blue shield
of california
foundation

clinic core support initiative

follow-up evaluation findings

LFA Group
2009

blue of california

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introduction

Blue Shield of California Foundation (BSCF) is committed to making health care effective, safe, and accessible for all Californians, particularly underserved populations, and to ending domestic violence. For the past six years, BSCF has provided core support funding to community clinics in California through the **Clinic Core Support Initiative**.

Over the last five years, BSCF has contributed more than $42 million in core support funds to more than 200 California community health clinics, clinic parent corporations, and clinic consortia/networks. The goal of these grants is to strengthen the network of those on the frontlines providing care to low-income and uninsured Californians.

BSCF engaged LFA Group (LFA, formerly LaFrance Associates, LLC) in October 2006 to create a multi-year evaluation plan and conduct a baseline assessment of grantee clinics and parent corporations.[1] In October 2008, BSCF engaged LFA to conduct a follow-up assessment. The primary goals of this multi-year assessment and evaluation were to:

- Capture trends over time within the field of community clinics in California; and
- Inform the debate in the field of philanthropy about the impact that core operating support can have.

This summary focuses on the themes and findings from the follow-up evaluation, and comparisons are made with data gathered during the baseline assessment that was completed in 2007. Please note that earlier assessment for any detailed questions about the methods and findings.

This follow-up evaluation was conducted between January and June 2009.

1 While the cohort of BSCF grantees includes clinics, parent corporations, and clinic consortia, this evaluation only focuses on the clinics and parent corporations. Clinic consortia are excluded because BSCF determined that they were too different from clinics and parent corporations to be included in the same evaluation.

evaluation methods

Evaluators employed a mixed-methods approach, collecting both quantitative and qualitative information from Core Support grantees. This report includes data from:

- Surveys administered in 2007 (baseline) and 2009 (follow-up);
- Phone interviews with 15 clinic executive directors or other senior leaders in 2006 and 2009;
- A second round of phone interviews with an additional nine clinic leaders in 2009 (in order to dig deeper on findings from the 2009 survey); and
- A series of online surveys. Those include:
  - All 178 clinics and parent corporations who were grantees in 2006 were asked to participate in a baseline online survey in 2007. A total of 126 grantees responded to the survey for a response rate of 71 percent.
  - In a follow-up survey online in March 2009, all 184 clinics and parent corporations that received grants in 2008 were invited to participate. Of those, 142 grantees responded to the survey for a response rate of 77 percent.
  - A total of 163 organizations received grants in both 2006 and 2008, therefore making them eligible to complete both the baseline and follow-up surveys. Of these, 99 (61 percent) completed both surveys.

executive summary

Findings from the 2009 follow-up assessment of BSCF Clinic Core Support grantees provide a profile of clinics' current capacity to serve uninsured patients and highlights trends in California's community clinic field. Key observations include:

The past year has been volatile for clinics. This follow-up evaluation was conducted during a six-month period of great change and economic uncertainty for California and the country. The recession, change in presidential administration, and California's budget crisis impacted survey and interview responses from clinics. They have faced declining contributions, more patients losing insurance, and the need to make tough decisions in light of immense cuts in public programs. Simultaneously, the Obama administration has brought new hope for healthcare reform – and possible stimulus funding.

Clinics grew. Compared to the 2007 study, clinics are now serving more patients, opening new locations, adding staff, and increasing operating budgets. This is due to increased demand for services, clinic mergers, new funding streams, and acquiring FQHC status. While clinic leaders report that they can meet the demand of the growing uninsured population, they constantly face the challenge of securing adequate resources to do so. They expect continued growth, but it will likely slow down in the current economic climate – and some clinic leaders are anxious about their short-term survival.

Clinics' financial savvy is increasing. Consistent with the growth in other areas, clinic revenues and expenses are also increasing. Because third-party revenues have decreased, clinics now receive more funding from state and local grants. They're becoming more financially savvy and reported a greater ability to use financial data to make decisions, more confidence in accurately projecting budgets, and increased satisfaction in their financial management and accounting skills. However, clinics have also experienced a decline in unrestricted income, and their self-reported

ratings of financial health decreased slightly since 2007. Overall, clinics are trying to maintain financial stability in a time of state budget cuts, even though their own budgets have grown since 2007.

