California Community Health Centers

Financial & Operational Performance Analysis, 2010-2013

Prepared by

CAPITAL LINK

Sponsored by

Blue Shield of California Foundation

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INTRODUCTION

This report, prepared by Capital Link for Blue Shield of California Foundation, was developed with the following primary objectives:

- To update Capital Link's statewide financial and operational profile of California health centers to incorporate 2013 information[1]
- To analyze select financial and operational trends for rural health centers more closely
- To assess operational characteristics and trends of a financially high-performing subgroup of health centers

By presenting multi-year statewide results as well as comparative data from health centers nationally, this report offers a framework for identifying the financial strengths, challenges, and benchmarks that will support opportunities for performance improvement. Covering the four-year period of 2010 to 2013, the analysis incorporates data from health center financial audits as well as operational and utilization data reported by the Uniform Data System (UDS)[2].

Together with a benchmarking toolkit to be published and distributed to California health centers and their stakeholders in early 2015, this report is intended to support efforts to stabilize, sustain, and grow health center operations and maximize access to high-quality primary health care.

The contents of this report are presented in four sections:

Section I includes the industry profile and growth rates of all Federally Qualified Health Centers (FQHCs) in California as reported by UDS.

Section II provides a financial profile and trend analysis of FQHC and FQHC Look-Alikes (LALs) for which financial audits were available in Capital Link's proprietary national health center database of audited financial statements.

Section III presents an operational analysis of California FQHCs, focusing on important measures such as productivity and staffing ratios.

Section IV offers a review of a subset of financially high-performing health centers to identify factors contributing to healthy results.

[1] Capital Link, *California Community Clinics, A Financial and Operational Profile, 2008-2011* (Published September 2013).

[2] Uniform Data System (UDS) reports are collected by the Health Resources and Services Administration (HRSA) from Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes as defined in Section 330 of the Public Health Service Act.

KEY FINDINGS

California Health Center Growth

- During the review period of 2010 to 2013, California FQHCs experienced a strong site-level growth rate of 44%, well outpacing the national rate of 32%.
- California FQHCs provided services to 3.4 million patients in 2013, up 16% from 2010. Annual patient visits increased 19% to 14.8 million over the four-year period.
- Medi-Cal, California's Medicaid program, covered 47% of patients served at California FQHCs in 2013 while 39% of California FQHC patients were uninsured.

Financial Health of California Health Centers

- Median operating performance for California health centers remained relatively consistent at approximately 2% between 2010 and 2013, in line with industry norms and national results.
- Although there is a group of financially high-performing health centers, at least 25% of centers operate in a very vulnerable financial position, with operating losses and insufficient cash reserves.
- Personnel-related expenses for health centers are 74% at the median. Health centers that spend 75% or more of their budget on personnel-related costs are at higher risk of generating operational losses.
- Rural health centers tend to operate with slightly lower margins and less liquidity than urban centers. Of heightened concern is the continued decline of those financially fragile health centers.

Operational Analysis of California Health Centers

- Provider productivity as measured in visits declined from 2010-2013, particularly among mid-level providers, with a 9% drop. The decrease coincides with the changes brought about by national healthcare reform and the implementation of electronic health records (EHRs) and patient-centered care initiatives.
- Medical support staffing ratios have increased over this time period, growing 17% at the median. This increase may be reflective of the transition to team-based care models.
- Though health centers are responding to the Affordable Care Act (ACA) and patient growth with the addition of new staff, the evolving models of team-based care are not yet enabling providers to manage more patients.

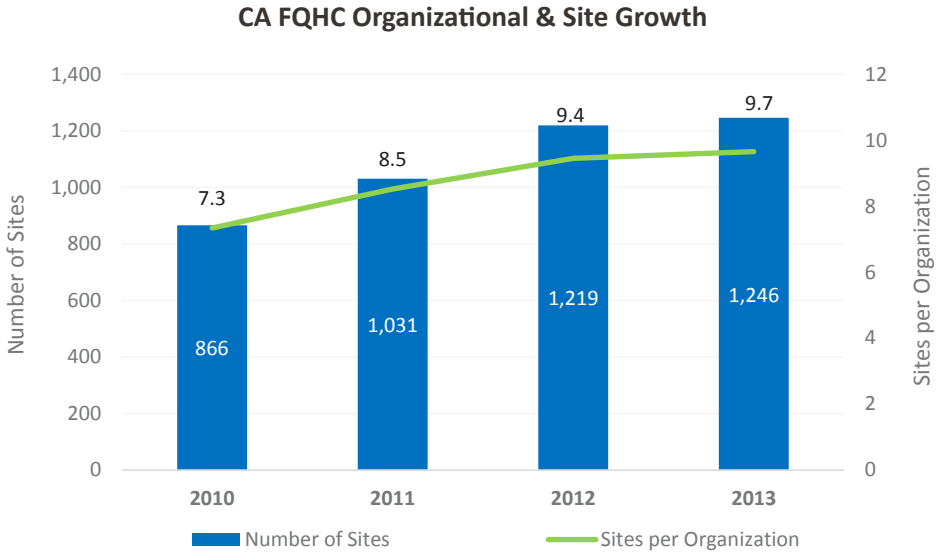
Financially High-Performing California Health Centers

- The subgroup of health centers with the strongest financial profiles generated higher relative productivity on several key performance metrics.
- The financially high-performing centers exhibited lower personnel-related costs and higher medical support staffing ratios than the larger group of California health centers.
- The ongoing transformation in patient care requires health centers to closely monitor team-based staffing structures so they can provide high-quality care while ensuring financial sustainability.

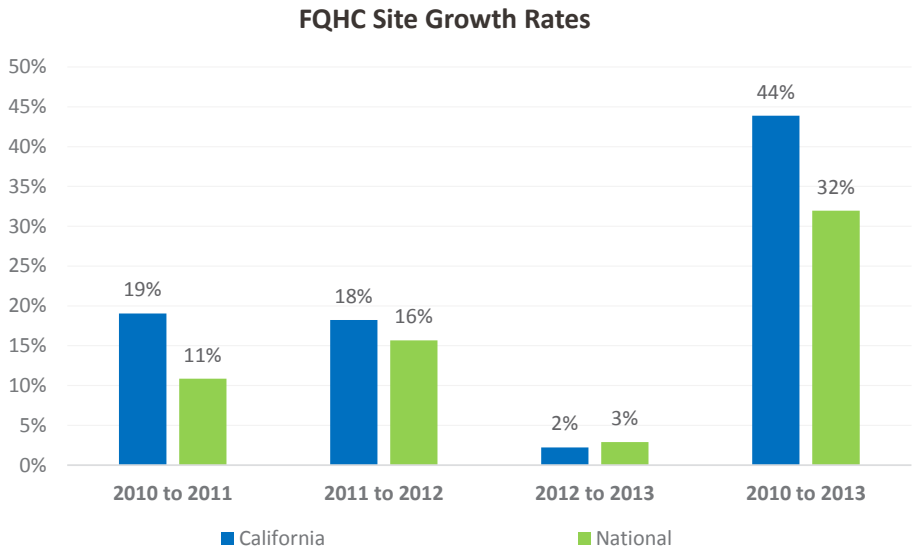
SECTION I: Profile of California Federally Qualified Health Centers

California Health Center Growth:

The FQHC program in California has continued to expand over recent years, with the number of health center organizations growing from 118 in 2010 to 129 centers in 2013, an increase of 9%. At the same time, total service delivery sites increased to almost 1,250 in 2013, representing a three-year growth rate of 44%. On average, each health center had almost 10 sites in 2013, up significantly from 7.3 sites in 2010.

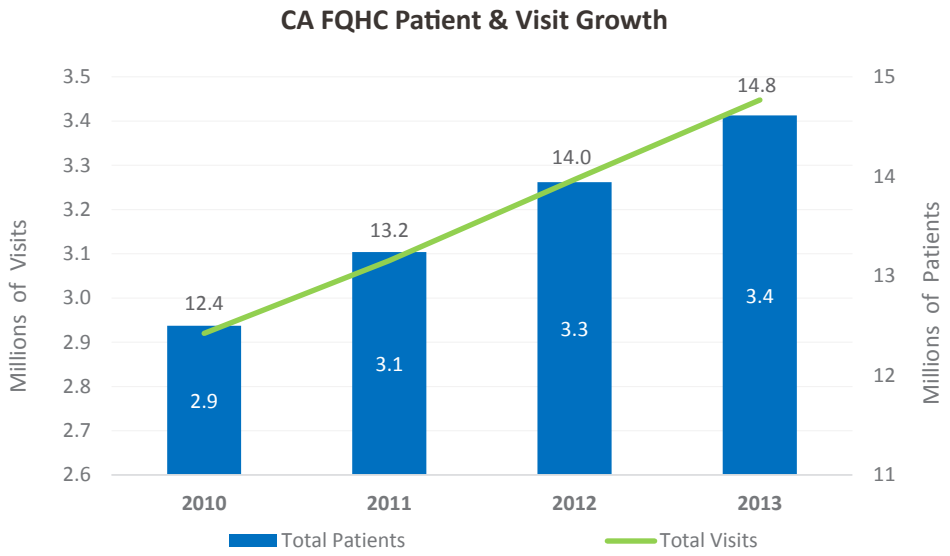


This site-level growth of California FQHCs has outpaced that of FQHCs nationally, particularly in 2011 and 2012 when it approached almost 20% annually.

