Borrower: JHW

Lending String: *FBC,M16,OCM,TTL

Patron: Barton, Normalie

Journal Title: Organizational ethics; healthcare, business, and policy; OE.

Volume: 4 Issue: 1
Month/Year: 2007 Pages: 35-42

Article Author:

Article Title: Shi L; Collins P; Public-private partnerships in community health ce

Imprint: Hagerstown, Md.; University Pub. Group,

ILL Number: 39370741

Call #: 3rd Floor
Location: Main Periodicals V. 2-2005- to present

ARIEL
Charge
Maxcost: 25.00IFM

Shipping Address:
Weich Medical Library, ILL
Johns Hopkins University
1900 E. Monument St.
Baltimore, MD 21205

Fax:
Ariel: 162 124 65 24
Public-Private Partnerships in Community Health Centers: Addressing the Needs of Underserved Populations

Leiyu Shi and Patricia B. Collins

ABSTRACT

Community health centers have provided high quality, cost-effective primary healthcare to underserved populations for over four decades. From the beginning, collaboration has been a central component of the community health center model of care. This article begins with an overview of community health center achievements and the drive for increased private-public partnerships in public health. The historic and current role of public-private partnerships within community health centers is described, with a particular focus on the Bureau of Primary Health Care initiatives (that is, the Health Disparities Collaborative and the Healthy Communities Access Program). Community health centers' establishment of partnerships in response to Hurricane Katrina and Medicare Part D is discussed. Finally, this article considers the continuing role of community health center public-private partnerships in the context of political and healthcare market shifts.

COMMUNITY HEALTH CENTER PROGRAM ACHIEVEMENTS, 1965-2007

Since the mid-1960s, community health centers have provided high quality, cost-efficient primary and preventive care services to the nation's most vulnerable populations. In 2004, about 1,000 community health centers served over 13 million people in every state and territory. Nearly two-thirds of these patients were members of racial/ethnic minority groups, and nearly three-quarters had incomes that were below 200 percent of the federal poverty level. More than 40 percent of community health center patients in 2004 were uninsured, and about 36 percent were covered by Medicaid. Community health center patients tend to have
poorer self-reported health status than non-community health patients, and are more likely to have a chronic illness compared to patients of office-based physicians.

The Community Health Center Program is authorized under Section 330 of the Public Health Service Act and is administered by the Health Resources and Services Administration (HRSA) Bureau of Primary Health Care (BPHC). Health centers are eligible for Federally Qualified Health Center (FQHC) status through Title XVIII, Medicare, and Title XIX, Medicaid, which entitles centers to receive enhanced Medicare and Medicaid reimbursement.

Since its inception, the Community Health Center Program has been firmly committed to a model of healthcare provision that is comprehensive and community-focused. To qualify for federal support, community health centers must comply with the following requirements:

1. Be located in a federally designated medically underserved area or serve a medically underserved population,
2. Be governed by a board of directors, at least half of whom must use the community health center,
3. Provide comprehensive primary health, oral, and mental health/substance abuse services, regardless of patients’ ability to pay,
4. Charge for services on a board-approved sliding-fee scale that is based on patients’ family size and income, and
5. Comply with other performance and accountability requirements established by federal and state regulations.

These requirements assure that the community health centers are accountable, not just to state and federal entities, but also to the communities in which they operate.

In the decades since the inception of the Community Health Center Program, the quality and cost-effectiveness of community health center services has been documented extensively in the literature. For instance, despite poorer health status, community health center patients have reported significantly better primary care experiences (that is, having a regular source of care, visiting a generalist in the past year, receiving a mammogram in the past two years, and receiving counseling on exercise) compared to similar patients nationally. Moreover, community health center patients who are uninsured or Medicaid-insured have reported better access to care, compared to non-community health center patients nationally. Citing community health centers’ record of improving health outcomes for higher-risk populations, the Institute of Medicine (IOM) recognized the program for its potential to reduce racial and ethnic disparities in health.

