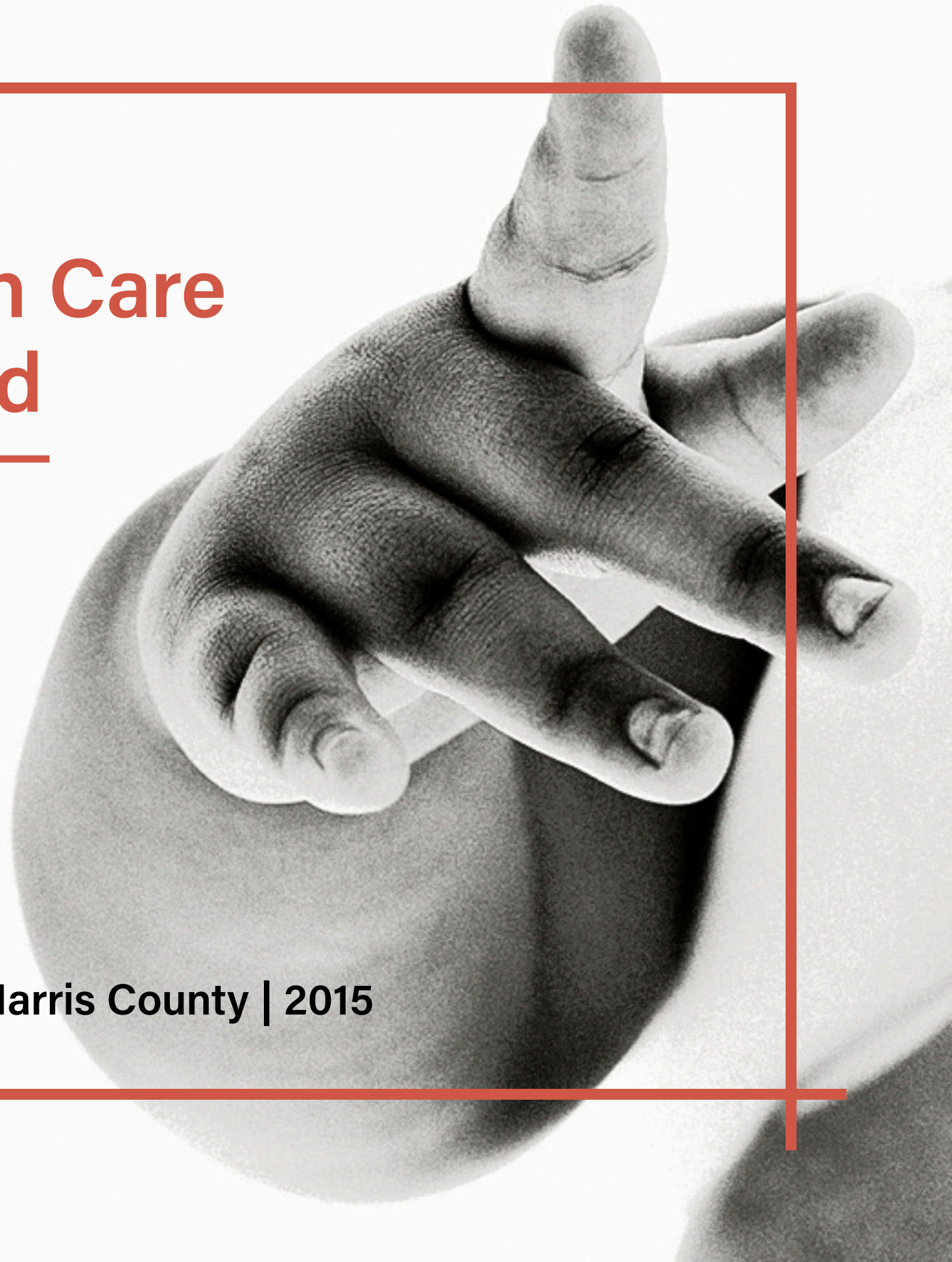


# Providing Health Care to Those In Need

Community Health Clinics in Harris County | 2015



# Contents

Submitted August, 2016

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# Executive Summary

## The community clinics serving residents of Harris County have expanded and strengthened their capacity, effectively meeting demand for primary care in the region.

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- While FQHC clinics are critical providers of primary healthcare for low-income residents of Harris County, charity/nonprofit clinics and Harris Health are also vital providers of care for the un- and under-insured.
- Since 2008, four new healthcare entities and 41 new clinic locations have been established in Harris County, bringing the total number of primary care entities to 23 and doubling the number of safety-net clinic locations to 78.
- Based on an analysis of supply and demand, these community clinics are located in the areas of greatest need.
- In 2015, these community clinics collectively provided 1.9 million patient visits, up 300% from 2008. This equates to approximately 546,274 patients served.
- Almost two-thirds (64%) of patients served by these community clinics in 2015 were uninsured.
- Based on a supply and demand analysis, and assuming that Harris Health continues to maintain its primary-care offerings at current levels, safety-net clinics in the county currently appear to have capacity to accommodate about 1/3 more patients.
- However, several clinics noted challenges in hiring and retaining providers, which limits their capacity to serve more people. Additionally, most (75%) of FQHCs report needing to hire one or more mental health providers.
- Access to specialty care remains the safety net's biggest gap in services, with 100% of community clinics naming it as one of their greatest needs.

## Operationally, many community clinics are organizing for comprehensive, outcomes-based care.

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- + FQHCs in Harris County provide more comprehensive primary care and more enabling and mental health services than they did in 2008, and more than the national average for FQHCs.
- + Many FQHC clinics are working to implement integrated healthcare, but are concerned that operational, provider, and financial constraints make true integrated care difficult to sustain.
- + While the majority of all community clinics offer some form of well-woman care, there is quite a bit of diversity around contraceptive care. Nearly all clinics do not have any policy or overall approach to contraceptive care, deferring counseling and education to the exam room. Only 50% of charity/nonprofit clinics provide some form of contraceptive care; those that do not provide contraceptive care do so for religious reasons or due to limited resources.
- + Clinic efforts over the past several years to install EHR systems that are compliant with ACA requirements are nearly complete, resulting in a narrowing of the EHR field. Eight clinic entities (seven FQHCs and Harris Health) are using systems that can “talk to each other” at some level.
- + 25% of clinics are in facilities that meet their current needs and 25% reported that their facilities meet their current and future needs. However, 50% of clinic entities reported that their facilities did not have space to accommodate growth.
- + The majority (60%) of clinics gave their board of directors an average ranking, noting that the boards generally fulfilled their aggregate roles and individual responsibilities, and worked fairly well with the CEO. Thirteen percent of clinics ranked their boards as below average.
- + The vast majority of clinic collaborations are with nonprofits that are working in the same community, with little overlap in collaborators. However, some potentially powerful collaborations among clinics, and between clinics and hospitals, are emerging.
- + Overall, the primary care “system” in Harris County is still best described as a “loosely organized group” of healthcare providers.

## **Being able to compare financials across business models will be critical to developing strategies that will achieve overall sustainability of the primary care system.**

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- ✦ The cost of supporting the primary care system in Harris County cannot be determined at this time due to differences in reporting between clinic types.
- ✦ As a whole, FQHCs have done a very good job of diversifying their finances. Patient revenues (including Medicaid, insurance, and self-pay) have increased to 46% of total revenues, higher than the Texas FQHC average. Federal, state, and local grants constitute only 23% of total revenues while philanthropy and earned revenues make up 31% of total revenues.
- ✦ Overall, charity and other nonprofit clinics rely largely on philanthropy (49%) and patient fees (32%) for their revenues. Nine percent (9%) of total revenues are from government grants – state grants in particular – as three clinics participate in the Healthy Texas Women program. When faith-based charity clinics are separated from this group, the reliance on private philanthropy is magnified; as charity clinics generally eschew government funds, 76% of faith-based clinic revenue is from private grants, in-kind donations, or revenues from fundraising activities.
- ✦ The anticipated shift to value-based reimbursement will provide opportunities for clinics that are already comfortable with cost-based accounting and population-based care.

**The policy landscape is like an unfinished bridge: Until Texas embraces a comprehensive implementation of the coverage aspects of the ACA, the survivability of community clinic services may well depend on the policy and financing decisions made at the Harris County Commissioners Court, the Capitol in Austin, and the US Capitol in Washington, DC.**

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+ Texas' decision not to adopt Medicaid expansion has created a policy/payer environment that continues to be difficult for safety-net clinics. 100% of FQHCs and Harris Health reported Medicaid expansion as their biggest policy concern.

+ Regardless of Medicaid expansion, federal policy and finance decisions are shifting from a historical model based on direct government/philanthropic funding to a model based on coverage and on value, not volume. This shift will require clinics to bill appropriately, share risk and share savings, and meet quality metrics to ensure financial sustainability. Adjusting to this shift will likely require a comprehensive restructuring of the business behaviors and models of the clinic system itself.

+ Policies are needed to support care of vulnerable populations, including women of child-bearing age, undocumented residents, and people in need of mental health services.

## The need for primary care in the Harris County area will continue to grow.

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- Based on current utilization data, 33 of 158 ZIP Codes in Harris County provide over 50% of the patients who use safety-net clinics. The majority of safety-net clinic patients live in southwest Houston along the SW Freeway, in Baytown, and in central parts that are near to and surround the south, east, and north neighborhoods of Houston's Downtown area.
- The population of the greater Houston region will continue to grow and resources will need to expand to accommodate that growth.
- In the larger Houston Metropolitan Area, over the next five years, the majority of population growth is expected to be in the western suburbs (western Montgomery County, Waller County, and Fort Bend County) west and north of the Grand Parkway corridor.
- Most of the population growth in Harris County for the next five years is expected to be in the western and northern areas, and significant population increases are also projected for the southern portions of the county, along Highway 288, and areas west of the Houston Ship Channel.
- The areas with the highest projected demand for low-cost primary care in Harris County are expected to be in the northeast, northwest, and south-central communities.
- As the population of the Houston Metro Area grows into rural areas, the need to find solutions to meet Houston's rural communities' healthcare needs will grow as well.



## To remain strong, given the evolving healthcare environment, clinics in the safety net will need to 'balance mission with margin' through new funding approaches and partnerships.

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Based on successful practices in clinic operations, and in light of what has been learned in the study, the research team identified several opportunities that offer the potential to enhance and strengthen community clinics in Harris County:

- + Support clinic leaders who understand the need for, and have demonstrated a willingness to, balance mission with margin. While community clinics need to pay attention to their central mission, given the evolving healthcare environment, those that are interested in exploring new funding approaches and partnerships should be supported.
- + Enhance clinic leadership – including executives and board members – to improve organizational capacity to navigate the changing healthcare environment. Potentially a clinic leadership academy or training program can help leaders share best practices as they move beyond a traditional clinical management approach.
- + Encourage and support clinics that have engaged, or are willing to engage, in creative collaborations. Clinics should continue to be encouraged to create networks of care where economies of scale can be achieved and where connectivity works in the best interest of patients.
- + While most clinics already employ strategies to engage their patients, largely through patient education and involving them in making decisions about their care, clinics should be encouraged to develop more substantive and sustained patient engagement efforts in order to achieve better outcomes at lower cost.

## To strengthen the healthcare system, more emphasis on population-based prevention and a better model to help patients access advanced care are needed.

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- ✦ Engage Harris Health in the effort to strengthen the primary care system in the county. Harris Health has a network of mature community clinics that provide care to a large percent of Harris County's underserved. The commitment of Harris Health to primary care is laudable, though going forward, there could be value in discussing how to continue to operate these clinics and/or shift Harris Health's priorities to fill gaps in specialty care for low-income residents of the county.
- ✦ Continue to seek solutions to specialty care access. Access to specialty care remains a critical but difficult issue. A first step might be to organize a summit of clinical leaders and tertiary healthcare providers to discuss and design a better model to help patients access needed advanced care. Another starting point would be looking at models that have successfully used cross-disciplinary collaboration and technology – such as telehealth and single-price or discount programs with local specialists – to leverage scarce healthcare resources and provide access to high-quality specialty care.
- ✦ Three populations in particular remain vulnerable in Harris County: women of child-bearing age, people in need of mental health services, and undocumented residents. As the political fight to limit funding for certain kinds of women's healthcare does not appear to have an end in sight, there is still a real question about how women will be able to access primary care and family planning services. Integrated healthcare efforts are moving forward but will continue to need operational, provider, and financial investments. Finally, even with a robust implementation of the ACA in Texas, undocumented residents will remain uninsured and with very limited means to pay for necessary care. Undocumented women and their unborn children (future Texas citizens) are especially at risk.
- ✦ Support population-based prevention. One relatively easy example would be to support charity clinics that struggle to provide immunizations because of high entry costs.
- ✦ Finally, recognizing that more people of all income levels are moving to surrounding counties in the Houston region, finding solutions for populations just within Harris County is not enough. We would encourage a regional summit to explore connections and networks across county lines.



# Background

FQHCs have received considerable attention over the past several years, so this study is unique in developing a fuller understanding of the role that all community clinics play in the provision of primary care in Harris County.

In 2008 a study of the primary care safety net in Harris County found that the safety net was a “loosely organized group of providers” that demonstrated “a significant gap between primary care need and primary care provided in the county.”

The purpose of this study is to re-assess the primary care landscape in Harris County some eight years later. As well as determining the extent of primary care availability for low-income residents of the county, the study also seeks to describe the ways in which clinics provide care, including the nature of services that are available, clinic staffing models, clinic efforts to achieve continuity of care, clinic finances and operations, and key collaborations that are used to enhance services for their patients.

Although there are many private healthcare providers that serve un- and under-insured residents in Harris County – including private hospitals, Medicaid-licensed physicians, and cash-based providers – this study takes a deep look at three types of community clinics: FQHCs; primary care clinics run by the Harris Health System; and Other/Charity clinics, including faith-based clinics and nonprofit clinics including Planned Parenthood.

