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A Retrospective Analysis of Sustainability: CHCS That Were Part of a Consortia When Federal Funding Ended

Latonya B. Dunlow
Medical University of South Carolina

A RETROSPECTIVE ANALYSIS OF SUSTAINABILITY: CHCS THAT WERE PART OF A CONSORTIA WHEN FEDERAL FUNDING ENDED

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Latonya B. Dunlow

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BY

Latonya Bree Dunlow

Approved by:

Andrea W. White April 9, 2012

Chair, Project Committee Andrea W. White, Ph.D. Date

Karen A Wager April 9, 2012

Member, Project Committee Karen A. Wager, DBA Date

Joann T Richardson April 9, 2012

Member, Project Committee Joann T. Richardson, Ph.D. Date

Lisa Saladin 4/30/12

Dean, College of Health Professions Lisa Saladin, Ph.D. Date

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Chairperson: Andrea W. White, Ph.D
Committee: Karen A. Wager, DBA
Joann T. Richardson, Ph.D

Community health centers (CHCs) serve an important role in addressing gaps in access to care experienced by millions of Americans. There have been programs in the past developed to provide funding support to increase access to care. However, when funding ends some grantees are faced with program sustainability challenges.

This study sought to identify factors and advice for sustainability of programs and services once funding ends. The findings of this study are consistent with the literature; however there were two qualities of leadership important to sustainability that were not as pronounced in the literature that were found in this study—perseverance and tenacity. Study findings were based on interviews with former CHC and non-CHC Healthy Communities Access Program (HCAP) grantees that were able to sustain programs and services despite the discontinuation of HCAP funding. Factors and advice identified in this study can be used by both prospective grantees and funding agencies.

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CHAPTER 1

INTRODUCTION

The United States is one of the richest countries in the world and is generally considered to have one of the best health care systems. However, there are aspects of the health care system that leave many citizens with limited health care options. One of the major issues is access to care. Access to care affects vulnerable populations, many of whom lack insurance and rely on community health care centers (CHCs) for their needs. Community health centers can be credited as being the largest system of comprehensive primary health care (Shi & Stevens, 2007).

With the passage of the American Recovery and Reinvestment Act of 2009 and health care reform legislation in March 2010, support has been directed to community health centers in terms of workforce enhancement, capital investment, modernization and operations. Additionally, the legislation includes funding for health information technology (HIT) adoption and infrastructure development and the expansion of services (Kaiser Commission on Medicaid and the Uninsured, 2009). Federal funding for CHCs has been appropriated to address access to care, quality, and increased demand issues. A source of funding support to community health centers is provided by the federal government through federal grants. Knowing how to sustain programs and continue services is a valuable resource.

Programs have been implemented in the past to address access to care issues. However, as a result of discontinued funding and support, they were unable to sustain programs and activities initiated with these funds, causing fragmentation and/or gaps in care for communities that had become dependent upon services that were no longer offered. One such program was the Healthy Communities Access Program (HCAP), which sought to assist communities and consortia of health care providers and others to develop or strengthen integrated community health care delivery systems that coordinated health care services for individuals who were uninsured or underinsured (Bureau of Primary Health Care, internal document, May 13, 2003). The HCAP evolved as a result of gaps in health care for the uninsured and underinsured in the United States.

Despite the discontinuation of this program and federal support to grantees being stymied, the need for continuity of care and services remained. Some HCAP consortia CHC programs were able to be sustained after federal funding ended. The researcher is interested in the factors that contributed to the sustainability of these projects and activities.

Background

Background and Need

Serving as a safety net since the mid 1960's by providing low or no cost care, CHCs are required by legislation to serve federally designated medically underserved areas (Cook et al., 2007). In 2010 alone, CHC grantees provided care to nearly 20 million patients throughout the nation (Kaiser Family Foundation, 2012).

Many people use the services of CHCs which fill important gaps in access to care. For the vulnerable populations in the United States, CHCs have served a critical health

care delivery role for years (Shi, Stevens, & Politzer, 2007). Starfield and Shi (2004) argue that people who received care in federally qualified CHCs, those centers that received grants from the federal government, have more favorable outcomes than in comparable populations without access to these types of centers. "Community health centers are found to outperform health maintenance organizations (HMOs) on primary care characteristics overall, in providing ongoing care, on coordination of care, on comprehensiveness of services received by users, and in community orientation and to perform comparably to HMOs on first-contact care and comprehensiveness of services available" (Starfield & Shi, 2004, p. 1495).

CHCs provide an array of assistance and services such as nutrition counseling, child care, child parenting classes, case management, health education, transportation, and translation in addition to traditional preventive and community based primary care services (Politzer et al., 2001). Politzer and associates also found that by confirming themselves as patients' normal source of care, CHCs were effective in decreasing and eliminating disparities in health access (Politzer et al., 2001). In 2002, President George W. Bush supported legislation that increased the number of new access points for new health centers servicing millions more underserved people and in at least 1,200 communities (Shi et al., 2007). However, this proposal was undercut by the fact that the Bush Administration and the U.S. Congress instituted $10 billion in Medicaid cuts and other social programs which forced CHCs to accommodate more of the vulnerable population (Shi et al., 2007).

Vulnerable populations are disproportionately impacted by access to care issues. Vulnerable populations include racial/ethnic minorities, uninsured, Medicaid-enrolled

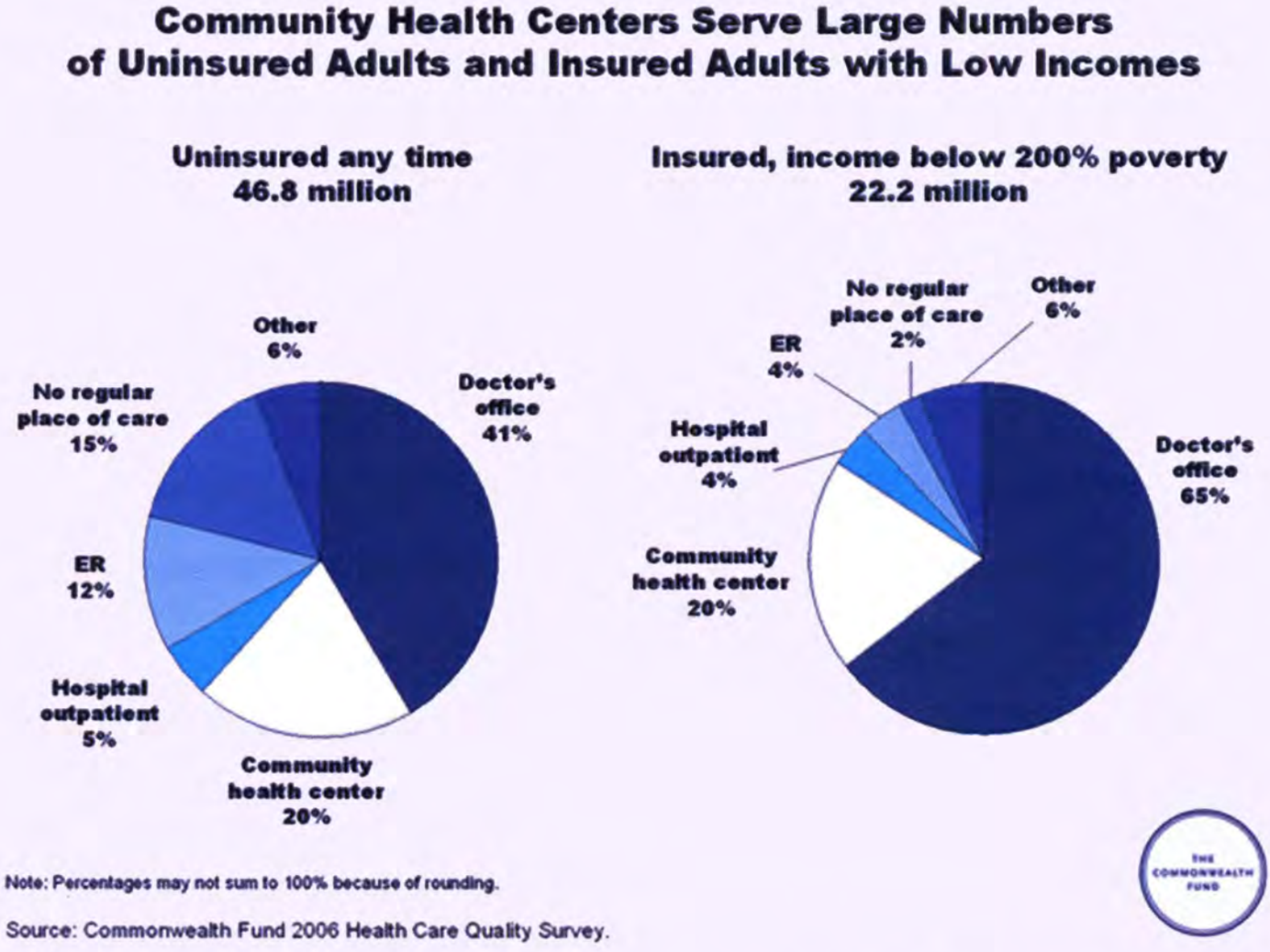
and low income persons (Shi et al., 2007). Economically disadvantaged people from minority groups encounter major challenges in receiving health care and experience more disparities in health outcomes and status (Politzer et al., 2001). Evidence suggests that this may be in part due to the lack of availability of affordable health care, the small number of providers that attend to the uninsured or Medicaid recipients, substandard accessibility geographically, insufficient transportation, and language or cultural competence barriers (Shi et al., 2007).

The number of uninsured patients utilizing CHCs has grown substantially over the past twenty years. Carlson and associates (2001) compared CHC patients with uninsured people nationwide with a focus on determining if the Healthy People 2000 (a national strategy with health promotion and disease prevention objectives to improve the health of Americans grouped by priority areas) objectives were being met with the primary care provided. They found that CHCs were performing at a favorable level. At the time of their study, the patient population of CHCs was increasing as the nation's overall uninsured increased.

The literature also reported a significant correlation between lack of a medical home, unmet health needs, increased mortality, and poorer health outcomes among the uninsured (Shi & Stevens, 2007; Shi et al., 2007; Shi, Tsai, Higgins, & Lebrun, 2009; Larson, Schlundt, Patel, McClellan, & Hargreaves, 2007). In 2006, at any time, 20% of the uninsured and 20% of the insured who have low incomes were served by health centers. (Commonwealth Fund 2006 Health Care Quality Survey [CF], 2007, figure 28) (See Figure 1 below). By 2007, at least 39% of patients being serviced at CHCs were uninsured (Kaiser, 2009). Although, at least 16% of CHC patients are recipients of

private health insurance, due to unaffordable deductibles, limited coverage and/or cost-sharing, a substantial number of patients rely still on community health centers for affordable care (Rosenbaum, Finnegan, & Shin, 2009).

Figure 1.



Report Closing the Divide: How Medical Homes Promote Equity in Health Care: Results from the Commonwealth Fund 2006 Health Care Quality Survey, June 2007, p. 24, figure 28.

Federal programs have been developed to close the access to care gap and repair an otherwise fragmented system of care. One such program was the HCAP which started out as a demonstration project prior to receiving legislative authorization. The demonstration project was known as Communities Access Program (CAP). The goal of

CAP was to engage community partners to collaborate in an effort to provide health care access for uninsured and underinsured individuals (Navigant Consulting, 2004). Communities Access Program (CAP) was a demonstration project funded by Congress in 2000, then in 2002 Congress passed legislation that created HCAP which was a continuation of CAP with a slightly different name. Healthy Communities Access Program (HCAP) had the same goals as CAP with an additional goal to improve care of patients with chronic conditions (NORC at the University of Chicago [NORC], 2005). Through grant awards, communities were supported in strengthening their health care infrastructure. The Institute of Medicine (IOM) released a report in March, 2000 entitled, *America's Safety Net: Intact But Endangered,* which "warned policy makers about the threat to safety net providers that jeopardized access to care for uninsured and disadvantaged populations" (S. Rep. No. 107-83, 2001, p. 10). The CAP demonstration project was a step in the right direction, according to the IOM, to develop a grant program to create safety net providers that provide care for the uninsured and other vulnerable populations (Institute of Medicine [IOM], 2000).

Although not authorized, CAP received appropriation for fiscal years 2000-2002 (Navigant Consulting, 2004). In October, 2002 CAP was authorized with the birth of the HCAP and was included in the Public Health Service Act (Navigant Consulting, 2004). Previously, as CAP, the program had been a one year demonstration; however, as HCAP, an official period of funding for three years was established. HCAP enhanced the CAP demonstration program which provided the groundwork for safety net provider connections (S. Rep. No. 107-83, 2001; Health Care Safety Net Amendments of 2001). CAP's evolution into HCAP, addressed the need to create an infrastructure to aid

integrated care for the uninsured (S. Rep. No. 107-83, 2001). In order to be eligible for funding under HCAP, a consortia had to include at least one of the following unless such providers did not exist--health centers, health departments, a hospital with a low income utilization rate greater than 25% and an interested public or private sector health care provider or organization that has a history serving the uninsured.

Focus of Study

This study will focus on the CHCs that were a part of an HCAP consortia, in particular, to identify factors that contribute to the sustainability of programs and activities of a federally funded entity after funds were discontinued. While working closely with grantees, consultants, and federal Project Officers, the researcher learned/gained insight about benefits and challenges of a federally funded health center. After HCAP was authorized but not appropriated funds during the Bush administration, some grantees were forced to reduce their workforce and/or discontinue activities enabled by funding. This population of underserved, uninsured and underinsured individuals already experience fragmented care and this lack of funding only reintroduces access to care issues to this vulnerable population.

