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The California Wellness Foundation

Grantmaking for a Healthier California

Reflections

On The Safety Net:
A Case for Core Support



The California Wellness Foundation

For most, the concept of the “safety net” evokes an image of a strong, meshed material designed to save people from potentially fatal falls. For those of us in health philanthropy, the safety net also implies the saving of lives, since the term refers to the system of public hospitals, community clinics and health centers that care for the uninsured and other vulnerable populations. But today’s sagging economy, state budget shortfalls, diminished foundation assets, and reduced individual giving are tearing holes in the net.

The reality is that the safety net, no matter its strength — or weakness — is the primary source of care for the uninsured and underserved in the state of California. Since these vulnerable populations are the focus of The California Wellness Foundation’s (TCWF) grantmaking, the question for us has been: How can we most effectively use our limited resources to support and strengthen the safety net so that health care can continue to be provided to those who have nowhere else to turn? One of our answers is to provide core operating support to community clinics and the associations that support them.

The results of our Foundation’s seven years of such funding to the community clinic portion of the safety net have demonstrated that the provision of core operating support can be an important strategy to fortify essential providers, leaving them better prepared to confront new challenges. And our grantees have told us that the flexibility of TCWF’s funding has provided a needed buffer to help them weather the current economic storm.

In many cases, TCWF grants have helped these clinics while they were undergoing the changes needed to attain status as Federally Qualified Health Centers to obtain substantial federal funds. Grant dollars have also been used to hire additional medical personnel and complete essential strategic planning. Our grants to clinic associations have helped ensure a strong regional voice and support system for clinics throughout the state. Advocacy efforts of clinic associations have been critical to sustaining local government funding for member clinics; the technical assistance provided by the associations has effectively strengthened member clinics; and the development of integrated and shared services has increased the efficiency and effectiveness of member clinics.

Providing core operating support to strengthen infrastructure and support the provision of existing health services for underserved populations may not be considered strategic grantmaking by some. However, under the economic and fiscal conditions that prevail today, sustaining the already frayed safety net is one of the most strategic things a foundation can do for those who lack other access to health care.

This issue of Reflections is authored by Ruth Holton, who has overseen much of the grantmaking that our Foundation has done to strengthen community clinics and clinic associations over the past few years. This document is shared with the hope that other foundations will explore the potential of providing core operating support to strengthen safety net organizations. We encourage your comments and feedback.

Gary L. Yates, President and CEO
The California Wellness Foundation

Reflections on the Safety Net: A Case for Core Support

By Ruth Holton

In its recent study titled “America’s Health Care Safety Net, Intact but Endangered,” the Institute of Medicine described the safety net as “the default system for caring for many of the nation’s uninsured and vulnerable populations” in the absence of a system of universal coverage. While the safety net has never been particularly safe or secure, today’s steadily growing demand for services, shrinking pool of federal, state and local funds available to pay for care, and rising costs of delivering care are stretching it to the breaking point. The study concludes with the sobering note that “failure to support these essential providers could have a devastating impact not only on the populations who depend on them for care” but on the entire health care delivery system.¹

Grantmakers can neither make up the funding that is being lost through government budget cuts nor cover the cost of care for the rising number of uninsured. We can, however, adopt grantmaking strategies that strengthen the capacity of safety net providers to meet the challenges of constantly changing health care and economic environments. For The California Wellness Foundation (TCWF), this has meant providing core operating support to the state’s community-based clinics and their regional associations. The purpose of this document is to share with the field our experiences over the past seven years funding these essential components of the state’s safety net.

CALIFORNIA’S SAFETY NET

Over the next five years, California’s public hospitals and health systems will face a cumulative budget shortfall of at least \$3 billion if they continue to serve patients at the current level.

Although there is no official definition of the health care safety net, it is commonly understood to encompass those health care providers who provide care regardless of a patient’s ability to pay. Typically, patients of safety net providers are uninsured, low-income underinsured, or covered by Medicaid or other state and local government programs.

