



Health Care Access for All

2006 - 2008 Strategic Plan

April 7, 2006

2006 – 2008 Strategic Plan

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I. Introduction

The California Primary Care Association (CPCA) was established in June 1994 as a membership organization comprised of California-based community clinics and health centers (CCHCs). Presently, the Association is comprised of over 645 community clinics and health center sites and regional consortia.

CPCA is charged with the mission of strengthening its member CCHCs and networks through advocacy, education, and services in order to improve the health status of their communities. Through its work with member organizations, CPCA accomplishes its mission, vision and core values by promoting and advocating for equal access to high quality health care for all Californians.

CPCA's original Strategic Plan was adopted by the House of Delegates in October 1996 and provided the strategic direction for the organization through 1998. Three strategic planning cycles have occurred since then. In early 2006, a new strategic planning cycle signaled recognition of the need to take CPCA's mission and operations to the next level of achievement in recognition of more than 10 years of successful service to its members.

Strategic planning is not an event; it is an ongoing process. As the State budget, health care and financing systems continue to change dramatically, it is imperative that the CPCA Board of Directors meet regularly to take stock of the organization's capacity and to evaluate the environmental factors influencing its future, and to modify the Strategic Plan as needed. As the internal environment continues to evolve and the external environment continues to offer opportunities and challenges, CPCA will constantly review and refine the Strategic Plan and will make adjustments as necessary. Although other additional goals might be added as circumstances arise or opportunities present themselves, CPCA will not retreat from the five goals defined in this document.

CPCA's senior staff, membership and Board of Directors undertook a systematic and comprehensive planning process to develop its 2006-2008 Strategic Plan. Using the 2003-2005 Strategic Plan as a base, accomplishments were analyzed and input from members and key stakeholders was gathered through internal and external stakeholder interviews (*see Appendix A*). An invitation was extended to CPCA members to attend and participate in a strategic planning retreat in February 2006 in San Diego, California (*see Appendix B*). New goals emerged to support the vision for 2015, where CPCA sees itself within the next 10 years.

II. Mission statement, vision, core values and guiding principles

As part of this strategic planning cycle, retreat participants suggested that the old mission statement no longer fully represented the intentions and directions of CPCA. After discussion, work group input, and presentation, a new mission statement was formed to guide the organization in the coming years:

The mission of CPCA is to strengthen its member community clinics and health centers and networks through advocacy, education, and services in order to improve the health status of their communities.

To put this **mission into practice**, CPCA and its members:

Empower individuals and families served.

Seek to maintain cost-effective, affordable and high quality service.

Recognize cultural diversity and, where appropriate, implement services to meet the linguistic and cultural needs of the populations.

Develop systems to ensure continuity, coordination, and comprehensive services as the provider of choice in the community.

Organize collectively to strengthen alliances, articulate and address community needs and maximize network opportunities.

CPCA is committed to the following **core values**:

Furthering access and promoting wellness through a well-integrated health care system without barriers such as financial, cultural, linguistic, religious, gender, sexual orientation, age, or geography.

Maintaining a statewide system of cost-competitive and high quality clinics.

Representing the interests of its members.

Heightening ethical standards that reflect and respect the needs of the communities served.

Valuing the important role of community-based, public service organizations that reinvest resources into local communities.

CPCA's vision encompasses the following **guiding principles**:

CPCA promotes community clinics and health centers as providers of choice and as an essential component of the health care delivery system.

CPCA identifies and develops benchmarks that reflect industry standards and assists with member accreditation.

CPCA promotes innovations in the provision of high quality health care and social services delivery at community clinic and health centers.

CPCA is a recognized and valued statewide network for community clinics and health centers.

CPCA is a resource for its members in building credibility, purchasing power, new business opportunities, a powerful public profile, defined market niches, new partnerships that support community health center and clinic goals and forums for exchanging information.

CPCA is an **acknowledged leader**, influencing public and social policy related to health care on issues that:

Affect all community health centers and clinics.

Require state-level decisions.

Impact public policy at regional, state and national levels.

Create favorable legislative perceptions and positive legislation to support core values.

Impact decisions about managed care and the delivery of health care to Medi-Cal beneficiaries and low-income uninsured individuals.

Promote community clinics and health centers' role in creating healthier communities.

Develop financial strategies to strengthen community health centers and clinics in the health care marketplace, particularly focusing on managed care models.

III. Environmental Factors

Community clinics and health centers (CCHCs) are an essential segment of the safety net. In many California counties, they are responsible for providing a significant proportion of comprehensive primary care services to those who are publicly subsidized or uninsured. In seeking to fulfill their mission, CCHCs must overcome enormous challenges including the changing faces and growing needs of California's low-income communities, uncertainty of government funding and the ever-changing health care environment. In meeting these challenges, CPCA must assist its membership both in taking advantage of key opportunities that may become available and in addressing the threats faced by California's CCHCs.

Demographic Changes in the Patient Population Served by CCHCs

As the needs of California's medically underserved communities continue to grow and change, CCHCs have responded. According to the Office of Statewide Health Planning and Development data, the total number of CCHCs in California has more than doubled over the past several years, from 325 sites in 1987 to 779 in 2004. Likewise, the total number of patients these CCHCs serve has increased significantly. Currently, CCHCs serve over 3 million low-income Californians and provide approximately 11 million patient visits annually. CCHCs also see a significantly larger percentage of uninsured patients. In 1987, approximately 20 percent of the patient population served by CCHCs were uninsured, compared to almost 30 percent or approximately 1 million uninsured patients in 2004. In 2004, CCHCs were the medical 'home' for almost 15 percent of California's 6.6 million uninsured individuals.

