California's Community Clinics and Health Centers

Taking initiative in a new health care landscape

VIEWPOINT LEARNING

2012

Support for this project was provided by:

blue of california foundation

Blue Shield of California Foundation is an Independent Licensee of the Blue Shield Association

California's Community Clinics and Health Centers:
Taking initiative in a new health care landscape

EXECUTIVE SUMMARY

IN SUMMER 2011, groups of stakeholders met in San Diego, Los Angeles, and Alameda Counties to discuss the implications of the Patient Protection and Affordable Care Act (ACA) for community clinics and health centers, in particular the expansion of coverage to millions of Californians. Each group was convened by a regional community clinic consortium, and the meetings were sponsored by Blue Shield of California Foundation. Participants included community clinic directors and staff, local hospital and medical professionals, business leaders, government officials, academics, public school leaders, advocates, faith leaders, clinic patients, and the media. Each group engaged in a dialogue about the future of community clinics in their region. In this new environment, how can clinics attract and keep the newly insured; improve the health of the community; and build capacity and financial stability? What has to change, what should stay the same, and what action steps make sense?

A striking amount of common ground emerged across all three groups. Some of the most important themes:

- ***Clinics will have to up their game.*** ACA presents significant challenges and opportunities, and clinics will need to make changes if they are to thrive in this new landscape. A few of the specific suggestions emphasized by all three groups:
  - **Increase collaboration:**
    - ***Within clinics*** (e.g. patient centered care provided by a team that includes physicians, non-physician providers, staff and others);
    - ***Among clinics*** (e.g. sharing access to specialists, coordination to increase patient access; exploring financial collaboration such as shared fiscal management, accounting, etc.);
    - ***With community*** (e.g. with community groups, schools, etc.).
  - **Focus on patient experience:** Clinics can emphasize integrated service, convenience and quality. This includes shorter wait times, cleaner facilities, friendly service, and attention to employee working conditions.
  - **Strengthen clinics' role in communities:** Clinics' long-standing links with their communities are an important competitive advantage, and they can do more to strengthen that role. This includes outreach through collaborations with schools, *promotores*, partnerships with community organizations—as well as bringing new patients in with 'value-added' services like wellness classes.
  - **Make greater use of technology:** For example, increase electronic access to appointments and health information; promote telemedicine; integrate electronic health records (EHRs) into patient care.

- **Strengthen advocacy:** Clinics need to work together and with the public and other stakeholders to advocate for needed changes. This will be especially important with respect to reimbursements and privacy issues.

- ***Clinics need to tell their story better.*** Most participants felt that community clinics are not doing well at communicating their strengths and successes. They felt that more effective marketing and branding would help change how clinics are perceived by payers, by patients, and by communities.

Participants recognized that these changes will not be easy. But participants from all sectors felt that clinics are up to the challenge. The last decade has shown that clinics have successfully made significant changes and adapted to changing circumstances. Many clinics are already ahead of the curve when it comes to changes required of all providers under ACA, including: providing culturally competent care, patient-centered care, wellness programs, adopting EHRs, and doing more with less.

This can't be just another meeting. Participants found the dialogues helpful and engaging—but in every dialogue they stressed the importance of turning the evening's talk into action. Time is short, they said: despite uncertainties about how the courts and the election will impact the future of ACA, permanent changes have already taken place and more are coming. Clinics must take the initiative or risk being left behind. Participants from all backgrounds and sectors emphasized the importance of continuing to work together and learn from each other as they move forward. They hoped to maintain and build on the momentum created in the dialogue to meet the challenges that lie ahead

CALIFORNIA'S COMMUNITY CLINICS AND HEALTH CENTERS are facing a sea change in the next five years. Long a mainstay of community health for the uninsured and underinsured, they will see dramatic changes as a result of the passage of the Patient Protection and Affordable Care Act (ACA). As many as 4 million Californians are expected to be added to the health insurance rolls through the new health insurance exchange and the expansion of MediCal, and there will be significant changes in areas like reimbursements and workforce development. What are the implications of these changes for clinics—and what changes will clinics need to make if they are to serve their communities in this new, more competitive environment?

