EXTERNAL STAKEHOLDERS' PERCEPTIONS OF MISSISSIPPI COMMUNITY HEALTH CENTERS

Prepared by

MISSISSIPPI **PRIMARY HEALTH CARE** ASSOCIATION

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Greetings:

The Community Health Center (CHC) was born out of a movement (The War on Poverty) over 50 years ago (1965) to provide healthcare to one of the poorest and poverty stricken regions in the entire United States of America (USA), the Mississippi Delta. From what is arguably the first CHC in the USA, Delta Health Center in Mound Bayou, the CHC movement has grown to more than 1300 CHCs serving over 9000 communities today nationwide.

Whereas the goal of yesterday was to provide mere basic healthcare to areas where medical bankruptcy was the norm, the goal of the CHC today is to provide access to comprehensive quality primary healthcare.

CHCs take pride in the fact that the movement got its humble beginning in Mississippi and now are among the leaders in addressing access to quality healthcare in the USA. In addition to providing access to quality healthcare, CHCs and the Mississippi Primary Health Care Association (MPHCA) intend to bring data and reports to demonstrate their impact.

MPHCA is happy to present you with the following presentation regarding select perceptions of CHC's in Mississippi.

Sincerely,

Rashad N. Ali, MD, JD, FACOG

Board President

EXTERNAL STAKEHOLDERS' PERCEPTIONS OF MISSISSIPPI COMMUNITY HEALTH CENTERS

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INTRODUCTION

In Mississippi there are twenty-one (21) community health centers operating approximately 190 sites statewide. Mississippi Community Health Centers (MS-CHCs) provide quality comprehensive healthcare in accredited medical homes to over 300,000 patients in underserved communities in Mississippi. MS-CHCs generate more than a quarter billion dollars per capita to the state's economy.

The Mississippi Primary Health Care Association (MPHCA) is the nonprofit membership organization supporting the 21 MS-CHCs who operate as Federally Qualified Health Centers (FQHCs). For over 30 years, MPHCA has provided its members with exceptional training, technical support, and advocacy at the state and federal level. As an advocate for vulnerable populations seeking access to basic health services, MPHCA works with its member MS-CHCs, the National Association of Community Health Centers (NACHC), the Mississippi State Department of Health, and a host of cooperative agencies and partners to ensure the continued growth of community-based programs, services and centers providing quality, affordable health care for Mississippi's most vulnerable and medically indigent populations.

Federally Qualified Health Centers (FQHCs) are organizations who receive grants under Section 330 of the Public Health Service Act (PHS). FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors, a majority of which comprise users of the health center.[1]

In a 2006 report from the U.S. Department of Health and Human Services (HHS) and the Health Resources and Services Administration (HRSA) the background of FQHCs is defined as[2]:

> *The term "Federally Qualified Health Center," or FQHC, refers to three different types of clinics:*
>
> • *Health Centers (HCs) funded under Section 330 of the Public Health Service (PHS) Act, including Community Health Centers (CHCs), Migrant Health Centers (MHCs), Health Care for the Homeless Health Centers (HCHs), and Public Housing Primary Care Centers (PHPCs); (Note: Information regarding HCHs and PHPCs is not included in this publication.*

[1] U.S. Department of Health and Human Services and Health Resources and Services Administration (HRSA), Health Information Technology website www.hhs.gov

[2] Comparison of the Rural Health Clinic and Federally Qualified Health Center Programs, Revised June 2006

Further information regarding these programs may be found at http://www.bphc.hrsa.gov)

• FQHC "Look-Alikes," or FQHCLAs, that have been identified by HRSA and certified by CMS as meeting the definition of "Health Center" under Section 330 7 of the PHS Act, although they do not receive grant funding under Section 330; and

• Outpatient health programs/facilities operated by tribal organizations (under the Indian Self-Determination Act) or urban Indian organizations (under the Indian Health Care Improvement Act).

MPHCA and MS-CHCs recognize that partnerships and stakeholder engagement are an important part of providing comprehensive primary and preventative health care to medically under-served areas. In a rapidly evolving healthcare industry it is important to solicit external stakeholders' perceptions of MS-CHCs to effectively ensure that the underserved populations have access to comprehensive primary healthcare. America Health Rankings recently cited that Mississippi is the lowest ranked state for prevention care and not meeting the national average in access to care, immunizations and chronic disease management.[3]

Each of the 21 MS-CHCs operate independently from each other with their own organization names, logos and marketing. Yet, as an FQHC each provides quality primary health care services that are outlined by the U.S. Department of Health and Human Services and the Health Resources and Services Administration (HRSA) ensuring a patient receives the same level of care across the United States at any FQHC. Local FQHCs are identical in all facets of primary care except where some choose to offer additional services such as dental, 340B prescription services and behavioral health for example. The National Association of Community Health Centers adds, '*Each Health Center takes a tailored approach to meet the diverse needs of their patients and communities as a whole. This local approach to healthcare, combined with an emphasis on comprehensive primary and preventative care, generates $24 billion in annual savings to the healthcare system for the American taxpayer; local, state, and federal governments; and public and private payers alike.'*[4]

[3] The overall prevention score is based on 13 prevention measures. For more information, see Spotlight: Prevention at www.americashealthrankings.org/spotlight/prevention.

[4] www.nacha.com – About Our Health Centers, http://www.nachc.com/about-our-health-centers.cfm

MPHCA believes certain questions emerge from this similarly structured, locally focused model under the FQHC designation, such as:

- What is the awareness of FQHCs as community health centers who are unique in their own capacity and are structured as a network of primary care providers with the same federal mandates?
- How do we educate communities that FQHCs and MS-CHCs are primary care providers who offer a patient-centered medical home for a host of healthcare (physical, including oral and mental health needs?
- How do we increase the awareness of MS-CHCs as a whole and advertise the unique capacity of each individual CHC?
- What is the external stakeholders' perception of FQHCs or Community Health Centers? Are they perceived as good partners? Are they impacting healthcare outcomes in Mississippi?
- Finally, based on the findings what areas does MPHCA need to explore further?

