



# California Community Clinics

## Financial and Staffing Analysis

FY06—FY09

PREPARED BY



UNDER CONTRACT WITH



## ACKNOWLEDGEMENTS

Capital Link was pleased to prepare *“California Community Clinics: Financial and Staffing Analysis, FY06-FY09,”* a report supported by a grant from the California HealthCare Foundation, based in Oakland, California. This study’s objectives were to provide metrics for the continued monitoring of clinic financial performance and developing trends, to identify staffing and program/service models which may contribute to financial success of clinics, and to provide a “best practice” framework for clinic leaders and policy makers as they plan for rapid growth in the era of health reform.

The **California HealthCare Foundation** is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, the Foundation’s goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford. For more information, visit [www.chcf.org](http://www.chcf.org).

**Capital Link**, established in 1998, is a non-profit organization dedicated to assisting community health centers in accessing capital for building and equipment projects. From market feasibility and program, staff and facility plans to comprehensive financing assistance, Capital Link provides extensive technical assistance to health centers to assist in strengthening their abilities to plan and carry out successful capital projects. Additionally, Capital Link works in partnership with primary care associations, consultants and other entities interested in improving access to capital for health centers.

Capital Link was founded by the National Association of Community Health Centers, Community Health Center Capital Fund, Massachusetts League of Community Health Centers, and Primary Care Associations in Illinois, North Carolina and Texas. Capital Link receives funding from governmental agencies, private foundations and fees charged to clients for services. For more information, visit [www.caplink.org](http://www.caplink.org).

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## INTRODUCTION

The financial health of California community clinics remains deeply rooted to the overall economic well-being of both the state and national economies. State lawmakers in California approved an FY2012 budget on June 28, 2011 that included \$15 billion in spending cuts and Governor Jerry Brown signed the budget into law on June 30, 2011, the day before the start of the fiscal year. However, state revenue collections fell over \$0.5 billion short of budgeted projections in the first month of FY12, and further cuts will be triggered automatically if revenue falls \$1.0 billion short of projections. Although the state economy and coffers may eventually begin to recover from the protracted downturn of the last few years, political leaders must still reconcile the structural deficit that has been part of the budget process for much of the last decade. To respond to these budget shortfalls, state lawmakers will need to implement additional programmatic cuts, likely including more cutbacks to healthcare programs and safety net support.

The outlook for clinics is also challenging at the federal level. Although the Affordable Care Act included significant investments in health centers, some of that funding has already been diverted to overcome \$600 million in base-level funding cuts slated for FY11. Given public demands for deficit reduction, additional cutbacks to the health center program may be inevitable. Even federal entitlement programs such as Medicaid and Medicare are being seriously included within the deficit reduction discussion for the first time, which will have dramatic implications for community clinics and the patients they serve. Despite these funding challenges, demands for clinic services continue to increase as the ranks of unemployed and uninsured grow as a result of the general economic malaise.

Although clinics will need to bolster their efforts to provide more services with fewer resources, clinics continue to struggle to define productive operational models. Questions often arise around the most appropriate staffing ratios, service mix, and provision of enabling services and how these factors might affect productivity and financial performance measures.

In this context, California HealthCare Foundation sponsored a study to determine the financial health of community clinics by examining the productivity and financial measures of community clinics in California. This study analyzes financial and productivity measures, and service models to determine if they correlated with clinic productivity and performance. To obtain deeper insights about the financial status of clinics, the research included case studies of a number of clinics that were selected through the research process. The case studies shed light on common approaches that can be shared with California clinics to improve efficiency and performance. The analysis offered in this report is the second update in a series going back to 2003.

The study's goals were to: (1) establish metrics for the continued monitoring of clinic financial performance and developing trends; (2) identify staffing and program/service models which may contribute to financial success; and (3) provide a "best practice" framework for clinic leaders and policy makers as they plan for rapid growth in the era of health reform.

## Financial Indicators and Trends

The initial phase of the study reviewed ten key financial ratios and trends to provide a data framework for monitoring the financial health of clinics. These financial indicators and ratios provided insight into four areas: profitability, growth, solvency and debt capacity. The ten ratios examined are described in Appendix A: Methodology.

The analysis in Section I utilizes IRS Form 990 data to report on the financial indicators and trends of California community clinics over the four-year period FY2006-2009. A few key observations of the study include:

- California community clinics continue to grow financially, with an overall inflation-adjusted total revenue growth rate of 20.7% between FY06 and FY09 and an average annual growth rate of 6.5%.<sup>1</sup> Total clinic revenues grew to \$2.4 billion in FY09.
- Clinic financial performance remains stratified. At the median, clinics operate with tight margins, averaging a 2.2% Operating Margin and a 2.9% Bottom Line Margin. While the Bottom Line Margin averaged a relatively robust 9.4% at the 75<sup>th</sup> percentile, the 25<sup>th</sup> percentile generated negative margins in each year for an average of -1.0%. Low or negative margins highlight the general vulnerability of clinic financial operations, particularly in times of continued economic decline and reductions in funding.
- Days Cash on Hand remained at a consistent level over the four-year assessment period, ranging from 50-54 Days Cash at the median. However, the four-year average at the 25<sup>th</sup> percentile was less than 20 Days Cash, well under minimum recommended cash levels of 45-60 Days Cash. Clinics with low levels of operating cash may struggle to pay bills on time and maintain operational stability and are extremely susceptible to delays in 3rd party reimbursement.

Although the FY09 financial ratios for many clinics did not change significantly from the prior years, it remains to be seen how funding cutbacks at the state and federal level in FY10, FY11, and beyond will impact the financial health of community clinics and their continued efforts to expand services to the growing number of underinsured.

## Staffing, Productivity, and Financial Performance

As clinics vary their approaches to staffing in response to specific community needs, questions naturally arise about how certain staffing models impact clinic finances and productivity. To provide answers, the next phase of the study combined the financial measures previously analyzed with utilization data from Federally Qualified Health Centers (FQHC) uniform data system (UDS) reports to assess potential relationships between existing staffing models and clinic financial performance and productivity.

Many community clinics, FQHCs in particular, share several defining characteristics of mission, governance, and the type of services they provide, and also showed similar values for some of the measures analyzed. However, the staffing analysis on the whole demonstrated a wide range of ratios and measures, thus precluding any notable levels of statistical correlation with either financial performance or productivity. For example, clinics with very similar staffing ratios showed a range of financial performance and productivity measures. Possible explanations may be that while clinics may have relatively similar staffing ratios,

<sup>1</sup> The data set included 167 community clinics for which revenue data was available for all four years.

## EXECUTIVE SUMMARY (continued)

the practice patterns and the roles fulfilled by specific staff such as physicians and mid-levels may vary considerably from one clinic to the next, resulting in differing measures. Despite the lack of a clear statistical relationship between staffing models and performance, several observations could be made when clinics were separated into highest and lowest financial and productivity cohorts:

- Clinics with a higher Mid-Level to Physician ratio appeared to have lower financial performance and productivity.
- While having a higher or lower Enabling Staff to Physician ratio did not appear to make much of a difference in terms of clinic financial performance, it appears that a higher Enabling Staff to Physician ratio negatively impacts productivity.
- Similarly, a higher Enabling Staff to Medical Provider (Physicians plus Mid-Levels) ratio also appeared to have a negative impact on productivity.

This cohort analysis suggests that higher staffing ratios of Mid-Levels to Physicians and Enabling Staff to Physicians tend to be associated with the lower productivity cohorts. In general the same could be observed for the lower financial cohorts, although the differentiation was not as clear as for productivity. However, clinics with larger enabling staffing tend to be responding to the medical or cultural acuity of its patient base – a factor which also decreases provider productivity. Other factors such as practice patterns and reimbursement rates also likely play a role in how different staffing ratios affect productivity and financial performance.

Looking at productivity, the highest financial cohorts generally displayed higher productivity values. The differentiation was more obvious for the more narrowly defined Medical Team than it was at the level of the entire organization. The productivity of Enabling Services appeared to have a noticeable positive impact on the level of financial performance. For most other measures however, there were areas of overlapping values even between clinics at the upper end of the lowest cohort and those towards the lower end of the highest cohort, again underscoring the wide range of productivity values within each cohort and the entire group in general.

### **Summary of Observations from Clinic Visits**

The clinic case studies give a glimpse into the operational realities and responses of eight California clinics serving within their unique communities. Several strategic trends emerged that were common to all of the clinics, and directly influences efforts to improve operational efficiencies. Further, the clinics identified possible systematic responses that would support their efforts to be both clinically responsive and financially sustainable over the long term.

By design, community clinics are mission-based organizations that are organized operationally to be responsive to the unique needs of their community constituents. Operational approaches that may work well to address the specific needs of their patient populations may not always support financial strength, which is a likely driver for the lack of statistical correlation in the operational data. Nonetheless, it is clear from the site visits that the clinics are striving to adapt to a rapidly changing healthcare environment while still responding to the evolving needs of their service areas. These trends include, but are not limited to, the move to a practice model that is technology-enhanced and team-based. At the same time, clinics continue to be reimbursed for services based on face-to-face provider encounters.

## EXECUTIVE SUMMARY (continued)

In response to these environmental pressures, the site visits clarified the critical role of a resilient operational culture that allows clinics to respond to their changing communities while incrementally adjusting their operational models. The site visits identified several current trends in the clinic operating environment that are challenging the clinics' ability to efficiently manage their programs and services. The clinics themselves also identified possible systematic changes which would support their efforts to be both clinically responsive and financially sustainable over the long-term.

### **Expansion and Growth**

As is true of most clinics throughout the state, the clinics visited for the case study analysis are all in the process of growing their service capacity to meet increasing demands from their communities. This continued (rapid) expansion puts stress on the organization, in particular as it relates to efforts to incorporate evolving models of care, maximize the role of technology and develop capital resources. Most commonly, the clinics visited have responded to the need to "see" more patients by hiring more providers. However, the rapid addition of providers has not yet produced the level of productivity and patient access projected. Two specific constraints were consistently identified by the clinics as impediments to efficiently increasing patient access and service capacity:

- a) **the process for implementing electronic health record systems has negatively impacted productivity.** Of significance was the fact that clinics post-implementation also reported a consistent leveling of productivity below that found with paper records;
- b) **the call to expand the patient base has encouraged the explosion of multiple "part-time" provider staff.** The majority of these part-time providers work a variety of schedules within the same system, creating turbulent patient flow and competition for resources.

### **Recommended Action Steps:**

- The process of care delivery in an electronic environment should be re-evaluated with an objective for more provider time to be spent on managing the patient rather than the record.
- Operations should be aligned with a focus on distributing facility and staff resources evenly as a prerequisite to effectively increasing patient access.

### **Physical Space, Practice Model And Staffing**

Clinics are continually faced with the challenge of determining their most effective staffing mix within the constraints and opportunities of their physical spaces. Notably, several clinics have been more successful implementing change at satellite sites, introducing innovative staffing and patient flow models more efficiently than at their larger, more established sites. New site construction or existing site renovation are often serving as pilot projects for clinics, allowing for manipulation of the physical space and supporting practice model and staffing changes.

A key driver for effective daily patient flow is to maintain the correct staffing for the designated operational task. In general, clinics are moving staff positions from rigidly defined roles within task-based teams to more flexible roles within process-based teams; allowing for increased flexibility in coverage and fewer hand-offs during the patient visit process. However, taking time to re-train existing staff and fully orient new staff is difficult in an environment in which maximizing the daily number of patient encounters is vital to operational and financial success.

## EXECUTIVE SUMMARY (continued)

### Recommended Action Steps:

- Long range capital development plans including adequate funding sources should be developed that support flexibility in the model of care delivery.
- Reimbursement mechanisms should be aligned to support the transition from task-based to process-based staff teams.

### **Operational Stability**

In an environment of increased expectations with decreased assurances, operational and financial stability is consistently sought as a platform to enable clinics to take risks and institute change. Clinics find the challenges of managing capital expansions, new technologies, new populations and new models of care compounded by the volatility of the reimbursement system and the reality of rising costs. Maintaining adequate cash flow is a continual challenge, even among clinics with a history of strong operating margins.

### Recommended Action Steps:

- Rapid access to short-term operational gap funding is critical to allow rapid response to needs and opportunities, filling the gap between initiation of an expansion or service change and the establishment of a sustainable revenue stream sufficient to support the change.
- Reimbursement mechanisms should be aligned to facilitate the financial integration of multiple operational models shown to be efficient and effective.

### **Culturally Effective Services**

Health centers find their patient populations increasingly diverse, challenging their ability to financially support culturally effective services. Transportation, employment, legal status, location, language, culture and age are all common barriers established providers have become adept at addressing. The change is in the volume of those barriers – for both the individual patient and the total population. The rising costs associated with facilitation of primary care services is not being covered by the existing reimbursement mechanism.

### Recommended Action Steps:

- Urban clinics in particular should seek community incentives for increasing transportation options, and targeted funding streams to support multi-lingual services and other types of culturally competent care.

Clinics are clearly faced with the continuing challenge of operating with slim margins and tight cash reserves while at the same time needing to meet the growing health needs and cultural nuances of their community constituents. Clinics are eager to adapt their practices with staffing models that promote efficiency while offering enhanced levels of care, yet they don't often have the financial flexibility to make dramatic departures from what has worked for them historically. Due to resource constraints, changes to practice patterns are more often implemented incrementally in order to minimize operational disruption and financial risk. Despite these challenges, clinics have demonstrated a general resiliency to persevere and even grow. However, without access to targeted funding streams and the realignment of reimbursement systems that support functionally efficient and patient-centered practice models, the future growth and sustainability of clinics may be jeopardized.

# SECTION I: FINANCIAL INDICATORS AND RATIOS



The following section examines data from IRS Form 990 in an effort to identify significant financial trends from FY06 to FY09, providing information on financial growth, profitability, financial condition and solvency of California Community Clinics. Taken in aggregate, these financial trends provide an updated snapshot of the financial profile of California Community Clinics and provide clinic management, Boards of Directors, and other clinic partners a basis for further analysis and action. Comparative national level trends for each for the key financial indicators is also provided for additional reference.

## Revenues and Expenses

The chart and accompanying table show the Total Revenues and Expenses for the 167 community clinics for which revenue data was available for all four years from FY06 through FY09.

### Short-term Trend: FY08 to FY09

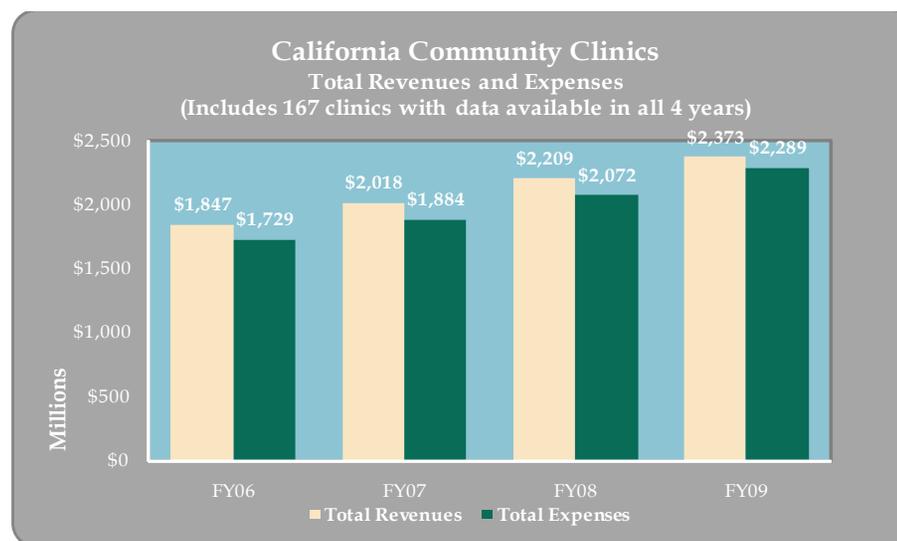
Total Revenues grew to \$2.37 billion in FY09, representing an inflation-adjusted increase of 7.8% from the prior year level. Median Total Revenue per health center was \$7.8 million in FY09.

Total Expenses increased to \$2.28 billion in FY09. With an inflation-adjusted increase of 10.9% over FY08, expenses grew faster than revenues. The Median Total Expenses per health center was \$7.5 million in FY09.

### Long-term Trend: FY06 to FY09

Total Revenues increased from \$1.8 billion in FY06 to \$2.4 billion in FY09, a 20.7% inflation-adjusted increase. Average annual growth rate over the period was 6.5%.

Total Expenses went from \$1.7 billion in FY06 to \$2.3 billion million in FY09, an inflation-adjusted increase of 24.4% over the period, with an average growth rate of 7.6%. Expense growth therefore outpaced revenue growth over the period.



Fiscal Year	FY06	FY07	FY08	FY09
Sample Size	167	167	167	167
Total Revenues	\$1,846,741,169	\$2,018,347,952	\$2,209,242,263	\$2,372,607,836
Total Expenses	\$1,729,422,037	\$1,883,645,424	\$2,071,758,053	\$2,288,649,121

\*FY07 through FY09 Total Revenues and Expenses adjusted to FY06 dollars using the Bureau of Labor Statistics online inflation calculator.

# SECTION I: FINANCIAL INDICATORS AND RATIOS



## Operating Revenue Growth Rate

This indicator measures the percent change in Operating Revenue relative to the prior year. Consistent growth in operating revenue is considered to be a positive indicator of financial performance.

### Short-term Trend: FY08 to FY09

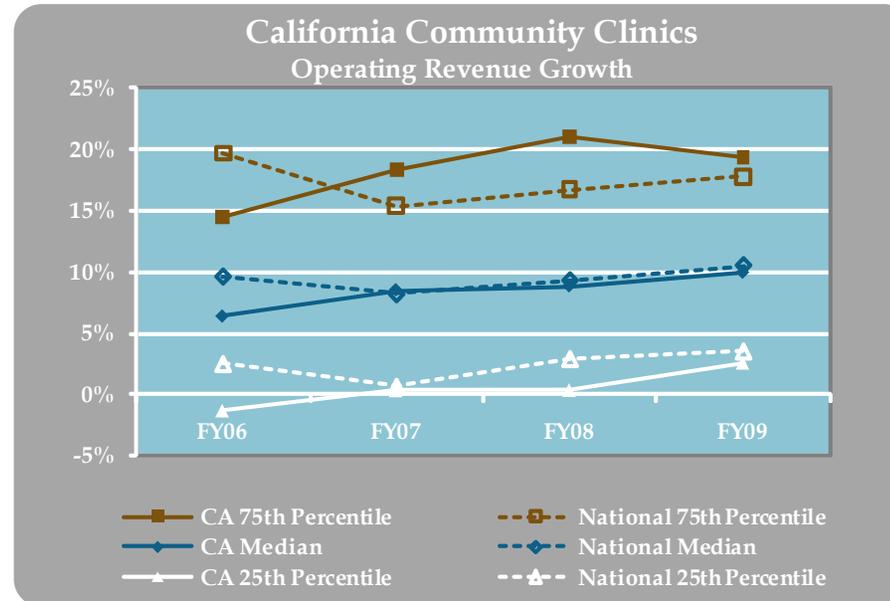
The median growth rate in Operating Revenue increased from 8.8 % in FY08 to 9.9 % in FY09. At the 75th percentile, the rate of revenue growth decreased slightly, but still hovered around 20.0%. The growth rate increased noticeably at the 25th percentile between FY08 and FY09.

### Long-term Trend: FY06 to FY09

The median revenue growth rate increased slightly every year over the 4-year period, averaging an 8.4% growth rate per year. At the 25th percentile, the average rate of growth was 0.5% per year, while at the 75th percentile, the average rate of growth was 18.3%.

### Comparative Trend: State to National

On average, revenue growth of the national clinics was slightly higher at the median and 25th percentile compared to California clinics between FY06-FY09. On the other hand, with the exception of FY06, California clinics outpaced their national peers in terms of revenue growth at the 75th percentile.



Fiscal Year	FY06	FY07	FY08	FY09
Sample Size	176	185	185	179
CA 75th Percentile	14.5%	18.3%	21.1%	19.4%
CA Median	6.4%	8.5%	8.8%	9.9%
CA 25th Percentile	-1.3%	0.3%	0.3%	2.6%

Fiscal Year	FY06	FY07	FY08	FY09
Sample Size	435	438	349	282
National 75th Percentile	19.7%	15.4%	16.7%	17.8%
National Median	9.6%	8.2%	9.3%	10.5%
National 25th Percentile	2.5%	0.7%	2.9%	3.5%

# SECTION I: FINANCIAL INDICATORS AND RATIOS



## Total Revenue Growth Rate

This indicator measures the percent change in Total Revenue (Operating Revenue plus Non-Operating Revenue) relative to the prior year. Consistent growth in Total Revenue is considered to be a positive indicator of financial performance.

### Short-term Trend: FY08 to FY09

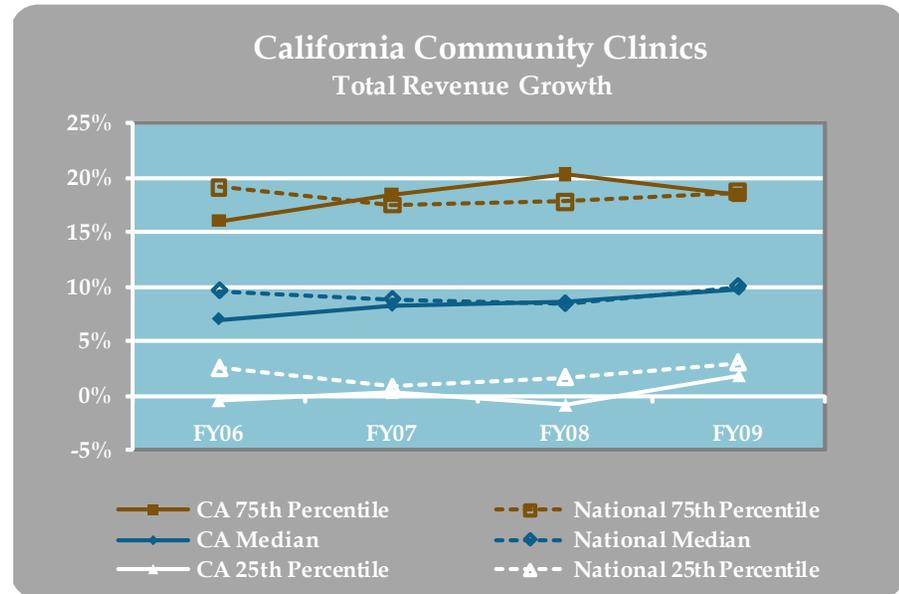
The median growth rate in Total Revenue increased from 8.6% in FY08 to 9.8% in FY09. Total Revenue grew over 18.0% at the 75th percentile in FY09.

### Long-term Trend: FY06 to FY09

At the median, the rate of Total Revenue growth increased each year between FY06-FY09, averaging an 8.4% annual growth rate. Though with some fluctuation, the 75th percentile of California clinics averaged an annual growth rate for Total Revenues of 18.3% while the growth rates for the 25th percentile averaged just 0.2% over the 4-year period.

### Comparative Trend: State to National

On average, the growth rates of Total Revenue for California clinics were somewhat similar to their national peers at both the median and 75th percentiles. However, the average growth rate of Total Revenue for the 25th percentile of national clinics outpaced that of California clinics (2.0% vs. 0.2%).



Fiscal Year	FY06	FY07	FY08	FY09
Sample Size	176	185	185	179
CA 75th Percentile	16.0%	18.4%	20.4%	18.4%
CA Median	7.0%	8.2%	8.6%	9.8%
CA 25th Percentile	-0.4%	0.3%	-0.9%	1.9%

Fiscal Year	FY06	FY07	FY08	FY09
Sample Size	440	445	356	287
National 75th Percentile	19.1%	17.5%	17.8%	18.7%
National Median	9.6%	8.8%	8.4%	10.0%
National 25th Percentile	2.5%	0.8%	1.7%	3.0%

# SECTION I: FINANCIAL INDICATORS AND RATIOS



## Operating Expense Growth Rate

This indicator measures the percent change in Operating Expense year-to-year. While it is to be expected that Operating Expense will grow as a result of increased patient visits and general inflation, this rate of growth ideally should not exceed the rate of growth in Operating Revenue.