In summer 2011, three groups of invited stakeholders met to discuss this question—one each in San Diego, Los Angeles, and Alameda Counties. Each group was convened by a regional community clinic consortium (the San Diego Council of Community Clinics, the Community Clinic Association of Los Angeles County, and the Alameda Health Consortium) for a four-hour dialogue. Each group included a range of stakeholders. Across the three sessions there were community clinic directors and staff, local hospital and medical professionals, business leaders, government officials, academics, public school leaders, advocates, faith leaders, clinic patients and the media.[1]

The meetings were sponsored by Blue Shield of California Foundation and conducted by Viewpoint Learning. In each session participants engaged in dialogue about the future of community clinics in their region as health care reform is implemented: what has to change, what should stay the same, and what action steps make sense?

What follows reflects common ground reached by participants across all three dialogues. In each session participants came from a range of sectors: each brought different perspectives, knowledge and expertise to the table. Some issues were more pressing (or simply more familiar) to participants from specific sectors, and we have indicated where possible when a concern or a comment was raised especially strongly by participants from one particular background or sector. But it is important to emphasize that these findings are common ground: both 'insiders' and 'outsiders' by and large agreed about the current situation and the most important steps to take moving forward, and the recommendations outlined here were offered and developed by participants from the full range of backgrounds.

Given the time constraints of a four-hour session, the ideas and recommendations that surfaced in the dialogues should necessarily be considered a starting point. Participants in all locations agreed that one key next step was to continue to engage in cross-sector dialogue about these and other issues facing clinics. They said this is especially vital given how quickly the health care environment is shifting as ACA moves towards implementation. Despite the uncertainties created by the 2012 Supreme Court decision and Presidential election, the health care landscape has already been permanently changed by ACA. If clinics are to continue to stay current and vital in this rapidly changing environment—let alone help shape those changes as they unfold—sustained, structured dialogue will be essential.

Changes and trends that have shaped the current environment

The dialogues began with a brief background on community clinics in California, how the Affordable Care Act will likely impact them, and how people currently perceive community clinics.[2] Then participants identified trends and changes that have shaped the health care system and the role of community clinics over the past 20 years. All three groups painted a similar picture; in particular they noted:

- ***Rising costs, for providers, employers and patients alike.*** Participants noted that more and more of the nation's GDP is going towards health care, and that health costs are fast outstripping wages.
- ***Changes in how people are covered.*** These include a drop in employer-provided coverage, a rise in the number of uninsured, and increasing pressure on government programs for low income people.
- ***Changes in the priorities and organization of the health care system.*** These included a rise in managed care and a move toward more comprehensive care, reinforced in recent years by growing government support for medical homes. Participants also cited the increased awareness of and attention to prevention, education, and wellness. And they saw a growing focus on community-based health, including community involvement in determining health care needs.
- ***Demographic changes.*** The population is aging, increasingly diverse, and underserved. All three groups particularly noted that immigration is changing the face of their communities, increasing the challenges of providing culturally competent care, while restrictions on immigrants receiving public services are tightening.
- ***Dramatic rise in chronic conditions.*** Diabetes, asthma, heart disease, and Alzheimer's are all becoming more common in these communities.
- ***Changes in technology.*** Participants pointed out that technology—especially electronic health records (EHRs)—has made it possible to change how health data is collected and used. At the same time, they noted that technology has increased the risk of information overload, as clinics struggle to implement and use technology in the most effective way.
- ***Changes in how providers are paid.*** This was a major concern in all three groups, especially among clinic staff—in particular the large and growing disconnect between the services clinic patients need and the services for which clinics are reimbursed. This gap is making it difficult for clinics to remain solvent.