A short survey was developed by staff at MPHCA in March of 2016. It was made available to unique webpage visitors at www.mphca.com; as well as disseminated via email to non-profit organizations, state agencies/employees, community action agencies, health plan providers, medical associations, state and local elected leaders, private health care companies/providers, partners, insurance providers, and patients across Mississippi.

MPHCA set out to develop a baseline survey to determine how external stakeholders define the organization, as well as how the work of the MS-CHCs is recognized and to assess the benefit of CHC partnerships towards an improved healthcare delivery system? The objective of this survey is to determine how MPHCA can develop a brand awareness of MS-CHCs that will in turn help impact positively, health outcomes of Mississippians. The secondary goal is by identifying gaps that emerge from the survey, we can improve awareness at both the state level (MPHCA) and at the individual health center level. These goals should aid MS-CHCs within their respective geographic areas as providers who are engaged partners within the local community, who respond to the changing demands of the community health needs.

METHODOLOGY

The survey population was made up of unique webpage visitors at www.mphca.com, non-profit organizations, state agencies/employees, community action agencies, health plan providers, medical

associations, state and local elected leaders, private health care companies/providers, partners, insurance providers, and patients across Mississippi.

Survey Monkey was used to develop the survey questionnaire structure. Email invites and webpage links were sent to over 500 potential respondents. Of those sent we received 144 surveys and 14 of those were returned partially completed. The survey results are from the period from March 7, 2016 to April 29, 2016.

The major sections of the survey were:

- What labels come to mind when you think of an FQHC?
- Have you visited or partnered with an FQHC in the last year?
- Which of the following best describes the work of an FQHC?
- How likely are you to refer a patient to an FQHC for healthcare services?

MPHCA did not conduct a pre-test prior to this survey. The survey serves as a baseline of information to assist with strategic planning for the MPHCA over the next several years. MPHCA used the internal survey monkey data analysis tool and exported data to an Excel spreadsheet to disseminate results.

RESULTS

In analyzing the results, MPHCA reviewed who respondents "primarily" identified as i.e. what type of organization they represented. The responses were then divided by groups into FQHCs and Non-FQHCs. The FQHCs are those who identified as FQHC employees, providers or board members. Non-FQHCs made up the remaining audience. Non-FQHCs made up 72% of the respondents. Those who primarily identify as 'Other' made up the majority of the respondents; but based on the specified answers they fell into one of the other listed categories. Only 2 total respondents did not fit into any listed categories. The second and third highest groups were 'Other Non-Profit Agencies/Employees' at 18% and 'State Agency/Employee' at 17%. These Non-FQHCs identify as the external stakeholder audience and are the focus of our survey results.

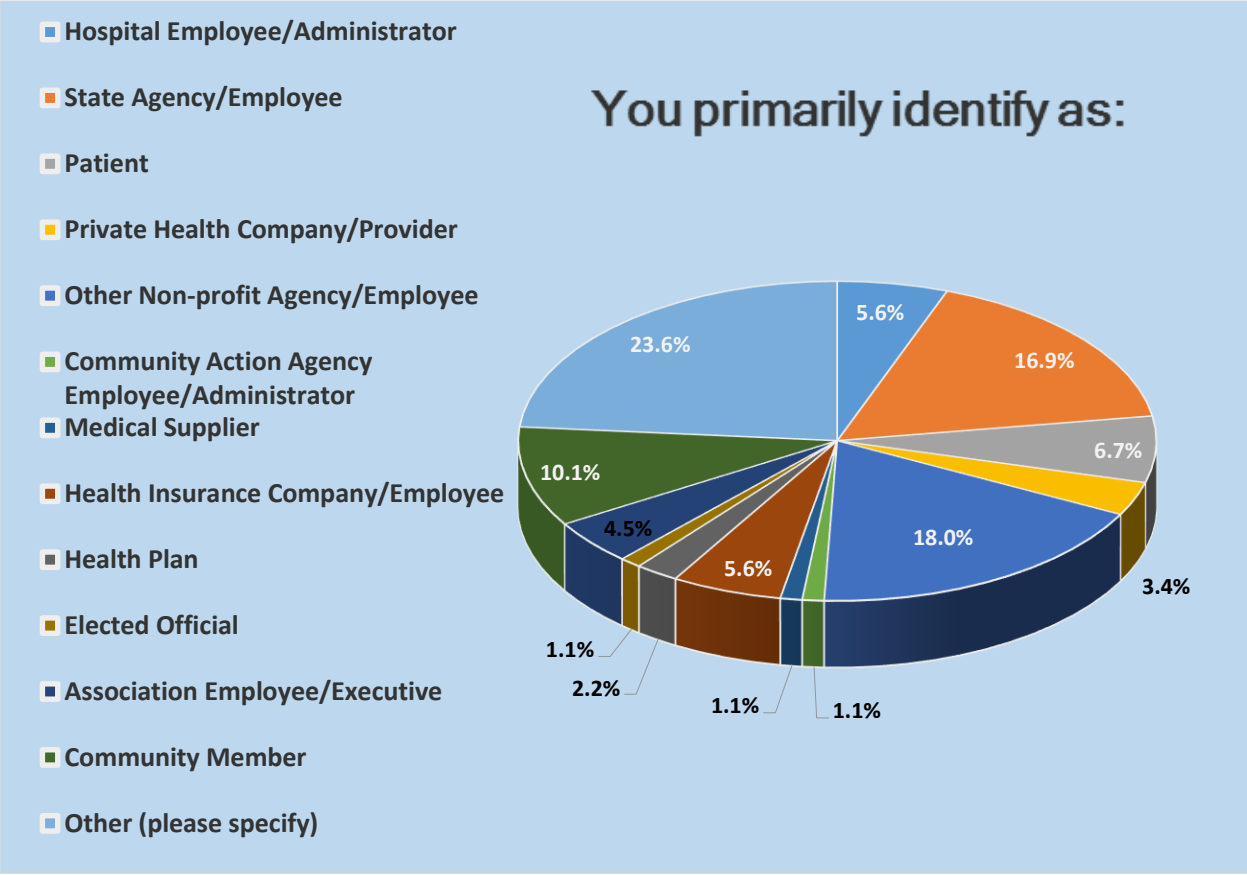

Chart 1: Non-FQHC respondents primary identify as (Question 8 – Community Assessment of FQHCs in MS)