### Short-term Trend: FY08 to FY09

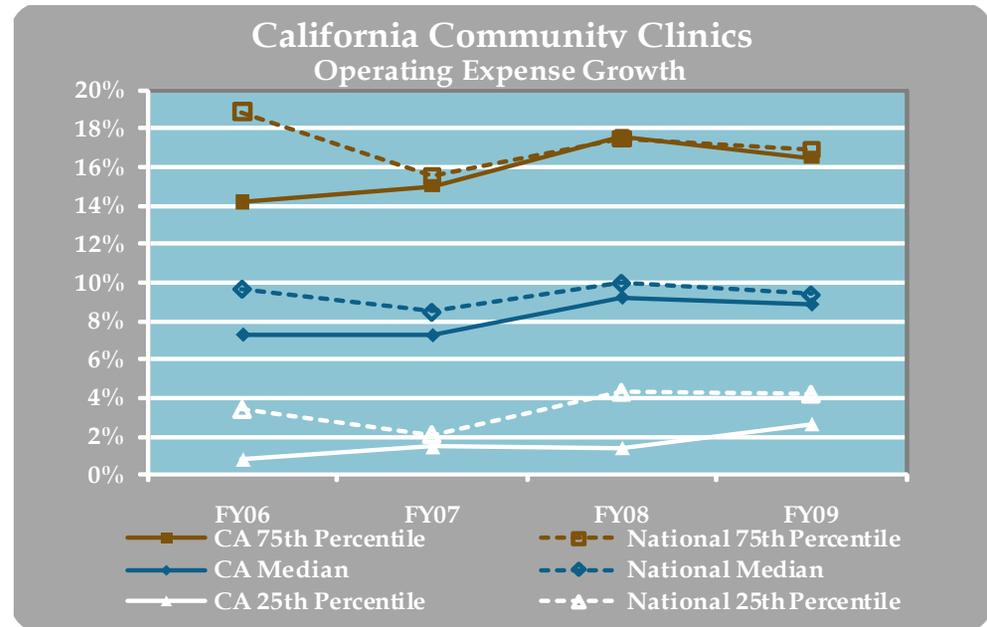
The median Operating Expense growth rate decreased from 9.2% in FY08 to 8.8% in FY09.

### Long-term Trend: FY06 to FY09

The median Operating Expense growth rate increased from 7.3% to 8.8%, averaging an 8.1% growth rate over the period. Clinics at the 75th percentile averaged a 15.8% growth rate for expenses, while the average growth rate for the 25th percentile was 1.6%

### Comparative Trend: State to National

The Operating Expense growth rate for California clinics was generally lower compared to national values in all years and at all levels, with the disparity more pronounced at the lowest quartile.



Fiscal Year	FY06	FY07	FY08	FY09
Sample Size	176	185	185	179
CA 75th Percentile	14.2%	15.0%	17.6%	16.5%
CA Median	7.3%	7.3%	9.2%	8.8%
CA 25th Percentile	0.8%	1.4%	1.4%	2.6%

Fiscal Year	FY06	FY07	FY08	FY09
Sample Size	435	439	350	282
National 75th Percentile	18.9%	15.5%	17.5%	16.9%
National Median	9.7%	8.5%	10.0%	9.4%
National 25th Percentile	3.4%	2.1%	4.3%	4.2%

# SECTION I: FINANCIAL INDICATORS AND RATIOS



## Operating Margin

Operating Margin and Bottom Line Margin are key indicators of health centers' ability to generate income needed to sustain current operations and to support both short-term and long-term growth. The Operating Margin specifically reflects the extent to which health centers were able to cover expenses related to patient care with revenues generated from, or allocated for, patient care. The higher the margin, the stronger the financial performance. A slim Operating Margin may limit a clinic's capacity to build financial reserves for economic downturns or to generate surplus resources for capital investment.

### Short-term Trend: FY08 to FY09

California clinics generated a median Operating Margin of 2.6% in FY09, up from 2.0% in FY08.

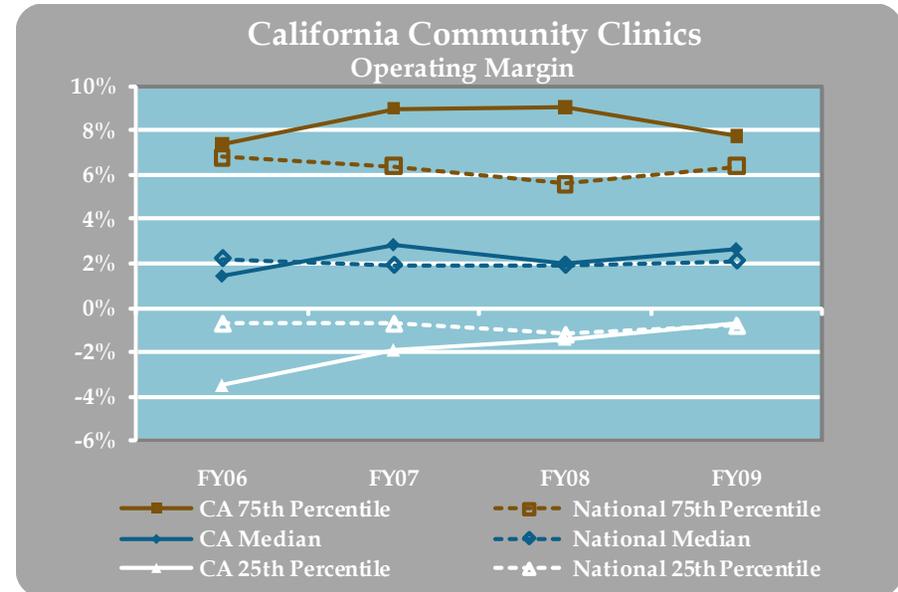
### Long-term Trend: FY06 to FY09

The median Operating Margin has shown some fluctuation from year to year but overall remained in the 2% range, averaging 2.2% over the four-year period.

The Operating Margin at the 75<sup>th</sup> percentile ranged between 7.4-9.1%, with a four-year average of 8.3%. The four-year average at the 25<sup>th</sup> percentile was -1.9%. While showing gradual improvement between FY06 and FY09, the Operating Margin for clinics at and below the 25<sup>th</sup> percentile still remained negative in FY09.

### Comparative Trend: State to National

On average, the clinics included in the national sample generated a median Operating Margin of 2.0%, very similar to California clinics. Notably, the trends for the 75<sup>th</sup> percentile of clinics were lower for the national clinics compared to California clinics, averaging 6.3% over the FY06-FY09 period.



Fiscal Year	FY06	FY07	FY08	FY09
Sample Size	194	189	196	181
CA 75th Percentile	7.4%	9.0%	9.1%	7.8%
CA Median	1.4%	2.8%	2.0%	2.6%
CA 25th Percentile	-3.5%	-1.9%	-1.4%	-0.7%

Fiscal Year	FY06	FY07	FY08	FY09
Sample Size	500	466	366	285
National 75th Percentile	6.8%	6.4%	5.6%	6.4%
National Median	2.2%	1.9%	1.9%	2.1%
National 25th Percentile	-0.7%	-0.7%	-1.2%	-0.8%

Formula: (Total Operating Revenue - Total Operating Expense) / Total Operating Revenue

# SECTION I: FINANCIAL INDICATORS AND RATIOS



## Bottom Line Margin

Operating Margin and Bottom Line Margin are key indicators of health centers' ability to generate income needed to sustain current operations and to support both short-term and long-term growth. The Bottom Line Margin specifically indicates the extent to which health centers are able to cover their Total Expense with both Operating and Non-Operating sources of revenue, including capital fundraising. The higher the margin, the stronger the financial performance. A bottom line margin of 3% or higher as well as consistent growth over time indicates relatively strong financial performance.

### Short-term Trend: FY08 to FY09

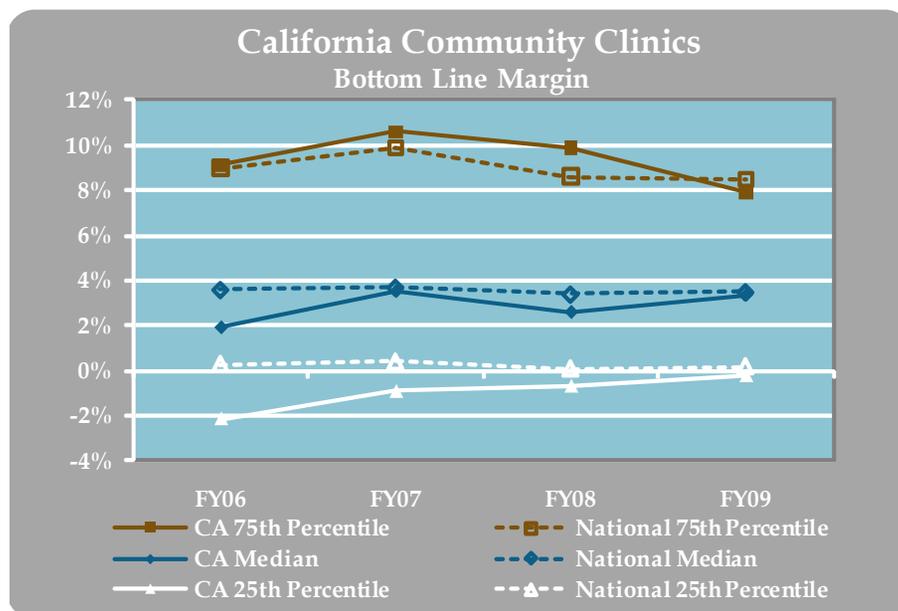
The median Bottom Line Margin trended upward in FY09, growing to 3.4% from 2.6% in FY08.

### Long-term Trend: FY06 to FY09

The median Bottom Line Margin for California Clinics averaged 2.9% over the FY06-FY09 period, with a high of 3.5% in FY07. Although the 75th percentile averaged a Bottom Line Margin of 9.4%, the lowest percentile (25th) generated negative margins in each year, averaging -1.0%. While still negative in FY09, the Operating Margin at the 25th percentile improved significantly between FY06 and FY09.

### Comparative Trend: State to National

At the median, national clinics performed consistently in the 3.5% -3.7% range, slightly better than their California peers. At the 75th percentile, California clinics performed slightly better than their peers at the national level, generating a 4-year average margin of 9.4% vs. 9.0% nationally.



Fiscal Year	FY06	FY07	FY08	FY09
Sample Size	194	189	196	181
CA 75th Percentile	9.1%	10.6%	9.9%	7.9%
CA Median	2.0%	3.5%	2.6%	3.4%
CA 25th Percentile	-2.1%	-0.9%	-0.7%	-0.2%

Fiscal Year	FY06	FY07	FY08	FY09
Sample Size	500	466	366	285
National 75th Percentile	9.0%	9.9%	8.6%	8.5%
National Median	3.6%	3.7%	3.4%	3.5%
National 25th Percentile	0.3%	0.4%	0.1%	0.2%

Formula: Net Income / Total Operating Revenues

## SECTION I: FINANCIAL INDICATORS AND RATIOS

### Days Unrestricted Cash on Hand

Days Cash on Hand measures the number of days of operating expense (less depreciation) that can be met with available unrestricted cash and investments if no additional revenue were received. Generally speaking, a higher number of Days Cash on Hand allows for more operational stability. For this reason, Capital Link generally recommends a minimum of 45-60 Days Cash on Hand. Limited cash reserves leaves clinics vulnerable to any slowdown in payments from payers and may inhibit their ability to address capital investment needs.

#### Short-term Trend: FY08 to FY09

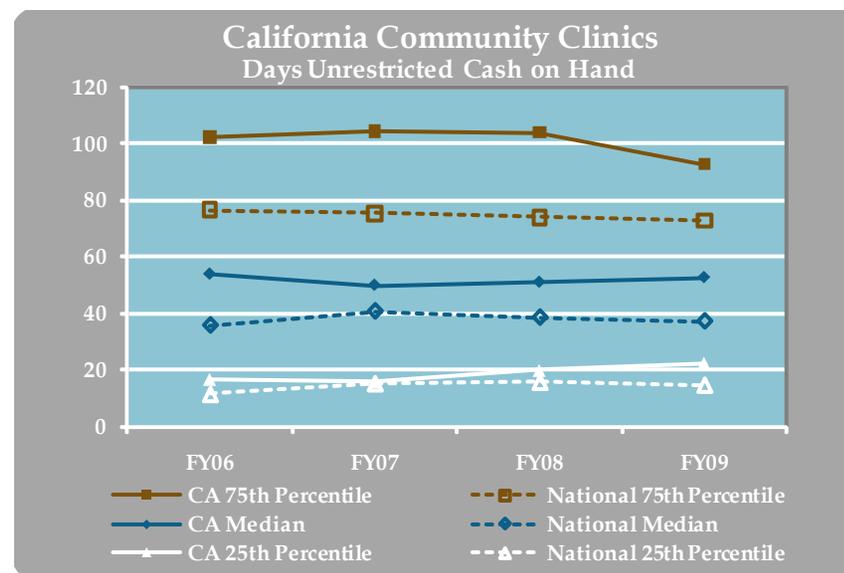
At the median, Days Cash on Hand remained relatively stable over this two year period at a healthy 51-52 Days.

#### Long-term Trend: FY06 to FY09

Similarly, Days Cash on Hand remained at a consistent level over the four-year period, ranging from 50-54 Days at the median. The 25th percentile of clinics generated a four-year average of 19 Days, well under minimum recommended cash levels. Health centers in this group may struggle paying bills on time. On the other hand, the 75th percentile of clinics generated a 4-year average of 101 Days Cash on Hand, representing over 3 months of operating reserves.

#### Comparative Trend: State to National

At all levels of Days Cash on Hand, California clinics operated with more cash on hand than their peers at the national level, particularly at the median and 75th percentile.



Fiscal Year	FY06	FY07	FY08	FY09
Sample Size	194	189	196	181
CA 75th Percentile	102.2	104.5	104.0	92.8
CA Median	54.1	50.0	51.1	52.8
CA 25th Percentile	16.8	15.9	20.0	22.6

Fiscal Year	FY06	FY07	FY08	FY09
Sample Size	500	466	366	286
National 75th Percentile	76.7	75.4	74.1	72.9
National Median	36.0	40.8	38.7	37.4
National 25th Percentile	11.5	15.2	15.7	14.7

Formula: Unrestricted Cash and Investments / ((Total Operating Expenses-Depreciation)/360 days)

# SECTION I: FINANCIAL INDICATORS AND RATIOS



## Days in All Accounts Receivable

Days in All Accounts Receivable measures the average number of days to collect outstanding receivables, including net patient receivables, grant and contract receivables and other receivables. Health centers should strive to maintain as fast a “receivables turn” as possible. A receivables turn of 90 days or more will be of concern to most funding sources.

### Short-term Trend: FY08 to FY09

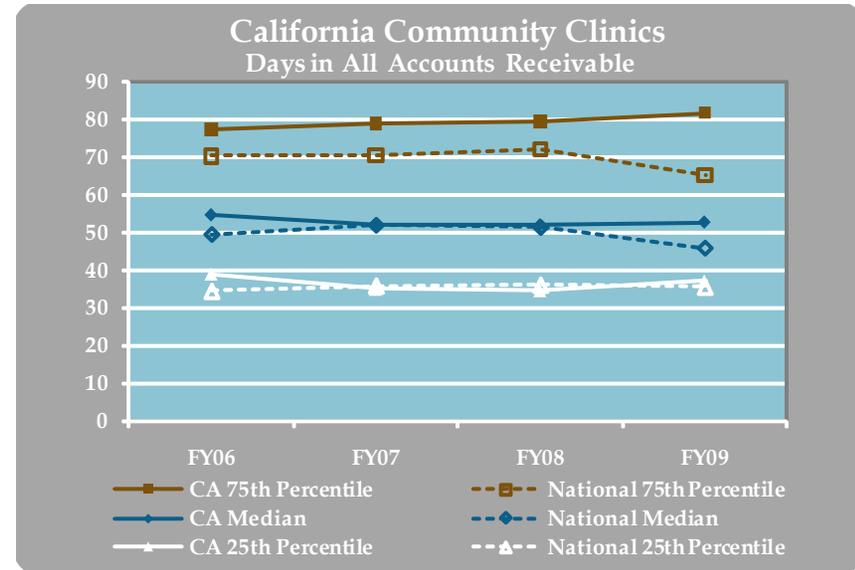
Median Days in All Accounts Receivable was just under 53 days in FY09, with very little change from FY08.

### Long-term Trend: FY06 to FY09

The median Days in Accounts Receivables stayed well below the 90 days recommended maximum over the period. At the median, California clinics generated an average receivables turn of 53 Days over this period, while at the 75th percentile clinics averaged 79 Days, well within the recommended guideline.

### Comparative Trend: State to National

Median Days in All Accounts Receivable for California clinics was equal to or slightly higher than comparative national values over the period.



Fiscal Year	FY06	FY07	FY08	FY09
Sample Size	181	178	191	180
CA 75th Percentile	77.3	78.9	79.4	81.7
CA Median	54.5	52.1	51.9	52.7
CA 25th Percentile	39.0	34.9	34.5	37.2

Fiscal Year	FY06	FY07	FY08	FY09
Sample Size	500	466	366	286
National 75th Percentile	70.2	70.5	72.0	65.2
National Median	49.5	52.0	51.4	45.8
National 25th Percentile	34.5	35.9	36.1	35.6

Formula:  $(\text{Net Patients Accounts Receivable} + \text{Pledges \& Grants \& Contracts Receivable} + \text{Other Receivables}) / ((\text{Net Patient Service Revenue} + \text{Grants \& Contracts Revenue} + \text{Net Assets Released from Restrictions})/360)$

# SECTION I: FINANCIAL INDICATORS AND RATIOS



## Days in Patient Accounts Receivable

Days in Patient Accounts Receivable measures the average number of days to collect payment for services provided to patients covered by third-party payers such as Medicaid and Medicare as well as to self-pay patients. Health centers should strive to maintain Days in Net Patient Receivables as low as possible, not exceeding 65 – 75 days.

### Short-term Trend: FY08 to FY09

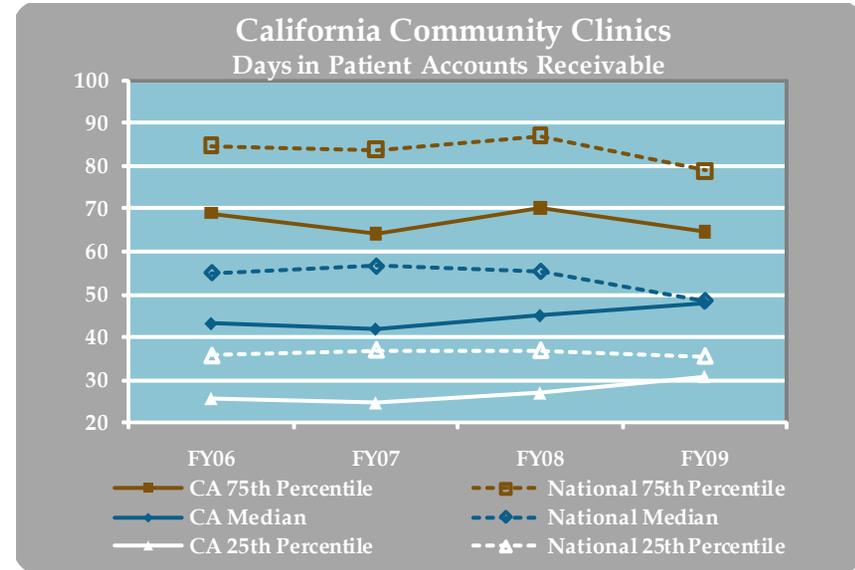
At the median, California clinics generated a relatively consistent and healthy level of Days in Patients Accounts Receivable (45-48 Days) during the most recent 2-year period. Even at the 75th percentile, the clinics did not exceed maximum recommended levels of 65-75 Days.

### Long-term Trend: FY06 to FY09

At the median, California clinics remained in the 40-50 Day range for patient collections, well within recommended levels for each year, and generated a 4-year average of 45 Days. At the 75th percentile, California clinics generated an average of 67 Days, also within the maximum recommended range but nevertheless may be indicative of billing or collection problems.

### Comparative Trend: State to National

At each percentile, California clinics generated a faster patient receivables turn than their national counterparts. In particular, the 75th percentile of the national clinics exceeded recommended collection cycle thresholds.



Fiscal Year	FY06	FY07	FY08	FY09
Sample Size	170	169	181	170
CA 75th Percentile	69.0	64.2	70.3	64.7
CA Median	43.2	41.9	45.0	47.8
CA 25th Percentile	25.6	24.5	26.8	30.6

Fiscal Year	FY06	FY07	FY08	FY09
Sample Size	493	461	364	283
National 75th Percentile	84.7	83.8	87.1	78.9
National Median	55.1	56.6	55.4	48.6
National 25th Percentile	35.7	37.0	36.9	35.6

Formula: Net Patient Accounts Receivable / ((Net Patient Service Revenue) / 360 days)

# SECTION I: FINANCIAL INDICATORS AND RATIOS



## Leverage Ratio

The Leverage Ratio measures a health center's total liabilities, both current and long-term, in relation to its net assets. A Leverage Ratio that is equal to 1.0 indicates that a health center's total liabilities (debt) are equal to its net assets (equity). Ideally, this ratio should not exceed 2.5, though health center's more commonly have a Leverage Ratio under 1.0.

### Short-term Trend: FY08 to FY09

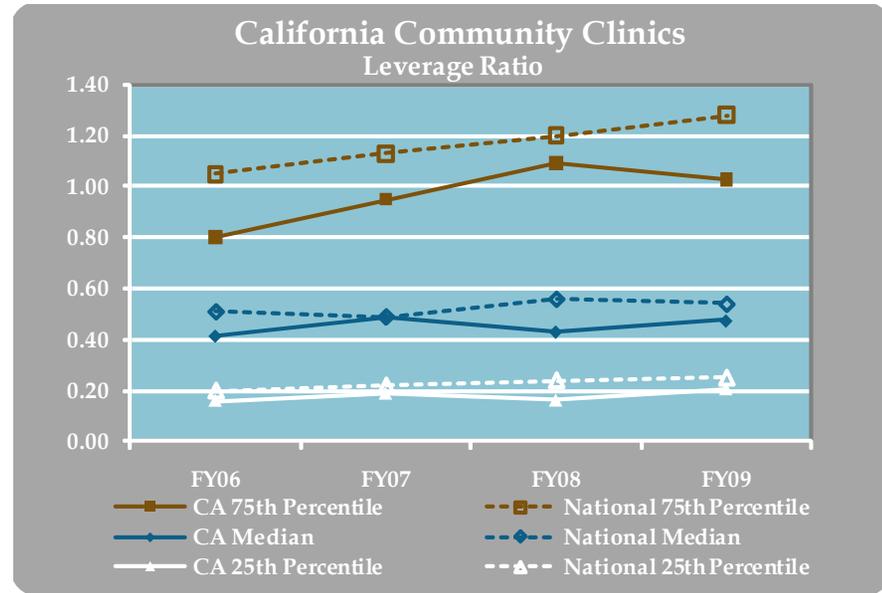
The median Leverage Ratio stayed relatively consistent, ranging from .43-.48 in this period.

### Long-term Trend: FY06 to FY09

Similarly, the 4-year results were very consistent, with the median Leverage Ratio fluctuating between 0.42-0.48. This leverage ratio would indicate that California clinics are carrying low levels of debt compared to their net asset position. Even at the 75th percentile, clinics averaged a 0.97 Leverage Ratio over this period, showing a financial position of less debt (liabilities) than equity (net assets). This overall low leverage may mean that that clinics have generally funded capital investment with grant support rather than with debt.

### Comparative Trend: State to National

The Leverage Ratio for California clinics is slightly lower compared to the national clinics, indicating that California clinics generally have less debt or more equity (or both) than their peers. However, the national clinics also generally operate from a position of low leverage, showing a mean Leverage Ratio that averages 0.53 over the 4-year period.



Fiscal Year	FY06	FY07	FY08	FY09
Sample Size	184	181	194	181
CA 75th Percentile	0.80	0.95	1.09	1.03
CA Median	0.42	0.48	0.43	0.48
CA 25th Percentile	0.16	0.19	0.16	0.21

Fiscal Year	FY06	FY07	FY08	FY09
Sample Size	499	466	366	285
National 75th Percentile	1.05	1.13	1.20	1.28
National Median	0.51	0.49	0.56	0.54
National 25th Percentile	0.20	0.22	0.24	0.25

Formula: Total Liabilities/Net Assets

## SECTION II: STAFFING MODELS AND CORRELATION ANALYSIS

One of the objectives of this study was to examine available data for potential relationships between various staffing ratios, productivity measures, and financial performance. To this end, various staffing ratios were calculated for each clinic based on available UDS data for 2006 through 2009. These staffing ratios were then analyzed for potential relationships with financial performance as defined by the Operating Margin for each year, based on IRS Form 990 data, as well as with certain productivity measures (UDS data) using correlation analysis.

For the purposes of this study, correlation between any variables is categorized as strong positive (0.70 to 1.00), moderate positive (0.50 to 0.69), weak positive (0.30 to 0.49), absent/no correlation (0.29 to -0.29), weak negative (-0.30 to -0.49), moderate negative (-0.50 to -0.69), or strong negative (-0.70 to -1.00).