This research is also timely and needed with the passing of the American Recovery and Reinvestment Act (ARRA) of 2009 and health care reform legislation in March 2010 (Hawkins & Groves, 2011). Signed into law as a result of the economic downturn the United States economy has been experiencing, the ARRA legislation was developed and implemented to stimulate the economy. Health Care Reform legislation (later termed the Affordable Care Act) was established to provide comprehensive health care coverage to millions of uninsured Americans (Hawkins & Groves, 2011). Both

pieces of legislation impacted the health care arena by making provisions to address access to care issues, the uninsured, and the underinsured. Under these pieces of important legislation, federal funding was appropriated to create, establish, and strengthen affordable and quality health care. For example, the Health Resources and Services Administration (HRSA) was one of the first federal agencies to begin awarding ARRA funds. Out of this funding, existing community health centers were expanded and new community health centers opened. New Access Points (NAPs) were developed to,

> "...support new health center sites and service areas; to increase services and providers at existing health center sites; and to address increases in the number of patients, including uninsured patients, seen by health centers. In addition, these funds will support the creation and retention of jobs in underserved communities across the country" (Health and Human Services [HHS], 2009, para. 2).

As a result of the recession, there were more uninsured patients and fortunately, ARRA invested $500 million over a two year period to support uninsured patients (Kaiser, 2009). Of the $500 million, $155 million was awarded to NAPs and approximately $345 million to existing CHCs to meet the increased demand for services (Health Resources and Services Administration, n.d., figure 1).

HRSA awarded 126 NAP grants to applicants that were approved but unfunded in 2008 (HHS, 2009). These new organizations had the challenge of commencing operations during a depressed economy as well as establishing a foundation for sustainability with 2 year grant funding.

One of the many benefits provided by the ARRA inspired NAP grant is that it created an opportunity for CHCs to support and expand services provided to various populations through technical assistance offered by HRSA. A key consideration that grantees should ponder and plan for is the sustainability of programs and services initiated and supported by federal funds. Therefore, grantees should start with the end in mind. Each activity (i.e., service delivery, outreach, technology, and infrastructure) planned should be performed with sustainability in mind. Will this activity be around long after the funds have disappeared? It would be extremely unfortunate for a grantee to become dependent on funding and not be prepared to continue activities and/or services when the funding ends, thereby, perpetuating a cycle that seems to exist once funding discontinues. Those impacted the most would be the patients who have become accustomed to receiving the benefits of certain services and activities enabled by funding.

Problem Statement

Considering the access to care problem in the U.S., there needs to be improvement to the health care delivery system. Some programs have been implemented in the past to address this issue. One such program was the HCAP. Grants were awarded to coordinate and integrate services in communities.

After the discontinuation of HCAP, some CHC programs have continued to thrive while others have failed. It would be of value to determine what variables have been instrumental in helping some programs succeed while others failed. It is possible that these factors can be identified, shared with grantees and/or included in federal grant opportunities. No such information has been collected from HCAP consortia CHC programs that survived, and this research would provide a valuable opportunity to learn key themes of survival for health centers and organizations that receive federal funding.

Research Questions

There is a rich source of information that can be gleaned from this research. Research questions are as follows:

- What are essential factors to ensure sustainability of programs and services of consortia of community health centers once federal grant funding ceases?
- What criteria/components do key players (i.e., staff and leadership actively involved with the preparation, facilitation, direction, management, and execution of the HCAP program within their respective organization) believe are essential for inclusion in potential funding in new projects/programs?

Population

Over the duration of CAP and HCAP there were 228 funded grantees. Personnel from survived HCAP consortia CHCs and non CHCs were chosen to participate. It was the intent that the experience of key players in the viable centers would inform this study. It can be argued that the knowledge we gain from this research will be transferable to other health centers and health care entities that compete for funding support in the future. When these entities receive federal support they are able to acquire and/or build new facilities, upgrade technology, hire additional clinical and support staff and implement new programs. However, once the grant funding ends, whether prematurely or as scheduled, some of the programs and staff may not be sustainable, particularly if they have not adequately planned for sustainability.

Another group that would benefit from this research is federal funding agencies that develop programs out of need and/or directive. A primer for program sustainability provided to grantees would increase the likelihood that they achieve sustainability after initial grant funding ends. Also, federal funding agencies will be assured that the funds being dispersed are not squandered or a one shot deal. When grantees receive the funds, it is not intended as a temporary measure, but rather a stepping stone or assistance for a long term plan for success (i.e., contribution to aid in the enhancement of quality health care delivery) within the grantee's organization.

Operational Definitions

Community Access Program (CAP) - Demonstration project in fiscal years 2000-2002 which was a possible solution to addressing the nation's problem of the uninsured and underinsured funded by Congress and implemented by HRSA. Key features of CAP were flexibility--to meet each community's unique needs; collaboration--of various

community groups, local government, and health care providers; and infrastructure—for development and implementation. Grants were provided to eliminate fragmented health care delivery systems, promote the prevention of disease and educate community members, rally private and public sector participation, and strengthen safety-net provider efficiencies (Navigant Consulting, 2004).

Federally Qualified Community Health Center (CHC) - Also referred to as health centers or community health centers. Health care organization/entity committed to serving and improving the health of the population in the geographic area which it is located. CHCs receive federal grant support and enhanced reimbursement for services provided; must serve predominantly uninsured, underinsured or individuals experiencing difficulty accessing health care.

Federal Funding-Funds awarded by the federal government to an entity that has applied for financial assistance to accomplish its goals and better serve its population.

Grantees-Health entities/organizations/centers/hospitals that receive federal financial support.

Healthy Communities Access Program (HCAP)--Authorized grant program in operation from 2003-2006 funded by Congress and implemented by HRSA to assist communities and consortia of health care providers and others to develop or strengthen integrated community health care delivery systems that coordinated health care services for individuals who were uninsured or underinsured.

HCAP Data Management System-Database accessed by Project Officers which was developed to organize, manage and store CAP and HCAP data with categories such as grantee profile, reports, activity trends, and primary contact information.

Key Players-Staff (i.e., coordinators, points of contacts) and leadership actively involved with the preparation, facilitation, direction, management, and execution of the HCAP program within their respective organization.

Project Officers-Federal employees/staff working within the Division of State and Community Assistance of the Health Resources and Services Administration (HRSA) responsible for the oversight and guidance of grantees' usage of HCAP funds.

Sustainability- The ability of an entity or program to be able to thrive and exist without the assistance of federal funding once discontinued.

Assumptions

The researcher is making the following assumptions:

- Viable community health consortia including health center programs/projects exist even though HCAP funding ceased.
- Key players involved in HCAP consortia will still be present at the CHCs to be studied.
- Key players will remember HCAP and communicate with the researcher.

The next chapter presents the findings from the literature review on community health care organizations' critical issues such as access to care, CHCs, sustainability, leadership, and funding.

CHAPTER 2

LITERATURE REVIEW

Throughout the literature reviewed, overarching themes emerged regarding access to care, community health centers (CHCs), sustainability, leadership, and funding. This literature review covers access to care issues that include vulnerability factors, lack of insurance and specialty care. Secondly, the CHC section of the literature review will capture the community benefits from CHCs and the impact of legislation. Sustainability of programs and initiatives, which is another major issue for CHCs brought forth strategic thinking/models, collaboration and entrepreneurship. Next, the literature on leadership supported the importance of a strong leader with qualities such as emotional intelligence, creativity, and trust. Finally, this literature review covers funding sources that support CHCs –federal, Medicaid and Non-federal.

Access to Care

Access to care is the ability to obtain quality health care that is affordable, culturally competent and without barriers—i.e., cost, geographically inaccessible, insufficient transportation, and lack of specialty care. Evidence suggests that the target populations for whom health centers are designed generally face access to care issues, and experience more disparities in health outcomes and status (Fiscella & Shin, 2005; Proser, 2005; Shi et al., 2007). Throughout the literature, several recurring access to care issues that were explored included—vulnerability factors, lack of insurance, and specialty care.

Vulnerability Factors

The population most in need of healthcare has the most challenges accessing it. Vulnerable populations include ethnic/racial minorities, low socioeconomic persons, the uninsured, and the Medicaid insured (Larson, Schlundt, Patel, McClellan, & Hargreaves, 2007; Shi et al., 2007). Also, when coupled with additional vulnerability factors, the less educated are also considered part of the vulnerable population (Larson et al., 2007; Shi, Tsai, Higgins, & Lebrun, 2009). Vulnerability factors that present a barrier to access to care include: inadequate insurance, residence in a medically underserved area, chronic illness, disability, and homelessness (Fiscella & Shin, 2005; Litaker, Koroukian, & Love, 2005). These vulnerability factors challenge CHC patients and make it more difficult to access care. Community health centers were designed to service vulnerable populations and address their unique needs. The care that is provided is respectful, culturally competent, high quality and cost effective (Proser, 2005; Shi et al., 2009). Community health centers are well positioned and suited to provide quality care for hard to reach populations.

Lack of Health Insurance

Growth in the number of uninsured is one of the main threats to the health care safety net. In 2002, President George W. Bush supported an expansion of health centers which increased the number of new access points for new health centers serving an additional 6.1 million underserved people in 1,200 communities (Shi & Stevens, 2007; Shi, Felix Aaron, Watters, & Breenblat Shah, 2007). However, this proposal was undercut by the fact that the Bush Administration and the U.S. Congress instituted $10

billion in Medicaid cuts and other social programs which forced CHCs to accommodate more of the vulnerable population (Shi et al., 2007).

Since the U.S. has experienced an economic recession, unemployment has increased which has led to a surge in the number of uninsured. This increase results in higher utilization of CHCs. However, President Barack Obama signed the 2010 Patient Protection and Affordable Care Act into law, which is intended to reduce the number of uninsured and restructure the delivery of healthcare (Kaiser Family Foundation [KFF], 2010).

Millions of Americans lack health insurance and a significant number are underinsured which places a barrier on access to health care (Politzer, Schempf, Starfield, & Shi, 2003). Gardner and Kahn (2006) reported that there is a strong correlation between lack of insurance coverage and access to care. The uninsured also postpone seeking care and do not utilize as many preventive services (Gardner & Kahn, 2006; Larson et al., 2007). There is a strong correlation between lack of a medical home, unmet health needs, increased mortality, poorer health outcomes and the uninsured. When comparing the uninsured that utilize a health center for their normal source of care with the uninsured in total, those that access health centers seek care more regularly and sooner which improves their overall health outcome (Larson et al., 2007; Shi & Stevens, 2007; Shi et al., 2009).

Shi et. al (2007) examined both Medicaid insured and uninsured CHC patients and compared them with the national population. There was consensus in the literature that identified four major attributes of health care: accessibility, longitudinality, comprehensiveness, and coordination (Shi et al., 2007; Litaker et al., 2005). There was a

sense that differences existed in how uninsured and Medicaid insured patients fared when compared with the national population. The study suggests while CHCs fill an important gap where there is a need for primary care, it still may not be sufficient to eliminate barriers among the uninsured.

Specialty Care

Community health centers are able to provide high quality care and serve as the medical home for many underserved populations. The literature suggests that although CHCs provide quality primary care services, specialty care is difficult for CHC patients to access (Larson et al., 2007; Litaker et al., 2005; Primo et al., 2009). Even with a referral or diagnostic testing, access to specialty care proved to be a challenge. Cook and associates (2007), evaluated access to specialty care for patients being seen in CHCs. Similarly, Gusmano, Fairbrother, and Park (2002) evaluated the ability of CHCs to manage caseloads of uninsured patients and discovered CHCs are able to provide medical supplies, medications, and primary care to most of their patients, but are lackluster in their ability to provide specialty, diagnostic, and behavioral services. Primo and associates (2009) argued the need for eye and vision care to be included at CHCs to reduce visual health disparities among the CHC population. During their study they found that visual health (excluding vision screening for children) was viewed as a specialty service and a review and change of the policy by the Health Resources and Services Administration (HRSA) was a recommended approach. With challenges accessing specialty care, many are concerned that a great proportion of uninsured patients will not be addressed by CHCs beyond primary care services (Gusmano, Fairbrother, & Park, 2002). Qualitative study data suggest that some uninsured or Medicaid patients are

refused services by specialty providers or are required to pay prior to the rendering of services (Cook et al., 2007).

If this issue were to be examined further, policymakers should consider a plan to include access to specialty (secondary and tertiary) care for the uninsured (Cook et al., 2007). Cook explored the answers to the following, " What is the relationship between perceived access to specialty medical and mental health services and patients' insurance status? What other factors are associated with better or worse access to off-site specialty services for uninsured and Medicaid patients?" (Cook et al., 2007, p. 1460). Their findings suggested that access to care for specialty services was a larger issue than thought previously for CHCs. Medical directors indicated major problems accessing specialized and mental health services for patients without insurance and those with Medicaid. In fact, the issues were greater in size and frequency amongst the uninsured.

Community Health Centers

Community health centers (CHCs) have long been a provider of health care delivery for vulnerable populations. Born in social justice and civil rights movements of the mid 1960's as part of the War on Poverty, the legislation authorizing CHCs requires provision of preventive and primary care along with social and support services at low or no cost in underserved areas (Lefkowitz, 2005; 2007; Wilensky & Roby, 2005; Zuvekas, 2005). It was also found that by confirming themselves as patients' normal source of care, CHCs were effective in decreasing disparities in access to care (Cook et al., 2007). Health centers possess unique qualities that enable them to be a valuable resource in the health care delivery system. Since the advent of CHCs, their existence and growth has

allowed many more Americans to access quality care. Below, we explore CHCs benefits to the community and the impact of legislation.

Community Benefits

Health centers have a few special characteristics that influence their success. These characteristics translate into a variety of benefits for the community. Literature states that CHCs:

- Are a source of income and gainful employment for residents of the communities they serve (Geiger, 2005; Hawkins & Schwartz, 2003).
- Sometimes act as a staple for the community in attracting other businesses, hospitals, pharmacies, and health care providers (Hawkins & Schwartz, 2003).
- Serve as a catalyst for economic development in the community (Geiger, 2005; Proser, 2005).
- Deliver quality care in a culturally competent manner (Fiscella & Shin, 2005; Hawkins & Schwartz, 2003).
- Provide leadership training and a feeling of ownership since patients and community members must serve as the majority on the governing boards (Geiger, 2005; Hawkins & Schwartz, 2003).

