

SNAPSHOT

Financial Health of Community Clinics

2011



CALIFORNIA
HEALTHCARE
FOUNDATION

Introduction

Community clinics are an integral part of California’s primary care and safety-net system, especially for uninsured, underinsured, and low-income people. This report captures key measures of clinics’ financial health from 2006 to 2009.* In addition to examining financial measures, the report looks at staffing and program/service models that may contribute to clinics’ financial success.

KEY FINDINGS INCLUDE:

- Both revenues and expenses climbed in each year from 2006 to 2009, with expenses growing faster than revenue. While total revenues rose by 20.7%, adjusted for inflation, total expenses went up 24.4%
- Clinic financial performance remained widely varied. The financially strongest clinics had 7.8% operating margins, while the weakest clinics had –0.7%. However, the bottom tier has improved their operating margin over time.
- There was limited correlation between staffing patterns and financial performance. However, clinics with a higher mid-level to physician ratio appeared to have lower financial performance and productivity, which may be attributed to patient mix. Mid-level staff includes nurse practitioners, physician assistants, and certified nurse midwives.

A related CHCF issue brief, *Doing More with Less: Operational and Financial Strategies of Eight Community Clinics*, can be found at: www.chcf.org. The issue brief discusses the research findings and the lessons learned from eight case studies.

*The full report by Capital Link, *California Community Clinics: Financial and Staffing Analysis, FY06–FY09*, can be downloaded at: www.caplink.org.

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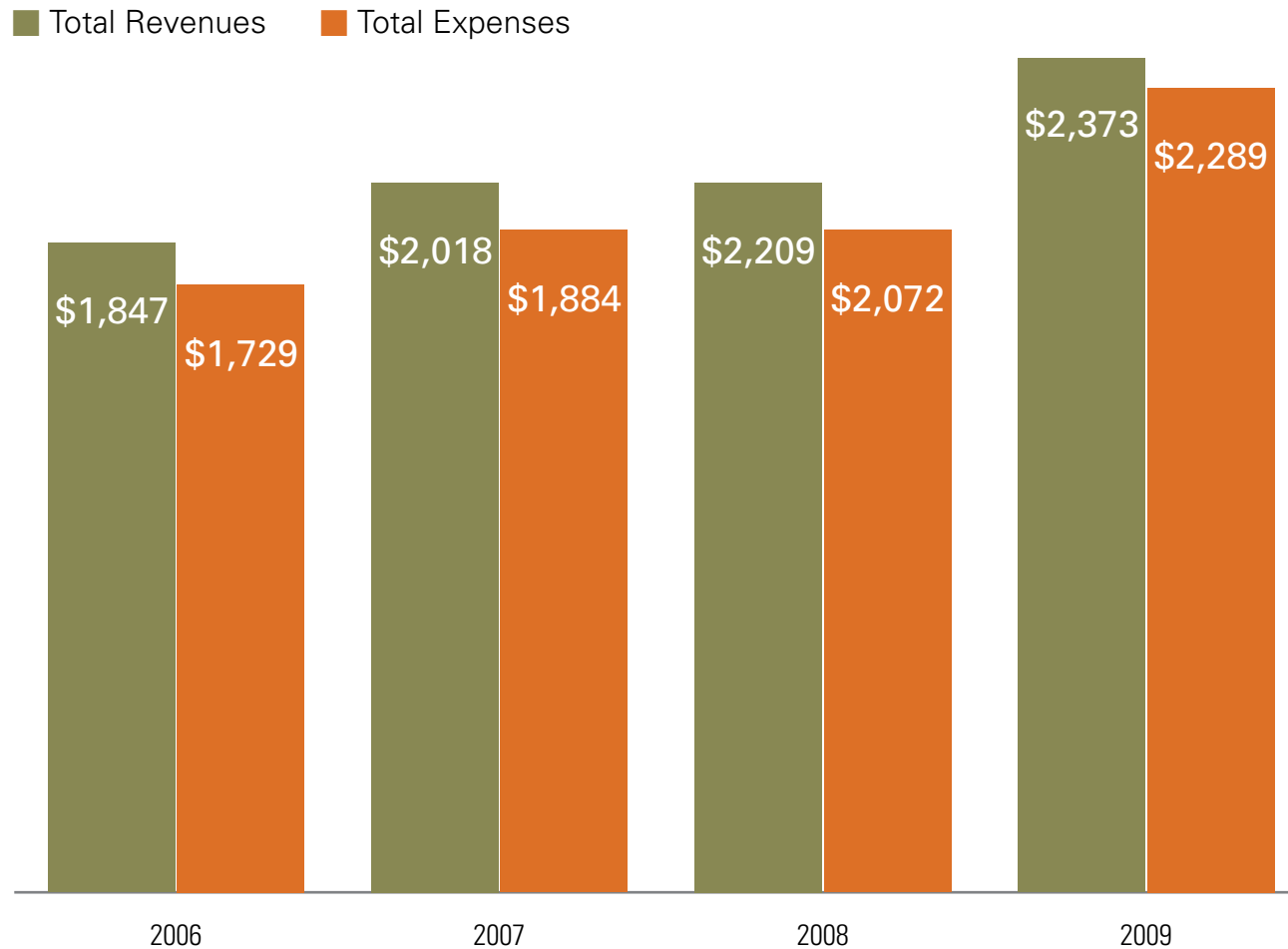
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Total Revenues and Expenses, FY06–FY09

