FORCES FOR CHANGE:

A LANDSCAPE OF THE STATEWIDE AND REGIONAL CLINIC CONSORTIA IN CALIFORNIA

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EXECUTIVE SUMMARY

California has a long history of statewide and regional clinic consortia serving its wide array of safety-net clinics: community health centers and community clinics, Planned Parenthood, and tribal and urban Indian Health organizations, collectively referred to as CCHC. Through an extensive and unique system that has been developed and refined over time, services and collaborative opportunities offered by the consortia are comprehensive, driven by member needs, and reflect the state's broad geography and policy environments. The statewide and regional clinic consortia have made important contributions to the success of CCHCs over the last 20 years.

Both the statewide and regional clinic consortia have long been financially supported by a variety of funders. Five funders — the Blue Shield of California Foundation, The California Endowment, The California Wellness Foundation, and Kaiser Permanente Community Benefit Northern California and Southern California — have funded ongoing infrastructure and operations for the statewide and regional consortia. Together, they have a shared history of commitment and have allocated millions of dollars over the last 25 years to help develop and sustain consortia operations, infrastructure, and activities. In addition, other funders, including the California Health Care Foundation (CHCF), have provided specific project support.

In 2017, CHCF and The California Wellness Foundation initiated this inquiry to document the breadth, scope, and recent work of statewide and regional clinic consortia. The California Endowment and Kaiser Permanente Community Benefit Northern California and Southern California joined as collaborative partners. Consortia CEOs participated throughout as advisors, reviewers, and historians. A project advisory group was created to review data collection tools and provide feedback on draft versions of this report and related issues. A range of data was collected through consortia staff directly, consortia surveys, publicly available data, and on-site interviews with consortia CEOs and senior staff. The authors also reviewed a series of reports and evaluations produced over the last 20 years regarding clinic consortia.

This report seeks to portray and highlight a comprehensive landscape: who the statewide and regional consortia are; their members, leadership, and staffing; and how their services are delivered and financed. The report documents how consortia work to advance access to health center services, ensure high-quality performance, and offer operational support to their members and communities. It describes select changes and evolution over time and concludes by recommending a series of strategic opportunities to further strengthen consortia impact.

As of 2018, there are five statewide clinic consortia and thirteen regional consortia that together represent 233 community clinics and health centers operating over 1,300 sites across the state. Consortia represent the vast majority of CCHCs and range in size from 3 to 177 health center members. Almost half of their members have been associated with a consortium for over 20 years. Collectively, the community clinics and health centers belonging to consortia provide care to over 6.5 million patients. In addition, data collection and analysis revealed the following key findings about consortia:

- Two-thirds of regional consortia have fewer than ten full-time employees (FTEs). Statewide consortia range in size from 6 to 86 FTEs on staff. The mean tenure for senior staff positions indicates stable staffing. CEOs of regional consortia have a median tenure of six years — the same as the average tenure for the CEO of small- to mid-sized nonprofits. The tenure of CEOs for statewide consortia has historically been over 20 years, with recent CEO changes among two longstanding statewide consortium leaders.

- All regional consortia have full dues-paying members; most are Federally Qualified Health Centers (FQHC) or FQHC Look-Alike health centers. Three of the statewide consortia have dues-paying full members; one has dues-paying associates; and one has no membership. Two of the statewide consortia with dues have flat yearly rates, and the other charges a fee based on health center gross revenue.
- The statewide and regional consortia vary in financial strength. Most of the consortia depend heavily on grants to conduct their work, have steadily increased member dues and other fees over time to represent a larger percentage of their income, and generally perform well on standard financial indicators.
- Five of the statewide and regional consortia have developed subsidiary entities to support members and patients in various ways. Several of the subsidiaries emerged specifically to play a role in their county or region's Medi-Cal managed care environment. Each subsidiary organization is wholly owned by the parent consortium, has separate membership criteria, and may be larger than its parent consortium in both revenue and staffing. Some staff are shared across the affiliated organizations.

Consortia provide a wide range of services — and their breadth has been growing. Below are the primary areas of activity across statewide and regional consortia that emerged from the data:

1. **Policy and Advocacy:** All consortia consistently prioritize and conduct large amounts of policy and advocacy at multiple levels. 2017 was a high-water mark of effort for county, state, and national policy efforts. Both statewide and regional consortia staff reported significant effort related to thwarting the repeal of the Affordable Care Act (ACA) and protecting Medi-Cal, immigration, and the remaining uninsured. Consortia report significant efforts to mobilize their members and collaborate across the state to develop messages and materials and advocate for vulnerable communities.
2. **Access to Care:** Both statewide and regional consortia prioritize and provide services supporting access to care for the state's underserved residents. Consortia frequently address the remaining uninsured and specialty care as part of these initiatives.
3. **Delivery System Transformation:** Regional consortia consistently lead or participate in formal partnerships with health care organizations such as health plans, hospitals, and county systems. They provide a strong voice that represents members at the county and regional level. Statewide consortia are active with state organizations such as the Department of Public Health and the Department of Health Care Services.
4. **Data-Sharing, Quality Improvement, and Social Determinants of Health:** All consortia report involvement in health information exchange and data-sharing activities. Data-sharing is often focused on quality metrics and clinical/operational quality improvement. Consortia also report increasing participation in local efforts to address social determinants of health.

Consortia have grown, expanded, and adjusted their activities based on the environment, shepherding CCHCs through a turbulent era. They have supported their members as they expanded to meet the increasing demand for primary care, behavioral health, and oral health across the state. The opportunity for coverage expansion through the ACA via both Medi-Cal and Covered California is a success story for CCHCs and their patients, thanks in part to the efforts of consortia and the relationships that have developed through consortia participation.

Yet there is more to be done. The current federal environment has created an elevated level of uncertainty and instability for CCHCs, their consortia, and their patients. Threats to federal funding, hostile immigration policies and enforcement, and repeated congressional attempts to repeal the ACA and undermine Medicaid require carefully tailored strategies, communication efforts, and strong and effective advocacy to protect access. In addition, new forces beyond

the purview of CCHCs, such as workforce shortages and value-based payment reform, have major implications for CCHCs; they create difficult dynamics between the regulated world of CCHCs and the need for innovation and change. Clinic consortia offer valuable forums for strategic discussions, provide quality improvement and technical assistance, and advocate for the specialized needs of CCHCs in this transitional period. Their capacity for quality improvement, data analysis, and understanding of social determinants of health are hallmarks of recent consortia activity that will continue to transform CCHCs in the future.

These strategic opportunities are a starting place for additional exploration to spur even stronger and bolder alliances on behalf of communities that continue to experience the greatest health disparities. They are focused on the ability of statewide and regional consortia to provide beneficial value-added services to their members, and would benefit from additional dialogue, targeted funding, and planning support to more fully examine their potential and risks.

1. **Policy Advocacy and Communication:** Local communities, regional collaborations, and statewide efforts have benefited from the consortia's focus on policy and their capacity to organize, develop, and share effective advocacy communications across the state. These efforts will need to expand to include new partners, stakeholders, and methods if they are to address multiple simultaneous threats effectively.

2. **Safety-Net Collaboration and Partnerships:** Consortia have demonstrated effective leadership in bringing together CCHCs and other safety-net providers to work together on common issues. Safety-net collaboration should be a key activity for every consortium. Efforts should support work on social determinants of health and other opportunities to improve the lives of patients and communities. While some collaboration between statewide clinic consortia and other safety-net organizations exists, greater alignment and more formalized partnerships could produce positive impact.

3. **Social Determinants of Health:** The willingness of hospitals, providers, and payers to engage in policy and system change that address social determinants is growing, as is the expectation that primary care providers address these factors. CCHC efforts to address social determinants as part of their mission to reduce inequity in health outcomes is strengthened by the consortia's capacity to collect and exchange meaningful data and engage partners in quality improvement efforts. Consortia are leading collaborations across health and social service entities, and offer myriad lessons learned about engaging residents and addressing the root causes of poor health. Consortia are well-positioned to ensure community efforts embrace best practices and prevent disease by modifying the social determinants of health or 'upstream' factors, as well as ensuring access to comprehensive and high quality health care services.

4. **Value-Based Care, Including Clinical Quality and Managed Care:** The goal of increasing the value and quality of health care services is driving transformation for all health providers and has profound implications for the way CCHCs operate and are paid. Improved quality increasingly leads to improved financial strength for CCHCs and better health for consumers. Although many clinic consortia are already strategically situated for these conversations, there is a continued opportunity to expand and deepen their efforts through quality improvement, information technology, data-sharing activities, and new organizational entities.

5. **Workforce Development Initiatives:** Maintaining the health care workforce is a longstanding and increasingly important challenge for CCHCs. There are many forces in the environment that influence their ability to recruit and retain staff, and providers and consortia have been challenged to identify the most appropriate strategies to use in this area. A series of strategic dialogues between CCHCs and consortia could align and expand efforts at the state and local policy levels. These discussions could strengthen the work that

the California Primary Care Association has already accomplished to organize statewide workforce discussions and to highlight the success regional consortia have had in this area.

California's community clinic consortia, both statewide and regional, have leveraged passionate leadership, engaged members, and effective strategies to help the community clinic field thrive amidst constant challenge and change. Collectively, California's consortia provide a powerful and coordinated policy and advocacy presence. They have helped clinics serve their patients and communities more effectively. With ongoing support from partners and allies, there is little question that they will continue to adapt and serve low-income Californians successfully in the coming decades.

FORCES FOR CHANGE:

A Landscape of Statewide and Regional Clinic Consortia in California

INTRODUCTION AND BACKGROUND

California has a long history of active statewide and regional clinic consortia serving a diverse array of community health centers, community clinics, Planned Parenthoods, tribal and urban Indian health organizations (collectively referred to as CCHCs). Currently, there are five statewide clinic consortia and thirteen regional clinic consortia representing county and multi-county efforts — an extensive and unique system of clinic consortia representing most community health centers and community clinics regionally and statewide in California. The services and collaborative opportunities they offer are comprehensive, the priorities are member-driven, and together, they reflect the breadth of the state's policy environment and geography. Particularly given the county-based Medi-Cal managed care system in California, regional consortia have been important to the successes CCHCs have experienced. In addition, the statewide consortia each have identified distinct roles, advocacy niches, and representation for their members and constituents, resulting in strong and well-recognized CCHCs across the state.

Clinic consortia have long been financially supported by a variety of funders. Prominent among those that have historically funded ongoing infrastructure and operations for both the statewide and regional consortia are Blue Shield of California Foundation, The California Endowment, The California Wellness Foundation, and Kaiser Permanente Community Benefit Northern California and Southern California. These funders have shared a long history of program support and have allocated millions of dollars over the last 25 years to sustain and develop consortia operations, infrastructure, and key activities. Due to changes in funding priorities, Blue Shield of California Foundation no longer provides dedicated consortia funding across all consortia. The California Health Care Foundation (CHCF), as well as other funders around the state, have funded selected projects that include consortia over time.

Statewide and regional clinic consortia joined together to form the Regional Associations of California — known today as RAC — to coordinate and better support common efforts in advocacy and program services. All of the regional consortia and three of the five statewide consortia are active participants. RAC has been a forum for consortia to share best practices, explore new consortia opportunities across the state, and to discuss and debate new and important initiatives impacting CCHCs.

Communities across the state have benefited, both individually and collectively, from consortia work. Tracing the work of consortia in California over recent years shows a landscape of linked and coordinated organizations that enables nimble responses to hyper-localized needs as well as collective impact at the state and national level. This report seeks to describe and highlight who the statewide and regional consortia are, how their services are arrayed, delivered, and financed, and what strategic opportunities for even greater impact may be ahead.

Early in 2017, the California Health Care Foundation began exploring a new project to better understand the breadth, scope, and work of statewide and regional clinic consortia. CHCF held conversations with other historical clinic consortia funders, and as a result, The California Wellness Foundation decided to join CHCF in funding the project. The California Endowment and

Kaiser Permanente Community Benefit Northern California and Southern California participated as collaborative partners, without providing funding, and advised the project throughout its duration. The Clinic Consortia Project formally launched in September 2017 and concluded in July 2018.

The funders collaborated in stating a joint purpose for this project: to provide historical context, describe the current capacity of the statewide and regional community clinic consortia, and identify potential strategic opportunities. Specifically, the funders wanted to better understand the role and potential of consortia through a process that would address the following key questions:

- How does each consortium define its membership? Which CCHCs are not served by consortia?
- What are the varying types of member services and supports offered by different consortia?
- What are the current and potential future roles that clinic consortia might play? What opportunities do clinic consortia have to advocate at the local and state level, promote access to care, improve quality of care and/or enhance the operational efficiency of member health centers?

This project was not intended to evaluate the performance or impact of the consortia, individually or collectively. Its funding offered approximately 10 hours of technical assistance to each consortium for use with a consultant and on a topic of their individual choice.

Pacific Health Consulting Group (PHCG) was chosen by the funders to conduct the project. PHCG is a California partnership of like-minded colleagues with the advantage of varied expertise and distinct individual talents. As was especially important for this project, the team has established relationships with CCHCs and consortia leaders in California dating back more than 25 years to the formation of statewide and regional clinic organizations, as well as a deep understanding of the financing environment for the health care safety net. The project's success also rested on strong assurances by funders about its purpose, and the collegial standing of the consulting team.

The project was launched after a period of unprecedented growth for CCHCs in California that followed the successful implementation of the Affordable Care Act. It also occurred during a period when CCHCs and their respective consortia — both statewide and regional — have been widely recognized for their contribution to improving the health status of low-income Californians and for their leadership on major health policy initiatives. It also came during a time of tremendous uncertainty about many issues related to federal health policy, federal funding, immigration, and reproductive health. As readers will learn in the report, all of the statewide and regional consortia have been actively engaged in these issues, both collectively and individually.

The project kicked off in September 2017 with a meeting hosted by the four funding partners with all statewide and regional clinic consortia. The meeting introduced the project to consortia leaders and established a tone of transparency. A project advisory group of six state and regional consortia representatives was created to provide guidance to the project and review the draft report. In addition, a document outlining data confidentiality provisions and principles was developed to guide the use of organization-specific data and information in the report. Data was collected in several ways. A data collection tool developed for the project requested individual consortium data on staffing, members, services, budget, financial statements, strategic plans, and project-related grants. An interview protocol was also created for an onsite meeting with each consortium that included interviews with consortium CEOs and staff. Eighteen site visits were conducted with each consortium during December 2017 and January 2018. Consultants also reviewed published and unpublished reports and completed additional research to inform the report findings. Following analysis and data confirmation by each individual consortium,

a preliminary draft report was reviewed by the advisory group in April 2018. Subsequently, consultants presented the draft report to all consortia in May 2018 and incorporated input and feedback prior to a review by the funders.

SECTION 1:

Who Are the Regional and Statewide Consortia?

REGIONAL CONSORTIA

Currently there are thirteen regional clinic consortia representing their members in county and multi-county organizations; soon there will be twelve. Capitol Health Network (CHN), serving the Sacramento County CCHCs, will terminate its work as a clinic consortium by the end of 2018. The Central Coast Health Network was previously funded by a federal HRSA grant and closed shortly after the grant ended in 2010. Also in 2010, Northern Sierra Rural Health Network merged with the Shasta Consortium of Community Health Centers to become the Health Alliance of Northern California (HANC) and some of its members joined HANC[1]. In addition, while Alliance for Rural Community Health (ARCH) still exists, it does not operate as a community clinic consortium, and in 2017, its CCHC members also joined HANC.[1] Table 2 illustrates current and past regional clinic consortia, their county/counties of operation and the year they were formed or transitioned their corporate structure.

Table 1: Area of Operation and Year of Establishment for the Regional Consortia

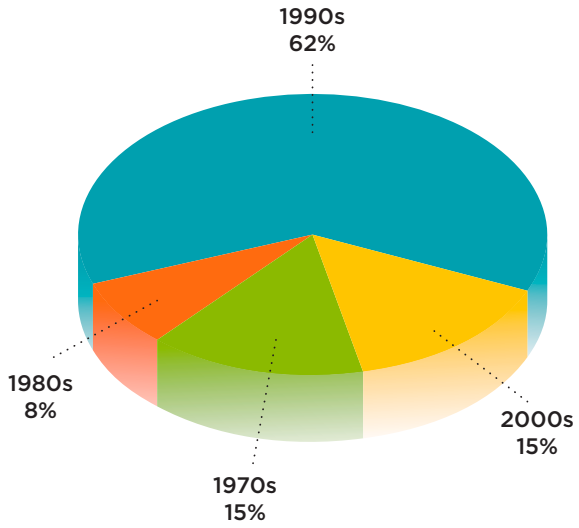
Regional Consortia Full Name	Abbreviation	Health Center Counties of Operation	Year Formed and Organizational Changes
Alameda Health Consortium	AHC	Alameda	1974
Alliance for Rural Community Health	ARCH	Lake and Mendocino	1998 •ARCH CCHC members joined HANC in 2017
Capitol Health Network	CHN	Sacramento, Yolo, Placer and Amador	1998 •Closing in 2018 as a clinic consortium
Central Coast Health Network	CCHN	Monterey, Ventura, San Luis Obispo and San Benito	1994 •No longer exists
Central Valley Health Network	CVHN	Butte, Colusa, El Dorado, Fresno, Glenn, Kern, Kings, Madera, Merced, Placer, Riverside, Sacramento, San Bernardino, San Joaquin, Solano, Stanislaus, Sutter, Tehama, Tulare, Yolo, Yuba	1998
Coalition of Orange County Community Clinics	COCCC	Orange	1974
Community Clinic Association of Los Angeles County	CCALAC	Los Angeles	1994

[1] All of the 330 FQHC members from ARCH joined HANC, except for a for-profit rural health clinic and the Consolidated Tribal Health Project. ARCH continues to exist for other local community collaborative purposes and operates CHRN, Community Hesketh Resource Network, which holds a risk-sharing contract with Partnership Health Plan.

Regional Consortia Full Name	Abbreviation	Health Center Counties of Operation	Year Formed and Organizational Changes
Community Clinic Consortium	CCC	Solano and Contra Costa	2004
Community Health Association Inland Southern Region (*formerly known as Community Clinic Association of San Bernardino County*)	CHAISR	Riverside and San Bernardino	2010
Community Health Partnership	CHP	Santa Clara and San Mateo	1993
Health Alliance of Northern California	HANC	Lake, Lassen, Mendocino, Modoc, Nevada, Placer, Plumas, Shasta, Sierra, Siskiyou, and Yuba	1998: Shasta Health Network began 2001: Name change to Shasta Consortium of Community Health Centers 2010: Shasta Consortium merged with Northern Sierra Rural Health Network to become Health Alliance of Northern California 2017: ARCH members joined HANC
Health Center Partners of Southern California (*formerly known as San Diego Council of Community Clinics*)	HCP	San Diego, Imperial and Riverside	1977
North Coast Clinics Network	NCCN	Humboldt, Del Norte, and Trinity	1994
Redwood Community Health Coalition	RCHC	Sonoma, Napa, Marin and Yolo	1994
San Francisco Community Clinic Consortium	SFCCC	San Francisco	1982

Figure 1 displays the proportion of regional consortia that were established by decade. Three consortia (23%) were established in the 1970s and 1980s. Eight consortia (62%) were established in the 1990s and two were established between 2000 and 2009. There is no single driver for the increase in clinic consortia over this period. The growth of managed care and the increasing number and size of FQHCs were contributing factors. Additionally, communities without consortia saw the value of regional consortia and organized to create them. The two newest consortia are Community Clinic Consortium (CCC) and Community Health Association Inland Southern Region (CHAISR).

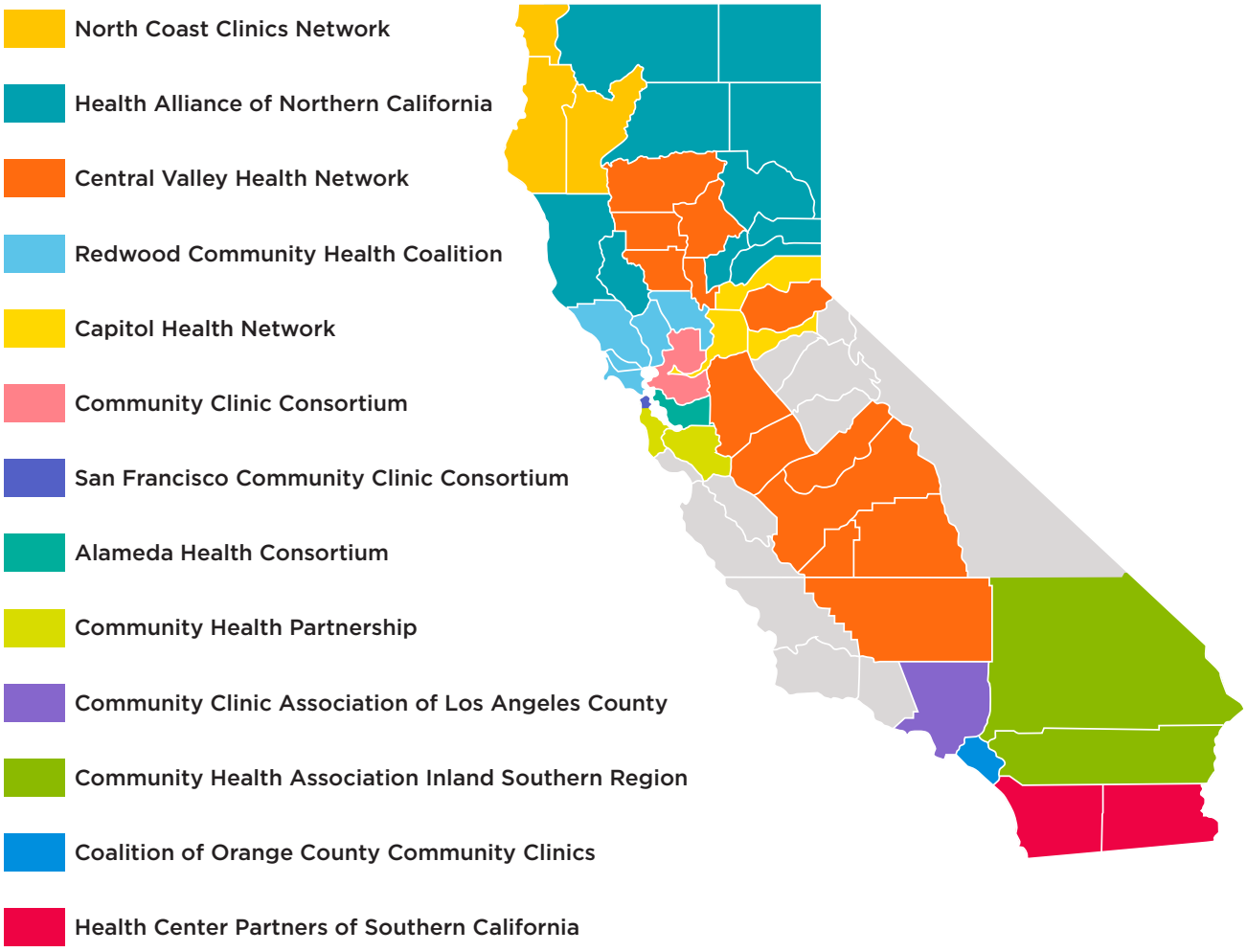
Figure 1: Groupings of Regional Consortia by Decade of Establishment



REGIONAL CONSORTIA GEOGRAPHY

California's thirteen regional clinic consortia provide services to 229 health organizations in 43 of the state's 58 counties. As the map in Figure 2 below depicts, regional consortia represent rural as well as major urban population centers of the state. Most consortia (75%) operate across several counties and 50% operate in three or more counties. As illustrated in the map, the central coast and central-eastern counties of California are two areas of the state not served by active regional consortia. The Central Coast Health Network, when active, supported some of the CCHCs in Monterey, Ventura, San Luis Obispo, Santa Barbara, and San Benito counties. Some CCHCs in these regions are members of statewide consortia; for example, Toiyabe Indian Health Project (Inyo County) and Mathieson Memorial Health Center (Tuolumne County) are tribal health members of CRIHB. Clinicas del Camino Real (Santa Barbara and Ventura Counties) is a member of CPCA and Planned Parenthood Central Coast (Santa Barbara, San Luis Obispo and Ventura Counties) is a member of PPAC.

Figure 2: Map of Regional Consortia Counties of Operation



Seventeen health centers maintain membership in more than one regional consortium because they operate sites in multiple counties that cross the geography of two or three different consortia. Table 3 displays details on these health centers and the counties where they operate.

Table 2: Area of Operation and Regional Consortia Affiliation of Health Centers with Dual Membership

Health Centers with Dual Membership	Consortia Memberships	Headquarter County of Health Center	Other Counties Served by Health Center
La Clinica	AHC & CCC	Alameda	Contra Costa, Solano
LifeLong Medical Care	AHC & CCC	Alameda	Contra Costa, Marin
Native American Health Center	AHC & SFCCC	Alameda	San Francisco

Health Centers with Dual Membership	Consortia Memberships	Headquarter County of Health Center	Other Counties Served by Health Center
AltaMed Health Services	CCALAC & COCCC	Los Angeles	Orange
Central Neighborhood Health Foundation	CCALAC & CHAISR	Los Angeles	San Bernardino, Riverside
Mission City Community Network	CCALAC & CHAISR	Los Angeles	Orange, San Bernardino
OLE Health	RCHC & CCC	Napa	Solano
Lestonnac Free Clinic	COCCC & CHAISR	Orange	Los Angeles, Riverside, San Bernardino
Central City Community Health Center	CCALAC, CHAISR & COCCC	Los Angeles	Orange, San Bernardino, Riverside
Community Health Systems, Inc.	CHAISR & HCP	Riverside	San Diego, San Bernardino
WellSpace Health	CHN & CVHN	Sacramento	Amador, El Dorado, Placer
One Community Health	CHN & CVHN	Sacramento	None
Parktree Community Health Center	CCALAC & CHAISR	Los Angeles	San Bernardino
Unicare Community Health Center	CHAISR & CCALAC	San Bernardino	Los Angeles
Vista Community Clinic	HCP & COCCC	San Diego	Orange, Riverside
North East Medical Services	SFCCC & CHP	San Francisco	San Mateo, Santa Clara
Community Medical Centers	CVHN & CCCC	San Joaquin	Solano, Yolo

Another way to look at this same data is by county. Nineteen counties in California had at least one health center with dual (or triple) consortia membership. Ten regional consortia (more than three-quarters of consortia in this study) shared at least one member health center with another regional consortia. Table 4 displays the health centers and consortia in the counties where at least one health center had dual membership and crossed county lines.

