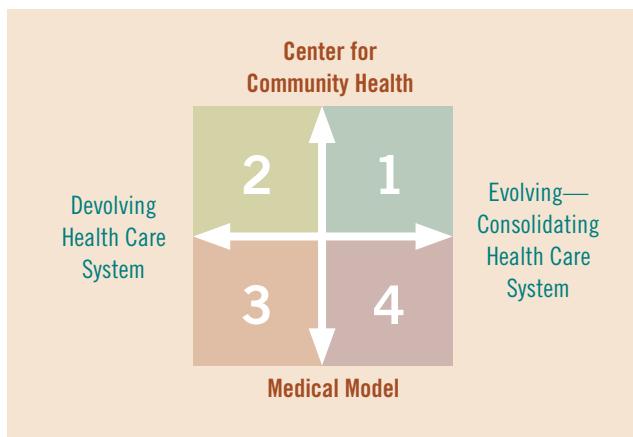
This Center would take a population-based approach, and its job would be to keep its customers healthy. It would build on IT systems currently being implemented to provide a true medical home for its patients that is linked to a variety of partner organizations both "traditional" (e.g. specialty care, hospitals, mental health) and "nontraditional" (e.g. farmers markets, health food stores, advocacy organizations). Provider leadership would play an important role in helping clinics develop new systems relationships and catalyzing local movement building. In sum, the Center will provide a model of high quality care that also sees the fulfillment of its mission of creating a healthier community by lifting up the collective voice of its constituents and building local power.



# Future Scenarios

The Global Business Network has pioneered the use of Scenario Planning<sup>1</sup> to help organizations plan for the future. We employed an abbreviated form of their process, and began by brainstorming a list of driving forces that we believe will affect the health of traditionally underserved populations in California over the next five years. We agreed to consider the growing diversity of California's population and other demographic trends (e.g. increasing income disparities) as a "meta" issue that affected every aspect of our discussion.

The group generated a list of 47 potential driving forces and then narrowed it down to six from that list that they deemed most important and most uncertain. These factors were: competition for resources, shortage of health care professionals, shift from acute to chronic care, increased competition for shrinking public funds, increasing coalitions and collaborative structures, and implosion of the larger health care system. We reframed these issues in more generic terms and, using these trends as "axes," constructed a four-cell matrix of possible future scenarios.



## CENTER FOR COMMUNITY HEALTH MODEL

In Scenario 1, the "best case" scenario, the model of care for the underserved is moving toward the creation of a true Center for Community Health, emphasizing cultural competence, and the health care system is evolving, consolidating and connecting in new ways to provide a more seamless experience for the patient. In Scenario 2, the model of care is moving toward a broad-based definition of community health, but in the context of a devolving, increasingly fragmented health system. In Scenario 3, market forces are pushing toward the dominance of a more limited medical model of care while the system continues to be disconnected and fractured. In the final scenario, the medical model predominates within a health care system characterized by increasing consolidation and homogenization. Four groups were formed to flesh out each scenario and to identify a leadership role for community health centers within their scenario.

**Scenario 1** provides the opportunity for clinics to morph into true Centers for Community Health. Services might be co-located with community partners to provide ready access to non-medical services from 7 a.m. to midnight such as farmers' markets, community events, GED classes, etc. Services would be accessible, affordable and provided in a friendly setting by staff that reflect the community. Specialty services would be integrated with primary care and available on site. The Center would be the hub of a virtual network to provide equity of access. Systems would facilitate care coordination, monitoring and accountability, with accompanying improvements in quality of care.

<sup>1</sup> Diana Scearce, Katherine Fulton, et.al. *What If? The Art of Scenario Thinking for Nonprofits*. Emeryville, CA: Global Business Network, 2004. Available from [www.gbn.com](http://www.gbn.com)

Clinics would be the driving force for the development of this model, acting as a catalyst for consolidation with community institutions as well as other health care providers. Clinics would also be seen as a source of innovation, nurturing best practices and actively promoting solutions for the health care system. Clinics could also take a more formal role in academic training programs preparing the next generation of health care professionals. Access and Connection would be the mantras to drive consolidation of the system, promoting integration but not necessarily formal mergers of organizations. Clinic leadership would also mean more involvement in grassroots organizing with a conscious focus on building the political power of their communities.

