



# Analysis of the Financial Sustainability of Rural Health Centers in Northeastern California

## **INTRODUCTION**

Health centers serving rural and frontier communities are a vital component in the delivery of primary health care services. These health centers are often the only providers of care in the region. Without them, residents would have no other options for primary health care, causing poorer health outcomes and increased emergency room utilization. As the national health care environment evolves into a more integrated system that attempts to address the multitude of factors affecting quality of life, health centers by design are structured to provide an array of services that specifically cater to the complex needs of patients. Primary care, behavioral health, oral health, sufficient transportation, needs of special populations, social determinants, legislation, workforce, government policy, and technology are all key factors that must support and improve one another under a changing reimbursement system that understandably strives to reward improved outcomes over frequency of encounters. While this transformation is being heralded as seemingly unavoidable, health centers in rural areas are at increased risk of difficulty or even failure for a number of reasons.

In an effort to shed light on the financial and operational factors that impact rural health centers in an era of health reform and identify opportunities to ensure financial sustainability, Capital Link has prepared the following report highlighting the unique challenges confronting frontier and rural health centers in Northeastern California, in particular given the changing nature of the healthcare landscape. To better understand the rural performance issues of this region, the following analysis highlights data trends from the Health Alliance of Northern California (HANC), a network of nine health centers with 26 service delivery sites serving rural and frontier northeastern California. In collaboration with HANC, senior executives of member health centers, California Primary Care Association (CPCA) representatives, and other industry thought leaders, this report seeks to identify and document the following:

- The unique market and operational challenges faced by health centers in the provision of primary care services in rural and frontier communities.
- Considerations for rural performance from the anticipated market changes and planned payment reform on the already financially fragile health centers.
- Ideas and strategies for strengthening operations at rural centers and providing support systems to ensure their financial sustainability and their ability to provide ongoing access to quality care in the rural and frontier communities they serve.

## **FACTORS IMPACTING RURAL HEALTH CENTERS NATIONWIDE**

Just over 19% of the U.S. population lives in rural or frontier areas<sup>i</sup> and health centers serve one in seven of those residents. The sustainability and vitality of many rural communities rests upon its health care delivery system. Rural health centers are often among the largest local employers, yielding more than \$5 billion annually in economic returns.<sup>ii</sup>

## **U.S. Rural Health Center Challenges:**

Residents in rural areas experience many of the same barriers to health care that affect underserved communities in urban areas—including cost, language, and transportation—however, there are several others that are specific to this population as outlined below.

**Patient Access:** Distance and limited public transportation options often make access a challenge for rural centers to monitor their patients, as well as for patients to receive on-site care. Many rural centers also lack appropriate specialty care services, including critical diagnostic services such as colonoscopies and cervical cancer screenings, among others. The distance to travel to the testing and specialty services can put them out of reach of some patients.<sup>iii</sup>

**Patients Require More Complex Care:** Compared to urban areas, rural areas are more likely to have a larger elderly population, higher rates of poverty, elevated uninsured rates, and higher rates of chronic medical conditions, disability, and mortality.<sup>iv</sup> For example, Hispanic and East Indian patients often have difficulty with language and culture accommodations, causing delays in entering into any health care arena and more progressed modalities. These patients in turn require more frequent visits to treat and monitor conditions. Furthermore, the teen birth rate is almost 50% in rural areas compared to 39% in urban areas. Also, the rural childhood obesity rate is 25% compared to 19% in urban areas.<sup>v</sup>

**Provider Shortages:** Thirty-seven percent of rural residents report having no access to a primary care physician compared to 21% of urban residents. Rural areas have about 68 primary care physicians per 100,000 people, compared with 84 physicians in urban centers<sup>vi</sup>. Recruitment and retention of qualified medical staff, in particular medical provider staff, is a big challenge for rural health centers. Not only does the limited supply of providers inhibit patient access, it also results in increased operating costs as health centers must compete with each other through increased compensation and/or use more expensive temporary providers.

**Demographic Shifts:** The U.S. has experienced an ongoing demographic shift from rural to urban areas. Between 2009 and 2013, more than 50% of rural counties in the U.S. saw a decline in population.<sup>vii</sup> This continuing trend is the result of fewer births coupled with outmigration<sup>viii</sup>. The younger generations are moving out of the region to seek jobs in more urban and suburban areas. In many cases, even aging rural residents are moving to more populated areas for retirement.<sup>ix</sup>

**Productivity:** Currently health centers are reimbursed based on the volume of billable patient care visits generated by the eligible primary care providers on staff. Higher visit productivity therefore leads to more patient revenue, while lower visit production has the opposite effect. Such measures in rural areas can be affected by shifts in population, a small change in provider services, or even increased competition. Provider productivity in rural clinics can also be impacted by the various patient access and workforce constraints described above. It is interesting to note that the utilization data available from the Uniform Data System (UDS)

shows that medical provider productivity in terms of visits has decreased across the board in California since 2011, which may be at least partially driven by the implementation of electronic health records and team-based care as parts of national health reform.

**Small Size:** Rural health centers tend to be among the smallest, and smaller health centers struggle more with financial viability than larger ones. The 2016 Capital Link study, "*Hallmarks of High Performance: Exploring the Relationship between Clinical, Financial and Operational Excellence at America's Health Centers*," found that larger clinics tend to have stronger operating margins and perform better on other key financial metrics. Larger-sized clinics have the benefit of economies of scale to help them deliver strong clinical outcomes while maintaining financial stability. <sup>x</sup>

**Financially Fragile:** In general, rural health centers tend to have weaker financial and operating profiles than their urban counterparts. Capital Link's study, "*California Community Health Centers: A Financial and Operational Performance Profile, 2010-2013*," found that larger clinics tend to financially outperform smaller clinics and clinics in rural areas are generally smaller than urban health centers. In particular, rural clinics have been shown to have lower profit margins and less cash reserves than urban centers, jeopardizing their long-term financial sustainability. <sup>xi</sup>