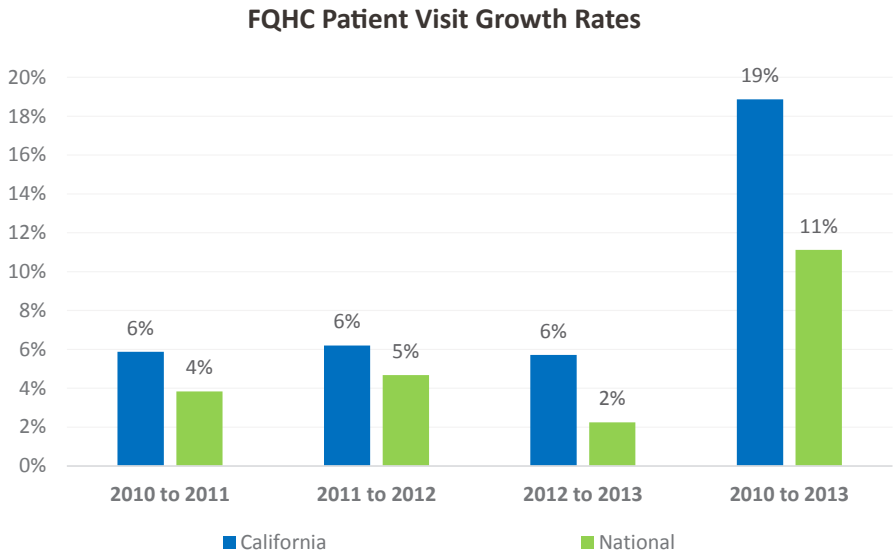


Patient Utilization:

Similarly, utilization at California health centers has increased consistently each year, with the number of FQHC patients growing 16% to 3.4 million over the 2010-2013 period and patient visits growing 19% to 14.8 million.



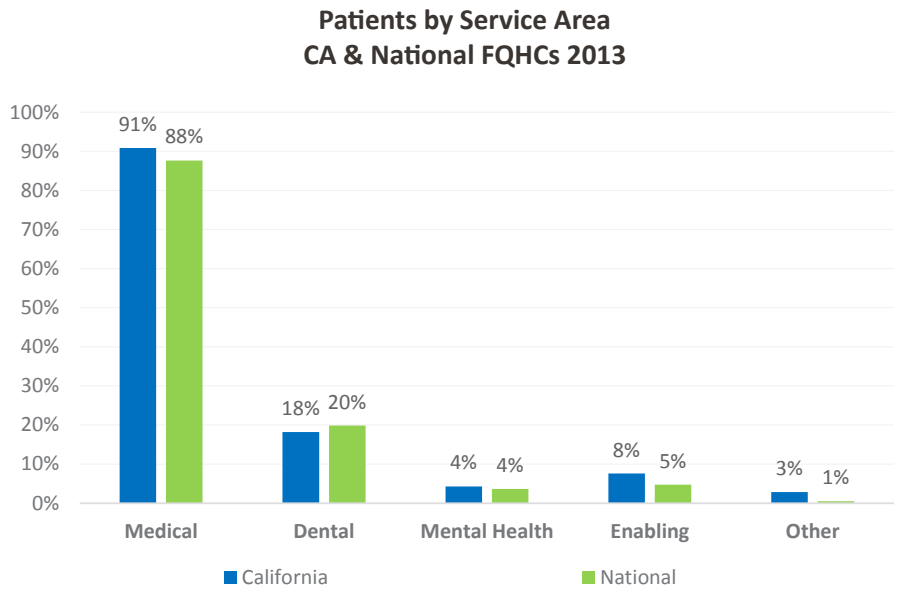
The increase in patient visits at California FQHCs has continued to outpace the level of visit growth for FQHCs nationally by a sizable amount.



Program Mix:

FQHCs provide comprehensive primary care and preventive health services to their patient populations. Although over 90% of patient utilization is medical related, health centers also offer dental, pharmacy, behavioral health, vision, and social services. In addition, health centers typically offer a variety of enabling services that

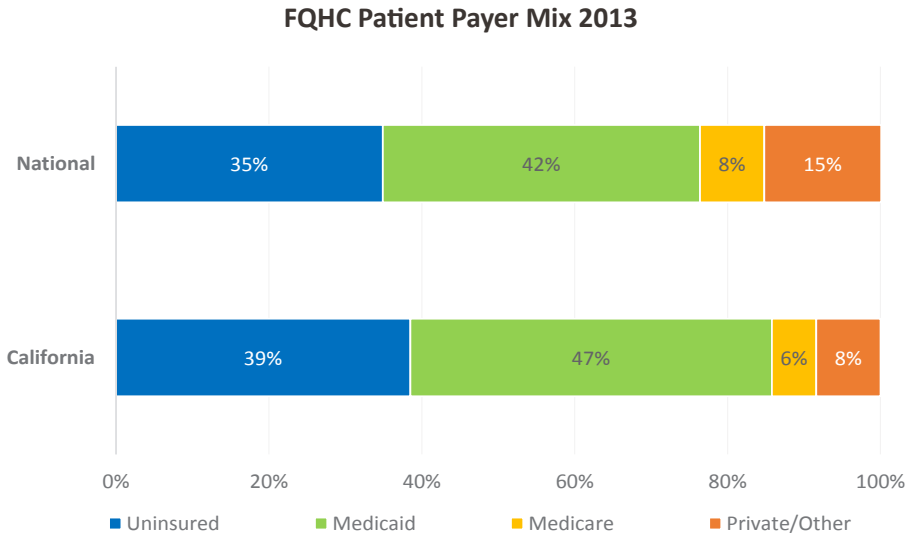
facilitate the health and well-being of their patients, including case management, translation, transportation, nutrition counseling, and other non-clinical support services. As shown in the chart below, California centers have a slightly higher mix of medical and enabling services than their national counterparts.



*Combined totals exceed 100% as some patients receive multiple services.

Payer Mix:

Medi-Cal, California's Medicaid program, remains the most important payer for patient services in California FQHCs. In 2013, nearly half of all California FQHC patients (47%) were covered by Medi-Cal, which is higher than the national average of 42% for Medicaid. However, 39% of the patients seen by California FQHCs were uninsured and billed on a sliding scale basis. The recent rollout of health reform initiatives is expected to significantly reduce the levels of uninsured and the impact will initially become evident in the 2014 UDS data that health centers report in early 2015.



SECTION II: Financial Health of California Health Centers

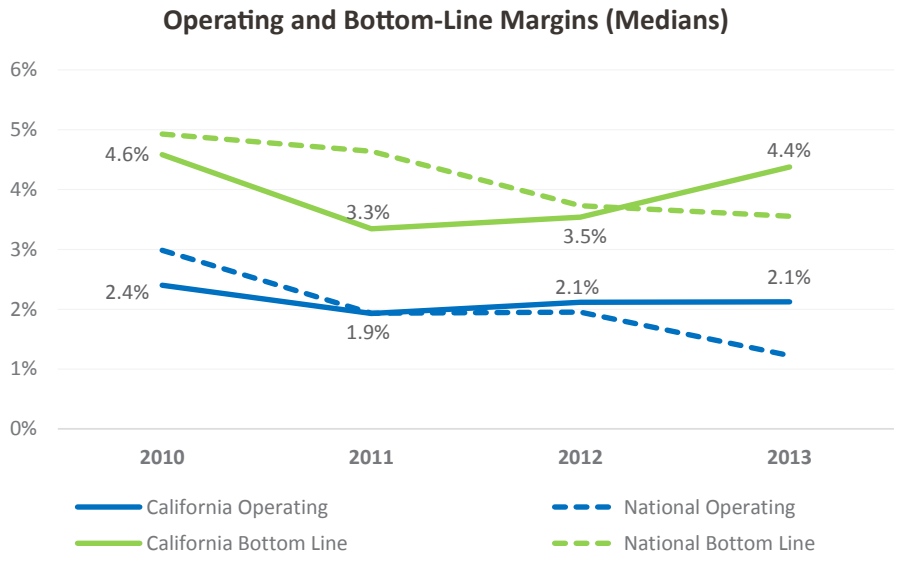
The following section highlights several key industry metrics for tracking the financial position and performance trends of California health centers, including FQHC's and LALs, over the 2010-2013 fiscal periods.