Legislation

Legislation plays a major role in the existence of CHCs. By being included in the federal Public Health Service Act, CHCs have the benefit of receiving federal attention and support. Conversely, CHCs have also been the target of opponents that wish to eliminate or reduce CHC funding from the federal budget. Fortunately, the realization of

CHC value has increased. There have been three occurrences when CHCs have gained the support of a sitting President—i.e., during the administrations of Richard Nixon, George W. Bush, and Barack Obama. Recent expansion of CHCs include support by the current and former U.S. Presidents—Barack Obama and George W. Bush, respectively.

The Affordable Care Act, signed into law March 23, 2010 by President Barack Obama provides access to care to millions more Americans. Community health centers are aligned to address the Act's provisions (Hawkins & Groves, 2011). This legislation is intended to assist with closing the gap of fragmented and disproportionate access to quality health care and makes it affordable to Americans through innovative initiatives and insurance coverage expansion (Kaiser Family Foundation [KFF], 2010). Improving the health care delivery system, expanding coverage and controlling health care costs are goals of the new law. The law continues to have its proponents and opponents, however, there are many uninsured or underinsured that will be served as a result of expansion of services and access to care that this legislation embodies.

The Health Care Safety Net Amendments of 2002-a bill that amended the Public Health Service Act to establish HCAP and to reauthorize and strengthen the National Health Service Corps and health centers- were passed by Congress with the support of the Bush Administration (Shi & Stevens, 2007). The Health Center Growth Initiative (HCGI) legislation called for a doubling of the number of health center sites to serve the uninsured and underinsured (Hawkins & Rosenbaum, 2005; Hawkins & Schwartz, 2003; Shi et al., 2009; Wilensky & Roby, 2005). This health center expansion program increased the number of health centers and also created new CHC access points in rural and urban economically depressed communities. According to research by Shi, LeBrun,

and Tsai (2010) the HCGI was to add or expand 1200 new health center sites between 2002 and 2007. They found that the goal was exceeded and the number of health center sites increased. The Kaiser Family Foundation reports that in 2009 there were 7,240 health center sites in the United States serving approximately 20 million people (Kaiser Family Foundation [KFF], 2010).

Sustainability

Sustainability is another important area of consideration that health centers receiving funding must face. The definition of sustainability varies, however, for the purpose of this discussion sustainability is referred to as the ability of the program/service to endure beyond initial grant funding. Grantees may be awarded funds to assist with infrastructure, continue existing programs, or develop new programs, however, the more challenging feat arrives when they are presented with how to sustain these activities or programs once the funding ceases. It was noted in the literature that sustainability should be poignantly addressed within grant applications, calls for proposals, ongoing activities of grants-funded programs and evaluations of initiatives (Brown & Garg, 2004; Kubisch et al., 2002; Padgett et al., 2005; Cornerstone Consulting Group, 2002). By addressing sustainability at these phases there is a higher probability of ongoing self-sufficient success. The literature also suggests various focus points in efforts to strengthen sustainability such as strategic thinking/models, working collaboratively, and entrepreneurship.

Strategic thinking and models set forth a framework to guide sustainability. Shediac-Rizkallah and Bone (1998) set forth a conceptual model of sustainability. The model encompasses project design and implementation, factors within the organizational

setting and external factors in the broader community. The eleven elements that fall under each of these three factors present a strong case in providing guidance for sustainability. The elements and factors are presented in Figure 2. Evashwick and Ory (2003) used the Shediac- Rizkallah and Bone model to determine factors that were important to sustainability of community based health programs for older adults. Based on the model and their findings, they determined the following to be important: financing, leadership, governance, marketing, evaluation/research, and organizational structure (Evashwick & Ory, 2003). Although these are insights gained from Evashwick and Ory's research, findings were consistent throughout the literature in terms of characteristics of frameworks and models used as a compass to direct a path to sustainability (Orton & Menkens, 2006; Mims, 2006).

Figure 2.Framework for Sustainability

Guidelines

Project design and implementation

1. Community involvement
2. Project effectiveness
3. Duration
4. Financing
5. Types of services (preventive, curative)
6. Training component

Factors within organizational setting

7. Institutional strength
8. Integration with existing programs
9. Leadership/champion

Factors in the broader community environment

10. General environment
11. Level of community participation

Source: Guidelines from Shediac-Rizkallah, M. And L. Bone, "Planning for the sustainability of community-based health programs: conceptual frameworks and future directions for research, practice, and policy." *Health Education Research*, 13(1): p.99, Table 2, 1998.

Padgett and associates established the following strategies in their findings while studying how "Turning Point" state partnerships sustain themselves—i.e., "institutionalization, developing alternative structures outside government, leveraging other funds, fostering strategic relationships, communication, and visibility" (Padgett, Bekemeier, & Berkowitz, 2005). Here again as with the Shediac-Rizkallah and Bone model the approach is multi-pronged. There is not one single effort or strategy within itself that is mentioned in the literature that has been proven to strengthen sustainability. Given such a lack of proven strategies that guarantee success, research continues to explore various approaches to determine the right balance/recipe with characteristics to ensure sustainability. This can be viewed or construed as how creative and dynamic a strategy or model must be to address all of the components that must be considered in ensuring sustainability.

Collaboration

Another major theme presented across the literature expressed the significance of collaboration. It also takes collaboration and support from different sources to continue grant-funded initiatives after the initial grant ends. Many successful pilots and initiatives that started out small were able to grow into larger programs as a result of collaboration with the community, other agencies, political allies, private sponsors, foundations or became a part of a bigger system or program within their organization -- in essence collaborating with others (Hunt, 2005; Mims, 2006).

Entrepreneurship

Entrepreneurship is viewed as the process by which individuals seek, identify and pursue opportunities that are useful and put them into practice. A few qualities associated

with entrepreneurial individuals include persistence, strong character, risk-taking, passion and creativity; all of which are important to thriving and surviving in today's turbulent healthcare environment. Innovative and entrepreneurial thinking also play a large role in sustainability (Orton & Menkens, 2006). For example, the Wilkes County Health Department was able to change their facility into a model of operation that was business oriented and created wealth and resources rather than being distributors (Shirin, Scotten & Absher, 2006). Leaders must execute entrepreneurial activities in order to develop innovative strategies that strengthen organizational survival (Guo, 2009; Baker & Porter, 2005; Orton & Menkens, 2006).

Leadership

Across the literature strong leadership with a visionary leader or champion continued to emerge as a key component to sustainable programs. Many of the sustainable programs indicated strong leadership was a key component to their success (Evashwick & Ory, 2003; Piper, 2005, 2010; Alexander, Zakocs, Earp, & French, 2006; Baker & Porter, 2005; Kinard & Kinard, 2008; Freshman & Rubino, 2002). Even when the leader who started a particular program left to pursue other interests, if the successor championed the program equally the program continued to be sustainable (Evashwick & Ory, 2003). There were a few qualities of the leaders that were important as well. These qualities, skill, dedication and charisma, kept the program going while it matured (Evashwick & Ory, 2003). Given that sustainability also requires innovation, creativity, and flexibility, a leader that is rigid, lacks vision, passion and effective communication would be viewed as a barrier to success.

Within the health care setting an effective leader may be the difference between a successful and sustainable organization/program or a struggling, chaotic one that is constantly riddled with uncertainty. Without question the former is what assures the most comfort amongst management, staff and community members. People like quality, certainty, reliability, dependability, and consistency—this could not be more important than in a health care setting (Bennis & Nanus, 2007; Harrison & Coppola, 2007). Literature on leadership in health care (i.e., CHCs, collaboratives, coalitions, hospitals, public health agencies) suggests common themes important for a leader to possess—emotional intelligence, trust, and creativity (Freshman & Rubino, 2002; Piper, 2010; Guo, 2009; Baker & Porter, 2005).

Emotional Intelligence (Passion)

In order for a leader to inspire, emotion must be present. Emotional intelligence is viewed as a quality that health care leaders must possess. Emotional intelligence is the ability to perceive, control and evaluate emotions (Freshman & Rubino, 2002). Goleman et. al states that it is needed to lead (Goleman, Boyatzis, & McKee, 2002). Similarly, Piper asserts that emotional intelligence in leadership is crucial in health care organizations and that passion is inspired by emotional intelligence and is also necessary (Piper, 2005). Passion in a health care leader would serve to motivate the organization, which would greatly impact the services provided to the community. Piper asserts that leadership requires the ACE factor; A-analytic ability, C-creativity, and E-emotional ability (Piper, 2005). This type of thinking and execution could take an organization from good to great as described by Collins (Collins, 2001; Piper, 2005).

Creativity

Creativity is a valuable characteristic for a leader to possess. It is commonplace for a leader to interact with others outside the organization and be strategic and creative at building relationships and rapport with others to shore up support (i.e., political, community, foundations) that may be financial or otherwise, in order to accomplish the mission of the organization or continue the work being performed. In a study by Alexander et. al., (2006) bridge-building skills were one of the three important findings of what made effective leaders in community coalitions. The other two findings were shared leadership and insider status. Contrary to other literature on the subject of attributes of effective leaders that indicated visionaries and experts as favorable attributes of leaders, Alexander et. al (2006) did not find this to be the case. Based on their data they cautioned against these attributes as they asserted that an expert may have preconceived ideas of solutions and soften one's ability to have a shared leadership role. Furthermore, visionaries would have the tendency to influence others to adopt their vision versus encouraging members of the coalition to take a collective perspective.

Trust

Trust is a basic human element that can make or break relationships whether they are professional or personal. Piper asserts that trust is fundamental for leadership (Piper, 2010). Leadership is deemed untrue without trust and since the leader is perceived to set the standard for values and the culture of the organization, it is imperative that trust is present. Trust in the healthcare arena appears in many situations—a patient trusting the health care provider, the family of the patient trusting the provider, the staff trusting leadership, the community trusting the health care organization to serve its needs, an

organization trusting its partners or allies. Without trust it is difficult to accomplish almost anything because instead of focusing on how to achieve the goal, the attention in fixated upon if what is being said or done is genuine, accurate, and transparent (Kramer, 2009; Piper, 2010).

Transparency is related to trust in that it involves communicating all details, clarity and no deceit and pretense. Covey maintains that trust is about good communication (Covey, 2006). A leader that is perceived to covet information and only provides portions of details to their followers is on his/her way to being ineffective. A shroud of doubt and distrust will start to loom and embed. It is far more difficult to regain trust after it has been violated or perceived negatively. This distrust and lack of transparency will affect the organization in that it will damage morale, which will in turn negatively affect the productivity and interest in the mission of the organization or program. As a result, ultimately those left suffering are the communities.

Funding

Federal and non-federal funding fuels CHC programs. Some CHC federal funding includes grants from agencies such as the Health Resources and Services Administration's Bureau of Primary Health Care, the Centers for Medicare and Medicaid Services, and the Centers for Disease Control and Prevention (Levi, Juliano, & Richardson, 2007; Shi, Collins, Aaron, Watters, & Shah, 2007; Buehler & Holtgrave, 2007). Non-federal funding can be obtained from state and local governments, foundations, and private entities (Shi et al., 2007). Health centers rely heavily on a mix of these funds for financial viability to continue to serve their communities. Blending and

diversifying funding sources must be mastered by managers to achieve financial stability (Orton & Menkens, 2006).

Federal

On average, federal grants make up 23% of health centers' revenues (Kaiser Family Foundation, 2012). Nelson and associates assert, "Funding acts as the 'fuel' that sustains programs: without adequate financial resources, crucial activities, such as building community awareness and capacity, providing program structure and administration, or conducting surveillance and evaluation must be curtailed or eliminated" (Nelson et al., 2007, p. 613). To assist in offsetting the cost of caring for the uninsured or underinsured the Bureau of Primary Health Care administers grants to health centers (Shi & Stevens, 2007; Shi, Collins, Aaron, Watters, & Shah, 2007). When funding is reduced or uncertain, it places the health center and its programs in a vulnerable situation.

As a result of the Affordable Care Act, there will be a total of $53.9 billion in health center economic activity by 2015 (Hawkins & Groves, 2011). This means that for every $1 million in federal funding for health center operations, $1.73 million in return will be yielded (Hawkins & Groves, 2011).

Medicaid

Medicaid is also a strong funding source for health centers funding approximately 38% of revenues (Kaiser Family Foundation, 2012). As a result of its consistent payout of reimbursements that are in alignment with the costs associated with health center services, Medicaid has been recognized as a cornerstone of health centers' financial health (Shi et al., 2007). With the enactment of the Affordable Care Act Medicaid is expanded to individuals under the age of 65 that have an income up to 133% of the federal poverty level (Hawkins & Groves, 2011). This expansion means that an additional 16 million people are expected to be insured and able to be seen at CHCs (Hawkins & Groves, 2011). Although CHCs are required to see patients without regard to their ability to pay for services, this newly insured population will allow CHCs to receive reimbursement for the services they provide. Therefore, there will be increased activity and service provided at CHCs to the medically underserved.

Nonfederal

Nonfederal funding entails support from state or local governments and private organizations. Although funding levels may not be as high as federal funding, it is nevertheless significant to the financial health of health centers and programs. Health centers and programs are not alone in their funding quandary. There are plenty of other organizations and programs that are susceptible to the same threat of funding instability and also receive funding from various sources. Nelson and associates argue that there are six key areas to maintaining funding: "(1) strong and experienced leadership, (2) broad and deep organization and community ties, (3) coordinated efforts, (4) strategic use of surveillance and evaluation data, (5) active dissemination of information about program

successes, and (6) policy maker champions" (Nelson et al., 2007, p. 612). According to Nelson and associates, these key areas should be able to be used by other programs facing funding dilemmas. One would reason that if a health center or agency received increased levels of federal and state funding local revenue contributions might be reduced. In a study conducted by Bernet, it was revealed that money begets money (Bernet, 2007). Local public health agencies that received an increased level of federal and state funding did not decrease their home grown—local revenue streams, but instead increased them. According to the study, it appeared as though higher funding at the federal and state level inspired increased local level funding (Bernet, 2007).