Acknowledging this consistent record of achievement, President George W. Bush announced plans in 2001 to open or expand 1,200 community health centers to serve an additional 6.1 million people. With concomitant support from Congress, which has allocated $750 million in new funding for community health centers over the past six years, significant progress has been made toward the President's goal. By 2005, the community health center program had increased by more than 600 new and expanded sites.

While this is a dynamic moment in the history of the Community Health Center Program, the core components of the program are unchanged. Community health centers remain committed to the provision of comprehensive primary and preventive healthcare services that are governed by national standards, but are firmly rooted in the local context. This community focus naturally translates to public-private partnerships within community health centers. Such partnerships have been crucial to the evolution of the program in the past 40 years, and remain central to community health centers’ continued success.

PUBLIC-PRIVATE PARTNERSHIP MODELS

Before describing the role of public-private partnerships in community health centers, it is instructive to explore the models and justifications for public-private partnerships in public health more broadly. In its 2002 report, The Future of the Public’s Health in the 21st Century, the IOM laid out a vision for a public health system, in which government agencies work in
partnership with business, the media, academia, communities, and the healthcare delivery system to assure the conditions for population health, with an emphasis on the interconnectedness of the multiple entities that shape determinants of health (see figure 1).15

Among the IOM recommendations for strengthening the public health system were the following:
1. An overhaul of the public health infrastructure to ensure quality of services and optimal performance;
2. Greater involvement of communities in public health system decisions and operations;
3. Better alignment between public health goals (for example, universal access to healthcare) and the health delivery system;
4. Development of mutually beneficial relationships between the business community and the public health system (for example, via federal incentives to enable small businesses to purchase health insurance; and employer sponsorship of health promotion and disease prevention programs for employees);
5. Stronger ties between the media and public health to encourage positive messages about health behavior and knowledge; and
6. Increased collaborations between academic institutions, research funders, and community-based organizations through the provision of services, research, and teaching.16

The collaborative focus of these recommendations underscores the links between population health and most other human endeavors. Each key partner is a critical link in assuring the conditions for population health; conversely, the absence of population health is detrimental to each key partner, be it a business, the government, or the community.

To address the complex and evolving set of challenges faced by the public health system, other prominent figures have echoed the IOM's call to strengthen public-private partnerships. Carolyn Clancy, MD, Director of the Agency for Healthcare Research and Quality (AHRQ), emphasized in a recent article that new partnerships between the public and private sectors will be crucial to achieving several goals, including the production of valid evidence for decision making in healthcare, the adoption of interoperable health information technology, and consumer-centered care.17

A framework for public-private partnerships in public health exists, and the importance of these partnerships is evident. However, the degree to which the IOM's recommendations and Clancy's collaborative vision have been achieved thus far is unclear. Georges C. Benjamin, MD, Executive Director of the American Public Health Association, feels there is room for improvement. Benjamin notes, "To date, public health supporters have not been as effective as they could be in engaging [the general public, the business community, and public policy makers] in ways that allow them to understand their potential both for improving community health and for investing in it."18

Dr. Benjamin's comments suggest the broader public health system could be more effective and proactive in its efforts to establish public-private partnerships. However, throughout its history, the Community Health Center Program has partnered with outside entities to strengthen systems of care for vulnerable populations. In the interest of providing a roadmap of sorts for application of the IOM's recommen-

---

Figure 1. Potential Partnerships to Improve Public Health

Institutions, we will discuss several examples of how community health centers have worked in collaboration with other organizations to ensure access to care, improve quality of care, and reduce disparities in the provision of healthcare that are based on racial and ethnic difference.

PUBLIC-PRIVATE PARTNERSHIPS IN COMMUNITY HEALTH CENTERS

As the nation’s largest unified primary care system, administered by the federal government but governed locally, the Community Health Center Program would be situated in the “governmental public health infrastructure.” Given their broad reach and the scope of services they provide, community health centers are one of the key players in assuring the conditions necessary for a healthy population.