The ethnic distribution of patients served is also changing and, therefore, CCHCs adapt in order to ensure that they meet the cultural and linguistic needs of California's diverse population. With the proportion of White non-Hispanic patients decreasing by approximately 10 percent over the last decade, African American patients decreasing by almost 3 percent, and Latino patients increasing by approximately 15 percent, CCHCs must continue to address the needs of all patients. The proportion of patients for whom English is not their first language grew by nearly 13 percent, presumably influenced by the large increase in Latino patients, but likely also by increasing numbers of Asian, Pacific Islander and other immigrant populations. The proportion of Asian and Pacific Islander patients served by CCHCs increased slightly over the 15-year period. Currently, almost 70 percent of CCHC patients are from ethnic communities, including 49 percent for whom English is not their primary language.

In a review of age and gender demographics over the last 5 years (1999 OSHPD compared with 2004 OSHPD), the demographic profile of the clinic population has remained relatively consistent. CCHCs continue to be the medical home for low-income children and women, particularly women of child bearing age. In 1999, children under age 19 represented 40 percent, or 1,007,403, of the clinic

patient population. This ratio decreased to 35 percent, or 1,172,047 children, by 2004.

Of the adults served by CCHCs, the vast majority are women. This ratio has remained consistent at approximately 70 percent of the adults served by clinics over the five year period. Health centers served more adult women than children. The largest representative age range for adult women, as mentioned, is women of child bearing age. In 1999, clinics served 595,262 women between the ages of 20-34 compared to 155,104 men in that age range. In 2004, clinics served 822,444 women between the ages of 20 and 34 compared to 244,923 men within that age range. The senior community continues to be a small percentage of the health center patient population representing approximately 4 percent of patients in 1999 and 2004. Given the rapid growth of the senior population in California and nationally, it can be anticipated that the number of seniors served by CCHCs will grow into the future.

The Outlook for Government Funding Has Improved, but Uncertainty Still Exists

Impact of the President's First Initiative

California has been a significant beneficiary of President Bush's First Health Center Initiative. The first five years of the President's Initiative have brought the following results for California:

- 79 new health center sites have been established
- 49 health centers have substantially expanded their capacity to serve more patients
- 7 health centers have expanded and improved their mental health and substance abuse programs
- 23 health centers have expanded and improved their dental programs

A recent study conducted by researchers from the Center for Studying Health System Change at the John Hopkins University in Baltimore concluded that the President's Initiative has helped reduce the nation's health disparities with improved quality and continuity of care.

California was particularly well suited to compete for these funds because of the many Federally Qualified Health Center (FQHC) look-alikes in our state. California's share of 330 grant funding has also increased significantly from 6.75 percent in 2001 to 14.78 percent in 2004. It also increased to 18.75 percent in 2005. Although the President's First Initiative has notably improved California's section 330 funding allocation, California health centers still only received \$199 (federal dollars) per uninsured patient served, which is significantly less than the national average of \$309 per uninsured patient and less than other states with large uninsured populations such as New Mexico (\$362) and Texas (\$247). California's huge uninsured community continues to make the case for 330 funding increases.

The State Budget

The last Strategic Plan took place when all levels of government were facing severe financial and budgetary constraints including California's unprecedented state fiscal crisis. The fiscal forecast for the upcoming years is distinctly different for California. Although California continues to suffer from considerable structural deficits, the growing economy provides forecasters with the ability to be optimistic about California's capacity to address its deficit. For the last few years because of the severity of California's fiscal crisis, CPCA staff and members have dedicated a significant amount of time and resources to ensure that health care services were not lost to low-income communities. The changing fiscal environment will allow for a critical transition in this primary focus. Resources dedicated to holding the line at the state level may be redirected to a more proactive fiscal agenda.

Proactive Efforts to Secure New CCHC Resources

CPCA and its members have been proactive in seeking out opportunities to secure new CCHC resources including efforts with the Insurance Commissioner, the Tobacco Tax Initiative, the Mental Health Services Act and the Health Coverage Initiative under the Hospital Financing Waiver. CCHCs were one of the only private entities identified as community beneficiaries of the WellPoint/Anthem merger. CCHCs were allocated \$35 million for a revival of the Cedillo Alarcon Community Clinic Act which provided funding for CCHC capital construction and equipment purchases. The success in securing these resources has resulted in other opportunities including the possibility of securing more resources from the PacifiCare/United Health Group merger and from the two \$200 million investment pools created under each of these mergers. In addition, CPCA is co-sponsoring a Tobacco Tax Initiative, which if successful will bring an additional \$58 million per year (almost double the amount of the Expanded Access to Primary Care Program) to assist CCHCs in serving uninsured and indigent communities. The passage of the Mental Health Service Act presents yet another opportunity for CCHCs to secure resources for providing behavioral health care to the CCHC patient population. Finally, the Hospital Financing Waiver approved last year also provides a significant opportunity for a Health Coverage Expansion Initiative with the possibility of CCHCs serving as central providers. CPCA must be prepared to assist CCHCs in positioning themselves to take advantage of key opportunities.

The Federal Budget

The primary threat to government funding to clinics is at the federal level. This year's final federal budget includes only a \$66 million increase in operational funding for health centers. This is considerably less than was originally sought by the Administration. The budget also included an across-the-board cut of

1 percent to federal discretionary programs including the health center program. This budget represents the final year of the President's first health center initiative.

The federal budget also includes \$6.4 billion in net savings from Medicare and about \$4.8 billion in net savings from Medicaid. The budget reconciliation bill will increase every state's ability to require co-payments and premiums from beneficiaries as well as limit benefits and tighten rules for transfers of assets by individuals to obtain Medicaid coverage for long-term care. At this point, it is difficult to measure the impact of the budget reconciliation bill and whether or not any of these changes will occur at the state level. However, for any state that chooses to act on the high level of flexibility afforded to states, it is safe to assume that many of the individuals unable to absorb these additional costs will end up uninsured. CPCA will need to closely monitor and be prepared to react to any legislative/administrative activities intended to act on the new flexibility available to states.