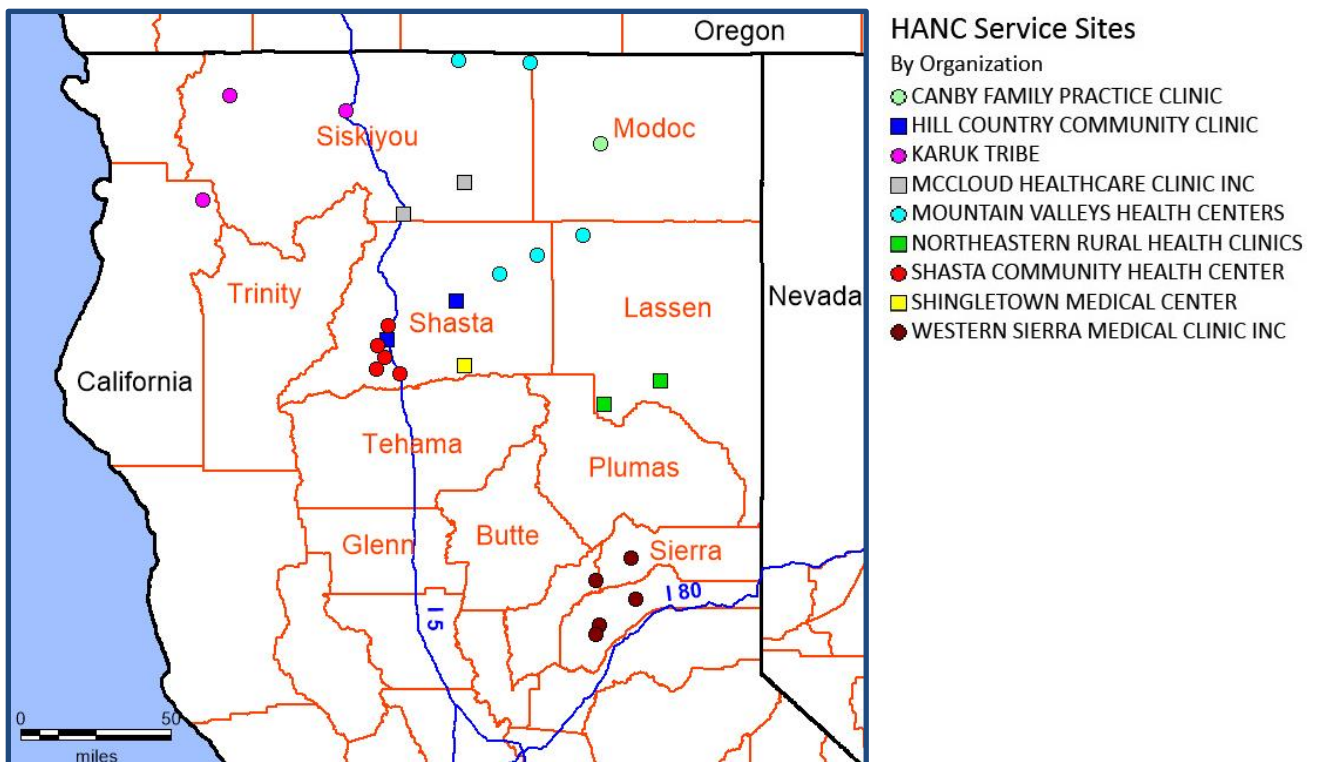
**Workforce and Staffing Costs:** The recruitment of skilled staff and providers is a fundamental challenge for rural health centers, which may often have to pay a premium in order to attract qualified personnel to their remote locations. This results in higher overall personnel costs and lower operating margins. The retention of existing staff is a related challenge given how difficult it is to replace them. The operating capacity of small clinics in particular can be severely hindered by the loss of just a single provider, which can result in severe financial disruption given the lack of healthy operating reserves for most rural health centers.

**Liquidity:** The more recent Capital Link study found that rural health centers continue to operate with less liquidity than their urban counterparts. At the median, rural health centers operate just above the minimum recommended level of 30 days cash reserves; however the bottom 25% of rural health centers struggle with under 17 days of operating cash. In 2012, urban health centers increased their median operating performance to 3%, up 1% from the prior year, while the median performance for rural centers declined to 1% from 2%.

**Revenue and Cost per Patient and per Visit:** The earlier Capital Link study showed that rural health centers had a higher average cost and revenue per patient compared to urban centers. They also saw patients more frequently, generating 3.7 visits per patient per year on average versus 3.2 visits per year for urban clinics. For urban health centers, patient revenue covers 67.4% of the cost of care, while for rural centers it covers 64.7%.

## A Closer Look: FACTORS IMPACTING HEALTH CENTERS IN RURAL CALIFORNIA

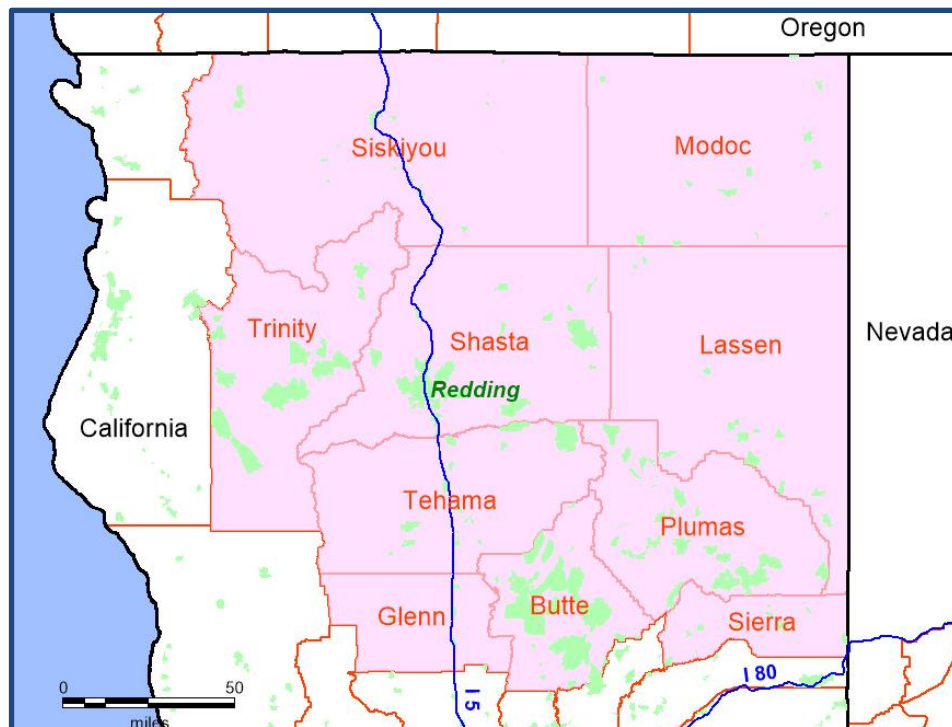
The Health Alliance of Northern California (HANC) is a network of nine non-profit community health centers with 26 service delivery sites that provides care to over 80,000 rural community residents. HANC’s member organizations include FQHCs, rural health clinics (RHCs), and Indian Health Centers in the far northern central and northeastern counties of California. With the exception of one FQHC and a few service delivery sites in the city of Redding, HANC member clinics predominantly service the rural communities and populations of the region, and several of the members are considered to be “frontier” clinics (see Appendix for full list).