In addition, this section also presents the trend for each staffing ratio over the four-year period and comparative national values for Federally Qualified Health Centers (FQHCs)..

### Mid-Level to Physician Ratio

**Area of Focus:** This ratio examines the staffing relationship between mid-level staff and physicians

**Formula:** Mid-Level/Physicians

**Definition:** Mid-Levels include Nurse Practitioners, Physician Assistants and Certified Nurse Midwives. Physicians include Family Practitioners, General Practitioners, Internists, Obstetricians/ Gynecologists, Pediatricians and other Specialty Physicians.

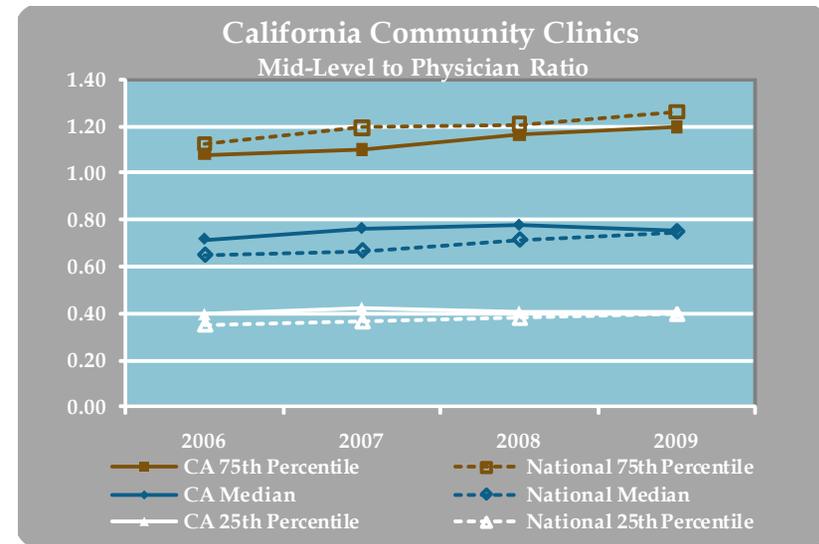
**Data Trends:** The California median for this ratio fluctuated only slightly between 2006 and 2009, moving between 0.72 – 0.78.

**National Comparison:** Overall, the ratio of Mid-Levels to Physicians for California clinics is relatively consistent with the clinics in the national FQHC data set.

### Correlation Analysis

An analysis of the relationship between this staffing ratio and financial performance, as measured by the Operating Margin showed no correlation (correlation = $r=0.01$ ).

Likewise, this staffing ratio showed no correlation to Physician Productivity, measured by Encounters per Physician ( $r=0.14$ ).



	2006	2007	2008	2009
Sample Size	75	80	84	87
CA 75th Percentile	1.08	1.10	1.16	1.20
CA Median	0.72	0.76	0.78	0.76
CA 25th Percentile	0.40	0.43	0.41	0.41

	2006	2007	2008	2009
Sample Size	968	1,031	1,059	1,113
National 75th Percentile	1.12	1.19	1.21	1.26
National Median	0.65	0.67	0.71	0.75
National 25th Percentile	0.35	0.37	0.38	0.40

## SECTION II: STAFFING MODELS AND CORRELATION ANALYSIS



### Enabling Staff to Physician Ratio

**Area of Focus:** This ratio examines at the staffing relationship between enabling staff and physicians.

**Formula:** Enabling Staff/Physicians

**Definition:** Enabling Staff includes Case Managers, Patient/Community Education Specialists, Outreach Workers, Transportation Staff, Eligibility Assistance Workers, Interpretation Staff, and Other Enabling Services.

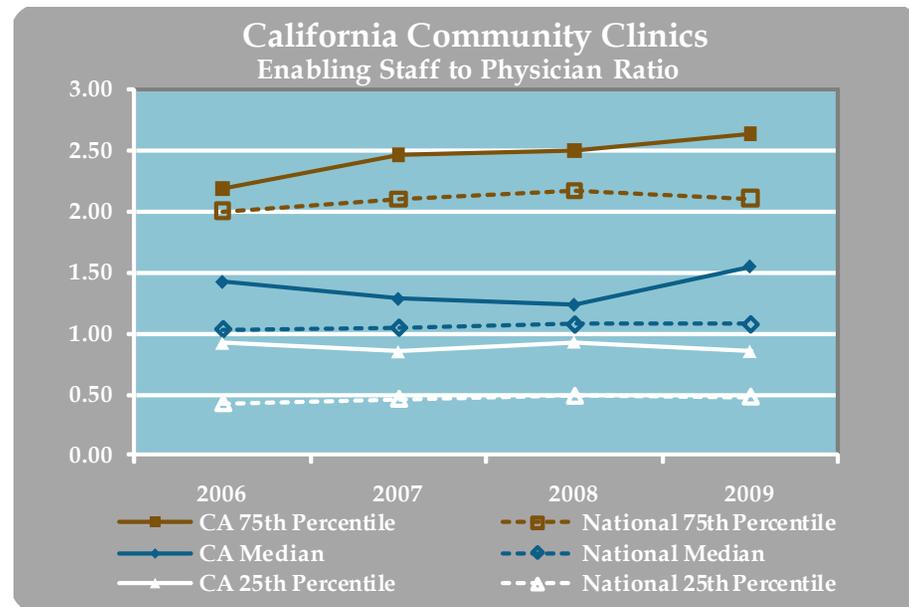
**Data Trends:** Over the four year review period, the median Enabling Staff to Physician Ratio grew only slightly from 1.42:1 to 1.55:1. The increase is more pronounced for the 75th percentile. .

**National Comparison:** Compared to their national peers, California clinics show a higher Enabling Staff to Physician Ratio at all percentiles.

#### Correlation Analysis

An analysis of the relationship between this staffing ratio and financial performance, as measured by the Operating Margin showed no correlation ( $r=0.11$ ).

This staffing ratio showed no correlation to Physician Productivity, measured by Encounters per Physician ( $r=0.02$ ).



	2006	2007	2008	2009
Sample Size	75	80	84	87
CA 75th Percentile	2.18	2.46	2.49	2.64
CA Median	1.42	1.29	1.24	1.55
CA 25th Percentile	0.92	0.85	0.93	0.85

	2006	2007	2008	2009
Sample Size	968	1,031	1,059	1,113
National 75th Percentile	2.00	2.10	2.17	2.10
National Median	1.04	1.05	1.07	1.07
National 25th Percentile	0.43	0.46	0.49	0.48

## SECTION II: STAFFING MODELS AND CORRELATION ANALYSIS



### Enabling Staff to Medical Provider Ratio

**Area of Focus:** This ratio examines the staffing relationship between enabling staff and medical providers.

**Formula:** Enabling Staff / (Physicians plus Mid-Levels)

**Definition:** Enabling Staff includes Case Managers, Patient/Community Education Specialists, Outreach Workers, Transportation Staff, Eligibility Assistance Workers, Interpretation Staff, and Other Enabling Services

Medical Providers include Physicians and Mid-Levels.

**Data Trends:** At the median, California clinics had a 0.85 Enabling Staff to Medical Provider ratio in 2009, while the 75th percentile had a support ratio of 1.46.

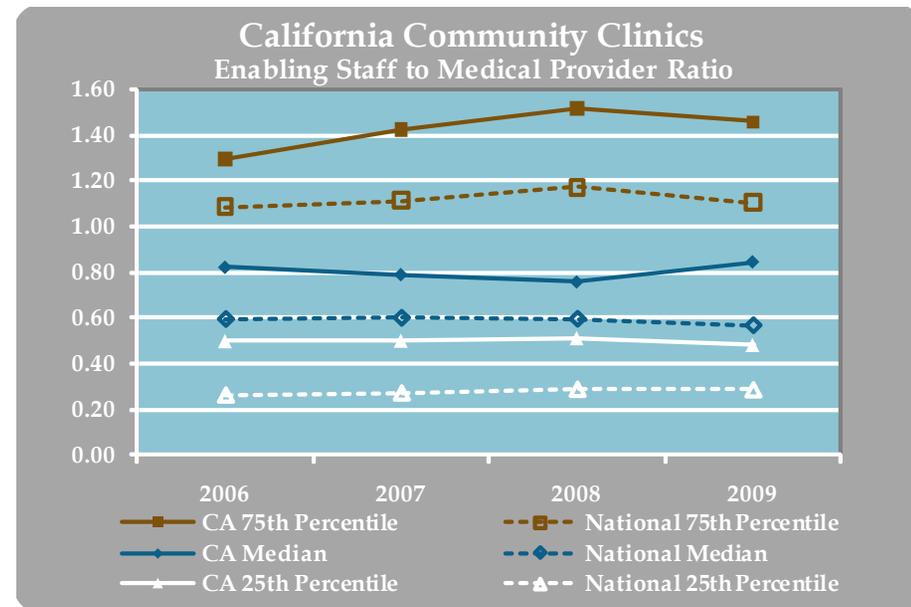
The Enabling Staff to Medical Provider Ratio remained relatively constant over the period.

**National Comparison:** The national clinics followed a similar pattern over the assessment period, though had a lower ratio for each year compared to their California peers.

#### Correlation Analysis

An analysis of the relationship between this staffing ratio and financial performance, as measured by the Operating Margin showed no correlation ( $r=0.18$ ).

This staffing ratio showed no correlation to Medical Provider Productivity, measured by Encounters per Medical Provider ( $r=0.05$ ).



	2006	2007	2008	2009
Sample Size	75	80	84	87
CA 75th Percentile	1.29	1.42	1.52	1.46
CA Median	0.82	0.79	0.76	0.85
CA 25th Percentile	0.50	0.50	0.51	0.49

	2006	2007	2008	2009
Sample Size	979	1,044	1,073	1,128
National 75th Percentile	1.08	1.11	1.17	1.10
National Median	0.59	0.60	0.60	0.57
National 25th Percentile	0.26	0.27	0.29	0.29

## SECTION II: STAFFING MODELS AND CORRELATION ANALYSIS



### Dental Support Staff to Dentist Ratio

**Formula:** Dental Support Staff / Dentists

**Area of Focus:** This ratio examines the staffing relationship between dental support staff and dentists.

**Definition:** Dental Support Staff: Dental Hygienists, Dental Assistants, Aides, Techs.

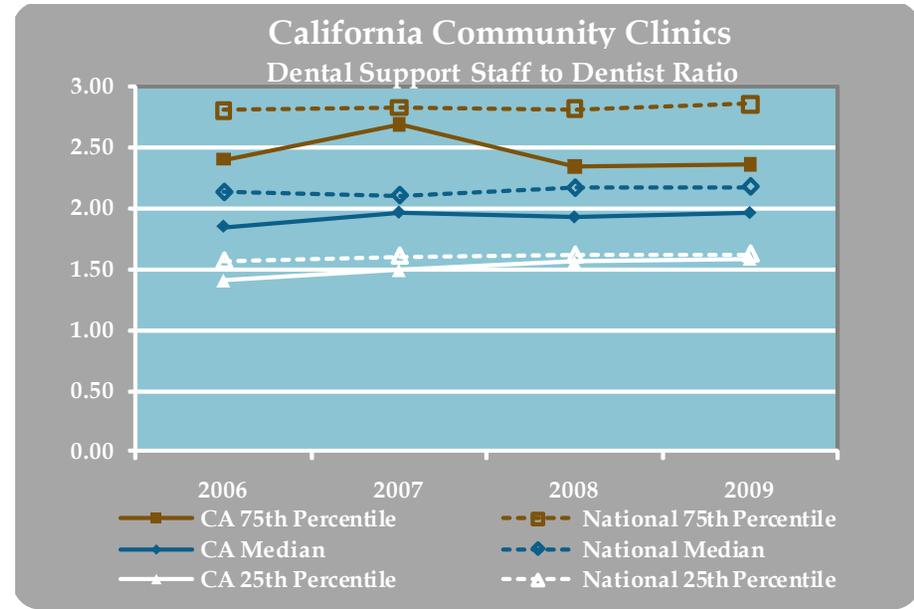
**Data Trends:** At the median level, California clinics had a Dental Support Staff to Dentist Ratio of just under 2:1 between 2006-2009.

**National Comparison:** The clinics within the national data consistently had a slightly higher support ratio for their dentists over the assessment period, though this difference is most pronounced at the 75th percentile.

### Correlation Analysis

An analysis of the relationship between this staffing ratio and financial performance, as measured by the Operating Margin showed no correlation ( $r=0.02$ ).

This staffing ratio showed no correlation to Dentist Productivity, measured by Encounters per Dentist ( $r=0.21$ ).



	2006	2007	2008	2009
Sample Size	56	62	66	67
CA 75th Percentile	2.40	2.68	2.34	2.35
CA Median	1.85	1.97	1.93	1.96
CA 25th Percentile	1.40	1.49	1.56	1.59

	2006	2007	2008	2009
Sample Size	709	757	782	823
National 75th Percentile	2.80	2.83	2.81	2.85
National Median	2.13	2.10	2.16	2.17
National 25th Percentile	1.57	1.60	1.61	1.62

## SECTION II: STAFFING MODELS AND CORRELATION ANALYSIS

### Mental Health Support Staff to Psychiatrist Ratio

**Area of Focus:** This ratio examines the staffing relationship between mental health support staff and psychiatrists.

**Formula:** Mental Support Staff/Psychiatrists

**Definition:** Mental Support Staff: Licensed Clinical Psychologists, Licensed Clinical Social Workers, Other Licensed Mental Health Providers, Other Mental Health Staff.

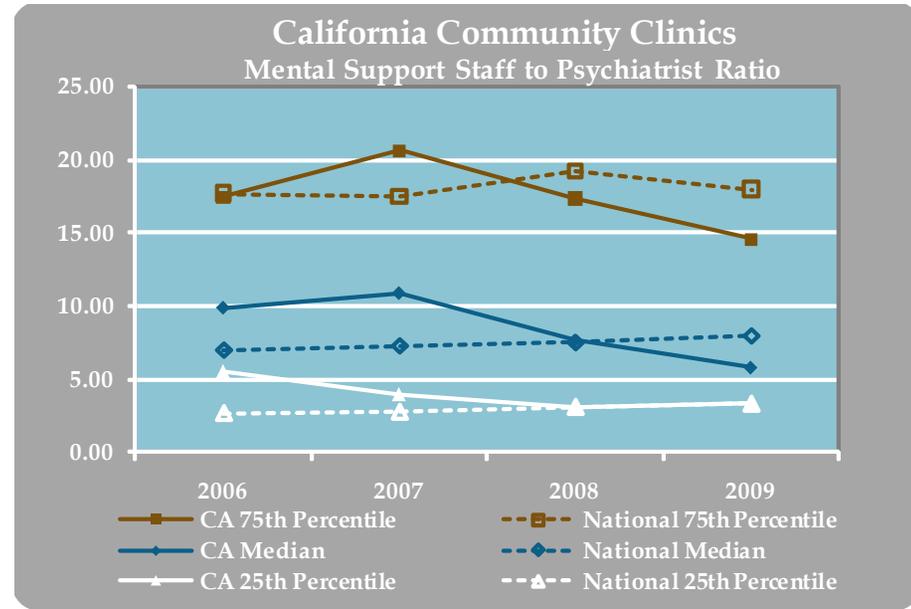
**Data Trends:** The data set illustrates significant variability in how California clinics staff for their psychiatrists. The Mental Support Staff to Psychiatrist ratio was between 10.9 to 5.8 at the median. The variability is even higher for the 75th percentile, fluctuating between 14.5 to 17.4. In both cases, the ratios are mostly trending downwards over the 4-year period.

**National Comparison:** The national data exhibit somewhat less variability over the assessment period, and at the median level stayed relatively flat at 7-8 Mental Support Staff per Psychiatrist.

#### Correlation Analysis

An analysis of the relationship between this staffing ratio and financial performance, as measured by the Operating Margin showed no correlation ( $r=0.16$ ).

This staffing ratio showed no correlation to Psychiatrist Productivity, measured by Encounters per Psychiatrist ( $r=0.18$ ).



	2006	2007	2008	2009
Sample Size	28	32	41	43
CA 75th Percentile	17.43	20.58	17.33	14.56
CA Median	9.91	10.91	7.67	5.80
CA 25th Percentile	5.51	3.98	3.08	3.41

	2006	2007	2008	2009
Sample Size	280	309	335	351
National 75th Percentile	17.67	17.50	19.21	17.98
National Median	6.97	7.28	7.51	8.00
National 25th Percentile	2.67	2.76	3.10	3.32

## SECTION III: STAFFING MODELS BY COHORT

Given the variability in clinic-level values of the measures examined in the previous section and the resulting lack of substantial correlation between variables, the clinics were grouped into cohorts according to their financial performance and productivity measures. The highest and lowest cohorts of both clinic groups (financial performance and productivity) were then compared using selected staffing ratios.

### Mid-Level to Physician Ratio: Highest and Lowest Financial Cohorts

**Area of focus:** This data illustrates the median staffing ratio of Mid-Levels to Physicians over the 2006-2009 period for the cohort of highest financial performers and lowest financial performers.

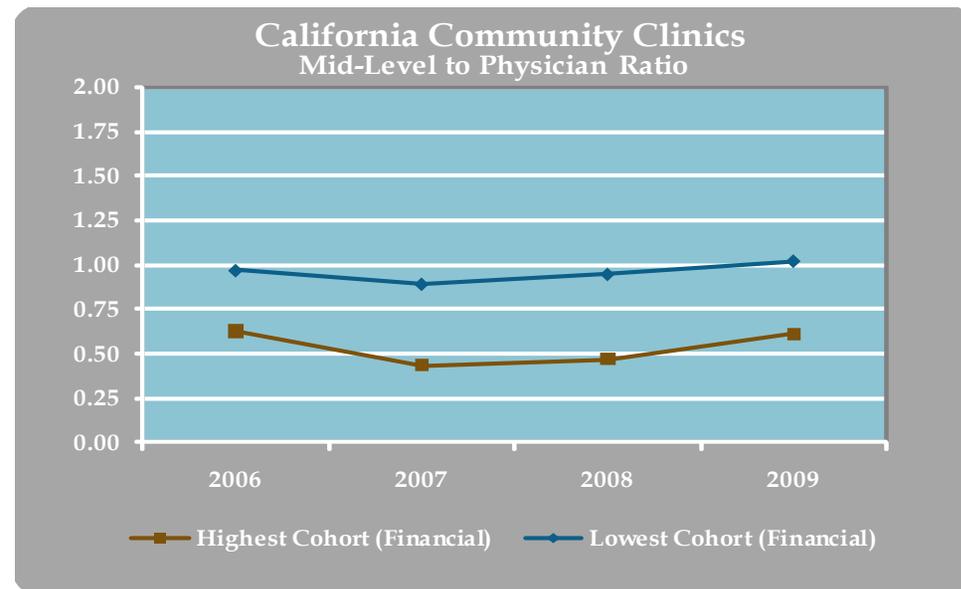
**Formula:** Mid-Level/Physicians

**Definition:** Mid-Levels include Nurse Practitioners, Physician Assistants and Certified Nurse Midwives. Physicians include Family Practitioners, General Practitioners, Internists, Obstetricians/Gynecologists, Pediatricians and other Specialty Physicians.

**Data Trends:** The highest performers had a median staffing ratio of 0.44-0.61 over the 4-year period, with an average result of 0.54 Mid-Levels per Physician.

The lowest performing cohort had a median staffing ratio of 0.89–1.02, with an average result of 0.96.

**Cohort Comparison:** The highest performing cohort consistently had a lower median staffing ratio of Mid-Levels to Physician than the lower performing cohort. On average, the ratio for the lowest cohort was almost twice that of the highest cohort.



Year	2006	2007	2008	2009	Average
<b>Ratio (Median)</b>					
Highest Cohort (Financial)	0.63	0.44	0.47	0.61	0.54
Lowest Cohort (Financial)	0.97	0.89	0.95	1.02	0.96
<b>Sample Size</b>					
Highest Cohort (Financial)	18	18	18	18	
Lowest Cohort (Financial)	29	29	29	29	

## SECTION III: STAFFING MODELS BY COHORT

### Mid-Level to Physician Ratio: Highest and Lowest Productivity Cohorts

**Area of Focus:** This data illustrates the median staffing ratio of Mid-Levels to Physicians over the 2006-2009 period for the cohort of most productive clinics and least productive clinics.

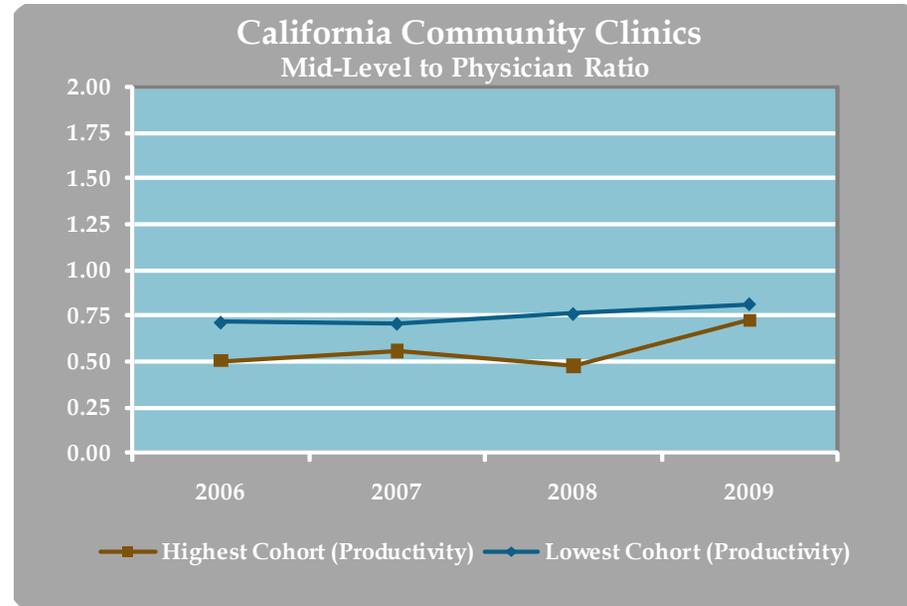
**Formula:** Mid-Level/Physicians

**Definition:** Mid-Levels include Nurse Practitioners, Physician Assistants and Certified Nurse Midwives. Physicians include Family Practitioners, General Practitioners, Internists, Obstetricians/Gynecologists, Pediatricians and other Specialty Physicians.

**Data Trends:** The most productive clinics had a median staffing ratio of 0.48 to 0.73 over the 4-year period, with an average result of **0.57 Mid-Levels per Physician**.

The least productive cohort had a median staffing ratio of 0.71 – 0.82, with an average result of **0.75**.

**Cohort Comparison:** Although the difference was not as pronounced as with the financial cohorts, the highest productivity cohort consistently also had a lower Mid-Level to Physician ratio than the lowest productivity cohort.



	2006	2007	2008	2009	Average
<b>Ratio (Median)</b>					
Highest Cohort (Productivity)	0.51	0.56	0.48	0.73	0.57
Lowest Cohort (Productivity)	0.72	0.71	0.76	0.82	0.75
<b>Sample Size</b>					
Highest Cohort (Productivity)	20	20	20	20	
Lowest Cohort (Productivity)	28	28	28	28	

## SECTION III: STAFFING MODELS BY COHORT

### Enabling Staff to Physician Ratio: Highest and Lowest Financial Cohorts

**Area of Focus:** This data illustrates the median staffing ratio of Enabling Staff to Physicians over the 2006-2009 period for the cohort of highest financial performers and lowest financial performers.

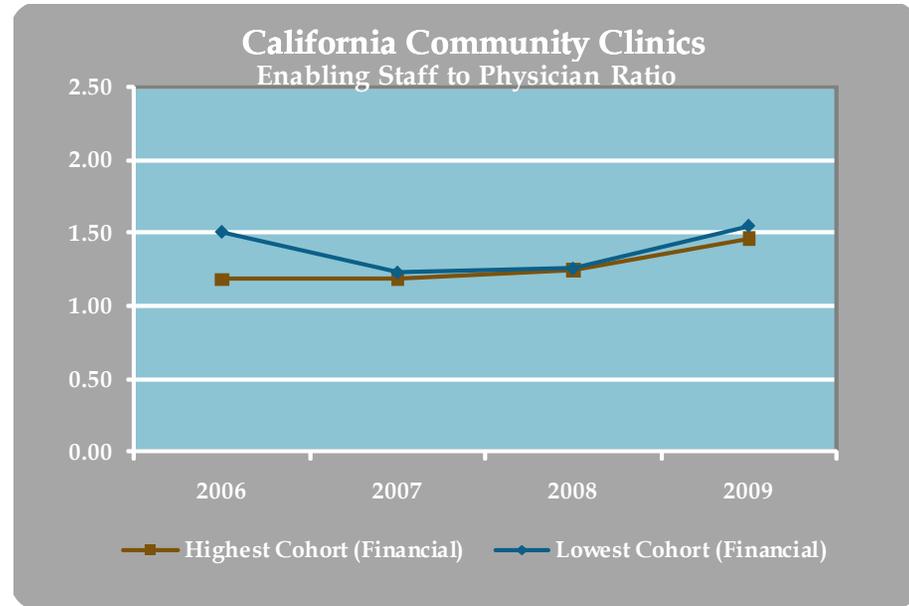
**Formula:** Enabling Staff/Physicians

**Definition:** Enabling Staff includes Case Managers, Patient/Community Education Specialists, Outreach Workers, Transportation Staff, Eligibility Assistance Workers, Interpretation Staff, and Other Enabling Services

**Data Trends:** The highest financial performers had a median staffing ratio of 1.18 to 1.46 over the 4-year period, with an average result of 1.27 Enabling staff per Physician.