Once we have identified our external stakeholders, we then compared the responses of the survey questions between FQHCs and Non-FQHC to determine the variance in the perceptions internally verses externally. The goal is to find the gaps in perception so we can strategically plan our network-wide branding, gauge the publics definition of FQHCs, and see what areas we can improve our

community services in the healthcare industry. Secondary, how do we view ourselves in this framework?

The first survey question asked what labels that come to mind when the respondent thinks of an FQHC. They were given a choice of 15 labels that ranged from services we provide, common labels used by our patients and partners, similar healthcare clinics who serve the public, and those promoted by HRSA, MPHCA and used nationally by other community health centers. The list was developed by staff at MPHCA and employees at the MS-CHCs. The results are as follows:

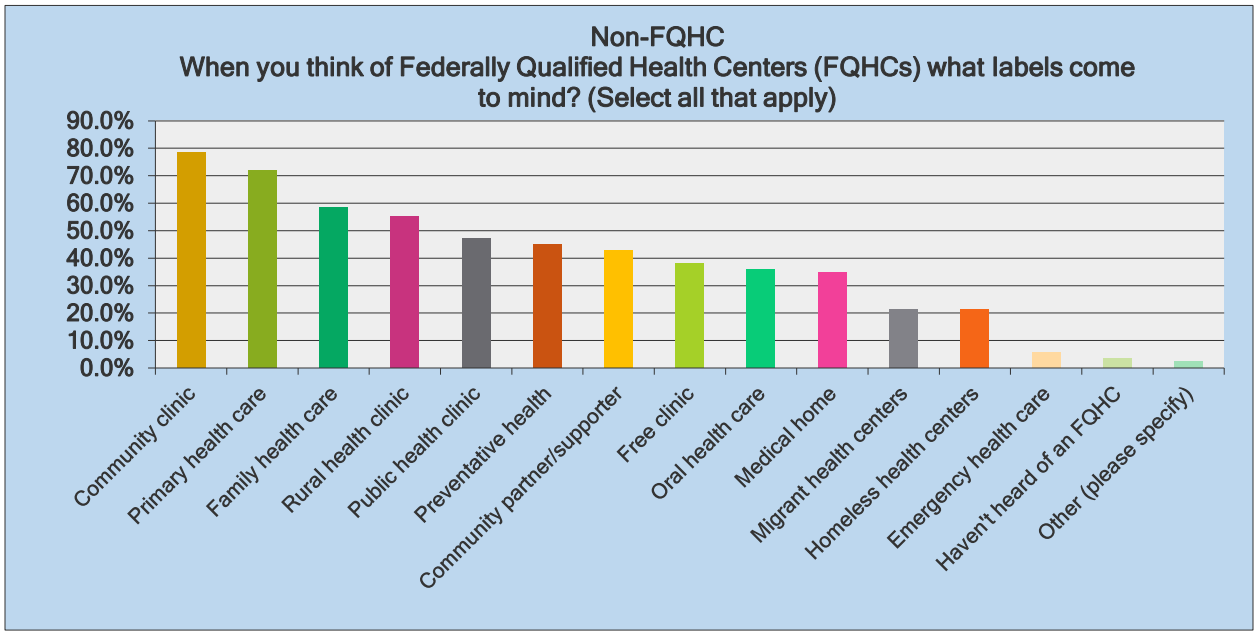

Chart 2: FQHCs only: What labels come to mind (Question 1 – Community Assessment of FQHCs in MS)

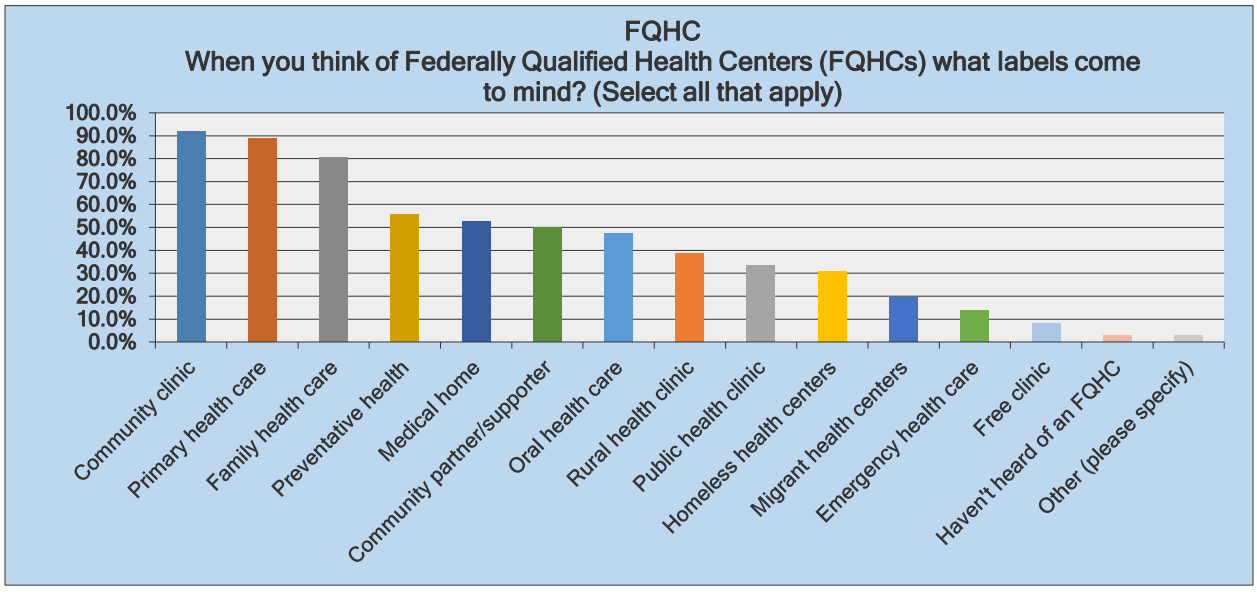

Chart 3: Non-FQHCs only: What labels come to mind (Question 1 – Community Assessment of FQHCs in MS)

The second question followed up by asking respondents to rank the top three labels that came to mind. While the response between the two groups show little variation in the top three labels, as we look at Question 2 where they were asked to rank the top three they chose we begin to see a divergence.