As part of its programmatic collaboration with HANC, Capital Link collected financial and operating data from seven of the rural health centers operating 18 sites throughout the northeastern California region. The urban health center headquartered in Redding was excluded from the data set. A detailed quantitative and qualitative analysis of the centers provides helpful context for better understanding rural health centers overall.

## HANC Challenges:

**Geography:** Large and sparsely populated, rural Northern California has characteristics that hinder patient access to care. Much of the geography is mountainous, making travel to and from medical appointments difficult, particularly in the winter months when weather conditions can be severe and many roads are closed. The delivery of health care services is further complicated by the limited public transportation options available. These geographic realities affect operational productivity because it is not possible to backfill no show appointments and cancellations, for example.



### Health Alliance of Northern California

- General Service Area
- County Boundaries
- Incorporated Places
- Interstates/Highways

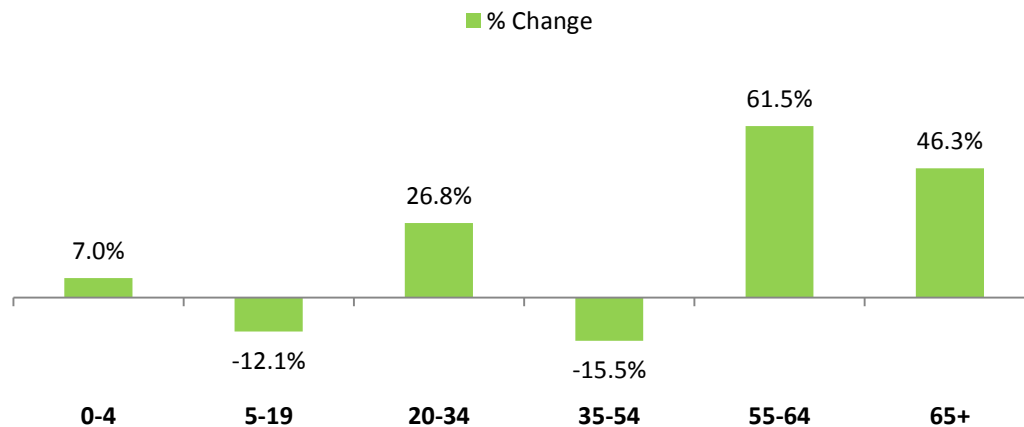
**Demographics:** Many small and rural communities in the region continue to struggle with low or even negative population growth. The region, representing 10 counties encompassing an estimated 28,000 square miles, is characterized by relatively stagnant population growth. The region experienced a very small overall population increase of less than 1% over the most

recent five-year period. The city of Redding represents roughly 15% of the regional population, and its urban population grew slightly faster than that of the outlying areas.

Regional Population of Rural NE California Counties <sup>1</sup>	2010 Census	2015 Est.	% Change
Regional Population of Rural NE California Counties <sup>1</sup>	615,325	618,252	0.5%
Population of Redding (Shasta Co.)	89,860	90,997	1.3%

Much of the decline can be traced to the outmigration of younger residents, including families. Notably, many school districts in the region have reported declining school enrollment figures. The percentage of older residents will continue to increase at a faster rate than the younger age groups, and notably both school age residents and the 35-54 age group will continue to shrink. This trend indicates the disproportionate concentration of older residents in the region, one that typically has more chronic and complex health care needs.

**Projected % Change in Population by Age Group for 10 N.E. Cal Rural Counties (2000-2020)**



This region also has a significant Latino/Hispanic population, which can present issues for HANC clinics related to communication and culturally appropriate care that affect operations. Often translation and interpretation services are essential to providing care to patients who have English as a second language. Though some managed care companies are beginning to offer telephone interpretation services, their focus has historically been in urban areas and only for their members. Also, while already challenging to recruit an adequate number of providers to rural areas, securing those that speak Spanish is even more difficult. Finally, due to the large number of migrant workers in the region, and the transient nature of their jobs, there is a growing consideration to provide care that satisfies the cultural needs for such groups, including Punjabi/East Indian patients.

<sup>1</sup> Includes Butte, Glenn, Lassen, Modoc, Plumas, Shasta, Sierra, Siskiyou, Tehama, and Trinity counties.