Operating Margin & Bottom Line Margin:

Operating margin is the primary indicator for assessing financial performance over time. The operating margin indicates the viability of the health center business model by showing whether the organization is able to generate sufficient revenue to cover the cost of offering healthcare services to the community. Negative operating margins over time indicate that a health center is unlikely to keep its doors open unless significant changes are made to its operating structure.

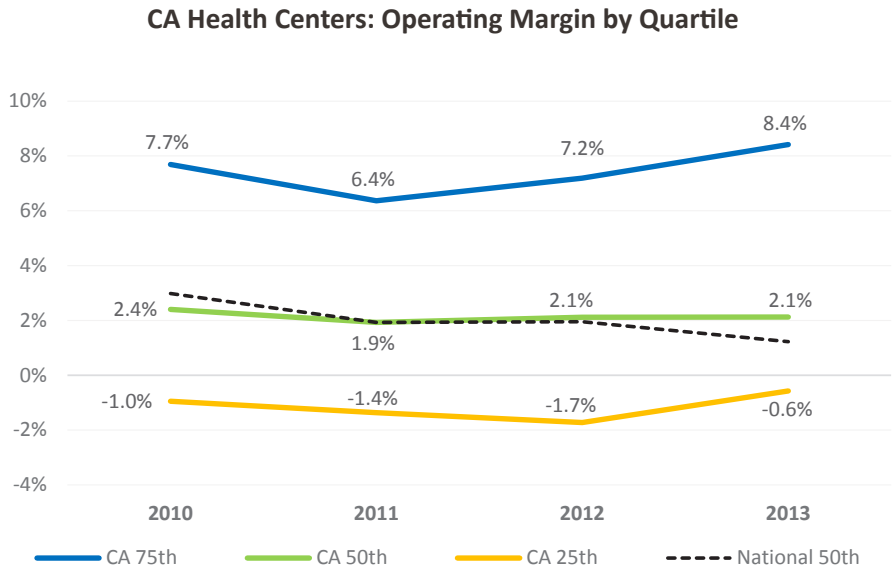
As shown below, the median operating margin for California FQHCs has remained relatively consistent at about 2% over the review period. Although California FQHC's have notably maintained relatively consistent median performance, the margin remains narrow and leaves them vulnerable to operational disruptions that can quickly result in financial losses.

The bottom line margin includes any additional revenue that supports non-operating activities such as facility expansion. Non-operating revenue, which is often unpredictable and fluctuates from year to year, may nonetheless provide an additional buffer against short-term fiscal fluctuations. The median bottom line margin for California FQHCs has hovered around 4%, roughly 2% higher than the operating margin over the review period. However, much of the non-operating revenue for many health centers over this period has come from various capital expansion funding programs offered by HRSA as part of the ACA—programs that are unlikely to continue at recent levels.



II: FINANCIAL HEALTH OF CALIFORNIA HEALTH CENTERS

Despite the relatively stable performance at the median, it is important to recognize the operating performance trends of both high and low performing health centers. As shown in the chart below, the top quartile of health centers generated operating margins of 6-8%. More notably, at least 25% of health centers continue to generate negative operating margins. Ongoing losses are not financially sustainable in the long-term, so the viability of these health centers will be dependent upon improving operational efficiencies and/or securing enhanced operational support for their safety net programs. Notably, there has been improvement in the lowest quartile of health centers as that group has improved its performance from -1.7% in 2012 to -.6% in 2013.

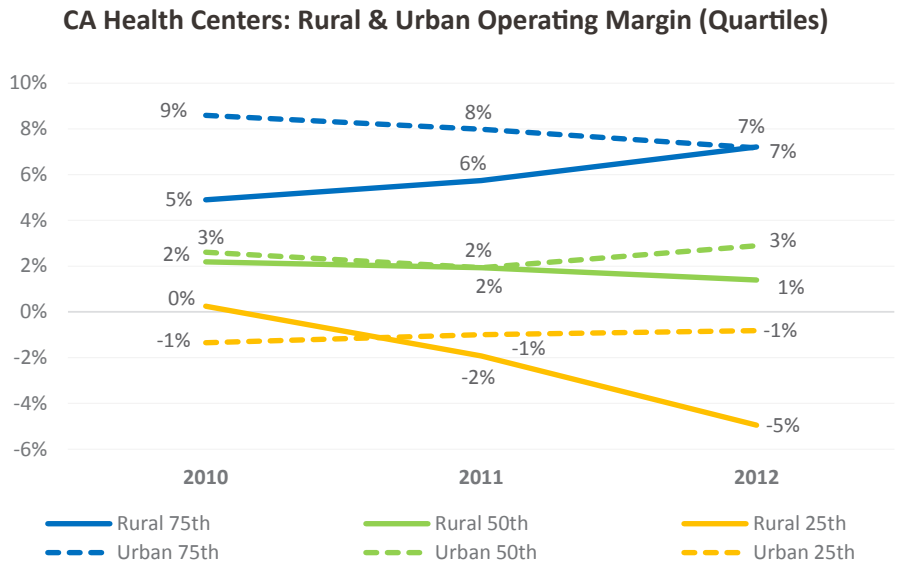


Rural vs. Urban Health Center Performance:

The margins for rural health centers are generally lower than those of their urban counterparts. There are a number of complicating factors inherent in the provision of healthcare services to rural populations, including provider recruitment and retention, patient access, dispersed sites, high rates of uninsured, and declining population bases, all of which contribute to the pressure on financial performance.

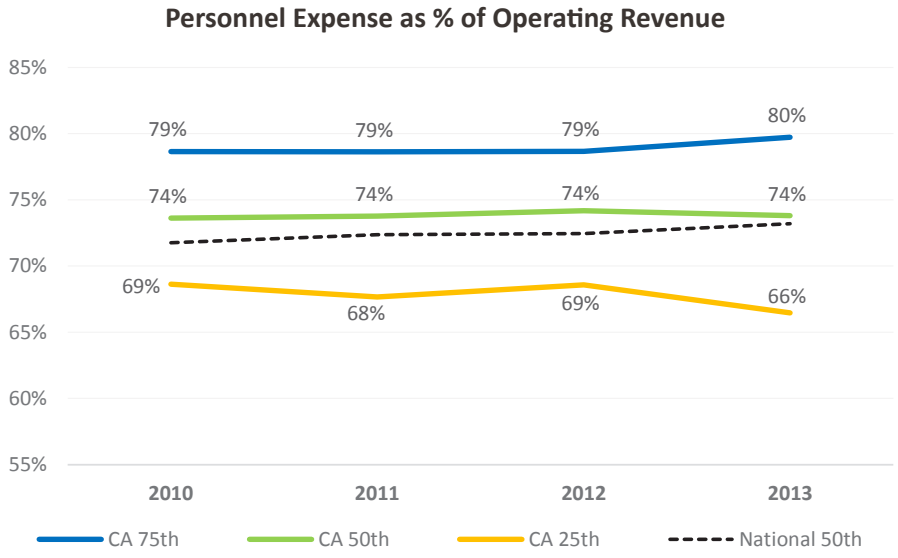
The following comparative analysis reviews operating margins for the three fiscal years 2010-2012[3]. In FY2012, urban health centers increased their median operating performance to 3%, up 1% from the prior year, while the median performance for rural centers declined to 1% from 2%. Although the highest performing rural group (75th percentile) showed an improving performance trend to a level consistent with their urban counterparts, the margin for the 25th percentile of rural health centers dropped precipitously to -5% in 2012, far below the comparable urban group. This quartile of rural health centers and their stakeholders will need to remain focused on performance improvement, particularly given the complexities of implementing health care reform initiatives.

[3]Analysis period does not include FY2013 due to insufficient data. Please see Methodology section for more information.



Personnel-Related Expense:

At the median, California health centers spend 74% of their operating budget on personnel-related expenses, including salaries, benefits, and professional services. Given that health centers at the median operate with just a 2% margin, it is important to manage this expense area carefully as a 2% increase in personnel expense, for example, would drop the median health center's operating margin to break-even performance (0%). Generally speaking, health centers that spend 75% of their budget or more on employee-related expenses tend to lose money at the operating level. The challenge to control personnel costs is only heightened by the transformation of service delivery models to team-based care.

