

ENHANCING RESEARCH ON HEALTH CENTERS AND THE MEDICALLY UNDERSERVED

Friday, May 14, 2004

Agency for Healthcare Research and Quality Conference Center
540 Gaither Road
Rockville, MD 20850

MEETING PROCEEDINGS

Welcome and Introductions

Dan Hawkins, Vice President for Federal, State and Public Affairs, National Association of Community Health Centers

Dan opened by setting the context for the meeting. Dan noted the following:

- In many ways, the problems that the health centers program was originally intended to address speak to most of the major failings of our healthcare system today.
- While research over the life of the health centers program have shed light on the positive impacts of health centers on improving health status and reducing use of more expensive, inappropriate sources of care, much more remains to be learned about how to better target resources where the need is greatest, about which services and delivery design features most powerfully affect access to and use of care, about what constitutes quality health care, and about how to best attack pervasive problems like racial and economic health disparities.
- We are also in a new era of health services research brought about by dramatically rising uninsured and managed care, aspects of the health system that necessarily involves health centers.
- This meeting is intended to foster a collaborative dialogue among meeting participants that will hone and strengthen some existing ideas, concepts, hypotheses, and spark new ideas for research on underservice, access to care, quality of care in a primary care setting, and other relevant topics.
- NACHC pledges to share our data, information, and resources in order to encourage and enhance research on health centers and the underserved. NACHC also pledges to encourage and facilitate the participation of health centers.

David Lanier, MD, Associate Director, Center for Primary Care, Prevention, and Clinical Partnerships, Agency for Healthcare Research and Quality

Dr. Lanier welcomed participants on behalf of AHRQ, and made the following comments:

- AHRQ and HRSA have had a collaborative relationship for research around health centers for over a decade, citing the CHCNet Advisory Committee, supporting HRSA pilot projects, and topics of health center research related to quality improvement (QI) issues.
- Research related to health centers has the potential to fit with much of the work AHRQ is interested in funding.
- He noted that some researchers raise a false dichotomy between research and Continuous Quality Improvement (CQI), whereas he believes that in some cases there is a continuum. For example, if an intervention is found effective in one center, others could adopt it, and if the intervention is confirmed effective at multiple centers, it can be widely adopted without a need for a control group. The question should be whether it has the potential to improve the health care delivered to patients and outcomes. He cited examples from the Practice-Based Research Networks (PBRNs).
- Given AHRQ's mission statement ("to improve the quality, safety, efficiency, and effectiveness of health care for all Americans"), he spoke of the National Healthcare Disparities report from December 2003, which provides a roadmap for change and defines a research agenda, and the Monitoring the Health Care Safety Net data initiative, which is intended to provide baseline information regarding the status of local safety nets as well as to develop and implement a research agenda.
- He noted that research is complex, multi-level, and conducted under less than ideal conditions posing substantial challenges. It is important to consider that qualitative findings are often at least as important as quantitative findings. Assembling the right experts/researchers is an important first step when studying the safety net.

Suzanne Feetham, PhD, RN, FAAN, Director, Division of Clinical Quality and Senior Advisor, Office of Director, Bureau of Primary Health Care, Health Resources and Services Administration

Dr. Feetham welcomed participants on behalf of HRSA, and made the following comments:

- HRSA is working on a focused research agenda. She described this as three levels: the Uniform Data System (UDS, through which all federally-funded health centers report data on patient demographics, utilization, staffing, financial, and other information) on all centers; additional information on scientific samples of centers, as in the Sentinel Centers project; and targeted studies on specific groups of centers/patients.
- Care for the poor must be quality care, and more research is needed on what produces best patient outcomes. She cited HRSA's commitment to extending the Health Disparities Collaborative.
- Regarding cost-effectiveness, a recent analysis of South Carolina health centers found that health centers experienced tremendous quality improvement and costs of care that were lower than other providers. More such research is needed.
- Health centers are in the top group of programs evaluated for their success in GPRA measures, receiving a score of 85.
- This meeting will help set priorities for research on health centers.

