Doing More with Less:
Operational and Financial Strategies of Eight Community Clinics

California HealthCare Foundation

ISSUE BRIEF

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Introduction and Background

The financial health of California's community clinics is crucial to the economic well-being of the state's health care system and its population. However, the budgets and stability of these clinics are under enormous pressure that is likely to increase over the next several years. California's budget for fiscal year (FY) 2012 includes $15 billion in spending cuts, with further decreases triggered automatically if revenue falls $1 billion short of projections. In addition, political leaders must reconcile the structural deficit that has been part of the budget process for much of the last decade.

There are also challenges at the federal level. Although the Affordable Care Act included significant investments in health centers, some of those funds have already been diverted to overcome $600 million in base-level funding cuts slated for FY 2011. Given the public demand for deficit reduction, additional cutbacks to the health center program may be inevitable. Even federal entitlement programs such as Medicaid and Medicare may be subject to deficit reduction, which would have dramatic implications for community clinics and their patients.

At the same time, demands for clinic services continue to increase as California's unemployed and uninsured populations grow due to the economic malaise. As clinics struggle to provide more services with fewer resources, they need to define productive operational models that include staffing ratios, service mix, and enabling services such as case management and transportation — and assess how these models perform on productivity and financial measures.

This issue brief offers findings from a study of the financial status and productivity of community clinics in California. The study examined financial indicators, staffing and utilization patterns, and service models to determine if they correlated with clinic productivity or performance. The financial analysis is the second update in a series going back to 2003. To obtain deeper insights about the financial status, efficiency, and performance of California's community clinics, the research included case studies of a number of clinics that were selected through the research process.

Insights gained through the case studies are the primary focus of this issue brief. A summary of observations and common themes from the site visits are discussed in the body of the report, while the case studies themselves are presented as Clinic Snapshots in the Appendix. The clinics are presented without identifying information and are numbered 1 through 8. For context, the report also includes a summary of indicators and trends uncovered by the financial analysis. A companion publication, *Snapshot: Financial Health of Community Clinics*, offers a more detailed look at the data generated by the study (www.chcf.org).

Methodology

The study's goals were to: (1) establish metrics for the continued monitoring of clinic financial performance; (2) identify staffing and program/service models that may contribute to financial success; and (3) provide a "best practice"

framework for clinic leaders and policymakers as they plan for rapid growth in the era of health reform.

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.[1] These financial indicators and ratios provided insight into four areas: profitability, growth, solvency, and debt capacity. The analysis used IRS Form 990 data to evaluate financial trends of clinics over the four-year period FYs 2006–2009.

The next phase of the study combined the financial measures described above 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.

Finally, site visits were conducted in June 2011 to further examine operational factors that may impact performance and productivity, and to understand the unique ways clinics are responding to the pressures they face. Eight clinics were visited, representing each of four performance and productivity quadrants:

- High productivity/high financial performance.
- High productivity/low financial performance.
- Low productivity/high financial performance.
- Low productivity/low financial performance.

The selected clinics included a cross-section of small and large organizations, new and well-established operations, and clinics in both rural and urban communities. Information and insights were gathered from each clinic through site tours, process observation, a standardized interview process with key clinic personnel, and group discussions focused on defining the environment of care and the operational model.

Summary of Financial Analysis

This study examined key financial ratios and compared them to staffing and productivity measures to gain insight into the relative effectiveness of different management strategies.

Key Ratio Analysis

Although the FY 2009 financial ratios for many clinics did not change significantly from prior years, it remains to be seen how funding cutbacks at the state and federal level in FY 2010, FY 2011, and beyond will impact the financial health of community clinics and their continued efforts to expand services to the growing number of underinsured.

Key financial observations of this study include the following:

- California community clinics continued to grow financially, with an overall inflation-adjusted total revenue growth rate of 20.7% between FY 2006 and FY 2009, and an average annual growth rate of 6.5%. Total clinic revenues grew to $2.4 billion in FY 2009.[2]
- Clinic financial performance remained stratified. At the median, clinics operated 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 75th percentile, the 25th 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 to 54 days cash at the median. However, the four-year average at the 25th percentile was less than 20 days cash, well under the minimum recommended cash levels of 45 to 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 third-party reimbursement.

Staffing and Productivity Measures

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 study examined a variety of staffing and productivity measures by combining the key financial ratio analysis with information from FQHC UDS reports.

Many community clinics — FQHCs in particular — share several defining characteristics in terms of mission, governance, and the types of services they provide. However, the staffing analysis showed a wide range of models, 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 the practice patterns and the roles fulfilled by specific staff such as physicians and mid-level providers may vary considerably from one clinic to the next, resulting in differing financial and productivity measures even if staffing ratios are relatively similar.