**Economy:** The rural counties of Northern California have significantly higher unemployment rates (7.3% to 13.9%) compared to state averages (5.8%).<sup>xii</sup> This region was particularly devastated by the recession, which was followed by a statewide drought and regional forest fires. All of these factors directly contribute to the region’s higher unemployment rates, outmigration, lower household incomes, and loss of economic activity.<sup>xiii</sup>

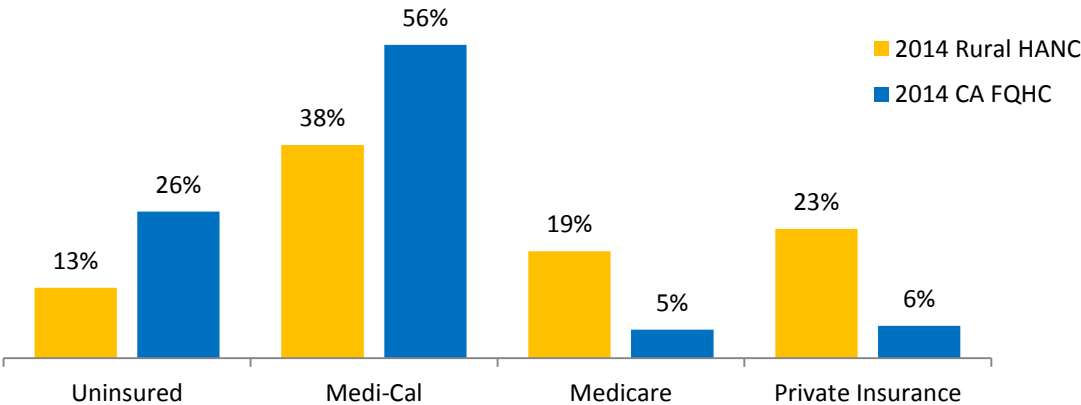
**Size:** HANC clinics are smaller on average, leading to additional operational and financial challenges. Smaller health centers, particularly those located in remote communities, tend to struggle to reach breakeven operating performance, and the continued operations of satellite clinics may be only viable if subsidized by a larger, more centralized main site.

A deeper analysis of the financial and operational profile of the HANC group demonstrates additional challenges as follows:

**Less Financially Favorable Payer Mix:** HANC health centers experienced growth in the Medi-Cal patient population, increasing from 27% of total patients in 2011 to 38% in 2014, directly resulting from the state’s insurance expansion. This shift is financially significant as Medi-Cal remains the best payer for community health centers due to the enhanced (cost-based) reimbursements received for providing comprehensive primary care services. However, the region has a relatively smaller Medi-Cal population compared to other more urban areas in the state, which puts the HANC clinics at a comparative financial disadvantage.

The median payer mix for HANC clinics also differs from statewide averages in terms of higher Medicare and privately insured patient populations. Medicare patients represent an older demographic, which is typically a more clinically complex and expensive population to manage. In addition, the reimbursement for services provided to patients with private commercial insurance is usually much lower than the comprehensive rates paid by the Medi-Cal program.

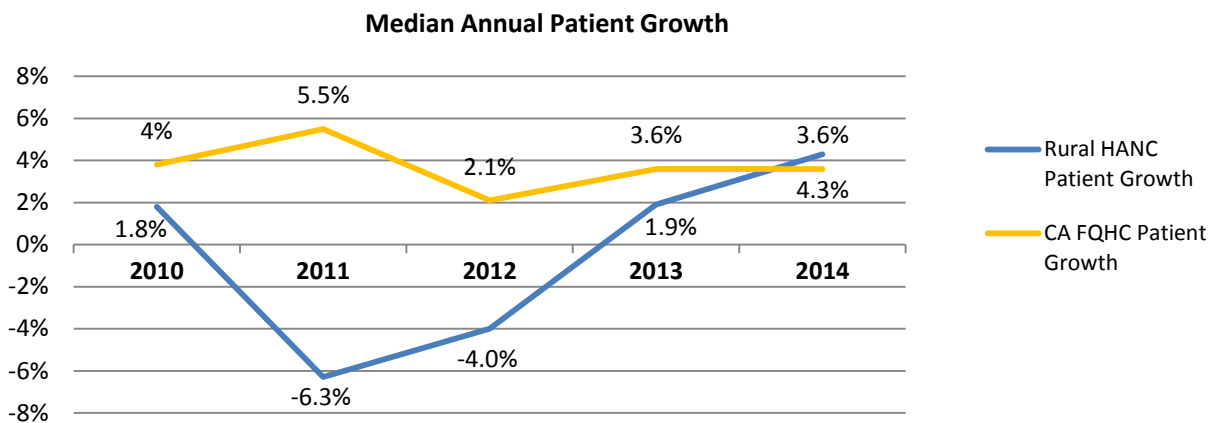
**2014 Patient Payer Mix: HANC Clinics vs CA (medians)**





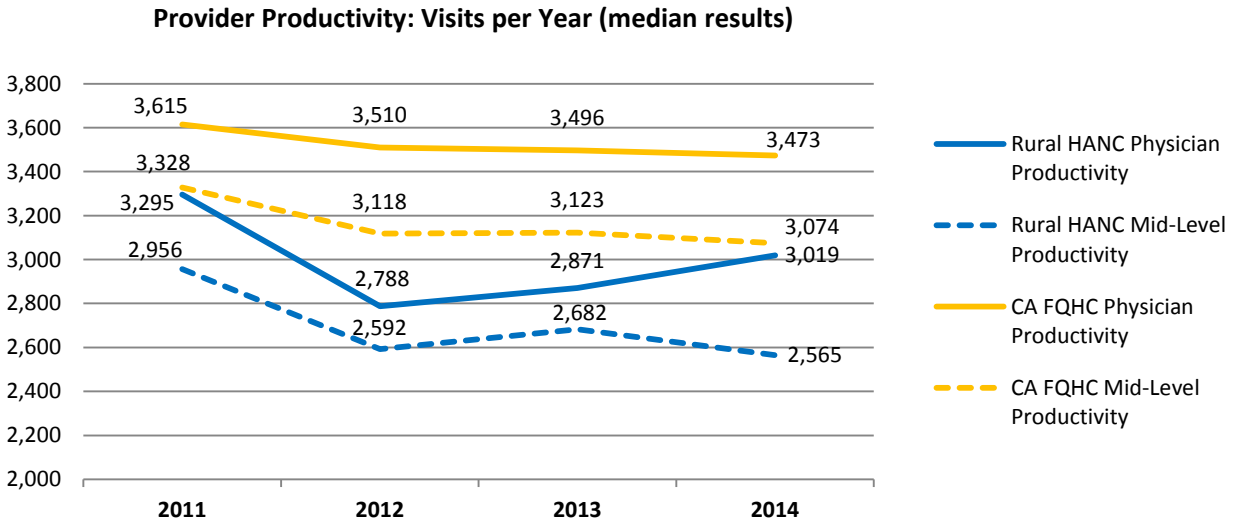
**Provider Shortages:** The expansion of Medi-Cal has put a greater strain on providers in the area. The additional insurance coverage does not guarantee that there are providers available or willing to see the newly insured. Provider recruitment and retention has been a long term challenge for rural and frontier health centers, and the newly insured have put additional strains on service capacity. Several practices have been closed to new patients. Between December 2013 and February 2016, Shasta County went from 39,000 Medi-Cal patients to 62,000<sup>xiv</sup>, indicating that providers in that area are already experiencing a burden. The shortage of providers in rural Northern California has directly impacted the ability of the health centers in the area to effectively manage the health of their assigned patient populations, which in turn affects the quality of patient outcomes and ultimately the ability to obtain grants for quality improvement.