IN MILLIONS

N = 167



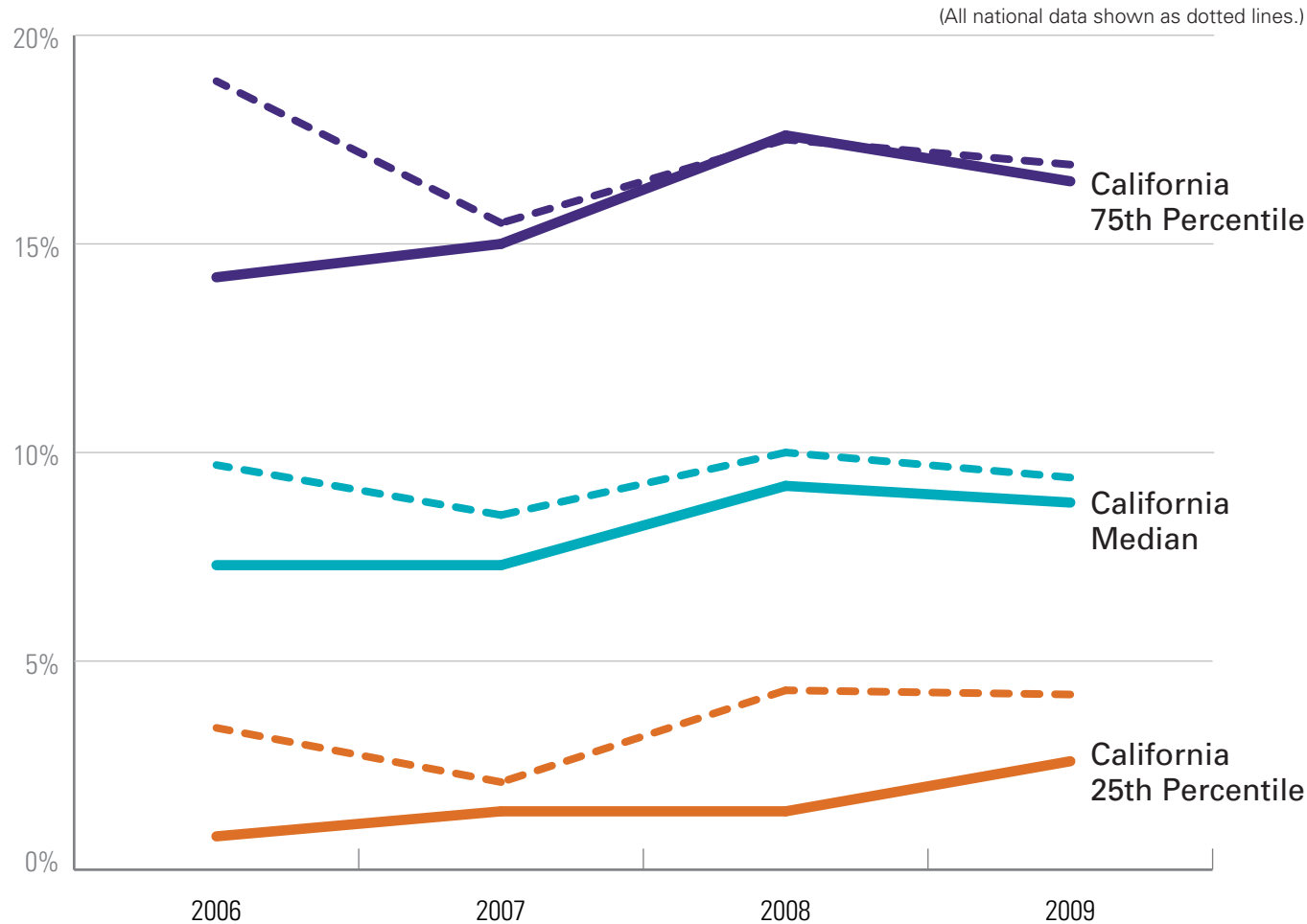
Community Clinics, Financial Health Overview

Revenues and expenses climbed in each year from 2006 to 2009. However, expenses grew faster than revenue. Total revenues rose from \$1.8 to \$2.4 billion in 2009, an inflation-adjusted increase of 20.7%. Total expenses went from \$1.7 billion in 2006 to \$2.3 billion in 2009, an average annual growth rate of 7.6%.

Notes: Financial data, ratios, and trends based on IRS Form 990. Reflects the 167 community clinics for which revenue data were available for all four years. All figures are inflation-adjusted. For more information, see [Methodology](#), page 13.

Source: Capital Link, *California Community Clinics—Financial and Staffing Analysis, FY06–FY09*, published in 2011, www.caplink.org.