The core of the health care safety net is public hospitals, county health systems, and nonprofit community clinics and health centers. In many inner-city and rural communities, safety net providers are the only source of care for low-income residents.

In California, the safety net is reliant on a tenuous patchwork of funding primarily made up of Medi-Cal² revenues and state and local funds. Available funds within this patchwork have neither kept pace with the rising costs of providing care nor with the increasing demand for care — and the

situation continues to worsen.³ Major cuts to the safety net are on the table as California grapples with its unprecedented \$38 billion deficit. At the local level, California’s counties are cutting their contributions to the safety net, cuts that could become even deeper, depending on the outcome of the state budget debate.

Los Angeles County, with the second largest public health care system in the nation, has been hit the hardest. In 2002, the county Health Department announced that it would be facing a \$700 million deficit by 2005. In response, the county Board of Supervisors voted to close 16 of the 18 county health clinics and two of the county’s six hospitals, and to reduce reimbursements to community-based clinics by 25 percent. The county Health Department received a package of new federal aid to help narrow the gap, but the long-term problem remains unresolved — the number of uninsured and underinsured seeking care is far greater than the funds available to provide that care.

In a recent study, the California Association of Public Hospitals and Health Systems estimated that “over the next five years, California’s public hospitals and health systems will face a cumulative budget shortfall of at least \$3 billion if they continue to serve patients at the current level.”⁴

TCWF’S RESPONSE

The Foundation concluded that the most strategic way to support the safety net was by focusing its efforts on strengthening and supporting nonprofit, community-based clinics and their regional associations.

Supporting the safety net has always been a high priority for The California Wellness Foundation. It is central to our mission “to improve the health of the people of California by making grants for health promotion, wellness education and disease prevention.” And it also addresses our goals “to address the particular health needs of traditionally underserved populations” and “to support and strengthen nonprofit organizations that seek to improve the health of underserved populations.”

Given the state’s size and the number of safety net providers, the Foundation concluded that the most strategic way to support the safety net was by focusing its efforts on strengthening and supporting nonprofit, community-based clinics⁵ and their regional associations. The Foundation also supports organizations that provide advocacy efforts to protect and increase funding for safety net providers.

California has approximately 175 clinic organizations that provide comprehensive primary care and family planning services to the majority of the state’s uninsured and underserved populations. Community clinics do more than provide health care services. Many play an integral role in the community, reaching out and bringing low-income, uninsured, monolingual, immigrant and other underserved populations into the health care system. They also act as advocates on behalf of their patients and the community to increase access to, and funding for, culturally competent and responsive care. Frequently, they provide or offer referrals to a host of supportive services such as child care,

transportation, food, housing, drug and alcohol programs, mental health services and other resources.

In many areas of the state, clinics have joined forces to form regional associations, also known as clinic consortia. These associations work together to support and enhance their member clinics' effectiveness through collaboration and service integration. Today, more than 90 percent of clinics are members of clinic consortia.⁶ Consortia have become key to strengthening the capacity of their member clinics and advocating for increased local and state funding for their regional safety net.

TCWF began funding clinics and clinic consortia in 1996, during the initial implementation of Medi-Cal managed care. Over the past seven years, TCWF has provided more than \$20 million in grants to 14 clinic consortia. These grants required that at least 50 percent of the grant dollars be distributed to the consortia's member clinics for the provision of primary and preventive care services. Since most clinics belong to a consortium, this has been an effective mechanism to give at least some support to virtually all the clinics in the state. In addition to funding the consortia, TCWF has also given grants totaling more than \$9 million directly to 54 clinics to support the provision of primary and preventive care services and to strengthen their infrastructures. Through this funding strategy, TCWF has supported the provision of primary and preventive health care services to almost half a million low-income Californians.

FUNDING STRATEGY:

CORE OPERATING SUPPORT

TCWF's core operating support grants have provided clinics and consortia the ability to become more strategic about how they tackle the challenges they face and craft their own solutions to enhance their effectiveness.

