Primary Care
Development
Corporation

2024-2028

STRATEGIC BUSINESS PLAN

Primary Care Development Corporation

INTRODUCTION

Primary Care Development Corporation's (PCDC) mission is to strengthen communities and build health equity through strategic primary care investment, expertise, and advocacy. As the preeminent non-profit provider of financing to Federally Qualified Health Centers (FQHCs) and other health care organizations serving low-income communities, PCDC helps to expand access to high-quality, affordable health care, increase local employment opportunities, and bolster local economies, thus improving the health and wealth of the communities in which we invest.

PRIMARY CARE IS VITAL TO COMMUNITIES

Primary care saves lives, leads to improved individual and community health, and is unequivocally central to health equity. According to the 2021 National Academy of Sciences, Engineering and Medicine (NASEM) report on primary care, "Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."[i] When it is available, accessible, and affordable, primary care is a cornerstone of vibrant, thriving communities and helps keep families healthy, children ready to learn, and adults able to pursue education and participate in the workforce. Primary care has been shown to reduce overall health care costs and is the only part of the health system proven to lengthen lives and reduce inequities in communities.

> ***"[W]ithout access to high-quality primary care, preventive care lags, minor health problems can spiral into chronic disease, chronic disease management becomes difficult and uncoordinated, visits to emergency departments increase, and health care spending soars to unsustainable levels."***[ii] NASEM Report, 2021.

Despite the evidence of its value, primary care has been underfunded for years. Nationally, primary care accounts for approximately 35% of all health care visits each year – yet only about 5 to 7 percent of all health care expenditures are for primary care.[iii] This lack of investment in primary care is one of the core problems affecting access to high-quality primary care in the United States; it impacts both patients and providers, and leads to low-quality care, poor health outcomes, and an overburdened and burnt-out workforce that loses experienced professionals and has trouble attracting new ones.[iv] The harms of underinvestment in primary care are not felt equally across populations but instead hit hardest in communities already suffering from other health and social inequities.[v]

The COVID-19 pandemic underscored and exacerbated existing health care disparities. People living in historically disinvested and rural communities, people of color, and low-income people had less access to primary care even before the pandemic and experienced both more COVID infections and greater COVID-related mortality and morbidity.[vi]

The U.S. is currently facing a primary care access crisis. By 2033, the national primary care physician supply is projected to fall short of demand by as much as 55,000 providers.[vii] However, an increase of just one primary care provider per 10,000 people can generate 5.5% fewer hospital visits, 11% fewer emergency department visits, and 7% fewer surgeries, saving lives, improving health, and reducing costs.[viii]

Deliberately investing more in primary care is one of the most effective ways to solve these urgent problems. Increased investment in primary care would make care more accessible, increase the number of providers, and support those providers to offer the full range of integrated services most needed in underserved communities, while reducing overall health costs over the long term.

By 2033, the national primary care physician supply is projected to **fall short of demand** by as much as **55,000 providers.**[xvii]

PRIMARY CARE DEVELOPMENT CORPORATION

The Primary Care Development Corporation (PCDC)

In the early 1990's, the primary care landscape in New York City was bleak, particularly in low-income communities and communities of color, with overcrowded health centers, poor health outcomes, and a dearth of primary care providers. Determining that the lack of capital financing was a major barrier to adequate community-based primary care, PCDC was founded in 1993 as a public-private partnership and health equity and social justice enterprise with a mandate to bring high-quality and affordable primary care to New York City's low-income, underserved, and disinvested neighborhoods.

In 1998, PCDC became a Community Development Financial Institution (CDFI), chartered by the U.S. Treasury's CDFI Fund. Capitalized with $17 million in grants from New York City and $250 million in New York State bond financing, PCDC invested in new primary care sites of FQHCs, other community-based health providers, and safety-net hospitals. PCDC also provided technical assistance to improve operations and financial sustainability, and advocated for primary care access, quality, and affordability.