In **Scenario 2**, an increasingly fragmented health care system increases the burden on the individual and family to negotiate its complexities. Various “cheap” alternatives compete for the business of low-income populations. Within this devolving picture, clinics represent a beacon of culturally competent, high quality care. The burden rests on the clinic to knit together a coherent system of care. Clinics assume a leadership role by doing what they can to broker relationships among providers on behalf of their patients. They are the driving force to create more coordinated, seamless systems of care through collaboration, referrals and providing the necessary “glue” to patch things together. It’s an uphill struggle, however, because financing care to meet the needs of all family members is an ongoing challenge.

**Clinics will need to lead by undertaking focused communications to educate the public about their capacity and to promote the image of a “Center for Community Health.”**

Clinics will need to lead by undertaking focused communications to educate the public about their capacity and to promote the image of a “Center for Community Health.” Amidst the cacophony of competing marketing

claims, this will not be easy. However, clinics can also use their IT expertise to move beyond simply HIT to create a network of virtual centers in the community to provide access to the internet, job searches, and access to other community resources.

**Scenario 3** is a world in which economic pressures are paramount. Despite increasing demands for services, the number of uninsured continues to rise and more restrictive eligibility standards are set for public programs in an effort to cap government expenditures. Patients are forced to pay for more and more of their care out of their own pockets. Providers are squeezed by payers and there are strong disincentives to provide more than a limited scope of services.

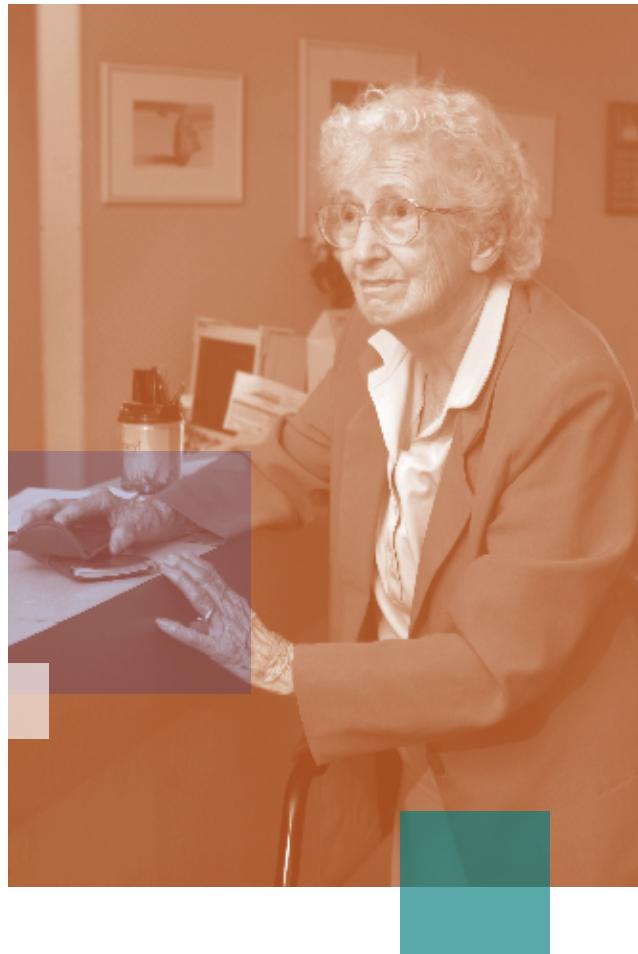
In this scenario, clinics continue to emerge as the voice for the underserved. They lead collective efforts to create a reorganized system that is more responsive to the needs of their patients. They reach out broadly to broker local alliances. Clinics also serve as a catalyst to foster volunteerism and lead efforts for social and economic change. Clinics also have an important role to play in forging partnerships with organizations like local community colleges to preserve their current workforce and to help ensure opportunities for the next generation of health workers.