Providing core operating support has been central to TCWF's funding strategy for clinics and clinic consortia. In an era of a constantly changing health care marketplace — with rising costs, increasing demand and unstable funding streams — the Foundation believes it is critical that safety net providers have the organizational strength and flexibility to continue to serve those most in need. TCWF's core operating support grants have provided clinics and consortia the ability to become more strategic about how they tackle the challenges they face and craft their own solutions to enhance their effectiveness, strengthen their staff and build their infrastructures.⁷

We believe that community clinics and consortia should be supported to do what they do best: provide quality, culturally competent care to anyone needing it regardless of ability to pay. Our core support grants to clinics are used to support existing services, with no expectation that they expand or “innovate.” Clinics also may use the grant to build the organization's internal capacity, although this is not a requirement. Approximately 65 percent of the grantees have used the funds to strengthen their infrastructure, including hiring administrative and medical personnel; developing strategic and business plans; and hiring development staff and consultants to assist with applications for

federal, state and foundation grants. The direct service goals and activities to strengthen capacity are determined by the grantee, not TCWE. Core support grants to consortia require that at least 50 percent of the grant be distributed to member clinics to support direct services. The remaining portion can be used to support and strengthen the consortium's infrastructure.

Recognizing that it takes time to build organizational capacity, our grants are multiyear. Until recently, most of our grants were for two years; but in order to provide greater stability to grantees and to give the grantees time to achieve their goals, we have moved to three-year cycles. We have also begun one-time payments for the full grant at the beginning of the grant period, giving grantees maximum flexibility and a financial cushion. Instead of mandating that the funds be spent equally throughout the grant period, grantees may determine how to allocate the funds in a manner that best meets their financial needs.

FUNDING CLINICS

Our core support grants have enabled clinics to strengthen their infrastructures in numerous ways: by improving fundraising capacity, preparing business and strategic plans, increasing medical personnel, and improving administrative practices.

Our grants to clinics generally range between \$100,000 and \$150,000 over a two- to three-year period. With so many clinics in the state seeking funding, one may ask how we choose. We have few hard and fast rules. We look for clinics that are cornerstone agencies in their communities, but we are certainly open to new clinics if there is a demonstrated need in the community. Since we are a statewide foundation, we also strive to distribute our funds proportionately across the state.⁸ The number of clinics we can support in a given region simultaneously depends upon the number of existing grants in that region. If we are fully funded in the region, we generally wait to bring forward new grantees.

In reviewing a request for funding, we ask the standard questions. Are the services meeting the needs of the population? Are they culturally competent and linguistically accessible? Do the staff and board reflect the population being served? Is the clinic responsive to community input? Is anyone else providing similar services in the community? Unlike project grants, where the discussion typically focuses on the details of the program design, staffing and budget, we also try to get at the larger and longer-term organizational issues. Where is the agency in its organizational life cycle? Is it new, growing, well-established or is it declining? What is the diversity of its funding base? What are its plans and prospects for long-term sustainability?

We seek to have a candid exchange with the prospective grantee about the challenges and opportunities facing the clinic so that we can determine how our core support grant can best be used. Clinics do not have to "ace" all of our questions to receive a grant. What they must have is an answer to how they plan to address the issues that these questions raise. If the clinic is facing difficulties, we do not automatically reject it. We are not averse to high-risk grants if justifications can be

provided for taking the risk. One question with high-risk grants is how will our funding enable the grantee to move out of the immediate crisis towards stability.

Strengthening Clinics

Maintaining fiscal stability is the key challenge facing clinics, and central to achieving that stability is building a solid infrastructure. Our core support grants have enabled clinics to address this challenge in numerous ways: by improving fundraising capacity, preparing business and strategic plans, increasing medical personnel, and improving administrative practices.

An effective way to leverage our grants and help grantees achieve long-term stability has been to assist clinics to apply for designation as a Federally Qualified Health Center (FQHC).⁹ With the attainment of FQHC status, clinics receive annual federal core support grants that can range from \$100,000 to more than \$1 million to cover the costs of indigent care. The average grants are around \$500,000.¹⁰ They also gain access to a variety of other federal programs that help reduce their costs and strengthen their infrastructures. FQHC clinics also receive far higher Medi-Cal reimbursement than the standard rate. Clinics that cannot meet all the FQHC standards can qualify to be “FQHC look-alikes,” which enables them to receive the higher FQHC reimbursement rate, a critical component of long-term sustainability.