Operating Expense Growth Rate, California vs. United States, FY06–FY09



CA	176	185	185	179	Varying sample size
US	435	439	350	282	

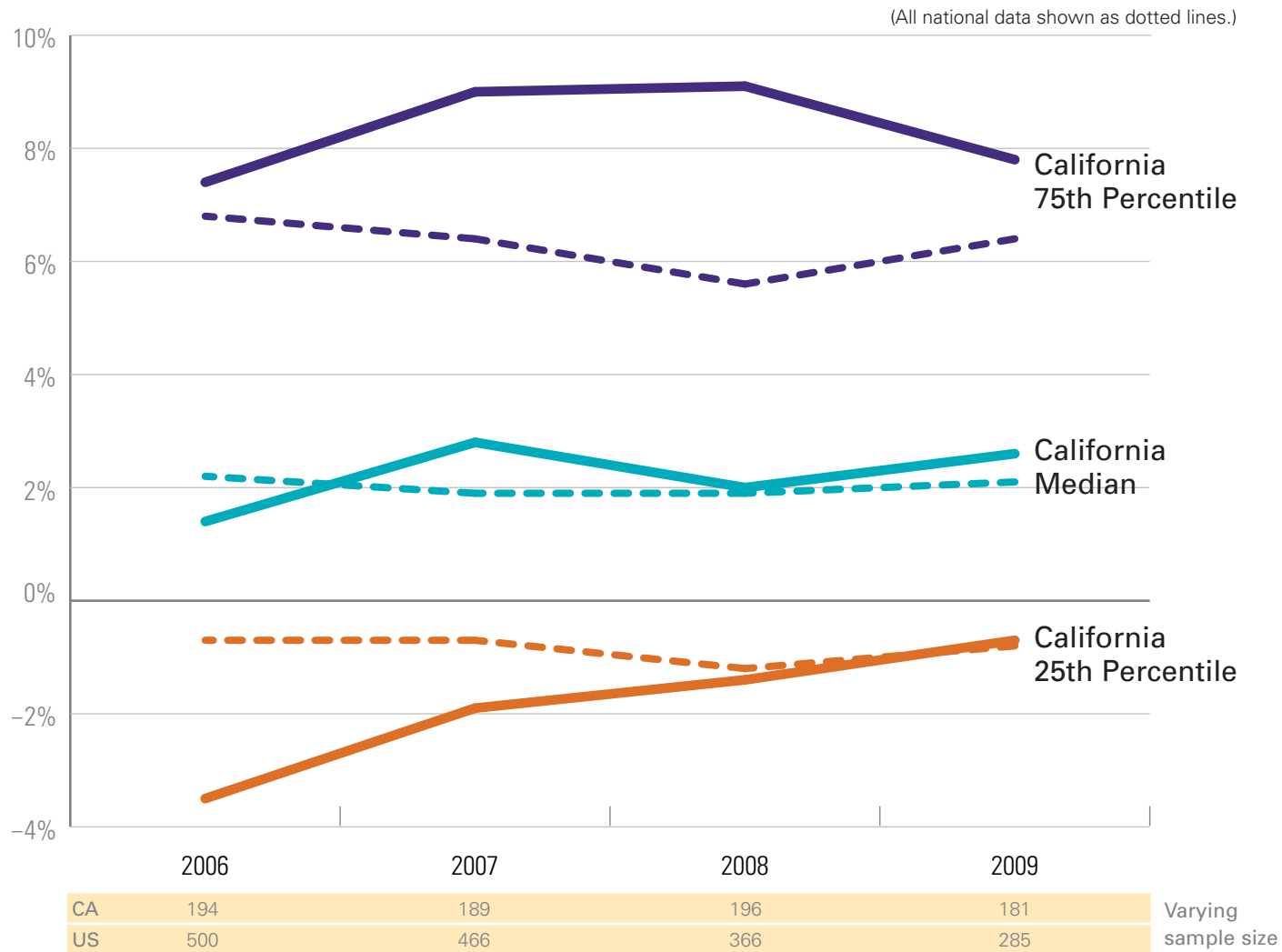
Notes: The community clinics were ranked and tiered into five groups (quintiles) based on overall financial performance. The highest or financially strongest are the top 25% and the lowest or financially weakest are the bottom 25%. For more information, see Methodology, page 13.

Source: Capital Link, *California Community Clinics—Financial and Staffing Analysis, FY06–FY09*, published in 2011, www.caplink.org.

Community Clinics, Financial Health California vs. United States

The median operating expense growth rate increased an average of 8.1% over the period. California clinics' operating expense growth rate for all years was slightly lower than nationally.

Operating Margin, California vs. United States, FY06–FY09



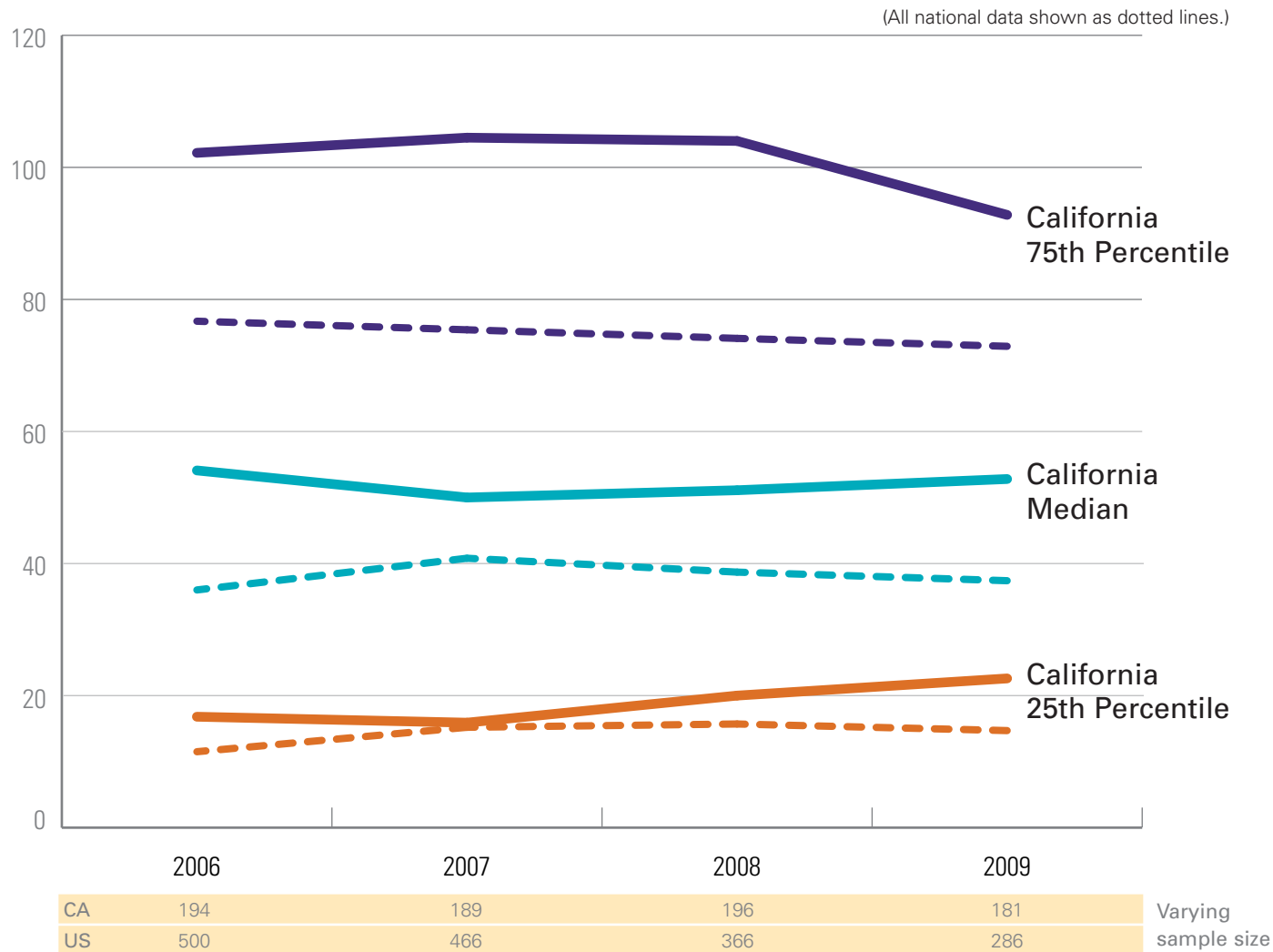
Community Clinics, Financial Health California vs. United States

The financial performance of California community clinics remained widely varied. At the median, clinics operated with tight operating margins, averaging 2.2%. For the financially strongest California clinics, the operating margins were notably higher than at the national level. However, the bottom fourth, while showing gradual improvement between 2006 and 2009, still had negative operating margins in 2009. These financially weaker clinics were doing worse than the national average.

