NEW JERSEY FEDERALLY QUALIFIED HEALTH CENTERS: CAPACITY

BUILDING AND SUSTAINABILITY UNDER THE AFFORDABLE CARE ACT

by

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ABSTRACT OF THE DISSERTATION

New Jersey's Federally Qualified Health Centers: Capacity Building and Sustainability

Under the Affordable Care Act

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Primary healthcare is the foundation of the nation's healthcare infrastructure. It is an essential component of advancing healthcare reform and better health outcomes for all. Federally Qualified Health Centers (FQHCs) constitute one of the largest networks of primary care providers both in New Jersey and across the nation. The Patient Protection and Affordable Care Act (ACA) has recognized that FQHCs are critical providers of primary healthcare to millions of uninsured and underinsured individuals. A significant body of literature suggests that FQHCs can exhibit strikingly different levels of readiness to function as sustainable providers, but there has been little research focusing on their capacity to adapt and meet the growing demands of the current healthcare environment. This qualitative study examined the capacity of New Jersey's FQHCs to expand and sustain access to primary healthcare services. It also explored the impact of the ACA on FQHC capacity building in the state. In Phase 1 of the project, both the Brown et al. (2001), Conceptual Framework for Mapping Capacity and the results of a focus group of FQHC administrators, staff and clinicians, and other industry leaders were used to design a semi-structured interview guide. In Phase 2 of the project, twenty in-depth interviews were conducted with FQHC board members, administrators, clinicians and staff from a wide range of New Jersey FQHCs. Study participants reported different levels of FQHC

readiness to respond to the ACA and varying levels of ability to engage in capacity

building for enhanced organizational performance. Study findings also highlight how the

contexts in which New Jersey FQHCs operate influence their approach to sustainability

and the degree to which they engage in capacity building. Finally, the results of this

study point to the need for research that examines the impact of public policy on capacity

building in FQHCs nationwide.

Dedication

To Julane Angeliki Green—my granddaughter, my inspiration, and my hope for the

generations to come—because you can! You can do all things through Christ who

strengthens you. You are enough, and you have all you need to succeed in all you do.

Dream big and believe in your dreams!

I pray that God will bless you with wisdom, grace, courage, and a kind and generous

heart, continuously. I pray too that His hand and His hedge of protection will be with

you always.

<div align="right">Love,</div>

<div align="right">Grandma Julane</div>

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I am sincerely grateful to my husband, John. Thank you for your patience, support, and love throughout every step of the process.

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Definitions

1. **Access**—The Institute of Medicine (IOM) defines access as the "timely use of personal healthcare services to achieve the best possible outcomes" (Millman, 1993, p. 4).

2. **Access capacity**—Access capacity is the ability to ensure timely entry to a location, healthcare provider, and/or primary care services.

3. **Affordable Care Act**—This is the final amended version of the healthcare reform law enacted in 2010; it is also known as The Patient Protection and Affordable Care Act and as Obamacare ("H.R.3590 - 111th Congress (2009-2010): Patient Protection and Affordable Care Act," 2010).

4. **Bounded Case**—A bounded case is a specific case that can be defined or described within certain parameters such as time, place, people involved, and so forth. Bounded cases are explored within real-life, contemporary context (Creswell & Poth, 2018).

5. **Capacity**—This is the ability/resources/influence achieved through capacity building to enable performance as expected or planned.

6. **Capacity building**—This refers to the process that enhances the ability and preparedness of systems, persons, organizations, or communities to meet objectives or to perform as expected, toward sustainability, or greater self-reliance, over time.

7. **Capacity components**—Capacity components are those resources that are critical to drive the operational functions which lead to the desired outcomes or products as well

as ensure the long-term impact necessary to achieve sustainable systems and improved health outcomes (Brown et al., 2001).

8. **Community Health Center Fund**—This is a mandatory multibillion-dollar fund established in the Patient Protection and Affordable Care Act (ACA, PL. 111-148) and extended into subsequent law. The most recent two-year extension was included in the Bipartisan Budget Act of 2018. The fund, initiated in 2011, was recently extended through 2019 (National Association of Community Health Centers, 2018).

9. **Federally Qualified Health Centers (FQHCs)**—FQHCs are community-based healthcare providers that receive funds from the HRSA Health Center Program to provide primary care services in underserved areas. They must meet a stringent set of requirements to qualify as an FQHC. They may include Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Health Centers for Residents of Public Housing. The defining legislation for Federally Qualified Health Centers (under the Consolidated Health Center Program) is Section 1905(l)(2)(B) of the Social Security Act (Bureau of Primary Health Care, 2019c). This study is limited to FQHCs that include Community Health Centers only.

10. **Health Disparities Collaborative**—The Health Disparities Collaboratives initiative was instituted as a national quality improvement program for FQHCs. Supported by HRSA, FQHCs across the country were incentivized to participate in one of several chronic disease collaborative care management models. The collaboratives focused on instituting quality improvement processes and the consistent application of evidence-based learning and practices in chronic care management.

11. **Health Equity**—The emerging consensus definition of health equity implies fairness—the opportunity to receive the same level or quality of healthcare when needed for all groups of people without regard to any personal, social, economic, or other characteristics.

12. **Health Insurance Marketplace**—This refers to a service that helps people shop for and enroll in affordable health insurance. For most states it is HealthCare.gov. Some states run their own marketplaces. It is also known as the *marketplace* or *exchange*. (See https://www.healthcare.gov/.)

13. **Health Professional Shortage Areas (HPSAs)**—These are geographic, population, or facility-based designations that indicate healthcare provider shortages in primary care, dental health, or mental health.

14. **Medically Underserved Area (MUA) and Medically Underserved Population (MUP)—**MUAs and MUPs identify geographic areas and populations with a lack of access to primary care services. MUAs have a shortage of primary care health services for residents within a defined geographic area. MUPs are specific sub-groups of people living in a defined geographic area with a shortage of primary healthcare; they may face economic, cultural, or linguistic barriers to healthcare (HRSA).

15. **Providers**—Providers here refers to primary care physicians. However, the industry, including FQHCs and the National Health Service Corps, recognize and employ nurse practitioners and physician assistants as primary care providers.

16. **Primary Care**—"Primary care is the provision of integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal

healthcare needs, developing a sustained partnership with patients, and practicing in the context of family and community" (Institute of Medicine (US) Committee on the Future of Primary Care, 1994).

17. **Primary Care Medical Home**—A primary care medical home is also referred to as a medical home, a primary-care home, or a patient-centered primary-care medical home. It is a source and a model of primary care that addresses total patient needs in a comprehensive and coordinated manner. It is characterized as patient-centered, comprehensive, team-based, coordinated, accessible care that is focused on quality and safety. It is a relationship-based, individual care approach to delivering comprehensive primary care to all age groups (Primary Care Collaborative, n.d.).

18. **Safety Net Providers**—Safety net providers have two distinguishing characteristics: by legal mandate or explicitly adopted mission they maintain an "open door," offering access to services to patients regardless of their ability to pay; and secondly, a substantial share of their patient mix is uninsured, Medicaid, and other vulnerable patients (Lewin & Altman, 2000).

19. **Sustainability**—Sustainability is the ability to maintain or hold on to achievements, improvements, or gains, relying upon institutional, systemic, or leadership abilities to effectively control and utilize available resources; recognize, analyze, and resolve challenges; and continuously build capacity toward greater self-reliance. It implies ability for the long term to respond to environmental changes efficiently and effectively (Brown et al., 2001).

20. **The Uniform Data System**—A repository of data that is collected by HRSA for all Community Health Centers, at the grantee, state, and national levels.

Acronyms

ACA	Affordable Care Act, also known as the Patient Protection and Act, and as Obamacare
ACO	Accountable Care Organization
ARRA	American Recovery and Reinvestment Act
BPHC	Bureau of Primary Health Care
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CHCF	Community Health Center Fund
CHIP	Children's Health Insurance Program
CMO	Chief Medical Officer
CMS	Centers for Medicare and Medicaid Services
COPC	Community Oriented Primary Care
DHSS	U.S. Department of Health and Human Services
EHR	Electronic Health Record
FQHC	Federally Qualified Health Center
HDC	HRSA Health Disparities Collaboratives (aka Collaboratives)
HIT	Health Information Technology
HRSA	Health Resources and Services Administration
MUA	Medically Underserved Areas
MUP	Medically Underserved Populations
NACHC	National Association of Community Health Centers
NJPCA	New Jersey Primary Care Association

NDP   National Demonstration Project

OEO   Office of Economic Opportunity

PCC   Patient Centered Care

PCMH   Patient Centered Medical Home

UDS   Uniform Data System

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Chapter 1: Introduction and Problem Statement

Federally Qualified Health Centers (FQHCs) are critical primary care providers in the nation's healthcare delivery system. The Health Resources and Services Administration—Bureau of Primary Health Care (HRSA/BPHC)[1] succinctly describes FQHCs (also referred to as *health centers*) as "community-based and patient-directed organizations that deliver comprehensive, culturally competent, high-quality primary healthcare services". "Health centers deliver care to the nation's most vulnerable individuals and families..." (Bureau of Primary Health Care [BPHC], 2019c, para. 1).

Nationally, FQHCs provided primary healthcare to over 28 million people in 2018. The New Jersey centers provided care to more than 528,000 individuals. Collectively the nation's FQHCs deliver primary care to 1 in 12 persons in the country, the overwhelming majority of whom are low income, uninsured, and minority individuals (National Association of Community Health Centers [NACHC], 2019a; NACHC, 2019c). Health centers are the most significant source of primary care for underserved populations and communities across the country (Rosenbaum et al., 2017). Largely because of their reach as primary care providers, the drive toward national healthcare reform has rekindled strong interest in the centers. Within the healthcare industry and among policy makers there is renewed attention to the value and contributions of FQHCs, especially with the implementation of the Patient Protection and Affordable Care Act, referred to as the Affordable Care Act (ACA)[2]. The primary goals for the ACA are

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[1] HRSA/BPHC: HRSA is the principal agency in the U.S. Department of Health and Human Services responsible for overseeing and regulating FQHCs. The BPHC is within HRSA and oversees funding and administration of the FQHC program.

[2] The ACA is the final amended version of the nation's comprehensive health care reform law that was enacted into law in 2010 by President Barack Obama.

conventionally described as the *Triple Aim*: to improve patient care and the patient experience, to reduce healthcare costs, and to improve population health. A fourth goal has been added (*Quadruple Aim*) by advocates for healthcare providers, to improve the provider experience.

Critical for FQHCs, the ACA reinforced the importance of primary care and access to a primary care home as the foundation of an effective, strong healthcare system (Abrams et al., 2011; Rosenbaum et al., 2018). One of the principal strategies identified for achieving the Triple Aim of the ACA was to expand access to patient-centered primary care medical homes (PCMH)[3] for all persons. As established primary care providers, Community Health Centers offered a ready, "turnkey" solution. Already an integral part of the national healthcare system, they are located in every state in critical underserved areas, providing a ready pathway for expanding access to patient-centered primary care (Hawkins & Groves, 2011; NACHC, 2012; Rosenbaum et al., 2018). Consequently, the move toward healthcare reform amplified support for Community Health Centers. At the same time, it also created new scrutiny of the organizations with respect to their ability to perform as essential players under the ACA (Hennessy, 2013).

A growing body of literature supports the contributions and impact of FQHCs as critical primary care providers and reinforces their acknowledged importance as part of the nations' healthcare infrastructure. Since ratification of the ACA, Community Health Centers increased the number of FQHC patients by close to 17 million individuals, a 168% growth in the number of patients served (BPHC, 2018b), thus confirming their

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[3] The patient-centered primary care medical home is also referred to as a medical home and a primary care medical home. Primary care medical home is defined in the definitions page in the front matter.

ability to expand access to services to meet the anticipated growth in demand for primary

care services. Additionally, research studies, some of which are based on self-reported

health center data from the U.S. Department of Health and Human Services Uniform

Data System (UDS)[4], document that FQHCs perform better than or comparable to

national averages on quality-of-care and process-of-care measures. Evidence also shows

that centers perform better or equally well on quality measures for access to preventative

services and that their patients experience better health status indicators when compared

to non-FQHC patients (Goldman, 2012; NACHC, 2019c; Shi et al., 2009). The NACHC

(2018) reports that 92% of FQHCs meet or exceed one or more of the Healthy People

2020 goals for improved health status.

Moreover, health center patients are found to experience better outcomes for

management of chronic diseases such as diabetes and hypertension (Hicks et al., 2006;

NACHC, 2019c). Preceding the ACA, many centers, nationally and in New Jersey,

participated in the HRSA Health Disparities Collaborative (HDC)[5] to effect quality

improvements in the care and management of chronically ill patients. The HDC program

resulted in better management for chronic diseases, such as diabetes and asthma, fewer

related hospitalizations, and better outcomes for FQHC patients (Chin, 2011; Hawkins &

Groves, 2011). Importantly, FQHCs' successful participation in the HDC initiative also

pointed to their ability to engage in activities to improve performance and outcomes for a

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[4] The Uniform Data System (UDS) is a repository of data that is collected by HRSA for all Community Health Centers, at the grantee, state, and national levels. Information about the UDS is found on the HRSA/BPHC website, https://bphc.hrsa.gov/datareporting/reporting/index.html

[5] The Health Disparities Collaborative (HDC) is a HRSA initiative. It is a continuous quality improvement initiative aimed at driving better, more cost-effective care and case management for high-risk chronically ill patients.

large patient population. In a systematic review of the literature on the HDC and FQHCs, Chin (2011) found that centers that engaged in the HDC initiatives demonstrated characteristics that emphasized their ability to manage growth and innovative changes in the delivery of primary care services. This is further evidenced by their more recent efforts to achieve Patient Centered Medical Home (PCMH) designation. Seventy-five percent (75%) of centers nationally and 83% in New Jersey have achieved PCMH recognition (NACHC, 2019c).

The patient-centered care approach closely aligns with the FQHC model. Health centers maintain that they have historically practiced patient-centered primary care. However, PCMH accreditation by the National Committee for Quality Assurance (NCQA) publicly confirms their ability to perform as patient centered medical homes and helps to position the centers as value added players in a changing environment.

Additionally, evidence shows that FQHCs are cost-effective primary care providers, they have lower healthcare costs and lower expenditures for preventive care (NACHC, 2019c). Research confirms health centers' ability to reduce the need for care in more costly hospital settings. FQHCs averaged 24% lower total healthcare expenditures in one year than the cost of treating ambulatory care needs in other settings. On average, they experience lower total healthcare costs as well as lower costs for ambulatory care (Richard, et al, 2012).

The demonstrated, collective ability of FQHCs to serve as high-quality, cost-effective patient-centered primary care providers, as well as to actively engage in progressive healthcare transformation initiatives, positively reinforces the ACAs advancement of centers as essential primary care providers. Research consistently

demonstrates that primary care contributes to "greater effectiveness and improved healthcare outcomes, greater efficiencies, and greater equity"[6] in healthcare (Phillips & Bazemore, 2010; Starfield, 2011; Starfield et al., 2005; Shi, 2012; World Health Organization, 2008).

Problem Statement

Collectively, FQHCs, as described above, are well positioned to serve as primary care anchors in a transformed healthcare system. But, while FQHCs in general add value, individual centers demonstrate marked variation in their ability to perform and to effect sustainable impact, locally and at the state level. Centers exhibit different degrees of development and varied stages of readiness to be sustainable, effective providers in an increasingly complex, competitive environment. Yet, the ACA and ensuing policies assume that FQHCs overall have the requisite ability, infrastructure, and resources to build and sustain capacity for expansion and to function in a new, more competitive environment. A critical issue with this assumption is the belief that all FQHCs have relatively equal capacity and capacity building capabilities. While all FQHCs are required to have similar structures and to adopt basic common policies that govern how they operate (i.e. governance structure, populations served, core scope of services offered, and financial practices), they are independent, unique organizations, with different infrastructures, practices, resources, and levels of local support. These individual characteristics and local context contribute to the varying success of FQHCs in

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[6] Health Equity in healthcare refers to the distribution of healthcare to ensure care when needed and as needed. The Institute of Medicine (IOM) defines equity as providing care that does not vary in quality because of personal characteristics or socioeconomic status.

achieving and sustaining access capacity[7] and programming, and in their ability to effect

capacity building to enhance overall organizational performance.

As a group, they are threatened by the same challenges affecting the healthcare

industry altogether (i.e. a shortage of clinical care providers, unstable funding, and

changes in how they are reimbursed for services). They also face issues that are unique

to primary care providers (i.e. lower reimbursement and professional compensation rates

than other medical specialties). Additionally, they experience challenges specific to

FQHCs (limiting regulations) that are compounded by the environment in which they

operate ((DeMarco & D'Orazio, 2015; Katz et al., 2011; Rosenbaum et al., 2017).

Also, despite the positive emphasis on FQHCs' experience as patient-centered

primary care providers, less than 1 out of 3 centers nationally were found to have all of

the attributes of a patient centered medical home in five selected PCMH domains,

although over 50% were found to have some capacity in three to four of the domains

(Doty et al., 2010). Growing interest in and research on PCMHs strongly supports the

accepted paradigm that the presence of more medical home attributes is an indicator of

greater capacity to improve patient care and health outcomes, as well as to ensure

continuous quality improvements and care across settings and among providers (Doty et

al., 2010). I provide greater detail about the significance of the findings by Doty, et al.

(2010) later in this study, but I emphasize them here to underscore the variation found in

the capacity of the centers to perform as primary care medical homes, and in their ability

to engage in capacity building initiatives, such as PCMH accreditation. The variation in

ability, readiness, and effectiveness among centers matter as policy makers and others

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[7] Access capacity is defined as the ability to ensure timely entry to a location, healthcare provider, and/or
primary care services.

increasingly seek to position the centers as integral primary care providers and as a significant resource in addressing the need for, and importance of, primary care in healthcare reform.

What's more, there is little empirical research that points to how or if FQHCs, individually and collectively, demonstrate the ability to effectively navigate challenges or optimize opportunities to strengthen their role or position and effectiveness within the healthcare industry. I highlighted below a small, select sample of the literature that points to the need for greater understanding of how capacity and capacity building[8] differ for individual centers, especially at local and state levels. This is especially necessary for centers and communities that have had a checkered history, perceived or real, with sustainability[9] of access capacity, including expanded services and programs, as is the case in New Jersey.

The Center for Studying Health System Change (HSC)[10] conducted a longitudinal Community Tracking Study, that included examination of how local healthcare systems and organizations responded to change over time, and how they evolved to sustain services and effectiveness. The study included centers from 12 national metropolitan

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[8] For the purposes of this study, capacity building is defined as the process that enhances the ability and preparedness of systems, persons, organizations, or communities to meet objectives or to perform as expected, toward sustainability, or greater self-reliance over time.

[9] For the purposes of this study, sustainability is defined as the ability to maintain or hold on to achievements, improvements, or gains, relying upon institutional, systemic, or leadership abilities to: effectively control and utilize available resources; recognize, analyze, and resolve challenges; and continuously build capacity toward greater self-reliance. It implies ability for the long term to respond to environmental changes efficiently and effectively.

[10] The HSC conducted longitudinal studies of health care systems and organizations in selected regions of the country, including Northern New Jersey. Although they defined the region as North New Jersey, based on my personal knowledge they included New Jersey centers that are also defined here as Central New Jersey in their cohort of research informants. The Center for Studying Health System Change ceased operations effective December 2013. Nevertheless, their work continues to add insight about the factors that influence capacity, and capacity building in New Jersey FQHCs.

areas across the country, including Northern New Jersey[11]. It showed that the Northern

New Jersey centers did achieve expansion; they increased access to care by adding new

sites and services over time, especially with the implementation of the ACA. Their

ability to achieve expansion was largely attributed to funding support from New Jersey

legislators and to advocacy by the New Jersey Primary Care Association (NJPCA) and

their ability to obtain financial resources and political support for the centers (Katz et al.,

2011). However, in reporting on the experience of the Northern New Jersey centers and

others this study also pointed to the tenuous nature of local support and the need for

continuous, concerted advocacy and leadership to effect change. It also suggested a need

for centers to focus on enhancing business and operational acumen to manage and sustain

improvements and growth. Overall, centers represented in the Katz et al. study reported

successful expansion efforts and the ability to build greater access capacity, as well as to

institute the infrastructure to support expansion. They attributed their success in part to

knowledgeable, skilled leaders and managers, but stressed the importance of their ability

to attain dedicated resources to not only engage in capacity building but also to sustain it.

Findings for the New Jersey centers represented in the same study by Katz et al.

(2011) were reported in the aggregate at the state level, but it showed that those Northern

New Jersey centers that did participate collectively expressed concern about their ability

to sustain expansions or operational and clinical improvement initiatives in the absence of

continuous dedicated federal support for that purpose. As a group, they were less sure of

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[11] For full disclosure, at one point in the HSC longitudinal study I represented one of the centers included in the HSC study and participated in some of the interviews. However, I had no access to the raw data, just the research article as cited here by Katz, et al. (2011). The reporting here of the Katz, et al. study (2011) findings is based only on the information that is represented in their research findings.

their abilities to sustain growth. Their reported experiences and insight highlighted the problems associated with capacity building, such as expansion of access, without a clear strategic plan or the leadership necessary to ensure sustainable, desired outcomes. This underscores the lack of knowledge among funders about the capacity of some FQHCs to engage in capacity building for the long term (Katz et al., 2011).

More pointedly, another study explored whether FQHCs are "up to the task" in this era of healthcare reform (Hennessy, 2013). An important takeaway from that study is that external environmental factors, such as public policies, prominently influence the capacity of FQHCs and their potential for capacity building. The ability of FQHCs across the country, including those in New Jersey, to expand access through the development of new sites and services is significantly affected by regulations that define both the conditions for FQHC expansion, and where it can take place (Hennessy, 2013). For example, access capacity is affected by a long-standing HRSA requirement that FQHCs must be located in areas officially designated as Medically Underserved Areas (MUAs) or having Medically Underserved Populations (MUPs). FQHCs have long contended that this requirement and the thresholds set for areas to be designated an MUA/MUP are outdated. The rules are inconsistent and contain unnecessary limitations that disqualify many underserved areas where there are evident, serious shortages of primary care providers. Despite the mandate under the ACA for FQHC expansion, policy makers have not addressed the MUA/MUP designation methodology and its limitations, thereby effectively limiting FQHCs' ability to increase access capacity in critical areas (Hennessy, 2013). Some centers are geographically confined and cannot engage in significant growth and expansion efforts because of the MUA/MUP rules. This

in turn, affects their ability to grow patient volume and revenues to support other desired capacity building and growth strategies.

Hennessy (2013) cited Somerset County New Jersey as an area that for many years was adversely affected by the MUA/MUP qualificaion requirements. Until very recently, underserved areas in this New Jersey county did not have access to an FQHC because the county as a whole did not meet the MUA/MUP requirements. It was only recently that changes in the demographic profile of the area made it possible for a select few communities in the county to qualify for MUA/MUP designation, allowing for FQHC expansion into the county. These same communities had previously demonstrated a lack of suficient access to primary care for residents. These barriers, outdated and restrictive regulations, adversely affect the ability of some FQHCs to increase access capacity, and with it the ability to meet the ACA mandate to expand access to care and to acquire new revenues or resources to sustain it.

Despite the recognized importance of primary care and the need to ensure a robust primary care system, research also shows that years of lack of attention and investment in the specialty of primary care threatens to further undermine the nation's primary care infrastructure. In the absence of more rapid and significant efforts to undergird a dwindling supply of primary care providers nationally, the practice of primary care and access to primary care providers are seriously threatened (Phillips & Bazemore, 2010; World Health Organization, 2008). Once again, FQHCs are a large and important component of the nation's primary care system. There is a critical shortage of primary care providers across the nation, and more providers talk about leaving the field for

reasons that run from quality-of-life issues to growing dissatisfaction with the field of medicine.

In addition to the threats to primary care itself, centers have long coped with challenges specific to FQHCs, challenges that have threatened their existence or capacity to be effective, efficient healthcare providers. The list of such challenges includes disproportionate reliance on unstable federal funding, an uneven burden of uncompensated care and high-risk patient populations, unfunded capital needs, inadequate infrastructures, competition with private providers and hospitals, and a mixed experience with consumer governance. These historical challenges continue, albeit it to varying degrees among centers, even as FQHCs take on a larger role (Hawkins & Groves, 2011; Lefkowitz, 2007). While federal funding does aid in increasing capacity to support growth in patient volume (Shi et al., 2010), it does not adequately sustain the growth or guarantee future, nor sufficient, resources for centers to become more self-reliant. Some centers continue to struggle; they lack the resources and ability for capacity building to achieve sustainable growth and performance improvements (Chin, 2011; DeMarco & D'Orazio, 2015; Katz et al., 2011; Sage Growth Partners, 2017).

Findings from a recent survey of 175 CEOs that included four in New Jersey identified six broad trends that challenge FQHCs today and that contribute to questions about their capacity, capacity building, and sustainability going forward (Sage Growth Partners, 2017). Sage Growth Partners (2017) identified several trends:

- **struggles with financial growth:** FQHCs continue to be mostly reliant on federal support, which over the years has proven to be unpredictable. Additionally, reimbursement methodologies and the impact of them for

primary care is uncertain, leaving centers without clear models for financial stability.

- **increased competition**: With healthcare reform, new types of providers are entering the primary care market, forcing smaller providers such as local FQHCs to seek more innovative ways to build and sustain their patient base or to partner with ACOs or other networks for access to necessary resources that will allow them to compete effectively.

- **payment reform**: Smaller and/or less technologically advanced centers predict they may be left behind because of their inability to move from current reimbursement models to new value-based payment models in a timely way. Some centers do not have the resources to pursue capacity building to improve financial systems.

- **leadership**: FQHCs need to balance their growing need to guarantee leadership to meet the business and fiscal management demands of the organization with their need to also ensure leadership that is committed to the FQHC model and values. Industry leaders are increasingly reexamining the historical FQHC model that promotes community grown leadership to make sure they have the leadership necessary to operate effectively in a more complex healthcare environment.

- **marketing and outreach**: With increased competition for patients and funding support, centers are rethinking how they tell their story, how they build support for advocacy, and how they convey the value that they add. Heretofore, many centers have not focused on marketing; instead they have relied on community relationships and the intrinsic value of their mission to secure public and private financial contributions and backing.

- **collaboration**: FQHCs have had uneven relationships with local hospitals and healthcare systems. Heretofore, hospitals and other providers benevolently co-existed with FQHCs because they targeted different patient populations. But with the evolution of centers as essential primary care providers while hospitals are investing in ACOs or Integrated Care systems with their own primary care networks, they are targeting the same expanded insured and

Medicaid markets. Thus, it is increasingly imperative for centers to focus on collaboration and partnerships, as they do not have the resources to scale up competition with larger hospital based primary care systems

As described at the beginning of this chapter, there is growing evidence in the academic literature and industry reports that illustrates the ability of FQHCs to expand access to care and to participate in new systems of care as accredited patient centered medical homes. However, research studies reviewed here also show there are still challenges to capacity building among FQHCs, as well as gaps in knowledge and understanding of how centers engage in capacity building to achieve greater self-reliance and the sustainability of programs and services. As essential providers, FQHCs are an integral part of the national healthcare system; a system which is reliant upon their ability to function effectively and to thrive in a reformed healthcare industry.

New Jersey FQHCs are a microcosm of the nation's health centers. They are a vital part of the state's healthcare infrastructure, representing rural and urban centers and large and small organizations. Some are independent while others are run by academic institutions or local governments. Some are outwardly successful, strong organizations, while others are yet struggling. They all share the same foundational mission and must adhere to the same HRSA/BPHC regulations, but like their colleagues nationally, they exhibit distinct cultures and organizational values. They have different approaches to, and understandings of, the environments in which they operate. I concentrated on examining centers located in New Jersey because of the diversity of the state's Community Health Centers, and because of this researcher's knowledge of the state's healthcare environment and the centers there. I am interested in learning why some New Jersey centers succeed in expansion and capacity building when others struggle to

achieve either. In studying New Jersey's centers, I hope to not only gain a greater understanding of how these centers engage in capacity building and why, but to be able to make informed inferences about similar centers, in similar contexts, nationally or within the state.

There is a lack of literature specific to New Jersey FQHCs. There is also little knowledge about how national healthcare policy is interpreted and implemented locally with respect to FQHCs, and especially the ACA. For example, the ACA, as a federal policy, forged broad changes in how primary care is delivered, valued, and paid for, but states have adopted provisions of the ACA, like Medicaid expansion, unevenly. New Jersey proactively expanded Medicaid, but at the same time enacted other polices that some FQHC professionals perceived as being counter-productive to the ACA's goals for developing additional access to healthcare through the expansion of FQHCs. FQHCs are subject to both national and state level policies that at times are incongruent, the result of which can undermine the ability of FQHCs to perform as intended or to engage in organizational capacity building.

Although several related studies cited in this chapter indicate the inclusion of New Jersey FQHCs, these studies reported the findings taken together for all centers that were involved in the respective studies (Doty et al., 2010; Hennessy, 2013; Sage Growth Partners, 2017). As noted earlier the Katz, et al. (2011) study did highlight data related to New Jersey centers represented in that study, but it also reported the findings taken together for those New Jersey centers. It did not address the variation found among individual centers in respect to the study findings. Nevertheless, the HRSA/BPHC UDS data show that, overall, New Jersey FQHCs made progress in meeting expansion goals of

the ACA, as measured by the growth in new access points and the increase in new patient

users at the centers (BPHC, 2018b). But as documented in the literature, New Jersey

FQHCs face many of the same challenges as their colleagues in developing and

sustaining access capacity and in enhancing operational and clinical capacity. A former

Deputy Commissioner of the New Jersey Department of Health and Senior Services says

some of New Jersey's FQHCs have succeeded in growing access capacity, however

"some centers are stronger responders than others" in this effort. Although this comment

was specific to access capacity, it rings true for the marked variation in the overall

capacity of New Jersey FQHCs and in their ability to effect capacity building toward

sustainable performance and effectiveness. To reiterate, there is a gap in basic

knowledge and little deeper understanding of the marked variation in the capacity and

capacity building among New Jersey centers, which function as a microcosm of FQHCs

across the country in respect to their ability to perform as essential primary care providers

in a new healthcare environment.

Purpose and Significance

The objective of this research is to gain a greater understanding of how the New Jersey

FQHC community[12] or *family* view their centers' organizational capability to perform as

essential primary care providers under the ACA. Moreover, the purpose is to increase

knowledge about the centers' ability to effect enhanced overall organizational

performance in an increasingly complex environment. This study examines participants'

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[12] The FQHC community or family refers to the leaders, workers, clinicians, volunteers., organizations, and advocates who have a vested or chosen interest in the success, sustainability, and impact of FQHCs. The FQHC community is referred to as the FQHC *family* hereafter in this research study to distinguish it from the FQHC geographic host community or service area. The FQHC service community refers to a geographic area.

perceptions about the complexity of navigating internal and external environmental

factors that influence performance and the sustainability of access capacity. It will

promote understanding of capacity components[13] that help to advance capacity building

in New Jersey's FQHCs in real time, as well as those that deter it, sometimes with

unintended consequences. This study can increase knowledge about New Jersey FQHCs,

their capacity, and their potential to develop greater capacity to maximize benefit for the

centers, their patients, and the entire healthcare context within which they operate. The

information can be useful in determining the type and scope of financial or technical

assistance that is needed to ensure sustainable capacity building among New Jersey

FQHCs.

New Jersey, at one time, invested substantial financial resources in the states'

FQHCs to promote expansion and capacity building (Holmes, 2005). Yet based on

personal and professional knowledge, despite state and federal investments, some New

Jersey centers are unable to expand or to maintain sustainable operating models.

Nevertheless, New Jersey centers, like their national counterparts, remain important

primary care providers. I have personally witnessed numerous cases where centers saved

lives or improved the quality of life for patients who otherwise would not have received

the care needed. I have also experienced their ability to improve the health status of their

service communities and populations by addressing the social conditions that adversely

affect health and health outcomes. Without New Jersey's centers thousands of

individuals would be without a primary care home and would lack access to quality

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[13] Capacity components are those resources that are critical to drive the operational functions which lead to desired outcomes or products as well as ensure the long-term impact necessary to achieve sustainable systems and improved health outcomes (Brown et al., 2001)

healthcare. FQHCs in New Jersey have made important contributions in improving the health status of vulnerable populations. Their record of accomplishment warrants evidence-based, informed policy to optimize their ability to perform and to thrive as critical primary care providers and leaders in a reformed and progressive healthcare system.

Finally, as indicated previously, this study can help the reader to develop informed theories or inferences about similar centers, in similar contexts, nationally or within the state, to build the case for further research or in understanding those factors that contribute to capacity building in centers overall (Creswell & Poth, 2018).

Research Questions

The primary research questions for this study developed from examination of the literature and input from the pilot focus group that was conducted in Phase 1 of this study. I refined the questions to explore three interrelated concepts that emerged as the principal areas of focus for this study: capacity building, sustainability and the ACA (policy). The research questions are:

1. What is the capacity of New Jersey FQHCs to perform as essential providers under the ACA and to sustain access over time?"
2. What is the impact of the ACA on capacity building in New Jersey FQHCs?
3. Can New Jersey FQHCs leverage the opportunities afforded by the ACA to foster greater sustainability—programmatically and financially?

A subset of questions explored components of each of the three concepts but centered primarily on the topic of capacity building to develop more in-depth information about how participants defined or characterized it and how they perceived it is operationalized in their centers, and toward what end. The subquestions included:

1. The ACA assumes a significant role for FQHCs. What is your understanding of how FQHCs are expected to participate in healthcare reform?

2. What has been the most significant change at your center since the ACA was implemented? What have you done differently as a result?

3. In general, do you think your center was ready to participate under the ACA? Did you have to make significant changes to be ready?

4. Is your center designated as a Patient-Centered Primary Care Medical Home? Has it changed how you operate and provide clinical care?

5. What is your understanding of capacity building? What is the primary goal of capacity building in your center?

6. How vulnerable are FQHCs to external influences?

7. Do you think capacity building contributes to, or plays a role in sustainability?

8. How do the history and culture of the center influence capacity building?

9. Does the center employ strategic fiscal management and planning to achieve sustainability beyond initial external support?

10. What resources (financial/staff) are targeted for capacity building? Can you identify specific capacity building initiatives achieved within the last 3 years?

11. What is New Jersey's investment in capacity building for its FQHCs? Has New Jersey undertaken efforts to promote performance enhancement, capital improvements, or access or service expansion?

The interview guide contained 29 primary questions with 3–5 probes for each primary question. It included questions and probes to aid in identifying and understanding capacity components, including internal and external factors, that are linked to organizational performance. The guide also contained questions aimed at understanding center's ability to effect efficient processes, improved outcomes, and meaningful, sustained impact (Brown et al., 2001; Cohn & Crabtree, 2006).

Theoretical Framework

A description of the study design, data collection and analysis are found in

Chapters 4 and 6 (Methods and Conceptual Framework chapters respectively). However,

this section briefly highlights the assumptions and interpretative framework that guided

this study. The case study approach, which included a thematic/framework analysis of

the data, as detailed in Chapters 4 and 6, is consistent with the purpose of this study,

which is to gain greater knowledge and an in-depth understanding of New Jersey FQHCs.

Briefly, to reiterate here, the study aimed to understand FQHCs capacity to participate as

essential primary care providers under the ACA and healthcare reform, as well as their

ability to engage in capacity building to improve access to care and to enhance their role

as essential primary care providers (Creswell & Poth, 2018; Crowe et al., 2011).

Again, while health centers share common history, mission, and guiding

principles, there is inherent value in examining the diverse viewpoints of those who work

to achieve the same mission but from different vantage points. It is also important to

understand why and how the varying perspectives of those within the FQHC industry

influence how centers perform or approach capacity building to achieve the mission.

Creswell and Poth (2018) highlights the utility of gaining an in-depth understanding of

multiple perspectives to construct meaning and understanding of complex cases or issues.

Through distillation of the data and identification of significant patterns of information

and meanings, we can identify those factors that are important for advancing capacity

building and the context that influences their importance or impact (Creswell & Poth,

2018). Funders and policy makers can better assess where capacity building is needed,

and target resources in a focused way to encourage it. Also, the case study design and

method for data collection enabled this researcher to "follow the data." The open-ended questions, interaction and discussion encouraged participant reflection and clarification of meanings. This facilitated the examination of complex data that reflected the experiences, viewpoints, and understandings of a diverse group of respondents.

Researchers have not advanced an adequate theoretical foundation for studying the importance and impact of capacity building in healthcare at the organizational level (Bergeron et al., 2017). Capacity building theories and models in healthcare, including transformational learning theories and ecological models have largely focused on evaluating the effectiveness of healthcare interventions in developing countries to learn where and how to target resources among large health systems or public health organizations, and within local communities to sustain the impact of initial investments to improve healthcare delivery and outcomes (Bergeron et al., 2017). Capacity building theories have done little to promote a better understanding of the role that it plays to improve and sustain enhanced performance in healthcare organizations (Brown et al., 2001). Furthermore, organizational capacity building theories tend to focus on separate dimensions of organizational development, such as leadership or programmatic improvements, rather than on systemic organizational performance (Bergeron et al., 2017; Boffin, 2002).

Capacity mapping frameworks, like that developed by Brown et al., (2001), the Conceptual Framework for Mapping Capacity in the Health Sector, and which was used to guide and to inform this study (see Chapter 6), can be useful in developing a more solid theoretical foundation for examining capacity building, developing interventions to foster it, and evaluating its impact. While not used to predict causal relationships, the

capacity mapping framework can aid in identifying significant relationships between variables to encourage theory development and to better inform strategic capacity building across the total healthcare system and at each dimension of it (Bergeron et al., 2017; Brown, et,al., 2001; Honadle, 1981).

I used the Conceptual Framework for Mapping Capacity in the Health Sector to (a) to guide my understanding of those factors that characterized capacity building and those widely viewed factors that influence it at some level and to (b) guide the organization of this study's data, to facilitate the data analysis, and to provide a visual representation of the elements that were found to be important in answering this study's main research questions. I created a three-part concept map (Mapping Capacity Building in New Jersey FQHCs) to depict the relationship between identified capacity components or variables that are thought to be important to capacity building, the thematic findings from the research data that are linked to specific capacity components, and the key concepts for this study. Brown et al. (2001) suggest the use of concept mapping to depict the relationship between capacity components because of the limited evidence about the causal relationship between capacity building and performance. In this study, mapping depicts the assumptions, and the perspectives discussed by study participants, about the relationships and offers a path for theory development and testing them. The concept map for Mapping Capacity building in New Jersey FQHCs (herein referred to as the concept map) provides a visual of the data that addresses this study's three research questions. It is described in detail in Chapter 6.

Structure of the Dissertation

The study describes FQHCs in general and New Jersey FQHCs as the central focus of interest and examination. As outlined above, this chapter advances the topic and research questions for study, as well as approach to examining the questions. Chapter 2 comprises a broad review of the FQHC literature, including that which describes FQHCs and the environments in which they operate at the national, state, and local levels. It also includes a review of the literature that explores the impact and effectiveness of FQHCs as primary care providers and major healthcare institutions. Further, the literature review concentrates on works that examine the concept of capacity building and sustainability as it relates to capacity building. This portion of the review included works that assessed current, evidence-based knowledge about capacity building and the implications for understanding capacity building in healthcare. Also, this chapter contains a review of the section of the Affordable Care Act that pertains to FQHCs, plus examination of studies on the ACA's impact on health centers. Existing literature on the ACA and Community Health Centers points to the need for a longitudinal review of the influence of the ACA on FQHCs and their ability to leverage the provisions of the law to effect sustainable improvements in performance and impact. Chapter 3 describes the historical origins and importance of the FQHC model for primary-care delivery. The evidence on capacity building in healthcare organizations frequently underlines the need to understand the historical underpinnings of the organizational culture, values, and governing principles of healthcare organizations to understand their views about, and approaches to, to capacity building. It also includes a detailed description of New Jersey FQHCs and the context in which they operate. It highlights the FQHC model and those factors that contribute to the

uniqueness and individuality of centers within the industry. Chapter 4 describes the

research case study design and strategies used for data collection and analysis. Chapter 5

contains a description of phase one of the study, the pilot focus group. It describes the

purpose, process for data collection and analysis, and the findings for this phase of the

study. The pilot focus group was instrumental in guiding the design of the interview tool

for phase two of the study (in-depth interviews) and importantly, in helping this

researcher to reflect on how I positioned myself, my values, and my experience in the

study. Chapter 6 describes the Conceptual Framework for Mapping Capacity in the

Health Sector. This framework guided the data analysis. Chapters 7 through 9 detail the

research findings for each of the three main research questions, respectively. In Chapter

10, I summarized the purpose for this study and its importance, as well as the salient

findings, but mainly I devoted discussion in Chapter 10 to outlining my conclusions and

their significance. I also underscore the implications for policy development to support

meaningful, future capacity building initiatives in FQHCs. The conclusion also

highlights the identified limitations of the study and the implications for future research.

CHAPTER 2: LITERATURE REVIEW

This literature review examines journal articles, research reports and public documents pertaining to Federally Qualified Health Centers, as well as the key concepts that are explored in this study. The literature search involved the use of Google Scholar, Medline, PubMed and Ovid Journals databases. It also included the use of public documents such as Public Law 111-148, the Patient Protection and Affordable Care Act and Public Law 111-153, the Health Care and Education Act of 2010. These documents are housed by the United States Government and made available to the public via the U.S. Government Publishing Office,[14] digital documents. Additionally, the literature review included the use of FQHC documents and data that are maintained by the Bureau of Primary Health Care (BPHC)[15], a department within the Health Resources and Services Administration (HRSA)[16]. The BPHC administers the Community Health Center program, which includes FQHCs.

BPHC/HRSA also maintains a digital library of journal and peer reviewed research articles on Community Health Centers. While the body of literature curated by HRSA covers a range of topics that address the quality and impact of health centers, only a handful of the studies explore capacity building and FQHCs. These studies primarily examine dimensions or components of capacity building in centers. They focus on access issues or efforts to enhance the delivery and quality of healthcare services. However, a smaller number of articles addresses capacity building to enhance organizational

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[14] Government Publishing Office https://www.gpo.gov/

[15] BPHC https://bphc.hrsa.gov/

[16]HRSA/BPHC UDS   https://bphc.hrsa.gov/datareporting/health-center-library

functions or processes such as health information technology (HIT) systems and management (HRSA, 2019).

Similarly, the NACHC maintains a collection of research studies and scholarly reports on FQHCs. Review of the works compiled by NACHC also revealed only a small body of literature specific to organizational capacity building among centers. There is overlap in the collections of literature compiled by HRSA and NACHC. NACHC also maintains a compendium of studies on health center quality of care, cost effectiveness, and health disparities that dates from the 1970s to now (NACHC, 2019b). Some of these studies are cited later in this chapter, which also includes a description of the progression of interest in FQHC research over the years.

The broader search of the FQHC literature (Google Scholar and Journal databases) yielded the same results in respect to the scope and type of available research on FQHCs. In all, the majority of FQHC literature is descriptive. However, the focus of the literature has changed over time. Earlier studies aimed to describe the Community Health Center model and the characteristics that distinguished them from non-federally authorized health centers. More recently, with implementation of the ACA, there is a developing collection of literature that concentrates on the role of FQHCs and their importance in the larger healthcare infrastructure, as well as their ability to participate in a changing healthcare landscape. There is still a lack of research that explicitly addresses overall FQHC organizational capacity, or capacity building.

Table 1 below summarizes the relevant search topics used to select the literature reviewed for this study. The selected literature contains studies and research reports that offer pertinent theoretical and evidence-based knowledge related to the key concepts and

research questions for this study. It also includes studies and other scholarly reports that describe the FQHC program and examines their model and impact. This study's key concepts were used as the initial search topics. Subsequently, I identified subtopics to facilitate the literature search, using a snowballing method to uncover applicable keywords found in other related studies and reports, as well as frequently cited studies that pertained to the topic of interest. The main topics and subtopics of interest are summarized in the table below.

Table 1

Key Topics for Literature Search

Databases Searched	Key Search Topics			
	FQHCs	Capacity Building	Sustainability	ACA
	Subtopics for Each Key Topic			
Google Scholar	BPHC-CHC	Capacity building	Capacity Building and Sustainability	Overview of goals for ACA
PubMed	Primary Care	Capacity building in healthcare		
Medline	PCMH		Sustainability of FQHCs	ACA provisions for FQHCs
Ovid Journals	FQHCs and ACA	Organizational development		
HRSA/NACHC Health Center Library/Studies	Impact of FQHCs	Capacity building in FQHCs		Impact on FQHCs
	Access Quality			

The literature review is organized by: (a) a review of public documents and reports, and research studies that provide descriptive data and narrative about the nation's Community Health Centers, their purpose and model of care, and (b) a review of relevant studies pertaining to the key concepts and research questions. Organization of the literature review also follows the progression of public, academic, and industry interest in FQHCs since their inception. Additionally, while sustainability was explored as a

separate relevant topic for this study, the literature review focused primarily on those studies that principally address capacity building as the main topic. Studies specific to the concept of sustainability are not included in this literature review. However, many of the studies pertaining to capacity building address the association between it and sustainability, and thus afforded a review of the pertinent, available knowledge about the relationship between the two concepts

Federally Qualified Health Centers Literature

Public documents developed by HRSA/BPHC, the NACHC and other nationally recognized organizations that promote public healthcare interest are routinely published to share data and research reports that describe FQHCs, their overall mission, characteristics, and services, as well as the rules and regulations that govern how the centers operate. Most of the widely available data that informs these reports are derived from the HRSA/BPHC Uniform Data System (UDS). The UDS includes Community Health Centers' self-reported information on FQHC services, clinical metrics, utilization rates, costs and revenues, and patient demographics. HRSA/BPHC collects, analyzes and maintains individual and aggregate FQHC data (BPHC, 2019a).

As described earlier in Chapter 1, HRSA defines FQHCs as "community-based, patient-directed organizations, that deiver comprehensive, culturally competent, high-quality primary healthcare services" (BPHC, 2019c, para. 1). FQHCs predominantly serve vulnerable individuals and populations. This definition reflects the shared purpose of all FQHCs. A brief profile of the centers that expands upon the HRSA definition is provided in this chapter, since a significant body of the FQHC literature seeks to describe the FQHC model, its unique attributes, and the differences and similarites between

centers. Also noted above, the HRSA UDS data are broadly cited in descriptive studies

and reports about Community Health Centers. As such, the composite profile of

Community Health Centers presented below represents a consistent description of the

centers throughout the FQHC literature.

There are numerous Community Health Centers across the country, however

FQHCs are distinguished from private communty health centers as federally authorized

health center organizations. The brand, FQHC is primarily a reimbursement designation

from the BPHC and the Centers for Medicaid and Medicare (CMS) for authorized

Community Health Centers. FQHCs include community, migrant, homeless, and public

housing programs. As previously stated, in this study, the terms FQHCs and health

centers are used interchangeably and refers to those centers that are federally funded

and/or meet the federal requirements for a Community Health Center, which are found in

Section 330 of the Public Health Service Act (PHSA), and that are reimbursed by CMS

as federally qualified (authorized) health centers. Also, HRSA distinguishes between

funded centers and those centers authorized as FQHCs, but that do not receive Section

330 Public Health Service grant dollars. The latter cohort of centers are considered

FQHC look-alikes and must adhere to the same requirements as HRSA/BPHC grant

funded centers. FQHC look-alikes benefit from policies intendended to support enhanced

revenue streams for all FQHCs. Herein, the terms Community Health Centers, centers,

and FQHCs include FQHC look-alikes unless otherwise indicated. FQHCs are mostly

independent, nonprofit, tax-exempt entities that are governed locally. However, public

institutions, such as academic health centers, also own and operate some FQHCs. All

FQHCs, however, fall under the authority and regulatory policies of HRSA. The centers

are required to have certain core capacities, services, and structures in place which are defined in statute and regulated by HRSA. (BPHC, 2018a). A summary of the Health Center Program Requirements is provided in Appendix A. However, to receive a designation of FQHC status, centers must be able to meet at minimum four basic requirements:

- Be in or serve a federally designated health professional shortage area, or medically underserved area or population, as defined by the U.S. BPHC
- Provide services regardless of insurance status or ability to pay
- Use a sliding fee scale for self-pay patients based on income
- Have a nonprofit corporation status and a board of directors that represents the center's primary service area. The majority of board members must be users of the organization.

(BPHC, 2018a). In addition, centers must also adhere to local state laws for licenses to operate as an ambulatory, primary healthcare facility (Holmes, 2005).

Demographically, FQHCs are in health professional shortage areas (HPSAs) or MUAs. There are 1,373 health centers, operating 11,056 sites in urban and rural communities in all 50 states, the District of Columbia, and U.S. territories. As described previously, the majority of FQHC patients are disproportionately low income, live at or below 100% of the federal poverty level (69% vs. 13% nationally), and are uninsured (23%), or publicly insured individuals (49%). They are predominantly members of racial or ethnic minority groups who are at significantly greater risk for lack of access to healthcare and poor health status outcomes (BPHC, 2019a).

In describing the FQHC model, earlier studies illustrate the rich history of Community Health Center programs, including how today's model emerged over time.

Moreover, studies highlight the importance of the centers' organizing mission and model of care. A detailed overview of the development and maturation of Community Health Centers is provided in Chapter 3 of this study, but significant literature findings are briefly reviewed here because they highlight the importance of the environment in which FQHCs emerged, especially its impact on the mission and values of FQHCs today.

Historically, albeit with varying degrees of government support across the years, health centers have been viewed as important components of the nation's healthcare safety-net system for vulnerable populations. Community Health Centers have provided healthcare services to underserved and high-risk populations, since the early 1800s (Sardell, 1988; Starr, 1982). However, earlier centers concentrated on public health education and interventions to promote the prevention of highly contagious diseases. Not until the 1960s, during the War on Poverty, did health centers gain significant momentum, acceptance and backing as more than public health organizations. The FQHC literature portrays a different and increased interest in health centers during the 1960s. They gained recognition as potentially useful primary healthcare delivery systems, to offer comprehensive medical treatment services and interventions to address the well-being of individuals, populations, and communities (Sardell, 1988; Starr, 1982).

The FQHC model today evolved as a critical component of the 1960s War on Poverty initiative. A segment of the FQHC literature emphasizes the development and importance of the Community Health Center movement during and since the War on Poverty era. It also describes the importance of the centers as essential institutions in advancing efforts to address more than disease prevention, by also helping eliminate health disparities and improving the social conditions that promote health inequities. The

same body of literature depicts Community Health Centers from the 1960s as critical

institutions that helped to advance the nations' goals for winning the war on poverty

during a turbulent political and social climate in the country (Geiger., 2002; Lefkowitz,

2007; Longlett et al., 2001; Taylor, 2004). Then and now, centers serve as more than

healthcare delivery systems; they were and are still viewed as community-based change

agents and economic engines. They are integral members of their host community

(Lefkowitz, 2007; Heisler, 2017; Ward, 2017). Their role during the War on Poverty

helped to cement their mission and commitment to the populations that they serve. The

War on Povery thus enmpowered not only communities but also Community Health

Centers. It validated and expanded the mission and purpose of the centers. The FQHC

literature highlights this important evolution of health centers and the political and social

context that helped to define and institutionalize the FQHC model and mission (Adashi et

al., 2010; Lefkowitz, 2007). Chapter 3 of this study further details the development of

centers during the 1960s, while, Chapters 8–10 describe the perceived impact of a culture

and mission that grew out of a particular political and social climate, and the relevance

today to the FQHC model in a more complex and different environment.

Critically, the focus of FQHC research shifted with the growth of the health center

movement and with changes in the political climate in the 1960s and thereafter. The

research focus changed from descriptive studies of the centers and their model of service

delivery, to studies that examined their quality of care and impact. This change reflected

not only continued interest in the centers, but importantly the need to provide evidence to

justify continued government funding following the War on Poverty. As public support

for the War on Poverty declined, and disinterest in supporting community-based

programs from that era grew, more critical, empirical research studies appeared, fueling varied positions with respect to the need for continued federal and private support of the centers. Much of the research provided evidence that backed the continued need for the centers as safety-net organizations, especially as attention to disparities in healthcare outcomes and access to care increased, along with growing calls for healthcare reform (Donaldson & Vanselow, 1996; Lefkowitz, 2007). Consequently, the volume of research on health centers that highlights their value as critical, effective safety-net organizations, has grown. More recently, additional research interest has focused on increasing the role and standing of FQHCs in the nation's healthcare delivery system. Significantly, studies began to emerge in the 1970s to explore the effectiveness of centers in addressing issues of quality, patient outcomes, health disparities, and access to care. More recent studies also examine the return on investment of public funding for health centers. Nevertheless, as the body of research on the centers has expanded, there is still a dearth of studies that addresses capacity building among FQHCs to demonstrate their ability to continue to adapt and thrive as healthcare reform efforts progress today

The aforementioned NACHC library of research studies on Community Health Centers contains reports, peer reviewed articles, and other scholarly works that address issues of quality, access, cost effectiveness, and patient satisfaction, among other relevant topics that speak to the role and importance of the centers in today's industry. The literature dates from the 1970s to today. NACHC's inventory of articles contains over 100 studies and reports, including eight studies from the 1970s that began to evaluate the financial and social value of Community Health Centers. NACHC provides brief

summaries of the research they compile. Example summaries are reproduced in

Appendix B. to highlight this NACHC resource.

Overall, the studies reviewed for this research, predominantly conclude that

FQHCs demonstrate the capacity to perform, at a point in time, better or equal to private

healthcare providers or other institutions on important nationally recognized healthcare

metrics for quality of care (Fontil et al., 2017; Heisler, 2017; Hicks et al., 2006; Shin et

al., 2008). One study using "process of care measures" from the 2006–2008 National

Ambulatory Medical Care Survey found that FQHCs did better on seven out of 18 quality

performance indicators for ambulatory care and equally well when adjusting for patient

characteristics on the other measures. Prior to accounting for the differences in patient

characteristics, the results were only slightly different; the centers did better on six

indicators and less well on only one of the measures, diet counseling for high-risk

adolescents (Goldman et al., 2012). Other research also showed the centers were more

likely to perform routine health maintenance or preventive care such as blood pressure

measures and laboratory tests (Shi et.al., 2012); achieve higher rates of immunizations for

children (Schempf et al., 2003); and demonstrate greater compliance in screenings for

preventative conditions such as cancer and diabetes (Dor et al., 2008; Ulmer et al., 2000).

FQHC patients were found to have higher utilization rates than non-FQHC patients for

preventative services, such as Pap smears (85% vs. 81%) and influenza vaccinations

among the elderly (70% vs. 65%) (Shi et al., 2009). Studies also show that FQHC

patients are found to have better than average health outcomes or indicators for control of

chronic illnesses. They are exceeding the Healthy People 2020 Goals for low birth

weight and access to timely prenatal care. Also, they have demonstrated decreased risks

for disparities in healthcare, such as in hypertension treatment and women receiving mammograms, as well as in the overall health status for their patient users, compared to those served by other providers. Moreover, according to public data and research, FQHCs have demonstrated outcomes that show decreased disparities in the disease management of patients of different ethnic, racial or insurance groups (NACHC, 2019c; Shi et al., 2012). Community Health Centers have been particularly effective in closing the gap between minority women and white women for low birth weight babies, especially among lower socioeconomic groups. A 2004 study reported that lower socioeconomic female patients at FQHCs had fewer low birth weight infants compared to all low-socioeconomic women. The racial/ethnic disparity in low birthweight found among the women at the centers was narrower, compared to that of women in the general population (Shi et al., 2004). More recent HRSA-UDS data show that FQHC minority patients have lower incidence of low birthweight (Black 11.7% and Hispanic 6,6%) than other minority women nationally, (13.4% and 7.4% respectively) (BPHC, 2019a).

These studies and reports also highlight the fact that health centers provide care for populations that are disproportionately at greater risk for access disparities, poorer than average health status indicators, and poorer utilization of preventative services. The research finds few or no disparities in the delivery and quality of care received by FQHC patients, nor in health outcomes among center users. The evidence consistently concludes that the high performance of the centers is a significant factor in reducing barriers to care, as well as in reducing health disparities among high- risk groups (Shi et al., 2009; Shi et al., 2010).

Studies also document the impact that centers have on the overall well-being of the communities in which they are located. The research shows that health centers are important economic engines in their host communities and surrounding areas, providing jobs and promoting economic growth as major consumers of local services. According to a report commissioned by the Center for American Progress (Whelan, 2010), FQHCs leveraged the $2 billion investment in FQHCs, authorized through the 2009 American Recovery and Reinvestment Act (AARA), to generate $20 billion economic activity in their local communities, including the creation of new jobs and businesses. Evidence of the economic impact of FQHCs on local communities is one of the significant factors in justifying public investment in these institutions as essential primary care providers (Heisler, 2017; Whelan, 2010).

