HEALTH CENTER CONTROLLED NETWORKS

Definition and Purpose

HRSA’s Health Center Controlled Networks (HCCNs) are networks controlled and acting on behalf of health centers as defined and funded under Section 330(e)(1)(C) of the Public Health Service Act and must consist of at least 3 collaborator organizations. The purpose is to ensure access to health care for the medically underserved populations through the enhancement of health center operations, including health information technology.

Mission

The mission of the HCCNs is to improve operational effectiveness and clinical quality in Health Centers through the provision of management, financial, technology and clinical support services. HCCN initiatives are typically focused in functional areas requiring high-cost and/or highly specialized trained personnel, procurement of large infrastructure systems or in functional areas where operational mass drives economies of scale.

History

HCCNs arose out of the health centers’ need to operate more efficiently by working together to form a business structure that would enable them to maximize the purchasing power of their limited dollars by sharing the costs of services. HCCNs, in their formation, are defined by the specific needs of the health centers in a given marketplace; therefore, HCCNs have a variety of organizational structures and areas of focus. As HCCNs mature, the cooperative skills developed through interaction with peers and the evolving needs of the health centers results in the addition of new functions in an effort to gain even greater economies. The more mature networks are known as Operational Networks, in which an essential mission critical function is performed at the network level, enabling the member’s center to perform its business and clinical operations more efficiently. This means that the activity is either shared or integrated at the network level and is not duplicated at the member/collaborator level. Operational Networks typically demonstrate the following characteristics: formal structure that has been in place for a minimum of two years (articles of incorporation, bylaws, etc…), existence of leadership structure and core network staff (e.g. exec. Management staff), a core function (administrative. clinical, finance, managed care and/or IS) is currently fully integrated and functioning for organizational members at the network level, evidence of outcomes achieved through the integration of the function, a strategic plan in place that outlines the long range (multi-year) goals and objectives of the network, and evidence of a declining dependence on federal funds for the network activities. Regardless of the maturity level of a network, there are two elements common to all networks – in terms of governance, each is majority controlled by health centers (or FQHCs), and there are high levels of collaboration among network members.

Activities

The majority of HCCNs are heavily engaged in clinical quality improvement and technology due to the skill sets and equipment backbone required to efficiently deploy and manage sophisticated technology to its health center members. Below are the examples of core areas and functions that HCCNs provide, based on the needs of the health centers.

Information Systems: IT Department and Infrastructure Development and Management, Data, Communications, Education/Training, Support, Reporting, Electronic Health Records, Practice Management Systems, Health information Exchanges
### Demonstrated Value of HCCNs

In March 2008, the California HealthCare Foundation (CHF) published a report of its findings from a study comparing safety net providers’ implementation of Electronic Health Records through networks versus stand-alone implementations. CHF’s findings demonstrated the financial and implementation benefits of network over stand-alone implementations. An important element of that study is this table indicating the benefits provided by the networks versus those provided by vendors, the typical resource for stand-alone implementations.

This same report indicated that, “EHR network(s) may be more suitable for:

- Organizations seeking products and services tailored to the safety net without need for extensive customization;
- Small or mid-sized organizations without a strong technical or quality improvement infrastructure;
- Community clinics or health centers that cannot divert a substantial amount of time from clinical, operational, and technical resources to the EHR implementation;
- Those with an interest in working with and learning from other clinics or health centers that have already adopted an EHR system; and,
- Organizations that want to implement disease management and QI programs predicate upon an EHR system.”

Networks build team skills across safety net providers to focus on those tasks that are most efficient and effective for the benefit of all network participants.

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