Our core support grants have been used to hire consultants to prepare the complex application, hire medical personnel necessary to meet the programmatic requirements, and support the merger of clinics so that they serve the required number of medically indigent patients. A grantee in downtown Los Angeles, Clinica Monsignor Oscar A. Romero, that was already an “FQHC look-alike,” used part of its grant to hire development staff, who prepared a successful application for FQHC status. As a result, the clinic will now receive an annual federal grant of \$650,000 for indigent care. A recently approved grant to Miners Clinic in Nevada County, which has been running with a deficit for years, will be used to hire a health educator to implement the formal prevention program needed to qualify for FQHC status. Once attained, its reimbursements for care will increase from \$18 to approximately \$85 a visit, and it will receive a federal grant to cover the cost of indigent care, which should make it financially stable.

Almost a fourth of TCWF clinic grantees have used core support grants for strategic planning and to develop and implement business and fundraising plans. Big Sur Health Center, a struggling clinic on the Central Coast that was the only provider of care in the region, used its core support to conduct a community needs assessment and hire a consultant to help its board develop a financial sustainability plan. As a result of the planning, the clinic made improvements in its operations, programs and community outreach, which in turn have led to increased reimbursement from state programs, greater awareness and support in the community of the clinic’s services, and a growing patient base. A \$20,000 grant to the Big Valley Medical Center for a feasibility study for the merger of two rural clinics in Northern California was instrumental to the successful merger. The merger

enabled the clinics to increase their services, which in turn helped them qualify for FQHC status that resulted in a \$600,000 annual grant for indigent care. Strategic planning doesn't always lead to expansion. In some cases, it has led clinics to decide against implementing programs and projects, as they were found to be organizationally or financially infeasible. We consider this an equally important outcome.

Core support grants to hire medical personnel have not only enabled clinics to increase services, but have also led to increased revenues, as the clinics are able to serve more Medi-Cal patients. In rural areas, increasing medical personnel, such as adding a physician, has increased the number of insured patients seeking care at a clinic, further improving its financial stability. Salud Para La Gente, a key provider of medical care for farmworkers in the Central Coast, hired an additional physician with core support funds. This not only enabled the clinic to better meet the demand for services, but led to increased reimbursement, which was sufficient to sustain the physician. A grant to the Los Angeles Free Clinic to support the staffing for a new pediatric dental program enabled the clinic to provide much-needed dental services and also helped to secure additional program funding. A grant for a Wellness Clinic Coordinator, who established operating procedures, secured the necessary licenses and hired staff, was instrumental to the startup and general operation of a new clinic in an underserved Latino community in Los Angeles County. In its first year, the clinic provided 18,500 visits; by the second year, visits increased by almost 50 percent. A small grant to support a nurse practitioner enabled the East County Community Clinic in San Diego to continue providing care during the restructuring of management services. The grant also helped the clinic meet the matching requirements of other funders. Now under new management, the clinic is back on its feet.

While many of the clinics we've funded have been able to sustain the additional personnel with increased reimbursements for the higher level of services, this is not always the case. Occasionally, increased income from patient visits has been "cancelled out" by an increase in uncompensated care. If clinics are unable to sustain support for additional staff hired with our grant but have met their direct service objectives, we do not consider the grant a failure. After all, uninsured individuals received health care. We also understand that without an adequate funding stream for uncompensated care, clinics will continue to struggle to strike a balance between meeting the demand for services and being able to cover the cost of providing them.