The Ever Changing Health Care Environment

Pay for Performance

Pay-for-performance is the new overarching trend in health care. Pay-for-performance focuses on developing financial and non-financial incentives for health care providers to improve the quality of health care. Typically, health care providers are evaluated for their performance on set clinical measures/practices and those that perform well receive an incentive. A Wall Street Journal article in September 2004 reported that CMS Administrator Mark McClellan projected that pay-for-performance compensation could account for up to 30 percent of what the government pays providers in the next 5-10 years.

Pay-for-performance is the convergence of reimbursement and quality of care. As such, it has the potential to bring financial and clinical priorities in closer alignment with CCHCs. Depending on how the set of measurements are crafted, CCHCs could benefit or lose in pay-for-performance programs. For example, if CCHCs are on the cutting edge of providing chronic disease management services, they may fare better in a pay-for-performance program as compared to other providers. On the other hand, if the measurements do not take into account the severity of conditions or health care needs of special populations, then CCHCs could fare worse as compared to other providers. CPCA must work with its membership to ensure that any benchmarks developed for the evaluation of CCHC performance adequately accounts for the CCHC high need patient population.

Health Information Technology

Health information technology (HIT) provides the foundation for increased patient health outcomes and organizational efficiencies. In order to build this foundation, CCHCs must have effective technology products, the knowledge of how to maximize the use of such products and the skills to analyze and base decisions

on the data collected via the technology. In the last five years, California's CCHCs have made unparalleled progress in advancing their internal HIT capabilities - primarily as a result of the significant resources invested in CCHCs by California foundations such as The California Endowment and The Tides Foundation. Such investments have allowed CCHCs to acquire advanced technology products.

Significant investments made by the Health Resources and Services Administration have also increased the use of technology in clinical work, as reflected in the health disparities collaboratives and in efforts focused on quality improvement. Emerging technology-based systems that have advanced clinical work include mechanisms for e-prescribing, patient registries and electronic results reporting from a reference laboratory. The accomplishments of the health disparities collaboratives and quality improvement efforts have demonstrated the critical need for attention to health information technology. Using technology to advance clinical practices is clearly a trend that will continue to grow.

Strong momentum on advancing HIT exists on the federal level. In large part, this momentum was initiated in April 2004 when President Bush unveiled an executive order for the national adoption of interoperable electronic health records (EHR) within ten years and for the creation of the National Coordinator of Health Information Technology (ONCHIT). In the past, there have been numerous similar efforts but never before has the federal government taken such a lead in advancing HIT.

California CCHCs must take this opportunity to increase vendor's awareness of the substantial CCHC market to assure that products are developed and that IT vendors are responsive to the unique needs of CCHCs. For example, a major focus of the Bush IT Initiative's current work is to develop vendor criteria for product development and to develop methods to certify vendors. The Tides Foundation and the California Healthcare Foundation have completed important research to identify product criteria that CCHCs need within EHR products. The foundations have also done critical work in fostering relationships and identifying IT vendors that may be responsive to the CCHC market. It is critical that the lessons learned from this work be brought into the national dialogue and that the needs of the CCHC community are represented within the IT vendor community.

In addition, there has been tremendous growth of Regional Health Information Organizations (RHIOs) who have been charged with designing regionally-based data exchange methodologies and standards, including developing individual patient health records (PHR) with unique patient identifiers. The California Regional Health Information Organization (CalRHIO) has been touted by President Bush as one of the premier RHIOs in the country. CalRHIO has received significant funding to support its work; yet, the California CCHC community is sorely underrepresented in the leadership of CalRHIO.

Based on the activity at the state and federal levels, California CCHCs must take advantage of opportunities in this area and resources must continue to be available in order to increase CCHC readiness and ability to adapt to advancing technologies. CCHC interests must be represented in the dialogue.

Universal Coverage

In California, external stakeholders and policy makers sought to secure universal coverage despite the crisis in government financing. These efforts continue with a strong focus on universal coverage for children. Last year, the Governor vetoed legislation that sought to provide universal coverage for children, primarily because no resources were available for this purpose. The inclusion of this coverage in the Tobacco Tax Initiative seeks to address the Administration's concerns. In addition to the efforts focused on children, legislation seeking a universal health care plan continues to move through the legislative process. Given the potential for a broader policy debate on health care coverage and access, CPCA must be prepared to take a leadership role to ensure CCHCs and their interests are brought to the table.

Managed Care Expansions

The Administration's effort to redesign Medi-Cal represents the best example of this Administration's interest in advancing managed care throughout California. The Schwarzenegger Administration has been extremely vocal regarding their belief that managed care will help contain costs in California's health care system. This positioning presents both threats and opportunities.

The 1115 Medicaid Waiver between the federal government and the State of California provides for the expansion of Medi-Cal Managed Care to 13 additional counties using one of two health plan models: 1) County Organized Health Care Systems (COHS), or 2) Geographic Managed Care (GMC). Three counties - El Dorado, Imperial, and Placer - are scheduled to transition to managed care by March 2007. These and other rural counties will continue to experiment with managed care, an experiment that has failed in the past primarily due to the lack of an adequate network to secure access to care. Although the Administration backed off its efforts to expand statewide mandatory Medi-Cal managed care enrollment to the population of seniors and persons with disabilities this year, this is Medi-Cal's most costly population. Therefore, the Administration is pursuing this agenda in their budget proposal and is proposing pilot projects for limited expansion of managed care in selected counties in the near future.

The dynamic nature of the health care environment is fraught with challenges that must be overcome and opportunities that must be captured. Based on the CCHC mission, our greatest challenge will continue to be meeting the complex and changing needs of low-income Californians. CPCA and its members must be flexible and creative in addressing the health care environment and optimizing our limited capacity.

IV. Goals and Objectives for 2006-2008

At the strategic planning retreat, five goal areas were identified: Policy and Advocacy, Education and Programs, Data and Information Technology, Clinical Leadership and Quality Improvement, and Financial Stability. In addition to developing three-year goals and objectives for each of the five goal areas, the retreat participants were asked to identify a ten year vision for each goal as well. A vision and goal statement is presented in each area below. Objectives and activities that support each goal are also specified.