In addition, beyond having a fiscal impact on local economies, HRSA-UDS data and relevant research studies find that Community Health Centers are cost-efficient organizations, and they help to lower healthcare costs, system wide. Centers have proven to be effective in preventing utilization of higher cost services such as emergency rooms and inpatient care, thus reducing overall costs to the healthcare system (Ku et al. 2010). FQHC Medicaid patients are shown to have fewer visits to hospital emergency departments and to be hospitalized less often for ambulatory-care-sensitive events. Moreover, the presence of FQHCs in medically underserved areas is associated with reduced rates of preventable hospitalizations and emergency room use (Epstein, 2001; Falik et al., 2006; Wright, 2018). Furthermore, many centers provide access to care after regular hours. The availability of after-hours care is associated with fewer emergency room visits and unmet healthcare needs. One study found that 30.4% of patients with

access to after-hours care had fewer emergency department visits compared to 37.7% of those who could not contact or visit their providers after-hours. Also 6.1% of patients with after-hours access experienced fewer unmet needs compared to 13.7% for non-after-hours patients (O'Malley, 2013). These findings on the cost-effectiveness of FQHCs underscores one of the significant premises of the ACA—that the expansion of Community Health Centers, and thus access to primary healthcare services and the prevention of more costly utilization of emergency departments, will help to reduce spending across the healthcare system. Using financial models to develop estimates of growth, utilization, and cost of patient care at FQHCs, one study suggests that the estimated cost savings contributed by FQHCs under the Community Health Center expansion initiative could reach $181 billion by 2019, with most of the savings realized at the state levels (Ku et al., 2010).

Research on FQHCs has continued to expand over the past two decades to further examine the value of FQHCs as comprehensive primary care centers. A selection of the literature on healthcare reform describes the heightened focus on primary care as the backbone of the nation's healthcare delivery system, as well as the recognition of FQHCs as one of the largest primary care systems in the nation. Studies consistently find that primary care is essential to achieving the goals for better health outcomes and lowering costs across the healthcare system (Abrams et al., 2011; Starfield, 2011; World Health Organization, 2008). As previously noted, FQHCs are a large system of primary care providers and are important contributors to reaching these goals (Showstack et al., 2003; Moore & Showstack, 2003; Stange et al., 2010). However, there is an evident need for

more robust, longitudinal research to evaluate the long-term impact of both primary care and FQHCs as critical sources of primary care.

Other studies have concentrated on documenting the ability of FQHCs to serve as patient-centered medical homes. To this end, several studies have focused on the ability of FQHCs to adopt the PCMH model and their capacity to achieve PCMH accreditation (Probst et al., 2009; Shi et al., 2012; Shi et al., 2007). A shared premise among many in the healthcare industry is that adoption and implementation of the PCMH model can lead to better primary healthcare delivery, systems of care, and patient outcomes. Several studies examine the central importance of primary care and the PCMH model as the prototype for high quality, comprehensive primary care (Crabtree et al., 2010; Nielsen et al., 2012). The PCMH model offers common standards that are considered proxies for provider capacity to deliver effective primary care.

Briefly, the most universally accepted definition of a medical home is that offered by the Patient Centered Primary Care Collaborative (PCPCC). As noted in Chapter 1, the PCPCC characterizes the patient-centered medical home concept as a relationship-based approach to delivering comprehensive care to all age groups. It also centers on team-based care that is patient centered, accessible and coordinated, and that emphasizes quality and safety. (Physician Membership Organization, 2007; Nielsen et al., 2012). In addition, the PCMH is supported by advanced health information systems, inter-professional care teams, payment reform, and trained clinical teams in the medical home model (Nielsen et al., 2012).

As described previously, FQHCs have long embraced the tenets of a medical home model and have stressed the similarities between the PCMH model and FQHCs.

Nevertheless, encouraged by public policy and industry support of the model as the "gold standard" for primary care, many FQHCs, also as noted in Chapter 1, have pursued and achieved NCQA PCMH accreditation (NACHC, 2019c). But, significantly, several studies highlight that there is considerable variation in the prioritization and adoption of various elements of PCMH among providers, thus medical homes can differ in significant ways (Carrier et al., 2009). There is also variation found in FQHCs' ability to perform as effective medical homes across some or all domains of the model (Doty et al., 2010). This is attributed in part to differences in access to ready resources, including the necessary infrastructure or financial resources to develop medical home capacity as prescribed by the PCMH model (Doty et al., 2010; Rosenthal, 2008).

The National Demonstration Project (NDP) is one of the most comprehensive attempts to study and broadly evaluate the PCMH model and the capacity of organizations to implement it (Crabtree et al., 2010; Nutting et al., 2010). Overall, a series of findings from the NDP demonstrated that highly motivated independent practices, with adequate support, could successfully implement most of the tactical components of a PCMH (i.e. critical HIT functionality). Moreover, the NDP study also highlighted areas where capacity building may be needed to effect changes to improve primary-care delivery. One of the most salient areas noted was the need for knowledge, training, and efficient systems to effect learning to function as a PCMH. This includes having a strong infrastructure, core resources (human, financial, and infrastructure), leadership, and "adaptive reserve," defined as the ability to both respond positively to change or to create change to achieve desired outcomes (Crabtree et al., 2010; Nutting et al., 2010; Stange et al., 2010). Finally, the NDP research found that external support,

additional resources, and local control of, or influence over, environmental factors are critical to the ability of providers to build effective PCMH models to advance comprehensive primary care practices.

One study specific to the PCMH and FQHCs concludes that the ACA builds upon the demonstrated success of FQHCs as health homes and upon their potential to expand what some FQHC advocates describes as a more advanced, but not new, patient-centered approach to preventative and cost-effective care (Adashi et al., 2010). This study supports FQHC advocates' assertion that health centers are a ready "turnkey solution" for enhancing access to primary care medical homes (Hawkins & Groves, 2011; NACHC, 2012). Notwithstanding this finding, another study reviewed for this research claims, and supports the conventional wisdom that exists among the FQHC family, that PCMH status does not define the capacity for primary care among FQHCs. PCMH standards do not consider unique characteristics of the FQHC model that exceed those standards such as community outreach and interventions to address social determinants of health, or the higher cost to FQHCs to implement PCMH. For example, regarding the issue of higher costs, enhanced IT capacity and quality improvement initiatives are related to higher costs per full-time physician in the centers, and implementation of six of the NCQA standards for a medical home were associated with higher operating costs in the centers (Nocon et al., 2012). Other research showed that primary care payment structures do not cover the full cost of adopting the PCMH model or implementing practices to enhance capacity for performance improvements (Hawkins & Groves, 2011; Ku et al., 2011: Nocon et al., 2012). More importantly, reimbursement reforms that favor achievement of PCMH status lack incentives to encourage FQHCs to pursue medical home status. A

central theme of these studies is that the absence of PCMH designation does not diminish the role or capacity of FQHCs for primary-care delivery. While adopting and achieving PCMH designation may signify accomplishment and improved primary-care delivery practices, the FQHC model alone ensures the ability of FQHCs to be effective primary care providers (Nocon et al., 2012). Nevertheless, it is evident that as changes to the reimbursement system evolve to reward PCMH status and practices, the ability of FQHCs to demonstrate PCMH accreditation becomes increasingly important.

Significantly, the drive toward adoption of the PCMH model as the preferred standard for primary-care delivery is evident in the ACA legislation (H.R. 3590-111th Congress, 2010). One of the ACA's principal elements, pertaining to FQHCs, was that it created the Community Health Center Fund (CHCF). The CHCF is a multibillion-dollar fund created to expand the FQHC program and to enhance FQHC infrastructure and operations, as well as clinical performance. The fund helped centers to meet the cost of building greater capacity to adopt models of care like that of the PCMH.

Importantly, the CHCF was intended to build upon the annual FQHC discretionary appropriations to health centers, but instead it has partially supplanted these appropriations, keeping funding levels for FQHCs lower than anticipated under the ACA (NACHC, 2018). The CHCF was intended to provide permanent funding support to sustain capacity building for FQHCs through 2019 (H.R. 3590-111th Congress, 2010; Congressional Research Service, 2019). While a more comprehensive review of the CHCF and its impact is beyond the scope of this study and literature review, it bears mentioning in the context of understanding the intended benefit to centers under the ACA, and the unintended use of the CHCF that resulted in the lack of resources available

to FQHCs for capacity building through PCMH accreditation or otherwise, beyond the initial dollars to catalyze capacity building and expansion.

The full text of the Public Law detailing the ACA is available on the U.S. Government Publishing Office's website. The relevant sections of this document and other public reports that offer in-depth analysis of the ACA provisions for FQHCs, plus relevant research, constitute the body of literature that was reviewed to understand the rationale and expectations for FQHCs under the ACA, as well as its impact. While the majority of studies pertaining to the impact of the ACA for centers shows that it has clearly afforded opportunities for the expansion of centers, others highlight the challenges centers face as reform efforts continue, such as the lack of adequate funding support to maintain access capacity for some centers or the absence of skilled team members to implement new, complex operating systems that are necessary to thrive in an era of reform. Such challenges can affect sustainability of the expansion efforts and the ability of some centers to enhance capacity as high performing primary-care medical homes. This latter body of literature raises questions about FQHCs' long-term capacity to sustain growth and expanded access for vulnerable populations (Katz et al., 2011; Hennessy, 2013; Ku et al., 2009; Sage Growth Partners, 2017; Taylor, 2012; Taylor, 2013)

Questions about the ability of FQHCs to perform consistently, effectively, and sustainably have also contributed to growing interest in research that focuses on organizational-level capacity and capacity building, in FQHCs. However, there are very few studies still that specifically address the issue of capacity building in FQHCs. Plus, a preponderance of studies on capacity building in healthcare emanates from international research that examines the ability of non-governmental organizations (NGOs) in

developing countries to address population health issues in a sustainable way. These studies examine the impact of public and private philanthropic efforts in tackling health disparities and poor health outcomes in those areas. They also seek to identify those factors that contribute to the success of a country, community, or neighborhood in constructing systems and processes to meet local healthcare needs, and to also effect greater self-reliance in promoting and providing for the health of its citizens. Only a few studies have concentrated specifically on capacity building in healthcare organizations in the United States, and especially among FQHCs. However, interest and research in both appear to be increasing. The sections below highlight a subsample of studies that pertain to the broad concept of capacity building as well as to capacity building in FQHCs.

Capacity Building Literature

A succinct overview of capacity building literature is provided to establish the context for examining capacity building in FQHCs and understanding the foundation for the studies that are pertinent to health centers. A significant part of the work on capacity building, especially earlier research and international studies, seeks to understand how capacity building is defined, particularly across non-profit agencies and NGOs, how they use or intellectualize the term, and what constitutes capacity building (Honadle, 1981; Whittle et al., 2011). Studies show that there is broad agreement that capacity building is a complex multidimensional concept that is typically examined along one dimension (such as the program or organizational level) or aspect of the concept. However, increasingly, scholars have pointed to the need to examine capacity building as a multifaceted concept that is interdependent and interrelated across domains. Also, there is need to understand the relationship between capacity building and performance within and across all levels

of healthcare—including at the community and individual levels—as well as sustainability of performance at all levels (Brown et al., 2001; Meyer et al., 2012; Schuh & Leviton, 2005; Whittle et al., 2011). Researchers maintain that governments, humanitarian organizations, philanthropic entities, and communities are increasingly invested in capacity building research to learn (a) how to sustain improvements in healthcare and health outcomes, especially where critical health disparities exist, and (b) how to foster greater self-reliance and less need for external support (Brown et al., 2001; Schuh & Leviton, 2005; Whittle et al., 2011). The interest in capacity building as a tool to foster greater self-reliance in healthcare is especially germane to the study of capacity building in FQHCs given their historical challenges with sustainable growth, and moreover, given their heightened role as essential providers within the nation's healthcare infrastructure.

Several cited studies and other research have surveyed the capacity building literature to assess the breadth of research and knowledge on capacity building in general, as well as in healthcare organizations (Boffin, 2002; Brown et al., 2001; Whittle et al., 2011). Common themes that are repeated across the literature include:

1. Capacity building is a multidimensional concept, with interrelated attributes.
2. Definitions of capacity building vary, but there is growing consensus on common attributes that are mapped to capacity building, along and across dimensions of the concept.
3. Capacity building implies performance toward achieving some outcome or impact.
4. The ability to measure capacity building is needed to determine where there are gaps in organizational performance and where support is needed to ensure sustainable operations and outcomes. There is a dearth of research and literature on how to identify aspects of capacity building and on how to measure it.

5. There is little agreement on how capacity building enhances performance or which elements of capacity building contribute to improved performance.

6. There is agreement that capacity building is important in fostering sustainability of performance and outcome improvements.

7. The external environment (political, social, economic, etc.), plays a role in organizational capacity building.

8. Internal capacity includes organizational culture, values, philosophy, and so forth—all of which are deemed important to promoting capacity building.

9. How capacity building is defined influences how systems, organizations, and individuals approach it.

From another perspective, Whittle et al. (2011) succinctly captured the categories of literature that are typically found on capacity building, noting also that these categories are fluid. The categories include:

- Literature that seeks to define capacity building, to understand or to establish a common capacity building language—definition and terminology

- Literature that explores causal relationships or asks how capacity building occurs or improves performance

- Literature that explores the dimensions, levels, or domains of capacity building and the approach to capacity building at each

- Literature that explores the overall approach to ensure capacity building at the systemic level and the infusion of capacity along each interrelated level or dimension

- Literature that focuses on political, global, and national influence on capacity building

Table 2 highlights a few pertinent studies that address capacity building within, and across, some of these categories. It contains some of the findings and shared

understandings of the broader concept. The table also includes samples of how capacity

building is defined or described throughout the literature.

Table 2

Overview of Selected Sample of Capacity Building (CB) Literature

Source	Purpose of Study	Key Findings	Definition/Elements
Whittle et al., 2011.	To review the scope of knowledge on organizational capacity building and to develop an understanding of the concept for shared learning. To examine capacity building strategies and impact on organizational development.	How organizations define and understand CB contributes to how they approach and intellectualize it. Systemic capacity building is necessary to effect organizational capacity.	CB implies developing the skills and knowledge necessary to perform effectively, over time to achieve desired outcomes. It involves systemic, long-term investments to effect planned change.
Potter and Brough, 2004.	To identify how/if financial investments at the systems level for CB might lead to sustainable effective changes that are less subject to environmental factors or institutionalized processes, and that effect enhanced qualities and features called capabilities that could be continually drawn upon over time for enhanced systemic performance and outcomes.	Capacity building at the systems level is essential to ensure ability and performance across all levels of an ecosystem. Poor or inadequate systemic arrangements adversely affect confidence in performance and organizational abilities. CB from the top down is needed	CB implies a hierarchy of CB needs and a systemic approach to diagnosing and effecting interdependent components that build upon each other in a linear but iterative way.
Meyer et al., 2012.	To define CB and how to measure it in PHS. To examine the link between capacity/performance and outcomes, and applicability of CB frameworks/measures to PHS	Capacity is a critical determinant of organizational performance. A systems-level approach to CB is essential	Capacity is a dynamic construct that incorporates multiple levels, including system, organization, community, and individual. It is multi-dimensional and includes multiple components

Source	Purpose of Study	Key Findings	Definition/Elements
Corrigan and McNeil, 2009.	To demonstrate the need for enhanced organizational capacity under healthcare reform and the rationale for investing public and private support in organizational CB.	Capacity is fortified through systems-level interventions and integration but, stronger organizational capacity is needed to achieve performance. CB at the organizational level requires resources, and purposeful policy toward that end.	Describes critical elements necessary to ensure CB in healthcare organizations, specifically, strong, consistent policy support, financial investments, and measurements and standards.
Brown et al., 2001.	To depict a conceptual framework for mapping capacity and capacity building to show the relationship between critical identified elements that are widely connected to CB across all dimensions. Primary goal is to contribute to development of tool(s) to measure presence/impact of CB.	Despite evidence that CB occurs across multiple levels, there is still little consensus on its impact or role in improving performance or outcomes, or standards for the approach to it. However, capacity components are related to improved organizational performance. CB should contribute to sustainability.	CB is a process that improves the ability of a person, group, organization, or system to meet its objectives or to perform better.

Researchers cited in Table 2 commonly note that gaps exist across capacity building

literature in the following areas:

1. There are a limited number of peer-reviewed studies.
2. There are few rigorous studies to document evidence of the impact of capacity building on service delivery, organizational processes, and systems performance.
3. There are no common standards or "gold standards" for measurement of capacity building.
4. There are no widely accepted indicators of what constitutes capacity building or progress toward that end.

5. Many studies on capacity building, especially organizational capacity building, adopt frameworks that focus on only one dimension of capacity building without examination of the interrelationship and integration of factors that may influence capacity building across dimensions.

6. There is little understanding of which elements or components of capacity building impact organizational development or processes at any given time, or over time.

7. The effect of environmental factors on capacity building is not clearly understood.

Also, since much of the earlier work on capacity building emanates from other countries, it raises questions about the context or environment in which effective capacity building can occur in this country. One study emphasized the need for building organizational capacity among healthcare organizations in the United States and the need for a national policy agenda that dedicates resources to capacity building across American healthcare organizations (Corrigan & McNeil, 2009). This study does not speak to how organizaional capacity relates to healthcare systems-level capacity.

Another more global study of capacity building supports the premise that policy and the ability of the organization to influence policy is related to their ability to effect sustainable organizational and systems-level capacity building (Rutten & Gelius, 2013).

Finally, studies on capacity building consistently point to the difficulty of measuring its presence and impact. The research by Brown et al., (2001) is frequently cited as an important contribution to understanding the issues associated with evaluating capacity building and its link to performance. A detailed review of the research by Brown et al., and its applicability to this study is found in Chapter 7.

Despite the noted limitations of research and evidence that demonstrates a causal relationship between capacity building and performance or the lack of agreement on how to measure it, there is clear agreement, indicated in the literature cited above, on its importance to effect desired outcomes and sustainable impact in healthcare.

The remainder of this section on capacity building concentrates specifically on the small but expanding volume of research that pertains to capacity building in FQHCs.

FQHC Capacity Building Literature

Briefly discussed here and detailed in Chapter 7, Brown et al., (2001) presented a useful framework (Conceptual Framework for Mapping Capacity in the Health Sector) for exploring organizational readiness (existing capacity) and evidence of capacity building in FQHCs. Their work supported two key premises for this study: (a) capacity building is important for the ability of FQHCs to perform as essential providers under the ACA and (b) capacity building can influence the ability of centers to achieve greater sustainability of new access and operational capacity improvements. As such, the Conceptual Framework for Mapping Capacity in the Health Sector was adopted to inform this study's approach to understanding capacity building in FQHCs and to facilitate the data analysis.

Importantly, as previously stated, this study's working definition for capacity building throughout, was drawn primarily from the work of Brown et al., but was also influenced by the commonalities found across the capacity building literature, as cited above in this chapter. To reiterate, I define capacity building in this study as: the process that enhances the ability and preparedness of systems, persons, organizations or communities to meet objectives or to perform as expected, toward sustainability or

greater self-reliance over time. This definition evolved over the course of this study and is informed by the capacity building literature, plus feedback from study participants in both Phases 1 and 2 of this study. It evolved to reflect newfound insight and understanding of how capacity building is viewed in healthcare, especially among FQHCs.

The limited body of capacity building studies pertaining to FQHCs consists primarily of studies that examine FQHC capacity building at a programmatic level, or indirectly, such as in the study of capacity building in primary-care delivery. Salient studies more specific to capacity building in FQHCs are reviewed below.

As previously noted, the Commonwealth Fund undertook one of the more comprehensive studies of FQHCs that examined their capacity to perform as essential primary-care providers. This study, (Doty et al., 2010), looked at the ability of FQHCs to perform in a changing environment and to serve as "highly-functional", sustainable primary-care providers. It also sought to identify areas where centers might benefit from capacity building and additional support to ensure their role as healthcare reform advances. The study involved a national survey of 795 FQHC respondents. It highlighted the common strengths and challenges found among the centers as indicators of existing capacity or areas of need for capacity building (Doty et al., 2010). The researchers adapted the PCMH model to assess FQHC capacity across domains they defined as: (a) access to care indicated by the ability to provide same/next day appointments; (b) ability to track and coordinate referrals; (c) data collection and reporting on clinical outcomes and patient satisfaction; (d) adoption and use of advanced health information technology such as the ability to segment and generate patient medical

information, and (e) the ability to manage and track laboratory tests. They also looked at

the overall ability of FQHCs to perform as PCMHs as defined by the PCPCC. The

PCMH, as noted earlier, provides a set of widely endorsed standards for quality

healthcare delivery and for improving access to primary care. Doty, et al. (2010) found

that most of the centers surveyed reported having capacity in some, if not all, the domains

associated with a patient centered medical home (PCMH). The findings showed that

55% of the FQHCs possessed capacity in 3–4 of the five domains above, while 16% were

found to have capacity in 0–2 domains, and 29% had it in all 5 domains. In the access

domain, the study authors found that the majority of the centers have the capacity and

systems to provide timely access to care for their patients. Most centers can schedule

patients for same day access (72%) and approximately 66% can accommodate same day

medical advice by telephone within scheduled office hours. However, centers vary in

their ability to provide after-hours care; only 37% have weekend hours for primary care

and 44% for sick or urgent care, and nearly all the centers (91%) have difficulties

acquiring access to specialty care for their patients. The Commonwealth Fund study also

showed that the centers varied in capacity on other measures such as the ability to track

patients to coordinate their care and to ensure access to a continuum of care or follow up

for preventive care. Most of the Centers have some HIT capacity to facilitate access for

their patients, such as to send reminders for follow up care (34%). However, some

centers are far more or far less advanced than others in the use of health information

technology to enhance access or patient care (Doty et al., 2010). Importantly, the

Commonwealth Fund study concluded that the majority of FQHCs are reasonably well

functioning primary-care providers within the control of their own organizations,

although most lack some capacity in one or more of the domains cited above. The findings from the Commonwealth Fund study are intended to inform policy and encourage adequate federal support to ensure the capacity of Community Health Centers to perform across all the domains associated with highly functioning medical homes.

Other studies specific to capacity building in FQHCs largely include a focus on one or more aspects of FQHC operations. Specifically, most of these studies highlight capacity building strengths or challenges related to clinical programs. But one study examined FQHC capacity to adopt and implement advanced health information technology. Importantly, this study also highlighted the importance of, and interdependence of, capacity building between systems and programs within organizations to ensure improved functioning of the entire entity (Frimpong et al., 2013). Frimpong et al., (2013) contend that highly developed HIT functioning is critical to the abillity of FQHCs to deliver overall quality care services, as well as to drive systems-level integration and sharing of patient health information. Highly functioning HIT capacity is also essential for FQHCs to participate in, and benefit from, new payment models under healthcare reform.

Several reports from HRSA and NACHC show that most FQHCs have some HIT capacity (NACHC, 2019c). However, Frimpong et al., (2013) also concluded that although funding was provided through the ACA to build upon health centers' existing HIT capacity, policy makers and funders possessed little understanding of the degree of FQHCs' technology capacity. There is little information about their ability to implement and utilize advanced health information technology.

Another study specific to FQHC capacity building pertains to the ability of centers to grow and thrive in an era of change. This study is described in Chapter 1 and expanded upon here. It proposes that capacity building in FQHCs is critical for the centers to remain relevant, vital providers, but that FQHC requirements and policies that define FQHC operations sometimes adversely influence their ability for capacity building (Hennessy, 2013). Hennessy makes a case that external factors play a major role in centers' ability to develop greater access capacity for primary-care services. He argues that FQHCs may not be fully able to achieve the magnitude of expansion that is needed to ensure access to primary care under the ACA because of this. Further, the same study notes that there is considerable variation found among centers related to their ability to effect and sustain access capacity as anticipated. But despite centers' best efforts, building access capacity is unnecessarily hindered by policies and rules that may not be relevant to the new norms under the ACA. Although Hennessy focused on access capacity, the findings are applicable to the broader issue of capacity building. The movement toward healthcare reform offers an opportunity to relook at policies and regulations to address barriers that affect organizational capacity building in FQHCs (Hennessy, 2013).

In examining the impact of the external environment on capacity building in FQHCs, another study focused on the relationship between FQHC "technical efficiencies" and the external environment (Amico et al., 2014). They describe technical efficiencies as variables that are similar to what Brown et al., (2001) identifies as capacity components, such as human resources, financial management, and resource development. Amico et al framed the study within a resource dependence theory to explain the

relationship between FQHC grant dependency and centers' ability to perform as efficient organizations with sustainable impact. They hypothesized that FQHCs technical efficiencies (i.e. labor or human capacity and cost or financial management) are dependent on external factors, most significantly on federal grant revenues and how they are awarded. They found that centers with higher dependence on federal grants experienced less capacity or technical efficiency to grow access capacity or to perform as expected. These centers demonstrated lower operating margins, higher costs, and generated fewer patient visits overall. They had poorer performance on indicators for efficiencies related to fiscal management and human resource functioning. Amico et al., underscored the need for centers to develop the ability to become less dependent on grant funding and to build new capacities that align with business models to ensure greater efficiencies and sustainability. The researchers concluded that additional research is needed to further examine the technical efficiency of FQHCs, and the influence of funding policies and how centers are reimbursed. The same authors emphasize that there are very few process measures found in the UDS set of data for FQHCs that help to measure efforts toward developing "technical efficiencies" or capacity building in health centers. They also highlighted the marked variation found in the technical efficiency of FQHCs (Amico et al., 2014).

Summary of Literature Review

There is a rich field of research that describes FQHCs, the model, and their impact as experienced primary-care providers. Studies find that centers (collectively) offer marked value in improving population health, reducing costs, and providing access to primary care for millions of people. However, the evidence also shows there is critical

variation in how centers perform and, in their ability, to effect sustainable capacity building efforts and outcomes (i.e. improved access capacity). Yet, there is a dearth of research studies that specifically examine capacity and capacity building in FQHCs, especially at the state level. Only a handful of studies focus on New Jersey FQHCs. To encourage more robust, empirical research on FQHCs, the NACHC is driving an effort to encourage greater research capacity within the FQHC family itself and in collaboration with others. NACHC, in partnership with other institutions such as the Clinical and Translational Science Institute at Children's National Medical Center, George Washington University, tout the readiness and ability of FQHCs to partner in research efforts to foster a greater understanding of the FQHC model, the impact of Community Health Centers, and their efforts toward improving capacity to be larger, sustainable players in a changing environment (Jester et al., 2014). They are actively promoting FQHCs as rich fields for research. They offer that FQHCs have an important vantage point for expanding initiatives to understand their unique approach to primary care, one that spans from bench to bedside to community.

The FQHC model, its approach and advantage, can help build greater systemic capacity for sustainable change and impact in primary-care delivery. NACHC reports that there is a growing and strong interest among FQHCs to develop greater capacity to not only be the subject of more robust research but to engage in and to lead research that focuses on FQHCs and evidence-based knowledge about the centers (Jester et al., 2014). With renewed interest in FQHCs today, the need for reliable data and measurement standards for capacity and capacity building in FQHCs is increasingly important.

CHAPTER 3: ORIGINS, HISTORY, AND CHARACTERISTICS OF FQHCs

History and Development of FQHCS

In Chapter 2, I briefly described the evolution of health centers that created today's FQHCs—their culture, values and mission. The literature on capacity building identifies these factors, along with external environmental components, as significant variables in how centers approach capacity building (Brown et.al., 2001; Whittle et al., 2011). Also noted in Chapter 2, several widely cited authors have described the effect of the political and social environment that existed during the 1960's on the development of the Community Health Center model in the United States. One of the most important aspects of the larger environment during that period was the social and political movement aimed at empowering communities. The War on Poverty sanctioned the development of local self-help programs, including neighborhood health centers, which were later referred to as Community Health Centers. These centers, as they are today, were community governed and community focused (Geiger, 1983; Geiger, 2002; Lefkowitz, 2007; Lewin & Altman, 2000; Sardell, 1988; Starr, 1982). While healthcare reform was not a priority of the War on Poverty movement, social reform advocates, especially Sargent Shriver, Director of the Office of Economic Opportunity (OEO)[17], persuaded President Lyndon Johnson and other policy makers that poor health was a chief factor in perpetuating the cycle of poverty (Sardell, 1988; Starr, 1982). Healthcare as a tool to help break the cycle of poverty resonated with influential political leaders who strongly championed the centers as a means of not only improving access to

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[17] The Office of Economic Opportunity (OEO) was a federal agency that was created to develop and oversee the War on Poverty programs.

healthcare and the health status of populations, but also as social engines to promote equity in healthcare and to help improve social and economic conditions in unserved communities (Sardell, 1988)

Consequently, the OEO launched the Community Health Center movement in the United States and laid the foundation for today's FQHCs. A central goal, like that of all OEO programs, was to improve the lives of the poor—economically, socially, politically, and personally, especially among minority populations (Lefkowitz, 2007; Sardell, 1988; Starr, 1982). The OEO however, did not create the health center model. It was predicated on the Community Oriented Primary Care (COPC) concept, in part, because the COPC model closely aligned with the popular ideology of the 1960s of self-help and community development to promote and sustain social change (Geiger, 1983; Goffin, 2006).

Drs. Sydney and Emily Kark pioneered the COPC model with the development and successful operation of the Pholela Health Center in South Africa. The COPC model was introduced in developing countries originally as an approach to help synthesize the principles and practices of community medicine with clinical medicine. Importantly, it influenced the integration of public health with clinical primary care, it encouraged the movement of Community Health Centers toward a population health focus rather than one of public health. The COPC model assumes responsibility for the health and well-being of a targeted, defined population and location, and the clinical, primary care of individual patients. COPC combines principles and practices of multiple approaches and methodologies, such as epidemiology, demographic studies, primary-care practices, environmental and social interventions, community organization and public health. It

seeks to change or alleviate environmental and social conditions that contribute to the ill

health or lack of overall well-being of those defined communities or groups and their

individual members (Donaldson & Vanselow, 1996; Geiger.,1983; Geiger, 2002; Goffin,

2006; Longlett et al., 2001). Critical components of the early COPC model that endure

today include: (a) emphasis on a team-based, multidisciplinary approach to primary care;

(b) focus on a defined community and population; and (c) reliance upon the community

to inform and help drive the identification of local healthcare priorities and interventions.

Also, it established the importance of health centers in creating local jobs, leadership

development, community environmental and infrastructure improvements, and local

control. It fostered local initiatives, such as community gardens and housing programs,

to address what are now popularly referred to as social determinants of health (Geiger,

2002; Longlett et al., 2001).

In addition, the COPC concept gained legitimacy in the American academic

community through the efforts and work of Dr. H. Jack Geiger, an American physician

who trained for a year at the Pholela Health Center under Dr. Sidney Kark. Dr. Geiger, at

Tufts Medical School, and Dr. John Cassel at the University of North Carolina-School of

Public Health, were instrumental in advocating for the adoption of the COPC model in

the U.S. They sought to drive social changes to aid in improving the health status of poor

and minority communities. They established two of the earliest federally funded, health

centers in the United States as demonstration programs—the Tufts-Delta Health Center in

Mound Bayou, Mississippi and the Columbia Point Health Center in Boston (Geiger,

2002; Lefkowitz, 2007; Longlett et al., 2001; Ward, 2017).

As the centers struggled to take hold during the 60s and 70s, they gained momentum through compromise with organized medicine, primarily the American Medical Association. Geiger, Shriver and others characterized the centers as healthcare organizations for unserved or underserved, disenfranchised populations and communities (a brand that remains today). They would not create direct competition with private physicians but would complement their ability to care for the poor. Private doctors were also guaranteed participation in the governance of the centers, and hospitals and medical schools were considered eligible to apply for grants to establish community-based centers. These concessions by Community Health Center advocates allayed fears about competition with private providers, and about the perceived inexperience of community groups to manage grants and ensure effective implementation of the programs. In addition, health center grants served as a new source of funding for those hospitals and medical schools that did successfully start Community Health Centers (Sardell, 1988). This historical perspective underscores a commonly repeated view, that acceptance and support for FQHCs by the broader healthcare industry and by the federal government stems from health centers' narrowly defined niche as safety-net providers. The conventional belief in the FQHC family is that the private healthcare sector does not view centers as a threat, providing they primarily care for populations that are financially, culturally, or otherwise marginalized. When Community Health Centers remain closely focused on their mission and historical target populations and geographic areas, they are less susceptible to external threats from the healthcare industry's private sector or hospital systems because of perceived competition with the private industry.

Community Health Centers were one of the few War on Poverty programs that survived that era. In addition to not being perceived as a threat to private providers, they were considered an insignificant risk to institutions overall (politically, socially, and economically), in part because they were started as demonstration programs, with no commitment for long-term funding. Today, FQHCs are still subject to discretionary federal grant funding. Additionally, centers served to support the newly introduced Medicaid program during the 1960s. They were viewed as cost-effective, supplementary programs to Medicaid and as a source of care for Medicaid patients.

Another critical factor that helped the centers to survive the demise of the War on Poverty was the fact that health centers were more acceptable than some of the other programs conceived at that time. Despite the mandate for community control of most War on Poverty programs, many of the first health centers were created and, in some cases, managed by professionals (i.e. physicians) who were considered accountable and free from local community control and perceived corruption, and who possessed the prerequisite skills and experience that loaned credibility to health centers. While the centers were touted for fostering community leadership, empowerment, and involvement, they were controlled or perceived as being controlled by health professionals. All these factors added to the legitimacy of the centers while at the same time supporting the call for social change and civil rights, and for some political leaders, helping to set the stage for movement toward healthcare reform (Lefkowitz, 2007; Sardell,1988).

Nevertheless, the development of Community Health Centers, as well as the reputation that they enjoy today, was not without challenges, opposition, and doubt that has lingered and threatened their survival over the past decades. Their success as a War

on Poverty creation contributed to the image of health centers as a healthcare system for the poor, especially the minority poor, and as an agency of the federal government, making it difficult for the organizations to attract private dollars, to broaden their service areas, and to diversity their sources for reimbursement, then and now. Their historical overdependence on discretionary federal funding and the lack of a significant insured patient base has contributed to critical financial challenges. For some centers, the ACA has improved their ability to increase their number of insured patients. However, centers have experienced opposition and competition over the years for Medicaid and other insured patients, despite the historical image of them as non-threatening organizations. Also, questions have persisted about their relevance since the end of the War on Poverty and in ensuing years. While many centers have succeeded, even thrived, others have faltered or closed (Geiger, 2002; Lefkowitz, 2007; McAlearney, 2002).

Despite these difficulties however, FQHC proponents believe Community Health Centers overall have weathered the various challenges, such as federal and state budget cuts, unfavorable changes in reimbursement policies, and perceived irrelevance in the nation's healthcare system to emerge as major systems of care under the ACA (Hawkins & Groves, 2011). Notwithstanding waning support during the 70 and early 80's, interest in the centers grew with increased recognition of their value as part of the nation's healthcare infrastructure. Accordingly, as noted in Chapter 2, the breadth and depth of literature on FQHCs started to evolve during the late 1980's, with the increased recognition of the centers as critical components of the larger national healthcare system that provides access to healthcare for millions of Americans.

As recounted previously, a portion of the FQHC literature reveals the heightened interest in the centers as the debate about, and realization of, healthcare reform progressed over the past three decades. Scholars and public interest groups have examined and documented the expansion of the centers over this time. The literature notes that renewed interest in the centers under President George W. Bush contributed to the growth in numbers of Community Health Centers during the 2000's and their capacity to provide greater access to primary care for underserved populations. Under President Bush's Health Centers Growth Initiative program, new funding opportunities were created to grow the number of FQHCs in underserved areas, to improve clinical capacity, and to develop strategies for long-term sustainability of the centers. Under this initiative, Community Health Centers were also encouraged to position themselves as providers of choice for populations other than those they typically serve, while also continuing their mission. While some centers have managed to diversify their patient base and to attract more Medicare or privately insured patients, the UDS data show that FQHCs have continued primarily to serve patients and communities that share the same demographic profile as those they have served historically (BPHC, HRSA, 2017). Nevertheless, health centers were increasingly viewed as options for expanding and enhancing primary care to meet the anticipated increase in demand for services among all groups as healthcare reform was debated (Johnson, 2006; O'Malley et al., 2005; Politzer et al., 2003). Importantly, some researchers noted that while the growth in the number of centers in underserved areas during the early 2000s proved to be beneficial for improving access to care for the uninsured, it was not a substitute for insurance coverage in ensuring greater access and utilization of services (Hadley & Cunningham, 2004).

Significantly, the 2010 healthcare reform Affordable Care Act (ACA), not only further expanded Community Health Centers as a core part of the national healthcare delivery system, it ensured broader access to insurance coverage for millions of people. It also further validated the FQHC model as a comprehensive patient-centered primary care home for patients, and it underscored the value of Community Health Centers in today's environment. But again, this came with increased scrutiny of their capacity to create organizational efficiencies and business models to ensure sustainability of newly expanded access capacity, as well as their ability to perform as comprehensive patient-centered medical homes, and most importantly to demonstrate improved outcomes and long-term impact in today's environment of comprehensive healthcare reform. With renewed interest in FQHCs—the expenditure of social and political capital in support of their advancement and enhanced financial investments—there is significant interest in their role and impact, as well their model of care and performance. This is evidenced, in part, by the growing volume of research to further understand and evaluate the FQHC model.

FQHCs in New Jersey share the same history, mission and foundational regulations as their colleagues across the country, an origin and foundation that distinguishes them from other, non-FQHC, primary-care providers. The sections below provide a description of New Jersey FQHCs and the context in which they operate.

New Jersey FQHCs: A Microcosm of Community Health Centers

There are over 1,400 Federally Qualified Health Centers (FQHCs) located across the nation, 23 of which are in New Jersey. FQHCs in New Jersey, like their national counterparts, share similar structural and demographic characteristics, owing to the

federal requirements that determine their designation as an FQHC. As such, the centers

represented in this study are comparable in many ways to their colleagues, nationally and

within the state. For this study, 20 FQHC staff and board members participated in in-

depth interviews, representing 10 New Jersey FQHCs, which include both rural and

urban centers. The interviewees also represent large and small centers, as well as mature

and more recently established sites. Together, New Jersey's FQHCs comprise the largest

healthcare safety net for the state's most underserved areas and populations. Figure 1

provides an overview of health centers in New Jersey. It is a partial replication of the

New Jersey Health Center Fact Sheet created by the NACHC (NACHC, 2019a). The

graphic depicts the most recent profile of New Jersey's centers. It is a snapshot of the

scope and breadth of FQHC presence in the state, their reach in the number of patients

served, the type of services they provide and the staff they employ. Subsequent tables

and illustrations found in this chapter provide a more detailed view of the New Jersey

FQHC patient profile and the growth in the number of patients served since the

implementation of the ACA, plus a look at the insurance mix for New Jersey's centers.

Figure 1

Overview of New Jersey FQHCs

Health Centers in New Jersey, 2017

Health Centers in NJ

# of Grantee Organizations	23
# of Delivery Sites	131
% Grantees with PCMH Recognition	83%
% Grantees w/ Staff Authorized to Prescribe Medication-Assisted Treatment *(MAT)* for Opioid Use Disorder	30%
% of Grantees Utilizing Telehealth	26%

NJ Health Center Patients

Children Served	170,072
Homeless Patients Served	26,997
Veterans Served	4,017
Growth in Patients since 2010	22%
Total Patients	**528,256**

	NJ Health Center Patients	NJ Residents	US Residents
% at or Below 100% Poverty	74%	10%	13%
% at or Below 200% Poverty	95%	23%	31%
% Racial/Ethnic Minority	77%	45%	39%
% Uninsured	28%	7%	9%
% Medicare	5%	18%	17%
% Medicaid	55%	16%	17%

NJ Health Center Staff Provide a Comprehensive Range of Services

	FTEs
Physicians	232
NPs/PAs/CNMs	156
Nurses	270
Dentists	115
Dental Hygienists	32
Behavioral Health Specialists	98
Pharmacy	17
Enabling Services	335
Vision	3
Other Staff	1,348
Total Staff	**3,289**

	Patient Visits
Chronic Conditions	352,338
Behavioral Health	204,998
Preventive Services	688,644
Dental Services	376,580
Total Visits	**1,962,415**

Did you know that health centers in New Jersey are economic drivers? Every $1 in federal investments generates $4.31 in economic activity across New Jersey. In total, health centers in New Jersey deliver $755.1 million in economic activity.

* **Notes:** Dual eligible beneficiaries enrolled in both Medicare and Medicaid are only included in Medicare estimates. "Federal investments" refer solely to Health Center Program Section 330 grants. **Sources:** 2017 Uniform Data System, BPHC, HRSA, DHHS. US Census Bureau. Leavitt Partners in collaboration with NACHC. Detailed sources are available at http://www.nachc.org/research-and-data/state-level-data-maps/.

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For more information, email federalaffairs@nachc.org.

Note: This table is a partial replication of the New Jersey Health Center Fact Sheet. This portion of the fact sheet provides a profile of NJ FQHCs.
Reprinted with permission from NACHC, New Jersey Health Center Fact Sheet, 2017 (NACHC, 2019a)

Like their counterparts, New Jersey FQHCs are also referred to as Community Health Centers, health centers, centers, or clinics. However, as noted previously, not all health centers are FQHCs. While there are many Community Health Centers or clinics in New Jersey, only 23 are FQHCs. Briefly, as outlined in Chapter 2 of this study and found in Section 330 of the Public Health Service Act Title 42 and the Health Center Program Compliance Manual (BPHC, 2018a), centers designated by HRSA as FQHCs are required to:

- locate themselves in unserved or underserved areas, as defined by the Public Health Service Act;
- provide a comprehensive scope of primary, preventive and enabling services;
- maintain critical staff, appropriately licensed, credentialed and privileged, to provide all required services, either directly or through contractual or referral arrangements;
- ensure access to services by providing accessible hours, including after-hours coverage and accessible locations;
- ensure continuity of care by arranging for hospital admitting privileges for FQHC providers/clinicians;
- provide sliding fee discounts to all eligible patients and ensure that no patient is denied services because of an inability to pay;
- maintain an ongoing quality improvement/quality assurance program to foster improved healthcare delivery and outcomes, as well as reasonable cost of care;
- provide appropriate and efficient leadership, management, and governance of the center;
- establish collaborative relationships to support comprehensive, integrated healthcare delivery, and effective use of resources.

Overview of New Jersey FQHCs

In this chapter, as throughout the study, the New Jersey FQHCs are referred to as FQHCs, health centers, or centers interchangeably. While similar in their adherence to the core tenants that define them as FQHCs, the centers do differ in meaningful ways relative to their overall cultures and structures. FQHCs also differ in how they respond to and reflect the characteristics of their host communities, as well as the political and social milieu in which they operate. In the FQHC world, there is a common adage that "if you have seen one FQHC, you have seen one FQHC." This chapter describes the similarities among FQHCs and the nuanced differences that distinguish New Jersey's FQHCs, from one another and from other providers. It also illustrates the political, social and physical environment in which they operate in New Jersey.

All FQHCs must send information annually to the HRSA/Bureau of Primary Health Care (HRSA/BPHC) using the Uniform Data System Resources (UDS) tool and defined measures for the UDS. As noted previously, they are required to report information that includes patient demographic information, total patient users and visits, services provided, clinical indicators, utilization rates, and costs and revenues. The demographic profile of the New Jersey FQHCs described in this chapter is based on UDS data, which is available to the public through the HRSA/BPHC Health Center Program website[18] UDS data is useful in describing the populations served by FQHCs (ethnicity, race, economic status, age, etc.), as well as the pattern of growth in the number of patients served by FQHCs since the implementation of the ACA.

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[18] HRSA/BPHC UDS   https://bphc.hrsa.gov/datareporting/index.html

Here, the environment in which New Jersey FQHCs operate is depicted through the lens of this study's respondents and my knowledge of the FQHC landscape in New Jersey. My knowledge of FQHCs, especially in New Jersey, draws on over 20 years' experience as a former Chief Executive Officer/Executive Director of a large FQHC in New Jersey, along with service as president of the New Jersey Primary Care Association, president of the Region II Primary Care Association of Community Health Centers, and as a member of numerous committees, boards, and organizations dedicated to addressing primary healthcare issues in the state. Similarly, to get at the full range of their experience, the study respondents were asked open-ended questions during the one-on-one interviews and encouraged to describe their roles within their centers. This provided a rich composite narrative about the patient populations served by FQHCs and the interconnectedness between the centers and their communities. Together, the UDS and interview data bring alive New Jersey's FQHCs, their organizational cultures and values, and the environments in which they operate, all of which influence how they approach the business of being an FQHC, including the incorporation of capacity building and financial sustainability.

New Jersey FQHC Demographic Profile

The Community Health Center movement in New Jersey began in the late 1960s with the first licensed, federally funded neighborhood health center, the Newark Community Health Center, in Newark, New Jersey (Holmes, 2005). Today, New Jersey boasts 23 centers with 131 sites located across the state[19] (BPHC, 2019a; NACHC,

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[19] The New Jersey Primary Care Association reports 24 centers which includes one look-alike center and 134 sites for 2018. HRSA and NACHC numbers are based on official UDS data for 2017. (NJPCA, 2018)

2019a). Some serve fewer than 500 patients, while more mature centers serve up to

70,000 individuals. Taken together, the number of patients served by the New Jersey

centers has increased since the implementation of the ACA. Together, as represented in

Figure 2, they have expanded access for over 175,000 patients, with the latest reported

total for 2017 numbering 528,256 (BPHC, 2019a;).

Figure 2

New Jersey FQHC Total Patient Users 2008-2017
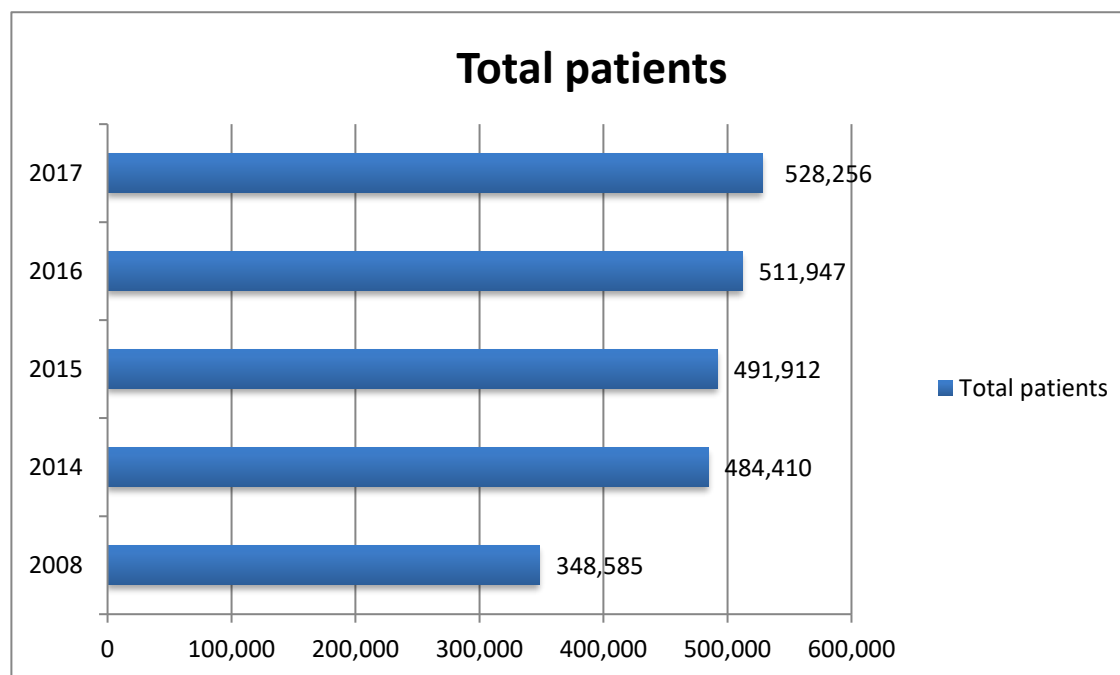
Note: The data in this graph is from the HRSA Uniform Data System (UDS) . Caution should be taken when comparing the data pror to 2016 with the years after 2016 as a change was made to the UDS data collection and measuring processes. https://bphc.hrsa.gov/datareporting/reporting/index.html

However, while some centers have steadily maintained their growth others have

witnessed occasional setbacks in their development over the years, resulting in declining

patient volumes, revenues and access capacity. Some centers that have experienced these

setbacks have managed to rebuild and continue their mission, albeit not at the same pace

or to the same degree as others. Nevertheless, the need for these centers outweighs the challenges they face. New Jersey communities, policymakers and other stakeholders have consistently supported the recovery of these centers.

Like all FQHCs, New Jersey centers provide healthcare services for mostly low-income and minority populations. They serve an uneven share of high-risk populations such as the homeless, compared to other primary care providers. Across New Jersey, more than 70% of FQHC patients live at or below 100% of the federal poverty level, while 95% of New Jersey health center patients are at or below 200% of poverty (Families USA, 2018; NACHC, 2019a). The United States Census Bureau establishes the federal poverty level (FPL) annually. The FPL information shows the number of people and households that have incomes that are less than what is required to meet three times the amount determined to be necessary for basic needs such as food and housing. This information is used to provide guidelines for eligibility for many government programs, such as Medicaid and subsidies for health insurance on the ACA Health Insurance Marketplace (also known as the *marketplace* or the *exchange*). Persons living at or below 100% of the federal poverty level have incomes or support that is equal to or less than the determined federal poverty level at any given time. Nationally, the FPL for 2018 is $12,140 for an individual.

Additionally, New Jersey FQHC patients are predominately Medicaid or uninsured. African Americans, Hispanics and other racial or ethnic minority groups are represented disproportionately in FQHCs (BPHC, 2019a). Figure 3 illustrates the racial/ethnic and economic profile of New Jersey FQHC patients. The data, like that in

subsequent tables in this chapter, covers 2008 to 2017, before and during implementation of the ACA.

Figure 3

Demographic Profile of New Jersey FQHC Patient Population
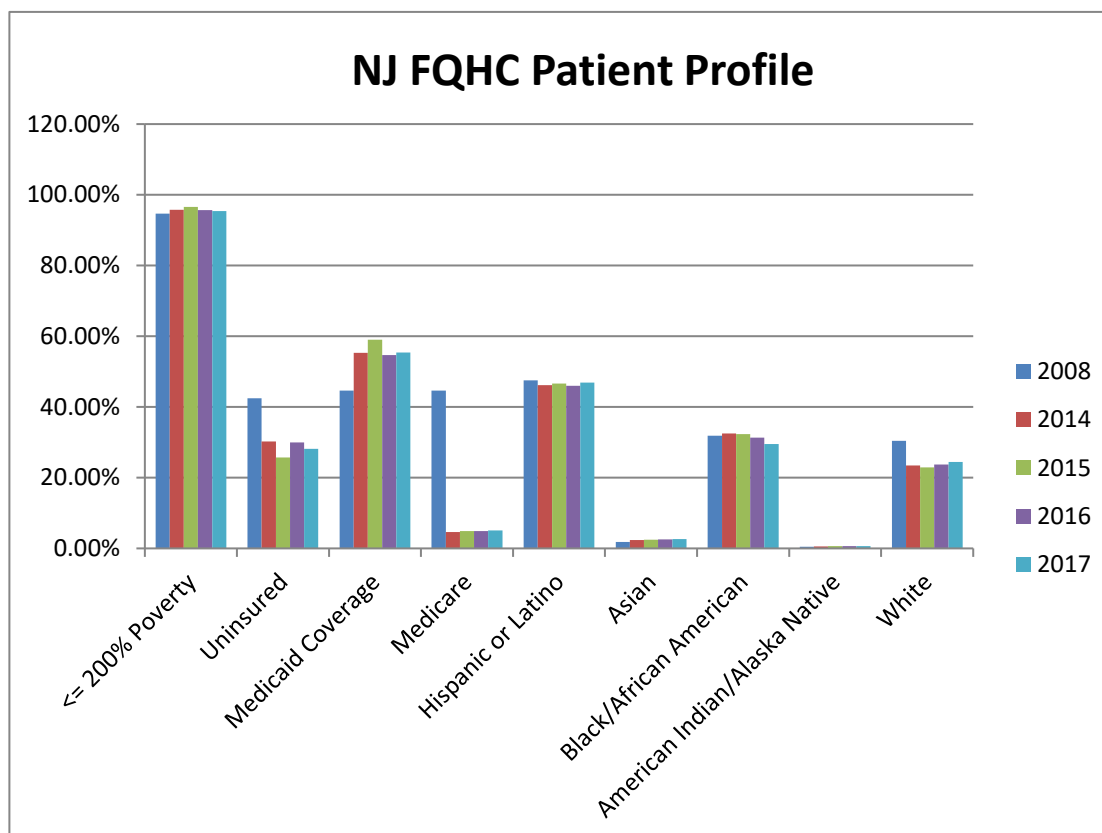
Note: The data in this graph is from the HRSA Uniform Data System (UDS) . Caution should be taken when comparing the data pror to 2016 with the years after 2016 as a change was made to the UDS data collection and measuring processes. https://bphc.hrsa.gov/datareporting/reporting/index.html

This same chart shows that FQHCs have consistently served a mostly low-income, uninsured and Medicaid minority population despite changes to improve access to care for all populations and the anticipated shift in how patients access care. First, there is little discernable difference in the number of FQHC indigent patients (below

200% FPL) since 2008. Figure 3 also shows a decrease in the number of uninsured

patients, but with a corresponding increase in Medicaid covered individuals. Most

markedly, it also demonstrates that a larger proportion of New Jersey FQHC patients are

Hispanic or Latino over time. There is a corresponding decrease in the number of

Black/African American patients in 2018. This marks a shift in the racial/ethnic mix of

New Jersey FQHC patients from earlier years, where from experience, most center

patients were Black/African American and non-Hispanic.

A more detailed look at the payer or insurance coverage mix of patients in each of

New Jersey's FQHCs is found in Figure 4. This chart portrays all New Jersey health

centers, including those represented in this study. It shows that the New Jersey centers

are similar in the proportion of Medicaid and uninsured patients that they serve, with a

few exceptions. The exceptions are three centers, one of which is attracting a larger share

of commercially insured individuals than most of their colleagues and two that have

significantly lower uninsured populations than other New Jersey centers.

Figure 4

New Jersey FQHC—Insurance Mix of Patients
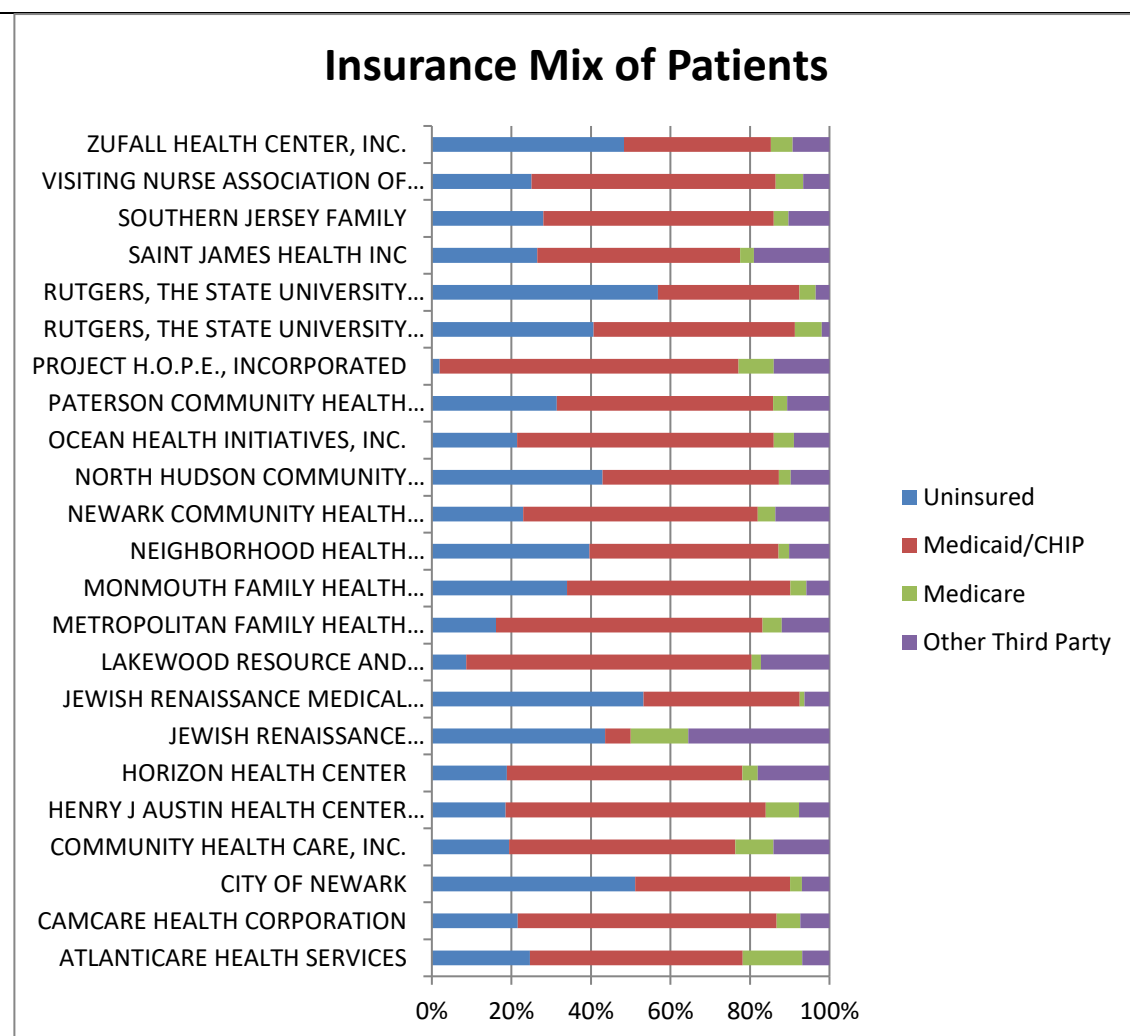
Note: The data in this chart is from the Uniform Data System (UDS) which is maintained by HRSA. The graph depicts year 2016 data for the payer mix of FQHC patients.
https://bphc.hrsa.gov/datareporting/reporting/index.html

In all, as shown in both Figures 3 and 4, the trend in the demographic makeup of FQHC patients has changed in some ways, but not in the disproportionate share of vulnerable populations that are cared for by health centers. This ongoing trend among New Jersey centers is consistent with that found among centers nationally (BPHC, 2019a). New Jersey FQHCs, like those across the country, continue to be a major

provider of care for those who are most economically disadvantaged and those most at

risk of lack of access to care. Health centers have contended with the pros and cons of

this fact over the years, with some viewing it as an advantage, while others are concerned

about the potentially adverse impact of the relatively unchanging econmic mix of its

patients on their ability for capacity building or even for sustainbility. A participant in

the interview phase of this study expressed their perspective that the demographic profile

of patients who use the New Jersey centers is a positive factor from the view of their

mission, but that it is also a reflection of the fact that they are providers for all

populations: The participant said:

> we have the whole gamut of populations…it's really a beautiful system that we
> serve and provide much-needed care to those who need it regardless of race,
> color, creed, religion, sexual orientation. There is no discrimination; everyone is
> treated as a human being and as a patient...