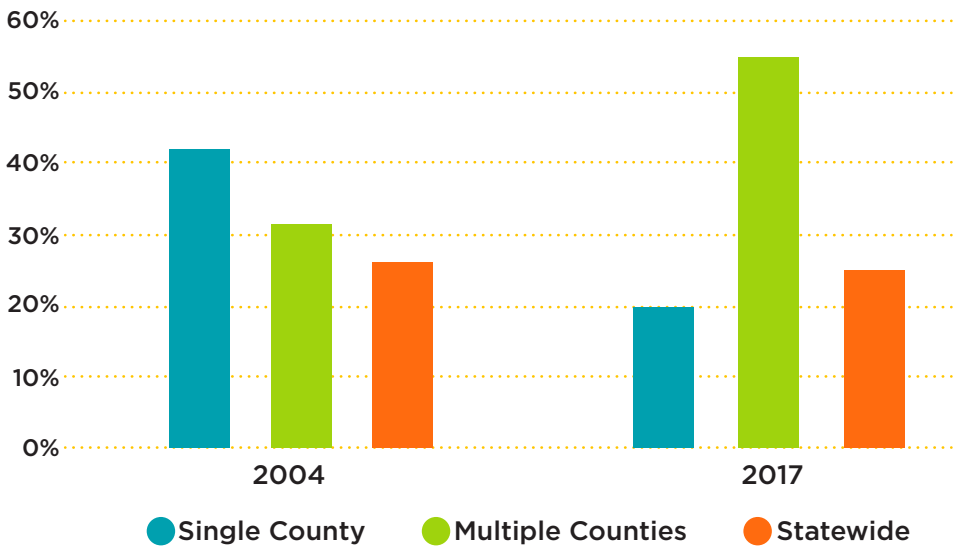
Table 3: Health Centers with Dual Membership in Two or Three Regional Consortia, By County

County	Health Center(s) with Dual Membership	Consortia Memberships
Alameda	La Clinica	AHC & CCC
	LifeLong Medical Care	AHC & CCC
	Native American Health Center	AHC & SFCCC
Amador	WellSpace Health	CHN & CVHN
Contra Costa	La Clinica	AHC & CCC
	LifeLong Medical Care	AHC & CCC
El Dorado	WellSpace Health	CHN & CVHN
Los Angeles	AltaMed Health Services	CCALAC & COCCC
	Central City Community Health Center	CCALAC, CHAISR & COCCC
	Central Neighborhood Health Foundation	CCALAC & CHAISR
	Mission City Community Network	CCALAC & CHAISR
	Parktree Community Health Center	CCALAC & CHAISR
	Unicare Community Health Center	CCALAC & CHAISR
Marin	LifeLong Medical Care	AHC & CCC
Napa	OLE Health	CCC & RCHC
Orange	AltaMed Health Services	CCALAC & COCCC
	Central City Community Health Center	CCALAC, CHAISR & COCCC
	Lestonnac Free Clinic	CHAISR & COCCC
	Mission City Community Network	CCALAC & CHAISR
	Vista Community Clinic	COCCC & HCP
Placer	WellSpace Health	CHN & CVHN
Riverside	Central City Community Health Center	CCALAC, CHAISR & COCCC
	Central Neighborhood Health Foundation	CCALAC & CHAISR
	Community Health Systems, Inc.	CHAISR & HCP
	Lestonnac Free Clinic	CHAISR & COCCC
	Vista Community Clinic	COCCC & HCP
Sacramento	WellSpace Health	CHN & CVHN
	One Community Health	CHN & CVHN
San Bernardino	Central City Community Health Center	CCALAC, CHAISR & COCCC
	Central Neighborhood Health Foundation	CCALAC & CHAISR
	Community Health Systems, Inc.	CHAISR & HCP
	Lestonnac Free Clinic	CHAISR & COCCC
	Mission City Community Network	CCALAC & CHAISR
	Parktree Community Health Center	CCALAC & CHAISR
	Unicare Community Health Center	CCALAC & CHAISR
San Diego	Community Health Systems, Inc.	CHAISR & HCP
	Vista Community Clinic	COCCC & HCP

County	Health Center(s) with Dual Membership	Consortia Memberships
San Francisco	Native American Health Center	AHC & SFCCC
	North East Medical Services	CHP & SFCCC
San Joaquin	Community Medical Centers	CCC & CVHN
San Mateo	North East Medical Services	CHP & SFCCC
Santa Clara	North East Medical Services	CHP & SFCCC
Solano	Community Medical Centers	CCC & CVHN
	La Clinica	AHC & CCC
	OLE Health	CCC & RCHC
Yolo	Community Medical Centers	CCC & CVHN

From 2004 to 2017[2], data indicate that a larger proportion of regional consortia represent multiple counties as shown in Figure 3 below. In 2004, 32% of regional consortia were multi-county and now it is 55%. This is primarily due to CCHCs opening additional sites in multiple counties and joining multiple consortia. Concurrently, the percent of consortia operating in only one county has declined from 42% in 2004 to 25% in 2017. Statewide consortia are illustrated in Figure 3 as well to show their generally consistent coverage across the state.

Figure 3: Geographic Scope of Regional and Statewide Consortia, 2004 vs. 2017



[2] The comparison in Figure 3 is drawn primarily from data collected specifically for this project and from the following publication: Claire Brindis, Annette Gardner, Sara Peterson, Mary Kreger, Nadine Chabrier & Joe Funk. Clinic Consortia Policy and Advocacy Evaluation: Creating a Legacy for Change. Clinic Consortia Policy and Advocacy Program Evaluation. Evaluator's Report: Year 1 Findings. Institute for Health Policy Studies, University of California, San Francisco, January 2004.

STATEWIDE CONSORTIA

There are five statewide clinic consortia in California. Essential Access Health (Essential Access) and California Rural Indian Health Board (CRIHB) were established in the 1960s. Planned Parenthood Affiliates of California (PPAC) was established in 1974. The California Primary Care Association (CPCA) has been in existence since 1994 and California Consortium for Urban Indian Health (CCUIH) is the most recently established in 2006. Planned Parenthood established a second entity, California Planned Parenthood Education Fund (CPPEF) in 1995; and CPCA established a second entity, CaliforniaHealth+ Advocates, in 2016.

Table 4: Year Statewide Consortia Established

Name of Statewide Consortia	Year Established
California Consortium for Urban Indian Health (CCUIH)	2006
California Primary Care Association (CPCA)	1994
Planned Parenthood Affiliates of California (PPAC)	1974
California Rural Indian Health Board (CRIHB)	1969
Essential Access Health (Essential Access)[3]	1968

[3] Formerly known as the Los Angeles Regional Family Planning Council and then as the California Family Health Council

SECTION 2:

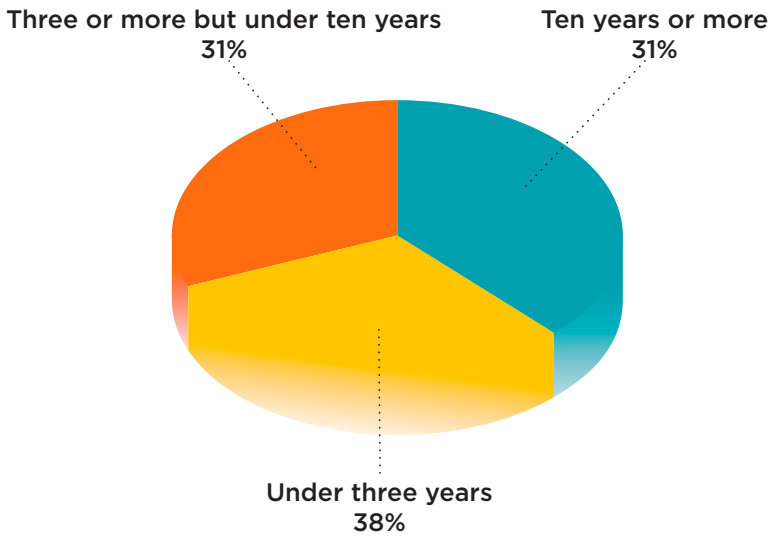
Regional Consortia: Programs, Services and Leadership

The thirteen regional consortia are unique, each reflecting distinct geography and membership. At the same time, regional consortia across the state share operational and programmatic similarities. In this section of the report, we provide an overview of regional consortia staffing, membership categories, dues/fees and scope of services, as well as data on patients and encounters for the health organizations in each consortium. The information reported in this section summarizes operational and service data collected through the data tool developed for this project as well as publicly available information and in-person site visits. Data were submitted by all thirteen regional clinic consortia and the additional entities operated by AHC, RCHC and HCP.

REGIONAL CONSORTIA STAFFING AND LEADERSHIP

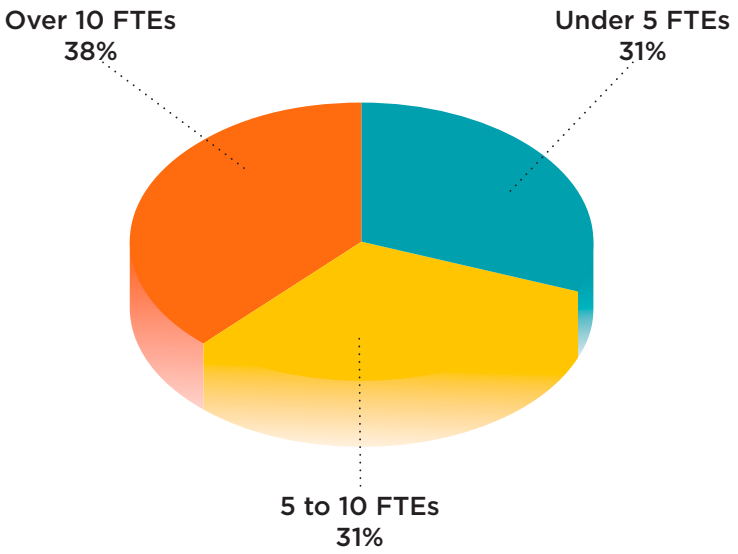
Chief Executive Officer (CEO) tenure depicted below in Figure 4 indicates that almost two-thirds of regional consortia CEOs have been in their positions more than three years and almost one-third have more than ten years on the job. Each of the three additional organizational entities share the same CEO as the parent regional consortium. The lowest CEO tenure is under one year and the highest is over 30 years. The median is six years. The Nonprofit Quarterly reports that the average tenure for a CEO of small to mid-sized nonprofits is about six years.

Figure 4: Groupings of Regional Consortia by CEO Tenure (In Years)



The overall staff size for regional consortia is shown in Figure 5 below. Almost one-third of consortia are small, with five or less FTEs, and just over one-third have more than ten FTEs. If staff from the three additional consortia entities are included, there are a total of seven organizations, or 54%, with ten or more FTEs.

Figure 5: Groupings of Regional Consortia by the Number of Staff Members (In FTE)



The project data collection tool also gathered information on job title and years of service for regional consortia senior staff, including the management team, department heads, and program directors. Organizational charts were submitted and analyzed by category and titles. Table 5 below demonstrates the wide variation in reported titles. Seven regional consortia (54%) report a Chief Operating Officer, eight (62%) report a Chief Financial Officer, four report a physician Chief Medical Officer (CMO) and six report a communications/policy position. In addition to CMO, two consortia report a Director of Clinical Services (one RN and one MPH) and two others report staff titles involving quality improvement. Finally, four consortia report HIT staff titles.

Table 5: Number and Percentage of Regional Consortia Reporting at least One Person in a Staff Category or Position Grouping

Staff Category/Position Grouping	Unduplicated Consortia with Position	Percentage of Consortia with at least One Position
CEO, Chief Executive Director	13	100%
COO, Chief Operating Officer, Executive VP	7	54%
CFO, Finance Officer, Director of Finance	8	62%
Chief Medical Officer/Medical Director	4	31%
Director of Clinical Services	2	15%
Communications, Advocacy, Policy	6	46%
Community Affairs, Community Outreach	3	23%
Strategy, Business Development	2	15%
Health Information Technology	4	31%
Quality Improvement	3	23%
Health Care Coverage, Access, Eligibility	4	31%
Other Directors and Officers	5	38%

Figure 6 displays three categories of tenure (under 3 years, 3 to 10 years, and 10 years or more) for the major staff categories. These categories can be further grouped and examined (not displayed in the figure). Among all staff reported on the survey, almost half (47%) were in the position for less than three years; a third (33%) of these positions had a tenure over 3 years but under 10 years; and one in five (20%) had a tenure of 10 or more years. For staff in the top three senior positions (CEO, COO and CFO), the tenure of ten years or longer is higher – over 35%. The shortest tenure was reported among Communications/Advocacy/ Policy and Community Affairs/ Community Outreach staff, with two-thirds of these staff members in their positions for fewer than three years. Those in positions of Chief Medical Officer, Director of Clinical Services and Quality Improvement staff report a shorter tenure than other positions overall: half (50%) have tenure over 3 years but under 10 years and none have tenure 10 years or more. Site visit interviews indicate these positions are more recent additions to consortia staff in response to managed care and quality improvement efforts; the short tenure may not signal turn-over but relatively new staff functions. Only three vacancies were reported among senior staff across all regional consortia in December 2017 - January 2018.

Figure 6: Groupings of the Number of Years in Position for Senior Staff

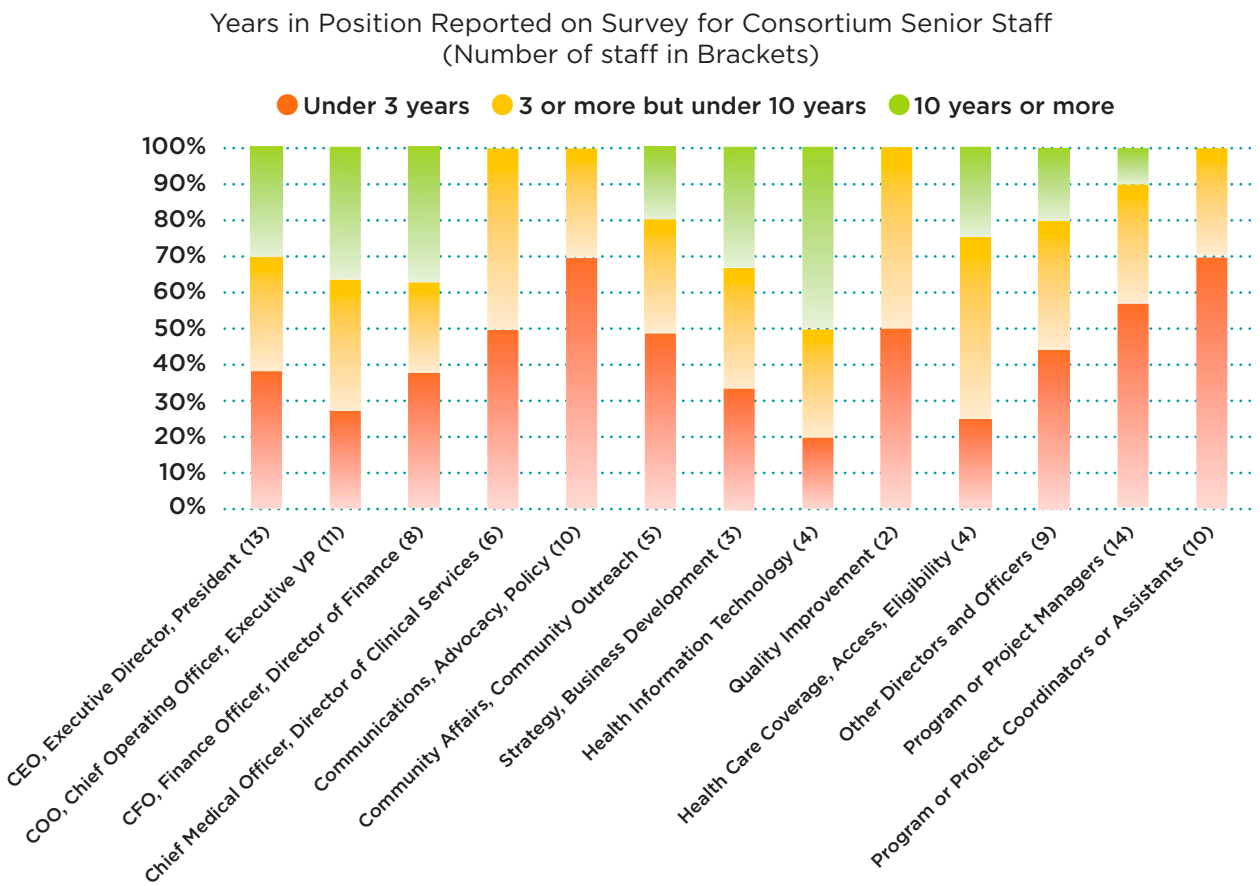


Table 6 indicates that three quarters (77%) of regional consortia report some level of outsourced services or staff functions. Among those consortia using outsourced services, there were an average of three outsourced services reported. Information Technology and Accounting/Finance were the most common services that are outsourced. There was no pattern to outsourcing as it was reported among large and small organizations as well as those with longer and shorter organizational history.

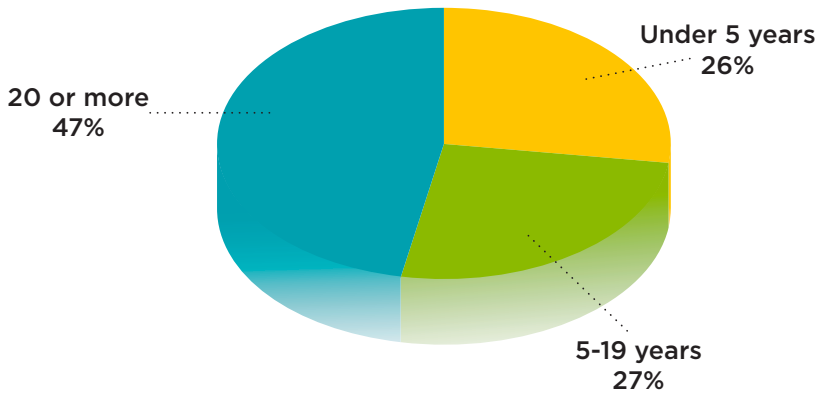
Table 6: Number of Regional Consortia Reporting Outsourced Functions or Services

Function or Service Category	Number of Consortia Reporting
Information Technology	8
Accounting/Financial Services	6
Data analytics/ Quality Improvement	3
Human Resources	2
CFO	2
Payroll	2
Other/Miscellaneous	4

REGIONAL CONSORTIA MEMBER SITES, PATIENTS AND ENCOUNTERS

The thirteen regional consortia represent a total of 212 CCHC or other health organizations serving 1,049 sites across the state. Almost half (47%) of the regional consortia's members report 20 or more years of consistent, on-going consortia membership.

Figure 7: Groupings of Health Center by Number of Years Associated with their Regional Consortium



One quarter (25%) of CCHC members in regional consortia have one service site and another quarter (27%) have six or more sites with an average of 4.8 sites per provider organization. Of the number of CCHC sites summarized by consortium in Figure 8, CVHN and HCP have the highest proportion of CCHC members with six or more reported sites. COCCC and SFCCC have the highest proportion of CCHCs with only one reported site.

Figure 8: Groupings of Member Health Center Sites, by Regional Consortium

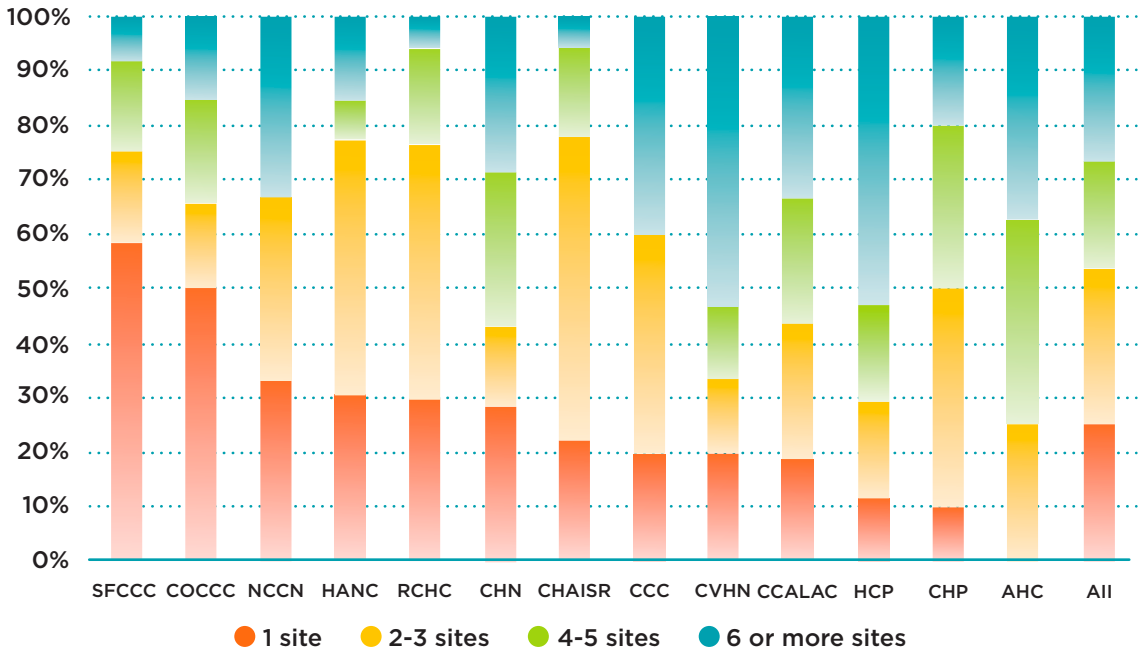


Table 7 displays the total number of patients and encounters from 2016 Office of Statewide Health Planning and Development (OSHPD) data for the 212 health care service organizations reporting. This data does not include nineteen additional members that represent other types of non-profit organization members of the consortia that are not licensed community clinics (which would be 231 total).[4] CCHC members of regional consortia provided over 13.7 million encounters to almost 4.2 million patients in 2016. The largest consortium is CCALAC with 63 health center members and 2 affiliate clinics, serving over 1.3 million patients and nearly 4.5 million encounters. HCP reported 17 health centers with nearly 2.7 million encounters; AHC and RCHC each had over a million encounters among members.

[4] All licensed clinics must submit annual utilization data. A few consortia have members that do not report patient/encounter data to OSHPD such as behavioral health providers, school health sites and a hearing and speech center.

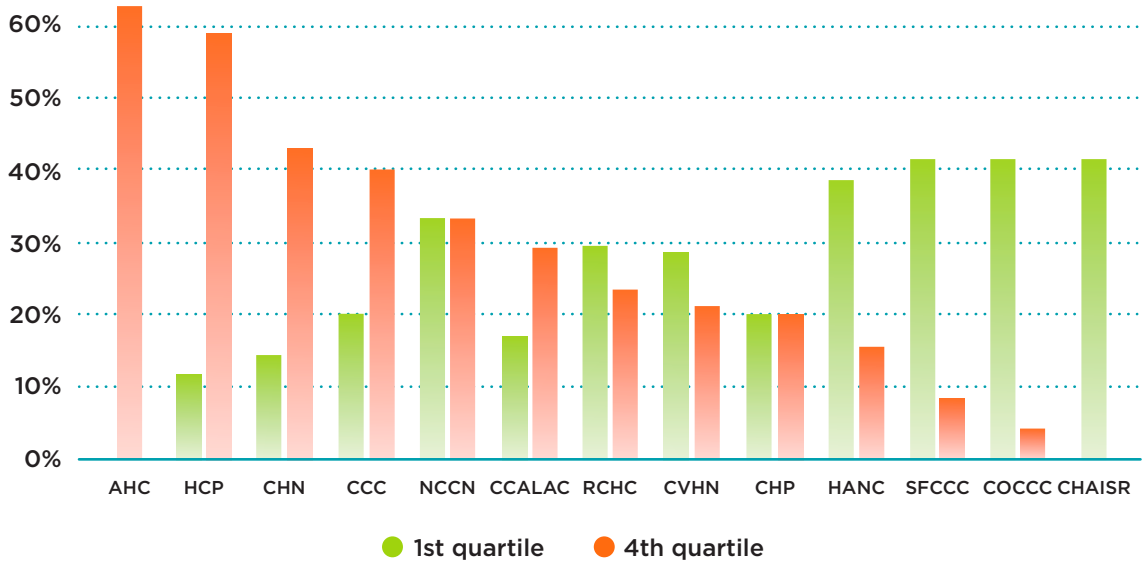
Table 7: Total Patients and Encounters Seen at Member and Affiliate Health Care Service Organizations, by Regional Consortium

Consortium Abbreviation	Health Care Service Organizations Reported*	Total Patients (2016)	Total Encounters (2016)	Organizations Not Reporting**
CCALAC	65	1,377,948	4,457,821	11
HCP	17	868,766	2,681,240	0
CVHN	15	627,987	2,197,958	1
RCHC	17	232,428	1,073,945	3
AHC	8	303,745	1,006,191	0
COCCC	23	287,558	866,778	3
HANC	13	134,321	568,329	0
CHN	7	175,028	551,673	0
CHAISR	18	176,506	459,719	1
CHP	10	168,997	458,935	0
SFCCC	11	108,903	389,494	0
CCC	5	151,165	329,912	0
NCCN	3	63,672	300,831	0
TOTAL	212	4,677,024	15,342,826	19

**These are typically organizations that saw patients and reported unduplicated patients and encounters. Most are member health centers, but some are affiliates.*
***These are typically organizations that are members or affiliates of the consortia but do not provide patient services or did not report those services in 2016.*

Figure 9 displays the percentage of health centers in a consortium in the lowest quartile (blue line) and highest quartile (orange line) for the number of patients served in 2016. Using the number of patients as an indicator of the size of health center shows that members AHC and HCP have the greatest proportion of large health centers. The chart is ordered left to right by highest percentage of unduplicated patients. The four consortia with a high proportion of health centers in the lowest quartile for the number of patients served, defined here as small health centers, are HANC, SFCCC, COCCC and CHAISR. Regional consortia with a high proportion of small health centers span large urban as well as rural geographies.

Figure 9: Regional Consortia Ordered by the Percentage of Very Large Health Centers (4th Quartile) in their Membership



REGIONAL CONSORTIA MEMBERSHIP AND DUES

All regional consortia report they have full dues-paying members. Across all regional consortia, 91% of members are full members and 9% are other categories. Four consortia (CCALAC, COCCC, RCHC, CHAISR) also have dues- or fee-paying affiliates and one (SFCCC) currently has dues-paying applicant members. Member organizations are varied and include free clinics, Planned Parenthoods, University of California health centers, Indian Health Centers and County Clinics as well as Federally Qualified Health Center (FQHC) organizations. Almost three quarters of full members of the regional consortia are FQHCs (70%) and FQHC look-alikes (4%). Consortia with more than 30% non-FQHC members are SFCCC, COCCC, CHAISR and CHN. Table 8 displays CCHC member-type by consortium.

Table 8: Membership Status and Health Center Type for Clinics Reported by Each Regional Consortium

Consortium	Member Organizations (Any Type)	Member Status		Health Care Service Organizations Reported*		
		Full	Affiliate	FQHC	Look Alike	Other
AHC	8	8	0	8	0	0
CCALAC	76	63	13	51	2	12
CCC	5	5	0	4	0	1
CHAISR	22	18	4	10	0	8
CHN	7	7	0	3	1	3
CHP	10	10	0	6	1	3
COCCC	26	23	3	12	4	7
CVHN	15	15	0	14	1	0
HANC	13	13	0	12	0	1
HCP	17	17	0	15	0	2
NCCN	3	3	0	3	0	0
RCHC	20	17	3	14	0	3
SFCCC	11	11	0	6	1	4
Total	233	210	23	158	10	44

**These are typically organizations that saw patients and reported unduplicated patients and encounters. Most are member health centers, but some are affiliates.*

The annual dues structure among regional consortia generally includes three basic types:

- **Flat fee:** Four consortia (almost a third) had a flat fee, which varied from $1,500/year to $8,000/year.
- **Fee relative to budget size:** Six consortia (just under half) were in this category, using one of two methods for calculating fees:
    - Fee directly proportional to total operating expenses. Three consortia fit this category and their members paid between 0.1% to 0.18% of their budget with a fee cap of between $10,000 to $20,000/year.
    - Fee category based on budget size. Three consortia fit this definition and the fees amounted to anywhere from 0.03% to 0.12% of the health center budget. The top categories had fees of approximately $10,000/year.
- **Combination structure:** Three consortia (just under 25%) had a base fee plus an additional fee depending on budget size, patients seen or encounters, with one consortia in this category setting a cap of $50,000.

Six consortia (just under half) reported a fee cap. Four had a cap between $10,000-$12,000/year. Six consortia (just under 50%) reported a minimum annual fee. Five had a minimum fee of $1,000/year. Table 9 illustrates dues methodology by consortium

Table 9: Details on the Fee Structure Maintained by Each Regional Consortium

Consortium	Fee or Dues Structure Category	Determining Factors	Portion Factor (of CCHC Budget)	Flat Fee or Dues (Per Year)	Fee Cap	Minimum Fee	Fees for Others?
AHC	Relative: Portion	Clinic Size				$1,000	
CCALAC	Relative: Portion	Budget	x 0.18%		$25,000 in FY17-18, increasing annually to $40,000 in FY19-20	$800 for budget under $1 million	Affiliates
CCC	Flat			$1,500			Associates
CHAISR	Relative: Portion	Budget	x 0.15%		$10,000	$500 for budget under $1 million	Affiliates
CHN	Flat			$1,500			
CHP	Relative: Categories	Budget	Approx. 0.03% - 0.10%		$10,000	$1,000 for under $1 million	
COCCC	Combination	Base + Budget	$1000 + 0.26%		$50,000	$1,000 (Minimum Base Portion)	
CVHN	Flat			$6,000			
HANC	Combination	Base + Unduplicated Patients	Varies				
HCP	Relative: Categories	Budget	Approx. 0.04% - 0.12%		$11,040	$6,240	
NCCN	Combination	Base + Encounters	Varies				
RCHC	Relative: Portion	Budget	x 0.10%		$12,000		
SFCCC	Flat			$8,000			

REGIONAL CONSORTIA SERVICES

The advance data tool requested information from consortia about past, current and planned services provided to members. The data tool offered 54 service options, such as *National Policy,* that were grouped in nine categories, including *Policy and Advocacy* and *Access to Care*. Each consortium reported on the services provided from 2013 to 2017 and services that they anticipated they would conduct in 2018. The service questions in the data tool were modeled on a tool previously created and used for a RAC survey in 2013 and 2015. Consortia also ranked whether they perceived each of the services as a high, medium or low priority for members. The services and priorities were self-reported and there may be variation in how consortia reported the findings. In addition, priorities may be influenced by a consortium's size, history, local needs and/or available funding.