POLICY AND ADVOCACY

VISION FOR 2015: CPCA WILL BE A LEADER IN POLICY DEVELOPMENT TO ASSIST ITS MEMBERS TO CREATE HEALTHY COMMUNITIES.

GOAL I:

CPCA will be an effective leader in health policy and advocacy at the state and federal level consistent with, and in support of, its mission.

Objective I.1

CPCA will become the leader in policy development to achieve universal access to quality care for all underserved in community clinics and health centers and ensure that efforts to expand access include sound financing provisions.

Activities:

- Evaluate major health policy initiatives and their impact on CCHCs.
- Develop and disseminate policy positions in order to expand CPCA's leadership role.
- Promote CPCA's role as the leader of the clinic safety-net and our importance to low income Californians.
- Communicate to key stakeholders the CPCA/CCHC leadership role in healthcare services to the underserved with the use of media, legislative briefings, editorial board meetings, community outreach, etc.

Objective I.2

CPCA will become the leader in policy development to preserve, enhance, support, expand and improve Medi-Cal and other government sponsored programs, and act as the premier expert on health issues and policies related to the populations served by CCHCs.

Activities:

- Develop knowledge and expertise on health policy issues, particularly those related to vulnerable and diverse populations, taking advantage of opportunities to provide policy input.
- Cultivate and elevate CPCA's partnership with key DHS and HHS leadership.
- Influence administrative and regulatory bodies to create/implement/reduce bureaucratic barriers and to secure clearer interpretation of policies that are supportive of CCHCs and their patients.
- Advocate for CCHC-friendly components to any Medi-Cal expansion or expansions to other programs serving CCHC patients.
- Advocate for legislation and budget allocations that support CCHCs.
- Develop strategies and collaborations to maximize the ability for CCHC patients to access specialty care and seek to expand promising practices in this area.
- Highlight CCHC's role as a medical 'home' for Medi-Cal patients and the uninsured in order to promote the critical role of CCHCs in the health care system.

Objective I.3

CPCA will serve as the convener in the development of critical policy issues and partnerships between member organizations and external stakeholders at the local, state, and national level.

Activities:

- Continue active involvement in organizations and coalitions where CPCA already has a presence.
- Spearhead key coalition-building efforts in priority policy areas.
- Identify emerging issues and develop convenings in order to bring attention to these issues and their impact on CCHCs.
- Strengthen non-traditional alliances with organizations such as the Chamber of Commerce, health insurance plans, etc.
- Develop a healthcare-specific strategy for the changing demographics of California, including age/race/ethnicity and other special populations.

Objective I.4

CPCA will impact state and federal health policy through grassroots advocacy.

Activities:

- Develop and expand the capacity for grassroots mobilization.
- Identify and maintain designated advocacy coordinators for community health centers.
- Clarify and enhance CPCA/RAC, CPCA/Consortia Policy Group, and CPCA/NACHC relationships to maximize the grassroots infrastructure.
- Develop and cultivate legislative 'Heros' and 'Champions,' and key contacts.
- Develop funding sources for grassroots mobilization infrastructure.

EDUCATION AND PROGRAMS

VISION FOR 2015: THROUGH A STATEWIDE, COORDINATED INFRASTRUCTURE, CPCA'S TRAINING PROGRAMS AND SERVICES ARE DEDICATED TO THE ONGOING DEVELOPMENT OF SUPPORTIVE RESEARCH, EDUCATION, AND HIGHLY SKILLED WORKFORCE SOLUTIONS FOR COMMUNITY CLINICS AND HEALTH CENTERS.

GOAL II:

CPCA will provide programs and services to assist community clinics and health centers and their networks to sustain, preserve and develop strong infrastructure and organizational capacity, and will be instrumental in encouraging an adequate workforce for community health centers.

Objective II.1

CPCA will provide training, technical assistance and other relevant services and products to support the needs of community clinics and health centers (CCHCs) and their networks.

Activities:

- Conduct needs assessment annually, at a minimum, to identify and prioritize training and technical assistance (TA) services and educational materials, and determine modifications needed to increase participant/user satisfaction.
- Advance CPCA's internal capacity to provide quality training and TA services, and enhance the capacity to publish educational and other resource materials.
- Develop strategies and advocate for funding to support CPCA's training program.
- Identify and develop tools that will increase the efficiency and the quality of TA services statewide.

Objective II.2

Establish state level activities, partnerships and relationships that will sustain, preserve and develop strong CCHC infrastructure and organizational capacity, including leading the advancement of the emerging statewide infrastructure for training and technical assistance.

Activities:

- Support and advance CPCA's Program Advisory Committee (PAC), whose mission is to advance a statewide infrastructure for CCHC training and TA inclusive of the Regional Associations of California (RAC).
- Assess and develop strategies to address statewide information management and dissemination processes.
- Identify and pursue opportunities to collaborate with partners on the development and provision of services.
- Cultivate and leverage relationships with academic, research and other training and TA providers.

Objective II.3

Ensure a place for emerging and existing CCHC leaders to access multi-disciplinary high level leadership training that honors the CCHC community roots in social justice.

Activities:

- Develop strategies and advocate for funding and partnerships to support a CCHC leadership development program.
- Identify and integrate existing research, curricula, faculty and programs within a high-level leadership institute that adds new curricula, case studies and faculty to address the unique unmet needs of CCHC leaders.
- Explore opportunities to cultivate current leaders as "training faculty."
- Implement a leadership development program.

Objective II.4

Ensure an adequate clinically, linguistically and culturally competent workforce at CCHCs.