Keynote Address

Dr. H. Jack Geiger, Logan Professor Emeritus at the City University of New York, gave the keynote address. Dr. Geiger, one of the founders of the health centers program, provided a historical overview of the program, including what his and other early pioneers' vision and expectations were at the program's creation. He noted that from the beginning, research was a core feature of health centers so that they could determine what works, what doesn't, and why. To underscore this point, Dr. Geiger recommended a book by Hollister et al, which reprints many of the early health center research efforts documenting the impacts of health centers on their communities.

Originally known as the Neighborhood Health Centers program, health centers were first funded by the federal Office of Economic Opportunity (OEO) as part of the War on Poverty. Early experience with Head Start had indicated an enormous need for health care. OEO was not satisfied with traditional provision of care to the poor and was looking for ways to better respond to communities. At the same time, Geiger and Count Gibson, participants in the civil rights movement, proposed a new model based on Geiger's experience with community-oriented primary care in South Africa, featuring a population based approach and social as well as medical intervention. The model met OEO's needs and was in accord with the principles of community action and participation of the poor. Grants were ultimately awarded to the first centers in Mound Bayou, Mississippi and Columbia Point, Massachusetts and then to other centers using a similar model.

Dr. Geiger suggested measuring the social impact of health centers, including education and training, for community residents and their children, career ladders and improved housing. He believes that community boards are central to this social impact and suggests designing the qualitative as well as quantitative research to investigate them. Also of interest to study is identifying the qualities that drive health center clinicians commitment to working there.

Discussion of Unmet Need

Meeting participants deliberated on what defines need, how to measure it, and how policy changes affect unmet need. Discussion centered on whether need is defined as medical care and/or social need, and the general consensus was that need includes social factors that cause or worsen poverty and consequently trigger health problems. With this broad definition, need then drives what services should be included in a comprehensive health care setting, the array of workforce, the community nature and social services provided, and public policy. Discussion also overlapped with other meeting topic areas, including impacts of health centers and quality of care.

Purposes of measuring need included dialogue around: 1) policy, or overall statements of unmet need to make the case for CHCs; 2) administration, to determine what and where centers should be funded; and 3) planning at the center level, to determine what services should be offered and locations pursued. In this matter, participants suggested the following:

- An assessment of all factors affecting a patient’s health and whether CHC services are meeting those needs.
- Determine why some people in the population in need do not utilize health center services (i.e., why aren’t health centers reaching them?), and why some populations do not feel comfortable using health centers (i.e., the newly uninsured).
- It is important to recognize strengths of health centers in meeting need.
- It is important to address need in ways that policymakers understand. This includes non-complicated formulas, looking at disparities, the number of people without a medical home, and stress the fact that both coverage and a usual source of care are equally important.
- Gross measures of population groups may not get at needed care for those sub-populations where unmet need is dramatic. Thus measuring need can be broken down into three levels: first, gross measures of unmet need for policy purposes; second, scale applications for health center funding to rank or differentiate those most in need for funding; and third, upon funding, determine what care the target population needs.
- While health centers often know how to improve health care, they often do not have the resources to do it (e.g., hiring a nutritionist), but studies could yield implications for policy (e.g., what services are funded).
- The research agenda should include a social agenda to inform action.

While there is no consensus on the best way to measure needed care, participants listed the following **indicators of unmet need**:

- Macro-level needs for providers (e.g., resources), which may vary by provider type.
- Lacking a medical home/usual source of care or “committed sponsor” of care regardless of insurance status.
- Whether private doctors accept publicly insured patients or provide charity care.
- Access to specialty and diagnostic services beyond primary care and outside the health center’s ability to provide onsite.
- Social needs/context, which we do not do a good job measuring.
- Lacking insurance or being underinsured.
- Culturally appropriate care.
- Community health risk assessments.
- Health status.
- Health disparities.

Methodology and measurement issues discussed include:

- Survey the amount private physicians are “giving away” part of their income through charity care and consider how vulnerable this factor is during economic downturns (i.e., how it fluctuates).
- Involve community members to survey need.
- Include mid-level clinicians, such as nurse practitioners and physician assistants, in calculating need, though currently there is no adequate means of counting.
- How to define and measure culturally competent care.
- Determine how cut backs in Medicaid/SCHIP affect health centers and their patients (e.g., regarding mortality, among those with medical home but no coverage).