In 2004, with its growing financial strength and expertise in primary care lending and supplemented by its first New Markets Tax Credit (NMTC) allocation from the CDFI Fund, PCDC expanded its lending to New York State. Five years later, it expanded financing activities nationwide, bringing low-cost and flexible financing to more low-income communities. As a result of 30+ years of steady growth, PCDC has leveraged more than $1.5 billion in both NMTC awards and direct loans in low-income communities, created over 20,000 well-paying construction and health care jobs, and provided technical assistance to hundreds of health care organizations around the country, creating financial sustainability, better access to primary care, and ultimately better health outcomes in low-income, urban, and rural communities, as well as communities of color, around the country.

Of PCDC's financing projects:

- **98%** are in counties with a shortage of primary care providers
- **90%** are in communities with high rates of uninsured people
- **83%** are in low-income census tracts
- **48%** are in high-poverty census tracts

MISSION

PCDC strengthens communities and builds health equity through strategic primary care investment, expertise, and advocacy.

VISION

PCDC envisions a future where all people have access to high-quality primary care because primary care is a cornerstone of healthy, vibrant communities.

1. PCDC'S COMMUNITY DEVELOPMENT STRATEGY

PCDC's community development strategy is focused on financing FQHCs and other health care organizations that provide accessible and high-quality primary care to low-income community residents, most often in communities of color, where residents disproportionately face chronic and complex health conditions compounded by inadequate health care access.

Over the next five years, PCDC's financing strategy will continue to focus on high-impact projects that deliver high-quality, accessible care through modern, well-configured facilities that address community needs for comprehensive primary medical care; are safety-net institutions in both urban and rural communities; possess sufficient capacity to meet current and projected demand; and offer integrated and whole-person services.

PCDC's target market is community-based health care organizations that:

1. Serve communities of color and low-income and rural communities, and areas where residents face substantial health disparities

2. Are in Health Professional Shortage Areas (HPSAs) or are in Medically Underserved Areas (MUAs)[1]

3. Are committed to providing high-quality services

4. Provide integrated care, especially those offering and/or expanding opioid use treatment and prevention, with mental health out-patient counseling and on-site pharmacy services

5. Are led by an experienced management team, reflective of the people they serve, with the capacity to complete the project

[1] These designations indicate either a low provider-to-population ratio in a specific geography and/or significant travel time required to reach primary care providers.

2. PCDC'S THEORY OF CHANGE

PCDC's Theory of Change (TOC) (Appendix 2) represents a high-level map of our economic development strategy.

Key tenets of our TOC include:

- **Primary care is essential to building healthy communities;**
- **Due to redlining and other historic disinvestment in low-income, urban, and rural communities and communities of color in the U.S., there is well-documented disparate access to primary and behavioral health care, leading to a significantly reduced life expectancy, lack of economic mobility, and poor health outcomes;**
- **Better health enables people to engage in work, school, and the civic life of their community.**

Each of PCDC's financial transactions and technical assistance projects are designed to address this fundamental reality, to improve the capacity of the health care organization to provide high-quality, accessible, and affordable care, and ultimately, to improve the health and economic well-being of the community they serve.

PCDC's Theory of Change has been borne out in New York City, PCDC's founding target market. From a study that was done in 1998 and replicated in 2018, the neighborhoods in which PCDC invested showed measurable improvements in key health status measures including immunization rates, preventable hospitalizations, and babies born with low birth weight. Over these years, and with PCDC's economic investment, communities with the fewest primary care providers in 1988 – all of which were the poorest communities in New York City – experienced up to 10-fold increases in primary care providers, often coupled with improved economic prosperity over this time.

With PCDC's economic investment, NYC communities with the fewest primary care providers **experienced up to 10-fold increases in primary care providers.**

3. PCDC'S TARGET MARKET

For the past 30 years, PCDC has focused on providing capital financing, training, and consulting services to Federally Qualified Health Centers. FQHCs are federally recognized, non-profit community health centers that primarily serve low-income communities and communities of color in both rural and urban areas of the country, without regard to patients' ability to pay. They are responsive to their communities and require that 51% of their Board members be patients from the local community.