# Although clinics were not required to participate, clinic participation in the study was quite strong.

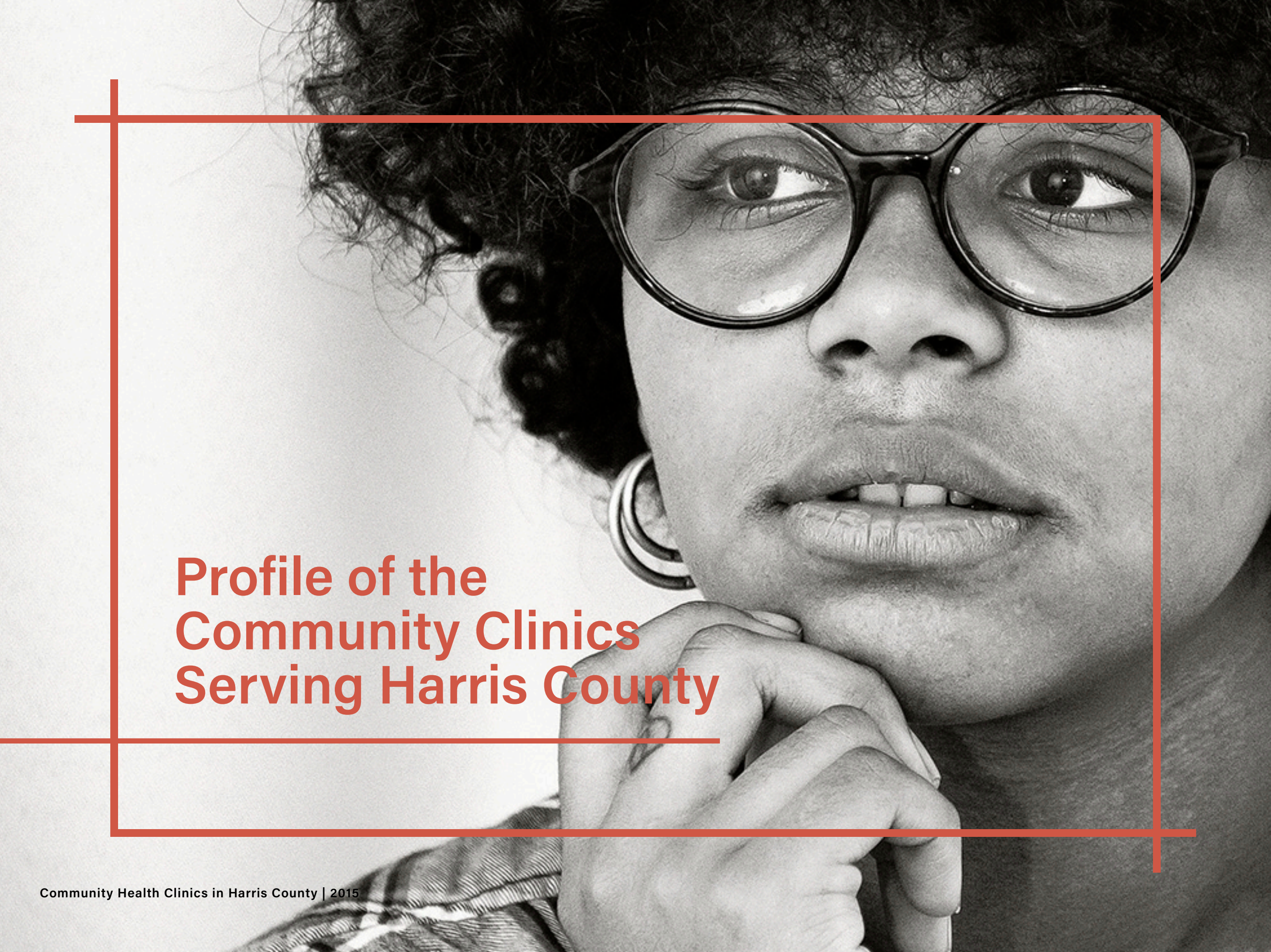
The study included a written survey of clinic services and operations, an interview with each clinic’s senior management to delve deeper into the survey and get a richer picture of the clinic and its operations, and an in-depth supply-and-demand study. Participation in the study was optional, but participation was strong. All but one of the FQHCs operating in Harris County participated in the study, Harris Health provided substantial information about patients served and operations of their adult primary care clinics, and all but one charity clinic participated fully in the study.

## Clinics That Participated In the Study

FQHCs	Harris Health*	Other/Charity Clinics
Bee Busy**	Acres Homes	Casa El Buen Samaritano
Central Care Integrated Health Services	Aldine	Christ Clinic
El Centro de Corazon	Baytown	CHRISTUS St. Mary’s Clinic
Good Neighbor Healthcare Center	Casa de Amigos	Ibn Sina
Healthcare for the Homeless	Cypress	Northwest Assistance Ministries Children’s Clinic
HOPE Clinic	Danny Jackson	Planned Parenthood Gulf Coast
Houston Area Community Services (HACS)	El Franco Lee	San Jose Clinic
Legacy Community Health	Gulfgate	Shifa Healthcare & Community Services**
Pasadena Health Center	Long Branch	TOMAGWA
Spring Branch Community Health Center	Martin Luther King	VCare Clinic
Vecino Health Centers	Northwest	
	Settegast	
	Squatty Lyons	
	Strawberry	
	Vallbona	

\* Of the 45 clinics operated by Harris Health Ambulatory Care Services, 15 non-specialty clinics that operate most like FQHCs were included in the study

\*\* Completed the written survey, but did not participate in the interview or clinic observation



# Profile of the Community Clinics Serving Harris County

# Number and Location of Primary Care Clinics

The local efforts of the past several years, together with some \$101 million in federal primary care grant funds, much of which was provided to build capacity of clinics to participate in the Affordable Care Act (ACA), have significantly expanded the primary care available in the county.

In 2008 there were 19 entities that operated a total of 37 locations. By the end of 2015, four new healthcare entities and 41 new clinic locations had been added, bringing the total number of healthcare entities to 23 and doubling the number of clinic locations to 78 clinics serving the uninsured and underserved population in Harris County.

The bulk of this growth happened within the FQHCs, where two new FQHCs were founded and eight FQHCs expanded their clinic locations. Harris Health added four primary care locations, three of which were opened using DSRIP funding in 2013. Among Other/Charity clinics, three clinic entities are new and Planned Parenthood and Ibn Sina added more clinic locations.

Not included in this list of clinic locations are school-based clinics, a growing phenomenon among all primary care entities.

## Primary Care Entities and Number of Clinic Locations Operating in Harris County, 2015

FQHCs	No. of Locations	Harris Health Clinics	Other/Charity	No. of Locations
Bee Busy Wellness	2	Acres Home	Casa El Buen Samaritano	1
Central Care	6	Aldine	Christ Clinic	1
El Centro de Corazon	4	Baytown	CHRISTUS St. Mary's Clinic	1
Good Neighbor	1	Casa de Amigos	Ibn Sina	4
Healthcare for the Homeless	3	Cypress	NAM Children's Clinic	1
HOPE Clinic	3	Danny Jackson	Planned Parenthood Gulf Coast	6
HACS	3	El Franco Lee	San Jose Clinic	1
Legacy	10	Gulfgate	Shifa Healthcare	4
Pasadena Health Center	1	Long Branch	TOMAGWA	3
St. Hope Foundation	2	MLK	Vcare Clinic	2
Spring Branch CHC	4	Northwest		
Vecino Health Centers	2	Settegast		
		Squatty Lyons		
		Strawberry		
		Vallbona		

For the first time in recent history, and assuming primary care clinics are maintained at current levels, Harris County seems to have an adequate supply of primary care access points for its residents. Comparing areas of highest utilization with areas of highest demand shows that there is a high degree of correlation between demand and utilization.



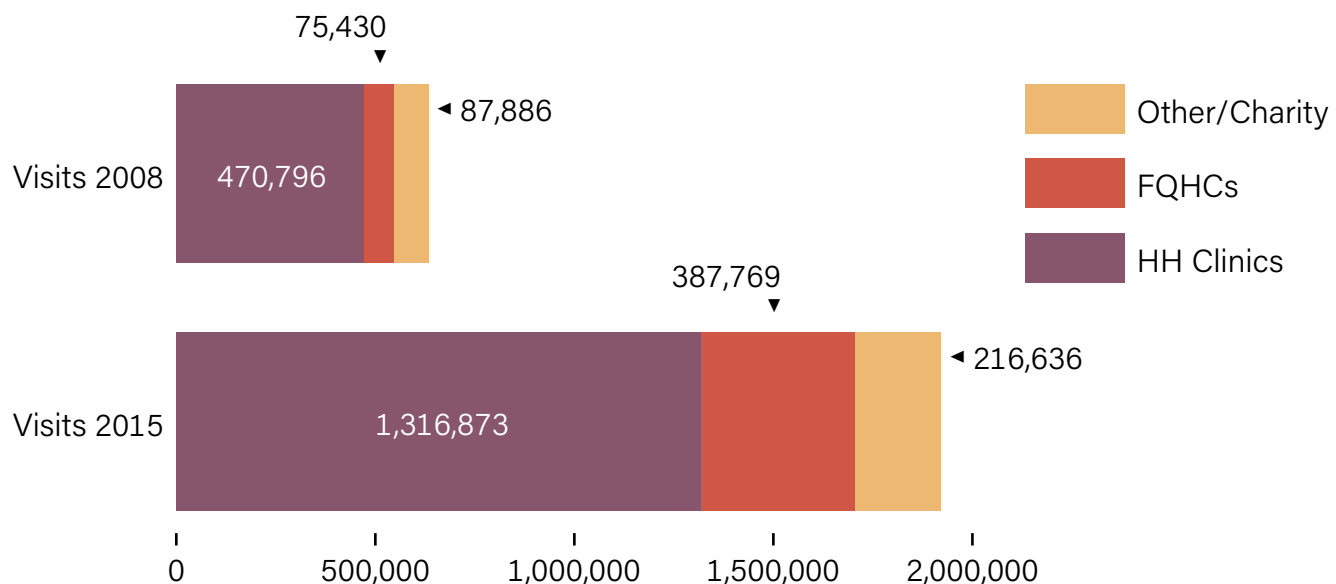
# Patients Served

With the expansion of clinics has come a substantial increase in patients served. In 2008, primary care clinics provided 593,000 patient visits; by the end of 2015, the number of patient visits had more than tripled to 1.9 million patient visits. Although FQHC and charity/nonprofit clinic capacity has increased by 270% since 2009, Harris Health patient visits still represent the majority (69%) of all visits in 2015. FQHCs provided 20% and charity/nonprofit clinics 11% of patient visits in 2015.

There are no data available on the number of patients served by all primary care entities in 2008, but 2015 data suggests that the three clinic types – FQHCs, Harris Health clinics, and charity/nonprofit clinics – each play a significant role in meeting the primary care needs of the low income residents in Harris County! The pie chart to the right illustrates the volume of patients served by each of the clinic types in 2015.

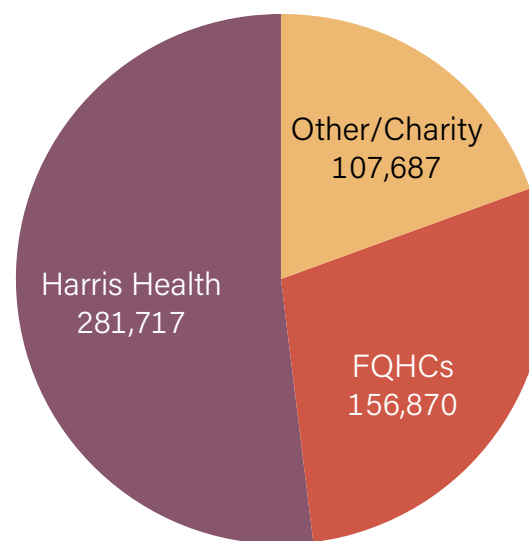
1. Harris Health patient data may include some duplication of patients; patients may also have been seen by more than one entity (e.g., the same patient may be counted by both Harris Health and charity clinics).

## Change in Patient Visits, 2009-2015



\* Note: Harris Health data represents "encounters."

## Total of Patients Served in 2015: 546,274



## Harris Health

The volume of patients served by Harris Health clinics perhaps should not be a surprise for a few reasons:

- + Many Harris Health primary care clinics have been in their communities for decades, which has given them time to be known throughout the community.
- + As entities of a larger hospital district, Harris Health community clinics have the advantage of public hospital referrals, which can provide a ready stream of patients who need to be followed in a primary care setting or to be established in a medical home.
- + Harris Health community clinics all have good signage, making them visible to community residents.

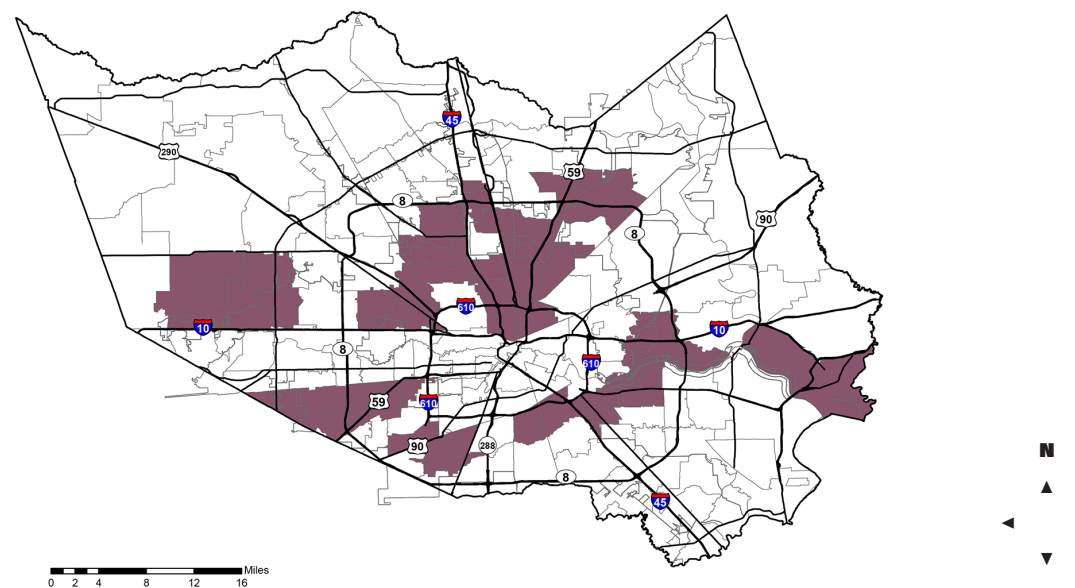
To demonstrate the reach that Harris Health clinics have in the community, the map to the right illustrates the ZIP Codes where the top 20% of Harris Health patients live.

## Community Clinic Timeline\*

1960s	1970s	1980s	1990s	2000s	2010s
Settegast Baytown	Casa de Amigos Acres Home MLK Northwest Strawberry Good Neighbor	Squatty Lions	Central Care (FQ) Healthcare Homeless (FQ) Vecino (FQ)	Hope (FQ) Spring Branch (FQ) Legacy (FQ) El Centro (FQ) Pasadena (FQ) El Franco Lee St. Hope (FQ)	HACS (FQ) Cypress Vallbona Bee Busy Danny Jackson (FQ) Long Branch (FQ)

\* Dates represent when clinics began serving patients in a community. Missing from the timeline are Harris Health's Aldine and Gulfgate clinics.

## Top 20% Harris Health Patient ZIP Codes (31 ZIP Codes)



Regardless of whether Harris Health continues  
to expand its primary care practice, it will remain a  
vital part of the safety net. Therefore, as it relates to  
policy, significant consideration should be given  
to decisions made by the Harris Health Board.