Along with the data tool, consortia submitted their current strategic plans. Table 10 displays the percentage of strategic plans that contained an objective or priority mapped to the data tool service categories to display the close tie between activities and strategic priorities. Organization strategic plans generally focus on future directions and are more likely to mention new activities, threats, and opportunities or responses to changes in the environment rather than to catalog or review current services or program improvements. All of the strategic plans mentioned advocating for member health centers or service populations as an objective or priority. About three-quarters of the consortia stated a strategic focus on health delivery systems, clinical quality improvement or their own infrastructure. Less often but frequently reported in strategic plans (54%) was a focus on managed care. Fifty-eight percent of consortia emphasized their member health centers as the subject of their mission statements. The remaining consortia stressed the population in the regional area or the population served by members.

Table 10: Frequency of Selected Service Areas from Regional Consortia Strategic Plans

Category	Service Areas	Percentage of Strategic Plans
Mission Statement	Focus on Regional Populations	41.7%
	Focus on Member Health Centers	58.3%
Health Care System	A. Policy and Advocacy	100.0%
	B. Managed Care	53.8%
	C. Health Delivery System	76.9%
Regional Populations	D. Access to Care	84.6%
	E. Outreach and Enrollment	61.5%
Member Performance	F. Health Center Operations	92.3%
	G. Clinical Management and Quality Improvement	76.9%
	H. Workforce Development	69.2%
Other	I. Consortium Infrastructure	76.9%

The following analysis offers a detailed view of what services are offered by regional consortia across the state, what level of priority consortia placed on specific services, and trends over time in the services conducted. Tables 11 through 21 present data for each of the 54 individual services conducted in 2017, services offered at least once over the report period of 2013-2017, and services conducted across all years reported as well as the priority reported for each service.

The data submitted are rich and multi-layered. The analysis begins with a high-level summary of the nine general categories followed by additional analysis of the individual services offered within the nine categories.

Reported Services Overview:

- At the major category level, data indicates that clinic consortia members are offered a wide range of services across the state. As reported later, the specific services may vary; however, the lowest frequency for a general service category, *Workforce Development*, is still offered by 60% of regional consortia.
- The breadth of services conducted is growing over time. Comparing the services offered in all years to services conducted in 2017 indicates an increase overall in the variety of services conducted in every category.
- Comparing the services offered in any one year between 2013 and 2016 to services conducted in 2017 documents eleven individual activities offered less often while nineteen activities were offered more often; twenty-four activities maintained at the same levels. Managed care and board development activities increased most often during this time period.
- There is a high level of variation in the priority assigned to services offered, and priorities do not always correlate to activities. For example, while two-thirds of consortia offer board development to members, only 11% consider this a high priority. Conversely, 74% of consortia report outreach and enrollment support as a high priority although only 63% of consortia offer this activity.
- The highest priority services reported for 2017 include *Outreach and Enrollment, Policy and Advocacy* and *Clinical Management and Quality Improvement.* The highest frequency services reported for 2017 are *Policy and Advocacy, Access to Care* and *Local Health Delivery System.*

Table 11 summarizes results across the nine general categories of consortia services ordered from highest to lowest frequency of service reported. This table includes the percentage of services offered in 2017 for each category and the average priority assigned to the services in each category across all consortia. Consortia were active across a wide range of services with nearly three-quarters (73%) of the 54 individual services listed in the data tool being offered to member health centers in 2017. As previously mentioned, the priority for each service offers a different view. Many consortia may offer a particular service but do not report all high frequency services as high priorities nor all high priority services as high frequency ones. For example, a service that is offered by the majority of consortia (high frequency) and is well established or only utilized by a subset of members may be considered lower priority due to lower effort, but this does not mean that it is of low importance or value. Consortia reported they offer a breadth of services to respond to the varied needs of health centers, however these may not be viewed as a high strategic priority.

Table 11: Summary of Services Provided and Priority Ranking Across Regional Consortia

Service Category (order of frequency)	Percentage of Services Provided in 2017	Service Priority in 2017		
		Low	Medium	High
Policy And Advocacy	92%	6%	21%	73%
Access To Care	84%	22%	30%	48%
Local Health Delivery System	86%	21%	31%	49%
Clinical Management And Quality Improvement	73%	21%	19%	60%
Health Center Board Development	69%	56%	33%	11%
Managed Care	66%	26%	21%	53%
Health Center Operations	63%	38%	27%	36%
Outreach And Enrollment	63%	7%	19%	74%
Workforce Development	60%	37%	17%	46%
Average	**73%**	**24%**	**24%**	**52%**

Regional consortia offer a wide array of individual activities and services with high levels of frequency. For example, an average of 92% of all regional consortia conducted *Policy and Advocacy* in 2017; frequencies ranged from 100% of consortia working on *National Policy* to 85% working on *Regional Policy*. The lowest reported category, *Workforce Development*, still was reported by an average of 60% of consortia across the state, with 54% reporting *Convening A Peer Network* of human resources and 77% reporting *Outreach Activities To Promote Health Careers*. The services listed in Table 12 were commonly offered in all years (2013-2018) and/or were rated as a high priority (2017) by the majority of consortia (over three-quarters). The four individual services shown in bold text were both commonly offered and rated as high priorities.

Table 12: Regional Consortia Services Most Commonly Offered Compared with Highest Priority Services

Service Category	Service Bolded items were provided in all years AND with high priority by 75% of Consortia	Service Provided in All Years (2013-2018) by over 75% of Consortia*	Stated Priority of "HIGH" (2017) by over 75% of Consortia**
POLICY AND ADVOCACY	**County policy**	**Yes**	**Yes**
	State policy	**Yes**	**Yes**
	National policy	**Yes**	**Yes**
LOCAL HEALTH DELIVERY SYSTEM	**Participate in formal partnerships with public health and health care organizations (e.g. hospitals, county health system)**	**Yes**	**Yes**
	Convene local/regional collaborations to integrate or improve health care delivery system	Yes	No
ACCESS TO CARE	Convene local leaders to address strategies for remaining uninsured	Yes	No
	Participate in collaborative efforts to expand coverage to remaining uninsured	Yes	No
	Advocate or participate in initiatives to improve access to specialty care	Yes	No
HEALTH CENTER OPERATIONS	Convene peer network meetings of CFOs, CMOs, HR, CIOs, etc.	Yes	No
CLINICAL MANAGEMENT AND QUALITY IMPROVEMENT	Convene peer network meetings of CMO/ Medical Directors	No	Yes
	Convene peer network meetings of QI staff	No	Yes
	Offer training on quality improvement best practices	No	Yes

** Reflects services provided in all years by three-fourths of consortia.*
*** Reflects services with a stated priority of "high" by over three-fourths of consortia*

As part of this project, a detailed analysis was performed on reported changes to services or priorities from 2013 to 2018. Among all service categories, *Access to Care* changed the most over the years. Regional consortia started more individual services in this category and reported greater movement upwards in terms of perceived priority. Health center *Board Development* was a category with a relatively high proportion of services starting around 2017. The categories of *Local Health Service Delivery and Managed Care* also had rising priorities around 2014 and 2018 respectively. Compared to starting services, consortia infrequently reported stopping a service over the years. Outreach and Enrollment was the category with the greatest decline beginning around 2015, perhaps due to reduced funding for this activity. The categories of *Policy and Advocacy* and *Access to Care* generally showed the same high effort and high priority over the years studied. Two consortia, Community Clinic Consortium (CCC) and Redwood Community Health Coalition (RCHC) reported the most constant and complete array of services from 2013 to 2018. The two consortia that reported starting the most services between 2013 and 2018

were Community Health Partnership (CHP) and Coalition of Orange County Community Clinics (COCCC). The new services at COCCC resulted from expansion of FQHCs in the local area; CHP started new services as a result of a new strategic direction approved by the Board.

Tables 13 through 21 depict data related to individual services within each of the nine categories and offer specific findings reflected by the data for that category. The nine categories are reported from highest to lowest frequency of activity across consortia. Each table depicts data of services delivered at least once during 2013-2017, services conducted in all years 2013-2017, and services reported for 2017. The dark green cells indicate that the service was reported by a high number of consortia and the red cells indicate a low number conducted the activity. The lighter green, orange and yellow colors signify intermediate values. For example, the dark green cells for *National Policy* indicate most consortia conduct this activity. In contrast, the multiple red cells next to *Engage with Local Accountable Care Organization (ACO)* indicate that there was relatively lower reported activity.

Color coding is completed independently for each column and cannot be compared across rows. The numerical values are included to allow comparison across rows.

Service Category 1: Policy and Advocacy (Table 13)

- All regional consortia consistently conducted high levels of policy and advocacy; 2017 was a high-water mark of effort for all levels of policy.
- 100% of consortia conducted *National Policy* at least once from 2013-2017; 85% of consortia conducted national policy in all years. This was confirmed during site visits, as consortia staff reported significant effort in 2017 related to the repeal of the ACA, community health center federal funding (fiscal cliff) and immigration. Consortia offered numerous examples of mobilizing members and working with statewide consortia to develop messages and materials, and advocate for vulnerable communities.
- *County, State and Regional P*olicy were conducted at high levels across the entire timeline, however there is variation in some years as evidenced by the higher numbers of consortia which conducted these services at least once rather than in all years. State and county policy efforts included working on the 1115 Medi-Cal Waiver and local efforts to expand coverage to the remaining uninsured.
- Interviewees noted that in 2017, regional consortia developed a strong, collaborative effort through the Consortia Policy Group to discuss and coordinate policy and communication in cooperation with the California Primary Care Association.

Table 13: Percentage of Regional Consortia Reporting Policy and Advocacy Services and High Priority

Service Category	Service Activities	Service Provided in Stated Year(s)				Percent of Consortia that Ranked this a HIGH Priority (2017)
		2017	Anticipated (2018)	At Least Once (2013-2016)	In All Years (2013-2018)	
POLICY AND ADVOCACY	County Policy	92%	77%	92%	77%	75%
	Regional Area Policy	85%	62%	77%	62%	40%
	State Policy	92%	77%	100%	77%	85%
	National Policy	100%	85%	100%	85%	85%

NOTE: Color coding is completed independently for each column and cannot be compared across rows. The numerical values are included to allow comparison across rows.

Service Category 2: Access to Care (Table 14)

- Overall, services in this category were provided at a high rate by the consortia in all years. The exception is *Coordinate Telehealth Service* projects, which was offered at a much lower rate and scored as a low priority.
- The most frequently reported services in the *Access to Care* category in 2017 are focused on convening and collaborating to address the remaining uninsured clients and initiatives to improve access to specialty care.
- This category tended to score in the medium range for priority (rather than high priority) compared to services in other categories.
- Excluding telehealth, two-thirds or more of consortia worked on multiple efforts to improve access to care from 2013-2016.

Table 14: Percentage of Regional Consortia Reporting Access to Care Services and High Priority

Service Category	Service Activities	Service Provided in Stated Year(s)				Percent of Consortia that Ranked this a HIGH Priority (2017)
		2017	Anticipated (2018)	At Least Once (2013-2016)	In All Years (2013-2018)	
ACCESS TO CARE	Negotiate or advocate for funding or contracts for services to remaining uninsured	85%	77%	85%	69%	67%
	Convene local leaders to address strategies for remaining uninsured	92%	85%	92%	77%	46%
	Educate local leaders on the remaining uninsured	85%	77%	85%	69%	50%
	Participate in collaborative efforts to expand coverage to remaining uninsured	92%	85%	92%	77%	54%
	Advocate or participate in initiatives to improve access to specialty care	92%	85%	92%	77%	46%
	Advocate or participate in initiatives related to health plan network improvements	85%	77%	85%	69%	42%
	Coordinate telehealth projects	54%	46%	54%	38%	14%

NOTE: Color coding is completed independently for each column and cannot be compared across rows. The numerical values are included to allow comparison across rows.

Service Category 3: Local Health Delivery System (Table 15)

- High levels of effort are reported in this category, representing the extensive work of each regional consortium in its local community. Interviews confirmed many instances of consortia tailoring local work to the managed care, policy and provider environment of their specific areas of the state.

- *Emergency Preparedness* and *Local Waiver Collaboration* are examples of consortia tailoring their services over time. While these were reported as high activity in 2017 (92% for each service), they were less frequently conducted by consortia across all the years (54% and 69%, respectively).
- Local ACO engagement was provided by less than one-third of consortia and no consortium marked it as a high priority.
- All consortia reported involvement in *Health Information Exchange and Data Sharing* activities and *Collaborative Efforts to Improve the Local Delivery System* in 2017.
- Consortia report increasing participation in local systems and collaborations to address social determinants of health.

Table 15: Percentage of Regional Consortia Reporting Local Health Delivery System Services and High Priority

Service Category	Service Activities	Service Provided in Stated Year(s)				Percent of Consortia that Ranked this a HIGH Priority (2017)
		2017	Anticipated (2018)	At Least Once (2013-2016)	In All Years (2013-2018)	
LOCAL HEALTH DELIVERY SYSTEM	Participate in local waiver collaboration	92%	77%	85%	54%	33%
	Participate in formal partnerships with public health and health care organizations (e.g. hospitals, county health system)	100%	85%	100%	77%	77%
	Engage with local ACO	31%	31%	31%	23%	0%
	Engage in planning or conducting data sharing/HIE	100%	77%	100%	69%	62%
	Convene local/regional collaborations to integrate or improve health care delivery system	100%	85%	92%	77%	69%
	Provide technical assistance on emergency preparedness	92%	77%	100%	69%	17%

NOTE: Color coding is completed independently for each column and cannot be compared across rows. The numerical values are included to allow comparison across rows.

Service Category 4: Clinical Management and Quality Improvement (Table 16)

* This category ranked fairly high for effort and perceived priority.
* Service activities reported in *Clinical Management* and *Quality Improvement* were discussed in site visits as closely tied to health center success under Medi-Cal managed care.

- The service that showed the biggest increase from all years to 2017 was *Collecting and Sharing Unblinded Data* – an important step toward value-based care. A full 85% of regional consortia facilitate unblinded data exchange and 75% facilitate blinded data exchange. For example, in northern California, Partnership Health Plan provides funding support to consortia to facilitate quality improvement to address HEDIS measures.
- Project data documents consistent increases in the number of consortia reporting that they convene peer networks of Medical Directors/CMOs (69% in all years compared to 85% in 2017) and case managers (38% in all years compared to 62% in 2017).
- Pass-through and project grants often support *Quality Improvement* and *Access to Care.* The time-limited nature of relying on grants for this activity makes it challenging to mount ongoing initiatives.

Table 16: Percentage of Regional Consortia Reporting Clinical Management and Quality Improvement Services and High Priority

Service Category	Service Activities	Service Provided in Stated Year(s)				Percent of Consortia that Ranked this a HIGH Priority (2017)
		2017	Anticipated (2018)	At Least Once (2013-2016)	In All Years (2013-2018)	
CLINICAL MANAGEMENT AND QUALITY IMPROVEMENT	Convene peer network meetings of CMO/Medical Directors	85%	77%	77%	69%	82%
	Convene peer network meetings of QI staff	77%	77%	77%	69%	80%
	Convene peer network meetings of case managers	62%	46%	46%	38%	50%
	Collect and share blinded clinical performance data across network	77%	77%	77%	62%	67%
	Collect and share unblinded clinical performance data across network	85%	77%	69%	62%	73%
	Collect and share clinical performance data with public e.g. on web site or other broad public forum	62%	62%	69%	46%	38%
	Collect patient level data across network	62%	54%	54%	46%	38%
	Offer training on clinical best practices	77%	77%	77%	62%	40%
	Offer training on quality improvement best practices	77%	77%	69%	62%	80%
	Offer training or coaching on PCMH	77%	77%	85%	69%	30%
	Convene planning or collaboration on quality measures	69%	62%	69%	54%	67%

NOTE: Color coding is completed independently for each column and cannot be compared across rows. The numerical values are included to allow comparison across rows.

Service Category 5: Health Center Board Development (Table 17)

- Support for *Strategic Planning* for health center members is reported more often than other individual health center *Board Development* services.
- Although more than half of regional consortia reported Board Recruitment, Onboarding and Training activities in 2017, activities in this category are reported at the lowest priority levels of any category.
- Site visit interviews suggested that these activities may be important to individual health center members but of lower strategic priority across members.

Table 17: Percentage of Regional Consortia Reporting Health Center Board Development Services and High Priority

Service Category	Service Activities	Service Provided in Stated Year(s)				Of Those with a Stated Priority of "HIGH" (2017)
		2017	Anticipated (2018)	At Least Once (2013-2016)	In All Years (2013-2018)	
HEALTH CENTER BOARD DEVELOPMENT	Support strategic planning for member health centers	85%	62%	69%	62%	9%
	Support board of health center recruitment or onboarding	54%	38%	31%	31%	0%
	Support board training for health center board members	69%	54%	54%	46%	22%

NOTE: Color coding is completed independently for each column and cannot be compared across rows. The numerical values are included to allow comparison across rows.

Service Category 6: Managed Care (Table 18)

- There were only moderate rates of activity and level of priority reported for work on *Managed Care* issues, however there were efforts reported in several other categories that relate to managed care. For example, seven regional consortia support credentialing (see Health Center Operations, Category 7).
- *Operating an IPA* or *MSO* are reported by fewer than a quarter of consortia. A number of consortia referenced strategic discussions about potentially starting an IPA and interest in learning from their colleagues. Three consortia (AHC, HCP, RCHC) operate additional entities focused on managed care contracting and business operations (summarized later in this section), including a network and/or an MSO. Three of the same consortia operate a network and two of the same consortia operate an MSO. This is a potential area for shared services, collaboration and learning among regional consortia. COCCC reported exploring the development of an IPA over the last few years and has created a separate entity, the Orange County Safety Net Foundation, ready to launch should the local Medi-Cal managed care health plan be willing to contract with a new IPA.
- *Pay for Performance* (P4P) and *Quality Incentive Programs* are reported at much higher levels of activity than other services in this area. Both priority and frequency of consortia work related to these services is increasing and represents their attention to value-based

outcomes and payment.

Table 18: Percentage of Regional Consortia Reporting Managed Care Services and High Priority

Service Category	Service	Service Provided in Stated Year(s)				Of Those with a Percent of Consortia that Ranked this a HIGH Priority (2017)
		2017	Anticipated (2018)	At Least Once (2013-2016)	In All Years (2013-2018)	
MANAGED CARE	Advocate with health plans about managed care contracts	69%	69%	69%	62%	67%
	Advocate for P4P or quality incentive programs	85%	62%	77%	54%	55%
	Support member success or reporting in P4P or quality incentive program	92%	77%	77%	62%	50%
	Operate an IPA or Clinically Integrated Network (CIN)	23%	23%	23%	23%	100%
	Operate an MSO	15%	15%	15%	15%	50%

NOTE: Color coding is completed independently for each column and cannot be compared across rows. The numerical values are included to allow comparison across rows.

Service Category 7: Health Center Operations (Table 19)

- Compared to other service categories, effort in this category was relatively lower and had lower priority.
- *Convening Peer Networks* of senior health center staff was conducted by almost all consortia in 2017 – a large change from previous years and part of the regional consortia's growing focus on workforce.
- Approximately half of the regional consortia work on supporting health centers in *Credentialing*. Of the seven consortia supporting credentialing, three also operate an IPA or Network and two operate an MSO.

Table 19: Percentage of Regional Consortia Reporting Health Center Operations Services and High Priority

Service Category	Service Activities	Service Provided in Stated Year(s)				Percent of Consortia that Ranked this a HIGH Priority (2017)
		2017	Anticipated (2018)	At Least Once (2013-2016)	In All Years (2013-2018)	
HEALTH CENTER OPERATIONS	Convene peer network meetings of CFOs, CMOs, HR, CIOs, etc.	92%	77%	77%	77%	64%
	Convene peer network meetings of IT staff	54%	54%	69%	46%	71%
	Host HIT or EHR systems	38%	38%	31%	23%	0%
	Joint purchasing of equipment or services	54%	54%	62%	54%	29%
	Support credentialing for providers	54%	54%	38%	38%	29%
	Offer training on operations	69%	69%	69%	54%	33%
	Offer technical assistance on PPS or billing	69%	69%	69%	69%	33%
	Offer technical assistance on 330 compliance	69%	62%	62%	54%	11%

NOTE: Color coding is completed independently for each column and cannot be compared across rows. The numerical values are included to allow comparison across rows.

Services Category 8: Outreach and Enrollment (Table 20)

- *Outreach and Enrollment* was conducted at consistently lower levels and was a modest priority across the years reported in spite of the importance of ACA enrollment from 2013 to the present.
- *Local Collaboration to Plan and Coordinate Outreach and Enrollment Activities* was the area of highest activity (77%) in all years including 2017.
- As enrollment in the ACA stabilized, enrollment and navigation efforts as well as grants for members to conduct outreach and enrollment were reduced in 2017. Insurance retention and renewal efforts remained consistent in about two thirds of all regional consortia.

Table 20: Percentage of Regional Consortia Reporting Outreach and Enrollment Services and High Priority

Service Category	Service Activities	Service Provided in Stated Year(s)				Percent of Consortia that Ranked this a HIGH Priority (2017)
		2017	Anticipated (2018)	At Least Once (2013-2016)	In All Years (2013-2018)	
OUTREACH AND ENROLLMENT	Convene Peer Network meetings of CEC	69%	69%	69%	54%	78%
	Collaborate locally to plan and coordinate outreach and enrollment	77%	62%	77%	54%	70%
	Staff and conduct enrollment or navigation services	54%	38%	62%	38%	71%
	Host contracts or grants for member outreach and enrollment services	54%	46%	62%	46%	75%
	Support retention and renewal of coverage	62%	46%	62%	46%	75%

NOTE: Color coding is completed independently for each column and cannot be compared across rows. The numerical values are included to allow comparison across rows.

Service Category 9: Workforce Development (Table 21)

- While the topic of workforce development came up regularly in site visits for this project, the modest activity and low priority ratings reported seem surprising given the emphasis on this topic during site visits.
- The most frequent service activity in this category across consortia is *Outreach to Promote Health Centers* in schools, community colleges and universities as reported by 77% of consortia in 2017.
- Two thirds of the regional consortia are also Area Health Education Centers (AHECs).
- Service activities reported in this category appear to be consistent over the years.
- Other sections of the services better reflect efforts in this area and perhaps this is one category that is challenging to isolate all the efforts underway.

Table 21: Percentage of Regional Consortia Reporting Workforce Development Services and High Priority

Service Category	Service Activities	Service Provided in Stated Year(s)				Percent of Consortia that Ranked this a HIGH Priority (2017)
		2017	Anticipated (2018)	At Least Once (2013-2016)	In All Years (2013-2018)	
WORKFORCE DEVELOPMENT	Convene peer network meetings of Human Resources	54%	54%	62%	38%	38%
	Operate an AHEC	69%	62%	62%	46%	50%
	Conduct outreach to promote health careers (school, community college, university)	77%	69%	77%	62%	44%
	Participate in Workforce Investment Board or other local collaborations to advance health workforce	69%	62%	69%	62%	50%
	Coordinate AmeriCorps and VISTA (Volunteers in Service to America) program	31%	31%	38%	23%	50%

NOTE: Color coding is completed independently for each column and cannot be compared across rows. The numerical values are included to allow comparison across rows.

REGIONAL CONSORTIA OPERATING ADDITIONAL ORGANIZATIONAL ENTITIES

In 2018, three regional consortia operate subsidiary entities to support members:

- Alameda Health Consortium (AHC) operates Community Health Center Network (CHCN)
- Health Center Partners of Southern California (HCP) operates Health Quality Partners (HQP), Integrated Health Partners (IHP) and CNECT (formerly called Council Connections)
- Redwood Community Health Coalition (RCHC) operates Redwood Community Health Network (RCHN) and Redwood Community Care Organization (RCCO).

Regional consortia formed subsidiaries as early as 1979 (CNECT) and as recently as 2016 (Integrated Health Partners). The primary goals for these entities are to secure contracts and advantageous financial arrangements with Medi-Cal managed care plans for member CCHCs, improve access for CCHC patients and advance quality improvement efforts. Each consortium approached these managed care situations differently since Medi-Cal managed care in California is generally a county-based and local endeavor. In each of the three consortia a separate

organization was created as a subsidiary of the parent consortium to segregate both the risk and the work of the new supporting organization. Each subsidiary organization is wholly owned by the parent consortium and has separate membership criteria that consortium members must meet. In the Alameda Health Consortium all consortium members now participate in CHCN but did not originally. In Health Center Partners, all of the HCP members may participate in Health Quality Partners and non-members may participate in grant funded projects; approximately half of HCP members participate in Integrated Health Partners. HCP members made a decision about their interest in joining IHP and there are criteria for membership in this additional entity. CNECT (formerly Council Connections) has a large national presence that goes far beyond HCP membership. Redwood Community Health Coalition (RCHN) is focused solely on Sonoma County members of RCHC and RCCO – the ACO – is comprised of a subset of RCHC consortium's membership. In CHCN, HQP and RCHN, only consortium members are eligible for participation.

In each case the principal subsidiary organizations (CHCN, HQP and RCHN) are larger from a budget and financial perspective than the parent consortium. None of the subsidiary organizations has a dues structure but all three are larger than their parent organizations in terms of revenue, ranging from 1.5 to 4.0 times the revenue of the parent organization. Two of the supporting organizations reported more staff FTEs than the parent, two reported more funding through major grants than the parent, and one supporting organization reported more pass-through funds than the parent. The income of these three consortia is more diversified than other consortia and they have more in-depth clinical quality and managed care contracting programs.

Alameda Health Consortium (AHC) operates Community Health Center Network (CHCN)

Formed in 1996, Community Health Center Network (CHCN) is a non-profit managed care organization accepting delegated risk from managed care plans and providing business administrative support for its member community health centers who are all members of AHC. Owned and operated by its member community health centers, CHCN provides resources for many managed care functions including HMO contracting, primary care contracting, specialty care contracting, utilization management, membership reporting, quality improvement services, population health management services, claims adjudication, capitation payment, credentialing, managed care information technology services and financial data reporting.

CHCN holds full professional risk managed care contracts with three HMOs on behalf of its member health centers and provides managed care services to approximately 130,000 Medi-Cal patients in Alameda and Contra Costa Counties. CHCN also has expanded insurance coverage to 7,000 additional patients through the California Children's Health Insurance Program (Healthy Families; now a Medi-Cal benefit) and four other managed care insurance products specifically designed for previously uninsured individuals and families. In January 2008, CHCN added a contract with a Medicare Advantage Special Needs Plan for dual eligible Medi-Cal and Medicare beneficiaries to its portfolio of offered plans.

CHCN is looked to by all statewide and regional consortia in California as a forerunner and leader in managed care contracting for member CCHCs.

Health Center Partners of Southern California (HCP) operates Health Quality Partners of Southern California (HQP), Integrated Health Partners (IHP) and CNECT

Health Center Partners has developed a family of companies under its corporate umbrella that includes the core consortium work under HCP; clinical quality improvement through its subsidiary HQP; a clinically integrated network, IHP, offering managed care contracting and related services to members; and CNECT (formerly Council Connections), a national group purchasing organization. HQP and IHP are relatively new efforts under HCP. CNECT was formed in 1979 and is nationally recognized. Due to proprietary business interests, information and data about IHP and CNECT were not shared as part of this project. HQP is working to become an innovation

hub and incubator to improve primary care and is doing this by evaluating new ideas, business concepts, best practices and care models. HQP has a successful track record in securing grants and administering funded programs aimed at improving access to care, quality health outcomes, and operational efficiencies.

Redwood Community Health Coalition (RCHC) operates the Redwood Community Health Network (RCHN) and Redwood Community Care Organization (RCCO)

A subsidiary of RCHC, RCHN is a network of RCHC's Sonoma County members who contract with Partnership HealthPlan of California – the single Medi-Cal managed care organization in Sonoma County – for primary care services on behalf of its Sonoma County members. RCHN's strategic priorities for 2016-18 are to:

- Facilitate and develop robust and coordinated behavioral health systems of care across Sonoma County;
- Establish new value-based reimbursement agreements with managed care plans and other payers;
- Implement a coordinated health care workforce pipeline and recruitment strategy among RCHN members; and
- Invest in the development of strong relationships and alignment with County agencies and major health systems.