At a fundamental level, the model of care espoused by community health centers is grounded by community resources, needs, and partnerships. In fact, the community health center model of care addresses the IOM’s first three recommendations. Community health centers help ensure quality of services and optimal performance of the public health infrastructure (IOM Recommendation 1) by providing excellent primary and preventive care services to millions of people who otherwise would lack access to such care. The governing boards of community health centers must include a majority membership of community members, ensuring greater involvement of communities in public health system decisions and operations (IOM Recommendation 2). Finally, by assuring access to care regardless of patients’ insurance status or ability to pay, community health centers help align public health goals and the health delivery system (IOM Recommendation 3).

Beyond the partnership-building characteristics of the standard community health center model of care, several recent large-scale initiatives illustrate how the program has embraced new public-private partnerships to enhance access to healthcare service, improve the quality of services delivered, and reduce disparities in the provision of healthcare services that are based on racial and ethnic difference. These initiatives include the BPHC Health Disparities Collaborative and Healthy Communities Access Program.

THE HEALTH DISPARITIES COLLABORATIVE

The most significant example of community health center public-private partnership efforts is the Health Disparities Collaborative (HDC). The HDC is an initiative that is sponsored by the BPHC, with two major goals:
1. To improve delivery systems of healthcare and
2. To eliminate disparities in the provision of healthcare services that are based on racial and ethnic difference.

The HDC was launched in 1998 at five pilot sites, and grew to approximately 800 community health centers by 2006.

Community health centers who participate in the HDC send a multi-disciplinary quality improvement team of three to five members to several regional or national learning sessions in the course of one year. At these learning sessions, participants receive training in quality improvement methods and compare strategies and experiences with other community health centers. Implementation of the HDC is left largely to individual community health centers; however, continued interaction is encouraged and technical assistance is available.

The theoretical foundation of the HDC approach is the Chronic Care Model, originally developed by Edward Wagner, MD, MPH, and colleagues. The Chronic Care Model emphasizes six focus areas for chronic care improvement:
1. Redesign of the system that delivers healthcare services — for example, reorganize the practice team and the way that chronic care visits are conducted.
2. Increase use of clinical information systems — for example, implement a patient registry and provide feedback to careproviders.
3. Provide support to careproviders in making decisions — for example, provide education, consultation, prompts for careproviders, and institute guidelines and protocols.
4. Increase interaction within the health system — for example, establish routine quality improvement meetings for all staff and
chief executive officers/chief financial officers of community health centers.

5. Increase collaboration with the community — for example, a community health center may partner with a local recreation center to supply free passes for patients with diabetes, or establish a series of health education workshops at places of worship.

6. Provide support for patients in the management of their own health — for example, establish self-care plans with patients.22

The heart of the Chronic Care Model and the HDC is collaboration and the fostering of public-private partnerships to improve quality. This collaboration and partnership happens at several different levels. Most broadly, the HDC involves a close working relationship between the federal Bureau of Primary Healthcare, state primary care associations, leaders of local community health centers, and the wisdom and know-how of the Institute of Healthcare Improvement (IHI), which operates HDC learning sessions and provides technical assistance to community health centers during implementation. At the micro level, implementation of the HDC within community health centers requires close collaboration between the clinical and administrative staff.

HDC implementation also benefits from partnerships between community health centers and other local organizations that support patients with chronic illness. Because a great deal of the management of chronic illness depends on patients’ attitudes, beliefs, and behaviors, these types of partnerships enhance the possibility of achieving better health outcomes.