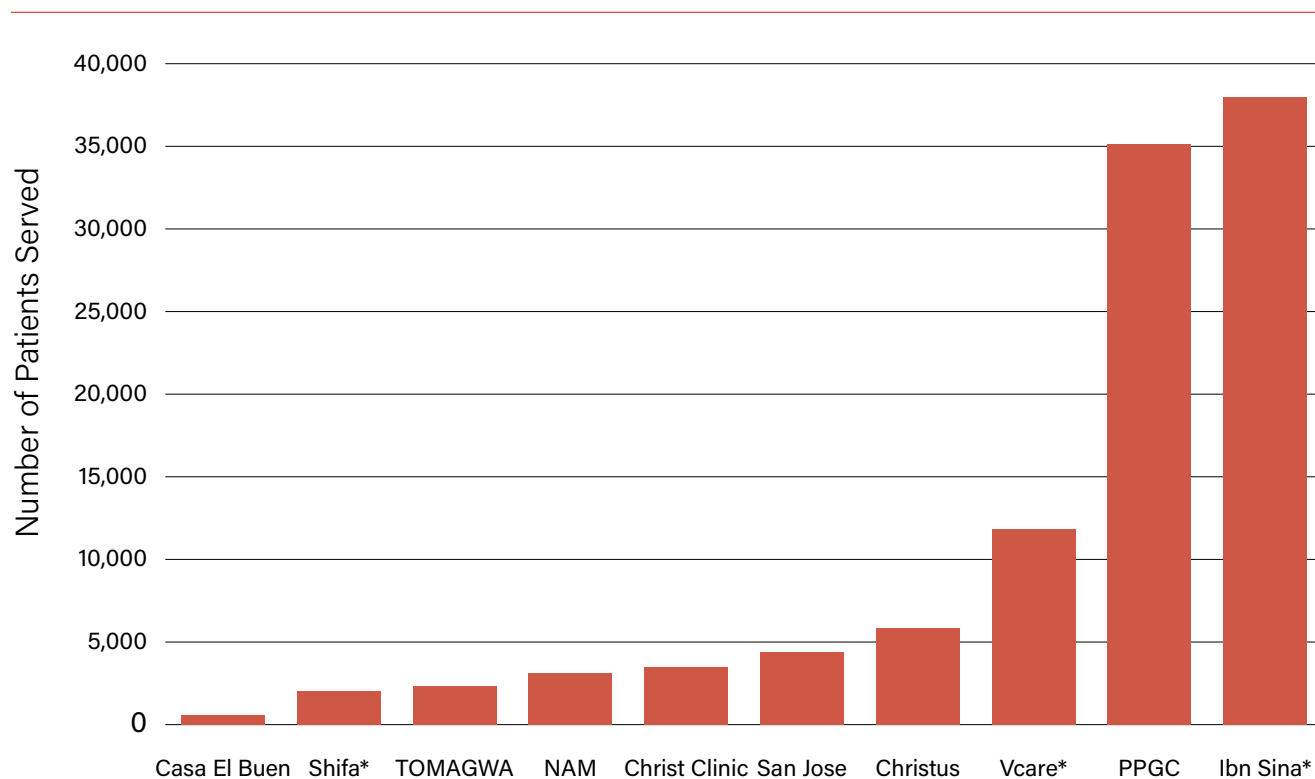


## Other/Charity Clinics

Although their services often are not as comprehensive as those provided by FQHCs or Harris Health clinics, charity and other nonprofit clinics play a vital role in serving the uninsured. Historical data on the number of patients served is not available, but in 2015, charity/nonprofit clinics served more than 100,000 patients, representing 20% of patients served in 2015. The volume of patients served by clinic varies dramatically, with Ibn Sina and Planned Parenthood clinics serving the vast majority of these patients.

Lacking ZIP Code data for all Other/Charity clinics makes it difficult to map the full reach of these clinics. However, for clinics where ZIP Code data are available, it appears that charity clinics are more likely to serve patients from outside of Harris County. This might be due to the dearth of public hospitals or clinics that serve the uninsured in surrounding counties.

Number of Patients Served by Other/Charity Clinics, 2015



\*Asterisks indicate 2014 data as 2015 data for these clinics were not available.

# Accessibility of Primary Care Clinics

While the number of clinics has expanded, the accessibility of clinic locations varies. An important ingredient in access to care is ensuring that patients can see their primary care provider outside of regular business hours. Taken together, slightly more than half of all community clinics are open on weekday evenings or weekends, which is better than the national average of 40%.

Another critical but often over-looked aspect of accessibility is how easy it is for residents to find and get to the community clinics. In this regard, about two-thirds of clinics have signage that is easy to see from the street and are accessible via public transportation.

## Ease of Accessing Community Clinics

Ease of Access	FQHCs	%	Other Clinics	%	Harris Health	%	All Clinics	%
<b>Number of clinic locations</b>	<b>41</b>		<b>22</b>		<b>15</b>		<b>78</b>	
Clinic locations open M-F, regular working hours	37	90%	14	64%	14	93%	65	83%
No. of clinic locations open on weekday evenings	24	59%	9	41%	5	33%	38	49%
No. of clinic locations open on weekends	14	34%	15	68%	0		29	37%
Signage is easily visible from the street	26	63%	17	77%	15	100%	58	74%

# Supply and Demand for Primary Care Services in Harris County

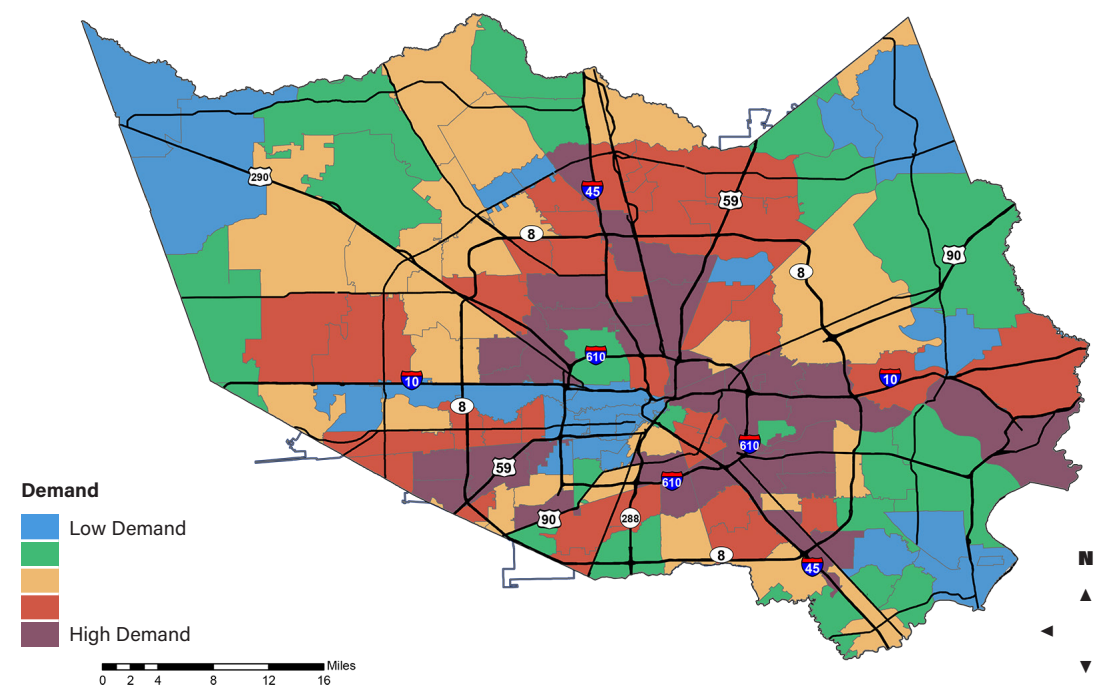
Based on an analysis of supply and demand, the current number of safety-net clinics and providers appears to be reaching sufficiently large portions of the populations that demand them.<sup>2</sup>

To estimate demand for primary healthcare, indices were created using several variables and then summed to determine areas most likely to have the greatest demand. Variables used in the indices included:

- + Population count of people under 200% of poverty
- + Median household income
- + Number of people without health insurance
- + Fertility rate among women ages 15 to 50
- + Number of people unemployed
- + Number of those employed less than fulltime on an annual basis
- + Number of non-US citizens

The map below illustrates areas of highest demand for affordable primary care services in Harris County.<sup>3</sup> The areas of highest demand are in the eastern portion of the county, north of Loop 610 to beyond Beltway 8, and in the southwest, along the I-59 corridor.

## Highest Demand



2. The major analyses for the supply and demand research were performed at the ZIP Code level. Population and demographic data were taken from the United States Census Bureau's One-year (2014) and Five-year (2010-2014) American Community Survey (ACS). Supply data came directly from utilization data provided by clinics that participated in the study, that is, ten FQHCs; all Harris Health adult, non-geriatric primary care clinics; and five of ten charity and other nonprofit clinics. For some FQHCs in this study, additional data were retrieved from the Health Resources and Services Administration (HRSA).

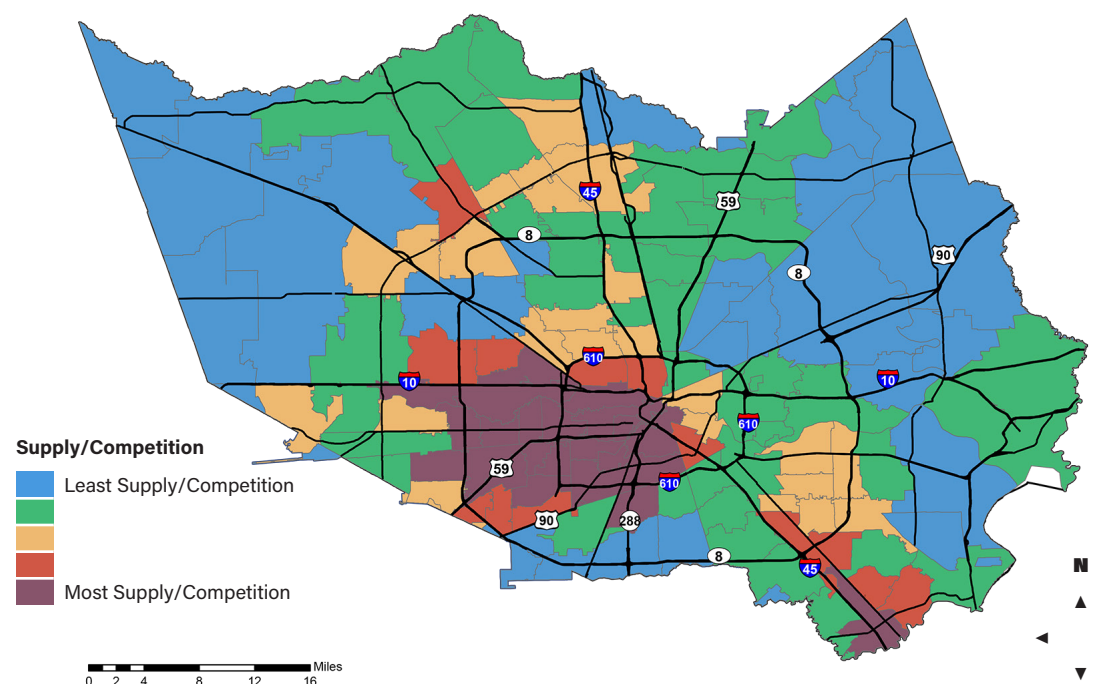
3. ZIP Code areas were ranked according to a "fractional rank as percent" method, using IBM SPSS Statistics 23. This method was used in order to limit the effect of outlying values, which frequently skew an index built from multiple values.

### 3 Profile of the Community Clinics Serving Harris County

To determine supply, variables included private healthcare providers and community clinics available to those most likely to need safety-net health services. Data for private healthcare providers included licensed practicing (not teaching) primary care physicians who were enrolled in Medicaid and Children’s Health Insurance Programs (CHIP) as of February 2016, whether in solo or group practice, and safety-net clinics.<sup>4</sup> Data for the safety-net clinics came from clinics that participated in the study and HRSA. The Texas Health and Human Services Commission (HHSC) provided 2016 data on the Medicaid and CHIP primary care providers.

As is evident in the map to the right, the greatest concentration of providers is in the southwest and near west portions of the county. A second, smaller area of concentration is in the southeast portion of the county, in the Clear Lake area. Areas with the lowest concentration of providers are in the northwest and northeast. These are areas that currently have low demand for safety-net health services, as the current population density is small.

### Supply and Competition



4. A caveat to consider is that, statewide, fewer than 35% of enrolled physicians are accepting “new” Medicaid patients, according to Texas Medical Association surveys; this is after an estimated 5% increase in participation due to the ACA.

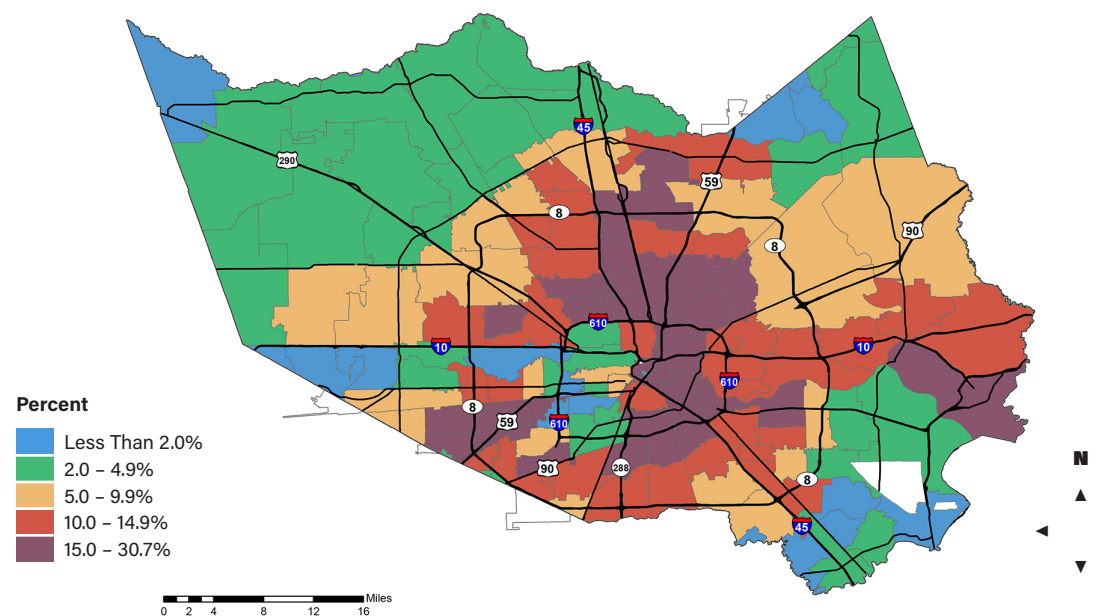


Taking the analysis one step further, actual utilization of clinics was determined using the number of unduplicated patients served in 2015 by each clinic. Based on these utilization data, 33 of 158 ZIP Codes in Harris County provide over 50% of the patients who use safety-net clinics. The areas in which most patients use safety-net clinics are southwest Houston along the SW Freeway, Baytown, and central parts that are near to and surround the south, east, and north neighborhoods of Houston's downtown area. These areas have anywhere from 15% to 31% of the total population using the safety-net clinics that took part in the study.