There are over 1,400 FQHCs with almost 18,000 service sites across the U.S. In 2022, **more than 30.5 million people relied on FQHCs for health care**, including:[ix]

- 1 in 9 **children**
- More than 24.2 million **uninsured, Medicaid, and Medicare patients**
- 27.5 million **people living below 200% of the federal poverty line** (or below $29,000/annual income)
- More than 9.6 million **rural residents**
- Nearly 1.4 million **people experiencing homelessness**
- Nearly 1 million **agricultural workers**
- More than 952,000 children served at **school-based health center sites**
- More than 395,000 **veterans**

Taken together, **FQHCs are among the most significant health care providers in low-income communities, serving approximately 1 in 10 people across the country**, and therefore have a significant role in improving health and economic mobility. Investments in FQHCs produce an economic ripple effect in their communities, creating jobs and fueling additional economic activity through the purchase of goods and services from local businesses. In 2021, with an annual federal investment of approximately $5.7 billion,[x] FQHCs provided more than 500,000 jobs, $85 billion in economic output, and more than $37 billion in labor income.[xi]

FQHCs are Community Development Agents and Essential Health Care Providers

Poor health affects economic status and mobility in a variety of ways. People who report "excellent health" have 74% more wealth than those who report fair or poor health.[xii] Studies show that poor health conditions in childhood may lead to lower educational attainment, and possibly less economic mobility.[xiii] Low-income communities have less access to high-quality education, nutritious food, and clean environments, all of which can lead to poorer health, which in turn, can lead to reduced socio-economic status and less economic mobility.

Adverse health conditions (e.g., diabetes, hypertension, low birth weight, obesity) are most severe for people living at the bottom rungs of the economic ladder, especially communities of color and rural communities.

> ***"Living in a poor or low-income household has been linked to poor health and increased risk for mental health problems in both children and adults that can persist across the life span."*** [xiv]

The health status of individuals and communities is significantly impacted by social drivers of health, among them inadequate housing, limited access to fresh, healthy food, and deficient educational opportunities, in addition to lack of access to high-quality, affordable, and culturally appropriate primary care.[xv] FQHCs are at the forefront of providing this kind of care, in addition to addressing social drivers of health in the country's poorest communities.[xvi]

FQHCs Need Capital Investment

FQHCs need capital investment for new site development and acquisition, renovations, and upgrades to modernize and address climate resiliency, and to invest in technology and workforce. Without access to low-cost and flexible capital, FQHCs are often reliant on limited federal or state capital grants. Many FQHCs are working at or above the capacity of their physical plant – even accounting for new telehealth visits – and many are burdened with obsolete equipment, with buildings that may be cramped, energy-inefficient, and poorly designed for delivering impactful health care that is patient-centered and integrated. Patient demand has compelled FQHCs to expand and/or construct new facilities, resulting in larger, more costly projects that strain cash flow. As non-profit health care organizations, FQHCs often have limited ability to meet a bank's equity requirement or to utilize high-cost debt. High construction costs – especially post-pandemic – for unique commercial properties such as FQHCs often exceed as-built appraised values, making it impossible to secure conventional financing due to high Loan-to-Value (LTV) ratios.

In addition to financing FQHCs, PCDC will continue to provide needed capital to other community-based safety-net health care and behavioral health providers as part of our mission to increase access points in communities that need it the most and advance the well-being of low-income communities.

Site visit to PCDC client Brooklyn Plaza Medical Center's new home in Central Brooklyn, NY

4. SUCCESSFUL 2017-2023 STRATEGIC BUSINESS PLAN

PCDC's FY2017-2023 strategic plan was an overall success with significant growth in assets under management, net asset growth, and attainment of low-cost capital. Intentional focus on the West Coast and later the Southeast, along with a continued focus on New York State and the Northeast in general, yielded significant results, with over 42 borrowers opening 45 sites, all of which serve low-income populations. Without PCDC's capital, these providers would not have been able to expand their services to reach new patients, create jobs, and begin the trajectory towards health improvement.

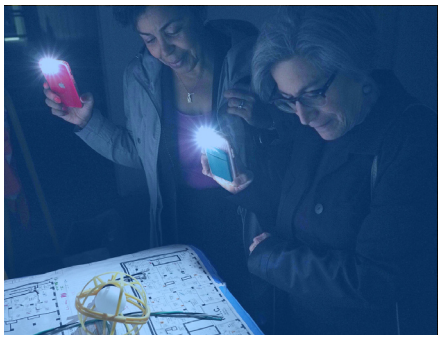
At the same time, these years were turbulent, with a major change in federal administration yielding uncertainty in the health care sector; the COVID-19 pandemic, which engulfed the country, particularly affecting primary care providers and the low-income communities served by FQHCs; the rising interest rate environment as the Federal Reserve Board aggressively raised interest rates to combat an inflationary trend; and the resurgence of a health equity and racial justice movement.