RCHC, in conjunction with Petaluma Health Centers, Santa Rosa Community Health, and West County Health Centers, formed RCCO in 2012. RCCO was accepted into the Medicare Shared Savings Program (MSSP) and began its first three-year agreement with CMS in 2014. During this time, RCHC provided all management and administrative support to RCCO. In 2017, administration and staffing of RCCO shifted. RCHC continues to staff the ACO for program compliance and reporting while two RCHC members, Santa Rosa Community Health and West County Health Centers, have taken on leadership and data analytics for the entity. The ACO experience has allowed participating RCHC members to gain new knowledge about the challenges of coordinating care for dual eligible Medicare and Medicaid beneficiaries, provided unprecedented access to data (which has had a substantial impact on population health management strategies), and provided an opportunity for participants to better prepare for a value-based payment system in the future.

The regional consortia with more than one organizational entity have made strategic choices, illustrated in Table 22, about how staffing, service activities and membership should be structured. In one case, membership is the same between the main consortia organization and the additional entity and this means that all quality improvement and data activities are best located in the additional entity. In another case, only a subset of members participate in the additional entity and this drives different staffing and structure.

Table 22: Comparison of the Main and Subsidiary Entities

Organization	FTE (Rounded)	Member Type		Revenue
		Main	Subsidiary	Comment
Main: AHC Subsidiary: CHCN	Main: 10 Subsidiary: 107	Members pay dues	Members, no dues	Subsidiary has about 4 times the revenue
Main: HCP Subsidiary: HQP NOTE: Financial data was not provided for IHP and CNECT	Main: 6 Subsidiary: 16	Members pay dues	No members	Subsidiary has about 1.5 times the revenue
Main: RCHC Subsidiary: RCHN	Main: 18 Subsidiary: 2	Members pay dues	Members, no dues	Subsidiary has about 3.5 times the revenue

NOTE: Pass through funding is not included as revenue in the data collection tool

Service information was reported and analyzed for CHCN, HQP/IHP and RCHN entities and compared to service information reported for the parent consortia for the nine broad service categories. Among the findings:

- *Policy and Advocacy* services are only offered through the parent consortia organizations, not the subsidiaries.
- Managed care is primarily handled by the additional or subsidiary entities and not within the core consortia programming for those regional consortia with additional entities.
- Local health systems, health center operations, and clinical management/quality improvement are joint functions of all the consortia and their subsidiaries.

SECTION 3:

Statewide Clinic Consortia: Programs, Services and Leadership

The information reported in Section 3 summarizes the operational and service data for statewide clinic consortia, collected through a data tool developed for this project, publicly available information and in-person site visits. Data was submitted by five statewide consortia and two additional entities: CPCA operates CaliforniaHealth+ Advocates and PPAC operates the California Planned Parenthood Education Fund. Given the breath and varied purpose of the five statewide clinic consortia, this section begins with a brief overview of each statewide consortium followed by the data analysis.

California Consortium for Urban Indian Health (CCUIH). The California Consortium for Urban Indian Health (CCUIH) supports health promotion and access for American Indians living in cities throughout California. CCUIH is a nonprofit statewide alliance of Urban Indian health organizations and substance abuse treatment facilities collectively referred to as UIHOs. CCUIH's mission is to facilitate shared development resources for its members and to raise public awareness in order to support a health and wellness network that meets the needs of American Indians living in urban communities. CCUIH's vision is a future in which all American Indians living in urban areas gain access to quality, sustainable, and self-determined health and wellness services, built upon a legacy of healthy American Indian communities for generations to come.

California Primary Care Association (CPCA). The California Primary Care Association (CPCA) has become the statewide leader and recognized voice representing the interests of California community clinics and health centers and their patients. CPCA represents more than 1,300 not-for-profit community health center sites (CCHCs) and Regional Consortia that provide comprehensive, quality health care services, particularly for low-income, uninsured and underserved Californians who might otherwise not have access to health care. The mission of CPCA is to lead and position community clinics, health centers and networks through advocacy, education and services as key players in the health care delivery system to improve the health status of their communities. CPCA operates two other entities, CaliforniaHealth+ Advocates (CHPA) and CPCA Ventures. CPCA is the largest of the statewide consortium and is recognized as the federally funded state primary care association (PCA) by HRSA.[5]

California Rural Indian Health Board (CRIHB). The California Rural Indian Health Board was formed to provide a central focal point in the state's Indian health field for planning, advocacy, funding, training, technical assistance, coordination, fund-raising, education, development and formulating common policy on Indian health care issues. CRIHB is a network of Tribal Health Programs, which are controlled and sanctioned by Indian people and their Tribal Governments. CHRIB passes through all Indian Health Service direct service funds in California as well as funding for numerous health and social wellness programs such as suicide prevention.

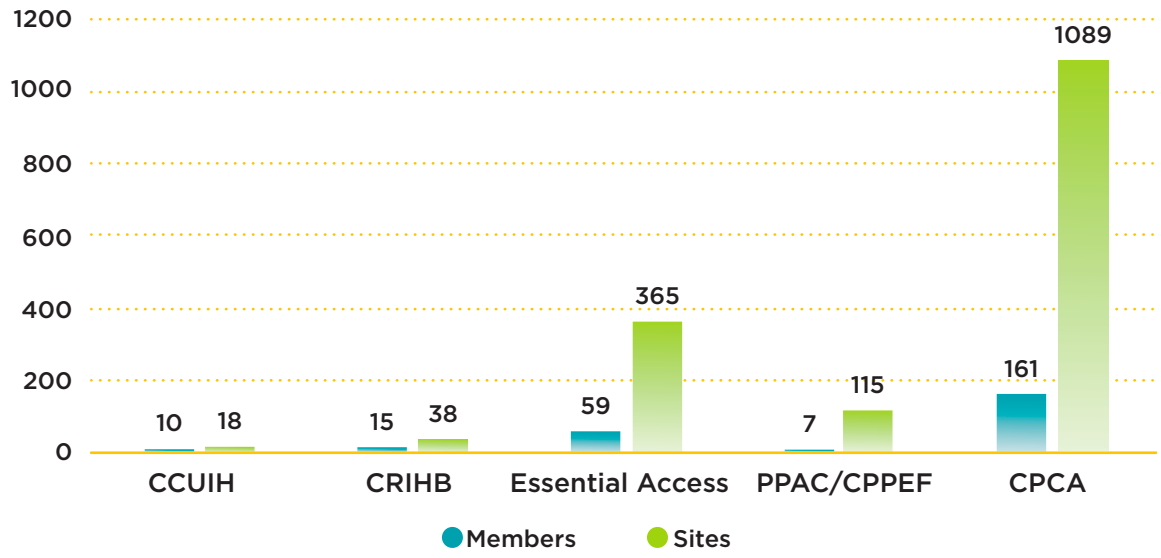
Essential Access Health (Essential Access). Essential Access Health champions and promotes quality sexual and reproductive health care for all Californians. It achieves its mission through an umbrella of programs and services including CCHC support initiatives, provider training, advanced clinical research, advocacy and consumer awareness. Essential Access Health's Title X federal family planning program collectively serves more than one million women, men and teens annually at 59 clinic organizations operating nearly 350 clinic locations in 37 of California's 58 counties.

[5] There are federally funded PCA in every state or region.

Planned Parenthood Affiliates of California (PPAC) is a 501(c)4 organization and is one of 21 state public affairs offices of Planned Parenthood Federation of America across the country. PPAC's mission is to create a personally and politically safe climate in which individuals have universal and unfettered access to sexual and reproductive health services and are free to follow their own beliefs, values and moral code when making decisions about these services. PPAC operates another entity, the California Planned Parenthood Education Fund (CPPEF).

Membership for each statewide clinic consortia is depicted below in Figure 10. CPCA reported membership of 161 CCHC organizations managing 1,089 sites. CPCA's Associate Program includes other non-member partners, such as public entities, corporations, individuals and not for profit organizations. PPAC/CPPEF and Essential Access both focus on reproductive health services and are the next largest consortia. CRIHB and CCUIH support health services for tribal health programs and Urban Indian health organizations and are the smallest statewide consortia in terms of membership numbers. Three of the statewide consortia are headquartered in Sacramento (CPCA, CRIHB and PPAC) while one is headquartered in San Francisco with a legislative office in Sacramento (CCUIH) and one is headquartered in Los Angeles with a second satellite corporate office in Berkeley (Essential Access).

Figure 10: Number of Health Care Organization Members among Statewide Consortia



STATEWIDE CONSORTIA STAFFING AND LEADERSHIP

With more than 20 years in her position, the CEO of CPCA has the longest tenure among the five statewide consortia as seen in Figure 11. Three of the five statewide consortia have experienced relatively recent leadership changes after long-term CEO tenure: the Essential Access CEO retired after 17 years, the PPAC CEO retired after 25 years and the CRIHB CEO retired after 27 years. The founding Executive Director of CCUIH still leads the organization after nine years in her position. Four of the five current CEO leaders are female and four are people of color.

Figure 11: CEO Tenure (In Years) among the Statewide Consortia

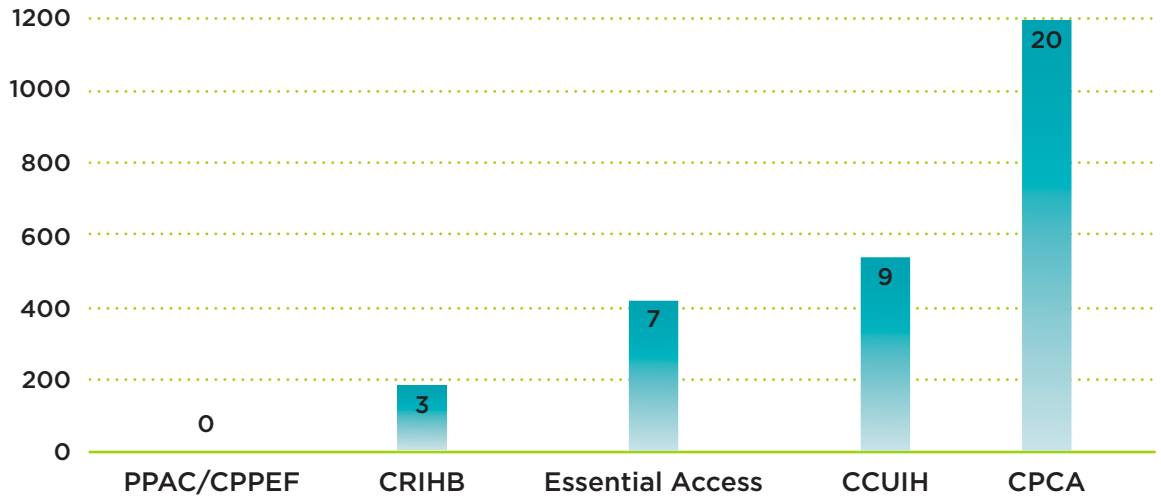
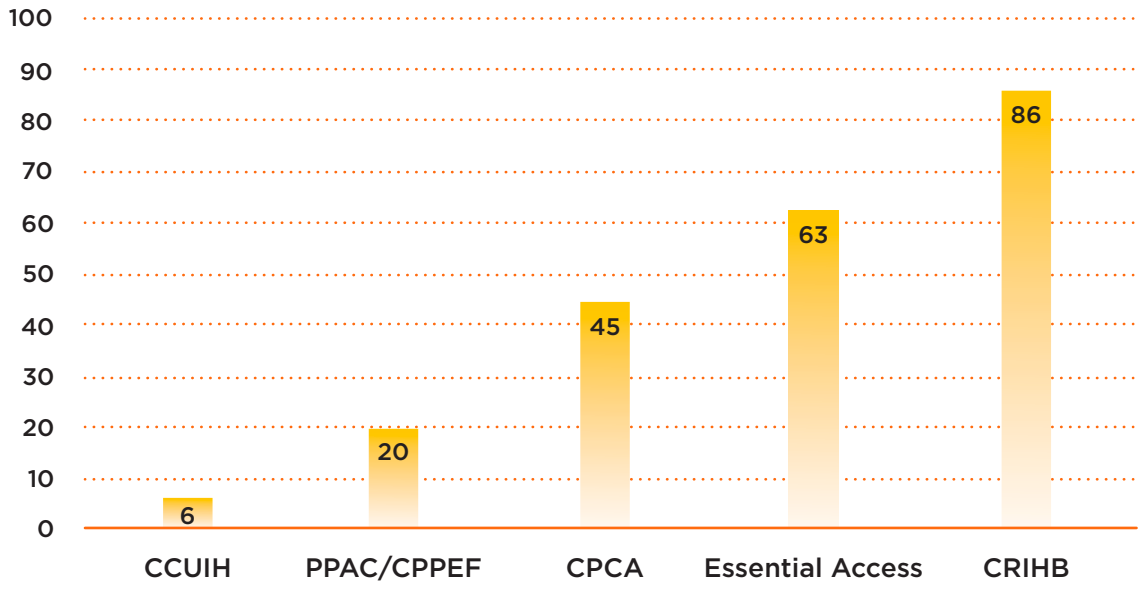


Figure 12 illustrates statewide consortia staff size. CRIHB is the largest organization, with 86 FTE staff, followed by Essential Access. The organizational charts for CRIHB and Essential Access indicate robust staffing in research. CRIHB also reports staffing for child development, health education, and health systems development. Essential Access staffs and operates several training and strategic initiatives. CCUIH has the smallest number of full time equivalent staff at six FTEs.

Figure 12: Total Organization Size (In FTE) among Statewide Consortia



The data tool asked for the job title and years of service for senior staff, reported in Table 23. All five statewide consortia report a Director of Evaluation, Research and/or Quality and a Director of Policy, External Affairs and/or Public Affairs. In general, the mean tenure for senior staff positions reported indicates stable staffing in most consortia. Only two statewide consortia report a CMO position and it is interesting to note the shorter tenure for CMOs, perhaps reflecting this as a

newer position within statewide consortia. Only the Director of Human Resources has a shorter mean tenure at one year.

Table 23: Number of Positions and Median Years of Tenure by Category for Statewide Consortia

Position Category	Positions Reported	Median (Years)
CEO, Executive Director, President	5	7
COO, Chief Operating Officer, Senior Vice President	3	10
CFO, Finance Officer, Director of Finance	4	6
Chief Medical Officer, Medical Director	2	2
Directors of Evaluation, Research, Quality	5	30
Directors of Policy, External Affairs, Public Affairs	5	7
Directors of Strategy, Business Development	3	9
Directors of Human Resources	3	1
Other Directors and Officers	9	4

Four of the five statewide consortia reported outsourcing functions or services with three to five different groups ranging from 150 to more than 400 hours per month. Only CRIHB reported no outsourced functions. Public Policy/Lobbyist was the most commonly reported outsourced service reported by all four statewide consortia. The second most common service was in the category Information Officer/information Technology, as shown in Table 24.

Table 24: Outsourced Positions by Function or Service Category: Statewide Consortia,

Function or service category	Outsource Reported	Number of consortia Reporting This Outsource Function
Accounting/financial services	1	1
Human Resources	1	1
Information officer/information technology	4	3
Public Policy/Lobbyist	6	4
Specific project management	3	1
Other	2	1

STATEWIDE CONSORTIA MEMBERSHIP AND DUES

As displayed in Table 25, CCUIH, CPCA and PPAC have dues-paying full members. CRIHB and Essential Access do not have dues-paying full members. CCUIH additionally has an Affiliate category (no dues) and CRIHB has an Associate category (dues required)). Essential Access reported not having traditional membership because they do not have members.

Table 25: Member Type, by Statewide Consortia

Statewide Consortium	Full members		Affiliate	Other category	Not applicable/ No members
	Dues required	No dues required	No dues required	Dues required	
CCUIH	X		X		
CPCA	X				
CRIHB		X		X (Associate)	
Essential Access					X
PPAC/ CPPEF	X				

Table 26 shows the dues structure for statewide consortia based on membership type. Essential Access does not have a traditional membership structure and has no membership dues. CCUIH and CRIHB charge a flat rate per year (only Associate members with CRIHB pay the fee). CCUIH's dues and fee schedule are scheduled to change significantly in July 2018: the new fee schedule will be based on IHS contract income and revenue, rather than flat rate, and this will result in substantially higher membership dues. Some CCUIH members are also paying dues to their regional consortia, and many to CPCA as well. Most members of CPCA are community health centers and pay a fee based on gross revenue. Regional consortia pay dues to CPCA that is discounted based on how many of their members are also members of CPCA. Both of these categories have a dues cap.

Table 26: Details on the Fee Structure Maintained by each Statewide Consortium

State Consortium	Member Type	Fee Structure Type	Determining Factors	Portion Factor (of Budget)	Flat Fee (per year)	Minimum Fee	Fee Cap
CCUIH	Members	Flat			$500		
CPCA	Community health center	Portion	Gross revenue	0.0015		$750	$30,000
	Regional consortia and associations	Portion	CPCA members*				$24,000
CRIHB	Contracting member	No fee					
	Associate member	Flat			$12,000		
Essential Access	No members	N/A					

**Cap minus fees paid by consortia members who are already members of CPCA*
NOTE: PPAC did not report details on membership fees

STATEWIDE CONSORTIA SERVICES

The data tool developed for the project collected information to document past, current (2013-2017) and planned (2018) services provided to statewide consortia members. Within eight general service categories, there were 52 enumerated services and seven "other" options. Consortia indicated if the service was provided in past years (through 2017) and if the service was anticipated in 2018. They also ranked the priority they attributed to each service (low, medium or high) in 2017.

The following analysis, seen in Table 27, focused on the current or most recent strategic plans submitted by the statewide consortia. It maps the strategic plan priorities to the service categories listed in the data tool. It does not reflect actual services that may or may not be performed by the consortia. It is very interesting to note the commonalities in strategic plan priorities and service categories that many of the statewide consortia share.

Table 27: Comparison of Strategic Plans and Services Priorities across Statewide Consortia

Category	Service	CCUIH	CRIHB	Essential Access*	PPAC**	CPCA
Health Care System	A. Policy and Advocacy	X	X	X	X	X
	B. Managed Care				X	X
	C. Health Delivery System		X	X		X
Regional Populations	D. Access to Care	X	X	X	X	X
	E. Outreach and Enrollment	X				X
Member Performance	F. Health Center Operations	X	X			X
	G. Clinical Management and Quality Improvement		X	X		X
	H. Workforce Development		X	X		X
Other	I. Consortium Infrastructure	X	X		X	
Mission Statement	Focus on Regional Populations		X	X	X	
	Focus on Member Health Organizations	X				X

**The strategic plan submitted was for CFHC (California Family Health Council)*
***The strategic plan submitted was for CPPEF (California Planned Parenthood Education Fund)*

Table 28 shows the eight service categories, the percentage of services within the category that were offered in 2017 by the five statewide consortia, and the relative priority assigned to the services within the category. The categories with the highest perceived priority were *Health Delivery System* and *Access to Care*; *Policy and Advocacy* was a close third. *Managed Care* and *Outreach and Enrollment* were the categories least commonly offered and had the lowest priority ratings.

Table 28: Summary of Services Provided and Perceived Priority

Service category	Percentage of consortia that offered (2017)	Perceived priority (2017)		
		Low	Medium	High
1. ACCESS TO CARE	76.7%	13.0%	26.1%	60.9%
2. CLINICAL MANAGEMENT AND QUALITY IMPROVEMENT	76.4%	32.6%	30.2%	37.2%
3. POLICY AND ADVOCACY	75.0%	20.0%	20.0%	60.0%
4. HEALTH DELIVERY SYSTEM	70.0%	18.2%	18.2%	63.6%
5. HEALTH CENTER OPERATIONS	70.0%	20.6%	38.2%	41.2%
6. WORKFORCE DEVELOPMENT	60.0%	38.1%	19.0%	42.9%
7. OUTREACH AND ENROLLMENT	53.3%	81.3%	12.5%	6.3%
8. MANAGED CARE	44.0%	63.6%	0.0%	36.4%
Average	66.9%	31.9%	24.3%	43.8%

Table 29 below documents the aggregated results for all 52 questions in the Statewide Consortium Service section of the data tool. It depicts the percentage of statewide consortia that conducted the service in 2017, anticipated offering it in 2018, offered it at least once between 2013 and 2016, and offered it in all the years mentioned (2013 through 2018). The table also reports the priority reported for each service (low, medium or high) and the weighted average. The shading and numeric value for the weighted average offers a view across the reported priority (low, medium and high weighted by a value of 1-3). The service summary table is color-coded to distinguish the variation in frequency or priority. Generally, cells with higher numbers are green or dark green and cells with lower numbers are orange and red (with yellow being in between). *Columns are coded independently and cannot be compared across the chart.*

Services Overview:

- The five statewide consortia conducted two-thirds of all 52 different services in 2017. There is variation in the mission and goals of the five statewide consortia that is evident in their services, however a high degree of alignment exists across the statewide consortia activities as reported.
- Two of the top three most frequently provided services are the same for statewide and regional consortia (*Policy and Advocacy; Access to Care*).
- Given the numbers and highlights in Table 29, certain services can be distinguished as the most commonly offered and the highest priority. The following services were offered by all five statewide consortia in 2017 and assigned the highest priority among questions (i.e., a weighted average of 2.8 or greater):
    - State-level Policy.
    - National Policy.
    - Advocate for funding or contracts for services to remaining uninsured.
    - Educate statewide leaders on the remaining uninsured.
    - Participate in formal partnerships with CDPH or CDHCS or DMHC.

- Offer trainings on operations.

- The statewide consortia also identified services that were **not** commonly offered and perceived to be low priorities. These were:
  - County-level policy and advocacy.
  - Operating IPAs and clinically-integrated network or MSO.
  - Coordinating an AmeriCorps program.

Table 29: Percentage of Statewide Consortia Providing each Service and Reporting a "High" Priority

Service Category	Service	Service Provided in Stated Year(s)				Of Those with a Stated Priority (2017)		
		2017	Anticipated (2018)	At Least Once (2013-2016)	In All Years (2013-2018)	Low	Medium	High
1. POLICY AND ADVOCACY	County Policy (specify the local area)	40%	20%	20%	20%	100%	0%	0%
	Regional Area Policy (specify the region)	60%	60%	60%	40%	33%	67%	0%
	State-level Policy	100%	100%	100%	100%	0%	0%	100%
	National Policy	100%	100%	100%	100%	0%	20%	80%

STATEWIDE CONSORTIA ADDITIONAL ORGANIZATIONAL ENTITIES

Two of the statewide consortia operate subsidiary entities to expand their ability to represent members. Both CPCA and PPAC have advocacy-focused organizations to increase their flexibility and impact to conduct policy and advocacy activities. In both cases, some staff are shared across the two affiliated organizations. PPAC was established in 1974 and its additional entity CPPEF in the 1990s for business operations. CPCA created CaliforniaHealth+ Advocates as a 501(c)(4) in 2016.

California Primary Care Association (CPCA) operates CaliforniaHealth+ Advocates

While CPCA is the trade association representing California's community clinics and health centers, CaliforniaHealth+ Advocates is the advocacy affiliate of CPCA. CPCA is organized as a 501(c)(3) and CaliforniaHealth+ Advocates is organized as a 501(c)(4). CaliforniaHealth+ was created to advance CPCA's advocacy agenda in a more visible and stronger way. CPCA and CaliforniaHealth+ Advocates each completed the data collection tool and reported on service activities

Planned Parenthood Affiliates of California (PPAC) operates California Planned Parenthood Education Fund (CPPEF)

PPAC is a 501(c)(4) organization that was established by the Planned Parenthood affiliates in California and is the legislative and advocacy vehicle for Planned Parenthood statewide. Its partners and the Planned Parenthood Federation of America recognizes PPAC as the state Planned Parenthood office. CPPEF is a non-profit 501(c)(3) organization established in the 1990s and governed by a Board of Directors comprised of one representative from each of the seven local Planned Parenthood affiliates. CPPEF focuses on affiliate business operations, billing, regulatory and compliance work. It is the hiring entity for the state office staff and holds a resource sharing agreement with PPAC.

PPAC and CPPEF submitted separate Service Category tables within their respective data tools. Although there is significant overlap between the two in terms of services offered and perceived priority, CPPEF offers additional services to its members. These are mostly clinic-level trainings in clinical management, operations and quality improvement, and convening meetings of peer networks.

A comparison of key organizational data for the statewide consortia with their corresponding additional entities is depicted in Table 30 below.

Table 30: Comparison Summary of Statewide Consortia Additional Entities

Consortia	FTE (Rounded)	Member Type		Revenue	Major Grants	Pass Through
		Main	Affiliate	Comment	Comment	Comment
Main: PPAC Affiliate: CPPEF	Reported together: 14 FTE with 7 FTE vacant	Members pay dues	Members pay dues	Main has about 1.25 times the revenue	Major funders only reported for affiliate	Main: none reported Affiliate: one small grant ending in 2017
Main: CPCA Affiliate: CH+A	Main: 45 Affiliate: 2	Members pay dues	No members	Main is much larger	Not reported separately	Main: reported pass-through funds Affiliate: none reported

SECTION 4:

Financial Health of Statewide and Regional Consortia

The statewide and regional consortia vary in size and financial strength. The majority of the consortia depend heavily on grants to conduct their work; have steadily increased member dues and other fees to represent a larger percentage of their income over the years; and, generally performed well on three standard financial indicators.

During interviews, many examples emerged of consortia expanding fee-based services and training based on member priorities including, for example, HRSA site visit preparation, patient-centered medical home certification, compliance assessments and more.

The statewide and regional consortia submitted budgets for the years 2013 – 2017 (both calendar and fiscal years, depending on their budget period) and financial statements for the years 2013 – 2017. The analysis that follows illustrates the overall financial health of the consortia and provides information about variation over time and across the state.

The summary includes analysis on the following indicators:

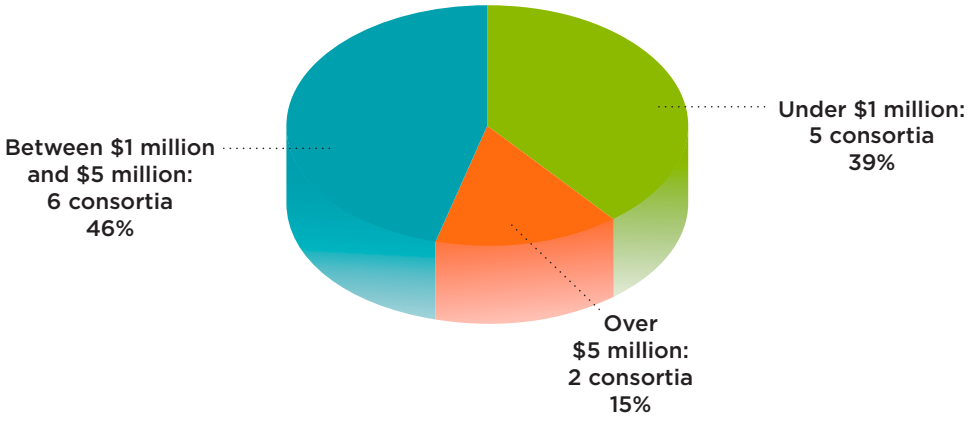
- Size of consortia
- Major revenue sources
- Project funding
- Major expense categories
- Pass-through funding
- Days cash on hand
- Current ratio
- Gross margin.

REGIONAL CONSORTIA SIZE AND REVENUE

The chart in Figure 13 below offers a view of the size of regional consortia, by 2017 revenue not including pass-through. Revenue was combined for the three regional consortia with multiple entities.[6] Overall, five regional consortia were in the category of revenue under $1 million and six were between $1 and $5 million for 2017. Only two regional consortia were in the revenue category of over $5 million in 2017.

[6] Health Center Partners and Quality Health Partners, Alameda Health Consortium and Community Health Center Network, Redwood Community Health Coalition and Redwood Community Health Network are included. There are two additional entities operated by Health Center Partners that were not reported.

Figure 13: Regional Consortia Total Revenue Reported Without Pass-Through Funding in 2017



The regional consortia reported revenue between 2013 and 2017 are shown in three graphs below (Figures 14 through 16). These figures reflect operating revenue, which does not include pass-through funding. In Figure 14, two consortia had annual revenue above $5 million in 2017. One of them was a regional consortium with two entities (AHC/CHCN). The second graph, Figure 15, shows that in this time period, six regional consortia (almost a half) had revenue generally between $1 and $5 million. The other two consortia with two entities (HCP/HQP and RCHC/RCHN) had the highest revenue in this group. The third chart, Figure 16, displays the revenue for the remaining five regional consortia (less than two-fifths) with revenue under $1 million.