Activities:

- Develop training programs tailored to build the skills of the CCHC workforce.
- Identify priority positions to target for recruitment and retention efforts in CCHCs.
- Identify and leverage partnerships that will advance CCHC's recruitment and retention activities.
- Advance policy change that will address the healthcare workforce crisis.
- Advocate for funding to support CCHC recruitment and retention initiatives.

DATA AND INFORMATION TECHNOLOGY

VISION FOR 2015: CPCA WILL ACT AS A LEADER TO ENSURE CPCA AND COMMUNITY CLINICS AND HEALTH CENTERS (CCHCs) ARE POSITIONED TO IMPLEMENT, MAINTAIN AND ADVANCE ROBUST TECHNOLOGY INFRASTRUCTURES. AS A RESULT, QUALITY DATA IS AVAILABLE TO VALIDATE AND OPTIMIZE HIGH QUALITY, COST-EFFECTIVE AND EFFICIENT SERVICES PROVIDED BY CCHC's.

GOAL III:

CPCA will act as a leader to ensure CPCA and community clinics and health centers are positioned to implement a competent and robust technology infrastructure.

Objective III.1

Ensure adequate CPCA resources and staffing to support statewide information technology initiatives.

Activities:

- Develop a revenue stream for CPCA to ensure adequate internal staffing capacity.
- Assess, prioritize and support the implementation of statewide initiatives that advance CCHC information technology and data infrastructure.
- Advocate for, and participate in, the design of viable funding streams to support CCHC's technological infrastructure.

Objective III.2

Provide community clinics and health centers with technical assistance for effective information technology decision-making.

Activities:

- Advocate with vendors to increase the standardization of CCHC products and technical assistance.
- Continue to offer the Help Desk, user groups and group purchasing.
- Provide technical assistance support for patient registry software for the Bureau of Primary Health Care Health Disparities Collaboratives.

Objective III.3

Facilitate structured research through the CPCA Data Institute.

Activities:

- Analyze, validate and optimize CCHC's financial, operational and clinical performance through the use of data.
- Identify, support and implement projects that increase the ability of CCHCs to collect and share quality data.
- Continue to support existing and foster new partnerships and collaborations.
- Publish key CCHC data for policymakers, stakeholders and the public.

Objective III.4

Ensure CCHC participation in Health Information Technology policy development.

Activities:

- Influence the implementation of the RHIO model in California.
- Advocate at the state and national level for inclusion of the CCHC perspective in Health Information Technology development.

CLINICAL LEADERSHIP AND QUALITY IMPROVEMENT

VISION FOR 2015: THE CLINICAL PERSPECTIVE, BEST PRACTICES, ADVOCACY, DATA AND STANDARDS WILL PERMEATE ALL ACTIVITIES AND FACETS OF CPCA.

GOAL IV:

CPCA will expand and strengthen its clinical component (including QI) and incorporate the clinical perspective into CPCA's activities and functions.

Objective IV.1

Establish a Department of Clinical Affairs to provide enhanced clinical programs and services.

Activities

- Hire a CPCA Director of Clinical Affairs.
- Develop and coordinate a statewide Quality Improvement infrastructure.
- Implement QI data collection, analysis and publications, a QI resource repository and a QI peer network.
- Coordinate the Bureau-sponsored Health Disparities Collaborative to ensure community clinic and health center access to cutting edge innovations in the delivery of patient care.
- Integrate consortia and CPCA roles in the QI arena.

Objective IV.2

Develop clinician leadership and include the clinical perspective into CPCA's activities and functions.

Activities

- Design and implement a comprehensive leadership development program in partnership with Kaiser Permanente and others.
- Develop opportunities for increased clinician participation in all aspects of CPCA, including governance.
- Enhance partnerships with the Harvard School of Public Health and the California Health Care Foundation leadership programs, the Western Clinicians Network (WCN) and Kaiser Permanente.

Objective IV.3

Identify and disseminate best practices in clinical operations which include high performance, value, and cost effectiveness.

Activities

- Identify best practices and Centers of Expertise to catalogue in the CPCA resource repository.
- Assess best practices and Centers of Expertise to determine which are candidates for standardization, i.e. Pay for Performance, EMR, and Access/Redesign.
- Facilitate the implementation of best practices by publication and dissemination, showcasing at training events, and developing policy strategies as needed.

FINANCIAL STABILITY

VISION FOR 2015: CPCA WILL HAVE THE FINANCIAL AND ORGANIZATIONAL CAPACITY TO SUPPORT THE GOALS AND OBJECTIVES OF THE ASSOCIATION ACCOMPLISHED, IN PART, BY LEVERAGING THE COLLECTIVE ECONOMIC POWER OF CCHCs STATEWIDE.

GOAL V:

CPCA will ensure its long-term success by continuing to build and strengthen membership and organizational infrastructure.

Objective V.I: Maintain and expand revenue sources.

Activities:

- Conduct a member needs assessment to determine the top priorities for group purchasing of services or products, i.e. IT purchases, Human Resources' services, Workers' Compensation, health benefits, etc.
- Analyze potential income-generating services based on needs assessment and research.
- Expand existing income-generating business services for members and explore new opportunities to leverage existing dollars.
- Maintain and build relationships with private funders to maximize opportunities for revenue generation.
- Advocate for new and continued public funding for the Association.

Objective V.2

The Board will proactively work to enhance Board function in governance and corporate compliance.

Activities:

- Assess and streamline the Board and committee process.
- Develop and implement a process for enforcement of CPCA's Code of Ethics.
- Develop and institute a Board orientation and training program.

Objective V.3

Continue to improve and expand organizational staffing and resources to support the work of CPCA.

Activities:

- Develop leadership in order to achieve internal coordination, integration, and collaboration.
- Plan for internal staff growth and assess financial/resource requirements.
- Involve the management team in the budget process and communicate to all staff.
- Sustain a positive working environment for CPCA staff to promote retention and recruitment.
- Provide opportunities for CPCA staff to directly experience the clinic environment.