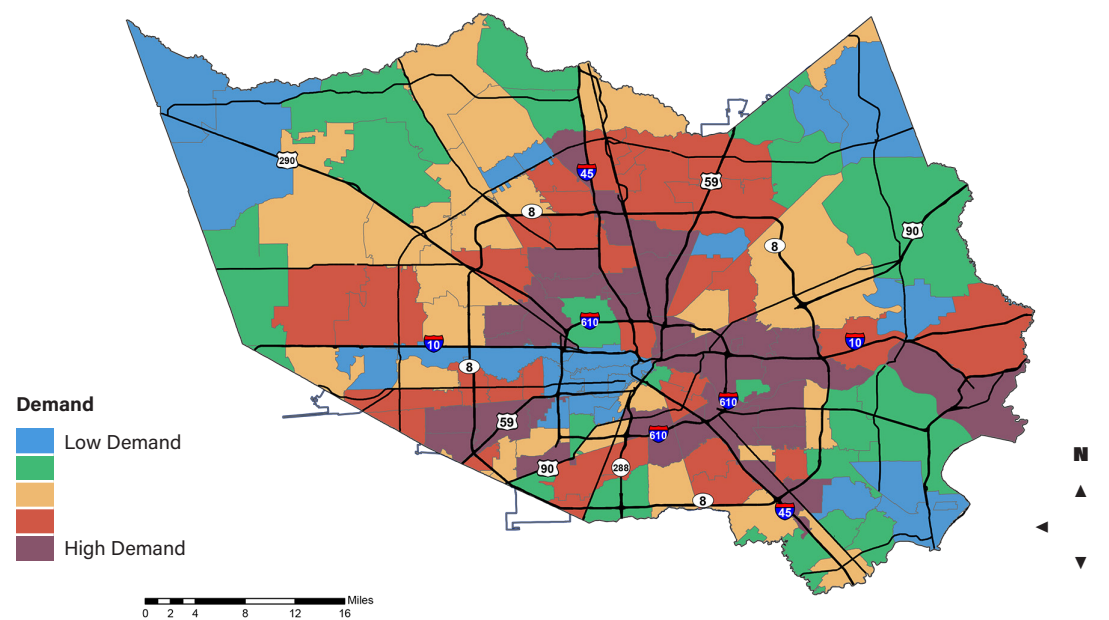
Comparing these areas of highest utilization with areas of highest demand shows that there is a high degree of correlation between demand and utilization. As the maps to the right illustrate, areas for which we expect the greatest demand for safety-net services are, in fact, those from which the majority of patients are using these services.

There is a high degree  
of correlation between  
demand and utilization.

### Percent of Total Population Using Safety Net Clinics



### Highest Demand



# Services and Staffing at Community Clinics

Basic primary medical care is available at all FQHCs, Harris Health Clinics, and charity clinics as well as at Planned Parenthood, which provides primary and preventive care within their scope of reproductive health. Where clinic types diverge in the nature of their services is in the extent of enhanced primary care services offered – including dental, vision, and mental health – and the availability of enabling services.

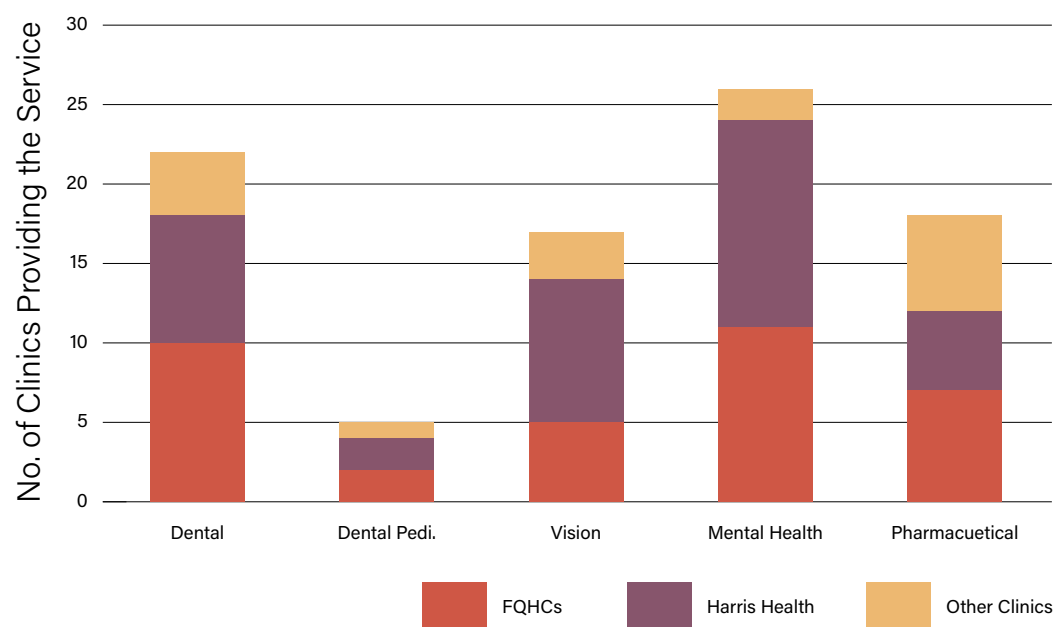
## Enhanced Primary Care Services

In terms of direct services offered (in other words, not including services that are offered by other agencies periodically onsite), FQHCs are leaders in providing comprehensive care. The areas of enhanced primary care which have had the largest growth since 2008 have been dental care and mental healthcare.

+ 83% of FQHCs and close to half of Harris Health and charity clinics offer dental care for adults (only five clinics across all clinic types offer pediatric dentistry).

+ In mental health, while the majority of FQHCs struggle to find psychiatrists and other licensed mental health providers (especially bi-lingual providers), nearly all FQHCs have been able to deepen their mental health services for their patients. Harris Health appears to have a psychiatrist available at all but two of their community clinic locations. While few charity clinics offer mental health directly, several have partnership arrangements that provide their patients with mental health services of some type. Despite these increases in access, nearly every FQHC and charity clinic noted that their services do not begin to address the extent of need for behavioral healthcare in the county.

## Community Clinics Offering Enhanced Primary Care Services in 2015



### Enabling Services

Enabling services – which include case management, eligibility assistance, transportation, and other efforts to connect patients to services they need – are increasingly recognized as being critical to providing quality primary healthcare. Enabling services break down known barriers to care and often are provided in culturally and linguistically appropriate ways. In regard to these services, FQHCs have significantly expanded their offerings, including medical and social case management, patient education, nutrition counseling, transportation, and a wide variety of other non-clinical support services. Charity clinics do not have the depth of enabling services that FQHCs do, but they recognize the importance of enabling services and focus their efforts on patient education (particularly diabetes education), case management, and translation. Harris Health has a nurse case manager available at all their community clinic locations and has patient navigators available to help patients.

### Policy Consideration: Services for Vulnerable Populations

**Given the challenges of ACA implementation coupled with the pending demise of the Texas 1115 Waiver, there are some policy areas that will impact clinic services in the Houston area more quickly than others:**

- ✦ In Mental Health, there are 38 mental health projects in the Houston region that were directly funded by the 1115 Waiver. These projects include better coordination with substance abuse treatment, jail diversion programs, crisis management, and several other identified service areas. It is generally understood by officials overseeing the 1115 Waiver that these programs likely will be forced to seek local funding for continuation, or will simply shut down, starting in 2018 when the Waiver extension expires (assuming the state is unsuccessful in again obtaining an extension).
- ✦ In Women’s Health/Family Planning, women’s health services, specifically those related to family planning, are facing a very different threat that is less about policy and more about politics. In the past five years, there have been several attempts in the Texas Legislature to cut all funds to Planned Parenthood and other abortion providers, including any services that may be separate and apart from abortion services. While the political battle is primarily focused on the issue of abortion, the results have directly affected numerous primary care services that women access through Planned Parenthood clinics, raising questions about how women will access primary care and family planning services. In the summer of 2016, the Texas HHSC launched an alternative program for low-income women seeking necessary services from providers who do not provide abortions (Healthy Texas Women). It is too soon to assess whether this program will adequately fill the void left without Planned Parenthood in the network.
- ✦ Regarding Undocumented Residents, the numerous undocumented persons who live and work in the Houston area create challenges for both the existing model of care as well as the coming new model of care under a more comprehensive implementation of the ACA, especially considering that the ACA categorically excludes undocumented residents from purchasing subsidized health insurance via the health insurance exchanges. This raises a similar question as above: Where can undocumented residents in the Houston area find healthcare when they are sick or hurt?

## Enhancements to services over the years have moved clinics, especially FQHCs, toward more comprehensive care.

An indicator of the more comprehensive, patient-centered approach being taken by clinics is the number of clinics that have achieved some level of Patient Centered Medical Home (PCMH) designation by the National Committee for Quality Assurance (NCQA). Eight of the 12 FQHCs (67%) and Harris Health have achieved some level of PCMH status. Four of the ten charity/nonprofit clinics, including Planned Parenthood, have received recognition or quality awards from local, state, or national organizations.

The accompanying chart illustrates some of the ways in which clinics have been working to improve the quality of care they provide and the patient experience.

### Clinics Are Working to Improve Quality of Care

	FQHCs	Harris Health System	Other Clinics
<b>Meet the linguistic needs of patients</b>			
Have bi-lingual staff	100% Usually or Often	Sometimes	100% Usually
<b>Engage all practice team</b>			
	<b>Most Agree</b>		<b>Most Agree</b>
Patient follow-up care is coordinated in a timely manner	36% Strongly Agree	Strongly Agree	50% Strongly Agree
Clinic has effective communication systems in place around individual patient care	45% Strongly Agree	Strongly Agree	30% Strongly Agree
<b>Implement CQI</b>			
Use a dashboard to track clinic activities	70%	yes	80%
	of these 70%		of these 80%
Use dashboard to track patient services	57%	yes	75%
Use dashboard to track patient care outcomes	71%		38%
Use dashboard to track patient satisfaction	57%	yes	50%

**Social Determinants and Population Health:** While clinics recognize the importance of social determinants of health, their ability to address them has been largely defined by specific grant funding, with its attendant limitations in time and scope. Currently, many clinics are focused on achieving PCMH metrics and on improving the quality of care for their patients in anticipation of value-based reimbursement, leaving little capacity for community-based initiatives (despite the fact that population-based health could help them achieve value-based goals).

## Specialty Care

Accessing specialty care was noted as a significant issue of concern in 2008, and providing patients with access to specialty care remains one of the biggest issues facing all community clinics in Harris County. To date there have been many efforts to address this need:

- ✦ Most charity clinics provide some specialty care using volunteer providers.
- ✦ Harris Health is an essential resource for specialty care for eligible residents, though wait times can stretch into months. And, according research conducted by the Harris County Healthcare Alliance in 2010, 25% of referrals to the Harris County Hospital District were denied because patients were unable to complete the required pre-diagnostic testing.
- ✦ Gateway to Care's Project Access, a specialty care network, is popular, but has a long waiting list.
- ✦ Accessing specialty care consultation through telehealth programs such as Baylor College of Medicine's Project ECHO.

While each of these efforts is very important, they do not begin to address the extent of need for timely access to specialty care in the community today, resulting in a cycle of unmanaged health complications for many low-income residents.

## Policy Consideration: Special Financing

Historically, a major decision driver for both charity clinics and FQHCs has been special governmental and philanthropic financing connected to specific populations and/or diseases. Rather than being reactive to episodic issues, policy and financing models that support long-term, community-based thinking are needed, but remain exceptionally challenging in the current political climate.

## Staffing

Staffing models at most of the community clinics reflect the changing nature of primary care. FQHCs in particular have embraced team-based care, hiring more support staff for their medical providers and more enabling staff. Many charity clinics utilize volunteer providers, so paid staff at these clinics tend to be mid-level providers who support the physicians and provide enabling services to patients. Based on the staffing numbers they provided, Harris Health appears to be using a more traditional medical model with their staffing, but this could be due to the clinics being staffed by doctors and trainees from Baylor and UT Health.

Despite the advantages of team-based care for both providers and patients, many clinics are challenged to recruit and/or retain providers. Four FQHCs reported shortages of primary-care physicians, and all but two other clinics would like to add at least one physician. Several clinics felt that not having more physicians limits their capacity to see more patients. Most (75%) FQHCs also report wanting to hire one or more mental health providers.

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“I know we’re providing fantastic care,  
but without more physicians, we can’t  
offer enough of it to meet the demand.”

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- Clinic CEO

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# Financial Health of the Community Clinics

Understanding the current financial status of community clinics in Harris County is difficult because each type of clinic – FQHCs, Harris Health, and charity clinics – collects and reports financial data differently. Because comparing financial data across different business models is fraught with the possibility of error, the tables below showing reported clinic revenues and expenses should be used with caution. In particular, the sources of funds cannot truly be compared across entities, nor can the totals be summed for an overall estimate of revenues and costs.

Each type of clinic collects  
and reports financial data  
differently, making it impossible  
to know the cost of providing  
primary care in the county.

## What can be said with some certainty about these reported revenues:

- + Patient revenues (including Medicaid, Medicare, private insurance, and patient fees) are a significant source of revenue for FQHCs (46%) and other clinics (42%).
- + Federal, state, and local government funds constitute less than a third of total FQHC funding and only a small percent of Other Clinic revenue (three nonprofit clinics in this grouping participate in the Healthy Texas Women program). In the case of Harris Health, the majority of their revenue comes from local tax dollars.
- + Other Clinics, especially faith-based clinics, rely more heavily on philanthropy, in-kind donations, and earned revenues, garnering 49% of total funding from these sources. Although FQHCs are not as reliant on philanthropic funds and earned revenues, these sources of funds are still a vital source of funding.

## Reported Revenues for 2015

Revenues	FQHCs	%	Harris Health	%	Other Clinics	%
Total Patient Revenue	\$70,512,835	46%	\$235,061,190	36%	\$18,683,502	42%
Total Gov't (Fed, State, Local) Funds	\$35,759,529	23%	\$410,068,332	64%	\$3,820,195	9%
Total Philanthropy and Earned Revenue	\$46,678,922	31%	—		\$21,507,873	49%
<b>Total Revenues</b>	<b>\$152,951,286</b>		<b>\$645,129,522</b>		<b>\$44,011,570</b>	



Primary care clinical services for low-income residents historically have been funded through an uncoordinated effort of poorly connected government programs, grants, donations, gifts, and volunteerism. This makes navigating the system as a low-income patient exceedingly difficult. While not an ideal system of care, sustaining even this level of clinical services through the next several years during the shift to value-based payment will be confounding for the operators and policy makers, as well as the philanthropic community, which has played a crucial role in helping to build and support the existing clinics.

### 3 Profile of the Community Clinics Serving Harris County

In regard to expenses, total expenses for all the FQHCs were \$154 million and \$42 million for charity/nonprofit clinics. Harris Health reported expenses of \$83 million for their community clinics in 2015. It is possible that some Harris Health clinic operating costs are system costs that are accounted for elsewhere in the Harris Health budget.

#### Reported Expenses for 2015

Expenses	FQHCs	Harris Health	Other Clinics
Total Expenses	\$154,710,030	\$83,297,727	\$41,698,446

Again, without a clear understanding of how costs are counted in the different business models, it is not possible to determine the full cost of primary care in the county. Thus, FQHCs and nonprofit/charity clinics are discussed separately below.

#### FQHC Funding

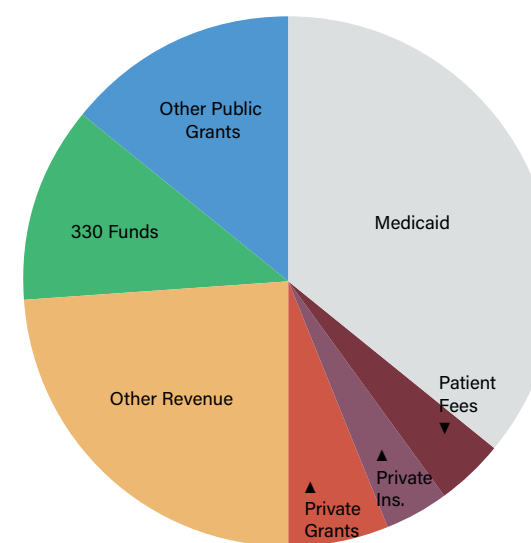
The 2008 report of the primary care safety net found that the Texas policy/payer environment made the FQHC business model extremely difficult, primarily due to the large number of uninsured people in need of care. At the time, 6% of patients seen by the eight FQHCs in the study had Medicaid and 72% of patients were uninsured.