> *"The payment mechanism doesn't recognize acuity. We call them "train wreck" patients—they walk in the door and you've got to spend an hour and a half with them; but your schedule [and the reimbursement model] says it's a 20 minute visit."*
>
> ***Clinic Staff***

- ***Political and economic trends.*** Participants saw hard economic times putting the squeeze on budgets, resulting in revenue battles between state and local governments as well as a tendency for budget-based policies to dictate the provision of care. More broadly, all three groups highlighted declining public support for and trust in government programs, and increasing politicization of health care.
- ***Growing role for and demands on community clinics.*** Shifts in the overall health care system have changed the role of community clinics. These shifts include:
  - Increased federal funding for FQHCs which allowed clinics to grow and expand.
  - A general shortage of health care resources and providers (especially at the county level). Participants in all three dialogues noted that their regions now had fewer providers, beds, and emergency rooms, even as the population has become larger, more diverse, and sicker. Clinics have been picking up the slack, but without any change in reimbursement.
- ***Providers are also businesses.*** In all three groups participants raised the idea that clinics are now no longer just providers with a social mission; they are also businesses. Most came to feel that these two aspects of the clinic's role should be held in balance, not compete. The question of how to preserve clinics' mission to care for their communities—what one participant called their "soul"—in a competitive environment surfaced repeatedly in the discussion and shaped many participants' responses and priorities.

> *"We have a social mission, and that's why we're here—but in order to fulfill that mission we're running businesses. If you'd asked me 25 years ago I wouldn't have known that was coming down the pike."*
>
> ***Consortium Staff***

> *"When we went to managed care it scared people to death—they were terrified. But most of our organizations are better for it… We need to be out and proud about the mission of clinics and about the need to be business oriented."*
>
> ***Faith Leader***

Challenges and opportunities with the passage of ACA

Next, participants were asked to identify key challenges and opportunities that will result from the implementation of ACA. Some of the **challenges** they identified:

- Once clinic patients have coverage, they may begin to seek care elsewhere—and if they feel they are not getting good value from the clinic they may be more inclined to shop around.
- Some people held a competing view: with so many people newly insured, clinics may be overwhelmed without adequate space, staff, or technology to deal with the influx.
- Clinic doctors, nurses, and other providers may leave as well, either looking for easier conditions or aging out.

- Health reform will not reach everyone, most notably the undocumented. The cohort of persistently uninsured is likely to be more vulnerable than ever, and they will continue to turn to clinics—but there will be fewer dollars available to care for them and less political will to find those funds.

"What happens to public support for the safety net after health care reform is implemented?"

Community Member

- Clinics will have to focus on meeting federal standards for patient outcomes, but these standards may not be the things that matter most to patients when they are deciding where to seek care. Even if a clinic does well on federal standards, if patients feel they are not getting good care they may go elsewhere.
- Many providers felt that current privacy regulations get in the way of clinics being able to use the full potential of EHRs to improve patient outcomes.

Participants also saw a number of ways that ACA may offer **opportunities**. First and foremost, they noted the benefit of having more people insured and able to access and pay for care. In addition, they anticipated:

- More and better opportunities for prevention and disease management, especially as the implementation of EHRs (already well underway at clinics) becomes universal.
- New funding becoming available for infrastructure and technology; this will mean both new and expanded clinic facilities and new ways of reaching patients (e.g. telemedicine, remote consultation with specialists, online scheduling).
- A chance to bolster innovation by reshaping how outcomes are measured and how they inform reimbursements.
- Areas where clinics are ahead of the curve in implementing many ACA requirements compared to other health organizations. In particular they mentioned:
  - Culturally competent care;
  - Integrated care, with providers working together to create a patient-centered medical home;
  - Community based care.

Many felt that clinics' expertise in these areas would make them more competitive and also provide models for other providers.

"The rest of the health care system is so bureaucratic and so set in its ways, so frightened. I think clinics can save them. But you have to keep your soul, don't get like them, you have to stay different."

Community Member

Perceptions of community clinics today

When participants were asked to describe their perception of community clinics in a single word, their responses—from "dilapidated" and "struggling" to "comprehensive," "scrappy" and "life-changing"—captured the scope of the challenges clinics face as well as the pride participants felt in the work clinics are doing.