This description of the New Jersey centers' patient mix reflects the demographics of the

communities that are served by FQHCs. Chapter 7 highlights FQHCs' commitment to

their host communities and the populations that make up those communities. However,

to illustrate the impact of the demographic mix of the health center patients on multiple

aspects of their operations, a brief review of pertinent data from this study is highlighted

here. First, interviewees in this study echoed pride in the fact that FQHCs serve all

comers, but mostly they expressed pride in the fact that they serve those who need it

most. Moreover, they provide care for disenfranchised individuals in settings that

promote dignity and consumer empowerment. Nonetheless, even though respondents

shared this view, many of them also talked about the challenges associated with the

patient mix, historically and today. One such challenge voiced was the apparent

continued identification of centers as institutions that serve only the poor or mostly

minority groups. While centers celebrate that they have the "whole gamut of populations," many centers, including those represented in this study have struggled with diversifying their patient population as is evident in the data shown in Figures 3 and 4. Some FQHCs have argued that the ability to diversify their patient mix is critical to future economic sustainability, as well as their ability to compete in the healthcare arena. Others have maintained that centers should remain focused on their core historical patient base, the uninsured and underinsured; minorities and special populations.

The sentiment expressed in the quote above that there is no discrimination and FQHCs welcome all comers, underlies the fact that health centers across the country, including in New Jersey, have tried to balance their mandate to serve the underserved or unserved with the need to attract more insured populations to either enhance revenues or to change the image of the centers. Their history and reputation for helping mostly financially disadvantaged persons have, in the opinion of some in the industry, acted as a barrier against attracting commercial or Medicare insured patients and thus new sources of income. Several study respondents referred to a lingering belief that FQHCs are primarily clinics for the poor. This stereotype is believed to have kept other populations away. One senior level interviewee summed up opinions echoed by other study participants saying that centers continue to be perceived as: "the free clinic, as the place where the poor go or that's a place where people just practice. They are not real doctors…." Nevertheless, FQHCs have fought to overcome the stereotypical images, while at the same time keeping their traditional patient base. They have attempted, with various levels of success, to expand and grow a diverse socioeconomic base of patients by creating an image of the FQHC as a place for all patients. Efforts to diversify the

patient mix have included rebranding, building a different image of the organizations as welcoming places for all groups and presenting them as inviting, modern, high-quality centers of care. This is illustrated in the statement of an interviewee:

> we let them know we look for people with insurance, without you know 200% below poverty [sic]... But we accept everything. We really focused on making them (the sites) warm and inviting, change in the color scheme, change in the flowers and adding TVs in the waiting rooms. You know, […] that when you think of a clinic you think of a place that is broken down, right. Oh, that's the clinic. No, we fixed the whole place, we spend a lot of money on making sure when you come to our site you can compare our site to any doctor or private physician. Even hospitals are going to say, listen that's not a clinic.

Many respondents pointed to enhanced marketing efforts, changes in operations and practices, and efforts aimed at building collaborative relationships to help change perceptions about FQHCs as mere clinics for the poor.

But, for some interviewees, while changing the stereotype of health centers is important, it is equally important that centers not abandon, or appear to abandon, their traditional underserved populations. Some felt strongly that FQHCs must never abandon the people they are mandated to help; centers must remain extremely focused on achieving their mission. In their opinion, decisions around capacity building, including ACA-related expansion of access, should be driven more by the core mandate to serve poor and marginalized populations. Greater diversification of the client population to ensure a higher mix of insured patients, as well as those with lower healthcare risk factors, should not intentionally or unintentionally decrease access for the groups that health centers are meant to serve. This often-repeated message was captured by one interviewee who stated: "Caring for those who need it most is who we are."

Others said that an undue focus on diversification might create barriers for underserved

groups. They voiced unease about potentially crowding out the unserved and those who

have limited access to resources for healthcare. These same interviewees, however, did

believe that FQHCs should accept all comers, and they are cognizant of the financial

considerations that might drive the need to diversify the patient population. However,

they stressed the importance of first ensuring access for all those who need it most.

Otherwise, as another interviewee put it: "You might [as well] not be a health center

anymore, just be a private business at that point."

A second group of respondents did express support for building upon the mission

and reputation of centers to make the centers more financially viable, sustainable entities.

They see the mission as an asset to generate greater local and state-wide support for

growing a diverse patient base and sources of revenue. These study participants referred

to the FQHC mission as a platform for soliciting and securing political and social

support, especially within the communities in which they are located. Host communities

and adjacent service areas have often acted as strong advocates in support of FQHCs, and

in my experience, they have been crucial activists and motivators to help drive capacity

building and garnering resources and support that enhance the sustainability of centers.

A third and smaller group of respondents shared the view that FQHCs need to

rebrand themselves, diversify the FQHC patient base and move away from the stereotype

that they only serve the poor. These respondents were not dismissive of the original

mission for FQHCs to serve disenfranchised groups, but they appeared more open to

innovative ideas and approaches that address the long-term outlook for FQHCs. They

perceived a need to position centers to compete with other primary care providers more

successfully. This group is more receptive to targeting new and different patient populations and to deliberately rebranding FQHCs as healthcare providers of choice. They do not see this position as abandoning the FQHC mission, but rather as expanding upon it. These respondents believed that concerns about crowing out the poor and uninsured were unfounded.

The views represented by this third and smaller subset of interviewees is significant because this group also mostly consisted of those respondents who are newer to the FQHC world. They represent an emerging, new generation of FQHC leaders. They appear to be more willing to explore the possibility and necessity of centers expanding beyond their original mission to become more competitive, viable primary care providers in a changing healthcare landscape. Anecdotally, this group or newer type of FQHC leaders is viewed with caution by those FQHC leaders who came out of the grassroots Community Health Center movement and who have been a part of the FQHC family for a long time. Some in this group have commented that, in New Jersey and nationally, the newer FQHC generation is led by professionals who are not tied to or rooted in the communities they serve. There is an underlying assumption that the newer generation of leadership have less commitment to the historical core values, culture, and mission of FQHCs. For the more traditional FQHC leaders, the newer FQHC generation foreshadows unwanted or undue changes in the mission, changes that could threaten access to care for traditional populations targeted by FQHCs, and moreover, the special ties that FQHCs share with their host communities.

Despite the differing perspectives about the implications of diversifying the demographics of the user groups, it is clear from the data that the respondents associated

with New Jersey FQHCs represented in this study maintain a commitment to ensuring

access to care for those who need it most.

New Jersey FQHC Connection to the Community

Those neighborhoods served by FQHCs have long supported their centers as vital

community assets. In my former role as CEO of an FQHC, I quickly learned that centers

are not just *in* the community, but *of* the community. Often, community dynamics

portend the growth, expansion and/or sometimes survival of a center. A positive and

highly collaborative relationship between the host community and the center can lead to

broad community involvement in support of the center, including active support for its

growth, expansion, and financial security. Where there is little community support or

involvement, centers have struggled more to overcome stereotypes and to attract new

patients and financial resources. FQHCs are part of the local social ecosystem, and they

interact with communities to address the total health and wellness of the neighborhoods

they serve. FQHCs play essential roles in their host communities and neighborhoods.

There are unofficial expectations of what the centers will provide in their local areas,

including:

- Employment for community residents
- Advancement and leadership development for residents
- Support for the community's non-clinical needs and priorities
- Partnerships and collaborative opportunities to combine resources
- Support for patient advocacy
- Willingness to serve as an anchor institution

Community Health Centers were always intended to be part of the fabric of a

community. They were designed not only to provide care but to be valued, contributing,

stakeholders and neighbors (Sardell, 1988). A scene forever etched in my memory that reminds me of the ownership and the value that residents place on FQHCs in their neighborhoods, is one of a group of young neighborhood boys riding their bicycles on a Saturday morning around the blocks near the center where I was then newly employed. On their bikes, they circled me and several of my colleagues as we accidentally set off an alarm while attempting to enter the health center building. The boys ranged in age from about 9 to 15 years old. They surrounded us on the steps of the building and demanded to know if we were trying to break into "their health center!" The center belonged to the whole community, and they were intent on protecting it from intruders. Like these young boys, many of the staff members and their families live in the neighborhoods around these centers. They receive their care there and they come to know the people who work there. The center belongs to them. It supports the life of the community with employment and it provides spillover value through the frequency of visits to local restaurants and other businesses. Besides, centers help to build local community capacity through leadership development as community members serve on their boards and as volunteers. The centers are anchor institutions that bring other resources to the area. I am aware of a pharmacy that was intentionally located in an area without geographic access to pharmacy services on the strength of an FQHC presence alone.

Several interviewees in this study emphasized their commitment to FQHCs because of the centers' connection to the community and because of the role that a center served in their professional or personal development. Sometimes their commitment was related to the way in which a center took care of their family members or friends. About one-half of study participants spent their careers in an FQHC. Several began as front-line

workers, lower level management, or staff physicians; they grew up professionally in a

center to become senior administrators or chief clinical leaders. They understood that

because center staff are from the community, they find it easier to connect with and

address the needs of the patients. One participant underscored in the quote below that

FQHC staff understood and could empathize with community issues. This participant

stated: "We have our pulse on the needs of the community."

Nevertheless, as noted previously, centers still struggle with the negative

connotations of being a clinic, even within their own host communities. Several

respondents observed that communities' loyalty to the centers is changing. According to

a few interviewees, there appears to be a growing sense of a loss of ownership or loyalty

to the centers as a primary source of healthcare for the community. Some expressed a

sense that patients, especially new groups moving into the areas, only use the centers as a

last choice—when they have no other financial access to care. There is still a sentiment

among this group of respondents that as soon as patients acquire any type of insurance,

they seek other providers of care because they no longer need to rely upon a "clinic" for

their healthcare services. They cited their experience with assisting patients in gaining

insurance under the ACA or the expanded Medicaid program as an example of this. They

recounted that as the ACA and the expansion of Medicaid made it possible for the health

center clients to receive insurance coverage, many patients voluntarily left the centers to

go elsewhere. In part, they believe this is because those patients do not want to be

defined by their use of the centers; they do not want to be stigmatized as being poor or

otherwise marginalized. But even more disturbing to those study participants is the

migration of their patients to other primary care providers once they do receive insurance

coverage because of the patients' reported preferences for better quality facilities or

services. Several respondents believe that this phenomenon remains an issue for health

centers, even among long-time patients. One respondent summed up this lingering

concern among patients about the quality of centers as a sense that some patients

believe…

> that you only go there (clinics) if you don't have insurance and that we are not
> high quality…I think in general that is the biggest struggle for FQHCs to change
> that perception and everywhere that I have been I have said that, that we really
> need to market the doctors because you know the communities don't know that
> the doctors in these FQHCs actually have two and three degrees.

For some study respondents, this sentiment remains problematic despite their ongoing

efforts to renew or foster broad local support and staunch community advocacy like that

experienced by health centers earlier in their existence. But it should be noted, as

described earlier in this chapter, that early Community Health Centers operated in a

different era when grassroots organizations figured prominently in social change

movements and enjoyed a different status and authority.

This study does not explore why community dynamics, perceptions of the centers

or levels of community support differ among the New Jersey FQHCs represented. But

the research data describing the community service areas and the varying relationships

that exist among the communities and centers highlight changing beliefs about how local

communities perceive the FQHCs, as well as how the centers are adapting to their

interactions with the communities. Those who described a higher level of intentional

engagement to build strong community connections and relationships also described

stronger support and more favorable perceptions of the center among local groups. Also,

they described a certain level of community loyalty and readiness to advocate on behalf of their FQHC.

Internal and External Physical Environments

Place, the environment and structures, matters for New Jersey FQHCs. They matter in part because of long-held historical perceptions about FQHCs, some of which have already been mentioned but which are emphasized here. Since the inception of almshouses or clinics created to serve the poor, the construct of the clinic conjures up stereotypical pictures of welfare organizations. The term "clinic" also suggests a place or environment that is less than inviting and one that is associated with substandard quality accommodations, or staff. Generally, FQHCs have worked hard to overcome these long-held negative perceptions about their organizations. But, whether real or perceived, their environment—the physical locations and structures that some have had to contend with over the years—tend to perpetuate the challenges they encounter.

Also, the choice of geographic location matters for FQHCs, both because of their mission and because of the federal regulations that dictate where they are situated. By both criteria their main site must be in an underserved community. These same areas or communities are often beset with challenging socioeconomic conditions. Nevertheless, despite the environmental difficulties, most centers have embraced the communities they serve. They view their mission as more than providing needed healthcare services to the area. Accordingly, some centers aggressively pursue the role of anchor institutions in their areas. They invest in the growth and development of neighborhoods; they actively seek to partner or to collaborate with other community leaders, organizations and businesses to promote the social and economic health of their host communities.

The importance of FQHC location and the environment in which they operate is explored in *Place Matters* (Dreier et al., 2004). *Place Matters* is a scholarly book that examines the impact of public policies and politics, plus other environmental factors on urban neighborhoods and communities. They explore how place matters in the physical conditions of locations and in the lives, attitudes, behaviors, and beliefs of people. The authors posit that the physical, political, and social environment in which organizations are located and in which people work, live, pray and play have a profound impact on the overall health and well-being of individuals. Their work supports the premise that patients relate the state of their physical environment to the quality of service and care they receive. Further, the authors explore how issues of poverty, racism, segregation and politics relate to aspects of space, physical structures, and location to convey or underscore organizational values and practices, as well as how organizations are perceived and valued. All of these are issues with which FQHCs continue to grapple. Questions about the standards and quality of each healthcare facility and the internal and external environment in which it operates are especially relevant when serving historically disenfranchised groups who believe that organizations treat them differently or inequitably.

Several study participants asserted that attention to long-held stereotypes about their physical environment was important because the negative impressions of centers are still common, despite efforts to overcome them. Moreover, the study participants are keenly aware of the impact of these factors on their ability to compete for patients. They are mindful of growing competition for newly insured patients because of the expansion of insurance coverage under the ACA. A theme that resonated among these study

participants was that the space and flow of patients and the physical location and

appearance of the facility (as well as comfort and amenities) are increasingly crucial

factors in competing for patients across all socio-economic levels. Recognizing that they

have limited options about their physical locations, they reported that some New Jersey

FQHCs have placed considerable emphasis on addressing their buildings, settings,

atmosphere, and culture to enhance the patient and worker experiences. Organizational

research consistently finds that these attributes matter. The entire context of what people

see and what they experience matters in how they receive and respond to organizations

and the services they offer (Becker & Douglass, 2008; Huisman et al., 2012; Kamimura

et al., 2016).

Internal Environment: Inside an FQHC

Today, most of New Jersey's FQHCs look no different than a typical private

provider's office, especially once you walk inside. Unlike many earlier centers, which

may have projected the stereotypical images of a clinic—uncomfortable chairs set tightly

together in open, crowed areas offering little privacy—today's centers employ designs

that impart comfort, privacy and dignity. They utilize design to protect patient privacy

and improve patient flow as well as to gain greater operational efficiency. Most are well

furnished, with modern exam rooms and equipment.

From my early tenure as an FQHC Chief Executive Officer (CEO), I recall

encounters in which potential patients explained why they avoided using a health center.

Their concerns involved issues of privacy and dignity. They were leery about potential

loss of privacy and about others' perceptions of their social or economic status if it

became known that they used the clinics. They remarked that when they walked into a

center, everyone from the community would be there, and "…their business would be out on the street." They worried that their neighbors or acquaintances would see them and know that they used the center and why. The open waiting room design, which is characteristic of earlier centers, typically crowded patients into one large room with intake cubicles within earshot of all. This did little to assuage concerns about privacy. People did not want their neighbors to see them using a center because it might suggest that they could not afford the services of a "regular doctor" or private physician. They thought a visit to the clinic said more about their socio-economic status than about their need for healthcare. These individuals held to the belief that FQHCs were a "poor place for poor people," with lower standards of quality, cleanliness and customer service. They used FQHC services until they could do better. But while earlier centers struggled with the ability to obtain modern facilities and state of the art equipment, often relying on donations of older equipment, this is no longer the norm for most FQHCs, nationally and in New Jersey.

From direct experience and frequent observation, I can attest that many New Jersey FQHCs, including those in this study, have modern offices, service sites, and "state of the art equipment." In recent years many have remodeled existing sites or built new facilities, largely using federal capital grant dollars that have been made available to FQHCs over the years. These modern structures offer decentralized waiting areas with entrances that do not pour directly into open rooms. The newer waiting room designs take into consideration patient characteristics such as age group, the severity of patients' physical conditions, and the nature of their visits. Pediatric waiting areas have age-appropriate seating and reading materials, and some health centers have educational

kiosks and televisions. Waiting room accommodations are often arranged in groupings that are more conversational in style. Patient intake is done in cubicles or small offices that afford more privacy. Many centers have removed patient intake areas from the view of nearby waiting rooms or positioned them away from areas where confidential information might be overheard. This was done in part because of patient privacy laws, but also to improve the patient experience. Some waiting areas are designed with a receptionist near the main entrance to direct patients to decentralized waiting or intake areas. Centers display wall art and other decor intended to denote comfort and modern, well-maintained environments. Cleanliness is the norm. Study respondents reported being offended by public remarks about the cleanliness of FQHCs; their stance was that it should be expected just as it is for any other healthcare provider. Additionally, several centers have enhanced their clinical space by relocating administrative functions to other professional buildings. In so doing, they have freed up space at their clinical sites for additional exam rooms, ancillary services, or diagnostic equipment.

On the other hand, at least one of the smaller, less resourced centers represented in this study has not made significant changes to its main physical location, despite trends signaling the changes that may be needed to handle potentially increased patient volumes or even increased competition to attract patients. This FQHC is housed in a small building that has reached its physical capacity. There is no land or redesign potential that will allow it to make significant changes in how it can utilize the existing space or improve upon it. It has little space for private waiting areas, although staff have tried to make the existing waiting room more comfortable and more conducive to private conversations. Exam room space is limited. The main facility has more of a "clinic feel"

than that of a private office. This organization has compensated for their lack of space at this site by expanding clinical services to two satellite sites, although both are also small and limited in capacity for use. However, this move has alleviated some of the crowded conditions at their primary facility. What this center lacks in space and physical amenities they have tried to redress in ambience, service, and professionalism to maintain a competitive edge in their ability to attract and retain a sustainable volume of patients.

External Environment: The Immediate External Surroundings

People have often expressed surprise by the professional appearance of FQHCs, once they visit a center. Nevertheless, the immediate external environment of some centers still serves as a deterrent to potential patients, volunteers and employees, as it sometimes inadvertently perpetuates fears and negative stereotypes about the safety of host neighborhoods. It is common to hear individuals who live outside of the host communities comment that they would be afraid to work in an FQHC neighborhood. Because FQHCs must be in MUAs, they are typically situated in marginalized communities that are sometimes surrounded by conditions that others see as threatening, such as low-income housing, urban deterioration or rural isolation. Areas that qualify as MUAs appear to struggle more than other communities with conditions that perpetuate perceptions about lack of safety and accessibility due to poverty and higher incidences of crime or drug-related activity.

A senior-level study respondent opined that one of the most significant challenges for their FQHC was the local neighborhood, which was known for high incidences of violence and other safety issues. Although this organization wanted to expand access to their services by extending their hours of operations to 10:00 or 11:00 pm on some

evenings, they feared that patients would not come or that they would not be able to recruit staff to work during those hours. This respondent stated that employees and patients were concerned about the safety of that neighborhood at night. However, FQHCs are needed most in exactly such areas. And this FQHC has earned its acceptance as a part of this community. For over fifty years FQHCs have persisted in their host communities, despite their environments and because of the positive impact they bring.

Several FQHCs represented in this study have maintained clinical sites or clinical services in highly disadvantaged communities or MUAs. They have also established locations in new, less marginal communities that still qualify as MUAs, either to address their goals for expansion of access under the ACA or as part of their strategic plan for the growth of their FQHCs. Centers have also relocated their administrative functions and staff to new locations outside of their original designated MUA communities; administrative offices have become the public face for these FQHCs, as well as places for conducting oversight and business functions while the clinical sites and services continue to be conducted in the places of greatest need. Their expansions into environments perceived as less threatening, especially moving administrative offices, are sometimes intended to create a different image of the centers, including higher perceptions of environmental safety, while at the same time not abandoning the mission or historical host communities.

But whatever strategy is adopted, the overall conventional view is that the FQHC presence in the host communities, whether as a satellite, administrative headquarters, or fully operational sites, is important to the stability of high-risk, marginal host communities. It can motivate efforts to revitalize and "clean up" deteriorating

neighborhoods. FQHC representatives believe that their presence adds to the physical and social attractiveness of marginalized communities and serves to curb crime and violence.

All study respondents indicated that New Jersey FQHCs aspire to create better environments to convey a positive message about the quality, professionalism, and high standards of the centers, despite the compromised geographic areas in which some are located.

The Patient Experience

The process of patient intake and triage in FQHCs is like that of any provider. Those interviewees who indicated their centers have pursued PCMH certification, however, relate that they have improved intake processes more so than others to create greater efficiencies and improve the patient experience. Nevertheless, in all centers the process of getting an appointment is no different than that encountered in any other doctor's office. The wait time for a clinical appointment or other services may vary by practice. It may be longer in some offices than in others. The reasons for this may also vary. Different FQHCs employ different scheduling protocols that are not specific to FQHCs, but to the needs, capacity, and norms of the specific organization. Once an appointment is made and patients arrive for their first visit, there is an intake process like that found in any provider's office. What may be different in an FQHC is the extensive initial interview that patients experience.

The initial interview is intended to assess the patient's needs, the reason for the visit and their ability to pay. The FQHC intake interview typically seeks to understand not only the clinical reasons for visits, but also the patient's socio/economic and mental

health status. However, in my experience, new patients do sometimes complain that the questions during the initial intake are too personal and invasive. They suspect that they are being labeled, categorized, or positioned to be stigmatized in some way. Patients who were already apprehensive about being a "clinic patient" were apt to resent questions that suggested they were being treated differently because of their socioeconomic status.

It may be that patients bothered by the intake process failed to realize that FQHCs are mandated to provide services addressing not only physical illnesses, but issues related to prevention and the social determinants of health. But detailed intake questions are part of the FQHC protocol to ensure patients receive comprehensive primary care services that address the underlying conditions contributing to poor health.

It is also true that health centers are mandated to see all patients regardless of their ability to pay or their economic status. However, to maximize public or private reimbursement for patient care or to determine the person's ability to pay, FQHCs require financial information that some may find intrusive. The initial financial assessment is necessary for centers to ensure compliance with policies that require them to document a patient's need for discounted fees or coverage through the state's uncompensated care fund. Extensive documentation is also necessary for centers to receive the federal or state reimbursements that subsidize indigent care.

FQHCs attempt to assign all patients to a provider of their choice. They also attempt to have the patient seen by the same provider at each visit, or at the very least, by the same team of clinicians. Patient care typically includes some level of case management, especially for high-risk patients. FQHCs also co-locate services to enhance access to a continuum of care, and thus a visit may consist of time with the primary care

provider, a visit to the social worker or nutritionist, lab work, a referral and/or a visit to

an onsite dentist or podiatrist. During a clinical appointment, patients might receive

assistance with medications, transportation, or services to help them apply for insurance

coverage or other types of financial aid such as pharmaceutical assistance. Interviewees

report that FQHCs' comprehensive array of services is viewed as beneficial by most

patients; they come to rely upon the assistance that centers provide to help coordinate and

assist with their healthcare needs. But for a minority of patients such assistance appears

unnecessary and is not wanted. Some may even feel that this is just another way of

underscoring that somehow, they are different and in need of these services because they

are poor and culturally, racially, or economically disadvantaged. Nevertheless, the

FQHC model of care delivery is not just for disenfranchised populations. It is a model

that promotes quality and patient-centered care, regardless of the demographics of the

populations that seek FQHC services. The current study's participants maintain that

FQHCs have always known the value of the care they provide, and that is evident when

one walks into most New Jersey Federally Qualified Health Centers and witnesses the

level of care and attention that their patients receive.

While FQHCs across the country continue to have challenges with recruitment

and retention of clinical staff, especially primary care providers, overall, centers,

including New Jersey FQHCs, have increased the number of clinical professionals

employed. (NACHC, 2018). In 2017, New Jersey FQHCs were supported by 1,951

clinical professionals or clincal care team members, representing physicians, nurse

practitioners, physician assistants, certified nurse midwives, nurses, dentists, behavioral

health specialists and others. Altogether, the centers employed 3,289 full time equivalent

workers consisting of clincial and mental health professionals, case managers, enabling

services staff, administrators and operational staff and other team members (BPHC,

2019a; NACHC, 2019a; NJPCA, 2018). They offered, and continue to offer, a broad

scope of services aimed at providing comprehensive primary care to their patients.

Beyond core clinical services, all centers represented in this study provide some dental

care on site. Several of the centers also provide on site behavioral healthcare, while all

provide referrrals to mental health services. A small subset offer onsite vision care

(BPHC, 2019c). Yet, many of the respondents reported that access to dental and mental

healthcare services remain a challenge. The demand for these services is greater than the

resources that are available. All New Jersey FQHCs offer case management services that

include enabling services, outreach, education, and care coordination.

As previously noted, FQHCs are committed to employing and mentoring local

talent. But as recruitment and retention is becoming increasingly difficult, especially for

primary care clinicians, the centers are increasingly expanding their reach for recruitment

of staff beyond their immediate communities and the state, especially for clinicians,

nurses, and other clinical team members. The focus group data pointed to a concern

recounted earlier in this chapter about the recruitment of senior leadership team members

who do not have historical links to the host communities of the centers and the

apprehension this has generated among those who grew up professionally in the centers.

Some stakeholders in the industry are concerned that the ties to the community and the

ability to nurture community support for the centers may be lost if the FQHCs become

too focused on hiring leaders and team members with no perceived connections to the

host communities. Nevertheless, there were many represented in this study who still

espouse the view that it takes a "special type of person" to work in an FQHC regardless of where they come from. Most study respondents praised the dedication of their team members and leaders in caring for underserved populations.

New Jersey: FQHC Political and Social Capital in the State

During my almost 20 years of direct experience as CEO of a New Jersey FQHC, support from the state varied, and it required continuous cultivation, documentation of value, and external advocacy to leverage state funding for the centers over different periods. In the view of study respondents, this tenuous relationship with the state did not change under the ACA. For some it progressively deteriorated with each successive administration from the 1990s up to recently. Centers have had to weather new administrative policies and a changing commitment to FQHCs in New Jersey with each new administration and legislature.

In the early 1990s, two influential New Jersey state legislators, Senators Richard Codey and then-Assemblyman Wayne Bryant undertook the fight to improve access to healthcare for medically needy communities and groups across the state. They championed legislation that resulted in a New Jersey state healthcare subsidy fund to reimburse the state's FQHCs for uninsured patient visits (an uncompensated care fund). The law also allowed centers to expand their services, as well as target resources for recruiting primary care physicians and dentists. It even created a fund to help strengthen relationships between hospitals and Community Health Centers. This real financial support and active championship of New Jersey centers helped to raise the profile of FQHCs in New Jersey at that time, giving them enhanced authority and credibility among policy makers and within the communities.

However, by the late 1990s, many of the centers began to experience instability and dwindling support. Multiple external factors adversely affected the financial health of New Jersey centers. These factors included the advent of Medicaid managed care, then a new payment methodology that tested the capacity of centers to compete effectively under the new rules, an increase in New Jersey's uninsured population, and flat or minimal growth in both the state's healthcare subsidy fund reimbursement levels and in federal grants.

For New Jersey centers, and other centers across the country, financial and political support has been cyclical, creating a "feast or famine" experience. Federal and state funding for centers is discretionary and dependent upon policy and budget priorities, changing perceptions regarding FQHC return on investment, and the strength of the center's collective political and social influence.

More recently, according to this group of study respondents, state policy over the past decade has been less than favorable for FQHCs. Some of the study respondents feel that they have lost ground in recent years because of diminished state support and the polices developed under a recent administration that undermined their financial stability. Their reported relationship with the state in the past eight years can be summed up by the fact that most of the centers represented in this study engaged in the lawsuit against New Jersey to acquire reimbursements for patient services that they claim were unfairly withheld from them. Most of the interviewees were aware of this lawsuit, but some, among front-line staff members, were not sure about the specifics of it. However, the consensus view is that the state was not treating centers fairly or providing adequate, timely reimbursement, which left them with no choice but to litigate in order to enforce

fairer practices and policies and reasonable levels of compensation. Some believe the state retaliated against New Jersey centers because of the lawsuit by continuing to delay payments with more lag time than before and by refusing to change certain regulations that adversely affect the centers. Because of the delay in payment to the centers by the state, two respondents expressed concerns about the immediate impact of this to their cash flow, and even potentially on the long-term viability of the organizations. Others asserted that they can withstand the current relationship with the state because of the very real need for the centers and the ongoing support of the communities that they serve. These study participants believe that the state could not afford to risk letting an FQHC close, especially as this would significantly diminish access to care. But there was no mention of strong state advocates, such as Senator Codey or former Senator Bryant, who were prepared to champion the centers at the state level; also no one described organized or strategic, collective community action on behalf of the centers in respect to the lawsuit or otherwise.

Respondents' central message about the state's attitude toward FQHCs over recent years is that it has been difficult to cultivate and sustain new state-level champions to help ensure necessary, reliable levels of state reimbursement and funding support. Diminishing state funding over time has contributed to the financial challenges of FQHCs as reported by several interviewees. Study participants believe this has led to the perception that centers are on tenuous financial footing, damaging their capacity building capabilities. According to one respondent: "New Jersey policies have been a shot in the foot. It ties up cash … it is too labor intensive to get money into the centers." Another study participant added that: "the posturing of the state has been an issue for FQHCs.

The state has persisted in tying our hands and promulgating rules and policies that have

hurt centers financially and our ability to expand services." This last response was a

reference to what most of the clinical and administrative leaders represented in this study

see as New Jersey's burdensome regulations and policies, which they believe unfairly

impede FQHCs' abilities to expand access and services, especially under the ACA. They

stated that some of the requirements for FQHCs, such as adding behavioral health

services, add unnecessary financial and administrative burdens for the centers.

Clearly, the context in which the centers operate, on the national and state levels,

as well as that of their host communities, impacts their potential for capacity building and

sustainability. It is evident that like their colleagues across the healthcare industry, New

Jersey centers must grapple with environmental and industry dynamics on multiple levels

to ensure their long-term viability and ability to deliver on their mission.

CHAPTER 4: METHODOLOGY

In this study, I employed a qualitative approach to explore the multifaceted characteristics of New Jersey FQHCs and the factors that define them. Additionally, I sought to generate greater understanding of capacity and capacity building within the context of the FQHC environment, and the ability of FQHCs to enact sustainable capacity building in an era of healthcare transformation under the ACA. I examined three salient, but complex, research questions from the perspective and knowledge of members of the New Jersey FQHC family—those who most are intimately involved in the daily operations and life of the centers. The research questions are:

- What is the capacity of New Jersey FQHCs to perform as essential providers under the ACA and to sustain access over time?
- What is the impact of the ACA on capacity building in New Jersey FQHCs?
- Can FQHCs leverage the opportunities afforded by the ACA to foster greater programmatic and financial sustainability?

Research Design

FQHCs are unique entities that are part of a defined system of organizations. They are also separate organizations that function within distinct organizational and cultural contexts. The case-study approach aligns with the study of FQHCs as a singular, intrinsic area of interest, but also as a multilayered bounded system that operates in a complex environment. The case-study approach enhances understanding of the centers, including how they respond to complex issues like capacity building (Crowe et al., 2011; Creswell & Poth, 2018; Stake, 2000). It is an effective method for generating in-depth knowledge about the diverse aspects of a complex bounded system, as well as the varied

perceptions that contribute to our understanding of why entities act, perform or operate

the way they do, in the environment in which they are situated (Stake, 2000).

Adapting the work of Creswell and Poth (2018), I used their approach to provide

an overview for this research case study design. The overview includes those elements

that Creswell and Poth, (2018) identify as key areas to define or address in designing a

case study. Below is a brief overview of the approach to, and explanation of, the main

elements of this case study design.

- **Context for the Study**. New Jersey FQHCs are part of a larger system of Community Health Centers that are considered essential primary care providers for underserved populations and communities. There is little research specific to New Jersey centers to drive greater understanding of the characteristics, qualifications or experiences of the centers that enable or impede their ability to perform or to develop the capacity to perform, effectively and sustainably in this period of healthcare reform.

- **Study objectives.** This study aims to generate greater understanding and knowledge of New Jersey FQHCs, from the perspective of those who are intimately involved with FQHCs in "real-time." It also aims to increase knowledge about the capacity of the centers in this period of healthcare reform, and the ability of FQHCs to enact sustainable capacity building toward improved organizational performance, outcomes, and impact.

- **Study Design.** This is a single case study (bounded system) conducted in two phases: (a) pilot focus group and (b) in-depth interviews.

- **The Case**. New Jersey Federally Qualified Health Centers

- **Data Collection**. Phase 1: Pilot Focus Group, N =10. Focus Group members included federal- and state-level industry experts, FQHC senior leadership, and clinical providers.

- **Phase 2**: In-depth interviews, N = 20. Interview participants represented 10 New Jersey FQHCs. Interviewees included FQHC senior leadership, staff team members, and governing board members.

- **Document Review**: I used public documents that included government reports and public law, industry reports, and FQHC data collected by HRSA. I also reviewed and used information and data from FQHC and New Jersey Primary Care Association websites.

- **Analysis.** For this study, I used a thematic/Framework analysis approach and QSR NVivo 10 (later upgraded to NVivo 12) to manage and categorize the data, identify thematic patterns of information, and produce mapping and interpretation of the data.

As described above, this study involved two phases: a pilot focus group and in-depth interviews. It also relied on the review of public documents and the HRSA-UDS for national, state, and individual level data for Community Health Centers. A brief overview of Phase 1, the pilot focus group, is provided below, however this study reviews the pilot focus group process, data analysis and findings separately, and in greater detail in Chapter 6. The remainder of this chapter is dedicated to the main component of this study, Phase 2, the in-depth interviews.

Phase 1: Pilot Focus Group Overview

I conducted a pilot focus group to: (a) assess the importance and relevance of the research questions, as well as the breadth of interest in New Jersey FQHCs and their role as critical primary care providers in the era of healthcare reform and (b) to elicit feedback on the first iteration of the semi-structured interview outline and guide for phase two of the study. The focus group reviewed the interview instrument and offered meaningful critiques, insight, and guidance about the inclusion and exclusion of questions and probes to generate meaningful data in response to the research questions. They also examined issues of capacity and capacity building, and sustainability among New Jersey FQHCs.

They provided insight about how centers and the FQHC family intellectualized these concepts and why.

Importantly, the pilot focus group validated, for this researcher, the importance of the study and the research questions. The focus group helped to clarify the research questions for this study and the semi-structured interview instrument. Also, it served to help this researcher process professional and personal biases related to health centers and capacity building, and thus to minimize or avoid introducing bias in the premise for the study, the interview tool, and in how the interviews were conducted. Finally, the pilot focus group aided in understanding the significance of the historical and contemporary context in which FQHCs operate, and the need to explore these factors to gain a greater grasp of FQHCs' attitude and approach toward capacity building, as well issues pertaining to sustainability. As indicated, a detailed account of the pilot focus group and findings are found in Chapter 6 of this study.

The remainder of this chapter describes the in-depth interview process and protocols.

Phase 2: In-Depth Interviews

In Phase 2 of the study I conducted in-depth interviews with 20 individuals who, at the time of the study, were employed by or served as a volunteer in a New Jersey FQHC. Overall, through in-depth, semi-structured interviews I sought to encourage conversation in which respondents shared detailed perspectives and understandings about New Jersey FQHCs and capacity building. The semi-structured interview format allowed for the flexibility to follow the respondent in exploring details and nuances of their responses.

The target group for this phase of the study consisted of FQHC employees who represented different job categories within the organization and volunteers who served in the capacity of a board member. Through a process of purposive selection, I included individuals who I thought could provide the best opportunity to learn from their perspective, expertise, and experiences (Stake, 2000). To this end, I selected participants based on their job function and position within a center, their tenure of employment with an FQHC, or their known lived experience with health centers, or ties to the host community. I also included informants who represented different types of FQHCs from different areas of the state. For clarification here, informants were selected, and participated in the study, not as official representatives of any center or to express the viewpoints of a center. They were selected for their knowledge, and personal and professional perspectives they could lend to understanding their respective organizations and New Jersey FQHCs altogether. Use of the term "represent" in this study means the FQHC where the participants were employed at the time of the interview. It does not convey a role or authority to speak on behalf of the organization. In summary, the inclusion criteria, listed below, entail:

- functions in a leadership role, such as the Chief Executive Officer, Executive Director, Medical Director, or the Chief Financial Officer, or as board member
- functions in a clinical role, such as a dentist, nurse practitioner, primary care physician, or staff nurse
- functions in a front-line staff role, such as biller, receptionist, outreach worker, or patient navigator
- has worked in the center less than 5 years
- has worked in the center or another New Jersey FQHC for over 10+ years

- lives in the host community or has significant/relevant ties to the host community

- has demonstrated experience with New Jersey's healthcare delivery system, as evidenced by any positions they may hold in the industry outside of the FQHC, or a role that they have in one of the many industry associations concerned with improving the healthcare delivery system in New Jersey

The selected participants who consented to participate in the study were from 10 different geographically dispersed New Jersey FQHCs. They represented centers that were older and some that were established more recently. Respondents from several types of centers offered opportunities to gain a more complete picture of New Jersey FQHCs. The richness of multiple viewpoints, grounded in diverse FQHC settings and local contexts, as well as shared historical and more contemporary experiences, added to a more robust, balanced but varied picture of New Jersey FQHCs—their shared reality and experience as health centers and their distinctive attributes—with respect to the research questions (Stake, 2000).

Participant Recruitment. As stated above, this researcher identified interview participants using a purposive sampling technique. In several instances, I also used snowballing to identify participants. Although, I employed a non-probability sampling technique, I also wanted to diversify the sample as much as possible to ensure a broad spectrum of perspectives from among centers across the state. I selected participants after first constructing a list of all New Jersey centers and the pertinent job titles/functions to be included in the study. I prioritized the list by simply randomly pulling the name of the center from a blinded box and listing the names in the order pulled. I did the same for the pertinent job functions/titles that fit the inclusion criteria. I

refined the list to ensure at least one center, in the order that they were drawn, was located in each area of the state, North, South and Central New Jersey, and that at least one job category/function was represented in the sample, as well as at least one rural and one urban center. Using this list as a starting point, I then identified potential participants from the centers in the order they were listed and by the order of job titles listed. Although I selected participants based on my knowledge of the people in those centers and referrals by others, I used the prioritized list of centers and job categories to guide selection of participants from across all centers to the extent possible, as well as to minimize the number of participants from any one organization. After recruiting one person from a center, I moved down the list of centers and job/functions and repeated the cycle from the top of the list focusing in turn on a different job category for each center, until I recruited 20 individuals willing to participate in the study. I also used the list to minimize bias in the inclusion of some centers over others or the inclusion of some job categories over others. I sought to ensure a broad, diverse representation of perspectives to aid in developing a "thick description" of FQHCs and capacity building in FQHCs (Geertz, 1973; Lincoln & Guba, 1985; Stake, 2000)

I excluded one New Jersey center, and anyone associated with that center from consideration for this study because of this researcher's personal connection with the organization, where I served as the Chief Executive Officer.

Twenty-five contacts were made to explore interest in participating in the study. The final sample as previously stated, included 20 individuals from 10 centers. The number of individual centers represented reflects only the fact that the 20 selected individuals were from those centers. Attempts were made to solicit participants from

additional centers before including more than two persons from any individual FQHC.

The sample size for this study was approved at 20-25 individuals. At least one person

from each of the centers was contacted for inclusion in the study.

Table 3 depicts a limited profile of participants and the centers represented. Some

profile information is not cited here, such as positions held in the industry outside of their

respective FQHC, the number of rural or urban centers, or the number of years

participants served in their positions, as it might enable the identification of either a

particular center or participant. Also, neither race nor sex of the participants was a

consideration for this study.

Table 3

*Composite Profile of In-Depth Interview Participants (*N *= 20)*

Type of participant (job or volunteer position in FQHC)	Range of participant experience with FQHCs	Identified as a product of the community or lived in the community	FQHC location (geographic area where participants are employed by an FQHC)

2 board members
7 CEOs
1 CFO
4 CMO/primary care providers
2 front line staff
  • biller
  • enrollment coordinator
4 clinical staff
  • midwife
  • staff nurse
  • RN and nurse administrator
  • DD/dentist
	> 30 years to < 5 years	7 participants	7 from North NJ
			
			7 from South NJ
			
			6 from Central NJ
			
			urban
			
			rural

Instrument: Interview Guide. I developed a semi-structured Interview Outline

and Guide (Appendix C) to facilitate the interview process and to stimulate reflection and

responses from the participants. The interview guide included the following components

(Creswell, 2003; Fontana & Frey, 2000)

- an opening statement by the interviewer and warm up questions
- key research questions to ensure response to each of the major concepts/topics
- open-ended questions and probes to elicit detail and to tap into respondents' areas of knowledge or expertise
- transition messages or structuring questions to move into different areas of discussion
- a concluding statement and opportunity for interviewees to add any other comments
- space to record reflective notes/comments

Incorporating the recommended components cited above, the guide contained defined

areas of interest to help direct conversation and ensure a response to each of the major

concepts and research questions. The categories are: (a) description of the respective

centers and of the environment in which they operate, (b) historical perspective of

FQHCs and influence on New Jersey FQHCs today, (c) contemporary perspective of

FQHCs' role as essential primary care providers, (d) knowledge of the ACA and its

impact on NJ FQHC, (e) capacity building and FQHCs' approach to it, as well as

challenges specific to FQHCs and capacity building, and (f) sustainability and how

centers approach issues of sustainability. Each category included questions that were

derived from input contributed by the study's pilot focus group in Phase 1 of this study or

by the pertinent literature, specifically the literature on capacity building. Open-ended

questions and probes were based on capacity components associated with capacity

building and which are identified in the Conceptual Framework for Mapping Capacity in

the Health Sector, referred to as the Conceptual Framework (Brown et al., 2001). (See

Figure 6.) The types of interview questions were varied to explore participants' views and understandings, to generate deeper detail and meaning, to encourage reflection, to clarify meanings, and to guide the discussion to different topics of conversation.

Procedure and Informed Consent. Using the list of potential participants described earlier, I systematically contacted individuals via phone or email to explore their interest and willingness to participate in the study. In two instances, based on advice and prior knowledge, I contacted the CEOs of the organizations first before reaching out to others within the organization, as a courtesy. I informed these CEOs that I would be soliciting participation of some of their employees for the study and that the identifications of those employees would remain confidential unless the employees expressly stated they wished to make the CEO aware of their participation. In one of these instances, the CEO preferred to recommend potential respondents to me and then leave it up to them if they wanted to participate or make it known they were participating in the study. In the other case, I made the CEO aware of my intent only as a formality. This CEO just required the courtesy of knowing that I was soliciting participants from within their center. They expressed appreciation for the notification but were not concerned about who I contacted. Several persons, from other centers, who were contacted directly, specifically requested that their CEO not be made aware of their involvement. In all instances, the confidentially of participants was carefully guarded. Board member participants were contacted directly without prior notification to the CEOs.

Individuals who consented to participating in the study received written guidance regarding informed consent. The written information explained the purpose and

parameters of the study; the benefits and risks to participants, steps to ensure confidentiality, participant rights, how the information will be used, and its potential benefit. The guidance also contained an explanation of the intent to audio-record the interview and their right to refuse it. Participants signed a separate consent for audio-recording before each interview. I provided an oral explanation of the same materials prior to each interview. All participants were required to acknowledge informed consent by signing the consent forms prior to the start of each interview. Rights of participants included the fact that participation in the study was completely voluntary. They could refuse to participate or withdraw from the study at any time, or to decline to answer certain questions. Additionally, they could refuse audio recording of the session or request that recording stop at any point. One respondent did request that their response to a particular question not be recorded and that the tape be turned off. Subsequently, as the interview proceeded, they voluntarily consented to turning on the tape for the reminder of the interview.

Additionally, participants were offered a choice regarding where, when, and how the interview would be conducted. Although a face-to-face interview was preferred by this researcher, only two persons chose to do so. All others preferred to be interviewed by telephone, primarily for convenience. In one instance, the interviewee preferred the interview via phone to ensure their privacy. All respondents but one consented to having the interview recorded. In this instance, I collected the data via hand-written notes.

The study posed minimal risk to participants. Minimal risk is defined as "the probability and magnitude of harm or discomfort that might be caused by this research is not greater than that ordinarily encountered in daily life, or during performance of routine

physical or psychological examination or tests" (United States Department of Health and Human Services Code of Federal Regulations 45CFR § 46.102).

Interviews were scheduled for one hour, however several sessions extended up to ten minutes beyond an hour with the permission of the interviewee. The participants were actively invested in expressing their views and having them understood, as well as in offering detailed information about their viewpoints.

At the conclusion of each interview, I reiterated that all information, including any identifying information, would remain confidential and that the data would be reported in the aggregate without explicit reference to any one person or institution that could result in the identification of either.

Data Collection and Analysis. The in-depth interviews were audio recorded, with the exception of two for which I manually recorded detailed notes, as previously stated. In one instance the tape recorder mal-functioned and in the second instance the interviewee requested that the session not be recorded. The audio taped interviews were subsequently transcribed to Word documents, as were the manually recorded interviews. These douments, plus this researcher's additional handwritten notes taken during the interviews, comprised the raw data for this phase of the study. The handwritten notes captured the researcher's observations and reflections about the respondents' affect, attitude, and reactions throughout the conversation.

The transcribed data were coded utilizing QRS NVivo 10 qualitative data analysis software. Additionally, the researcher performed manual coding of sub-sections of the transcribed data to augment further synthesis and categorization of the data that was coded using the NVivo software. This dual process for categorizing the information

enabled detailed review of the context for the coded data. The process for analysis of the

data followed what Creswell and Poth (2018) describe as a Data Analysis Spiral which

is illustrated in Figure5.

Figure 5

Data Analysis Spiral

Note: The data analysis spiral frames a process of data collection, management, and reporting in a qualitative study. From *Qualitative Inquiry Research Design* by J.W. Creswell and C. N. Poth, 2018. p. 186. Copyright 2018 by Sage Publications
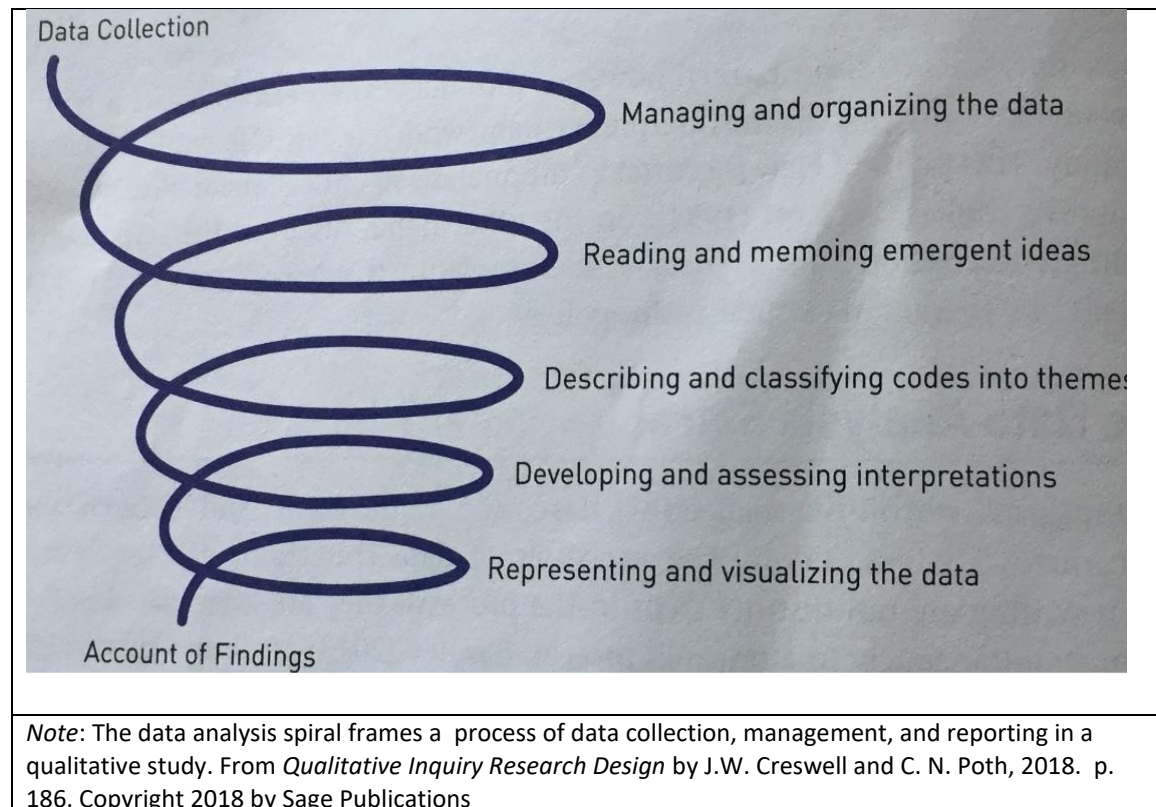
The Data Analyis Spiral strategy entails a non-linear approach in which several

widely accepted steps of analysis "circle around". The process is iterative and the steps

are fluid. Different strategies are employed within each spiral, aspects of which are

interdependent or interconnected. The data collection strategies are described above.

Other aspects of the Data Analysis Spiral are briefly described below, but are detailed

further in Chapter 7 of this study, which describes the framework and process used for analysis and mapping of the interview data.

The process for managing and organizing the data involved reading the full transcripts to gain a broad perspective of the overall data and capturing first impressions of the tone and direction of the information. I subsequently created a code book to furhter categorize and identify patterns of data (thematic analysis) and to begin to assign meaning to the data. To facilitate coding and categorizing the data, I used the Conceptual Framework (Brown et al., 2001). As stated above, this framework is detailed in Chapter 6. It facilitated organization and mapping of the data to crosswalk key codes and thematic patterns of information to the study's key concepts and related research questions. All of this aided in examining meaning attributed to the data.

Additionally, I used word clouds as another visualization tool to highlight the interviewees' most frequently used words or data points to express their views and understanding of capacity building. I used a free web-based word cloud tool, WordItOut[20] to develop a pictorial representation of how respondents thought about and described their understanding of capacity building. I created word clouds to depict the data by types of interviewees: front-line staff members, CEOs, CMOs, clinical staff, and board members, and then combined the data for all groups. Several of the more significant word clouds are reviewed in Chapter 8. The data points from the word clouds (the largest bolded words that appeared the most times in the textual data) were used to provide further insight into the qualitative interview data.

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[20] WordItOut https://worditout.com/

Finally as depicted in the Data Analysis Spiral, I represented the interview data in a three-part concept map—Mapping Capacity Building in New Jersey FQHCs. Each of the three parts is related to one of the three research questions and key concepts for this study. My concept maps are predicated on the Brown et al. (2001) Conceptual Framework. They are described in Chapter 6 of this study and further illustrated in Chapters 7–9.

This researcher also incorporated UDS FQHC data that is collected and made public by HRSA as explained previously. The data was used in examination of the research questions and to inform the data analysis. The UDS data are reported by individual centers or in aggregate by state or at the national level. Additionally, I used public reports that are based on the HRSA/BPHC-UDS data (BPHC, 2019a; NACHC, 2019c; Rosenbaum et al., 2018). The UDS data, public reports, and professional association information, as well as the FQHC literature, augmented the interview data and analysis.

Chapters 7–9 details the findings from the data analysis for each of the research questions.

Credibility, Transferability, Dependability and Confirmability. Researchers have reconceptualized validity and reliability in qualitative research, but ultimately, the goal in qualitative research is to demonstrate if researchers got it right (Creswell & Poth, 2018; Denzin & Lincoln, 2000). Recognizing that getting it right as a researcher is directional, or an aim, rather than an absolute, qualitative research employs widely accepted strategies toward that end. In this study, I use the tools described below to optimize the credibility(vaildity), transferability (generalizability), dependability

(realibility) and confirmability (objectivity) of the findings (Denzin & Lincoln, 2000; Lincoln & Guba, 1985).

I used multiple sources of data (triangulation of sources) to gather broad, diverse perspectives and understandings about New Jersey FQHCs. The sources described in this chapter included: in-depth interviews, a focus group; HRSA reports and databases, and the FQHC research literature. The triangulation of sources contributed to a robust and comprehensive account of the data and findings, which lends credibility to, and confidence in, the data and findings (Cohn & Crabtree, 2006; Creswell & Poth, 2018; Janesick, 2000; Stake, 2000).

Additionally, the interviewees represented different types of New Jersey FQHCs. The diversity of the types of study participants, as well the centers they represented, enhanced the depth of information and perspectives shared in examination of the research questions and key concepts. The diversity and breadth of knowledge and familiarity with New Jersey FQHCs and their varied, individual contextual environments aids in identifying consistencies across perspectives and interpretations, as well as inconsistencies or differences of opinions or interpretations and to understand why. Triangulation of sources, plus inclusion of diverse perspectives and types of informants, lends credibility to the research findings (Janesick, 2000).

I also established an audit trail to document and store files for future examination if needed. The documents include the raw data. The audit trail also includes synthesized notes on the group and interview processes, instrument development, and the thematic analysis process. The documents also include a code book that was used to direct consistency in applying the codes. The audit trail documents the evolution of the study,

the thinking, and the processes that occurred to arrive at the findings. It serves to help establish dependendability (Cohn & Crabtree, 2006;Creswell & Poth, 2018; Lincoln & Guba, 1985).

Further, I used thick description of FQHCs as a tool that promotes transferability of the data. Thick description is used in qualitative research to provide in-depth, comprehensive accounts through which others can decide the extent to which the data and findings are transferable to similar cases, settings, experiences, or phenomena. It promotes learning and application of those learnings to cases in similar contexts (Creswell & Poth, 2018).

Ethical Considerations

Establishing confirmability (objectivity) employs strategies that also address ethical considerations such as minimizing and acknowledging areas of bias (Lincoln & Guba, 1985). I used reflexivity as a tool to acknowledge my position, relevant values, and biases throughout the study. However, briefly, in this section I describe my personal perspectives and experiences with New Jersey FQHCs. I have a long interest in New Jersey FQHCs, a trusted relationship with the FQHC family, and a history of promoting healthcare for vulnerable populations. As indicated earlier, I served as the Chief Executive Officer and President of a New Jersey FQHC for close to twenty years and in leadership roles in the FQHC and other professional associations. In these positions, and after I left my health center for another position, I developed extensive insight and first-hand knowledge about the successes and challenges that New Jersey FQHCs have experienced and continue to face. I built personal relationships with the leaders and staff members of centers and with policy makers who influenced Community Health Centers

or policies that impacted them financially, operationally, and politically. With this

background, I recognize the value that is provided by New Jersey FQHCs. As critical,

safety-net, primary-care organizations, Community Health Centers, nationally and in the

state, provide healthcare for millions of underserved and unserved individuals, who

otherwise would have no or limited access to primary care. New Jersey boasts some

highly successful FQHCs. However, having witnessed the challenges that other centers

have experienced, as well as the cyclical nature of the success for some centers, I remain

very interested in how New Jersey FQHCs have fared under the ACA and whether or not

they have the ability to engage in capacity building to ensure their role as essential

providers as healthcare reform continues to evolve. To reiterate, I am invested in the

success of Community Health Centers, and especially New Jersey FQHCs, where I spent

close to half of my professional career. However, beginning this study, I was acutely

aware of the preconceived images and knowledge that I have about New Jersey centers

and the challenges they face to ensure capacity building and sustainability of the centers.