- Comparing health status to identify those most vulnerable, then identify all disparities and create a framework to look at them before considering how to address them.
- Develop a framework to determine whether outcomes are a function of unmet needs and if so whether they are a function of unmet clinical or community needs.
- Potential methodologies to measure all levels of need include small area/community analysis, qualitative studies to show how health centers engage in addressing community social needs, and natural experiments to show what goes on at a health center.
- Because we have not done a good job measuring the social nature of a community, need to borrow from sociology.
- Involve community members in determining need. Consumer engagement/self-involvement must clearly be recognized. Community definition of need may be different than professional definition, thus community members must be active in designing clinical nature and structure of the health intervention program. Even if a health center provides the highest quality of care, it still will not maximize the potential to fully serve all health needs without community involvement to reinforce that care.
- Geographical mapping, but may not be as useful in the future as populations and demographics (e.g., poverty and coverage) change over time.
- Compile disparate quantitative and qualitative variables.
- Current data used to measure disparities is outdated and may no longer accurately reflect the community.
- Medical staff at health centers may be drivers for the research agenda and solutions.
- Must address the need for health centers to participate in research.

Other issues that came up in discussion include:

- The problem of Medically Underserved Areas (MUAs) as a threshold measure of need because it may be useable for a gross measure but need to be able to stratify MUAs.
- Insurance coverage is needed to help provide services outside primary care.
- “Evidence-based management” (i.e., linking health centers into management networks) could help address need.
- Electronic medical records can generate needed visits and needed outreach, education, and workforce. These factors influence where money is invested.

Direct and Indirect Impacts of Health Centers

Meeting participants discussed the positive, direct effects of health centers such as improved access, clinical effectiveness, and cost effectiveness/efficiency of their care, including savings to society in the costs of medical care. Indirect benefits were also discussed, and spanned community benefits, other cost benefits to society (such as productivity), and leadership development. In addition, this session also covered limitations and challenges health centers face.

Participants agreed that health centers are associated with numerous positive effects and that measuring them is often difficult. There were also some potential or alleged negative effects,

especially concerning the effect on other community-based providers, but research is needed to assess whether this is the case and if so, to measure the extent.

Based on the dialogue, **direct effects** include:

- Going beyond primary care to provide enabling and other support services that make health centers unique and allow them to address unmet needs for low income communities.
- Some direct impacts are dependent on others: health centers promote access, leading to rendering quality care that is comparable or better than other providers, leading to improved patient outcomes and satisfaction, leading to reduced disparities across many factors, and producing cost effective care.

Based on the dialogue, **indirect effects** include:

- Providing educational opportunities.
- Health center boards promote “cross-fertilization” and increase the ease of workforce recruitment. “Economic engines” that encourage or create development and create jobs at health centers and other area businesses.
- Promoting workforce development.
- Increasing voter participation.
- Use of mid-level clinicians at health centers has a significant impact on the delivery of culturally-competent, comprehensive care.
- Affecting other community-based providers, with discussion of both positive and alleged negative effects (e.g., positive impact on health care practices of other local providers vs. actual or feared threat of competition).
- Providing an important advocacy role to serve as a voice for the underserved and bring issues into public policy discussions.

Potential **methodologies, frameworks, and research questions** for studying effects:

- Study the 55-65 age group as they transition into Medicare to determine whether the first few years of Medicare utilization is different among those who had been using the CHC as a their medical home. This is especially interesting given that the near-elderly is the fast growing age group seen at health centers. Hypothesis is that health center produces savings.
- Because health centers may have indirect effect on other community-based organizations, look at the relationship between health centers and other social groups that form around low income communities and the activities that develop.
- Compare health centers to other providers on provision of enabling and preventive services known to be linked to improved outcomes and patient satisfaction.
- Document what health centers do or provide that contributes to their reducing disparities and how it is accomplished. However, it may be difficult to tease out the separate impact of specific center characteristics such as staffing, range of services and governance, and more work is needed to structure the research. (I think that is what is meant. See also health center model discussion).
- Research into how all health center attributes related to their successes should be translated into the health center expansion strategy.

