

# The Vital Role of Community Clinics and Health Centers



*Assuring Access for All Californians*

**CPCA**  
California Primary  
Care Association

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## Assuring Access for All Californians

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Community clinics and health centers (CCHCs) play a critical role in assuring access to health care for Californians, especially those who are uninsured or who experience other barriers to care. California is home to 6.6 million uninsured – the largest number in any U.S. state and 15% of the country’s total uninsured.<sup>1</sup> Nearly one in every five Californians has no health insurance.<sup>2</sup>

CCHCs are vitally important as a medical home to a significant portion of the state’s population: A statewide network of nearly 800 clinic sites provides a great portion of care to the uninsured. In 2005, CCHCs delivered more than 11 million encounters to over 3.6 million patients.<sup>3</sup> Nearly two-thirds of clinic patients (62%) have incomes below the federal poverty line; 83% live below 200% of poverty.<sup>4</sup> CCHCs offer a comprehensive continuum of care to all Californians, regardless of their ability to pay. In some communities, CCHCs are the only providers available to low-income residents who are uninsured or are on Medi-Cal.

In 2007 and 2008, California failed to pass a health reform package to extend coverage to uninsured Californians. As it continues to seek a viable means for expanding coverage, the state will have to consider who will provide this care. California’s CCHCs have the experience and expertise to provide culturally sensitive, cost-effective care to the uninsured and newly insured. They are an essential segment of California’s health system, and should be considered a critical component of any proposal for change in health coverage and policy.

The health care access strategies included here will help assure that CCHCs are prepared to continue and expand their role as a cornerstone of California’s health care system, especially for the state’s most vulnerable communities.

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# California CCHCs: A Wise Investment

The National Association of Community Health Centers estimates that health centers generate savings of \$9.9 to \$17.6 billion annually.

## Health Centers Reduce Costs

The Federal Office of Management and Budget has ranked health centers one of the ten most effective federal programs. By focusing on prevention, CCHCs save substantial dollars in avoided emergency room visits, medical treatment, and hospitalization.

Patients who receive most of their medical care at a health center have significantly lower total medical expenses, with annual medical expenses 41% lower for health center patients.<sup>5</sup> The average total annual cost of care per patient in CCHCs is \$455 compared to \$657 for office-based medical providers. Furthermore, clinics have reduced Medicaid spending by 30%.<sup>6</sup> The National Association of Community Health Centers has documented that, “If every American made use of primary care, the health care system would see \$67 billion in savings annually...”<sup>7</sup>

The comprehensive model used by CCHCs has been shown to provide high-quality and cost-effective care that reduces the number of hospitalizations and emergency department visits. It also reduces costly care by specialists. An analysis of medical records of CCHC patients found that their quality of care was comparable to or better than care delivered elsewhere, as measured by reduced hospitalizations and emergency department visits, higher vaccination rates, and higher cancer screening rates.<sup>8</sup> Nationwide, compared with Medicaid patients treated elsewhere, Medicaid patients served at CCHCs are between 11% and 22% less likely to be hospitalized for avoidable conditions; 19% less likely to use the emergency room for avoidable conditions; and have lower hospital admission rates, shorter lengths of hospital stays, less costly admissions, and lower outpatient and other care costs. Together, this amounts to 30% to 33% in total cost savings for each Medicaid beneficiary served in a CCHC.<sup>9,10</sup>

Other studies have found that CCHCs produce significant savings for payers compared with private physicians,<sup>11,12</sup> and provide higher quality care at a significantly lower cost than other primary care or ambulatory care settings.<sup>13</sup>

Because health centers have a proven record of success, President Bush has made the Health Center Program the centerpiece of his health care plan, asking Congress to increase funding for the program in FY 2007 by \$181 million.

## Health Centers Increase Access with Enhanced Services

Having a usual source of care, or ‘medical home,’ has been demonstrated to improve health status and outcomes.<sup>14</sup> The American College of Physicians, the American Academy of Family Physicians, the American Academy of Pediatrics, and the American Osteopathic Association, together have proposed a patient-centered medical home model as a way to reduce cost and increase the quality of care.<sup>15</sup>

CCHCs assure a medical home for the hardest to reach patients by addressing the obstacles that keep them away from care. They offer a comprehensive, coordinated system of care that includes access to essential services on-site or by referral including oral health, behavioral health, substance abuse, and specialty care.