Note: For more information, see Methodology, page 13.

Source: Capital Link, *California Community Clinics—Financial and Staffing Analysis, FY06–FY09*, published in 2011, www.caplink.org.

Days Unrestricted Cash on Hand, California vs. United States, FY06–FY09



Note: For more information, see Methodology, page 13.

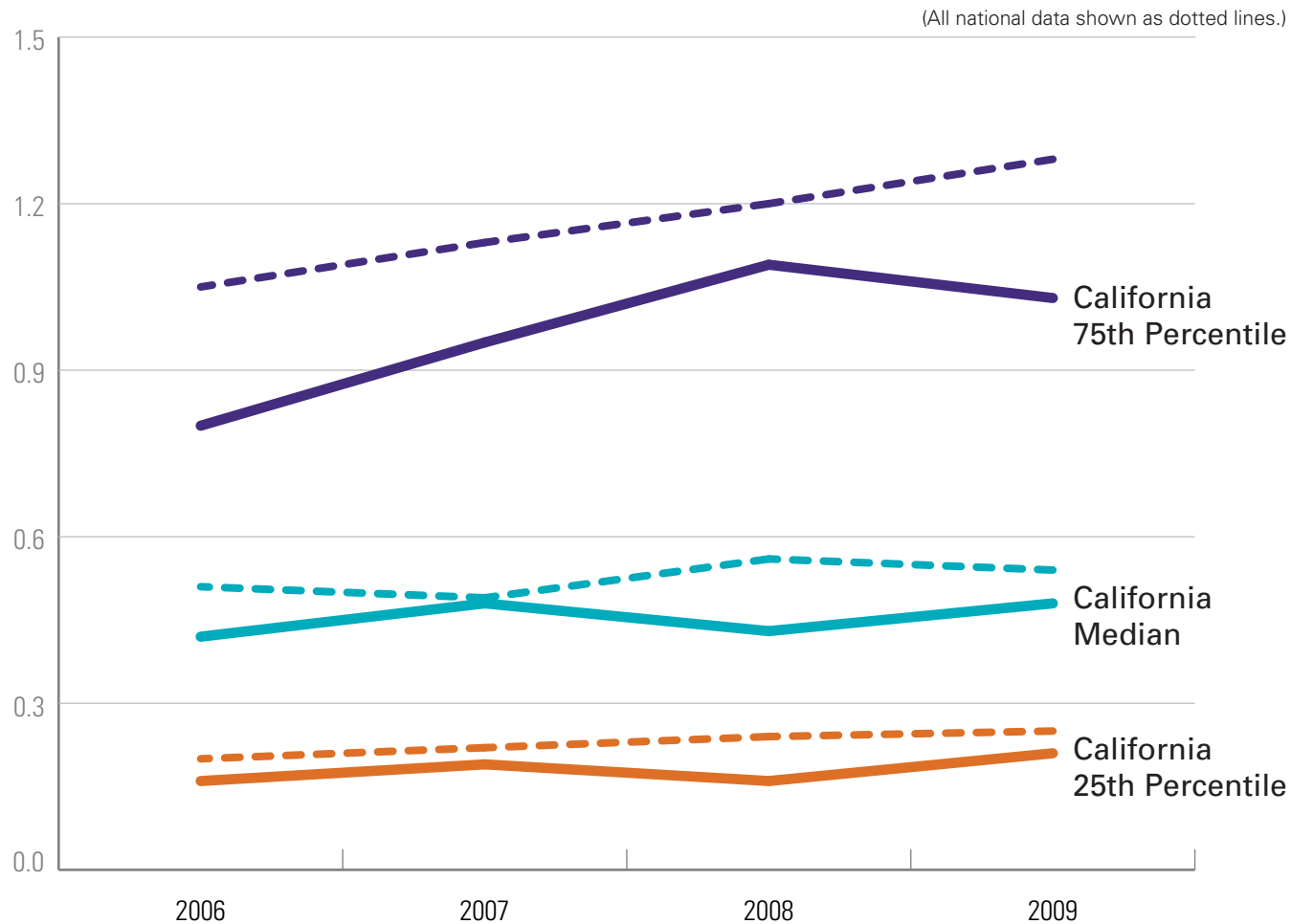
Source: Capital Link, *California Community Clinics—Financial and Staffing Analysis, FY06–FY09*, published in 2011, www.caplink.org.

Community Clinics, Financial Health California vs. United States

At the median, California clinics had 53 days cash on hand* in 2009, higher than the national median of 37 days. The highest performing clinics generated a four-year average of 101 days cash on hand, representing over three months of operating reserves. However, the bottom fourth of clinics had only 19 days, making them vulnerable to any interruption in revenue flow.

*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, a higher number of days allows for more operational stability. For efficient operation, it is generally recommended that clinics have at least 30 to 45 days cash on hand.

Debt Ratio, California vs. United States, FY06–FY09



CA	184	181	194	181	Varying sample size
US	499	466	366	285	

Notes: The leverage ratio measures a health center's total liabilities, both current and long-term, in relation to its net assets. Ideally, this ratio should not exceed 2.5. For more information, see Methodology, page 13.