Clinics are making great technological strides. Clinics recognize the importance of using technology to improve efficiency and increase the quality of care. Many reported implementing (or preparing to implement) EMRs or EHRs, and more advanced practice management systems. Clinics also invest time in teaching their staff how to use new systems to make data-driven decisions for patient services and finances. While clinics are eager to adopt new technology, they do report challenges securing adequate funding for IT.

Clinics are investing more in professional development. Clinics are increasing the amount they spend on professional development opportunities and making those opportunities available to more staff, especially management teams. They report an increased focus on leadership development and opportunities related to quality assurance. Clinics, especially those with smaller budgets, continue to recognize and invest in emerging leaders. The main challenge is finding room in a tight budget to allocate fair and sufficient amounts of paid professional development time for employees.

Clinics are increasing collaborations with county health system and other clinics. Compared to the 2007 study, clinics report more and new ways of collaborating with the county health system (e.g., giving and receiving referrals, providing immunizations, ensuring that patients receive mental health care, etc.). However, the level of collaboration varies across the state and depends on the capacity of the county. Clinics also report increased efficiency through collaborations with other clinics. Inter-clinic collaboration allows clinics to apply for grants together and increases funding opportunities, as well as upgrade technology and other systems or services that they could not afford alone. As resources remain scarce, clinics expect to collaborate further in order to capitalize on best practices and to avoid duplication of services.

Clinics continue to engage in policy and advocacy activities. While the amount of money spent on policy and advocacy decreased overall, clinics reported expanding the *types* of activities that they engage in. They are primarily reactive to state and local policy developments, and most of their activities focus on protecting or securing funding sources. Executive

directors do most of the policy and advocacy work – in addition to their normal activities – and much of the work occurs outside of clinic hours. Clinics' engagement in policy and advocacy has become increasingly important during the current economic climate.

Core Support grants primarily go toward operating expenses and uninsured care. While some clinics report that they use Core Support for other areas (e.g., technology, professional development, new equipment, etc.), clinics most commonly depend on these grants as additional revenue to meet immediate operating needs. Clinics appreciate the flexibility and dependability of the grant. Core Support also allows clinics to "free up" funds for areas that otherwise would have received fewer or no dollars at all. Clinics continue to report that the grants help them leverage additional funding sources (by using the money to go after additional dollars and because of the credibility associated with the BSCF name).

key findings

clinic growth

One of the major themes that emerged from evaluating the Clinic Core Support Initiative is growth: clinics report serving more patients, expanding to new sites, growing their staff, and increased operating budgets.

patients and services

Clinics report an increase in the number of people they serve. Both the number of unduplicated patients and the number of patient encounters increased over the past two years. Clinics in the matched sample who responded to both surveys saw an average of 1,072 more unduplicated patients annually in 2009 (mean=21,361) than in 2007 (mean=20,195). The trend of growing patient volumes was also described by clinic leadership in interviews in 2007 and 2009.

"We have always served uninsured and people with incomes under 200 percent of the poverty level," said one executive director, describing the increase in her clinic in 2009. "We have a seen a major increase in patients because of people who have lost their jobs. Some are people who always thought they would have insurance and that we were for the 'other guy.' So, we are reaching a broader group in the community."