Improving administrative infrastructure is another important way that clinics can enhance their long-term sustainability. By developing more efficient ways to track service provision and mechanisms to ensure that the clinic is billing for all reimbursable services, clinics can maximize their revenue from existing sources. The Pediatric and Family Medical Center in Los Angeles used part of its grant to increase the efficiency of its accounts receivable collections, thus reducing the delay between billing and reimbursement by 20 percent. A grant to the National Medical Association Comprehensive Health Center in San Diego helped consolidate the human resource functions

of two community health centers, leading to cost savings that were redirected to primary and preventive services. Delta Health Care and Management Services Corporation, which runs school-based health centers in Stockton, used a portion of its grant to improve its systems for client tracking, case management and billing.

Supporting Clinic Services

We require a preventive health service objective for every clinic receiving a core support grant. The grants are used to support the provision of a wide range of primary and preventive health care services including mental health services, dental care, optometry services, case management services, health education, chronic disease management and reproductive services.

While many grantees have used the core support grants for ongoing services, several have also used the grants as opportunities to improve service delivery. Glide Health Clinic in the Tenderloin District of San Francisco serves a large homeless population. Our grant was used to assist the clinic in shifting from acute, episodic care to a model that encouraged patients to stay connected to the clinic through the provision of in-house mental health services and complementary care therapies, thus improving continuity of care. The South Bay Free Clinic in Manhattan Beach used its grant to fully integrate teen-friendly services into its comprehensive medical and social service programs.

Lessons Learned

Not all grantees met their objectives. In some cases, the original goals were unrealistic. In others, the clinic faced unexpected operating challenges precipitated by outside factors. Still, all grantees were able to meet at least one of their objectives. The following are lessons learned from both the successes and shortfalls.

Grantees are not accustomed to core support grants. Many grantees write proposals that read more like project grants and do not take advantage of the opportunities presented by a core support grant, such as using the funds to apply for FQHC status, develop a business plan or improve administrative functions. It is important at site visits to explain the purpose of core support and then explore with the clinic the organizational challenges it might address through the grant. The questions that are most fruitful are: What does your organization really need that you can't get money for? What do you need to strengthen your ability to effectively fulfill your mission? Such a conversation frequently leads to changes in objectives that are much more focused on the infrastructure needs of the grantee. Grantees are also skeptical about our not expecting them to start anything new or increase the units of service.

Grantees are worried about frank conversations. If the potential grantee organization does not already have a relationship with the Foundation, it may be reluctant to speak frankly — believing that revealing organizational problems will result in the Foundation not providing a grant.

We have found that potential grantees relax somewhat and open up when we make it clear that we understand that challenges are inevitable and that our goal is to strengthen the clinic's ability to address those challenges.

Rural grantees have particular difficulty recruiting and retaining personnel. Given the isolation of many rural communities, recruiting and keeping personnel is an ongoing struggle. When a rural grantee proposes to use the grant to hire medical personnel, it is important to discuss the recruitment and retention plan. We also make note in the board write-up that this will be a risky grant. In the best cases, the medical professional to be hired is already in the community. Occasionally, even when the grantee has already identified someone, the person leaves after the grant begins. Other recruitment and retention issues facing rural communities include how to help integrate a person who comes from outside of the area (and may well be from a different country) into the clinic and the community. Frequently, we have had to extend the time period of the grant for those grantees who have not been able to recruit personnel in the time they expected. In cases where grantees were unable to recruit personnel or the person left, the clinic has used the resources to support existing services.

Flexibility is important. There will always be those grantees that will be unable to meet their original objectives. Either they are faced with unexpected challenges or are unrealistic about the demand for untested programs. In these situations, it is important to discuss with the grantee how the grant can be used to help them through the crisis or how they may use the funds in a more effective way. For example, when a small rural clinic lost its lease, TCWF funds were put into a separate account and used to sustain services while the clinic transitioned to a new location and merged with a larger provider. In another case, a clinic decided to hold health fairs and provide vouchers for free medical services to increase access to care. When the strategy failed to meet the clinic's expectations, in consultation with TCWF staff, it shifted the funds to support an existing chemical dependency program. We now require that core support grants be used to support existing services. While a grantee might fail to meet some of the original objectives, we would consider the grant successful if it was used to help the grantee out of a crisis or to provide a satisfactory level of direct primary or preventive care services.