CALIFORNIA PRIMARY CARE ASSOCIATION

Synopsis of Key Interview Findings Conducted for the CPCA Strategic Planning Process, 2006-2008

Presented by Tapper & Associates

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APPENDIX A.

I. Background of the Interview Process

In order to prepare for the development of CPCA's 2006-2008 Strategic Plan, senior management engaged Tapper & Associates Consultants in September, 2005, to assist with two initiatives: (1) conducting an internal organizational assessment to support ongoing organizational improvement efforts, and (2) collecting background information in preparation for the February 2-3, 2006 Strategic Planning Retreat. These two projects would initiate CPCA's 2006-2008 strategic planning process.

- Both initiatives entailed conducting individual and group interviews with approximately 75 key informants from September through December, 2005. Included were CPCA Staff and Managers, Board Members, Member Clinics and Health Centers, and External Stakeholders (see Attachment A.1).
- The interview data was assimilated and summarized into key findings. In order to prepare for the Strategic Planning Retreat, these findings have been consolidated into a high-level synopsis format, highlighting the most significant elements of the interviews.
- The remainder of this document outlines the key findings in four (4) areas:
 - Vision, Mission and Factors Attracting CPCA Membership
 - External Opportunities and Threats;
 - Internal Organizational Strengths and Areas for Improvement; and
 - Board and Governance Issues (findings to be reported separately).

APPENDIX A.

II. Key Findings: CPCA's Vision for 2015; CPCA Mission; Factors Attracting CPCA Membership

A. Vision for 2015

All Staff, Members and External Stakeholders interviewed envision CPCA becoming a major leading statewide organization, recognized as providing preeminent health care expertise and advocacy. Moreover, CPCA would be a national force in health care policy, as highly visible and respected as the AMA or AHA. No legislative matters regarding the uninsured, such as universal health care insurance, would be made without consulting CPCA. More detailed findings are described below:

- CPCA's expertise in advocacy and legislative policy matters, and funding and reimbursement issues would be sought out by the larger community of health care providers, payers, and policy makers.
- CPCA members would be recognized as the providers of choice in disease management and leaders in public health issues. CPCA community clinics and health centers would be viewed as the "gold standard" model, or "blueprint" for delivering high quality, cost effective services to all populations.
- CPCA would maintain a central data repository (RHIO), documenting delivery models and outcomes.
- CPCA would author data standards for the industry, and compile operating statistics.
- CPCA would offer the major training programs for Community Clinics and Health Centers, and be the recognized expert on operational issues.
- CPCA would be consulted by all leading foundations and non-profits when establishing their funding priorities and strategic goals.
- CPCA would assume a leadership role in bringing together other associations to influence national health care reform and policy, and shape the delivery and funding of U.S. health care.

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B. CPCA's Mission

When interviewees were asked to describe CPCA's mission, responses included the following: (1) to serve as an advocate of California's Primary Care Providers and Clinics on behalf of the uninsured populations of California; (2) to assist Community Clinics and Health Centers access funding, improve clinical outcomes and operational efficiencies; (3) to support Community Clinics and Health Centers to expand and improve primary care for the uninsured and underserved; and (4) to advocate for primary health care by increasing outreach to diverse and varied entities. Though there were very few recommendations for changing the mission, the following issues were raised:

- CPCA serves as both as a trade association for all the Community Clinics and Health Centers in California and as an advocacy group for the uninsured. While most informants believe CPCA needs to be both, this creates confusion regarding the strategic priorities and direction for CPCA.
- While CPCA could expand its membership base by reaching out and marketing to similar or aligned professional organizations, and even the general public, there is consensus among Members that CPCA's core constituency is the community clinics and health centers in California.

C. Factors Attracting CPCA Membership

CPCA is perceived to be highly responsive to the increasingly complex needs of its members. In order to continue to attract and retain members, CPCA will need to prioritize its efforts, due to its limited internal resources and capabilities. More details follow regarding why members join and suggestions for CPCA's major focus:

- Members are attracted to join CPCA for 5 key reasons: (1) to belong to a strong statewide organization with a single unified voice, which has demonstrated its ability to advocate for California's Community Clinics and Health Centers, (2) to access funding (including State and Federal monies, private foundations, grants, other), (3) to stay abreast of important legislative issues and access key individuals at DHS, the California State legislature, Federal legislature, NACHC, etc.; (4) to network and professionally interact with leaders in their respective fields who share the same mission and commitment; and (5) to receive training and technical assistance with financial matters (i.e. billing, reporting requirements, etc), clinical issues (i.e. best

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practices, disease management programs), and operational issues (i.e. staffing shortages, information technology, etc).

- CPCA should be the “central address” for Member Clinics and Health Centers for assistance with recruitment, mentoring, best practices, training (in conjunction with regional Consortia), quality issues, fiscal and reimbursement issues, accounting and reporting requirements, grants and other funding needs.
- When informants were asked to identify the major areas on which CPCA should focus, they cited a broad range. These included: (1) public policy and advocacy to protect and expand access to care (i.e. universal health care coverage, budgets cuts disproportionately affecting the poor, etc); (2) quality issues including cultural competencies; (3) workforce planning (diversity, professional development and training, top management succession planning, provider shortages, etc); (4) training and technical assistance; (5) research (i.e. statewide test pilot using a Smart Card to improve access for the underserved); (6) information technology and other operational efficiencies (i.e. electronic medical record, etc); (7) emergency planning and preparedness; and (8) public education and media.
- CPCA’s limited internal capacity may present barriers to meeting these increasingly broader and more complex needs. The Board will need to define and prioritize its core focal areas for CPCA in order to ensure an organization that attracts and retains the requisite talent, expertise and resources to support those priorities.
- The largest Community Clinics and Health Centers in California are members of CPCA; opportunity may exist to attract new members, though most non-member clinics are smaller operators with financial limitations. Therefore, revenue growth at CPCA will most probably need to come from securing new grants and other funding sources. However, CPCA’s potential to increase its membership base requires further analysis.
- Opportunity exists to attract new disciplines and provider groups from existing members by offering expanded programs and services.

