

Academic Health Centers and Community Health Centers: The Landscape of Current Partnerships

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Together, academic and community health centers can treat patients, perform research, and expand clinical trials in ways that neither would be able to do on their own.

Academic health centers play an essential role in advancing health and well-being, not only in the treatment of patients, through innovative research, and with the education of the future health workforce, but also in long-standing community partnerships. Through community outreach and local partnerships, academic health centers are expanding the realm in which they educate, research, and provide care. A significant, but often overlooked, component of academic health center community involvement is the collaborative relationship with community health centers. These relationships have enhanced the academic health center role as healthcare provider and community health leader.

To learn more about the evolving partnerships between academic health centers and community health centers, and to better understand the policy and regulatory environment guiding such collaborations, the Association of Academic Health Centers (AAHC) conducted a survey of its member institutions. This paper presents the initial findings of the AAHC survey, providing a broad profile of academic and community health center partnerships throughout the United States. The results are based on AAHC member responses gathered in the spring and fall of 2009. A total of 39 AAHC member institutions provided information, representing nearly 40 percent of the AAHC membership.

ACADEMIC AND COMMUNITY HEALTH CENTER PARTNERSHIPS — THE NUMBERS

Academic and community health center partnerships are a significant component of the nation's health care system. According to the results of the AAHC survey, 89 percent of the responding academic health centers have established partnerships with community health centers. In total, more than 175 community health



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centers are partnered with the 35 academic health centers that responded to the survey and have relationships with community health centers. Of the partnering community health centers, the vast majority are Federally Qualified Health Centers (FQHCs). FQHCs make up more than 60 percent of the partnering institutions. This is followed by rural health centers at 14 percent, and FQHC Look-Alikes at 10 percent. The remaining community health centers include other centers, such as migrant and homeless health centers.

The differentiation among the designations of health centers is based on the definitions and requirements provided by the U.S. Health Resources and Services Administration (HRSA) and the Centers for Medicare and Medicaid Services (CMS). For a health center to be designated an FQHC or FQHC Look-Alike it must serve a Medically Underserved Area (MUA) or Health Professional Shortage Area (HPSA).¹ FQHCs and FQHC Look-Alikes must meet the same HRSA and CMS requirements; however, FQHC Look-Alikes, although meeting the requirements to receive Section 330 grant funding of the Public Health Service Act, do not actually receive such funding.² Rural Health Centers (RHCs) must be located in non-urbanized areas and are also required to serve a MUA or HPSA; they may also qualify if they serve a shortage area designated by a Governor and approved by the Bureau of Health Professions.³ In addition to serving high-need communities, health centers are required to provide comprehensive coverage and support services to all, regardless of financial or insurance status, with fees adjusted based on patients' ability to pay.⁴

Federal designation of health centers is significant because it allows them to be eligible for Section 330 grant funding to offset the costs of uncompensated care, access to medical malpractice coverage (however, FQHC Look-Alikes are not eligible for malpractice coverage), and drug pricing

discounts.⁵ In aggregate, community health centers make up a vital component of the nation's health care safety net, providing care to millions of underserved Americans.