**Utilization:** Despite declining populations affecting rural communities as a whole, HANC health centers experienced a recent improvement in patient growth of 4.3% in 2014, exceeding even the median growth rate for their statewide peers. This recent improvement, driven by state health reform initiatives such as Medi-Cal insurance expansion, contrasts starkly with declining patient growth in 2011 and 2012. Perhaps the reinstatement of adult dental coverage within the Medi-Cal program has been a source for new patient demand, especially given the lack of dental options in rural communities. Given the capitated environment of the Medi-Cal program, it will become more important for health centers to continue to provide quality care and improve patient health by effectively utilizing existing resources, while also reducing patient utilization (office visits).

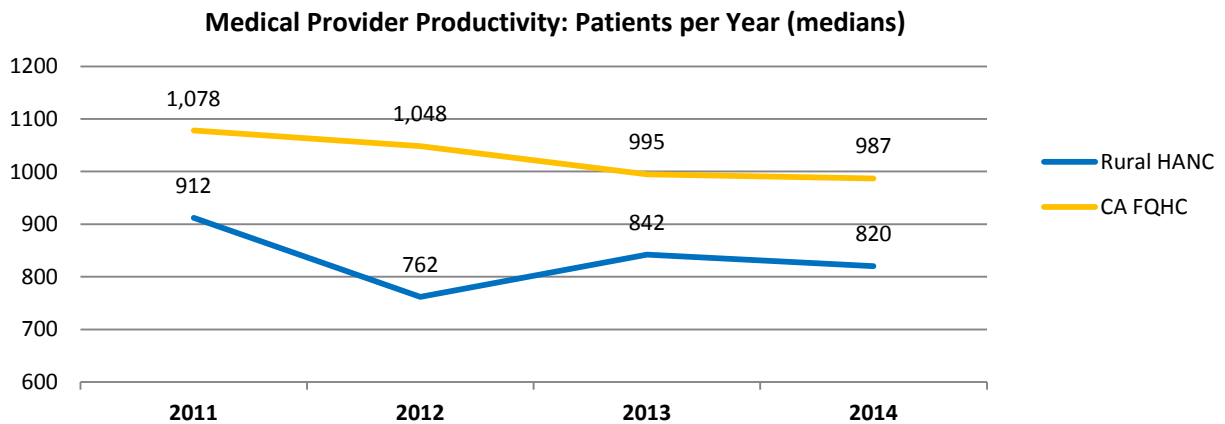


**Productivity:** During this period of operational and financial transformation for health centers, driven by national health reform, HANC rural health centers experienced larger declines in productivity than their statewide peers and remain below median statewide levels. However, more recently, there has been some recovery in annual visit productivity for HANC health centers. Though physician visit (median) performance has been climbing since 2012, it remains below 2011 levels, while mid-level provider productivity (median) again dipped in 2014 after showing some improvement in 2013. Some of this patient visit productivity loss is expected to be recovered due to changes in practice models that allow for more mid-level provider visits as

well as continued adoption of electronic medical records. Generally, productivity is strengthening if established patients are having better outcomes with fewer billable encounters using a variety of interventions that do not necessarily increase the number of face-to-face billable encounters.

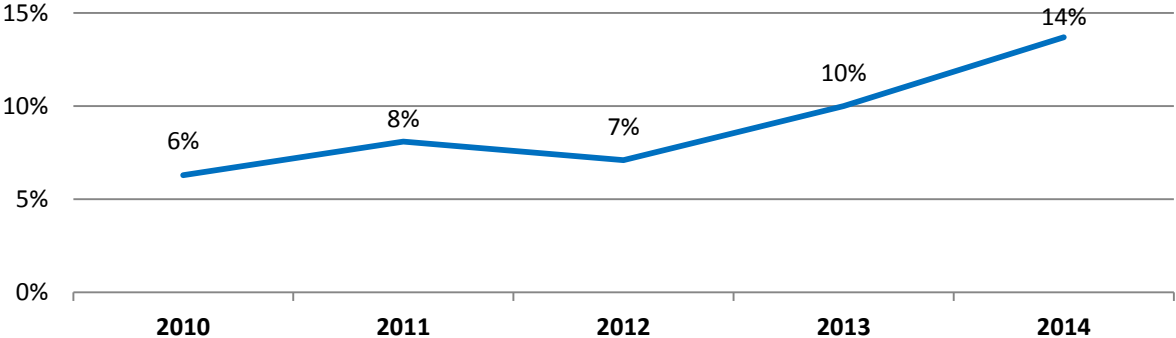


As mentioned earlier, the transition to managed care for the Medi-Cal program, with its capitated payments for each assigned member, shifts the responsibility of care on the health center due to the fixed per-member per-month payment model. Therefore, it is becoming increasingly important to look at productivity not just in terms of visits generated per year, but also by the number of patients managed by each provider. The health centers of the region have lower patient per provider productivity levels, which can be largely explained by the access challenges faced by rural populations described above.