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 seem to make much of a difference in terms of clinic financial performance, it appeared that a higher enabling staff-to-physician ratio negatively impacted productivity.
- Similarly, a higher enabling staff-to-medical provider (physicians plus mid-levels) ratio also appeared to have a negative impact on productivity.

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 influenced 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.

Because community clinics are mission-based organizations that are designed to be responsive to the unique needs of their service areas, operational approaches that may work well to address the specific needs of their patient populations may not always support financial strength. Adding enabling staff may increase the efficiency and effectiveness of care, but not totally mitigate the increased cost of providing services in multiple languages within a diverse cultural context.

Balancing what are, at times, conflicting priorities may be a reason 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 health care environment while still responding to the specific patient demographics of their service areas.

The site visits identified several current trends in the clinical operating environment that are challenging the clinics' ability to manage their programs and services efficiently. Common trends include:

- Practice models are evolving towards technology-enhanced and team-based models.
- Although practice models are changing, clinics continue to be reimbursed for services based on face-to-face provider encounters, which can negatively impact their financial health.
- The need for facility expansion to serve a growing patient base must be achieved while implementing a patient-centered model of care, often with scant resources and thin margins.

These pressures contribute to operational responses that are, by necessity, low-risk and minimally disruptive, which can result in lower productivity.

Clinics employing similar operational responses met with varying degrees of success depending on the cultures of their communities, suggesting the difficulty of discovering recommendations that can be implemented industry-wide. For example, expanding hours to include evenings and weekends was extremely successful in Clinics 2 and 8, but resoundingly unsuccessful in Clinics 5 and 6. Of note is that all four of these clinics are in rural communities.

Likewise, clinics have generally handled walk-in patients with a "work-in" model, filling vacancies in the schedule with unscheduled requests. Clinic 6 has established a highly utilized daily walk-in clinic service, but Clinic 7 closed a similar service because of underutilization.

The case studies clarified the importance of a resilient operational culture that allows clinics to respond to their changing communities while incrementally adjusting their operational models.

Common Issues and Action Steps

All the clinics visited — whether financially strong or struggling to meet weekly payroll, whether managing many patients with few staff or many staff with few patients — showed evidence of the commitment to not only survive but thrive. Universally, both leadership and staff demonstrated and verbalized a desire to give "great care." Typical responses to the question "What makes a great day?" included: "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 eight clinics 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.

The subsections below describe several common issues experienced by all the clinics visited. For each issue, this report offers suggestions for recommended action steps based on case study findings.

Expansion and Growth

Every clinic visited for this study 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 that will be needed.

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 on efficiency during individual encounters. For clinics going through the planning and training process, the expectation is for rapid recovery following

implementation. However, clinics consistently reported a post-implementation leveling of productivity below that found with paper records.

2. **The call to expand the patient base has encouraged the explosion of multiple part-time provider staff.** Nearly all the clinics reported efforts to increase patient access by expanding hours, which can be facilitated by part-time provider staff. However, it was observed that the majority of these part-time providers work a variety of schedules within the same system, creating turbulent patient flow and competition for resources. Support staff, exam spaces, and equipment are not uniformly distributed to make expanded provider availability an effective access route.

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

A common challenge reported by clinics was the pursuit of a successful alignment of the clinic's physical space with an efficient practice model and an effective staffing mix. In some cases site expansion has allowed new sites to serve as pilot projects within the system, often with promising results. Several clinics — Clinic 3 in particular — have been more successful at satellite sites than at their more established sites.

However, 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 that 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 that includes adequate funding sources is critical for any clinic, regardless of its current financial position.

In general, staff represents the largest portion of clinic operating budgets. 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; this allows 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 were consistently reported as a challenge for the clinics' long-term stability.

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.

Risk Within the Operational Environment

The challenge of successfully managing 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 service areas 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 members is a key leadership skill in managing change.

However, effective management skills did not necessarily correlate with financial strength or productivity. While

a management team with a broad skill set is key to a innovative work environment, there was no correlation observed between management teams' skill sets and the financial stability of the organization. A highly competent management team may make financial stability possible, but does not guarantee it.

RECOMMENDED ACTION STEPS

- Clinics should invest in leadership development in the areas of risk management and change process. While not a guarantee for financial stability, these skill sets can contribute substantially to a clinic's ability to respond effectively to a changing environment.