FQHCs Only: Based on your prior answers, rank the top three (1 to 3)

First	Second	Third
Primary Health Care	**Community Clinic**	**Family Medical Care**
Community Clinic	Medical Home	Medical Home
Family Health Care	Primary Health Care	Community Clinic
Medical Home (tie)	Rural Health Clinic	Community Partner
Public Health (tie)	Preventative Health	Primary Health Care
Rural Health (tie)		

Ranking 1: FQHCs Top Three Labels (Question 2 – Community Assessment of FQHCs in MS)

Non-FQHCs Only: Based on your prior answers, rank the top three (1 to 3)

First	Second	Third
Primary Health Care	**Community Clinic**	**Community Clinic**
Community Clinic	Primary Health Care	Family Health Care
Free Clinic	Public Health Clinic	Free Clinic
Public Health Clinic	Family Health Care	Rural Health Clinic
Rural Health Clinic	Free Clinic	Primary Health Care

Ranking 2: Non-FQHCs Top Three Labels (Question 2 – Community Assessment of FQHCs in MS)

These rankings revea that internally and externally MS-CHCs are seen as primary health care providers within the community and providing family medical care. First impressions are ranked as positive and accurate descriptions of the services provided at our centers. However, externally contrary terms begin to emerge in the rankings: Free Clinic, Public Health Clinic and Rural Health Clinic.

While FQHCs provide services to low-income underserved populations, they are not 'free' healthcare facilities. The HRSA Program Requirement for Sliding Fee Discounts states:

Sliding Fee Discounts

Health center has a system in place to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay.

- *This system must provide a full discount to individuals and families with annual incomes at or below 100% of the Federal poverty guidelines (only nominal fees may be charged) and for those with incomes between 100% and 200% of poverty, fees must be charged in accordance with a sliding discount policy based on family size and income.*
- *No discounts may be provided to patients with incomes over 200 % of the Federal poverty guidelines.*
- *No patient will be denied health care services due to an individual's inability to pay for such services by the health center, assuring that any fees or payments required by the center for such services will be reduced or waived.*[5]

FQHCs receive federal funding through the 330 Act Grant. Through this grant Community Health Centers do provide service to low-income, no-income and patients without health insurance. However, this award accounts for 30% of the yearly operating budget of an FQHC. The remainder of the revenue comes through Medicaid and Medicare patients and those who have ACA or private health insurance. It is important that FQHCs focus on education campaigns that promote the sliding scale discounts that benefit eligible populations to fulfill the primary mission of community health centers. Yet, in an ever increasing competition for healthcare dollars with private providers who are focused on insured patients, non-profit CHCs must cater to both audiences to stay financially viable. In Mississippi healthcare system trends reveal rapidly growing provider networks - like Merit Health - though conglomeration and acquisitions of existing health facilities or by building new facilities outside their primary market area.[6]

The other high external rankings of Rural Health Clinic shows that MS-CHCs are being confused with (FQHC) Rural Health Clinics as previous defined in the Introduction. These clinics do not offer the full scope of primary health care nor are they staffed with level of medical providers one finds at a CHC. It is especially important that MS-CHCs differentiate their model of healthcare from these two clinics. Rural Health Clinics (RHC) are also funded through the Section 330 of the Public Service Act. Yet, these

[5] (Section 330(k)(3)(G) of the PHS Act, 42 CFR 51c.303(f), and 42 CFR 51c.303(u))
[6] Merit Press Release "Six hospitals in region combine to create the new Merit Health system" Jan. 28, 2015

facilities are offer significantly less healthcare services than FQHCs. Per the HRSA website: *RHCs are required to be staffed by a team that includes one mid-level provider, such as a nurse practitioner (NP), physician assistant (PA), or certified nurse midwife (CNM), that must be on-site to see patients at least 50 percent of the time the clinic is open, and a physician (MD or DO) to supervise the mid-level practitioner in a manner consistent with state and federal law. While federally qualified health centers (FQHCs) provide dental, mental health, substance abuse, and transportation services, RHCs are only required to provide outpatient primary care services and basic laboratory services. RHCs must be located within non-urban rural areas that have health care shortage designations.*[7]

Additionally, RHCs focus is to increase rural Medicare and Medicaid patients' access to primary care services and utilize a prospective payment system (PPS) through CMS rather than via a cost-based reimbursement system used in FQHCs for CMS qualified patients.