The lowest performing cohort had a median staffing ratio of 1.23 to 1.55, with an average result of 1.38 Enabling Staff per Physician.

**Cohort Comparison:** The trend lines of this ratio show similar results for both the high financial performers and the low financial performers.



Year	2006	2007	2008	2009	Average
<b>Ratio (Median)</b>					
Highest Cohort (Financial)	1.18	1.19	1.24	1.46	1.27
Lowest Cohort (Financial)	1.51	1.23	1.26	1.55	1.38
<b>Sample Size</b>					
Highest Cohort (Financial)	18	18	18	18	
Lowest Cohort (Financial)	29	29	29	29	

## SECTION III: STAFFING MODELS BY COHORT

### Enabling Staff to Physician Ratio: Highest and Lowest Productivity Cohorts

**Area of Focus:** This data illustrates the median staffing ratio of Enabling Staff to Physicians over the 2006-2009 period for the cohort of most productive clinics and least productive clinics.

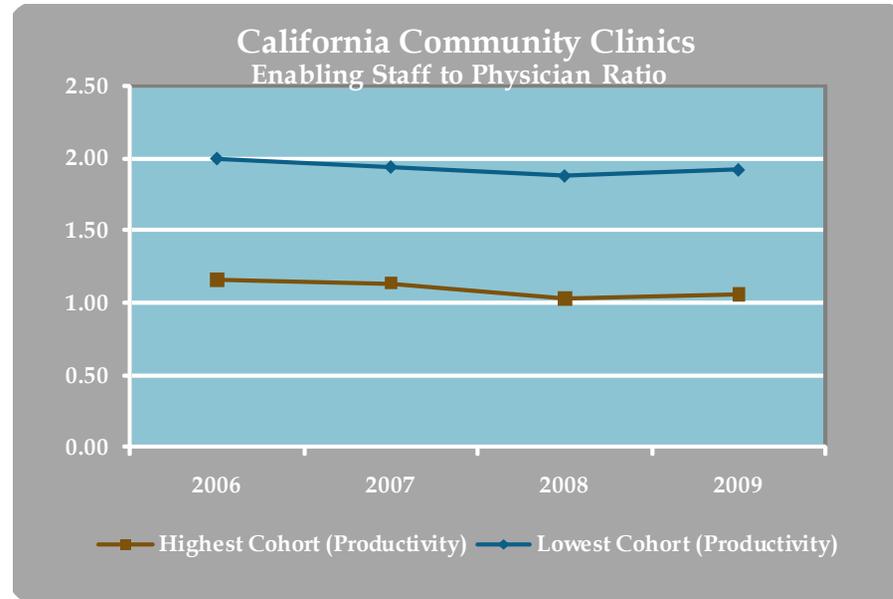
**Formula:** Enabling Staff/Physicians

**Definition:** Enabling Staff includes Case Managers, Patient/Community Education Specialists, Outreach Workers, Transportation Staff, Eligibility Assistance Workers, Interpretation Staff, and Other Enabling Services

**Data Trends:** The most productive clinics had a median staffing ratio of 1.03 to 1.14 over the 4-year period, with an average result of 1.1 Enabling Staff per Physician.

The least productive clinic cohort had a median staffing ratio of 1.92 to 2.0, with an average result of 1.94 Enabling Staff per Physician.

**Cohort Comparison:** As shown by the graphic, in general the high productivity performers consistently had a lower Enabling Staff to Physician ratio than their peers in the lowest productivity cohort.



	2006	2007	2008	2009	Average
<b>Ratio (Median)</b>					
Highest Cohort (Productivity)	1.16	1.14	1.03	1.06	1.10
Lowest Cohort (Productivity)	2.00	1.94	1.88	1.92	1.94
<b>Sample Size</b>					
Highest Cohort (Productivity)	20	20	20	20	
Lowest Cohort (Productivity)	28	28	28	28	

## SECTION III: STAFFING MODELS BY COHORT

### Enabling Staff to Medical Provider Ratio: Highest and Lowest Financial Cohorts

**Area of Focus:** This data illustrates the median staffing ratio of Enabling Staff to Providers over the 2006-2009 period for the cohort of high financial performers as well as for the cohort of low financial performers.

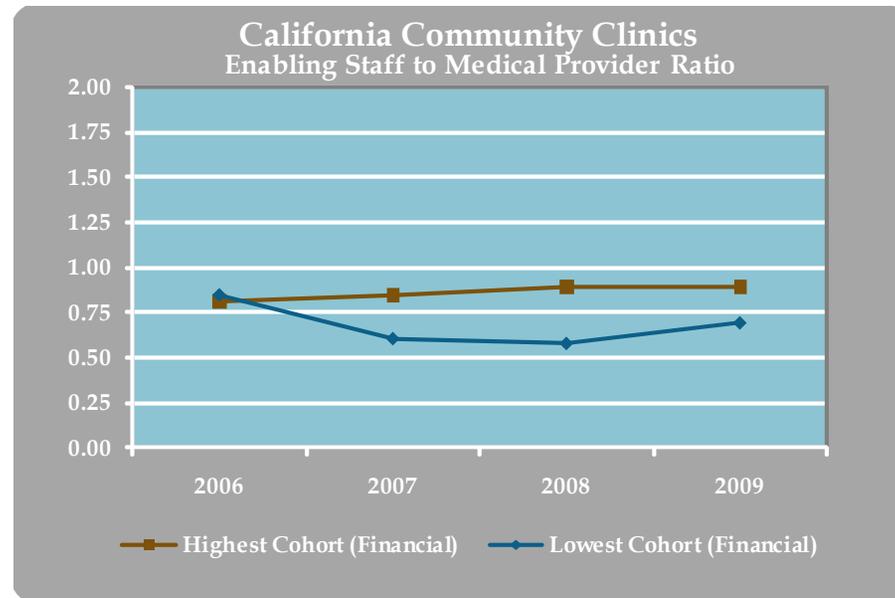
**Formula:** Enabling Staff / (Physicians plus Mid-Levels)

**Definition:** Enabling Staff includes Case Managers, Patient/Community Education Specialists, Outreach Workers, Transportation Staff, Eligibility Assistance Workers, Interpretation Staff, and Other Enabling Services. Medical Providers include Physicians and Mid-Levels.

**Data Trends:** The highest financial performers had a median staffing ratio of 0.81 to 0.89 over the 4-year period, with an average result of 0.86 Enabling Staff per Medical Provider.

The lowest performing cohort had a median staffing ratio of 1.23 to 1.55, with an average result of 0.68 Enabling Staff per Medical Provider.

**Cohort Comparison:** The trend lines of this ratio show that, at the median, the highest performing clinics have a similar but slightly higher ratio of Enabling Staff to Medical Provider than the clinics in the lowest performing cohort.



Year	2006	2007	2008	2009	Average
Ratio (Median)					
Highest Cohort (Financial)	0.81	0.85	0.89	0.89	0.86
Lowest Cohort (Financial)	0.85	0.60	0.58	0.69	0.68
Sample Size					
Highest Cohort (Financial)	18	18	18	18	
Lowest Cohort (Financial)	29	29	29	29	

## SECTION III: STAFFING MODELS BY COHORT

### Enabling Staff to Medical Provider Ratio: Highest and Lowest Productivity Cohorts

**Area of Focus:** This data illustrates the median staffing ratio of Enabling Staff to Providers over the 2006-2009 period for the cohort of most productive clinics and least productive clinics.

**Formula:** Enabling Staff / (Physicians plus Mid-Levels)

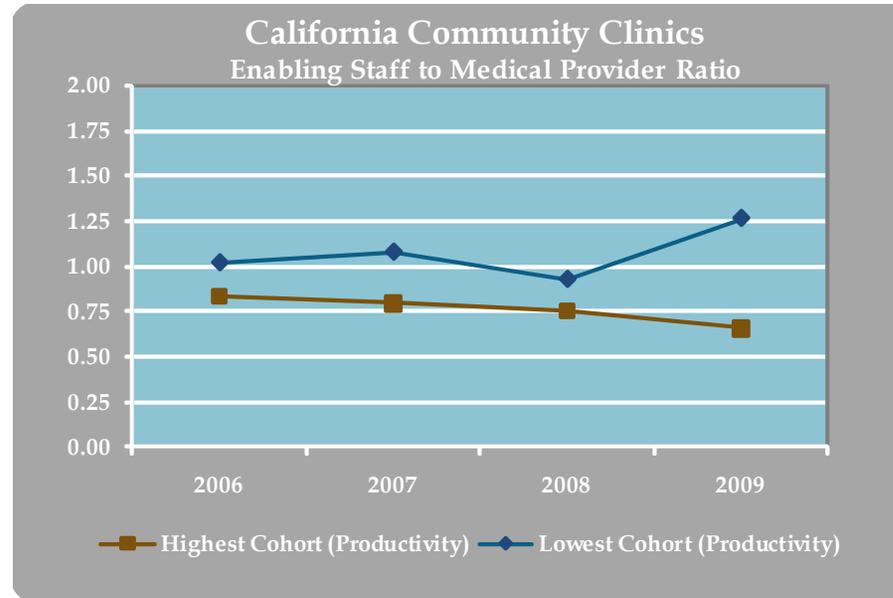
**Definition:** Enabling Staff includes Case Managers, Patient/Community Education Specialists, Outreach Workers, Transportation Staff, Eligibility Assistance Workers, Interpretation Staff, and Other Enabling Services

Medical Providers include Physicians and Mid-Levels.

**Data Trends:** The most productive clinics had a median staffing ratio of 0.66 to 0.83 over the 4-year period, with an average result of 0.76 Enabling Staff per Medical Provider.

The least productive clinic cohort had a median staffing ratio of 0.9 to 1.27, with an average result of 1.08 Enabling Staff per Medical Provider.

**Cohort Comparison:** As shown by the graphic, the highly productive performers consistently had a lower Enabling Staff to Medical Provider ratio than their peers in the lowest cohort.



	2006	2007	2008	2009	Average
<b>Ratio (Median)</b>					
Highest Cohort (Productivity)	0.83	0.79	0.76	0.66	0.76
Lowest Cohort (Productivity)	1.02	1.08	0.93	1.27	1.08
<b>Sample Size</b>					
Highest Cohort (Productivity)	20	20	20	20	
Lowest Cohort (Productivity)	28	28	28	28	

## SECTION IV: PRODUCTIVITY MEASURES BY FINANCIAL COHORT

Similar to the previous section, this section examines potential differentiation between the highest and lowest financial performance cohorts based on a number of productivity measures. Productivity is measured at three different levels; the entire organization, the clinical team, and all providers, as defined below. For each level, productivity is examined both in terms of the number of encounters as well as number of patients served with the purpose of assessing whether either of these measures may be more closely associated with financial performance.

### Organizational Productivity-Encounters

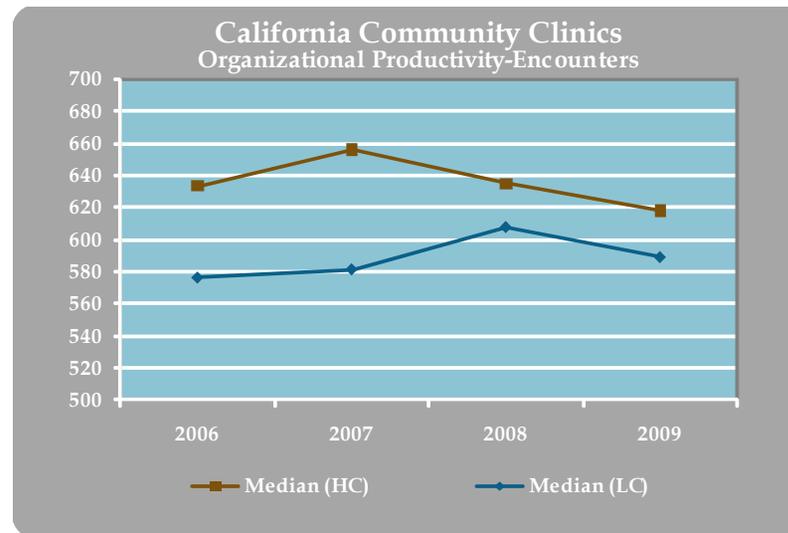
**Area of Focus:** The following illustrates the organizational productivity measure Total Encounters/Total FTEs over the 2006-2009 period for the cohort of highest financial performers clinics and lowest financial performers.

**Formula:** Total Encounters/Total FTEs

**Data Trends:** The highest performing clinics had a median organizational productivity measure of 618-656 Encounters/Total FTEs over the 4-year period, with an average result of 636 Encounters/FTE.

The lowest performing clinics had a median organizational productivity measure of 576-608 Encounters/Total FTEs over the 4-year period, with an average result of 589 Encounters/FTE.

**Cohort Comparison:** At the median level, the clinics in the high performing cohort consistently had a higher organizational productivity measure (Encounters/FTEs) than the clinics in the lowest performing cohorts. At the same time, there was significant variability in this productivity measure within each cohort.



	2006	2007	2008	2009	Average
<b>Highest Cohort (HC)</b>					
60th Percentile	677	683	669	702	683
<b>Median (HC)</b>	<b>633</b>	<b>656</b>	<b>635</b>	<b>618</b>	<b>636</b>
40th Percentile	569	620	590	598	594
<b>Lowest Cohort (LC)</b>					
60th Percentile	585	608	622	602	604
<b>Median (LC)</b>	<b>576</b>	<b>582</b>	<b>608</b>	<b>589</b>	<b>589</b>
40th Percentile	558	562	594	559	568
<b>Sample Size</b>					
	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	
Highest Cohort	18	18	18	18	
Lowest Cohort	29	29	29	29	

## SECTION IV: PRODUCTIVITY MEASURES BY FINANCIAL COHORT

### Organizational Productivity-Patients

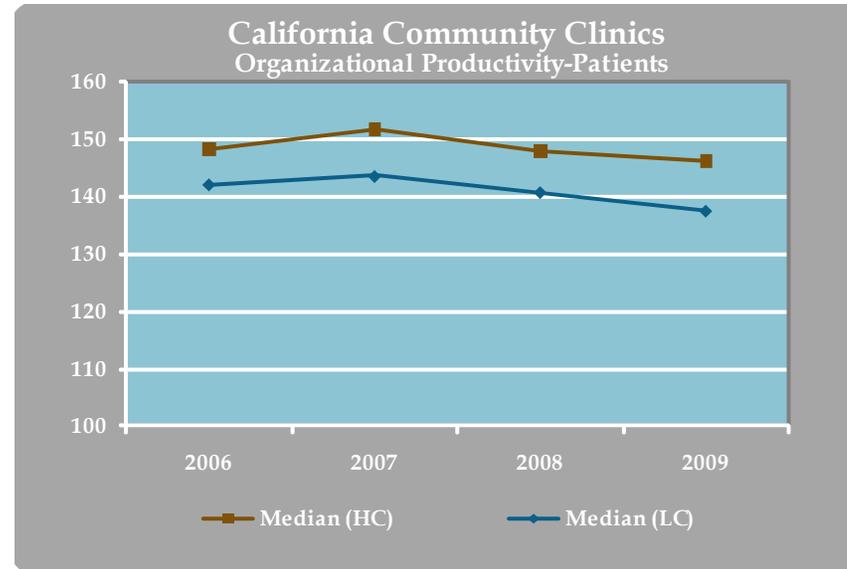
**Area of Focus:** The following illustrates the organizational productivity measure Total Patients/Total FTEs over the 2006-2009 period for the cohort of highest financial performers clinics and lowest financial performers.

**Formula:** Total Patients/Total FTEs

**Data Trends:** The highest cohort clinics had a median organizational productivity measure of 146-152 Patients/Total FTEs over the 4-year period, with an average result of 148 Patients per FTE.

The least productive clinics had a median organizational productivity measure of 137-142 Patients/Total FTEs over the 4-year period, with an average result of 141 Patients per FTE.

**Cohort Comparison:** At the median level, the clinics in the high performing cohort consistently had a higher organizational productivity measure (Patients/FTEs) than the clinics in the lowest performing cohorts. At the same time, there was significant variability in this productivity measure within each cohort.



	2006	2007	2008	2009	Average
<b>Highest Cohort (HC)</b>					
60th Percentile	158	166	153	160	159
<b>Median (HC)</b>	<b>148</b>	<b>152</b>	<b>148</b>	<b>146</b>	<b>148</b>
40th Percentile	138	142	133	138	138
<b>Lowest Cohort (LC)</b>					
60th Percentile	149	151	147	145	148
<b>Median (LC)</b>	<b>142</b>	<b>144</b>	<b>141</b>	<b>137</b>	<b>141</b>
40th Percentile	136	137	137	134	136
<b>Sample Size</b>					
	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	
Highest Cohort	18	18	18	18	
Lowest Cohort	29	29	29	29	

## SECTION IV: PRODUCTIVITY MEASURES BY FINANCIAL COHORT

### Clinical Team Productivity-Encounters

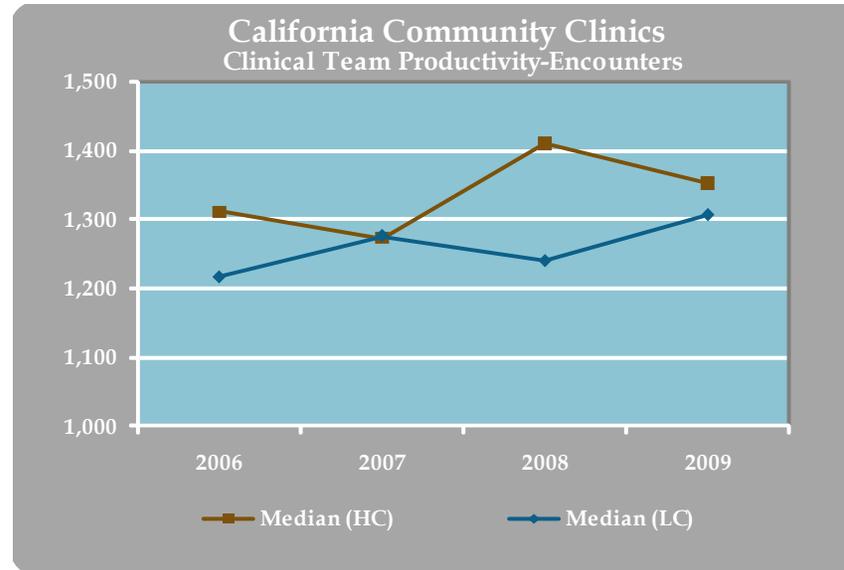
**Area of Focus:** The following illustrates the productivity measure Clinical Team Encounters/Clinical Team FTEs over the 2006-2009 period for the cohort of highest financial performers clinics and lowest financial performers.

**Formula:** Medical+Dental+Mental+Substance Abuse Encounters/Medical+Dental+Mental+Substance Abuse Team FTEs

**Data Trends:** The highest performing clinics had a median clinical team productivity measure of 1,273-1,410 Team Encounters/Team FTEs over the 4-year period, with an average result of 1,337 Clinical Team Encounters/Clinical Team FTE.

The lowest performing clinics had a median clinical team productivity measure of 1,216-1,306 Team Encounters/Team FTEs over the 4-year period, with an average result of 1,259 Clinical Team Encounters/Clinical Team FTE.

**Cohort Comparison:** At the median level, there is some cross over between the cohorts in this productivity measure during the 4-year assessment period, though in general the highest performing clinics were more productive based on this clinical team measure.



	2006	2007	2008	2009	Average
<b>Highest Cohort (HC)</b>					
60th Percentile	1,391	1,330	1,449	1,458	1,407
<b>Median (HC)</b>	<b>1,311</b>	<b>1,273</b>	<b>1,410</b>	<b>1,353</b>	<b>1,337</b>
40th Percentile	1,194	1,228	1,283	1,272	1,244
<b>Lowest Cohort (LC)</b>					
60th Percentile	1,311	1,346	1,334	1,386	1,344
<b>Median (LC)</b>	<b>1,216</b>	<b>1,276</b>	<b>1,240</b>	<b>1,306</b>	<b>1,259</b>
40th Percentile	1,179	1,150	1,143	1,224	1,174
<b>Sample Size</b>					
	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	
Highest Cohort	18	18	18	18	
Lowest Cohort	29	29	29	29	

# SECTION IV: PRODUCTIVITY MEASURES BY FINANCIAL COHORT



## Clinical Team Productivity-Patients

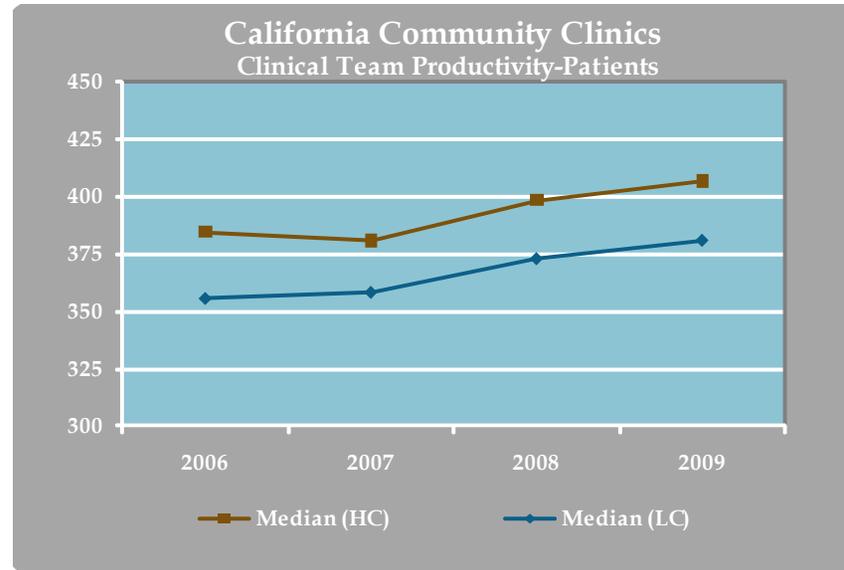
**Area of Focus:** The following illustrates the productivity measure Clinical Team Patients /Clinical Team FTEs over the 2006-2009 period for the cohort of highest financial performers clinics and lowest financial performers.

**Formula:** Medical+Dental+Mental+Substance Abuse Patients/Medical+Dental+Mental+Substance Abuse Team FTEs

**Data Trends:** The highest performing clinics had a median clinical team productivity measure of 381-406 Clinical Team Patients/Clinical Team FTEs over the 4-year period, with an average result of 392 Clinical Team Patients/Clinical Team FTE.

The lowest performing clinics had a median clinical team productivity measure of 356-381 Clinical Team Patients/Clinical Team FTEs over the 4-year period, with an average result of 367 Clinical Team Patients/Clinic Team FTE.

**Cohort Comparison:** At the median level, the highest performing clinics consistently demonstrated a slightly higher ratio of Clinical Team Patients/Clinical Team FTEs than their peers in the lowest performing cohort.