COOPERATING TO ENHANCE PATIENT CARE

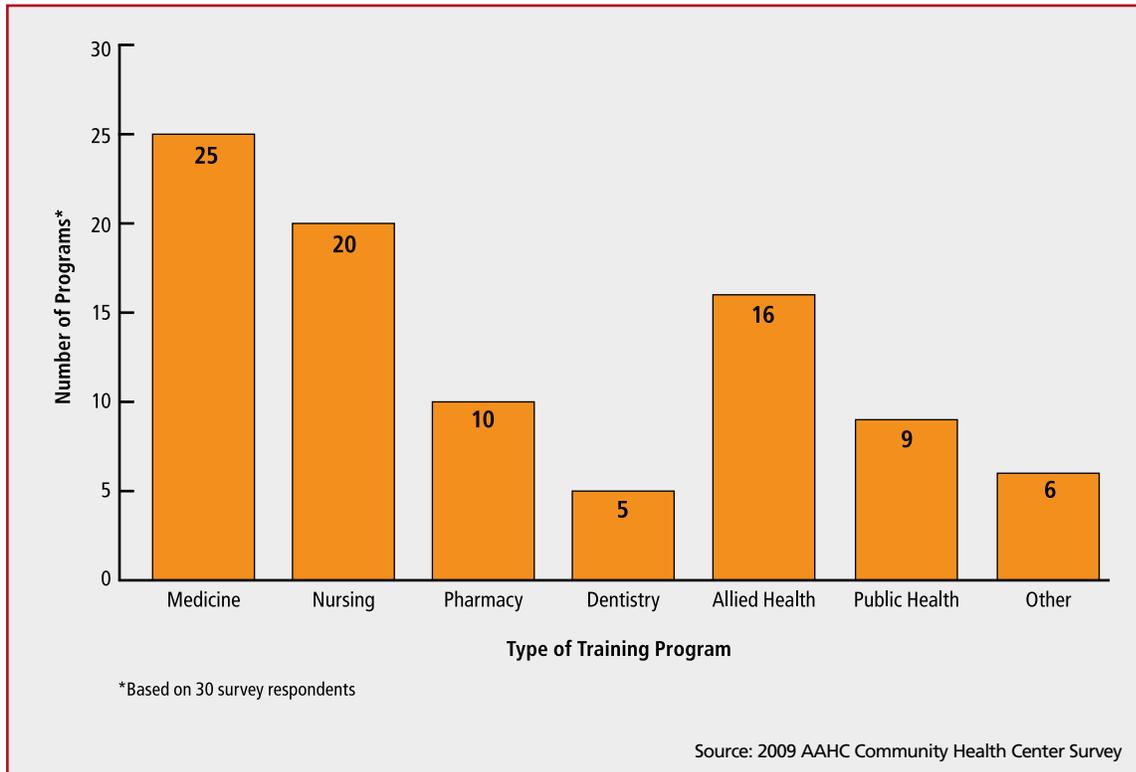
Community health centers in the United States provide care to more than 20 million people, over 70 percent of whom live in poverty.⁶ Academic health centers that collaborate with community health centers enhance patient care by expanding the health workforce of community health centers, funding community health center expansions, providing access to innovative treatments, and much more.

Survey respondents noted that their schools of nursing, departments of family medicine, and students and professionals from many other programs provide a broad range of care at community health centers, including primary and preventive care, family planning, ob-gyn services, hearing, vision, and dental screening, immunization, and more. By partnering, academic and community health centers are able to increase access to health care and improve the quality of care provided to underserved populations.

FOSTERING EDUCATION THROUGH PARTNERSHIPS

The types and degree of academic and community health center partnerships vary across institutions; however, there are significant commonalities among partnerships. In all cases of academic and community health center partnerships, academic health centers educate students working at community health centers. The range of training varies from rotating undergraduate students through the community-clinic environment to supervising medical residents in full-time rotations. Across institutions, students in virtually all health fields, including medicine, nursing, physical therapy, social work, mental health, allied health professions, and undergraduate scholars in the biomedical and health sciences, train and learn in community health centers.

Number and Type of Programs Training Students in Community Health Centers



Student health care training in community health centers provides a unique opportunity for experience with diverse populations and clinical situations. Community health centers provide unique environments to teach students to develop culturally appropriate care and unique delivery methods for clinical situations. One of the study respondents noted that “the mechanisms for service in school-based clinics differs widely from primary care delivered to the under/uninsured, homeless, and migrant farmers [who are treated in community health centers].” Whether it is overcoming language barriers and working with translators, or ensuring that proper care is continued after the visitation, particularly if a patient has no permanent home, community health centers present health professional students

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with an array of challenges that enhance and expand their education.