I was also aware that many in the FQHC family know my background and the nature of

my past and ongoing relationships with some FQHC leaders and staff members today. I

was challenged to examine preconceived assessments about the capacity of some centers

and the direction of their leadership, whether positive or negative, in order to accurately

hear, understand and reflect upon the meaning that participants ascribed to their own

lived experiences, values, and views. I was sensitive to any hesitation by interviewees to

share their views because of mistrust, familiarity, professional relationships, or

friendship, with respect to my role in the study. As noted elsewhere in this study, I

encountered only one instance in which a respondent expressed (non-verbally) an attitude

of caution in answering the questions. I perceived their attitude as silently conveying something like: "you should know us," "you should know that FQHCs add value and perform as efficient, effective primary-care providers, despite the challenges and environment in which we operate," and "why are you asking certain questions?" In this interview, I was careful to reinforce the confidential nature of the interview and to impart interest in hearing, understanding and conveying their perspective, not my own preconceptions and biases. I also recognized the unspoken concern about how the data might be used to portray New Jersey FQHCs. The encounter reminded me of how the health center family in general reacts to lingering stereotypical perceptions and portrayal of health centers as clinics for the poor, with mediocre quality, and poor outcomes. Based on experience, and described earlier, the health center community is sensitive to how others portray FQHCs. They reject negative images that perpetuate negative stereotypes of health centers. The encounter reinforced the need to communicate a balanced and reflective approach to interpreting the data and describing New Jersey FQHCs and their environment.

Finally, I think it is important for policy makers to understand how and why FQHCs are unique providers and to learn from "real-time, on-the-ground" experiences, values, culture, and so forth, about the impact of policies on FQHCs, on their ability to build organizational and access capacity, and on effective long-term performance.

As a point of process, findings of this study will be distributed in accordance with the normal channels used by the School of Nursing Urban Systems Doctoral Program at Rutgers, The State University of New Jersey for publicizing dissertations. I will explore further research based on the findings, as well as publishing findings from this study.

CHAPTER 5: PILOT FOCUS GROUP

This qualitative research study involved two phases. As explained in Chapter 5, the first phase entailed a pilot focus group to: (a) explore the importance and relevance of this study's research questions and interest in New Jersey FQHCs as essential primary healthcare providers under the ACA and (b) to elicit input for construction of the interview tool used in Phase 2 of this study. This chapter describes the focus group methodology and findings.

Focus Group Participant Selection and Process

A purposeful sample of individuals were selected to participate in the pilot focus group. Individuals were chosen based on this investigator's knowledge of their expertise and experience with FQHCs, their grasp of the broader issues and concepts important to this study. Focus group participants were also selected based on the recommendations of other health industry experts. Twenty-five potential focus group participants were identified and fourteen were invited to participate. Ten agreed to take part in the focus group. The pilot focus group members represented a broad cross-section of people with demonstrated knowledge of FQHCs, specifically New Jersey's FQHCs, and the political, industry, and regulatory environment in which they operate. Also, they had demonstrated knowledge about national issues affecting healthcare providers and healthcare delivery. No focus group participants were interviewed for Phase 2 of the study.

Focus group participants represented diverse backgrounds and expertise, as well as institutions and organizations across multiple sectors of the healthcare industry. The breadth of their experience included health policy, direct clinical services, advocacy, health center oversight and evaluation, and healthcare/FQHC administration. Focus

group participants brought varied and informed perspectives to the group discussion.

Some participants' experiences and their associations crossed multiple areas of expertise

and affiliated institutions. The information below provides an overview of the breadth of

affiliations, expertise and experience represented by the focus group participants.

The focus group members represented:

- New Jersey FQHCs
- The New Jersey healthcare system
- The New Jersey Department of Health
- New Jersey Primary Care Association
- Independent HRSA Consultant
- Private/non-profit healthcare advocacy group
- DHSS/HRSA, Region 11 New York Regional Division

Areas of expertise and experience represented among focus group members were:

- FQHC administration/leadership
- Healthcare/FQHC advocacy
- Healthcare policy, both state and national
- FQHC history and development
- Primary care (clinical)
- Healthcare administration/policy at national level
- Consumer advocate
- Population health
- FQHC monitoring and evaluation

Each of the 25 initial candidates for the focus group was contacted by phone and

invited to be a part of the study. Those indicating availability and willingness to

participate received a follow-up letter detailing the purpose for the research study and

pilot group, an overview of the process for their participation, and information about the consent process. They were informed that their involvement was voluntary. They could choose to withdraw from the focus group at any time. Group members also received further details about the organization and guidelines for the meeting. The guidelines specified that the session would be recorded and that a notetaker would be present during the meeting.

The focus group session was conducted in an accessible public location, but in a private meeting room conducive to conversation and confidentiality. All participants agreed to the location. The session included a meal for the group. The session was originally scheduled for 60-90 minutes, but participants decided to continue the discussion beyond the scheduled time. It continued for close to two hours and ended with the group agreeing that they had exhausted the discussion points.

As the primary investigator, I facilitated an informal discussion using a prepared agenda and semi-structured questions (See Appendix D: Focus Group Outline and Guide). I introduced topics and questions to solicit thoughtful input, and to stimulate reflection and discussion. All participants actively engaged in the conversation offering their insight, expertise and opinions about the topics introduced. They also introduced other relevant points of discussion.

Foremost, focus group participants were asked to expound upon the current capacity or ability of New Jersey FQHCs to operate and thrive as the ACA and healthcare reform advanced. They addressed open-ended questions and topics that were identified based on the investigator's knowledge of FQHCs and the healthcare industry, as well as the literature reviewed for this study. Group members also introduced topics and

questions that derived from their own experience and expertise. The key topics explored

in the focus group session included:

- FQHC history and culture, and impact on today's centers
- State and local environmental factors affecting FQHCs and providers across the healthcare delivery system
- FQHC capacity or readiness for healthcare reform
- Capacity building among New Jersey FQHCs
- Strategic and operational planning in FQHCs
- Impact of PCMH on FQHCs
- Impact of the ACA on FQHCs
- Primary care demand and access to care in New Jersey
- FQHC leadership development and training
- Impact of the FQHC's relationship with local community – political and social capital
- Patient engagement and consumer empowerment
- Sustainability of FQHCs
- Role of quality improvement in capacity building in FQHCs
- FQHC marketing and public relations—impact on capacity building

Focus Group Data Analysis

Focus group data were collected via researcher field notes and audiotaping. An

assistant also made handwritten notes during the session. The audiotape of the session

was transcribed, and the assistant note taker produced a word-processed summary of their

field notes. The field notes, which augmented the audiotaped transcript data, captured

observations of the participants' reactions and demeanor and were used to recall what the

researcher heard and witnessed during this process. This researcher compared the word-

processed notes to the transcribed data for accuracy, consistency, and completeness and

to ensure all salient information was captured. I conducted a manual analysis of the data, which included coding units of information to identify recurring themes and topics of importance to the group members. The participants' comments were synthesized according to key topics that emerged from the vigorous group discussion and the subsequent review of, and feedback on, the summary report generated from that discussion. A copy of the summary report was shared with each focus group participant to confirm that it accurately captured their views and to ensure that all important, priority topics, concepts, and recommendations aimed at informing the in-depth interview questionnaire for Phase 2 of the study were included. Feedback was received from all group members, with three of them offering clarifications on the perspectives they had shared. The final, revised summary was shared with all group participants; they offered no further changes.

The focus group findings were organized by topic, highlighting the areas that informed the in-depth interview guide. Findings from the focus group data are detailed below in this chapter.

Focus Group Findings: Key Themes

The focus group participants identified nine topics that they judged to be critical to understanding capacity building among New Jersey FQHCs' and their ability to be competitive, sustainable, primary-care providers. The topics included themes related to the major concepts explored in this study—capacity building, the ACA, and sustainability. This section outlines the salient discussion points synthesized from the data for each of the nine thematic topics also derived from the data. They are listed below:

1. Capacity building and sustainability
2. FQHCs' narrow view of capacity building
3. Capacity building and the influence of public policy/regulations
4. FQHC readiness to compete under the ACA
5. Patient Centered Medical Home (PCMH) status as an indicator of capacity building in FQHCs
6. Impact of the ACA
7. FQHC attitude toward change
8. Leadership and capacity building in FQHCs
9. Marketing and capacity building

Capacity Building and Sustainability

For the focus group session, I initially defined capacity building as the process that enhances the ability and preparedness of systems, persons, organizations or communities to meet objectives or to perform as expected toward sustainability, independent of external support. Focus group participants were asked if they agreed with this definition in respect to FQHCs. Does it apply to FQHCs? They were also asked these questions: Do centers strategically pursue capacity building? Do they connect it to their performance and long-term sustainability? Most participants agreed with the core elements of the definition. They concurred that capacity building is a dynamic process that should enable organizations to enhance performance and to meet goals. However, they all questioned whether "sustainability, independent of external support" should be the goal of capacity building among FQHCs. They disagreed with a premise that suggested FQHCs can engage in capacity building without regard to external factors that influence them, or that they can be altogether sustainable without explicit external financial support.

The term "independent" was thought to negate or undermine the power of external influencers and their impact on capacity building and sustainability in Community Health Centers. However, participants emphasized that the centers can and should move toward sustainability, albeit not completely independent of external support. They strongly cautioned that capacity building and sustainability for FQHCs must be framed within the context of the external environment and how it affects their overall function and ability as safety-net organizations. They emphasized that health centers are deeply subject to public and private influences, including those of the larger healthcare system in which they operate. This perspective was echoed by all group members and succinctly stated by one who said: "The readiness and capacity of a health center are so interrelated with its environment that it cannot be taken out of that context to determine sustainability or capacity building."

Group members stressed that health centers are highly interdependent and dependent organizations because of their role as safety net providers. They are an integral part of the broader healthcare delivery system, including public and private institutions that ensure the health and well-being of vulnerable populations. FQHCs rely on formal and informal systems and networks to ensure comprehensive care for their patients, care that includes access to medical services that extend beyond primary care. One member explained that: "Nothing is independent of the external factors that drives [sic] the FQHCs…federal, state government, or hospitals." This participant emphasized that all components of the healthcare system are interdependent. Capacity building and sustainability must be addressed across the entire system and not at any one level without consideration of the whole. Just as FQHCs are dependent on other providers and

institutions to meet the needs of their patients, other healthcare institutions and providers rely upon the centers' ability to be effective safety-net providers. From my experience, a good example of this is how acute care hospitals rely upon FQHCs to help reduce or prevent unnecessary, costly hospital admissions or emergency department visits. FQHCs work closely with local hospitals to ensure that patients receive the care needed in the most appropriate and cost-effective setting. Centers in turn rely upon the hospitals to meet the needs of their uninsured patients (for diagnostic testing and obstetrical care, etc.), thus supplementing health center resources and their ability to provide a necessary continuum of care for their patients. FQHCs are required to ensure that their patients have access to necessary services beyond primary care to meet their healthcare needs; this is a scope of service mandate required by the HRSA/BPHC. The informant concurred that FQHCs' interdependence with other providers/organizations across the overall healthcare system, as well as their susceptibility to environmental factors, makes it impractical, if not impossible, for centers to be independently sustainable organizations.

A related theme that emerged from this part of the discussion was that capacity building is a tool that should lessen dependence on external sources and better position centers as financially viable institutions. Although capacity building might not render them altogether independent of external support or influence, many group members asserted that centers should strive to decrease dependence on public financial support as much as possible. Some did think that centers should work toward adopting more of a business model to achieve less dependence on unstable grant funding, but to achieve greater self-reliance rather than financial independence, absent of external support. One expressed this viewpoint in stating: "You need to run this [health center] like a business;

you are a 501c3 …. It is a small corporation. FQHCs are small businesses and need to be managed as such."

Others, however, cautioned that while a business model might be necessary to ensure a sound financial position, centers must balance the business approach with their mission. They emphasized that financial sustainability must be weighed in view of the fact that the FQHC mission and function as a safety-net organization is a shared mission with the public. The government and public should bear some responsibility for ensuring that mission. A clinician in the focus group talked about the quality of care that is provided to patients at FQHCs and the center's positive impact on their host community, as well as on population and public health. The participant argued that centers should strive to balance the mission with issues of sustainability and the need to build capacity toward that end, but first policy makers, the public, and FQHCs themselves, must understand that FQHC services are about more than the number of encounters (the number of face-to-face visits with patients) and the dollars that are generated from those encounters. This group member strongly suggested that FQHCs should be careful in how they measure success for capacity building. They stressed that expansion of services and financial sustainability are important goals for capacity building, but also it is about more than that; capacity building is also about the impact on the community and the ability to deliver quality care. The group member said that:

> I think there is an appreciation of what a Community Health Center means to a community; that it [the community] has grown over the years that the health center has been in operation in that community. You're there for the long term. You're there for the people, the groups, that you're trying to serve. Unfortunately, we still get tied back to encounters being the measure of our success, although that is not always the most meaningful.

Altogether, focus group members agreed with the importance of examining the impact of the external environment in studying capacity building and sustainability for FQHCs. They suggested that the definition used in the study should be presented as a starting point in the in-depth interviews, not as a definitive position or definition of capacity building. It should be a starting point to explore participant views about the value and impact of capacity building in achieving sustainability, with the intent of understanding how interviewees view sustainability independent of external support. Is financial independence a realistic or desired goal for capacity building in FQHCs?

In summary, the group concluded that sustainability independent of external support should not be an assumed outcome or even one that is necessarily desired in the FQHC family. Rather, sustainability should be understood from the perspective of FQHCs relative to their relationship with federal and state funders, their community, and the rule that mandates that they provide access to primary care for uninsured populations, regardless of their ability to pay, as well as coordinate access to a comprehensive continuum of care for their patients. A few participants questioned whether financial independence should ever be a goal for FQHCs. They asserted that sustainability should not be the primary driver pushing centers to engage in capacity building.

FQHCs Narrow View of Capacity Building

Focus group participants offered their views about how FQHC staff approach capacity building. Generally, they suggested that capacity building is not defined or assigned as a specific strategy in most centers. The group observed that many FQHC staff and boards view capacity building very narrowly as expansion of access to care. This is also thought to be true of policy makers. As noted by one group participant, "most of the emphasis is

on expansion," which involves creating new access sites or expanding hours of operations, and so forth. A group participant said that: "Some talk about capacity and label it as access—without defining capacity." Group members believed that centers must pursue a broader approach to capacity building and that new sources of government funding under the ACA should be used to incentivize critical, effective capacity building across the organization to enhance components and functions such as governance, staff performance, and financial management. Capacity building literature, as noted in Chapter 2 of this study, bears out the group's insight that capacity building is a complex, multidimensional concept. Little weight is given to capacity building as a strategic, multifaceted process, including operational and human resource capacities (Brown et.al., 2001).

Group participants cited the following areas as examples of strategic processes or practices that FQHCs should focus on for capacity building, beyond access capacity, to ensure greater viability and ability to deliver on their mission:

- leveraging community resources for the common good
- building better partnerships, understanding the dynamics of partnerships, and cultivating interdependent relationships
- focusing on healthcare delivery
- training staff
- growing healthcare information technology skills and use
- fiscal management systems

Capacity Building and the Influence of Public Policy/Governmental Regulations

In the discussion about capacity building and sustainability as described above, focus group members were firmly and unanimously focused on the impact of government

policies and regulations that limit or enhance centers' ability to enact capacity building or

to pursue sustainability. A focus group member who was a senior-level federal employee

in the Bureau of Primary Care at the time of the session provided additional written

comments afterwards to further emphasize the view that FQHCs are heavily regulated

healthcare organizations. This respondent wrote:

> FQHCs are the most regulated healthcare entities in the healthcare industry,
> affected by federal, state, and local compliance regulations. Federal funding and
> compliance requirements result in Centers promoting maximum access, including
> extended hours/weekends, accepting lower social [*sic*] economic status [patients]
> who are financially insecure, and uninsured clients….Federal fiscal constraints
> include, centers can't turn anyone away for lack of dollars or insurance, and they
> must have a flexible sliding fee scale prominently displayed in public areas. The
> federal data reporting system [UDS] tracks center performance on clinical
> compliance, up to date clinical standards, credentialing of providers, referral
> relationships, and stringent Quality Assurance Program (QAP) systems,
> administrative and fiscal management. State policies may overlap with federal
> requirements also to regulate facilities, lab/x-ray standards.

This comment was received in response to the draft summary report that was sent to the

focus group participants for their review, confirmation, and additional comment. It was

subsequently included and shared with the entire group in the final focus group summary.

In this statement, the respondent attempted to further highlight some of the policies and

regulations that centers must adhere to and which impact how they do business. Group

members concurred that centers are subject to policies/regulations that other providers do

not have to adhere to, such as having to promote and provide maximum access to

individuals regardless of their ability to pay or having to ensure extended hours of

operations for uninsured or indigent patients. They also pointed to a general belief

among centers that FQHCs have more arduous reporting requirements than other

healthcare providers. In the quote above, the respondent supported this view in

describing a regulatory environment in which the centers must adhere to federal, state and

local regulations which sometimes are redundant, again adding additional administrative

burdens and costs that are specific to FQHCs. Other group members noted that in

addition to the FQHC specific requirements, centers are at the same time subject to

regulations that everyone else must adhere to. Supporting this view, a respondent noted

that "centers need ambulatory care licensing and JCAHO [Joint Commission

Accreditation of Hospital Organizations] like hospitals." The health centers must not

only comply with regulations that are applicable to most providers, they must also meet

regulatory requirements that apply to FQHCs only. They cannot use state licensure

approvals to satisfy federal requirements for administrative, facility, and clinical

standards that are required for HRSA funding and FQHC status, although the criteria that

they are evaluated on overlap greatly. A salient theme from this part of the discussion

was that policies and regulations that govern how centers operate must be reviewed to

ease administrative burdens and to produce a level playing field to allow centers greater

leeway for capacity building and to be more financially viable. FQHCs may be unduly

burdened with regulations and policies. This was suggested as an area that should be

explored further with the main study interviewees.

However, despite the view about the potential adverse impact of the state and

federal regulatory environment on FQHCs, some group members were careful once more

to point out that external factors such as regulatory practices or enacted policies should

not prevent FQHCs from striving to operate as businesses. All group participants

reiterated that centers have a responsibility to manage as efficiently and responsibly as

possible because they hold a public trust. For example, they must be able to meet

standards for licensure, as well as for FQHC status. They should also seek to achieve

accreditations that attest to the quality and efficiency of their operations and clinical care.

As such they should institute strategic capacity building initiatives and work toward

sustainability of performance to the extent possible. This is not contrary to the mission of

centers. Here group members encouraged a significant focus on understanding the

business models of FQHCs in order to explore whether capacity building within centers

can lead to more efficient processes and sound practices to ensure their ability to comply

with necessary or beneficial regulations as efficiently as possible. However, they also

stressed that centers should seek capacity building to improve advocacy for policy and

regulatory changes that are more streamlined, consistent to ease the administrative and

financial burdens on FQHCs, as well as to protect the interest of the public.

FQHC Readiness to Compete Under the ACA

Focus group participants believed that there was significant variability among

New Jersey FQHCs with respect to how prepared they were to capitalize on the ACA,

and especially regarding their readiness to engage in new payment and healthcare

delivery models. In general, participants agreed that while some New Jersey centers are

doing very well, others are struggling to keep up or to capitalize on ACA policies and

grant funding intended to benefit FQHCs. Group members noted variously that: "[there

is] mixed readiness among FQHCs in New Jersey;" "some are more ready than others—

some are bringing up the rear;" "centers have [are in] different states on the continuum, a

mixed bag."

Focus group participants attributed the varying degrees of readiness among the

centers to their different levels of resources and abilities to anticipate, plan for, and

navigate change. They offered that some centers were less prepared than others because

they did not commit resources or engage sufficiently in strategic capacity building, such

as leadership and staff development. Nor did these same centers understand the

dynamics and potential impact of trending changes in the healthcare industry or those

factors that impact healthcare. Group participants said:

> …Health centers need to understand and have good decision making about their
> own capacity
> …We do not do training around [if or how] can you grow; can you grow well
>
> …Centers need to understand better the community, internal abilities and
> populations to be served

The context for this last statement involved discussion about the need for centers to

understand and respond to the changing population demographics in many FQHC host

communities, as well as the need for centers to be prepared for such changes. The

participant sought to highlight that centers need to better understand new community

dynamics and their implications. Group members acknowledged that while health

centers are intended to be rooted in the social, cultural, political, and economic fabric of

their communities, they may no longer have the same social or political access to new

groups as the demographic make-up of their host communities change and the

institutional memories and significance of the FQHC/community bond are lost. They

stressed that some centers are losing rapport with new patient groups who have little or

no appreciation for health centers' role in anchoring communities and their historical

significance to their host community. Centers must be prepared to respond to

demographic changes in their service areas to remain relevant, valuable resources in their

host community and in new service areas. Also, new patient demographics in areas

served by FQHCs are creating different alliances and new priorities for available

resources. Changes in the industry as well as in the community require that centers have

the necessary skills, leadership, and resources to maintain community support and to

continue to cultivate patient loyalty.

While the group members agreed that some centers demonstrate less readiness

than others and point to the need for them to be knowledgeable and prepared to navigate

changes in their environment, they again highlighted the unintended consequences of

changes that affect centers regardless of their degree of preparedness for change. One

participant noted that centers cannot operate as effectively as possible because of external

and internal environmental factors and health care trends that are sometimes beyond their

control or resources. This participant simply commented that: "centers are not operating

strong due to other factors." Other group members commented further that some other

competing factors included challenges within the centers: "There is [*sic*] competing crisis

of everyday needs within the centers for the management," and "[they have to balance

resources for] what is needed to keep the place running." These participants and other

group members emphasized that internal factors sometimes cause competing priorities for

health centers and force those that are less well-prepared to focus more on short-term

needs than long-term strategic planning and capacity building. Some centers regularly

struggle with ensuring their daily or short-term operational needs, such as adequate

staffing and enough cash flow. They do not have the team or capital to put toward

addressing long-term capacity building or sustainability issues when they must focus on

short-term viability. Nevertheless, as noted by the group members, some manage to do

both, and they do it well. But the sentiment expressed here is that sometimes the

challenges that affect immediate operational or clinical needs are not always within

centers' control, making timely resolutions difficult, despite how well prepared they may

be. Their degree of readiness enables them to successfully navigate unforeseen or

unavoidable challenges but not necessarily to change how the environment affects

centers, near or long term, or their outcomes.

To illustrate this view, group members pointed to the example of the impact of

some unintended consequences of the ACA which adversely affected all FQHCs, but to

varying degrees. They explained one salient example of this. Initial problems with

rollout of the ACA resulted in unexpected and rapid attrition of the traditional patient

base for FQHCs because of federal policies that governed the auto-assignment of patients

to other providers when they enrolled in the ACA marketplace. A participant succinctly

explained this issue:

> Centers are not allowed to influence patients' choice of providers [upon
> enrollment], so even when clients want to continue at the centers, some patients
> are being auto assigned to private providers. Patients must disenroll from
> assigned private providers and reenroll with the centers.

The auto-assignment problem was acknowledged by focus group participants as a

particularly challenging factor that impacted the ability of some centers to fully embrace

the benefit of the ACA. However, they framed the problem within the context of the

need for centers' to effectively deal with the "competing crisis of everyday needs" as well

as the threats to long-term sustainability. The challenges associated with the auto-

assignment problems involved the rapid and sudden loss of revenues and patients, both of

which created immediate cash flow problems and problematic projections for long-term

fiscal stability. While most FQHCs anticipated new competition for patients under the

ACA and some loss of patient volume in the short term, they did not expect forced

attrition of their patients to other providers, nor the immediate impact of it. The specific

circumstances and dynamics related to auto-assignment of newly insured health center

patients to other providers was discussed more intentionally by the main study interview

participants and is recounted in detail in the findings' chapters. Nevertheless, its

relevance as recounted by the focus group was that it presented an immediate, unforeseen

challenge to centers to handle the immediate problem, despite their level of preparedness

for the ACA, as well as their overall ability to adapt to or to overcome external factors

affecting capacity building.

One group participant also suggested that the variation in planning and strategic

capacity building among FQHCs is further demonstrated in their adoption and effective

implementation of continuous quality improvement (CQI) initiatives. This participant

reported that: "every center has a CQI plan because they have to…some live by it, some

put it on the shelf." Another participant added: "they must live by it [CQI plan]. In terms

of grant dollars, they must show evidence that they are doing it."

Other group members explained that although having an effective CQI plan is

required and centers do provide quality care, the capacity of various centers in this area is

not always evident or clear. They suggested that the interview guide include probes to

understand whether centers do comply with their mandate to implement robust CQI plans

and if staff and board members are aware and actively engaged in CQI. Group members

suspect that centers are doing more in this area than most realize. They emphasized the

lack of understanding or real-time knowledge about the degree to which health centers

implement CQI practices, or about the ability of health centers to engage in capacity building to effect CQI.

Overall, participants expressed their view that some centers were struggling before the ACA was implemented, and they continue to struggle. This was attributed, in part, to the force of external factors, but also to the lack of ability and resources to engage in strategic capacity building to ensure their ability to understand and manage change, to react responsibly and effectively to unforeseen challenges, and to effectively navigate competing short-term crises that might prevent centers from acting upon real opportunities for growth and to enhance organizational performance.

These findings prompted the inclusion of interview questions and probes in the research study guide about the readiness of centers to navigate competing demands for attention to near- and long-term goals or to effect strategic capacity building toward sustaining performance and impact over time. Probes were added to clarify of readiness in strategic areas, such as having effective CQI programs or organizational strategic plans that incorporated deliberate attention addressing environmental factors and attention to capacity building.

Patient Centered Medical Home (PCMH) Status as an Indicator of Capacity Building in FQHCs

A starting premise for this study was that PCMH designation might be an important capacity building tool for New Jersey FQHCs as they prepared for the implementation and impact of the ACA. To reiterate, and as detailed previously in this study, PCMH is a patient-centered, primary-care delivery model designed to transform how care is organized and provided to address the health of patients. I queried focus

group participants about the importance of PCMH accreditation as an indicator of

capacity building in FQHCs given the enthusiasm in the industry for PCMH as an

effective care delivery model and quality improvement tool. Industry support for PCMH

certification is evident in the partnerships supported by HRSA to enable centers to pursue

certification through multiple accrediting bodies such as JCAHO (also referred to as The

Joint Commission) and the National Committee on Quality Assurance (NCQA). But,

from the clinical providers to the administrators in the focus group, the response was

clear. PCMH status might not be the most appropriate or the best indicator of readiness,

the presence of capacity building, or the potential for FQHC sustainability. At the time

that I conducted the focus group, a participant reported that eleven New Jersey centers

had already achieved some level of accreditation. Others confirmed that the eleven

centers were at various levels of PCMH recognition. Additionally, group members

observed that even though these centers have acquired one or more levels of PCMH

certification, they still demonstrate varying degrees of capacity building strengths and

achievements that are not necessarily congruent with their levels of certification.

Participants supported the view expressed by one of the group members that: "even

having gone through PCMH accreditation, some centers are still not operationally

strong." In their opinion, some PCMH designated centers are still not necessarily

prepared to compete effectively as healthcare reform progresses. Group members felt

that others, however, who have experience with the PCMH model have developed greater

sustained capacity for improving clinical care services, including enhanced quality of

care and better outcomes. The group's advice regarding this issue was to avoid

evaluating FQHC capacity building by their ability to achieve PCMH status alone or

using it as a key indicator of readiness of centers to succeed in a changing environment.

They asserted that PCMH status does not provide an accurate assessment of a center's

operational efficiencies, economic strength, or systems readiness to participate as critical

players in expanded health systems or networks, or as stand-alone entities. The PCMH

model focuses more on the care and management of the patient, not on operational

practices or processes, or factors that contribute to overall organizational capacity and

efficiency.

Also, FQHC leaders involved in the focus group added that some centers do not

think it is necessary to become a PCMH. One member explained that:

> [PCMH designation] …to them it's just a label. They are [already] doing
> something about capacity building. It's about looking within your organization to
> do that improvement. For some people, it is to go to a patient-centered medical
> home and for others it was about the work they started with the collaborative.

As reflected in this statement, group members offered that some centers question the real

value of the PCMH accreditation, especially since they believe that the core concepts of a

PCMH are already embedded in the mission and model of FQHCs. Another participant

added:

> What happens is that the center may not have a designation as a patient-centered
> medical home. But if I went into that center and looked at what they actually do,
> I bet you that they would be [considered] such a high-level, patient-centered
> medical home; however, they haven't bothered to go for the designation. Their
> attitude would be, why bother?
> This is where many centers have their strengths because most health
> centers started caring for children and mommies. The patient-centered medical
> home concept is really a pediatric model.

Group members reported that the "why bother" attitude exists in some centers not only

because these centers believe they have long practiced the PCMH model of care delivery

effectively, but also because they question the cost-effectiveness of seeking PCMH

status, especially owing to the way FQHC reimbursement is structured. A participant

explained that: "centers receive the same PPS [Prospective Payment System][21] rate for

care provided, whether PCMH or not." The PPS provides an enhanced reimbursement

rate for health centers over what other primary care providers receive, but as centers have

repeatedly emphasized, non-FQHC providers are not subject to the same requirements for

comprehensive patient care as FQHCs, including case management, which is otherwise

under-reimbursed or not reimbursed at all. Moreover, the PPS rates too are also

considered to be insufficient to cover mandated FQHC services. The participants thought

CMS should add adequate incentive payments for care coordination beyond the PPS rate

for PCMH services to incentivize greater uptake of the model. A participant emphasized

that:

> People are talking about how CMS is now looking at how we can reimburse the
> case management piece because it takes more time and people….They recognize
> that, and they are working on it, but we don't know when it's going to happen.

However, a second group member added: "Currently there is no additional financial

reimbursement, therefore the [financial] benefit of enhanced PCMH model is not

realized." Furthermore, several participants explained that most New Jersey centers have

participated in the HRSA supported HDC initiative. Health center participation in the

HDC enabled centers to improve the care and management of chronically ill patients

through improved clinical service delivery practices, enhanced data systems, and

implementation of CQI plans. The HDC encouraged the development of integrated care

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[21] PPS is a Centers for Medicare and Medicaid Services (CMS) prospective payment system that is based on a predetermined amount for a service or category of services, with fixed adjustments for factors such as initial patient visits or chronic care management (Centers for Medicare & Medicaid Services). https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS

models across providers for management of chronic care patients. Focus group

participants believed the centers would view their participation in the HDC as being just

as beneficial as PCMH certification without the additional cost.

Still, a few members did argue in support of centers pursuing PCMH status as a

capacity building tool. They noted that PCMH certification is more widely recognized as

an indicator of quality care than participation in the HDC. It is more useful as a

marketing tool because it is a more recognized, evidence-based model of care that

conveys quality and the capacity to successfully participate in new care delivery models.

One participant observed: "Acknowledgement as a PCMH is a good marketing strategy

to increase patient share and expansion, similar to magnet status for hospitals." In other

words, having PCMH status could only serve to bolster their standing in the industry as

high-quality, efficient, primary-care providers. It is a recognized and accepted

endorsement of quality and capacity for delivering coordinated, integrated primary-care

services. The certification could enhance centers' appeal to patients and to health

systems seeking to partner with FQHCs. PCMH certification might be leverage for

FQHCs seeking to participate in new care delivery models, such as Accountable Care

Organizations (ACO) or Integrated Care Networks.

Additionally, a few members, particularly the clinicians, argued that PCMH

designation should be valued and pursued for what it is—simply as a tool to enhance

patient-centered care. One participant said:

> The nice thing about patient-centered medical homes in terms of capacity building
> is that it's about the patient not the encounter [the visit and payment for the visit].
> Can we begin to think about want [*sic*] routine quality care looks like? Should the
> measure of success be that you had 13 visits? It might not make economic
> success; it [PCMH certification] may be a measure of quality but is it a reflection
> of what is really needed.

Yet the members mostly echoed the theme that PCMH status might not be the best indicator of capacity building because it is a clinical-care model that does not focus on building organizational capacity in a comprehensive way, and because the FQHC clinical-care model is so close to that of a PCMH model. It is a cost-intensive endeavor for FQHCs to acquire certification for something they believe they have been doing and continue to do already. One group member reiterated the anticipated lack of enthusiasm among FQHCs about the PCMH in stating: "The criteria of achieving the designation of a medical home is not necessarily the right tool to assess readiness or preparedness of an FQHC for capacity building or sustainability."

Nevertheless, focus group members concluded that each center should strategically determine the best tool or course of action that would allow it to enhance capacity and achieve its goals, whether it is PCMH certification, participation in the HDC, or accreditation by other accepted agencies that evaluate and set standards for quality assurance and performance improvement. such as the Joint Commission. One participant emphasized that: "Each center is different and should look to what their own center or organization needs." Accordingly, the participants articulated that it might be more informative for this research study to present the PCMH as one important pathway for strengthening clinical capacity, and to encourage the main study interviewees to expound upon those CQI initiatives or other programs that might or might not facilitate capacity building in key areas for their organizations.

Impact of the ACA

In discussing the impact of the ACA on FQHC capacity building New Jersey, group members highlighted policy makers' strong emphasis on leveraging the ACA to grow access to primary care and the use of FQHCs as an important pathway to achieve this goal. For health centers, expansion of access capacity included adding additional physical space and new sites, as well as expanding hours to accommodate the anticipated growth in demand for primary care services. It also highlighted what group members viewed as one of the most significant gains for FQHCs because of the ACA—a new source of money to fund capital projects for expansion and growth. Group members emphasized that one of the most important benefits of the ACA for FQHCs was capital funding, which allowed centers to build new or renovate existing facilities and to purchase new equipment. They stressed that this was a critical need among New Jersey centers.

The focus group added that FQHCs should also seek to optimize ACA provisions for other opportunities to build capacity, across the board, particularly to gain resources to help them develop or enhance operational capacities, such as information technology, staff and leadership training and professional development, and participation in integrated care models. Also, group members thought that the ACA afforded FQHCs opportunity to revisit regulations and policies that adversely impact capacity building in the centers. Several participants referred to the inability of FQHCs to implement behavioral health integration models in FQHCs because of licensing restrictions as an example of regulations that might be successfully revisited under the ACA. A group participant explained this issue:

New Jersey state regulations i.e. restrict reimbursement for certain mental health professionals on site [in FQHCs]. [This] has resulted in a significant barrier to efforts to assist centers through the federal National Health Services Corp (NHSC) loan repayment program for mental health/behavioral health assignees [to FQHCs] in New Jersey.

This problem is much more complicated than stated here, but it reflects a challenge that prevents FQHCs and other providers in New Jersey from expanding access to mental health services because of rules governing payment for how and where mental health care is delivered. Also, it does not allow FQHC professionals, such as licensed clinical social workers to practice at the top of their license and be reimbursed. This issue is critical to all primary-care providers because of the impact of mental illnesses on patient-care management and patient-care outcomes. However, because of the impetus under the ACA for providers to adopt enhanced capacity for coordination of care and the development of new care delivery models, some group participants thought the ACA provided an opportune environment for renewed advocacy to change such regulations that impact how care is delivered and reimbursed in FQHCs.

Also, a few group members noted that ACA benefits to FQHCs include the expansion of the National Health Service Corp (NHSC). NHSC is a department of HRSA. The program provides loan repayments to primary-care providers in certain disciplines who serve in areas where there is limited access to healthcare services. These areas, known as Health Professional Shortage Areas (HPSAs) must be designated by the federal government as geographic areas that have a critical shortage of primary-care, mental health, and dental providers. Some group members highlighted this ACA provision, again because it an example of how policies can prevent New Jersey FQHCs from fully realizing some important ACA benefits to the centers. A group member

reported that nationally "some [FQHCs] have really benefited from expansion of the

NHSC, but not New Jersey. Because they can't." This participant clarified that New

Jersey FQHCs have problems acquiring NSHC providers because of how the federal and

state governments define HPSAs in the state. As noted previously, the methodology for

defining HPSAs is considered problematic for New Jersey because it presents limitations

to what can be considered geographic HPSAs. Although there are designated rural health

centers in areas that serve large migrant and farming populations, New Jersey does not

have rural HPSA designations. This impedes the ability of FQHCs in rural areas from

participating in the NHSC program for recruitment of clinical staff, thereby decreasing

their ability to expand or increase access capacity due to a lack of primary-care providers.

Focus group members reiterated that the in-depth research interviews should

include discussion of New Jersey state-level policies and regulations and how they align

or not with federal policy to impact capacity building.

In addition to its importance to the primary research question for this study, the

ACA signifies a larger movement toward comprehensive healthcare transformation and

long-term changes that will affect all healthcare providers. The pilot focus group

affirmed the importance of focusing on the ACA as a critical indicator of the system-wide

changes occurring in healthcare. The ACA provides a lens through which to understand

both the near- and long-term consequences of the environmental changes for FQHCs that

are driving wide-spread healthcare transformation.

FQHC Attitude Toward Change

Healthcare policy leaders participating in the group strongly supported including

questions in the research study's in-depth interviews to understand the interviewees'

perceptions about their centers' approach to managing change. They suggested that the inclusion of questions pertaining to FQHCs viewpoints or attitudes about changes in the industry or in the environment altogether were important to understanding the organizations' readiness to participate in and thrive under the ACA and in the years to come. Many group participants expressed concern that centers that do not understand the need for change or that are unwilling to adapt to it will be left behind. They will not be able to marshal the resources to compete. Centers that have resisted change or have not kept up with it, are not among the more progressive and successful New Jersey centers according to several group members. This opinion is reflected in the following two comments; they reveal views about the need for centers to proactively attend to critical environmental changes: "To figure out [how to be] sustainable, health centers must be able to change. It's important that centers get in front of the issues. Must figure out how to change the mindset [in] FQHCs" and "Increased knowledge is important for this changing environment."

In the latter statement, the group member continued to stress that centers must be more strategic in how they plan for and manage change. They must be sensitive to the market in which they operate, even within the constraints of their mission. In discussing this the participant added:

> This is extremely important. Change started in the 90s [for FQHCs] with the implementation of the PPS rate, everyone did not adapt to them [Prospective Payment System rates] then because Feds [federal government] were still giving our subsidies. FQHCs are small businesses and need to be managed as such.

This participant pointed to what they considered a commonly held view among centers, that regardless of how the environment changes, their status and mission as essential

providers will be sustained through federal funding. Health centers will always be able to rely on subsidies for operations and financial sustainability. Focus group members however suggested that centers can no longer rely heavily on public subsidies as a primary funding source either for operations or for sustainability. While they think there is a need and role for some government subsidy of FQHCs, as previously discussed, they also stressed that some New Jersey centers that do not recognize the urgency or need to enhance their ability to change how they operate under new funding structures. They may be at risk of being left behind. They will not have the resources to sustain existing capacity or to develop it.

Group members suggested that this study ask how centers adapt and prepare for change. They specifically underscored the earlier discussion about the need for centers to understand how their host communities and targeted patient populations are changing. With apparently weakening connections between some FQHCs and their host communities, coupled with patients having greater access to insurance, as well as changes in how patients access care, will centers have the ability to adapt to these changes in a timely, constructive, and sustainable way? A participant asserted that it is critical that centers recognize change when it occurs. With respect to changes in the demographic makeup of FQHC service areas, a focus group member observed: "You must recognize when your community changes…We have had to make dramatic shifts in certain areas. When you don't recognize the changes and you don't hire staff that reflect the community changes you are in trouble." Similarly, other group members offered that centers must be proactive in understanding shifts in not only their patient population, but also changes in the social, political, and economic environment in which they operate,

locally, at the state level, and nationally. Focus group members concluded that FQHC

leaders generally need to become savvier players in the healthcare arena, be attuned to

the changes and prepared to react to them in order to address external factors that can

affect their ability to engage in capacity building and to move closer to becoming more

self-reliant, viable organizations. Two group members noted:

> We must understand where each center is in the marketplace in order for them to maintain their market share. Some people on the [FQHC] boards may understand because of their business background but does everyone else have the same understanding?
> The centers have to be more aggressive and stay on top of this [environmental changes]. People will not always support you because that's your mission.

The focus group's input about change and the centers' approach to it supported

my initial premise that the FQHCs' response to the ACA is important in understanding

how centers manage change, how they ensure the capacity to optimize changes in the

environment toward capacity building and sustainability. The group agreed that the ACA

is a significant bellwether of changes in the industry and how FQHCs respond to it.

Leadership is Essential to Effect Capacity Building in FQHCs

The focus group stressed that leadership is critical to ensuring that centers engage

in capacity building. They viewed centers with the strongest leadership, in the form of

knowledgeable, skilled management and active boards, as being better positioned to

succeed at capacity building and sustainability. Those who interacted with centers most

often found that some boards are more engaged than others in planning and monitoring

strategic action and ongoing progress; these board members participate in necessary

training to better understand their environment and what their center requires to meet the

needs of their host community. The discussion about FQHC leadership focused mainly

on the boards; group members thought that while many centers had strong executive

teams, there is room for greater capacity building across most FQHC boards. Views

expressed in the following two quotations resonated with all group members: "centers

that are advancing more than others all have stronger leadership and boards;" and

"governance is the most important piece—they have to ask the right questions."

This data reflected that group members also thought that centers should pay more

attention to ensuring that they have well rounded leadership teams—board and

management. They stressed FQHC leadership must have the requisite skills for strategic

capacity building and to position the center for sustainability. Group members suggested

that FQHCs must develop or enhance their governance capacity because of changes

under the ACA. They must ensure a mix of skills among board members for proper

oversight and encourage greater ownership of their role. Again, referring to how earlier

Model Cities' health centers operated, and the influence of those traditions and practices

still, one participant suggested that board members must provide leadership to help

transform health centers' attitudes about change, especially today with the momentous

transformations that are occurring in healthcare:

> Old timers still see Model Cities; the new leadership sees it differently, they don't
> see it as just a mission but as a business….If boards are stagnant or they don't
> grow and evolve, they are not keeping pace with the changes and are not moving
> forward.

Another participant added that: "Boards have to change; [they] must grow with change."

Group members stressed that boards and management must participate in training to build

leadership capacity, and centers must recruit board and senior management staff with the

skills and knowledge that are necessary to succeed in new models for care delivery and

reimbursement. They strongly agreed that health center boards should be prepared to provide strategic leadership and to be more engaged in directing capacity building toward sustainable growth and operations. Group members recommended that questions pertaining to the strength of FQHC leadership be included in the in-depth interview tool as an important factor in studying capacity building in New Jersey FQHCs.

Marketing and Capacity Building

Focus group members suggested that centers should engage more in public relations and "sing their song" differently. Competition for FQHC patients is anticipated to increase from multiple sectors. Coupled with the ACA emphasis on building relationships and partnering to advance healthcare, participants suggested that it is important for FQHCs to develop new or additional capacity in marketing, outreach and advocacy. They asserted that centers should focus on making others aware of the value of FQHCs, most importantly the quality of care delivered by the centers and the positive impact they have on the health of communities. Marketing, outreach, and advocacy are all important in creating external support and patient loyalty, as well as reinforcing the FQHC brand to leverage resources. However, as noted earlier, group members expressed that there is marked variability the overall capacity of FQHCs, including for marketing and advocacy. They observed that some centers do not prioritize marketing. These centers rely upon reputation, community ties, the strength of their mission, and their status as essential providers to gain public recognition and financial support. Group members emphasized their view that FQHCs must do more to influence or to control how they are measured and evaluated in the industry, by the public, and by their patients. Expanding on an earlier statement, one participant reflected that:

> It has a lot to do with how we sing our song. If the health center does not put up that banner that says...best in the country…how does anybody ever know that we're doing a good job? We have to sing that song; sometimes we don't.

Group members further concurred that much of what centers do is not new, and many of the emerging concepts (medical homes, case management, coordinated care) are ideas long embraced and practiced by centers. They anticipated that the larger FQHC family would argue that centers already have the existing experience, although at varying degrees, for implementing a patient-centered care delivery model. Group members echoed the FQHC literature that shows that FQHCs are outperforming other primary-care providers in meeting clinical care performance metrics and improving patient outcomes, but that most of the public, or even the healthcare industry, is not aware of these facts. The focus group pointed out that New Jersey centers are not proactively building upon the strengths they possess to better position themselves in state's healthcare industry. They thought that centers need to better define their existing capacity or abilities for comprehensive care delivery, including care coordination and case management, to the public. A clinician in the group said:

> They are not marketing themselves well. People think that coordinated care is new under the ACA model. [FQHCs] have a reputation for coordinating care for the chronically ill. No one else is doing that. What is different about the health centers is that they have experience with special populations. Centers need to tout outcomes with patients, and [outcomes] at a lower cost.

Another participant clarified that it is also important for centers to hone their abilities to understand and explain their own data in marketing the strength of their clinical care and patient outcomes. This same participant cited an example where FQHC data was

presented in a national report card but not adequately explained or understood, creating

an unfounded negative image of clinical-care delivery in health centers, recounting that:

> Kaiser published a report card on FQHCs that was brutal. They needed an appropriate reference group [in] comparing FQHCs to the general population, without explaining indicators to inquires [sic]. Why aren't you doing better on all of this, you have all this money? What is in your way of doing better?

This respondent expressed frustration that critical questions were left unanswered about

the Kaiser report. This interviewee reported that questions like those from the public

who read the report should be addressed. This example underscored the group members'

perspective that it is important that FQHCs have the capacity to effectively control their

own story and to ensure that it is accurate and easily understood. Supporting this view,

another group member indicated that what was not conveyed by the Kaiser report card,

was the fact that FQHCs care for a disproportionate share of high-risk populations with

chronic illnesses and poorer than average health status. This participant added that when

the Kaiser report card was issued:

> some FQHCs were [already] reportedly ranked better for certain quality indicators than that of the Healthy People 2020 metrics. Not all health centers were reported as doing good, but not all were reported as doing as bad as per the Kaiser report.

Centers might have lessened the negative impact of the Kaiser report with their own data,

their ability to explain the data, and their ability to tell their story about their value and

impact.

Marketing, public relations and advocacy require having or creating adequate

capacity that includes human resources, technology, and talent. Focus group members

considered marketing and the ability to enhance public relations to be an important aspect

of capacity building to explore in the main study. It is important in order to understand

how centers are positioning themselves in the public arena to compete and to control how they are viewed by funders, policy makers, competitors, partners, and patients.

Summary of Focus Group Discussion and Findings

Focus group participants readily shared their insights about the importance of exploring capacity building in FQHCs. They affirmed the relevancy and usefulness of the study. Plus, they supported the use of a capacity building framework to gain greater understanding about the readiness of New Jersey FQHCs to perform as essential providers as healthcare reform continues to reshape the healthcare landscape. Importantly, they also helped to reframe the importance of how issues of sustainability are positioned in the study. They soundly expressed the need to explore environmental factors that might make independent financial sustainability for FQHCs unrealistic or impractical, despite capacity building efforts. Additionally, focus group members also confirmed the importance of the ACA for its impact on FQHCs. They thought it important to explore the opportunities and challenges it presented for capacity building, as well as its importance as a compelling representation of the changing environment and signal of the need for change in how FQHCs do business and deliver healthcare.

As the focus group data and analysis suggest, the pilot focus group session greatly influenced the development of the in-depth interview questionnaire used in this study. Additionally, and importantly, the discussion and interaction with the focus group alerted me to researcher bias and preconceived beliefs about capacity building and sustainability among New Jersey FQHCs. Specifically, my views about FQHC sustainability were marked by a long-held premise that sustainability is largely (a) driven by a business model approach, and (b) that it should be an organic, and desired, goal and outcome of

capacity building. Moreover, a belief that capacity building can lead to sustainability

independent of reliance on federal funding was unexamined. Some focus group members

contended that a possible underlying assumption behind this belief was that centers were

not already operating as a business or engaging in sound fiscal practices. One participant

said, with the agreement of several members of the group, that:

> …bottom line, the most significant provision for FQHCs under the ACA was money, the infusion of cash directly to the centers. Most health centers have done an excellent job of managing revenues, as evidenced by their longevity and continued ability to service the most vulnerable populations in the state. What they need is money. Most have managed up to now.

The discussion that this statement generated underscored the groups' caution that centers

have long struggled with issues of sustainability, but for many this is not because they

have not engaged in sound financial or management practices. On the contrary, some

group participants felt that most centers, including those in New Jersey have managed to

sustain their businesses despite limited financial resources because they have managed so

well. They have the capacity to operate and to execute sound financial practices; what

they do not have are necessary dollars. Importantly, as stressed before, the reasons for

their lack of financial resources, and sometimes their inability to generate new sources of

income, are beyond their control. Most New Jersey centers have managed to survive and

to continue to provide critical services to disadvantaged populations despite their

mandate to take all patients, regardless of their ability to pay for their care.

Others maintained that while they agreed with this point, the issue of health center

sustainability is critical and should be studied to ensure future availability of FQHC

services. However, it should be explored in a way that examines and identifies those

factors that influence capacity building and sustainability, including centers' ability to

institute improved fiscal practices and policies. One participant, who has long advocated

for FQHCs, strongly cautioned that the examination of sustainability in centers should

not be conflated with beliefs that centers should strive to build capacity primarily for

independent sustainability; "FQHCs are small businesses and need to manage and run the

organizations as such…but not necessarily with a goal of independence from public

support." Group members agreed that centers need to ensure they can always thrive, but

their sentiments about independent sustainability are interpreted to mean that FQHCs

should not bear the total burden for caring for indigent, uninsured populations—

populations they are mandated to serve. This discussion led this researcher to reflect

more on the value that many in the industry place on the center's role as safety-net

providers and the belief that their role as such is a public, societal benefit, the cost of

which should be shared. The focus group discussion underscored important, long-held

debates about social responsibility for healthcare for unserved or underserved citizens. Is

government responsible for the well-being of these citizens? Who should pay to ensure

that basic healthcare needs are met, especially for children and the elderly? These are but

two of the many related questions that go beyond the scope of this study, but the

perspectives of the group members on financial independence and sustainability for

FQHCs raise important considerations about how we view issues of sustainability for

organizations like FQHCs that are commissioned to care for vulnerable groups. The

ACA, in declaring FQHCs essential providers for primary care for these populations

provides an opportunity for centers and supporters of FQHCs to make this case and to

reinforce the need for shared public and private resources to ensure capacity building and

sustainability of safety-net organizations like FQHCs.

The group's deliberations encouraged the inclusion of interview questions designed to provoke a rich, in-depth understanding of the main concepts that pertain to this study and to generate more meaningful, deep insights to address the three main research questions. Thus, as already noted, questions and topics suggested by the focus group were added to the in-depth interview tool and/or used to clarify the intent of parts of the tool. Specifically, questions and probes were added to understand the interviewees perspectives about the relationship between capacity building and sustainability and the environment in which they operate. The tool included new questions to understand perceptions about engaging in capacity building to achieve sustainability "independent of external support."

Questions were also added to elicit greater understanding of interviewees' perceptions about the centers' pre- and post-ACA level of preparedness and to understand where the research interviewees thought capacity could be augmented and how.

Focus group members agreed that New Jersey centers, by necessity, are very responsive to, and adept at, molding their strategic focus, plans and goals to align with the specifications of their primary sources of support and funding. They emphasized this point to highlight that ACA funding to FQHCs was targeted primarily for expansion of access to care. While FQHCs might have a more comprehensive view of capacity building, ACA funding might have led many centers to operationalize the concept of capacity building strictly in accordance with the ACA goals. Centers may view capacity building narrowly as the expansion of access capacity rather than as a continuous process for enhancing organizational operations and practices, in respect to the ACA. Questions were added or refined for the in-depth interview tool to explore performance

enhancement activities that participants might not readily describe as capacity building, but which are consistent with capacity building as described in the capacity building literature.

Finally, I initially thought to include an extensive line of questions about PCMH status as a framework for exploring capacity building in New Jersey FQHCs. Instead, at the suggestion of the focus group I included one open-ended question to gain a better understanding of how the interviewees perceived the value of PCMH in promoting capacity building.

In all, findings from the focus group data helped to refine the interview guide. The final in-depth interview guide is included as Appendix C. As noted, the focus group experience also enabled this researcher to examine and acknowledge researcher bias and to position my interactions and conversations during the interviews, as well as in the data analysis and reporting, carefully and responsibly.

**CHAPTER 6: CONCEPTUAL FRAMEWORK FOR MAPPING CAPACITY IN
THE HEALTH SECTOR**

This study used "Measuring Capacity Building," the widely cited work of Brown et al., (2001), to aid in organizing and analyzing data from the interviews conducted for Phase 2 of this study. In this work, Brown et al., (2001) developed the Conceptual Framework. They introduced the model as a tool for understanding the relationship between capacity building and performance across the healthcare sector and to advance greater comprehension regarding the evaluation and measure of capacity building and its impact on improving healthcare and healthcare outcomes. The Conceptual Framework consists of two parts: an overview of the capacity levels within the healthcare sector and their interconnectedness (Figure 6), and a depiction of each capacity level within the healthcare system. Both parts of the Conceptual Framework are clarified below in this chapter. But in the second part, the Health Service and Civil Society Organizations level of the Conceptual Framework (Figure 7) is most relevant to mapping and understanding capacity building in healthcare organizations like FQHCs.

As a reminder, this study examines three key concepts to fully address the associated research questions. The key concepts are capacity building, sustainability, and the Affordable Care Act. The Conceptual Framework contributed importantly to the selection and refinement of codes and themes that were used in organizing this study's data as it relates to each key concept. It provided a useful model for mapping the data and succinctly depicting capacity components, which are defined further in this chapter, and that are believed to influence capacity building and sustainability in New Jersey FQHC's under the ACA. Also, as discussed previously, for this study I used a composite

definition of capacity building that evolved over the course of this study with increased

knowledge of the concept and how it relates to FQHCs. The composite definition

captures the commonly held elements of the term found in the literature. It also reflects

input derived from the pilot focus group, but mostly it borrows heavily from the

definition proposed by Brown et al. (2001). Once again, here, and for the purposes of

this study going forward, capacity building means the process that enhances the ability

and preparedness of systems, persons, organizations or communities to meet objectives or

to perform as expected, toward sustainability, or greater self-reliance over time. Capacity

is defined as having the ability/resources/influence achieved through capacity building to

perform as expected or planned. This understanding of capacity building and capacity

guided my exploration of how FQHC team members conceptualized and operationalized

those terms to manage opportunities and challenges under the ACA. The definitions

point to preparedness, performance, and self-reliance, as well as the capability to achieve

desired goals and effect long-term impact.

The Conceptual Framework includes capacity components found in other models

that also attempt to explain the concept of capacity building. It defines internal and

external components that are believed to be critical to capacity building and sustainable

progress or improved performance and outcomes. The Conceptual Framework also

highlights assumptions about the relationship between aspects of capacity and capacity

building and the need for further study to explore those assumptions. First, it identifies

multiple dimensions of capacity building which include four broad, capacity levels within

a healthcare ecosystem. The four levels are depicted in the overview of the framework as

shown in Figure 6. This overview is an illustration of four capacity levels within the

healthcare ecosystem. These four levels are: (a) health system; (b) organizations; (c)

health program personnel; and (d) individual/community capacity. The overview

represents the interconnectivity and interdependence between the levels that are theorized

to influence capacity, performance, and sustainability over time, all of which are essential

to achieving improved health status outcomes. Moreover, it illustrates that at all levels,

performance and sustainability are also influenced by community and individual level

capacity and behaviors, and external environmental factors.