Participants across the board agreed that clinics need to tell that story more effectively. As one clinic staffer put it, "We have a great story, but it might be the best kept secret in town!" Many clinic staffers and consortium members were frustrated that clinics' ongoing work in the community was not more widely recognized. Many participants who were not clinic 'insiders' agreed, but they also warned against complacency—the good work clinics are doing may be going unsung, but singing it louder might not be enough. In this shifting environment clinics would do well to step back and consider not only how they present themselves but also what they DO, especially when it comes to caring for patients, engaging their communities and collaborating with other clinics and providers.

> *"The perception issue is such a major issue for community clinics. But frankly, perceptions come from reality. So are there ways that you can improve your processes so that [people] have a true perception of what's going on?"*
>
> ***Business Leader***

Practical steps forward

Next, participants in each group discussed practical steps clinics could take to achieve three objectives:

1. Attract and keep the newly insured, who will now have more choices;
2. Help to improve the health of the community;
3. Build capacity and financial stability.

Participants arrived at a great deal of common ground, and their recommendations—which reflect input from participants from many backgrounds and sectors—were strikingly consistent across all three dialogues. Time constraints precluded in-depth discussion of every point; instead, participants flagged the following key issues as especially important for clinics and their communities to explore going forward.

1. Attracting/Retaining the newly insured

- ***Focus on patient-centered care.*** This was a key point in every dialogue. Participants especially emphasized improving the patient experience with shorter wait times, clean facilities, and friendly service, as well as gaining a better understanding of what clinic patients need and want. Many clinic staffers observed that good customer service is not simply a matter of patients' interaction with providers: it also requires attention to employee working conditions.

> *"When you talk about smiling at your patients, and the patient experience.... We are so burdened with figuring out which of the 12 forms to fill out, and which one do you do for the Healthy Way L.A. and which do you do for the HMO and which do you do for the IPA, that nobody can smile. People feel like you have to have a Ph.D. to be a front office worker. If you could simplify that, people would be able to give the patient a better experience because they wouldn't be burdened trying to figure out these complexities that have evolved."*
>
> ***Clinic Staff***

Improving the patient experience will require clinics to emphasize convenience and quality, making sure clinics offer accessible, convenient, high-quality care. This includes integrated service delivery and a team-driven approach to patient care. Participants felt it would also include offering longer hours, including evenings and weekends, to accommodate patients who can't come in during regular hours.

- ***Build on clinics' strengths.*** Clinics surpass their competitors in many areas, and these should be highlighted in branding and marketing efforts:
  - In particular, participants pointed to clinics' long-standing ties to their communities, and their language and cultural competency.
  - Clinics would also do well to highlight the additional health-related services that they offer (such as wellness, nutrition, disease management, mental/dental care, holistic health) as well as any facilities like meeting rooms or parking lot space that can be made available to the broader community.

> *"Community health centers are driven by the needs of the community, historically and going forward. That community trust is key to success. It's something you can't buy. You have to work to maintain it. But it's something that health centers really have and other providers don't always."*
>
> ***Public Agency Staff***

- ***Make greater use of technology.*** Participants in all three dialogues noted that some new technologies raise privacy concerns, but also that current laws unduly limit the ways that new technologies can be applied. They called for advocacy and careful policy work to find ways of expanding and using new technology while still protecting privacy and vital civil liberties. Some specific examples of how technology might be used to improve care:
  - **Make it easier for patients to access care and health information electronically:**[3] All participants agreed that patients should be able to easily make/change appointments, refill prescriptions, and get information about healthy behaviors or self-care for chronic conditions.
  - **Use EHRs to help patients get timely personal health information:** Examples raised in the dialogues included giving each patient a printout indicating her blood pressure trends over the last several visits, or reminders about when to get a flu shot.
  - **Promote telemedicine:** This included online Q&A with providers. Many providers also suggested that they would like to be able to consult remotely with specialists.
- ***Develop a marketing/branding campaign.*** Finding better ways of communicating clinic quality to the broader public was a central point in all three dialogues. Both clinic insiders and community members felt that community clinics are not doing especially well at telling the story of the good work they are doing, and they felt that effective marketing would help change how clinics are perceived by payers, by patients, and by communities. A few mentioned Kaiser Permanente's "Thrive" campaign as a useful model and suggested that clinics should similarly market their quality of service, range of offerings, excellent outcomes and cultural competence. But as noted earlier, participants agreed that better marketing alone would not be enough to help clinics attract and retain patients: for that, clinics would need to rethink how they care for their patients and interact with their communities.