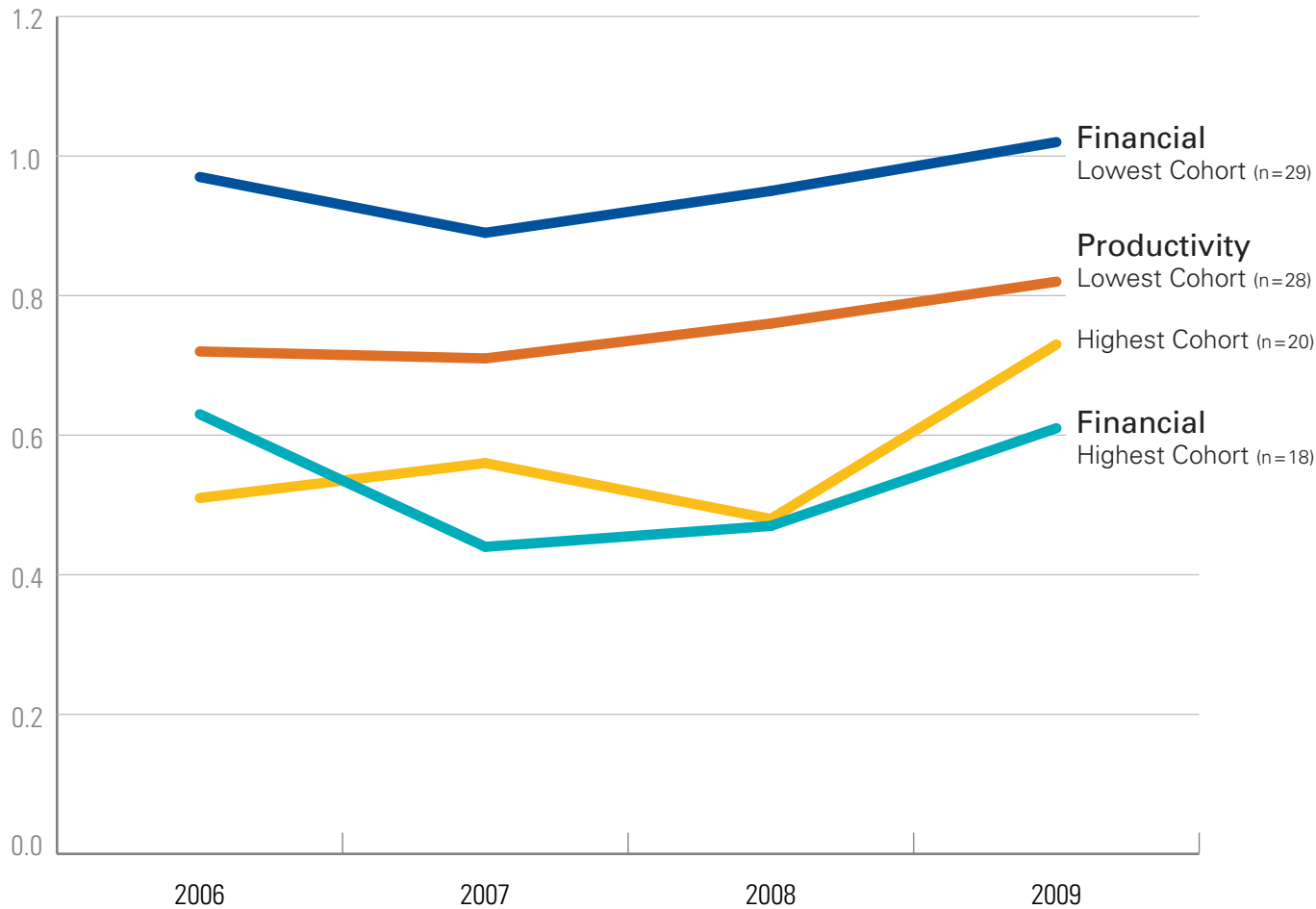
Source: Capital Link, *California Community Clinics—Financial and Staffing Analysis, FY06–FY09*, published in 2011, www.caplink.org.

Community Clinics, Financial Health California vs. United States

The median leverage — or debt — ratio remained low over the period, with values of between 0.42 and 0.48. This indicates that California clinics are carrying low levels of debt relative to assets. Low leverage may mean that clinics have generally funded capital investment with equity and grant support rather than with debt.

Mid-Level Staff to Physician Ratio, by Financial and Productivity Performance, FY06–FY09