Summary

This literature review covered important recurring themes and factors that may contribute to the sustainability of CHC programs when funding is discontinued. Those overlapping areas included access to care, CHCs, sustainability, leadership, and funding.

Community health centers have unique characteristics and provide care to millions of uninsured and underinsured in the United States in a cost efficient manner. There are community benefits that CHCs provide in addition to the services they offer. Despite these benefits, CHCs have been susceptible to budget cuts and have been a part of/impacted by legislation.

As mentioned in the literature, some researchers view this model as an effective and efficient way to provide health care. Although there are varied sources of federal and non-federal funding utilized by CHCs, they depend greatly on federal funding sources. Many CHCs depend on this funding to create new programs, expand coverage, and

implement new systems. Literature suggests that a mixture of funding streams is the approach to take when considering the funding aspect of sustainability.

Not only do CHCs need to consider funding sources, but the literature indicates how leadership also plays a role in sustainability. A good leader with qualities such as trust, creativity, vision and passion could provide a culture and environment that thrives even in the face of uncertainty and challenges. Leadership is also tied into sustainability in that the literature notes that leadership, entrepreneurial thinking, and collaboration were associated with sustainability. Leaders of CHCs must be innovative in their approaches to continuing to thrive. Collaborating with medical schools, hospitals, health departments and others to achieve sustainability were found to be strategies used by CHCs.

Collaborating with others was also used to provide better access to certain types of care. CHC patients are faced with access to care issues. Through review of the body of knowledge, research indicates that access to care issues experienced by vulnerable populations--such as migrant farm workers, the economically disadvantaged, racial/ethnic minorities, the disabled and/or chronically ill also include accessing barriers to specialty care.

CHCs should have guidance as to what key components and strategies must be in place to align themselves with program sustainability. It is expected that this study will contribute to the body of knowledge for CHCs and other entities and provide best practices on how to position themselves to be sustainable (i.e., programs/services, etc. initiated or supported by federal funding). This study will interview former Healthy Communities Access Program grantees whose funding was discontinued that are still

operating HCAP enabled activities. It is our intention to glean from these interviews pearls of wisdom and practice for others receiving federal funding that strive for program sustainability. Insights gained may be cross cutting in that they may apply to any program—health or otherwise receiving federal funding, and show how to plan for success through sound sustainability strategies.

CHAPTER 3

METHODOLOGY

Research Design or Method

This study was an exploratory qualitative study. The researcher chose this methodology because a great deal could be learned from key players that were part of an HCAP who had experienced the elimination of grant funding and still managed to have their CHC programs and services initiated by HCAP survive. This study examined what actions they took and what strategies they employed to keep these programs viable. This exploratory qualitative research garnered information from experts, who in this study are the HCAP CHC and non CHC consortia that received federal CAP and HCAP funding between the years of 2001-2004.

To gather information for this study, two data collection methods were used: archival review and key informant interviews. The researcher identified CHCs that remained viable when the HCAP funding was eliminated. There were 55 people associated with the CHCs who were contacted. Eight agreed to participate and after the contacts were made, participants willingly suggested other senior leaders in their consortia to be interviewed. This led the researcher to interview approximately 14 additional participants that were not in CHCs, but they were part of sustainable HCAP consortia. The researcher felt these individuals also had valuable information to contribute.

Programs that were funded at least one year or more were included in the sample. The assumption was that people involved in the sustainable HCAP consortia CHCs had a wealth of knowledge that was helpful to other entities and instrumental in designing

future funding projects. In sum, 22 contacts met the inclusion criteria and were willing to participate.

Data Collection/Archival Review

For this research, archival data was extracted from the HCAP database. After an archival review of the HCAP database grantees were contacted to determine whether their HCAP enabled programs and services were sustainable or not. The database contained information about the HCAP grantee profile such as organization information (grantee name, grant number, primary point of contact address, telephone, email, etc.), consortium information (members, member organization types, structure, collaboration activities, etc.), HCAP Project profile (initial funding date, target population, ethnic groups, scope of service, impact on community, etc.) and HCAP compendium (consortium name, consortia members, HCAP vision, community environmental conditions, project goals, etc.).

Data Collection/Key Informant

Key informants were defined as those individuals who were points of contact for HCAP. Even if key informants had moved on to other organizations and/or positions they were offered an interview as long as they were willing and able and met the qualifying criteria. Key informants were also health center staff that facilitated, coordinated and managed the program and also included leadership such as chief executive officers and chief operating officers of CHCs and non CHCS who were involved in/actively guiding and leading the efforts to ensure sustainability. By including these individuals, a perspective of the vision, planning, messages, and activities that led to sustainability was gained. Once the programs that managed to survive were selected, an introductory letter was emailed to potential key informants explaining the purpose of the research,

requesting consent and asking for availability for an interview. When willing participants were identified, they were asked to complete the form indicating their consent to participate in the study. A time was scheduled and semi-structured phone interviews were conducted with key informants from former HCAP consortia CHCs and non CHCs. Prior to commencing with the interview, participants were read a telephone introduction script (See Appendix A) which thanked them for agreeing to participate in the study, assured confidentiality, advised them the call would be recorded and again requested their consent to proceed. After each interview a thank you email was sent to each participant. Also, after each interview, participants suggested other HCAP consortia members that would provide valuable insights even though they were not part of a CHC. Contact information was provided and the researcher followed up using the same process as with the CHC participants. There were 14 non CHC participants in the study.

Instrumentation

A semi-structured interview was conducted with each key informant. Please see Appendix B for the questionnaire. The researcher called the participant and began to establish rapport with the individual. Questions were asked about: (1) the impact of receiving and then later losing the HCAP funding; (2) factors that contributed to the organization's ability to continue providing services and programs initially funded by the grant; and,(3) advice or suggestions for health centers applying for funding or managing their programs and activities after funding is received.

Selection of Participants

Healthy Communities Access Program grantees from 2001-2004 who were able to maintain their efforts initiated by HCAP after the program had officially ended were

considered sustainable for the purpose of selection of participants. Also, HCAP consortium CHC and non CHC points of contact and the organization's leadership were deliberately selected to be interviewed. They were able to provide a more accurate and detailed account of their HCAP experience, including how the organization's HCAP dependent programs flourished after funds were no longer available. Criteria was as follows:

- Healthy Communities Access Program grantee from 2001-2004.
- CHC or non CHC included in HCAP consortia.
- CHC or non CHC able to maintain programs and services after the program had officially ended.
- Served as point of contact for the program.
- May have served as CHC's or non CHC's leadership.
- Had to be at organization when HCAP funding started and discontinued.
- Knowledge about sustainability after funds discontinued.

Criteria was set forth for the selection of participants because the researcher wanted to: a) determine cross cutting themes amongst sustainable HCAP consortia CHCs and Non CHCs, and b) have a representation of HCAP consortia CHCs and Non CHCs across the country and in various stages of their HCAP grant award.

Data Collection/Procedure

Data such as email addresses, phone numbers and points of contact were extracted from the data source. The researcher took field notes during the semi-structured telephone interview. Also, with the permission of the key informant, interviews were recorded so that the researcher could ensure the responses were captured accurately and in their entirety. Interviews lasted approximately 45-60 minutes. It took approximately one month for the sole interviewer to interview each key informant. This took into consideration the initial contact, following up with CHC and suggested non CHC HCAP

consortia contacts, and scheduling time to conduct the telephone interview. A set of semi-structured questions were asked to obtain information about how their HCAP activities worked and key factors that were initiated to enable the sustainability of the program. There was flexibility in the interview in that key elements that were discovered were explored further through clarification in the interview and reported in the findings. Each interview was professionally transcribed.

Data Analysis

The researcher gained insights and perspectives and was able to identify common themes across the interviews. Semi-structured interview responses allowed meaningful quotes and feedback to be captured which allowed the voice of participants to resonate. The robust comments recorded were analyzed for commonalities and translated into valuable information. A professional transcriptionist was used to transcribe the recordings. The researcher reviewed the recordings and transcripts to identify common themes and rich comments.

The researcher compared findings from each interview with findings from previous interviews, recognizing that data collection and analysis in qualitative research is an iterative and integrated process and should therefore be done concurrently. As data from each interview was analyzed, cross-cutting themes were noted. Concepts and key factors were drawn from the themes, providing guidance for sustainability for future grant recipients.

To make sure the data gathered and interpreted was accurate, credible, and consistent, a peer reviewer was utilized to compare and assess results with the results of the researcher. The peer reviewer had several years of experience as a researcher and

works with vulnerable populations. Using a peer reviewer added a second level of analysis and helped identify or reinforce themes noted by the researcher.

The peer reviewer was sent the interview transcripts and independently reviewed them. Based on the review critical factors, advice, and common themes were identified by the peer reviewer. Both the peer reviewer and researcher compared findings by telephone and agreed on the themes and factors that emerged.

Field notes were also taken during each interview. This allowed the researcher to make notes and immediately highlight and document interesting explanations, opinions, and statements given by participant responses. It also allowed the researcher to develop further questions or points to clarify or explore with other participants.

Limitations/Delimitations

Quite a few years have passed since the ending of HCAP. Thus, a number of the consortia CHC and non CHC points of contact were no longer with the organization. However, points of contact were included as participants if they could be reached and if the researcher felt they could beneficially add to the findings. As long as they were at the organization when the HCAP funding was received and discontinued, had knowledge of sustainability activities, and recalled their experiences with the HCAP they were allowed to participate.

A second limitation was the telephone interview rather than an in-person interview. A face-to-face interview with grantees would have been ideal, but because of budget constraints for research, the researcher was not able to meet with the participants face-to-face since they were spread across the country. A face-to-face meeting would have been more personable and perhaps elicited more feedback and responses.

A few delimitations have been also noted for this research. The researcher only included those HCAP consortia CHCs and non CHCs with programs that were sustainable versus including those who were not sustainable. The study was bounded to only include HCAP grantees instead of a variety of federal grantees across health and human services and/or federal agencies.

Protection of Human Subjects

The Institutional Review Board of the Medical University of South Carolina conducted and approved an expedited review.

CHAPTER 4

RESULTS

The results of interviews conducted with participants that were part of an HCAP consortia are presented in this chapter. The interviews revealed that the HCAP grantee community still remains a tight knit and supportive family of health care providers committed to addressing access to care issues. The two research questions which are being explored in this study are:

1.) What are essential factors to ensure sustainability of programs and services of consortia of community health centers once federal grant funding ceases?

2.) What criteria/components do key players (i.e., staff and leadership actively involved with the preparation, facilitation, direction, management, and execution of the HCAP program within their respective organization) believe are essential for inclusion in potential funding for new projects/programs?

The researcher originally intended to interview 8-10 participants. While conducting interviews, participants referred their HCAP consortia members and other HCAP peers whom they felt could provide additional valuable experiences and insights to the researcher. The researcher decided to contact them to obtain their insights as well. In total there were 22 total participants who were interviewed. Fourteen of these individuals were not with CHCs, however, they were senior leaders of an HCAP consortia member and played a major role in the days of HCAP. These additional interviews brought forth rich comments and advice that also is being reported in this chapter. Both CHC and non CHC participant responses are presented in the research

findings. As noted in the methodology, no identifying information such as personal identifiers or names/sizes of organizations is being reported.

Participants were interviewed from 12 states across the country. The majority of interviewees were CEOs of health centers, provider organizations, and health systems. Also, seventeen participants remained with their organization after HCAP funding ended; however, there were five that transitioned to different organizations and once contacted, expressed an interest in being interviewed.

Despite the length of time that has elapsed since the sunset of HCAP, all participants were willing and able to share their experiences with the program. All had extremely complimentary comments about the program and viewed it as a stepping stone despite its early demise. Factors that contributed to the answers for the first research question are found under each underlined heading. Additionally, participants' advice on criteria/components essential for inclusion in potential funding in new project/programs provided answers to the second research question. The researcher noticed several recurring themes that emerged which were consistent across interviews regarding the essential factors for ensuring sustainability of programs and services. These themes were: collaboration, measuring and sharing outcomes, leadership/relationships, creativity, and diversified funding.

The discussion in this chapter is primarily organized according to the two research questions. The researcher has provided factors and advice, an analysis and responses from participants that address the study's two research questions.

Research Question Findings

This section provides an analysis of the findings from interviews with participants that continued to sustain after the discontinuation of HCAP funding. The findings have been synthesized and answer the study's two research questions.

The first research question was:

What are essential factors to ensure sustainability of programs and services of consortia of community health centers once federal grant funding ceases?

Participants in this study identified ten common factors essential for sustainability of programs and services. These factors are: collaboration, addressing and resolving trust issues, sustainability and strategic plans, establishing and nurturing relationships, measuring and sharing outcomes to demonstrate the importance of a program or service, committed and strong leadership, perseverance and tenacity, entrepreneurial mindset, testimonials of early successes, and diversity of funding.

Collaboration

The HCAP grant required grantees to collaborate with others. Participants reported that working and communicating with other organizations fostered a symbiotic relationship. Building relationships and networks proved not only advantageous to the organization, but more importantly to the community because it allowed patients to access more services. Participants shared the importance of being able to resource the services and tools of their community partners and stakeholders to accomplish objectives.