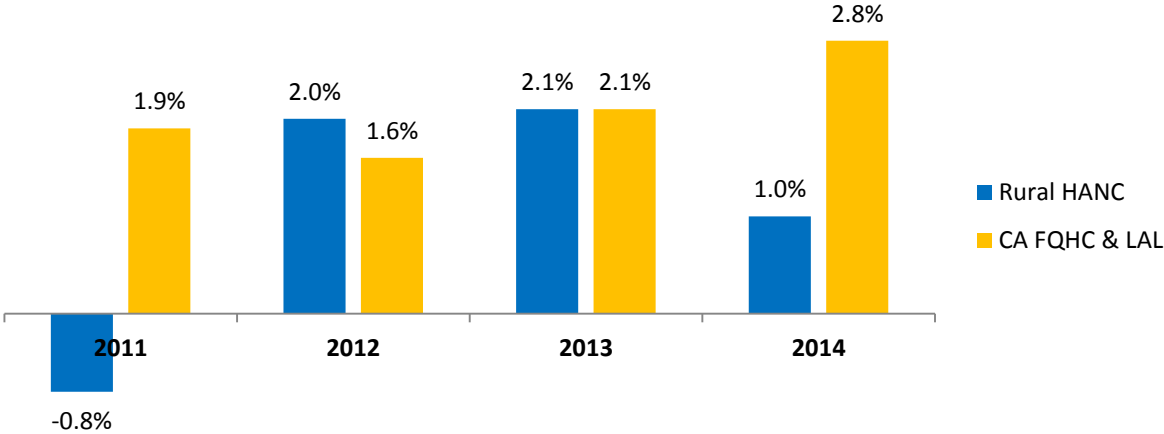
**Financial Performance:** Despite the demographic, geographic, and productivity challenges noted above, the HANC rural community health centers experienced relatively high growth in terms of patient revenue as a result of the insurance expansion, including double digit growth in the most recent two years. In addition to the increase in revenue from the growing Medi-Cal patient base, the health centers of the region also benefitted from other health reform initiatives such as quality improvement grants and behavioral health integration grants.

**Rural HANC Clinics: Net Patient Revenue Growth (median)**

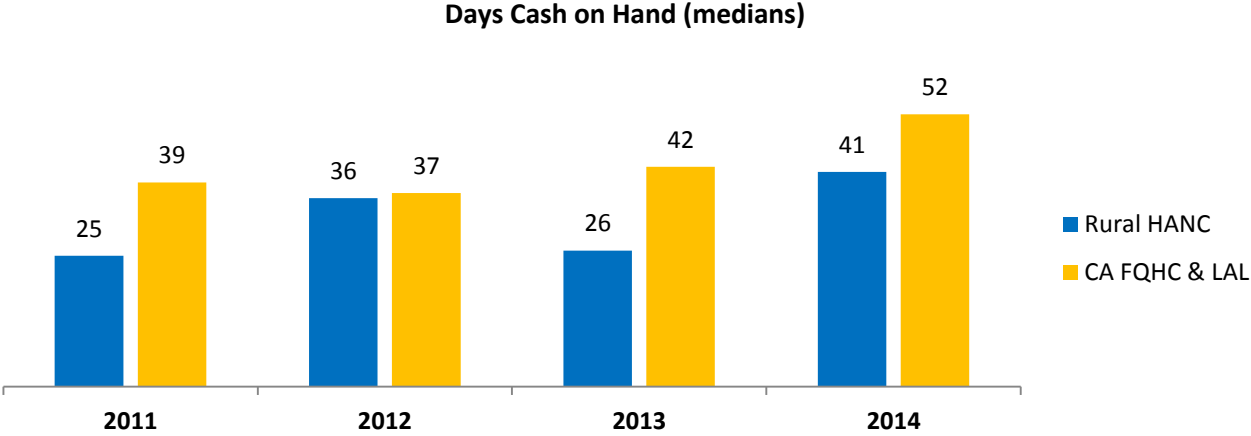


- Operating Margin** - Despite this growth in patient revenue, financial sustainability is dependent upon generating sufficient operating revenue to cover the costs of providing care to the targeted populations. In 2014, the median operating margin for the group of rural health centers in Northern California was 1.0%, or just above a break even performance level. However, three of the eight rural clinics in the region generated negative operating margins in 2014, a performance level that is not sustainable over the long term.

**Median Operating Margin**

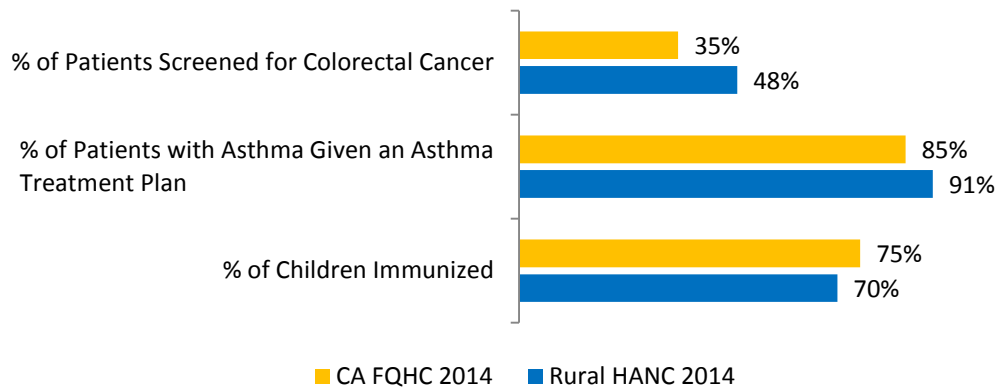


- Liquidity (Cash Reserves)** - Despite the tight operating margins, median days cash on hand improved in 2014 to 41 days, the minimum targeted benchmark level, from 26 days the prior year. The recent improvement is at least partially due to the Medi-Cal expansion, resulting in more patients with a payer source with which to bill for services, and more consistent cash flow due to the fact that Medi-Cal patients have been transitioned to a managed care program with fixed per-member per-month payments. The regional health plans grants to incentivize quality improvement as well as behavioral health integration have also helped to improve the financial position of regional health centers. Nevertheless, two of the clinics from the group still had less than 20 days of cash on hand in 2014, well below the minimum target benchmark of 30 days, limiting their ability to expand operations to meet increased demand.