A valuable component of the education partnership of academic health centers and community health centers is community-based medical residency programs. According to the AAHC survey, 75 percent of academic health centers with ties to community health centers supervise medical residents in community health centers. Although many academic health centers have established residency programs with partnering community health centers, respondents also noted that federal regulations made it challenging to establish such partnerships. It was specifically noted that the incentives for community-based boards of directors, which are generally focused on patient care, are not aligned with the educational goals of residency programs. A further challenge is that community health centers do not typically reimburse the academic health center for any of the graduate medical education (GME) costs. Of all survey respondents, only one academic health center received reimbursement from the community health center for GME costs.

ACADEMIC HEALTH CENTERS AND COMMUNITY HEALTH CENTERS: THE LANDSCAPE OF CURRENT PARTNERSHIPS

“One component of research that has been highlighted in academic and community health center partnerships is translational research.”

This is an area that warrants additional research, as survey responses suggest that policy improvements could enhance the ability to form residency partnerships in the future.

EXPANDING RESEARCH THROUGH COLLABORATION

In addition to fostering diverse education, academic health centers are partnering with community health centers to increase access to research studies and expand the realm of clinical and translational research. Of the academic health centers that partner with community health centers, 72 percent noted that they collaborate or partner with community health centers for research. These partnerships provide the community health center and its patients with broader resources and advanced clinical treatments, while also providing patients greater access to population-based clinical studies and cutting edge research. Such partnerships allow community health centers to deliver a broader range of care to underserved populations, while also fostering innovative medical research. Together, academic health centers and community health centers can treat patients, perform research, and expand clinical trials in ways that neither would be able to do on their own.

One component of research that has been highlighted in academic and community health center partnerships is translational research. Indeed, the translational research objective has been explicitly defined in some partnerships. In one case, the academic health center noted that a key objective of working with a community health center was “to facilitate bi-directional translation of best evidence into local practice and conversely the translation of effective local practices into the development of new evidence and novel strategies.” The translational research component has been further enhanced through the Clinical and Translational Science Awards (CTSAs) of the

National Institutes of Health. Of the AAHC survey respondents, more than 30 percent of academic health centers conducting research with community health centers are doing so as part of a CTSA.

MANAGEMENT AND GOVERNANCE: CHALLENGES AND SUCCESS

Contending with Regulatory Requirements

The federal requirements for FQHCs and FQHC Look-Alikes necessitate that community health centers are governed by a board of directors comprising a majority of individuals served by the health center.⁷ For some academic health centers, this has been an obstacle to cooperation with community health centers. One respondent to the AAHC survey noted that a potential partnership with an FQHC was terminated because “FQHC requirements require ceding control over university-owned teaching sites.” From the perspective of academic health centers, there is a perceived risk associated with devoting human, financial, and physical resources to a health center operated by an independent community board. Although governance can be an obstacle to some partnerships, many academic health centers have developed valuable partnerships. One respondent highlighted that their relationship with community health centers is “strong, resilient, and mutually supportive.”

Where partnerships have formed, some academic health centers have allowed their buildings and assets to be used by community health centers with the understanding that the community health center board of directors manages the operation of the community health center. In one partnership, the academic health center funded capital expansion of the community health center to include six additional exam rooms — an investment of more than \$300,000. Seven of the survey respondents also noted that they own community health centers which are governed by a community board of directors (if they are an FQHC or FQHC Look-Alike) or fall under other governance requirements, such as those for rural

health centers. Given the number and diversity of academic and community health center partnerships, it is clear that the management and governance challenges associated with partnerships can be overcome in many situations, allowing for collaborative relationships to succeed.

Overcoming Divergent Missions

The nature and extent of management challenges for academic and community health center partnerships range from cultural differences to discordant missions and fiscal challenges. In particular, one respondent highlighted the cultural differences between the community health center board of directors and the university management, which often stems from the distinct goals of the partners. Although the challenges to managing partnerships between academic health centers and community health centers can be significant, they can also provide areas for unique collaboration. The same respondent who identified the cultural differences also noted that the value of combining the scientific knowledge of the academic health center with the community and patient expertise of the community health center outweighed the challenges to collaboration.