One participant shared:

Being really open and looking for opportunities to collaborate because that's the only way that we've been able to accomplish what we have accomplished is

because of that true collaboration. And really there's a lot of things that happened in our community that you don't often see happening in other communities and more around how the different community health centers work together. (CHC Participant)

Another said:

We made a lot of progress in getting everyone behind one big vision and collaborating to achieve that goal [increased access] and then breaking it down into doable steps. We started many initiatives that spun off to be owned by the community. (Non CHC Participant)

Another stated:

Learning collaboration is not easy. It's a continuing challenge but the project [HCAP] really focused on collaboration. They taught us how to do collaboration and community organizing and we continue to use that today. We run a multitude of different programs in our little office through collaboration with other partners. (Non CHC Participant)

A fourth shared:

I think that collaborating has been key and will continue to be key. It helped a lot and we were able to do much more. (Non CHC Participant)

Addressing and Resolving Trust Issues

While many participants shared they attributed some of their accomplishments to working with multiple partners, they also expressed that it was a challenge working with several partners. The more partners there were, the higher the potential for the focus to be shifted. Many shared that it was important to convey that no one partner's needs were

prioritized over another's—they all were equally important. Some even went as far as rotating meeting spaces amongst consortia members so that the partner hosting the meeting would not have a seemingly unfair advantage of monopolizing the agenda and/or conversation because they were the hosts.

Participants indicated at times trust was a challenge. Most felt it was imperative that any ill feelings or contempt be "put on the table" so that the group could move forward. They indicated that these situations typically occurred when the group began meeting, but once issues were resolved, the group was more productive. Most participants described how they continue to work with some of the same consortia members/organizations and felt this was one of the reasons why they were able to stay focused.

One participant said:

I think some of the challenges were really more involved with some of the partners in getting everybody on the same page, one vision for primary healthcare for the community and making sure that all the partners bought into that vision. So I think there was a challenge in the beginning. (CHC participant)

Another shared:

One of the challenges primarily related to trust—at least in the beginning. It related to us just figuring out how to trust each other to work together. Because here you have a significant amount of money coming in and you have health systems at the table that compete with each other on one level. But here in taking care of the uninsured and safety net types of services, we were coming together. But there was still a little bit of that competition there. So we had to overcome

that and ultimately build trust in working with each other in this area. And I'm happy to say that we did achieve that. (Non CHC Participant)

A third stated:

The momentum that was created brought many benefits but sometimes the energy that you gather in getting people to talk seriously about a really difficult challenge generates a lot of agreement that goes other places. We can still see those relationships that were tightened, bearing fruit. Many of the key people we drew together were not really working closely together previously and distrusted each other in the beginning. (Non CHC Participant)

With multiple partners, there may be times, especially in the beginning, when partners may not be in alignment with the group's objectives or distrustful of others within the consortia. Transparency along with honest, candid and respectful dialogue is encouraged and necessary to move forward in a productive manner.

Sustainability and Strategic Plans

Participants were asked about sustainability and strategic plans. Most stated that it was part of the grant requirement. Participants shared how they continued to revisit the plan on a continuous basis and factors that were important such as support from local government, a desire to sustain the program, being able to sustain after grant funding has discontinued, and planning in the event the funds are not received. They also shared that there was sometimes a challenge in executing their plans in the projected timeframe and maintained that it took time to implement changes and then to see the impact.

One participant said:

Yes. You know that was—HCAP, the HRSA HCAP program, stressed developing a strategic plan as part of the program. And so, that was one of the accomplishments that you had to have. We created a couple of varieties of strategic plans and had a little challenge in—and I would say we didn't get that under our belts until actually about a year after. (Non CHC Participant)

Another shared:

The entire [strategic plan] framework had been originated and based on the grant requirements. So it was a program that was launched around the requirements of that [HCAP] program. The sustainability plan was developed as part of the [HCAP] funding. That was a requirement to have sustainability. (Non CHC Participant)

Funding should be included in sustainability and strategic plans. Despite perhaps being a grant requirement for funding applications, organizations should be as realistic as possible and also include contingency plans in case funding unexpectedly discontinues. Organizations should also consider how they will use this opportunity to sustain a particular program and use it as a stepping stone for growth.

Measuring and Sharing Outcomes to Demonstrate the Importance of Program or Service

Another factor that emerged from interviews was the importance of measuring and sharing outcomes. Tracking and reporting was part of the HCAP requirements. However, many of the participants learned to use this requirement to their advantage to capture and track data to identify trends. This information was also used to share with potential sponsors, partners and political allies to support funding requests. In addition,

some participants indicated information systems that were developed or enhanced and shared with other providers in the community to track patients.

A participant shared:

Certainly it laid the groundwork in this community for a centralized enrollment process, and kind of intake enrollment, and then the ability to collect data for the data warehouse that was created. It continues to be operational today and has been the basis if not only continuing to inform the network, which still exists, but was the structure created through the HCAP grant. And it has provided data for other community health initiatives as well. (CHC Participant)

Data tracked and reported can be shared to demonstrate the value to the community. This can also be used to strengthen requests for funding support as data outcomes will show the impact of the program and/or service.

A participant said:

Really take the time to figure out your measures of success. They want to know you helped people into care, people who couldn't get care before, what kept them out of the emergency room and doing better, you know, as a result of what you are doing. (Non CHC Participant)

Another shared:

I think what sustains this at every level including government funding is the ability to demonstrate real successes. If you can't demonstrate that you have done anything with what's been given to you then I don't know how you will continue to be funded. You have to demonstrate outcomes and real accountability in the use of services and funding. (Non CHC Participant)

Sharing the need, impact and successes of the program or service to the community and potential funders is important. One can only imagine where the support may come; an unlikely funder could emerge and become a viable and dependable supporter.

Committed and Strong Leadership

All of the CHCs were board driven and 51% of the CHC boards are patient based. Participants were asked to describe their organization's leadership and characteristics of their leadership that they felt were important to sustainability. All described the importance of support and the ability to inspire, motivate and join groups or people together who may not otherwise have tolerated one another.

One participant spoke of his CEO:

Her leadership is quite unusual. And it has personal characteristics that inspire trust and confidence and a willingness to talk confidentially about things that might be too divisive for the same person to do in a public discussion. And then she will draw people together in one to one. She will make it safe for them to talk directly to come to better understanding each other's views. And she's done that numerous times across many lines. (Non CHC Participant)

Another stated:

Our board is a strong board. We've got great leadership so we were able to adapt.

(CHC Participant)

A third shared:

They have to be committed in terms of their time and their talent. They have to make difficult decisions. You can't have 'fraidy cats' at the table. They have to have courage and be willing to take some heat with very strong business acumen and be connected. (Non CHC Participant)

Leaders that are strong and committed to sustaining a program and/or service are also important to sustainability. In addition to the CEO, committed and strong leadership also extends to the governing board. These members can play a significant role in a program's continued success. A few leadership qualities that are important include: trust, honesty, good communication skills, being a visionary, dedication, and fiscal responsibility.

Perseverance and Tenacity

Two other leadership qualities that emerged as factors to sustainability were perseverance and tenacity. Participants shared the importance of perseverance especially in turbulent times. Many had a "pull yourself up by the bootstraps" perspective. They also expressed how tenacity was an asset on several occasions and how tapping into relationships they had established before helped tremendously:

Insane tenacity I think. So I think part of the leadership qualities was just the depth of the social capital in terms of the relationships that were in place and then the passion for the work, believing it's the right thing to do. I think having leadership that was really looking at the overall health care system was really beneficial to our survival. (Non CHC Participant)

Another participant said:

We were persistent and determined to make it work. We knew there was a need and we knew that we were the only ones who were going to service the need. So, we were going to stick to it and keep doing the best we could. And if you're the only one serving the need and other people recognize the need, they have to come to you. (Non CHC Participant)

In turbulent or uncertain times, perseverance and tenacity are imperative. These qualities rallied many to stay around the table, to put their heads together, and strategize how their ultimate goal could be accomplished—sustainability.

Establishing and Nurturing Relationships

Another factor that recurred throughout interviews was the importance of relationships. Many participants spoke about how they have developed relationships with political leaders as well as stakeholders in the community. Time and time again participants reiterated the importance of keeping these individuals and entities informed about the work they were doing and the importance of the work continuing. It was often the case where participants tapped into these relationships for financial support—and were successful.

One participant said:

We wanted to leverage the next phase of the organization and that's what happened. We were really fortunate. We really developed strong relationships with the city and some private foundations and knew that we were going to have to rely on those sectors to continue our funding.

Although participants received federal funding, many spoke about how their local government and others stepped in to support their efforts. Fostering relationships and ongoing conversations with local officials proved to be beneficial to participants when they requested support. A participant shared how the county stepped in after HCAP funding discontinued:

> *When the [HCAP] funding stopped is when the funding from the county kicked in. So there was no drop in services, no delay in services. We presented to the county that it wouldn't be a good move without having that ongoing county support. So once the HCAP funding was not available the county government kicked in and has been sustaining the program since then. (CHC Participant)*

Another participant shared a similar experience where they demonstrated success and was able to secure local long term funding:

> *We have secured long term—it's annual, but long term funding. We had developed enough success because we had those grants then we went back to the city council and county commission and said here are some areas of success. Now we need continued local support. So that really gave us credibility to go back to the early funding partners to say you need to be our sustainability plan. And they did. (Non CHC Participant)*

The respondents felt that relationships with local and state politicians and other community partners to provide support should be established and nurtured in the event they need to be resourced. It is both prudent and advantageous to keep the community, politicians, and potential funders and/or partners aware of the community's need, the work of the organization, and the impact on a consistent basis.

Entrepreneurial Mindset

Most of the participants indicated entrepreneurial thinking was exercised and in fact questioned how successful health organizations could sustain without it.

One participant said:

I don't know that we would have survived and I don't know if you want to add success to it but we have been able to keep our doors open. (Non CHC Participant)

Along with an entrepreneurial mindset, creativity was viewed as being very important. Participants shared experiences of nontraditional activities they engaged in to continue to sustain their programs and organizations as well as innovative fundraising and networking strategies. Participants indicated the need to strategize in entrepreneurial ways to address a variety of challenges. Some of the factors that led to this type of thinking included—leveraging what they had to get what they needed, navigating a sensitive political environment, and being flexible so a solution could be born and finessed.

A participant shared:

We've had to be entrepreneurial I think for a really important reason. We are in a very conservative state and we have people here who strongly believe that you're individually responsible for your own living condition. And so, we had to figure out how to be entrepreneurial and work within the private sector to meet community needs. I really think we had to leverage an entrepreneurial mindset from inside the community, with private supporters to keep us functioning. (Non CHC Participant)

Another participant stated:

It takes a lot of effort and skill to hold together activities and a lot of flexibility and entrepreneurial ability to adjust; constantly adjust. As one thing became less promising, we would morph it into something that could succeed. (Non CHC Participant)

Participants felt that entrepreneurial thinking must be exercised in the ever evolving health care arena. Flexibility and creativity are qualities of the entrepreneurial mindset that are important to sustainability. In addition, innovative funding and networking strategies can be used to leverage and navigate sensitive political environments.

Diversity of Funding

Participants were asked about their sources of support used to sustain the programs. Most indicated there was support from federal, state, local, foundations, and private sponsorships. Participants felt strongly that the best approach to funding was to have a funding mix. In other words, they supported diversifying the funding and not depending on a single source if at all possible. They also indicated that even when they didn't need to secure funding they still sought it and/or made connections with funders that could later be resourced. It seemed that community and political relationships also may have played a role in funding support.

Developing a relationship with local and state government was viewed important. Most participants felt that proving the positive impact they were making on the community strengthened the chances of receiving funding from these and other sources.

Many strongly correlated data and outcomes with funding. All but one of the participants indicated they have a funding mix of the following--federal, state, local, and foundations.

One participant shared the breakdown of their funding mix:

We receive about 55% of our grants from governmental sources, and that includes the federal government, the local county government, the city as well as the state. So about 55% of our revenue comes from governmental grants and then another 18% is from patient revenue, collection of co-pays, billing, Medicaid, Medicare, as well as any special contracts that we may have. And then 9% comes from private support, private donations, as well as foundations and corporations. And then about 18% is in-kind. (CHC Participant)

Another echoed:

We looked at ways to diversify our funding. We had grants from a number of different sources. You know, looked at fundraisers and different ways to generate revenue, but I think it will always be a challenge. We had some federal grants. We had local foundations and local grants. There were some state grants. So you know, it was a good mix—diverse mix of funding. (Non CHC Participant)

A third participant shared:

We always felt that all three levels of government federal, state, and local ought to have a role to play in helping to fund. For example, we've gotten excellent support from our local community and from our county government. We have had small amounts of support from the state. (Non CHC Participant)

A diverse funding mix positions the funding of an entity to not be controlled or entirely dependent upon one source, which if discontinued, would cause a significant and

inevitable disruption. Furthermore, diverse funding allows the entity to recover without as much disruption because there is not as much to supplement. Diversified sources of support include a mix of: federal, state, local, private and foundation funding. Relationships that have been established and nurtured with local and state government officials and politicians would be instrumental in securing "home grown" funding.

Testimonials of Early Successes

Participants were asked about instrumental sustainability practices that allowed them to continue. Some participants spoke about how the early successes helped to motivate them to stay committed. These early successes were also shared with potential funders and partners to demonstrate the need and impact of what they were doing. Personal testimonies from patients also helped to inspire participants.

A participant shared how the dependence on past success helped to propel them forward:

> *I think what's been the most instrumental is that we've had some success. You know, we had success in the early years of demonstrating that we could help a lot of people. We would have testimonies from people that talk about how it helped them and what it did for their lives to be able to get care—uninsured individuals. I think again, I would summarize it and say, that the early successes of the program kept us all motivated and kept us all going, and we're still going. (CHC Participant)*

Another stated:

> *So, you've got to be able to measure as well as articulate and communicate on a regular basis the successes out of that, and have the patients involved even to help*

do that. Be able to demonstrate and communicate widely the successes; and early if possible. (Non CHC Participant)

Testimonials of early successes can be used as motivation and/or to demonstrate the personal impact of the work being done. This also serves as a reminder to those passionate about their work and what inspires them.

A participant shared:

Make sure you're collecting narrative stories because there's so many wonderful things that happen. If you don't take a few minutes to write that down occasionally you'll forget. (Non CHC Participant)

Summary

Participants indicated factors essential to sustainability. (See table 1.) Many of these valuable factors overlapped which demonstrates how relevant one is with the other. This also shows that there is not a single factor alone that can ensure sustainability. Furthermore, there are many varied factors and considerations that are essential to sustainability. Through the experiences and recollections of participants, others may gain helpful insight and knowledge of essential factors to ensure sustainability.