Figure 6

Overview Conceptual Framework

Note: This conceptual framework illustrates the role of capacity at the health systems level. It depicts the relationship between the levels of the healthcare system and capacity at the different levels and performance. "Measuring Capacity Building" by L. Brown, A. LaFond, and K. Macintyre, 2001. University of North Carolina. www.cpc.unc.edu/measure
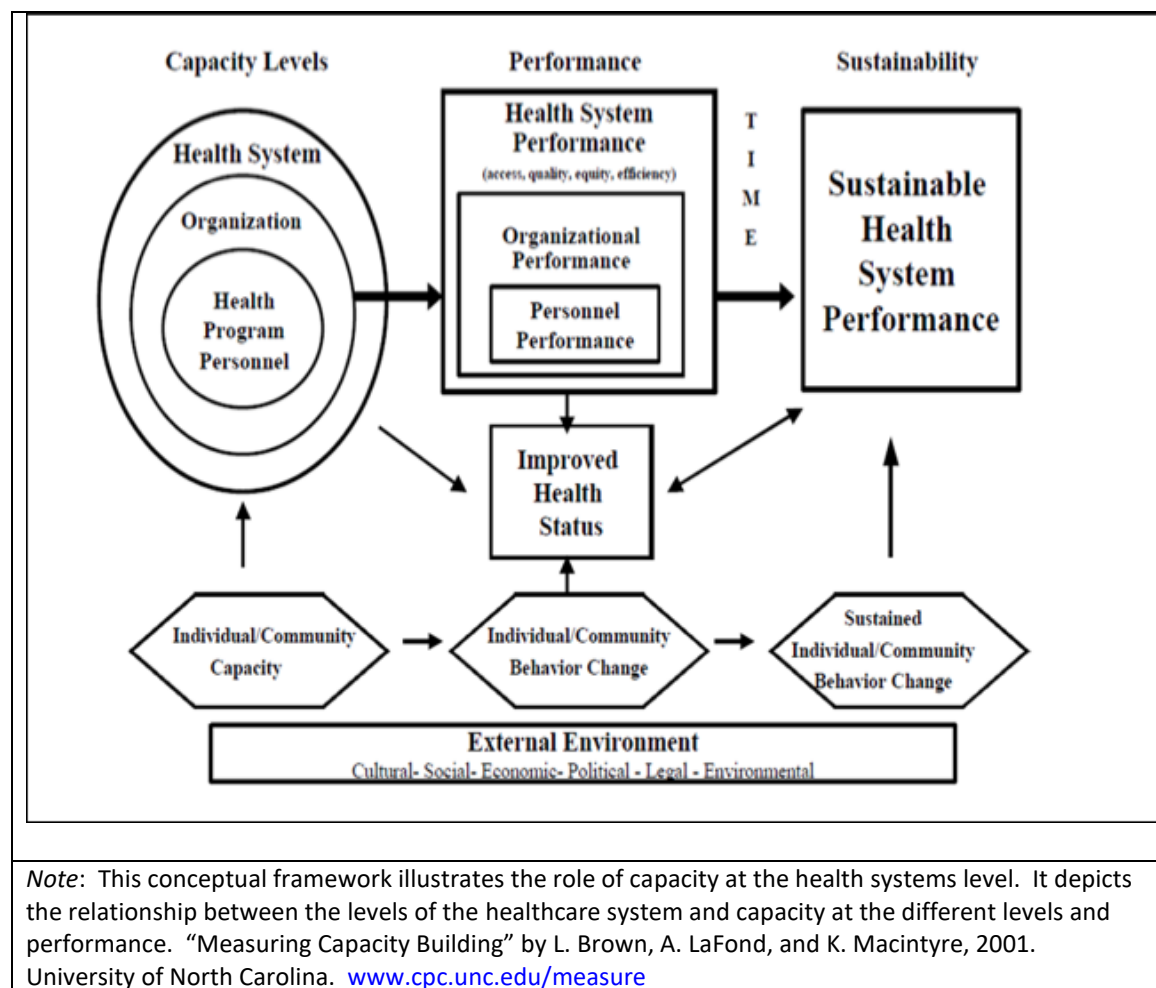
Each of the four capacity levels of the Conceptual Framework, shown here in

Figure 6, is defined in Table 4. Definitions found in this table are paraphrased or quoted

from Brown et al. (2001). The authors noted that most of the work and literature related

to capacity building in the health industry focuses on the organization and health

program/personnel capacity levels. However, the Conceptual Framework also

emphasizes the individual/community capacity level because it is increasingly recognized

as an important component in the health sector. Individuals and communities contribute

to the management of their health and the sustainability of healthcare institutions. They

provide feedback or engagement that can inform operations and organizational business

and care delivery strategies. Brown et al. also noted that inclusion and study of the

overall health system level is an important dimension of capacity building; it has emerged

as the critical dimension for sustainability and integration of the other capacity levels.

Table 4

Conceptual Framework—Definition of Capacity Levels

Capacity Level	Definition
Health System Level	This level represents the entirety of the healthcare sector; it is influenced by its component parts (organizations, personnel, individuals and communities) but it also influences the capacity and performance of those entities. The system provides 4 important functions to influence capacity across all levels: financing; provision of support services; resource generation; and stewardship. Stewardship includes setting a strategic direction for all; monitoring actors, rules and regulations; and helping to ensure the capacity of components /dimensions of the system
Organization Level	This level includes the structures, processes, and management systems necessary for organizations to function effectively and to adapt to changing circumstances. It includes processes necessary to transform human, financial and physical capital into tangible services.
Human Resources (Health Program Personnel) Level	This level encompasses the collective body of people who work in the health system. It includes every category of personnel needed to ensure performance across all four levels.
Individual or Community Level	This level comprises individuals and communities, which are key to building sustainable health systems and organizations. The participation of each in feedback, consumer engagement, advocacy, and managing their own or population health, etcetera is paramount to the sustainability of institutions and systems.

Note: Table 4 is a summary of Brown et al., description of each level of the healthcare system. "Measuring Capacity Building" by L. Brown, A. LaFond, and K. Macintyre, 2001. University of North Carolina. www.cpc.unc.edu/measure

As noted, the second part of the Conceptual Framework, Figure 7, depicts a subset of frameworks that are related to each of the identified capacity levels shown in the overview of the model in Figure 6. The subset of frameworks illustrates capacity components and variables, which are those factors that are believed to be necessary at each capacity level to effect performance and desired outcomes. This study focuses primarily on the Health Service and Civil Society Organizations level of the Conceptual Framework depicted in Figure7. Herein, this level of the framework is referred to as the organization level. The capacity components for all levels are described as inputs,

processes, outputs, and intermediate outcomes. The capacity components for the

organization level are shown in Figure 7. Each component includes multiple variables

that effect processes and outputs to achieve desired outcomes at this level. Figure 7 also

shows external factors (health system environmental factors), which encompass variables

that impact the entire health sector across each capacity level. External factors include

the social, economic, political, and regulatory environment, as well as local culture, and

so forth. Both capacity components and external factors define the context within which

capacity building occur

Figure 7

Health Service and Civil Society Organizations

Inputs	Process	Outputs	Intermediate Outcomes
Mission **Leadership** **Organizational structure** **Finances** **Supplies** **Infrastructure** **Human Resources** **- Technical** **- Managerial** **History and Culture**	**Strategic and Operational Planning** **Human resource management and development** **Logistics/supplies management** **Quality assurance** **Research and evaluation** **Coordination with other units** **Resource mobilization** **IEC** **Advocacy** **Community mobilization**	**Strategic and Operation plans** **Staff trained and supported** **Functional management systems (i.e. supplies available, supervision done)** **Functional financial management systems (i.e. Resources available, costs contained)** **Functional health information and communication system (information collected, analyzed and used)** **Functional service delivery systems (i.e. services available)** **Regular IEC and community mobilization activities**	**Capacity to assess and cope with environmental change** **Responsiveness to client** **Financial self-reliance** **Community involvement** **Service cost effectiveness** **Quality control**

Health System Environmental Factors

Adapted from "Measuring Capacity Building" by L. Brown, A. LaFond, and K. Macintyre, 2001. University of North Carolina. www.cpc.unc.edu/measure

The Conceptual Framework explains the capacity components as those resources that are critical to drive the operational functions which lead to the desired outcomes or products as well as ensure the long-term impact necessary to achieve sustainable systems and improved health outcomes. Table 5 includes the Brown et al., (2001) definitions of capacity components.

Table 5

Definition of Capacity Components: The Conceptual Framework for Mapping Capacity in the Health Sector

Capacity Component	Component Definition
Input	Set of resources, including service personnel, financial resources, space, policy orientation, and program service recipients that are the raw material required to perform functions at each capacity level (system, organization, health personnel, and individual/community)
Process	Set of activities or functions by which the resources are utilized in pursuit of the expected results
Output	Set of products anticipated through the execution of the functions or activities using the inputs
Intermediate outcomes (or performance at the organization, health personnel and individual/community levels)	Set of short-term results expected to occur as a direct result of the capacity built at all four levels (system, organization, health personnel, and individual). The four levels together contribute to overall performance at system level.
Ultimate outcomes (impact)	Long-term results achieved through the improved performance of the overall health system (at all levels): sustainable health system and improved health status

Note: Table 5 provides definitions of the terms (capacity components) used in conceptual framework. From "Measuring Capacity Building" by L. Brown, A. LaFond, and K. Macintyre, 2001. University of North Carolina. www.cpc.unc.edu/measure

Brown et al., (2001) stress that although the magnitude of the desired outcomes may be larger at the health system level as opposed to the health organization level (i.e. the health of a country versus the health of a community or population), many of the same capacity component variables related to process and performance are necessary at both levels. For example, process capacity variables, such as financial management and human resource management, are essential capacities at both levels to ensure access to care and quality services across the entire system and at each stratum of society. The Conceptual Framework assumes the interaction of capacity components and external factors within and across each capacity level to drive performance and outcomes. It demonstrates that the levels are interdependent; one cannot function successfully without another.

Nevertheless, despite the simple but important recapitulation of interaction and interdependence, the Conceptual Framework does not demonstrate the direct role or level of influence that the capacity components play in capacity building. Instead, it depicts a link or relationship between variables and provides a tool for understanding those factors that are associated with capacity and capacity building, its presence and impact, and the gaps in capacity that may exist at each level of the overall healthcare system. Identifying gaps in capacity is important for determining areas for needed capacity building (Brown et.al., 2001; Meyer et al, 2012). Although the relationship between the capacity components and variables at each level is not yet fully understood, the Conceptual Framework maps out the most widely cited components and environmental factors believed to contribute to capacity building at each level of the healthcare system.

In all, the Conceptual Framework (Brown et al., 2001) clearly demonstrates that capacity and capacity building are dynamic phenomena, which are related to or influence effective performance toward achieving planned outcomes. It also illustrates the relationship between performance and sustainable improvements in health outcomes, processes, and influence. As previously explained, the framework emphasizes that there are multiple levels and dimensions of a comprehensive healthcare system. It depicts the interconnectivity, and the way varied public, private, and community level organizations are essential in any comprehensive health system. Each level is required to ensure the provision and coordination of all aspects of care delivery, management, and regulation. FQHCs are important service delivery provider organizations within this landscape.

The Conceptual Framework provided a useful model for framing and analyzing the interview data. First, I used the defined capacity components and external factors for the organization level of the Conceptual Framework, as shown in Figure 7, as well as components found in the framework at the systems level in developing the probes used in the in-depth interview guide for Phase 2 of the study (See Appendix C). They were incorporated as topics for exploration and discussion. The relevance of the selected components was confirmed by the focus group data and the capacity building literature. Many of the same components and related variables, such as infrastructure, leadership, fiscal/economic systems, and strategic planning are consistently described in the larger body of capacity building literature as important contributing factors (Corrigan & McNeil, 2009; Meyer et al., 2012; Potter & Brough, 2004). The pilot focus group members in Phase 1 of the the study confirmed the importance of the selected capacity components as important variables or topics for exploration and understanding of capcity

building in FQHCs. The reader should note that across the literature and within this study, some capacity components or variables may be labeled differently but upon examination they seen to refer to the same phenomena. For example, in the literature, inputs such as human resources may be referred to as personnel, supervisory staff, or workforce.

Second, the Conceptual Framework was also used to help guide analysis of the interview data. Capacity components found in the framework were used as topical codes to organize the data, and also to map the interview data to identify thematic patterns linked to each of the research questions and key concepts. As emphasized previously, while mapping does not show observed evidence about the link between the capacity components and the key concepts, it is used here as a tool to illustrate how capacity components that were found to be significant in the data relate to each of this study's key concept and research questions. It aids in understanding factors that are considered critical to organization performance at the healthcare level (Brown et al., 2001).

Tables 6–8, Mapping Capacity Building in New Jersey FQHCs, illustrate how the research data was organized for each of the research questions and its respective key concepts. Tables 6–8, herein referred to as the concept maps, highlight those capacity components and environmental factors at the organizational and systems levels that are believed to be important to this study and to the data analysis for each research question. Table 6 illustrates those factors and key thematic findings that are related to capacity building and research question one; table 7 illustrates factors and findings related to the ACA and research question two; and Table 8, those for sustainability and research question three.

At the initial stage of coding, the interview data was organized very broadly under each of the concepts, where relevant. It was further coded and categorized under topical and subtopical codes within each concept (herein both are referred to as topical codes). These topical codes consisted of identified capacity components and variables, including pertinent environmental factors. Once categorized, these codes were then translated into themes that connect to and amply respondents' views and understanding of each of the key concepts, and aid in answering the corresponding research questions. These themes represent respondents' most salient views about their centers' approach to and engagement in capacity building, as well as those capacity components that influence successful performance and sustainable achievements, specifically under the ACA.

Table 6

Mapping Capacity Building in New Jersey FQHCs—Key Concept: Capacity Building

Key concept and associated research question	Capacity components and variables	Themes	Lists of broad codes and sub-codes
Key concept: capacity building **Research question**: What is the capacity of New Jersey FQHCs to perform as essential providers under the ACA and to sustain expansion and access?	**Inputs**: knowledge leadership [a] [b] history [a] [b] culture [a] [b] human resources [a] mission [a] regulatory environment [a] [b] finances orientation **Process**: training operational functions financial management [a] quality assurance [a] [b] collaboration [a] [b] advocacy [a] **Outcomes**: strategic and operations plan functional management financial and clinical care systems [a] [b] increased financial self-reliance [a] functional IT [a] [b] coalitions [a] [b]	Organizational orientation toward capacity building shapes the approach to and understanding of capacity building. Patient centered and community focused orientation is a central driver for capacity building. Expansion of access capacity is a key goal for capacity building. Evidence of operational enhancements, readiness, and ability to perform exist among centers. Centers adopt a business-as-usual approach to capacity building.	definition of CB and capacity access quality ability to see more patients operational performance customer service knowledge culture organizational structure board composition staff and leadership training internal communications part of what we do without calling it CB PCMH preparation CQI planning

[a] Focus Group Data
[b] Interview Data

Table 7

Mapping Capacity Building in New Jersey FQHCs—Key Concept: ACA

Key concept and associated research question	Capacity components/variables	Themes	List of broad codes and subcodes
Key concept: Affordable Care Act (ACA)	**Inputs:**	The ACA presented a "mixed bag" of opportunities and challenges for FQHCs.	transformation trends
	infrastructure policies [a] [b]		ACA provisions, ACA grants, benefits, and challenges
Research question:	leadership [a] [b]		
	social and demographic factors [a] [b]		
What is the impact of the ACA on capacity building in New Jersey FQHCs?	finances [a] [b]	Sub-themes for opportunities:	industry competition
	collaboration [a]	a) new Funding	FQHC expansion
	Process:	b) Medicaid expansion;	
		c) heightened influence.	technical assistance, HRSA influence
	strategic plan coalitions		
	marketing and communications plan [a]		community influence
	trained workforce	Sub-themes for challenges:	state policy
	Outcomes:	a) critical losses in patient volume and income.	advocacy
	competitive service delivery system [a] [b]		social/political capital
	expansion [a] [b]	External factors— Public policies and regulations— adversely impact capacity building.	
	increased access [a] [b]		
		Sub-themes for external factors: a) auto-assignment of patients to providers; b) changes in reimbursement methodologies	

[a] Focus Group Data
[b] Interview Data

Table 8

Mapping Capacity Building in New Jersey FQHCs—Key Concept: Sustainability

Key concept and associated research question	Capacity components/variables	Themes	List of broad codes and sub-codes
Key concept: sustainability **Research question**: Can FQHCs leverage the opportunities afforded by the ACA to build greater capacity toward sustainability?	**Inputs**: mission [a] [b] finances [a] [b] history and culture [a] [b] leadership [a] [b] political capital [a] resource allocation health policy laws and regulations [a] [b] marketing [a] donor coordination finances **Process**: strategic planning financial management [a] resource mobilization [a] [b] collaboration **Outcomes**: strategic finanical plan coaliations [a] [b] viability [b] increased self-reliance [a] [b]	Mission vs. margin—are perspectives that frame issues of sustainability for FQHCs. Operational enhancements to address infrastructure needs, aid in efforts to develop greater self-reliance and sustainability. External influencers affect FQHCs efforts aimed at greater self-reliance and sustainability.	mission vision strategic plan CHC history, viability charity care policies and regulations FQHC reimbursement communications plan quality improvement structure providers industry competition HRSA requirements community impact of state advocacy, social and political capital

[a] Focus Group Data
[b] Interview Data

Some capacity components and variables used in analyzing the data for this study were

predetermined by this researcher based on the Conceptual Framework, the capacity

building literature, and input from the pilot focus group. Significantly, some of the same

components were introduced organically during the interviewees by the participants

themselves. They articulated those components or variables that they thought important

in expressing their views about each of the key concepts. As might be expected, there was overlap in the components that were highlighted across all sources. However, it underscores the importance of the identified capacity components in understanding capacity building in FQHCs and their significance to this study. Again, Tables 6–8 depict the capacity components that are relevant to each of the key concepts for this study and research questions.

The information in the tables also highlights the coded data linked to the capacity component variables. In some instances, the same text was coded in multiple ways. Where patterns in the codes emerged, the researcher synthesized the data under the most pertinent capacity component to develop related themes. Some examples of this include use of the the terms "knowledge," definition," and "access" as topical codes to capture study participants' own understanding of capacity building. In this instance, the researcher was especially interested in claryfing whether or not study participants demonstrated a conscious understanidng of capacity building or if they engaged in capacity building without naming it as such. All data relating to their understanding of capacity building and of the other concepts were ultimately coded as knowledge.

Altogether, the Brown et al., (2001) Conceptual Framework enabled mapping and analysis of the research data. It guided the construction of the data analysis framework for Mapping Capacity Building in New Jersey FQHCs (Tables 6–8). The tables succinctly depict the salient capacity components and key thematic findings related to the key concepts and main research questions. To reiterate, the map of this data illustrates the main study interviewees' perspectives about the relationship between critical capacity building components and this study's research questions. The data analysis and key

findings as illustrated in each of the concept maps for the respective research questions

and key concepts are detailed in Chapters 7–9.

CHAPTER 7: RESEARCH STUDY RESULTS—INTRODUCTION AND
RESEARCH QUESTION ONE: CAPACITY BUILDING

This chapter, along with Chapters 8 and 9, presents the findings from Phase 2 of this study, the in-depth interviews. The study results outlined in this chapter address the main research question: What is the capacity of New Jersey FQHCs to perform as essential providers under the ACA and to sustain access over time? As previously described in Chapter 6, this phase of the study relied upon the Brown et al., (2001) Conceptual Framework to guide analysis and reporting of the interview data. The analysis process involved linking the coded information to critical capacity components to identify thematic patterns of meanings in the data that address the research questions. This is illustrated in Chapter 6 in Tables 6–8: Mapping Capacity Building in New Jersey FQHCs. As detailed in that chapter, I refer to the three tables as concept maps. The concept maps illustrate the significant study findings for each of the primary research questions. This chapter, and Chapters 8 and 9, are organized accordingly. To facilitate reference to the data that are most relevant to each research question, the appropriate concept map is repeated at the beginning of each respective chapter for easier reference.

In reporting the study findings, this researcher was careful to ensure the confidentiality of the respondents. Therefore, interviewees are referred to in the third person as "they." Participants are also referred to by title, including Chief Executive Officer (CEO), Chief Medical Officer (CMO), Chief Financial Officer (CFO), Director of Nursing (DON), and board member. Other interviewees are referred to by their job function: front-line staff member (includes biller and outreach worker) and clinical staff (includes physicians, dentists, advanced practice nurses). References to respondents by

title or job function are used only when no association can be made with the person or their respective centers. FQHCs represented in this study are not identified by name or location.

Once again, the in-depth interview phase of this study involved 20 interviewees (N=20) from 10 different New Jersey FQHCs. (See Table 3, Chapter 4).

Research Question 1 and Key Concept: Capacity Building

The key goals in exploring the primary research question were (a) to gain in-depth knowledge about how FQHCs view and engage in capacity building, and whether they deliberately engage in it to advance the goals of the organization in a purposeful and sustainable way, and (b) to understand the readiness and long-term capabilities of the centers to be key providers in an evolving healthcare environment. The data generated five themes that address the main research question and the goals stated above: (a) organizational orientation (i.e. values, mission) shapes the approach to, and understanding of, capacity building, (b) patient-centered and community focused orientation is a central driver for capacity building, (c) expansion of access capacity is a key goal for capacity building, (d) evidence of operational enhancements, readiness and ability to perform exist among centers, and (e) centers adopt a "business as usual" approach to capacity building. Each theme and the related capacity components are explored in this chapter. Table 6 illustrates these thematic findings, and as previously noted, is repeated from Chapter 6.

Table 6

Mapping Capacity Building in New Jersey FQHCs—Key Concept: Capacity Building

Key concept and associated research question	Capacity components and variables	Themes	Lists of broad codes and sub-codes
Key concept: capacity building **Research question**: What is the capacity of New Jersey FQHCs to perform as essential providers under the ACA and to sustain expansion and access?	**Inputs**: knowledge leadership [a] [b] history [a] [b] culture [a] [b] human resources [a] mission [a] regulatory environment [a] [b] finances orientation **Process**: training operational functions financial management [a] quality assurance [a] [b] collaboration [a] [b] advocacy [a] **Outcomes**: strategic and operations plan functional management financial and clinical care systems [a] [b] increased financial self-reliance [a] functional IT [a] [b] coalitions [a] [b]	Organizational orientation toward capacity building shapes the approach to and understanding of capacity building Patient centered and community focused orientation, a central driver for capacity building Expansion of access capacity is a key goal for capacity building Evidence of operational enhancements, readiness, and ability to perform exist among centers. Centers adopt business as usual approach to capacity building	definition of CB and capacity access quality ability to see more patients operational performance customer service knowledge culture organizational structure board composition staff and leadership training internal communications part of what we do without calling it CB PCMH preparation CQI planning

[a] Focus Group Data
[b] Interview Data

Defining Capacity Building

In answering the main research question related to capacity building and FQHC

readiness under the ACA, I sought first to understand the interviewees' perspectives

about the concept of capacity building. How do they define or describe it, and what constitutes capacity building? The participants expressed differing interpretations or understandings of capacity building. Mostly, when asked how they defined the concept, they did not provide a concise definition. Instead, eighteen of the twenty respondents tended to describe characteristics of the concept, including the fact that it is influenced by external factors; still, with some overlap, five of the interviewees did offer that capacity building is also a continuous process. All respondents identified capacity components that are necessary to effect capacity building, such as leadership or functional operational systems. Further, and significantly, all participants articulated a specific orientation, especially a patient-centered orientation toward healthcare, that framed their understanding of the concept. Those who expressed an understanding of the concept as more of an outcome rather than a process articulated a frame of reference that was in keeping with their understanding of the mission and values of FQHCs. Additionally, their orientation toward healthcare and their view of capacity building shaped participant's perspectives about organizational readiness and the ability of FQHCs, altogether, to perform as essential providers for newly insured individuals because of the ACA.

To the extent that participants were focused on centers' ability to achieve their mission and to improve access to care as a major goal for capacity building, they strongly expressed a patient-centered/community-focused orientation in how they described capacity building; they described furthering the mission and the FQHC model of care as a desired outcome of capacity building. These participants (14 or 70%) formed the core group of participants who demonstrated that how centers frame their understanding of the

concept also aids in understanding their approach to capacity building and importantly how they also frame their readiness to perform as essential providers.

With further probes, participants offered additional insight into their understanding of capacity building, especially in respect to the ACA. They described the organization's goals for capacity building—again anticipated outcomes—in conveying their understanding of the concept. Participants however sometimes described organizational goals as strategic goals and sometimes as being opportunistic goals (i.e. goals that aligned with available grant funding independent of organizational strategic plans). Importantly, they reiterated the ACA's goal for expansion of access capacity as the primary goal for capacity building in their organization in response the ACA. To the degree that centers were able to effect new access capacity, some participants viewed their organizations as being prepared and ready as the ACA unfolded.

The five interviewees, noted above, who described capacity building as a continuous process described an understanding of the concept that is more aligned with widely accepted definitions of capacity building that are found in the research literature. This smaller cohort of interviewees explained their view of capacity building as a deliberate, strategic process to improve performance. They also described a more systemic approach to capacity building within their organizations, as opposed to capacity building to enhance a singular aspect or level of the organization's infrastructure, programs, or services. They readily cited evidence of capacity building occurring within their centers, although they differed in their view about the impetus for the organizational enhancements, just as others did with respect to the goals for engaging in organizational enhancements. But for this group, regardless of the catalyst for engaging in capacity

building, they viewed it as necessary for their ability to perform as essential providers.

The themes for this research question, and which are listed in Table 6, are detailed in the

rest of this chapter.

Organizational Orientation: Shapes Approach to Capacity Building Theme

Respondents revealed different orientations in how they explained or talked about

capacity building. As previously detailed in the methods chapter, I used a word-cloud

tool to give a visual representation of the data, to illustrate how respondents thought

about and framed their understanding of capacity building in response to the research

questions. This researcher discussed the word-cloud data points first in reporting the

research findings related to this theme to highlight participants' orientations or the

context through which they view capacity building. Three of the more significant word-

clouds are depicted in this chapter.

The word cloud in Figure 8 illustrates how CMOs and other clinical staff

members expressed their view of capacity building. The term or data point highlighted in

this word cloud is the word "patients." This segment of participants also talked

frequently about services, adequate care, resources and sustainability. Similarly, the

word cloud in Figure 9 shows that front-line staff members also spoke about the patients

most often in describing their understanding of capacity building.

Figure 8

Word Cloud—Definition of Capacity Building: Clinical Staff
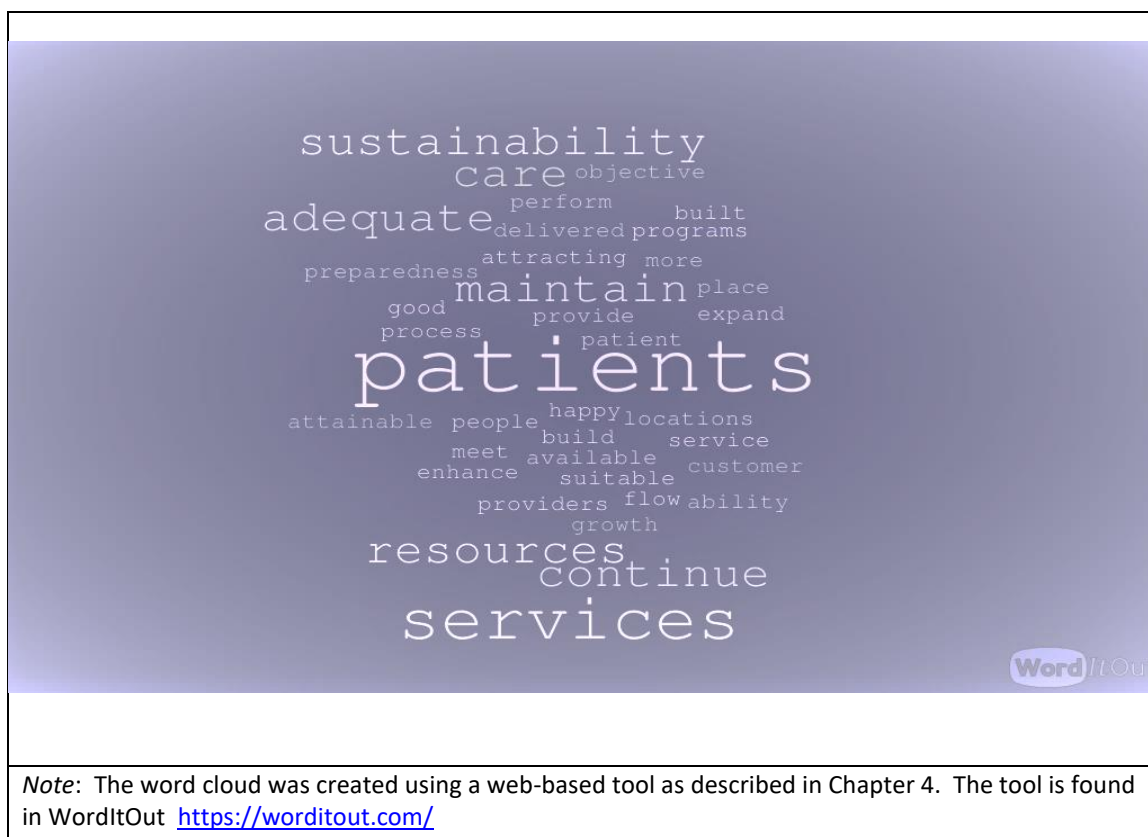
Note: The word cloud was created using a web-based tool as described in Chapter 4. The tool is found in WordItOut https://worditout.com/

Figure 9

Word Cloud—Definition of Capacity Building: Front-Line Staff

Note: The word cloud was created using a web-based tool as described in Chapter 4. The tool is found in WordItOut https://worditout.com/

The interview data provided important context for the visual representations here. Together, the illustrations in Figures 8 and 9 depict what I interpret as a patient-centered orientation and characterization of capacity building. The word clouds illustrate views that are consistent with the healthcare industry and ACA's emphasis on patient-centered primary healthcare as the preferred model of care in a transformed healthcare system. The interview data also underlines the patient-centered orientation of this group of participants; it highlights how they characterize capacity building, and how they view their center's approach to it. Focusing on the interview data, three clinical level

respondents emphasized the patient-centered frame of reference in describing capacity building. One participant described their view of capacity building by stating, "from the standpoint, it [sic] [capacity building] would be to maintain the patients that we have and continue to build and expand on that, with trying to make sure that healthcare is attainable to everyone." This participant expressed their understanding that capacity building first involves ensuring greater access to healthcare for patients. Another clinical-level respondent offered that capacity building is, "to be able to offer quality and, to have good patient experiences." This participant emphasized that capacity building in FQHCs should entail efforts to enhance the patient experience. They explained that patients should always expect to receive quality healthcare services because of capacity building in healthcare, and especially in FQHCs. Capacity building should also help to ensure a good patient/provider relationship. Most importantly it should lead to improved health outcomes, consistently. A third participant offered that "patients should be at the top or the main focus of capacity building." Further, additional interview data showed that all clinical and front-line-staff level participants aligned with this view, in which the participant quoted here clearly underscored a patient-centered orientation in explaining why FQHCs pursue, or should pursue, capacity building. Brown et al., (2001) argues that a central capacity component associated with interpreting capacity building at the systems and organization levels in healthcare is the attainment of ultimate outcomes or long-term impacts resulting from capacity building. The ultimate outcome and evidence of it, from the perspective of all those who espoused the patient-centered orientation to capacity building, is succinctly stated below by one clinical level interviewee. This

interviewee said capacity building is "being able to serve the patient. Our focus should always be on the patient."

High quality patient services that result in improved healthcare outcomes and the overall well-being of FQHC patients defines these interviewees' perspectives or orientation to capacity building, how they intellectualize the concept, and importantly, their view of how their respective centers approach capacity building.

A third word cloud, Figure 10, depicts the recurrent data points that illustrated how CEO level participants framed their understanding similarly. Although they often repeated words or phrases like those used by the CMOs and front-line staff members in describing capacity building, the CEOs tended to emphasize a focus on the community and community needs, in addition to the individual patient, as illustrated in Figure 10.
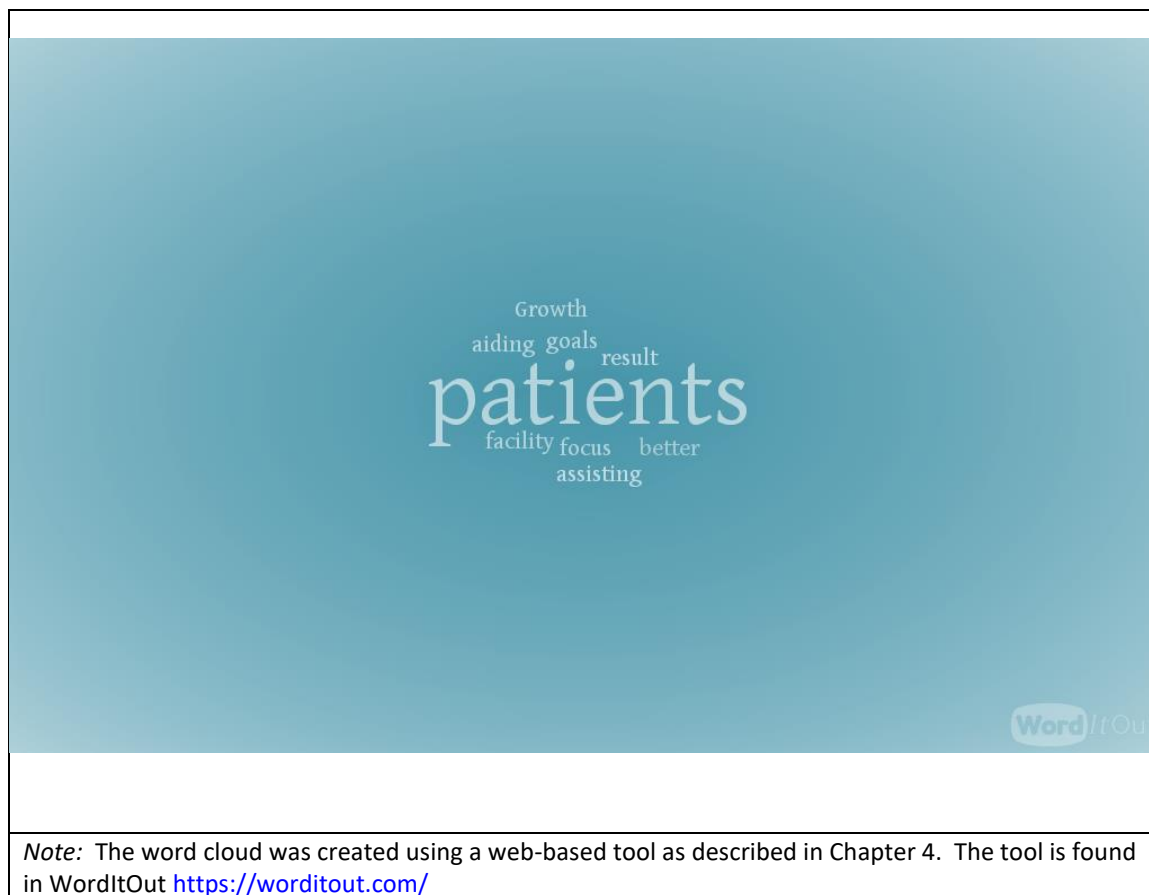
Figure 10

Word Cloud—Definition of Capacity Building: CEOs

Note: The word cloud was created using a web-based tool as described in Chapter 4. The tool is found in WordItOut https://worditout.com/

The interview data showed that the frequent mention of community among CEO level participants, as illustrated above, is grounded in their belief that capacity building should enable centers to address health and healthcare at the community level. The interview data illuminated the CEOs' focus on the overall community in how they characterized capacity building. The text below highlights several examples from the interview data that illustrate this:

> Well my understanding [capacity building] is to ensure that we are providing access to the patients and that we perform, or I should say having [sic] high performing community based primary care….

> My understanding of capacity building has to do more with meeting the needs of the patients, the community…. We need to have people and services and programs to meet the needs of the community that we serve.

> I would say really to meet whatever needs of the community in which we are housed…that we make sure that those primary healthcare needs are met.

The CEO participants tended to define capacity building through a broader lens than that of their staff. Their frequent reference to the community may reflect self-awareness of their larger sphere of responsibility to their entire geographic service area, or it may be influenced by their fidelity to FQHCs' historical role and ties to their host communities, or both. The data suggest the latter.

Again, the interview data underscore the visual depictions of how most study participants framed their understanding or characterization of capacity building. Whether among the leadership, senior-level interviewees, or clinical or front-line staff members, they all view or define capacity building in terms of the impact or ultimate outcome for FQHC patients and the communities they serve. This view is in keeping with the FQHC mission and purpose as community-based and patient-directed organizations. To the extent centers were equipped to engage in clinical care toward these ends, participants expressed a sense of readiness and ability to be essential providers for the long term in reflecting upon their readiness leading up to the implementation of the ACA. Interestingly, sustainability did not readily emerge as a frequently used description or characterization of the concept, except among a few participants. Nevertheless, the predominant orientation expressed by most participants—the patient-centered/community-focused orientation—is explored further in the theme below.

Patient-Centered/Community-Focused Orientation Theme

The patient-centered/community-focused theme percolates across each theme that emerged in the data analysis. As discussed above, this theme emerged from a foundational belief in, and orientation toward, how FQHCs should deliver care and

towards what end. Conventionally, patient-centered/community-focused care (PCCF) encompasses programs or interventions that address health related needs detected and prioritized by the patient or the community. It also refers to a deeper provider connection to the patient or community, and the provider's responsibility to give and to enable healthcare that is based on trust and empowerment of the patient or community as active participants in the management of their own care. As reflected by the word clouds and how participants frame their understanding of capacity building, the PCCF theme underscores participants' perspectives that the patient and the community are at the heart of the FQHC model of care.

This theme reflects the view that in-depth knowledge of the community and the patient population is important in determining capacity building goals for their centers. Such knowledge is important to how centers determine the need for improving organizational capacity and the priorities for their center. As such, participants explained that their center engaged in operational capacity building upon assessing and understanding the populations and communities they serve, their needs and their priorities. One participant offered a salient example of this in discussion of the changing demographics in their host community. Through a planned community needs assessment, their center determined the need to address language barriers to healthcare that persisted for new non-English speaking populations in their host community. The FQHC obtained resources to develop a call center staffed with multilingual personnel for the community's non-English speaking groups. Additionally, they enhanced their human resource capabilities by hiring skilled, multilingual staff members to improve the scheduling process and to increase access to care for their patients and community.

Importantly, participants articulated that because FQHCs are integrally involved in the total well-being of their community and patients, and because they have in-depth, meaningful knowledge that informs the services and resources that are necessary for them to meet identified needs, they were more ready than most providers to serve as essential providers for newly insured populations. Two respondents stressed that the goals of the ACA for FQHCs were a natural fit for their center because of their PCCF orientation, their knowledge of community needs, and their adeptness at meeting those needs. These same respondents reflected that: "we are here to serve populations that need our care…. We look to grow strategically, we weigh the needs of the community and the dynamics in the environment [to guide planning and growth]," and "we are making sure that we understand, we assess, and we truly interact with the people in the community so that we are seeing their needs and…are changing to ensure we can deliver." The central message in these data excerpts is that respondents viewed their experiences and their rapport with the community as evidence of their readiness and their ability to perform as essential providers with respect to the ACA and continuing healthcare reform. In the data excerpts above, the respondents stressed that FQHCs are highly attuned to their host communities. Although centers have seen changes in more recent years, FQHCs have relied on the fact that they have a shared history and culture with their patients and host communities, factors that contribute to their knowledge of the populations served, the priority healthcare issues, and thus to their understanding of where and when capacity building is needed to address those issues.

Following up on one of the original premises of this study, plus the recommendations from the pilot focus group, this researcher introduced the topic of the

PCMH and its influence on the readiness of centers as patient-centered healthcare

providers under the ACA, and as a pathway for engaging in capacity building to ensure

their readiness for change. All interviewees, (except those front-line staff members who

indicated little knowledge about the PCMH model) expounded on the similarities

between the PCMH and FQHC models of care. As noted previously, a few participants

repeated a common view that the PCMH model is the FQHC model. They reiterated that

FQHCs embraced and practiced comprehensive, team-based, patient-centered care before

introduction of the PCMH model. FQHCs are required by statute, described in Chapters

2 and 3 of this study, to ensure comprehensive patient care, to practice team-based care,

to provide case management and coordination of services, including providing or

facilitating access to enabling services for patients (i.e. diagnostic and pharmaceutical

services, and transportation). HRSA regulations also require centers to routinely institute

CQI to affect such care and to measure its impact. The main study interview data herein

confirmed that most study participants agreed in their perceptions about participation in

the PCMH program. They communicated that: (a) obtaining PCMH status was not

critical to capacity building for FQHCs and (b) achieving the designation did not bring

considerable new value. And importantly, it is not what defines FQHCs as a patient-

centered medical home. Again, their experience and their historical orientation to PCCF

care defines their ready ability to perform as expected in the new healthcare arena.

However, some participants did acknowledge their belief that participation in the

PCMH program added some value for centers, albeit not necessarily to promote

organizational capacity building. They explained that while the PCMH designation

helped their centers to improve upon what they were already doing, the greatest value lies

in that it adds prestige to the organizations; importantly, it validates the quality of care

that FQHCs have always delivered. The data illustrate these interviewees' perceptions

about the benefits of PCMH status:

> Yes, I mean it [clinical operations] changed somewhat, it [PCMH] kind of
> allowed us to add additional staff once, which is [sic] chronic-care
> coordinators…. Things like that we did, but kind of…like pulled everything
> together.

> I think people look and say wow, you have accomplished something, you have the
> designation for it... The people don't have to come in to look at your data.
> You have the designation; you sort of assume that you are doing the right
> thing and you are achieving the right outcomes.

> I think, you know, once we've taken the steps to meet the challenge of becoming
> a patient-centered medical home, I think that kind of put everything in the right
> prospective...[sic] I think you know you can talk; you can act like a medical
> practice but, you don't function like a medical practice. I think that's one of the
> advantages of having that type of recognition.

However, as stated here and previously, most interviewees articulated that participation

in the PCMH program is not essential to how they operate or to their ability to improve

how they operate. Also, for some it was not a cost-effective proposition—it did not add

additional financial benefit and it increased their costs. For these interviewees, having

the designation status only attested to their existing capacity and experience as patient-

centered, primary-care providers. They expressed that they would have achieved

capacity building goals for improving patient care or new access capacity without the

PCMH designation, as further expressed by others in the excerpts below:

> We're focused, we are watching our outcomes. It's [PCMH] a good designation
> to have. It sorts [sic] of keeps our cost and expenses down, but I think we would
> have achieved what we did without their designation.
> I just really haven't seen results of that yet. I do know that within our FQHC
> world, it's a great accomplishment when you're able to receive, you know major
> accreditation.

> … I think it's always been [how we deliver care]. We just got accreditation; I believe it was last year.

This set of respondents was clear in articulating that their organizations participated in initiatives like the PCMH not to change how they deliver healthcare, but to reinforce what they are already doing.

While most did not think the designation was necessary, having it publicly underscored their readiness as essential providers and, moreover, their ability to deliver PCCF care. Interviewees reported that others in the healthcare industry valued their experience in PCCF care and their ties to the community as a significant strength in fostering the intent of the ACA for healthcare reform. As such, some interviewees explained that it is a natural progression for centers to expand upon their existing relationships with their host communities to support capacity building aimed at developing new access capacity.

To reiterate and to underscore the importance participants placed on the PCCF capacity of FQHCs, here are additional data excerpts that strongly supported this theme:

> I think it's important to know that we are very dedicated to the community, so it is not just the patients, but also being part of the community and being a resource for the community.

> It's important that in this role, that we keep our pulse on the community needs and that is by making sure that we are constantly assessing what they feel are their needs…to make sure that if necessary that we bring additional resources or we redeploy resources in order to make sure that their needs are met and the only way to know that is to actually make sure we are getting feedback from our patients regarding the services that we provide.

> Some of our staff are from the community. This makes it better to address the needs of the community. They have the personal connection and they have a commitment to the community. This helps to drive our mission and our organization.

>We have some doctors that have been here for years and of course when you have been here for a while people get to know you. And they basically say this is Dr. A's site or that it is who they come to see. We have that recognition in the community, were we are known as some of the best doctors.

>As I explained earlier, we have community people on our board, and staff members who live and work in the community. That makes a difference. People are committed to the center and to what we do. We have support from the community.

In summary, this data, like that discussed previously, illustrate that interviewees believe that FQHCs are experienced, mission-driven, primary-care providers. They have consistently provided patient-centered/community-focused healthcare and they have historically held to the importance of ensuring continuous quality improvement practices to enhance PCCF care. They cultivate and value critical ties and connections to their patients and the communities they serve. As such, respondents embracing the tenets of this theme viewed FQHCs' long-standing competence and reputation for consistently and comprehensively meeting the needs of their patients and the community as evidence of their readiness and their ability to effect capacity building to fully participate as competitive healthcare delivery systems going forward. They strongly supported the notion that FQHCs have and will continue to have the capacity to compete successfully as the healthcare industry evolves because of their experience in, and commitment to, delivering and fostering patient-centered/community focused healthcare. Most participants viewed PCCF care as one of their greatest strengths and evidence of their ability to be essential providers, thus bolstering their ability to overcome and to adapt to changes in the environment. Significantly, this deeply held premise also influences their views about capacity building and the sustainability of their organizations, which is discussed in Chapter 9.

Expansion of Access Capacity Theme

The expansion of access capacity theme (herein referred to as the access theme) is strongly linked with the participants' understanding of the ACA mandate for FQHCs. For those who principally espoused the access theme, their "working definition" of the concept centered primarily on capacity building as an outcome aimed at improving care and the health status of those that they serve through increased access to care; this goal was guided by the ACA mandate for FQHCs. Respondents who informed this theme also maintained their PCCF orientation toward capacity building, but they more readily described the concept as the expansion of access to care, which includes the development of new care delivery sites, expansion of service hours, and the recruitment of additional primary care providers. In this theme, they emphasized their centers' efforts toward growing their ability to accommodate more patients as the anticipated demand for services increased among newly insured patients. Furthermore, they viewed their ability to create new access capacity as important to establishing their position and readiness to participate as essential providers as healthcare reform progressed. Several excerpts from the data show how the interviewees aligned their description of capacity building to correspond with the ACA's goals for increasing access to care. An important reason for this is that they looked to maximize ACA funding toward this end. Coded text that informed the access theme included:

> Capacity building includes expanding access to and increasing the number of people you can see, preparing ourselves to receive the increased number of newly insured into our health systems.

> I look at capacity building as expanding patient volume and utilization. Our primary goals for capacity building are to have more users—to increase our volume…

To receive the increased number of newly insured into our health systems, to have a workforce that was sufficient and facilities that were adequate to serve as new population of newly insured persons…

One of our roles under the ACA—to register as many people for the ACA as possible

The most significant focus is on increasing our market share, since the reforms started to influence access for patients.

They are trying to improve the facilities so that they can accommodate more people

We are definitely going to maintain the sites we have, but we are actually now exploring the opportunities to, maybe, expand in other areas where we are not…so that patients have access…

As noted above, these are descriptions or characterizations of capacity building that focus on expansion of access capacity. Participants described expansion activities such as developing new sites or renovating existing facilities that they recounted as having been a part of their existing, strategic plans for expansion. Up to the implementation of the ACA, they had lacked capital funding to execute those plans. Several interviewees stressed that alignment with the ACA's view of, and goals for, capacity building were in keeping with their long-term plans. The ACA offered an opportunity to secure grant funding or enhanced appropriations for much needed capital improvements. The CEO participants especially expressed that the ACA provided opportunity to realize not only new access capacity but to fund other infrastructure needs to support the new access capacity, as well as to enhance their overall organizational position and performance.

Regardless of their focus on expansion of access capacity, most interviewees who espoused the access theme also demonstrated awareness of the complexities of capacity

building. The data show they were aware that other factors or capacity components,

beyond financial resources, were important to their overall ability to support the

expansions going forward. The CFO who participated in the interviews especially

underlined the fact that although grant dollars were available for creating access capacity,

accompanying funding was not readily available or adequate for ensuring the necessary

staffing levels or system enhancements that are needed to support new access capacity for

some centers.

Other interviewees too noted that ensuring and sustaining new access capacity

requires adequate capabilities across the organization. Centers must also be able to

ensure capacity that includes fiscal management and the existence of functional

operational systems to administer expansion initiatives. Respondents said that centers

must be aware of their own capacity to generate financial resources as a factor in

supporting new access capacity. One participant remarked that all New Jersey FQHCs

may not have the ability to develop new access capacity. Each center should assess this

before pursuing grant funding under the ACA or any grant for expanding access to care.

This interviewee, a CEO, stated:

> You have to be very careful how and if you build capacity. You have to evaluate
> carefully where you are sitting. If you are long on [not have] money, you have no
> business trying to build capacity. You cannot sustain it. It's different at every
> center, and a local decision, about how and if they seek to build their capacity and
> if they can sustain it…. There seems to be a move towards having more sites…but
> as I said, you have to be careful.
> This same interviewee's center secured ACA grant funding and renovated

existing sites to increase access for additional patient volumes at each site. They created

new exam-room space and dental operatories. Additionally, according to the CEO who is

quoted above, their center assured the availability of staffing, equipment, and other

necessary infrastructure capacity to support the expansions. Although this CEO did

describe capacity building in terms of expansion and growing access, upon further

discussion they did reveal an understanding that capacity building is multidimensional.

They also explained that adding new sites was beyond their strategic plans and view of

what they could sustain and remain essential providers. They further underscored their

orientation towards a patient-centered/community-focused approach to capacity building.

They emphasized that "to do capacity building" centers must do, "what makes sense for

their community," saying:

> …each center is different and will do what makes sense in their communities to
> adapt to the change. However, in response to the change we have hired staff, we
> are trying to build the skills within that are needed to deliver care in this model.
> We have new people with new skills. We have restructured our website…to
> attract more patients and providers.…We are looking to build a stronger
> infrastructure and we are upgrading our employee training.

They added that their leadership team, including their board, was attuned to the need for

capacity building to be competitive organizations. As such, their organization

consistently enforced strategic planning efforts and periodic evaluation of those plans as

their internal guide for proactive capacity building, including the development of new

access capacity and the resources to sustain it. They stressed that strategic planning, their

preparedness and their knowledge of trending changes in the healthcare arena prepared

them to take advantage of the ACA funding, which helped to position them to compete as

essential providers going forward.

Similarly, two other participants placed significant importance on the ACA grant

dollars as sources of new funding to fulfill heretofore unfunded strategic plans to enhance

their organizations' existing facilities and to establish new sites toward reinforcing, for

policy makers and funders, their readiness and ability to effect capacity building. They stressed that they were prepared strategically; they needed the financial resources to move forward. The grants provided the opportunity for them to continue with already planned expansions; moreover, the funds allowed them to enhance their infrastructure as well to support new access points. These two interviewees noted that the ACA also offered opportunities to support expansion efforts. It provided funding support to develop or improve critical operational and management systems like health information technology (HIT) systems. These same participants were also among the minority of respondents who articulated that participation in the opportunities afforded by the ACA could lead to greater financial sustainability. They recounted their understanding of the possibilities for enhanced financial reimbursements because of the ACA, but also that this required improved infrastructure capacity to allow them to participate in new reimbursement models. One of these two interviewees excitedly described their center's readiness to seize the grant opportunities, saying: "[There is] a real opportunity sprout in this environment….There is an opportunity out there to put our footprint in our neighborhoods in this area of the [city] but also outside of the [city] area." This same respondent reported the receipt of new capital dollars and their ready ability to use those dollars to establish new access points. They were very intent on developing new access capacity through building numerous FQHCs throughout their catchment area and viewed the ACA as a "tremendous opportunity" to do so. Like their counterparts, however, this CEO also voiced the need to be strategic in seeking grant dollars, for the reasons previously noted by their colleague, but also because it was important to them to control

federal interest in their facilities. This participant wanted to maintain FQHC ownership of the properties; they viewed them as assets to support future sustainability.

Conversely, a smaller number (3) of interviewees was less enthusiastic or confident about their organization's ability to effect new access capacity and thus their ability to obtain significant new funding under the ACA. They acknowledged that they felt their centers were less prepared for expansion than they had hoped, and that creating new access capacity might only serve to worsen their current inability to perform as essential providers under the ACA. They cited the lack of providers and ready financial resources as particular challenges to their ability to engage in capacity building, regardless of how they defined it, and to perform as expected as the ACA progressed. These respondents said, respectively:

> In a way, I would say that we are sort of glad that we didn't get that big explosion (of new patients) because on the side of having an adequate number of providers that's going to take care of a large increase of new patients at once, we were not prepared for that. So, we are sort of glad that we, it didn't happen for us…

> …we tried to prepare almost a year in advance to ensure that we would have those plans in place and I'm sorry to say that some of those plans are still not in place…

> …We do not have a long-term plan to expand services much beyond what we have now, but we want to attract those who are here and not receiving services. Our long-term plan is to bring new patients into the sites and programs that we have already. We can and need to increase our volume for existing sites.

In the last data excerpt, the CFO participant emphasized that their center's existing sites were already underutilized. While their organization wanted to expand, they were not fully utilizing their existing capacity to achieve greater access for patients or the community. Strategically and financially, any new expansion of access capacity posed a risk for their organization. Therefore, their center opted to concentrate on maximizing

utilization of their existing sites by new patients. Their center did not add new services,
enhance or create additional sites, nor did they add new hours of operations or provider
staff. Instead the center concentrated on building their marketing and outreach capacities
to draw new patients within their existing service area to the center. Marketing is an
identified capacity component in some of the literature. They characterized expanding
utilization of their existing sites and services as "working toward capacity building."
They did not explain how this supported the center's readiness or ability to engage in
broader capacity building efforts to support their ability to perform in a heightened role in
a new environment.

In all, the data related to the access theme represented that some New Jersey
centers were intentional in how they characterized capacity building to align with the
goals of the ACA to achieve new access capacity. But it also clearly showed that most of
the participants were very cognizant that their descriptions of capacity building entailed
an opportunistic and pragmatic approach. While it was specific to the ACA, it also
demonstrated how they pursued other opportunities to effect capacity building depending
upon external resources or other environmental factors, either strategically pursuing the
opportunities or conforming how they plan, direct growth or other capacity building
efforts to the funding opportunities as they present for the centers.

Most participants who focused on capacity building to achieve new funding
support and new access capacity expressed some degree of awareness of the complexities
associated with capacity building and the need for a multifaceted approach to it. They
talked about multiple capacity components, beyond financial resources, that are described
in the Conceptual Framework as being important to driving capacity building on a

broader scale. Some participants especially highlighted the need for strategic planning to drive how they pursue and utilize grant funding opportunities to effect capacity building. Their caution underscored their concern about sustaining new access and thus their ability to perform for the long term in heightened roles in a more complex, competitive environment.

Finally, the same interviewees subscribing to the access theme reinforced their support for the patient-centered/community-focused theme. These same respondents recounted that the intended outcome of creating new access to primary care was to position their centers to meet the needs of the patients and the communities they serve. As more individuals gained access to insurance, providers including FQHCs anticipated a higher demand for primary-care services. Expansion of new access capacity positioned centers to meet the demand.

Evidence of Operational Enhancements, Readiness and Ability to Perform Theme

Fewer respondents defined capacity building as a process to enhance overall organizational performance, although many of the interviewees agreed that improved systemic performance is important to their center. Whether they also supported the patient-centered/community-focused theme in characterizing capacity building or defined it as expansion of access to healthcare services, the group of interviewees espousing this theme also described necessary system-wide capacity components, such as knowledge and functional management and financial systems, as being associated with capacity building. Significantly, while some of their colleagues explained their understanding of capacity building in terms of outcomes (i.e. new access capacity, growth in patient volume, or PCMH accreditation), this smaller group strongly expressed the need for

centers to ensure their ability for long-term, sustainable impact through enhancement of overall organizational performance or capacity building, which entailed the development of organizational infrastructure, human resources and improved systems for operations. These factors are depicted in the Conceptual Framework and in other related literature as input capacity components that influence organizational and systems-level capacity building.

This small group of respondents included board member participants, one of whom stressed the need for strategic organizational capacity building in FQHCs. By strategic capacity building they meant planned development and growth, and internal improvements with dedicated resources. This board member added that: "Every organization should be concerned about capacity building, understanding what they do, what it takes to meet their goals and if they have what is needed to achieve their goals." The same board member also discussed changes on the horizon for FQHCs and observed that centers must change too if they are going to be sustainable and gain more financial self-reliance. They implied that such change required organization-wide improvements, not just improvements to address the clinical needs of patients or to build new access capacity, but improvements to ensure organizational sustainability and the overall ability to compete with other healthcare providers. In addition to this board member, others in leadership positions also stressed the importance of FQHCs' attention to overall operational enhancements to optimize overall organizational performance. The board member participant added that their center was focused on building a strong infrastructure; they described capacity building as: "…it's preparing every department for performing at their best, their highest level…" and added "…[it's] the processes, the

infrastructure…what we consider capacity building…" This participant and the few others espousing this theme intentionally conveyed the importance of establishing a comprehensive, integrated, and systems-wide approach to capacity building for multiple reasons—short term and long term. They added that capacity building is necessary to support patient/centered community-focused healthcare services, as well as new access capacity. Moreover, it is necessary to improve and sustain overall performance for the long term if centers are to play a heightened role under healthcare reform, to sustain access capacity and to be competitive providers. Some respondents who informed this theme thought that although their centers were already positioned as they entered the environment for healthcare, they had work to do to ensure their heightened role. They did convey that their centers had some of the tools necessary to effect new infrastructure but that enhanced capacity in areas such as added resources, advanced skilled leadership and/or staff were necessary as changes to the external environment progressed.

Critically, although other respondents among the larger group of interviewees may not have expressly described capacity building as a process to improve overall operational performance, they did identify some abilities for capacity building; they described ongoing activities and the presence of capacity components towards effecting it. One of the most significant, often cited example that figured throughout the data was the mention of efforts across the centers to enhance their technology capabilities, including health information technology (HIT) capabilities across the institutions. Most respondents recounted some capacity building activities related to operational enhancements management and health information technology. The data excerpts below

illustrate some of the related initiatives or investments aimed at improving technology

functions across some of the centers:

> I think you can't take the next steps until you make sure all the right technology is in place, because if not you are setting yourself up for failure. So, I think it's very important to have the right servers, resources, capacity, so that we are ready.