2. Improving the Health of the Community

- ***Further strengthen clinics' role in communities.*** Community health centers are and should continue to be a community resource. Providers and community members alike supported moving towards a more extensive vision of health that extends beyond the four walls of the clinic. Some specific possibilities included:
  - **School based screenings and assessments:** Schools are on the front line of public health in many ways (e.g. providing TDAP immunizations) and clinics can reach parents by reaching their kids.
  - **Outreach, outreach, outreach:** Clinics should be visible at schools, community events, libraries, farmers' markets, in community media etc.
  - **Support and expand partnerships with community organizations:** Examples included the YMCA, Boys and Girls Club, Alcoholics Anonymous, and faith groups.
- ***Support and expand the promotores model.*** Participants saw *promotores*, and cultural competence more generally, as a major strength of most clinics and an effective form of public health education.

- ***Focus on clinics' value-added.*** Community clinics don't provide just health care—many also address broader community needs. Clinics will do well to emphasize and expand "value-added" services; they benefit patients, build loyalty, and will bring people to the clinic when they need health care. For example:
  - **Make waiting time count:** Waiting time in clinics can be an opportunity to educate and engage patients—while the overall goal is to reduce waiting times, clinics can do more to make that time productive.
  - **Offer health and wellness classes:** Classes in exercise, parenting, nutrition, and cooking were especially popular among clinic patients at the dialogue.
  - **Consider offering classes and services that address broader community needs:** A few clinics said they were offering services in "non-health" areas like microfinance, as a further benefit to the well-being of their community.

> *"[Clinic] has 50 people three times a week for exercise classes in their parking lot. They do projects that generate income for individuals, and they also use that time as a way to talk about different health issues. There's an incentive for the patients to come to these classes and then they get the benefit of the health experts at the same time."*
>
> ***Clinic Patient/Staff***

- ***Engage and empower patients.*** In every dialogue, participants emphasized that patients are a vital resource. Participants saw a two-fold rationale for improving public engagement: not only are patients sources of expertise about what the community needs, they can be powerful advocates on clinics' behalf.
  - **Initiate a two-way conversation about community needs and priorities:** Community members in particular underscored the importance of listening as well as advocating (and suggested that clinics often neglect the former). One participant, a health care academic, put it succinctly: "If you're going to go to the trouble of doing patient surveys, be sure to listen to those surveys and do something with them!"

> *"There's a lot of community expertise out there. Not necessarily people that have high degrees, but they have a lot of expertise on what's good for them and how to change their communities. We should all be listening to that."*
>
> ***Health Care Academic***

  - **Make sure patients' stories are heard:** Patient stories get to the heart of the clinic experience, and clinics should do more to make sure those stories are heard by policy makers and the general community. But participants across the board emphasized that patients are not just sources of stories to be deployed for marketing purposes. Patients can be ambassadors and powerful advocates with both decision-makers and the broader

community. This was especially apparent to community members and to staff at clinics with especially active community outreach: patients are the "face" of the clinic, and clinics should do more to recognize and support that role.

3. Building Capacity/ Financial Stability

- ***Foster collaboration.*** Participants emphasized the importance of collaboration to making clinics more efficient and effective. In particular, they noted the need for collaboration in three areas:
  - **Within clinics:** Clinics should continue to work towards a patient-centered model in which care is provided by a team that includes physicians, non-physician providers, staff and others. Many participants, especially those in teaching professions, emphasized the need to make sure that a clinic's front office and back office operations are likewise collaborating effectively.
  - **With community groups:** Many educators in the groups noted that clinics can do more to work with schools to bring in providers, nurses and allied professionals. In addition, they can forge relationships with community groups like the YMCA or the Boys and Girls Club, as well as providing health screenings at farmer's markets and other community events.
  - **Among clinics and other providers:** Clinic providers and staff pointed to the need for clinics (and other providers) to break out of their silos: to foster stronger collaboration, avoid duplication, and share best practices with each other. In particular there was interest in inter-clinic referrals and sharing access to outside providers with specialized expertise. Providers and clinic directors in some groups mentioned Independent Practice Associations (IPAs) that let clinics specialize in what they do best, such as HIV care, reproductive health care, or managing less common chronic conditions. They stressed that it will be essential to set metrics and share best practices (providers, advocates and community members raised Planned Parenthood as an example of an organization that does this well); they also underscored the need to move forward quickly with compatible EHR systems.