Developing Collaborative Strategies

A wide range of partnerships and management models are employed to further the collaborative potential of academic health centers and community health centers. One of the more common strategies for developing successful partnerships is establishing management structures that integrate academic and community health center personnel. According to survey respondents, this is done in a variety of ways, including academic health center representation on the community health center board of directors, community health center management using academic health center schools (most often

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the School of Nursing), and having an academic health center employee act as the community health center medical director. These strategies are employed to ensure that the parallel, yet distinct, missions of the academic health center and the community health center can be carried out and enhanced through collaboration.

In some cases, community health center management is heavily integrated into the academic health center management structure. In one such partnership, the academic health center has fiduciary, human resources, and operating responsibilities for the community health center, with the advice and consent of the community health center board of directors. The academic health center effectively operates the community health center; however, the community health center board of directors retains oversight of the center's operations. In cases where the academic health center plays a significant role in managing community health center operations, a portion of the federally designated Section 330 grant funding has been allocated to the academic health center for administrative services. This alleviates some of the financial burden, but rarely compensates the full value of services the academic health center provides.

Although many academic health centers and community health centers have created successful management partnerships, a number of survey respondents noted that regulatory restrictions had created delays in establishing or implementing programs, which had limited opportunities for some of the partnerships. Based on the multitude of successful partnership models in existence, academic health centers and community health centers would be well served to share strategies and models to enhance their partnership structures, minimize regulatory delays, and capitalize on the full potential of their relationships.

STAFFING AND FINANCIAL SUPPORT

Academic health centers and community health centers also cooperate through sharing financial and personnel responsibilities at community health centers. In some cases, academic health

centers provide all of the physicians and nurse practitioners for community health centers, in addition to funding the administrative, cleaning, maintenance, legal counsel, mal-practice insurance, and other indirect costs of operating a community health center. Of the survey respondents who partner with community health centers, 58 percent fund or cost-share activities with those centers. In one example of cost sharing, the academic health center provides regular subsidies to the community health center to continue its operation. These subsidies have been as high as \$1.5 million per year, but decreased to \$250,000 in the most recent fiscal year.

In some cases, academic health centers and community health centers split the salaries of health professionals and administrative staff at the community health centers. This can be carried out through direct sharing of salary payments, or through stipends paid to the community health center by the academic health center for time spent on academic matters. In addition to funding community health center staffing, academic health centers often participate in the recruitment of community health center physicians and staff. However, even when academic health centers play a significant role in the recruitment and staffing of community health centers, numerous survey respondents noted that it was challenging to maintain adequate staffing and physician support at community health centers.

CONCLUSION

The AAHC survey affirms the significant breadth and depth of academic and community health center partnerships. The central functions of academic health centers — education, research, and patient care — are enhanced through collaboration with community health centers, and the community health center mission of expanding care to underserved populations is supported through partnerships with academic health centers. These mutually beneficial relationships are an important component of the nation's health care safety net.

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Although the survey reveals many benefits of academic and community health center partnerships, it also suggests there are policies and practices that can be improved to further enhance these important collaborations. The strict federal requirements over the designation of community health centers, as well as insufficient funding and reimbursement, were broadly recognized as impediments to expanding academic and community health center partnerships and the provision of care to underserved populations. The negative perceptions of some existing federal policies suggest that the designation requirements and operating policies of community health centers may be inefficient and that new policies are needed to expand health care delivery to underserved populations. To address the shortcomings of such policies and plan for the changing needs of the nation's population, additional research into the regulatory, financing, and management needs and policies of community health centers is necessary.

To facilitate the development of academic and community center partnerships, academic health centers and community health centers can work together by sharing best practices and collaborative models. The AAHC will also continue to examine the evolution of such relationships, helping to ensure that academic and community health center partnerships can adapt to the changing needs of the nation and continue to be a vital component of the health care system.

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