The Texas policy/payer environment continues to be difficult for community clinics. Texas' failure to expand Medicaid as part of the ACA

has ensured that many Harris County residents are still without insurance. Despite these challenges, the FQHCs as a whole have done a good job of diversifying their finances, making them more financially stable.

Most notably, FQHCs have been able to grow patient revenues to nearly half of total FQHC revenue in 2015. Largely by serving more children, Harris County FQHCs increased their percent of Medicaid revenue from 16% of total revenue in 2008 to 36% of total revenue in 2015. This percentage is higher than the Texas average for 2015 (28.5%), but lower than the national average for FQHCs (48.9%). Also, as more patients have secured health insurance through the ACA, the percent of total revenue from private insurance has increased, though it remains only a small percent (4%) of total FQHC revenue. Taken together, the sum of Medicaid, Medicare, private insurance, and patient fees brings total patient revenue collected to 46% of total FQHC revenue in 2015. This is lower than the national average, which was 63.8% in 2015.

#### FQHC Sources of Revenue, 2015



Although the increase in patient revenue is a significant achievement, 23% of all FQHC funding still comes from federal, state, and local funds. The threat of losing federal community health center (Section 330) grants is still a possibility and would be a significant loss for all of the FQHCs. However, by diversifying their revenues, six FQHCs have been able to reduce their reliance on 330 funds to less than 20% of their total revenues. Indeed, collectively, Section 330 funds were only 12% of total Harris County FQHC revenues in 2015, better than the 2015 national average of 19.7%.

Despite increases in patient funding and reduced reliance on government funding, Harris County FQHCs still rely considerably on philanthropic support and earned revenues through fundraising events. Among all FQHCs, private grants and giving represent 31% of total revenues.

Overall, FQHCs have been able to increase patient revenue and reduce reliance on federal funding. However discretionary grants, individual donations, and earned revenues are still a significant source of funds.

### Policy Consideration: 340B Funding

Harris Health and FQHCs rely on special funding for the pharmaceutical needs of low-income patients, through a federal program that is commonly referred to as 340B. This program was created over 20 years ago to help overburdened public hospitals, but it was expanded under the ACA to allow more providers to access the program. Due to the program's growing expense, it is widely expected that Congress will intervene and fundamentally change its operations. Such a change may place additional challenges on the providers who have come to rely on this program to secure drugs for their qualifying patients.

### Charity/Nonprofit Clinic Funding

Overall this category of clinics receives 42% of total funding from patient revenues, 9% from federal/state/local grants, and 49% of revenue from philanthropic contributions and earned revenue. However, this category of clinics includes several different types of clinics – faith-based clinics, nonprofit clinics, and Planned Parenthood – each of which differ considerably in both funding approach and status. Illuminating the differences illustrates the financial strengths and weaknesses behind each type of clinic.

Most faith-based clinics require patients to pay a minimal fee to be served, and, because few accept Medicaid or private insurance, patient revenue among these clinics is only 24% of their total revenue. This, together with the fact that most faith-based clinics are reluctant to accept government funding, results in these clinics being significantly more reliant on private philanthropy – from churches, individual donors, private foundations, and corporations – to support their work. A total of 76% of faith-based clinic revenue is from philanthropy and fundraising activities.

In contrast, the nonprofit and Planned Parenthood clinics have more diversified funding. Most of these clinics accept Medicaid and private insurance, which, together with patient self-pay, brings patient revenue for this group of clinics to 54% of total revenue. Some of these clinics also participate in the state’s Healthy Texas Women program (which specifically excludes Planned Parenthood), which contributes 14% of total revenue for those clinics. As a result of more robust patient revenue and state funding, philanthropy and earned revenue constitute 31% of total revenue for these clinics, in keeping with FQHC ratios.

#### Taken together:

- + Faith-based clinics are significantly more susceptible to variations in private giving.
- + While nonprofit clinics also depend on philanthropic funds, they have more diversified funding by accepting Medicaid and participating in state grant programs.
- + Planned Parenthood, while not overly dependent on private giving, must deal with uncertain government funding for women’s health services.

# Clinic Operations

## Electronic Health Records

Clinic efforts over the past several years to install EHR systems that are compliant with ACA requirements are nearly complete, resulting in a narrowing of the EHR field. Four FQHCs are using eClinical Works and three FQHCs and Harris Health are using EPIC. The remaining four FQHCs are using four different systems (Centricity, Sevocity, SuccessEHS, and Aprima). Because eClinical Works can interface in some ways with EPIC, the result is that seven FQHCs and Harris Health are using systems that can “talk to each other” at some level. Among the ten nonprofit/charity clinics, six are currently using EHR systems.

Greater Houston Health Connect also exists to connect healthcare providers and facilitate provider access to patient health information. Seven of eleven (58%) FQHCs are members, as are Harris Health and one nonprofit clinic. However, among clinics that are members, very few report using the system and several reported that GHHC does not add value to them. Indeed, several clinics felt that accessing patient histories through EPIC was more effective than GHHC because the patients they see are more likely to have received treatment at Harris Health or one of the other providers using EPIC.

## Board of Directors

Having a strong board is critical to the overall strength and stability of an organization. In the case of the community clinics, board strength is a mixed bag, with several clinics reporting challenging situations (e.g., open positions, lack of turnover) with their boards.

Using a continuum ranking board strength on a scale of 1 – 10:

- ✦ The majority (60%) of clinics ranked their boards as average (assigning a 5 – 8 out of 10). These clinics felt that their boards generally fulfilled their aggregate roles and individual responsibilities, and worked fairly well with the CEO.
- ✦ 22% of clinics gave their board the highest ranking (assigning a 9 – 10 out of 10). These clinics felt they had a high-functioning board that provided strong strategic and fiduciary guidance, and helped to raise the funds needed for the clinic.
- ✦ Three clinics ranked their board strength as very low (assigning a 1 – 4 out of 10). These clinics reported that their board struggled to fulfill their roles or fulfilled only the most basic roles, and that the board and CEO did not communicate well.

## Clinic Operations (cont'd)

### Facilities

The state of clinic facilities, in terms of their ability to accommodate growth and the extent to which they are well maintained and equipped, is key to a clinic's ability to expand or serve more patients. In this regard, the majority of clinics felt that their facilities had adequate space for existing offices and service needs, but were not enough to accommodate growth. Specifically:

- + 47% of clinics reported having adequate space for current operations, but that existing facilities were not able to accommodate growth.
- + 26% of clinics reported that their facilities lacked adequate space and so were compromising their ability to serve patients, or that space was becoming somewhat of a challenge.
- + 26% of clinics reported that their facilities had ample space for current operations and were sufficiently sized to accommodate future growth.

Based on these reports, if clinics are going to continue to grow their capacity, expanding facilities or finding larger facilities will be necessary.

Looking ahead we will likely need a comprehensive restructuring of the business behaviors and models of the safety-net clinic system itself. In the meantime, the challenge of staying financially viable as the healthcare environment, and particularly payment mechanisms, continue to change will require creative financing, comprehensive real-time data tracking, and cost management for every clinic regardless of its affiliations and designations.

## Collaborations

In 2008 the primary care safety net system was described as a “loosely organized group of providers.” Based on the extent of collaborations that exist among clinics and between clinics and hospitals today, that characterization remains a good description of the primary care “system” in Harris County. While all of the clinics are engaged in collaborations, the vast majority of the collaborations are with nonprofits that are working in the same community, with very little overlap in collaborators.

To demonstrate this point, a total of 94 organizations were listed as “important collaborators” to the clinics that participated in the study. Of these 94 organizations, only six were mentioned by more than four clinics. The six are:

- + Houston Methodist, which was mentioned frequently by the charity clinics for in-kind services;

- + The Rose, which was mentioned by FQHCs and charity clinics for their mammography services;

- + Harris Health, which was mentioned mostly by FQHCs as a referral for specialty care;

- + Gateway to Care, which was mentioned by many clinics as an advocacy partner;

- + City of Houston, which was mentioned by several clinics that utilize city facilities for their clinics; and

- + MD Anderson, which was mentioned for cancer screening programs.

While substantial collaborations are more the exception than the rule, there are some interesting collaborations under development that show promise for building a stronger system of primary care. Specifically:

- + Four FQHCs – El Centro, HACS, Spring Branch, and Vecino – are working to create a “virtual clinic” where the four entities would create efficiencies by sharing key administrative functions.

- + The Katy Collaborative is a collaboration of a charity clinic (Christ Clinic), two FQHCs (Spring Branch and Access Health), and two hospitals (Methodist and CHRISTUS Health) to divert patients from the hospital emergency department and connect them to medical homes.

- + School-based care appears to be a growing trend among clinics.

- + Several clinics (Harris Health, NAM, and Vecino in particular) have collaborations with medical training programs and many clinics serve as training sites for community colleges. These collaborations have been important sources of providers and medical assistants for the clinics.

As the transition to value-based payments begins, meaningful collaborations with entities that can help strengthen continuity of care and improve patient outcomes will be beneficial to both clinics and hospitals.

**Value-Based Payment and Collaborations:** In January 2015, the Department of Health and Human Services (HHS), announced ambitious goals for transitioning Medicare payment policies from volume-driven fee-for-service arrangements to systems that promote and reward value. This goal will be achieved through investment in advanced PCMH models, alternative payment models such as Accountable Care Organizations (ACOs), new bundled payment models for episodes of care, and integrated care demonstrations for beneficiaries dually eligible for Medicare and Medicaid. The potential impact of these payment reforms on clinical providers is largely unknown, but the anticipation is that hospitals and health systems will be reaching out to community clinics and local support organizations that can help them build these models of care. Value-based payment could prove to be a tremendous financial opportunity for clinics that have the capacity to collaborate with health systems and hospitals to achieve better health outcomes.





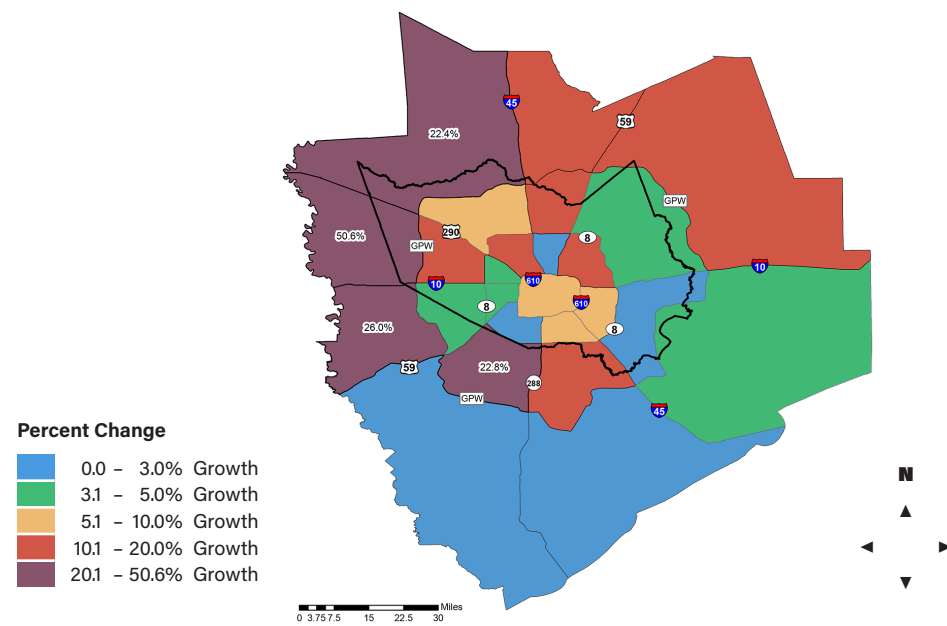
# Future Considerations

**The discussion above is a description of current community clinic activity and capacity. However, Harris County is in a rapidly growing region and population growth is certain to require additional increases in capacity to meet the new demand.**

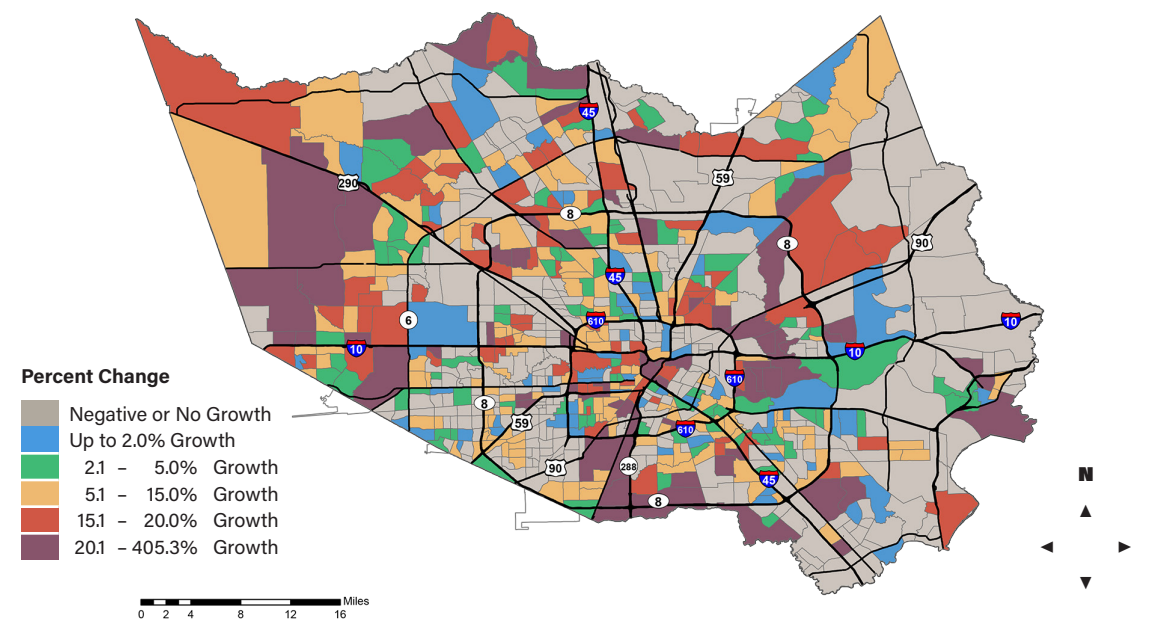
Based on HGAC short-term regional demographic projections, over the next five years, the majority of population growth in the Houston Metropolitan Area will be in the western suburbs, extending into western Montgomery, Waller, and Fort Bend Counties. This growth is projected to be west and north of the Grand Parkway corridor. An area in eastern Fort Bend County, which includes a portion of the City of Houston that extends outside the Harris County boundary, is also expected to have a population increase of approximately 23%.

Within Harris County, most of the population growth will be in the western and northern areas. Significant population increases are also projected for southern portions of the county, along Highway 288, and areas west of the Houston Ship Channel. As illustrated in gray in the map below, in the short-term, areas projected to have little or no population growth are those in the west, between Loop 610 and Beltway 8, as well as in the rural and industrial areas in the eastern parts of the county. Neighborhoods northeast of the Houston downtown area and within Loop 610 are also expected to grow little or not at all. This includes communities near downtown and just west of the Houston Ship Channel.