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These services are supplemented by a broad range of enhanced services that together assure access to care including outreach, patient education, translation and interpretation, labor coaching, childbirth education classes, child care, transportation vouchers, and assistance applying for health insurance coverage. Case management ties these together, assuring that patients receive the full range of services they need.

## Health Centers Help to Reduce Health Disparities

CCHCs are leaders in addressing ethnic and racial health disparities and improve health outcomes for the patients they serve. A report by the Kaiser Family Foundation concludes that the nation's diversity is growing – nearly one-third of the population identified as a member of a racial or ethnic minority group in 2005, and those numbers are expected to increase to nearly half by 2050.<sup>16</sup> Minority representation is even greater in California, where nearly half (46%) of children birth to 18 years are Hispanic compared to 20% of the nation as a whole.<sup>17</sup> Almost 60% of the state's uninsured are Latino.<sup>18</sup>

Prevalence of specific health problems – such as diabetes or obesity – is higher among minority populations and can have serious health consequences. Death rates due to many common diseases, including cancer and heart disease, are higher for some minorities than for Whites. Yet racial and ethnic minority Americans are less likely than Whites to have a usual place to receive care or to have a health care visit. For Hispanics, these differences persist even when accounting for income.<sup>19</sup>

CCHC patients often face chronic illness and multiple health problems. Effective management of chronic disease at health centers has improved outcomes and lowered the cost of treating patients with chronic illness. In a recent study, health center Medicaid patients with diabetes cost \$400 less per patient than diabetic Medicaid patients treated by family practice physicians, despite having more office visits per patient as well as more patients with multiple chronic diseases.<sup>20</sup>

A 2002 Institute of Medicine (IOM) describes the important role of health centers in increasing access to care and in improving health outcomes for all patients. The report concludes that minorities do not receive the same quality of health care as non-minorities, even after accounting for differences in income, insurance status, and medical conditions. As a result, minorities have disproportionately high rates of morbidity and mortality.<sup>21</sup> The report identifies factors contributing to disparities, including language barriers, inadequate coverage, provider bias, and a lack of minority doctors.

This is not true for patients at CCHCs. Requirements for health center funding under Section 330 of the Public Health Services Act serve to reduce these disparities through providing access to care in medically underserved areas; offering comprehensive services – including the enabling services described above – serving all who seek care regardless of their ability to pay; governance by a community board; and rigorous performance and accountability requirements.

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But CCHCs don't stop there. A 2003 issue brief published by the National Association of Community Health Centers describes the ways in which CCHCs have historically gone beyond those mandates to employ many of the methods the IOM recommends for reducing health disparities.<sup>22</sup> Specifically, the brief points to effective provider-patient communication, use of community health workers and health promoters, treatment by multi-disciplinary teams, and continuity of care.

Many health centers participate in Bureau of Primary Health Care sponsored Health Disparities Collaboratives designed to actively engage both providers and patients in improving health outcomes for chronic conditions such as diabetes, cardiovascular disease, asthma, depression, prevention, cancer, and HIV. The Collaboratives employ a population-based chronic care model that uses best practices to track and address chronic illness using electronic registries, and to document outcomes used to evaluate the success of the program.

The Health Disparities Collaboratives show the success of the CCHC model in reducing disparities and improving outcomes while at the same time reducing cost. One study found that patients in underserved areas served by federally qualified health centers (FQHCs) had 5.8 fewer preventable hospitalizations per 1,000 population over three years than did those in underserved areas not served by an FQHC.<sup>23</sup> At the time of the NACHC brief in 2003, studies already were finding that health centers produced Medicaid savings of at least 30% annually due to reduced specialty care referrals and fewer hospitalizations. NACHC estimated, based on that data, that health centers were saving almost \$3 billion annually in combined federal and state Medicaid expenditures – \$1.2 billion in state spending alone. These savings amount to more than four times the total of state-appropriated funding provided to health centers nation-wide.<sup>24</sup>