Interviews with clinic leaders in January and May 2009 confirm that clinics saw an increase in the percentage of uninsured patients in the first half of 2009. In May, clinic directors expressed concern that the declining economy was sending more patients – who had lost jobs and could not afford insurance – to community clinics.

exhibit 1
matched sample: average number of unduplicated patients per year
n=88

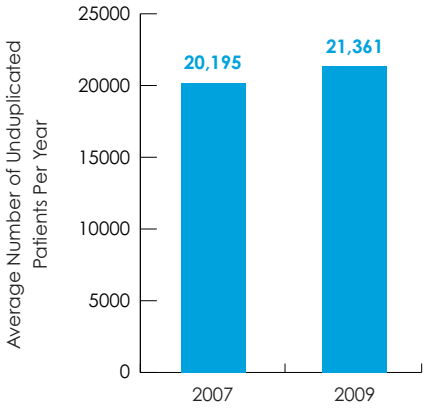
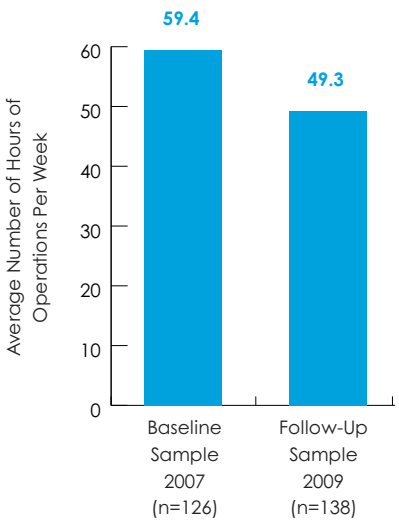


exhibit 2
baseline and follow-up samples: average number of hours of operations per week



clinic hours and locations

In interviews, many clinics reported expanding the number of sites and hours that they were open. An executive director described the effect of increased hours on their clinic: "Now we have expanded hours. We are open until 6:30 pm for all services. This is increased access, and people who work and need services can come in. It has also helped the financial side."

The survey data tell a more nuanced story. Since 2007, 53 percent of clinics report they have expanded their hours of operation, 47 percent of clinics report they have added a new location, and 42 percent report they have expanded their existing facilities.

However, when you examine the change in the average number of clinic locations and average number of sites per clinic in 2007 and 2009, there has actually been a decrease in both. This information seemingly contradicts the anecdotal reports from clinics and the number of clinics in the survey that report expanding their hours and facilities. A possible explanation is that while many clinics are expanding, that expansion may be relatively small. When coupled with other clinics that are shrinking more dramatically, the data indicate that the field is, on average, shortening their hours and decreasing the number of clinic sites.

"The climate is really bad right now. The governor cut 10 to 15 percent of funding to community clinics, and then we got cuts from the county. But we also recently became an FQHC. So while we were expanding at some sites [with federal funds], we had to close one clinic… We've been working on our productivity so we can have less staff but maintain access for patients."

Clinic Executive Director

factors influencing growth

Taken together, the survey and interview findings do indicate that clinics in California are experiencing growth (i.e., seeing more patients, hiring more staff, and increasing annual budgets). LFA spoke with clinics to determine why some were growing and what factors influenced growth. A few key reasons emerged, although many clinics were unable to attribute their growth to one particular cause. Factors included: experiencing a merger, gaining FQHC status, an increase in demand for services, and the availability of funds.

"We have seen a huge amount of growth. Most of the growth is from our merger, but also the Central Valley continues to grow. Some of the growth is because of the downturn in the economy and because people no longer have health insurance. There are also new Medicaid populations."

Clinic Executive Director

Clinics do believe that they will continue to grow over the long term. However, they are unsure about their future trajectories for growth. The political and economic volatility is challenging, and clinic leaders are currently working to preserve and maintain as many of their programs as possible. Some clinics are hopeful that the federal stimulus will infuse some much-needed funds into the field, but the state budget crisis is severe and will continue to affect clinics.