Across the country, the impact of the pandemic had a disproportionately harsh effect on low-income communities and communities of color, as evidenced by higher rates of illness and death, reduced access to primary care, and reduced access to capital. In all these areas, racial and economic disparities stand out. PCDC is and has always been committed to increasing capacity at the very primary care institutions that provide care to these communities.

Since 1993, PCDC has:

- leveraged **over $1.5 billion in financing**
- **supported primary care practices and providers** in 44 states, as well as Washington, D.C., Puerto Rico, Virgin Islands, and American Samoa
- **expanded capacity to support 4.8 million primary care visits for 1.4 million patients *annually***

Celebrating the opening of Apicha Community Health Center's new 14,400 square-foot location in 2023, providing comprehensive, integrated primary, behavioral health, and dental care to adults and children in the Jackson Heights/Elmhurst neighborhoods of Queens, NY.



Site visit in 2024 to see construction of the new Brooklyn Plaza Medical Center FQHC with Dr. Pascale Kersaint and PCDC's Louise Cohen.

5. LOOKING FORWARD

Over the next five years, PCDC will seek to maintain our leading role as a community health lender, continue to facilitate operational excellence, financial sustainability, and integrated care among primary care practices and health centers, and advocate for increased investment in primary care at the local, state, and federal levels.

PCDC will continue to grow its balance sheet lending, apply for and deploy New Markets Tax Credits, and uphold our reputation as the premier CDFI providing financing to FQHCs, behavioral health centers, and other community safety-net health care providers across the country.

PCDC is embarking on the next five years with a strong balance sheet as of 12/31/23, with over $145M in committed capital sources, including over $100M low- or zero-cost to PCDC, and will continue to be a leader in lending to primary care and behavioral health organizations.

An underserved, rural community in Louisiana now has increased access to integrated primary care and behavioral health services, thanks to financing from PCDC. In 2021, CommuniHealth Services in Morehouse Parish broke ground on this $14 million facility.

"Sometimes it's tough for low-income patients in rural communities to get to larger cities so we want to provide care for them here at home. We know that patients have better outcomes when they can get care locally in the communities where they live."

Katie Parnell, CEO, CommuniHealth Services

5a. ENVIRONMENTAL OUTLOOK

The COVID-19 pandemic has been devastating, sharply reducing U.S. life expectancy, impacting hundreds of millions of lives, and upending the economy. Nowhere was COVID-19 more directly impactful than in the health care sector. While hospitals and health care workers desperately fought against the tide of illness and death, the country's primary care system was also deeply affected. In the first wave, many primary care centers were fully or partially closed, resulting in critical losses of income and reduced access to basic health care services, which led to even worse health outcomes in many communities. Once vaccines were available, primary care providers became central to the country's COVID-19 mitigation strategy and were critical access points in many communities for testing, treatment, and vaccine delivery. The Federal government provided significant funding infusions, particularly for FQHCs and safety-net hospitals, although most independent primary care providers were unable to access these funds. During this period, PCDC's lending and consulting slowed.

As the pandemic has ebbed, many communities are experiencing worse health than before the pandemic due to both COVID-19 illness and long-term effects, as well as deferred care for prevention and management of chronic disease. As of early 2023, primary care providers had returned to addressing the more routine needs of communities, including providing childhood vaccinations, addressing chronic disease, and providing preventive care, early diagnosis, and treatment.

During the COVID years, some significant changes occurred in the health care regulatory environment, notably the very quick rise in the use of telehealth. The health care workforce has been stressed to its breaking point, severely impacting recruitment and retention. Market volatility, including rising interest rates and general inflation, has significantly affected health care organizations' ability to expand or invest in needed infrastructure and workforce. Wages have increased but trail the rate of inflation and pose challenges to many primary care providers to attract and retain the workforce.