	2006	2007	2008	2009	Average
<b>Highest Cohort (HC)</b>					
60th Percentile	410	397	441	415	416
<b>Median (HC)</b>	<b>385</b>	<b>381</b>	<b>398</b>	<b>406</b>	<b>392</b>
40th Percentile	344	342	371	382	360
<b>Lowest Cohort (LC)</b>					
60th Percentile	391	389	389	386	389
<b>Median (LC)</b>	<b>356</b>	<b>358</b>	<b>373</b>	<b>381</b>	<b>367</b>
40th Percentile	338	334	336	345	338
<b>Sample Size</b>					
	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	
Highest Cohort	18	18	18	18	
Lowest Cohort	29	29	29	29	

## SECTION IV: PRODUCTIVITY MEASURES BY FINANCIAL COHORT

### All Provider Productivity-Encounters

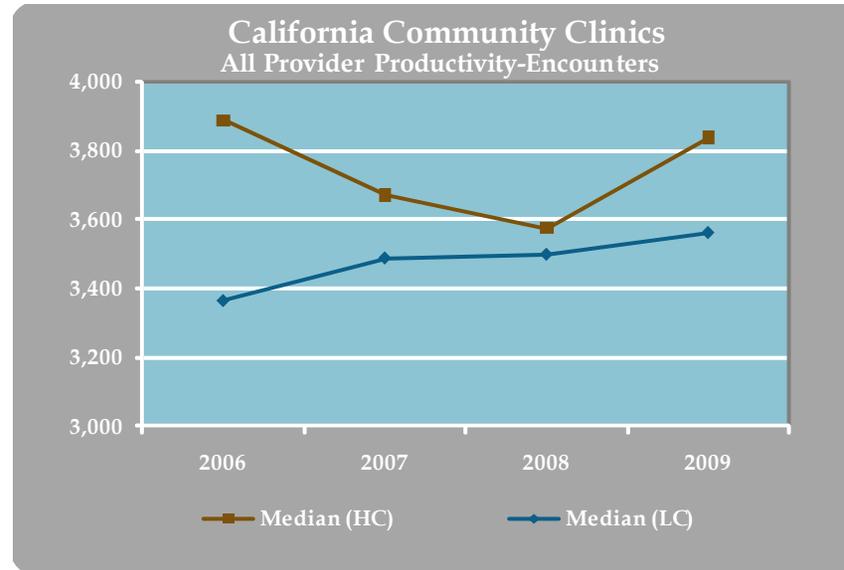
**Area of Focus:** The following illustrates the productivity measure All Provider Encounters/ All Provider FTEs over the 2006-2009 period for the cohort of highest financial performers clinics and lowest financial performers.

**Formula:** Medical+Dental+Mental+Substance Abuse Encounters/Medical+Dental+Mental+Substance Abuse Provider FTEs

**Data Trends:** At the median, the highest performing clinics had an all provider productivity measure of 3,575-3,887 All Provider Encounters/ All Provider FTEs over the 4-year period, with an average result of 3,743 All Provider Encounters/ All Provider FTEs.

The lowest performing clinics had a median clinical team productivity measure of 3,367-3,561 All Provider Encounters/ All Provider FTEs over the 4-year period, with an average result of 3,479 All Provider Encounters/ All Provider FTEs.

**Cohort Comparison:** At the median level, the highest performing clinics were consistently more productive based on this measure than their peers in the lowest performing cohort, though the two cohorts had similar productivity ratios in 2008.



	2006	2007	2008	2009	Average
<b>Highest Cohort (HC)</b>					
60th Percentile	4,133	3,868	4,042	3,930	3,993
<b>Median (HC)</b>	<b>3,887</b>	<b>3,669</b>	<b>3,575</b>	<b>3,839</b>	<b>3,743</b>
40th Percentile	3,657	2,944	3,010	3,299	3,227
<b>Lowest Cohort (LC)</b>					
60th Percentile	3,766	3,753	3,783	3,703	3,751
<b>Median (LC)</b>	<b>3,367</b>	<b>3,489</b>	<b>3,499</b>	<b>3,561</b>	<b>3,479</b>
40th Percentile	3,187	3,189	3,314	3,519	3,302
<b>Sample Size</b>					
	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	
Highest Cohort	18	18	18	18	
Lowest Cohort	29	29	29	29	

## SECTION IV: PRODUCTIVITY MEASURES BY FINANCIAL COHORT

### All Provider Productivity-Patients

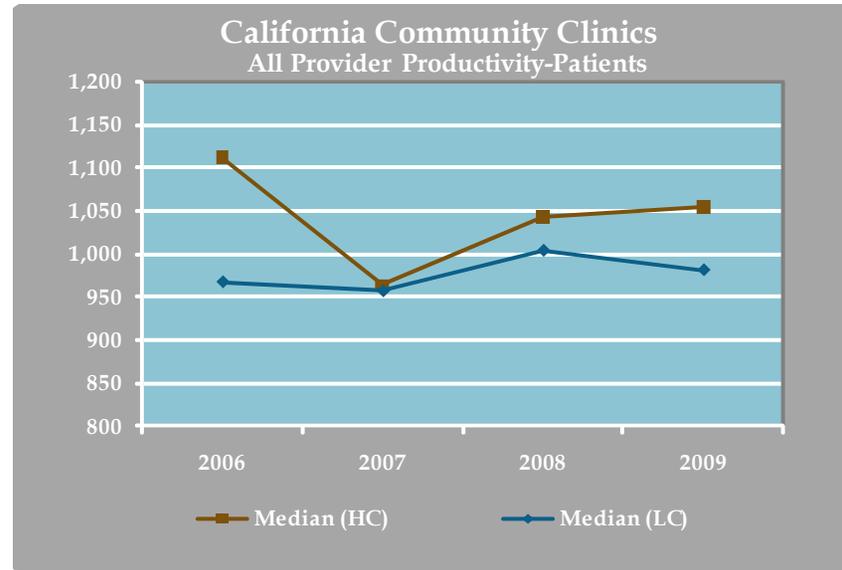
**Area of Focus:** The following illustrates the productivity measure All Provider Patients/All Provider FTEs over the 2006-2009 period for the cohort of highest financial performers clinics and lowest financial performers.

**Formula:** Medical+Dental+Mental+Substance Abuse Patients/Medical+Dental+Mental+Substance Abuse Provider FTEs

**Data Trends:** At the median, the highest performing clinics had an all provider productivity measure of 964-1,112 All Provider Patients/All Provider FTEs over the 4-year period, with an average result of 1,043 All Provider Patients/All Provider FTEs.

The lowest performing clinics had a median clinical team productivity measure of 957-1,005 Team Encounters/Team FTEs over the 4-year period, with an average result of 978 All Provider Patients/All Provider FTEs.

**Cohort Comparison:** At the median level, the highest performing clinics were somewhat more productive based on this measure than their peers in the lowest performing cohort, though there were significant productivity variations within each cohort.



	2006	2007	2008	2009	Average
<b>Highest Cohort (HC)</b>					
60th Percentile	1,162	1,072	1,075	1,153	1,116
<b>Median (HC)</b>	<b>1,112</b>	<b>964</b>	<b>1,043</b>	<b>1,055</b>	<b>1,043</b>
40th Percentile	957	868	969	957	938
<b>Lowest Cohort (LC)</b>					
60th Percentile	1,102	1,080	1,146	1,062	1,097
<b>Median (LC)</b>	<b>968</b>	<b>957</b>	<b>1,005</b>	<b>982</b>	<b>978</b>
40th Percentile	897	930	941	916	921
<b>Sample Size</b>					
Highest Cohort	18	18	18	18	
Lowest Cohort	29	29	29	29	

## SECTION IV: PRODUCTIVITY MEASURES BY FINANCIAL COHORT



### Medical Team Productivity-Encounters

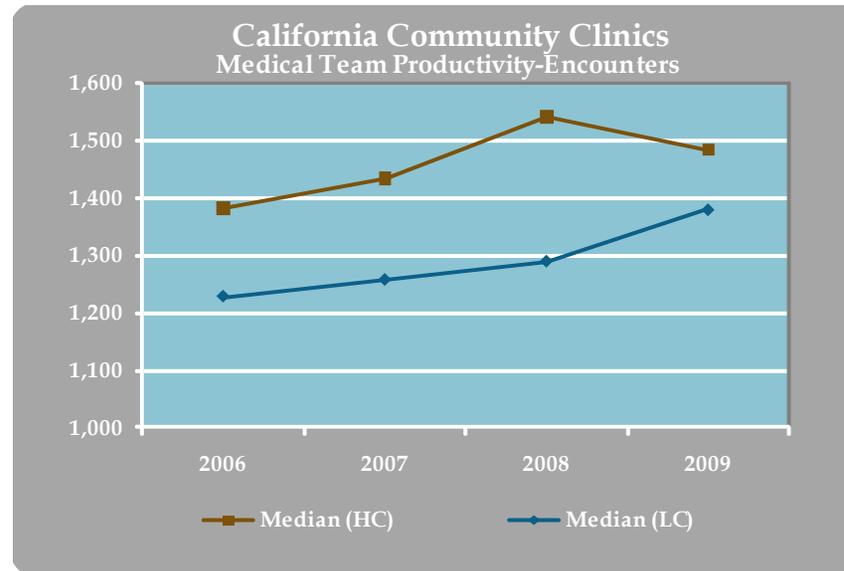
**Area of Focus:** The following illustrates the productivity measure Medical Team Encounters /Medical Team FTEs over the 2006-2009 period for the cohort of highest financial performers and lowest financial performers.

**Formula:** Total Medical Encounters/Total Medical FTEs

**Data Trends:** The highest performing clinics had a median medical team productivity measure of 1,383-1,541 Medical Team Encounters /Medical Team FTEs over the 4-year period, with an average result of 1,460 Medical Team Encounters /Medical Team FTE.

The lowest performing clinics had a median clinical team productivity measure of 1,228-1,380 Medical Team Encounters Medical Team FTEs over the 4-year period, with an average result of 1,289 Medical Team Encounters /Medical Team FTE.

**Cohort Comparison:** At the median level, the highest performing clinics consistently demonstrated a significantly higher ratio of Medical Team Encounters per Medical Team FTE than their peers in the lowest performing cohort.



	2006	2007	2008	2009	Average
<b>Highest Cohort (HC)</b>					
60th Percentile	1,498	1,485	1,614	1,571	1,542
<b>Median (HC)</b>	<b>1,383</b>	<b>1,434</b>	<b>1,541</b>	<b>1,483</b>	<b>1,460</b>
40th Percentile	1,367	1,360	1,414	1,430	1,393
<b>Lowest Cohort (LC)</b>					
60th Percentile	1,368	1,420	1,367	1,449	1,401
<b>Median (LC)</b>	<b>1,228</b>	<b>1,257</b>	<b>1,290</b>	<b>1,380</b>	<b>1,289</b>
40th Percentile	1,189	1,165	1,237	1,298	1,222
<b>Sample Size</b>					
	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	
Highest Cohort	18	18	18	18	
Lowest Cohort	29	29	29	29	

## SECTION IV: PRODUCTIVITY MEASURES BY FINANCIAL COHORT

### Medical Team Productivity-Patients

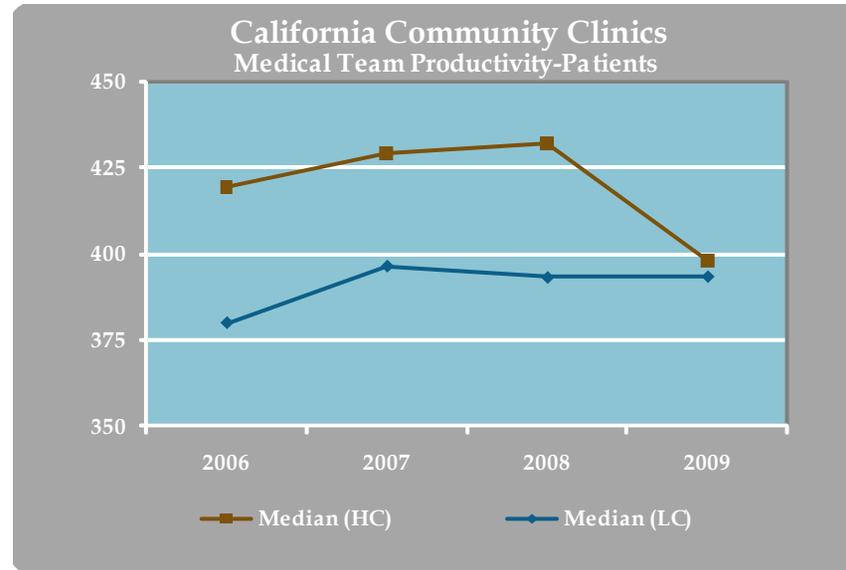
**Area of Focus:** The following illustrates the productivity measure Medical Team Patients /Medical Team FTEs over the 2006-2009 period for the cohort of highest financial performers and lowest financial performers.

**Formula:** Total Medical Patients/Total Medical FTEs

**Data Trends:** The highest performing clinics had a median medical team productivity measure of 398-432 Medical Team Patients /Medical Team FTEs over the 4-year period, with an average result of 420 Medical Team Patients/Medical Team FTE.

The lowest performing clinics had a median medical team productivity measure of 380-397 Medical Team Patients / Medical Team FTEs over the 4-year period, with an average result of 391 Medical Team Patients/Medical Team FTE.

**Cohort Comparison:** At the median level, the highest performing clinics consistently demonstrated a higher ratio of Medical Team Patients per Medical Team FTE than their peers in the lowest performing cohort, though in 2009 the difference was marginal.



	2006	2007	2008	2009	Average
<b>Highest Cohort (HC)</b>					
60th Percentile	476	467	457	418	454
<b>Median (HC)</b>	<b>419</b>	<b>429</b>	<b>432</b>	<b>398</b>	<b>420</b>
40th Percentile	364	368	386	381	375
<b>Lowest Cohort (LC)</b>					
60th Percentile	401	413	410	412	409
<b>Median (LC)</b>	<b>380</b>	<b>397</b>	<b>393</b>	<b>394</b>	<b>391</b>
40th Percentile	351	343	341	362	349
<b>Sample Size</b>					
Highest Cohort	18	18	18	18	
Lowest Cohort	29	29	29	29	

## SECTION IV: PRODUCTIVITY MEASURES BY FINANCIAL COHORT



### Enabling Productivity-Encounters

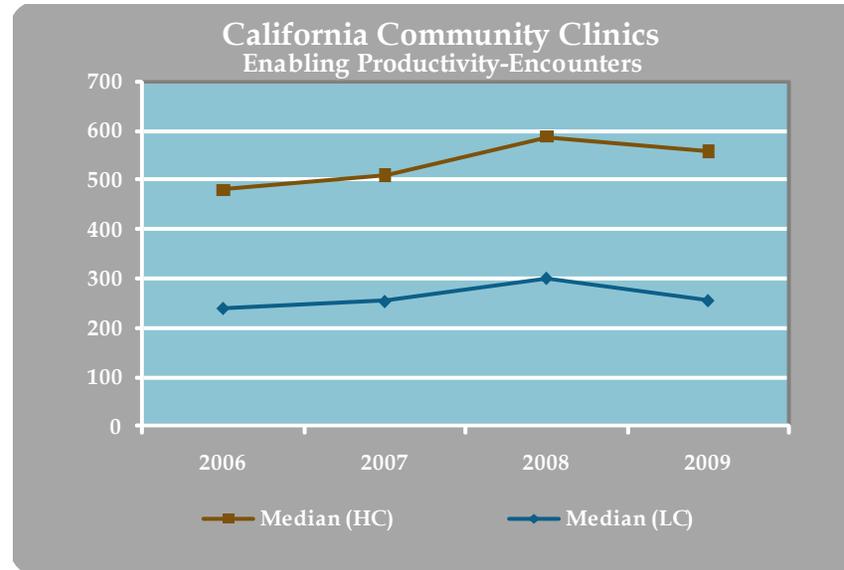
**Area of Focus:** The following illustrates the productivity measure Enabling Encounters/Enabling FTEs over the 2006-2009 period for the cohort of highest financial performers and lowest financial performers.

**Formula:** Total Enabling Encounters/Total Enabling FTEs

**Data Trends:** The highest performing clinics had an enabling productivity measure of 480-588 Enabling Encounters/Enabling FTEs over the 4-year period, with an average result of 534 Enabling Encounters/Enabling FTEs.

The lowest performing clinics had a median enabling productivity measure of 241-300 Enabling Encounters/Enabling FTEs over the 4-year period, with an average result of 263 Enabling Encounters/Enabling FTE.

**Cohort Comparison:** At the median level, the highest performing clinics consistently demonstrated a significantly higher ratio of Enabling Encounters per Enabling FTE than their peers in the lowest performing cohort.



	2006	2007	2008	2009	Average
<b>Highest Cohort (HC)</b>					
60th Percentile	674	565	635	697	643
<b>Median (HC)</b>	<b>480</b>	<b>509</b>	<b>588</b>	<b>558</b>	<b>534</b>
40th Percentile	361	399	468	441	417
<b>Lowest Cohort (LC)</b>					
60th Percentile	261	303	408	369	335
<b>Median (LC)</b>	<b>241</b>	<b>254</b>	<b>300</b>	<b>256</b>	<b>263</b>
40th Percentile	184	186	134	175	170
<b>Sample Size</b>					
	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	
Highest Cohort	17	17	18	18	
Lowest Cohort	29	29	29	29	

## SECTION IV: PRODUCTIVITY MEASURES BY FINANCIAL COHORT

### Enabling Productivity-Patients

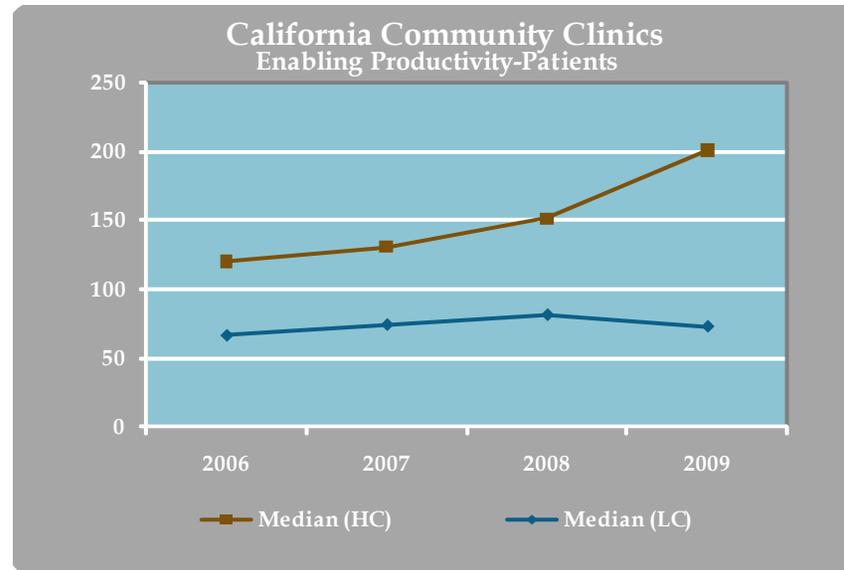
**Area of Focus:** The following illustrates the productivity measure Enabling Patients/Enabling FTEs over the 2006-2009 period for the cohort of highest financial performers and lowest financial performers.

**Formula:** Total Enabling Patients/Total Enabling FTEs

**Data Trends:** The highest performing clinics had an enabling team productivity measure of 120-201 Enabling Team Patients /Enabling FTEs over the 4-year period, with an average result of 151 Enabling Patients /Enabling FTE.

The lowest performing clinics had a median enabling team productivity measure of 67-82 Enabling Team Patients / Enabling Team FTEs over the 4-year period, with an average result of 74 Enabling Patients/Enabling FTE.

**Cohort Comparison:** At the median level, the highest performing clinics consistently demonstrated a significantly higher ratio of enabling team patients per enabling team FTE than their peers in the lowest performing cohort. On average, the enabling team productivity of the highest financial performers was twice that of the lowest performers.



	2006	2007	2008	2009	Average
<b>Highest Cohort (HC)</b>					
60th Percentile	242	225	270	328	266
<b>Median (HC)</b>	<b>120</b>	<b>131</b>	<b>151</b>	<b>201</b>	<b>151</b>
40th Percentile	97	101	97	115	103
<b>Lowest Cohort (LC)</b>					
60th Percentile	94	100	102	123	105
<b>Median (LC)</b>	<b>67</b>	<b>75</b>	<b>82</b>	<b>73</b>	<b>74</b>
40th Percentile	37	49	48	43	44
<b>Sample Size</b>					
Highest Cohort	17	17	18	18	
Lowest Cohort	29	29	29	29	

### Clinic Case Study Overview

Section V provides a framework for assessing operational considerations that impact performance and productivity beyond the program and staffing parameters discussed in the prior sections. Although the prior analysis did not show direct statistical relationships that would support a hypothesis for the most efficient or productive staffing model, the case studies nevertheless presented an opportunity to explore multiple operational factors that impact clinic performance and financial health. What emerged was the critical role of a resilient operational culture, able and willing to respond to a rapidly changing healthcare environment while effectively responding to growing needs within their local communities.

Site visits were completed with eight clinics representing each of the four performance and productivity quadrants. Additionally, the clinics selected included a cross-section of small and large organizations, new and well-established operations, as well as rural and urban communities (see Methodology section). Information and insights were gathered from each clinic through site tours and process observation, a standardized interview process with key clinic personnel, and group discussions focused on defining the environment of care and the operational model. A summary of operations for each clinic is included in this section, with comprehensive data tables presented in appendix B. Several strategic trends that directly influence their efforts to improve operational efficiencies emerged that were common to all of the clinics. Further, the clinics identified possible systematic responses that would support their efforts to be both clinically responsive and financially sustainable over the long-term.

### Striving for Excellence

Whether financially strong or struggling to meet weekly payroll, whether managing many patients with few staff or many staff with few patients, there was evidence of the commitment to not only survive but thrive. Universally, both leadership and staff visited demonstrated and verbalized a desire to give “great care.” Typical responses to “What makes a great day?” include: “When everyone’s expectations are met;” “When all the patients get what they need;” “When our flow is smooth and everyone stays calm;” “When we really give quality care.”

All of the clinics visited are active in local, regional, state and national initiatives to monitor and improve patient outcomes. All are pursuing growth. All are striving to align quality and quantity while maintaining stability.

### Expansion and Growth

Every clinic visited is expanding, growing and changing. There is a universal understanding of the need to keep abreast of evolving models of care, maximize the role of technology and develop capital resources. The cultural imperative is to “Do more for more patients and do it better – and cheaper.” Each clinic, has responded to the effort to see more patients and offer more services by increasing provider staff. However, adding more staff has not universally increased the level of services delivered, resulting in frustration on the part of patients as well as staff. The rapid addition of providers has not yet produced the level of patient access projected.

Two specific constraints were consistently identified by the clinics as impediments to efficiently increasing patient access and service capacity:

1. **The process for implementing electronic health record systems has negatively impacted productivity.** Planning, training, and implementation all take a toll on hours worked in the exam room as well as efficiency during the individual encounter. For clinics going through the planning and training process, the expectation is for rapid recovery following implementation. However, clinics post-implementation report a consistent leveling of productivity below that found with paper records. More provider time spent in managing the record rather than the patient calls for re-evaluation of the process of care delivery.
2. **The call to expand the patient base has encouraged the explosion of multiple “part-time” provider staff.** These part-time providers are working a variety of schedules within the same system, creating a confusing patient flow pattern. Increased patient access by expansion of hours is a uniform action step which can be facilitated by part-time provider staff. However, in many cases space and support systems are not uniformly distributed to make those hours effective doors of access. Generally, the use of multiple part-time providers does not typically result in an efficient operating model.

### Physical Space, Practice Model and Staffing

Achieving the balance of physical spaces to work in the most efficient manner with the most effective staffing mix was reported as a common challenge. Several clinics have been more successful at satellite sites—clinic 3 in particular— than at their more established sites. Expansion of sites has allowed new sites to serve as pilot projects within the system, often with promising results. Resources to manage the process of change are scarce. Renovation and replacement of existing facilities need to be a priority if team spaces and alternative types of visits for a wide range of patient demographics are to become a reality. Even clinics which have recently received funding to open or renovate one site are struggling to implement necessary changes at other sites. A long range capital development plan with supportive funding is critical to each system visited regardless of their current financial position.

In general, the largest portion of the clinic operating budget is staffing. Further, the key to effective daily flow is the correct staffing for the task. In general, clinics are moving staff positions from rigidly defined roles within task-based teams to more flexible roles within process-based teams; allowing for increased flexibility in coverage and fewer hand-offs during the patient visit process. However, taking time to re-train existing staff and fully orient new staff is difficult in an environment in which maximizing the daily number of patient encounters is vital to operational and financial success. Staff recruitment, retention and development consistently presented as a challenge for the long-term stability of the clinics.

### Risk Within the Operational Environment

The ability to successfully manage risk for long-term gain was a consistent theme among the clinics visited. Some Boards of Directors are risk averse, making it difficult to move into new areas of service or implement dramatic changes. Some providers are slow to change established patterns of patient care or implement new technologies. The ability to create an aura of confidence among the community, staff and board is a key leadership skill in managing change.

However, managing change effectively did not necessarily correlate with financial strength or productive activity. While a management team with a broad skill set that possesses the ability to work effectively is key to a creative work environment, there was no correlation observed between the skill set and interpersonal dynamics of the management team and the financial stability of the organization. It may make it possible – it does not guarantee it!