**Percent Population Change Between 2016 and 2020  
Houston Metropolitan Area, HGAC 25 Sectors**



**Percent Population Change Between 2016 and 2020  
HGAC Harris County Census Tract Projections**

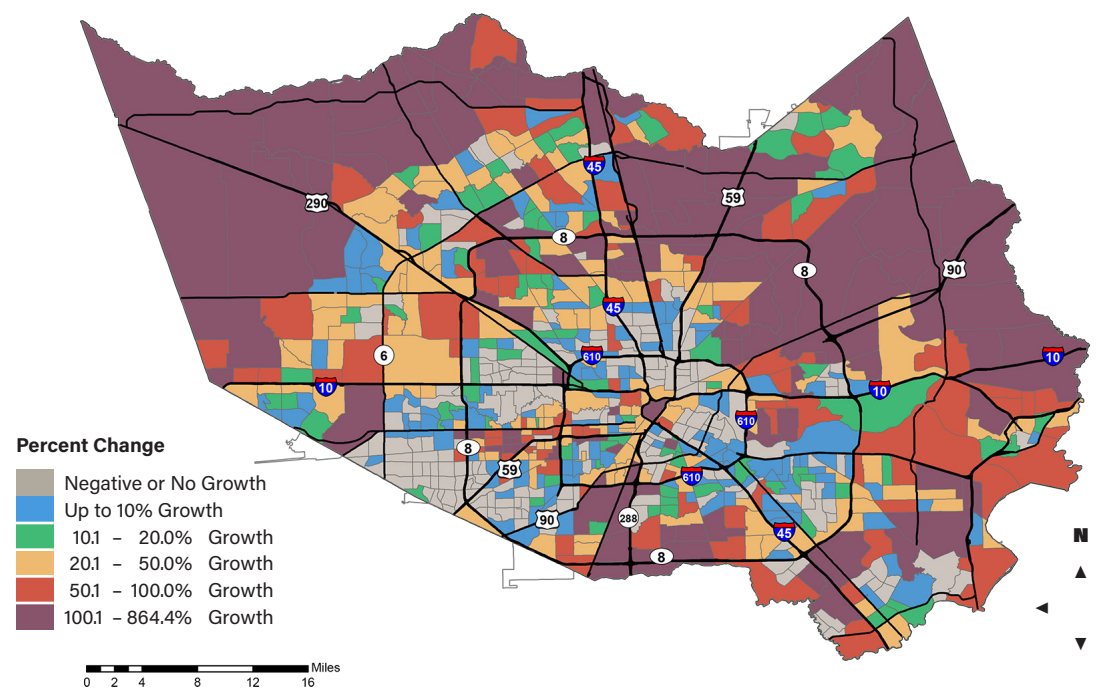


Looking further into the future, in the next 25 years the greatest growth in the region is expected to be in the Houston Metropolitan Area suburbs, with the largest increases being outside the Grand Parkway corridor. As was seen in the short-term projections, the western and southwestern regions will continue to grow. Also, in the long-term, fast population growth is projected for the northeast sectors of the region, especially in the Humble, Atascocita, and southern Liberty County areas.

For Harris County, in the long term, the largest population growth will be in the northwest and northeast portions of the county. Growth in the south central parts of Harris County along Highway 288 is also expected to continue. These areas border the City of Pearland, in Brazoria County, which has been one of the fastest growing areas in the region.

In the long-term, we can also expect that many communities in Harris County will have reached an optimal or maximum density of housing, and therefore population. Areas in the western and southwestern part of the county, including those between Beltway 8 and Highway 6, within the Spring Branch-Carverdale area, and along the Southwest Freeway are expected to no longer grow in population, and some are projected to lose population. Increased industrialization, much of it around the Houston Ship Channel, is also expected to negatively affect population growth in communities bordering the downtown area.

### Percent Population Change Between 2016 and 2040 HGAC Harris County Census Tract Projections



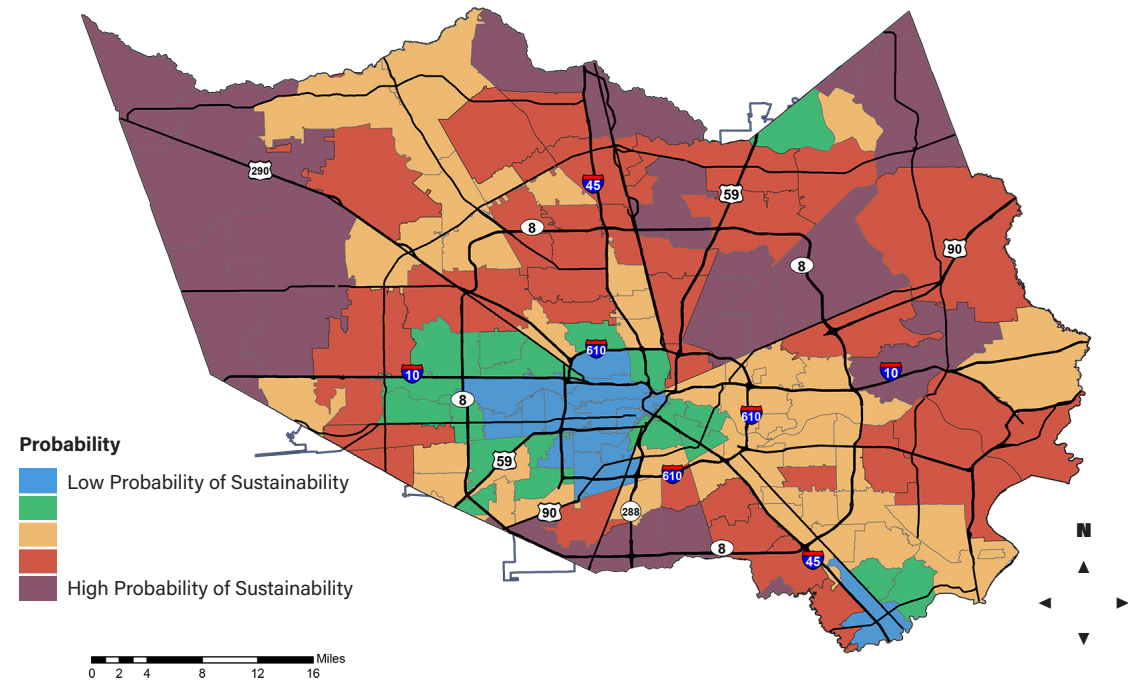
# Areas for Sustainable Expansion

Based on these population projections, areas where sustainable safety-net clinic growth is most likely are those with reduced competition from similar providers, sufficient population growth, and increased likelihood of payment. For this analysis, an index was created based on the population within a ZIP Code, which took into account comparative and relative values of three factors:

- + The rates of CHIP and Medicaid coverage among those under 200% of poverty;
- + The number of safety-net providers, using the results of our supply analysis; and
- + Population growth, using the HGAC Census tract projections estimated to ZIP Code levels of geography using the tract centroid.

The results of this analysis show that health service providers will need to expand into the northeast, northwest, and south central communities of Harris County. Those who move into these areas with high-quality, in-demand services should be able to sustain and expand their clinics throughout the long-term.

## Expansion and Sustainability



### Policy Consideration:

The reality is that more people of all income levels are moving to surrounding counties in the Houston region. Finding solutions just for populations within Harris County will not be enough to meet demand.



# Opportunities to Enhance the Safety Net

In the future, the availability of public funding for community clinics will be far more uncertain, and how those funds will be available will require changes in clinic business models, suggesting that community clinics need to redouble their efforts to diversify and expand their revenue base, and build collaborations with a focus on improving population health.

Expanded accessibility, more comprehensive services, and (in many cases) greater diversification of revenues are all impressive improvements in primary healthcare in Harris County. However, these changes have taken place during a time when significant federal funding was available.

Recent studies of effective community clinics have found that, in the current healthcare environment, clinics must maintain an organization that is both clinically focused and financially healthy. Successful strategies include:

- + Leadership that is willing to balance the mission to serve the un- and under-insured with the need to maintain a strong organization (“a balanced focus on mission and margin”). This includes thinking beyond government funding to accepting insurance, effective revenue cycle management, increasing marketing and outreach efforts, pursuing new markets, and enhancing organizational operations and workflows to achieve efficiencies and improve services;
- + Ensuring that clinic programs meet the evolving needs of their communities and are focused on improving the health of the patient population; and
- + Creating partnerships – with hospitals as well as with complementary organizations – that expand the continuum of care while strengthening the clinics’ ability to compete in the more competitive healthcare environment.

**Based on these successful practices and in light of what has been learned in the study, the research team identified several opportunities that offer the potential to enhance and strengthen community clinics in Harris County:**

- ✦ Engage Harris Health in the effort to strengthen the primary care system in the county. Harris Health has a network of mature community clinics that provide care to a large percent of Harris County's underserved. The commitment of Harris Health to primary care is laudable, though going forward, there could be value in discussing how to continue to operate these clinics and/or shift Harris Health's priorities to fill gaps in specialty care for low-income residents of the county.
- ✦ Support clinic leaders who understand the need for, and have demonstrated a willingness to, balance mission with margin. While community clinics need to pay attention to their central mission, given the evolving healthcare environment, those that are interested in exploring new funding approaches and partnerships should be supported.
- ✦ Enhance clinic leadership – including executives and Board members – to improve organizational capacity to navigate the changing healthcare environment. Potentially a clinic leadership academy or training program could help leaders share best practices and move beyond a traditional clinical management approach.
- ✦ Encourage and support clinics that have engaged, or are willing to engage, in creative collaborations. Clinics should continue to be encouraged to create networks of care where economies of scale can be achieved and where connectivity works in the best interest of patients.
- ✦ While most clinics already employ strategies to engage their patients, largely through patient education and involving them in making decisions about their care, clinics should be encouraged to develop more substantive and sustained patient engagement efforts in order to achieve better outcomes at lower cost.
- ✦ Support population-based prevention. One relatively easy example would be to support charity clinics that struggle to provide immunizations because of high entry costs.
- ✦ Continue to seek solutions to specialty care access. Access to specialty care remains a critical but difficult issue. A first step might be to organize a summit of clinical leaders and tertiary healthcare providers to discuss and design a better model to help patients access needed advanced care. Another starting point would be looking at models that have successfully used cross-disciplinary collaboration and technology – such as telehealth and single-price or discount programs with local specialists – to leverage scarce healthcare resources and provide access to high-quality specialty care.

## 5 Opportunities to Enhance the Safety Net

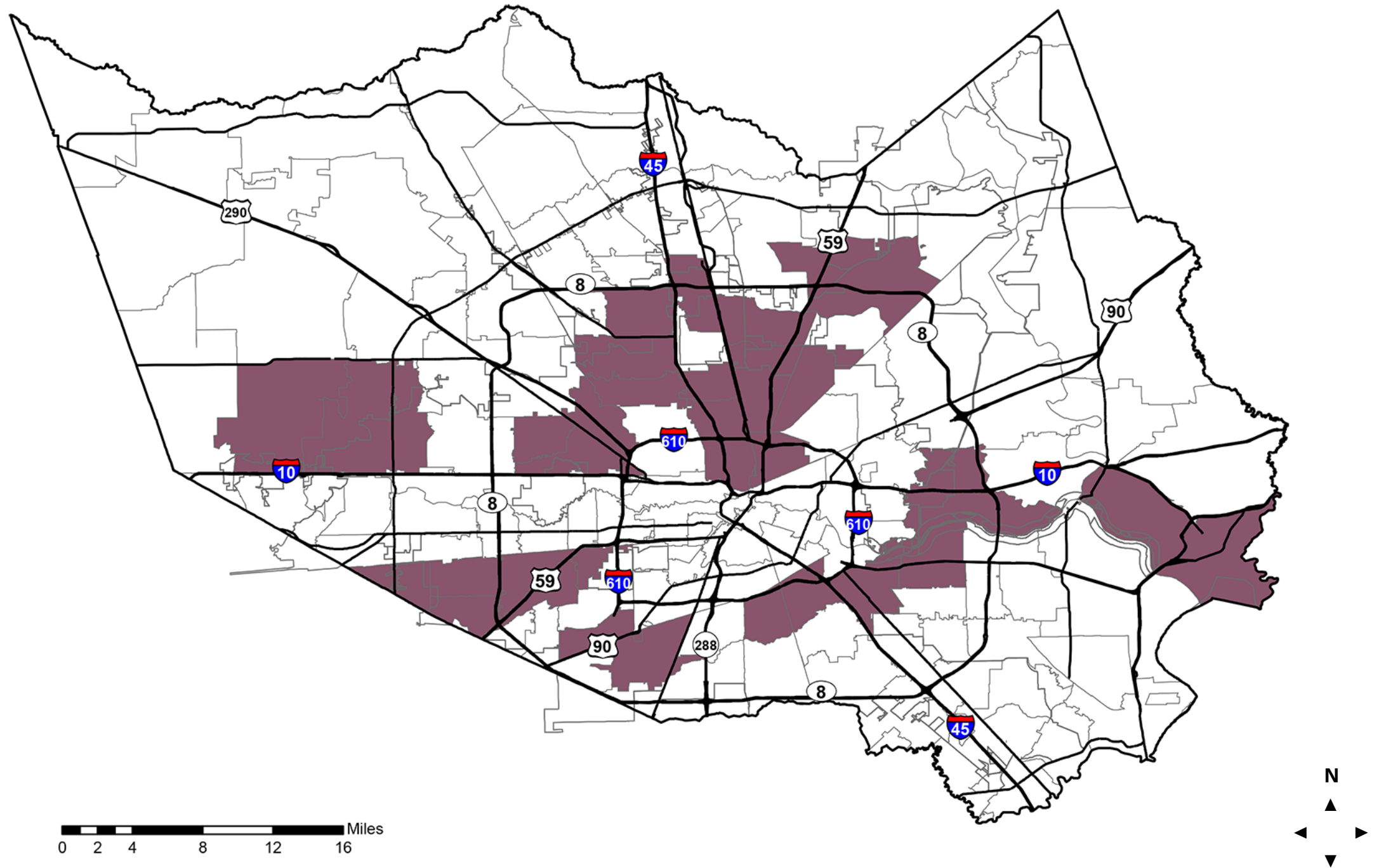
✦ Three populations in particular remain vulnerable in Harris County: women of child-bearing age, people in need of mental health services, and undocumented residents. As the political fight to limit funding for certain kinds of women's healthcare does not appear to have an end in sight, there is still a real question about how women will be able to access primary care and family planning services. Integrated healthcare efforts are moving forward but will continue to need operational, provider, and financial investments. Finally, even with a robust implementation of the ACA in Texas, undocumented residents will remain uninsured and with very limited means to pay for necessary care. Undocumented women and their unborn children (future Texas citizens) are especially at risk.

✦ Finally, recognizing that more people of all income levels are moving to surrounding counties in the Houston region, finding solutions for populations just within Harris County will not be enough. We would encourage a regional summit to explore connections and networks across county lines.