Figure 14: Reported Revenue (Without Pass-Through Funds) from 2013 to 2017 for the Group of Regional Consortia with Annual Revenue Above $5 Million

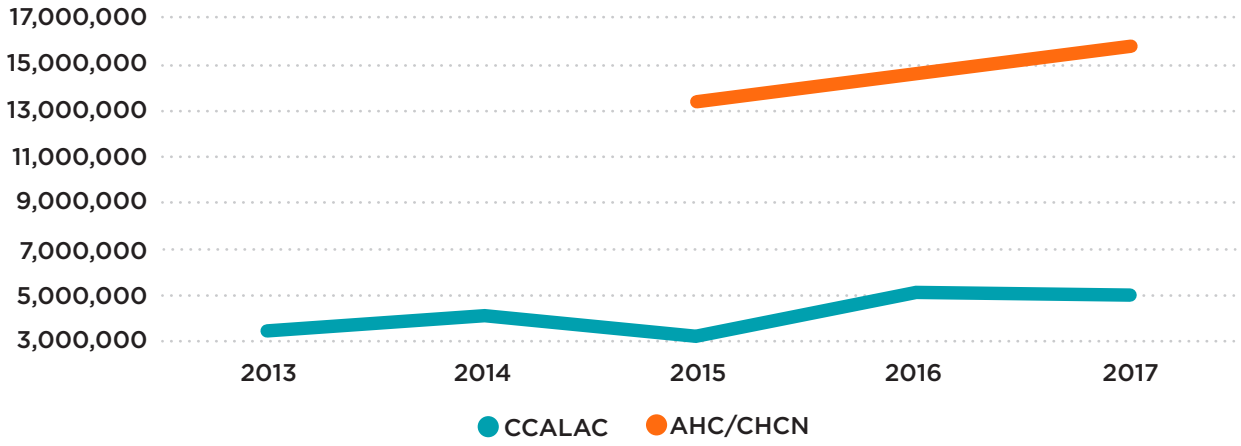


Figure 15: Reported Revenue (Without Pass-Through Funds) from 2013 to 2017 for the Group of Regional Consortia with Annual Revenue Between $1 Million and $5 Million.

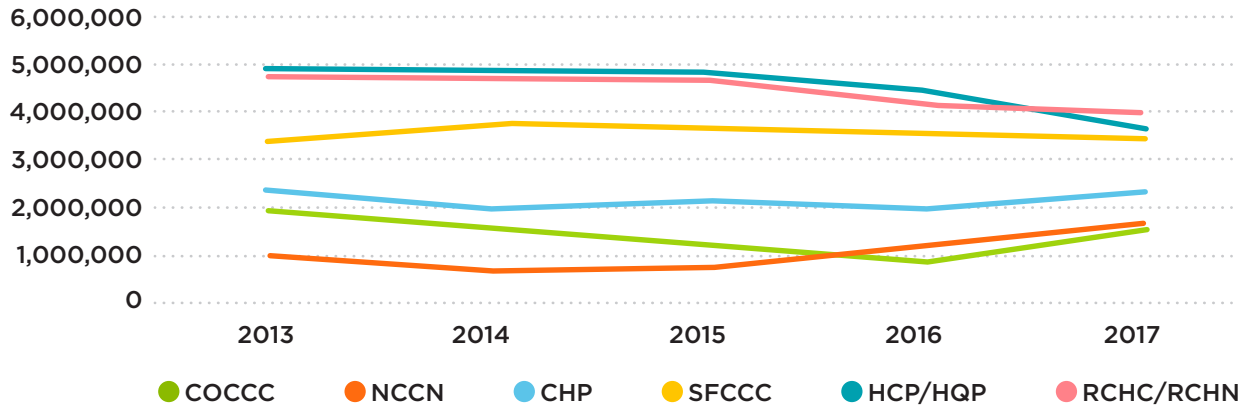
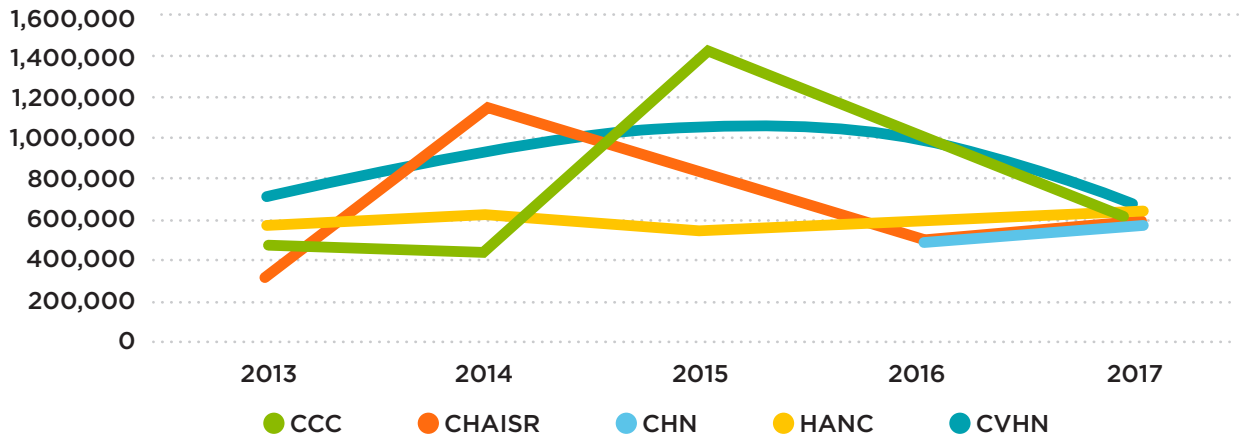


Figure 16: Reported Revenue (Without Pass-Through Funds) from 2013 to 2017 for the Group of Regional Consortia with Annual Revenue Under $1 Million

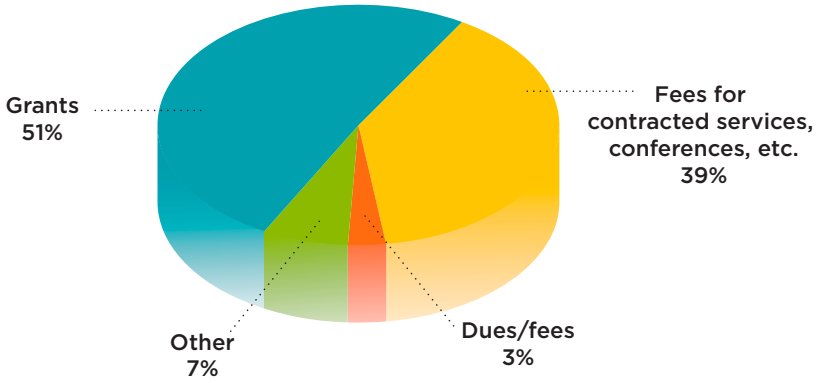


In the charts above, note that the scales are different, making the relative change year-to-year more pronounced for consortia with 2017 revenue under $1 million. When compared to each other on the same scale, it can be seen that the consortia with higher revenue had more variability over time while the consortia with lower revenue were flatter over time. Commonly, revenue varies over time, usually due to grant cycles beginning and ending. The year-to-year individual grant totals were not requested on the survey, so it is not known what kind of grants were causing the upward or downward trends seen in the above graphs. Nonetheless, the transitory nature of some of these grants can cause the total revenue to swing considerably one year to the next. For example, the crest in the revenue graph for CHAISR in 2014 was due to Covered California outreach and enrollment funds.

REGIONAL CONSORTIA MAJOR SOURCES OF REVENUE

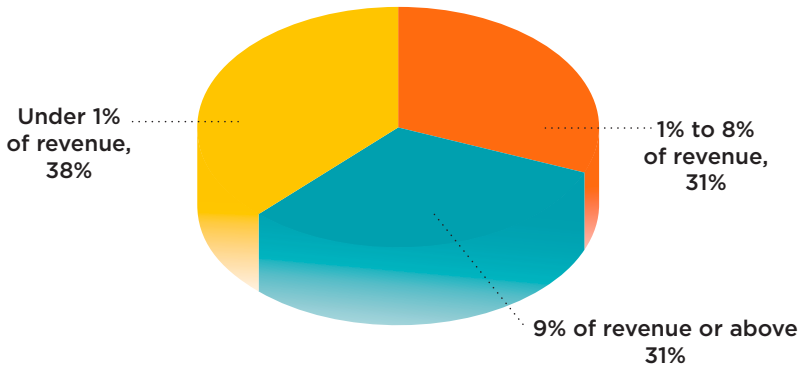
Figure 17 below shows the four major revenue sources taken as an average for the regional consortia in 2017. The chart shows that the consortia are highly dependent on grants. The sources of the grants are discussed in more detail below. Averaged across the combined revenue for consortia and their additional entities, half of revenue came from grants and nearly 40% came from fees for contracted services and conferences. The revenue from contracted sources is highest among consortia with additional entities.

Figure 17: Major Revenue Sources Across All Regional Consortia in 2017



Revenue from dues is around 3% across all regional consortia, however there is significant variation between consortia. Figure 18 below displays the proportion of consortia in three ranges of revenue from dues. Four consortia (31%) report 9-14% of revenue from dues. None of the consortia in this range have an additional entity organization. Four of the consortia (31%) report between 1% and 8% of revenue from dues and five consortia (38%) report under 1% of revenue from dues. While only partial data is available on revenue for multiple years, it would appear that regional consortia have diversified the sources of revenue over time.

Figure 18: Percentage of Regional Consortia Within Ranges of Revenue from Dues (2017)



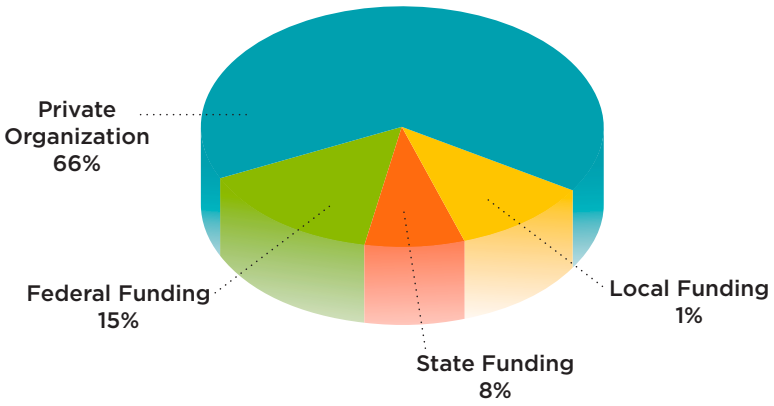
Twelve of thirteen regional consortia provided lists of major grant funding. Below, Table 31 describes the different sources of funding in 2017. Of the twelve regional consortia reporting, ten (83.3%) received federal funding, mostly because many regional consortia managed AHEC grants (8 consortia) or Health Center Controlled Networks (HCCN) (5 consortia). About a third of the regional consortia have state funding, such as Covered California and First 5 California. Half of regional consortia received local funding, commonly the county health departments or health plan funding. All regional consortia receive funding from private sources, which include foundations and other philanthropic sources.

Table 31: Source of Funding from Major Grants Across All Regional Consortia in 2017

Regional Consortia Funding Source	Percentage of consortia with at least one source
Federal Funding	83.3%
State Funding	33.3%
Local Funding	50.0%
Private organization	100.0%

In addition to reporting the sources of overall revenue, regional consortia provided brief descriptions of projects funded by grants through major funding sources. Regional consortia provided brief descriptions of individual projects supported by grants from major funding sources. Two-thirds (66%) of individual projects reported in 2017 were funded by private organizations. Local funding sponsored around 11% of individual projects (around 11%) while state and federal funding accounted for around 8% and 15% of projects respectively. The chart below, Figure 19, displays the proportion of projects funded in 2017, by funding source averaged across the regional consortia.

Figure 19: Funding Sources for Individual Projects in 2017 Among Regional Consortia



There were 105 projects active in 2017 through the funding sources listed above among the twelve consortia who reported detailed funding sources. Table 32 below depicts projects in groupings by type of project and percentage of consortia conducting each type of project. Around a third of projects (32%) involved training or capacity building of the member health centers. Nearly all (91.7%) reporting consortia had at least one project of this kind. One in five projects supported the staff or core funding of the consortium itself, with two-thirds of consortia reporting this kind of funding. Another two-thirds of consortia reported receiving funding for a specific health

service from a range of different funders, such as tele-dentistry, mental health services, breast health diagnostic services, etc. These services accounted for only around 17% of projects. Some projects also involved policy/advocacy work (around 11% of projects among 58% of consortia) or outreach to the community (around 8% of projects, usually health insurance enrollment projects, among 42% of consortia). Two thirds of the regional consortia were involved with an Area Health Education Center (AHEC) and one third with a Health Center Controlled Network (HCCN). Since these were mostly single projects within the category, they only accounted for around 8% and 4% respectively of all projects reported.

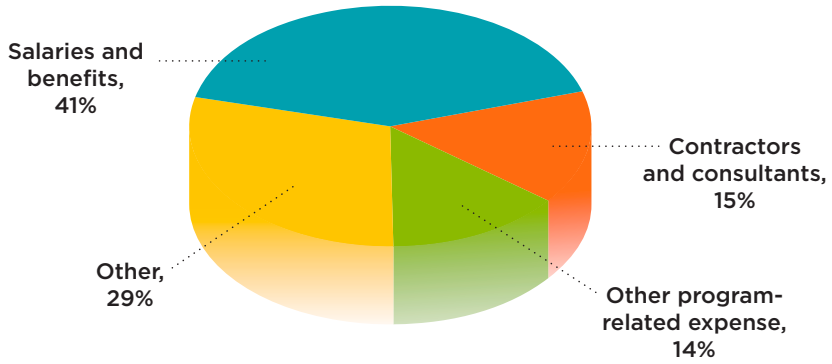
Table 32: Type of Project Funded by the Major Grants Across All Regional Consortia in 2017

Type of project funded	Percentage of projects (2017)	Percentage of consortia with at least one project
Member trainings	32.4%	91.7%
Staff/capacity/core funding	20.0%	66.7%
Support specific health service	17.1%	66.7%
Policy/advocacy	11.4%	58.3%
Outreach to community	7.6%	41.7%
AHEC	7.6%	66.7%
HCCN	3.8%	33.3%

REGIONAL CONSORTIA MAJOR EXPENSES

Figure 20 below shows a summary of 2017 expenses among all regional consortia, by major category requested on the data collection tool. The 'Other' category contains several line items like equipment, software/IT, travel, general office administration, human resources, etc. Even though the weighted average for salaries and benefits in 2017 was 41%, the median value was higher, at 61%. This was because many of the smaller consortia had higher proportions of their overall budget going to salaries and benefits.

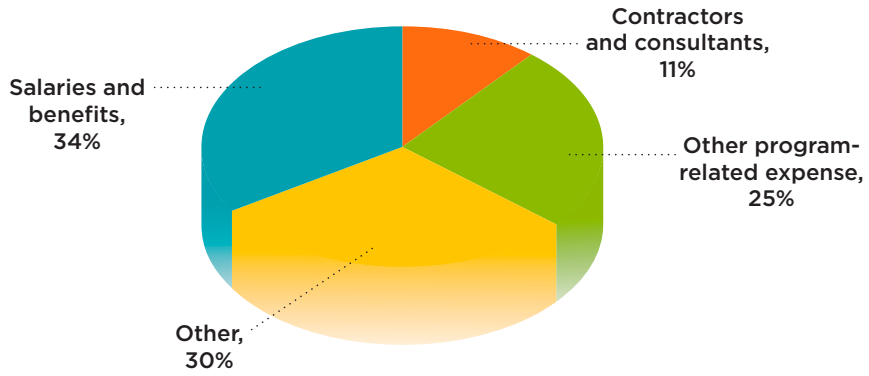
Figure 20: The Average of Major Expense Categories Across All Regional Consortia in 2017



Although fewer (around two-thirds) of regional consortia reported expense detail in 2013, the same categories can be reviewed. Figure 21, below, displays the expense categories reported in 2013. Of those reporting, a smaller proportion of total expenses went into salaries and benefits in 2013 (around 34%) than 2017 (around 41%). Some consortia report this change reflects a strategy

of using consultants for initial staff capacity expansion that may convert to regular staff positions as the need and sustainability become clear. The median value among the individual consortia was 47% for salaries and benefits in 2013, which is higher than the weighted average but still lower than the proportion in 2017.

Figure 21: The Average of Major Expense Categories Across All Regional Consortia in 2013



REGIONAL CONSORTIA PASS-THROUGH FUNDS

Pass-through funds are resources that the regional consortia receive on behalf of their members and pass on directly to their members to provide services or activities. Pass-through funds are federal, state and county grants as well as private sources such as managed care funds. In some cases, such as the San Francisco Clinic Consortium federal funds for the Health Care for the Homeless 330 Grant are also passed through, including to an entity that is not a member. Nine regional consortia reported nearly $16M in pass-through funds for 2017. Four consortia reported around $2.5M for 2016 and three consortia reported almost $2.4M in pass-through funds for 2015.

Ten regional consortia reported on pass-through funding. Two consortia marked Not Applicable on the survey meaning that they did not receive pass-through funding and one consortium left the table blank. Half (50%) of the reporting consortia had at least one federally-funded pass-through project, usually an HCCN or AHEC, and 60% had pass-through funding from at least one private philanthropic organization. State (30% of regional consortia) and local government (10% of regional consortia) were less common sources of pass-through funding. Table 33, below, shows the source of funding for the 35 pass-through programs active in 2017 among the regional consortia.

Table 33: Source of Pass-Through Funding for Individual Projects Reported by the Regional Consortia in 2017

Source of Pass-Through Funding	Percentage of projects (2017)
Federal Funding	20.0%
State Funding	17.1%
Local Funding	2.9%
Private Organization	60.0%

STATEWIDE CONSORTIA REVENUE

Figure 22 below shows statewide consortia reported revenue, not including pass-through funds, in 2017 by size. The statewide consortia tend to be larger than the regional consortia, with 60% of them over the $5 million mark, compared to 15% among regional consortia.

Figure 22: Statewide Consortia Total Revenue Reported Without Pass-Through Funding in 2017

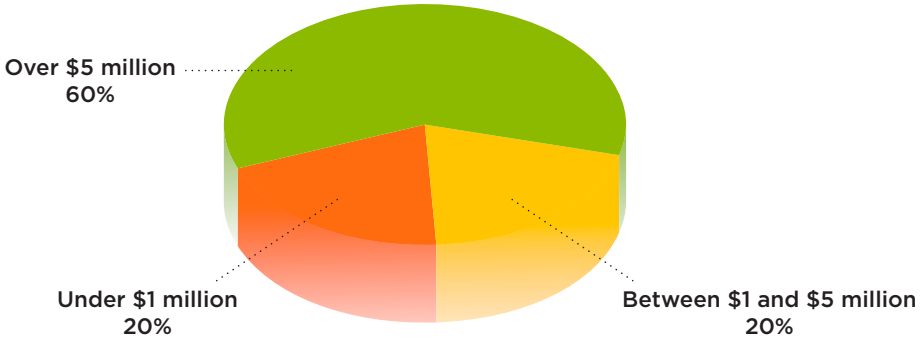
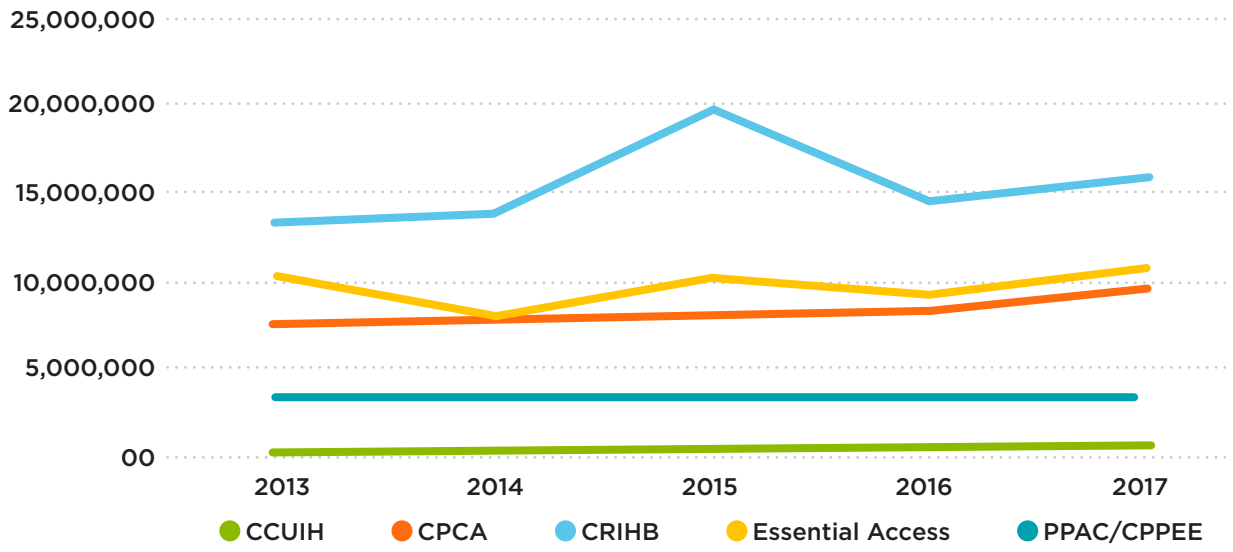


Figure 23 shows the reported revenue among the statewide consortia from 2013-2017. Generally, the revenue for the statewide consortia are less variable than the regional consortia. The exception is CRIHB, which received a one-time settlement in 2015 from the federal government as a result of a successful lawsuit related to underfunding of services in California.

Figure 23: Reported Revenue from 2013 to 2017 Among Statewide Consortia



All five statewide consortia reported major sources of funding for programs and projects. Figure 24 shows the three major revenue sources for the statewide consortia taken as an average for the years 2015, 2016 and 2017. Except for PPAC, statewide consortia show a similar overall proportion of revenue from membership dues as regional consortia. PPAC is an outlier with 72 percent of its revenue from dues. Except for PPAC, statewide consortia reported similarly high dependence on grant funding as regional consortia.

Figure 24: Comparison of Revenue Sources between Planned Parenthood Affiliates of California and the Rest of the Statewide Consortia

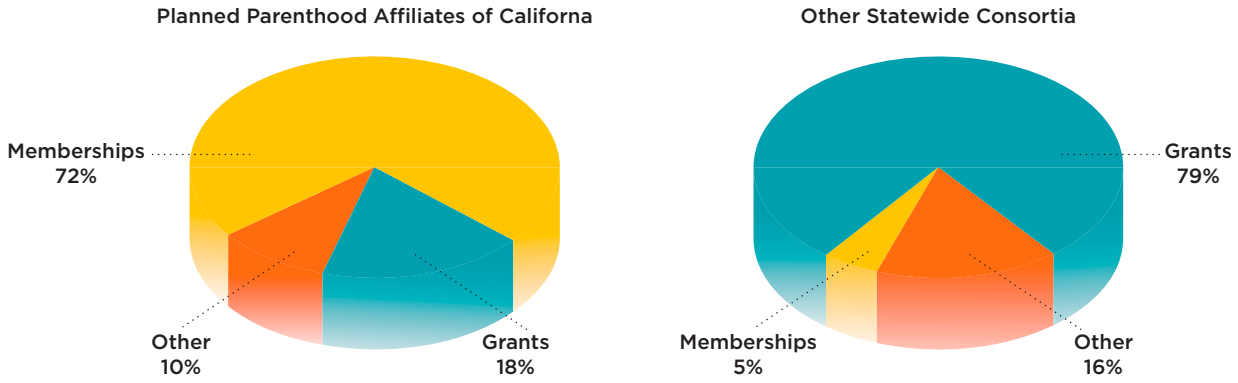


Table 34 groups the category of grant funding for all statewide consortia. All (100%) statewide consortia receive private funding from foundations and other philanthropic organizations. Most (80%) of statewide consortia reported federal funding as well. State funding (20%) and local government funding (40%) were less common among statewide consortia.

Table 34: Source of Funding From Major Grants Across All Statewide Consortia in 2017

Category of Funding	Percentage of consortia with at least one source
Federal government	80.0%
State government	20.0%
Local government	40.0%
Private philanthropic organization	100.0%

Statewide consortia reported funding for 57 projects in 2017 overall. Figure 25 shows the funding sources for these projects in 2017. Private philanthropic organizations funded just under two-thirds and federal sources funded a little less than one-third of projects. The rest (around 5%) were funded by state and local governments.

Figure 25: The Funding Source for All Reported Projects in 2017 Among Statewide Consortia

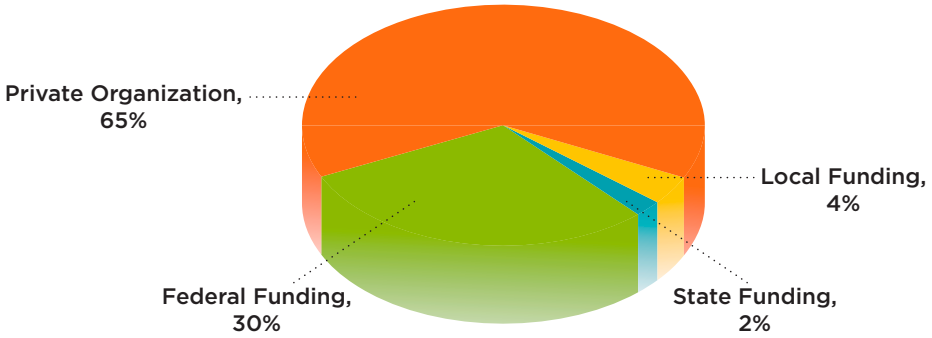


Table 35 groups the projects and programs into general categories. Almost half of the programs supported the provision of a specific health service or targeting a specific disease, such as STD prevention, tobacco cessation, domestic violence prevention, etc. Trainings of consortia members accounted for the second most-common programs supported, for example, case management training, emergency preparedness, etc.

Table 35: Type of Project Funded by the Major Grants Across Statewide Consortia in 2017

General program description	Percentage of programs	Percentage of consortia with at least one source
Support specific health service	48.1%	100.0%
Member trainings	24.1%	50.0%
Staff/capacity/ core funding	13.0%	75.0%
Policy/advocacy	11.1%	75.0%
Outreach to community	3.7%	50.0%

NOTE: PPAC/CPPEF did not report program descriptions so they are excluded from this table

STATEWIDE CONSORTIA MAJOR EXPENSES

Figure 26 displays the major expense categories in 2017 for all statewide consortia together. Compared to the proportions among the regional consortia as a whole, statewide consortia have more expenses in the contractor/consultant category and fewer expenses in the program-related expense category. The 'Other' category, which includes equipment, software/IT, travel, general office administration, human resources, etc. was also lower among the statewide consortia. Salaries and benefits were very close between statewide and regional consortia.

Figure 26: Average of Major Expense Categories in 2017 Among Statewide Consortia

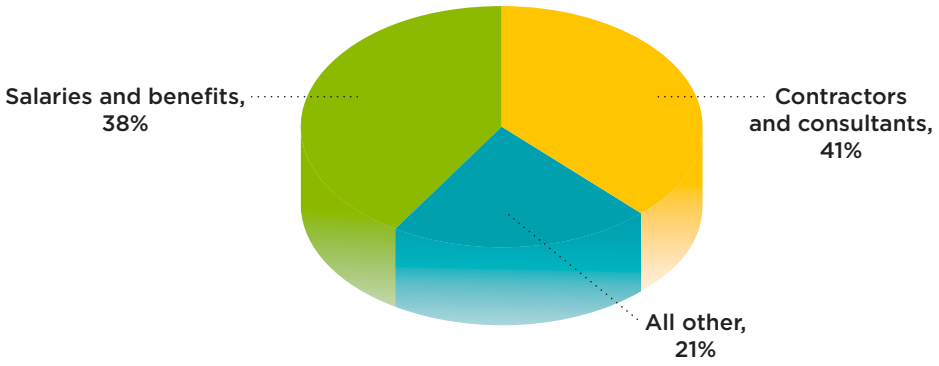
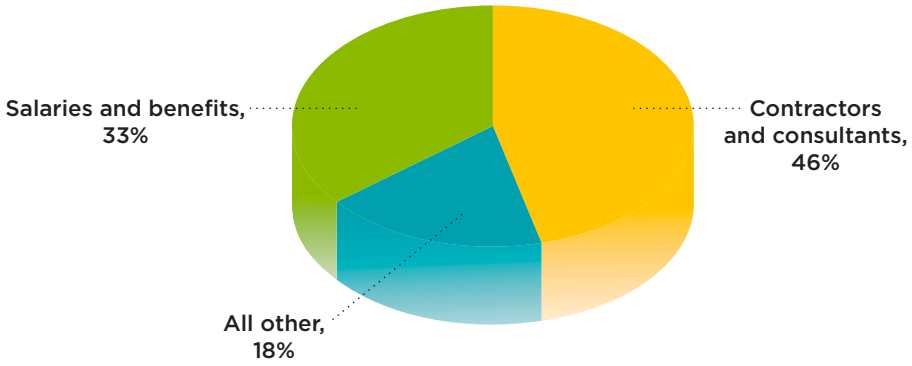


Figure 27 displays the major expense categories for 2013 among statewide consortia. Compared to 2017, the proportions in each category did not change very much (around 5% or less). The greatest change was for the contractor/consultant category, which was higher in 2013 (46%) than 2017 (41%).