### **Operational Stability**

In an environment of increased expectations with decreased assurances, operational stability is an important factor in clinics' ability to adapt to change. Clinics find the challenge of managing new technologies, new populations and new models of care compounded by the volatility of the reimbursement system and the reality of rising costs. Maintaining adequate cash flow is a continual challenge, even among clinics with a history of strong operating margins. Capital expansion results in higher long-term operational costs. Staff expansion results not only in increased salary costs, but also in greater requirements for infrastructure support. Uniformly, the unpredictable environment coupled with increased costs is challenging clinics' ability to successfully achieve process improvement.

Organizational tension especially arises when alternate operational models would benefit the target population but are not favorably reimbursed or if trends in operational models are ahead of reimbursement mechanisms, causing a gap in revenue. Clinics continue to operate within an encounter-driven reimbursement environment, which inhibits significant changes to their patient-care models. Therefore there is a need to align reimbursement mechanisms to financially facilitate the integration of multiple operational models.

The ability of clinics to respond quickly to changes in demographics and gaps in services while maintaining a positive operating margin is also a common challenge. Health centers struggling to meet payroll do not have the reserves to initiate change. Traditionally, local businesses, foundations and individuals have been the primary source of seed money for new projects. However, in today's changing environment the same factors that call for rapid response are often accompanied by diminished economic stability in the service area; reducing the capacity of traditional funding sources just as the community need is increasing. Rapid access to short-term operational gap funding is critical to allow rapid response to needs and opportunities, filling the gap between initiation of an expansion or service change and the establishment of a sustainable revenue stream sufficient to support the change.

### **Culturally Effective Services**

Health centers find their patient populations increasingly diverse, challenging their ability to financially support culturally effective services. Safety net providers have always been challenged to provide services to those whose access barriers go way beyond their lack of financial resources. Transportation, employment, legal status, location, language, culture and age are all common barriers established providers have become adept at addressing. The change is in the volume of those barriers – for both the individual patient and the total population. Similar to the oft spoken of rising medical acuity of the elder population, the rising cultural acuity of the general population must be addressed using economically sustainable models. Targeted funding streams for multi-lingual services and community incentives for increasing transportation options are potential initiatives. The rising costs associated with facilitation of primary care services is not being covered by the existing reimbursement mechanism.

#### Clinic 1

##### Operational Context

**Target Population:** Vulnerable populations representing multiple cultures within the context of urban neighborhoods.

**Internal Focus:** Redefining the model of care within an expanded facility with an ever-increasingly diverse patient and staff population.

**Internal Challenge(s):** Successful transition from a process-focused model of care that was productive and efficient to a patient-focused model that maintains productivity and efficiency while improving effectiveness.

**External Focus:** Responsive expansion of sites and services.

**External Challenge(s):** Sustaining community development efforts, including fund raising, to provide direction and seed money for new initiatives.

##### Operational Responses

**Establishing the Patient Base:** Although anyone is welcome at any clinic site, each site location has been carefully planned to provide care within the unique cultural context of that neighborhood. Social service programs and community development projects led by the health center are used, not only as a means to strengthen the community, but to define and develop primary care sites which address the unique health challenges of that neighborhood in a manner that is approachable and acceptable. Rather than developing education and support services to meet the needs of medical patients who struggle to carry out the plan of care, medical services have been developed to meet the identified healthcare needs of persons participating in employment, education and support services.

**Defining Site Operations:** Hours of operation, scheduling templates, response to walk-ins, staffing patterns and the organization of physical spaces is unique at each site. The goal is to present an appropriate structure within the cultural context which is flexible enough to respond to individual needs while being rigid enough to develop patterns and expectations which are attainable.

**Connecting with the Community:** The clinic has made a concerted effort to hire staff from each neighborhood, providing training if qualified individuals are not available. Small businesses owned by patients are supported in purchasing and in on-site marketing. The main, and largest, site is a replacement facility which was designed to accommodate multiple services in one location. Gaps in resources within the neighborhood have been addressed on-site with a full-service pharmacy, fitness area, food pantry and re-use retail store included in the layout. Community services are largely grant supported.

##### Looking Forward

The internal challenge will be to maintain productivity within an increasingly responsive environment. The recent investment in facilities communicate quality and cultural awareness to visitors as well as improve the patient care process. While these upgrades may challenge the day-to-day cash flow, they hold promise for supporting long-term growth. The external challenge will be to sustain the enthusiasm and subsequent support fostered by visible capital and dramatic program development. Many of the community education programs, special interest events and family support services which have effectively bridged the gap between neighborhood cultures and the organization are dependent on continued grant funding and philanthropic giving. Attention to both internal and external revenue generation will be necessary to sustain the model.

## Section V: CLINIC CASE STUDIES

### Clinic Snapshots: 2



#### Clinic 2

##### Operational Context

**Target Population:** High-risk and underserved populations within an economically declining, bi-cultural rural community defined by geographic boundaries.

**Internal Focus:** Integrate technology, maximize facilities and develop staffing to expand efficient and effective capacity.

**Internal Challenge(s):** To maintain sufficient cash flow to support hard and soft costs of development.

**External Focus:** Endure as a vital resource within an economically challenged region.

**External Challenge(s):** Maintain supply of primary and specialty providers to locally address the growing needs of the community.

##### Operational Responses

**Integration of Technology:** The clinic is currently in the process of implementing an electronic health record system. This process has challenged established processes, compromised work spaces and diminished patient visit capacity. Decreased revenues and increased expenses have impacted cash flow resulting in mandatory furlough hours in order to maintain staffing and not contribute to the community's rising unemployment rate.

**Maximization of Facilities:** Dental site has been renovated to improve efficiency and expand capacity. The main site was recently painted and equipment up-graded. An unfinished area of the main site is being renovated to provide group space and storage space, freeing square footage in the clinical zone for direct patient care. Subsequent reorganization of spaces to support new work processes promises to improve the patient and staff experience.

**Development of Staffing Model:** Planned recruitment of education and case management staff will assist the patient in carrying out the plan of care while relieving clinical staff to focus on presenting patients. The clinic has been successful in recruiting specialists to provide on-site services. Efforts to match patient load to hours worked for on-site consulting specialists and provide consistent inter-visit education and follow-up with the addition of dedicated case management will improve the sustainability of this expanded patient service.

##### Looking Forward

The clinic's experience highlights two considerations in planning for dramatic change. First, either sufficient cash reserves or project seed money are important to maintain cash flow during the implementation of expansions or improvements and avoid jeopardizing the stability of the organization. Careful development of project timelines becomes essential to sustaining consistent, measured growth. Second, working in a declining environment, in effect moving against the norm, becomes increasingly challenging as the pool of resources dwindles. As families move to find work, qualified staff become scarce while the skill level required to meet the increasingly complex needs of those who remain grows. Private and corporate philanthropy diminishes, essentially drying up the customary resources for seed money to support expansion. External support becomes increasingly important.

### Clinic 3

#### Operational Context

**Target Population:** Community-at-large in multiple communities with a focus on addressing the barriers to care of vulnerable populations.

**Internal Focus:** Stabilize the organization to allow for future growth.

**Internal Challenge(s):** Maintain services responsive to the needs of the community while experiencing significant staff, management and Board turnover.

**External Focus:** Develop a strong network of support and collaboration.

**External Challenge(s):** Communicate excellence as an employer, business entity and healthcare provider in the midst of organizational restructure.

#### Operational Responses

**Strengthen the Board of Directors:** Recruitment, retention and development of Board members who are committed, consistently available, close to or part of the patient population, representative of the communities served, business savvy, and passionate about the mission of community health centers is key to the ability of the organization to take calculated risks to assure responsiveness to community need and sustain organizational growth. Development of the Board of Directors continues to be an organizational priority.

**Stabilize Staffing:** Historically, clinical productivity addressed the needs of many patients on a daily basis. Selective replacement and focused staff development was key to maintaining services. Responses to a staff survey indicated that a lack of thorough and timely information produced the highest stress levels for both individuals and the team, making improved internal communication the highest staff priority. Measures to improve internal communication include: 1) Full staff meetings including staff from remote sites 2) Utilization of the internal e-mail system for regular communication to all staff. 3) Elimination of “trickle down” information by communicating key information directly from senior management to front line staff.

**Expose Peers to the Organization:** By offering training to health professionals at two of its clinics, and actively recruiting area specialists to provide intermittent on-site services, the clinic creates multiple opportunities for professional peers to learn about the mission, vision, and operations of the clinic.

**Collect Timely, Useful Data:** Purchasing and implementing an electronic practice management and patient health record system facilitated a higher level of tracking, monitoring and planning than previously possible. The data collected has been used to develop annual strategic operational plans for each clinic site which allow monitoring and trending within unique communities using variable models of care delivery.

**Pilot New Concepts in Patient Care Delivery:** Federal funding allowed for the replacement of a satellite site facility. The capital development opportunity was used to develop a pilot for team-based care rather than the traditional panel-based care in existing sites. Lessons learned will be translated to other sites.

#### Looking Forward

The clinic has restructured its Board of Directors and management team and implemented systems for monitoring and evaluating finance, clinical and operational processes. The future challenge is to effectively use the information that is now being gathered to reshape the model of care in a way that is financially and clinically productive, patient and community responsive, and operationally flexible. Early successes with expanding service types and redefining the model of care are promising indicators for the development of systemwide stability and effectiveness.

## Section V: CLINIC CASE STUDIES

### Clinic Snapshots: 4



#### Clinic 4

##### Operational Context

**Target Population:** Diverse multi-lingual Asian population within a defined geographic area.

**Internal Focus:** Delivery of culturally responsive primary care in the common language of the individual patient and their family.

**Internal Challenge(s):** Facility which does not support desired model of care. Increasing number of presenting languages.

**External Focus:** Facilitation of active advocacy with and for the target population.

**External Challenge(s):** In an increasingly culturally diverse geographic area, managing the primary care needs of non-Asian cultures while maintaining historical and cultural identity so as to not dilute effectiveness with and for the original target population.

##### Operational Responses

As a result of the need to respond daily to multiple languages, gaps and overlaps in task assignments and staff roles are not uncommon. When observing patient flow at the main site, multiple staffing patterns are evident with a traditional front and back office model utilized with majority languages and a more fluid patient navigator model utilized for minority languages. The patient navigator model is well received by patients and encourages clarity in role responsibilities with the identification of a primary advocate for the patient and family. Clinical care, including education, follows a similar fluid model with the role of health coaches for those managing chronic diseases.

These two models were used exclusively when the new primary care site was organized. Patient care is delivered by a team of patient navigators, health coaches and providers. Although well-received by patients and consistent with the clinic's mission and model of care, this staffing pattern has its drawbacks. The fair distribution of workload is a challenge. Balancing trained staff with requisite languages with the number of patients speaking each of those requisite languages is proving to be difficult as the patient panel continues to grow. Staff persons fluent in more common languages often carry a disproportional workload. Likewise, the availability of qualified staff with requisite language skills is an ongoing challenge. This has significant cost, continuity of care and staff retention implications. Work continues on "right-sizing" the model to assure sustainability. Early indicators show that the site will need to be larger in all aspects to support the model.

##### Looking Forward

Clinical services are preparing to move toward a team-based model of care. The unique approach will be the use of patient demographics to define team members skill sets rather than the type of service provided by the primary care provider.

Developments underway include implementing an electronic health record system; expanding the types of visits offered by including more group medical visits and health education offerings; and meeting the requirements of changing reimbursement mechanisms. The clinic will also continue to use patient leadership councils organized to represent each major language and cultural group to facilitate external advocacy and internal monitoring as the clinic evolves.

#### Clinic 5

##### Operational Context

**Target Population:** Community-at-large within a rural region defined by geographic and cultural boundaries.

**Internal Focus:** To broaden the established medical model of primary care delivery to include integration of behavioral health, dental, community health and education services.

**Internal Challenge(s):** To create an integrated care system within multiple buildings totaling minimal square footage with minimal staff resources.

**External Focus:** Commitment of and to the community to maintain a local access point for primary care services.

**External Challenge(s):** To develop financial stability while expanding both the scope and capacity of services.

##### Operational Responses

By focusing initial expansion on stabilization of care to the medical patient and expansion of services to those patients, the clinic was able to broaden the scope of services with an established patient base and pilot multiple integration techniques and outreach initiatives with a known population. Initial growth has been most dramatic with the full integration of behavioral health, resulting in patient growth of 26% and visit growth of 280% over the last three years. The focus of growth has been on intensity of services to the established medical patient population. Alternately, dental has experienced a patient growth of 70% and a visit growth of 98%, focusing instead on outreach and the initiation of dental care to a large portion of the population who have never had access to dental care. During the same period, medical had modest patient growth of 17% and visit growth of 7%.

With a system of care in place, the clinic's focus turned to supporting coordination and monitoring of that care. An electronic health record was adopted which enables patient information to be available at multiple locations. The provider at the clinical site and the enabling staff at the education site can both have access to the patient record. Coordination across disciplines is developed using the record as the common nexus. Additionally, to address the patient and system challenge of coordinating care between multiple part-time staff, movement is being made to organize the medical patient base into patient panels; each managed by a team of two medical providers, one behavioral health provider, two MAs and one front desk staff. The goal is for at least one member of the team to always be scheduled, allowing the patient a point-of-contact at any given time. The care system infrastructure continues to be developed with active recruitment for a registered nurse case manager.

##### Looking Forward

Two challenges face this relatively new system of care: facility development and capacity building. Physically uniting into one larger facility will encourage full community utilization of the entire integrated care system. This will expand patient care zones, allowing for more providers. While planning for future capital development, the existing staff is faced with the task of increasing daily productivity by matching availability with patient demand and streamlining the process of patient care. The system has been developed on a financially sound foundation. The challenge is now to build capacity in response to community need.

#### Clinic 6

##### Operational Context

**Target Population:** Community-at-large with targeted outreach efforts to vulnerable populations within a rural region defined by natural boundaries.

**Internal Focus:** Development of a model of primary care delivery which is both cost-effective and clinically-effective.

**Internal Challenge(s):** Facility which does not support the desired model of care. Multiple part-time providers present a challenge for consistent access and maximization of infrastructure resources.

**External Focus:** Maintain strong cross-section of community advocates facilitating creative outreach to vulnerable populations and promoting long-term stability.

**External Challenge(s):** Established medical practice(s) joining system highlights support of community while challenging integration of staff, maximization of reimbursement streams and consistent attainment of quality indicators.

##### Operational Responses

Capacity for scheduled patient appointments was dramatically reduced to allow extra time for providers and staff to develop proficiency with the electronic health record. As is typically the case, this has resulted in decreased system productivity. The reduced number of encounters has decreased the work load of individual billing staff. Work time has been redirected to working old accounts receivables with a resulting jump in collections, thus maintaining cash flow during the integration period.

After nearly two years, the daily late afternoon walk-in clinic for acute illnesses has become a well-known and highly utilized patient service. Consistent, well-defined times to access a provider for an acute illness has significantly decreased the wait time, creating a service which is patient-centric. Rather than sick patients being intrusive to efficient flow, publicly blocking times and providers has allowed more sick patients to be served in a shorter time with higher patient and staff satisfaction. (Patients who walk-in at alternate times have the option of waiting to be worked into a no-show appointment slot or returning during walk-in hours.) Patients' most common obstacle to fully utilizing dedicated hours is access to transportation.

Creative outreach efforts include a dedicated teen clinic with a private entrance and monthly on-site luncheons for the homeless population.

##### Looking Forward

Following full integration of an electronic health record system, clinical services will move to redefine the patient care team. This will require redistribution of the daily work load, cross-training of staff and renovation/expansion of the existing facility. Acquiring project funding and maintaining adequate cash flow are requisite to the ability of the clinical staff to successfully redesign the model of care.

Expanding the volume and types of specialty services offered on-site will relieve some of the current difficulties in facilitating patient specialty follow-up, which often requires extensive travel to unfamiliar and often uncomfortable environments. Employing telemedicine technology to decrease the number of trips out of the area is being explored. In light of space constraints, significant service expansion is dependent on facility expansion.

#### Clinic 7

##### Operational Context

**Target Population:** Historically, vulnerable populations within the community with significant barriers to primary care; more recently, the community-at-large. As many community medical providers are aging and the Medicaid eligible population is growing, the clinic is moving to address a community-wide access gap.

**Internal Focus:** Provide integrated, efficient and effective primary care that is financially sustainable and, at a minimum, comparable to community services.

**Internal Challenge(s):** Successfully developing the infrastructure to manage new models of care delivered to a broader population while assuring sustainability.

**External Focus:** Effectively respond to gaps in services produced by change in community services and/or demographics of population.

**External Challenge(s):** Maintaining community support while moving from a provider for the poor and disenfranchised to the provider of choice for the community-at-large.

**Innovative Response(s):** Strategic Infrastructure Development

**Information Technology Development:** Major capital investment in information technology has been matched with a significantly broader and deeper investment in the full utilization of that technology than is generally seen in the clinic environment. Seven staff are dedicated to day-to-day management and strategic development of technological capabilities to expand, improve and monitor care. Strategically, the clinic has chosen not just to manage the required conversion to electronic records, but since the investment must be made, consider ways in which that investment can be maximized for long-term gain.

**Facility Development:** Phased expansion and renovation of facilities will create an environment aligned with the philosophy and model of care delivered by allowing for alternative types of visits, team work areas, and physical integration of medical and behavioral health. Additionally, care is being taken to design and finish the new spaces utilizing color, finishes, space and light to decrease patient and staff environmental stress. The resulting spaces will not only benefit the current staff and patients, but serve as a strong recruitment tool.

**Staff Development:** Investment in formal and informal customer service training for front-line staff is proving effective in creating an inclusive environment.

**Service Development:** Interdisciplinary multi-skilled teams providing care to a defined panel of patients has been effective in providing perinatal care to this population. In the summer of 2011, the clinic initiated the first integrated Patient Care Team in Family Practice. In addition to the coordination advantages afforded to the patient; as the clinic currently provides an above average number of services per patient, the team approach promises to be a tool for managing more patients per provider thus increasing the overall productivity of the team and expanding the clinic client base.

##### Looking Forward:

The promise of infrastructure development is future stability. The concurrent challenge is to continue to maintain a strong client base and meet the very real needs of the day by providing timely, effective clinical care to established and presenting patients. Maintaining cash flow remains a challenge when large financial investments have slow operational return.

#### Clinic 8

##### Operational Context

**Target Population:** Vulnerable populations within a rural community – in particular low income, uninsured and non-English speaking – facing access challenges.

**Internal Focus:** Aligning facility and staff to maximize the strengths of both, thus allowing for more effective interactions with patients.

**Internal Challenge(s):** High volume produced by a part-time task-based staffing model while practicing in a facility designed for a low volume full-time panel-based staffing model.

**External Focus:** Strengthen alliances with community providers to expand access to a full range of health care services.

**External Challenge(s):** Rural community does not have excess capacity, offering an opportunity for the clinic to take a leadership role in community-wide development of services targeting the needs of the low-income working population.

##### Operational Responses: Infrastructure Development

**Immediate Reorganization:** Reassigning work spaces will consolidate and streamline the patient visit, and acquiring storage spaces will free work spaces within the clinical zone. Leadership staff is being hired to oversee not only daily operations but cross-training and professional development of support staff.

**Image Development:** A singular identity with community and patients is being created by developing protocols, processes and systematic responses consistently applied by multiple part-time staff.

**Facility Development:** A replacement facility is being developed that will enable services to be consolidated, allowing patients and staff to work as a fluid team during the patient visit. In selecting a site, a high priority is to identify a location within the daily zone of activity of the clinic's established patient population, increasing visibility and accessibility. The clinic is exploring participation in a multi-use development project to strengthen community infrastructure.

**System Development:** The transition to an electronic health record environment has begun. Plans are underway to increase medical and behavioral health provider staff by one each in an effort to maintain current patient service levels during implementation.

##### Looking Forward

Similar to many peer clinics, this clinic's focus has shifted from expansion of services to infrastructure development. The challenge is to pull staff and funding resources from daily operations in order to accomplish long-range goals while maintaining current daily productivity.

## Data Sources

The analysis and results contained in this report are based on two major data sources:

- Internal Revenue Service (IRS) Form 990 data
- Uniform Data System (UDS)

The financial trends and indicators in Section I are based on IRS Form 990 data, as available for most non-profit organizations through GuideStar, an organization that combines information on the mission, programs, leaders, goals, accomplishments, and needs of non-profit organizations, including health centers and community clinics nationally. Form 990 data, which is reported based on an organization's fiscal year end to the IRS, includes many of the same financial data elements that are reported on audited financial statements. While Form 990 data does not provide the same level of detail, it is still a useful and readily accessible source for financial data for the generation of a number of key financial ratios and trends.

Based on the list of screened clinics from the previous report "California Community Clinics; A Financial Profile" Form 990 data was obtained for those community clinics whose data was available in any of the fiscal years from 2008 through 2009. The 990 data was purchased from GuideStar in an electronic format (Excel) and was converted into a database format. Data available in each of the years included in the Financial Trends Analysis is as follows: FY06: 194; FY07: 189; FY08: 196; FY09: 181. Data was available for all four years for 167 of the clinics.

The financial ratios presented in this report are:

- Total Revenues and Expenses
- Operating Revenue Growth Rate
- Total Revenue Growth Rate
- Operating Expense Growth Rate
- Bottom Line Margin
- Days in All Receivables
- Days in Patient Accounts Receivable
- Leverage Ratio

The 990 data sample size for specific ratios and growth rates may vary because certain clinics may not present some financial information in some years.

## Comparison to National Database

The California community clinics' financial ratios and trends generated from Form 990 data were also compared to similar trends at the national level based on Capital Link's extensive database of health center and clinic audited financial statements. The number of audited financial statements available in the national sample is as follows: FY06: 500; FY07:466; FY08: 366; FY09: 285

Similar to the national universe of health centers and clinics, the majority of entities included in Capital Link's financial database are FQHCs and FQHC-Look-Alikes. However, a number of non-FQHC health centers are also included in the database.

### Median, 75th Percentile and 25th Percentile

Statistical measures used to describe the financial ratios and trends include the median, 75th percentile, and 25th percentile. The median is the number in the middle of a set of numerically ordered data; by definition, half the values in the set are greater than the median, and half are less. For example, the median value of the set {3, 8, 9, 10, 11, 11, 15} is 10. If there is an even number of values in the set, the median is calculated as the average of the two values in the middle of the set. The median is not skewed by extremely large or small values outside the typical range of the rest of the data. This attribute is particularly important when dealing with relatively small data sets. At the same time, it is important to note that this presentation treats each clinic's data as having equal weight in the group. An organization with \$40 million in annual revenue and an organization with \$2 million in annual revenue will affect the results equally.

The percentile is the percentage of observations in a distribution that is at or below a given value. The 75th percentile is a value that is equal to or greater than 75 percent of the values. The 25th percentile is a value that is equal to or greater than 25 percent of the values. The 50th percentile is the same as the median value.

The staffing ratios and productivity measures in this report are based on Uniform Data System (UDS) data. UDS is a reporting requirement for grantees, also known as Federally Qualified Health Centers (FQHCs), of the Health Resources and Services Administration (HRSA) primary care programs. The UDS includes information on patient demographics, services provided, staffing, clinical indicators, utilization rates, costs, and revenues.

The Section II analysis includes all FQHCs for which both UDS as well as IRS Form 990 data was available in a particular year. Staffing ratios were defined as specified under the Formula and Definition headings for each ratio. The Mid-Level to Physician Ratio, Enabling Staff to Physician Ratio, Enabling Staff to Medical Provider Ratio, Dental Support Staff to Dentist Ratio and Mental Health Support Staff to Psychiatrist Ratio were then analyzed for potential relationships with financial performance. These relationships were measured by the Operating Margin for each year, based on IRS Form 990 data, as well as with certain productivity measures based on UDS data and defined under the Correlation Analysis heading for each ratio. The Excel Data Analysis Tool Pak was used for correlation analysis. Correlation measures the strength of association between variables, expressed in the form of a correlation coefficient. The value of a correlation coefficient, symbolized by the Greek letter "rho," ranges from -1 for perfect negative correlation to zero for no correlation at all, to +1 for a perfect positive correlation. For the purposes of this study, correlation between any variables was categorized as strong positive (0.70 to 1.00), moderate positive (0.50 to 0.69), weak positive (0.30 to 0.49), absent/no correlation (0.29 to -0.29), weak negative (-0.30 to -0.49), moderate negative (-0.50 to -0.69), or strong negative (-0.70 to -1.00.)

For the analysis presented in Section III the clinics were divided into five cohorts of financial performance. Similarly, clinics were divided into five cohorts of productivity based on a composite score of several productivity measures over the four-year period

Financial performance for individual clinics was defined by the Operating Margin, based on a combined score of Operating Margin values in each of the four years relative to defined cut-off values for each cohort of performance.