The label rankings by our external partners reveal that while some of the preferred labels are at the top of the list, MS-CHCs need to develop an education and awareness plan to highlight the sliding scale discount and the brand of CHCs as a medical or health care home that is a patient and family center source of care that offers regular, continuous primary and preventative are for the people it serves. The advantages of this identity within the community according to NACHC is *"Medical homes have been shown to benefit patients by preventing sickness, managing chronic illness, mitigating disparities, and reducing the need for avoidable, costlier care such as emergency room visits and hospitalizations. Health centers function as comprehensive "health care homes," given expanded services that include behavioral and oral health."*[8]

Those who work in the health centers have Medical Home ranked extremely high whereas it isn't even in the top third of the top three in the Non-FQHC rankings. Community Health Centers have used the term medical home and health care home for almost ten years to emphasize that they function as comprehensive primary care facilities with expanded services that include behavioral, oral and family planning health care. Additionally, the medical home model is defined as initiatives involving private physician practices, community health centers and even home health care providers.[9] This labeling gap

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[7] www.hrsa.gov – What are Rural Health Clinics (RHCs)
[8] NACHC Fact Sheet: America's Health Centers: Serving as Health Care Homes, Nov. 2009
[9] *The Affordable Care Act's Payment and Delivery System Reforms: A Progress Report at Five Years,* The Commonwealth Fund http://www.commonwealthfund.org/publications/issue-briefs/2015/may/aca-payment-and-delivery-system-reforms-at-5-years , May 7, 2015 (Abrams, Nuzum, Zezza, Ryan, Kiszla, Guterman)

exists among external stakeholders even though it is a preferred, and marketable, term in community health to define the myriad of services offered and the developed partnerships in healthcare.

This displays that MPHCA and the MS-CHCs can use this multitude of healthcare services provided under one roof as a marketable difference from the stand-alone private health clinic who relies on a network of provider referrals for its patients. This is especially important in vulnerable and rural communities who often have no other source of care. Each MS-CHC has the flexibility to offer specialized services tailored to their communities' unique cultural and health needs further increasing its capacity as a medical or health care home.

MS-CHCs should also work to differentiate its services from the 'Public Health Clinics' which are operated by the state department of health as county health facilities. MS-CHCs have an opportunity to gain new patients due to the Mississippi State Department of Health announcing reduced clinic hours effective February 1, 2016 and no longer enrolling new maternity patients.[10]

Moving to Question 3 in the survey we asked, 'In the last 12 months have you visited an FQHC provider for healthcare services?' We will focus on the Non-FQHC external response for evaluation. Question 3 reveals that our external stakeholders utilize other providers for healthcare services.

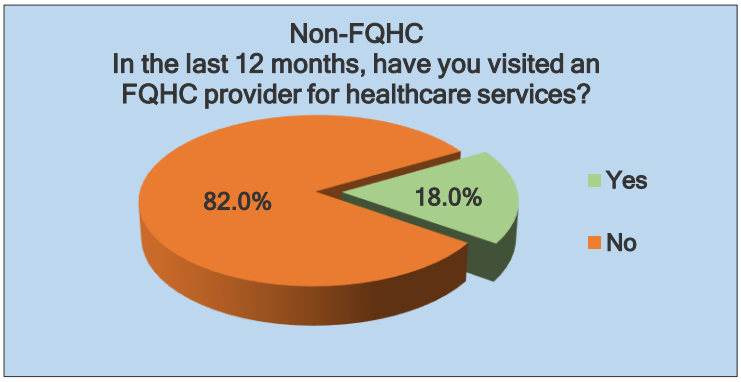

Chart 4: Non-FQHC visited in last 12 months (Question 3 – Community Assessment of FQHCs in MS)

Conversely, in Question 4 our external stakeholders state that 57.3% have partnered with an FQHC in the last month.

While a majority do not visit the MS-CHCs for healthcare services they do partner with us in various capacities.

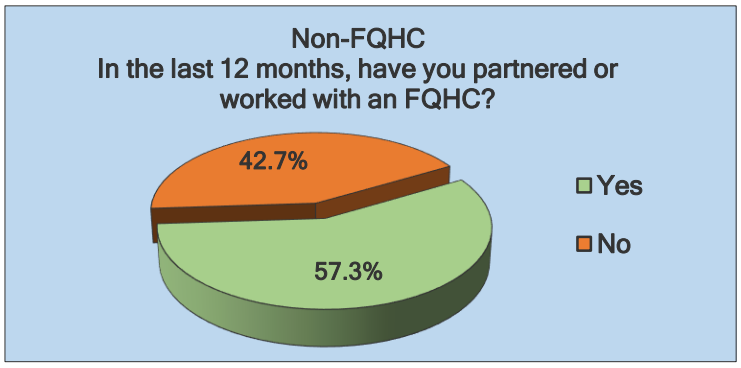

Chart5: Non-FQHC partnered in last 12 months (Question 3 – Community Assessment of FQHCs in MS)

[10] *Health Department Changes Clinic Hours, Shifts Focus To Preventive Health*, MSDH website - http://msdh.ms.gov/msdhsite/_static/23,17211,341.html, Jan. 20, 2016

MPHCA needs to investigate further the partnerships with the MS-CHCs and to determine what percentage of respondents were former patients or may benefit from learning about the value of visiting a MS-CHC for primary health care.

We also wanted to know how many MS-CHCs (FQHCs) the Non-FQHC respondents can identify. Forty-six percent of the external stakeholders can identify 5 or more FQHCs in Mississippi. Over 60% can identify 3 or more.

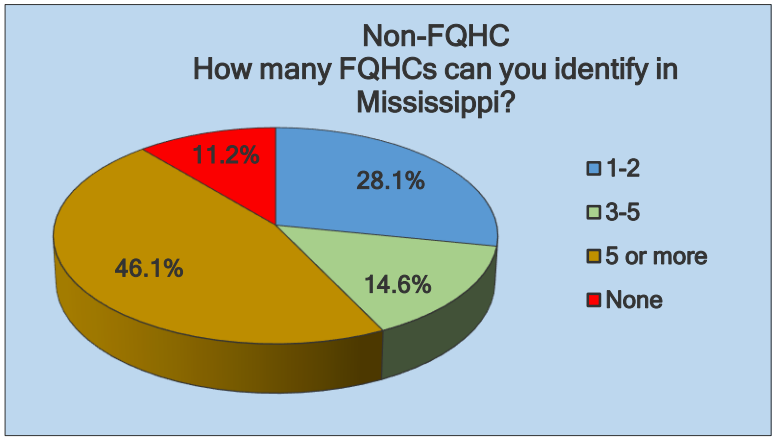

Chart 6: Non-FQHC: How many FQHCs can you identify? (Question 5 – Community Assessment of FQHCs in MS)

Most important to our efforts to gauge external stakeholder perceptions of MS-CHCs, we wanted to know what best describes the work of an FQHC in the respondents area for community health. In Question 6 we provided a list of questions and asked for them to rank along a scale their answers. Here it is important to use the answers of both the FQHCs and the Non-FQHCs to determine the gaps that may exist.