The pre-pandemic movement towards integrating physical and behavioral health – mental illness and substance use disorders – has continued. In addition, a movement towards paying for value (i.e., better care and better outcomes) rather than paying for visits has continued. Increasing attention is being paid to the integration of social services and primary care. Finally, the health care market is also undergoing significant change due to the injection of billions of dollars of private equity investments leading to both horizontal and vertical consolidation, though not always to the benefit of low-income communities and/or communities of color.

There is growing recognition of the role that high-quality, accessible, affordable, and community-based primary care plays in creating healthier communities and lowering costs. Federally Qualified Health Centers have become more widely recognized as key to improving health outcomes in low-income and historically disinvested communities. FQHCs, a solid asset class, will continue to need capital and technical assistance to grow, flourish, and achieve their mission.

6. PCDC'S 5-YEAR STRATEGIC BUSINESS PLAN: 2024-2028

While it is impossible to project with absolute certainty, PCDC expects that several factors will continue to drive the market and provide opportunities for PCDC to grow and achieve impact over the next few years. Key among them include that interest rates will continue to rise or stay stable and high; primary care will continue to be driven towards integrated care and value-based payments; and there will be increased attention to the intersection of primary care and social drivers of health. **PCDC's core market of borrowers will continue to need investment to increase their ability to provide these integrated, high-quality services in the communities they serve.**

PCDC contributed $16 million to Care Resource Health Centers in Miami-Dade County, FL to open a large new clinic and provide a wide range of desperately needed services.

Premier Community HealthCare Group partnered with PCDC to build two new clinics in Florida's Gulf Coast, offering primary care, dental, behavioral health, and women's health services.

"Thanks to financing from PCDC, Premier is able to expand much needed health care services to an underserved population in Florida. Our patients will be able to receive the care they need in modern and clean facilities."

Joseph Resnick, CEO, Premier Community HealthCare Group

Financial Outlook

PCDC's large pool of low- or no-cost capital, along with Community Reinvestment Act-related bank capital, and the likelihood of additional NMTC allocations, position PCDC to continue to be the "go-to" lender for community health care providers around the country. PCDC is consistently lending to larger projects, investing in organizations dedicated to integrating care and providing access to uninsured, publicly-insured, low-income, and minority communities, and strategically creating partnerships with banks, impact investors, and other CDFIs to drive business and advance health equity.

PCDC's technical assistance and training services will increase revenue by 5% year-over-year, leading to improved financial sustainability and operational excellence of PCDC's target market.

PCDC will continue to advocate for policies that improve access to, quality of, and financial sustainability of primary care, particularly for low-income communities and communities of color, both in urban and rural neighborhoods.

From FY2017-2023, PCDC significantly grew its assets under management, primarily through increases in NMTC transactions, and currently is holding steady at approximately $335 million of assets under management. This success, along with revolving capital pools, careful expense management, and philanthropic growth, helped PCDC significantly exceed its 5-year target for unrestricted net asset growth. Direct lending growth accelerated tremendously during FY23, the final year of PCDC's prior strategic plan, reaching a new high for total loans outstanding.

PCDC's financial goal for the next five years is to grow revenues and net assets by 5% on a year-over-year basis, primarily through increasing our direct lending activities and maintaining our base of NMTCs under management, focusing on our target market of Federally Qualified Health Centers.

2022 ribbon-cutting for Santa Cruz Community Health Center's new 20,000 square-foot site, providing medical and behavioral health care, with a focus on pediatrics and those experiencing homelessness. This project was financed by PCDC.

APPENDIX

PCDC Consolidated — Business Plan Forecast FY24-FY26 ($000)

	FY24	FY25	FY26
Capital Deployment (Loans & NMTC)	5,124	6,897	9,237
Grants & Contracts	4,465	2,891	3,038
Program Fees , Investment & Other Income	5,603	5,301	5,218
TOTAL REVENUES	***15,192***	***15,088***	***17,494***
% growth in Revenue	*1%*	*-1%*	*16%*
Personnel Expenses (Incl. Fringe)	9,411	9,959	10,395
Capital Deployment Expenses	2,029	1,966	2,075
Consultant & Prof Fees	1,061	977	1,032
All Other OTPS	2,220	2,107	2,045
Total Expenses	***14,721***	***15,009***	***15,547***
% growth in Expenses	*4%*	*2%*	*4%*
Surplus/(Deficit)	***471***	***79***	***1,947***

PCDC's Economic Development Theory of Change

Current situation: well-documented disparate access to primary & behavioral care in low income & BIPOC communities leading to poor health outcomes, significantly reduced life expectancy, & lack of economic mobility

Primary care is the only part of the health care system that has been shown to improve health, lead to better health outcomes and lower costs, moving toward health equity

INPUT (intervention into the system):
PCDC provides loans and training and consulting support to FQHCs.