**Quality Measures:** Despite the challenges of providing primary care services in a rural environment, the HANC clinics have demonstrated the ability to perform well across several quality-of-care metrics, including the Healthcare Effectiveness Data and Information Set (HEDIS) performance measures. Patient outcome measures as reported to UDS in 2014 show median performance of this rural clinic group to be relatively consistent or even better than their statewide peers.

### Rural HANC Clinics vs CA FQHC Quality Metrics (2014 medians)



It is important to put these quality results into context. As mentioned earlier in this report, rural health centers are often unable to provide appropriate access to appropriate specialty care due to lack of specialists, including critical diagnostic services, and this is reflected in the results illustrated in the chart above.

### PAYMENT REFORM CONSIDERATIONS

Focusing on providing high-quality care more efficiently becomes even more important considering payment reform since revenue will be derived from the number of healthy patients rather than the number of patient encounters. As health centers transition from fee-for-service environment to a capitated environment, it will be important to:

- **Achieve adequate reimbursement** - Carefully negotiate payment rates to ensure that the costs associated with system transformation—whether through visits or other means of care—are reimbursed under any new payment methodology. Also negotiate with payers for supplemental payments for specialty services for complex patients.
- **Reevaluate the role of productivity** - In a fee-for-service environment, productivity drives revenue, while in a capitated environment, visits drive costs. Health centers will need to analyze their own data to determine when a certain type of patient interaction or number of visits (or a combination) becomes an expense rather than revenue.
- **Develop new methods of patient interaction** - Traditional face-to-face encounters will no longer be the most financially effective means of communicating with patients, especially in rural areas where transportation is a barrier. Tele-health, telephone, mobile apps, wearable technology, and improved communication between health systems and additional provider types will all play a role in these service delivery models.

These changes require purposeful operational investments, whether they are due to a new payment methodology, a new billing procedure, a new electronic health record system, a new location, a new provider, or enhanced services. Efforts are reflected in patient outcomes and satisfaction, so implementing a reliable data collection and analytic system, and encouraging an organizational culture that acknowledges and respects the data's impact on the organization is essential to accurately assess impacts.

The tracking of patients and their health statuses as expected within payment reform offers its own challenges. Patients are assigned to managed care plans, which in turn assign them to a provider who is responsible for their care. Providers have the task of ensuring not only that their patients are aware of the health center's services and are receiving quality care in that setting, but that patients also understand that they must take responsibility for maintaining their health when they are away from the health center. This requires a great deal of communication between all parties and a willingness to share in the challenges as well as the rewards<sup>xv</sup>.

### **Suggestions for Strengthening Rural Community Health Centers:**

While several concerns and challenges have been presented, there are possibilities and methods that can alleviate some of the uncertainties, reduce the number of impractical options, and specify some actions that health centers can support and build upon. One acknowledgement that should be made is that many health centers and systems were already struggling with many of these concerns prior to health care's payment reform. While this fact does little to rectify the concerns, it does imply that rural health centers may not be worse off and could take advantage of the changes to replace, revise, rebuild, or renew their practices. Below are some opportunities available to mitigate the transitional period:

- **Payment reform pilots, research, and experiments** - There are ongoing efforts to establish service delivery models and benchmarks that will guide the next stage of changes. HANC has already seen success in forging relationships with engaged health plans, such as Partnership HealthPlan of California, that has provided quality grants, funding for recruitment and retention, etc. Health centers should stay informed and also be keenly aware of their operational capacities, strengths, and weaknesses in order to confidently work with governments, managed care plans, other health systems, and their communities in determining the best course of action.
- **Outreach and education** - Health centers are uniquely qualified to help the growing number of insured populations who may need guidance in navigating health care opportunities and delivery. Marketing to these newly insured patients as well as reengaging with previous and current patients could ensure a financially sustainable patient base.
- **Negotiating for a more stable cash position** - While some financial arrangements with payers may appear to be somewhat fixed, given the fluctuation of reimbursement structures, a negotiated cash flow with the possibility of maximizing incentive payments

could provide a more stable cash position. Alternative methods of care, such as shifting responsibilities to mid-level providers and transitioning to team-based care, will likely reduce the burden on physicians and other highly skilled providers alleviating some provider shortage concerns and potentially reducing personnel costs.

- **Revenues from alternate sources** - Some of the country's most successful health centers bring in revenues through a spectrum of alternate methods such as PACE, pharmacy, behavioral health, etc. Given that many rural communities have more elderly patients, this might be an opportunity as well.
- **Targeted trainings and coaching to strengthen team-based operations** - Specific education and discussion on enhanced productivity, building optimal care teams, strategic growth planning, financial modeling, staff development, succession planning, and many other relevant topics could provide the surroundings to best facilitate learning.
- **Shared services with other providers** - Shared purchasing agreements, billing and collection, financial services, affordable care organizations, and specialty care may help reduce expenses, provide additional revenue efficiency, and lessen the burdens of key staff.
- **Mergers or acquisition of similar organizations** - In some cases, it may benefit smaller centers to align communications and resources. In fact, the Health Resources and Services Administration recently released guidance clarifying the activities around such decisions.<sup>xvi</sup>
- **Using data to track progress** - A greater use of data analytics may offer guidance in evaluating current operations, establishing breakeven points, determining appropriate benchmarks of care and operations, and benchmarking best practices. Health centers will need to overcome the challenge of disparate data platforms, but better integration and sharing of information should be a goal.
- **Monitor staff satisfaction** - To ensure care teams are working toward a common goal, it is essential to stay true to organizational mission, establish and communicate goals, and be sure to celebrate successes no matter how small and seemingly insignificant. Acknowledgement of a job well done encourages healthy competition, coaching of co-workers, and the guiding of the team to and through changes. Higher staff satisfaction leads to less turnover and higher patient satisfaction, surely two of the metrics that will continue to become greater drivers in health reform.