finances

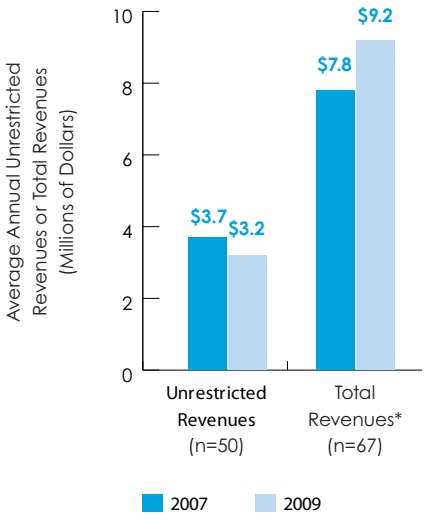
BSCF provides general operating support based on a core belief that unrestricted funds can contribute to an organization's overall financial health. The evaluation team examined a key set of questions and indicators around financial health to determine what trends the field experienced over the past two years. We examined changes in revenues, unrestricted income, types of revenue streams, accounting and financial management capacity, and staff financial capacity. This section focuses on financial trends in California clinics over the past two years.

revenues and expenses

Consistent with the growth seen in other areas of clinic capacity, clinics' total revenues and expenses increased between 2007 and 2009 – from an average of $7.8 million in 2007 to an average of $9.2 million per clinic in 2009, representing 18 percent growth.

However, while revenues increased, unrestricted revenues decreased over the same period in real dollars as well as when examined as a percentage of operating budget. In 2007, an average of 47 percent of clinic revenues were unrestricted, representing an average of $3.7 million of unrestricted revenues. In 2009, clinics were only receiving an average of $3.2 million in unrestricted revenues, or 35 percent of their total revenues. This drop in

exhibit 3
matched sample: average annual unrestricted revenues and total revenues



*The change between 2007 and 2009 is significant at p<.05.

unrestricted revenues highlights the challenges that clinics have in finding funds to cover operating expenses – and emphasizes how important BSCF Core Support grants are to these organizations.

There was little change in the "days of cash" that organizations have on hand from 2007 to 2009. Less than one-fourth of clinics had more than 90 days of cash on hand in 2007 (22 percent) and 2009 (24 percent), while approximately 20 percent in 2007 and 2009 had none or less than 30 days of cash on hand. This is quite remarkable given the challenging current economy and the delays that some clinics have experienced in receiving reimbursements.

exhibit 4
baseline and follow-up samples: days of cash on hand

days of cash on hand	baseline sample 2007 (n=107)	follow-up sample 2009 (n=129)
None	1 percent	3 percent
Less than 30 days	22 percent	19 percent
30 days	23 percent	17 percent
60 days	24 percent	28 percent
90 days	8 percent	9 percent
More than 90 days	22 percent	24 percent

technology

practice management systems

Clinics strive to stay current with technology trends in the field. They recognize that the healthcare field has moved away from paper-based records and charts and is rapidly moving toward implementation of electronic health records (EHR) and practice management software programs. In 2007, a majority (81 percent) of clinics in the matched sample had already adopted or were in the process of developing electronic practice management systems for patient care and information. Over the last two years, an increasing number of clinics have implemented such systems, resulting in a total of 87 percent of clinics with such systems.

Practice management systems perform a variety of operational functions in the clinics, and they have provided mostly the same functions in 2009 as

in 2007. Most commonly, they help clinics track basic patient information, patient billing and reimbursements, patient care received, and provider productivity.

Among those with electronic practice management systems, 47 percent of clinics in the matched sample report that the practice management system is meeting their needs better in 2009 than in 2007.

exhibit 5
baseline and follow-up samples: percentage of respondents with or developing a practice management system

functions of practice management system	baseline sample 2007 (n=93)	follow-up sample 2009 (n=124)
Basic patient information	99 percent	93 percent
Patient billing and reimbursements	92 percent	87 percent
Patient care received	75 percent	77 percent
Provider productivity	70 percent	73 percent
Patient referrals	58 percent	60 percent
Patient follow-up on referrals	41 percent	40 percent
Patient care outcomes	29 percent	39 percent
Patient health education and non-care outcomes	24 percent	29 percent

technology budgets

Consistent with the overall movement toward adoption of technologies and increased capacity to make data informed decisions, the average amount spent on IT and telecommunications significantly increased between 2007 and 2009: $99,468 more for the average clinic.

exhibit 6
matched sample: average amount spent on IT and telecommunications by clinic annual operating budget*
n=69

annual budget	2007	2009
Less than $2 million	$27,473	$22,635
$2 to $5 million	$99,464	$159,932
$5 to $10 million	$87,916	$186,013
More than $10 million	$296,728	$618,249
Total Matched Sample+ (n=70)	$149,300	$248,768

*Indicates the difference between groups of clinic operating budget is significant at p<.05.
+Indicates the change between 2007 and 2009 is significant at p<.05.