Short-term Output: # FQHCs supported annually	Short-term Output: $ invested

MEASUREMENT

Medium-term Output: # patients, including income level, race/ethnicity & gender	Medium-term Output: # jobs created; square footage renovated or built

EVALUATION

Impact: cost savings from increased access to care	Impact: overall community economic impact	Impact: Better community health outcomes

End notes

[i] National Academy of Science, Engineering and Medicine, *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care* (2021) [hereinafter "NASEM Report"].

[ii] NASEM Report; see also Mark W. Friedberg, Peter S. Hussey, & Eric C. Schneider, *Primary Care: A Critical Review of the Evidence on Quality and Costs of Health Care,* 29 Health Affairs Vol. 5, May 2010, abstract available at https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2010.0025.

[iii] NASEM Report. See also *Patient Centered Primary Care Collaborative, Investing in Primary Care: A State Level Analysis,* July 2019, available at https://www.pcpcc.org/sites/default/files/resources/pcmh_evidence_report_2019_0.pdf.

[iv] NASEM Report. See also Kriti Prasad et al., *Prevalence and correlates of stress and burnout among U.S. healthcare workers during the COVID-19 pandemic: A national cross-sectional survey study,* 35 E. Clinical Med. 100879 (2021), available at https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(21)00159-0/fulltext.

[v] Primary Care Development Corporation, *The intersection of COVID-19 and chronic disease in New York City: underscores the immediate need to strengthen primary care systems to avoid deepening health disparities,* Points On Care Series, May 2020, https://www.pcdc.org/wp-content/uploads/Points-on-Care-_-Issue-3-COVID-_FINAL.pdf.

[vi] Ibid

[vii] Association of American Medical Colleges, *The Complexities of Physician Supply and Demand: Projections From 2018 to 2033,* June 2020, available at https://www.aamc.org/system/files/2020-06/stratcomm-aamc-physician-workforce-projections-june-2020.pdf.

[viii] Steven J. Kravet et al. Health Care Utilization and the Proportion of Primary Care Physicians. JAMA Internal Medicine. 2008; 121(2), 142-148. Doi: 10.1016/j. amjmed.2007.10.021

[ix] Health Resources and Services Administration. *Health Center Program: Impact and Growth.* August 2023. https://bphc.hrsa.gov/about-health-centers/health-center-program-impact-growth

[x] https://www.nachc.org/wp-content/uploads/2023/07/Overlooked-Decline-Community-Health-Center-Funding_2023_Full-report.pdf

[xi] Matrix Global Advisors. *Economic Impact of Community Health Centers in the United States.* March 2023. https://www.nachc.org/wp-content/uploads/2023/06/Economic-Impact-of-Community-Health-Centers-US_2023_final.pdf

[xii] Health and Economic Mobility. The Urban Institute. https://www.urban.org/sites/default/files/publication/31181/1001161-health-and-economic-mobility.pdf

[xiii] Ibid

[xiv] Pediatrics 2017 Jan; 139(1): e20151175 Hodgkinson S, Godoy L, Savio Beers L, Lewin A: Improving Mental health Access for Low-Income Children and Families in the Primary Care setting.

[xv] https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/

[xvi] https://catalyst.nejm.org/doi/full/10.1056/CAT.21.0303

[xvii] Association of American Medical Colleges, *The Complexities of Physician Supply and Demand: Projections From 2018 to 2033,* June 2020, available at https://www.aamc.org/system/files/2020-06/stratcomm-aamc-physician-workforce-projections-june-2020.pdf.

Primary Care Development Corporation (PCDC)
45 Broadway, 5th Floor, New York, NY 10006
212-437-3900 | **www.pcdc.org**