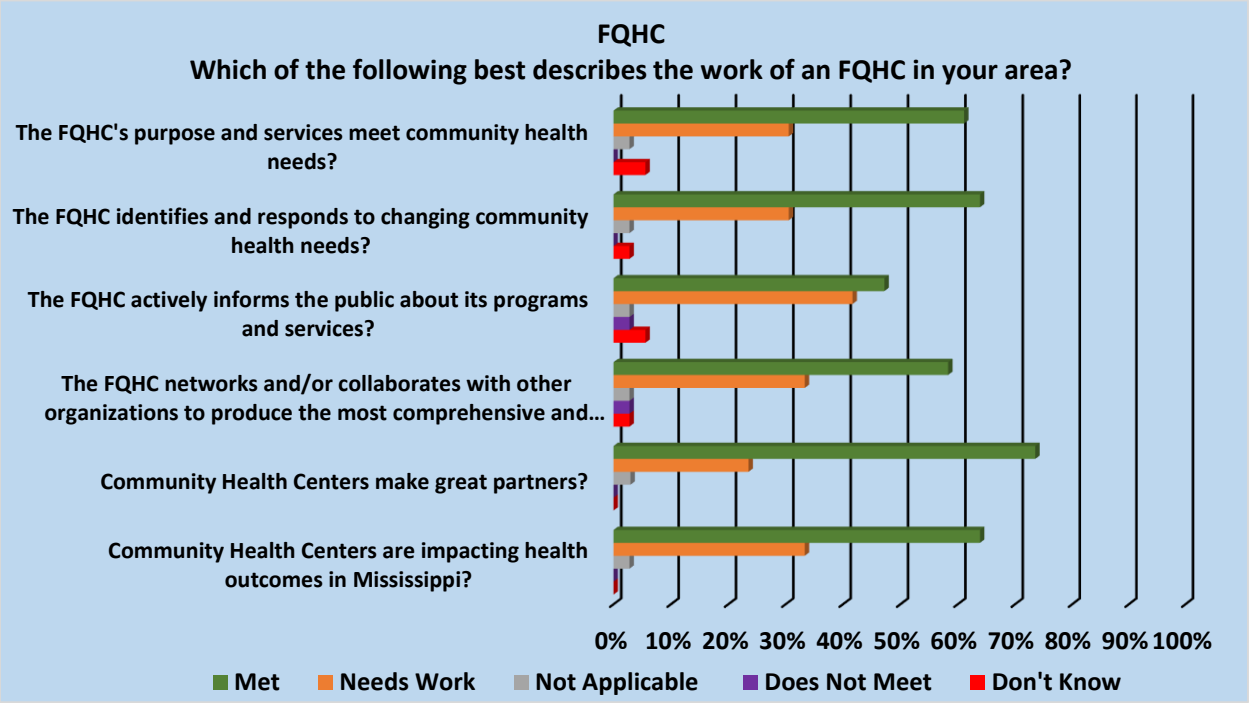

Chart 7: FQHC: Which of the following best describes the work? (Question 6 – Community Assessment of FQHCs in MS)

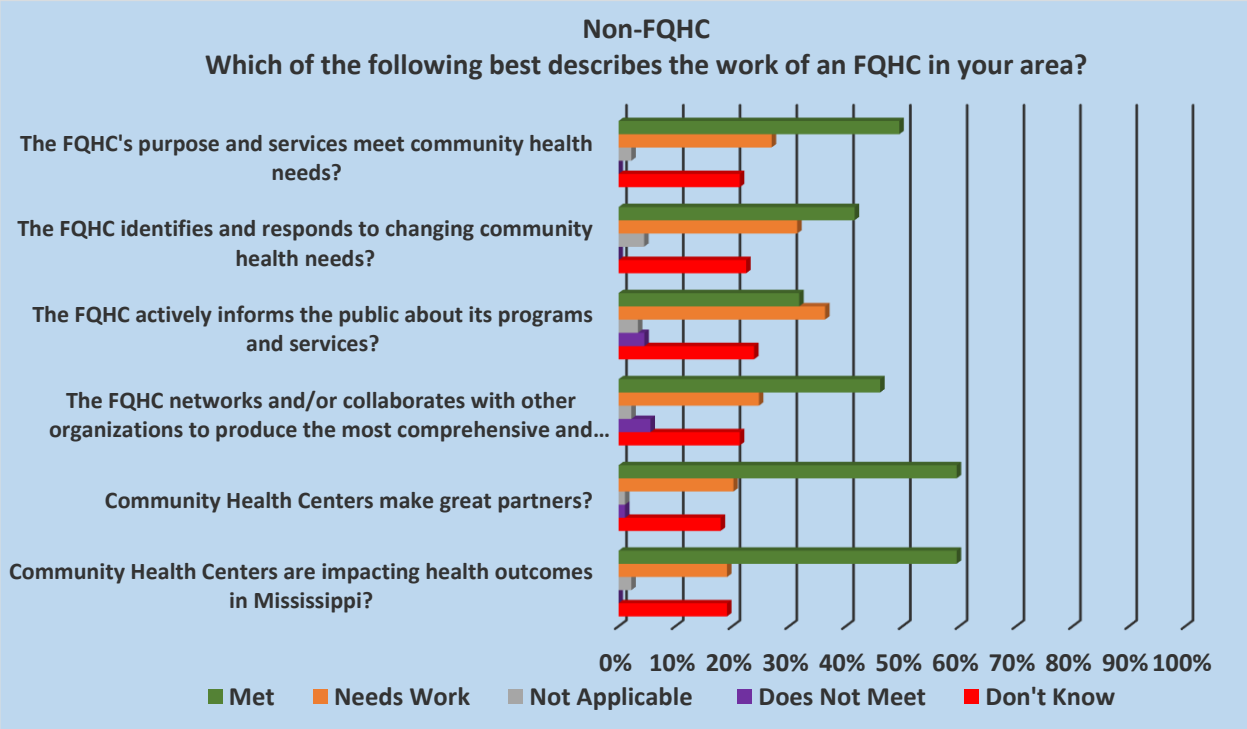

Chart 8: Non-FQHC: Which of the following best describes the work? (Ques. 6 – Community Assessment of FQHCs in MS)