### **Cut-off values and scores were defined as follows:**

For each measure the 70th, 60th, 50th (=Median), 40th, and 30th percentile value in each year was determined.

For each measure, the average value of the 70th, 60th, 50th (=Median), 40th, and 30th percentile over all four years was determined.

For each measure, the average value of each percentile over all four years was defined as a cut-off point and assigned a score as follows:

- Equal to or above Average of 70th percentile=4
- Between Average of 60th percentile and Average of 70th percentile=3
- Between Average of 50th percentile and Average of 60th percentile=2
- Between Average of 30th percentile and Average of 50th percentile=1
- Equal to or below 30th percentile=0

Using Form 990 data, the financial performance of each of the clinics over the 4-year period was assessed as detailed below:

Financial ratio assessed: Operating Margin, as this ratio was determined to be the best financial measure of clinic operating performance.

The ratio was calculated for each clinic in each of the four years.

The ratio in each year was assigned a score between 0 (weakest) and 4 (strongest) relative to how it compared to the cut-off points above.

The total score was compiled for each clinic. Maximum total score possible for each clinic was 16, which included all four years. Based on this approach, clinics whose ratios were consistently strong across all four years had the highest total score.

Clinics were ranked by their total score from highest to lowest.

Clinics were divided into five cohorts based on their total score:

- Highest Cohort: 12 and higher
- Fourth Cohort: 10-11
- Third Cohort: 8-9
- Second Cohort: 6-7
- Lowest Cohort: 5 and below

**Using UDS data, the following productivity measures of each of the clinics over the 4-year period were assessed:**

Performance measures assessed:

- Total Encounters/Total FTEs
- Total Patients/Total FTEs
- Clinical Team Encounters/Clinical Team FTEs
- Clinical Team Patients /Clinical Team FTEs
- All Provider Encounters/All Provider FTEs
- All Provider Patients/All Provider FTEs

Each measure was calculated for each clinic in each of the four years.

Each measure in each year was assigned a score between 0 (weakest) and 4 (strongest) relative to how it compared to the cut-off points above.

The total score was compiled for each clinic. Maximum total score possible for each clinic was 96, which included all six measures for all four years. Based on this approach, clinics whose ratios were consistently strong across all four years had the highest total score.

Clinics were ranked by their total score from highest to lowest.

Clinics were divided into five cohorts based on their total score:

- Highest Cohort: 70 and higher
- Fourth Cohort: 60-69
- Third Cohort: 46-59
- Second Cohort: 33-45
- Lowest Cohort: 32 and below

Staffing ratios for the highest and lowest financial and productivity cohorts were then compared across each of the four years.

Section III uses the same methodology as outlined above in defining financial performance and productivity. The 40th and 60th percentile value for each of the productivity measures are included to show the spread of values close to median.

For Section IV utilization data and financial data collected as part of the initial investigation (Phase I & II) was analyzed as a basis for separating the clinics within the study into four groups. These groups were segmented by 2 primary factors, productivity levels and performance levels.

### **Clinic Groupings for Case Study Analysis**

- High Productivity/High Financial Performance
- High Productivity/Low Financial Performance
- Low Productivity/High Financial Performance
- Low Productivity/Low Financial Performance

One to two clinics in each group were selected for participation in a case study analysis.

The case study approach was based on on-site interviews of key clinic staff conducted by Capital Link program staff. Standardized questionnaires provided the framework for collecting both additional data as well as assessing other operational metrics (beyond program types and staffing ratios) that may relate to performance and productivity. The site visits also includes focus group discussions with key clinic staff.

## APPENDIX B: CLINIC CASE STUDIES

### Data Collection: Clinic 1



Access	
Appointment Scheduling Model	Traditional scheduling model with designated same day appointment slots.
Hours of Operation/Patterns of Utilization	M-F until 6PM with highest utilization in morning and between 2 and 4. Sat 10-2 with improved utilization following establishment of consistent Saturday provider.
Response to new patients	Wait period for well, non-pregnant patient is two months. Walk-in Department is primary entry for unestablished acute patients. Primary referral mechanism is clinic sponsored community programs. New pregnant patients initiate care via appointment with perinatal case management and education program.
Response to walk-in patients	Established patients seen by designated PCP if available. Designated Walk-in Service responds to established and new patients presenting with acute illness or need for minor procedures. Will do follow-up visit for procedures. New patients referred for intake appointment which includes eligibility screening.
Transportation options	Established patients seen by designated PCP if available. Designated Walk-in Service responds to established and new patients presenting with acute illness or need for minor procedures. Will do follow-up visit for procedures. New patients referred for intake appointment which includes eligibility screening.

Scope	
Range of Clinical Services	Family Practice, Pediatrics, Gerontology, OB/GYN, Optometry, Dental, Behavioral Health
Provide Hospital Services?	Contract Obstetricians provide deliveries.
Provide Home-based Services?	No
Provide Nursing Home Services?	No
Provide Other Off-site Services?	No
Types of Providers Employed	Physicians and Mid-levels. In process of expanding number and range of specialists on-site, supplemented by telemedicine consults.
Patient/Provider/Staff Relationship	Beginning to develop Patient Care Teams with initial pilot in process. To ensure long-term continuity of care, the organizational goal is for patients to identify primarily with the organization rather than an individual provider while being managed by a team rather than an individual.

## APPENDIX B: CLINIC CASE STUDIES

### Data Collection: Clinic 1



Facilitation	
Enabling/enhanced services on site	Interpretative services (many staff are multi-lingual); transportation; education; casemanagement; resource development.
How enhanced services impact patient flow	Case management available during family visits. Perinatal program, education, eligibility screening in defined suite with direct access from main entrance.
Model of care coordination/case mgt.	Centric. Services defined as petals surrounding a central core of case management.
Patient participation outside exam room	Off-site social services and community programs serve as a bridge between the exam room and the patient/family. High level of participation in advocacy, employment and education services. Services offered individually, in community groups and in family groups.
Plan of care completed on site?	Pharmacy, Lab. Developing radiology. Rotating specialties accommodated on-site.
Level of inclusion of family/friends in visit	Adequate seating in waiting and exam areas to accommodate family/caretaker. Consultation areas available. Observed family visits.

Environment of Care	
Sq. footage/provider/day	Medical: 1,875 square feet
Sq. footage/encounter/day	Medical: 2.2 square feet
Spaces used for intended purposes?	Generally. Minimal definition between clinical staff work and patient triage/vitals area allowing spill-over of functions. Waiting areas not utilized by patients as defined in facility design. Sick waiting area utilized as general waiting. Child waiting not utilized as design does not allow for staff monitoring.
Space support patient processing flow?	Adaptations needed have all surrounded efforts to increase confidentiality in open plan.
Does environment reflect staff philosophy?	Yes.
Elements contributing to PCMH model	Natural light, warm-toned colors and culturally meaningful finishes all work to decrease patient stress level. The use of vertical space in the design communicates capacity within a tightly developed urban neighborhood. Greeter at street level entry allows for personal contact and orientation before moving to the interior of building. Exam room size and availability of conference areas adjacent to patient waiting facilitate family and group involvement in care process.

## APPENDIX B: CLINIC CASE STUDIES

### Data Collection: Clinic 1



Utilization	
Patient Encounter Patterns	Scheduling template tailored to provider panel. No show rates variable by site with a range of 21-34% Main site averages 32% no-show rate.
Target Facility Utilization	Currently average 3.8 exam rooms per provider. At full capacity, the facility will allow 2 exam rooms per provider.
Number of Providers for Optimal Flow	Distribution by Service Area with current daily staffing of 8 providers: Pediatrics - 2; Family Practice - 3; OB - 2; Walk - in - 1.

Referral Patterns	
Rates for referrals made/completed	In the previous six months, 1472 referrals were made and 969 completed giving a 65% rate of follow-up.
Financial risk related to referrals	Provide space for area specialists to provide rotational services in an effort to decrease access waiting period. Provide transportation to specialty appointments. No direct payment for specialty care.

Staffing Patterns	
Provider : Clinical Support Staff	3 providers : 2 Medical Assistants and 1 RN
Provider : Enabling/Enhanced Services Staff	Approximately 3:1
Provider Activity	Average encounters per hour: Medical 2.3 - 2.8 with 1.7 in gerontology; Dental 1.3; Behavioral Health .75. Statistical analysis indicates full-time status is positive indicator of increased hourly productivity.
Student/Resident Involvement	N/A
Recruitment and Retention	General Staff: Retention efforts beyond professional development center on breaking down barriers between staff by liberally supplying food at meetings, supporting group activities and personal affirmation. Provider Staff: 75% with organization greater than six years. Recruitment efforts place strong emphasis on mission-oriented hiring.

## APPENDIX B: CLINIC CASE STUDIES

### Data Collection: Clinic 2



Access	
Appointment Scheduling Model	Traditional scheduling template with appointments every 15 minutes.
Hours of Operation/Patterns of Utilization	7AM - 6PM with provider start times staggered every half hour. Highest utilization at beginning of morning and afternoon sessions and Saturday.
Response to new patients	Scheduled appointment in 1-2 weeks for requests for routine visit. Process request for new sick visit as walk-in patient with financial screening during visit wait period.
Response to walk-in patients	Registered and worked into scheduled appointment gaps work with designated provider in order of acuity based on RN triage. 35 - 40 % of patient encounters per day are walk-in patients.
Transportation options	Primary mode of transportation is bus. Bus stop on-site. Clinic provides free van transportation servicing all sites on alternate days. Alternatives: walking, cars (designated parking area), taxi.

Scope	
Range of Clinical Services	Adult Family Practice/Specialty; Pediatrics; Ob/GYN (Women's Health); Dental; Behavioral Health
Provide Hospital Services?	Hospitalists provided by referring hospital. Pediatrician participates in call schedule. Off-site OB/GYN practice owned by clinic provides perinatal hospital services.
Provide Home-based Services?	No
Provide Nursing Home Services?	No
Provide Other Off-site Services?	No
Types of Providers Employed	Physicians, Nurse Practitioners, Dentists, Behavioral Health Interns. 1:1 ratio of physicians to mid-levels.
Patient/Provider/Staff Relationship	No defined patient panels. Patients may schedule with provider of choice. Walk-in patients seen by next available provider. Support staff assignments are task based.

## APPENDIX B: CLINIC CASE STUDIES

### Data Collection: Clinic 2



#### Facilitation

<b>Enabling/enhanced services on site</b>	Transportation; HIV Education; Eligibility Screening and Application Assistance; Promotoras Program. Range of education services variable secondary to difficulty recruiting and retaining qualified staff.
<b>How enhanced services impact patient flow</b>	Facilitate integration of new patients by providing eligibility determination as part of walk-in process. Community Service Workers stationed in main reception area to facilitate pre, post and inter-visit patient access to application process.
<b>Model of care coordination/case mgt.</b>	General nursing function. No designated case managers.
<b>Patient participation outside exam room</b>	Weekly diabetic education class led by Promotoras. Historically low participation.
<b>Plan of care completed on site?</b>	Pharmacy; Specialty Care referrals; prenatal testing.
<b>Level of inclusion of family/friends in visit</b>	Majority of patients observed accompanied by extended family units. Space limitations limit level of involvement in visit process. Increased ability to accommodate families in Pediatrics and Women's Health.

#### Environment of Care

<b>Sq. footage/provider /day</b>	Dental: 1120 square feet Medical: 1800 square feet.
<b>Sq. footage/encounter /day</b>	Dental: .09 square feet Medical: 0.23 square feet (main site).
<b>Spaces used for intended purposes?</b>	Generally, yes. Currently expanding finished area to accommodate storage and relieve crowding in clinical areas. See patient processing flow note below.
<b>Space support patient processing flow?</b>	Patient waiting/reception process has alternate flows dependent on service area which is a result of space configuration rather than patient/staff design. Staff report "working around" existing spaces rather than "with or in" existing spaces. In the clinical areas, the introduction of hardware supporting the electronic health record has broken the established flow patterns. New patterns are awkward as they require repeated back-step flow resulting in an environment that is more chaotic than the activity warrants.
<b>Does environment reflect staff philosophy?</b>	Yes, although larger areas for designated functions would better reflect the family orientation of the culture which is supported by the staff but not facilitated by the spaces.
<b>Elements contributing to PCMH model</b>	Separate area out of view of waiting area for patient payments. Bilingual environment (audible and visible).

## APPENDIX B: CLINIC CASE STUDIES

### Data Collection: Clinic 2



Utilization	
<b>Patient Encounter Patterns</b>	Dental: Increasing adult no-show rate since discontinuance of adult MediCal coverage. Near 100% show rate for children. Medical: Average 25% no-show rate. Walk-in rate is greater than the no-show rate resulting in an average of 120% of schedule utilization.
<b>Target Facility Utilization</b>	All exam rooms utilized every day as number of providers is consistent. If fluctuation related to leave, remaining providers utilize vacant exam rooms.
<b>Number of Providers for Optimal Flow</b>	Family Practice: 4-5 scheduled providers, 1-2 walk-in providers and 1 specialist per day (7) Pediatrics: 1 MD and 1 NP per day (2) Women's Health: (2) Dental: (2).

Referral Patterns	
<b>Rates for referrals made/completed</b>	Nearly all referral appointments completed. Since large number of specialists on-site, referrals represent significant clinical issues which have high value to the patient.
<b>Financial risk related to referrals</b>	Provide multiple specialties on-site on a part-time contract basis supporting with space and support staff: Podiatry, Cardiology, Obstetrics, Orthopedics, Ophthalmology, Chiropractics, Infectious Disease, Immunology, Gastroenterology. No payment for off-site referrals.

Staffing Patterns	
<b>Provider : Clinical Support Staff</b>	Family Practice: 1:1 MA, 0.15 RN; Pediatrics: 1:2 MA, 0.5 LVN; Women's Health: 1:2 MA , 0.5 LVN Dental: 1:1.5 RDA, .5 DA
<b>Provider : Enabling/Enhanced Services Staff</b>	1:0.4 (outreach and transportation).
<b>Provider Activity</b>	Targeted Activity: 25 encounters/provider/day. Prior to current electronic record implementation process, averaged 22/day. During transition process encounters have dropped to a range of 10-17/day resulting in long waits, strict triage for walk-in appointments and patient dissatisfaction as expectations for prompt same-day care are challenged.
<b>Student/Resident Involvement</b>	Behavioral Health Interns completing extended clinical rotations under the direction of faculty provide on-site capacity for scheduled consultations and integrated visits.
<b>Recruitment and Retention</b>	Recruitment: Maintaining adequate education and casemanagement staff is chronically difficult as there is a minimal pool of qualified applicants and high demand in the service area. Retention: Average number of years employment of providers is 3.4 years and clinical support staff is 5.4 years. Recent implementation of mandatory weekly furlough hours is challenging coverage, but indicative of the organizational commitment to avoid lay-offs in an economically depressed community.

## APPENDIX B: CLINIC CASE STUDIES

### Data Collection: Clinic 3



Access	
Appointment Scheduling Model	Traditional Scheduling Template.
Hours of Operation/Patterns of Utilization	M-F 8:00 - 5:30 with highest utilization mid-morning and mid-afternoon.
Response to new patients	Scheduled appointment with eligibility screening during initial appointment.
Response to walk-in patients	Worked into daily patient visit flow utilizing no-show and open appointment slots.
Transportation options	Generally patients drive to sites. Ample, designated parking available.

Scope	
Range of Clinical Services	Family Practice, OB/GYN, Internal Medicine, Optometry, Behavioral Health, Dental
Provide Hospital Services?	OB/GYN provide hospital services.
Provide Home-based Services?	No
Provide Nursing Home Services?	Internal Medicine
Provide Other Off-site Services?	No
Types of Providers Employed	Physicians and Mid-levels: Base of full-time staff providers supplemented by part-time contract providers.
Patient/Provider/Staff Relationship	Traditional panel-based care at main site. Recently expanded satellite re-organized into interdisciplinary Patient Care Teams.

## APPENDIX B: CLINIC CASE STUDIES

### Data Collection: Clinic 3



Facilitation	
Enabling/enhanced services on site	Eligibility; health education; outreach.
How enhanced services impact patient flow	Main site: Facility capacity allows for delivery of enhanced services without impacting space available for provider encounters.
Model of care coordination/case mgt.	Diagnosis Based. Expanded satellite utilizing integrated case management and education in patient care team model.
Patient participation outside exam room	Minimal except for special events.
Plan of care completed on site?	Developing panel of part-time contract specialists representing high volume referral types to provide consultations on-site. Current Specialties: OB/GYN, Psychiatry, Optometry. Evaluating: Gastroenterology.
Level of inclusion of family/friends in visit	Patients presenting in extended family groups or couplets observed. Exam rooms offer ample seating for partner/caretaker.

Environment of Care	
Sq. footage/provider /day	Data for the four primary sites: 1,233 square feet; 1,694 square feet; 1,634 square feet (team model); 2,980 square feet (main site)
Sq. footage/encounter /day	Data for the four primary sites: 104 square feet; 130 square feet; 135 square feet; 222 square feet (main site which is not fully staffed).
Spaces used for intended purposes?	Generally, yes. Some patient care rooms have been converted to staff offices. As demand for patient care areas increases with addition of providers, space for staff work may be insufficient under current model.
Space support patient processing flow?	Yes. However if team-based care piloted at satellite is adopted system-wide, reorganization of spaces with minor renovation will be needed.
Does environment reflect staff philosophy?	Clean, quiet environment reflects philosophy of professional excellence. Customer service training for support staff reported to have positive results in communicating professionalism.
Elements contributing to PCMH model	Ample spaces to accommodate family members in waiting and exam areas. Plantings and finishes at main entrance communicate stability and invite entry. Satellite site recently reorganized to allow team work spaces fostering interdisciplinary caremanagement.

## APPENDIX B: CLINIC CASE STUDIES

### Data Collection: Clinic 3



#### Utilization

<b>Patient Encounter Patterns</b>	Medical: 22% no-show rate. Dental: 27% no-show rate. Kept appointments and walk-ins produce patient encounters equaling 65% of schedule capacity.
<b>Target Facility Utilization</b>	Daily utilization of main site capacity is approx. 40%. Exam room turnaround time averages 50 minutes; general provider flow utilizes 3 exam rooms servicing up to 24 patients per day per provider. Dental provider flow utilizes 3-4 operatories. Optometry utilizes 1 exam room.
<b>Number of Providers for Optimal Flow</b>	Current Staffing Pattern: Medical - 2; Dental - 1; Optometry - 1; Specialty including OB/GYN - 1

#### Referral Patterns

<b>Rates for referrals made/completed</b>	30-40 days for completion of referrals. Tracking via electronic health record. Utilizing IT to define priorities for on-site contract specialties.
<b>Financial risk related to referrals</b>	Staffing investment of referral clerks with process monitored by Quality Assurance nurse. No direct payment for services.

#### Staffing Patterns

<b>Provider : Clinical Support Staff</b>	1:2 MA plus designated referral and front office staff.
<b>Provider : Enabling/Enhanced Services Staff</b>	Not available
<b>Provider Activity</b>	System Provider Averages: Medical - 16/day; Dental - 14/day; BH - 8/day; Optometry - 9/day System Site Averages (all services): 71/day with 6 providers; 78/day with 6 providers; 109/day with 9 provider team; 67/day with 5 providers.
<b>Student/Resident Involvement</b>	Viewed by the organization as key activity in building external network of support. Current extended rotations in advanced practice nursing and psychiatry. Medical scholar placement for exposure to CHC mission and model.
<b>Recruitment and Retention</b>	Retention: Provider / Staff retention patterns mirror the three phases of the organization. Initial Development (>20 years), Organizational Restructuring (3-4 years) and Current Redevelopment (<2 years). Staff retention rate during restructuring and redevelopment is 50% for providers and 47% for support staff. Retention efforts currently center on team building and internal communication.

## APPENDIX B: CLINIC CASE STUDIES

### Data Collection: Clinic 4



Access	
<b>Appointment Scheduling Model</b>	Pediatrics utilizes open access scheduling in response to process improvement initiative. Balance of services utilize traditional appointment scheduling as cultural implication of long-range scheduled appointment guarantees access.
<b>Hours of Operation/Patterns of Utilization</b>	Monday - Friday 8:30 - 5:00; Saturday 8:30 - 1:00. Scheduled appointments evenly distributed with influx of volume in waiting area mid-session each day. Walk-in patient utilization highest Monday and Friday.
<b>Response to new patients</b>	Long wait list to "join" and become a "member". If all patients on wait list could be accommodated this month, the total number of users would jump 10%. Process: Screening and registration area for new patients by appointment in adjacent building. Wait period for healthy adults several months, adults with chronic diseases one month. Point of Entry: Medical.
<b>Response to walk-in patients</b>	Utilizing walk-in patients to fill no-show appointments. Pediatrics: increased # of walk-ins after 3PM (school closing). Adults: increased # of patients Monday and Friday. Walk-in appointments for established patients.
<b>Transportation options</b>	Many patients walk. Public transportation options include subway, bus or taxi. Bus passes and taxi vouchers available upon request (Funded through Community Care Fund). Parking validation available if applicable.

Scope	
<b>Range of Clinical Services</b>	Medical (Pediatrics, Family Practice, Internal Medicine), Dental and Behavioral Health. Rotating specialists and complementary medicine providers available on a regular schedule.
<b>Provide Hospital Services?</b>	No - labor coach program for prenatal patients.
<b>Provide Home-based Services?</b>	No
<b>Provide Nursing Home Services?</b>	No
<b>Provide Other Off-site Services?</b>	No
<b>Types of Providers Employed</b>	Physicians, dentists, nurse practitioners, physician assistants, licensed clinical social workers.
<b>Patient/Provider/Staff Relationship</b>	Staff and providers currently work in role-defined teams (front office / back office / clinicians/ etc.). Moving toward task-defined teams with a variety of member compositions depending on task to be accomplished.

## APPENDIX B: CLINIC CASE STUDIES

### Data Collection: Clinic 4



#### Facilitation

<b>Enabling/enhanced services on site</b>	Enabling services available in eleven languages, supplemented by other staff language skills as needed. Most frequently occurring: Interpretive Services. Greatest allocation of time: Eligibility Screening. Other available services: Health Education, Casemanagement. Staff positions providing enabling services include nurses, health coaches, health navigators, patient navigators, case managers.
<b>How enhanced services impact patient flow</b>	Alternate patient flow patterns accompany different language groups dependent on commonality of languages spoken by patient and staff. New site: Patient navigators initiate the visit process and provide language support.
<b>Model of care coordination/case mgt.</b>	Chronic disease panel management. Team led by chronic care manger and comprised of provider, patient, family, patient navigator, health coach, nurse.
<b>Patient participation outside exam room</b>	Main site: limited except for chronic disease and prenatal care education and management. New site: additional space allows for intervisit education and support groups as well as group medical visits.
<b>Plan of care completed on site?</b>	Specialty care available on-site on a rotational basis. Lab within walking distance of main site. Radiology on site. Pharmacy adjacent to main site.
<b>Level of inclusion of family/friends in visit</b>	Visitor seating available in exam rooms. New site: inclusion of family members in patient care process is facilitated with larger exam rooms and inclusion of small and large group rooms.

#### Environment of Care

<b>Sq. footage/provider /day</b>	Main Site: Medical / clinical space only - 833 square feet. New Site: Medical / all functions - 2,000 square feet.
<b>Sq. footage/encounter /day</b>	Main Site: Medical / clinical space only - 42 square feet. New Site: Medical / all functions - 100 square feet.
<b>Spaces used for intended purposes?</b>	Transition of spaces for patient/staff interaction into staff work space. Ex: part of waiting room converted to work zones. Lab relocated and replaced by offices.
<b>Space support patient processing flow?</b>	Site will begin transition to electronic health records Jan 2012. Process elimination of paper records will free space for staff work, returning current work spaces to patient interaction areas, better supporting flow by moving interactions from open/hall spaces. Observed: Alternate flow process dependent on language group and re-use of spaces requires patients to be dependent on staff for direction. Multi-directional flow during staff work processes.
<b>Does environment reflect staff philosophy?</b>	New satellite site designed to integrate several pilot projects at main site. Clinical area supportive of philosophy. Family / group / individual education areas remain inconsistent in design with intended use. Consistent with stated philosophy, patients in all facilities are supported but not autonomous in environment.
<b>Elements contributing to PCMH model</b>	Culturally appropriate art work. Multiple audible languages draw patients to native tongue speaker. Positive diversion in Pediatrics: Wall-mounted fish tank, textural wall mural. Maximization of natural light within new satellite site. Patient care team currently dispersed, integration to be facilitated with EMR expanding on improvement of coordination experienced with recent digitization of radiology.