In **Scenario 4**, the market forces ongoing consolidation of the system, characterized by pressure to provide only a limited scope of services and increased attention to quality, benchmarking and widespread use of HIT. Clinics have an opportunity to shine in this world, but competitive pressures and economics will likely encourage consolidation of the clinic corporations into larger clinic systems. Clinics will emerge as exemplars of quality and efficiency, as measured by population health outcomes.

Clinics will broker an appropriate leadership position in the system by taking the first dollar to assure best outcomes and the most cost containment. They will also lead by allying themselves with innovators, including labor and health economists. Clinics will also play an active political role in educating policy makers about their models of care.

**When asked which of these scenarios is most likely to transpire over the next five years in California, the group consensus is that the system will continue to devolve.**

When asked which of these scenarios is most likely to transpire over the next five years in California, the group consensus is that the system will continue to devolve, with the majority of the group fairly evenly split between Scenario 3 and Scenario 2. Taking a ten year view, the group felt that the system would move towards cultural competence, with the majority split between Scenario 2 and Scenario 1. The remaining members opted for Scenario 4. All in all, the exercise provided strong support for clinics taking a leadership role in promoting the Center for Community Health model as an important element of their future competitiveness, regardless of the direction the larger system takes.



# Elements of a Center for Community Health

On the second day of the meeting, we addressed this question: What will it take for clinics to assume a leadership role in redesigning the health care system for those who have been traditionally underserved? Each of the conversations<sup>2</sup> used the concept of a Center for Community Health as a jumping off point. Three general themes emerged:

## **Research and Data**

For clinics to emerge as Centers of Community Health, they need to learn to collect, analyze and share data and information effectively. Data can be used to show the value of CHCs, define them as centers of excellence, and to help them be leaders in moving the political agenda of health reform from coverage to health and health care delivery issues. Clinics can support their own workforce development by collecting data that highlights their training, practice and leadership development opportunities.

By collecting, analyzing and actively disseminating data, clinics can develop a proactive research agenda for themselves and become advocates for community health. They need to take a community based, patient centered approach to their research, informed by how patients define health and healthcare. CHC-driven research will also allow clinics to answer operations questions and for problem solving.

## **Leadership**

Clinics need to define and cultivate leadership at all levels in their organizations, including their board, to become Centers of Community Health. Leadership development expectations should be added to job descriptions, and the correct training and cultivation tools identified. Leadership and advocacy skills should be developed not only at the staff level, but also among the patients since leadership in health lies in the larger community and not just the clinic.

Clinic leadership needs to bring together diverse stakeholders to respond to community needs. They have a responsibility to organize and lead partnerships with a goal of defining

and promoting community health, rethinking how care is delivered and increasing access.

## **Partnerships**

Clinics need to connect with a broad circle of partners in order to achieve their health reform goals. This could be with other clinics as well as with new partners such as hospitals, health plans, private doctors or other community based organizations. The partners will need to be engaged strategically and must support everyone's short term needs while pushing towards a long term vision of health promotion. Obtaining resources for health promotion will require advocacy, so partnerships will need to happen on all levels with roles for clinics, consortia, statewide and national organizations.

The roots of the community will be empowered and represented in these partnerships through patients, allies and actively involved providers. Patients who are trained as advocates can aid the clinic in cross sector approaches and help redefine health, prevention and wellness.

<sup>2</sup> Juanita Brown, David Isaacs, et al. *The World Cafe: Shaping Our Futures Through Conversations That Matter* San Francisco: Berrett-Koehler, 2005.