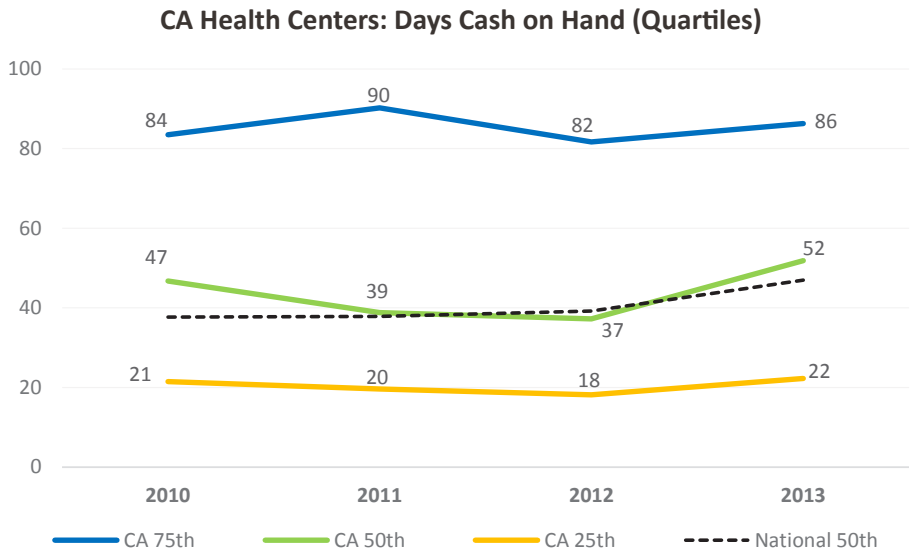


*Note: 25th percentile represents the better performance since costs are lower.

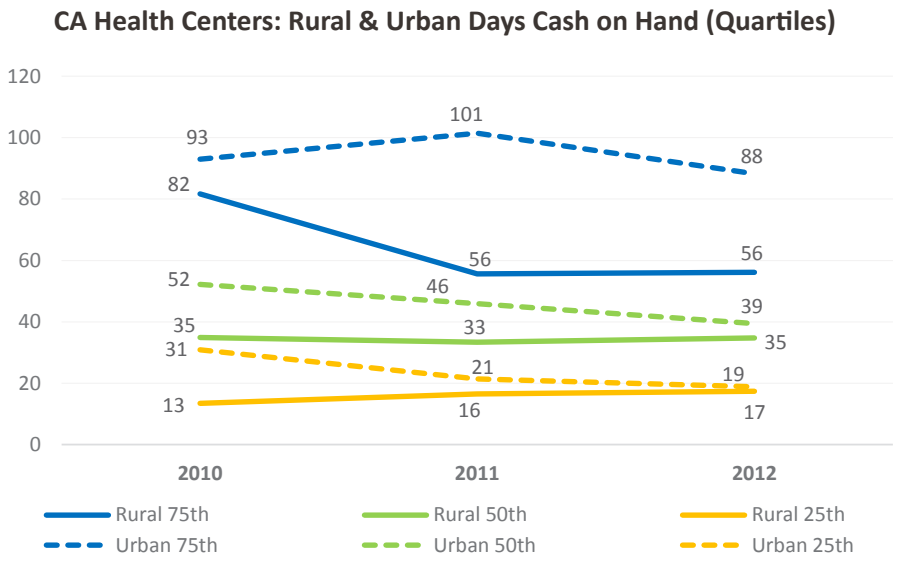
Days Cash on Hand:

In 2013, California health centers operated with 52 days cash on hand at the median, above Capital Link's recommended range of 30-45 days. Despite a slight dip in recent years, the median performance of California health centers indicates operational reserves within industry standard levels.

Although there is a top cohort of health centers with 80 or more days cash on hand, 25% of health centers have less than three weeks operating cash reserves. At this level, health centers are very vulnerable to any interruption in cash flow such as delayed reimbursement or reconciliation payments. With low cash reserves, health centers may need to rely on operating lines of credit to keep operations running smoothly, resulting in additional operating expenses due to borrowing costs.

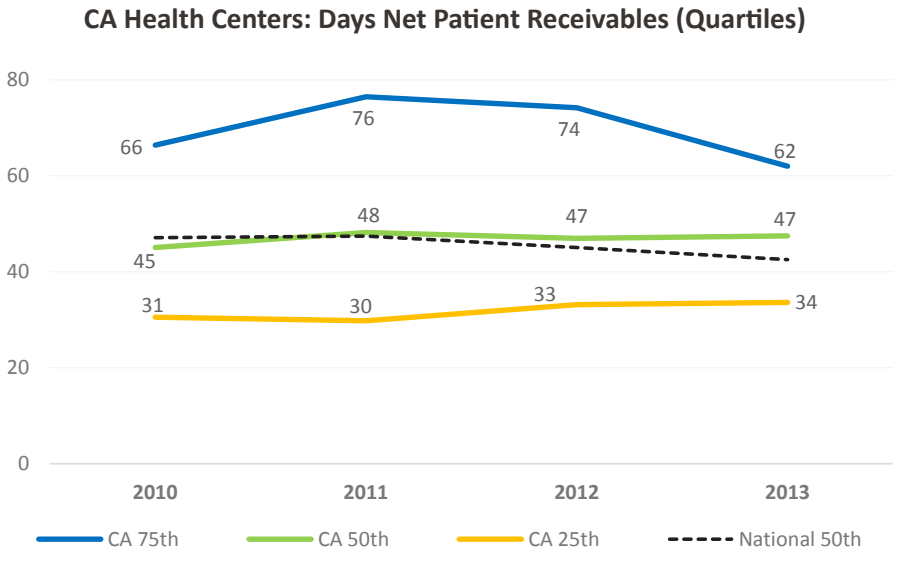


Similar to their financial performance differential, rural health centers continue to operate with less liquidity than their urban counterparts. At the median, rural health centers operate just above the minimum recommended level of 30 days cash reserves; however the bottom 25% of rural health centers struggle with under 17 days of operating cash.



Days Net Patient Accounts Receivable:

The median result for net patient accounts receivable has been relatively consistent over the four-year review period at just over 45 days. This result is within Capital Link's recommended maximum threshold of 60 days. However, as shown by the top line in the chart below, roughly 25% of health centers operate with a collections cycle that is beyond this recommended target level. Higher accounts collection periods constrain liquidity and inhibit the ability to run financial operations flexibly and efficiently.



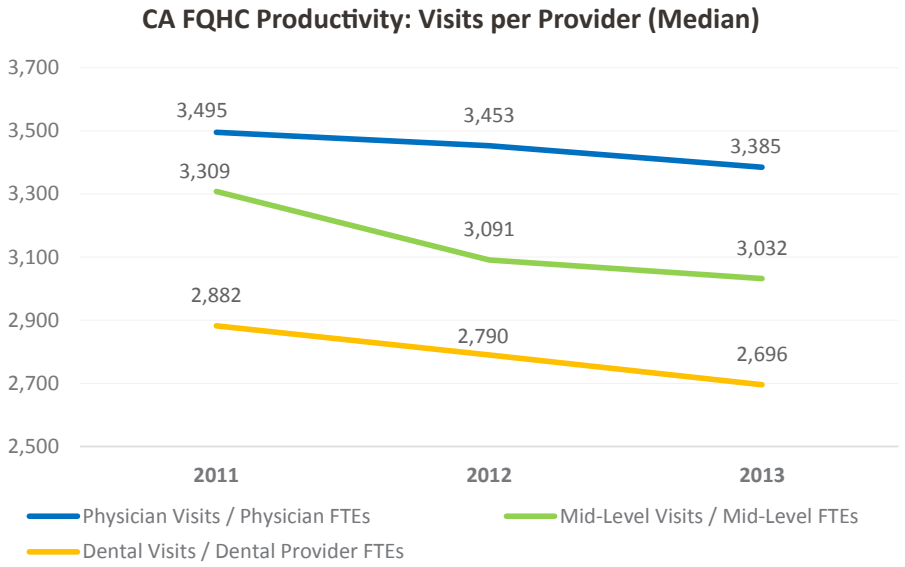
*Note: 25th percentile is the stronger performer since collections are quicker.

SECTION III: Operational Analysis of California Health Centers

Similar to tracking financial health, there are a wide variety of indicators that may be used to measure operational performance of health centers. This section highlights a few of these indicators, focusing on productivity metrics both in terms of visits (consistent with the current reimbursement model) and patients (consistent with the emerging patient-centered care model) as well as select staffing ratios of interest.