Figure 27: Average of Major Expense Categories in 2017 Among Statewide Consortia



STATEWIDE CONSORTIA MAJOR PASS-THROUGH FUNDING

Four statewide consortia (all except CCUIH) reported pass-through funding in the data provided. In 2017, three-quarters of statewide consortia reported at least one private source of pass-through funding and half reported a federal source. A quarter of statewide consortia each reported at least one state or at least one local government source of pass-through funding.

A total of 18 pass-through funding programs were reported by the statewide consortia in 2017. Table 36 describes the source of funding for the individual programs. The most common source of pass-through funding was federal (44.4% of programs) with private sources a close second (38.9%).

Table 36: Source of Pass-Through Funding for Individual Projects Reported by the Statewide Consortia in 2017

Category of Funding for Statewide Consortia Pass-Through Programs	Percentage of programs
Federal government	44.4%
State government	11.1%
Local government	5.6%
Private organizations	38.9%

In summary, the majority of funds for the statewide and regional consortia come from grants, membership dues and contracts for services/fees for conferences. There is, however, significant diversity in the kinds of grants and degree of dependency and risk associated with the grants for each organization. For example, CRIHB and Essential Access are heavily dependent on pass-through federal funding but may assign different levels of risk to the likelihood that this source of funding will change. Regional consortia depend heavily on private foundation grants. Moreover, there is significant variation in the ability of individual consortium to further diversify grant funding. Some areas of the state, notably the north state, Central Valley and Inland Empire do not have the range of philanthropic resources available elsewhere. In the consortia with supporting entities, however, there is significant income generated for their operations that mitigate the risk of dependence on foundation grants.

STANDARD FINANCIAL INDICATORS: REGIONAL AND STATEWIDE CONSORTIA

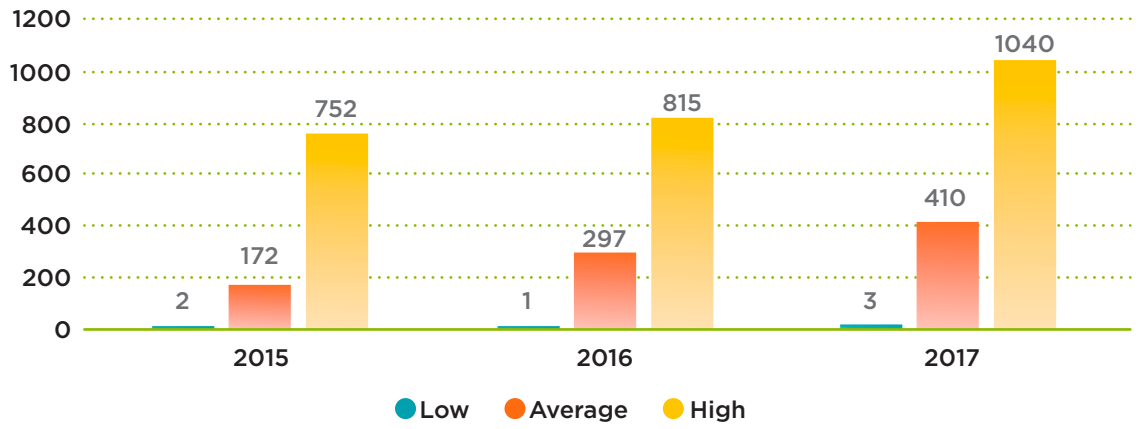
Both statewide and regional consortia performed well on the three key financial indicators of days cash on hand, current ratio and gross margin.

Days Cash on Hand. Days Cash on Hand is a financial quality measure that indicates the number of days an organization could cover its daily operating expenses in the event all new cash inflows were to cease.[7] To determine a reasonable standard or benchmark for regional or statewide consortia, each consortium would need to consider the time needed to generate and collect cash from funding sources. If funds are prepaid (often in grant funding), the consortium could have fewer days of cash at different time periods depending on when grant funds are received and expended. A good benchmark is 40 days cash on hand.

The charts below show statewide and regional performance as a result of financial results of audited financial statements and other data collected. The chart displays the low and high values across all regional and all statewide consortia (in respective charts) and also displays the average value.

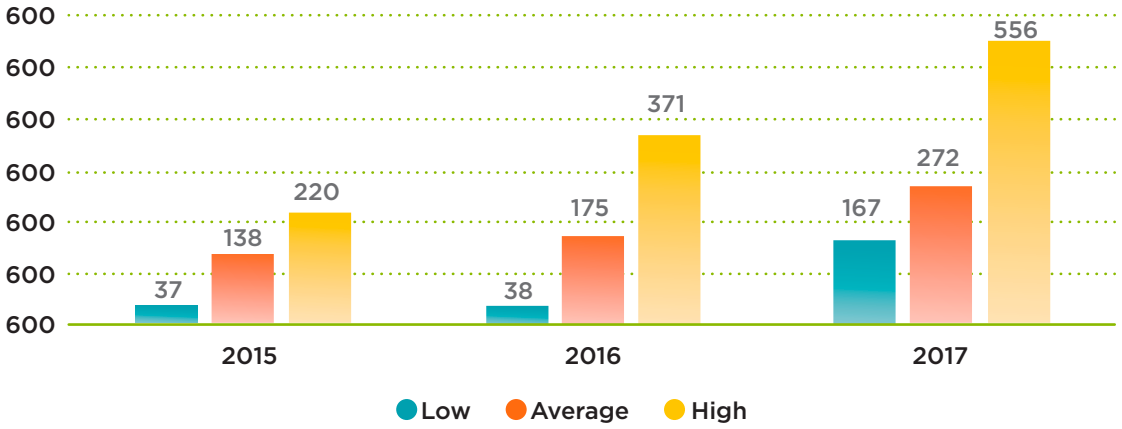
Figures 28 and 29 show that both statewide and regional consortia had high averages of Days Cash on Hand. One regional consortia did consistently report cash on hand below the benchmark. The statewide consortia had more cash on hand than the regional consortia and the average days cash on hand for 2017 is well above the benchmark.

Figure 28: Average and Range for Days Cash On Hand Among Regional Consortia 2015 to 2017



[7] Definition source: Capital Link, Hallmarks of High Performance (2016). The formula is Current Assets (i.e., cash, receivables, and other assets that could be converted to cash within one year) / Current Liabilities (due within one year)

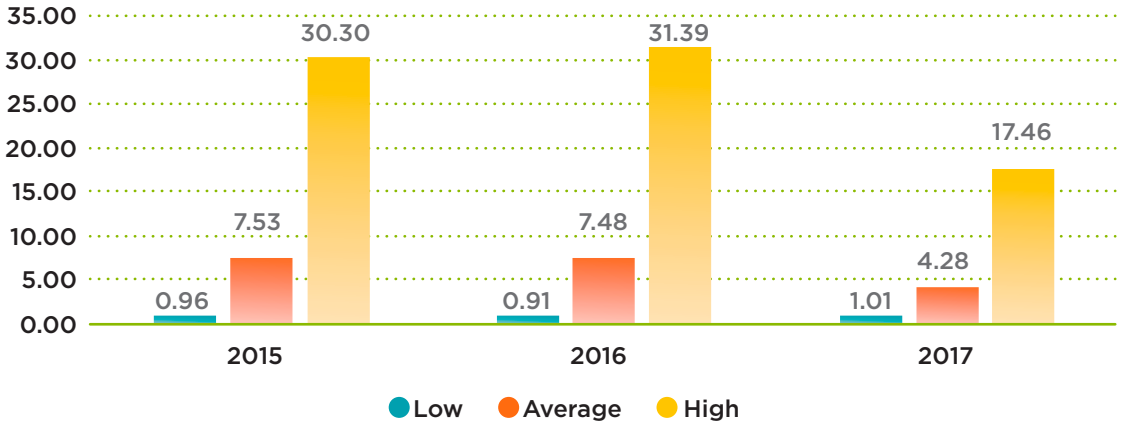
Figure 29: Average and Range for Days Cash On Hand Among Statewide Consortia 2015 to 2017



Current Ratio. Current ratio is a financial quality measure that measures an organization's ability to meet its current obligations with its current assets.[8]

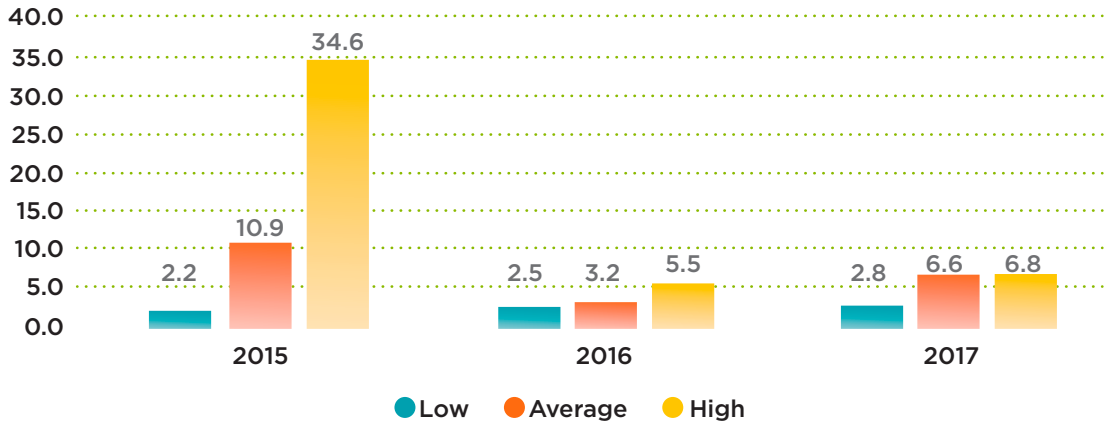
Figures 30 and 31 display details on the Current Ratio for statewide and regional consortia. Many statewide and regional consortia had current ratios higher than 2.0 which is a good current ratio benchmark. If a consortium has a high current ratio (anywhere above 1.0), they are capable of paying their short-term obligations. The higher the current ratio, the more financially strong the consortium. On the other hand, if any consortium's current ratio is below 1.0, it would suggest that the consortium probably has difficulty paying their short-term liabilities. Eleven of the thirteen regional consortia were consistently higher than the 1.0 and all consortia approach the benchmark for all years.

Figure 30: Average and Range for Current Ratio Among Regional Consortia 2015 to 2017



[8] Definition source: Capital Link, Hallmarks of High Performance (2016). The formula is Current Assets (i.e., cash, receivables, and other assets that could be converted to cash within one year) / Current Liabilities (due within one year)

Figure 31: Average and Range for Current Ratio Among Statewide Consortia 2015 to 2017



Gross Margin: The analysis used Gross Margin instead of a more standard ratio of operating margin. The operating margin is challenging to calculate for organizations without major sources of income beyond grants and membership dues. The calculations in the charts are, therefore, based on 'gross margin.' This is the total net income divided by the total revenue earned.

An organization with a positive gross margin is better prepared to withstand unusual or unforeseen expenses. An organization that operates on the margin with no excess income or below will have financial challenges, therefore some small positive gross margin over time is a practice. This can be difficult to achieve with grant funding sources although private foundations could allow a practice of budgeting reserves or other practices to achieve positive gross margin. A gross margin of 1.6% is a good ratio for these organizations given that the higher the percentage the stronger the ability to weather uncertain times.

Figures 32 and 33 show the Gross Margin for the statewide and regional consortia. This ratio for Gross Margin had the most variability within the statewide consortia, within the regional consortia and between the two types of consortia. A few of the consortia seem to struggle to add any margin to their retained earnings which makes them unable to make investments or do long term financial planning or recover from unforeseen events. In the regional consortia, there was a high of approximately 13.5% gross margin to a low of -25% gross margin. In the statewide consortia, the gross margin was a high of 10% to a low of -11%. The ratios for the consortia may be skewed somewhat due to different auditor's classification of temporary restricted assets. Note that sometimes the receipt of grant dollars may not occur in the same fiscal year that grant-related expenses are paid, so this can affect the gross margin of a particular year especially when the grant is large.

Figure 32: Average and Range for Gross Margin Among Regional Consortia 2015 to 2017

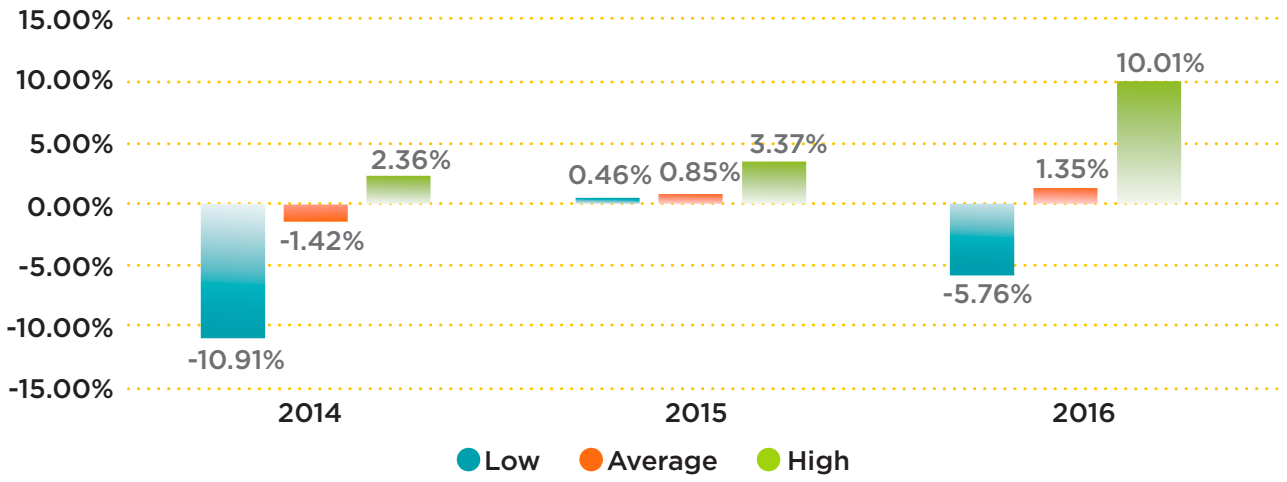
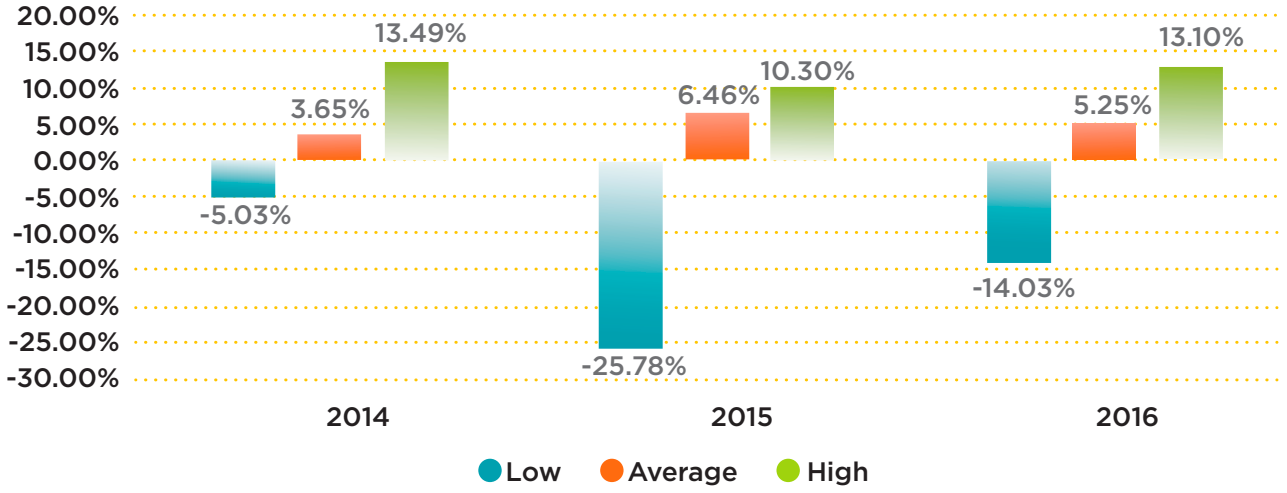


Figure 33: Average and Range for Gross Margin Among Statewide Consortia 2015 to 2017



SECTION 5:

California's Unique Environment Strategic Opportunities for Dialogue and Future Investment

This report documents many examples of how statewide and regional consortia work together and individually to advance access to health center services, ensure high-quality performance, and offer operational support to their members and communities. California's unique structure of aligned statewide and regional organizations offers a powerful policy and advocacy presence as well as a strong foundation for joint efforts to improve quality and services. The strategic opportunities for future investment described below are intended to stimulate discussions among consortia and funders to propel consortia — and their members — forward both collectively and individually.

The current federal environment has created a high level of uncertainty and a feeling of instability for community clinics and health centers (CCHCs), their consortia, and certainly for patients. Threats to federal funding, hostile immigration policy and enforcement, and repeated congressional attempts to repeal the Affordable Care Act (ACA) and undermine Medicaid require carefully tailored strategies, communication efforts, and strong and effective advocacy. A multi-layered and geographically diverse advocacy presence may help to diminish the potential impact of these significant threats.

California's Medi-Cal managed care environment has also offered both threats and opportunities for CCHCs, and consortia have responded in multiple ways. Because the Medi-Cal managed care system is organized by counties, CCHCs have long turned to statewide and regional consortia for education, legal support, advocacy, business strategy, quality improvement, clinical transformation and joint planning to succeed in an increasingly managed care environment. These efforts have resulted in increasing market share for CCHCs in managed care plans. CCHCs' success under managed care requires ongoing support and innovation, and will continue to drive consortia priorities for the foreseeable future. There are additional health system forces beyond the direct and individual purview of CCHCs, such as primary care workforce shortages, new value-based payment methodologies, and growing expectations for primary care providers to address social determinants of health. These trends carry huge implications for CCHCs and create difficult dynamics between their regulated world and the need for innovation and change. Statewide and regional consortia offer a forum for strategic discussion, provide quality and operational technical assistance, and advocate for the specialized needs of CCHCs.

As we look back to the early 2000s and compare them to the landscape today, a number of important trends emerge for California's community clinic consortia — both statewide and regional. This comparison is drawn primarily from a report authored by Claire Brindis, PhD, MPH, Annette Gardner, PhD, and other researchers at the University of California, San Francisco (UCSF) Institute for Health Policy Studies in 2004.[9]

Here are a few reflections on the changes and themes over the last two decades for clinic consortia in California:

[9] Claire Brindis, Annette Gardner, Sara Peterson, Mary Kreger, Nadine Chabrier, and Joe Funk, *Clinic Consortia Policy and Advocacy Evaluation: Creating a Legacy for Change. Clinic Consortia Policy and Advocacy Program Evaluation. Evaluator's Report: Year 1 Findings*. Institute for Health Policy Studies, University of California, San Francisco, January 2004.

Growing number of member clinics and clinic sites. From 574 clinics sites in 2004, there are now more than 1,300 clinic sites across California. There are more Federally Qualified Health Centers (FQHCs) and FQHC Look-Alike health centers compared to the early 2000s, in part because consortia supported their members in becoming FQHCs through a targeted objective of foundation funding in the early 2000s.

Higher degree of member activation. In 2004, 15 of 19 consortia described member participation in activities as "uneven." Today, consortia leaders describe near universal engagement from clinic members.

Stable core activities. Virtually all clinic consortia engaged in three core activities across 20 years: policy and advocacy, partnerships, and technical assistance to members. Access to care, workforce development, and outreach and enrollment are now central to consortia work, in great part due to the ACA. These focus areas are associated with shifts in the external business and policy environment at various levels and highlight how consortia stay relevant and support their member CCHCs by anticipating and responding to significant trends.

Stronger relationships with managed care plans. Relationships with health plans, particularly for Medi-Cal beneficiaries, are stronger now and continuing to expand as health centers' market share grows. Consortia — both statewide and regional — are more involved in managed care contracting arrangements, quality improvement, health information exchanges, and value-based care. Consortia with subsidiaries and additional entities that focus on managed care have stronger and more stable financial health than those which do not.

Overlapping membership. Then and now, a number of CCHCs belong to more than one consortium. This is due to CCHCs with sites in multiple counties becoming members of all relevant regional consortia and also maintaining membership in statewide consortia.

Major support from grant funding. The capacity of consortia in 2017 to convene and collaborate locally and statewide to support improved systems of care for vulnerable populations is significantly greater than it was in 2004. However, this capacity remains largely dependent on continued flexible grant support, or core funding, from public and private sources.

Increasing revenue from membership fees. The proportion of regional consortia receiving revenue from membership dues grew from 84% to 100% in the examined period.

Strengthened capacity and more diverse business operations. Since 2004, consortia have developed shared services and programmatic partnerships to bolster economies of scale and offer fee-based services. For example, the Community Clinic Association of Los Angeles County (CCALAC) offers 340B Program compliance training and technical support, as well as clinical dispensary staffing through a fee-for-service model for both clinic members and other consortia. The Southern California Regional Symposium is offered as a collaboration between three consortia (CCALAC, Health Center Partners of Southern California, and the Coalition of Orange County Community Health Centers) and serves as a model for other regions. Essential Access operates a consulting and training practice to support the integration of CCHC services and operations, such as family planning integration into primary care. Many regional consortia offer fee-based services to members that may benefit member CCHCs in adjacent consortia.

NATIONAL AND STATE AFFILIATIONS

The link between California's statewide and regional consortia and their national counterparts is more complex than in most states, especially for federally funded health centers and Indian

Health clinics. All states have Health Resources and Services Administration (HRSA)-recognized and -funded Primary Care Associations (PCAs) offering technical assistance; the California Primary Care Association (CPCA) is California's PCA. However, California is the only state with regional consortia[10] representing community clinics and health centers. California's regional consortia are not officially recognized or directly funded by HRSA, and regional consortia are not able to represent their HRSA-funded members with issues related to HRSA or Section 330 grants. Technical assistance on Section 330 grants is provided by 69% of regional consortia.

In addition to supporting PCAs, HRSA also funds networks of FQHCs through Health Center Controlled Networks (HCCNs). In California, HCCNs are often regional consortia that meet federal criteria and successfully compete for these highly competitive, multi-year grants. HCCNs can serve many types of safety-net providers, including FQHCs as well as other Section 330 programs and entities. To qualify for funding, however, a specific number of FQHCs must be participating in the applicant organization. The grants allow networks to provide support to their members' health centers in the adoption of technology solutions like medical and dental electronic health records (EHRs), practice management systems, data aggregation, analytics and reporting tools, Health Information Exchange (HIE) technology, and practice transformation activities, as well as managed care efforts. In California, five regional clinic consortia currently have HCCN grants from HRSA.

Beyond the advantageous funding relationship with HRSA, there are national-state affiliations that do not provide funding but do offer a useful forum for sharing policy and operational initiatives. CPCA is an active member of the National Association of Community Health Centers (NACHC), as are many of its members. Several regional consortia are also members of NACHC. Similarly, the Planned Parenthood Federation of America is the national organization of Planned Parenthood affiliates, and Planned Parenthood Affiliates of California (PPAC) is a longstanding and very active member. Essential Access is an active member of the National Family Planning and Reproductive Health Association.

The landscape for Indian Health national affiliations is less robust. The California Consortium for Urban Indian Health (CCUIH) is the country's only state-level Urban Indian Health consortium and operates without the benefit of any federal consortia or Indian Health Service (IHS) funding. California has the largest number of Urban Indian Health Programs (UIHPs) — 10 programs representing nearly one-third of the nation's 34 programs. CCUIH's clinic members receive IHS contract dollars but CCUIH does not. The National Council for Urban Indian Health (NCUIH) is the only other membership organization for UIHPs, and they receive a cooperative agreement from IHS to provide training, technical assistance, and other support to individual UIHPs nationwide. Historically, NCUIH has not offered any policy advocacy support at the state level. There is also an Urban Indian epidemiological center, the Urban Indian Health Institute, and it too receives its funding from IHS and has a national focus.

The California Rural Indian Health Board (CRIHB) is a founding member of the National Indian Health Board (NIHB) and serves as the area representative for California's tribal programs. NIHB focuses on national issues related to IHS and is made up of representatives from 12 area offices. NIHB receives federal funding. CRIHB is the only IHS organization that is a membership organization and contracting agency for two primary types of IHS funding. The first is pass-through funding directly to California's tribal health programs to provide direct health care services to their communities. The second is the Area Office Functions Contract, under which CRIHB provides a variety of training and technical assistance services to contracted members. In addition, CRIHB has other grants and contracts from state, federal, and private entities. Some only support member programs while others, such as the Tribal Epicenter and Dental Support Center, provide services to all tribal health programs in the state.

[10] HRSA funds multi-state regional consortia. In this document, regional consortia are those operating at county or multi-county levels within a single state.

Unique also to California is the creation of RAC — the Regional Associations of California — the collaborative backbone of all statewide and regional clinic consortia. RAC membership currently includes all 13 regional consortia and three statewide consortia — CPCA, CCUIH, and Essential Access — although all other statewide clinic consortia are eligible to join. PPAC and CRIHB do not currently participate, although PPAC did join RAC several years ago and terminated its participation for time and resource reasons.

This state-level coalition of statewide and regional consortia has been meeting and evolving since 1997. Essential Access serves as the fiscal sponsor for RAC. Members get value from the opportunity for regular meetings of state and regional organizations. They commented that RAC offers an important forum for shared project implementation, grant-seeking, decision-making, and alignment between CCHCs and consortia toward common goals. New consortium CEOs also receive a mentor, and RAC offers the ability to accelerate forming relationships and gaining an understanding of how other consortia operate across the state.

STRATEGIC OPPORTUNITIES

As the report documents, consortia have spread, grown, and responded to member needs over time — yet there is more to be done. The potential strategic opportunities presented here are offered as a starting place for additional exploration to spur even stronger and bolder strategic alliances on behalf of communities that continue to experience the greatest inequities. Key to the thinking about future investments is the question of how consortia can continue to support the culture of innovation among CCHCs in a rapidly and constantly changing environment.

These suggested opportunities would benefit from targeted funding and planning support to more fully examine their potential and risks. They are focused on the health care environment and the continued ability of statewide and regional consortia to provide value-added, beneficial services to their members.

1. **Policy, Advocacy, and Communication**: Policy and advocacy have long been the cornerstone of statewide and regional consortia efforts. With the implementation of the ACA, and given the current policy environment, efforts in advocacy and communications have reached new levels. The capacity to organize, develop effective advocacy communications, and respond to multiple pressing threats simultaneously is a direct result of the support and emphasis of statewide health funders over many years — and the need to expand these efforts will continue. At all levels of impact, local communities, regional collaborations, and statewide efforts have benefited from the statewide and regional consortia's important focus on policy. For example, Health Alliance of Northern California (HANC) and the North Coast Clinic Network (NCCN) collaborated to advocate for Partnership Health Plan's expansion into Northern California, a move that has benefited area residents and CCHCs alike. PPAC successfully advocated for increased reimbursement rates for abortion services and the Family Planning Access Care and Treatment Program. Sustained advocacy efforts since the 2016 presidential election are combatting threats to the survival of the ACA, changes to immigration enforcement, and the health center funding "cliff"[11] — all of which threaten progress to date in California.

   Communications go hand in hand with policy advocacy, and new initiatives have begun to increase the consortia's communications capacity. CPCA and the regional consortia worked together on a joint procurement effort for communications on behalf of all regional consortia, funded by The California Wellness Foundation. While there were challenges in this project, CPCA and the regional consortia reference it as a valuable opportunity to learn about jointly procuring services and developing common messaging. In a complementary project, Kaiser

[11] The Community Health Center Fund is the federal funding source for FQHCs created in 2010 and financed through discretionary funding passed by Congress for each fiscal year. It came close to depletion multiple times as congress enacted only short-term, continuing resolutions that threatened the viability of community health centers nationally.

Permanente Northern California Community Benefit provided in-house communications expertise to assist the Northern California regional consortia in Kaiser Permanente service areas in developing individual, consortium-specific infographics to depict the impact of CCHCs and individual consortia in the region. This offered an opportunity to develop coherent, effective, and targeted communications tools and strategies for many consortia. Attention to bolstering the image and message for each of the consortia in a coordinated way across the state will serve them well in the future.

Policy is the most-valued service that consortia offer to members at all levels and is a continued expectation by members and funders. However, it is the most vulnerable to change and has the most significant need for continued funding and support.