# Navigating the Badlands

At the second meeting of the Futures Group, we began by examining Mary O'Hara Devereaux's schematic of the Badlands, taken from her book *Navigating the Badlands*<sup>3</sup>. It tells a story about the challenges and impacts the global transformation of the economy and society is causing organizations. The annotated map of the Health Care Badlands looks at our current situation in light of the failure of managed care. The quality, access, and cost-effectiveness of America's health care system is degrading, with no clear vision for the future. Structural changes in all sectors of the economy will make it difficult for health care to sustain itself. To take advantage of the opportunities provided by the knowledge economy, health care will have to be radically redesigned.

In small group discussions, the participants discussed what kinds of leadership and partnerships need to be cultivated for clinics to successfully navigate the Badlands.

## Leadership

The small groups looked at leadership from three perspectives: positional, structural and personal.

### Positional

Leadership needs to be inspirational, dynamic and focused on larger social as well as health issues. Clinics can be a catalyst by building the alliances necessary to address the broad social determinants of health. Leaders that share a common vision and principles need to identify the systems needed to achieve healthy communities. A neutral infrastructure is necessary to nurture these leaders to become catalysts for change.

### Structural

Clinics need to cultivate leadership at every level of their organizations and should include leadership in their mission. Everyone in the organization should be empowered to become leaders, including patients who can mobilize constituencies and help organize their community. Clinician leadership should be advanced with providers acting as advocates with the

patients and the community. The CEO is an external advocate for the organization and will need to collaborate effectively with a wide variety of traditional and non traditional partners to improve the health of their communities.

### Personal

An effective leader must have credibility, integrity, flexibility, curiosity and the ability to hear hard truths, know their biases and identify barriers. Leaders must be committed in the face of failure or rejection without losing their persistence to achieve their vision. They must continually scan, scout and steer, use data to inform their decisions and be open to radical innovation. A leader must be driven by the mission of the organization and able to move everyone in a common direction. Leaders must be able to build and maintain relationships across disciplines.

### Partnership

There is a unique opportunity now, with health care reform prominent on the national agenda, to build alliances and coalitions to address the broad determinants of health and organizations will have more influence by speaking together. The small groups came up with a comprehensive list of traditional and nontraditional partners in the healthcare field as well as in education, labor, immigrant rights, law

<sup>3</sup> Mary O'Hara-Devereaux *Navigating the Badlands: Thriving in the Decade of Radical Transformation* San Francisco: Jossey-Bass, 2004.

enforcement, business, housing, media, art, environmental justice, community organizers, community coalitions, foster care, slow food movement, faith based community, and in the progressive private sector. To successfully partner with organizations such as these, the motivating factors need to be identified to pull everyone together to form a movement, recognizing that both sustained and episodic partnerships are of value.

Clinics must be thoughtful about their partners' priorities and goals and need to determine each partner's expertise and what is appropriate for them to address. These partnerships should also include integrated programs and risk assessment. Partners should be invited to participate who are not supporters of community health centers to further stimulate innovation. Current models of successful partnerships need to be identified and used as a learning opportunity if replication is not realistic.

### **Reflections**

Clinics need to focus on moving from Healthcare to Health and create the strategies to get there. They need to take a long view of health and its social determinants, but also need to push for changes in healthcare financing in the short term. A flexible vision is needed that can grow.

In order to achieve that vision clinics need to create successful partnerships. These partnerships should be carefully considered and the enlightened self interest of each organization identified to keep them at the table. They can build and strengthen the relationships by asking what their partners need and planning strategically with them. They need to think about a variety of potential partners including those who are not focused on health.

Once partnerships have been established, clinics need to design a structured and practical program to advance their goals. They need to consider different strategies for making change. In order to gain momentum and strengthen their partnerships, clinics will need to engage in doable experiments and have immediate wins before pushing the envelope and moving towards their longer vision.