Table 1 Essential Factors for Sustainability

1. Collaboration
2. Addressing and resolving trust issues
3. Sustainability and strategic plans
4. Establishing and nurturing relationships
5. Measuring and sharing outcomes to demonstrate the importance of program or service
6. Committed and strong leadership
7. Perseverance and tenacity
8. Entrepreneurial mindset
9. Testimonials of early successes
10. Diversity of funding

For research question two, seven criteria/components were identified as essential for inclusion in potential funding: The second research question was:

What criteria/components do key players (i.e., staff and leadership actively involved with the preparation, facilitation, direction, management, and execution of the HCAP program within their respective organization) believe are essential for inclusion in potential funding for new projects/programs?

Participants offered seven helpful pieces of advice and recommendations for organizations applying for grant funding. This advice included: establish a relationship with the Project Officer, develop collaboration, allow time to demonstrate impact,

promote and facilitate leveraging, facilitate peer to peer mentoring/coaching, establish a strong advocacy team, and facilitate innovation.

Establish a Relationship with the Project Officer

When asked about advice for an organization either planning to apply for, or recently having received funding, participants indicated the importance of being aware of and following grant requirements. They shared that staying in alignment with these helped to avoid some challenges, especially with regard to reporting. They also mentioned establishing and maintaining a relationship with the grant Project Officer. Fostering and nurturing this relationship seemed to keep participants intimately familiar with grant requirements, and with this line of communication open, it was easier to seek advice or reach out for help. Most times when a challenge was shared, participants felt that grant Project Officers went out of their way to assist them.

A participant shared insight on the importance of being aware of grant requirements and maintaining a relationship with the grant Project Officer:

> *I would definitely say to be aware of the do's and don'ts. Follow the funding requirements and the deliverables you know as they're stated. And always, if you have a Project Officer who is your contact for the federal funding to remain in contact with them and bounce any and all ideas off of them and just keep them informed. (Non CHC Participant)*

Another shared:

> *Our Project Officer was very important to us with this [HCAP] grant. This was our first time as a federal project and we were very unfamiliar with what our obligations were. I still remember clearly at one of the conferences one of the*

Project Officers said to me that it was important for them to have the data and the facts but she also wanted to know the story of how this impacted our community. That has been a building block as we've moved forward because we recognize the power in that and the impact and value it brings to our work. (Non CHC Participant)

It was noted that a relationship with the funding agency's Project Officer helps to ensure that the Project Officer is informed of the progress and challenges of the grantees. The Project Officer also serves as a valuable resource to grantees by providing oversight and guidance.

Develop Collaboration

Throughout the interview process, participants shared advice regarding collaboration and communication. Communication was essential to good collaboration in that it was important to convey clear objectives and vision with partners. Participants elaborated on how trust is tested when communication is inadequate. One participant shared advice about collaborating with others:

If we're talking about a collaborative where you have several different organizations, I think the key to that is, one, everybody getting on the same page, ensuring that trust and that openness is there because I think one of the things, when we were talking about challenges and I mentioned trying to get everybody on the same page behind a shared vision for the health of our community, I think at that point there was some lack of trust that may have been present. And then when there's a lack of trust that tends to kind of spread throughout whatever is going on. And if there's some trust issues get it out on the table so they can be

addressed, or if there are any issues, get it out on the table. Try to address issues as they come up and not wait for them to fester. (CHC Participant)

Another said:

You need at least a culture of collaboration. Collaboration is really a very unnatural act for most organizations. And if it's not there you won't succeed, I just guarantee you. You need very good communication. You need to communicate more than you expect to and it has to continue. You have to communicate with all of your key audiences. Your key audiences include your partners, providers, funders and politicians. (Non CHC Participant)

It was noted that collaborating with others in the community allows entities to build relationships for a common cause. It also provides more support and services that would not be available with an entity trying to accomplish their goals single handedly. This is also a way of bringing the community together; however, it needs to be the right fit among partners.

Allow Time to Demonstrate Impact

Participants indicated they felt they needed more time to see results. They projected a certain end date for a milestone; however, the actual milestone accomplishment most times occurred afterwards. Participants shared that it takes time to actually get up and running and then more time to see the fruits of their labor. Although participants were grateful for grants and the funding they received, they also offered advice to funding agencies such as allowing time to demonstrate impact.

And so I would—and I know it's a bad time to talk about additional funds, but I think that's one of the things that should be looked at is the duration of funding

for projects that are getting up off the ground and you want sustainability. It's easy to write. In an application, you say how you are going to sustain a project, but you really need to have sufficient amount of time to begin to see the benefits of the initiative to then see that could help sustain it. (CHC Participant)

Another shared:

It takes multiple years. You can't expect us to get up—whoever the funders are—to get things up and running and be able to demonstrate part of the results and all of that—within one year. You need three to five years to be able to demonstrate that. It helps you to establish a foundation of success that you can grow from. I would say five is really almost a minimum to me but I know most funders don't want to go that far. But you really do need that when you're dealing with a problem like this [access to care]. (Non CHC Participant)

It takes time to witness an impact, and participants noted that funding agencies should consider this when developing requirements and parameters.

Promote and Facilitate Leveraging

Sustainability plans are important to long term maintenance and growth. Strategic planning and leveraging led to sustainable programs and activities that many times have blossomed into serving more patients and a myriad of services with a strong infrastructure and supported resources. A participant shared how his organization did not pursue funding until they were confident they could sustain it without the assistance of federal funding. His organization was in the practice of leveraging so they could continuously sustain and build. He shared the following:

We didn't ask for the money until we knew that we had a commitment to sustain the project once the federal funds were expended. And those expenses were budgeted and placed in our county budget long range. And the expectation was that those services and programs would continue. So sustainability from our standpoint we didn't do anything that would have required us to seek additional funds to continue. (Non CHC Participant)

Many participants shared how important it has been to leverage. They have learned to implement a structure and culture of sustaining and building. Some have been so successful in this practice that they have been able to offer services to other organizations and/or proudly market their model. This in turn allowed them to accomplish their internal goals and objectives to sustain and grow.

A participant shared:

One of the things that I determined was that we needed to build a service—in working this area build a service that we could then provide consulting assistance and since we were in technology, anchored in technology and I'd hired people with technology experience, we started a consulting program in the clinic area on the use of telemedicine. (Non CHC Participant)

Sustaining what an entity has and using this to grow is important to continued building and growth. Information regarding additional funds that are leveraged as part of the project or program can then be shared with funders to demonstrate sustainability and growth.

Facilitate Peer to Peer Mentoring/Coaching

Participants were able to expand services as a result of working with other consortia members. The expansion of services offered increased access to patients that might not otherwise have received specialty care. One participant commented:

> *The specialty care piece was a huge challenge at one point, but once it was accessible, it's what makes our program stand out above others that we've seen in other counties. Often times other counties come and listen to a presentation of what we are doing. (Non CHC Participant)*

Another shared:

> *Learn from each other. Create a learning community and get engaged. Get engaged with others and see what they are doing. Make offers and requests in terms of helping each other out. (Non CHC Participant)*

Peer mentoring allows peers to share their successes and challenges. Also, sustainable peers offer coaching and guidance to their fellow peers.

Establish a Strong Advocacy Team

Many participants indicated the importance of a strong advocacy team. Quite often this supportive ally included politicians. For example, they shared the progress and outcomes of the work they were doing with the politicians on an ongoing basis and in turn, made it less challenging to request and receive funding support. A participant shared the following about having political allies a part of the advocacy team:

> *We had our act together as best we could and our political leadership saw that and our political leadership really embraced the program because it was a way to have access to services. If the county mayor and your board of county*

commissioners are behind you, then it makes life a whole lot easier, and we had that support. And we had gained that through proving that what we were doing was having an impact where we told them early on it would. (Non CHC Participant)

Another participant said how advocacy made a significant difference in terms of sustainability:

I think it is that our partners had a strong commitment to us. I think it helped enormously to have really good relationships with state legislators. They were very excited about the program and we were positioned politically to be able to contact the right people and to build support for some funding. (Non CHC Participant)

A third participant shared:

They bring people to the table for us. They leverage a lot of relationships for us. (CHC Participant)

In addition to leaders that spearhead efforts, champions, executive teams, and boards help to spread the word and advocate for projects/programs.

Facilitate Innovation

Other advice that emerged across responses was the importance of innovation and creativity. Participants expressed that creativity and flexibility were integral to brainstorming innovative approaches to addressing challenges. What works in one community may not work in another. Each community is different and has its own issues that can be best addressed by leaders and providers with the knowledge, creativity, flexibility, and resources to do so.

A participant shared:

We had some people who didn't believe in donated health care or in working with uninsured people. So we had to navigate relationships with people who might think very differently. So, we've had to be innovative and I don't think you can function without it. (Non CHC Participant)

Participants mentioned that flexibility has played a role as a critical component to entrepreneurial thinking. They indicated that in such an evolving arena as health care, flexibility and innovation are important and not every solution is a success the first time around. Therefore, being innovative and flexible to develop the most appropriate solution is integral. A participant summed it up by saying:

You can't approach things from the point of view of somebody is going to tell you how to make it happen. You have to make something happen that has never happened before and so you have to be flexible, you have to be innovative. (CHC Participant)

Innovation occurs at the local level and allows entities to be creative in addressing their community's needs in a customized manner. Flexibility has been the impetus for creative and innovative approaches to addressing access to care issues.

Summary

Participants shared valuable criteria or components that should be included in potential funding in new projects and programs. (See table 2.) The advice offered by participants has been incorporated into their ongoing strategy to achieving sustainability and growth. Despite HCAP ending prematurely, participants were able to sustain and

make tremendous strides since and were eager to share their lessons learned with others that may be faced with similar challenges.

Table 2 Criteria/Components Essential for Inclusion in Potential Funding

1.	Establish a relationship with the Project Officer
2.	Develop collaboration
3.	Allow time to demonstrate impact
4.	Promote and facilitate leveraging
5.	Facilitate peer to peer mentoring/coaching
6.	Establish a strong advocacy team
7.	Facilitate innovation

Chapter Summary

Overall participants provided robust and insightful responses with cross-cutting themes throughout the interviews. There were ten essential factors for sustainability identified that addressed the first research question and seven key points of advice identified as essential for inclusion in potential funding for new projects/programs that addressed the second research question. In addition, there were recurring themes drawn from the factors and advice. The next chapter will provide a discussion of the results presented in this chapter.

Chapter 5

DISCUSSION

This chapter discusses results of this study within the context of the literature review and delineates themes that emerged from the research questions. There were two research questions—the first addressed factors essential to sustainability while the second solicited recommendations on criteria essential in seeking potential funding for new projects/programs. Semi-structured interviews were conducted with questions designed to allow flexibility in responding so that participants could elaborate and/or provide detail on an area they felt was important to include. In addition, this also allowed participants to share additional insights and/or topics that may not have been covered in the structure of the researcher's questions.

Much of what was found in the literature was consistent with the findings of this study. Ten key factors essential to sustainability were identified in the study. These factors were clearly expressed by participants across interviews. Seven key points of advice essential for seeking funding were also identified. Many of the factors identified from research question 1 as well as the advice provided from research question 2 align with the Shediac-Rizkallah and Bone model as presented by Evashwick and Ory (2003).

The Shediac-Rizkallah and Bone Model's framework for sustainability includes many elements and factors that were identified in this current study. This model includes the following guidelines: 1) community involvement, 2) project effectiveness, 3) duration, 4) financing, 5) types of services, 6) training component, 7) institutional strength, 8) integration with existing programs, 9) leadership/champion, 10) general

environment, and 11) level of community participation. Compared with this model's guidelines, the current study found many parallel findings including the importance of collaborating with others in the community; the significance of tracking, measuring and sharing outcomes; the value of diversified funding; the importance of strong leadership and relationships; and the significance of leveraging. In regard to the model's element of community involvement, since CHCs' boards must be at least 51% patient-based, this element was already built in.

The research questions and findings are presented below: The first research question was: **What are essential factors to ensure sustainability of programs and services of consortia of community health centers once federal grant funding ceases?**

Participants in this study identified common factors essential for sustainability of programs and services. These factors are:

- Collaboration
- Addressing and Resolving Trust Issues
- Sustainability and Strategic Plans
- Establishing and Nurturing Relationships
- Measuring and Sharing Outcomes to Demonstrate the Importance of a Program or Service
- Committed and Strong Leadership
- Perseverance and Tenacity
- Entrepreneurial Mindset
- Testimonials of Early Successes
- Diversity of Funding

In addition, criteria/advice essential for inclusion in potential funding were identified in the findings for research question two. Research question two was:

What criteria/components do key players (i.e., staff and leadership actively involved with the preparation, facilitation, direction, management, and execution of the HCAP program within their respective organization) believe are essential for inclusion in potential funding for new projects/programs?

Participants offered very helpful advice and recommendations for organizations applying for grant funding. This advice included:

- Establish a Relationship with the Project Officer
- Allow Time to Demonstrate Impact
- Promote and Facilitate Leveraging
- Develop Collaboration
- Facilitate Peer to Peer Mentoring/Coaching
- Establish a Strong Advocacy Team
- Facilitate Innovation

The focus of this discussion is on the factors and advice that emerged in the participant responses that relate to the findings and the literature. This chapter also presents the implications of the research, a discussion of the limitations of this study, and future research that may be explored.

Discussion of Study Findings with the Reviewed Literature

The findings of this study revealed numerous essential factors for sustainability as well as advice for sustainability and seeking potential funding. The researcher synthesized the identified factors and advice/recommendations into recurring themes. The

themes were: collaboration, measuring and sharing outcomes, leadership/relationships, creativity, and diversified funding. The following discussion has been organized by themes and expounds on their alignment with the findings and the literature. In addition, the interrelatedness and interdependence of the themes is noteworthy.