NUMBER OF MID-LEVEL STAFF PER ONE PHYSICIAN



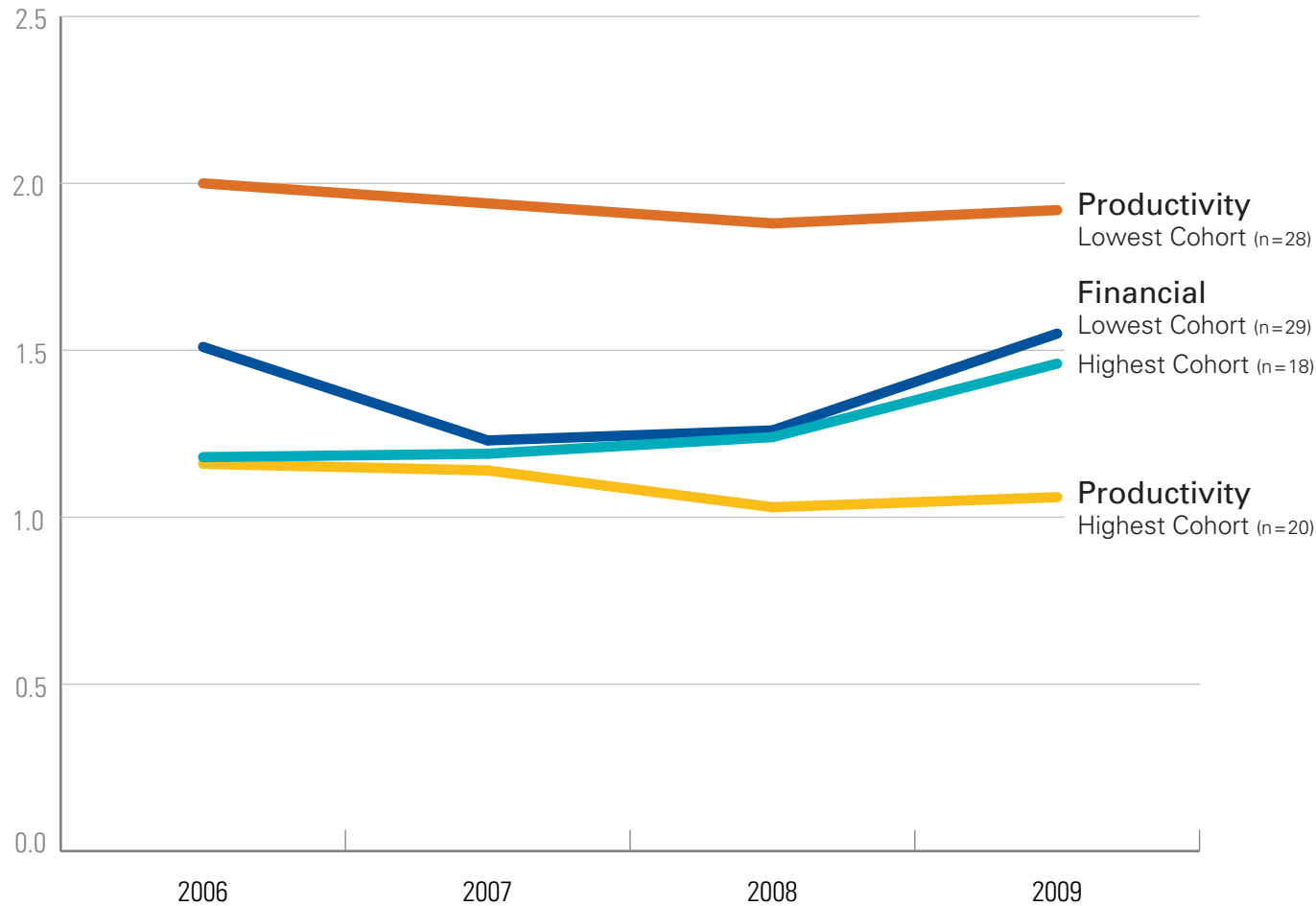
Clinics with a higher mid-level staff to physician ratio appeared to have lower financial performance and productivity.

Notes: Mid-level staff includes: nurse practitioners, physician assistants, and certified nurse midwives. For more information, see [Methodology](#), page 13.

Source: Capital Link, *California Community Clinics—Financial and Staffing Analysis, FY06–FY09*, published in 2011, www.caplink.org.

Enabling Staff to Physician Ratio, by Financial and Productivity Performance, FY06–FY09

NUMBER OF ENABLING STAFF PER ONE PHYSICIAN



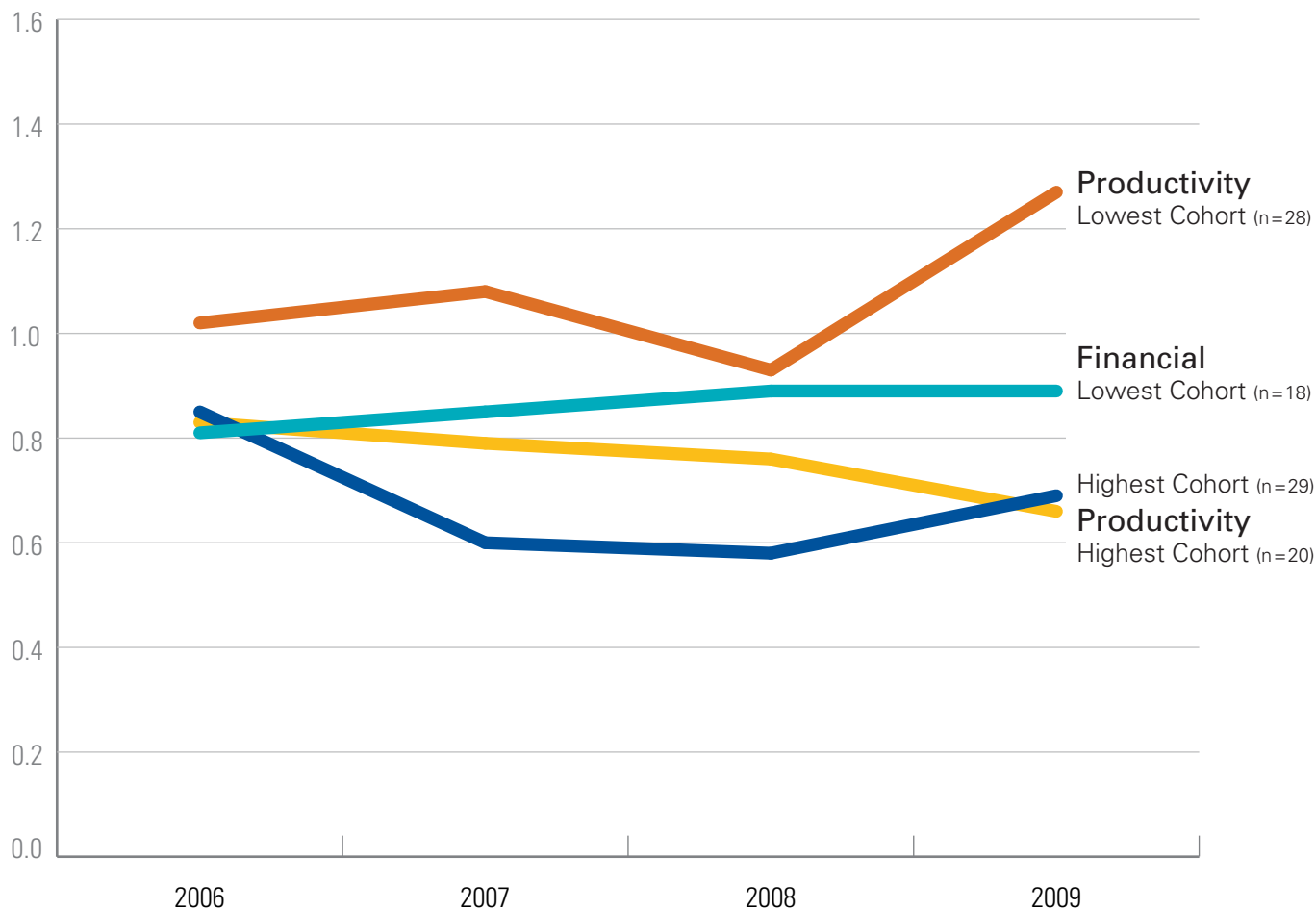
Notes: Enabling staff includes case managers, patient/community education specialists, outreach workers, transportation staff, eligibility assistance workers, interpretation, and other enabling services. For more information, see Methodology, page 13.