Taking risks can result in great returns. Grants to clinics that are facing financial difficulty or are in a crisis situation can be very successful. The key is having a plan to address the crisis. In these cases, TCWF funds are used to support its implementation or enable the clinic to continue to provide care during the plan's implementation.

Small grants can make a difference. We have given several grants in the range of \$10,000-\$20,000 to pay for a consultant to assist with an FQHC application or merger proposal. We've also given small grants to meet the matching requirements of other funders to help a clinic through a short-term crisis. In every case, the grant has enabled the clinic to successfully meet its objectives.

FUNDING CLINIC CONSORTIA

Consortia has used their core support grants to strengthen their advocacy capacity, improve technical assistance to the membership, develop shared services, strengthen development programs, and support clinic members.

The California Wellness Foundation began investing in the state's clinic consortia in 1996. At the time, clinics were facing the difficult transition to Medi-Cal managed care and struggling with the impact of the new welfare and immigration reforms that changed the rules for Medi-Cal eligibility. Clinics were worried about maintaining their market share in Medi-Cal and being left with the uninsured patients and no resources to cover the cost of care. The goal of the first round of funding was to help the consortia and their member clinics develop the infrastructure necessary to compete in a managed care environment. Funding also provided clinics with grants for primary and preventive care services during the transition period.

In the first round of funding, TCWF invested more than \$9 million, including one-year grants of \$1 million to each of the five existing urban clinic associations. These were located in Alameda, Orange, San Diego, San Francisco and Santa Clara counties. Planned Parenthood received funding to distribute to its member clinics, and in Sacramento and Los Angeles, when there were no consortia, funds were distributed through intermediaries to clinics in the region. Funding also included start-up costs for a new clinic association, the Community Clinic Association of Los Angeles County. An evaluation of this first round found that clinics and their associations had made significant strides in building their infrastructures to address the challenges presented by managed care. Successes included educating and enrolling patients; developing provider networks; developing systems to meet contracting requirements of managed care plans; contracting with managed care plans and negotiating favorable terms; developing member services; implementing strategies to help clinics retain market share and attract new clients; and reducing costs through sharing and centralizing selected functions and establishing group purchasing programs.¹¹

Given the success of this first round of funding, TCWF has followed up with three additional rounds for the urban consortia, providing \$300,000 to \$400,000 over two years in each subsequent round. We also have provided two rounds of funding of \$300,000 for each of the more recently established rural consortia. For many of the rural consortia, the first round of grants enabled them to hire a full-time executive director. Similar grants were provided at the same time by The California Endowment, the largest health foundation in California. Together, these grants got the rural consortia off the ground.

Strengthening Consortia

Consortia have used their core support grants to strengthen their advocacy capacity, improve technical assistance to the membership, develop shared services, strengthen development programs, and support clinic members. The following are some examples of this work.

All of the consortia have used their grants to strengthen their advocacy capacity and increase the

visibility of clinics in their regions. They have become powerful voices for their clinics and the patients they serve. Their advocacy efforts have led to millions of dollars in local government funds for their member clinics. The Coalition of Orange County Community Clinics helped lead a successful ballot measure campaign to allocate tobacco settlement dollars for the provision of health care to the underserved. The campaign resulted in an annual allocation of \$6 million to Orange County community-based clinics. The county has contracted with the consortia to distribute the funds. The Community Clinic Association of Los Angeles County led the advocacy effort for the county's public-private partnership program. This resulted in \$60 million for clinics that contracted with the county to provide health services. The Council of Community Clinics in San Diego used TCWF funds toward documenting the lack of county funding for indigent care. Its report and subsequent advocacy efforts resulted in the Board of Supervisors increasing, for the first time in eight years, the income eligibility level for the county's medically indigent program. The Central Valley Health Network recently released a study of indigent health and public health programs in the Central Valley, which has become an important tool for its members as they advocate for funding in their counties.