- Case studies of some of the “original” health centers as well as newer centers, with different infrastructures and range of services. Descriptions can illustrate best practices and more rigorous case studies/field work may help determine what aspects are important.
- Study innovation among health centers and compare innovation between a CHC and a private primary care provider (e.g., use of “enabling” services integrated with medical care).
- Need measurement tools with benchmarks to spread and implement best practices. However, benchmarks are an expectation and may not be appropriate for every health center.
- Consider how state Primary Care Associations have impacted what happens at the state level, both in terms of policy development and in helping health centers improve effectiveness, quality and cost-efficiencies.
- How health centers influence other providers (the pros and cons), especially in rural areas (e.g., retention, stabilization, growth vs. reductions, losses, closures).
- Need to look at history of how CHCs are involved in the community and compare areas with and without centers on factors such as fostering community development. To do this, need to combine a variety of methodologies that involve other disciplines such as sociologists, anthropologists, community organizers, political scientists, and consumer advocates. Need different perspectives to look at the whole.
- Research other potential effects of health centers, including:
 - whether health centers involved in teaching and training clinicians affect their students’ practice at other provider sites;
 - preventing child abuse or affecting rates of local violence, crime, quality or education and housing;
 - long term effects on teaching disease self-management, though it is difficult to do a cost effectiveness analysis regarding the long term effects of health education;
 - how they affect other providers; and
 - the impact on health care as a whole in the US.
- Measure impact within cost context. Moreover, define and determine the value or “value added” of health center care. This will be helpful for policymakers especially while dealing with a budget crisis and facing program cuts.
- Study whether health centers are or can take over the workload of community-based public health where local support for public health has declined.
- What health workforce consequences and policy implications result from health center expansions.

Video Presentation

During lunch, participants had the opportunity to watch “Out in the Rural,” a 1974 documentary on the first rural community health center in Mound Bayou, Mississippi that recounts the founding vision and comprehensive programs offered by the health center, and the societal factors that drove the need for such services. Direct and indirect results were also discussed. The documentary will soon be available for purchase from NACHC.

Discussion of Quality of Care

Participants discussed issues related to measuring and assuring quality of care, including quality of chronic disease management.

Extensive discussion occurred regarding the lack of consensus around whether health centers should have quality measures that are the same or different from the private sector. Those supporting the notion that health centers should have different measures stated that their quality measures should be designed to reflect the unique social factors of their patient populations. This is because the problems of health center patients are more complex than the general public, and there is a concern that patient mix drives outcomes more than anything physicians can do. They argue that using similar quality measures to compare health centers and other providers would make the health centers appear to be doing a poor job, which in turn could steer away publicly and privately insured patients to supposedly better providers. They believe that more research is needed on appropriate measures for health centers and it is crucial to consider the impact of patient characteristics (i.e., case mix) before choosing measures. May also need to consider provider mix and how it impacts quality.

Those supporting the notion that health centers quality measures should be similar to or the same as the private sector explained that different measures create different standards. Measures can be created to recognize that health center patients are at higher risk and therefore need access to more comprehensive care (e.g., health educators, case managers, etc). Health centers must capture in their data what it will take to produce the same outcomes as national and private practice outcomes. It is important to maintain the integrity of the health center model and recognize that health centers are lacking some of the inputs needed to improve health outcomes. Therefore, we can measure the “inputs and throughputs” to achieve the same high standards. Similar measures are needed to measure the effect of the entire health provider team, not just the primary care physician, and there must be a way to factor in the effects of case mix. In other words, it is possible to use the same outcomes standards while recognizing that additional resources may be needed to bring about improvement. Key points made during discussion include: 1) the research on adopting HEDIS measures has already been done; 2) CHCs actually do quite well vis-à-vis other providers in published studies (e.g. Starfield) and where HEDIS or other quality measures are applied; and 3) the market and states are already requiring or will soon require that CHCs report the same measures as other providers, so it’s best to prepare now.