A recent large-scale, controlled evaluation of the impact of the HDC by Bruce Landon, MD, MBA, and colleagues, reported that the initiative was associated with significant improvements in quality measures for asthma and diabetes care.23 The study found no improvement in intermediate health outcomes, but was careful to note such outcomes are difficult to assess in the short-term. Moreover, the study emphasized that “environmental factors... pose particular challenges for patients treated” at community health centers.24 These environmental factors (for example, poverty, neighborhood infrastructure, education, health beliefs) powerfully shape health outcomes and should be a focus of the public-private partnerships that are established as part of the HDC. A major strength of the HDC is that it brings everyone to the table: federal and state governments, local healthcare systems, technical experts, supportive community organizations, administrators and care providers at community health centers, and patients. With this collaborative structure in place, community health centers have an opportunity to leverage partners’ diverse expertise and resources to address the multiple determinants of health. This strategy may have a significantly positive long-term impact on patients’ health outcomes.

THE HEALTHY COMMUNITIES ACCESS PROGRAM

Another recent BPHC initiative to foster public-private partnerships was the Healthy Communities Access Program (HCAP). Between 2002 and 2006, HCAP provided grants and technical assistance to public and private healthcare providers to collaborate on better coordination of the health services provided to uninsured and underserved people.25

 Consortia funded by HCAP were required to include a community health center, a hospital with more than one-quarter low-income patients, a public health department, and a public or private-sector healthcare provider or organization that has traditionally served uninsured and underserved patients. Beyond the required member organizations, consortia were encouraged to partner with other community organizations that provided services that support the uninsured and underserved (for example, social services, transportation, and health education).

The goal of HCAP was to help consortia develop systems of care to coordinate health services across providers, conduct outreach and education, expand access to care, improve the quality of services provided, reduce costs, build sustainability through leveraging additional funding, and develop strong relationships across member organizations. HCAP grant support for successful applicants was available for up to
three years, after which consortia were expected to find other sources of funding to continue their work.

Like the HDC, HCAP relied on public-private partnerships to improve access and quality, streamline and coordinate care, and ultimately improve people's health. The end of federal funding for HCAP in 2006 raises an important issue: the sustainability of its improvement efforts. It remains to be seen whether the consortia sponsored by HCAP and the changes in the delivery system instituted by HDC participants can be maintained in the absence of an active, financially supported collaborative structure. This is a challenge for public-private partnerships more broadly. While there are certain challenges to initiating public-private partnerships, the challenges of sustaining these relationships over time — given personnel turnover, financial considerations, and market shifts — are more substantial. Identifying the factors that promote or inhibit the sustainability of public-private partnerships in public health is an important area for further research and reflection.

RESPONSE TO HURRICANE KATRINA

In addition to the two federally sponsored, partnership-focused initiatives described above, community health centers have traditionally developed their own local collaborations to better fulfill their mission. The first community health centers emerged during the era of President Lyndon Johnson's War on Poverty, and attempted to link healthcare services to job training, nutrition, and local economic development. Early collaborators in the community health center movement included not only federal, state, and local governments, but also activist organizations and churches, some of which served as start-up facilities for the centers.

Since these early collaborations, community health centers have grown to assume a central role in the nation's health safety net system. As new healthcare-related challenges arise, new community health center partnerships emerge. For instance, in the aftermath of Hurricane Katrina, the community health centers in Louisiana and surrounding states were faced with the enormous task of caring for thousands of New Orleans evacuees, the vast majority of whom had low incomes and lacked health insurance. The U.S. Centers for Disease Control and Prevention (CDC) reported that one-third of the evacuees' health concerns that were addressed in community health centers in Arkansas, Louisiana, Mississippi, and Texas were related to chronic illness. Mental health, skin, and gastrointestinal problems were also pervasive. The health concerns faced by evacuees were compounded by the economic and personal devastation produced by the storm.