Within the FQHCs, each gave favorable scores (50% or greater) to the following statements given. Only 'The FQHC actively informs the public about its programs and services?' had a score less than 50%. This statement also received the highest 'Needs Work' selection. The positive view point is that the MS-CHCs recognize the need to do a better job educating and providing awareness to the public about its programs and services. MPHCA must investigate what barriers are hindering individual CHCs from informing the public and how it can provide better training and technical assistance in marketing and community outreach. MPHCA believes that the silo approach of marketing the individual CHCs can be better served at an association level through a unifying state-wide branding campaign of the MS-CHCs. The campaign should be developed to increase the publics' knowledge of the benefits of the primary care services provided at MS-CHCs as a whole. This campaign is not to replace local community marketing by the CHC – as each has its own community needs that must be met in addition to primary health care – but to complement the idea that a CHC in one geographic location is just as valuable as another in another part of the state. We currently see in Mississippi this branding model being used by Merit Health System and Baptist Health Systems as two examples in our area.

However, if MS-CHCs – individually or as a whole – recognize they are not actively informing the public about its programs and services, there is an increased potential to lose market share. This could become more problematic with more people gaining insurance through the ACA marketplace and seeking more traditional medical providers in the private sector.

What our external stakeholders show is exciting for MS-CHCs. Almost 60% state that 'Community Health Centers make great partners' and 'Community Health Centers are impacting health outcomes in Mississippi.' Mississippi is routinely ranked last in most health indicator categories and disparities and to find that our external partners see us as a positive contributor to health outcomes in Mississippi is a key component to future marketing of MS-CHCs. Overall, they ranked as 'Met' at a higher percentage in each statement; but the percentages lagged behind the internal FQHCs responses.

Once again, we see that communication and information about our MS-CHCs is ranked even lower by our external stakeholders. This may attribute to the higher percentages of those stating 'Don't Know' in each of the questions? And we see higher percentages for the statements in 'Needs Work.'

These gaps provide us with valuable data to use in our strategic planning and overall branding and marketing campaigns to be developed at the association level. What are we doing right and what can we improve through an overall branding strategy?

We also wanted to determine the likeability factor of our MS-CHCs by asking how likely they are to refer a friend to a CHC for health care service.

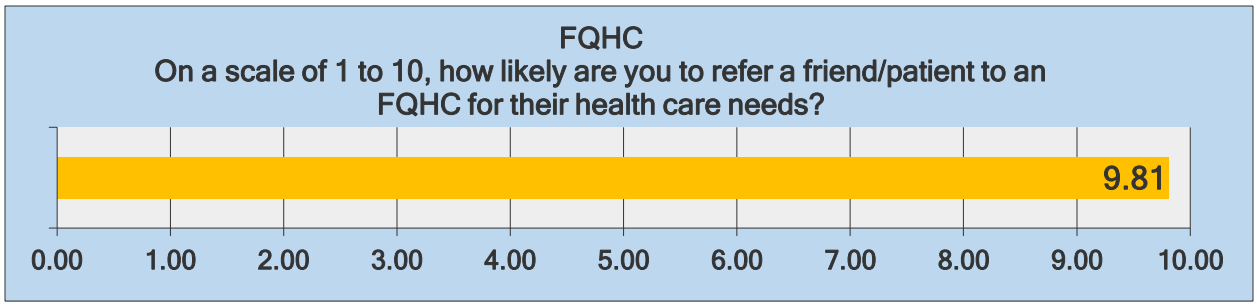

Chart 9: FQHC: How likely to refer a friend? (Question 7 – Community Assessment of FQHCs in MS)

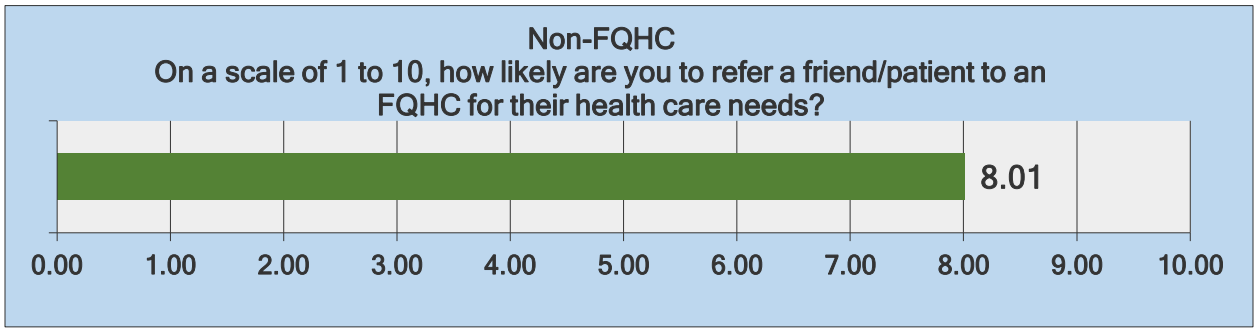

Chart 10: Non-FQHC: How likely to refer a friend? (Question 7 – Community Assessment of FQHCs in MS)

It is important to note that our external stakeholders are very likely to refer a friend or a patient to a MS-CHC for health care services.