One idea discussed here was to measure both proportionate change (i.e., improvement, assumedly from a baseline that takes case mix into account) as well as absolute change (compared to a standard or benchmark). The former would show the effect of health centers in the context of sicker patients, while the latter would show progress towards universal goals for all primary care practices.

Participants also engaged in extensive discussion around the Health Disparities Collaboratives (HDCs). Some research is currently underway to document the scope of interventions that health centers have and how it translates into effective HDCs/quality improvement. (See participant handouts in meeting materials for more information on these studies.) Information

technology may play an important role, as does well-trained staff, good leadership, and patient self-management – a feature often lacking in other practice settings. Regarding the HDCs' spread and sustainability, the positive experiences and business case for operating HDCs need to be promoted in order for the practices to spread, as do how health centers customize their practice. In general, the HDCs' success may be due to the fact that they are a process of care rather than a single intervention that balance community needs with outcomes measures. Process measures in turn may be less confounded by patient mix.

Other individual measures that potentially evaluate quality:

- Health status.
- Primary care assessment quality measures vs. community level quality measures:
 - Primary care assessments cover all provider levels and are related to disease outcome measures;
 - Community level measures cover population and system measures; and
 - E.g., John Hopkins University PCAT available to the public and covers the patient, provider, facility, and health care system.
- Selected disease indicators collected by health centers, though not every measure is relevant for every health center.
- How patients integrate into the broader society (e.g., going beyond narrowly construed health measures to include social factors, activities of daily living, school attendance, and progress).
- Patient satisfaction measures, including patient experience of care that considers cultural competency.
- Potentially avoidable hospitalizations.
- Measures of prevention.
- Effective communication with patients, though difficult to measure is a must for health centers.

Other potential methodologies, frameworks, and research questions for studying quality:

- Healthy People 2010.
- Focus on percent of improvement rather than a fixed quality level.
- Assessment studies should be quantitative but may need qualitative studies to determine what the measures should be and pose possible hypotheses regarding results.
- Link patient-reported data to other data sources.
- Determine why certain local residents do use a health center while others do not.
- How can quality case management be measured.
- What are the resources health centers need to produce good outcomes, and how are outcomes related to professional staff model (multispecialty vs. family practice) and range of services.
- What can organizations (e.g., BPHC) do to improve quality improvement activities.
- Because many quality guidelines measure disease progression, we should also build quality measures around prevention.

Other issues that came up in discussion include:

- Negative perceptions of health centers may be related to their amenities (e.g., crowded wait rooms), not their quality of care.

Discussion of the Health Center Model

Participants discussed the characteristics that make the health center model unique and whether these characteristics contribute to the success of the program.

Participants agreed that while every health center is unique, and that given their different locations, patient mix, and function they ought to look different, they should not look different in terms of performance. More research is needed to describe the range of how centers implement common requirements – all meet the same governance rules but their boards differ in size and how they function; range of services and depth of specific services depends on community needs and resource decisions. Participants engaged in fairly extensive discussion around the governing board, which is required to be representative of the community as a whole and have a user majority. Such a board is intended to give the community being served an influential voice in shaping the health centers' services and operations, and to make the health center responsive to community needs. One particular concern regarding this structure raised at the meeting was whether current size and process requirements are appropriate for a multi-site organization. Some participants strongly felt that the boards were the source of the health center program's success, strength and survival. Thus qualitative research is needed to describe how they work and what their relationship is with the community and ultimately how effective they are, and could include interviewing people, determining what benefits they attribute to the board structure, comparing areas served by programs with and without CHC governance requirements.

Based on the dialogue, the **important characteristics that make up the health center model** include:

- Providing care to all patients seeking it regardless of insurance status or ability to pay.
- Governing (not advisory) board consisting of majority patients.
- Federally-collected reporting standards that enhance accountability for quality, governance, and finances.
- Health centers operate through a complex business model that encompasses working with a governing board, facing management challenges, and operating through unique revenue streams.
- Being grant dependent as this relates to assets and liability, relying on public capital, which creates a different business model than private practice, revenue mix, and safety net function.
- Diversity of patient population, even within health centers.
- Dependency on interdisciplinary teams and its significant use of non-physician/mid-level providers.
- Provision of enabling, behavioral health and support services.
- Community-oriented and often tied to other community organizations.
- Mission driven as well as idealism and creativity of staff, which is especially necessary in resource poor areas.
- More prevention-oriented and often open to alternative medicine.