2. **Safety-Net Collaboration and Partnerships:** Safety-net collaboration within health care and across health and social service entities is a longstanding value of CCHCs. Consortia, both statewide and regional, have demonstrated effective leadership in bringing together CCHCs and other safety-net providers to work on common issues. In local communities, these efforts are initiated and often led by a regional consortium; in some counties efforts are led by the county health agency with strong participation from the local consortium. For example, consortia are at the forefront of coverage expansions to the remaining uninsured and efforts to integrate behavioral health and primary care. In addition, consortia are active partners in the implementation of Whole Person Care pilots in local communities. There is strong benefit to the relationships and targeted projects that result from these collaborations, and it seems clear the need for these efforts will only increase in the future. Therefore, widespread and continuing effort to lead and actively participate in safety-net collaboration should be a key activity for every consortium.

   Where these efforts do not exist, a key role for the statewide and regional consortia could be to initiate and facilitate the development or strengthening of collaborative partnerships between key safety-net players, county health services, county behavioral health, local managed care plans, and social services agencies supporting social determinants of health.

   There is more opportunity today than perhaps ever before for stronger alliances and joint efforts for both statewide and regional consortia — together and individually — on their many shared priorities and policy initiatives. In particular, statewide consortia can garner greater leverage through collaboration on policy efforts that impact all CCHCs, such as workforce development, timely access reporting, and managed care procurement. Stronger collaboration between the statewide clinic consortia and other safety-net organizations, such as the California Association of Public Hospitals and Health Systems (CAPH) and Local Health Plans of California (LHPC), continues to offer opportunity for greater impact by formalizing the many conversations and individual partnerships into a collaborative focused on the safety net at the state level. An example of this would be the recent in-depth planning that CPCA and CAPH have done on the Capitation Payment Preparedness (CP3) Program to design and implement an alternative payment methodology for a pilot project.

   While these types of efforts are happening throughout the state, a more deliberate and concerted effort could have tremendous benefits locally, regionally, and statewide, with potential impact on access to care in every community in the state.

3. **Social Determinants of Health:** From their inception, CCHCs and consortia have recognized the role of social determinants of health and inequity in health outcomes. As early advocates for community development, fair housing, social services, and harm-reduction philosophies, it is natural to witness consortia as central to the increasing attention and focus on population health outcomes and social determinants. This work is strengthened by consortia's capacity to collect and exchange meaningful data and engage partners in quality improvement efforts.

Consortia are supporting CCHC participation in initiatives such as Whole Person Care and Health Homes. In addition, consortia are leading collaboration within and across health and social service entities. They offer myriad lessons about to engage residents and address the root causes of poor health. Because CCHCs are well-positioned to collect social determinant data, CPCA and regional consortia are supporting the implementation of PRAPARE (Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences), a social determinant data tool, while other regional consortia are facilitating technology implementation to "close the loop" on clinical-community service referrals. Still others serve in leadership roles in California Accountable Communities for Health Initiative to test and sustain multi-sector health improvement strategies.

The willingness of hospitals, providers, and payers to engage in policy and systems change that addresses social determinants and inequity is growing. Both statewide and regional consortia are well-positioned to ensure these efforts embrace best practices and include upstream strategies to prevent disease by modifying the social determinants of health. However, support for their capacity to sustain relationships, participate actively in collaboratives, and conduct skillful advocacy is central to success.

4. **Value-Based Care, Including Clinical Quality and Managed Care:** The goal of increasing the value and quality of health care services is driving transformation for all health providers, and has profound implications for the way CCHCs operate and are paid. Access to care is a top strategy for all consortia and CCHCs. California's Medi-Cal managed care program operates through county-based or regional models; therefore, consortia are well-positioned to play a leadership role with local health plans on behalf of their members to build on past efforts and strengthen locally relevant services to the benefit of both members and consumers. Although many of the clinic consortia are already situated for these conversations, there is an opportunity to expand and deepen their efforts through additional staffing, information technology capacity, data-sharing activities, and new organizational entities. Only a small number of consortia employ or contract for a chief medical officer, quality improvement director, or have data analytics or health information technology arrangements.

   Regional consortia are particularly well-suited to quality improvement efforts as these require common data reporting and benefit from collaborative learning. Regional consortia have been leaders in developing data exchange infrastructure and data collection expertise while modeling transparency in data reporting to improve delivery of care — beginning with the RISE Initiative to improve clinical and operational performance, funded jointly by the California Health Care Foundation, the Blue Shield of California Foundation, and Kaiser Permanente Community Benefit Northern California and Southern California. Improved quality increasingly leads to increased financial strength and, importantly, better health for consumers. Although some regional consortia have longstanding histories of working on quality improvement and others have begun quality initiatives, support to sustain and deepen these efforts is more important than ever.

   Each regional consortium should consider a role for clinical leadership at the local consortium level — whether full-time, part-time, or shared with member CCHCs or other consortia. Perhaps there are opportunities for managed care plans to bring new funding to regional consortia to coordinate health information exchange, data analysis, quality improvement, and more. The exact role of regional consortia will vary from region to region and from county to county, but an expanded and recognized role could be a key ingredient in supporting member CCHCs and seeking a pathway to a more diverse financial portfolio. It will be important for regional consortia to clearly delineate how their role is different from local CCHCs and work carefully with their members to coordinate efforts with the health plans.

   Regional and state associations have an opportunity to learn from current health center and regional consortia independent practice association or management services organization

(IPA/MSO) activities and to think strategically about how to expand this capacity to all consortia that are ready and interested in participation. About one-third of the regional consortia offer years of managed care experience to build on and currently, statewide and regional consortia have partnered to develop an ambitious set of managed care priorities to focus on in the next few years. These priorities include: (1) new administration and leadership at the Department of Health Care Services (DHCS); (2) commercial plan procurement; (3) pay-for-performance (P4P), Healthcare Effectiveness Data and Information Set (HEDIS), and quality alignment; and (4) enrollment efficiency and default assignment. Future discussions could consider supporting these priorities as well as using these skills, expertise, knowledge, relationships, infrastructure, and history to build a stronger foundation for a broader statewide or regional effort aimed at supporting value-based care.

5. **Workforce Development Initiatives:** The health care workforce is a longstanding and increasing challenge for CCHCs. There are many forces at work in the environment that influence the ability of CCHCs to recruit and retain all levels of providers, and it has been a challenge to identify the most appropriate strategies for both consortia and CCHCs to use in this area. CCHCs report that workforce is one of their biggest ongoing challenges. Both statewide (65%) and regional (67%) consortia report varied activity on workforce development; eight regional consortia operate Area Health Education Centers (AHECs). Given the difficulty CCHCs experience in recruiting, training, and retaining staff, a series of strategic dialogues between member CCHCs and regional consortia, as well as across statewide and regional consortia, could align and perhaps expand efforts at the state and local policy levels. These discussions could focus on the work that CPCA has already accomplished to organize statewide workforce discussions with a broad array of stakeholders, as well as highlight the success regional consortia have had in this area — for example, the negotiation of physician recruitment contracts with three national firms at a significant discount by Council Connections (a supporting organization of Health Center Partners of Southern California). Statewide and regional consortia are continuing to convene members and strategize and advocate at all levels for systemic solutions. Ongoing effort and the support of funders for targeted solutions within CCHCs as well as the broad policy environment are critical for the future.

CONCLUDING COMMENTS

California's statewide and regional clinic consortia have made important contributions to the success of CCHCs over the last 20 years. Consortia have grown and expanded; they have adjusted services and priorities, have and shepherded CCHCs through a turbulent era. They have supported CCHCs as they expanded to meet the increasing demand for primary care, behavioral health, and oral health across the state. The opportunity of coverage expansion through the ACA in both Medi-Cal and Covered California is a success story for CCHCs and their patients that relied heavily on the strength of consortia. These consortia have responded to the opportunity of coverage expansion and the requirements of managed care with local- and state-level policy, communications, enrollment activities, and innovations to address member needs in ways that have advanced the system of CCHCs. The capacity and strong commitment to improved quality, data analysis, and social determinants of health are hallmarks of more recent consortia activity that will continue to transform CCHCs in the future.

APPENDICES

- Appendix A – List of All Consortia, CEOs, Logos, and Websites
- Appendix B – List of Tables and Figures
- Appendix C - Previous Reports and Studies on Clinic Consortia
- Appendix D – Detailed Approach and Methodology
- Appendix E – Advance Data Collection Tool
- Appendix F – On-Site Interview Protocol
- Appendix G – Data Confidentiality and Sharing Agreement

APPENDIX A: LIST OF ALL CONSORTIA, CEOS, LOGOS, AND WEBSITES

REGIONAL CONSORTIA

Alameda Health Consortium and Community Health Center Network (AHC & CHCN)
Executive Director: Ralph Silber
https://www.alamedahealthconsortium.org/
https://chcnetwork.org/

Community Clinic Association of Los Angeles County (CCALAC)
President and Chief Executive Officer:
Louise McCarthy
https://ccalac.org/

Community Clinic Consortium (CCC)
Executive Director: Alvaro Fuentes
http://clinicconsortium.org/

Community Health Association Inland Southern Region (CHAISR)
President and Chief Executive Officer:
Deanna Stover
http://chaisr.org/

Capitol Health Network (CHN)
Executive Director: Steve Heath
https://capitolhealthnetwork.org/

Community Health Partnership (CHP)
Chief Executive Officer: Dolores Alvarado
http://www.chpscc.org

Coalition of Orange County Community Clinics (COCCC)
Chief Executive Officer: Isabel Becerra
http://www.coccc.org/

Central Valley Health Network (CVHN)
Interim Chief Executive Officer: Jason Vega
http://cvhnclinics.org/

Health Alliance of Northern California (HANC)
Executive Director: Doreen Bradshaw
http://thehanc.org/

Health Center Partners of Southern California and Health Quality Partners (HCP & HQP)
President and Chief Executive Officer: Henry Tuttle
http://hcpsocal.org/
https://www.hqp.org

North Coast Clinics Network (NCCN)
Executive Director: Tim Rine
http://www.northcoastclinics.org/

Redwood Community Health Coalition and Redwood Community Health Network (RCHC & RCHN)
Chief Executive Officer: Suzie Shupe
https://www.rchc.net/

San Francisco Community Clinic Consortium (SFCCC)
President and Chief Executive Officer: Sabra Matovsky
https://www.sfccc.org

STATEWIDE CONSORTIA

California Consortium for Urban Indian Health (CCUIH)
Executive Director: Jyl Marden
http://ccuih.org/

California Primary Care Association (CPCA) and CaliforniaHealth+ Advocates
President and Chief Executive Officer: Carmela Castellano-Garcia
https://www.cpca.org/cpca/
https://www.healthplusadvocates.org/

California Rural Indian Health Board (CRIHB)
Executive Director: Mark LeBeau
https://crihb.org

Essential Access Health (EAH)
President and Chief Executive Officer: Julie Rabinovitz
https://www.essentialaccess.org/

Planned Parenthood Affiliates of California and California Planned Parenthood Education Fund (PPAC & CPPEF)

Chief Executive Officer: Crystal Strait

http://www.ppactionca.org/

http://www.cppef.org/

APPENDIX B – LIST OF TABLES AND FIGURES

TABLES

FIGURES

APPENDIX C - PREVIOUS REPORTS AND STUDIES ON CLINIC CONSORTIA

Since the mid-1990s, a number of reports and studies have been conducted by consortia themselves and by the consortia's funders to explore different aspects of the consortia's work, accomplishments and potential future. Those reports and studies are reviewed and summarized below to give the reader a glimpse of how other efforts have addressed similar issues to this project.

1. **Cooperative Business Development Opportunities, Final Report and Recommendations. Report to Alameda Health Consortium, 1996. Bobbie Wunsch and Jennie Schacht.** This report identified cooperative business development efforts that could benefit the Alameda Health Consortium member clinics in the transition to managed care. The study identified a range of opportunities and recommended several phased strategies based on feasibility, cost savings, efficiency, quality, risk, benefit and long-term viability. These criteria were used to evaluate options and make recommendations which ranged from shared standards and services to vertical integration and a full MSO. Other recommendations included pharmacy services, group insurance, shared staff, shared protocols and procedures, and common/linked IS and patient referral systems. Many options and a suggested structure for decision-making were included for the consortium and its member clinics/Board.

2. **Clinic Consortia Policy and Advocacy Program Evaluation, 2001-2003. Annette Gardner, Claire Brindis, Sara Geierstanger, Coline McConnel, Nadine Chabrier, Eunice Stephens, Melissa Martin-Mollard and Joe Funk. Institute for Health Policy Studies, UCSF, 2005. Sponsored by The California Endowment.** The California Endowment provided multi-year funding for fifteen regional consortia and four statewide consortia to strengthen their role and capacity in order to support the management, leadership development, policy and systems integration needs of community clinics. In 2001, nearly $10 million in funding was awarded and in 2004, $8.8 million of funding supported specific activities related to policy advocacy, technical assistance, media advocacy and shared services. From 2001-2003, This multi-year, multi-site evaluation found that grantees made considerable progress, accomplishing 89% of their short-term project outcomes. Specifically, grantees:

    - increased policymaker awareness and support for clinic policy issues;
    - influenced the media agenda and increased the likelihood of securing coverage of key issues, such as the role of clinics in supporting the health care safety net, through front-page coverage in local and major daily newspapers;
    - increased public awareness of key clinic policy issues;
    - increased financial stability for clinics by leveraging significant grant funding;
    - secured many state and local policy "wins;"
    - became more indispensable to member clinics in several ways;
    - created new partnerships; and
    - strengthened clinic operations.

3. **Securing the Safety Net: A Profile of Community Health Clinic and Health Center Leadership in California. Jeanne Peters, Catalina Ruiz-Healy and Kara Vassily, Compass Point Nonprofit Services, October 2003. Funded by The California Wellness Foundation.** Based on concern about large-scale pending clinic CEO retirement, CompassPoint

conducted a web-based survey for CEOs of California clinics and clinic consortia, as well as two focus groups and interviews. 97 surveys were completed, including 15 consortia CEOs. The survey found that consortia CEOs were similar demographically to clinic CEOs although slightly younger – 83% women, 78% white, and 61% in their 50s at the time of survey. 61% had a Master's degree and the average consortium CEO salary was $99,311. Consortia CEOs are experienced in the field, mission-driven, and report high job satisfaction but are just as stressed as clinic CEOs with a primary stress being their Boards of Directors. Among the issues raised: competition among board members, lack of engagement by board members, the potential for power struggle between consortia CEOs and board members, and the mixture of small and large clinics, which can lead to conflict over priorities and perceptions of disrespect. Consortia CEOs identified communication, vision, leadership and political savvy as helping them succeed in their roles. The report concludes with a recommendation that consortia build awareness among members about the emerging field of executive leadership services and promote the value of intentional executive transition planning. It also suggests that consortia consider board and organizational structure changes to mitigate competition and conflict among members.

4. **Shared Services Assessment and Analysis for the Redwood Community Health Coalition. Memo to RCHC Leadership, Pacific Health Consulting Group, 2005.** This memo explored creation of a shared CFO position across the Coalition's member clinics, recommended a job description and duties, as well as the costs and benefits of this arrangement. The logic was that this position could provide more sophisticated financial planning and analysis than the member clinics were capable of during a time of ongoing growth and change. The shared CFO would be accountable to CEOs at each member clinic and the author recommended creating a Limited Liability Corporation with shared costs across member clinics. The goal was to make improvements in the fiscal management and control of the clinics and provide a foundation for future collaborative strategies by standardizing certain functions within the group as feasible. The memo predicted that the plan would reduce administrative costs to 21% of total cost for the collective group by year three of the plan resulting in $1 million in administrative costs averted by 2009.

5. **California's Safety-Net Clinics: A Primer. Elizabeth C. Saviano and Margie Powers, California Health Care Foundation, November 2005.** This guide includes a chapter on clinic associations and consortia, which provide technical assistance, policy information, training, and advocacy, and sometimes act as funding conduits for safety-net clinics. According to the primer, the Bureau of Primary Health Care funds state and regional primary care associations. In addition, the BPHC funds clinic consortia through the HCAP program. "Regional consortia—which support the collaboration between clinics and health centers, or between clinics and other types of healthcare providers, located in the same geographic area—play a critical role in safety-net operations in California. While these consortia vary in size, history, and sophistication, they all serve as a foundation of support and assistance for their member clinics and health centers. The associations and consortia are not direct service providers but do offer a high level of support and expertise in such areas as information technology, quality improvement, data collection, and public policy advocacy. Coalitions may also provide economies of scale for negotiating shared purchase agreements or obtaining grant funding." It then provides contact information for California's regional and statewide clinic consortia.

6. **The California Endowment Clinic Consortia Policy and Advocacy Program Issue Brief: Media Advocacy. The Institute for Health Policy Studies, UCSF, July 2006.** The nineteen clinic consortia funded by The California Endowment increased their ability to raise awareness and frame the debate about the needs of clinics and clinic patients. Using different media advocacy venues, including newspaper, TV, radio, video, brochures, newsletters, and websites, grantees have made progress in increasing policymaker and public awareness. For example, many policymakers and community leaders interviewed

recalled consortia media activities and used this information to educate others. Media representatives and consultants also indicated public awareness had increased as a result of long-term, consistent efforts on the part of consortia. This study finds that clinic consortia developed their own media advocacy approaches and positioned themselves as credible voices, increasing awareness of issues important to the health of their communities.

7. **Building Capacity & Improving Care: The Impact of the Kaiser Permanente Community Clinic Partnership. Kim Ammann Howard, Kris Helé, Tom David, Ellen Irie and Regina Sheridan, BTW Consultants Inc., October 2007.** The Kaiser Permanente Community Clinic Partnership was a collaboration of Kaiser, community clinics and clinic consortia (called "networks" in this publication) in California. It was initiated in the 1990s during a time of increasing uninsured and health disparities in California, and also in response to SB 697's expectations of hospitals with respect to community benefits. The Partnership was officially codified in 2003 to strengthen the capacity of community clinics and clinic consortia to operate efficiently, enhance quality of care and improve access to care by supporting effective management infrastructure and systems; enhance access to care for patients through collaboration; and support the development of effective community-based systems of chronic disease management and prevention. The Partnership did fund several regional and statewide consortia, as well as the "Urban Coalition of California," which worked with clinic networks and CPCA on the behalf of community clinics. Between 2002 and 2005 Kaiser Permanente (KP) provided $24.6 million in grant funding to over 80 community clinics and 9 clinic networks. It also offered grantees a wealth of health care expertise and resources related to clinical care, facilities, equipment, technology, and organizational capacity. This evaluation found that from 2002-2005, the Partnership resulted in:

   - advances in clinical care;
   - improved operational capacity;
   - enhanced connections and collaborations;
   - increased access to and quality of clinical care;
   - enhanced infrastructure, core operational practices and financial stability among clinics, clinic consortia and Regional Associations of California (RAC);
   - knowledge sharing, cross-learning and peer support;
   - stronger clinician leaders;
   - more effective advocacy for clinics, their patients and communities; and
   - increased visibility and credibility of the community clinics field.

   Several of the consortia spearheaded chronic disease collaboratives in conjunction with the Partnership and on behalf of their member clinics. The Partnership helped enhance quality improvement activities and infrastructure, especially technology-enabled quality improvement (e.g. registries). In another example, the Partnership sponsored a consortium in Orange County to study and expand specialty care services for the county's uninsured population (ultimately modeled after Operation Access). Beyond serving patient needs, this process and new program helped increase the visibility of the consortium. In another example, the Partnership supported a new Medical Director position for a regional clinic consortium – a position that ultimately became invaluable and very strategic to both the consortium and its member clinics. Since that time, many other consortia have hired Medical Directors. Finally, KP's support of the RAC contributed to the development of

a statewide affiliation of clinic networks that represents and advocates for the needs of community clinics throughout California. KP's funds supported the technical and logistical aspects of the RAC's work. This forum allowed RAC members, who are the directors of clinic networks and state associations, to meet regularly to share successful programs and practices as well as strategize around challenges they face individually and collectively.

8. **Strategic Restructuring for Community Clinics: Options and Examples. California Health Care Foundation, 2009.** This issue brief explored clinics' and consortia's experiences with various partnerships, including administrative consolidation and merger, and examined what opportunities strategic restructuring might offer community clinics seeking to strengthen their positions during a time of economic downturn. Most of the existing experience is around information collaboration, and consortia have helped strengthen clinic capacity by creating pooled resources such as shared IT and EHR management. The brief describes non-merger collaborations in and outside California, including those supported by HRSA's Health Center Controlled Networks Initiative. Services provided include disease and quality management, managed care contracting, IT support, shared staff and project management. One consortium has expanded into a full-service managed care service organization. The brief suggests that clinic consortia – which have often facilitated such restructuring in California – play an important role in modeling collaborative and partnership opportunities and providing technical support to member clinics. One way funders and others could help engage clinics in strategic restructuring would be to provide funding and training to consortia so that they can support and mobilize this process with their membership and Board members.

9. **Community Clinic Case Studies. LFA Group, 2011.** The Blue Shield of California Foundation commissioned several surveys and in-depth interviews with clinic grantees to explore the impact of its core support funds on community clinics. Findings related to clinic consortia include:

    - Three types of clinic capacity – collaboration, financial health, and professional development – contribute importantly to the accessibility and quality of care that clinics provide. Clinic consortia can help most in the areas of collaboration and professional development;
    - High-performing clinic consortia provide clinic members with HIT training, technical assistance, and resources that support access and quality;
    - Consortia can help provide professional development activities that clinics cannot provide themselves, researching and providing trainings that will create the most value for their members;
    - Clinic consortia play an important role in facilitating collaborations as a partner and a facilitator;
    - Clinics say that the most important consortia functions are coordinating training and networking opportunities, sharing grant funds with clinics, and conducting advocacy work;
    - Clinic consortia convene gatherings that help share skills and best practices within functional peer groups. They offer technical services such as video conferencing;
    - Clinics that do *not* have access to consortium participation for whatever reason (e.g., membership fees, consortium capacity) were often unhappy about this; and
    - One concern is that consortia activities may be inconsistent as they follow targeted grant projects.

The report concludes that clinics that are members of high-functioning, active consortia will be better poised to thrive in a post-healthcare reform environment. It also recommends that clinic consortia continue to provide services that demonstrate the value of consortia membership; consider expanding membership; and consider consolidating operations. As regional and statewide consortia expand, smaller consortia struggle to provide the depth and scope of services clinics need. Instead, it poses the question of whether new consortia are sustainable, and whether high-functioning consortia should instead expand to provide their services to expanded regions. The field should also consider whether consortia should specialize in areas of expertise and technical assistance support in order to refine their service offerings and maximize efficiencies.

10. **Blue Shield of California Foundation (BSCF) Community Health Center Consortia Grantmaking 2011-2013.** BSCF has invested over $6.5 million in community health center consortia and statewide associations to drive performance improvement and prepare community health centers (CHC) for success in a transformed health care environment. In 2009 the foundation shifted its grantmaking from general operations for all consortia to project-specific grants aligned with the foundation's strategies to help members prepare for health reform. Grants were used for: building financial capacity; local health reform; coordination and integration; improving the patient experience; data analytics and using data for performance improvement (e.g., standardization and dashboards). This funding has resulted in much more consistent reporting of clinical and operational measures; greater sharing and collaboration across health centers; and the adoption of analytic tools like PopIQ, with capacity developed at both the health center and consortium level. The foundation reflects, in this report, that capacity building for data and analytics is a long-term effort and that it was premature in some of its efforts to support data analytics, financial and patient experience measures. Its efforts supported benchmarking and health plan pay-for-performance participation. The foundation acknowledged that capacity building projects take longer than one year and that much work remains to be prepared for payment reform.

11. **Clinic Consortia Activities and Services Survey Findings. Power Point presentation, 2013. Regional Associations of California.** Reviews ten single-county, five multi-county and three statewide consortia located across California. The most common activities were found to be advocacy, monitoring and advocating around patient centered medical homes, and educating and training on quality improvement, operations and clinical practice. The review found that consortia are planning to implement the following new strategies: ACO discussions; MSO operations; operate an IPA/negotiate managed care contracts, facilitate peer networks for enrollment.

12. **Internal Memo on Regional Associations of California: "Deep Dive Survey of Consortia Activities," from Clinic Consortia Survey Work Group to RAC Directors based on survey conducted by Melanie Ridley at Ridley Consulting, January 2015.** This survey focused on activities designed to support health center transformation through operational efficiencies and reorganization. The areas with the most consortia activity: workforce development, health center operations, health center data and quality improvement, patient care transformation (PCHH) and financial health. The main ways consortia provide support is through training and technical assistance, with a smaller number of consortia offering business services. In the areas of Health Information Technology, only a very small number of consortia actually own analytic, exchange or other functions.

13. **The Network Resource Guide. National Association of Community Health Centers, 2015.** This guide provides information about 50 health center networks (including consortia) and presents an overview of the work currently being conducted by networks in the field. The majority of these are independent non-profits funded in part by the federal Department

of Health and Human Services through BPHC/HRSA grants and with a smattering of other funding. Many are less than 5 years old, and they represent a wide range of 330 funded programs, from only 3 organizations to as many as 729 clinic locations! Networks provide a wide range of support services for EHR, EDR and EPM platforms, with many different applications represented. Many networks are also involved in data analytics, performance reporting, practice transformation, quality improvement and/or Health Information Exchange. In general, many fewer networks are involved with managed care activities such as negotiating with payers or utilization review. A minority of networks provide administrative support for areas like accounting, HR or group purchasing.

APPENDIX D – APPROACH AND METHODOLOGY

Step One

The project was kicked off in September 2017 in a special meeting hosted by the four funding partners with all of the statewide and regional clinic consortia. The meeting was part of a previously scheduled meeting of the Regional Associations of California – a collaborative of all regional clinic consortia plus the California Primary Care Association, Essential Access Health and California Consortium for Urban Indian Health. The other statewide consortia who do not participate with RAC – Planned Parenthood Affiliates of California and California Rural Indian Health Board – were invited and attended. The funders and Pacific Health Consulting Group consulted with the Chair of the RAC to develop the agenda. Led by the funders, the kick-off meeting introduced the project to the consortia to establish a tone of transparency.

Step Two

As a result of the special meeting, a project advisory group was created, representing both the statewide and regional consortia, to provide guidance on key issues to the funders and consultants related to the project and to review the draft project report before it is released to all of the consortia.

Step Three

The Project Advisory Group, made up of 6 consortia representatives (Carmela Castellano-Garcia, CEO, California Primary Care Association (CPCA); Henry Tuttle, Chair, Regional Associations of California (RAC); Suzie Shupe, Former Chair, RAC; Doreen Bradshaw, CEO, Health Alliance of Northern California (HANC); Deanna Stover, CEO, Community Health Association Inland Southern Region (CHAISR); Louise McCarthy, CEO, Community Clinic Association of Los Angeles County (CCLAC); Isabel Becerra, CEO, Coalition of Orange County munity Clinics (COCCC) met 3 times during the course of the project to:

- review and provide feedback on the data collection tools and site visit protocol;
- discuss confidentiality agreement for data collected; and
- provide early feedback on the draft report of the project.

Step Four

To initiate the data collection process, the project consultants created a Timeline, an Advance Data Collection Tool and an On-Site Interview Protocol that was shared for comment with the Advisory Group and then sent out to all statewide and regional consortia. The Advance Data Collection Tool and the On-Site Interview Protocol are included in the Appendices. The key questions addressed by the project's data collection and interviews focused on membership; services and member supports; consortia financing over time; current and potential roles; and additional opportunities for advocacy, promoting access to care, improving quality of care and/or enhancing the operational efficiency of member health centers. Barriers to expanding services, opportunities for external support to enhance the range or intensity of services, and opportunities to improve the operational structure and/or membership structure were explored in on-site discussions with consortia CEOs and senior staff.

Step Five

The Advisory Group and several other consortia leaders raised issues that had not been considered previously about the confidentiality of data collected. As a result of numerous conversations all consortia participated in a November 2017 call to review a set of data confidentiality provisions and principles (listed below). It was agreed by the consortia that the

consultants would employ these provisions and principles throughout the project. A commitment was made that any data included in the report that identified an individual consortium would be sent to the affected consortium in advance for their review and approval. The memo codifying this agreement is included in the appendices.