All of the consortia have used TCWF grants to provide technical assistance to their members in the areas of clinic operations, finance, human resources, program development and fund development. Many of the consortia, for example, have held trainings on compliance with the new federal Health Insurance Portability and Accountability Act, and how to make the transition from fee-for-service and cost-based reimbursement systems to the new Prospective Payment system. With technical assistance from the Redwood Community Health Coalition, six member clinics successfully applied for FQHC status. The North Coast Clinics Network used a portion of its grant for a scholarship fund to enable clinic staff to attend trainings and conferences outside of the region. Several of the newer consortia have used their funds to conduct surveys of members to identify training needs and are developing programs based on the findings. An important component of the technical assistance has been the development and ongoing support of peer committees of clinic personnel such as medical directors, human resource directors, fiscal officers and eligibility workers. These committees serve as important support groups for the members by providing an opportunity to problem solve and share best practices. In some cases, this has led to the standardization of forms and practices across the clinics. For example, the chief financial officers of the members of the Council of Community Clinics in San Diego are working to standardize members' systems of accounts.

One of the long-term goals of the consortia is to increase efficiency and reduce costs for member clinics by integrating functions and developing shared services. TCWF funds have been used to develop and implement plans for these programs. Two consortia, the Alameda Health Consortium and the Council of Community Clinics, have established management service organizations that provide a variety of shared and centralized services in such areas as quality management, disease management, finances, managed care and human resources. The Central Valley Health Network has implemented a joint purchasing program for payroll services, saving the

membership 30 percent of its costs, and is developing a model electronic medical records program. The Community Clinic Association of Los Angeles County hired a pharmacist who is now the pharmacist of record for 25 members. He assists member clinics with dispensary operations, pricing, suppliers and licensing. The most recent grant to the Shasta Consortium of Community Health Centers will enable it to develop an integrated pharmaceutical program. The San Francisco Community Clinic Consortium is in the process of linking each of its member clinics to the San Francisco Department of Public Health's shared electronic medical records system, which will enable its members to more effectively access patients' medical records and lab reports.

Improving the quality of care in member clinics is an important focus of consortium-integrated service efforts. Several consortia have developed quality improvement projects to address diabetes and other chronic diseases. The Redwood Community Health Coalition implemented a chronic disease management program covering diabetes, asthma, hypertension and reproductive health. The program standardized treatment and data collection across clinics and has improved outcomes for patients throughout the consortium. The Northern Sierra Rural Health Network launched a regional mental health project to integrate mental health into primary care. Because its rural members are often extremely isolated, the program used the consortium's telemedicine network to provide psychiatric services.

TCWF funding has also been instrumental in developing the fundraising capacity of the consortia. Since the implementation of TCWF's consortia funding strategy, fund development and advocacy efforts of the consortia have resulted in as much as \$27 million in new funding to clinics and consortia. A significant portion of the private funding has come from The California Endowment's clinic initiatives.

Supporting Member Services

One of the requirements of TCWF grants to consortia is that at least 50 percent be used to support primary and preventive services. The direct services supported through the consortia grants include primary care, dental care, outreach and community education, case management, and supportive services such as transportation and child care. Several of the consortia have divided the direct service portion of their grants equally among their member clinics. Others have allocated some portion of funds equally among clinics and then allocated the remainder based on the number of patient visits or the budget size of the member clinic. Because of its large membership (39 clinics), the Community Clinic Association of Los Angeles County has a policy restricting it from regranteeing monies to its membership. TCWF's grant was used to establish its group pharmacy project described previously.

Lessons Learned

All consortia go through an evolutionary process. At the early stages, the most effective roles consortia can play are to advocate, build community awareness of the local safety net, and

support the development of cross-clinic committees for staff with the same function. The members of a consortium must have time to build their relationships and gain trust in each other before attempting to develop and implement shared or integrated services. Developing shared services becomes more complicated in consortia with larger numbers of members and with clinics that vary significantly in the size and sophistication of their operations.

Consortia play a vital role in strengthening their member clinics. From simply providing a forum for clinic personnel to support each other and share best practices, to providing a broad array of centralized and integrated services, consortia efforts have strengthened the infrastructure of each of their members. As one clinic director said in the first evaluation, “Clinics cannot go it alone anymore. . . they must be part of larger provider networks to maintain their safety net mission.”