> We did target resources for capacity building, such as upgrading our IT system. That is the biggest investment in capacity building right now.

> We are a completely paperless system when it comes to care…it's all through EMR and electronic healthcare systems in terms of making sure that those systems are in place.

> …we realized that one must have an EMR that is integrated into operations and connected to all the sites. We are so invested in technology.

These interviewees discussed the importance of creating new capacity in their technology

and for management and clinical services, to: (a) adapt to the changes in how healthcare

organizations manage financial systems, (b) connect with patients and the community,

and (c) ensure compliance with required reporting and documentation of clinical and

administrative practices. CEOs and the CFO respondent especially commented on the

changes that necessitated improved technology capacity at all levels. They recognize that

all aspects of the healthcare business are increasingly reliant on advanced technology and

skilled IT staff. Clinicians and other clinical staff also recognized the importance of

using advanced HIT to support clinical services, and to achieve a seamless continuum of

care across organizations for their patients. Two clinicians described the capacity

building activities within their organizations targeted toward organization-wide

improvements to support clinical care services. They said:

> There are computers at every clinician's desk and computers within the exam rooms, so you can see the patient and you can either document what you need to

>in the room or you can go to your desk and do it. And it kind of keeps the flow better…. They have an on-site IT team that is really good…
>
>The main thing needed is more IT focus at all points…having that IT department there at our beck and call really keeps the systems well-greased and keeps it going. And they'll just do more; they do our phone systems; they're involved in every technology aspect of our operations.

One of the respondents cited in the text above has worked in an FQHC for over 30 years and thought that the new technology was challenging at first, but embraced it as being necessary to facilitate and track patient care, especially patient-centered care, including their center's participation in the PCMH program.

Not all centers however were successful in their efforts to effect capacity building to achieve enhanced systems and infrastructure. Again, using advanced technology as an example, one participant expressed concern and even anger over their organization's inability and lack of readiness to participate fully in a changing environment. They cited their organization's lack of capacity components such as planning and systems enhancements to drive readiness. They especially noted the lack of a functioning HIT infrastructure, including the necessary staff to manage it. They offered that their center had invested considerable dollars in a new EMR system only to not be able to use it because they lacked human resource capacity to operate the equipment. They did not think their center was prepared as they should be to perform in a changing environment. Overall, those embracing this theme identified some capacity building activities that pointed to their ability to effect it and to ensure their ability to further position the centers as competitive primary care providers in a new arena of care. However, some participants also relayed that their centers were more strategic and deliberate than others in how they pursued and used available resources to ensure long-term capabilities. These

participants noted awareness of the factors that contributed to their success in capacity

building such as effective leadership. Further, they thought their centers were prepared to

participate as essential providers under the ACA and ensuing healthcare reform efforts

because they had deliberately prepared for it. They tried to identify gaps in their

operations that would hinder their ability to be effective providers under the ACA and

going forward. A CEO among this group summed up their efforts toward achieving

overall organizational performance and that of others in saying: "We are adapting…we

know about all the processes and things we need to have in place." In further

conversation, this interviewee described some of the deliberate systems and changes their

center concentrated on for capacity building, including hiring new staff with advanced

skills necessary to elevate organizational operations. Like others in this group, this

interviewee thought New Jersey centers were mostly ready to compete. They touted that

their organization was especially ready. However, they emphasized that centers need to

stay competitive by deliberately engaging in capacity building or organization-wide

operational enhancements in an ongoing way.

Business-as-Usual Approach Theme

> We were waiting…We do this every day. It was business as usual…we just need
> resources.

> So, things are being done, meetings are held, people are trained. We are doing it,
> maybe not capacity building, but this is the everyday things that we do, to
> improve our system

These are excerpts from the interview data which reflect the views of another small

segment of the respondents, but it is another important pattern of responses. Interviewees

who expressed this view, like their colleagues in this study, also closely aligned with the

perspective discussed earlier that FQHCs were inherently prepared to participate under

the ACA because of their PCCF orientation and attention to the needs of their patients

and communities. The nuanced difference in the perspective of this group who

represented the business-as-usual theme is that they expressed little urgency or concern

about the need for capacity building in the face of healthcare reform ushered in by the

ACA. They did not think that a concerted focus on capacity building was necessarily a

defined component of their organizations' strategic plans, nor did some of them know if

their organization dedicated resources for capacity building. They expressed less concern

because the "business" of being FQHCs, in their estimation, is providing primary care

services. They are in the business of providing those services every day and ensuring

whatever that entails.

One of the data excerpts cited earlier and repeated here, was made by a clinical

leader who was new to their center. They said: "We were waiting [for the changes]

…We do this every day. It was business as usual…we just need resources." This clinical

leader was impressed with the operations, efficiencies, and leadership found in their

center and the fact that, in their view, this center was progressive and already performing

as necessary to navigate change as a normal course of how they operate. They just

needed the resources to continue to do so. Moreover, this interviewee conveyed that

other than resources, there was, no concern about doing anything differently in respect to

capacity building because of the ACA. This participant also offered a definition of

capacity building that was in line with those who see it as expanding access to care,

having the facilities and providers to see more patients. This perspective underscored the

fact that they did not perceive that anything new or different was needed in the way of

capacity building, just the resources to expand access to care.

Contrasting this view of the business-as-usual theme was a second set of interviewees who conveyed more of a sense of deliberate planning around capacity building, but again as a normal course of business for centers. They too supported the notion that FQHCs were inherently ready for the ACA, but only to a degree; they also aligned with the operational enhancement's viewpoint. Unlike their colleagues who adhered more closely to the business-as-usual perspective in conveying that no extraordinary planning or changes were necessary in how they conducted business or capacity building in respect to the ACA, this set of participants expressed the need for timely, deliberate capacity building, supported by current knowledge and information. They indicated the need for FQHCs to stay abreast of new developments in healthcare and to strategically leverage opportunities for growth. This segment of respondents however also portrayed that this is what centers "normally do;" they engage proactively in promoting capacity building within their organizations, to improve operations, build staff skills and knowledge, grow and expand access, and so forth, as the normal course of their business.

Overall, those who contributed to this theme, business as usual, conveyed a viewpoint that suggests FQHCs just need to build upon what they "normally do, who they are, their model of care to effectively engage in the changing environment. In their view, the organizations are ready to be essential providers because of how they have approached and continue to readily approach change of any kind. The ACA and impending reforms do not require different measures or attitudes toward capacity for centers in the opinion of those expressing this theme. Most significantly, they implied they will continue to act and perform as FQHCs, to do what they were already doing to

ensure their ability to be essential primary-care providers. The two small groups who

shared nuanced takes on this theme, differ only in the degree to which change influences

how and when they engage in capacity building and the degree to which they institute it

deliberately. Interviewees who espoused this business as usual theme said:

> We have not done much differently. We anticipated correctly the Medicaid
> expansion and we were ready to get patients signed up…

> Capacity building has always been in place and we always have discussions about
> it…We have initiated new systems to reduce no-show rates and to improve our
> operations, while decreasing costs.

> The only thing that is different for us is that the enrollment process is more
> aggressive…

> Well, like I said, we are not doing anything in particular, nothing specific, but I
> think we all understand what things about the organization need to be addressed.

> I am going to say there is nothing different for the FQHC, because everything we
> are doing, we have been doing and will constantly do it.

A participant who further emphasized that not much had changed in how they do

business, recounted the last excerpt above. They added that not much has changed with

the ACA; the problems in healthcare remain the same, and the efforts to address some of

them through FQHC services are consistent. This same respondent attempted to explain

how even in change, things remain the same and the challenges and opportunities are

cyclical for FQHCs. This CEO reflected that: "An elephant is an elephant and [it's] an

elephant even though you put a shirt on it. And the question is does it really need a

shirt?" In this statement, this CEO emphasized that the ACA did little to affect how

FQHCs do business, how they operate, or how they engage in capacity building to

optimize operations, services, and sustainability. The essence of this can be summed up

as: FQHCs have historically seized opportunities for growth and capacity building, but at

the same time they have had to exercise acumen and deliver value to be sustainable

organizations in the face of challenges to their existence or to their ability to be effective

service providers. For this respondent, the ACA did not change this dynamic for FQHCs.

As others stressed earlier, it did not prompt their center's need for capacity building.

Experience and the nature of being an FQHC determines their strategic efforts toward

capacity building. They prepare for change and how to sustain the organization through

change, whether good or bad. But this researcher noted that even in observing how much

things remain the same, this respondent subsequently went on to talk about hiring new

staff, enhancing their IT systems under the ACA, and renovating sites to accommodate

more patients. In this way, they acknowledged their continued, but proactive efforts

toward capacity building, even though they saw the events unfolding under the ACA as

more of the same for FQHCs.

Participants' recounting of continuous operational enhancements occurring in

their centers illustrates the overlap of this theme with the operational enhancements

theme discussed earlier. Whether or not participants identified capacity components that

are associated with capacity building in their organizations, or whether capacity building

in the centers is considered as part of a strategic plan or business as usual, the data does

show that many centers are obviously engaging in some aspects of operational

enhancements, particularly in improving IT systems and the recruitment of new,

advanced skilled staff members.

But there was one respondent who shared a view of this business-as-usual theme

that I interpreted as the only pessimistic opinion of business as usual. This respondent

emphatically declared that their center was not ready to participate in healthcare reform

initiatives or to compete effectively as an essential primary care provider. They remarked

about poor planning within their organization, among other things that they deemed

problematic. This interviewee also indicated they did not think their organization would

be able to successfully adapt to a changing healthcare environment because they "are

struggling." When asked directly about capacity building in their organization the

respondent said: "I think we could do better." They relayed that their organization did

not have well defined capacity building goals. This researcher understood this

respondent's perspective to mean there was not enough focus on capacity building at the

center—it was "business as usual" to them in the sense that the respondent did not see

efforts to adapt to change or the capacity of the organization to ensure their ability to be

competitive, effective providers. The respondent confirmed this in reflecting on the value

of the external marketing the center was engaged in, saying:

> Yes. Market it [the health center] outside and also walk-the talk. Don't market
> yourself if you are not ready to market yourself. Clean up your house, make sure
> it's spotless, provide customer service…word of mouth in the community is the
> biggest marketing tool.

They did not see the value or benefit from marketing for their center, because they

perceived that nothing was changing to improve how they operated otherwise.

In contrast, "business as usual" for the other respondents meant their center was

ready for change. They were doing and would continue to do what FQHCs have always

done well, signaling their belief in the intrinsic capacity of the centers to participate under

the ACA and to continue to be effective primary-care providers.

Summary of Findings—Research Question 1 and Key Concept: Capacity Building

The interview data linked to capacity building clearly demonstrates that New Jersey centers engage in capacity building to different degrees and that respondents report varied stages of readiness or perceived readiness to perform as essential providers and to sustain new access capacity developed because of the ACA. This variation reflects in part the different perspectives about capacity building that exist among the respondents and the centers they represent. Their understanding of the concept is framed by their own knowledge of it, their experience and involvement with FQHCs, and the organizational culture and mission.

Also, some respondents who reported that their centers approach to capacity building is shaped to a degree by funding opportunities, elected to define capacity building specific to the ACA and the mandate and funding support for centers to create new access capacity. The ACA's goal for capacity building for FQHCs and the grant dollars afforded for FQHCs guided how some interviews operationalized the concept. Nevertheless, the data show that many of these same respondents clearly understood capacity building as a multidimensional concept and that it involves attention to processes as well as outcomes to effect enhanced organizational performance.

Respondents also assigned different importance to capacity building. Some centers approach capacity building as a deliberate, strategic process towards achieving their operational goals and long-term impact. Others thought their centers were less deliberate in pursuing it, either intentionally or because they were not prepared to do so. They expressed capacity building as a normal course of their business. Their centers incorporate it in activities such as quality improvement programs for enhancing clinical

care or routine board/leadership/staff trainings to enhance knowledge about trends in healthcare and the impact on health centers.

However, regardless of how interviewees defined the concept or how their centers pursued the development of necessary capacity components, most respondents shared the perspective that capacity building should benefit the patient and the community. Just a few interviewees expanded upon this to say capacity building should enhance organizational performance to ensure effective, sustainable organizational systems and services. This smaller group of respondents embraced a broader view of capacity building than most of their colleagues. They understood it as a process that entails strategic and resourced organization-wide improvements to achieve a desired impact, which also includes enhanced benefit to patients and the community.

The Brown et al. Conceptual Framework (2001) offered a useful tool to help categorize those capacity components that were found to influence capacity building in the centers, whether respondents identified them as such or not. Notably, many centers were engaged at some level of capacity building. However, as stated above and noted by the respondents themselves, some centers were more ready than others to engage in change and to perform as essential primary care providers under the ACA. Some interviewees readily described strengths or existing capacity, such as the strong presence of critical capacity components, including functional systems for operations, and so forth, within their organizations. They identified these components to mark their preparedness to participate as essential providers under the ACA and to sustain new capacity. They also cited capacity building activities, such as expansion of access to care and the hiring of new, skilled staff members as evidence of the same.

Furthermore, the FQHC leadership, primarily the CEOs represented in the study, expressed more confidence than other participants about their organizations' existing capacity and preparedness to be essential providers under the ACA. In one instance where there were two respondents from the same center, the CEO voiced great confidence in the FQHC's ability for capacity building, and their readiness to participate in the evolving landscape. The CMO from the same center expressively conveyed that the center was ill prepared for the ACA and they did not see evidence of their ability to develop the capacity necessary for expansion, to attract new patients, nor to keep up with the changes occurring around them. Nevertheless, their CEO recounted numerous capacity building activities that were underway as evidence of their readiness. A front-line staff member from another center was also less confident than their CEO about the future of capacity building in their organization, but not because they believed the center was unable to effect it. This person confessed a general lack of knowledge about what was happening in their center related to capacity building, beyond their knowledge of the outreach efforts that were occurring.

Those participants who concentrated narrowly on expansion to access in how they conceptualized capacity building under they ACA recounted their centers' efforts to use the federal grant dollars to expand their footprint in communities and to capture larger market shares. One CEO also sought to leverage the new grant dollars to position their center to be a sought-after partner by hospital systems as the ACA advanced, and to secure system-level alignments and access to other resources. This same participant succinctly summed up their view about the opportunity for internal and external capacity

building under the ACA for FQHCs. They likened FQHCs to a growing force with existing and developing capacity to be not only essential providers, but essential partners.

Overall, the data supports that most New Jersey FQHCs aspire to capacity building, albeit in different ways and with different goals, but to fulfill the vision for improved access to essential primary care services for vulnerable populations and communities. Some interviewees reported more aggressive efforts toward this end than others. Moreover, while some respondents readily identified the presence of existing capacity components found in their centers, others did not. Nevertheless, the data reflect that many centers demonstrate the presence of existing capacity components in their organizations, but it also reveals varying abilities among the centers to effect capacity building.

Critically, some interviewees, mostly those representing the leadership of FQHCs were also cognizant of issues of sustainability that are associated with capacity building. As Chapter 9 shows, respondents also expressed different views about sustainability as it relates to capacity building and FQHCs. Nevertheless, overall, the data show that most respondents had confidence in their capacity to perform as essential providers under the ACA and in their capacity to sustain new capacities gained because of the ACA. But respondents clearly reported that some centers were more ready than others and some demonstrated more ability than others to effect capacity building to sustain access capacity and the infrastructure necessary to support it.

Table 9 shows the numbers and percentages of interviewees who contributed to the salient findings for research question one. The table also shows the numbers and percentages of centers represented by these interviewees. Because some of the

interviewees were from the same centers, the percentage of centers shown in this table, and in Tables 10 and 11 in Chapters 8 and 9, may not add up to 100. This occurs because interviewees from the same centers expressed different opinions about the research topics. They expressed different perspectives about what was occurring within their center and how their center responded to the ACA, and about how their center addressed issues associated with capacity building. Additionally, interviewees sometimes articulated responses that informed multiple themes or that supported nuanced perspectives about the same issues.

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Table 9

Summary of Key Findings for Research Question 1 and Percentage of Interviewees and Centers Associated with Each Finding

Key Findings	Interviewees (N=20)		FQHCs Represented (N=10)	
	n	%	n	%
The Patient Centered/Community-Focused (PCCF) orientation shaped most participants' views and understanding of capacity building, and how the centers approach capacity building. Their understanding of capacity building emanates from their core beliefs about the value of the FQHC mission and the FQHCs' connection to the communities and patients they serve	14	70	8	80
Capacity building defined as a strategic process to enhance overall organizational performance and preparedness toward achieving greater self-reliance resonated with a small subset of interviews. While the PCCF orientation was a factor for this subset, they also articulated the need to view capacity building from a broader perspective as well.	5	25	5	50
A subset of participants linked their understanding of capacity building to the ACA mandate for FQHCs. Accordingly, they described capacity building as an outcome—the expansion of access to healthcare.	9	45	9	90
Some participants described capacity building as being an inherent function of the FQHC model.	9	45	6	60
Some interviewees described capacity building as a deliberate, strategic part of the FQHC operating model.	7	35	6	60
FQHCs were strategically prepared for the onset of the ACA	11	55	7	70

CHAPTER 8: RESEARCH STUDY RESULTS—RESEARCH QUESTION TWO: IMPACT OF THE ACA

Research question two asks: What is the impact of the ACA on capacity building in New Jersey FQHCs? This question examines whether the ACA served to promote capacity building in New Jersey FQHCs and towards what end. This researcher explored the ACA as a key concept because an assumption for this study is that it bought about significant changes across the healthcare industry, changes that presented challenges and opportunities for centers, nationally and at the state level. Based on professional knowledge and assessment of the changes that are occurring in the healthcare industry this researcher anticipated that New Jersey FQHCs, like others in healthcare, would face significant tests of their effectiveness, viability, and sustainability as healthcare reform continues to evolve. Therefore, during Phase 1 of this study, I solicited input from the pilot focus group members about the importance of the ACA and its anticipated impact on New Jersey's FQHCs. They confirmed that how centers responded to the ACA and their readiness to respond to it were critical issues to examine. The pilot focus group agreed that the ACA was a bellwether for understanding how centers view capacity building, and its impact on their ability to successfully navigate significant changes in the industry to ensure sustainable, effective healthcare services.

The data analysis process for this chapter is the same as that described in Chapters 4 and 6. The Brown et al., (2001) Conceptual Framework guided the identification of those capacity components, including external factors, that were considered important to understanding how interviewees perceived the impact of the ACA among New Jersey centers, particularly its role in fostering or supporting capacity building in the centers.

The study findings related to research question two illustrate that seven respondents (35%) reported significant impact and benefit for their health center and for FQHCs in general because of the ACA, while others recounted some benefit but to a lesser degree than that of some of their counterparts. One respondent described the impact of the ACA for New Jersey FQHCs as a "mixed bag." Relevantly, the ACA did present opportunities for centers to engage in capacity building to create new access capacity and to strengthen their infrastructure to support expansion and growth. Moreover, the ACA also afforded opportunities for centers to enhance their positions as essential providers through participation in new care delivery models. Importantly, those who recounted that the ACA created such meaningful opportunities for New Jersey centers also described their organization's readiness and their ability to realize the advantages presented by the healthcare reform law. These interviewees highlighted capacity strengths, including the presence of internal capacity components that they perceived as particular organizational capabilities (i.e. leadership and functional management systems) that contributed to their ability to leverage grant opportunities and other advantages of the ACA. Significantly they also underlined their organizations' ability to adapt to or to overcome the reported associated challenges that centers also faced because of the ACA.

In contrast, however, the data also showed that a few (4) interviewees reported that their centers experienced critical adverse consequences related to the ACA that outweighed any benefit. The most severe consequence was the unanticipated loss of revenues, which hampered capacity building in their organizations, as well as their ability to fully benefit from and participate in changes resulting from the healthcare reform law. They highlighted public policies and rules as the most critical external factors that

contributed to the unfavorable consequences, intended and unintended, of the law for their FQHCs and other New Jersey centers.

Notably, another group of respondents (25%) offered that the ACA did not have a real discernable impact on their operations, either good or bad. They aligned with those who espoused that centers performed "business as usual" both before and after the implementation of the ACA, as discussed in the previous chapter. They represented that the ACA did not change their organization, their financial outlook, or how they operated. The text cited here characterized the viewpoint of this subgroup that the ACA was but one of many federal initiatives that affected FQHCs. They considered expansion of access to primary care services as just another federal mandate for FQHCs. A participant in this group said: "I don't know if it [the ACA] was favorable or unfavorable, but I know it was something we had to do."

This participant added that FQHCs are adept at dealing with federal mandates and all that such mandates entail. They, and those who aligned with this sentiment, thought the ACA did not present anything extraordinary in the way of opportunities or challenges for New Jersey centers. They implied that New Jersey centers have successfully utilized grant opportunities in the past, as well as managed to handle what they considered ongoing challenges presented by public policies and practices that affected FQHCs.

The principal responses that informed the prominent themes about the impact of the ACA emanated from those who discussed, as noted above, the tangible benefits and challenges to New Jersey centers that were linked to the law. The broad thematic headings that captured several sub-themes were: (a) the ACA presented a mixed bag of new opportunities and financial challenges for New Jersey FQHCs, and (b) external

factors—policies and regulations that adversely impact capacity building in New Jersey

FQHCs. As in the previous findings chapter, Table 7 is repeated here to facilitate

reference to the data.

Table 7

Mapping Capacity Building in New Jersey FQHCs—Key Concept: ACA

Key concept and associated research question	Capacity components/variables	Themes	List of broad codes and sub-codes
Key concept: Affordable Care Act (ACA) **Research question**: What is the impact of the ACA on capacity building in New Jersey FQHCs?	**Inputs**: infrastructure policies [a] [b] leadership [a] [b] social and demographic factors [a] [b] finances [a] [b] collaboration [a] **Process**: strategic plan coalitions marketing and communications plan [a] trained workforce **Outcomes**: competitive service delivery system [a] [b] expansion [a] [b] increased access [a] [b]	The ACA presented a "mixed bag" of opportunities and challenges for FQHCs. Sub-themes for opportunities: a) new Funding b) Medicaid expansion; c) heightened influence. Sub-themes for challenges: a) critical losses in patient volume and income. External factors—Public policies and regulations—adversely impact capacity building Sub-themes for external factors: a) auto-assignment of patients to providers; b) changes in reimbursement methodologies	transformation trends ACA provisions, ACA grants, benefits, and challenges industry competition FQHC expansion technical assistance, HRSA influence community influence state policy advocacy social/political capital

[a] Focus Group Data
[b] Interview Data

ACA Impact: Mixed Bag of New Opportunities and Financial Challenges Theme

The data linked to interviewees' responses about the impact of the ACA shows

that most respondents (11 or 55%) expressed that the advantages provided by the ACA

eventually outweighed the short-term challenges or setbacks that they may have

experienced during the early phases of the implementation of the ACA. Some

respondents, however, countered that the ACA raised or promoted policies and rules that

led to significant financial losses for their organization, plus decreases in their insured

patient volume. Two of these same participants stated their organization was still

wrestling with financial instability linked to the implementation of the ACA. The

sections below detail the salient subthemes that highlighted the opportunities and

advantages afforded by the ACA for New Jersey centers. It also details the financial

challenges that impeded the ability of some centers to expand access capacity or to

readily engage in capacity building in the near-term.

Opportunities: New Funding and Access Capacity, Medicaid Expansion, Heightened Influence Subthemes

Those interviewees who counted the ACA as an opportunity for FQHCs (despite

the degree to which their centers benefited from it) identified three important subthemes

that underlined areas in which they thought the ACA critically benefited FQHCs and to

varying degrees their own center. The subthemes were: (a) the ACA provided new

capital funding to build new facilities or renovate existing ones, and to enhance

infrastructure, add new hours of operations, clinical services, and so forth (80% of

respondents acknowledged some capital funding and activity), (b) it provided

opportunities for states to expand Medicaid coverage to previously uninsured individuals,

and (c) the ACA heightened the influence of FQHCs; it strengthened the position of New Jersey centers as significant primary-care providers in the new healthcare environment.

As discussed, in Chapter 7, interviewees highlighted the impact of ACA funding that supported new physical, organizational, and programmatic enhancements for FQHCs. Briefly, in providing new funding through enhanced appropriations, grant dollars, and incentive payments for the development of new access capacity and other capacity building initiatives, the ACA allowed five of the centers represented in this study to act upon their existing strategic plans to address identified capital needs, and organizational infrastructure needs. It provided crucial, non-programmatic dollars to construct new facilities and to renovate existing sites. Additionally, it funded initiatives to improve the organizational infrastructure—to hire advanced-skilled staff, implement innovative technology, enhance marketing and outreach systems, and so forth. Equally important, the capital improvements allowed all but two of the centers represented in this study to expand their footprint in their service area or to accommodate significantly more patients at existing facilities. The data show that all centers did receive some enhanced funding through the ACA for capacity building; however, as also noted previously, some were more successful than others in their efforts to develop new access sites, expand hours, and enhance the center's infrastructure.

Further, some centers benefited from the ACAs investment in the NHSC to booster health centers' ability to attract new primary care providers to support the new access capacity. The NHSC provides scholarships and loan repayments to primary-care providers in exchange for practicing in underserved areas. At least two respondents indicated that the NHSC was a valuable resource to their organizations in support of their

expansion efforts; it aided their ability to staff new sites or hours of operations as they achieved plans to realize additional access capacity.

Beyond the cash infusions to fund capital needs and to expand access capacity, or indirect financial support to hire new providers, nine participants (45%) viewed the Medicaid expansion initiative as having the most critical impact for the centers, near and long term. Very significantly, Medicaid expansion gave centers increased opportunity to generate new patient service revenues. For some centers, this allowed them to operate with improved financial margins; it also helped to position them to leverage other financial opportunities, such as the ability to finance additional facility needs through loans or partnerships. The increased revenues from Medicaid improved their outlook for sustaining growth and for pursuing other capacity building initiatives. As a reminder, and as described in Chapter 3, FQHCs have historically cared for large and disproportionate numbers of uninsured patients. Under the ACA, thousands of previously uninsured FQHC patients in New Jersey gained access to Medicaid insurance, which reimburses FQHCs at a higher rate than other insurance carriers. The FQHC Medicaid rate is also higher than what centers receive from the state to compensate for charity care (healthcare for the uninsured). The increase in Medicaid revenues for FQHCs is due to the more significant numbers of FQHC patients who received Medicaid insurance coverage because of the state's Medicaid expansion program in response to the ACA. The ability to increase service revenues facilitates planning and the means to dedicate resources for capacity building and programs. Federal grant funding, although reauthorized repeatedly throughout the history of the centers, is less predictable and reliable for planning greater self-reliance or programmatic stability for the long term.

Altogether, most centers experienced significant increases in their Medicaid patient population and correspondingly, an increase in their patient service revenues (Figures 3 and 4 in Chapter 3). Several respondents repeated some version of the following comments with respect to the impact of Medicaid expansion under the ACA:

> Well, the most significant change for us, of course, number one, is that we are actually taking more people from being uninsured to having insurance…

> New Jersey has the Medicaid expansion. So, our reimbursement stream… has actually increased …

> …We've seen our Medicaid numbers jump up to 65%. So that is pretty good for us. When we were just at 40%...and you know that is what you really want to do. Cause [sic] you know Medicaid is the highest payer.

Overall, these participants, plus others, viewed Medicaid expansion and the resultant growth in revenues as the opportunity to strengthen their financial ability to sustain expansions made under the ACA, as well as to pursue further capacity building such as the recruitment and retention of advanced, skilled team members to help facilitate their ability to compete in new complex systems of care and reimbursement models. As stated earlier, most participants viewed the expanded Medicaid coverage as having had the most significant impact on their ability to generate increased revenues in recent years.

Additionally, participants did not just see Medicaid expansion as a benefit to the centers; they also emphasized the benefit for the patients. The patient-centered/community-focused theme discussed in Chapter 7 permeated throughout conversations about the impact of the ACA. Interviewees stressed that Medicaid expansion was especially significant because it provided access to care and the opportunity for patients and populations to improve their health status and healthcare outcomes. Participants emphasized that the ACA expansion efforts, in total, should focus

on ensuring access to patient-centered primary care and the resultant benefit to patients.

Two clinicians highlighted the views expressed about the anticipated impact on patients,

saying:

> Patients get the opportunity to have, you know, have access, either have expanded [insurance] or access to Medicaid which they didn't have before and some patients have access to 3rd party insurance. I think the greatest impact [of the ACA] is we continue to be the safety net. It strengthens us as a safety net. The patients who were before uninsured will now become insured—in those cases probably through Medicaid managed care, if anything.

> I think providing care to a needed population. We still have millions of people who are uninsured, who didn't [get] care and now they are able to get care, not only to treat their illnesses, but to prevent illness.

As shown in these excerpts, respondents pointed to the importance of insurance coverage

for individuals and families. Medicaid expansion was a significant factor in bolstering

their ability to provide expanded access to care for unserved and underserved

populations. For some respondents, as illustrated in the first excerpt above, it reinforced

the ACA's stated intent for FQHCs to be essential providers in the healthcare industry,

also meaning their ability to be the safety net for those who otherwise would not have

access to healthcare services. Significantly, all respondents in leadership positions

acknowledged the importance of centers' continued role as safety-net providers, even

with increased access to insurance for more individuals. Fundamentally they perceived

there will always be a need for a safety net for significant numbers of patients, and thus a

need for sustainable FQHC services.

The third significant impact of the ACA is that it aimed to heighten influence for

FQHCs; it helped to strengthen the position and role of FQHCs in the healthcare industry.

It added new leverage for centers to exert influence in how they partnered with others in

the larger healthcare system. The ACA provided incentives for healthcare systems and other healthcare organizations, as well as independent providers, to form new models for healthcare delivery. Importantly for FQHCs, the ACA legislation also strongly supported the inclusion of primary-care providers in ACOs and other innovative service delivery models. One criterion for federal approval to form such service delivery models or new systems is that they must show meaningful involvement of a primary-care partner(s). While the ACA rule fell short of specifying the inclusion of FQHCs as large primary-care systems, the law declared FQHCs as essential providers of primary care and it opened up opportunity for centers to negotiate inclusion in new care-delivery systems based on their primary-care experience, quality of care, and the large numbers of patients that they serve. Some New Jersey FQHCs have attempted to proactively take advantage of this provision to become partners of choice in such arrangements.

Five participants (25%) highlighted the exposure and advantage that the ACA provided for centers to participate in Clinical Integrated Networks (CIN) and Accountable Care Organizations (ACO). They stated their centers were actively pursuing participation in a hospital based ACO, plus they and other FQHC colleagues were also exploring an FQHC led ACO. Importantly, participation in these new models for care delivery and the ability to partner across the larger healthcare systems also offers centers new access to additional resources, like group purchasing, integrated electronic medical records, access to specialty and diagnostic resources, and again, validation and prestige as integral, quality healthcare providers in New Jersey's healthcare networks. Two excerpts from the data highlight participants' understanding of the new-found leverage that the

ACA afforded FQHCs in negotiating partnerships or their participation in an ACO

system of care. Two separate interviewees offered, respectively:

> One of the initiatives we were actually embarking on…was a direct result of the ACA, in terms of the formalization of an ACO.

> You know, the individuals that I've seen, more like [over one half] of the [total number of people in the area] …when you are talking to the hospitals…they are not used to talking to you as respectfully as they probably should.[22]

In the latter statement, a CEO participant indicated they were very much aware of their

organization's strength and ability to bring a sizeable number of primary-care patients to

the table in negotiating new partnerships. They stated that their center was poised to take

advantage of the ACA provision for the inclusion of primary-care providers in innovative

systems of care. This same participant emphasized the fact that their organization was

the largest provider of primary care in the area. They explained that the size of their

patient panel accounted for more than one half of their service area's total population. In

their view, this demanded attention from hospital systems looking to create new

healthcare delivery models in their service area. More senior-level interviewees

supported the view that the ACA positioned New Jersey centers to build new partnerships

and to assume expanded roles in the state's healthcare infrastructure. Another participant

reinforced this, stating:

> It's an opportunity. I think the Affordable Care Act, what it has done, it has engaged all FQHCs to continue to think about their role in the environment and how to implement services to the environment and that is a good thing.

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[22] The respondent used actual numbers in this coded text, but this researcher replaced the numbers with text to protect the identity of the center. The inserted text represents the proportion of patients that use this center in relation to the total number of people in the service area.

In this text, they highlighted the opportunity for FQHCs to rethink their influence and strength as essential providers and valued players, to use their heightened capacity and the ACA to operate at a different systemic level. In all, this same participant, a CEO, expressed that FQHCs should actively broaden their vision for how they operate in the new landscape.

At the time of this study, interviewees noted that several FQHCs were already working toward partnering and greater collaboration with major healthcare systems to participate in ACOs and other networks. Some participants reported ongoing negotiations, with a few centers having already established relationships that could lead to greater collaboration and integration of services and resources. Collaboration and sharing of resources at the system level may be critical to ensuring FQHCs ability to obtain ready access to the resources needed for continuous capacity building as the new healthcare environment evolves.

Challenges: Critical Losses in Patient Volume and Income Subtheme

In contrast to those who articulated that the ACA generated a mostly positive impact for centers, at least five participants (25%) recounted a critical loss of patient volume and related service income for their centers at the onset of the ACA that resulted in lasting financial impact. Although centers anticipated some loss of patient volume as individuals gained insurance upon enactment of the ACA, the majority of participants declared FQHCs, in general, did not expect the rapid and severe decline in the number of patients and associated revenues that they experienced early on during the initial implementation phase of the ACA. Senior-level interviewees attributed the problems they encountered to the influence of ill-considered state-level policies associated with

how the state implemented ACA provisions such as Medicaid expansion, and the unintended impact of national-level policies and rules that governed how newly insured patients were assigned to primary-care providers, both of which are external factors that participants viewed as being beyond their immediate control, if at all. Two front-line staff member interviewees and two midlevel clinicians who participated in this study were aware of problems associated with low patient volumes but did not connect the issue to the impact of external policies or any other external factors.

Notably, however, two senior-level participants did reflect that some of the financial challenges their organization experienced, plus their inability to attract and retain new patients, were due to their respective centers' lack of preparedness for implementation of the ACA, and thus to their inability to withstand the challenges as other centers did when hit by the unanticipated, rapid decline in revenues and patient volumes early on. Recall one of these same respondents said that they were glad their center did not get the onslaught of patients they originally anticipated because the center was not prepared to accommodate additional patients, while another interviewee indicated that despite their organization's best efforts to prepare for the ACA, the center did not have the operational systems in place to manage any new volume of patients or to ensure proper financial management to recoup or maximize revenues. While most other centers eventually recovered financially and regained patient volume as the implementation of the ACA progressed, without lasting harm, a few centers were still struggling to catch up, financially and otherwise.

Critically, interviewees attributed specific challenges arising from the ACA for FQHCs to external public policies, rules, and practices. The data reflecting these views

informed the second theme, pertaining to external factors that influenced the impact of the ACA on FQHCs. Participants underscored that the challenges to capacity building for most centers emanated from external environmental factors. This researcher included discussion of these challenges, which is recounted below as part of the external factors and influencers theme. They are included in this theme because centers had limited control over some of the initial factors or policies that evolved with the introduction of the ACA, nor were they able to influence how those policies were operationalized at the state level.

External Factors: Adverse Impact of Public Policies and Regulations Theme

Participants were unanimous in their view that external environmental factors, specifically state-level policies and rules linked to the ACA, significantly impacted how FQHCs engaged in capacity building or benefited from it in respect to the ACA. Participants highlighted the most salient challenges they experienced because of public policies, rules, or regulations that were linked to the ACA or otherwise: (a) auto-assignment of patients to non-FQHC providers, (b) changes in New Jersey charity care payment methodology and Medicaid reimbursement. Albeit to differing degrees, these external policies and rules resulted in weakening centers' near-term financial positions, and for a few organizations, it threatened the sustainability of some operations. Two respondents stressed that the unanticipated decreased in revenues that their center encountered because of these issues limited their ability to focus on or to engage in capacity building as the ACA rolled out. These respondents reported that their health center had little or no revenue to reinvest in capacity building. Their need to focus on cash-flow issues and more immediate threats to existing programs and services diverted

their resources and attention from capacity building to the everyday needs of ensuring

their ability to operate and to remain viable entities for the short-term.

Auto Assignment of Patients to Providers Subtheme

One of the more significant policies related to the implementation of the ACA

that adversely affected FQHCs involved rules that guided the auto-assignment of patients

to providers when they enrolled for insurance coverage under the ACA. States translated

federal policy for Medicaid expansion to set their own rules for how they implemented it.

However, the problem associated with auto-assignment reflects ongoing questions and

discussions at the federal and state levels about the attribution or assignment of patients

and payments as policy makers and the industry continue to put forth, test, and implement

new payment models for healthcare reform. Initially, New Jersey Medicaid used auto-

assignment of patients as a default method to assign patients and payments to providers.

The problems with auto-assignment were widely known throughout the New Jersey

FQHC industry. Members of the focus group, during the first phase of this study,

mentioned it, and participants in the in-depth interview phase talked about this issue more

extensively. Briefly, auto-assignment refers to the automatic and random assignment or

attribution of patients, by insurers, to a primary care provider if the patient failed to select

a provider of their choice upon enrolling for insurance coverage under the ACA. While

this policy affected all New Jersey centers, several participants represented it as

disproportionately contributing to financial distress for their centers. Even though

FQHCs were actively engaged in enrolling patients for insurance through the ACA

marketplace, ACA rules prevented enrollment workers from steering patients to a specific

provider. Also, despite efforts to educate patients about the process for enrollment for

insurance coverage, newly insured individuals still neglected to choose a provider within the required time before auto-assignment occurred. In many cases, patients themselves were unknowingly assigned to a provider other than a health center that had heretofore been their primary-care home. This factor, coupled with the already anticipated normal rate of attrition of patient volume as more people gained insurance coverage, caused initial sharp declines in patient numbers—and therefore income—for some New Jersey FQHCs. Centers had expected some decrease in volume, but they were not prepared for the rapid loss of patients and associated income. One CMO, who described their organization as being prepared for the changing environment, remarked that this and other events still caught their organization off guard. They said:

> I think we went through the change, the hardship when it started changing when the enrollment started happening thru the marketplace, and we went into the expansion of Medicaid. And I think that we didn't expect that it would be such a drop initially…we had a big drop in numbers. So, we suffered financially.

The interviewee quoted above reported that their center was able to work through the challenges associated with the unexpected decline in their patient volume and income, but not without some financial struggles. They reported their center was able to put fixes in place and to recover financially more so than others.

In contrast, one participant who described their center as already struggling financially before the implementation of the ACA explained the critically negative impact of the auto-assignment policy that their center experienced. This participant, as noted in Chapter 7, indicated that their center was already underutilized; they were already experiencing issues associated with low patient volume and low revenues before the enrollment and assignment of newly insured individuals to providers started with the

introduction of the health insurance marketplace. The auto-assignment issue exacerbated

their problems as the implementation of the ACA evolved. The respondent described the

impact in two different statements: "We are at a disadvantage because of cash flow

needs. We are not able to set aside money for capacity building or to be more

sustainable;" and "We are struggling [because of the decrease in revenues due to low

patient volume] we had to actually lay off people. " In all, despite the early financial

problems described for this participant's center and a few others represented in this study,

more respondents noted their organizations were able to recover from the challenges

associated with the implementation of the health insurance marketplace and the Medicaid

expansion program, albeit at different paces and levels of recovery. Most of the centers

represented in this study were able to overcome the immediate financial problems and to

regain patient volume as the state and federal government corrected issues with the

enrollment process, and patients were able to change back to the centers as their primary-

care providers. More importantly, as the volume of the centers' Medicaid insured

patients increased, revenues did as well. However, five respondents (25%) representing

three different centers, reported that their centers continued to struggle with declining

patient volume and revenues in the aftermath of the ACA.

***Changes in Charity Care Reimbursement and Medicaid Payment Methodologies
Subthemes***

In further discussing the perceived challenges precipitated by external forces in

respect to the ACA, ten respondents (50%) expressed that New Jersey policies and

practices toward FQHCs generated more problems for the centers as healthcare reform

advanced than did the actual ACA legislation itself. They reported that the state's

response to the federal implementation of the ACA created additional financial threats for the FQHCs that hindered their ability to focus on or to effect capacity building initiatives in preparation for the ACA and going forward afterwards. Compounding the challenges that centers faced with decreased revenues because of the auto-assignment issue, New Jersey changed their policy on how they would reimburse centers for charity care, according to some respondents. The state terminated uncompensated-care reimbursement for individuals immediately upon determination of their eligibility for insurance coverage under the Medicaid expansion program. A critical complicating factor associated with this decision was that thousands of patients deemed eligible for Medicaid did not receive insurance coverage until they obtained their physical insurance card, which served as the official authorization for active coverage of services delivered by an approved provider. With this change in policy for charity-care reimbursement, the state denied payments for needed patient care that occurred during the gap between when a patient was determined eligible for Medicaid and when they officially received proof of their insurance coverage. Centers provided needed services with no source for reimbursement, either from Medicaid or through the state uncompensated-care fund for charity care during that critical gap.

Although New Jersey centers resolved the charity-care issue with the state before the interviews were conducted for this study, four participants highlighted it as a salient example of how state-level policy adversely affected the centers because of changes occurring under the ACA. They indicated the change in policy regarding charity care reimbursement had the most unexpected and profound impact on their immediate cash flow as provisions of the ACA were operationalized, more so than the issues associated

with the auto-assignment of patients. In effect, instead of gaining new revenues for newly insured persons, they lost income. Again, this factor exacerbated the negative financial position for New Jersey health centers; respondents described some centers' inability to focus on or participate in capacity building activities because of their uncertain financial condition, a condition worsened by changes in policy for charity-care reimbursements. Additionally, while interviewees reported that the unexpected change in how the state reimbursed for charity care caused immediate financial harm for some centers, they also underscored the adverse impact on patients; the changes also undermined patients' ability to access timely healthcare services.

The interviewees reported that in response to considerable advocacy by New Jersey FQHCs and others, New Jersey eventually reversed the uncompensated-care reimbursement policy and opted to allow payments to centers for uncompensated care until Medicaid officially activated a patient's insurance coverage. Nevertheless, the reported financial recovery from the interruption in charity care payments was slow for some centers, as noted above.

Also, all respondents who cited issues with how the state implemented polices in respect to the ACA discussed how New Jersey reimbursed the centers for Medicaid services as another salient issue that adversely impacted their financial status and the ability for capacity building. Although the centers' problems with Medicaid reimbursement preceded implementation of the ACA, and the challenges were not directly related to it, interviewees raised the problems that they experienced with Medicaid reimbursement policies and practices to illustrate their ongoing issues with how the state implemented policy without informed awareness of its unfavorable impact on

the centers and the patients they serve. Participants offered different degrees of detail in describing their understanding of the perceived or real issues with the state over Medicaid reimbursement, but one participant summed up what they believed to be the crux of the problems that centers experienced in New Jersey, at the time of this study. They said: "…the current lawsuit against the state is proving to be counterproductive. The state is playing hardball because of the suit and delaying approval of claims." This respondent explained that New Jersey FQHCs were still dealing with the impact of a lawsuit that they filed against the state in 2012. They stated that New Jersey FQHCs contested the state's Medicaid reimbursement policies and procedures for health centers. The interviewee explained that this created lengthy delays in centers' receiving payment for services. They asserted that the state's payment practices were unfair and not in keeping with the federal policies for reimbursement to FQHCs. Another respondent, speaking to the same issues with Medicaid, offered that centers in general thought that state-level policies that guided how New Jersey interacted with or regulated health centers were not helpful to FQHCs, especially with respect to the ACA, for promoting capacity building or otherwise. This participant stated:

> Well to me, they [New Jersey] have been more harmful to the centers than they've been helpful. I mean the ACA is not a state initiative…but as far as, I guess, I am biased toward the state of New Jersey, and we are the only state that sued Medicaid just to let you know. So, of course they have their biases with us also…they take their time paying us. Like Medicaid wraparound…they take forever to pay us, so we sued them, and we won, and they still didn't pay…So now we are going back to court…

In the text above, this participant referred to the Medicaid wraparound, which is a methodology for Medicaid reimbursement for FQHCs. Also, in this text, they clearly meant they were biased against the state of New Jersey. They clarified that problems

about how New Jersey handles Medicaid payments to FQHCs led to the lawsuit that is discussed above. The same respondent reiterated that problems associated with how New Jersey reimburses FQHCs for services are not new or specific to the ACA, but the Medicaid lawsuit when coupled with other reimbursement problems with the state, worsened the financial challenges for some New Jersey centers as the ACA approached. The frustrations expressed by respondents over the state's relationship with the centers resonated across most of the interviews. Even those participants who recounted that their centers were able to recoup financially and more quickly than others in the aftermath of some of the policy-induced issues, still thought it important to emphasize the negative impact of state- level policy on FQHCs in the face of the ACA. One participant observed that: "the state has persisted in tying our hands and promulgating rules and policies that have hurt centers financially, and in our ability to expand services." The relationship between New Jersey's health centers and the state, as discussed in Chapter 3 has changed repeatedly over the history of the centers. Despite the sentiment expressed in the statement above, the literature and documents show that New Jersey has at times been incredibly supportive of FQHCs. The support or the challenges posed by the state appear to be linked to the political climate and economic status of the state in different periods, national trends in healthcare, and the external support that is demonstrated for the state's centers during any given period in their history. However, how the state regulates and sets policies that impact the centers is a fertile area for research aimed at building knowledge that benefits both parties and their mutual ability to create, promulgate, and enact policies and practices that can lead to more effective collaboration and practices that better serve New Jersey residents.

Finally, regarding the external factors that influenced the impact of the ACA on the centers, participants indicated that centers did expect that federal implementation of the law, state-level Medicaid expansion, and changes around how healthcare providers align to deliver care might drive greater competition for centers. However, twelve of the 20 interviewees (60%) expressed that their centers were prepared, since before implementation of the ACA, for increased competition. Conversely, two of the respondents thought their centers were definitely not positioned to handle competition, before or after the ACA, while the rest were either unsure or did not offer an opinion. But the expressed confidence in their level of preparedness to handle increased competition emanated from different perspectives about the impact of the FQHC model, their relationship with their patients/communities, and their ready capacity to attract and retain patients, especially their historical base of patients. This was more so, for some respondents, than from stated evidence or examples of capacity building aimed at preparing for enhanced competition.

When asked if they anticipated heightened competition under the ACA as a challenge for New Jersey centers, most interviewees readily agreed that increased competition was a reality. Nevertheless, they did not think it was as significant of an issue for centers as was the auto-assignment problem in affecting their ability to retain patients. While they acknowledged the threat of increased competition and its potential impact, the data did not reflect that they were overly concerned about it. They indicated that managing unforced competition was something within their control to manage. As such, ten respondents (50%) did talk about capacity building efforts specifically to ensure their ability to compete more effectively for newly insured patients. As described in

previous chapters, these efforts included attention to making clinical-care facilities more

attractive and patient-friendly, enhancing their ability to facilitate access to care through

developing new access capacity, and enhancing practices to improve primary-care

delivery and outcomes, among other efforts. Some of these respondents, plus other

participants (8 or 40%) who anticipated greater competition revealed, as noted above, that

their organizations could also rely on the FQHC legacy to bolster their ability to attract

and retain patients. They strongly anticipated that even if heretofore FQHC patients

selected a new provider upon acquiring health insurance, patients would eventually return

to their FQHC home because of the care they received, the relationships centers have

cultivated within their host communities, and the center's ability to deliver culturally and

linguistically appropriate services (CLAS).

Additionally, some of these same respondents commented that they believed the

private providers were already leaving or would soon leave the Medicaid market because

of the low reimbursement rates that they received. Medicaid does not reimburse private

providers at the same rate as they do for FQHCs. They predicted that as private providers

left the Medicaid market, newly insured patients would return to the centers.

Notwithstanding this group's views about the low threat of competition, most of

them still noted it was not a factor to ignore. To this point, one respondent explained

how they viewed competition. The interviewee observed:

> There are more patients insured and more providers that may be competing for the
> patients that we would normally serve. We have to do more to partner with
> others. Providers are expanding their reach across county lines into other areas

This interviewee conveyed that not only did they anticipate competition, but also that

centers should consider the fact that they do not have unlimited ability to accommodate

continual growth in patient numbers. They emphasized that competition with other primary-care providers was not the main challenge for FQHCs, rather it is the anticipated lack of primary-care capacity at some point to handle the volume of patients who need access to primary-care services. They advocated for changes that focused less on competing for patients and more on partnering with other primary-care providers in their communities to build additional access to primary-care services. This same participant hoped to ward off what they perceived as the greater threat from non-primary care organizations moving into their service areas, particularly urgent-care organizations that do not, in their estimation, promote primary care or the importance of it. This CMO respondent was concerned about the growing proliferation of freestanding urgent-care providers occurring with the expansion of insurance coverage for patients. Their concern emanated more from their view about the importance of primary care—its focus on patient-centered care and the overall well-being of individuals. Their views reflected their understanding of the need to promote and provide access to primary-care services more so than any concerns about competition for patients or service revenues.

Some may argue that the ACA and related federal policies that aid expansion of insurance coverage and access to new healthcare services did play a part in the proliferation of urgent-care organizations. Whether or not the increase in urgent-care services is eroding utilization of primary care and its benefits is another area that requires further examination and understanding as centers and others continue to promote the value of primary care and its importance in healthcare reform.

Summary of Findings—Research Question 2 and Key Concept: ACA

The data consistently point to the perceived readiness of some centers to perform more efficiently and sustainably than others, notwithstanding the influence of the ACA. But despite participants' perceptions about readiness for the ACA and healthcare reform, most interviewees described meaningful, positive benefit derived for FQHCs because of the ACA. Importantly however, they did not portray the ACA as a harbinger of change for the centers because of the opportunities that it provided for them to strengthen their operations, access capacity, and so forth. Many respondents indicated it did not change how the centers operated, nor did it alter their short-term or strategic goals. Importantly, most interviewees did not view it as a critical factor in driving capacity building for centers, but more as an opportunity to take advantage of the benefits that facilitated or aided in capacity building. In some cases, the challenges and unintended consequences of the policies associated with the ACA upon its initial implementation dampened some enthusiasm for the ACA as a pathway to support capacity building, long term.

However, overall, as indicated in this chapter and in Chapter 7, many interviewees saw the ACA as creating significant positive opportunities for FQHCs, despite the external factors that tested their organizations' ready ability to manage the early, unexpected, and rapid declines in New Jersey centers' revenues and patient volumes because of policies linked to the ACA. They recounted an overall positive impact for their centers because of the ACA; the centers did experience increased revenues associated with Medicaid expansion and an increase in patient volumes. They also received some enhanced appropriations and grant dollars for expansion, and to improve their infrastructure and operational systems. The ACA also provided leverage

for centers to participate at a different level with healthcare systems in forging new models for healthcare delivery. Clearly, however, the impact or benefit that resonated positively across all the participants was again the ACA's focus on promoting patient-centered primary care and improving access to care for vulnerable, previously uninsured populations and individuals.

How the participants framed the impact of the ACA highlighted again the fact that the centers experienced different degrees of preparedness to manage the changes that occurred because of the ACA.

As in the previous chapter, Table 10 shows the numbers and percentages of interviewees who contributed to the key findings for research question two. Also, as explained in Chapter 7, and for the reasons outlined therein, the percentages shown in this table may not add up to 100.

Table 10

Summary of Key Findings for Research Question 2 and Percentage of Interviewees and Centers Associated with Each Finding.

Key Findings	Interviewees (N=20)		FQHCs Represented (N=10)	
	n	%	n	%
The ACA presented a "mixed bag" of opportunities and challenges for the centers, however, the advantages (enhanced funding support; Medicaid expansion and new source of revenue; development of new access capacity; improvements to infrastructure) outweighed the challenges.	11	55	7	70
The ACA resulted in critical adverse challenges for the centers that led to or contributed to long-term financial instability for some.	5	25	3	30
External factors—specifically, state level public policies—created undue problems that affected how FHQCs engaged in capacity building or benefited from it with respect to the ACA.	10	50	9	90
Medicaid expansion had the most significant positive impact for New Jersey FQHCs and the opportunity to foster greater self-reliance.	9	45	6	60
FQHCs were inherently prepared for increased competition under the ACA	12	60	7	70

CHAPTER 9: RESEARCH STUDY RESULTS—RESEARCH QUESTION THREE: SUSTAINABILITY

In the experience of this researcher, FQHCs have faced persistent challenges associated with the sustainability of programs and services. As such, the third research question for this study asks: Can FQHCs leverage the opportunities afforded by the ACA to foster greater sustainability—programmatically and financially? As previously discussed, this question builds upon an original premise for this study, that deliberate capacity building is necessary to ensure the sustainability of FQHCs, as well as their financial independence. In the early phase of exploring this premise, the pilot focus group data strongly supported refining the interview questions to understand how the FQHC family conceptualizes sustainability for Community Health Centers. What does sustainability mean to them? Is capacity building thought to be a crucial factor in health centers' ability to sustain expansions achieved under the ACA? Or do centers attribute sustainability of their programs and services to other factors? Also, as discussed in Chapter 5, the pilot focus group thought it important to understand whether or not centers pursue capacity building with sustainability as a key goal or outcome for their organizations. Thus, the issue of sustainability evolved in this study as an important, related concept to explore in the interviews. Like capacity building, it is a complex and multidimensional topic. Further, for the purposes of this study, the main study interviews and data analysis focused primarily on whether participants thought capacity building positioned them for sustainability, as they defined it. Altogether, while centers have demonstrated the ability to maintain the FQHC mission and model of care since the 1960s, most interviewees highlighted critical issues associated with the sustainability of

FQHC services and programs, as well as expanded access to care, in today's increasingly

complex healthcare environment. Study participants emphasized that the challenges

FQHCs face with respect to sustainability extend beyond the immediate control of the

centers. These issues are highlighted in the data relevant to the findings discussed in this

chapter.

As in the previous results Chapters 7 and 8, the Brown et al., (2001) Conceptual

Framework is used to guide analysis of the data related to sustainability. In the

Conceptual Framework model, sustainability is described as increased financial self-

reliance or the ability to generate resources and/or a healthy, reliable funding base. It is

one of the key characteristics associated with capacity building. Sustainability, as

described by Brown et al. is a capacity component outcome at the healthcare systems and

organizational levels. Notably, increased financial self-reliance does not necessarily

involve financial independence. As defined by Brown et al., I included sustainability in

Table 8 as a capacity component outcome. Also, interviewees described capacity

building activities, goals, and outcomes that they highlighted as being important to their

understanding of the concept of sustainability and the idea of increased financial self-

reliance.

Table 8, which illustrates the codes, capacity components, and themes mapped to

sustainability, is repeated here to facilitate easy reference to the relevant research data.

Table 8

Mapping Capacity Building in New Jersey FQHCs—Key Concept: Sustainability

Key concept and associated research question	Capacity components/variables	Themes	List of broad codes and sub-codes
Key concept: sustainability	**Inputs**:	Mission vs. margin—perceptions that frame issues of sustainability for FQHCs	mission vision strategic plan CHC history, viability charity care policies and regulations FQHC reimbursement
Research question:	mission [a] [b] finances [a] [b] history and culture [a] [b] leadership [a] [b] political capital [a] resource allocation health policy laws and regulations [a] [b] marketing [a] donor coordination finances		
Can FQHCs leverage the opportunities afforded by the ACA to build greater capacity toward sustainability?		Operational enhancements to address infrastructure needs, aid in efforts to develop greater self-reliance and sustainability	communications plan quality improvement structure providers industry competition
	Process:		HRSA requirements community
	strategic planning financial management [a] resource mobilization [a] [b] collaboration	External influencers affect FQHCs efforts aimed at greater self-reliance and sustainability	impact of state advocacy, social and political capital
	Outcomes:		
	strategic finifical plan coaliations [a] [b] viability [b] increased self-reliance [a] [b]		

[a] Focus Group Data
[b] Interview Data

The research findings illustrated in this chapter indicate that the majority of the 20 interviewees do think of sustainability as a multidimensional concept. They conveyed the understanding that financial self-reliance is but one aspect of sustainability for healthcare organizations. Thematic patterns in the data show that eleven participants (55%) referred to the importance of preserving institutional mission and culture as critical

factors in sustaining the integrity and identity of an organization, especially FQHCs. Additionally, the data point to participants' views about the impact of external environmental factors on the sustainability of centers. As seen in previous results chapters, participants readily identify those external factors (i.e. public policy and regulations) that they believe influence capacity building in FQHCs. The data examined in this chapter show that participants identified some of these same factors as being important to the sustainability of FQHCs, notwithstanding efforts toward capacity building.

The results reviewed in this chapter are organized by the salient themes found in the data. These themes illustrate how participants characterize sustainability in respect to FQHCs, how they perceive the impact of the ACA, and more specifically capacity building, in fostering sustainability of the FQHC model, programs and services.