Potential **methodologies, frameworks, and research questions** for studying the effects of the health center model:

- What motivates a health center to accept the rigorous reporting standards and expectations when the federal grant accounts for around 20% of the average center's revenue?
- What are the essential elements that make the model sustainable?

Other issues that came up in discussion include:

- In order to make the case for medical students to work in health centers, need to stress that such work provides experience in advocacy and policy, not just clinical experience.

Break-Out Sessions

In order to facilitate a closer look at potential research questions and hypotheses, participants broke into smaller groups around the following topic areas:

- Assessing Access and Need;
- Costs and Impacts;
- Quality of Care; and
- Assessing and Comparing the Health Center Model.

In order to facilitate productive discussion on research needed to advance knowledge of health centers as well as any potential hypotheses, each group attempted to answer to the following questions before reporting back to the larger group:

1. What research questions do you find interesting?
2. Given the current health care environment, what research questions need to be answered soon?
3. What do you need to move forward?

Because break out discussions were loosely structured, not every group had the time to consider every question and used the time to simply brainstorm. Below is a brief, bulleted description of the deliberations from each group, as well as any additional comments from non-group members during presentations.

Unmet needs

- I. What are the most intriguing research questions?
 1. Assess community needs
 - a. What area do we serve?
 - b. What area are the people coming from?
 - c. What conditions or diseases do they have (service planning)?
 2. Can we geographically map it?

3. We need cooperative resources to work with health centers to identify/track underservice, and other needs assessment (especially from federal and state agencies with needed databases).
 4. What are the patients' and communities' "at-risk" parameters?
 5. Who are the uninsured and underinsured? Who are the insured, but have only limited catastrophic insurance? How do we tease it out?
- II. What research questions are most urgent and should be answered first?
1. Has the new funding for health centers gone to areas of identified need? What short and long-term impacts have new centers had on their patients and communities? It seems that grants are distributed on need but also the readiness and feasibility of operating a health center. In other words, high-quality grant applications and the ability to start up quickly are major factors.
- III. What is needed to move forward?
1. Who have the data?
 2. How do we get them? E.g., Board affiliations or community associations.

Comments:

Some communities needing health centers cannot find an organization to take the lead to apply for and develop a health center. Capacity development in those communities may need to be funded.

Costs and Impacts

- I. Among research questions discussed by this group, the three that are most urgent given the current environment are as follows:
1. Does mix of providers affect outcomes and costs?
 2. How does instability of insurance affect CHC outcomes and rolls?
 - a. What is needed: intensive data sets looking at CHC rolls, yet not every CHC can report on changing insurance and self-reported info is not reliable. (GWU studied this matter briefly four or five years ago.)
 3. Determine economic impact valuation of health centers on communities and across the country. But how do you tease out what impact is in actual dollars and what is anecdotal?
 - a. What is needed:
 - ii. Convince CHCs that research is necessary
 - iii. Advocacy
 - b. Discussion:
 - i. Are there measurable factors that came out anecdotally to use for a larger study? What are those tangible things with monetary value associated with them? E.g., economic multipliers.
 - ii. Given the scarcity of health center resources, it is critical to show policymakers that health centers are a good investment.
 - iii. Also show economic sustainability.
 - iv. Three different standards of value:

2. Breaking even in monetary terms only. Spending now offsets later costs, and it is only "economically good" if the later cost savings (in terms of real dollars spent) are at least as large as the expenditures that are necessary now. This might be restricted to the same payer, but changes in insurance status could hamper this.
3. A "positive net benefit," including things like decreases in lost productivity. Thus, the money value of the health gains is larger than the expenditures, but the gains are not all going to the payer and some of the gains are less tangible.
4. Those things that might cost more money but lead to large health improvements that are difficult to place a dollar value on. Here, there would be no standard by which something would be judged to save money in the short or long run for the individual payer or for society, but there is some other benefit that can't be valued in monetary terms yet makes the intervention worthwhile.