Data Confidentiality Provisions and Principles:

- Data is being collected from the clinic consortia project in several ways – through written requests for advance data, collection of publicly available data, review of previous reports about consortia and through on-site interviews with consortia CEOs and senior staff.
- Pacific Health Consulting Group has the sole responsibility with the clinic consortia for ensuring that the quality and integrity of the data are preserved and respect for the data source is maintained by ensuring privacy where appropriate and providing appropriate citations for the data. There will be a final report developed for project funders and possibly a shorter issue brief or executive summary that will be distributed more widely (potentially to other funders and others identified by consortia and/or funders at a later date in the project). The Clinic Consortia Project Advisory Group (made up of representatives of the statewide and regional clinic consortia) will review and comment on the draft final report. Any data elements in the draft final report that identify a specific, individual consortium will be reviewed and approved by the CEO of the referenced consortium in advance of sharing any version of the draft report with the project funders.
- Individual and aggregated data about consortia in regional or other sub-groups may be included in the final report. Much of this data will be provided to Pacific Health Consulting Group directly by the individual consortia through data requests and conversations. Individual data that may be used in the report would include but not be limited to items like number of members, dues structure, strategic initiatives, annual budget and revenues, number of FTE staff, etc. Publicly available information about an individual consortium may be included in the final report. Sources for any data will be identified in the report.
- No proprietary business or confidential information about an individual consortium will be shared in the report. It is the individual consortia's responsibility to notify Pacific Health Consulting Group of any conversations or data provided that are confidential or proprietary and should not be cited or included in the final report or other materials provided to the project funders.
- A short two-page report about the technical assistance provided to individual consortia will be shared with the project funders for each consortium that receives technical assistance funded by this project.
- The draft final report will be reviewed in conjunction with the Statewide and Regional Consortia during the Regional Associations of California (RAC) regular May meeting scheduled for May 10, 2018. Non-RAC member consortia involved in this project (Planned Parenthood Affiliates of California and California Rural Indian Health Board) will be invited to participate in this meeting. Prior to that meeting, the project Advisory Group will review and provide feedback on the draft final report.

Step Six

Regular updates about the project were developed and circulated to all the statewide and regional consortia and the funders in advance of each regularly scheduled RAC meeting. Each RAC meeting agenda included time for discussion and feedback about the project to the consultants.

Step Seven

After advance data was received from each consortium, an on-site visit was conducted according to the Site Visit Interview Protocol. The consortia were all extremely cooperative and flexible in the scheduling of site visits. The first 90 minutes of the site visit were conducted with the consortium CEO alone and the final 2.5-hour session on-site was conducted with the senior staff. In most cases the CEO stayed and participated in the senior staff session. The schedule of site visits is listed below.

- December 4, 2017: Health Center Partners
- December 11, 2017: Orange County Coalition of Community Clinics
- December 12, 2017: Community Clinic Association of Los Angeles County
- December 13, 2017: Community Health Association Inland Southern Region
- December 14, 2017: Essential Access Health
- December 18, 2017: Community Health Partnership
- December 18, 2017: Redwood Community Health Coalition
- December 19, 2017: Alameda Health Consortium
- December 19, 2017: Contra Costa-Solano Community Clinic Consortium
- December 20, 2017: San Francisco Community Clinic Consortium
- December 20, 2017: California Consortium for Urban Indian Health
- January 8, 2018: California Primary Care Association
- January 8, 2018: Capitol Health Network
- January 9, 2018: California Rural Indian Health Board
- January 9, 2018: North Coast Clinics Network (via video)
- January 10, 2018: Central Valley Health Network
- January 10, 2018: Planned Parenthood Affiliates of California
- January 12, 2018: Health Alliance of Northern California.

Step Eight

From mid-January, 2018 through March 31, 2018, consultants conducted the data analysis. Consultants often reached out to clarify questions about the data or request additional information. The consortia were very helpful by quickly providing the data requested.

Step Nine

During the week of April 8, 2018, individual data were circulated to each consortium that would be used in the draft report. Each consortium was asked to verify the accuracy of the data distributed and provide confirmation that the data could be used in the report based on the confidentiality principles described above.

Step Ten

The draft project report was distributed the week of April 14, 2018 to the Advisory Group for their review in advance of the April 18 meeting to provide preliminary feedback on the draft report.

Step Eleven

The draft review was revised and then circulated to all statewide and regional clinic consortium the week of May 4, 2018 in advance of a meeting held May 10, 2018 to solicit feedback from all the consortia on the project draft report.

Step Twelve

The draft report was revised based on feedback and presented to the funders for their review. Prior to this time, the funders had not seen the previous drafts or any of the collected data based on the agreements in the data principles.

Step Thirteen

Technical assistance was provided to 12 regional consortia and all five statewide consortia for up to $2,000 each, based on the individual consortium's identification of need and selection of consultant(s). The project distributed payment to consultants after a short report was provided. The reports from the technical assistance efforts form an addendum to this report.

Step Fourteen

Once the report is reviewed by the consortia and funders, a decision will be made about the value of developing a short, easy-to-read public version for wider distribution to other funders, policy makers and others interested in the work of the consortia.

Step Fifteen

On-going calls were held with the project funders to keep them updated on the progress of the project.

Step Sixteen

Project funders will meet with consortia to discuss findings and implications.

APPENDIX E – ADVANCE DATA COLLECTION TOOL

REGIONAL CLINIC CONSORTIA PROJECT ADVANCE DATA TOOL
November 2017

If the consortium operates multiple entities or organizations, complete the survey for each company.[12]

1. Name of Consortium _____
2. Address and telephone of Consortium administrative offices _____

   _____
3. Date the organization began _____
4. Geography Served (list all counties served) _____

   _____
5. Total FTE staff in the organization

   _____
6. Executive Director Tenure (how long has the Executive Director/CEO been in his/her position)

   _____

[12] For example, fill out individual survey tools for Alameda Health Consortium and Community Health Center Network; Redwood Community Health Coalition, Redwood Community Health Network and Redwood Community Care Organization ACO; Health Center Partners, Health Quality Partners, Integrated Health Partners and CNECT.

7. CONSORTIUM STAFF

Position title and role: if your Consortium has more than 10 staff members, list only the management team, senior staff, program directors and department heads. Include any external contractors that function as staff. Include vacant positions. Feel free to provide an existing list if available.		
Name	**Title**	**Years of Service**

8. OUTSOURCED FUNCTIONS OR SERVICES

List any outsourced functions or core services, such as human resources, IT or data analytics.		
Contractor	**Function or Service Provided**	**Hours included in Contract If contract is not hourly, please estimate how many hours of service are used per month**

9. MARK ALL MEMBER TYPES INCLUDED IN THE CONSORTIUM.

__Full members, dues paying

__Full members, no dues required

__Affiliate members, dues paying

__ Affiliate members, no dues required

__Other membership category (specify how you refer to this group, e.g. Associate), dues paying

__Other membership category (specify how you refer to this group), no dues required

__Not applicable; No members

10. MEMBER DATA: Complete the chart columns for each member organization for the consortium and for each business entity.

Organization Name	Number of Licensed Clinic sites in the consortia geography	Type of Member and Years of Membership (use the member type in Q9)	Member Designation e.g. county, hospital, FQHC, licensed community clinic	HRSA Grantee List Grantee Category e.g. homeless, migrant	Number of Unduplicated Patients in 2016 (OSHPD data)	Number of Encounters in 2016 (OSHPD data)

11. Operating Revenue Sources and Amount of Funding Anticipated and Past Five Years

Provide a picture of the revenue upon which your organization operates. Do not include pass through funding to members but fees or overhead charged to pass-through funding should be recorded.

Revenue	2017	2016	2015	2014	2013	Anticipated 2018	Anticipated 2019
Member Dues							
Individual Donations							
Consortia operated business							

Fees (contracted services; conferences)							
HRSA Health Center Controlled Network Grant (HCCN)							
Private Foundations							
Local Funding e.g. county							
Hospital Grant							
Other Contracts: List source							
Other Grants: List source							
Other revenue: List type							

12. PASS-THROUGH FUNDING: If the organization receives money that is re-granted or passed through to members or stakeholders, list it here.

Type of funding/ Source of funding	Purpose of the re-grant pass through	Total Amount of regranting/ pass through funding

13. OPERATING EXPENSES

Expense Category	2017	2016	2015	2014	2013	Anticipated 2018
Salaries						
Benefits						
Contractors and Consultants						
Insurance, Legal, Audit						
Occupancy						

General administration/ supplies and office operation						
Communication						
Equipment						
Software/IT/Website						
Travel						
Human Resources/ Recruitment						
Professional Development						
Program-related expense						
Meeting expenses						
Miscellaneous						

14. Identify your PAST (years 2013, 2014, 2015, 2016), CURRENT (2017) and PLANNED (2018) Consortium Services on behalf of or to Members. *Complete for the main consortium organization only*. Simply check the box for each service the consortium provided in the specified year or anticipates providing in 2018. *For 2017 ONLY*, mark LOW, MEDIUM AND HIGH to designate a general level of effort for each service the consortium offered.

Service Category	2017 Low, Medium, High for each service	2016	2015	2014	2013	Anticipated in 2018
POLICY AND ADVOCACY						
County Policy (specify the county)						
Regional Area Policy (specify the region)						
State Policy						
National Policy						

Service Category	2017 Low, Medium, High for each service	2016	2015	2014	2013	Anticipated in 2018
ACCESS TO CARE						
Negotiate or advocate for funding or contracts for services to remaining uninsured						
Convene local leaders to address strategies for remaining uninsured						
Educate local leaders on the remaining uninsured						
Participate in collaborative efforts to expand coverage to remaining uninsured						
Advocate or participate in initiatives to improve access to specialty care						
Advocate or participate in initiatives related to health plan network improvements						
Coordinate telehealth projects						
Other:						
LOCAL HEALTH DELIVERY SYSTEM						
Participate in local waiver collaboration						
Participate in formal partnerships with public health and health care organizations (e.g. hospitals, county health system)						
Engage with local ACO						
Engage in planning or conducting data Sharing/HIE						
Convene local/regional collaborations to integrate or improve health care delivery system						
Provide technical assistance on emergency preparedness						

Service Category	2017 Low, Medium, High for each service	2016	2015	2014	2013	Anticipated in 2018
Other:						
MANAGED CARE						
Advocate with health plans about managed care contracts						
Advocate for P4P or quality incentive programs						
Support member success or reporting in P4P or quality incentive program						
Operate an IPA or Clinically Integrated Network (CIN)						
Operate an MSO						
Other:						
HEALTH CENTER BOARD DEVELOPMENT						
Support strategic planning for member health centers						
Support board of health center recruitment or onboarding						
Support board training for health center board members						
Other:						
HEALTH CENTER OPERATIONS						
Convene Peer Network meetings of CFOs, CMOs, HR, CIOs, etc.						
Convene Peer Network meetings of IT staff						
Host HIT or EHR systems						

Service Category	2017 Low, Medium, High for each service	2016	2015	2014	2013	Anticipated in 2018
Joint purchasing of equipment or services						
Support credentialing for providers						
Offer training on operations						
Offer technical assistance on PPS or billing						
Offer technical assistance on 330 compliance						
Other:						
OUTREACH AND ENROLLMENT						
Convene Peer Network meetings of CAA						
Collaborate locally to plan and coordinate outreach and enrollment						
Staff and conduct enrollment or navigation services						
Host contracts or grants for member outreach and enrollment services						
Support retention and renewal of coverage						
Other:						
CLINICAL MANAGEMENT AND QUALITY IMPROVEMENT						
Convene Peer Network meetings of CMO/Medical Directors						
Convene Peer Network meetings of QI staff						
Convene Peer Network meetings of case managers						

Service Category	2017 Low, Medium, High for each service	2016	2015	2014	2013	Anticipated in 2018
Collect and share blinded clinical performance data across network						
Collect and share unblinded clinical performance data across network						
Collect and share clinical performance data with public e.g. on web site or other broad public forum						
Collect patient level data across network						
Offer training on clinical best practices						
Offer training on quality improvement best practices						
Offer training or coaching on PCMH						
Convene planning or collaboration on quality measures						
Other:						
WORKFORCE DEVELOPMENT						
Convene Peer Network meetings of Human Resources						
Operate an AHEC						
Conduct outreach to promote health careers (school, community college, university)						
Participate in Workforce Investment Board of or other local collaborations to advance health workforce						
Coordinate AmeriCorps VISTA (Volunteers in Service to America) program						

15. What are your consortium's goals for project support from The California Wellness Foundation and Imprenta to improve communications? How will this improve your organization's communications? How will it improve joint communications between consortia and statewide associations?

_____

_____

_____

_____

_____

_____

Attachments: PLEASE INCLUDE THESE DOCUMENTS WITH YOUR SURVEY RESPONSE.

A. Current and previous strategic plan (for each organization)

B. Current organization chart (for each organization)

C. Current fiscal year budget (or current and next calendar year if more appropriate)

D. Year-end Financial statements for the current year and previous 5 years

E. Dues structure

F. List major sources of grant or contract funding and the purpose of the funding.

G. Kaiser funded infographic (if applicable/Northern CA only)

STATEWIDE CLINIC CONSORTIA PROJECT ADVANCE DATA TOOL

November 2017

If the consortium operates multiple entities or organizations, complete the survey for each entity[13]

1. Name of Statewide Association/Consortium _____

   _____

2. Address and telephone of administrative offices _____

   _____

3. Date the organization began_____

4. What is the total number of members of the consortium_____

5. What is the total number of clinic organizations served and licensed clinic sites served

6. Total FTE staff in the statewide association/consortium _____

7. Executive Director Tenure (how long has the Executive Director/CEO been in his/her position)

   _____

[13] For example, if the organization has a separate 501(c)4 or other separate business, complete a survey tool for each separate entity.

8. STAFF

Position title and role: if your Association/Consortium has more than 10 staff members, list only the management team, senior staff, program directors and department heads. Include any external contractors that function as staff. Include vacant positions. Feel free to provide an existing list if available.		
Name	**Title**	**Years of Service**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

9. OUTSOURCED FUNCTIONS OR SERVICES

List any outsourced functions or core services, such as human resources, IT or lobbyist.		
Contractor	**Function or Service Provided**	**Hours included in Contract If contract is not hourly, please estimate how many hours of service are used per month**

Mark all member types included in the consortium.

__Full members, dues paying

__Full members, no dues required

__Affiliate members, dues paying

__ Affiliate members, no dues required

__Other membership category (specify how you refer to this group, e.g. Associate), dues paying

__ Other membership category (specify how you refer to this group), no dues required

__ Not applicable/No members

10. Operating Revenue Sources and Amount of Funding Anticipated and Past Five Years
Provide a picture of the revenue upon which your organization operates. Do not include pass through funding to members but fees or overhead charged to pass-through funding should be recorded.

Revenue	2017	2016	2015	2014	2013	Anticipated 2018	Anticipated 2019
Member Dues							
Individual Donations							
HRSA Health Center Controlled Network Grant (HCCN)							
Other Federal Source (identify)							
State Source (identify)							
Private Foundations							
Fees (training; conferences)							
Income from Contracted Services							
Other Grant Income (identify source)							
Other revenue: List type							

11. Pass-Through Funding: If the organization receives money that is re-granted or passed through to members or stakeholders, list it here.

Type of funding/Source of funding	Purpose of the re-grant/pass through	Total Amount of regranting/ pass through funding

12. Operating Expenses

Expense Category	2017	2016	2015	2014	2013	Anticipated 2018
Salaries						
Benefits						
Contractors and Consultants						
Insurance, Legal, Audit						
Occupancy						
General administration/ supplies and office operation						
Communication						
Equipment						
Software/IT/Website						
Travel						
Human Resources/ Recruitment						
Professional Development						
Conference or regional convenings						
Program-related expense						

Expense Category	2017	2016	2015	2014	2013	Anticipated 2018
Other						

13. Identify your PAST (years 2013, 2014, 2015, 2016), CURRENT (2017) and PLANNED (2018) Consortium Services on behalf of or to Members. *Complete for the main consortium organization only*. Simply check the box for each service the consortium provided in the specified year or anticipates providing in 2018. *For 2017 ONLY*, mark LOW, MEDIUM AND HIGH to designate a general level of effort for each service the consortium offered.

Service Category	2017 Low, Medium, High for each service	2016	2015	2014	2013	Anticipated in 2018
POLICY AND ADVOCACY						
County Policy (specify the local area)						
Regional Area Policy (specify the region)						
State-level Policy						
National Policy						
ACCESS TO CARE						
Advocate for funding or contracts for services to remaining uninsured						
Convene statewide leaders to address strategies for remaining uninsured						
Educate statewide leaders on the remaining uninsured						
Participate in statewide or regional collaborative efforts to expand coverage to remaining uninsured						
Coordinate telehealth projects						

Service Category	2017 Low, Medium, High for each service	2016	2015	2014	2013	Anticipated in 2018
Other:						
HEALTH DELIVERY SYSTEM						
Participate in waiver-related planning or collaboration						
Participate in formal partnerships with CDPH or CDHCS or DMHC						
Engage in planning or conducting data sharing/HIE or other IT projects						
Convene collaborations to integrate health care delivery system						
Provide technical assistance on emergency preparedness						
Other:						
MANAGED CARE						
Advocate with managed care plans for better arrangements for members statewide						
Educate and Advocate for P4P or quality incentive programs with health plans						
Operate an IPA or Clinically Integrated Network						
Operate an MSO						
Other:						
HEALTH CENTER OPERATIONS						
Convene Peer Network meetings of CFOs						
Convene Peer Network meetings of IT staff						

Service Category	2017 Low, Medium, High for each service	2016	2015	2014	2013	Anticipated in 2018
Host HIT or EHR systems						
Joint purchasing of equipment or services						
Offer trainings on operations						
Offer technical assistance on PPS or billing						
Offer technical assistance on 330 compliance						
Other:						
OUTREACH AND ENROLLMENT						
Convene Peer Network meetings of CAA						
Convene or participate statewide partners to plan and coordinate outreach and enrollment						
Provide members education on ct enrollment or navigation services						
Host contracts or grants for outreach and enrollment services						
Support retention and renewal of coverage						
Other:						
CLINICAL MANAGEMENT AND QUALITY IMPROVEMENT						
Convene Peer Network meetings of CMO/Medical Directors						
Convene Peer Network meetings of QI staff						
Convene Peer Network meetings of case managers						

Service Category	2017 Low, Medium, High for each service	2016	2015	2014	2013	Anticipated in 2018
Collect and share blinded clinical performance data across network						
Collect and share unblinded clinical performance data across network						
Collect and share clinical performance data with public e.g. on web site or other broad public forum						
Offer training on clinical best practices						
Offer training on quality improvement best practices						
Offer training or coaching on PCMH						
Convene planning or collaboration on quality measures						
Other:						
WORKFORCE DEVELOPMENT						
Convene Peer Network meetings of Human Resources						
Conduct outreach to promote health careers (school, community college, university)						
Participate in Workforce Investment Board of or other statewide collaborations to advance health workforce						
Convene workforce development stakeholder meetings						
Coordinate AmeriCorps VISTA (Volunteers in Service to America) program						
Other:						

14. What are your consortium's goals for project support from The California Wellness Foundation and Imprenta to improve communications? How will this improve your organization's communications? How will it improve joint communications between consortia and statewide associations?

_____

_____

_____

_____

_____

_____

Attachments: PLEASE SUBMIT THE FOLLOWING DOCUMENTS IN ADDITION WITH THE SURVEY.

1. Current and previous strategic plan (for each organization)
2. Current organization chart (for each organization)
3. Current fiscal year budget (or current and next calendar year budget if appropriate)
4. Year-end Financial statements for the current year and previous 5 years
5. Dues structure
6. List major sources of grant or contract funding and the purpose of the funding.

APPENDIX F - ON-SITE INTERVIEW PROTOCOL

CLINIC CONSORTIA PROJECT
INTERVIEW PROTOCOL FOR REGIONAL CONSORTIA SITE VISITS

Objectives and Priorities for the Site Visit:

1. Purpose and funding of clinic consortia project
2. Understand the local context and history for the consortium
3. Clarify any questions about the consortium data submitted
4. Highlight areas that will inform future technical assistance

CEO Interview (60 – 90 minutes)

1. Tell us about the history of your consortium
    a. Who were the founding members? When was it founded?
    b. What have been the key milestones in the recent history of the consortium?
2. Describe the key drivers of the political climate in each county you serve and how this impacts your consortium's work.
3. Describe your current programs and business projects including the expected results of each.
    a. with members
    b. with community partners
    c. with health plans
    d. with other consortia.
4. Thinking about the next 3-5 years, describe strategic opportunities for your consortium:
    a. expansion of members or change to types of members?
    b. expansion of geography?
    c. working with other regional consortia?
    d. new business opportunities?
    e. potential new funding sources?
    f. new role with health plans?
    g. other?
5. Are there particular management or operational challenges you expect health center members will face over the next 3-5 years? What is the role of your consortium in these issues?
6. What has been the history of key staffing milestones of increased or decreased staffing levels that have impacted your work?
7. What types of consortium projects are needed over the next 3-5 years?
8. What is your level of involvement in

   a. With other consortia?
   b. State association?
   c. National association?

9. Describe your ideas about technical assistance needs for your consortium and why you need this support.
   a. What types of assistance are needed over the next 3-5 years?
   b. Are there consultants identified to support this work?
   c. Have you received TA for this topic previously?

10. Other issues that you'd like to bring up.

Staff Meeting (60-90 minutes)

1. Consortium-specific clarifying questions about the advance data submitted, as needed.
2. Describe the most important accomplishment(s) for your consortium over the past 3-5 years:
   a. For members?
   b. For the consortium?
   c. With community partners?
   d. With health plans?
   e. With other consortia?
3. Describe the status of your consortium's strategic plan priorities (strategic plan was submitted prior to this meeting).
   a. What are the biggest challenges facing members?
   b. What are the biggest challenges facing the Consortium?
   c. What do you see as the biggest opportunities ahead?
4. From the advance data, discuss grants or projects the consortium is doing that are not considered core services.
   a. Are these projects needed for the long-term? How will you continue them at the end of current funding?
   b. Tell us about other projects that are needed but not funded over the next 3-5 years?
   c. How likely are you to launch these?
5. Describe your consortium's role with health center technology and data sharing and what is on the horizon in this area over the next 3 years.
6. Do you support a consortium-wide (member-wide) patient advisory council? If so, tell us about how it operates, what the consortium's role is with it and its accomplishments.
7. Describe how you are incorporating the communications plan funded by The California Wellness Foundation into your work with members?
8. Describe your highest priority(ies) for your consortium over the next 3-5 years. What direction do you see your work going in over the next 3-5 years?

CLINIC CONSORTIA PROJECT

INTERVIEW PROTOCOL FOR STATEWIDE CONSORTIA SITE VISITS

Objectives and Priorities for the Site Visit:

1. Purpose and funding of clinic consortia project
2. Understand the local context and history for the consortium
3. Clarify any questions about the consortium data submitted
4. Highlight areas that will inform future technical assistance

CEO Interview (60 – 90 minutes)

1. Tell us about the history of your consortium
    a. Who were the founding members? When was it founded?
    b. What have been the key milestones in the recent history of the consortium?
2. Describe the key drivers of the political climate and how this impacts your consortium's work.
3. Describe your current programs and business projects including the expected results of each.
    a. with members
    b. with community partners
    c. with health plans
    d. with other statewide and regional consortia.
4. Thinking about the next 3-5 years, describe strategic opportunities for your consortium:
    a. expansion of members or change to types of members?
    b. working with other statewide or regional consortia?
    c. new business opportunities?
    d. potential new funding sources?
    e. new role with health plans?
    f. other?
5. Are there particular management or operational challenges you expect health center members will face over the next 3-5 years? What is the role of your statewide consortium in these issues?
6. What has been the history of key staffing milestones of increased or decreased staffing levels that have impacted your work?
7. What types of projects are needed over the next 3-5 years for your consortium?
8. What is your level of involvement in
    a. With other statewide consortia?
    b. With other regional consortia?
    c. With your national association?
9. What do you see as the main leverage point(s) for your statewide consortium and the

strategic advantage offered by your consortium?

10. Describe your ideas about technical assistance needs for your consortium and why you need this support.
    a. What types of assistance are needed over the next 3-5 years?
    b. Are there consultants identified to support this work?
    c. Have you received TA for this topic previously?

11. Other issues that you'd like to bring up.

Staff Meeting (60-90 minutes)

1. Consortium-specific clarifying questions about the advance data submitted, as needed.
2. Describe the most important accomplishment(s) for your consortium over the past 3-5 years:
    a. For members?
    b. For the consortium?_
    c. With community partners?
    d. With health plans?
    e. With other statewide or regional consortia?
    f. With other statewide associations?
3. Describe the status of your consortium's strategic plan priorities (strategic plan was submitted prior to this meeting).
    a. What are the biggest challenges facing members?
    b. What are the biggest challenges facing your consortium?
    c.qWhat do you see as the biggest opportunities ahead?
4. From the advance data, discuss grants or projects the consortium is doing that are not considered core services.
    a. Are these projects needed for the long-term? How will you continue them at the end of current funding?
    b. Tell us about other projects that are needed but not funded over the next 3-5 years?
    c. How likely are you to launch these?
5. Describe your consortium's role with health center technology and data sharing and what is on the horizon in this area over the next 3 years.
6. Do you support a consortium-wide (member-wide) patient advisory council? If so, tell us about how it operates, what the consortium's role is with it and its accomplishments.
7. Describe how you are incorporating the communications plan funded by The California Wellness Foundation into your work with members?
8. Describe your highest priority(ies) for your consortium over the next 3-5 years. What direction do you see your work going in over the next 3-5 years?

APPENDIX G - DATA CONFIDENTIALITY AND SHARING AGREEMENT

November 29, 2017

TO: **STATEWIDE and REGIONAL CLINIC CONSORTIA**

FROM: **Bobbie Wunsch, Founder and Partner, Pacific Health Consulting Group**
Laura Hogan, Senior Consultant, Pacific Health Consulting Group
Carlina Hansen, Senior Program Officer, California Health Care Foundation
Earl Lui, Program Officer, The California Wellness Foundation

RE: **Principles Governing Use of Clinic Consortia Data**

This memo confirms an understanding between the Statewide and Regional Clinic Consortia, Pacific Health Consulting Group, the California Health Care Foundation and The California Wellness Foundation that the following Data Principles will be used to guide the use of data collected during the clinic consortia project.

1. Data is being collected for the clinic consortia project in several ways – through written requests for advance data, collection of publicly available data, review of previous reports about consortia as well as through on-site interviews with consortia CEOs and senior staff.

2. Pacific Health Consulting Group has the sole responsibility with the clinic consortia for ensuring that the quality and integrity of the data are preserved, and respect for the data source is maintained by ensuring privacy where appropriate, and providing appropriate citations for the data. It is the individual consortia's responsibility to notify Pacific Health Consulting Group of any conversations or data provided that is confidential or proprietary and should not be cited or included in the final report or any materials provided to the project funders.

3. There will be a final report developed for project funders (The California Endowment, The California Wellness Foundation, the California Health Care Foundation and Kaiser Permanente Community Benefit Northern California and Southern California.) and possibly a shorter issue brief or executive summary that will be distributed more widely (potentially to other funders and others identified by consortia and/or funders at a later date in the project). The Clinic Consortia Project Advisory Group (made up of representatives of the statewide and regional clinic consortia) will review and comment on the draft final report; and then the draft final report will be presented to all the statewide and regional consortia involved in the project for feedback before it is submitted to the project funders. This review will occur at the May RAC meeting and will include the non-RAC statewide consortia. Any additional executive summary or issue brief will go through the same review process as the final report.

4. Any data elements in the draft final report that identify a specific, individual consortium will be reviewed and approved by the CEO of the referenced consortium in advance of sharing any version of the draft report with the project funders.

5. Individual data and aggregated data about consortia, in regional or other sub-groups (not yet developed), will be included in the final report. Much of this data will be provided to Pacific Health Consulting Group directly by the individual consortia through data requests and conversations. Individual data that may be used in the report would include but not be limited to items like number of members, dues structure, strategic initiatives, annual budget and revenues, number of FTE staff, etc. Publicly available information about an individual consortium may be included in the final report. Sources for any data will be identified in the report.

6. No proprietary business or confidential information for an individual consortium will be shared in the report. It is the individual consortia's responsibility to notify Pacific Health Consulting Group if information provided in the advance data or during the site visit is proprietary or confidential.

7. A short two-page report about the technical assistance provided to individual consortia will be shared with the project funders for each consortium that requests the technical assistance funded by this project.

8. The draft final report will be reviewed in conjunction with the Statewide and Regional Consortia during the Regional Associations of California (RAC) regular May meeting currently scheduled for May 10, 2017. Non-RAC member consortia involved in this project (Planned Parenthood Affiliates of California (PPAC) and California Rural Indian Health Board (CRIHB) will be invited to participate in this meeting. Prior to that meeting, the project Advisory Group will review and provide feedback on the draft final report.