> *"I think it's so critical for all of the community health centers to be able to talk to each other when it comes to their medical records. We need to really push for that so that everyone can share the same data. I'm not seeing that now. Everyone is so silo-ed. The hospitals aren't going to be able to talk to the clinics and the clinics aren't going to be able to talk to each other. All of that is going to increase costs, and the delivery of health care for underserved folks will be compromised. That's a missed opportunity. That's where the policy dialogue really needs to take place."*
>
> ***Clinic Staff***

Clinic providers and community members also supported coordination to increase patient access points and expand hours of operation. Many also were interested in exploring financial and administrative collaboration, including shared fiscal management, accounting, and centralizing administration across clinics.

- ***Measure value.*** Clinic staff and health experts emphasized the importance of using measures like the National Committee for Quality Asurance (NCQA) and Healthcare Effectiveness Data and Information Set (HEDIS) to monitor the impact of clinics' work and demonstrate its value. Measuring outcomes and demonstrating clinic effectiveness will be an increasingly important way of attracting funding, not only from the government, but also from private insurers, private insurance patients and the broader community.

- ***Focus on efficiencies.*** Specific examples raised by participants included:

  - **Pursue efficiencies through technology:** Use technology to create economies of scale. Several providers were interested in exploring remote medicine, online monitoring of health indicators and other new forms of care. While some technology-driven improvements (most notably conversion to EHRs) are already well underway, many clinic users and employees were frustrated by the pace of adoption and especially eager to make sure that clinics, hospitals and other providers would be able to talk to each other efficiently.

  - **Rethink clinic culture:** Several clinic employees and users noted that clinic clients, staff and management sometimes seem to be pulling in different directions; getting all parties onto the same page would require a change in clinic culture.

  - **Simplify paperwork, payments, procedures:** Eliminate redundancies and annoyances that overwhelm staff and frustrate patients. This will require regulatory change as well as systems/efficiency change at clinics.

  - **Invest in capable financial management:** As clinics operate more and more as businesses, their staff and other participants agreed that clinics need to build up financial leadership and expertise.

- ***Fix the compensation system.*** In all three sessions clinic staff highlighted the need for reform of the reimbursement model. Clinics need to be able to properly value services (especially those in demand for the clinic population that are currently under-resourced) and get paid for them. Done right, they said, this can be a basis for further expansion.

- ***Focus on advocacy.*** Throughout the meetings, it became clear that many of the changes participants were discussing would require policy change. High priority areas included: reforming reimbursements, privacy policies, and workforce policies, and participants emphasized the many opportunities for advocacy and education around these issues.

  Participants felt that clinics, the public and other stakeholders like business and education leaders should be allies in the push for advocacy, and that clinics need to find ways to engage them more fully. In particular they noted the need to enlist the public and clinic patients as allies in these efforts—encouraging them to contact their representatives and make known their support for clinics.

"You need some kind of an outreach to communities and community organizations saying 'We exist and this is what we do.' Then when it's time to fight for you, you've got your people there and they stand up and say 'No, you're not taking my clinic!' They would be out there supporting you now, but right now most of them don't know."

Clinic Staff

Differences among dialogues

Similar concerns and themes surfaced in all three dialogues—there were no major differences of substance among them. There were, however, some interesting differences in tone and emphasis. Some of these stemmed from particular conditions in the region; others seemed to arise from the specific mix of individuals in the room at each dialogue.