II. What is needed to go forward in general?

1. Access to health centers for research.
2. Linkages to ideas coming from Quality and Needs Breakout groups because health centers are meeting these needs better than other providers. Therefore it is important to consider where these research interests fall with other groups.

III. Other research questions discussed but not prioritized:

1. What are the experiences of health centers serving patients transitioning onto and off of public insurance (e.g., near-elderly into Medicare, 18-21 year olds off of Medicaid/SCHIP)?
2. What is most cost effective: comprehensive case management, disease-specific management, or no management?

Comments:

If researching whether mix of providers affects outcomes and costs, it is important to break out outcomes since some conditions are much more sensitive to provider mix than others.

Quality

- I. Putting quality research in the context of the current environment, the following issues were discussed:
 1. The current Administration is very supportive of health centers, making this a good time to reflect on health center issues.
 2. Need to prepare for an end to the current expansion period or the imposition of uniform quality measures.
 3. Financial strains.
 4. Expansion occurring while Medicaid coverage is declining.
 5. Health care is on the political agenda.
 6. Under-resourced environment, including meeting staff needs and retention.

7. The shift in emphasis and acceptance regarding research in health centers.
8. Increasing diversities of communities served.

II. Quality Indicators and Measurement Issues:

1. Current BPHC and/or NACHC indicators include:
 - a. BPHC users visit surveys (1995 and 2000), which are based on the National Health Interview Survey
 - b. Health Disparities Collaboratives measures
 - c. The Uniform Data System
 - d. NACHC patient satisfaction survey (PEERS)
 - e. Sentinel Health Centers, a limited, representative sample of health centers providing data on patient demographics, encounters, pharmaceuticals, etc.
2. Cross system comparisons, including:
 - a. CHCs and other systems, but there is an issue of claims data (e.g., current Medicaid claims data are not useful for the managed care era. Perhaps look for hospital-related data such as Ambulatory Care Sensitive Conditions and ER use).
 - b. Demonstrate total burden to determine what it costs to care for uninsured families. (Several studies have done this, including some from Johns Hopkins.)
3. Stability of health center patients and defining primary source of care.
4. Determining standard measures for chronic illness and preventive care.
5. Accessing the organizational capacity of health centers to engage in evaluating quality of care, and develop processes to improve it and monitor it over time.
6. The translation of research into clinical practice, which could start by looking at diabetes pilot projects and recent research to prevent onset of diabetes to study the decrease time to implement new research into practice.
7. Looking at the “culture” of health centers to determine how well they match community needs and community owned centers.
8. The impact of enabling services.

Health Center Model

- I. Most urgent issues: Management capacity and governance
 1. Discussion of management capacity:
 - a. Self-assessment tool available from the Tides Foundation.
 - b. Mission is crucial.
 - c. What differentiates health centers from service delivery programs that are publicly sponsored and all other providers (not just medical practices)?
 - d. Identifying failure (i.e., not operating to mission/distinctive model and why).
 - i. Might include older CHCs suffering from cutbacks and newer ones who don’t understand how to get started.
 - ii. The role of leadership is crucial.
 - iii. What is success and how to identify it? May depend on if environmental changes are permanent or cyclical.

- iv. Is intervention in social determinants of health a measure of success or a response to population and community engagement?
- 2. Discussion of governance:
 - a. History: strongest requirement of any federal grant program.
 - b. Need to describe model in typology and capture variations within the common requirements.
 - c. Governing boards and health centers' role in state health access efforts (e.g., Maine's Dirigo plan); boards as channel for policy advocacy
 - d. Questions may include:
 - i. Relationship of governing board to survival and success of extant model.
 - ii. Community empowerment, consciousness of disease disparities, impact on non-health conditions, perception of center and board in community (social capital).
 - iii. What do those who are challenging board requirement really want; how has it worked where hospitals/other institutions establish a user majority governing board?
 - iv. How boards work, their range of responsibility, how they work with staff, problems they have, other models of governance.
 - e. Possible study method: comparing communities and their centers over time where CHC board existed/was strong and similar communities without such an entity.