# Designing a Network

We next assembled 40 invited participants (see list in Appendix A) and divided them into six interdisciplinary design teams and gave them the following challenge:

*Starting with a community health center, your task is to design a network to promote the health of an underserved community. Our work at CCI has focused on community health centers, and we think they have an important role to play in developing those networks... but they can't get the work done all by themselves. Therefore, we'd like your team to use your collective intelligence and creativity to imagine how an extended network of organizations might be built to advance health.*

*We're asking each team to address the "art of the possible" and to sketch out networks that might connect existing resources (with some additional money) to work together in new ways that might benefit all.*

The teams designed an impressive array of local networks for health promotion. Absent a specific community context, it was somewhat challenging for them to think in more generic terms. Nevertheless, several themes emerged from their designs, among them:

**Passion needs to be at the core of network development.** What issue(s) evoke the community's passion? It could be a catalytic event such as the death of a child, or a widely-shared concern such as obesity or diabetes. The point is that this can not be solely a data-driven endeavor. To be meaningful, it must address a deeply felt need.

**The "center" of the network will be identified by the community.** In some cases, the community clinic may not be at the center of the network, even though it has a critical role to play. Clinics should be encouraged to engage with a variety of partners and to build their own capacity (e.g. as a convener) to begin to be seen as a natural "node" of the network, even if it does not occupy the center.

**Build on existing connections and relationships.** The most effective efforts are likely to be those that fully utilize existing

naturally-occurring networks rather than trying to supplant them with new structures.

**Involve young people from the outset to build their sense of ownership of the activity.** They can bring tremendous energy and enthusiasm to the work, not to mention an entirely different set of personal networks and relationships. They also tend to be savvier about technology, which is a critical tool for network development, even in its simplest forms (e.g. cell phones).

**Start by organizing patients as a bridge to the larger community.** Community clinics in California serve more than 3.5 million patients a year, a group larger than that served by organized labor. It represents a potentially potent political force and as the logical place to begin to develop a critical mass of visionary leaders.

**Build the business case for networking and advocacy** by aligning the activity with the core interests of the clinic and demonstrating the contributions of advocacy to the accomplishment of the organization's mission. In order for individual clinics and the field at large to justify the expenses that accompany these activities, they need to understand how they support the larger goal of improving community health.

**Devote sufficient resources to capacity building** among partners, possibly through mini-grants for organizing, training and technical assistance. It is also important to build the capacity of the clinic itself and to document those advances in order to contribute to the larger dialogue about the future of community health centers.

If clinics are to play a vital role in organizing and sustaining networks to promote community health, they will need to embrace an expanded paradigm for their work, which the group referred to as the "Medical Model Plus." In addition

to providing top quality health care services, they also need to recognize and reinforce the critical role that social support plays in improved health. By educating their patients and by engaging with partners in community organizing, clinics can recapture their original commitment to a community health empowerment agenda.

It was generally acknowledged that this kind of work is not for everyone. It makes sense to prioritize those who are already committed to community engagement. Any work that is funded should build on what already exists. There is no need to reinvent the wheel, particularly when current resources for community mobilization are so limited. It's also appropriate to acknowledge the natural tensions between clinics' business imperatives and the resources required to do this right. As mentioned above, an important part of the work is to develop metrics that can demonstrate the value that these activities add to the clinic's larger mission of promoting community health.

**By educating their patients and by engaging with partners in community organizing, clinics can recapture their original commitment to a community health empowerment agenda.**

The critical importance of readiness should not be underestimated. It is necessary to meet clinics and communities "where they are," and to allow appropriate gestation time to build relationships. As the group observed, it is very different to build mission-level sustained partnerships vs. more typical tactical-level relationships dedicated to accomplishing a short-term objective. Listening, openness and trust building are all essential components of activating and maintaining these kinds of community networks. By taking the appropriate time to establish real trust, the network will be less dependent on individual leaders and will evolve into a true system to support the work over time.



Data is also an essential element of this work. By listening to what the community needs wants and values (not just those served by the clinic) and appropriately sharing the resulting data, clinics can effectively help to lay the groundwork for collective action. By directly engaging patients and other community members in that process, they can also encourage personal empowerment in taking more responsibility for the health of their families and their neighbors.