The themes linked to sustainability for FQHCs are (a) mission vs. margin—perceptions that frame issues of sustainability for FQHCs; (b) operational enhancements to address infrastructure needs aid in efforts to develop greater self-reliance and sustainability; and (c) external influencers affect FQHC's efforts aimed at greater self-reliance and sustainability. Across the data, there is variability in how participants viewed sustainability, just as with their views on capacity building. However, despite these differences, they were more aligned than not in their perspectives about the relationship between capacity building and sustainability in FQHCs. Seventy-five percent (75%) of interviewees also shared the belief that external public financial support was just as important, if not more so, than capacity building in addressing sustainability for FQHCs. This perspective resonates across each theme as outlined below.

Mission vs Margin Theme

Interviewees were asked to describe their understanding of sustainability and how they viewed FQHCs' approach to it. They were also encouraged to talk about sustainability as an outcome of capacity building. Almost equally divided, participants aligned along two viewpoints in how they defined or characterized sustainability in centers. They identified two different but related perspectives, which emerged as two subthemes that shaped the broader mission vs. margin theme. The subthemes articulated by 55% and 45% of interviewees respectively are: (a) no mission–no FQHC and (b) no margin–no mission.

All interviewees agreed that sustainability is an important topic for FQHCs, however, they did not agree on what defined sustainability for centers. But there was considerable alignment on the viewpoint that independent financial sustainability may not be an optimal or even desirable goal for FQHCs. Thirteen participants (65%) agreed more with the definition found in the Brown et al., (2001) Conceptual Framework that describes sustainability as increased financial self-reliance, not financial independence. Furthermore, some participants questioned whether centers should engage in capacity building aimed at achieving financial independence at any expense to the mission and identity of FQHCs. These participants were among those who reasoned the no mission– no FQHC viewpoint. They articulated that sustainability for health centers should be driven more by goals that pertain to preserving the mission, culture, and brand of FQHCs than by goals to achieve financial independence. They cautioned against a pure business orientation concerning sustainability for FQHCs. This same group further offered that

sustainability, if defined as financial independence, should not be the desired, ultimate

outcome for capacity building for FQHCs.

Meanwhile, those who expressed support for the no margin–no mission theme

countered that the mission and the pursuit of sustainability for FQHCs are not conflicting

goals. However, like their other colleagues, this group of participants was also careful to

clarify that they do not subscribe to the definition of sustainability for FQHCs as total

financial independence. However, they were emphatic in their view that FQHCs must be

more deliberate about pursuing capacity building toward achieving greater financial self-

reliance.

No Mission–No FQHC Subtheme

Underscoring the findings in Chapter 7, respondents who stressed the importance

of having a patient-centered/community-focused orientation toward capacity building

maintained a similar orientation in how they viewed issues of sustainability for FQHCs.

These respondents formed the cohort of participants who expressed the no mission–no

FQHC sub-theme. Their primary message was that centers should not be driven by goals

for financial sustainability, especially financial independence, without regard to the

impact on the patients and the communities they serve. This same group of respondents

raised concerns that efforts toward that end could jeopardize centers' focus on, or

commitment to, the mission. Most participants espousing this view expressed some

variation of this perspective. Their reflections on the issue are captured in the statements

made by two clinicians and a front-line staff member, respectively, who offered the

following views:

> …if you want to talk about really sustainability, then you have to make sure that
> you are fiscally responsible and that sort of in of itself implies that you have to

have a business strategy and a business model in mind. But you know you don't have that, at least I would not want to have that model, at the expense of patient care...never at the expense of the patient.

We are a non-profit organization and our goal is not to produce revenue. That is what the business model would do. We have to be careful that we do not change our priorities of putting the patient first and taking care of those that need FQHCs. We can be self-sustaining, but not to generate profits.

There is a limit to how much you can do and still remain a health center. And without a health center, it would be a private business at that point you know. …If all you are worried about is sustainability and not the health and the needs of the people that you are trying to serve, the underserved population, then you might lose. You might not be a health center any more…you have to be true to the mission, basically.

These data excerpts accentuate participants' views about the fundamental purpose of

FQHCs; the organizations exist to serve the patients/communities. They exist to provide

healthcare for those underserved or unserved individuals or populations who experience

socioeconomic challenges that affect their access to comprehensive primary healthcare

services. In the comments quoted above, respondents explained that FQHCs' attention to

sustainability must be about ensuring their ability to deliver on their purpose. Moreover,

they must maintain their focus on the patient, not the financial bottom line of the

organization. Interviewees who supported this stance cautioned that a singular focus on

financial sustainability, in which centers valued the business model over their mission,

could adversely impact who they are. It could impact their existence as an FQHC. This

view is aptly captured above.

Notably, also illustrated in the data supporting this subtheme, most respondents in

this group did agree also that centers should seek to guarantee their capacity for fiscal

responsibility. But importantly, they also thought that when there is a conflict between

the business side of the center and providing care for the patient, decisions should not be

made at the expense of the patient. Equally important, the CMOs stressed that providers should not be arbitrators of when or how patients receive care based on the patient's ability to pay or their insurance status.

Briefly, to clarify here, although centers are mandated to see patients regardless of their ability to pay, they can still require that patients pay some minimum share of the cost of their care, co-payment, or deductible where applicable. To the concern of some FQHC providers, more centers are reportedly adopting practices to enforce internal policies that require patients to contribute to their care, no matter how minimal that contribution might be.

Added to the reasons why centers are considering organizational policies to enforce some small payment from patients is the fact that federal grants do not fully cover all mandated FQHC services. Clinicians and others do not want to triage who gets what services when patients cannot pay for them. Nevertheless, some centers are struggling to maintain a broad scope of unreimbursed or inadequately reimbursed services and programs. One interviewee offered that their center is considering triaging how and when patients receive such uncovered services. Within this context, one of the CMOs, whose views are summarized above, stressed that financial sustainability should never be pursued at the expense of the patient. They said:

> At times, they [financial sustainability and patient care] conflict with each other.
> I believe—so you want to make sure—that whatever business model you have in
> place that our financial and fiscal people should deal, probably, with that and they
> do.

This CMO was adamant that the provider staff and all those who deliver services to the patients should not be burdened with concerns about how, or if, a patient can pay

for their care. They emphasized that financial concerns should not be a factor in how or when clinicians engage in patient care. Indirectly, this participant underlined the need for efficient leadership and the presence of functioning financial management staff and systems (all capacity components) to manage issues associated with how and when patients pay for services. This infrastructure is necessary for centers to maintain the clinicians' ability to focus on the patient instead of the business side of the operations, although arguably, clinicians do have a role in ensuring the sustainability of the organizations. Nevertheless, from the perspective of the CMO quoted above, providers should not be conflicted in their role as primary-care clinicians.

Additionally, participants who espoused to both the no mission–no FQHC theme and the patient-centered/community-focused theme described in Chapter 7 asserted further that patient-centered care is not just a desirable outcome for FQHCs, it is also integral and necessary to ensuring sustainability. The data highlighting this perspective is illustrated in these remarks, in which three participants, a CMO, a front-line team member, and a CEO said:

> Patient satisfaction is the measurement of sustainability.

> If we provide a service that patients need and want, we are more sustainable

> Sustainability and stability to me are all in one to make sure, to me anyway, that staff are satisfied, that you listen to what the issues are and that you try to work with staff or patients to make sure that this is really where they want to come or this really is where they want to work…You know to make sure that this is a place that people want to come to. Whether it's an employee or a patient.

The participants cited here sought to stress the importance of focusing on caring for the needs of the patients and the community, and in the last statement, also the needs of the staff in how centers approach sustainability. Historically, FQHCs have celebrated the

loyalty of their staff, patients, and communities to the FQHC mission. Participants

reflected on this and the importance that FQHC constituents place on centers. In

underscoring this point, the no mission–no FQHC sub-group reiterated that centers are

not only located in the community, they are also an important part of the community.

Furthermore, these participants maintain that centers must strive to maintain their

relationship and perceived value as patient-centered, community-based providers. They

suggested that FQHCs' value as such is a critical factor in their ability to secure

necessary external resources to sustain their mission, to have a reliable funding base

beyond that of the federal grant. Additionally, they emphasized the fact that centers

provide needed quality services that patients also value. A non-physician clinician

underlined this perspective in the text found below:

> Obviously, sustainability would be the ability to continue to do, to provide what
> you have been providing over time….It's a balancing act…looking at the whole
> sustainability issue, when patients come—I think that what keeps them coming
> back is that you are not cutting services, you are doing what you said you were
> going to do, and the patients will become you know over time [to see] this is their
> medical home. And they will bring their cousin, aunt, and brother. And you
> know it allows…for continuation.

The respondent cited here offered this view in the context of relaying their long- time

experience with FQHCs. They stressed that in their experience quality of care, a

consistent presence, and consistency in service, are important in the retention of FQHC

patients and in growing the patient and revenue base. In this text, this same clinician

characterized sustainability as "continuation," the ability to continue to provide what you

have been providing over time. Probed for clarification, they confirmed that they view

the capacity of centers to be able to continue to provide consistent services—to be there

for the patient—as critical to the ability of FQHCs to remain sustainable organizations.

They emphasized the importance of the patient/community relationship with centers. They expressed that the patient's trust in the organization's presence and the consistency of their services is one of the factors they believed to be most important to the sustainability of FQHCs. In this respondent's experience, some centers have not always had the capacity to be consistent in their ability to maintain services or the programs they offer. Too often centers are faced with having to cut back on services or to discontinue programs because of inadequate funding or other challenges. In their view, this affects patient loyalty, external funding support, and thus the overall sustainability of organizations.

Although the segment of participants who espoused the no mission–no FQHC subtheme stressed the importance of the mission and its influence on the sustainability of FQHCs, five of the interviewees in this subgroup (n=11) did also acknowledge the financial challenges associated with the mission. Because of the increasing burden of providing uncompensated care, despite the expansion of insurance coverage, several of these same interviewees emphasized the financial challenges that persist for some centers in caring for a disproportionate share of the uninsured. However, they still held to the view that centers must look for innovative ways to overcome the challenges without compromising the mission. They still viewed the mission as being more of an asset than a barrier in fostering sustainability of FQHCs. One clinical participant, who held this viewpoint succinctly summarized this perspective in the text below:

> The mission does not present any challenge to sustainability or capacity building. I don't agree that it does. It is who we are. We must look to other ways to make us solvent and to sustain capacity.

Altogether, for those respondents who supported the no mission–no FQHC theme, capacity building aimed at sustainability must focus on remaining true to the mission, and thus to the organizations' identity as an FQHC. Clinicians in this group also offered that quality of care and patient satisfaction should be the measures for fostering sustainability, as much as, if not more so, financial profit for FQHCs. All those in this group voiced concern that FQHCs that focus principally on the bottom line might lose sight of who and what they are, and they run the risk of becoming a business other than an FQHC. A respondent who especially held to this subtheme said: "We reinforce our values, our commitment to mission and our vision, constantly to remind us of who we are and why we exist." This statement aptly captured the sentiment of those interviewees who touted the no mission–no FQHC subtheme. This group essentially argued that the pathway toward sustainability for FQHCs must follow a different model than that of a traditional business approach.

No Margin—No Mission Subtheme

Contrary to their colleagues who emphasized the importance of the FQHC mission in fostering sustainability for FQHCs, an almost equal number of interviewees recounted the financial challenges that some centers face and the adverse impact of the FQHC mission in overcoming those challenges. While they also strongly value being an FQHC, they believe equally strongly that FQHCs must do business differently to increase their ability to sustain the mission, to become more self-reliant and less dependent on federal grants. This group more readily interjected the fact that centers must see patients regardless of their ability to pay. FQHCs must provide services that are not reimbursable; moreover, federal funding for FQHCs does not cover such services

entirely. In this no margin–no mission subgroup's view, these issues present significant barriers to sustainability for FQHCs. They also emphasized their belief that centers must engage in capacity building to achieve greater financial self-reliance. One CEO concisely captured the central message in this subtheme in the following statement: "The mission is important but not having the resources to continue it is a problem." The same interviewee quoted here echoed the practical stance of other interviewees who offered that it takes money to sustain the mission. All respondents who supported this view that centers must have a focus on financial sustainability stressed that the issue of sustainability is not a chicken and egg game. Dollars are needed foremost to drive their ability to achieve the mission. They can no longer rely on the mission to ensure the dollars. Underlining this viewpoint is the increasing recognition that centers are operating in an environment where the ability to rely on public grant dollars or state level subsidies is decreasing. Centers, like all other healthcare providers, must look toward service generated revenues to support their operations and mission.

From the perspective of those who informed the no margin–no mission subtheme, the environmental realities, coupled with their mandate to provide services for patients regardless of their ability to pay, makes it necessary for centers to be more deliberate about capacity building toward greater financial self-reliance. Again, this group, like their colleagues, did not describe sustainability as total financial independence. Their view of sustainability centered on their belief that centers should develop the ability to control their financial position and outlook. They explained this as having the ability to plan for, and to foster, reasonable growth, as well as enhancements to the organization's infrastructure and performance. And most important, the ability to maintain it or devise

innovative relationships to ensure patients can have continuity of services and care as necessary.

This group disagreed with their colleagues about the strength of the FQHC mission as a reliable factor in generating the type of public and private support that it may have once engendered towards health centers. One respondent highlighted the challenges of relying on the mission in today's environment to drive sustainability. They said: "Getting people to see and actually believe in the mission, to try to attract people to it— that is really difficult, because the world is so margin driven." This respondent pointed to the fact that the healthcare industry is increasingly outcomes driven. In discussion, they and other respondents displayed knowledge and understanding that under the ACA, healthcare providers are pushed to demonstrate value, to show their impact on driving down costs, improving quality, and improving healthcare outcomes. The mission is important, and it continues to help centers attract dollars to some extent, but outcomes and return on value are today's mantras in healthcare. More specifically, CEO level interviewees especially noted that the industry is margin driven in that dollars (grants and provider contracts) are being targeted more toward those who can demonstrate capacity to deliver not only on quality services, but also on financial management to control costs, as well as to ensure the availability of access.

Two respondents offered additional remarks that reflect the views of participants who informed the no margin–no mission theme:

> We have expanded hours, but we are seeing less [sic] patients. This is a problem. It is also a problem that we, the FQHC, is not allowed to show a profit—this impacts sustainability. You have to have the dollars to be sustainable.

> …Financial viability is the biggest problem.

As indicated by the respondent in the first statement, despite their center's efforts toward expansion, they were not seeing the volume of patients needed to support the expansion. Plus, they expressed frustration with the fact that they had no financial reserves. They explained that this is due to their understanding that FQHCs are not allowed to show a profit. Briefly, this respondent was referring to the belief that their federal grant dollars might be offset by whatever net revenues that they generate from patient care. Many healthcare leaders have commonly cited this as a problem in that, in their view, this does not allow centers to build the reserves necessary to plan for long-term sustainability. While, this researcher did not confirm that this policy was still in existence at the time of this study, the respondents held that their understanding of it forces them to think more about short-term viability than planning for long-term sustainability. As this researcher has heard it phrased, the practice causes them to live from paycheck to paycheck. But as implied in the text above, the overall data that defined this subtheme stresses that centers must be able to generate adequate revenues to become more financially self-reliant.

Some clinician level interviewees, although they supported the no mission–no FQHC subtheme, also supported the need for centers to become more aggressive or attentive to generating additional revenues or new sources of financial support. Two clinical-level interviewees, who initially strongly asserted that the mission should be at the core of how centers view sustainability, added that centers need to pursue increased financial strength. They stated:

> …It's really unfortunately a dollar/cents proposition. That's the best way [for] any system to sustain…it has to have the proper funding.

> I think at the end of the day, you can't sustain it if you are not making money. I mean it's just the reality. As much as people don't think that healthcare is a business, it really is.

Although cautious in how they presented this information, these two clinicians did acknowledge the need for centers to generate money to sustain services. They believed FQHCs must have a plan to drive financial viability if not long-term sustainability. Nevertheless, they also held to their position that FQHC efforts toward sustainability should not be at the expense of patients.

But those adhering more purely to the no margin–no mission subtheme proposed that patients must take more financial responsibility for contributing to their own care. These same participants recognized that patients' contributions might result in nominal payments. However, they suggested that the mission dissuades some patients from contributing to their care, and it perpetuates the belief that centers are wholly supported by federal grant dollars. Moreover, it does not empower populations and communities to be a part of sustaining FQHC services. Participants did not suggest how centers should enforce payment from all patients. But they stressed that the mission and mandate of taking all comers increasingly frustrated FQHCs' ability to achieve long-term financial sustainability, as well as short-term financial stability. The CFO participant clearly shared this view; they said: "The mission hampers us when you have to take all comers regardless of ability to pay and the cost of their care."

Two other interviewees, a board member and CEO, both from the same center, also described their perceptions about the impact of the mission and their experience with those patients who do not contribute financially to support it. They said:

> I think the numbers have gone up and the types of people have changed; we have more people not willing, not willing but able to pay.

> …there has to be some penalties for the patients that are eligible for certain things and they don't enroll, and to not rely on us to create special discounts if they're not meeting their eligibility or doing what they're supposed to do.

The board member cited in the first excerpt above explained that the types of people using their main clinical facility were changing. The demographics of their community are changing, with new populations who share no history with, or commitment to, the center. In this respondent's view, new populations have little knowledge of the importance of the contributions made by centers over the years in addressing community healthcare needs. This board member felt that patients were not willing to pay because of a perception that the center is supported and sustained through government funding, or patients just do not think about how the center continues to provide services. Either way, this board member suggested that patients should either be willing or forced to contribute to their care and thus to sustaining FQHC services for the community. They suggested that the ability of FQHCs to rely on patient and community loyalty to support the institutions even minimally was changing with the changing demographics of the communities.

Four respondents (20%) who also said their centers were being impacted by the dynamics of a changing community recounted that their organizations instituted enhanced outreach efforts to their host communities to build new relationships and to cultivate greater patient and community investment in supporting the organizations. However, they did not comment on the impact of these efforts in incentivizing patients to pay for any portion of their care.

In the second text cited above, the interviewee explained that their center was overwhelmed with patients who refused to pay or who did not readily take advantage of the opportunity to acquire insurance coverage. This same interviewee clarified that in addition to some patients being unwilling to pay, some patients also delayed enrolling in

health insurance under the ACA, or they declined to take up health insurance altogether. This CEO commented that patients who could get health insurance and did not, should be forced to pay some share of the cost for their healthcare. They did not see their stance about requiring patients to contribute to their care as dismissing the FQHC mission. They believed that patients must be more invested in sustaining healthcare services and especially FQHCs that are their medical homes.

Altogether, many of the participants—some more passionate than others about preserving the mission—did agree that all FQHCs must have some focus on ensuring resources to sustain services. Those who stressed the importance of centers directing more attention to issues of financial sustainability were also more inclined to view the mission as a challenge to the sustainability of the organizations. But they also did not think the mission prohibited centers from capacity building to achieve financial self-reliance. One CEO summarized this view, saying: "The mission creates challenges, especially when you know you will not get paid, but it does not hamper capacity building or the pursuit of sustainability. It does not have to be a conflict."

Operational Enhancements to Address Infrastructure Needs Theme

Although the infrastructure needs theme received less focus related directly to the sustainability concept than it did in the previous results chapter on capacity building, eleven of the interviewees (55%) did identify infrastructure development as an important capacity component related to the sustainability of health centers. In Chapter 7, which focused on capacity building activities in FQHCs, many participants described significant infrastructure developments under the ACA and/or capacity components that supported infrastructure development in centers. In this theme relative to sustainability, five of the

participating CEOs specifically stated that one of the goals for enhancing organizational

infrastructure was to shore up their ability to ensure greater sustainability of the new

access capacity they achieved with the grant dollars provided through the ACA.

One seemingly progressive CEO, whose view is representative of other

participants, explained that infrastructure development is necessary to promote

sustainability in the face of increased competition under the ACA. They commented:

> So here we are realizing that we have taken the challenge and we must be
> sustainable, and we must be relevant and operate under ambulatory care
> guidelines…. And, here is the problem. Do you know we are engaged in a
> healthcare environment and Affordable Care Act, which gives grants to other
> entities who are not patient focused…? We are in an age where the Affordable
> Care Act is issuing or funding grants to these non-clinical entities to offer the
> same services. So now we have a problem. We are striving to be sustainable and
> to be sustainable we have to get resources so that we can put in place the
> infrastructure to handle these new relevant issues….

This CEO recounted their center's success in building a more robust human resource

department and new IT capabilities among other initiatives to support their efforts toward

sustaining programs and services, as well as new access capacity. As described

previously, this respondent's center hired a skilled Chief Human Resource Officer, a

move that they thought necessary to build a skilled team to support advanced operational

functions, such as financial management. They also enhanced their IT capabilities and

instituted a paperless system to facilitate their capacity to better manage patient medical

information and care coordination. The same CEO recited other developments, but

importantly they said that they viewed these efforts as strategic capacity building to

promote sustainability in the face of increased competition for resources and for patients.

This interviewee articulated awareness of the growing competition that centers face

because of the ACA's push to support new models for primary-care delivery and to help

meet heightened demand for access to primary-care services. They conveyed that since centers accepted the designation as essential providers under the ACA, utilized the federal grant dollars for expansion, and touted their ability to grow access to primary-care services, they must now be able to sustain all that was gained. Importantly, the CEO thought that centers must also be able to operate in a new environment, in a more sustainable way. To do this, health centers need the necessary infrastructure, including human resources, effective financial systems, and other highly functional systems such as IT management, and so forth.

Participants (40%) also highlighted the enhancement of IT systems as one of the principal areas for infrastructure development under the ACA. Advanced IT capacity is critical to aid in developing more advanced financial systems in centers as new payment models have emerged because of the ACA. The one CFO participant, in anticipating the push for expansion of FQHCs, commented on the need for more sophisticated technology and skills to sustain expansions. The CFO remarked that: "We need [the tools] to be able to forecast revenues better in order to sustain new programs, before we incur new costs." The CFO did not think their center had the infrastructure in place, especially IT, to handle expansion in a sustainable way under the ACA. They were concerned about expansion without first counting the cost. They did not have the IT sophistication and in-house ability to project and plan for sustaining growth.

Most respondents agreed that centers need optimal infrastructure, effective systems, and organizational functioning, to be competitive, sustainable providers in the evolving landscape.

Impact of External Influencers Theme

The Brown et al., (2001) Conceptual Framework, described in Chapter 7,

illustrates those external factors that are linked to capacity building across all levels of the

healthcare system. In the Conceptual Framework, these factors are also referred to as

contextual or environmental variables. They include political, cultural, regulatory, legal,

social and economic variables. In Table 8, external variables that are identified in the

research data are labeled and depicted as capacity components. For example, data that

points to the influence of government laws and regulations that determine how centers

are funded are included in the concept map as input capacity components. Government

laws and regulations influence two of the main sources of revenues for FQHCs—grants

and reimbursement for services. Both are critical factors in determining the ability of

centers to move toward sustainability or greater self-reliance.

Overall, the relevant data that informed this theme shows that some participants

did actively engage in efforts to control external factors that they believe affect their

ability to achieve financial self-reliance. The research data highlight that participants are

aware that some external factors present challenges that may be beyond their control (i.e.

geographic factors); however, the data also shows that they seek to act where they can to

mitigate adverse external influence on their financial position, near and long term. One

board member offered that centers operate in an environment of uncertainty and change,

saying: "Centers should strive to maintain what they have, but it's hard to know what is

going to happen." They suggested further that despite the uncertainty about the impact of

policies, regulations, funding, and so on, centers must continuously and deliberately seek

to be sustainable entities. This same board member and other respondents contended that

through capacity building and deliberate planning, FQHCs can position their

organizations for greater financial self-reliance, despite the influence of some

environmental factors. For example, the study results show that six of the centers (60%)

represented in this study demonstrated a ready ability to recover financially in the

aftermath of a sharp decline in their revenues and patient volume, albeit some among this

group recovered more rapidly than others. As explained previously, the decrease in

patient volume and revenues at the onset of the ACA was largely caused by the

unintended, adverse impact of federal and state rules and regulations related to the rollout

of the ACA and New Jersey reimbursement policies and practices for FQHCs. This is

significant here because respondents representing the six centers talked about the need for

greater self-reliance and the strategic ability of their organizations to recover financially.

They linked their center's recovery to the presence of critical capacity components.

These components included the presence of a functioning infrastructure (IT, Human

Resources, and efficient financial systems) to manage change, as well as critical

leadership, partnerships, and political capital. Because of their level of preparedness, the

presence of essential capacity components, and their ability to perform as needed, these

organizations had the ability to weather the unanticipated adverse impact of the rules that

governed how some ACA provisions were implemented.

Eight participants (40%) also expounded upon the importance of centers staying

abreast of changes and trends in the environment. They viewed knowledge, training, and

education as salient capacity component inputs that aided in their ability to manage the

impact of change. One CEO attributed their center's ability to stay relevant and to

remain a viable organization, in part, to their efforts to understand and anticipate

environmental changes. This respondent said:

> We always try to keep up with what's happening…We always have to make sure
> that we stay one step ahead of what is going on, what's happening…we bring
> those changes to the doctors first and then the staff and then we have to educate,
> educate, educate…

This same CEO stressed the importance and power of knowledge, such as understanding

industry trends and engaging in continuous learning about the environment in which they

operate, as being key to their ability to cope with and manage change in a proactive and

sustainable way.

However, as noted above, interviewees agreed that capacity building efforts alone

are not always enough to effect sustainability of FQHC programs and services. Most

participants stated that it is still necessary for centers to rely upon external support. This

is due to their mission, as well as the impact of some federal and state regulations and

policies, such as those that affect their ability to generate or to retain excess revenues.

While the FQHC family contends that capacity building to achieve greater financial self-

reliance should be a strategic goal for all FQHCs, they argue that all parties who are

invested in improving population health should share the financial burden of the FQHC

mission. The underlying premise of this viewpoint, as previously highlighted, is that

public and private sectors, as well as patients and communities served by the centers,

have a responsibility to contribute to the care of all those who are at risk for lack of

access to primary healthcare services.

Interviewees agreeing with this assessment added that in addition to their

disproportionate burden of caring for uninsured, indigent populations, there are other

important external and contextual issues that challenge their ability to become more

financially self-reliant, such as persistent low reimbursement rates and unfunded

mandates. However, many of these same interviewees focused on the destabilizing

nature of government grants and funding policies, and the impact of such on the financial

health of centers.

Several data excerpts reflect the views of respondents about the impact of funding

policies:

> ...If that funding [federal funding] is cut at any point or significantly reduced, it
> would significantly impact our center. So, I think, I guess that political changes
> or things that would not be in favor of you know, helping the underserved would
> affect us significantly…

> I think it would be very difficult. Because you know, you need the political
> commitment, financial support. You know if you are talking about federal grants
> and things like that, I don't know if centers could be sustained without that
> support.

> We are not proactive enough in operating as a business because of our mission.
> The basic laws that apply to other nonprofits are not necessarily applicable to
> FQHCs.

> Some of our goals…we still can't seem to achieve. You know we put things in
> place but sometimes as the year unfolds, we are never able to complete some
> things. One of the things that we are always looking for is some grant to enhance
> something.

The core, underlying message that threads these texts is that the politics and uncertainty

around FQHC funding threatens the sustainability of centers. Issues related to FQHC

funding from the federal government include the fact that funding for FQHCs must be

periodically reauthorized; it is discretionary funding. The funding is subject to arbitrary

cuts to make up for other federal budget shortfalls and it becomes necessary for centers to

advocate for resources, and to cultivate political champions to ensure continuous funding

at levels that can sustain their mission and overall operations. FQHCs do not have a

dedicated federal budget line for funding that guarantees stable long-term appropriations

that could support the ability of centers to plan for sustainability. Also, as noted in the

last statement above, too many centers are too dependent on grant funding, which leads to

their inability to sustain momentum toward growth or increased financial reliance.

Furthermore, federal rules and regulations that govern FQHCs and how grant

dollars are used also pose barriers to centers' ability to achieve financial sustainability.

One CEO, acknowledging FQHCs dependence on federal grants, stressed that the grants

come with a cost. This CEO said:

> Yes. HRSA rules impact FQHCs considerably. We need HRSA funding, but we
> are burdened by the rules. It is hard to achieve sustainability without external
> support. But we have to be careful accepting grants because we do not always
> have the ability or the volume to maintain the growth or expansion that the grants
> can bring.

Here, this respondent explained that the HRSA regulations are barriers that

centers have little control over. In accepting grant dollars centers are obligated to abide

by those rules. This CEO suggested centers must weigh the cost of accepting grant

dollars that restrict their ability to grow, and to become less reliant on future grant

dollars. As stressed previously, interviewees especially pointed to the mandate that

centers must care for all patients regardless of their ability to pay as a limiting factor in

their ability to become more financially self-reliant. Three other participants also

highlighted the HRSA rule that dictates the composition of the FQHC board. They

stressed the need for centers to have more control over the board development to ensure

the right mix of skills necessary to help foster sustainability for their centers. Notably

however, some participants also noted the value that consumer board members add in

respect to sustainability, namely their ability to connect centers to community resources.

In addition to the limitations posed on centers by the conditions of their federal grants,

they also face challenges that other non-FQHC primary care providers do not have, such

as restrictions on where they can locate their organizations and regulations that dictate the

types of services they must provide, despite their inability to charge for those services.

Altogether, the data reflect participants' shared viewpoint that FQHCs are very

challenged to operate without external government support, meaning they cannot rely

completely on their internal ability to generate enough revenues to be financially

sustainable organizations, independent of the federal grants, and sustain the FQHC model

for care delivery. As noted previously, most participants (75%) agree that centers need to

maintain external support to ensure financial sustainability, and most of all to ensure their

ability to deliver on their mission. A few examples of the many data excerpts confirming

this point are cited below:

> Centers cannot achieve sustainability…not without external funding. The
> reimbursements are not there to maintain them. They close them down. No one
> is immune from that. The funding has to be there. Whether we generate
> [revenues] internally, from seeing patients, that's only one part of it.….We need
> shell funding to keep us going and to sustain us….Improve the reimbursement
> because of the quality of care we are providing, and then maybe we could sustain
> ourselves…

> …if those resources [external support] were to go away, then what we can do for
> our community would definitely decrease, that is for sure. I don't know if we will
> completely ever be totally you know independent in terms of being able to
> provide the care that we provide and the services without external resources. We
> are very vulnerable to external factors...if our federal resources were cut, then
> FQHC programs as we know it today would change drastically, because we
> would not be able to service as many patients as we do without that external
> resources. It would be travesty for the U.S., I tell you the truth.

> External Support is needed for sustainability. They may be able to sustain aspects
> but not the full operations.

It [sustainability] cannot happen independent of external support. It just cannot. Because, if we decide that for us to be sustainable and for us to be successful in our mission…somebody has got to pay for it. The insurance company is not paying.

Sustainability is I cover all my expenses, and something is left over for me, that's sustainability…In a Community Health Center or qualified health center like ours, that entails a little bit more because you have a lot more services, a lot more expenses, a lot of layers of services that have to be covered and to achieve sustainability requires again right now with the current system and current reimbursements, we require outside funding.

Significantly, most respondents, including those cited in these texts, articulated that centers should be supported in their mission, otherwise as one of the interviewees noted, the FQHC program as it is organized today could not and would not exist.

This widely accepted stance about the need for, and expectation of, external financial support for FQHCs was fittingly expressed by a clinical-support staff respondent who likened the need for support of FQHCs to the metaphor of the need for a village to raise a child. This respondent said:

…I think it's almost like it takes the thought process, that it takes a village. It would take everyone to participate in [ensuring the ability] to make sure that we can get the patients the best care possible.

This text reiterates the view that sustainability of the FQHC model requires a collective effort, shared commitment, and multiple sources of income, including grants, donations, appropriations, and service revenue. Centers have long advocated for non-discretionary federal- and state-level appropriations to support FQHCs to avail. Nevertheless, as recognized essential primary-care providers under the ACA, the respondent quoted above, and most of the other interviewees, view the FQHC mission as a shared responsibility, deserving of external financial support.

Summary of Findings Research Question 3 and Key Concept: Sustainability

Clearly the results outlined in this chapter illustrate that like capacity building, the respondents view sustainability for FQHCs as a complex issue. There are many factors that present persistent challenges to the long-term financial health of the organizations, most notably challenges such as the rules that govern the FQHC model. While many respondents do not see the mission as being contrary to increased financial self-reliance for centers, they do agree that sustainability for FQHCs does not, nor should it, mean financial independence from external support. Sustainability of FQHCs must be approached differently than that for other types of healthcare organizations. Additionally, eleven of the respondents (55%) agreed that enhanced financial self-reliance requires capacity building to develop the necessary infrastructure for effective financial management and functional systems. One CEO said that "capacity building and sustainability is all one." This participant emphasized the critical need for centers to proactively seek to ensure their ready ability to navigate change, to grow and to maintain growth.

Furthermore, participants think that capacity building is necessary to enhance centers' ability to manage, and to control where possible, those external factors that persist in challenging the financial and operational strength of the organizations. Five of the seven interviewees who were CEOs of their organization at the time of the interviews, plus the one CFO interviewee, concurred that it is important for new Jersey centers to strive to manage the impact of external influencers where they can, through advocacy, planning, and ensuring operational capacity. Critically, participants also highlighted that FQHCs should focus on sustainability not only as a financial goal—to achieve greater

financial self-reliance, but also to maintain the FQHC model. Most participants agreed that capacity building in the centers should also promote efforts to sustain the brand, the mission, and the culture of FQHCs, in addition to the services, programs and access to care. Otherwise, as several respondents noted, they might as well not be FQHCs, but another business providing healthcare. Again, this broader view of sustainability requires a broader commitment from stakeholders external to the FQHCs.

As in the previous results chapters, Table 11 below depicts the numbers and percentages of interviewees who contributed to the key findings that addressed research question three. It also shows the number and percentage of centers represented by the respondents. And again, because some interviewees were from the same centers, the percentages of centers shown in this table may not total to 100 across responses.

In four of the centers in which there was more than one participant representing that center, interviewees expressed divergent viewpoints about the topic of sustainability for Community Health Centers. Those representing the clinical or front-line staff were more inclined to support views that stressed the importance of focusing on the mission when considering sustainability for FQHCs, while those who represented the senior leadership staff emphasized the need for FQHCs to address sustainability through strategic capacity building to enhance fiscal management and diversify sources of revenue. They also stressed the need to advocate for greater external investment in the sustainability of FQHCs.

Table 11

Summary of Key Findings for Research Question 3 and Percentage of Interviewees and Centers Associated with Each Finding

Key Findings	Interviewees (N=20)		FQHCs Represented (N=10)	
	n	%	n	%
FQHCs do not, nor should they define sustainability for FQHCs as financial independence but as increased financial self-reliance	13	65	9	90
Sustainability of FQHCs requires external, public support	15	75	9	90
Sustainability for FQHCs should not be driven by goals for financial independence or financial gain	11	55	7	70
Achieving sustainability for FQHCs entails health centers to strategically pursue greater financial self-reliance and to become less dependent on public funding	9	45	7	70
Preserving the FQHC mission and culture are important to the sustainability of FQHCs	11	55	7	70
Capacity building that involves enhanced financial management is important to sustainability for FQHCs	11	55	9	90
Centers with enhanced capacity for managing change demonstrated more ready ability to manage the state-level challenges associated with the implementation of the ACA than their counterparts.	6	30	6	60

**CHAPTER 10: RESEARCH STUDY CONCLUSIONS:
DISCUSSION AND FUTURE IMPLICATIONS**

Recap: The Research Problem and Research Questions

Research Problem

Research studies on Federally Qualified Health Centers (FQHCs), plus the FQHC

data compiled by HRSA, attest to their meaningful impact, especially their ability to

ensure access to critical primary healthcare services for millions of individuals nationally

and in New Jersey (Heisler, 2017). For this reason, this qualitative study examined the

capacity of New Jersey's FQHCs to expand and sustain access to primary healthcare

services in response to the ACA and ongoing efforts to achieve broad healthcare reforms

across all sectors of the healthcare industry. This study employed a case-study approach

to understand, and gain in-depth knowledge about, New Jersey centers, focusing on their

capacity, and their ability to achieve capacity building, to perform as essential healthcare

providers in an evolving, complex healthcare environment. The study involved 20 in-

depth interviews with individuals who represented ten New Jersey FQHCs. As detailed

in the methodology section of this dissertation, the individual centers represented reflect

only the fact that the 20 interviewees were from those centers. Nevertheless, these

centers include a varied selection of FQHCs in respect to size, location, and years in

operation.

The literature relevant to this study provides considerable evidence of the

importance of FQHCs, nationally and in New Jersey (Fontil, 2017; Lefkowitz, 2007;

NACHC, 2019.b). It highlights the positive impact of the centers in improving the health

status of individuals, populations, and communities (Dor et al., 2008; BPHC, 2019b; Shi

et al., 2004). However, while the literature shows the collective, positive, and significant impact of FQHCs on vulnerable populations and communities, it also highlights gaps in the capacity of some centers to ensure sustainable operations; it raises questions about the ability of some centers to perform consistently over time (Abrams et al., 2014; DeMarco, 2015; Katz et al., 2011). Moreover, there is little research about the ability of centers to achieve capacity building, which includes the ability to enhance their overall organizational performance; to maintain access capacity; and to perform as essential, reliable primary-care partners in changing models of healthcare delivery. There is also a lack of research aimed at informing decision making among policy makers about the variation that exists among centers in their abilities to develop and sustain capacity building initiatives and outcomes.

Finally, the literature on capacity building is inconclusive about the long-term impact of capacity building on performance, and about the value of accepted capacity components that are linked to performance in healthcare organizations. However the data does point to a need for more robust exploartaion of the relationship between capacity components and performance (Boffin, 2002; Brown et al., 2001; Doty et al., 2010).

In New Jersey, as across the country, research shows the continued need for FQHCs as primary-care, safety-net providers. New Jersey health centers have experienced a 22% growth in users since 2010. Fully 28% of their patients remain uninsured compared to 7% of all state residents who identified as uninsured (NACHC, 2019a). Furthermore, the literature supports primary care as a critical—and necessary— platform for advancing healthcare reform and improving access to affordable, patient-centered care (Davis et al., 2005; World Health Organization, 2019).

Because New Jersey centers, like their counterparts nationally, are large reputable primary-care providers; they are positioned to meet increased demands for primary care services. However, importantly, as demonstrated by the findings of this study and as supported by the literature, FQHCs in New Jersey, since their inception, have experienced ongoing challenges that undermine their ability to plan for and to engage in sustainable capacity building initiatives.

Likewise, in this researcher's experience, New Jersey centers have marked variability in their capacity to manage internal and external challenges that hinder their ability to institute and maintain administrative and operational processes that are essential to organizational-level capacity building as described in the Brown et al., (2001) Conceptual Framework for Mapping Capacity in the Health Sector. Moreover, some centers demonstrate less efficacy in developing the resources necessary to consistently sustain enhanced performance. These centers, such as the ones represented by three of the respondents in this study, report frequent cyclical challenges whereby they receive funding for capacity building, but not for maintaining improvements or new organizational processes. FQHCs that have fewer organizational resources (i.e. management systems, leadership, or staff) to support change, experience operational setbacks more often than their better prepared counterparts. FQHCs must develop the capability to strategically manage environmental change and to sustain organizational and clinical capacities to meet community needs. The capability of FQHCs to continue to develop as sustainable, high-functioning, essential, primary-care providers is important, because trends point to increased competition, and new economic and operating challenges for all healthcare providers, including FQHCs in the future. (DeMarco &

D'Orazio, 2015; Katz et al., 2011). Unfortunately, funding decisions and policies that target FQHCs and other healthcare providers together too often identify and fund health centers as primary-care resources without considering how, in contrast to many providers, FQHCs function, and that they have paricular and variable needs with respect to their infrastructure and available resources. Both of these factors are crucial for centers to perform effectively in managing changes such as those enacted by the ACA, and for the longer term.

This dissertation's findings highlight the variability found among centers in their preparededness for the implementation of the ACA. Such variability affected not only some centers' ability to achieve organizational-level capacity building in response to ACA funding, but also to plan for, and respond to, future organizational and clinical needs. Significantly, the findings underline the capacity components (internal and external) that respondents themselves identified as being important factors in their organizations' ability to enhance overall organizational performance, as well as to enact the kinds of sustainabile strategic capacity building processes that could lead to greater self-reliance.

Research Questions

To examine the research problem summarized above, this researcher asked the following questions:

1. What is the capacity of New Jersey FQHCs to perform as essential providers under the ACA and to sustain access to healthcare over time?
2. What is the impact of the ACA on capacity building in New Jersey FQHCs?
3. Can FQHCs leverage the opportunities afforded by the ACA to foster greater programmatic and financial sustainability?

Question one was rephrased to reflect the insight gained during Phase 1 of the study, leading up to the in-depth interviews. The revised question, shown above, does not assume or suggest how centers should define sustainability, or that sustainability, independent of external resources, should be or is a desired outcome of capacity building, or that sustainability is a static condition. Accordingly, this researcher added questions to the interview guide to reflect the need to explore and understand more about how participants understand sustainability and its relationship to capacity building. The additional questions and probes prompted participants to express their own understanding of sustainability, how their centers view it, and if they perceived it as a desired or planned outcome of capacity building within their organizations.

Research Question 1: Capacity Building—Findings and Implications

Capacity Building: Findings

Research question one examined the ready ability of centers to effect sustainable capacity building in advance of the ACA and afterward. Capacity building, in this study, is defined as the process that enhances the ability and preparedness of systems, persons, organizations, or communities to meet objectives or to perform as expected, toward sustainability, or greater self-reliance over time.

The key findings in response to this question highlight that New Jersey centers vary in their capacity to perform as essential providers in a complex environment, as well as in their approach to, and goals for, ongoing capacity building. How they view and define capacity building shapes their approach to it. Their perspectives about the FQHC mission, their organizational values, and their understanding of what it means to be an FQHC all influence their view of the concept of capacity building and its role in FQHCs.

The data underscore the fact that FQHCs are distinct organizations; they operate within the unique context of their specific organizational culture and their local environment. As stressed in the literature and in this study, FQHCs share many characteristics, including a legacy mission and regulations that dictate how they operate. However, they are not cookie-cutter organizations. In terms of capacity building and preparedness for the implementation of the ACA and healthcare reform, this study's findings align with the literature that illustrates that FQHCs exhibit different degrees of development and varying stages of readiness to maintain optimal organizational, clinical, and financial performance over the long term. They have developed differently and to different degrees with respect to their access capacity and operational capabilities, both of which are influenced, as demonstrated in the findings of this study, by the characteristics of the local environment, and by how centers approach and define capacity building (Hennessy, 2013; Honadle, 1981; Katz et al., 2011; Whittle et al., 2011).

Some respondents reported that their centers were strategically prepared to benefit from the ACA's provisions for expansion and the opportunities it provided to develop and enhance their infrastructure, both to position the organizations to manage change and to thrive under healthcare reform. They cited evidence of improvements to their operations and internal structures in anticipation of the ACA, as well as their ongoing efforts and success in taking advantage of funding and other provisions provided because of the ACA. Significantly, many of these same respondents pointed to a strategic and deliberate approach to capacity building within their organizations. Other participants, however, noted a lack of strategic efforts toward capacity building or evidence of it within their organizations in response to healthcare reform. This cohort of participants

highlighted how their centers lacked resources and, in some cases, a clear direction ahead of the ACA. Some were unable to capitalize on the funding made available. Furthermore, centers represented by this group of respondents were the least prepared to manage the challenges associated with the implementation of ACA policies at the state level.

On the other hand, the data illuminated the fact that some respondents believed that a significant factor in how centers approach capacity building is their structure, which includes the values that they embrace as an FQHC. Their ability to adhere to the mandates and rules that govern FQHCs inherently prepares them to effect and manage change under most circumstances. Participants said that capacity building is an ordinary course of their business as an FQHC; it does not require a concerted focus as a new strategy for centers. But, underscoring the differences found among the centers, still another group of respondents stressed that their organizations understood capacity building as a process that requires a strategic approach to achieve a desired impact, unlike their colleagues who viewed it as an organic occurrence within their organizations. Nevertheless, most respondents expressed the belief that being an FQHC and all that it entails aptly prepares the organizations for changes in the environment and fosters their ability to perform as essential providers.

Additionally, in response to questions about their ability to sustain potential or actual benefits afforded by the ACA, such as adding new access capacity, as well as to become more sustainable entities overall, respondents offered valuable insights about their understanding of how, or if, capacity building is linked to sustainability for FQHCs. Altogether they expressed the idea that the sustainability of FQHC programs and services

is a complex issue that goes beyond considerations of capacity building. Nevertheless, discussing capacity building, 80% of participants acknowledged issues associated with the financial sustainability of the mission of the organizations and the FQHC model of care. Still, they stressed that centers do not focus on capacity building in and of itself as a pathway toward financial independence. They recognize the importance of seeking to sustain services and programs, but they do not view capacity building that emphasizes a financial business model as being either desirable or practical for Community Health Centers. Instead, most respondents stressed the importance of the FQHC mission and the FQHC model of care as being the most salient factors in how they view capacity building in FQHCs, and the fundamental rationale for determining when and how the organizations engage in it. The data illustrate that all respondents agreed that the central purpose of capacity building in centers should be to ensure better outcomes for the patients and communities they serve, not financial gain or even financial independence, although they recognized the importance of financial viability and ensuring organizational capacity for effective financial management. Respondents who identified as clinical staff (40%), especially emphasized that capacity building outcomes should reflect their mission and their reason for being an FQHC. They hold the view that capacity building in order to ensure support for the mission—their ability to deliver patient-centered care and access to care for vulnerable populations and communities—should be valued as much as, if not more so, than capacity building toward financial sustainability of the organizations.

Overall, the data show that all New Jersey FQHCs represented in this study engaged in some level of capacity building, albeit it to different degrees and with varying

success, but importantly with different goals as implementation of the ACA was realized

nationally and in New Jersey. Fifty-five percent of the respondents, representing six of

ten centers, reported that their centers were aggressive and strategic in their efforts to

effect organizational and clinical capacity building. For example, some among this group

of centers expanded access to healthcare for their communities through the addition of

new facilities, service hours, or providers. Others enhanced operational and

administrative capacity by hiring new, higher skilled team members or training existing

personnel as well as implementing current information management technology.

Conversely, respondents (25%) associated with four other FQHCs in this study reported

that their organizations were not strategic in how they approached capacity building as

the ACA was implemented or in its wake. Nevertheless, all respondents from centers

identified some capacity components that existed in their organization. Centers that

expressed more deliberate intent toward capacity building (whether defined as such or

not) viewed their level of preparedness as evidence of their ability to increase their role in

New Jersey's healthcare system as essential providers and to strengthen their role as such.

The data showed that 70% of the centers represented in this study were described as

prepared for the anticipated changes associated with the implementation of the ACA,

albeit to varying degrees of preparedness. However, when interviewees addressed the

issue of sustainability, the percentage of centers described as having the ability to

withstand the financial challenges and the loss of patient volume that FQHCs

encountered at the onset of the ACA was slightly lower. Sixty percent of the centers

were described as having the ability to recover losses more rapidly than their counterparts

and to continue to thrive as healthcare reform initiatives progressed under the ACA.

The data support the Brown et al., (2001) findings that capacity building is linked to or influenced by multiple factors associated with the internal environment of organizations (culture, values, and infrastructure) and the external environment (social, political, and economic factors).

Capacity Building: Implications of Findings

The degree of variation that exists among New Jersey FQHCs, both in their ready capacity to perform and in their ability to effect sustainable capacity building poses a challenge for funders and policy makers in how they design support for, and distribute resources toward, bolstering FQHCs as integral, essential providers in the state's healthcare system. As summarized above, the centers are unique organizations with varied abilities to perform consistently and sustainably for the long term. The variation in ability, readiness, and effectiveness among centers matters as policy makers and others increasingly seek to position FQHCs as a broad, accessible primary-care system, and as an already available resource to address the need for primary care in healthcare reform. The variable capacity also matters because centers have historically struggled with sustaining access capacity and with maintaining optimal organizational performance. This is primarily because of external factors, such as challenging public policies or inadequate funding, and inadequate internal systems and infrastructure to support growth or consistent performance.

If centers are to serve as sustainable, essential primary-care organizations, policy makers, and other supporters must increase their understanding of how FQHCs function as part of an overall system, as well as their individual capabilities. More in-depth knowledge of how FQHCs function and operate at the organizational level is necessary to

identify weaknesses and strengths in their collective and separate capabilities to perform

as sustainable nonprofit businesses and service-delivery organizations, as well as how

FQHCs can continue to build capacity for greater self-reliance as the larger healthcare

industry evolves.

The marked variation found among the centers, illustrated in the study findings

and in the FQHC literature, necessitates concerted efforts on the part of funders to better

assess and target resources to centers going forward. While all centers can benefit from

additional financial support, the data clearly illustrate that not all centers can effectively

maximize such support. Funders and policy makers must be able to discern how best to

target resources to support centers in areas such as leadership training and infrastructure

development to increase and manage internal operations strategically for the long term.

At one time, the state and the FQHC leadership infrastructure supported pairing health

centers allowing stable, advanced FQHCs to mentor and support fledgling health centers.

Anecdotal evidence suggests this was a successful initiative that helped some centers to

develop the capacity needed for them to remain sustainable and to ensure their ability to

perform well. Such programs consider the needs of organizations beyond financial

support to ensure capacity building.

Typically, grant funding simply assumes that centers have the capacity to perform

as dictated or as intended. But strategic funding and technical support are needed to

make this so for some centers. The significant variation among the centers in their

readiness for capacity building, and their ability to navigate their external environment

predicts the continued instability of some centers and thus uncertainty about their ability

to sustain programs and services. Many centers will continue to flourish; however,

current policies limit how and where they can expand access capacity. Some centers cannot readily fill a gap where services are needed, or they are not able to maximize their potential to provide essential care. Thus, more effort is needed to strengthen capacity building in centers to ensure broad, state-wide availability of FQHC services across all medically underserved areas of the state. This can be achieved through consistent, long-term, targeted financial investment and technical assistance aimed at ensuring capacity building in centers (training, systems and infrastructure improvements) along with the more predominant current focus on funding to support program development and expansion of access.

Finally, as underscored by this study's findings, beyond financial and technical support for centers, continued advocacy and a shared understanding of the need for FQHC services are crucial to garnering ongoing support for the safety-net role of the centers. Capacity components that are linked to building external support for the mission (marketing, advocacy, enhanced public relations) are often overlooked as factors that affect organizational capacity building and sustainability. If public funders value these safety-net providers, they must take greater ownership in promoting and fostering the FQHC model and the centers as safety-net providers; this is essential to enable FQHCs to be effective, sustainable organizations.

Research Question 2: Impact of the ACA—Findings and Implications

ACA: Findings

The data from this study demonstrate that the ACA generated both opportunities and challenges for New Jersey health centers. Specifically, it highlighted three significant benefits that some centers derived because of the ACA. Most significantly, it

provided funding support for building greater access capacity and enhancing the

infrastructure of centers. Second, through Medicaid expansion, it enhanced the potential

for centers to gain more insured patients. Finally, the ACA endorsed primary care as the

foundation of healthcare reform and FQHCs as established primary-care providers in the

new landscape.

In the first instance, the ACA provided an infusion of cash for FQHCs that

allowed some New Jersey centers to realize prior plans for expansion and planned capital

projects. They seized the opportunity to expand access to healthcare and to enhance or

build new sites. In some cases, expansion was a strategic approach to capacity building,

but in others it was more of an opportunistic gambit. Regardless of the approach,

however, the funding provisions for centers under the ACA allowed New Jersey FQHCs

to enhance their human resource capacity—to hire the talent necessary to ensure their

ability to compete in a more complex industry under healthcare reform, and to enhance

financial and information technology systems. The funding also supported improvements

in programs and service delivery.

In the second case, the data highlight that Medicaid expansion, supported by the

ACA, provided the most critical benefit for New Jersey centers; it helped to create greater

access to care for more patients and, moreover, it increased revenues to the centers. The

literature shows that the FQHC industry overall viewed Medicaid expansion as the most

significant benefit to centers in states such as New Jersey that were proactive

implementers of Medicaid expansion programs. New Jersey was an early responder to

Medicaid expansion, and it maximized the provisions offering increased insurance

coverage for individuals. Thus, Medicaid expansion contributed to the ability of centers

to generate higher revenues which supported capacity building across the organizations. In states with higher rates of Medicaid expansion, centers reported increased capacity to provide expanded access to services (Rosenbaum et al., 2017; Rosenbaum et al., 2018).

The increase in revenues strengthened the financial position for some centers, allowed for reinvestment in further capacity building, and increased their ability to sustain the new access capacity funded by the ACA. The enhanced revenues from Medicaid, plus new appropriations and grant funding, fueled capacity building for many centers, as illustrated in the data. Once again, more than half of the respondents recounted that their centers were able to either build new facilities or renovate existing ones to expand their space for clinical care, add new clinical-care providers, or programs such as dentistry, or expand service hours.

Lastly, but significantly, the ACA elevated the value and role of primary care as the building block for healthcare transformation (Davis et al., 2011). At the same time, it positioned FQHCs politically to participate in new ways at the broader systems level in healthcare, nationally and at state levels, as an already existing, extensive, accessible primary-care system—a network of primary-care providers and care coordinators across the country (Abrams et al., 2011; Hawkins & Groves, 2011). The ACA offered financial support and the policy incentives intended to strengthen their ability to deliver primary-care services to a larger population. Additionally, the ACA promoted policies that fostered centers' participation in new healthcare delivery models by requiring that such models include significant primary-care networks. Some New Jersey centers promoted their elevated role and heightened leverage as primary-care providers when negotiating

participation in ACOs or other new partnerships in the broader healthcare system within the state.

In contrast to findings that demonstrated the positive impact of the ACA, this research also shows how the ACA included policies that presented constant challenges for some centers and undermined their ability to perform as anticipated. The legal language of the ACA allowed states to interpret and translate how they implemented some federal ACA provisions, most critically Medicaid expansion. The data show that respondents viewed the resultant state-level policies and practices as having a profoundly adverse impact on FQHCs. Several state actions, as discussed in Chapter 8, including the change in how the state reimbursed for uncompensated care at the onset of the implementation of the ACA in New Jersey, presented critical financial and operational challenges for the centers. At the time of the interviews, some respondents indicated that their organizations were struggling financially because of events engendered by state policies that led to sharp declines in New Jersey centers' revenues and the loss of a critical mass of patients, especially newly insured Medicaid patients. Respondents representing three of New Jersey FQHCs reported their centers experienced prolonged financial harm because of how the state interpreted and implemented ACA policies concerning FQHCs, again findings highlighted in Chapter 8 of this study. External influences, in the form of state-level policies and rules, adversely influenced income and patient volume for all the centers represented in this study but to different degrees. Moreover, among the three centers where the respondents indicated prolonged adverse fiscal impact, all reported having to reduce staff, cutting back on services or hours of operation or being unable to significantly expand access to healthcare for more patients.

These situations exacerbated their inability to demonstrate viability in the face of change and to compete effectively as the ACA unfolded. Significantly, respondents who reported that their centers experienced a prolonged negative impact because of external factors before the implementation of the ACA, such as the impact of the New Jersey FQHC Medicaid lawsuit against the state (see Chapter 8), depicted their centers as being less prepared for the implementation of the ACA. Additionally, the same respondents indicated that their centers did not anticipate the impact of the ACA and its implications for FQHCs, which made the negative impacts even more challenging.

The data also show that some respondents (45%) agreed with the view that the ACA was yet another federal initiative to which they are were obligated to respond. This viewpoint factored in the business-as-usual theme. These respondents offered that their centers did not conduct business differently or engage in new efforts to address implementation of the ACA and the associated policies that targeted FQHCs. However, two among this group of interviewees, representing different FQHCs, indicated that their centers may have undervalued the ACA's possibilities for FQHCs, thus underscoring the lack of urgency to be more informed and to understand the changes heralded by the ACA. These same two respondents thought their centers showed insufficient attention to the ACA as it developed; they pointed to a lack of knowledge about its broader implications, or indifference to it as a catalyst for change and opportunity for the centers. In any case, the attitude that the ACA was just another federal initiative that centers were accustomed to managing worsened its impact on some of the centers, especially the two referenced above which were less well prepared for the changes that unfolded—changes that affected how patients accessed healthcare and how centers are reimbursed for healthcare.

However, others who underestimated the ACA's potential impact on their centers before its implementation did acknowledge that as the law unfolded, they were increasingly aware that the centers needed to become more knowledgeable, proactive, and deliberate about how they prepared for and responded to the changes. Their responses pointed to knowledge as an important capacity component (as defined by Brown et al., 2001) that is necessary for discerning healthcare and environmental trends and their implications, and for strategic capacity building to address them.

The findings put into perspective how the ACA did not change the culture or attitudes about capacity building in some centers, nor provoke more purposeful investment in efforts to enhance capacity or performance. However, overall, the positive impact of the ACA (enhanced operating and access capacity, for most of the centers represented in the study) outweighed the challenges that they encountered related to state-level policies and rules that govern the FQHCs.