Collaboration

It was evident in the study that collaboration was a key to success. Findings were consistent with the literature where it was noted that collaboration was necessary to build sustainability (Evashwick & Ory, 2003; Shediac-Rizkallah &Bone, 1998). Participants felt this was a major reason they were able to sustain and grow and shared how they collaborated with others in the community to achieve mutual goals which in turn provided increased resources and offerings to patients. Mims (2006) addressed how many successful pilots or initiatives started out and were able to sustain and grow as a result of collaboration. Some participants shared how collaboration was critical in sustainability after funding discontinued. As a result of these relationships, partners were willing to step up and fill in the gap so that they could continue without disruption.

It is important to note that trust and good communication were also important to participants when collaborating with others. In the literature, Covey (2006) equates trust with good communication. These constructs are consistent with the findings of the present study in that participants spoke about being sure that the collaboration is a good fit. When multiple partners were involved, there seemed to be a sense of distrust that could emerge in the beginning. However, they all agreed that voicing concerns and working through these issues were imperative and allowed them to move forward. Furthermore, resolution and transparency allowed better and more candid communication

amongst the group. Participants reported that they developed and shared these attributes over time, that it felt good and made it easier to see someone in a meeting and then pick up the phone and call them if they needed support or had an issue with something they were working and/or collaborating on.

This study also found that collaboration was a leadership quality that participants found important. They shared that it was crucial for a leader to be able to foster relationships and work with others in the community. In addition, they made it clear that strong leadership that possessed this quality was able to articulate the organization's strengths, accomplishments, needs, and gaps while negotiating a symbiotic collaborative relationship with a partner.

Measuring and Sharing Outcomes

Participants shared a variety of reasons why measuring and sharing outcomes were necessary. They spoke about how it helped to identify trends, strengthened requests for funding, and added value to the work they were doing. Many established what they would measure very early. Participants felt that when funding requests were made, there was strength in presenting their data and outcomes. This put a quantitative expression to the work being done and its impact in addressing a need; thereby, making a convincing and justifiable argument for continued support to funders.

Additionally, the study found that keeping track and sharing outcomes with the community and politicians was also advantageous. Participants elaborated on how it has helped and stressed its importance which provides more depth to the body of knowledge. They said it was imperative to continuously nurture the relationships, and while doing so, to acknowledge the needs of the community, report the work being done, and share the

accomplishments and outcomes. In fact, they stated this was especially useful in securing local support.

Also, in demonstrating impact by measuring and sharing outcomes, participants added value to the work being done. Participants shared that they are inspired and motivated by testimonials that put a face with what they are doing and why they are doing it, but they also lean on early successes. These early successes are not only conveyed by testimonials, but outcomes as well used to quantify their work.

Leadership/Relationships

The findings of this study also were similar to findings in the literature regarding the significance of leadership and relationships to sustainability. Participants said strong leadership was instrumental in their success which was also identified in the literature by Piper (2005, 2010), Kinard & Kinard (2008) and Evashwick & Ory (2003). These researchers also suggested that success was correlated to strong leadership. When asked about leadership and its impact on sustainability, participants shared critical leadership qualities and the importance of relationships.

This study also found specific leadership qualities viewed as important to sustainability. Most were identified in the literature, such as trust, passion, charisma, innovation, and creativity (Piper, 2005, 2010). However, a few emerged in the study findings and were represented more frequently than expressed in the literature, including perseverance and tenacity. This new finding adds to the body of knowledge as it exemplifies additional critical qualities of leadership. Participants expressed how in turbulent and uncertain times perseverance and tenacity kept them at the table to strategize approaches to their challenges and to be persistent with local and state officials

to show them the value of their program and/or services, why it is needed and why it is important to fund. Participants shared that when one door would close, they would go to the next and even through windows until they exhausted all approaches. Even in the face of adversity, participants felt a leader with perseverance and tenacity assesses the situation, explores multiple approaches, digs deep and holds on tight until the storm passes.

In addition, participants felt it was important that leaders had strong relationship-building skills. They expressed frequently that accomplishments and access to additional care, services, equipment and resources could be attributed to relationships. Some of these relationships were with healthcare organizations in the community or with the political and/or private sector organizations. Developing and nurturing these relationships by consistently sharing their value in meeting the needs of the community, and by sharing their impact positioned them in a more propitious standing when and/or if there was a time they needed to be resourced.

Creativity

When asked about leadership qualities important to sustainability, participants stated creativity was important. In fact, they felt creativity was a characteristic of an entrepreneurial mind-set that, along with flexibility, was important to sustainability. It seemed as though an entrepreneurial mind-set was a prerequisite quality. They also shared this sentiment in other parts of the interview, specifically when asked about funding. Creativity was also mentioned in the literature where it was stated that leaders exercise creativity when they are building relationships and rallying funding support (Alexander et. al, 2006). Additionally, the current study found that creativity was used

when there were challenges on the political landscape. For example, when there was a state that was not in alignment with federal access to care issues and approaches, participants first faced that fact and then found themselves becoming more creative in building more relationships in the private sector for support.

Participants also elaborated on how they were creative in diversifying funding. They shared a variety of sources they sought—federal, state, local/county, foundations, and sponsorships. In addition, they stated there were non-traditional and/or innovative approaches to funding, to relationship building, and to resolving issues that they successfully executed. They also discussed how every community was different and with the ever evolving arena of health care, leaders and their staff must be creative in addressing their communities' needs.

Diversified Funding

Nelson et. al., (2007) assert that there are six factors for maintaining funding: 1) strong and experienced leadership, 2) broad and deep organizational ties, 3) coordinated efforts, 4) strategic use of surveillance and evaluation data, 5) active dissemination of information about program successes, and 6) policy-maker champions. The findings of this current study are consistent with Nelson's findings. As it relates to funding and other areas noted by Nelson, this study also found strong leadership to be essential for funding, as well as the importance of coordinated and collaborative efforts, the significance of measuring and sharing outcomes, proving value and leaning on successes, and the strength of relationships.

This study found that participants recognized the importance of diversified funding. In their responses both CHCs and non CHCs made it clear that this was a

practice they strongly encourage others to incorporate. This finding supports the literature in that blending resources must be a strong practice to be successful at financial stability (Orton & Menkens, 2006). The blending mix was from a variety of sources that included federal, state, local, private, and foundation support. The goal was to not become too dependent on any one source of funding. Incorporating a practice of multiple sources of funding softens the blow in the event funding unexpectedly discontinues or even ends as expected.

One of the key elements to growing diversified funding was nurturing relationships and flexibility. This study's findings showed that developing and fostering strategic relationships helped participants to secure funding. This was especially true when there was a relationship with state and/or local legislators. Additionally, participants also strongly advocated sharing the need for the funding, accomplishments, testimonials, and outcomes to strengthen requests.

In addition, participants stated there was an element of flexibility involved with diversifying funds. By this, they believed that an organization needed to be creative in the manner they diversified and generated funds. For example, a participant shared that a motorcycle club provided $15,000 annually for a period of five years, and the organization considered this funding. However, with this finding and advice, participants also issued a note of caution. They spoke about the importance of not pursuing funding that was not in alignment with their goals, mission, and vision. To clarify, it was acceptable and encouraged to have creative funding sources or activities that led to revenue generation; however, it was not encouraged to apply for funding that had absolutely nothing to do with the direction they were going. Funding that is awarded but

not a good fit brings forth the following: 1) more of a challenge following requirements and guidelines and 2) greater difficulty to build or leverage. This study found that obtaining and sustaining the right funding also lent itself to leveraging when aligned with the organization's strategic and sustainability plans.

Summary

The findings of this study are fundamentally congruent with the findings in the literature. However, it was noted that perseverance and tenacity were two attributes that arose from this study's participants and were not well noted in other reviewed literature findings. These two qualities of leadership were deemed significant to sustainability by participants. Additionally, participants repeatedly indicated the importance of these qualities, especially during turbulent times but also while rallying for funding and relationship building. Perseverance and tenacity motivated many to stay committed to their cause, focus on issue resolution, and persist in their sustainability efforts.

Implications

The results of this study fulfilled the goal of adding to the body of knowledge by yielding factors essential for sustainability of programs and services in addition to crucial advice for inclusion in potential funding as identified by former HCAP CHC and non CHC consortia leaders. These findings can be used by organizations planning to pursue funding as well as funding agencies. Both those competing for and disseminating grant support would find the essential factors and advice valuable. In addition, funding agencies gain perspective on how they might incorporate some of the factors and/or advice in grant applications or other initiatives to assist communities in addressing access to care issues and being able to leverage and sustain growth.

For example, participants shared their experiences related to the length of time allowed to report progress/milestones. Some stated they needed more time to allow programs to generate and report outcomes and felt as though there was not enough time allowed to demonstrate the impact of their work within the confines of some grant application requirements. Conversely, they also understood the need for federal funders to be able to report progress to the agency and Congress in a timely manner and how this directly impacted appropriations.

Discussion of Limitations

As mentioned in Chapter 3 a few limitations were identified. The first limitation was that a number of years passed since the sunset of HCAP. As a result, some of the points of contact were no longer with the organizations. It is possible that more interviews could have been conducted which would have increased the sample size. This limitation was a concern going into the study. The researcher was also concerned that consortia leaders might not remember or would have moved on. However, once the conversations started, the researcher discovered that they had strong recollections regarding HCAP. In fact, CHC participants were excited to share their experiences and even referred non CHC HCAP consortia members to participate in this study.

Some participants had moved on to other organizations or positions as was anticipated. However, the researcher was able to reach and interview them and they, too, were enthusiastic about sharing their experiences and advice. It must be stated, however, that there may have been CHC points of contact who did not agree to participate because of the number of years that have passed since HCAP and that they could not recall

experiences during that time. The researcher believes that those who agreed to participate experienced many successes as a result of HCAP and, therefore, found it easier to recall.

A second limitation was that interviews were conducted by telephone rather than in person. It is possible that a face to face interview may have yielded further discussion based on non-verbal cues. Conducting in-person interviews was ideal but cost prohibitive in this study as participants were across the country.

Future Research

The findings from this study suggest other research studies which could be conducted. Factors for sustainability and essential advice for inclusion in potential funding were identified by former CHC and non CHC HCAP consortia grantees. Although these qualitative findings are robust and valuable in their own right, they could provide the basis for logical extensions for future research. For example, the participants in this study were HCAP grantees. A similar study with a different grant or agency may be of interest to researchers as they may confirm or dispute the findings of this study and may add other insights about the sustainability of programs and services after funding is eliminated.

Secondly, this was a qualitative study where participants' concentrated descriptions of their experiences were captured. Many factors and advice were revealed. Since several necessary factors have been developed as essential for sustainability, it might be helpful to explore through a quantitative study, which of the factors are most important to sustainability.

Finally, sustainable CHCs were included in this study. It may be of interest to explore factors and advice of unsustainable CHCs—those that were not able to continue

efforts that were enabled by HCAP funding. They may add new perspectives and insights about sustainability factors.

Conclusion

Community health centers serve to address the access to care gap by providing programs and primary care services for the medically underserved, uninsured, and underinsured. The literature has provided some factors that contribute to sustainability. The findings of this study appear consistent with the literature and reveal the following as the most important factors to sustainability: collaboration, strong leadership/relationships, diversified funding, an entrepreneurial mindset and measuring and sharing outcomes. Strong leadership is an important factor to sustainability, and this study has added two leadership qualities to the body of knowledge -- perseverance and tenacity. Participants consistently stressed their importance.

Study findings also revealed important advice when seeking potential project/program funding. Of the advice the following was found most frequently: collaboration, facilitating innovation, leveraging, a strong advocacy team, and a relationship with Project Officers.

The results indicate there are many factors that play a role in sustainability. Participants were adamant in expressing that sustainability starts before the grant application begins and is continuous. Stepping stones that have led to accomplishments and growth should be leveraged to continue to sustain and build.

Participants made it clear that they were thankful for the opportunity to be an HCAP grantee, how it launched their growth and the tremendous strides made since funds were discontinued. In fact, several attribute the lessons learned during and after the

time of HCAP to their success today. They have been in the trenches and have been able to regroup, recover, and continue to sustain and grow.

Access to care for millions of medically underserved, uninsured, and underinsured Americans continues to be a challenge and there is legislation and funding in place to provide support. Those that have sought, received and sustained this support in the past have provided through this study insightful guidance for those seeking and providing this support in the future. Sustainability factors and advice shared by CHC and non CHC HCAP consortia leadership is valuable not only to CHCs but also to other health care organizations applying for funding. Other entities and funding agencies may also find the results of this study useful in planning for and executing sustainability.

References

Alexander, M., Zakocs, R., Earp, J., & French, E. (2006). Community coalition project directors: what makes them effective leaders. *Journal of Public Health Management Practice*, *12*(2), 201-209.

Andrulius, D. (1998). Access to care is the centerpiece in the elimination of socioeconomic disparities in health. *Annals of Internal Medicine*, *129*(5), 412-416.

Baker, E., & Porter, J. (2005). Practicing management and leadership: creating the information network for public health officials. *Journal of Health Management Practice*, *11*(5), 469-473.

Bashir, Z., Brown, D., Dunkle, K., Kaba, S., & McCarthy, C. (2004). The impact of federal funding on local bioterrorism preparedness. *Journal of Public Health Management Practice*, *10*(5), 475-478.

Beal, A., Dotty, M., Hernandez, S., Shea, K., & Davis, K. (2007, June). *Closing the divide: How medical homes promote equity in health care Results from the commonwealth fund 2006 health equity survey* (Survey Report). Retrieved from Commonwealth Fund website: www.commonwealthfund.org

Bennis, W., & Nanus, B. (2007). *Leaders: Strategies for taking charge* (2nd ed.). New York: Harper Collins.

Bernet, P. (2007). Local public health agency funding: money begets money. *Journal of Public Health Management Practice*, *13*(2), 188-193.

Brown, P., & Garg, S. (2004). *Foundations and comprehensive community initiatives: the challenges of partnerships*. Retrieved February 22, 2011, from www.chapinhall.org/home_new.asp.