There was a significant difference in the amount spent on IT and telecommunications by clinic operating budget size: Clinics with larger budgets increased their annual spending significantly more than those with smaller budgets. Clinics with the smallest budgets actually decreased the average amount spent on IT and telecommunications over the last two years.

As the field transitions into electronic data systems, the process is not without challenges. Clinic leaders reported ongoing struggles to:

- Maintain systems;
- Fund IT support;
- Fund IT training for staff; and
- Upgrade to the latest versions of technology.

Clinic leaders reported that core support plays a critical role in helping clinics maintain technology and stabilize operating budgets as they invest in technology. "It absolutely makes it more feasible for us to do EHR," said one clinic leader. "Technically, we use it to cover uncompensated care, but [the grant allows us to] use other funds for uncompensated care and invest in EHR. The [BSCF] grant provides the level in stability and revenue that helps tremendously."

professional development

Surveys and interviews highlight the importance and value that clinics place on professional development and continuing education. Not only is continuing education required for licensure, but professional development is viewed as a retention strategy and a key to employee satisfaction. Nearly all clinics offer their staff the opportunities to participate in employer-sponsored professional development or continuing education, or they provide paid educational leave. For almost all staff positions, more clinics offer professional development opportunities in 2009 than in 2007. Significantly more clinics in the matched sample are offering professional development opportunities for their management teams, social workers, and counselors.

exhibit 7
matched sample: priority professional development topics for management teams n=86

professional development topics	2007	2009
Leadership*	44 percent	62 percent
Team management and collaboration	53 percent	56 percent
Information management and analysis	63 percent	53 percent
Strategic financial management	51 percent	51 percent
Strategic planning	33 percent	42 percent

*Indicates the change between 2007 and 2009 is significant at p<.05.

Clinics encourage their staff to participate in professional trainings, workshops, and conferences on a variety of topics, especially those related to quality assurance. Trainings around best practices of care are particularly valuable and can engage all positions, from frontline staff to medical directors, in quality-improvement series.

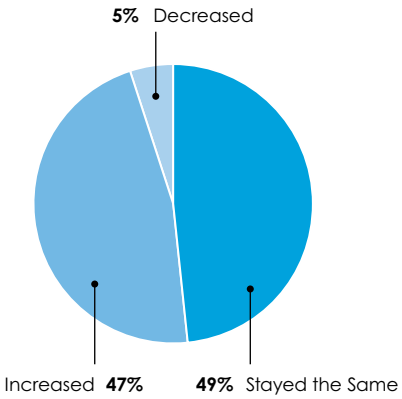
In regards to professional development for financial and leadership teams, clinics stressed the importance of strong accounting skills and encourage their management teams and other senior administrative staff to continuously develop financial skills.

In the follow-up survey, clinics identified the areas of professional development most important for their management teams. Leadership development was rated as a top priority by significantly more clinics in the matched sample in 2009 (62 percent) than in 2007 (44 percent).

Clinics recognize that offering paid professional development time is an employee recruitment and retention strategy, and are working toward formalizing professional development policies. However, clinics report that allocating fair and sufficient amounts of paid time for employees when managing the overall budget is an ongoing challenge. Interviews revealed that while leaders would ideally like to fully invest in their employees' educations, finding the financial capacity does not come easy. For many clinics, the Core Support grant alleviated this pressure in the budget. "We would not have been able to spend nearly what we have on staff development without the money freed up from [BSCF]," said one clinic leader. "It probably increased our training budget by 50 percent this year."

collaboration

exhibit 8
follow-up sample: change in collaboration with the country health system over the last two years
n=134



Clinics reported collaborating with many other organizations, including county departments of public health, other clinics, schools, and county boards of supervisors. The most common collaborations occur with county departments of public health (also referred to as the "county health system") and other clinics. Clinics reported a trend toward increasing their level of collaboration with these organizations.