ACA: Implications of Findings

Implementation of the ACA was an important milestone for FQHCs, whether respondents perceived it as such or not. It helped to elevate the FQHC profile, and it provided needed capital for developing new access capacity and improving organizational systems such as IT. Additionally, it contributed to the financial sustainability of the organizations though enactment of the CHCF mentioned earlier which the ACA initially intended as new, additional funding for centers, mandated by law for appropriations to health centers through year 2015. Congress has extended the CHCF twice since 2015. (Congressional Research Service, 2019).

Although the data show that at least 45% respondents did not readily hold the

view that the ACA was a harbinger of change for the centers, the ACA has advanced the

movement toward healthcare reform across the country, a move that is effecting changes

that are critical to FQHCs going forward. The ACA has prompted developments that are

aligned with the FQHC patient-centered model of healthcare delivery. As such, it led to

greater capacity building among some centers, such as strengthening their fiscal

management capacity to participate in new payment models for healthcare delivery that

supports case management and team-based care in primary care practices. Additionally,

some centers have focused on aligning their care-delivery model with new integrated

clinical care systems or ACOs that demand greater collaboration or partnering at the

systems level to greater access to a more comprehensive range of services for their

patients.

While most centers benefited from the ACA, the ACA did not necessarily or

directly influence how a subset of the centers (40%) approached capacity building.

Respondents who indicated their centers did not engage in strategic capacity building

before or leading up to the ACA, also stated the ACA did not change if or how they

addressed the need for capacity building in the organization. However, reported trends in

healthcare illustrate the need for New Jersey centers to assess how they approach the

need for capacity building and pay attention to how major policy changes, such as those

created by the ACA, affect their ability to be effective, sustainable organizations in the

coming years. To reiterate, the findings summarized above illustrate that external

influences (politics and policy, rules, and regulations) related to the implementation of

the ACA had the most adverse impact on New Jersey centers. This is likely to continue if

centers do not heed or understand the changes that are occurring. For example, the National Academy of Medicine compiled a report on the various new or innovative payment models that are projected to soon take the place of fee-for-service reimbursement in healthcare (Dzau et al., 2017; McClellan et al., 2017). Payment reform, an outgrowth of the ACA, might be the most significant external factor that will affect how centers compete, thrive, or participate as essential providers in the coming years. Inattention to the intended and unintended consequences of the ACA on New Jersey FQHCs may lead to an even greater inability of some centers to anticipate and prepare for the changes in how payers reimburse healthcare providers. It is incumbent upon centers, as well as policy makers, payers, and others, to evaluate the real impact of changes like these on the centers' long-term ability to perform.

Significantly, the ACA did raise both new interest in, and questions about, the ability of centers to perform as essential providers and to be a competitive force in a changing market for consumers. Continued healthcare reform may fuel greater competition and other challenges for New Jersey centers. While the ACA provided new funding to centers to stimulate growth and operational enhancements, the literature on organizational capacity building notes that dollars alone cannot ensure sustainable capacity, performance and outcomes. The ACA has highlighted the need for funders, policy makers, and centers themselves, to invest on multiple levels, financially, politically, and morally, in ensuring the ability of centers to maintain access capacity for vulnerable populations; this entails enabling strategic, sustainable capacity building among the centers as stressed previously.

Research Question 3: New Jersey FQHC Sustainability—Findings and Implications

Sustainability: Findings

The study findings underscore the stated mission of FQHCs as safety-net organizations. Moreover, the findings show that external environmental factors (i.e., public policies) that impact FQHCs are significant considerations in how New Jersey centers seek to sustain their mission and role as safety-net organizations. Significantly, the findings show that all respondents concurred that financial independence defined as sustainability independent of external, public support for FQHCs is not a practical goal, nor is it a desired goal because of their safety-net role and historic mission. So, study participants framed their view of sustainability and its relationship to capacity building more from the patient-centered orientation. The patient-centered orientation better shapes how FQHCs define and approach capacity building as opposed to that of a business model orientation in which the focus may be more toward ensuring internal practices and policies to achieve financial gain. FQHCs engage in capacity building toward ensuring access to healthcare for their patients, regardless of the patient's ability to pay for services. They also focus on capacity building to ensure quality, comprehensive care for their patients. Because of their safety-net role and their mission, centers strongly insist that funders, policy makers, and others should not expect FQHCs to be wholly financially independent organizations. More importantly, the findings show that New Jersey centers see the sustainability of their role and mission as a shared public responsibility. The study findings highlight the concerns of some respondents about what they perceive as a push for centers to become more focused on financial independence as the path for ensuring sustainability of the FQHCs. While more than half of the

respondents stated they agreed that centers should be concerned about becoming more financially self-reliant, they stress that centers should not focus on issues of sustainability from a purely financial business model. The literature depicts similar views, but at the same time, it also suggests that while centers are mission-driven organizations, they can no longer rely on their status as safety-net providers to ensure financial sustainability (DeMarco & D'Orazio, 2015; Hennessy, 2013). Proponents of this more financial self-reliance viewpoint argue that centers must be more focused on issues of financial sustainability because public support for safety-net healthcare providers is too tenuous. Public funding is dependent to a large degree on politics and the economic environment. New Jersey centers, for example, are heavily dependent on discretionary federal dollars and mandated, time limited funding (CHCF). They depend on appropriations that are subject to budget cuts and political wrangling over budget priorities. The profile of New Jersey centers' sources of revenue illustrates that their reliance on such funding is substantial. In 2017, New Jersey centers derived 42% of their support from federal HRSA grants and other federal support such as Ryan White HIV intervention grants (New Jersey Hospital Association, 2018). Furthermore, despite the infusion of dollars to FQHCs, such as the ACA funding, some centers still experience financial challenges that undermine their ability to perform consistently and to maintain needed services, a fact illustrated both in the findings from this study and in the literature. As noted previously some healthcare organizations, including some New Jersey FQHCs, do not have the requisite ability to manage resources to develop and sustain new programs, or new access capacity, or new infrastructure capacity (DeLia et al., 2004; DeMarco, 2015; DeMarco & D'Orazio, 2015; Honadle, 1981; Katz et al., 2011).

Moreover, the literature demonstrates that the FQHC mission no longer engenders a protected status for FQHCs, whether ensuring the sustainability of services and programs, or the organizations themselves (DeMarco & D'Orazio, 2015). Some respondents, who pointed to the trends in healthcare concurred. Importantly, they stressed that centers must be focused on issues of sustainability that lead to greater self-reliance, and that capacity building toward this end does not have to conflict with the mission and their role as safety-net providers.

Accordingly, the study findings illustrate that some New Jersey centers do engage in capacity building to effect greater self-reliance. For example, the data show that three CEO respondents, from three different New Jersey centers, emphasized their focus on ensuring functional and effective management, and financial systems aimed at attracting and retaining more insured patients. In addition to these three CEOs, other interviewees (total 50%) also maintained that centers, despite their focus on mission, must be willing to assess and change how they approach capacity building and issues of sustainability if Community Health Centers are going to continue to support the mission and the FQHC model of care. Four interviewees in this group of respondents stressed that their FQHCs are deliberate in how and when they engage in initiatives to ensure they can maintain programs, additional hours of operations, staff, and services for the long term. Their centers participate in grant-funded or grant-dependent initiatives, including the ACA funded expansion efforts, only to the extent that they have a plan for sustaining growth and the infrastructure that is needed to support the growth or expansions. Several centers particularly stressed that developing new access capacity requires strategic planning that

includes consideration of how they will maintain that new access capacity for the long term.

Clearly, the data show that sustainability is a critical component linked to capacity building for New Jersey centers, especially in how they ensure their ability to deliver on their mission without compromising it.

Sustainability: Implications of Findings

FQHCs have long relied upon their legacy and their role as safety-net providers to encourage and to safeguard funding and support for their organizations, from both the public and private sectors. However, as market forces drive healthcare reform, and the business of providing healthcare becomes increasingly complex and resource intensive, the environment progressively challenges FQHCs to focus on issues of sustainability, especially strategic capacity building toward greater self-reliance and diverse revenue streams.

New Jersey centers, like their colleagues nationally, must develop the internal ability to generate revenues and to secure external support. This perspective does not, as some study respondents stressed, imply that centers must abandon their focus on mission or adherence to the FQHC commitment to serve all persons regardless of their ability to pay. However, it does mean, for some New Jersey centers, doing business differently. It means directing deliberate attention, effort, and resources to capacity building aimed at greater self-reliance. Sustainability, defined as greater self-reliance, does require a concerted focus on maximizing revenues and financial support for the centers. However, as stressed by study participants, it should not compromise patient care. Participants articulated that they understand this entails a broader perspective on how sustainability

for FQHCs might be achieved. It entails a focus that is centered on ensuring sound financial functioning, including internal fiscal processes and policies based on best practices. It also involves capacity building to ensure the necessary infrastructure not only to optimize the organization's ability to generate revenues, but also the ability to manage its financial health and to gain new income through private funding, increased public support, and where possible new, but compatible lines of business. It requires cultivating external support while maintaining a competitive advantage by attracting insured patients through patient-centered and community-focused care, especially quality, accessible healthcare services.

Doing business differently also means engaging in deliberate capacity building to participate in new care-delivery arrangements, such as ACOs. The changing environment presents increasing challenges for smaller healthcare providers like independent practitioners and individual FQHCs. However, the ACA positioned FQHCs to leverage their expertise and strength as primary-care organizations to forge new partnerships or collaborations that will bring with them greater access to technical assistance, shared resources, and new avenues of financial support. Nonetheless, with their heightened role in New Jersey's healthcare landscape, the centers must be reliable, sustainable partners in meeting the need for primary care.

In all, the literature and this study's findings demonstrate the struggles that some New Jersey centers continue to have around issues of sustainability, including negative external influences, such as public policies that create unintended adverse financial harm to FQHCs and thus affect their ability to ensure the financial health of the organizations. As noted previously, too many centers continue to lack adequate resources and the ability

for meaningful capacity building to enable sustainable growth and performance improvements (Chin, 2011; DeMarco & D'Orazio, 2015; Katz et al., 2011; Sage Growth Partners, 2017). Thus, study participants highlighted that sustainability of the FQHC model and the mission must be a shared responsibility across the public and private sectors.

Study Limitations

The capacity building literature consistently points to the need for further examination of how individual capacity components influence overall capacity building. Which factors, internal and external, exert influence on organizational performance and sustainability, and how? Capacity building models that begin to measure gaps in capacity or that identify factors linked to organizational capacities, such as the Brown et al., (2001) Conceptual Framework which was used to organize and analyze the data for this study, (see Chapter 6) identify theoretical foundations for examining capacity building. This study points to those factors that are perceived to be critical factors in capacity building by the interviewees for this study, such as leadership and meaningful strategic planning, but more robust examination is necessary to identify how and how much these factors influence capacity building, and if these findings are applicable to a larger sample of FQHCs.

Additionally, few longitudinal studies such as that conducted for the HSC (Cunningham & Felland, 2008; Katz et al., 2011) track the performance of FQHCs, over time. Capacity building is a process that results in short- and long-term outcomes. This study is a look at FQHCs at one point in time. A longitudinal study can reveal how capacity building impacts the centers over time, especially their ability to become more

self-reliant and their ability to navigate intended and unintended consequences of public policy and other external factors to ensure long-term sustainability.

Finally, the data from this study reveal that respondents believe that misperceptions about the role of FQHCs and their ability to function as essential primary care providers persist. Respondents still refer to the stigma associated with being a "clinic," a stigma that shapes broader public perceptions about their quality and their capacity to function in today's healthcare environment. There is still widespread misinformation about, and a lack of understanding of, FQHCs among those who develop and implement policy for the NJ centers. More studies are needed that provide evidence of the value and quality of both the FQHC model and FQHCs as a system, as well as independently operated organizations. Additionally, the literature on FQHCs that aims to inform decision making and policy development in support of capacity building among centers can help to dispel negative stereotypes by pointing to the social, economic, and political factors that continue to perpetuate such stereotypes. Issues of race, poverty, and class play a significant role in issues of health and healthcare, as do negative public perceptions, as well as those that persist among other healthcare providers, about FQHCs as providers of care for mostly indigent, minority and disenfranchised groups.

Summary of Discussion and Future Implications

New Jersey FQHCs are critical primary care providers in the state. The ACA intended to bolster the role of the centers and to position them to compete in a changing environment. However, as highlighted in this study New Jersey health centers demonstrated marked variation in their ability to prepare for and to take advantage of the funding and policy provisions provided by the ACA for FQHCs. Their diverse reactions

to the ACA underscore the need for policymakers and other funders to both target public and private resources strategically, and to deliberately aid in optimizing the health centers' ability to benefit from such support and from changes in the external environment. Public funding and technical support too often do not consider the significant variation that exists among the centers with respect to their capacity to perform, short and long term. Equally important, there is little evidence of research that focuses on the evaluation of health centers' ability to effect sustainable capacity building, especially longitudinal studies that would examine how critical public policies impact centers and the sustainability of their programs, services, and access capacity long term. While HRSA and state and national trade associations offer technical support to centers that enable capacity building, there is little empirical evidence about the impact of such assistance New Jersey centers.

In a recent public forum, CMS officials discussed their exploration of a promising approach to targeting incentive funding for participation in advanced payment reform models. A representative proposed technical support and feedback to providers to assist them in assessing their capacity to participate in new, alternative payment models before they submitted full applications to do so. They proposed assisting potential applicants to assess their operational capacity and the gaps in capacity before they invested in joining the Primary Care First Payment Models initiative[23]. In exploring this approach of offering technical assistance to help primary-care providers in the on-ramp toward participating in new payment models, CMS acknowledged that primary-care providers,

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[23] For additional information on the Primary Care First Payment Models see
https://innovation.cms.gov/initiatives/primary-care-first-model-options/

including FQHCs, do possess different degrees of readiness for payment reform and that providers differ in their ability to become ready. While this approach—assessing the readiness of primary care providers to participate in payment models that involve both potential benefit and risk, in advance of their applications—might be a resource-intense process for any public/private funder upfront, it would enhance the chances of success for healthcare providers who engage in such initiatives; such an approach helps to target resources where needed to assess capacity and to determine gaps that must be addressed for successful participation in alternative payment models. Significantly, and to reiterate, this approach does not assume that all applicants will have the same degree of readiness or ability to succeed, even with enhanced funding support. This proposed tactic is a meaningful public/private approach to incentivizing capacity building in healthcare organizations. Targeted assessment of the ability of FQHCs to perform, plus technical assistance to help build capacity in the areas of identified gaps or weaknesses, is especially necessary for health centers that demonstrate less readiness or ability to navigate change and to effect sustainable operational and programmatic improvements. In all, such an approach acknowledges the variability found among healthcare organizations in their ability to manage change and to thrive as healthcare and payment reform continue to evolve.

If FQHCs are to remain as essential, safety-net, primary-care providers, federal- and state-level policymakers and funders must make more significant efforts, such as the one described above, to understand those capacity components (internal and external) that are necessary for FQHCs to perform collectively, and most importantly separately, as unique organizations. Proponents of healthcare reform must be willing to invest time and

resources in capacity building to ensure the ability of a healthcare system as diverse as that of FQHCs to succeed. Research should inform a more comprehensive and targeted policy agenda that is evidence based to strengthen the collective and individual capacity of New Jersey centers to perform as sustainable, effective primary care providers.

Additionally, while HRSA, New Jersey, and health industry trade organizations do offer some technical assistance to FQHCs, this researcher's understanding is that centers, policy makers, and funders do not proactively measure the impact of such assistance to the centers or assess the potential return on investment. Moreover, technical assistance is not consistent, nor frequent enough to support ongoing ability to manage constant environmental changes. Furthermore, such assistance and training for FQHCs often relies on a consultant model in which centers are the recipients of ready-made or one-size-fits-all capacity building programs as opposed to more targeted efforts based on specific organizational needs. Also, current efforts do not focus on developing FQHC leadership or expertise among the organizations' team members, including board members, to manage the processes aimed at planning the best approach to capacity building—one that is tailored to the specific needs or strengths of individual organizations. The literature highlights how internally driven capacity building is more effective at facilitating the transfer of knowledge, skills, and insights that are necessary to develop higher organizational abilities and self-reliance (Honadle, 1981).

Further, if New Jersey FQHCs and other centers are to continue to serve in the role of essential safety-net providers, policymakers must exert a more significant effort to depoliticize the way the government funds health centers. FQHC advocates underscore the need for stable, reliable public funding as the most important public policy issue for

all health centers. However, New Jersey FQHCs and their counterparts across the

country are still subject to reauthorization and budget uncertainties that threaten their

ability to plan effectively and to ensure sustainable programs. However, at the same

time, the state and federal governments champion the centers as essential safety-net

providers. Although it is outside the scope of this study, the dichotomy between how

FQHCs are funded and the evident broad public support for their role as safety-net

providers raise complex questions around issues associated with health equity and who is

responsible for ensuring it. FQHCs play a significant role in addressing health equity

issues for marginalized populations. Community Health Centers in general underscore

the need for a stronger public/private role in ensuring access to healthcare services that

promote the health and well-being of all citizens, especially at-risk populations. This is

consistent with the findings of this study.

To reiterate, public policymakers have long designated FQHCs as safety-net

providers. As such, there is precedent for the argument that the sustainability of the

FQHC model and services is not the sole responsibility of the individual health centers.

While the conventional wisdom is that centers must become more self-reliant financially,

their established role as safety-net healthcare providers warrants deeper discussion about,

and commitment to, the oft-repeated need for shared responsibility for the sustainability

of the organizations. Either New Jersey FQHCs, like other health centers, are going to be

safety-net organizations or not. Policy makers must renew their commitment to

supporting these organizations as safety net providers by investing responsibly in

capacity building that enhances overall organizational performance, the centers' ability to

diversify and maximize resources, and their ability to become sustainable primary care providers in new healthcare systems.

Additionally, all parties invested in the future of FQHCs must aim to raise the profile of centers as safety-net organizations to encourage broader support for sustaining their role in addressing health inequities. This includes deliberate discussion about capacity building and sustainability of FQHCs in state and national level policy decision making that is aimed at ensuring health equity for at-risk populations. FQHCs are important resources that help to reduce or to eliminate health disparities among vulnerable populations. The health centers successfully address social determinants of health that affect the overall well-being and health status of at-risk groups.

Nevertheless, while many acknowledge that the mission of FQHCs demands public support, New Jersey centers, and FQHCs in general, must continue to examine how they themselves approach and manage changes that affect how they operate and the viability of their organizations. FQHCs cannot rely solely on the legacy of their mission or their ties to the community to ensure their viability. Health centers must strategically weigh the impact of change and engage in deliberate capacity building to manage that change, whether positive or negative. As such, FQHCs must engage in strategic actions, such as capacity building that involves greater involvement in monitoring and influencing healthcare policies, at the national, state, and local levels.

Key Policy Issues and a Policy Agenda for New Jersey FQHCs: Near-and Long-Term

Health center advocates and leaders mostly agree on the fundamental issues that should drive the policy agenda for FQHCs near and long term. As discussed previously,

nationally, the FQHC industry identifies the need to secure long-term, stable public funding for community health centers as the top policy agenda for all health centers; interviewees for this study agree that it is a central issue for New Jersey health centers as well. In addition to stable public funding, FQHCs also identify the need to promote policies that address anticipated environmental changes that will affect all health systems going forward: workforce shortages, the move toward payment reform, and the adoption of alternative payment models that involve greater financial risk to providers.

More specific to New Jersey health centers, state-level, charity-care reimbursement is a priority policy issue. New Jersey partially reimburses the state's FQHCs for charity-care services (health care for patients who have no ability to pay for the cost of the services provided), and the funding levels are subject to change with state budget cycles. In part, state-level funding for charity-care services also supplements federal support for uncompensated-care services that health centers provide. However, uncompensated care is broader than charity-care services. Uncompensated care services include comprehensive case-management for all patients regardless of their ability to pay or the type of insurance coverage they have. In theory, the federal grant pays for comprehensive case-management services. However, FQHCs contend that they are not adequately reimbursed for comprehensive case management, regardless of the payer source, but especially that the federal grant is not enough to cover such services, which are federally mandated FQHC services for the insured and uninsured. Policies for both charity-care reimbursement and reimbursement for uncompensated care affect New Jersey FQHCs' ability to support their mission, especially their ability to provide comprehensive services to all patients

I have summarized the issues highlighted above in outline form to provide an overview of the major near- and long-term policy issues and changes for New Jersey FQHCs that will have an impact on how the centers operate and thrive going forward. The information below is organized by policy topic, with a statement that outlines the context and key issues related to each of the policy issue areas, and recommendations for a policy agenda that aims to not only address existing and anticipated challenges for FQHCs, but also catalyze and support opportunities for sustainable capacity building among New Jersey FQHCs.

Public Funding for FQHCs:

Federal funding for FQHCs remains uncertain with every federal budget cycle. Currently, FQHCs are guaranteed to receive annual discretionary funding through May 2020, but with no certainty beyond that. Additionally, the Community Health Center Fund (CHCF) which totaled close to $4 billion in 2019 and which helps to fund expansion of access to healthcare, infrastructure development, and new clinical-care programs, will also expire in CY2020. There is no certainty that the government will renew CHCF funding beyond CY2020.

Recommended Policy Agenda.

1. Create long-term operational funding solutions for FQHCs, aimed at stabilizing the organizations and allowing for sustainable capacity building initiatives

2. Incorporate assessment and technical support for New Jersey FQHCs in funding policies to enable individual centers to optimize public dollars to build and sustain operational infrastructure that will help the organizations to manage environmental change and to become more self-reliant.

3. Institute policies to incentivize capacity building among New Jersey centers, but also institute accountability standards to sustain it.

Workforce Development:

As described in this study, primary-care providers are leaving the profession, creating a dearth of providers and increased competition for primary care clinicians. Again, many centers rely upon federal support, such as funding for the NHSC to help with recruitment and retention of primary-care clinicians. But the NHSC alone cannot address the need for recruitment and retention of primary-care providers, a need that is growing across the entire healthcare industry. Many states are turning to legislation to expand the use of other primary-care clinicians, as well as to help ensure necessary investments in primary care to help strengthen existing primary-care practices and to help grow the primary-care workforce. Additionally, New Jersey is one of the states where the proportion of spending on primary care is lower than that for other healthcare providers, hospitals and other healthcare services. Underinvestment in primary care is widely considered a key factor that is contributing to the lack of primary-care providers in states like New Jersey.

Recommended Policy Agenda.

1. Strengthen New Jersey rules and regulations to allow for Advanced Practice Nurses to practice at the top of their licenses
2. Promulgate polices to increase New Jersey's investment in primary care. Other states have instituted legislation that raises the proportion of overall health care spending for primary care; sets state targets for investing in primary care; mandates investments in developing primary care infrastructure to manage payment reform; or establishes government oversight of efforts to increase investment in primary care, among other efforts.

*Payment Reform***:**

Public policies aimed at reducing the cost of healthcare are increasingly state

driven, because of the growing adverse impact on state budgets of healthcare costs. The

need to control healthcare spending in New Jersey and other states is a critical factor in

the drive toward payment reform. Two widely accepted paths toward payment reform

are the adoption of value-based payment models and strengthening primary care to create

more cost-effective care-delivery systems. Both paths include a push for primary-care

providers to adopt and participate in the new value-based payment models.

Recommended Policy Agenda.

1. Pursue legislation and rules to minimize the administrative burden and
   costs that have come to be associated with provider efforts to adopt
   value-based payment (VBP) models. Primary-care practices,
   including FQHCs, cite increased administrative burden and costs
   associated with the adoption of value-based payment as real deterrents
   to their moving toward adoption of VBP models.
2. Support the development and utility of accessible healthcare claims
   databases that incorporate timely clinical data to facilitate FQHC
   access to data and data management necessary to participate in value-
   based payment initiatives.

*Charity Care/Uncompensated Care Reimbursement***:**

New Jersey FQHCs continue to be the most significant primary-care providers for

charity care in the state. In addition, they provide uncompensated-care services for all,

regardless of the insurance type or the patients' ability to pay for case-management

services. While New Jersey is one of the few states that pay FQHCs for indigent care,

New Jersey centers contend that the reimbursement is insufficient and contributes to their

inability to achieve greater financial stability or expansion of access to healthcare. Additionally, the federal grants do not adequately cover the provision of comprehensive care for the uninsured or the insured FQHC patients.

Recommended Policy Agenda.

1. Review the state's practices and regulations for reimbursing for charity-care services and amend or create new legislation to provide proportional and sustainable reimbursement for charity-care services, including reimbursement to help defray the costs of uncompensated comprehensive services for the uninsured population.

As stated previously, federal- and state-level policy agendas that focus on encouraging greater financial investment in New Jersey health centers to enhance and to sustain their role as essential providers should be a priority. A review of the healthcare legislative agenda in New Jersey over this past year reveals inattention to the following: fostering primary care as a platform for healthcare reform, support for New Jersey FQHCs as essential providers of primary care, and investment in capacity building among the centers to enhance their ability to meet the need for primary-care services in the state.

A concerted policy focus on FQHCs requires political will, as well as leadership. It involves external champions and the expanded ability among FQHCs to help drive attention to their role, their impact; and their ability to help achieve statewide goals for improving health and healthcare delivery, as well to reduce overall health care costs. As such, policy agendas that focus on FQHCs going forward must include legislation to ensure their inclusion in innovative developments to address healthcare reforms at the systems levels as well as at the organizational level. For example, current policies are

inadequate for driving inclusion of FQHCs in larger healthcare delivery networks or ACOs, whether health system or FQHC based. To date the incentives for FQHCs to participate in such networks, as well as legislation that institutes stronger mandates that foster their inclusion have been insufficient.

System-level care-delivery models contribute to greater and more stable organizational capacity by establishing economies of scale for functions such as data acquisition and analysis and securing affordable access to services such as specialty care for their patients. Public policy can either incentivize capacity building among FQHCs or mandate it as a course for expanding greater, sustainable access to primary care across the state.

Many states are wrestling with the issue of whether to enforce top-down change or to encourage and empower the healthcare industry to lead the changes that are necessary for sustaining access to affordable, quality healthcare services in the states and in the nation. New Jersey FQHCs must adopt a stronger policy agenda to ensure they have meaningful input in how reforms will progress in New Jersey, and how they will impact FQHCs, as well as how they will strengthen those organizations most in need of organizational capacity building.

The policy agendas proposed here are in various stages of consideration and advancement in New Jersey. For example, over the past years FQHC advocates have consistently pushed for stable, long-term public funding for the centers, but at the same time, there has been little or no effort to promote policies to ensure organizational capacity building among the centers. Additionally, New Jersey and the federal government have demonstrated little political will to depoliticize public spending for

Community Health Centers; legislators continue to negotiate FQHC appropriations annually. This study underscores the need for *proactive* policy agendas to continue to raise awareness about the value of New Jersey FQHCs and their counterparts, and their impact on all aspects of primary healthcare delivery and healthcare outcomes. Greater awareness and the development of increased political and social capital may generate more bipartisan support and champions for achieving long-term, stable, mandatory funding for the centers and investment in capacity building near and long term.

To recap, this study provides greater understanding about the variation in the ready capacity that exists among New Jersey's FQHCs, and the variation that exists in the centers' ability to effect strategic planning toward achieving new capacity over time. Further, it illustrates the value of targeting funding support, prioritizing policy agendas, and enabling the centers—separately and collectively—to develop the organizational infrastructure and other capacity that is considered necessary for forging sustainable growth and access to healthcare. The study adds to the knowledge about the capacity components that help to advance such capacity building in New Jersey's FQHCs, as well as the factors that impede it.

The data in this study and from the FQHC literature demonstrate that the centers have long added value toward achieving the goals for healthcare reform, especially in improving population health and delivering cost-effective services. Strategic investments in FQHC capacity building and the role of FQHCs as essential providers strengthens the move toward establishing patient-centered healthcare reform in New Jersey and nationally.

Lastly, this study can help the reader to develop informed theories or inferences about FQHCs in similar contexts, nationally or within the state to build the case for further research and further investment in a proven healthcare delivery system.

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I want to restate my appreciation for those who participated in this study. In my experience and based on the documented value of FQHCs in New Jersey and across the country, health centers are critical primary-care providers. This study acknowledges the work and dedication of those who endeavor to ensure the success and sustainability of FQHCs, the mission, and the organizations. I am grateful for your willingness to help tell the FQHC story and to help advance greater clarity about issues of capacity building and sustainability among the centers. Thank you for your time, your transparency, and your willingness to share your perspective about New Jersey's FQHCs to help foster the continued work of the centers. This study was only possible because of your participation!

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APPENDICES

Appendix A. FQHC Program Requirements Summary

PROGRAM REQUIREMENTS	
NEEDS VERIFICATION	
Needs Assessment	Must have capacity to demonstrate and document needs of target populations and service areas. Must serve a federally designated health professional shortage area, or a medically underserved area or population, as defined by the U.S. Bureau of Primary Health Care
CORE SERVICES	
Required and Additional Services	Must provide all required primary, preventative, enabling health services and additional services to address identified unique population/service area needs that affect health status, to be provided directly or through established written arrangements and referrals
Staffing	Must maintain core staff as required and necessary to carry out all required services, either directly or through established arrangements and referrals.
Accessible Hours and Locations	Services must be provided at times and locations that meet the needs of the population served
After Hours Coverage	Must provide professional coverage after regular operating hours
Hospital Admitting Privileges and Continuum of Care	Health Center physicians have admitting privileges at one or more referral hospitals, or other arrangements to ensure continuity of care.
Sliding Fee Discounts	Must have a system to ensure services regardless of patient's ability to pay; Must have a system to determine eligibility based on need (poverty level) for full or partial discounts
Quality Improvement/Assurance Plan	Must have an ongoing QI/QA plan under the auspices of a clinical director
MANAGEMENT and FINANCE	
Key Management Staff	Must maintain a fully staffed management team appropriate for the size and needs of the center
Contractual/Affiliation Agreements	Must have appropriate oversight and authority over all contracted services, including assuring that any subrecipient(s) meets FQHC requirements
Collaborative Relationships	Must make and document efforts to establish and maintain collaborative relationships with other healthcare providers
Financial Management and Control Policies	Must maintain accounting and internal control systems appropriate to the size and complexity of the organization reflecting Generally Accepted Accounting Principles; Must assure an annual independent financial audit

PROGRAM REQUIREMENTS	
MANAGEMENT and FINANCE	
Billing and Collections	Must have systems to maximize collections and reimbursements for costs of providing services.
Budget	Must develop an appropriate operating budget to accomplish the service delivery plan
Program Data Reporting System	Must have systems for accurate data collection, reporting, and to support decision making
Scope of Project	Must maintain its funded scope of project (sites, services, service area, target population, and providers)
GOVERNANCE	
Board Authority	Board must maintain appropriate authority to oversee the operations of the center, including the selection of hours of operation, and hiring and firing of the CEO.
Board Composition	The majority of Board members must be users of the Center, and must represent the individuals served by the center demographically
Conflict of Interest	Bylaws and written board approved policies must have provisions that prohibit conflict of interest by board members and all employees and consultants to the center.

Adapted from Health Resources and Services Administration-Bureau of Primary Health Care: Health Center Program Compliance Manual (Bureau of Primary Health Care, 2018a;)

Appendix B. Sample: NACHC Health Center Innovations And Research Summaries

A compilation of research topics and related annotated summaries is found on the

NACHC website at:

http://www.nachc.org/research-and-data/summaries-on-health-center-research/

SAMPLE: NACHC Annotated Summaries of Studies of Health Center Quality of Care.

Fontil, V, Bibbins-Domingo, K, Nguyen, O, et al. Management of Hypertension in Primary Care Safety-Net Clinics in the United States: A Comparison of Community Health Centers and Private Physicians' Offices. Health Services Research. April 2017. 52(2): 807-825.

> This study examined National Ambulatory Medical Care Survey data from 2006-2010 and compared patients with uncontrolled hypertension who received care at Community Health Centers and private physician offices. Specifically, they compared health center and private physician office patients with uncontrolled hypertension on four hypertension treatment practices. The authors found that health center patients with uncontrolled hypertension were more likely to receive a new antihypertensive medication than patients at private physician offices (18.3% vs. 16.2%). They also found that health center patients covered by Medicaid with uncontrolled hypertension were more likely to be prescribed new medication than private physician office Medicaid patients (20.8% vs. 9.0%), providing evidence that health centers also play a role in reducing disparities in quality of care for Medicaid patients.

Cole M, Galárraga O, Wilson I, et al. At Federally Funded Health Centers, Medicaid Expansion Was Associated with Improved Quality of Care. Health Affairs. 2017. 36(1):40-48.

> This study compared changes in patient populations and quality of care in federally funded health centers between 2011 and 2014 in states that did and did not expand Medicaid. In contrast to non-expansion states, the authors found that Medicaid expansion states saw an 11% decrease in uninsured patients and an almost 12% increase in patients with Medicaid. The authors also found that Medicaid expansion status was positively associated with increased performance on quality measures for asthma treatment (5.2%), pap testing (2.3%), BMI assessment (4.5%), and hypertension control (2.1%) compared to health centers in states that did not expand Medicaid. This study's findings suggest that expansion of Medicaid is associated with both an increase in rate of insurance coverage among health center patients as well as impro

Appendix C. In-Depth Interview Outline And Guide

VERSION 2—August 9, 2014

Title of Project: <u>**New Jersey Federally Qualified Health Centers-Capacity and**</u>
                                   <u>**Sustainability under the Affordable Care Act**</u>

Principal Investigator: <u>**Julane W. Miller-Armbrister, MSW; Ph.D. Candidate**</u>

Funding Source: <u>**Departmental Funding-School of Nursing**</u>

(**Note for the IRB**: This interview guide has been refined based on information gained
from Component I of this research study—the Exploratory Focus Group. Questions have
been revised and added or deleted from Version 1 of this In-depth Interview Outline and
Guide).

<u>Introduction (audio recorded)</u>

Thank you for agreeing to participate in this interview.   As you know, I am Julane
Miller-Armbrister, the Principal Investigator for this research project, *New Jersey
Federally Qualified Health Centers − Capacity Building & Sustainability under the
Patient Protection and Affordable Care Act*.   I am currently a Ph.D. candidate in the
Rutgers, Joint Urban Systems Ph.D. program. I served as the CEO of a Federally
Qualified Health Center (FQHC) for 19 years.   I am interested in contributing to
knowledge that will promote the sustainability of FQHCs as essential primary care
providers.
The purpose of this study is to gain knowledge about the current capacity of New Jersey
FQHCs and facilitate an in-depth understanding of the barriers, opportunities, and
realities associated with capacity building in New Jersey FQHCs, within the context of
the Patient Protection and Affordability Care Act (ACA).
This study will specifically examine the capacity building strengths of New Jersey
FQHCs and the opportunities and challenges FQHCs face in this changing healthcare
environment. The ACA supports FQHC expansion and as such provides funding and
other assistance to help them achieve fundamental, sustainable improvements that result
in expanded access to primary care, improved health service delivery systems, and health
outcomes for the populations and communities they serve.   This study will help to
facilitate an in-depth understanding of how the Centers employ different processes,
resources, political and social capital, and vision to define and shape capacity building
and to sustain those efforts over time. In addition, the study is intended to inform policies
and strategies that are designed to support the efforts of New Jersey FQHCs to function
effectively under the ACA, as well as to enhance their role in improving the State's
healthcare delivery system.
I will pose questions to you to generate thought and discussion. There is no right or
wrong answer. If you do not wish to participate in this interview or you become
uncomfortable with the topics or the conversation, you may terminate the interview and

you can withdraw from the study at any time. Our conversation is private and only those assisting in this research will have access to this tape. In addition, my Faculty advisors (Drs. Jeffrey Backstrand, Terri Lassiter, Susan Ault and Sabrina Chase) may access information that could identify you or connect you to parts of our conversation. However, each of us is committed to protecting your confidentiality.   I will not share your name or any identifier with anyone outside those I have named. All information will be kept strictly confidential.

I anticipate this session will last between 60 to 90 minutes.

Statement of Confidentiality

I am audio recording this session to ensure the accuracy and validity of the information gained. Your identity will remain confidential. The transcriber and I are the only ones that will have access to this recording. Everything said here is confidential. The information gathered during this interview will be used for research purposes only. Please indicate if you wish to have the recorder turned off for any reason. I will stop recording and resume it when, and if, you give permission to do so.

Are there any questions at this point about the process?

 (Note: Inform interviewee--All references to FQHCs in the questions that follow refer specifically to New Jersey FQHCs unless otherwise stated. The Center refers to the FQHC where the interviewee is currently working.)

First, I am going to ask a few general questions about your role and function at your FQHC and about the Center itself.

1.   Tell me about your background and experience in working with FQHCs.

   Probe: How long have you been at the Center?
   Probe: Have you worked at other FQHCs?

2.   Tell me about your role at the Center

   Probe: What are your areas of responsibility?
   Probe: Have you always had this job (role) at this Center?
   Probe: What other jobs (roles) have you had at this FQHC?

3.   Tell me about your Center.

   Probe: How long has your Center been an FQHC?
   Probe: What patient population do you serve?
   Probe: How many patients does the FQHC serve annually?
   Probe: How many satellite sites do you have? Locations? Types?
   Probe: Were any satellite sites added because of expansion efforts under the ACA?
   Probe: Has the Center closed any sites since the implementation of the ACA?
    Ever?
    Why?
   Probe: What are the primary revenue sources for your Center?

4.   Tell me about your Center's mission and goals/the vision for your Center.

   Probe: What is the most important thing that you (the FQHC) do?
   Probe: Is the Center meeting its goals/achieving its vision?

Probe: What is the most important thing (s) the Center is doing to achieve its mission and vision?
Probe: Where do you think the Center is headed 3-5 years from now?

5. Tell me about the Center's leadership (executive level and governance).
   Probe: What is the Board structured?
   Probe: What is the Board's role versus the CEO's role?
   Probe: Does the Center engage in leadership/governance training/succession planning?
   Probe: How does the leadership interact with the Center?
   Probe: Is the Board aware of the opportunities/challenges that face the Center?
   Probe: Does the leadership team and Board have the right mix of skills and leadership abilities? What skills/abilities are represented on the Board? What is missing?
   Probe: What defines a strong board? Does your board reflect your definition of a strong board?

6. Is there anything else that you think important about your Center or your role that you want to add?

Now, I will ask you a few questions about the Affordable Care Act, your Center's response to the provisions and mandates of the ACA for FQHCs, and the healthcare environment in general.

7. The Affordable Care Act assumes a significant role for FQHCs. What is your understanding of how FQHCs are expected to participate in healthcare reform?
   Probe: What is your understanding of the provisions under the ACA specific to FQHCs?
   Probe: How does your Center view these expectations and how does it respond to them?
   Probe: What has your Center done or is doing differently now that the ACA is enacted?

8. What has been the most significant change at your Center since the Affordable Care Act was implemented?
   Probe: Have you as an organization/ staff discussed the ACA provisions and how they affect the Center? What have you done differently at the Center as a result?
   Probe: Is your Center experiencing greater patient demand (more patients trying to get appointments)?

9. In general, do you think your Center was/is ready to participate effectively under the Affordable Care Act (ACA)?
   Probe: Did you have to make significant changes to be ready for healthcare reform?

Probe: Have you changed how you operate to meet increased patient demand? In what way?

10. Is your Center designated as a Patient Centered Medical Home? What level of designation does it have? What official body?

   Probe: If not does it intend to seek PCMH designation? Why/Why not?
   Probe: If yes, why did your Center pursue PCMH status?
   Probe: Has it changed how you operate or provide clinical care in any way?
   Probe: Has the designation helped to improve your operations/ clinical care in any way?
   Probe: Has it benefited the Center in any other way? Does it enhance the Center's ability to compete in the marketplace?
   Probe: Does the Center participate in a Chronic Disease Management Collaborative? If so, has this benefited the Center? How?
   Probe: If the Center is in a CDMC, is a PCMH designation necessary and/or beneficial? Why or why not?
   Probe: Does the Center have the resources (financial, staff, facility, leadership etc.) to pursue/participate as a PCMH?

11. Are you aware of the funding opportunities for FQHCs under the ACA?

   Probe: Has your Center applied for any of the ACA grants available to FQHCs? Which ones?
   Probe: Do you meet the eligibility criteria to apply for the grants? Why or Why not?
   Probe: Which one(s) have you received?
   Probe: Are there any factors that have prevented your Center from applying or being eligible for any types of grants under the ACA?

12. What is your understanding of capacity building?

   Probe: What are some of the most significant efforts your Center has or is making to improve access; to meet patient demand; to improve operations; to provide training?
   Note-Describe my definition of capacity building after the interviewee provides theirs: Capacity Building is defined for purposes of this study as: the process that enhances ability and preparedness of systems, persons, organizations or communities to meet objectives or to perform as expected, toward sustainability (independent of external support over time).
   Probe: What is the primary goal of capacity building in your Center?

13. Are FQHCs vulnerable to external influences? How vulnerable are FQHCs in general to external influences?

   Probe: What are some examples of external influences that affect capacity building? Sustainability?
   Probe: How critical is external support to sustainability?
   Probe: Can the Center achieve sustainability (maintain enhanced performance/expansion over time without extraordinary external funding)?

Probe: Should Centers strive for sustainability that means independence from external support or subsidies? Why? Why not?

14. Do you think capacity building contribute to, or play a role in sustainability?
    Probe: How do you define sustainability?
    Probe: Should there be greater emphasis or concern about capacity building in the Center? Why
    Probe: How do you know or measure sustainability? How do you know when your Center is in a stronger or weaker position for sustainability?

15. How have the healthcare environment/ service community changed relative to your Center? To New Jersey FQHCs in general?
    Probe: How is your Center adapting to the changing healthcare environment?
    Probe: How is your Center adapting to service area changes?
    Probe: Are the changes viewed as a threat or an opportunity in your organization?
    Probe: What are specific examples of how your Center is reacting to the changing healthcare environment within the last five years?
    Probe: How has the Center adapted to population/service area changes?
    Probe: Can the Center meet the needs of a changing service area/community/healthcare environment?

16. Does the Center engage in strategic planning?
    Probe: Does the strategic plan include capacity-building goals? Goals for sustainability? Is there a focus on capacity building in the planning process or in any strategic plan of the Center?
    Probe: Is the Center engaged in specific strategies or activities because of the changes in the healthcare environment? How has the ACA influenced the Center's strategic plan?
    Probe: Is expansion (define expansion efforts) a strategic initiative for you Center?

17. Are resources (financial, staff, etc.) targeted for capacity building? (i.e., staff and leadership development, expansion of hours, hiring additional clinical staff, upgrading information technology capabilities)
    Probe: Can you identify specific capacity building initiatives achieved within the last three years?
    Probe: Technology is considered a critical tool in the changing healthcare environment. Does your Center have adequate technology capabilities and resources to manage the changing environment?

18. What practices are in place to enhance clinical practices or operational performance at your FQHC?
    Probe: Describe your clinical structure. Clinical leadership?
    Probe: Does the Center have a quality improvement program?

Probe: How is it staffed?
Probe: How are quality improvement assessments and results disseminated and used?
Probe: Do you participate in training that leads to enhanced performance?
Probe: Does the Center believe quality improvement is important to capacity building? How is this demonstrated?
Probe: How does the Center ensure optimal access to clinical services?

19. How involved is your Board in capacity building? How involved are they in ensuring a more sustainable position for the Center?
    Probe: Does the Board develop and approve policies or plans that support expansion, performance assessment and enhancement?
    Probe: Does the Board communicate with the staff about capacity building? With others? How?
    Probe: Does the Center already engage in activities or planning for enhancing governance as a function of capacity building?

20. What is New Jersey's investment in capacity building for its FQHCs?
    Probe: Has New Jersey undertaken any efforts to promote performance enhancement/capital improvements/ access or service expansions among the FQHCs?
    Probe: Has your Center benefited from any direct state interventions to help achieve performance enhancement/capital improvements or expansions, etc.?
    Probe: Has your Center been harmed by state policies, or actions/ inactions relevant to FQHCs in any way?

21. Does your Center have strong local support from community members or leaders?
    Probe: Are there community advocates for the Center?
    Probe How do they benefit the Center?
    Probe: Do they contribute in any way to capacity building or sustainability for the Center?

22. Does your Center collaborate with other community agencies or institutions to share resources or to ensure continuity of patient care?
    Probe: Does your Center strategically pursue partnership building? Can you provide an example of such?
    Probe: What types of partnerships are important to your Center; To achieve success in capacity building; To move toward sustainability?
    Probe: Is the Center engaged in partnerships now or plan to be because of the implementation of the ACA? Describe the relationship(s).
    Probe: Does the Center engage in partnerships or collaborations that enhance its operations or clinical practices?

23. Generally, are FQHCs competitive in the changing healthcare environment?

Probe: Is your Center positioned to compete effectively in the marketplace? Why/why not?

Probe: What evidence describes the Center's readiness to compete/or not to compete in this marketplace?

Probe: Is your Center engaged in specific strategies or activities to enhance its capacity to compete effectively?

Probe: How successful is your Center in competing for patients? Resources? What are some specific successes?

Probe: Can the Center sustain any competitive position?

Probe: Does the Center anticipate more competition because of the ACA?

24. Should FQHCs seek to operate with a business model? What does this mean to you?

    Probe: Do FQHCs currently strive to operate as a business?

    Probe: What do you consider best practices of a business model? Are these implemented in your Center? In FQHCs in general?

    Probe: Are there benefits in implementing business practices in the FQHC model? Does this enhance capacity building or sustainability?

    Probe: Are there constraints (federal/state/regulatory/policy) that prevent FQHCs from implementing business practices? Provide examples of such constraints.

25. What is the Center's greatest strength in meeting its goals for performance enhancement/expansion/ and sustainability?

    Probe: How does it affect the Center's ability to achieve its goals?

    Probe: What are the critical factors/ successes in the Center that are moving the Center toward sustainability?

26. What is the Center's greatest challenge in meeting its goals for performance enhancement/expansion/ and sustainability?

    Probe: What makes it a challenge?

    Probe: How does it affect the Center's ability to achieve its goals?

    Probe: Does the mission of FQHCs present a challenge in any way to achieving capacity building or sustainability goals?

27. Is your Center actively engaged in advocacy/education efforts to influence political/regulatory policy makers to the benefit of FQHCs?

    Probe: If policy makers could make one thing happen to promote capacity building and sustainability, as you understand it, what should that be?

    Probe: Are there any factors at the State level that have hindered NJ FQHCs in capacity building?

    Probe: How effective is your Center in advocacy/education efforts to influence political/regulatory policy makers to the benefit of FQHCs?

    Probe: Does the State/general public/ local community demonstrate recognition of the value of FQHCs? How?

Probe: How does your Center communicate about capacity building? Internally and externally?

Probe: Does your FQHC have political capital in the State to effectively change or affect policy/regulations to benefit the Centers? Why/Why not?

28. Does your Center aspire to achieve capacity building, as you understand it?
    Probe: What specific capacity building successes have your Center experienced? How has it moved the Center toward sustainability?

29. How visible is your center to stakeholders?
    Probe: Does the Center share its vision/mission/goals widely shared with stakeholders?
    Probe: Does your Center have a marketing or public relations strategy or plan? Is it implemented?
    Probe: What are the critical successes that should be known about your Center? FQHCs in general? Are they known and how broadly?
    Probe: What must change to achieve the vision and to ensure the mission?
    Probe: Does your Center communicate capacity building goals/achievements internally/externally and impact on mission/vision? How?
    Probe: How are successes/needs communicated?
    Probe: Is there awareness of the "valued added" by FQHCs as essential providers and community partners? Why/Why not?

Thank you for your time. Is there anything else that you want to share or do have any questions about the study or the process?

Appendix D. Focus Group Outline and Guide

VERSION 1--December 17, 2013

FOCUS GROUP OUTLINE AND GUIDE

Title of Project: **New Jersey Federally Qualified Health Centers-Capacity and Sustainability under The Affordable Care Act**

Principal Investigator: **Julane W. Miller-Armbrister, MSW; Ph.D. Candidate**

Funding Source: **Departmental Funding-School of Nursing**

Introduction (audio recorded)
Thank you for agreeing to participate in this study and focus group. Before we begin the group session, let me first introduce myself and provide a brief overview of the study, *New Jersey Federally Qualified Health Centers − Capacity Building & Sustainability under the Patient Protection and Affordable Care Act,* and the logistics for this session.

I am Julane Miller-Armbrister, the Principal Investigator for this research project. I am currently a PHD candidate in the Rutgers, Joint Urban Systems Ph.D. program. I served as the CEO of a New Jersey Federally Qualified Health Center (FQHC) for 19 years. I am interested in contributing to knowledge that will promote the sustainability of FQHCs as essential primary care providers.

Joining me is [NAME], who will assist me. [NAME] (title) will transcribe the audio data from this session.

The purpose of this study is to gain knowledge about the current capacity of the FQHCs and facilitate an in-depth understanding of the barriers, opportunities, and realities associated with capacity building in New Jersey FQHCs, within the context of the Patient Protection and Affordability Care Act (ACA).

This study will specifically examine the capacity building strengths of FQHCs and the opportunities and challenges FQHCs face in this changing healthcare environment. The ACA supports FQHC expansion and as such provides funding and other assistance to help them achieve fundamental, sustainable improvements that result in expanded access to primary care, improved health service delivery systems, and health outcomes for the populations and communities they serve. This study will help to facilitate an in-depth understanding of how the centers employ different processes, resources, political and social capital, and vision to define and shape capacity building and to sustain those efforts over time. In addition, the study is intended to inform policies and strategies that are designed to support the efforts of New Jersey FQHCs to function effectively under

the ACA, as well as to enhance their role in improving the State's healthcare delivery system.

I will pose questions to you to help generate thought and discussion. There is no right or wrong answer to any question. Your participation in the study will be kept confidential. I ask that each of you respect the confidentiality of your colleagues and refrain from discussing anything you hear during this session itself, outside of here. You may refuse to participate in any part of the focus group discussion at any time.

I anticipate this session will last between 60 to 90 minutes.

Statement of Confidentiality
I am audio recording this session to ensure the accuracy and validity of the information gained. Your identity will remain confidential. [NAME] (transcriber) and I are the only ones that will have access to this recording. Everything said here is confidential. The information gathered during this focus group will be used for research purposes only.

Please indicate if you wish to have the recorder turned off for any reason. I will stop recording and resume it when, or if, you and all other session participants give their permission for it.
Are there any questions at this point about the process? We will break for five minutes to allow time for you to get your meal, which is buffet style. We will start the formal discussion in five minutes.

(Upon completion of any Q & A about the process—take a five minutes break to get food and be seated. Stop audio recording)

Formal Discussion (start audio recording):

Focus Group Participants –**introduction of each participant:**
We are beginning the formal discussion for this study. Because we are recording, I ask that you please set your phones on vibrate. If you must answer a call, please leave the room while doing so. Also, please avoid any side conversations, so that we can all benefit from hearing each other's comments. Thank you in advance for your cooperation in doing so. Let us begin now with each of you introducing yourself to the group. Briefly, please give your name, affiliation and connection to the FQHC community –no more than one minute please.

(Allow ten minutes total for introductions)

(Note: Inform focus group that all references to FQHCs in the questions to follow refer specifically to New Jersey FQHCs unless otherwise stated)

Opening Questions

30. The Affordable Care Act (ACA) assumes a significant role for FQHCs (nationally). What is your understanding of the role of FQHCs under the ACA? How do the centers (in general) help to advance healthcare reform?

    Probe: Are you aware of any provisions under the ACA specific to FQHCs?
    Probe: What is the most important provision for FQHCs and why?

31. In general, how do you describe the current state of readiness of FQHCs to function under the Affordable Care Act (ACA)?

    Probe: Are FQHCs prepared to expand sites, services or programs?
    Probe: What has been the outcome of FQHC preparations and participation in healthcare reform to date?

32. What is your understanding of capacity building?

    Note-Describe my understanding of capacity building after the interviewee provides theirs: Capacity Building is defined for purposes of this study as: the process that enhances ability and preparedness of systems, persons, organizations or communities to meet objectives or to perform as expected, toward sustainability, independent of external support over time.
    Probe: How do you think the FQHCs view capacity building?

33. Do FQHCs engage in deliberate strategies to enhance administrative, operational or governance functions?

    Probe: What evidence is there that FQHCs engage in deliberate capacity building, as you understand it?

34. How much emphases do the centers place on expansion, performance enhancement, sustainability, etc.?

    Probe: Do the centers differ or have similar practices in place to achieve these goals?
    Probe: Should there be greater emphasis or concern about capacity building in the Centers? Why?

35. How important is capacity building, as you understand it?

    Probe: What are the implications for centers that do or do not engage in activities to enhance their abilities or preparedness in respect to systems, personnel, governance in the current changing healthcare environment?

    Probe: Can the centers sustain expansions, quality enhancements without extraordinary external funding over time?
    Probe: What is needed for sustainability?

36. How does the history and culture of FQHCs influence their ability for sustainability?

Probe: Does the historical mission of the centers affect their abilities for capacity building to achieve sustainability?

External Environment and Impact

1. If policy makers could address one key issue to support capacity building over time in FQHCs, what should it be?
   Probe: What is the most persistent challenge to capacity building for the centers?

2. Should other state stakeholders be concerned about the ability and preparedness of FQHCS under the ACA?
   Probe: How have stakeholders addressed the issue of sustainability in FQHCs?
   Probe: What stakeholders are invested in enhancing preparedness and ability in New Jersey FQHCs or should be invested in it?

3. How does the expansion of insurance coverage affect FQHCs?
   Probe: Are centers concerned about competition with private providers or newly created healthcare delivery organizations (i.e. ACO)?
   Probe: Can the centers compete effectively?

4. How do you view the political and social capital of FQHCs within the state?
   Probe: In general, do local communities invest in sustainability of the centers—how and why/not?
   Probe: In what ways have the centers engaged in relationship building to enhance support?
   Probe: How would you describe FQHC relationships with policy makers? In addition, with community members and community leaders?
5. **Probe:** How do stakeholders (policy makers and external funders) assess achievements toward capacity building?

Internal Environment and Impact

1. Do most centers have a clear mission and vision?
   Probe: Is it widely shared with stakeholders?
   Probe: Can you state the vision (and /or mission) of one center?
   Probe: Do FQHCs engage in strategic process to achieve their vision/mission?

2. What percentages of FQHC budgets are funded by external sources?
   Probe: How does the distribution of revenue streams affect capacity building/ sustainability?

3. What is your perception of the center's efforts to engage in continuous quality improvement and how is it used to promote capacity building/sustainability?

4. How do the Boards engage in efforts to ensure the preparedness and ability of FQHCs to achieve sustainability beyond the funding support provided under the ACA?

Probe: What is the skill composition on most Boards?
Probe: How do Boards promote sustainability?

5. What is the most successful practice within an FQHC that you are aware of that promotes capacity building/sustainability?
   Probe: What makes this a successful practice?

Impact of the ACA on FQHC capacity building and sustainability
   1. How has the capacity of FQHCs changed with the implementation of the ACA?
      Probe: What was it prior to the ACA?

   2. Are the FQHCs ready to participate as patient centered medical homes (PCMH)? Why/why not?
      Probe: For those that have gained a PCMH designation or some level of it, how has it benefited their efforts toward capacity building?
      Probe: How has the ACA advanced FQHC participation as a PCMH?
      Probe: Is PCMH designation important for FQHCs to compete effectively under the ACA; to enhance clinical and/or operational performance; to achieve and sustain growth; to sustain financial health?

   3. Are the FQHCs participating in Accountable Care Organizations (ACO)? Why/why not?
      Probe: Is ACO participation important for sustainability of the FQHCs"

Appendix E. Summary of Key FQHC Provisions in the Affordable Care Act*

Summary of Key FQHC Provisions in Affordable Care Act

ACA Provision	Purpose
$11 Billion for Program Expansion over 5 years beginning in FY2011	$9.5 billion to expand operational capacity and serve 20 million additional patients, enhance medical, oral, and behavioral health services $1.5 billion for capital needs –expansion of improvement of existing facilities and construction of new sites
$1.5 Billion for National Health Service Corps over five year, beginning in FY2011	Place an estimated 15,000 primary care providers in medically underserved communities. Potential to address primary care retention and recruitment needs of the FQHCs
Expands Medicaid to 133% of the Federal Poverty Level (FPL) beginning in FY2014	Expands insurance coverage without categorical restrictions to approximately 16 million and is expected to increase the demand for primary care and FQHC services. Also provides enhance source of revenue for FQHCs as charity care patients gain insurance coverage
Payment Protections and Improvements	Requires insurers to pay FQHCs no less than their Medicaid PPS rate and that plans contract with health centers; Ensures FQHCs are not excluded from participation in the new insurance products and that they are paid adequately for services
Medicare Payment for Preventative Services	Allows FQHCS to be paid for services heretofore excluded from payment by Medicare; facilitates sustainability of programs and services that compliment medical care and enhances quality of care
Authorize and Fund new programs for health center-based residencies $230 million over 5 years for the Title III program payments	Authorizes a new Title VII program for development of residency programs at health centers and creates a new Title III program to provide payments to community-based entities that operate teaching programs

* From NACHC www.nachc.com/healthreform.com