### Health Centers Contribute to Stronger Local Economies

CCHCs benefit their communities in many ways beyond the direct effect of the care they provide. In a 2008 brief, researchers from the School of Public Health and Health Services at The George Washington University estimated that a \$250 million investment in community health centers nationwide would yield care for an additional 1.8 million patients, providing nearly \$1 billion in direct benefits and more than \$1.1 billion in indirect benefits. In California, the report estimates that each investment of \$1 million would stimulate \$12.9 million in economic activity, nearly a 13-to-1 return on investment. This includes \$6.4 million in new revenues, 12,500 new patients served, and 141 FTE jobs.<sup>25</sup>

A 2006 Economic Impact Analysis performed by Capital Link in collaboration with the California Primary Care Association likewise found that CCHCs make an important contribution to their local economies.<sup>26</sup> In 2005, California's 794 CCHCs had an overall economic impact of more than \$3.15 billion, directly injecting almost \$1.6 billion into their local economies and supporting more than 26,500 jobs.

# Obstacles to Fulfilling CCHCs Role

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CCHCs have demonstrated their ability to provide high quality care while keeping health care costs down. Yet, they face important obstacles to further improving outcomes and reducing cost.

## Capital Shortfalls for Needed Infrastructure Expansions

In order to be effective, efforts to reform health care in California must include investments in clinic infrastructure. As policy makers seek to expand coverage to the uninsured, they must examine the systems able to provide the new care that will be covered. As part of California's safety net, CCHCs have essential experience and expertise in delivering culturally sensitive, cost-effective care to the uninsured and underinsured.

Infrastructure investments in CCHCs offer demonstrated gains in access to quality care. Through the Cedillo-Alarcón Community Clinic Investment Act, an investment of \$30 million in clinic infrastructure funds resulted in an increase of more than 700,000 patient visits. Every \$1 million of infrastructure investment in CCHCs translates to an additional 23,000 patient visits.

Yet, while CCHCs are best suited to serve many of the coverage expansion populations, their capacity to provide additional services is limited. Capital Link has identified a need for \$989 million in capital funding for California CCHCs through 2011.<sup>28</sup> State investments in health center infrastructure can allow additional low-income Californians to secure a medical home and to access effective primary and preventive health care services. Investments in expanding access to quality, affordable care through CCHCs can save the state millions by mitigating the need for more costly emergency room care.

## Inadequate Reimbursement Rates

Many of the patients who come to the clinics with chronic diseases requiring extensive medical care have no coverage. For those who are covered by Medi-Cal, that program does not reimburse for team-based, non-physician services, even though early results for clinics implementing the chronic care model show improved health outcomes resulting from these services.

California spends an average \$5257 per Medi-Cal beneficiary annually, almost 30% less than the national average of \$7188. In fact, California ranks 47<sup>th</sup> out of 50 U.S. states in total Medicaid (Medi-Cal in California) spending per patient and spends the least per beneficiary among the ten most populous states.<sup>29</sup> Medi-Cal managed care capitation rates are the lowest in the nation.

This has a strong effect on CCHCs, which receive a little more than half (51%) of their patient revenues from Medi-Cal, and another 34% from public programs for the uninsured such as Healthy Families, CHDP, Family PACT, and county medically indigent programs.<sup>30</sup>

Choosing between expanding the safety net and expanding health insurance coverage will not eliminate barriers to access currently felt by insured and uninsured Californians. Instead, pursuing both is necessary to improve access.<sup>27</sup>

To remain viable, clinics will need to continue receiving payments under PPS for all Medi-Cal populations – those directly enrolled as well as expansion populations whose coverage is financed by Medi-Cal.

CCHCs have transitioned from a cost-based reimbursement system to a fixed price, per-visit prospective payment system (PPS) that rewards clinics for efficiency but does not always cover the full cost of care. To remain viable, clinics will need to continue receiving payments under PPS for all Medi-Cal populations – those directly enrolled as well as expansion populations whose coverage is financed by Medi-Cal.

Of particular concern is the lack of reimbursement for enabling services. Despite the fact that these services have been demonstrated to vastly improve the effectiveness of care and to improve health outcomes, CCHCs are not reimbursed for services such as outreach, patient education, care management, translation and interpretation, labor coaching, childbirth education classes, and transportation vouchers when those services are provided on the same day as a medical visit – the very services known to increase access, improve outcomes, and reduce disparities.