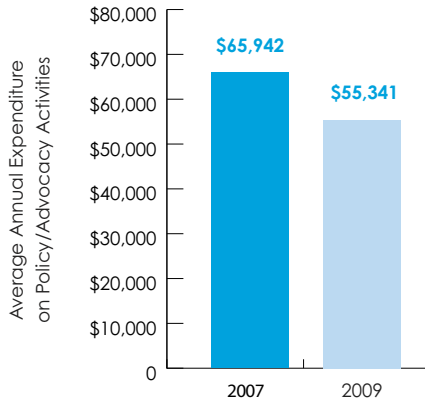
The ways in which community clinics collaborate with their county health systems – and the extent to which they do so – varies by the capacity of each county. Since 2007, clinics have either increased their level of collaboration with the county or sustained the same level. Nearly half (47 percent) of the clinics in the follow-up sample reported that they collaborate more with the county health system now than they did two years ago, 48 percent reported the same level of collaboration, and only 5 percent report decreased collaboration.

The three most common types of collaboration between clinics and counties include: providing and receiving referrals for specialty care (27 percent); participating in immunization programs (18 percent); and securing funding and providing services for mental health (16 percent).

Other less frequently mentioned forms of collaboration include: primary care referrals and services; chronic disease management; HIV services; oral health services; lead testing; information exchange; communicable disease reporting and treatment; and needle exchanges.

policy/advocacy

exhibit 9
matched sample: average annual expenditures on policy and advocacy activities
n=37



The policy environment changes at a fast pace, and clinics have been hit especially hard in the past year by the recession, California budget crisis, and the governor's cuts to safety net program. Clinic leaders need to react quickly to these policy changes to protect funding and seek new sources that allow them to provide necessary services to the uninsured. Clinics also engage in policy and advocacy activities to participate in the greater healthcare reform debate.

The follow-up survey revealed that while clinics spent less money on policy and advocacy activities in 2009 than in 2007, they have maintained or increased their level of engagement in these activities. Clinics in the

matched sample reported spending less money on policy and advocacy activities in 2009 than two years ago: the average clinic spent less at follow-up ($55,321) than at baseline ($65,942). (See Exhibit 9.)

The reduction can be explained, in part, by the increase in the extent to which executive directors and board members engage in the work themselves, rather than allocating funds for dedicated staff members to lead these activities.

exhibit 10
baseline and follow-up samples: percentage of clinics involved in policy and advocacy activities

policy and advocacy activity	baseline sample 2007 (n=117)	follow-up sample 2009 (n=106)
Participating in coalitions	72 percent	79 percent
Community planning and organizing	71 percent	70 percent
Getting constituents to write letters or vote	44 percent	53 percent
Grassroots organizing	48 percent	52 percent

Please note: Percentages do not total 100 because respondents could check all that apply.

Despite decreased funding, clinics in the matched sample have increased their engagement in a few types of policy and advocacy activities since the 2007 survey. There was an increase in the percentage of clinics who reported involvement in grassroots organizing, constituent letter writing, and participation in coalitions. The only area that showed essentially no change is community planning and organizing. The most common way in which clinics engage in policy and advocacy is through participation in coalitions (79 percent), followed by community planning and organizing (70 percent).