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III. Key Findings: Opportunities and Threats

All informants acknowledged that CPCA is recognized and respected for its expertise in advocacy and legislative policy; funding and reimbursement issues; research and clinical outcomes management; and training and technical support, resulting in many opportunities for future growth.

- Funding cuts at the State and Federal level are the greatest threat facing Member Clinics and Health Centers; CPCA's top priority should be to protect and preserve Safety Net funding.
- CPCA leadership is well respected by state legislators and health officials, and lauded for its legislative victories (i.e. Cedillo-Alarcon); opportunity exists to leverage these successes in Sacramento and Washington, DC and to assume a lead role in broader health care policy and legislative issues.
- Members' needs have become broader and more complex; CPCA's greatest challenge will be to strengthen its limited staff resources and expand its current organizational capacity and capabilities to address these needs.
- CPCA has demonstrated success in supporting quality improvement efforts; it should leverage this expertise to promote California's Community Clinics and Health Centers as the "provider of choice," capable of managing broad public health issues and all types of patients.
- Information technology is a cutting edge growth area for streamlining health care access and improving quality of care; opportunity exists for CPCA to assume a lead role in statewide quality improvement projects.
- The number of clinicians participating in CPCA has increased, and opportunity exists to continue to grow and expand CPCA's clinical sections.
- Members are facing workforce recruitment, retention, and succession planning issues; opportunity exists to expand programs and services to address these problems.
- CPCA has provided excellent training programs and technical assistance to its Members; opportunity exists to assess member needs, improve on the current offerings and build new programs and services.

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- CPCA has successfully secured new funding sources for members, making them more self-sustaining without having to rely solely on grants; efforts should continue to develop creative new sources of revenue.
- Community Clinics and Health Centers should be recognized as leaders in delivering high quality, low cost clinical services; opportunity exists for CPCA to increase the visibility and image of its members as the “provider of choice.”
- Some of CPCA’s members and allies are also “competitors,” including regional coalitions of community clinics in California and various professional associations (i.e. Planned Parenthood); CPCA’s efforts to collaborate with these groups have been well received, but opportunity exists to build stronger consensus and cooperation with these groups.
- The regional community clinic consortia should be considered in any organizational recommendations implemented by CPCA. Existing consortia program offerings, information technology capabilities, quality improvement programs, and other initiatives present synergistic opportunities that should be evaluated before CPCA undertakes any potential growth or expansion plans.

IV. Key Findings: Organizational Strengths, Accomplishments and Improvement Areas

A. Organizational Strengths and Accomplishments

Board, members, external stakeholders, and staff identified a number of significant strengths and accomplishments with respect to CPCA’s performance and capabilities. Foremost among them was CPCA’s effectiveness in government affairs and advocacy for clinics and health centers. This was followed by acknowledgement of CPCA’s programmatic assistance and responsiveness to its members, the strengths of its leadership and staff, increased collaboration with consortia and other agencies, heightened role of clinical issues and disease collaboratives, and improvements internal to the CPCA organization. More details follow:

- There was universal agreement among all interviewees that the most significant strength and accomplishment of CPCA has been its impact in the advocacy and public policy arena, with major legislation

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to support it. The ability to present a unified voice at the State and Federal level has resulted in the increase in funding to health centers and community clinics, in the number of community clinics and health centers, and in access to care for the uninsured and underinsured populations of California. Examples of major funding accomplishments included the PPS Bill, the dispersal of \$35 million from the Anthem-WellPoint merger, the Tobacco Initiative, and the Cedillo-Alarcon Bill.

- CPCA has provided major programmatic assistance to the community clinics and health centers with impressive scope, both in breadth and depth. Interviewees referred to a wide variety of programmatic support to members that included quality improvement training, technical service to clinics, Peer Networks and the concept of the 330 Help Desk.
- CPCA is viewed as responsive to members' needs, maintaining good relationships with the membership and Board. In general, staff was acknowledged as responsive to members' calls and e-mails, in providing updates and action alerts to Board members, and in taking their responsibilities to the membership very seriously. The Annual Conference was mentioned as an example of an event that provides important information to members as well as opportunities for networking among members.
- There was general agreement from all those interviewed that the CPCA staff is a significant asset, comprised of strong, competent, committed, knowledgeable, responsive and professional individuals. CPCA staff achieves its objectives and accomplishes a broad scope of work.
- The CEO was described as a major strength of CPCA, as an outstanding leader, who is strategic, visionary and effective with her Board. She was acknowledged as having created a major force in the advocacy arena within a relatively short time frame, with having been able to balance the diverse needs of hundreds of members, and effectively networking with Board members and external stakeholders. Terms used included, "visionary thinker," "mover and shaker," "fire for building the organization", and "well known and respected voice" for the organization.
- CPCA's Executive Team was viewed as comprised of strong, talented, expert, and committed leaders. Directors were described as "bright, knowledgeable, and complementing one another". Moreover, they functioned well together as a team during the CEO's leave of absence.

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- CPCA has taken the leadership role with the Disease Collaboratives. They provide a unique model for disease management, and, as a result, CPCA is becoming a leader nationwide.
- CPCA has increased its attempts to collaborate with consortia and other agencies and organizations. Examples cited included the Tides Foundation, Kaiser, California Endowment, CHA, CMA, California Dental Association, nursing associations, and other organizations with intersecting interests.
- Specific improvements within the CPCA organization have occurred. These include significant growth in membership and staff, leadership initiatives in addressing staff morale, and increased infrastructure in the Policy department.
- The voice of physicians and clinicians has been increased. Examples of this development were the inclusion of a clinical goal in the last strategic planning cycle and the creation of a Clinicians Committee to obtain ongoing clinician input.