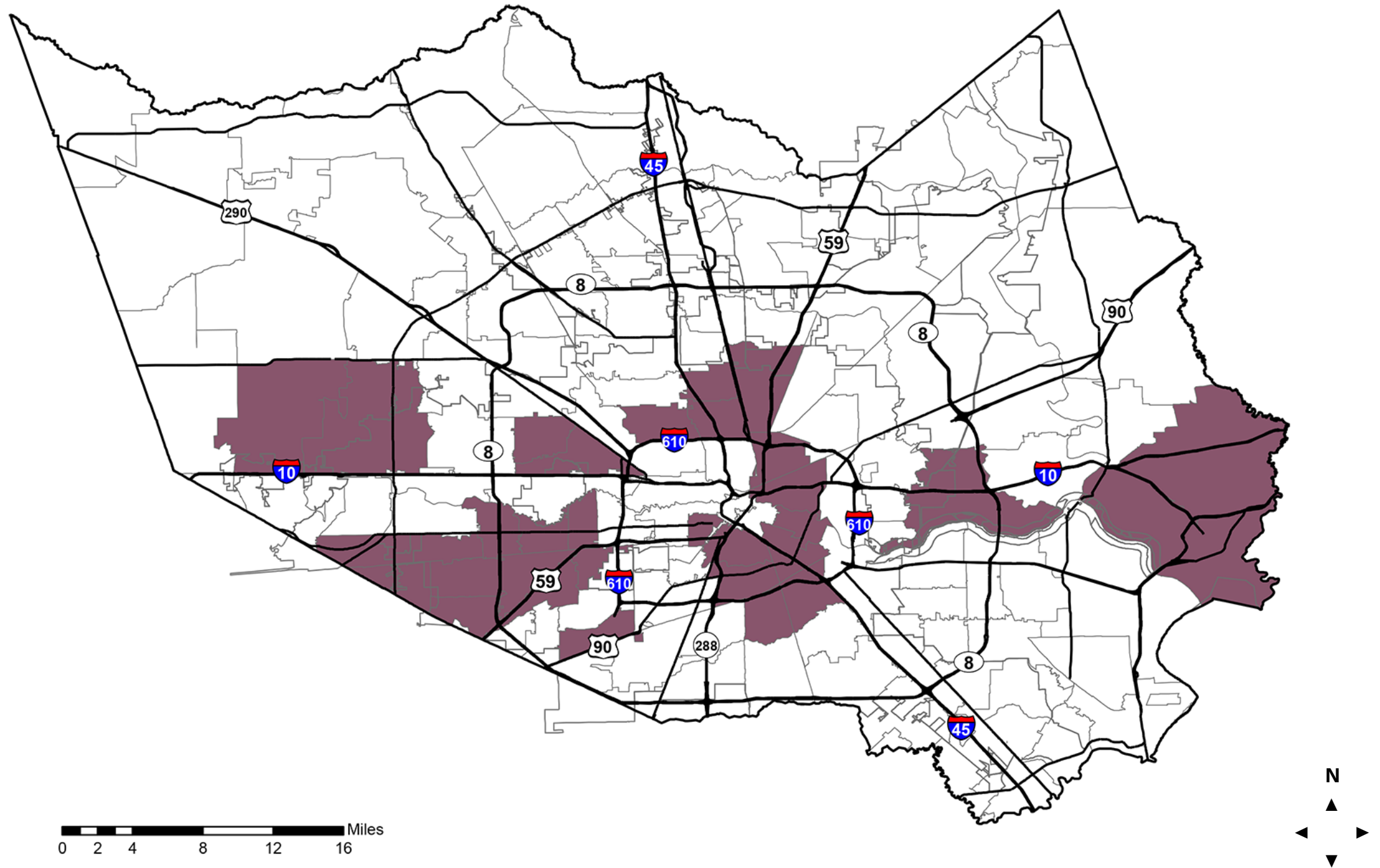


# Full Size Maps

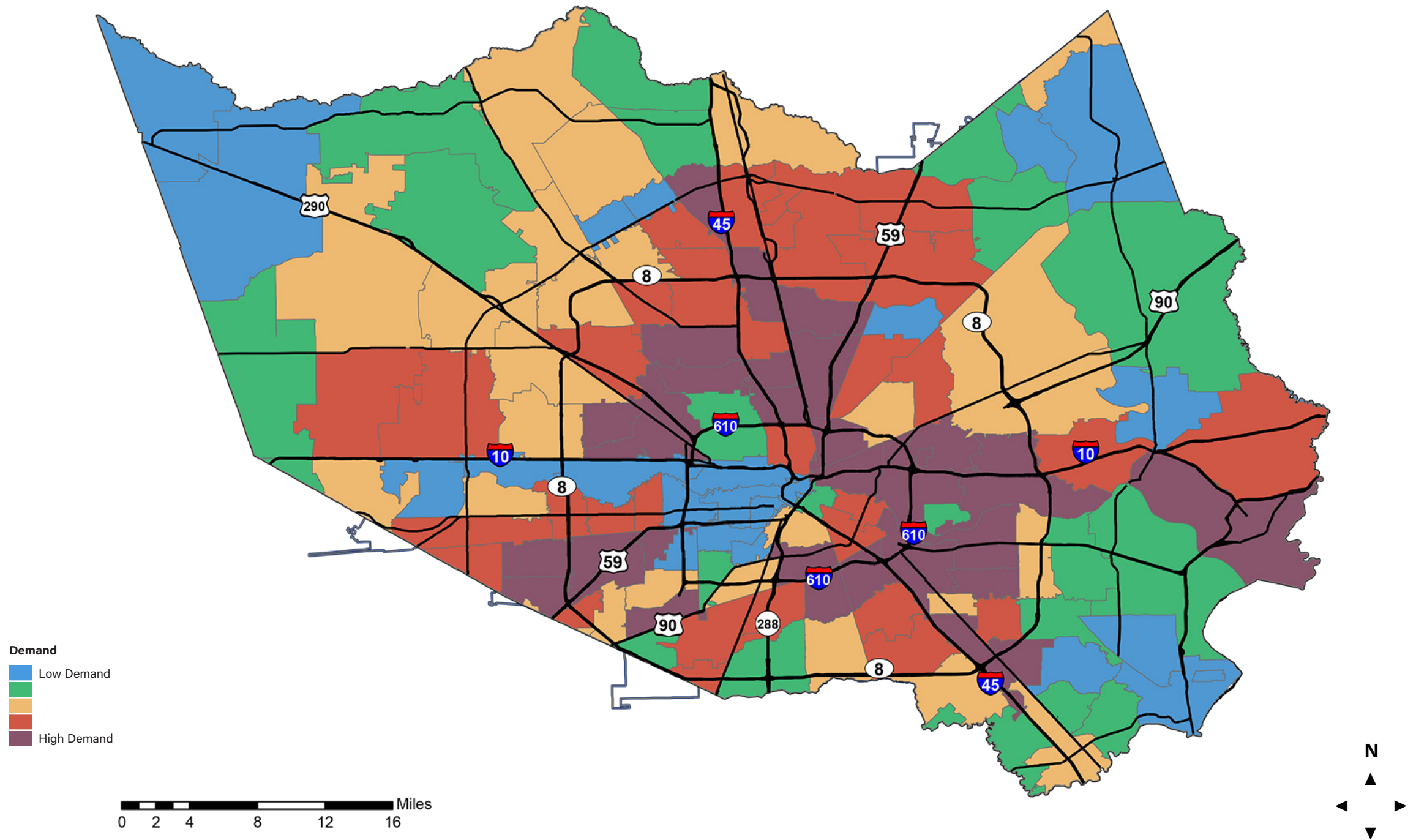
# Top 20% Harris Health Patient ZIP Codes (31 ZIP Codes)



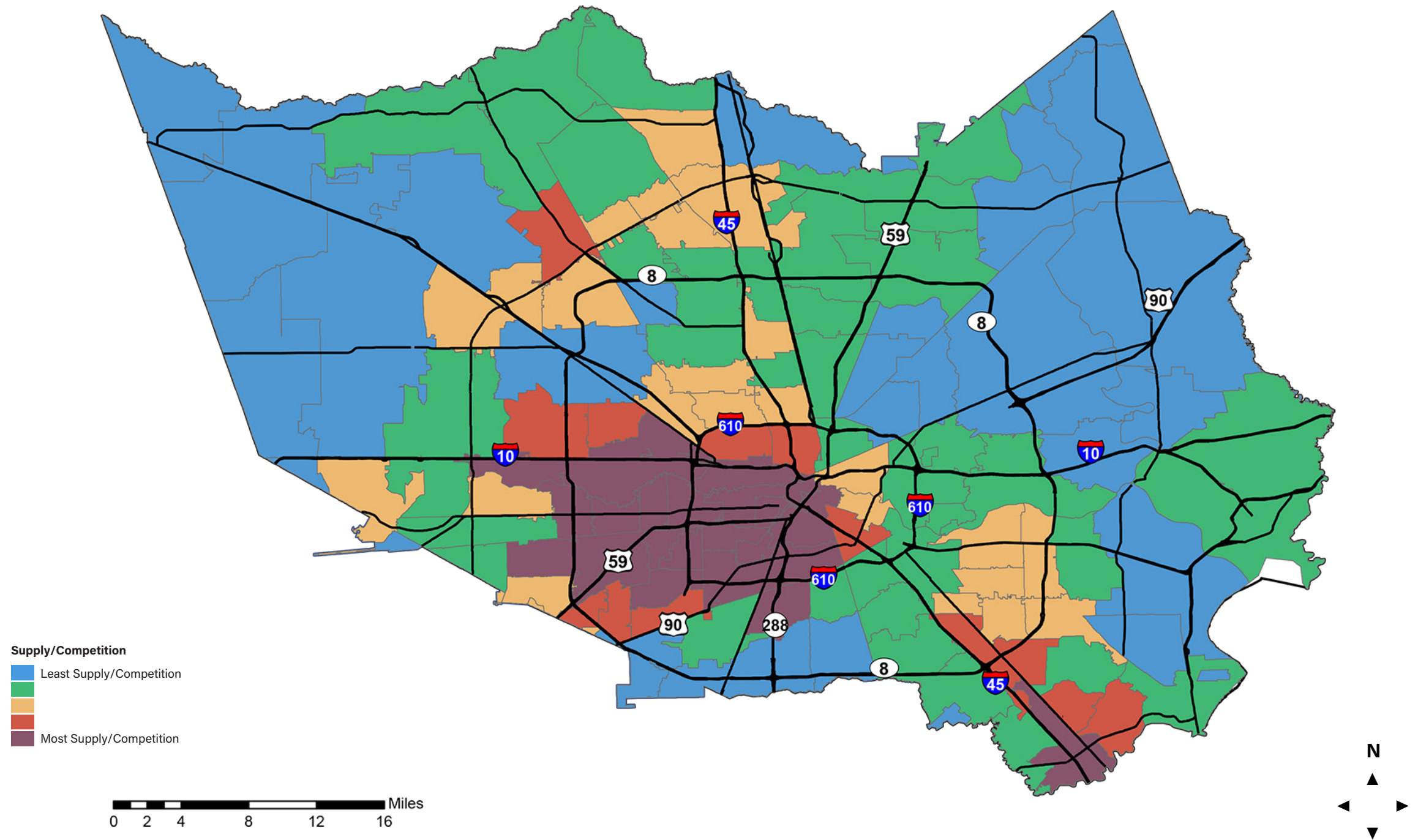
# Top 20% FQHC Patient ZIP Codes (31 ZIP Codes)