Buehler, J., & Holtgrave, D. (2007). Who gets how much: funding formulas in federal public health programs. *Journal of Public Health Management Practice*, *13*(2), 151-155.

Carlson, B., Eden, J., O'Connor, D., & Regan, J. (2001). Primary care of patients without insurance by community health centers. *Journal of Ambulatory Care Management*, *24*(2), 47-59.

Cochran, C., & Peltier, J. (2003). Retaining medical directors in community health centers: The importance of administrative relationships. *Journal of Ambulatory Care Management*, *26*(3), 250-259.

Collins, J. (2001). *Good to great*. New York: Harper Collins.

Commonwealth Fund 2006 Health Care Quality Survey. (Cartographer). (2007). Report closing the divide: How medical homes promote equity in health care: Results from the Commonwealth fund 2006 health care quality survey. : Commonwealth Fund.

Congress (2002, October 26). Health care safety net amendments of 2002. Retrieved February 22, 2011 from http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=107_cong_public_laws&docid=f:publ251.107.pdf.

Cook, N., Hicks, L., O'Malley, J., Keegan, T., Guadagnoli, E., & Landon, B. (2007). Access to specialty care and medical services in community health centers. *Health Affairs*, *26*, 1459-1468.

Cornerstone Consulting Group. (2002). *Endgames: The Challenge of sustainability.* Retrieved from The Annie E. Casey Foundation: www.aecf.org/publications/data/endgames.pdf.

Covey, S. (2006). *The Speed of trust: the one thing that changes everything.* New York, NY: Free Press.

Evashwick, C., & Ory, M. (2003). Organizational characteristics of successful innovative health care programs sustained over time. *Family Community Health*, *26*(3), 177-193.

Fiscella, K., & Shin, P. (2005). The inverse care law: Implications for healthcare of vulnerable populations. *Journal of Ambulatory Care Management*, *28*(4), 304-312.

Freshman, B., & Rubino, L. (*20*02). Emotional intelligence: a core competency for health care administrators. *Health Care Manager*, 20(4), 1-9.

Gardner, A., & Kahn, J. (2006). Increasing access to care for the uninsured: Considering the options in California counties. *Journal of Health Care for the Poor and Underserved*, *17*, 830-850.

Geiger, H. (2005). The first community health centers: A model of enduring value. *Journal of Ambulatory Care Management*, *28*(4), 313-320.

Goleman, D., Boyatzis, R., & McKee, A. (2002) . In (Ed.), *A Primal leadership: learning to lead with emotional intelligence* (pp. 3-30). Boston, MA: Harvard Business School Press.

Guo, K. (2009). Core competencies of the entrepreneurial leader in health care organizations. *The Health Care Manager*, *28*(1), 19-29.

Gusmano, M., Fairbrother, G., & Park, H. (2002). Exploring the limits of the safety net: Community health centers and care for the uninsured. *Health Affairs*, *21*, 188-194.

Harrison, J., & Coppola, M. (2007). Is the quality of hospital care a function of leadership. *The Health Care Manager*, *26*(3), 263-272.

Hawkins, D., & Groves, D. (2011). The future role of community health centers in a changing health care landscape. *Journal of Ambulatory Care Management*, *34*(1), 90-99.

Hawkins, D., & Rosenbaum, S. (2005). Health centers at 40: Implications for future public policy. *Journal of Ambulatory Care Management*, *28*(4), 357-365.

Hawkins, D., & Schwartz, R. (2003). Health centers and the states: Partnership potential to address the fiscal crisis. *Journal of Ambulatory Care Management*, *26*(4), 285-295.

Health Resources and Services Administration (n.d.). HRSA program specific plan. Retrieved June 15, 2009 from www.hrsa.gov.

Health and Human Services. (2009). HHS releases $338 million to expand community health centers, serve more patients. Retrieved February 12, 2011 from http://www.hhs.gov/news/press/2009pres/03/20090327a.html.

Hunt, Jr., J. (2005). Community health centers' impact on the political and economic environment: The Massachusetts example. *Journal of Ambulatory Care Management*, *28*(4), 340-347.

Institute of Medicine. (2000). *America's safety net: Intact but endangered.* pp 12-14.

Kaiser Commission on Medicaid and the Uninsured. (2009). American reinvestment and recovery act (ARRA): Medicaid and health care provisions. Retrieved March 25, 2011 from http://www.kff.rog/medicaid/upload/7872.pdf.

Kaiser Family Foundation. (2010, November). *Service delivery sites operated by federally funded federally qualified health centers 2009*. Retrieved from Kaiser Family Foundation website: www.kff.org.

Kaiser Family Foundation. (2010). Summary of New Health Reform Law. Retrieved March 25, 2011 from http://www.kff.org/healthreform/upload/8061.pdf.

Kaiser Family Foundation. (2012). Community Health Centers: The Challenge to Meet the Need for Primary Care in Underserved Communities. Retrieved April 8, 2012 from http://www.kff.org/uninsured/upload/8098-2.pdf.

Kinard, J., & Kinard, B. (2008). Straight talk for health care managers: back to the basics of leadership. *The Health Care Manager*, *27*(1), 89-93.

Kramer, R. (2009). Rethinking trust. *Harvard Business Review*, *87*(6), 69-77.

Kubisch, A., Auspos, P., Brown, P., Chaskin, R., Fulbright-Anderson, K., & Hamilton, R. (2002). Voices from the field II: Reflections on comprehensive community change; roundtable on comprehensive community initiatives for children and families. *Washington, DC: The Aspen Institute*.

Larson, C., Schlundt, D., Patel, K., McClellan, L., & Hargreaves, M. (2007). Disparities in perceptions of healthcare access in a community sample. *Journal of Ambulatory Care Management*, *30*(2), 142-149.

Lefkowitz, B. (2005). The health center story: Forty years of commitment. *Journal of Ambulatory Care Management*, *28*(4), 295-303.

Levi, J., Juliano, C., & Richardson, M. (2007). Financing public health: Diminished funding for core needs and state-by-state variation in support. *Journal of Public Health Management Practice*, *13*(3), 97-102.

Litaker, D., Koroukian, S., & Love, T. (2005). Context and healthcare access: Looking beyond the individual. *Medical Care*, *43*(6), 531-540.

McConnell, C. (2007). The leadership contradiction: examining leadership's mixed motivations. *The Health Care Manager*, *26*(3), 273-283.

Mims, S. (2006). A sustainable behavioral health program integrated with public health primary care. *Journal of Public Health Management Practice*, *12*(5), 456-461.

NORC at the University of Chicago. (2005, July 15). *Evaluation of the healthy communities access program* (Report to Congress). : University of Chicago.

Navigant Consulting. (2004). *Practices to expand primary care services, implement disease management protocols, and achieve sustainability among community access program grantees*. Baltimore, MD.

Nelson, D., Reynolds, J., Luke, D., Mueller, N., Eischen, M., Jordan, J., Lancaster, R., Marcus, S., & Vallone, D. (2007). Successfully maintaining program funding during trying times: lessons from tobacco control programs in five states. *Journal of Public Health Management Practice*, *13*(6), 612-620.

Orton, S., & Menkens, A. (2006). Business planning for public health form the North Carolina institute for public health. *Journal of Public Health Management Practice*, *12*(5), 489-492.

Padgett, S., Bekemeier, B., & Berkowitz, B. (2005). Building sustainable public health systems change at the state level. *Journal of Public Health Management Practice*, *11*(2), 109-115.

Piper, L. (2005). Passion in today's health care leaders. *The Health Care Manager*, *24*(1), 44-47.

Piper, L. (2010). Trust: The sublime duty in health care leadership. *The Health Care Manager*, *29*(1), 34-40.

Politzer, R., Schempf, A., Starfield, B., & Shi, L. (2003). The future role of health centers in improving national health. *Journal of Public Health Policy*, *24*, 296-306.

Politzer, R., Yoon, J., Shi, L., Hughes, R., Regan, J., & Gaston, M. (2001). Inequality in America: The Contribution of health centers in reducing and eliminating disparities in access to care. *Medical Care Research Review*, *58*, 234-248.

Primo, S., Wilson, R., Hunt, Jr., J., Cooper, J., Desrivieres, D., Johnson, L., & Kalaczinski, L. (2009). Reducing visual health disparities in at-risk community health center populations. *Journal of Public Health Management Practice*, *15*(6), 529-534.

Proser, M. (2005). Deserving the spotlight: Health centers provide high-quality and cost effective care. *Journal of Ambulatory Care Management*, *28*(4), 321-330.

Provan, K., Lamb, G., & Doyle, M. (2004). Building legitimacy and the early growth of health networks for the uninsured. *Health Care Management Review*, *29*(2), 117-128.

Rosenbaum, S., Finnegan, B., & Shin, P. (2009). Community health centers in an era of health system reform and economic downturns: Prospects and challenges. Retrieved March 11, 2011 from http://www.kff.org/uninsured/upload/7876.pdf.

Rowitz, L. (2010). Management and leadership. *Journal of Public Health Management Practice*, *16*(2), 174-176.

Service delivery sites operated by federally funded qualified health centers, 2009. (2009). Retrieved from www.kff.org.

Shediac-Rizkallah, M., & Bone, L. (1998). Planning for the sustainability of community-based health programs: conceptual frameworks and future directions for research, practice and policy. *Health Education Research*, *13*(1), 87-108.

Shi, L., Collins, P., Aaron, K., Watters, V., & Shah, L. (2007). Health center financial performance: national trends and state variation, 1998-2004. *Journal of Public Health Management Practice*, *12*(2), 133-150.

Shi, L., LeBrun, L., & Tsai, J. (2010, March-April). Assessing the impact of the health center growth initiative on health center patients. *Public Health Reports*, *125*, 258-266. Retrieved from www.ncbi.nlm.nih.gov.

Shi, L., & Stevens, G. (2007). The role of community health centers in delivering primary care to the underserved: Experiences of the uninsured and Medicaid insured. *Journal of Ambulatory Care Management*, *30*(2), 159-170.

Shi, L., Stevens, G., & Politzer, R. (2007). Access to care for U.S. health center patients and patients nationally: How do the most vulnerable populations fare? *Medical Care*, *45*(3), 206-213.

Shi, L., Tsai, J., Higgins, P., & Lebrun, L. (2009). Racial/ethnic and socioeconomic disparities in access to care and quality of care for U.S. health center patients compared with non-health center patients. *Journal of Ambulatory Care Management*, *32*(4), 342-350.

Shirin L Scotten, E., & Absher, A. (2006). Creating community based access to primary healthcare for the uninsured through strategic alliances and restructuring local health department programs. *Journal of Public Health Management Practice*, *12*, 446-451.

Starfield, B., & Shi, L. (2004). The medical home, access to care, and insurance: a preview of evidence. *Pediatrics*, *113*, 1493-1498.

Summary of New Health Reform Law. (2010). Retrieved from http://www.kff.org/healthreform/upload/8061.pdf.

Walker, K. (2006). Management matters: Sustaining funds for youth development programs. *Journal of Public Health Management Practice*, S17-S22.

Wetta-Hall, R., Ablah, E., Oler-Manske, J., Berry, M., & Molgaard, C. (2004). Strategies for community-based organization capacity building: planning on a shoestring budget. *Health Care Manager*, *23*(4), 302-309.

Wilensky, S., & Roby, D. (2005). Health centers and health insurance: Complements, not alternatives. *Journal of Ambulatory Care Management*, *28*(4), 348-356.

Zuvekas, A. (2005). Health centers and the healthcare system. *Journal of Ambulatory Care Management*, *28*(4), 331-339.

APPENDIX A

Telephone Introduction/Consent

Hello-

Thank you for agreeing to participate and taking the time out of your busy schedule to be interviewed about your experiences with the Healthy Communities Access Program and your program's sustainability. I am expecting that this interview will take about 30 minutes. I certainly believe your experience and insights will provide valuable information to funders and to other healthcare facilities. This study is being conducted with approval from the Institutional Review Board of the Medical University of South Carolina.

I want to let you know that I am recording our conversation to be certain that I am capturing your responses accurately. This way I can pay full attention to our conversation and know that I will be able to later analyze the responses from all of the participants of this study to identify common themes. Please be assured that our interview is strictly confidential and there will be no personal identifiers to associate you with your responses. If at any time you do not want to answer a question or want to stop the interview, you certainly can tell me that. Is the information that I have given you clear, and are you ready to proceed?

APPENDIX B

Semi-Structured Interview Questions

Through the semi-structured interviews, the researcher will gain further insight into the following:

- What are some of the accomplishments you can recall about the program?
    - What were the programs and/or activities implemented after receiving funding?
    - If so, what types?
- What are some of the challenges you can recall about the program?
- Was the program and funding considered in the strategic plan of the organization?
- Was there a sustainability plan? When was it developed-- before, during or after funds were discontinued?
    - How often was it revisited?
    - What were the main areas addressed?
- If there wasn't a sustainability plan, why do you think activities, staff and programs supported by HCAP were able to continue?
- What happened after funding discontinued?
- Tell me about your organizations' leadership.
- What leadership qualities are/were important to sustainability?
- Do you think certain characteristics were inherent in the organization's leadership?

- Do you think entrepreneurial thinking was exercised—were innovative funding, networking strategies used? If so, how and what were they?
- Tell me about your sources of support used to sustain the programs (i.e., a mix of federal, state, local and foundations).
- After funding discontinued, what do you think was most instrumental in the sustainability of this program or activities that still thrive as a result of this program?
    - How much of a role, if any, do you feel leadership played in sustaining the program?
    - Do you feel the right people were in place to lead and manage to ensure sustainability of the program or would you say that there were other factors to consider that contributed to sustainability? If so, what are they?
    - Is it helpful to have community partners? Please explain your answer.
- What advice would you give an organization that is planning to apply for and/or has recently received federal funding? What might be helpful for a community health center that has just been awarded federal funds to ensure sustainability?