### **Obstacles to Participating in Public and Private Health Care Systems**

The difficulties clinics have faced participating in managed care highlights some of the challenges to participating in newly designed health systems. When Medi-Cal patients were first transitioned to managed care, CCHCs had difficulty securing contracts with managed care plans. The plans were accustomed to assigning patients to specific providers and not to provider organizations such as clinics. As a result, when a provider left a clinic, their assigned patients were transferred with them, separating them from their established medical home. CPCA brought legislation to clarify that plans could assign lives to clinics and not just to individual providers. When Healthy Families (California's SCHIP program) was established, beneficiaries were permitted to select a community provider at a lower cost than for other program providers.

As the medical home to the state's most vulnerable populations, CCHCs must be included an integral part of any care expansions serving this population. Including CCHCs in new provider networks established under health reform will assure continuity for CCHC patients requiring culturally and linguistically appropriate services. A requirement mandating their inclusion in provider networks would enhance the ability of CCHCs to negotiate for adequate reimbursement rates, increasing their ongoing sustainability.

Passed by the voters in 2004, California Proposition 63 (the Mental Health Services Act) provides funding to counties to expand services and develop innovative programs and integrated service plans for addressing mental health issues in children, adults, and the elderly. This funding offers opportunities for integration between counties and CCHCs to jointly implement programs to achieve improvements in mental health.

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## Difficulties Accessing Specialty Care

A 2002-2003 survey of the medical directors of California FQHCs found access to specialty care for their uninsured patients to be an especially significant problem, with 85% of medical directors reporting problems accessing specialty care for their patients.<sup>31</sup> Half said the problem had worsened over the previous two years. The report recommends increasing the supply of specialty physicians and strengthening relationships between primary care providers and hospitals, which are the major providers of specialty care to the uninsured receiving care in FQHCs. The report also suggests that, “shortages in low-income areas could be exacerbated by any additional cuts in Medi-Cal that reduce provider reimbursement.”

## Lack of Resources to Support Expanding Health Information Technologies

Health information technology (HIT) is critical to achieving affordable, safe and accessible health care in California. HIT improvements have contributed to better communications, better quality assurance through data-driven decision-making, increased efficiency, enhanced quality of care, and ultimately to stronger, healthier communities. Increasing technology demands, coupled with insufficient resources to meet them, make it difficult for clinics to keep up. Limited funding prevents CCHCs from fully implementing HIT to provide more efficient, cost-effective care, and to fully track that care and the outcomes it produces.

## Workforce Shortages

Finally, persistent shortages in the health care workforce make it difficult for CCHCs to recruit and retain staff. There is particularly heightened competition for culturally and linguistically competent staff to serve California’s increasingly diversified population. This challenge affects all levels of clinic employees, from line staff to chief executives, and providers including physicians, dentists, nurses, and nearly 200 allied health professions. Challenges include assuring a pipeline of adequately prepared providers, support for salaries and benefits to attract quality staff, and incentives to retain providers, especially in remote or otherwise challenging positions and locations.

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# Health Care Access Strategies For California

Clinics are critically important to the economic success of their communities.

We offer the following strategies to preserve and advance the vital role of CCHCs in assuring that all Californians have access to a medical home and to essential and effective health care services.

## Expand Primary Care Capacity

California's large population of un- and under-insured and other disenfranchised individuals puts the need for expanded primary care capacity at the top of the list. Clinics serve a large proportion of Californians with incomes at or below 200% of poverty, and nearly half of clinic patients are uninsured. CCHCs must be able to expand their facilities and infrastructure if they are to continue meeting the health care needs of California's underserved.

Despite the availability of funding over the past few years, CCHCs still have much unmet need for expansion of physical infrastructure: buildings and equipment. Capital Link has estimated that California clinics have a total expansion need of approximately 2.475 million square feet over the next five years at a cost of \$989 million.

Clinics are critically important to the economic success of their communities. In light of their proven track record in providing cost effective, quality care, funding for their expanded infrastructure should be an important element of any proposal for health care reform. Recognizing this with significant investments in clinic infrastructure and capacity can help not only to increase the volume of patient care, but also to improve the health of communities, reducing the need for care. Key areas for capacity expansion include core support, capital, and technology. (The latter is discussed separately, below.)