Provider Productivity:

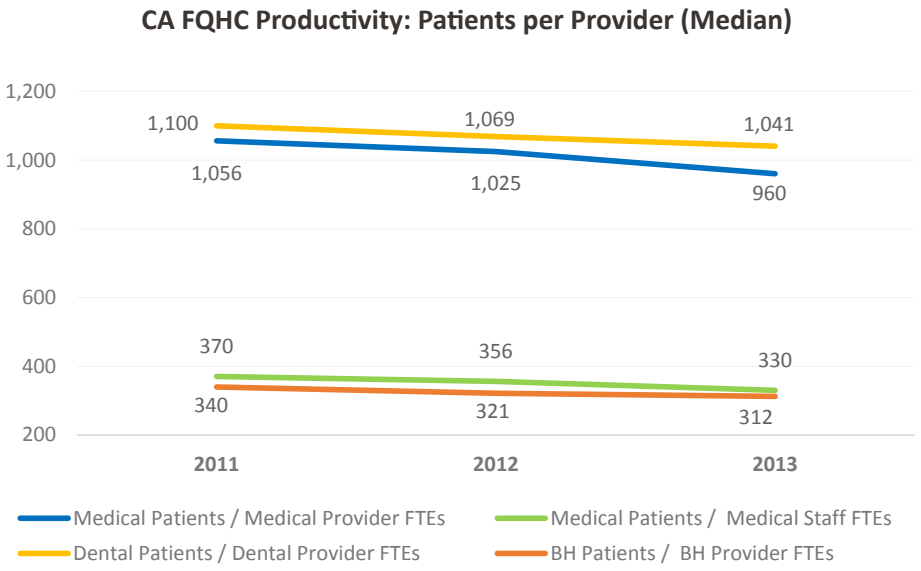
California FQHCs experienced decreasing provider productivity levels between 2011 and 2013, most notably a more than 9% decrease in mid-level productivity. This decline coincides with a period of transformation of health center operational models associated with national health reform, in particular the implementation of EHRs and meaningful use certification, the conversion of health centers to become accredited patient-centered medical homes, and the transition to Medi-Cal managed care.



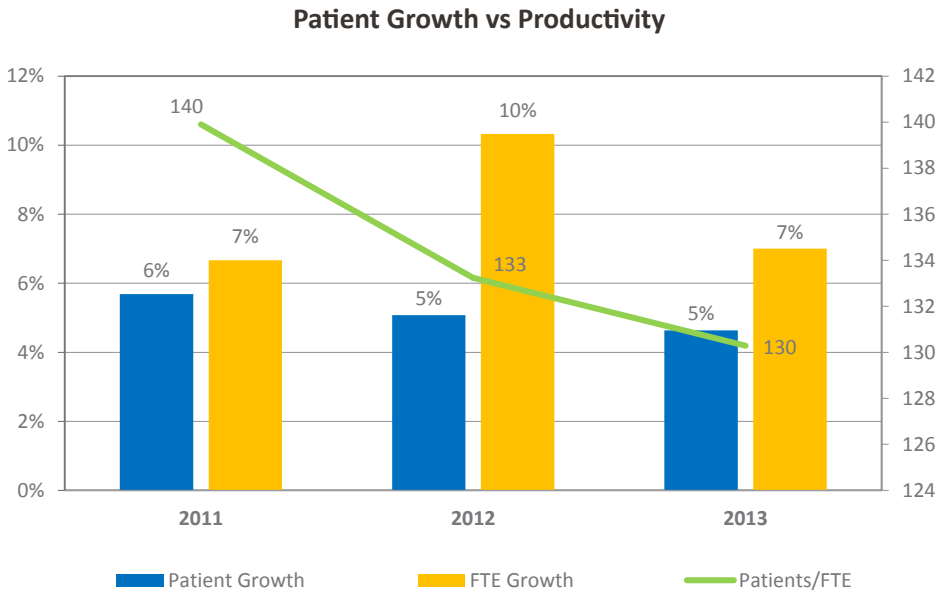
*Note: Mid-level providers, as reported by UDS, include Physician Assistants, Nurse Practitioners, and Certified Nurse Midwives.

Patient Productivity:

The decrease in productivity, in terms of the number of patients managed by providers at health centers, has been more pronounced, with medical productivity falling 10-12% and dental productivity decreasing 6%. This decreased productivity, whether unavoidable due to changing external requirements or driven by factors within managements' control, puts continued pressure on operating margins.



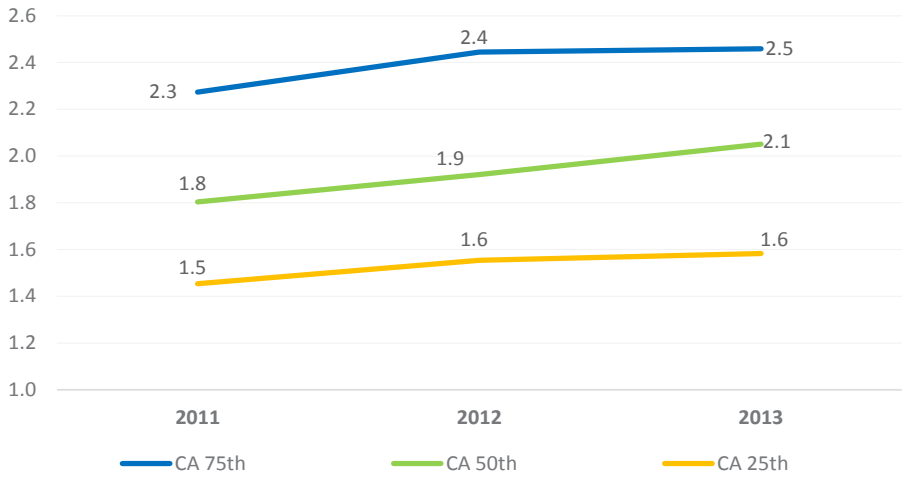
Though health centers are responding to the ACA and patient growth with the addition of new staff, the evolving models of team-based care are not yet enabling providers to manage more patients as demonstrated in the chart below, which shows that patient/provider full-time equivalent employees (FTEs) declined in California overall from 2011-2013.



Medical Support Staffing:

FQHCs in all quartiles have shown an increase in support staffing levels for their medical providers over the 2011-2013 period, with a median three-year increase of 17%. These data trends may be reflective of the gradual transition to team-based care.

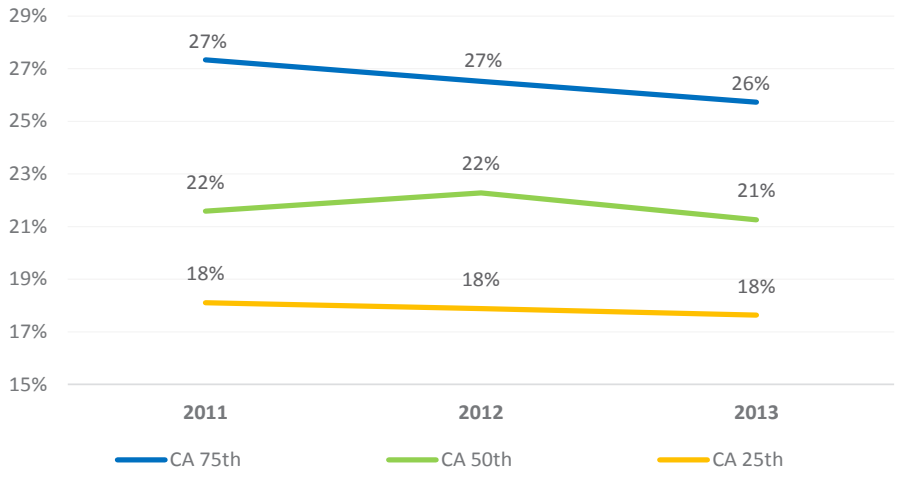
CA FQHC Staffing: Medical Support Staff per Medical Provider (Quartiles)



Administrative and Non-Clinical Support Staffing Ratio:

California FQHCs, at the median, reported 21-22% of their full-time equivalent employees (FTEs) were non-clinical support staff including administration. Both the health centers with the lower administrative support ratios (the 25th percentile) and those with the higher ratios (the 75th percentile) showed slightly decreasing trends over the period, resulting in an overall quartile range of 18-26% in 2013. Continued close management of overhead expenses will be essential to ensure financial sustainability in the future.

CA FQHC Staffing: Admin & Non-Clinical Staff as % of Total FTEs (Quartiles)



*Note: 25th percentile represents the better financial performance as non-clinical costs are lower.