## APPENDIX B: CLINIC CASE STUDIES

### Data Collection: Clinic 4



#### Utilization

<b>Patient Encounter Patterns</b>	Medical: Nine to eleven appointments per half-day session plus walk-ins as needed. Generally sufficient additional walk-ins (even with one dedicated provider) to fill no-show appointment slots.
<b>Target Facility Utilization</b>	Target medical: 2 exam rooms per provider. New site includes swing room. Note: Exams are not identical; function of select exam rooms increases their utilization. Dental: 2-3 operatories per provider.
<b>Number of Providers for Optimal Flow</b>	Main Site Medical: Optimal achieved approx. 80% of schedule. Pediatrics - 3, Family Practice/Internal Medicine - 12 divided into three work zones. Each zone has 8 exam rooms, difficult flow with 5 providers.

#### Referral Patterns

<b>Rates for referrals made/completed</b>	Unavailable.
<b>Financial risk related to referrals</b>	No direct payment for services. Organizational investment of staffing time - shared by multiple staff. Managed by patient navigator if patient is assigned patient navigator re: language group.

#### Staffing Patterns

<b>Provider : Clinical Support Staff</b>	1: 2 - 2.5 dependent on multi-language proficiency. Sufficiency of amount of support strongly dependent on match between staff language proficiency and presenting patient language.
<b>Provider : Enabling/Enhanced Services Staff</b>	Approximately 1: 0.3. Number of enabling staff matched to number of patient groups supported. Not related to provider panel.
<b>Provider Activity</b>	Medical encounters per provider per day average 20. Have dedicated walk-in/drop-in provider with scheduled providers supplementing dependent on presenting show rate.
<b>Student/Resident Involvement</b>	Occasional mid-level students in Medical. Regular flow of dental assistant students in Dental.
<b>Recruitment and Retention</b>	Ratios Unavailable. Retention Strategies: 1) Paid sabbatical incentive for longevity 2) Mechanism for approval for non-clinical time to pursue special projects.

## APPENDIX B: CLINIC CASE STUDIES

### Data Collection: Clinic 5



Access	
Appointment Scheduling Model	Traditional appointment slot scheduling model. Return appointments made in exam room at end of visit.
Hours of Operation/Patterns of Utilization	Medical: M & F 8-5 with highest utilization; Tu-Wed-Th 8-9 with Th lowest utilization; no demand for Sat hours. 70% utilization of potential visit hrs. Dental: M-F 8-5 with no capacity for evening hours.
Response to new patients	Available new well appointment 1-2 weeks. If no coverage, sliding fee short form for 1st visit with follow-up appointment for full eligibility screening (off-site). Point of Entry - Primarily Medical: Monthly outreach to migrant camps for screening and referral for provider appointment (no transportation). Dental: New patients must be from geographic service area with priority given to established medical patients. Behavioral Health: Will accept new self-referrals. Medical appt. to establish care after first appt.
Response to walk-in patients	Capacity to work in all walk-in patients same day.
Transportation options	Minimal public transportation. Bus passes provided if service available.

Scope	
Range of Clinical Services	Medical: Family Practice base supplemented by part-time Internal Medicine and Pediatrics. Integrated Behavioral Health. Prenatal care with referral for delivery. Dental.
Provide Hospital Services?	No. Hospitalists provided by referral hospital.
Provide Home-based Services?	Yes - Family Practice
Provide Nursing Home Services?	No
Provide Other Off-site Services?	Not provider. Nursing, outreach, education provided off-site.
Types of Providers Employed	Medical: MD, PA Dental: Dentist and DH Behavioral Health: Psychologist, LCSW (Fall 2011)
Patient/Provider/Staff Relationship	Majority of patients are adults. Developing Primary Care Panels: Group of identified patients managed by a team of 2 medical providers, 1 behavioral health provider, 2 medical assistants, 1 front desk staff with the goal that at least one member of the team would be on-site at all times to provide point-of-contact for patient. Goal: Achieve integration and provide continuity with multiple part-time staff.

# APPENDIX B: CLINIC CASE STUDIES

## Data Collection: Clinic 5



Facilitation	
Enabling/enhanced services on site	Eligibility, Promotoras program, nutrition education, lactation consultation and general preventive health education. Note: Majority of services provided in extension office several blocks from clinical site.
How enhanced services impact patient flow	Alternate appointment or coordination of staff moving to clinical site or patient moving to education site.
Model of care coordination/case mgt.	Diagnosis - based. Prenatal Coordinator provides case management, consultation and education. RN Casemanager serves as supervisor of MA staff and chronic disease casemanager (vacant position).
Patient participation outside exam room	Multiple group offerings targeted at cultural, language and diagnostic sub-groups. Level of participation dependent on topic. Focus on healthy lifestyle. On and off-site.
Plan of care completed on site?	Pharmacy adjacent to clinic site. Enabling (see note above). Lab Specimen collection. Radiology and specialty by referral off -site.
Level of inclusion of family/friends in visit	Enabling services provided to family groups. Exam rooms large enough to accommodate family/caretaker.

Environment of Care	
Sq. footage/provider /day	Medical: 650-975 square feet. Dental: 292 square feet.
Sq. footage/encounter /day	Medical: 3 encounters/square feet/yr Dental: 1.7 encounters/square feet/year.
Spaces used for intended purposes?	Renovation of space within the last year. Triage / Phone area not in use as lack of confidentiality where placed. Break area shares utilization as staff work area.
Space support patient processing flow?	Check-in/reception area lacks confidentiality. Optimal flow would allow eligibility screening to be done at clinical site if confidential area created. Walk-in triage audible and visible from waiting area and doubles as vitals area impacting number of patients served at one time.
Does environment reflect staff philosophy?	Providing team-based care in site where work zones are task based. Reorganization of shared task areas with staff work stations co-located in team area would support philosophy of care. Full reorganization of space limited by structural integrity of facility. Physical co-location of medical and behavioral health services reflects model of care.
Elements contributing to PCMH model	Patient Focused Exam Rooms: Door swing allows screening from hall, computer screen visible to patient and provider while allowing provider to enter data and maintain eye contact with patient; adequate seating for family/caretaker; colors and finishes utilized known to decrease heart rate indicative of decreased stress.

## APPENDIX B: CLINIC CASE STUDIES

### Data Collection: Clinic 5



#### Utilization

<b>Patient Encounter Patterns</b>	Medical: every 20 minutes with 15 minute flow buffers 4 times each day. Dental: every 30 min; every 60 min hygiene 13% no-show rate; 11% cancel rate.
<b>Target Facility Utilization</b>	100% of patient care rooms used at all hours, flex flow to number of providers. Able to provide coverage for 88% of available shifts (open hours, optimal staffing).
<b>Number of Providers for Optimal Flow</b>	Medical: 2; Behavioral Health: 1; Dental: 1 dentist, 2 dental hygienists.

#### Referral Patterns

<b>Rates for referrals made/completed</b>	20-25 referrals per month. Recent implementation of electronic record system initiated new tracking options.
<b>Financial risk related to referrals</b>	Partner in regional specialty care imitative. No financial risk for referrals. Radiology: 40% cash up front discount for patients. Clinic will accept risk for upfront payment and bill patient. Labs: Flat fee for sliding fee patients. Clinic pays discounted balance.

#### Staffing Patterns

<b>Provider : Clinical Support Staff</b>	Medical: 1: 1.5 MA support with 1:1 couplet and float/flow/referral task MA. 90% of time same two staff work as couplet. Dental 1:0.66 DA.
<b>Provider : Enabling/Enhanced Services Staff</b>	System: 2:1 including Promotoras. Not assigned to providers as roles defined by target population or task.
<b>Provider Activity</b>	Medical: average 14 encounters/day/provider. In last three years, 17% growth in Medical, 70% growth in Dental and 26% growth in Behavioral Health patient population.
<b>Student/Resident Involvement</b>	No
<b>Recruitment and Retention</b>	Provider: average tenure 3.5 years with 89% retention rate. Support: 80% retention. Greatest difficulty recruiting RN positions.

## APPENDIX B: CLINIC CASE STUDIES

### Data Collection: Clinic 6



Access	
Appointment Scheduling Model	Traditional Scheduling Model with return appt made at check-out. Late Arrivals: Patients >10 min late choose to be re-scheduled, processed as walk-ins or return to walk-in clinic. Hospital Follow-ups: Scheduled slots distributed to patients by hospital staff.
Hours of Operation/Patterns of Utilization	M-F 9-6:30 Even utilization except for Latino population: high utilization after 3PM re: to work/transportation schedules. Discontinued Saturday hours in response to non-utilization.
Response to new patients	Request eligibility screening prior to 1st appt. Well new given appt 2-3 weeks. Sick new seen as walk-in for acute care visit. Point of Entry: Any service except Behavioral Medicine.
Response to walk-in patients	Medical - Single provider walk-in clinic at end of day 4 days/wk (Total of 10 hrs/wk). Acute care, established pts. High utilization. Alternate time walk-ins fit in to no-show slots.
Transportation options	Regional and local bus service. Center provides vouchers per patient request (Minimal requests). Lack of out-of-area transportation options is barrier to referral follow-up.

Scope	
Range of Clinical Services	Medical: Family Practice base with IM, OB, Behavioral Medicine on staff. Podiatry every month. Adding Pediatrics 7/2011. Dental. Behavioral Health.
Provide Hospital Services?	No, except OB is in community rotation. Hospitalists hired by hospital..
Provide Home-based Services?	Occasionally to shut-ins.
Provide Nursing Home Services?	Yes
Provide Other Off-site Services?	No
Types of Providers Employed	Medical: Physician/Midlevel providers in multi-person shared offices. Nursing/MA staff in separate work area. Team: Provider/MA couplets with supporting team of referral, outreach and RN/LPN staff. Each nurse assigned a primary clinical/program focus. Dental: Provider office and DA work stations. BHS/BM: Consultation offices.
Patient/Provider/Staff Relationship	No defined provider panel. Patient may self-select provider of choice. Next available scheduling of appointments. Rotate walk-in patients.

## APPENDIX B: CLINIC CASE STUDIES

### Data Collection: Clinic 6



Facilitation	
Enabling/enhanced services on site	Eligibility screening, PAP, nursing education, casemanagement for targeted diagnosis.
How enhanced services impact patient flow	Nursing education, casemanagement, referral follow-up and eligibility/resource screening all completed via intervisit appointment.
Model of care coordination/case mgt.	By diagnosis, incl. in nursing function except for financial screening and referrals management.
Patient participation outside exam room	As defined by provider/patient dyad for chronic disease management. By appointment.
Plan of care completed on site?	Dermatology screening; retinal screening; P/T podiatry by referral.
Level of inclusion of family/friends in visit	Rooms sized to accommodate family members. Two guest chairs in exam rooms. No designated family waiting, visit or meeting area.

Environment of Care	
Sq. footage/provider /day	Family Practice Medical: 860 sqft; OB Medical: 620 sqft; Behavioral Medical: 850 sqft; Dental: 2,100 sqft.
Sq. footage/encounter /day	Family Practice Medical: 62 sqft; OB Medical: 77 sqft; Behavioral Medical: 94 sqft; Dental: 140 sqft.
Spaces used for intended purposes?	Yes, with the exception of added work stations and storage in clinical processing areas.
Space support patient processing flow?	Yes, electronic conversion in process. Spaces reconfigured to support conversion.
Does environment reflect staff philosophy?	Current model, yes. Staff moving toward more team focused care. Physical layout does not currently support team model..
Elements contributing to PCMH model	Main waiting area: Play area for children, public phone, natural light, soft seating options. Local art on main corridor walls.

# APPENDIX B: CLINIC CASE STUDIES

## Data Collection: Clinic 6



### Utilization

<b>Patient Encounter Patterns</b>	Appointment Template: Medical - every 20/40 min; Dental every 30/60 min; BH on the hr; BM every 20/30 min. Average appointments per day in Medical is 75% of scheduled capacity.
<b>Target Facility Utilization</b>	Med: 2 rooms/provider Dental: 2.5 rooms/provider BM/H: 1 room/provider.
<b>Number of Providers for Optimal Flow</b>	13 - Med: FP: 7 OB: 2; Dental: 2; BM: 2 Achieved 60% of scheduled hrs.

### Referral Patterns

<b>Rates for referrals made/completed</b>	Referrals tracked until completed or alternate plan of care. 2 FTE manage 450 open referral cases. Rates for initial completion unknown. Access Barrier: payer source; Fulfillment Barrier: culture (language, distance/transportation, intimidating environment).
<b>Financial risk related to referrals</b>	No payment for referrals made. Investment of 2 FTE in case management of referrals.

### Staffing Patterns

<b>Provider : Clinical Support Staff</b>	1:0.75 Front Desk Support incl. phones Medical: 1 : 1 MA : 0.33 RN/LVN Dental: 2 : 5 DA
<b>Provider : Enabling/Enhanced Services Staff</b>	Included in nursing levels above. In addition, 4 FTE for outreach, eligibility and referrals.
<b>Provider Activity</b>	Average encounters/day per type of provider: Fam Practice Medical - 14; OB/GYN Medical - 8; Behavioral Medical - 9; Dental - 15.
<b>Student/Resident Involvement</b>	Midlevel student 8 week rotations. Active shadowing. No significant change in flow/activity.
<b>Recruitment and Retention</b>	Rates not available. Recent expansion via acquisition of private practice.

## APPENDIX B: CLINIC CASE STUDIES

### Data Collection: Clinic 7



Access	
Appointment Scheduling Model	Traditional Scheduling Template.
Hours of Operation/Patterns of Utilization	M-T-W-F open 8-5:30 with appointments 9-5; Th open until 7P. High afternoon utilization, Low morning utilization with high no-show rate. Lab open early to accommodate pre-work and pre-visit testing. Saturday hours discontinued secondary to underutilization.
Response to new patients	Given scheduled appointment and asked to come early for financial screening. No pre-visit appointment. Point of Entry: Any Service.
Response to walk-in patients	Fit in to schedule utilizing no-show appointments. Prioritized by presenting complaint/concern. Discontinued financially unaffordable walk-in clinic - uneven utilization patterns, difficulty attaining clinical continuity.
Transportation options	Maintain van transportation system to/from appointments with stops at Pharmacy. Homeless Population: Clinic van route includes shelter stop. Bus fare from shelter to clinic covered by clinic.

Scope	
Range of Clinical Services	Behavioral Health, Dental and Medical including Perinatal Program and Rotating Specialties.
Provide Hospital Services?	Perinatal including Deliveries.
Provide Home-based Services?	No
Provide Nursing Home Services?	Yes
Provide Other Off-site Services?	Targeted Screening, Outreach to Homeless Population.
Types of Providers Employed	Medical: Physician, PA, NP, CNM. Dental: Dentist BH: Psychiatrist, Psychologist, LCSW. Adding Internal Medicine capacity in response to higher acuity, aging population. Historically adult population in response to gap in access within community. Seeking to increase number of children by adding Pediatrician to create bridge from Perinatal to Family Medical.
Patient/Provider/Staff Relationship	Currently established individual provider panels with walk-in, sick coverage by next available provider. Summer 2011 piloting Team Care with patient panel belonging to 12 member team composed of 3 medical providers, 1 behavioral health provider, 1 case manager, 1 nurse and 6 support.

# APPENDIX B: CLINIC CASE STUDIES

## Data Collection: Clinic 7



Facilitation	
Enabling/enhanced services on site	Eligibility screening, nursing education, casemanagement and referral.
How enhanced services impact patient flow	Provision of education can occupy an exam room, interrupting provider flow when utilizing two exam rooms.
Model of care coordination/case mgt.	Currently diagnosis-based with dedicated staff in Pain Management, HIV, Perinatal and Substance Abuse. Patient Management Goal: all patients assigned a case manager. Action Step: Moving to model in which a casemanager is assigned to a team of providers. Challenge: Effectively matching casemanagers' skill/knowledge base to the needs of the patients man-
Patient participation outside exam room	Education sessions for target populations including on-going groups for Pain Mgmt and Smoking Cessation.
Plan of care completed on site?	Lab Services. On-site Pharmacy for sliding-fee patients. Hospital Services nearby.
Level of inclusion of family/friends in visit	Waiting and exam areas sized to accommodate multiple persons. Majority of observed patients were adults presenting alone.

Environment of Care	
Sq. footage/provider /day	Not applicable. Widely variable within site and within system.
Sq. footage/encounter /day	Not applicable. Widely variable within site and within system.
Spaces used for intended purposes?	Pre-existing room layout which does not account for variations in space requirements. Some rooms too large for intended use, some too small.
Space support patient processing flow?	Space encourages parallel individual flow rather than Team Process flow. Expansions of original site have alternative, compact design more supportive of flow. Dental organized in distinct pods - one per dentist. Clinic reports improved function and productivity within newly organized spaces..
Does environment reflect staff philosophy?	Not consistently. See above.
Elements contributing to PCMH model	Stress reduction techniques upon entry to building: Scented plantings at main entrance. Alternate seating options in general waiting area. Positive distractions including reading material and child-friendly television. Facilitation of access: Bilingual staff. Bus stop. Adequate parking. Residential setting. Patient Control: Exam rooms offer multiple seating options based on patient preference or task.

## APPENDIX B: CLINIC CASE STUDIES

### Data Collection: Clinic 7



#### Utilization

<b>Patient Encounter Patterns</b>	12% overall no-show rate, highest rate in Behavioral Health. Policy: Patients with 3 no-shows in 6 months moved to walk-in status.
<b>Target Facility Utilization</b>	Medical: Able to provide 2 exam rooms/provider 60% of scheduled hours. Goal for Expansions/New Sites is 3 exam rooms per provider to allow consistent provider flow (see Facilitation) while maintaining current 2 per provider if required. Dental: 100%. by FTE; dedicated provider pods of 3-4 operatories.
<b>Number of Providers for Optimal Flow</b>	Medical: 8-10 providers. Have sufficient providers on-staff to achieve; however, 40% of time > or < number secondary to provider schedule. Coverage for extended hours and part-time provider availability contributing factors.

#### Referral Patterns

<b>Rates for referrals made/completed</b>	Rates unavailable. System supports seven referral positions (approx 1: 3 providers) utilizing the electronic record system to work as a team. Considering relocating to a central location to strengthen team function, mirroring success of Central Call Center.
<b>Financial risk related to referrals</b>	No payment for services. Investment in 7 FTEs for access facilitation.

#### Staffing Patterns

<b>Provider : Clinical Support Staff</b>	Behavioral Health: 1:1 including support, coordination and outreach. Dental: 3:8 with 2 RDAs assigned to each dentist and 2 floats. Medical: 1:2 MA per physician; 1:1 MA per mid-level. Additional LVN/RN staff, check-out staff and ward clerk. Team model pilot: 12 person Teams (see Scope).
<b>Provider : Enabling/Enhanced Services Staff</b>	Referrals 3:1, not assigned to provider. Casemanagement / Education approx 5:1.
<b>Provider Activity</b>	Target: overall average of 18 encounters/provider/ day to meet expenses. Achieving prior to implementation of electronic record. Following full implementation, overall average encounters per day have plateaued at 16 reflecting impact of provider involvement in maintaining record.
<b>Student/Resident Involvement</b>	No residents. Mid-level rotations by provider request. Regular RN, LVN and MA rotations.
<b>Recruitment and Retention</b>	Focus: Bilingual Staff. 2010 Retained all but 1 provider and all clinical support except for 4 returning to school. Have found active participation in RN, LVN and MA training an effective recruitment tool. Strategic investment in expansion to 7 FTE Information Technology staff.

## APPENDIX B: CLINIC CASE STUDIES

### Data Collection: Clinic 8



Access	
Appointment Scheduling Model	Traditional scheduling template. Return appointments made at reception desk during check-out process.
Hours of Operation/Patterns of Utilization	M-T-W-T 8-8; F-S 8-5; highest utilization in evenings and Sat with higher incidence of urgent/acute illness. Saturday staffed by two appointment scheduled providers and one dedicated walk-in provider. Dedicated evening when site serves as a Teen Clinic.
Response to new patients	New patient appointment in 2-3 weeks. Phone screening for payment options including confirmation of HMO assignment and sliding fee eligibility. If screened as eligible for sliding fee, given separate eligibility appointment. 90% show rate for eligibility appointment. Point of Entry: Medical.
Response to walk-in patients	Managed in the same way as call -ins: limited same day appointment slots. Dedicated provider on Sat.
Transportation options	Limited bus transportation. Most patients drive to appointments. Site selection for consolidated site will place high priority on location within walking distance of core patient residential area or within patient population's established shopping/services zone.

Scope	
Range of Clinical Services	Medical: Family Practice with rotational specialties including prenatal program. Behavioral Health including Substance Abuse Treatment, the only service available to persons who are not established medical patients.
Provide Hospital Services?	Hospitalists manage patients in hospital; participate in OB and Newborn Nursery rotations.
Provide Home-based Services?	No
Provide Nursing Home Services?	No
Provide Other Off-site Services?	No
Types of Providers Employed	Medical: Physicians, Nurse Practitioners Behavioral Health: Psychiatrist, Psychologist, LCSW.
Patient/Provider/Staff Relationship	Task-based work. No defined teams. All staff are part-time. Emphasis on cross-training for full flexibility of support staff between and within front and back functional areas. Patients show preference for provider by scheduling request; however, there are no defined patient panels. Challenge: Not to overload "popular providers" in task-based environment. Key is effective, equitable sharing of the work load.

## APPENDIX B: CLINIC CASE STUDIES

### Data Collection: Clinic 8



Facilitation	
Enabling/enhanced services on site	Referrals management, RD/nutrition education , eligibility determination.
How enhanced services impact patient flow	Provided in separate building.
Model of care coordination/case mgt.	No dedicated casemanagement staff. Perinatal Program RNs monitor prenatal follow-up/outcomes. Nutritionist monitors diabetic patients. Dedicated data entry staff for transfer of clinical data to chronic disease management system.
Patient participation outside exam room	Nutrition Education: Individual and group by referral. Substance Abuse Treatment: Individual and group by referral. Cross-cultural interaction accepted by community in waiting/clinical area but not in group treatment venue.
Plan of care completed on site?	340B pharmaceuticals/samples available for pick-up on-site; OB, GYN, Podiatry and Urology on-site.
Level of inclusion of family/friends in visit	Two visitor chairs in exam rooms to accommodate family. Nutrition Services provided to family groups.

Environment of Care	
Sq. footage/provider /day	Medical: 625 sqft      Behavioral Health: 209 sqft
Sq. footage/encounter /day	Medical: 0.09 sqft      Behavioral Health: 0.49 sqft.
Spaces used for intended purposes?	Storage of supplies/records negatively impacting work space. Recently acquired expanded space for materials management freeing up original spaces intended for on-site storage to be used for patient care process. Enabling service work area moved to adjacent site to reassign work areas for clinical services.
Space support patient processing flow?	Flow consistent with organization of spaces except for need for patients to pass through staff work area to access some services, requiring increased escorting and decreased confidentiality of staff work process.
Does environment reflect staff philosophy?	Design of adjacent suite more closely mirrors staff philosophy of a confidential, patient friendly environment. However, division of staff/services into non-communicating suites does not support the integrated model the staff is working to attain. For example, enabling services staff no longer available as clinical team resource.
Elements contributing to PCMH model	Language: 75% of staff are bi-lingual (Eng/Span) including all front desk and medical assistant staff. All providers speak some Spanish.

## APPENDIX B: CLINIC CASE STUDIES

### Data Collection: Clinic 8



#### Utilization

<b>Patient Encounter Patterns</b>	Medical: Schedule 75 minutes of appointment time each 60 minutes to account for 18-24% no-show rate.
<b>Target Facility Utilization</b>	Space is limited for both staff work and patient evaluation. All spaces used 100% of time with flexing of work spaces to increase/decrease size of work zone relative to number of persons present.
<b>Number of Providers for Optimal Flow</b>	3 Medical and 3 Behavioral Health. Attained 70% of scheduled work week.

#### Referral Patterns

<b>Rates for referrals made/completed</b>	Unavailable.
<b>Financial risk related to referrals</b>	No direct payment for services. Dental services available by coordinated referral to limited access points. Dedicate referral staff position.

#### Staffing Patterns

<b>Provider : Clinical Support Staff</b>	3:2 MA plus one site-wide floater. Separate staff for registration, phones, referrals, chart management.
<b>Provider : Enabling/Enhanced Services Staff</b>	Not applicable as all staff part-time. At any given time, one or two enabling staff on-site.
<b>Provider Activity</b>	Medical: Average 20 patients/day per provider.
<b>Student/Resident Involvement</b>	No established rotations.
<b>Recruitment and Retention</b>	All providers and all clinical support staff are part-time employees except for one RN. Retention efforts focus on team building with dedicated slot for internal meetings each week and bimonthly staff retreat.

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