B. Organizational Improvement Areas

While CPCA has placed significant emphasis on organizational improvements during the 2003-2005 Strategic Planning cycle, interviewees identified a number of concerns related to CPCA's organizational functioning. More detailed findings follow:

- The most prevalent concern raised, irrespective of stakeholder group, is the turnover of CPCA staff. Interviewees are perplexed about the causes of the turnover and are frustrated by its impact on continuity and effectiveness in dealing with such highly visible and complex issues. Key losses in the Policy and Legal arenas are of particular concern.
- A range of concerns regarding leadership styles, skills, and practices were raised in the interviews. These include the need for leadership skills development at all levels of management, appropriate level of delegation, increased capacity for strategic and innovative thinking, and ongoing attention to developing skills of staff, in order to optimize expertise and performance.

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- While CPCA provides a broad range of programmatic assistance to community clinics and health centers, there is less clarity and consensus regarding the mission, priorities, and value of the Programs function of CPCA.
- There are differing perceptions among members regarding communication and responsiveness of CPCA to the membership. Some believe that higher visibility members receive more attention than others, some would like more opportunities to provide input regarding needed services, and others would like communications to be more strategic and filtered.
- CPCA Board, members and staff cited the insufficient clinical focus of CPCA staff, both in terms of their understanding of, and expertise in, issues that clinics face. This includes day-to-day administration of clinic operations, as well as the delivery of quality health care services.
- Insufficient resources are dedicated to information technology, in terms of staff expertise and the technology itself, to meet current and future needs of CPCA's membership.

**APPENDIX B. — Strategic Planning Retreat Attendees
February 2-3, 2006**

Pat Aguilera, CFO/COO
Community Health Center Network

Yvonne Bice, Executive Director
Central Valley Health Network

Linda Bien, Chief Executive Officer
North East Medical Services

Dr. Bennie Brown, Medical Director
Tiburcio Vasquez Health Center

Jeff Bujer, Co-Chief Executive Officer
Los Angeles Free Clinic

David Bunnett, Consumer Representative
Coastal Health Alliance

Carl Coan, President/Chief Exec. Officer
Eisner Pediatric & Family Med. Center

Paula Cohen, Executive Director
Mendocino Coast Clinics, Inc.

Reymundo Espinoza, Chief Exec. Officer
Gardner Family Health Network

Deb Farmer, President/CEO
Westside Women's Health Center

Liz Forer, Chief Executive Officer
Venice Family Clinic

Harry Foster, President/Chief Exec. Officer
Family Health Care Network

Cathy Frey, Executive Director
Alliance for Rural Community Health

Naomi Fuchs, Chief Executive Officer
Southwest Community Health Center

Jane Garcia, Chief Executive Officer
La Clinica de La Raza

Jose Joel Garcia, Executive Director
Tiburcio Vasquez Health Center

C. Dean Germano, Chief Executive Officer
Shasta Community Health Center

Juan Gomez, Consumer Representative
Tiburcio Vasquez Health Center, Inc.

Franklin Gonzalez, Administrative Director
California Family Care Medical Group

Dr. David Gorchoff, Medical Director
Redwood Community Health Coalition

John Gressman, President / CEO
San Francisco Comm. Clinic Consortium

Ray Hamby, Financial Consultant
Hill Country Community Clinic, Inc.

Jann Hamilton-Lee, Chief Executive Officer
South Bay Family Health Center

Sherry Hirota, Chief Executive Officer
Asian Health Services

Dick Hodgson, VP Policy and Planning
San Francisco Comm. Clinic Consortium

Linnea Hunter, President / CEO
Mendocino Community Health Clinics

Roberto Juarez, Chief Executive Officer
Clinicas del Camino Real

Chris Kiefer, Consumer Representative
LifeLong Medical Care

Mike Kirkpatrick, Chief Executive Officer
Community Medical Centers, Inc.

Susan Leonard, Director - Technical Svcs.
Council of Community Clinics

**APPENDIX B. — Strategic Planning Retreat Attendees
February 2-3, 2006**

Marty Lynch, Executive Director
Lifelong Medical Care

Alicia Mardini, Chief Executive Officer
East Valley Community Health Center

Ed Martinez, Chief Executive Officer
San Ysidro Health Center

Jean Merwin, Consultant
Merwin & Associates

Vicky Penland, Chief Executive Officer
Council of Community Clinics

Gloria Rodriguez, Chief Executive Officer
Community Clinic Assoc. of L.A.County

Gladys Sandlin, Executive Director
Mission Neighborhood Health Center

Justine Sarver, Vice President
Community Clinic Assoc. of L.A.County

John Severson, Executive Director
Coastal Health Alliance

Kazue Shibata, Chief Executive Officer
Asian Pacific Health Care Ventures

Herrmann Spetzler, Executive Director
OPEN DOOR Community Health Ctrs.

Marie Torres, Ph.D., Sr. Vice President
Alta Med Health Services

Christine Tyler, Dir. of Policy & Clinic
Activities
Community Health Partnership

Dr. Gilbert Varela, Medical Director
El Proyecto del Barrio

Richard Veloz, Chief Executive Officer
South Central Family Health Center

Arcadio Viveros, Chief Executive Officer
Salud Para La Gente

Debra Ward, Deputy Director
Community Clinic Assoc. of L.A. County

Tony Weber, Vice President - Finance
Family Health Care Network

Dr. Mike Witte, Medical Director
Coastal Health Alliance

CPCA Staff

Carmela Castellano-Garcia, CEO

Elia Gallardo, Director of Gov't. Affairs

Sandra Birkman, Dir.of Finance & Ops.

Lucette DeCorde, Director of Programs

Dorian Seamster, Deputy Director – Policy

Christina Wildlake, Deputy Dir. – Programs

JP Banks, Deputy Dir. – Clinical Programs

Jodi Johnson, Asst. Dir. – Finance & Ops.

Sandi Bauer, Asst. Director – Collaborative

Carole Loeb, Executive Assistant