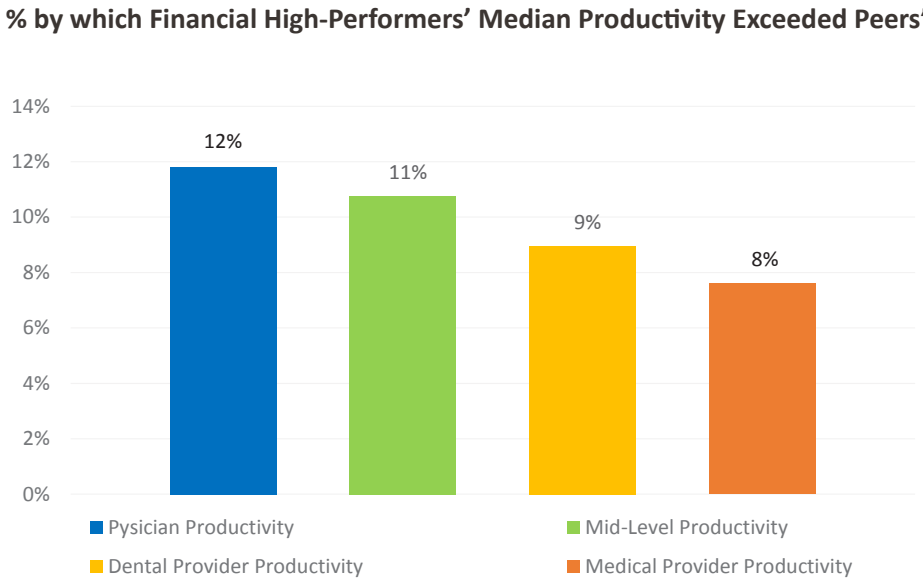
SECTION IV: Financially High-Performing Health Center Subset Analysis

A number of factors have been found to influence the financial strength of health centers including: location (rural vs. urban), size, region, number of sites, and program and payer mix[4]. Many of these performance drivers are, to a large extent, outside of management's control. However, health center leaders may be able to affect performance results through fiscal management strategies that address productivity, payroll, and staffing[5].

Operating benchmarks are not widely available and are not always appropriate given the unique characteristics of the communities where health centers operate. Ultimately, each health center needs to establish its own target ranges for operational performance to ensure organizational growth and sustainability. However, there is value in benchmarking peer data since it can provide insights regarding best operating practices. To assist health centers in better evaluating target ranges for productivity and staffing ratios, a cohort of health centers identified to be "financially high performing[6]" was analyzed independently from the larger data set used for this report. The following section highlights the findings from this analysis.

Provider Productivity Measures:

As one might expect, the cohort of financially high-performing health centers generated higher provider productivity results across a variety of metrics. The following chart illustrates the percentage by which the financially strongest health center subgroup exceeded their peers on select productivity measures:



[4]Capital Link, *California Community Clinics, A Financial and Operational Profile*, 2008-2011 (Published September 2013), 6.

[5]Capital Link and Community Health Center Capital Fund, *Community Health Centers Financial Perspectives*, Issue 5, "Identifying the Risks of Health Center Failure, A Guide for Health Centers" (Published April 2014), 1-2.

[6]Please see Methodology section for more information regarding the criteria used to select financially high-performing health centers.

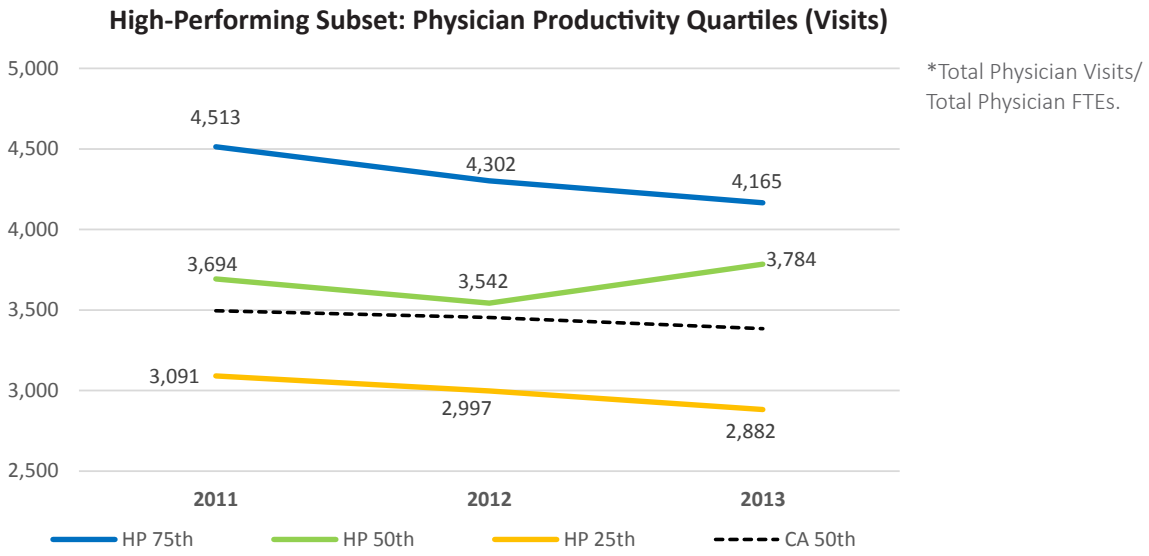
IV: FINANCIALLY HIGH-PERFORMING HEALTH CENTER SUBSET ANALYSIS

It is important to note that differences in productivity are related to various factors that make it challenging to compare the provider productivity of one health center against another. For example, one primary driver of varying productivity levels is acuity differences among patient populations. Variations in target patient population groups that affect productivity include complexity of care and/or chronic disease management needs. Some health centers may have a higher proportion of seniors and/or persons with disabilities, others may have a higher percentage of patients with a mental health diagnosis, and others may focus on immigrant populations, all of which may require more time-intensive care.

Nevertheless, the following charts illustrate the productivity quartiles of the financially high-performing subset without adjusting for the variances such as the complexity of care between health center patients or other differences in operating models, patient mix, program mix, or organizational characteristics.

Physician Productivity:

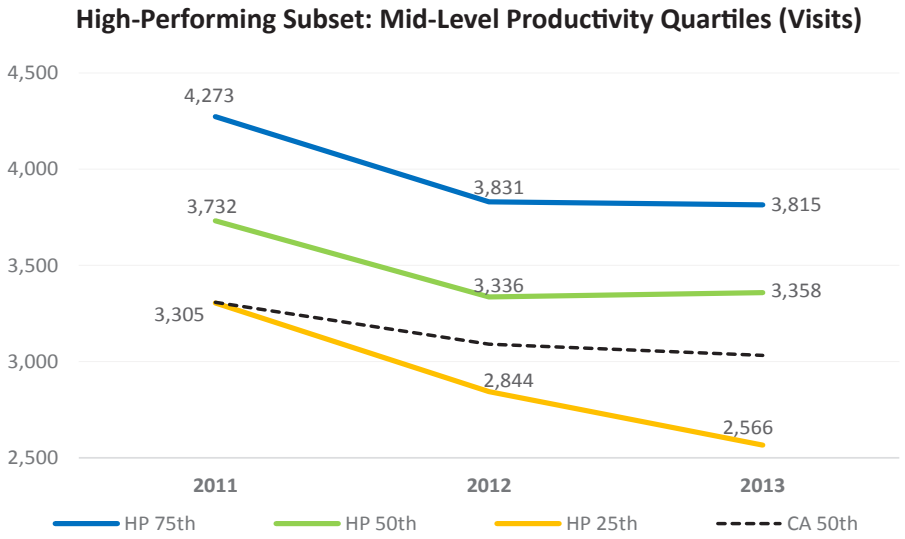
Over the period tracked, the median physician productivity for all California health centers declined each year while the high financial performers, at the median, saw a strong uptick in 2013 productivity. The median result for high performers of 3,784 physician visits per FTE physician is 12% higher than the full FQHC data set of 3,385. As shown, the 2013 quartile range for the financial high performers is about 2,900-4,100 visits.



*Total Physician Visits/ Total Physician FTEs.

Mid-Level Productivity:

The variance in results for mid-level productivity is similarly pronounced between the financially high-performing subset and the larger health center study group. In 2013, the median number of mid-level visits compared to mid-level FTEs for the high performers was 326 visits higher per year than the larger study data set, a variance of 11% (3,358 vs. 3,032). The quartile range for the financial high performers is about 2,500-3,800 visits per mid-level, per year.