Source: Capital Link, *California Community Clinics—Financial and Staffing Analysis, FY06–FY09*, published in 2011, www.caplink.org.

A higher ratio of enabling staff to physicians appeared to negatively impact productivity, although there was no correlation with financial performance. This could be due to a more complex patient population.

Enabling Staff to Medical Provider Ratio, by Financial and Productivity Performance, FY06–FY09

NUMBER OF ENABLING STAFF PER ONE MEDICAL PROVIDER



Notes: Medical providers include physicians and mid-levels. Mid-levels include nurse practitioners, physician assistants, and certified nurse midwives. For more information, see [Methodology](#), page 13.

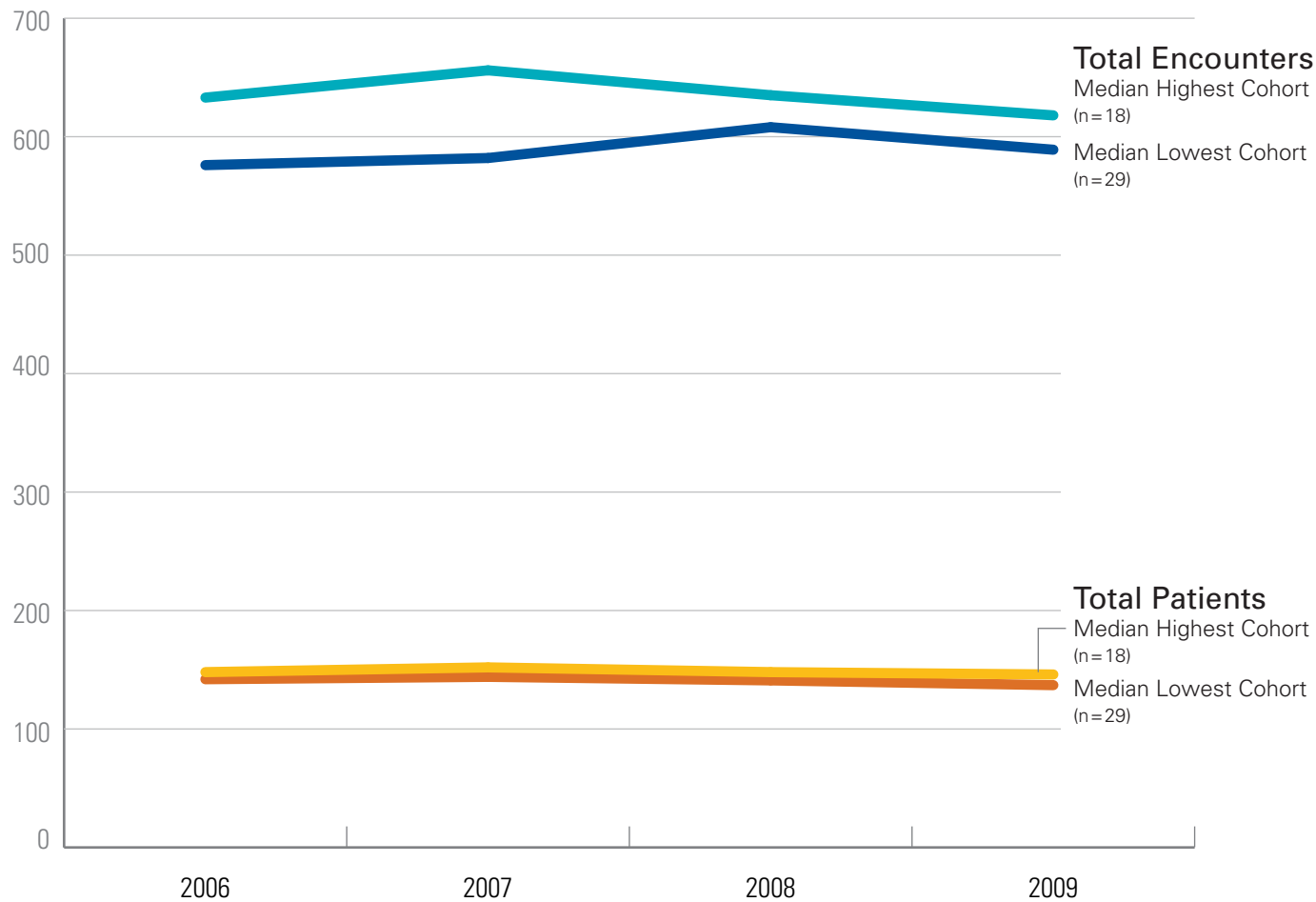
Source: Capital Link, *California Community Clinics—Financial and Staffing Analysis, FY06–FY09*, published in 2011, www.capl原因.org.

Community Clinics, Financial Health Productivity Measures

The financially strongest clinics had a slightly higher ratio of enabling staff to medical providers than the financially weakest clinics. The best performing clinics in terms of productivity consistently had a lower enabling staff to medical provider ratio than the lowest performers. A possible reason is that clinics with larger enabling staffing are responding to the medical or cultural acuity of their patient base — a factor that also decreases provider productivity.

Productivity, by Encounters and Patients, FY06–FY09

NUMBER OF TOTAL ENCOUNTERS / PATIENTS PER TOTAL FTEs



Notes: Productivity was measured at three levels: the entire organization, the clinical team, and all providers. For more information, see [Methodology](#), page 13.