# Conclusion

Because of the many factors that will influence the future of health care in low-income communities, we see the formation and sustained effort of networks as an important strategy for long-term health improvement. While community clinics may not necessarily occupy the center of the network in every neighborhood, our aim should be to help them realize their potential to make a significant contribution to the larger goal of promoting community health.



Three key elements of that strategy that emerged from our discussions are Partnerships, Leadership and Research & Data, each with different potential elements. The resulting networks should not only offer high quality, culturally competent health care, but also help to build political power and take a population-based approach to health improvement.

Our Futures Group recognized that this would entail a fundamental paradigm shift for clinics if they are to become true centers for community health. However, it builds on their history, their mission, and their strengths. Clinics' increased capacity to collect and analyze data will provide the foundation on which all other mobilization activities can be based. Involvement in community organizing will help to engage young people, nurture new leadership and build collective power. By combining high quality medical services with an expanded approach to local networking and engagement, clinics can serve as what one of our Group members called "the catalytic conscience of community health."

# Appendix A

## Future's Group:

<b>David Campa</b> Chief Medical Officer Northeast Valley Health Corporation	<b>Participating from The California Endowment</b>
<b>Carl Coan</b> President & CEO Eisner Pediatric & Family Medical Center	<b>Mario Gutierrez</b> Director, Agricultural Worker Health and Binational Programs
<b>Beth Greenwood</b> Director of Special Projects Shasta Community Health Center	<b>Laura Hogan</b> Vice President, Program
<b>Sherry Hirota</b> Executive Director Asian Health Services	<b>Robert Phillips</b> Senior Program Officer
<b>Ed Martinez</b> Chief Executive Officer San Ysidro Health Center	<b>Participating from the Community Clinics Initiative</b>
<b>Rhonda McClinton-Brown</b> Executive Director Community Health Partnership of Santa Clara County	<b>Tom David</b> Senior Strategist
<b>Ralph Silber</b> Executive Director Community Health Center Network	<b>Ellen Friedman</b> Managing Director
<b>Hermann Spetzler</b> Chief Executive Officer Open Door Community Health Centers	<b>Sarah Frankfurth</b> Program Coordinator for Learning
<b>Linda Williams</b> President & CEO Planned Parenthood Mar Monte	<b>Kathy Ko</b> Program Director

## June Meeting Additional Attendees:

<b>Alfredo Aguirre</b> San Diego Co. Department of Mental Health	<b>Melissa Stafford Jones</b> CA Association of Public Hospitals
<b>America Bracho</b> Latino Health Access	<b>Howard Kahn</b> LA Care
<b>Jeremy Cantor</b> Prevention Institute	<b>Hugo Morales</b> Radio Bilingue
<b>Carmela Castellano-Garcia</b> California Primary Care Association	<b>Drummond Pike</b> Tides
<b>Sandy Close</b> Pacific News Service	<b>Steve Rosenberg</b> Community Oriented Correctional Health Services
<b>Katherine Culberg</b> Oakland High School	<b>Brian Smedley</b> The Opportunity Agenda
<b>Catherine Douglas</b> Private Essential Access Community Hospitals	<b>Hermann Spetzler</b> Open Door Community Health Centers
<b>Peggy Edwards</b>	<b>Joan Twiss</b> Center for Civic Partnerships
<b>Nanette Falkenberg</b>	<b>Winston Wong</b> Kaiser Permanente
<b>Dean Germano</b> Shasta Community Health Center	<b>Participating from The California Endowment</b>
<b>Alan Glaseroff</b> Humboldt County IPA	<b>Marion Standish</b> Director, Disparities in Health
<b>Ellen Hafer</b> Massachusetts League of Community Health Centers	<b>Dianne Yamashiro Omi</b> Senior Program Officer
<b>Kim Ammann Howard</b> BTW informing change	<b>Participating from the Community Clinics Initiative</b>
<b>Carla Javits</b> REDF	<b>Olivia Nava</b> Program Coordinator for Grantmaking
<b>Fran Jemmott</b> SCOPE	
<b>Mandy Johnson</b> Integrated Behavioral Health Project	