Twenty-Five Years of Service

Partnership for Community Health
Evaluation Report

December 11, 2007
ABOUT SFCCC

THE BEGINNING

The San Francisco Community Clinic Consortium (SFCCC) is a non profit health care organization that was established by its Partner Health Clinics in 1982. The SFCCC ten partner clinics provide quality, culturally and linguistically appropriate primary health care for more than 70,000 San Franciscans each year.
SFCCC MISSION STATEMENT

The San Francisco Community Clinic Consortium develops programs and advocates for policies that increase access to community-based primary care for all San Franciscans, targeting the uninsured and underserved.
In 2005 CPMC provided funds to SFCCC for “Charity Care” to be delivered through selected SFCCC clinics.

- The majority of the funding was allocated to support Primary Care Provided (PCP) Services.
- The program was also funded to provide limited diagnostic specialty care through CPMC specialists.
- The “Charity Care” program has been re-titled Partnership for Community Health (PCH).
Haelland was retained to evaluate PCH programs results after two years of service provision.

Focus of the evaluation was primarily on process and activities as long term health results are not yet evident.
SFCCC retained Halleland as experienced and independent evaluators of health care programs. The evaluation was interim as the program is just two years old. SFCCC and CPMC were both involved in the identification of information sources and guiding principles. Of necessity, this evaluation was qualitative in nature, but quantitative where possible.
Document review (white paper, policies and procedures, management reports, forms, agreements and contracts, etc).

Data analysis (eligibility and utilization data, to the extent it was available).

Interviews with key stakeholders.

Clinic specific project plan review.

Brief literature review.
Advancing the State of the Art Community Benefit (ASACB) guiding principles that frame the program goals, and therefore the evaluation:

- Emphasis on disproportionate unmet health needs
- Emphasis on primary prevention
- Building a seamless continuum of care
- Building a community capacity
- Emphasis on collaborative oversight
Other Evaluation Guidelines

- Goals from specific business plans.
- Program replicability and sustainability.
EMPHASIS ON DISPROPORTIONATE UNMET HEALTH NEEDS

Key Indicators

- Plan design to reach high need areas.
- Number of patients served.
- Income level of people served.
- Services provided.
- Community Outreach.
Key Findings
- Participating clinics were selected based on high-need areas; zip codes of patients track to underserved areas.
- Funding allowed hiring of medical personnel in several clinics to serve more patients.
- In CY 2006, PCH served 8,695 patients. 6,601 were new patients.

22,501 units of service provided
- Primary Care services
- Community Outreach services, including participation in Health Fairs, external health education and other outreach projects.
Key Findings (continued)

- Clinic generally screen for other available funding.
- Income level of patients served:
  - 63% at or below FPL
  - 24% between 100-200% FPL
  - 13% between 200-400% FPL
EMPHASIS ON PRIMARY PREVENTION

Key Indicators

- Expanded access to care
- Provision of basic primary care services
- Provision of chronic illness management
- Health Education
- Primary Care “Home”
Key Findings

- Expanded access to care through new staff and/or disease management programs.
- Preventive/Screening programs offered among clinics and at CPMC:
  - Tobacco Assessment
  - Pediatric Immunizations
  - Diabetes Education and Management
  - Lab Services
  - Health Education
  - Colonoscopy Screenings
BUILD A SEAMLESS CONTINUUM OF CARE

Key Indicators

- Timely access to specialist care
- PCP/Specialist coordination
- Access to hospital care
- Reduction in ER Visits and avoidable admissions
- Case Management
- Availability of support services
- Clinician involvement in Program Design
Key Findings

- Referral program developed to access specialist care through CPMC physicians.
- Process developed for communication and follow-up between PCP and Specialists.
- Case management services provided.
- Support services (translation and transportation) integrated into program design.
- Clinician involvement in program development.
- It is premature to assess affect on ER visits and avoidable admissions.
BUILDING COMMUNITY CAPACITY

Key Indicators

- Funding supported existing community clinics.
- Referral program enhanced access to specialty care through community doctors.
- Grant funds did not supplant other funding sources.
BUILDING COMMUNITY CAPACITY

Key Indicators

- Collaborative structure in place.
- Involvement of all stakeholders.
- Shared accountability among stakeholders.
COLLABORATIVE OVERSIGHT

Key Findings
- Joint Advisory Committee established with representatives of SFCCC, CPMC and the clinics.
- Active participation by all parties in referral development.
- Shared accountability for design and funding.
SUSTAINABLE AND REPLICABILITY

Key Findings

- Meets ongoing community needs.
- Interest by stakeholders to sustain and replicate program features.
- Ability to incorporate into long-term planning.
- Program Design flexibility.
Key Findings

- Indicators suggest that health delivery to the undeserved has been enhanced.
- Broad national interest in results
  - Health and Human Services Chief of Staff visit with SFCCC and CPMC
  - VHA-Leadership Award for Excellence in Community Benefit
- Sponsors and Advisory Committee can support solutions in response to market changes.
CONCLUSIONS

- Program was designed to meet the criteria of Community Benefit.
- Clinic-specific Business Plans allowed flexibility for clinics to allocate dollars to support their respective needs.
- Primary care and preventive services were enhanced in all clinics.
- Specialty care referral process through private hospital and physicians was developed and implemented.
Diagnostic tests were more readily available resulting in earlier diagnosis and treatment of acute illness.

Joint Advisory Committee created forum for collaboration and problem-solving.

Future enhancement of IT systems is needed to support improved data collection and analysis.

Program concept is unique and sustainable.

All parties agree that model could be replicated in other locales.
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We at the San Francisco Community Clinic Consortium (SFCCC) thank you for taking time to learn more about our organization, our partner clinics, and our programs.

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