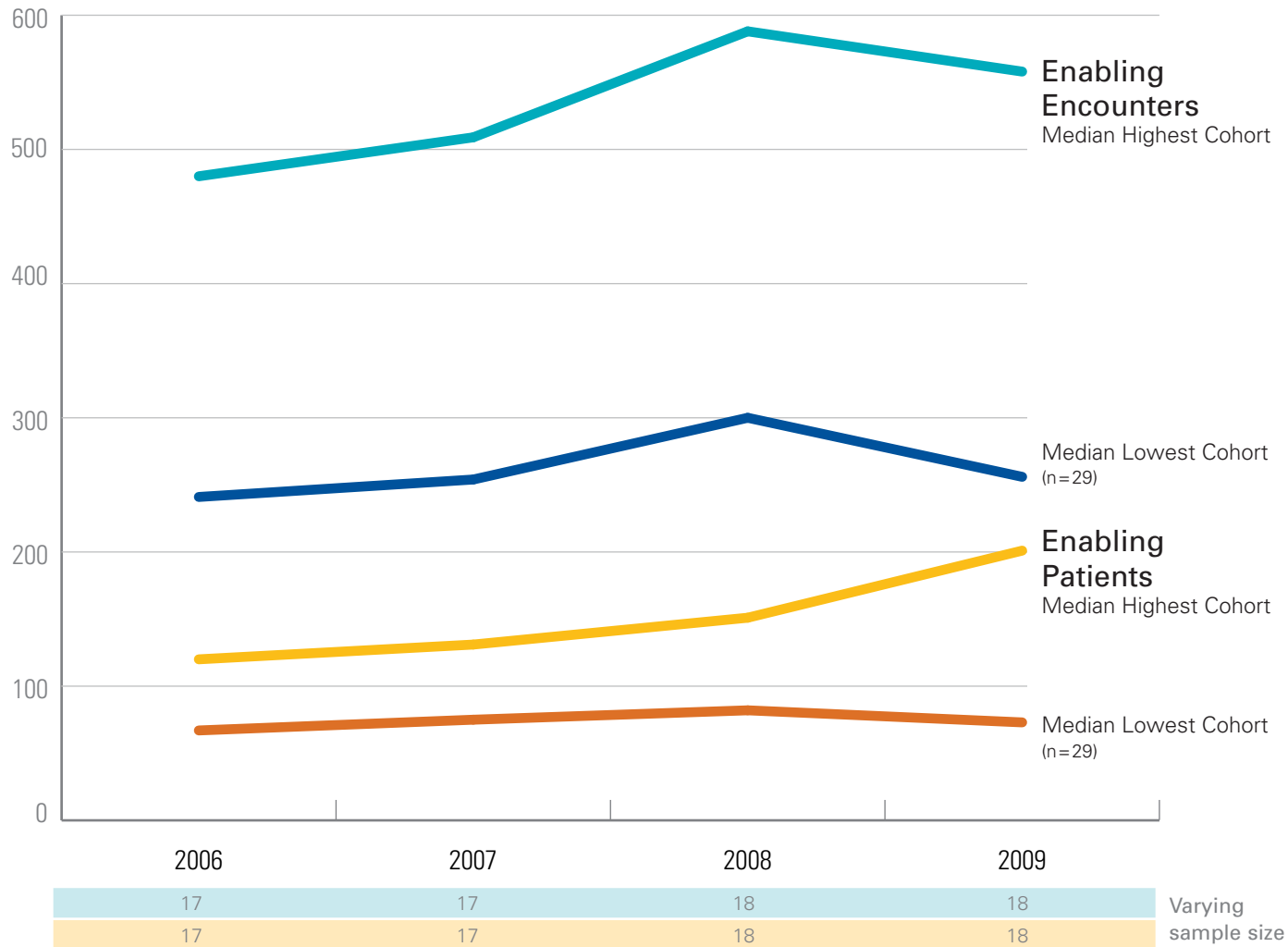
Source: Capital Link, *California Community Clinics—Financial and Staffing Analysis, FY06–FY09*, published in 2011, www.caplink.org.

Community Clinics, Financial Health Productivity Measures

The highest performing clinics consistently had a higher encounters/FTEs ratio than the financially weakest clinics.

Enabling Staff Productivity, by Encounters and Patients, FY06–FY09

NUMBER OF TOTAL ENABLING ENCOUNTERS / PATIENTS PER TOTAL ENABLING FTEs



Note: For more information, see Methodology, page 13.

Source: Capital Link, *California Community Clinics—Financial and Staffing Analysis, FY06–FY09*, published in 2011, www.caplink.org.

Community Clinics, Financial Health Productivity Measures

Overall, the financially strongest clinics displayed higher productivity as measured by the ratio of enabling encounters to enabling FTEs, and the ratio of enabling encounters to patients. However, there was a wide range of productivity values within each cohort and the entire group in general.

Methodology

IRS Form 990 data were used to assess the financial performance of each of the clinics over the four-year period. These data are available for most nonprofit organizations through GuideStar, an organization that combines information on the mission, programs, leaders, goals, accomplishments, and needs of nonprofit organizations, including health centers and community clinics nationally. Form 990 data, which are reported based on an organization's fiscal year end to the IRS, include many of the same financial data elements that are reported on audited financial statements.

Based on the list of screened clinics from the previous report in this series, Form 990 data were obtained for those community clinics whose data were available in any of the fiscal years from 2008 to 2009. The 990 data were purchased from GuideStar in an electronic format and converted into a database format. Data available in each of the years included in the financial trends analysis were: FY06: 194; FY07: 189; FY08: 196; FY09: 181. Data were available for all four years for 167 of the clinics.

The operating margin was used in assessing financial performance, 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 previously determined cut-off points for the sample. The total score was compiled for each clinic. The 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.

Using Uniform Data System (UDS) data, the following productivity measures of each of the clinics over the four-year period were 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 previously determined cut-off points for the sample. 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.

Community Clinics, Financial Health

ABOUT THE AUTHORS

Capital Link, established in 1998, is a nonprofit 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.

FOR MORE INFORMATION



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