### **Creative Approaches Applied in Other Rural Programs:**

Below are a few examples of health systems in rural areas that revised their operating models in response to specific problems. In these cases, initial, small successes led to larger improvements across their organizations.

- A rural health system in Minnesota began to focus on the social determinants of its patients' health and found that efficient care coordination and connections with local social services reduced the costs of its most expensive patients.
- A rural health association in Missouri created a multi-county transportation system that provides reliable access to health care locations otherwise out of reach for many of its constituents. While this particular area is not geographically similar to northeastern California, it does indicate a successful collaboration by partners sharing in a united service and goal.

## **CONCLUSION**

For many of the challenges facing rural health centers that are addressed in this report, there is no simple remedy. The primary focus remains: the patients. Although they have similar responsibilities and shared experiences, it is clear that each individual health center is unique. Each health center must analyze its day-to-day challenges and identify the issues that are at the root of those challenges in order to enact change. Rural health centers need to have an awareness and a willingness to collaborate with other organizations that have the appropriate experience and resources. While respecting distinctive structures and personalities, mutual sharing and learning can be a significant tool in alleviating unnecessary learning curves and burdens.

The recognition of resources and productive operational methods has not been lacking in rural health centers. Many of the findings and suggestions in this report are not new but within this volatile climate, it is productive to build off those labors using a mix of innovative and familiar techniques to not only sustain but expand these health centers. This could be compared to a craftsman who utilizes recycled tools and materials to build a new product. Rural health centers are a product of that kind of determination as evidenced through a perseverance to succeed according to their high standards of caring for their communities.



## **Capital Link**

Capital Link is a national, non-profit organization that has worked with hundreds of health centers and Primary Care Associations for over 15 years to plan capital projects, finance growth, and identify ways to improve performance. We provide innovative consulting services and extensive technical assistance with the goal of supporting and expanding community-based health care. Established in the late 1990s as a joint effort of the National Association of Community Health Centers (NACHC), several state-based Primary Care Associations (PCAs), and the Bureau of Primary Health Care, Capital Link grew out of the community health center family and continues to support it through creative capital development and analytic activities. For more information, visit [www.caplink.org](http://www.caplink.org).

## **Blue Shield of California Foundation**

Blue Shield of California Foundation (BSCF) is one of California's largest and most trusted grantmaking organizations. BSCF focuses its support in two program areas: Health Care and Coverage and Blue Shield Against Violence. The foundation's mission is to improve the lives of all Californians, particularly the underserved, by making health care accessible, effective, and affordable, and by ending domestic violence. For more information, visit [www.blueshieldcafoundation.org](http://www.blueshieldcafoundation.org).

## **Health Association of Northern California**

The Health Alliance of Northern California (HANC) is a network of community health centers working to promote the health and well-being of our communities in rural, Northern California. HANC's member organizations include Federally Qualified Health Centers (FQHC's), Rural Health Clinics, and Indian Health Centers in north central and eastern California.

## **Special Contributors**

Capital Link greatly appreciates the HANC community health centers that provided valuable input and shared data with us to complete this analysis – the grantees listed in the appendix. Special thanks to the following individuals for their contributions to this report:

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Meaghan McCamman  
Assistant Director of Policy  
California Primary Care Association

## APPENDIX

Sites represented in the map on page 5.

GRANTEE	SITE	CITY
Canby Family Practice Clinic	Canby Family Practice Clinic	Canby
Hill Country Community Clinic	Hill Country Community Clinic	Round Mountain
Hill Country Community Clinic	Redding Hill Country	Redding
Karuk Tribe	Karuk Tribal Health Yreka Clinic	Yreka
Karuk Tribe	Karuk Tribe of California	Happy Camp
Karuk Tribe	Orleans Karuk Medical Clinic	Orleans
McCloud Healthcare Clinic, Inc.	Dunsmuir Community Health Center	Dunsmuir
McCloud Healthcare Clinic, Inc.	McCloud Healthcare Clinic, Inc.	McCloud
Mountain Valleys Health Centers	Big Valley Medical Center	Bieber
Mountain Valleys Health Centers	Burney Health Center	Burney
Mountain Valleys Health Centers	Butte Valley Health Center	Dorris
Mountain Valleys Health Centers	Fall River Valley Health Center	Fall River Mills
Mountain Valleys Health Centers	Tulelake Health Center	Tulelake
Northeastern Rural Health Clinics	Northeastern Health Center	Susanville
Northeastern Rural Health Clinics	Westwood Family Practice	Westwood
Shasta Community Health Center	Anderson Family Health Center	Anderson
Shasta Community Health Center	Happy Valley Family Health Center	Anderson
Shasta Community Health Center	PCN Clinic	Redding
Shasta Community Health Center	Shasta Community Dental Clinic	Redding
Shasta Community Health Center	Shasta Community Health Center	Redding
Shasta Community Health Center	Shasta Lake City Family Health Center	Shasta Lake
Shingletown Medical Center	Shingletown Medical Center	Shingletown
Western Sierra Medical Clinic, Inc.	Western Sierra Medical Center	Grass Valley
Western Sierra Medical Clinic, Inc.	Western Sierra Medical Clinic	Downieville
Western Sierra Medical Clinic, Inc.	Western Sierra Medical Clinic (CoRR)	Grass Valley
Western Sierra Medical Clinic, Inc.	Town of Washington - Fire Station	Nevada City

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## SOURCES

- <sup>i</sup> United States Census Bureau, “Frequently Asked Questions,” *How many people reside in urban or rural areas for the 2010 Census? What percentage of the U.S. population is urban or rural?* <https://ask.census.gov/faq.php?id=5000&faqId=5971> (accessed February 2016).
- <sup>ii</sup> National Association of Community Health Centers, “Removing Barriers to Care: Community Health Centers in Rural Areas,” 2013
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