The herculean effort by community health centers to care for these patients required public-private partnerships to succeed. The collaborations included extensive coordination with foundations, corporations, organizations, and private citizens who donated money, supplies, and time to the community health centers that provided care to evacuees. Hundreds of non-community health center clinicians volunteered in community health centers after the hurricane, because they were able to continue providing services when other healthcare facilities were unable to stay open. As one physician noted, "When nothing else was working, when the government was saying to call this phone number and leave a message, the network of health centers was working." Individual community health centers also forged smaller-scale partnerships post-Katrina: for instance, a Mississippi community health center managed to secure funding from the Children's Health Fund for a mobile clinic to treat the mental health needs of children. Continued public-private partnerships, including community health centers, will be essential to rebuild the public health infrastructure in New Orleans and to address the healthcare needs of a population that is struggling to regroup after this tragedy.

MEDICARE PART D
OUTREACH AND ENROLLMENT

Changes in healthcare policy also shape the establishment of public-private partnerships involving community health centers. For instance, the implementation of the Medicare prescription drug benefit in 2006 compelled community health centers to collaborate with others to educate, assist, and enroll Medicare patients
into the drug-discount care and transitional assistance program. A best-practices report from the National Association of Community Health Centers (NACHC) found that public-private partnerships were a key element of successful community health center efforts in this area. The NACHC recommended that community health centers partner with state pharmacy assistance programs, Meals on Wheels, AARP, Area Agencies on Aging, professional and civic organizations (such as the Elks), local Veterans of Foreign Wars branches, other healthcare providers (such as nursing facilities and assisted living facilities), county and state health boards, colleges and universities, the media, and pharmacies. Such partnerships not only ensure that senior citizens receive the benefits to which they are entitled, but also reduce any duplicated efforts by the community-based organizations that serve this population. Moreover, the NACHC notes that these types of partnerships build trust within communities and spur additional partnerships, which benefits everyone involved.

CONCLUSION

This article discussed the historic and current role of public-private partnerships within community health centers and presented several such examples including the Health Disparities Collaborative, the Healthy Communities Access Program, and partnerships in response to Hurricane Katrina and Medicare Part D. Although the federal community health center initiative has provided the stimulus for partnerships with the community, many health centers perceive this partnership to be a fundamental requisite to delivering healthcare to the underserved. In today’s healthcare environment, direct funding from the government for expanding access to care by the underserved is very limited. The community has to rely on its own resources, including support from the private sector, to make this sustainable. The community health center experience indicates that successful public-private partnerships require the following ingredients:

- A shared vision to expand care to all those in need,
- Shared governance, through which an agenda for healthcare access is truly “owned” by its partners, rather than by the health center,
- Designated time and resources by members of the partnership,
- Ongoing assessment and adjustment to continually improve performance, and
- Transformed community attitudes and norms to promote health.

The community health center experience may serve as a model for the rest of the healthcare sector in terms of providing quality of healthcare to all in need in a market-dominated society.

NOTES

3. Ibid.
7. Ibid.
8. For an extensive list of articles on community health center quality of care and cost-effectiveness, see the National Association of Community Health Centers (NACHC) website, www.nachc.com/research.
9. L. Shi and G.D. Stevens, “The Role of Community Health Centers in Delivering Primary Care to the Underserved: Experiences of the Uninsured and Medicaid Insured,” Journal of Ambulatory Care Management 30, no. 2


16. Duke, see note 14 above.


20. Benjamin, see note 18 above.


24. Ibid., 929.


28. Ibid., 10.

29. Ibid., 6.

Health, Nutrition and Population (HNP) Discussion Paper. Public-Private Partnerships and Collaboration in the Health Sector: An Overview with Case Studies from Recent European Experience Dr. Irina A. Nikolic (M.Phil., Ph.D.)a, Dipl.KH-BW Harald Maikisch (MSc, MAS)b a Europe and Central Asia Human Development, the World Bank, Washington, DC, United States of America b Deputy CEO, Vorarlberg Hospital Management Company, Vorarlberg, Austria. The preparation of this brief builds on analysis, presentations and contributions by the World Bank team delivered at the workshop on Public-Private Partners...