Lastly, to determine survey respondents by geographic area or the MS-CHC they closely associate with, we asked respondents to select the primary FQHC in their area. The following chart shows that a majority of respondents recognize the Metro Jackson Area CHCs. Yet, we received responses from across Mississippi. This results show wide response from across the state and in both rural and urban areas.

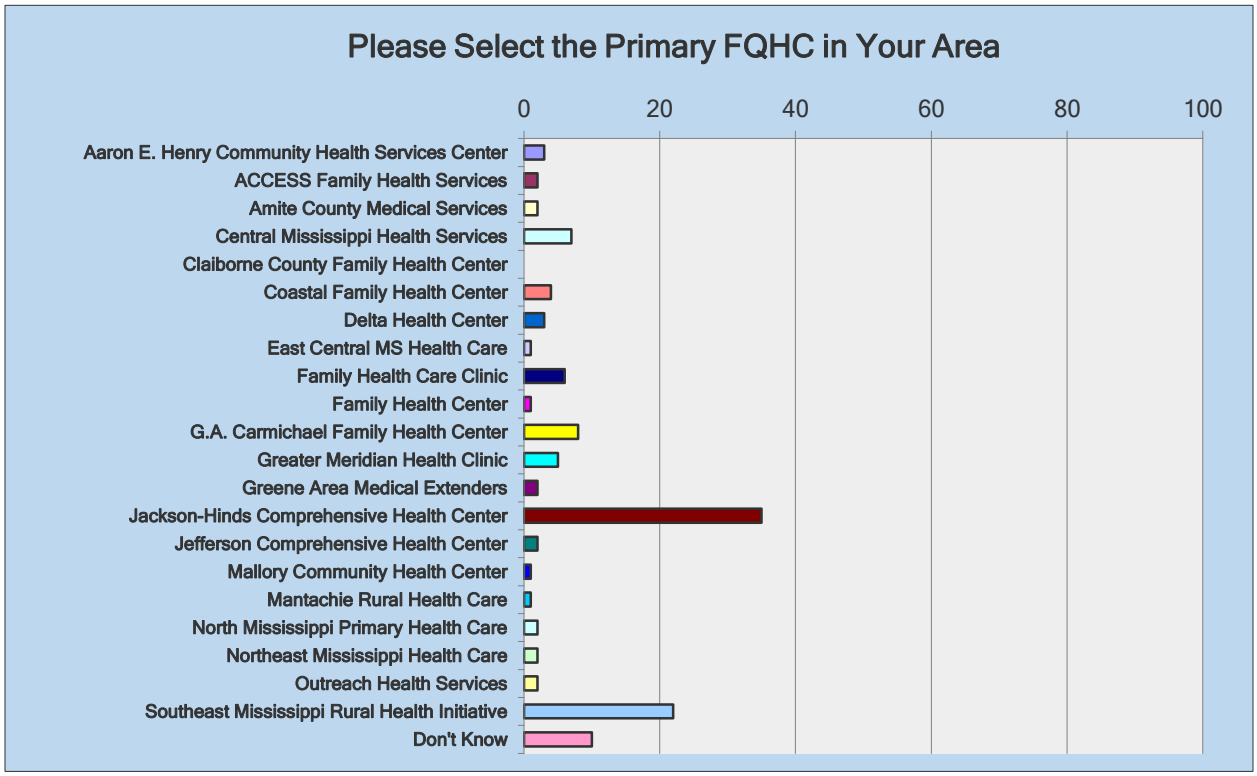

Chart 11: FQHC and Non-FQHC responses by primary FQHC in your area

CONCLUSIONS AND RECOMMENDATIONS

MPHCA incorporated elements of the survey as baseline questions that were explored during its 2016 Strategic Planning session in hopes of defining ways to assist with engaging a stronger relationship between the MS-CHCs and its external stakeholders:

Again the challenges identified as question on Page 2 of the document and summarized:

- Awareness of FQHCs as community health centers both uniquely and collectively
- The challenge of educating communities regarding the broad scope of services that FQHCs and MS-CHCs offer?
- The need to increase the awareness of MS-CHCs as a whole and advertise the unique capacity of each individual CHC?

- Capitalizing on the external stakeholder perception of MS-CHCs to enhance partnerships and work more strategically to positively impact the health outcomes of Mississippians.

In conclusion, a majority external stakeholders reported that, for the most part, MS-CHCs are doing a good job as identifying themselves as primary care facilities and community health centers; that MS-CHCs are great partners; impact health outcomes in Mississippi; and are likely to refer a friend or patient to a MS-CHC for primary care. MS-CHCs are recognized as serving their purpose as primary health care providers, ability to collaborate with other providers and are known as being capable of adapting to changing community needs.

Yet, internally and externally, MS-CHCs suffer from a messaging gap. Especially in two areas: informing the public about its programs and services and the alignment of our services with the preferred labels that highlight the broad array of primary care and best describes what an FQHC/CHC is and/or is not.

MPHCA has incorporated within its strategic plan developments that focuses on the following:

- Education and Awareness Campaign
    - Informs the public and patients what a community health center is within the FQHC framework.
    - Why CHCs are a high quality, cost effective service delivery model – especially for underserved populations in MS.
    - How CHCs are different from Rural Health Clinics and are not defined as Public Health Clinics.
    - CHCs and their work towards the Primary Care Medical Home approach to primary care by enhancing existing partnerships and exploring new ones.
    - ~~o~~ Incorporating the Social Determinants of Health as a focus for partnership development and strengthening the safety net.
    - Better use and sharing of CHC healthcare data to promote healthy outcomes.
- Branding Campaign at the association level around the MS-CHCs that emphasizes the unique strengths of community health statewide while building marketing capacity on a local level for individual CHCs to use.
    - Logo development
    - Media campaigns
    - Tag lines
    - Unifying cause or event

    - Website development
- Increased exposure of MPHCA and MS-CHCs through more engagement within communities through various media channels, local events and business/government associations.
- Reevaluate perceptions at periodic phases during the campaign through more in-depth surveys or focus groups