II. General Comments

- 1. For research on the model, first need to describe what's out there in a typology and capture variations within the common requirements, including board makeup, leadership (can vary from charismatic approach to institutionalized change, geographic diversity, how differences among centers relate to community characteristics).
- 2. Qualitative research is needed. Hierarchy: Questionnaires to larger universe of centers; phone interviews with sample representative of differences; case studies/field work with a subset.
- 3. Further discussion of model characteristics: Is "model" normative? No, but it is possible to specify dimensions/variations of model, including:
 - a. Perceptions of who health centers serve (i.e., distinct populations).
 - b. Extent to which organization of services addresses needs of population.
 - c. Whether clinical and related programs focus on major health problems of population.
 - d. Whether ancillary services – as examples of what is different about health centers – meet needs.
 - e. Community engagement as related to the diffusion of health center patients into power.
- 4. Anecdotal history to cover:
 - a. Mapping/inventorying social medicine (i.e., how health centers cooperate/relate with other providers, services, and community-based organizations).

b. Who does what in community with whom.

III. Other issues raised:

1. CHCs response to AIDS epidemic.
2. Urbanization of rural poverty.

Comments:

Regarding the question of how health centers work with other institutions, one research question could be how rural health centers react to downsizing or closure of hospitals. Also, current environments in states such as Maine who are developing universal access plans may present opportunities to conduct natural experiments on how these initiatives impact the health center model.

Work Plan for Future Research

In this final session of the day, participants discussed ways to promote and advance research related to health centers and the populations they serve.

Much of the discussion centered on the need for more funding (both public/federal and state and private/foundation and other) to be earmarked for health center research, so that health centers become an identified research category. Designated funding for health center-related research will broaden the awareness of health centers, which in turn raises the level of interest among students. However, because this may promote different types of research than generally funded (i.e., quantitative research), grant reviewers should be experienced in qualitative research.

Funding is essential for promoting more health center-related research on a university level, but prestige is also important. Accordingly, structured fellowships would raise the profile of health center research. Foundations support many fellows, and these foundations should systematically look for fellows interested in this type of work.

One challenge to enhancing research involving health centers is their perception that research should not be a priority and may therefore be reluctant to participate in studies and surveys. Health centers often do not see research as part of their role. This needs to be changed so that health centers perceive participation in research as being community responsive and therefore beneficial to them and their patients. Partnerships between universities and health centers may produce more research, but “where the money goes” is an issue. Establishing long-term relationships with health centers eases the ability to conduct research. Pilot (seed) funding can plant the research, then additional funding from different sources can promote these relationships so that an actual study is produced. Seed money to support health center participation may bring in additional funding to establish an infrastructure for their participation.

In order to encourage health centers to participate in research, HRSA is working on informing investigators on what data is already available to avoid collecting duplicative information, and training health centers on what questions to ask when participating in research studies.

Streamlining the process of conducting research at health centers can help ease the collection of information.

Another challenge is to have health center-related research accepted by journals for publication. Journals should be involved in the discussion of advancing health center research in order to gain acceptance. The Government Performance and Results Act may provide guidance on publishing quality research. Published research should “leave something behind” to encourage additional and follow up studies.

Meeting Summary

Dan Hawkins from NACHC wrapped up the day long meeting. He noted the meeting was a starting point for new ideas, promoting more research and the prioritization of health centers on multiple research agendas. NACHC wants to partner with other organizations and academic centers on establishing more academically developed programs to promote such work and develop skills of future researchers. NACHC will also work to find new sources of funding. NACHC has numerous available resources that can enhance research, and can send the message to health centers that research is important and worthwhile. Lastly, researchers should know that they are always invited and encouraged to submit abstracts of research projects or studies for presenting at NACHC conferences.

For more information on working with NACHC or utilizing NACHC resources, contact Michelle Proser at (202) 296-1960 or mproser@nachc.com.