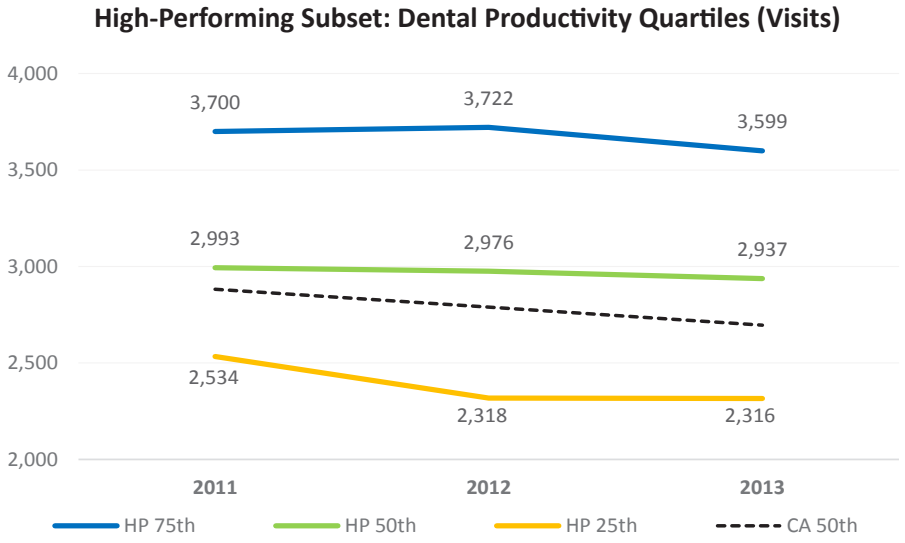


*Total Mid-Level Visits/ Total Mid-Level FTEs.

The decline in recent years' productivity is more pronounced for mid-level providers than for physicians and may be explained by several industry-wide factors. For example, health centers are wrestling with various forces that impact productivity, including EHR implementation, meaningful use certification, the transformation to team-based care, and the transition to managed care in California for the Medi-Cal patient base. These changes appear to be impacting mid-level productivity more significantly than that of the physician-level.

Dental Productivity:

The dental providers in the financially high-performing group outperformed the comparative FQHC data set by over 9% at the median in 2013. The quartile ranges for dental provider productivity for the high performers is 2,300-3,600 visits per year in 2013.



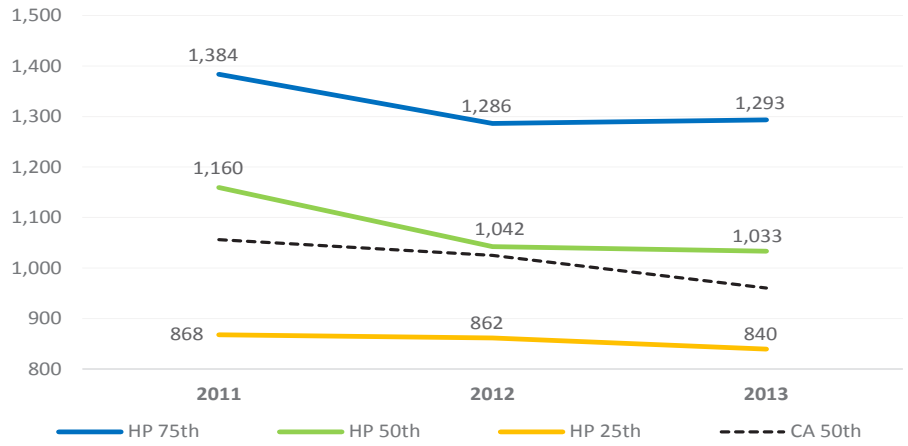
*Dental Visits/Dental Provider FTEs.

IV: FINANCIALLY HIGH-PERFORMING HEALTH CENTER SUBSET ANALYSIS

Medical Patients per Medical Provider:

When productivity is compared in terms of patients per medical provider, the 2013 median result for the high-performing subgroup (1,033) is 8% higher than the median result for the full FQHC group (960). The quartile range for the high-performing group is approximately 840-1300 patients per medical provider annually.

High-Performing Subset: Medical Patients per Medical Provider (Quartiles)

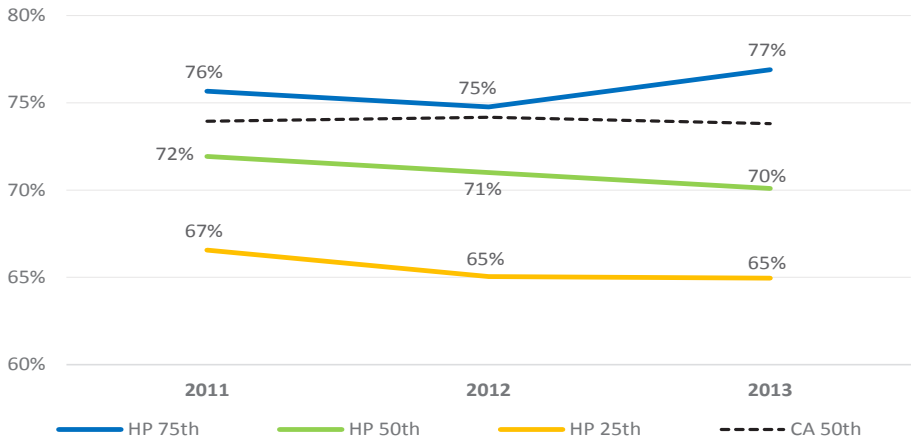


*Medical Patients/ Medical Provider FTEs.

Staffing & Personnel:

As shown below, the median high performers spent 70-72% of their budgets on employment related expenses, and the figure actually fell by 2% over the period tracked. At the same time, the median results for the full data set remained a consistent 74%. Note that in the employment-related expenses chart, the 25th percentile represents the stronger performers since the objective is to achieve a lower percentage on this metric. Therefore, the top quartile of high performers spent 67% on employment-related expenses in 2011 and 65% in 2013. Their ability to closely manage these costs is likely a significant contributor to their solid financial performance.

High-Performing Subset: Employment-Related Expense (Quartiles)

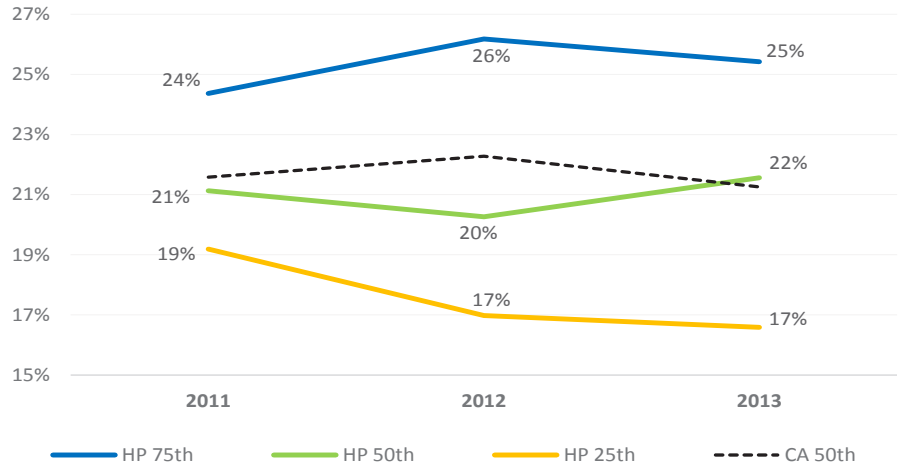


*Note: 25th percentile represents better performance as related costs may be lower.

IV: FINANCIALLY HIGH-PERFORMING HEALTH CENTER SUBSET ANALYSIS

Although provider-related costs are a key driver of employment-related expense, health centers also use varying levels of administrative and non-clinical staffing models to support the delivery of primary care services. As illustrated in the chart below, the financial high performers had a median administrative and non-clinical FTE staffing ratio ranging from 20-22% over the period, similar to all California health centers. It is interesting to note that the highest performers (the 25th percentile in the chart below) decreased their administrative expense ratio from 19% to 17% over the period, likely influencing their financial success.

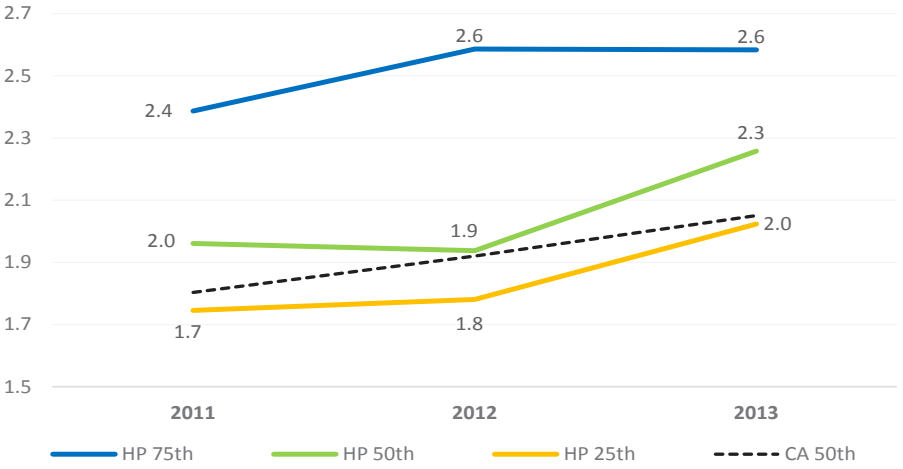
High-Performing Subset:
Admin & Non-Clinical Staff as % of Total FTEs (Quartiles)



*Note: on this chart, 25th percentile represents better performance as related costs may be lower.