Disseminating funds through the consortia helps to enhance the value of the association to its member clinics. The mandate to provide half the grant to clinic members for preventive health services helped new consortia to demonstrate quickly the benefits of membership. This, in turn, strengthened member support of and participation in the consortium. Our evaluation also found that the process of coming to an agreement on an allocation formula for distributing funding to member clinics was empowering for consortium members.

Consortia advocacy efforts are critical to long-term sustainability of the safety net. Consortia have been extraordinarily effective at increasing local funding for their membership. They have also strengthened considerably the advocacy efforts at the state level for support of safety net providers. Public funds, while they are currently being cut, will always be the bread-and-butter funding for community clinics. It is, therefore, crucial that consortia continue to receive support for their advocacy efforts.

CONCLUSION

The question for health grantmakers is how can foundations most effectively use their resources to support the safety net given the very limited resources of foundations compared to the need.

In the absence of a system of universal care, the safety net, no matter how frayed, will continue to be the primary source of care for the uninsured and underserved. The question for health grantmakers that focus on these populations, therefore, is how can foundations most effectively use their resources to support the safety net given the very limited resources of foundations compared to the need. Our answer is to provide core operating support to clinics and clinic consortia.

TCWF grants to clinics have enabled them to bring in hundreds of thousands of dollars in federal funding to cover their indigent care costs; hire medical personnel to meet the demand for care, which in many cases has also led to increased revenue; and take the time to develop the strategic and business plans they need to better guide the organizations in these challenging times. Our grants to clinic consortia have helped ensure that there is a strong regional voice and support system for

clinics throughout the state. Advocacy efforts of the consortia have been critical to increasing local government funding for member clinics; the technical assistance provided by consortia has effectively strengthened member clinics; and the development of integrated and shared services has increased the efficiency and effectiveness of member clinics. Since more than 90 percent of clinics in California belong to a consortium, funding them has also been a very effective way to provide some resources to virtually every clinic in the state for the provision of preventive health services.

Providing core operating support for organizational infrastructure and direct services may not be considered new or innovative grantmaking. But as the results of seven years of funding have demonstrated, it is a highly effective way to support essential safety net providers and leaves them far better prepared to confront the inevitable parade of new challenges.

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ENDNOTES

- 1 “America’s Health Care Safety Net, Intact but Endangered,” Institute of Medicine, March 2000, p. 2.
- 2 California’s Medicaid program.
- 3 More than 6 million children and nonelderly adults were uninsured for all or part of 2001 (UCLA Center for Health Policy Research).
- 4 “On the Brink: How the Crisis in California’s Public Hospitals Threatens Access to Care for Millions,” California Association of Public Hospitals and Health Systems, 2003, p. 2.
- 5 In this document, the term “clinics” also refers to health centers.
- 6 “The Future of California Community Clinics and Health Centers in the Safety Net, A Blueprint for Action,” 1999, p. 18.
- 7 Much of TCWF’s early grantmaking was through proactive, project-driven initiatives; however, through our special projects — developed to fund opportunities that fit our mission but are outside of the established funding priorities — the Foundation began to provide core support to clinics and consortia. The success of this strategy led the board to establish the funding criteria of 60 percent core operating support in all the established funding priorities and special projects.
- 8 We have divided the state into eight regions and try to keep the percentage of our grantmaking in each region equivalent to the region’s population.
- 9 Eligible clinics must provide care in a federally designated Medically Underserved Area or to a federally designated Medically Underserved Population. There are also multiple requirements for the standard of care.
- 10 These federal grants are reviewed on a competitive basis every 3-5 years.
- 11 TCWF Special Projects Cluster Evaluation Report: “Funding Regional Clinic Associations and Consortia,” by Jennie Schacht, 2002; Schacht, J. Evaluation Report: “Creating Partnerships with Clinic Associations to Preserve the Safety Net,” Health Affairs (May/June 1998), pp. 248-252.

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