Operational Stability

In an environment of increased expectations and decreased predictability, 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 is especially pronounced 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. Consequently, there is a need to align reimbursement mechanisms to facilitate the financial 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 sources of seed money for new projects. However, in today's changing environment the same factors that call for an urgent response are often accompanied by diminished economic stability in the service area, reducing the capacity of traditional funding sources just as the community's need is increasing. Access to short-term operational gap funding is critical to allow rapid responses to needs and opportunities, and to create a bridge between an expansion or service change and the establishment of a sustainable revenue stream sufficient to support the change.

RECOMMENDED ACTION STEPS

- Sources of short-term operational gap funding should be identified to allow rapid responses to needs and opportunities that don't yet have a sustainable revenue stream.
- Reimbursement mechanisms should be aligned to facilitate the financial integration of multiple operational models shown to be efficient and effective with diverse populations.

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 beyond a mere 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, both for the individual patient and the total population.

Similar to the rising medical acuity of the elder population, the rising cultural acuity of the general population must be addressed using economically sustainable models. This was particularly evident during site visits to urban clinics. The rising costs associated with facilitation of primary care services is not being covered by existing reimbursement mechanisms.

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.

Conclusion

California's community clinics face the continuing challenge of operating with slim margins and tight cash reserves while 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 often don't 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.

As demonstrated in the eight clinic snapshots, 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.

Author

Capital Link

About the Foundation

The California HealthCare Foundation works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit us online at www.chcf.org.

Appendix: Clinic Snapshots

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 fundraising, to provide direction and seed money for new initiatives.

Operational Response

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 health care 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 attainable expectations.

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 investments 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 primary care services of the organization are dependent on continued grant funding and philanthropic giving. Attention to both internal and external revenue generation will be necessary to sustain this model.

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. Integrating technology, maximize facilities, and develop staffing to expand efficient and effective capacity.

Internal challenge(s). Maintaining sufficient cash flow to support hard and soft costs of development.

External focus. Enduring as a vital resource within an economically challenged region.

External challenge(s). Maintaining supply of primary and specialty providers to locally address the growing needs of the community.

Operational Response

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. The dental site has been renovated to improve efficiency and expand capacity. The main clinic site was recently painted and equipment upgraded. 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 patients in carrying out plans 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 to 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. Stabilizing the organization to allow for future growth.

Internal challenge(s). Maintaining services responsive to the needs of the community while experiencing significant staff, management, and Board turnover.

External focus. Developing a strong network of support and collaboration.

External challenge(s). Communicate excellence as an employer, business entity, and health care provider in the midst of organizational restructuring.

Operational Response

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, 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 taken to improve internal communication included: (1) full staff meetings including staff from remote sites, (2) utilization of the internal email 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 a satellite site facility to be replaced. 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 in satellite locations are promising indicators for the development of systemwide stability and effectiveness.

CLINIC 4

Operational Context

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

Internal focus. Delivering 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. Facilitating 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 within the original target population.

Operational Response

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 used for majority languages, and a more fluid patient navigator model used 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 approach will be unique in using 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. Broadening the established medical model of primary care delivery to include integration of behavioral health, dental, community health, and education services.

Internal challenge(s). Creating 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). Developing financial stability while expanding both the scope and capacity of services.

Operational Response

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 is managed by a team of two medical providers, one behavioral health provider, two medical assistants, and one front desk staff person. The goal is for at least one member of the team to always be scheduled, allowing the patient a familiar 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. Developing 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. Maintaining a 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 Response

Capacity for scheduled patient appointments was dramatically reduced to allow extra time for providers and staff to develop proficiency with the newly implemented electronic health record. As is typically the case, this has resulted in decreased system productivity. The reduced number of encounters has decreased the workload 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 composition and function of the patient care team. This will require redistribution of the daily workload, cross-training of staff, and renovation/expansion of the existing facility. Acquiring project funding and maintaining adequate cash flow will be necessary for the clinical staff to be able 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 sometimes 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. Providing 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 responding 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.

Operational Response

Information technology development. Major capital investment in information technology has been matched with a significantly broader and deeper investment in fully implementing that technology than is generally seen in the clinic environment. Seven staff members 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, also to 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. At the time of the site visit, the clinic had plans to initiate 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. Strengthening 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 Response

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, and ensuring these measures are 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 patient visits. 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.

Endnotes

1. The ten ratios calculated: (1) total revenues and expenses, (2) operating revenue growth, (3) total revenue growth, (4) operating expense growth, (5) operating margin, (6) bottom line margin, (7) days all accounts receivables, (8) days patient accounts receivables, (9) days unrestricted cash on hand, and (10) leverage ratio.
2. The data set for total clinic revenue included 167 community clinics for which revenue data was available for all four years.