Another notable staffing insight is that the financially high-performing group of health centers shows a larger median medical support staff per provider than the full group of health centers. The variance on this measure between groups is 10% at the median in 2013 (2.3 vs. 2.0). It is interesting to note that the medical support staff per provider ratio increased at all levels during the period tracked, consistent with changing staffing models.

High-Performing Subset: Medical Support Staff per Medical Provider



This finding lends support to the theory that adequate levels of medical support per provider results in higher productivity (and therefore better profitability). This result is also consistent with the finding of lower employment related expenses overall—since a higher proportion of lower-cost medical support can help to contain overall staffing costs while allowing providers to operate at the top of their licenses.

It is clear that the ongoing transformation in patient care will require centers to continue to closely monitor team-based staffing structures to find the proper balance in order to provide the highest quality of care while ensuring financial sustainability.

METHODOLOGY

Data Sources:

The analysis and information contained in this report are based on data from two primary sources covering the 2010-2013 review period:

- Audited financial statements of FQHCs and LALs as reported by fiscal year
- UDS reports as submitted annually by FQHCs and LALs by calendar year to HRSA

The clinics included in the California financial data set largely consist of grantees of Blue Shield of California Foundation's (BSCF) Core Support Program. Financial audits from BSCF were combined with audit records in Capital Link's database to create the full financial data set.

The comparative national health center data set was developed specifically from Capital Link's proprietary database of health center audited financial statements.

Percentile Analysis:

Throughout the report, statistical measures used to describe the financial and operational ratios and trends include the 50th percentile (median), 75th percentile, and 25th percentile. By definition, half the values in a set are greater than the median and half are less. Therefore, the median is not skewed by large or small values outside the typical range, which can happen with average figures. The 75th percentile is a value that is equal to or greater than 75% of others in the data set. The 25th percentile is a value that is equal to or greater than 25% of others.

Section I: Profile of California Federally Qualified Health Centers

Section I reviews growth rates, and patient and payer mix for California and national FQHCs as reported by UDS. The number of FQHCs included in the data set is summarized as follows:

Calendar Year	2010	2011	2012	2013
California (FQHCs only)	118	121	129	129
National (FQHCs only)	1,124	1,128	1,198	1,202

Section II: Financial Health of California Health Centers

The Section II data set includes all FQHC and LALs for which financial audits were provided to Capital Link. The number of audits included in the data set varies each year and Capital Link continues to add audits to its

database as they become available. The health center data set used for the current analysis is summarized as follows:

Fiscal Year	FY10	FY11	FY12	FY13
California FQHCs	105	104	98	67
California LALs	17	16	13	6
California Total	**122**	**120**	**111**	**73**
National FQHCs	560	570	509	333
National LALs	23	24	17	10
National Total	**583**	**594**	**526**	**343**

Rural and Urban Subset Analysis:

For purposes of assessing rural and urban health center performance, the FQHCs and LALs included in the financial data set were further separated into their respective subgroups based on HRSA's rural health center classification. The 2013 financial data is excluded from this comparative analysis as the available number of financial audits from rural health centers was too limited to be considered as statistically reliable. The data sets used for the rural and urban financial analysis are summarized as follows:

Calendar Year	2010	2011	2012
Rural FQHCs	37	37	35
Rural LALs	3	4	4
Rural Total	**40**	**41**	**39**
Urban FQHCs	70	67	63
Urban LALs	12	12	9
Urban Total	**82**	**79**	**72**
Combined Total	**122**	**120**	**111**

Section III: Operational Analysis of California Health Centers

Section III includes operational data from all California and national FQHCs as reported by UDS. Given the significant changes in the industry in recent years due to health reform, the analysis focused on the most recent three year period of 2011-2013.

Calendar Year	2011	2012	2013
California (FQHCs only)	121	129	129
National (FQHCs only)	1,128	1,198	1,202

Section IV: Financially High-Performing Health Centers Subset Analysis

Section IV includes a review of health centers in California with consistently strong financial results as exhibited over the four-year period of FY2010-FY2013. This cohort of high performers was selected from the overall group of 70 California FQHCs and LALs for which four years of audited financial data was available at the time of the study. Identifying those health centers to include in the financially high-performing subset involved a statistical scoring methodology as follows:

1. Two key financial metrics, operating margin and days cash on hand, were calculated for each year.
2. The health centers were then sorted into quartiles based on the average of their four years' operating margin and the average of their four years' days of cash on hand as follows:
    - The organizations ranked above the 75th percentile on each measure received a score of 4
    - Those rated between the 50th and the 75th percentile on each measure received a score of 3
    - Those rated between the 25th and the 50th percentile on each measure received a score of 2
    - Those organizations ranked below the 25th percentile on each measure received a score of 1
3. The two scores (for operating margin and days cash on hand) were summed and any health center receiving a total score of 6, 7, or 8 was included in the financially high-performing group. A total of 25 health centers were ultimately included in the cohort of high performers.

Operational statistics for measures such as productivity and staffing based on UDS information was then generated for the high-performing group and compared to the broader California data set. The 25th, 50th (median), and 75th percentiles for the financial high performers was calculated. The median results for the high-performing cohort and the comparative California group were compared on several metrics. The data sets for the financially high-performing subset analysis are summarized as follows:

Calendar Year	2011	2012	2013
Financial High-Performing Cohort	25	25	25
Comparative California Health Center Group	70	70	70

APPENDIX

	CALIFORNIA PERFORMANCE SNAPSHOT	Capital Link Target	2011 CA Median	2012 CA Median	2013 CA Median	CA Financial High Performers 2013 Median	2013 National Median
# of Health Centers (Financial Audits)			*120*	*111*	*73*	*25*	*343*
FINANCIAL HEALTH							
1	Operating Margin	>1-3%	1.9%	2.1%	2.1%	7.1%	1.2%
2	Bottom Line Margin	>3%	3.3%	3.5%	4.4%	6.7%	3.6%
3	Days Cash on Hand	>30-45 Days	39	37	52	90	47
4	Days in Net Patient Receivables	<60 Days	48	47	47	53	43
5	Personnel-Related Expense as % of Operating Revenue	<70-75%	73.8%	74.2%	73.8%	70%	73.2%
# of Health Centers (UDS Data)			*121*	*129*	*129*	*25*	*1,202*
PRODUCTIVITY & FINANCIAL OPERATIONS							
6	Physician Visits / Physician FTEs		3,495	3,453	3,385	3,784	3,118
7	Mid-Level Visits / Mid-Level FTEs		3,309	3,091	3,032	3,358	2,632
8	Dental Visits / Dental Provider FTEs		2,882	2,790	2,696	2,937	1,981
9	Medical Patients / Medical Provider FTEs		1,056	1,025	960	1,033	964
10	Medical Patients / Total Medical Staff FTEs		370	356	330	344	329
11	Accrued Cost per Patient Visit		$165	$175	$186	$170	$187
12	Accrued Cost per Patient		$685	$726	$779	$661	$680
STAFFING & UTILIZATION							
13	Medical Support Staff Ratio		1.80	1.92	2.05	2.3	1.88
14	Administrative & Non-Clinical Staff Percentage		21.6%	22.3%	21.3%	22%	20.9%
15	Patient Visit Growth Rate		4.7%	0.4%	6.0%	7.1%	2.0%

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Blue Shield of California Foundation

Blue Shield of California Foundation (BSCF) is one of California's largest and most trusted grantmaking organizations. BSCF focuses its support in two program areas: Health Care and Coverage and Blue Shield Against Violence. The foundation's mission is to improve the lives of all Californians, particularly the underserved, by making health care accessible, effective, and affordable, and by ending domestic violence. For more information, visit www.blueshieldcafoundation.org.

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About Capital Link

Capital Link is a national, non-profit organization that has worked with hundreds of health centers and Primary Care Associations for over 15 years to plan capital projects, finance growth, and identify ways to improve performance. We provide innovative consulting services and extensive technical assistance with the goal of supporting and expanding community-based health care. For more information, visit www.caplink.org.