In the interviews, executive directors gave examples of policy and advocacy goals, and the issues in which they engage. They reported being more reactive rather than proactive, and most policy and advocacy work is focused on protecting existing funding streams and securing new funding.

uses of the core support grant

exhibit 11

baseline and follow-up samples: average percentage of the core support grant spent

area of operation	baseline sample 2007 (n=125)	follow-up sample 2009 (n=121)
Uncompensated care reimbursement	30 percent	30 percent
Operation expenses	24 percent	28 percent
IT or telecommunications	4 percent	7 percent
Equipment	7 percent	6 percent
Additional clinic hours or services	4 percent	5 percent
Medical supplies	4 percent	4 percent
Program expansion	4 percent	3 percent
Staff training or development	6 percent	2 percent
Fund development	4 percent	2 percent
Needs assessment/Strategic planning	2 percent	2 percent
New program or services	4 percent	1 percent
Patient education	4 percent	1 percent
Board training or development	1 percent	1 percent
Policy or advocacy	1 percent	<1 percent
Technical assistance services	1 percent	<1 percent
Evaluation	1 percent	<1 percent

On average, clinics reported in the follow-up survey that they spent more than a quarter of the grant in two areas: uncompensated care reimbursements (30 percent) and operating expenses (28 percent). This supports the idea that core support is used as a resource to meet frontline needs of community clinics – and echoes 2007 survey findings.

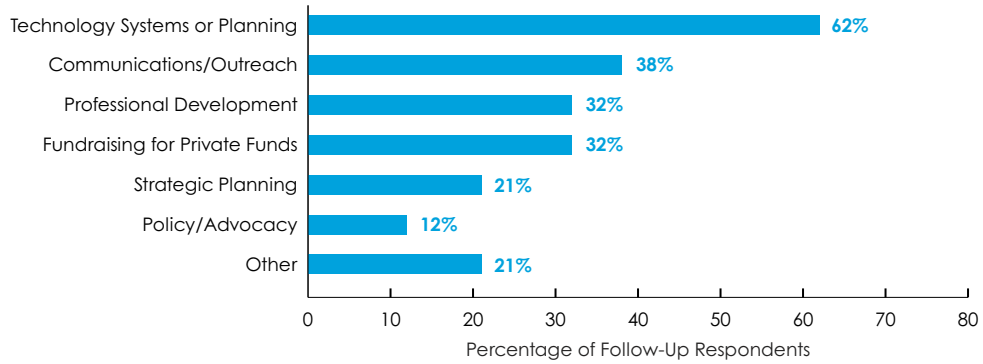
While clinics primarily use the Core Support grants for operating expenses and uncompensated care, 29 percent identified innovative programs that they were able to develop or support with the grant. Examples include (but are not limited to): bilingual English and Spanish chronic care classes open to the entire community; new technologies to improve operations (e.g., touch pad patient identification systems); and hiring a staff member for patient advocacy and benefits analysis in order to connect patients with entitlement programs and special services.

"freed up" funds

Core Support funding has additional benefits. By spending these grants on one service area, dollars are "freed up" for other areas where investments

otherwise would not be made – or fewer dollars would have been invested. More than half (59 percent) of the follow-up survey respondents reported this to be the case. Among grantees that reported that Core Support grants freed up funds, nearly two-thirds (62 percent) reported that technology systems or planning was the most common area that received extra support.

exhibit 12
follow-up sample: percentage of respondents who report the grant "freed up" existing funds to be spent in different areas
n=73



Please note, percentages do not total 100 percent because respondents could check all that apply.

leveraged funding sources

Another way in which clinics benefit from Core Support is by using the grants to leverage additional funding sources. They reference the Core Support on other grant applications or use the funds to increase staff capacity to apply for other grants that will provide matched funding for programs or initiatives started with the Core Support funds. More clinics (57 percent) in the follow-up sample reported that they used the Core Support grant to leverage funds than in the baseline sample (42 percent), as shown in Exhibit 13.

In the interviews and follow-up survey, clinics explained that the BSCF brand name is attractive to other funders and sends a message that their clinic has already been vetted and approved. As one clinic executive director said, "We have heard from multiple funders that when they see 'Blue Shield of California Foundation,' their eyes light up and ears perk to attention. Seeing that the clinic is a recipient of those kinds of dollars is absolutely important."

exhibit 13
baseline and follow-up samples: percentage of respondents who reported the core support grant leveraged new funding sources