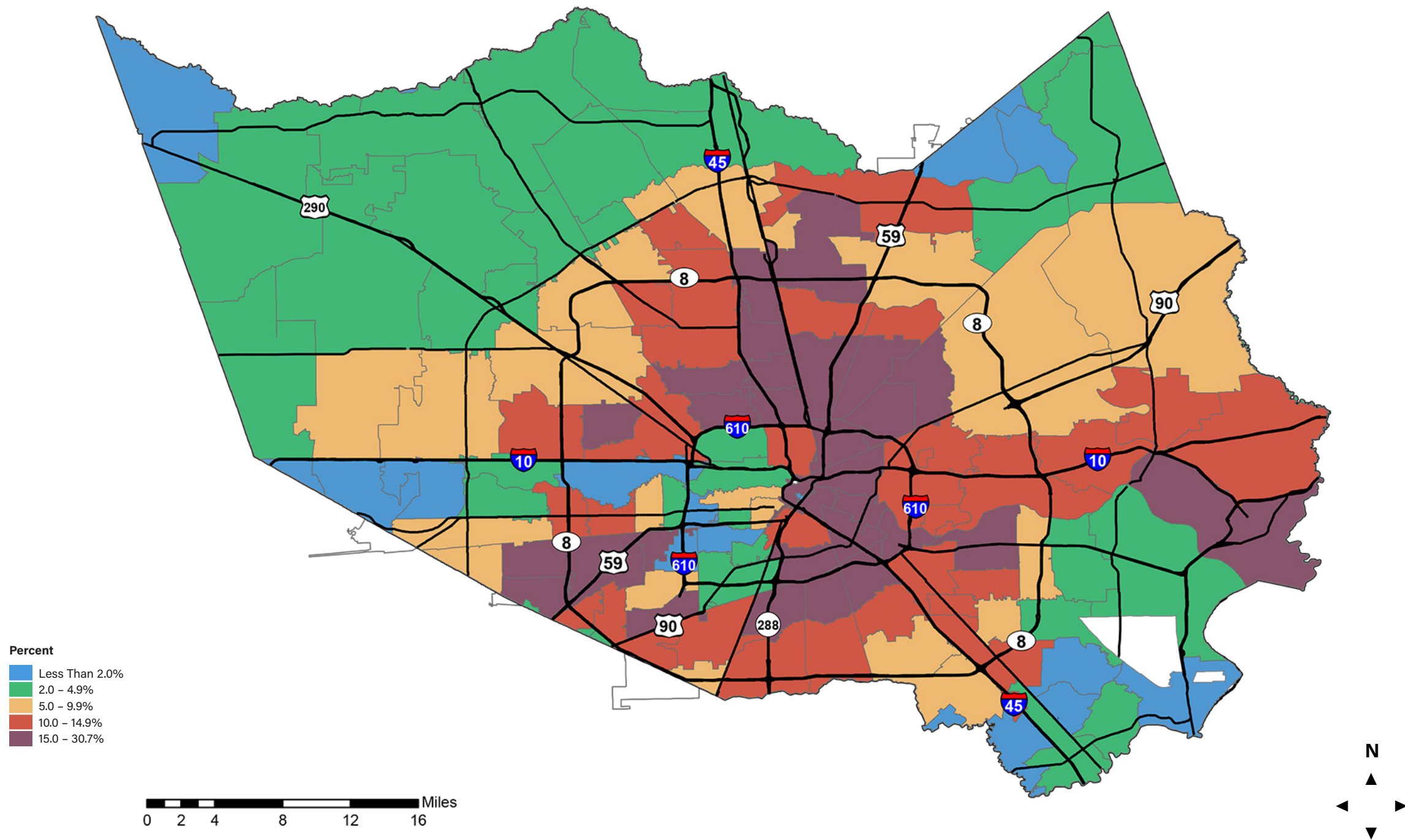
# Highest Demand



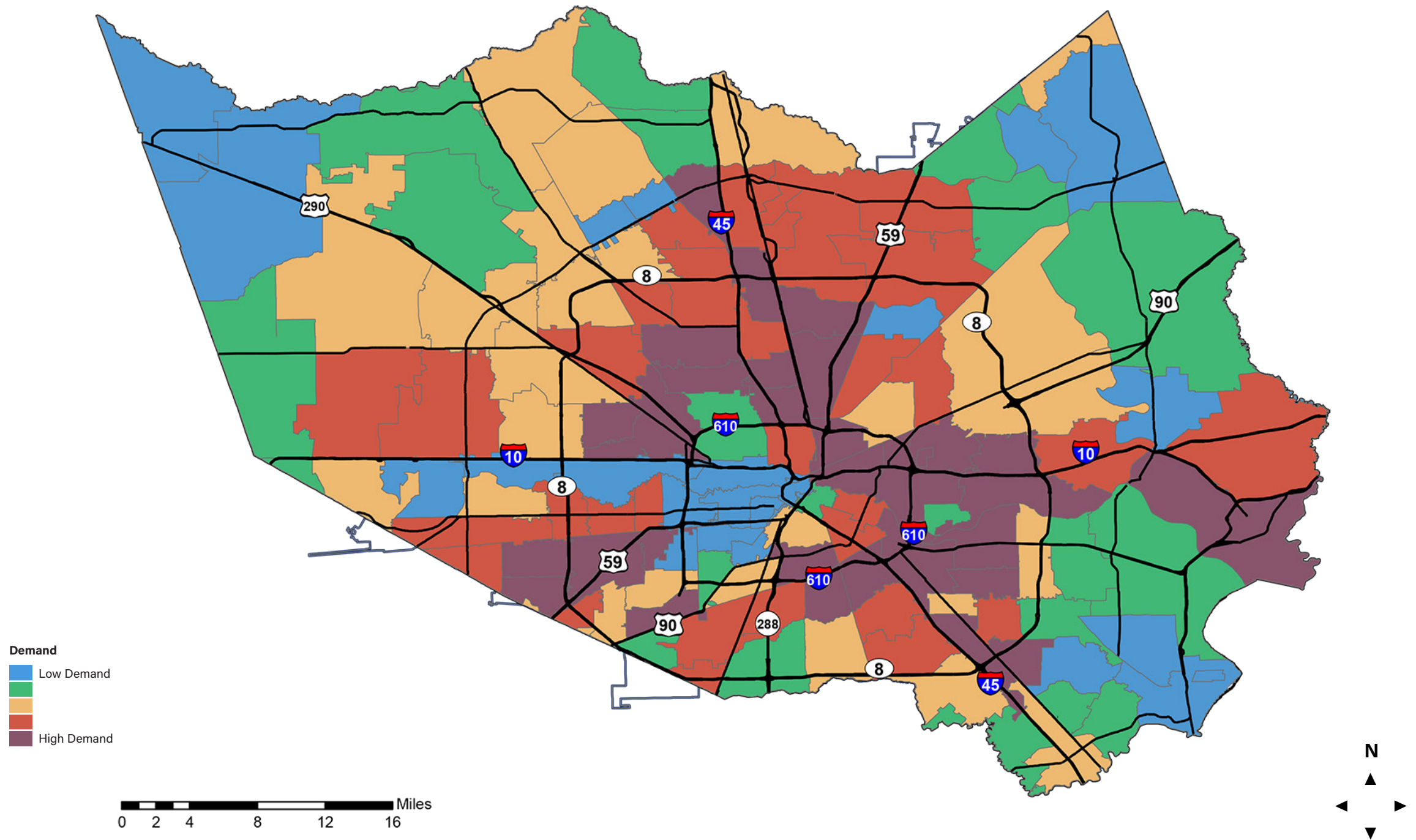
# Supply and Competition



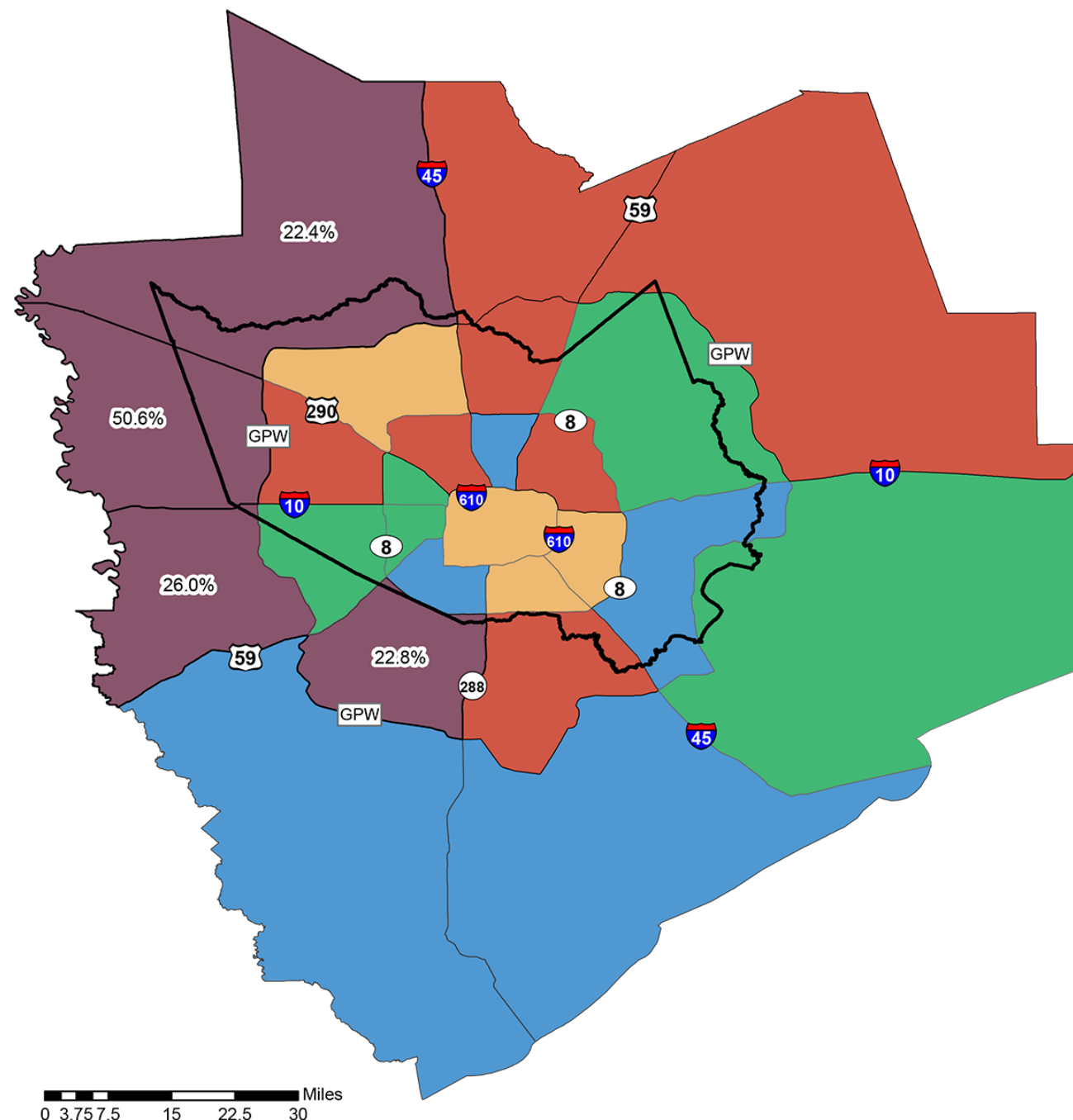
# Percent of Total Population Using Safety Net Clinics



# Highest Demand

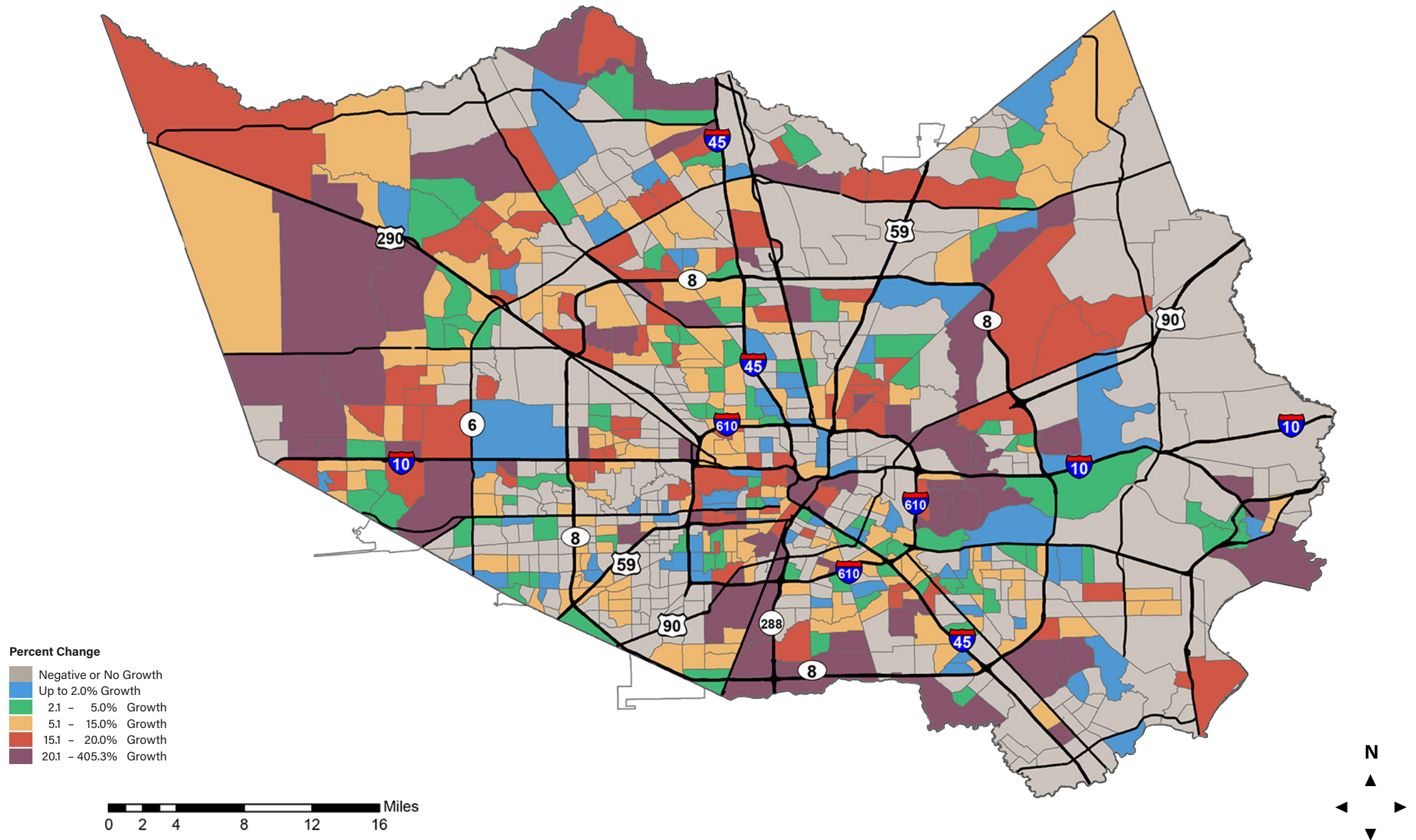


# Percent Population Change Between 2016 and 2020 Houston Metropolitan Area, HGAC 25 Sectors

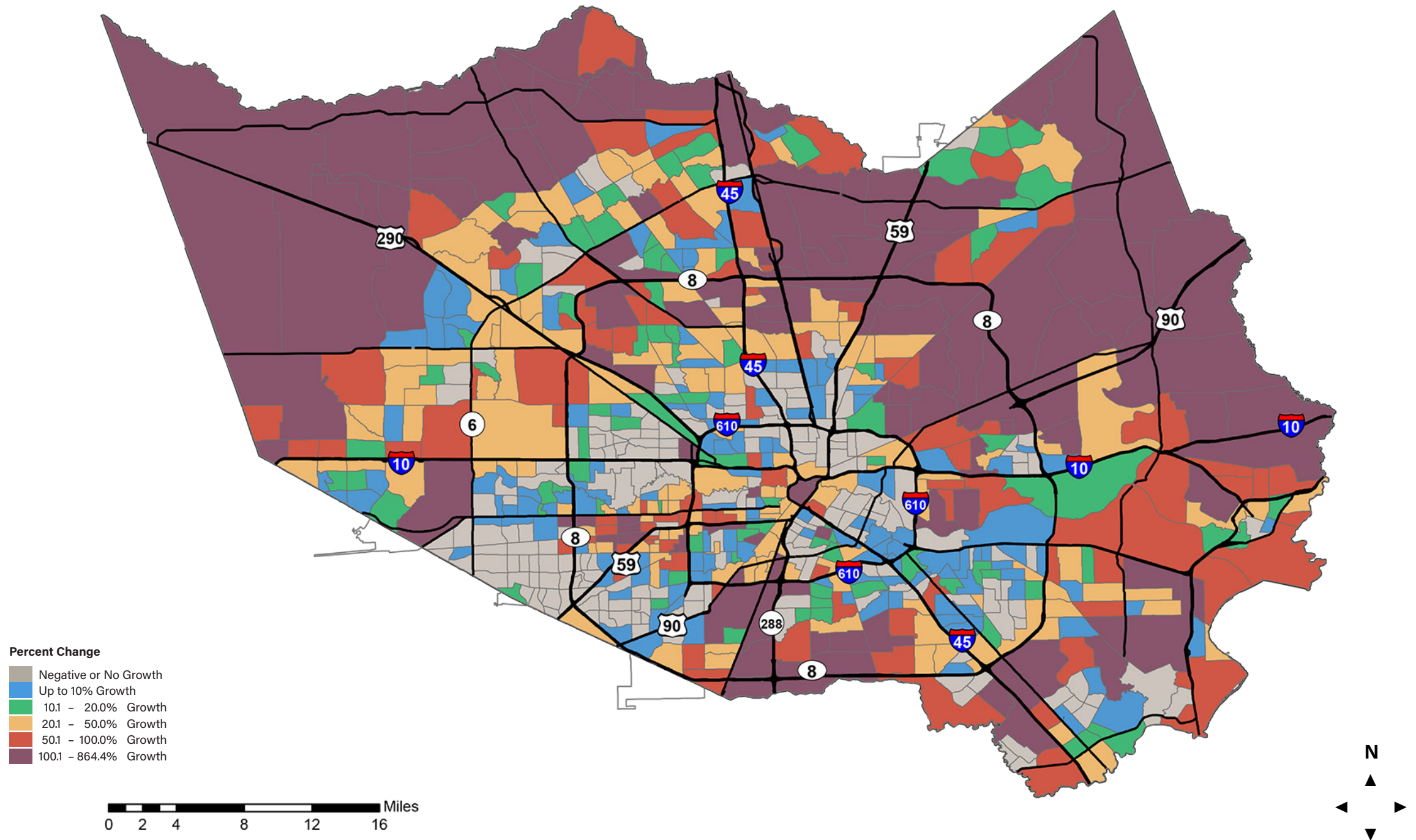




# Percent Population Change Between 2016 and 2020 HGAC Harris County Census Tract Projections



# Percent Population Change Between 2016 and 2040 HGAC Harris County Census Tract Projections



# Expansion and Sustainability