## Enhance Health Information Technology

Technology has become increasingly essential to the quality of care, efficiency, alliance-building, infrastructure, and financial viability of safety net providers. Health information technology (HIT) is essential to the clinics' ability to provide safe and affordable health care to their clients. Our survey showed that CCHCs believe HIT is important and that they are ready to move forward in implementing technological advances.

One key area for HIT in the coming years will be enhancing the ability to use technology to support and document quality improvements. Technology-enabled quality improvement supports the recent proposal of four physician groups to promote a patient-centered medical home (PC-MH) model as described in the section above on chronic illness. Such a model incorporates much of what CCHCs already are known for: assuring patients have a primary physician as their home base, assisting patients in navigating the continuum of care, and using health IT to support care integration, including the expanded use of chronic disease registries.

Other areas for enhanced HIT include:

- Broadening implementation of electronic health records to enable providers to make quick and accurate diagnoses and clinic decisions using real-time information.

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- Helping clinics to systematize, document, and track the care they already provide for both internal (cost and quality) as well as external (contract reporting, information exchange) purposes.
  - Increasing capacity for and use of telemedicine.
  - Participating in regional and statewide health information exchange.

Technology is expensive. It cannot be funded through patient revenues or cost savings, at least not in the short term. But while technology requires a significant up-front investment, there is good reason to believe that it will pay off eventually in better care, ultimately leading to reduced costs. Until that happens, clinics will require external funding in order to meet this essential need.

### Address Workforce Obstacles

Workforce issues have emerged as a growing concern among clinics, which have experienced reduced availability of qualified medical and other staff, especially those who are prepared to address the linguistic and cultural needs of their patients. To be successful, workforce strategies will need to address the full spectrum of issues, from the supply of physicians and other providers, to adequate salaries and benefits or other incentives to attract them, to training and other programs that can improve retention rates. Workforce obstacles are particularly challenging in rural areas and in patient populations with cultural and linguistic barriers to care. Workforce initiatives should take into consideration the \$3.15 billion in business that California clinics and health centers bring to their communities and to the state. This includes providing 26,500 jobs, many offering lower income opportunities for advancement.

### Support CCHC Model Practices In Prevention, Population Health, and Chronic Disease Care

There is much data to support the efficacy and cost-effectiveness of the clinic model. Support is needed to continue and expand these efforts, which have been proven to improve the health of communities while reducing costs. At the same time, more and better data are needed to document and widely disseminate these innovative practices. At the core of the clinic model is prevention and a population-based health strategy that treats the patient as a whole person within a community, providing comprehensive primary care and preventive services in one setting along with case management and supportive services that allow patients to access and actively participate in their care. CCHCs have taken a leadership role in using this approach to manage the chronic conditions that disproportionately affect their patients through their participation in chronic disease registries and other quality initiatives. Investments are needed to support the technology and infrastructure required to build on these innovations to reduce health disparities, as well as to support core services that are not compensated through traditional health care reimbursement systems. In the long term, supporting effective clinic models can lead to shifts in public reimbursement programs to

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better cover the actual cost associated with the expanded and supportive services CCHCs provide.

### **Promote Integrated Systems That Link Safety Net and Other Providers to Address Multiple Patient Needs**

Clinics already do a good job of addressing the complex needs of their patient populations in an integrated way. Integration among providers can help to spread effective practices between clinics and other entities to promote the best interest of the patient. Such relationships may include alliances and partnerships that coordinate comprehensive care and create access across multiple systems, including between CCHCs and private providers. Integrated systems can help CCHCs and others to develop and achieve shared financial risk, resources, and financial accountability, as well as common medical records, quality standards, and approaches to disease management. One area ripe for integration is to facilitate CCHC involvement in local and regional public health efforts.

### **Conclusion**

Community clinics and health centers are uniquely positioned to help California achieve prevention objectives while reducing cost and improving the economic well-being of communities and of the state as a whole. In order to do this, they must be recognized and appropriately supported for the pivotal role they play in California's health care system.

Already stretched to the limit and beyond, CCHCs require additional resources and protections to meet their continuing role and to grow effectively to meet the increased need associated with future expansions in coverage. The strategies outlined above are intended to assure that CCHCs are able to continue to play a pivotal role in delivering quality health care to all Californians.

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