- ***San Diego:*** This dialogue was the most diverse in terms of participants (many from non-health care fields, business, media—as well as a larger number of clinic patients). The participants in San Diego focused especially intensely on the "value added" that clinics provide; in part because of successful efforts by local clinics to offer resources like micro-finance, English, and cooking classes. They painted a picture of clinics that are deeply embedded in specific neighborhoods and communities, and one key challenge they identified was getting those clinics to work together and share resources.

- ***Los Angeles:*** The Los Angeles dialogue included many participants from academia and provider training organizations. Participants focused extensively on how to improve clinic operations and culture, as well as on policy and advocacy. This group had the most detailed discussion about how clinics might collaborate and share resources. Many of the clinics in the room had developed significant expertise in specific areas (HIV, pediatrics, certain chronic conditions) and saw potential for cross-clinic referrals.

- ***Alameda:*** The Alameda group had relatively few participants from non-health related sectors like business or media; there also were relatively few clinic patients. This group was especially focused on the social determinants of health, such as poverty, violence, and the overwhelmed safety net—and how clinics might be able to address these as well. They also had the most extended discussion of the tension between clinics' social mission and their need to act as businesses.

Closing remarks

When asked for closing thoughts, participants saw their dialogues as a valuable opportunity to learn from each other and deepen connections across the community, and they thanked Blue Shield of California Foundation and the regional consortia for making it possible.

Participants in all three dialogues agreed that one of clinics' greatest strengths is their long-standing commitment to working in and serving their communities: advocating for those communities and making sure their voices are heard will be key to future success. As one faith leader put it, "We have a story to tell the nation. And it's a great story."

But most agreed that telling the story was not enough. In the changing environment of the ACA, clinics will need to make some real changes like those outlined above—and they will need to do it soon. But while the sense of urgency was palpable, participants also noted that they are not starting from scratch. They saw clinics ahead of the curve when it comes to many changes that all health providers will have to make: clinics have a long and successful track record when it comes to culturally competent care, wellness, serving communities as well as individuals, and making more out of less.

At the close of the sessions, many participants said they were inspired and energized by the diversity of perspectives in the room, the creativity being shown by clinics today, and the common commitment to helping clinics fulfill their potential and serve their communities. Clinic directors and staff said they found the dialogue especially valuable: focused as they often are on the immediate and urgent demands of each day, they appreciated the opportunity afforded by the dialogue to step back and take the long view.

Many participants, clinic 'insiders' and 'outsiders' alike, emphasized that this dialogue must be the start of an ongoing and expanding process. In the current climate of uncertainty, they said, clinics and other stakeholders need sustained, structured dialogue if they are to be nimble and flexible enough to meet the challenges. Far from a series of one-off meetings, they said, these dialogues should be a model for a long-term conversation that brings in an even wider range of stakeholders and brings the power of communities to bear.

Several noted that time is short. In spite of uncertainties about the future of ACA, changes have already begun and more are coming. Clinics must take the initiative or risk being left behind as the health care environment changes around them. Most stressed the need to maintain and build on the momentum created in the dialogue to be able to meet that challenge.

ENDNOTES

1. A total of 84 stakeholder participants took part: 28 participants in San Diego, 34 in Los Angeles, and 22 in Alameda.
2. See *California's Community Clinics and Health Centers: The Online Conversation* (Viewpoint Learning, June 2011); available at: **http://www.viewpointlearning.com/wp-content/uploads/2011/04/BSCF_CCHCSOnline_WEB.pdf**. See also *On the Cusp of Change: The Health Care Preferences of Low Income Californians* (Langer Research Associates, June 2011); available at: **http://www.blueshieldcafoundation.org/publications/cusp-change-healthcare-preferences-low-income-californians**.
3. Californians are going online in increasing numbers, and the digital divide is narrowing. According to the Public Policy Institute of California (PPIC), 72% of Californians with household incomes under $40K go online, and the rate of online access is growing rapidly in these populations. In addition, mobile phones are transforming access, especially for minorities and low-income households: African Americans and Latinos are especially likely to use mobile phones as their primary way of accessing the Internet. These trends are likely to continue. See *PPIC Statewide Survey: Californians and Technology* (June 2011).