

blue shield
of california
foundation



evaluation of the
2006 community clinic
core support initiative:
baseline report

introduction and purpose

For the past four years, Blue Shield of California Foundation (BSCF) has provided more than \$22 million in core support funding to community health clinics, clinic parent corporations, and clinic consortia/networks through an annual Community Clinic and Consortium Core Support Initiative. The ultimate goal of these grants is to strengthen the network of front line healthcare providers that provide care to low-income and uninsured Californians.

BSCF engaged LaFrance Associates, LLC (LFA) in October 2006 to create a multi-year evaluation plan and conduct a baseline assessment of the 2006 Clinic Core Support Initiative grantees. The primary goals of the evaluation are to:

- Establish baseline measurements of 178 clinics and parent corporations that were grantees of the 2006 BSCF Clinic Core Support Initiative
- Inform the debate in the field of philanthropy about the potential impact core support funding can have on community clinics

The Community Clinics Initiative (CCI), a joint project of Tides and The California Endowment, has previously measured and reported on California clinics' organizational strengths. CCI's 2004 report to the field, *Assessing the Capacity of California's Community Clinics*, reported baseline information on clinics in the areas of mission, vision, and planning; community engagement and collaboration; management team leadership; board leadership; financial systems and position; fund development; and data-informed decision making. LFA referred to this report and the evaluation framework in designing the evaluation for BSCF.

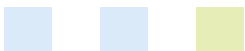




The LFA team and Foundation staff together developed a hypothesis of how an organization might be affected by core support grants. First and foremost, the Foundation believes that core support will increase a clinic's ability to serve uninsured patients, thereby strengthening California's statewide safety net. The secondary hypothesis is that core support will increase capacity areas related to organizational functioning and stability. These core capacity areas are:

- Strategic Planning
- Staffing and Professional Development
- Technology and Data Management
- Collaborations
- Advocacy and Policy-Related Activities
- Financial Management and Stability

Given the study hypotheses, the multi-year evaluation is focused on measuring change over time in clinics' ability to serve uninsured patients and core capacity areas. This report is a summary of the first phase of evaluation: a baseline assessment of grantees focusing on organizational status in the key areas that the Foundation believes the Clinic Initiative grants will impact. In two years, these same grantees will be reassessed to determine changes in the areas of intended impact.



evaluation methods

The LFA evaluation team employed a mixed-methods research design for this evaluation, collecting both qualitative (key informant interviews) and quantitative (survey) data collection from clinics and parent corporations funded through the initiative. LFA interviewed 15 Executive Directors of grantee organizations, randomly selected to ensure a representative sample in terms of organization type (American Indian health clinic, community clinic, free clinic, and parent organization), grant amount, and geographical region.

LFA also sent an online survey to all 178 clinic grantees, excluding consortia/networks, to gather baseline measures in key areas of interest for the evaluation. A total of 126 grantees responded to the survey for a 71 percent response rate.¹

key findings

intended use of the clinic initiative grant

Grantees indicated areas in which they are planning to use their Clinic Initiative grant, and what percentage of the grant they are planning to allocate to each area. A total of 57 clinics are planning to use an average of 67 percent of their total grant to cover uncompensated care reimbursement, and 55 clinics are planning to use an average of 54 percent of the total grant to cover operating expenses. The areas where the smallest percentage of the grant is being used are evaluation, policy or advocacy, and board training and development. See exhibit a, page 4.

¹ Many questions were answered by almost all 126 survey respondents. In cases where less than 115 respondents answered a question, the number of respondents is noted.

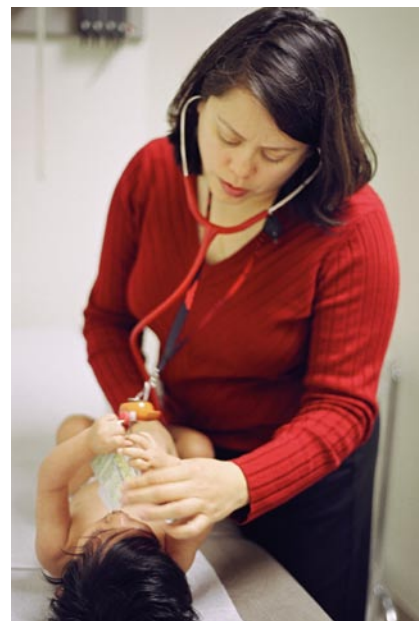
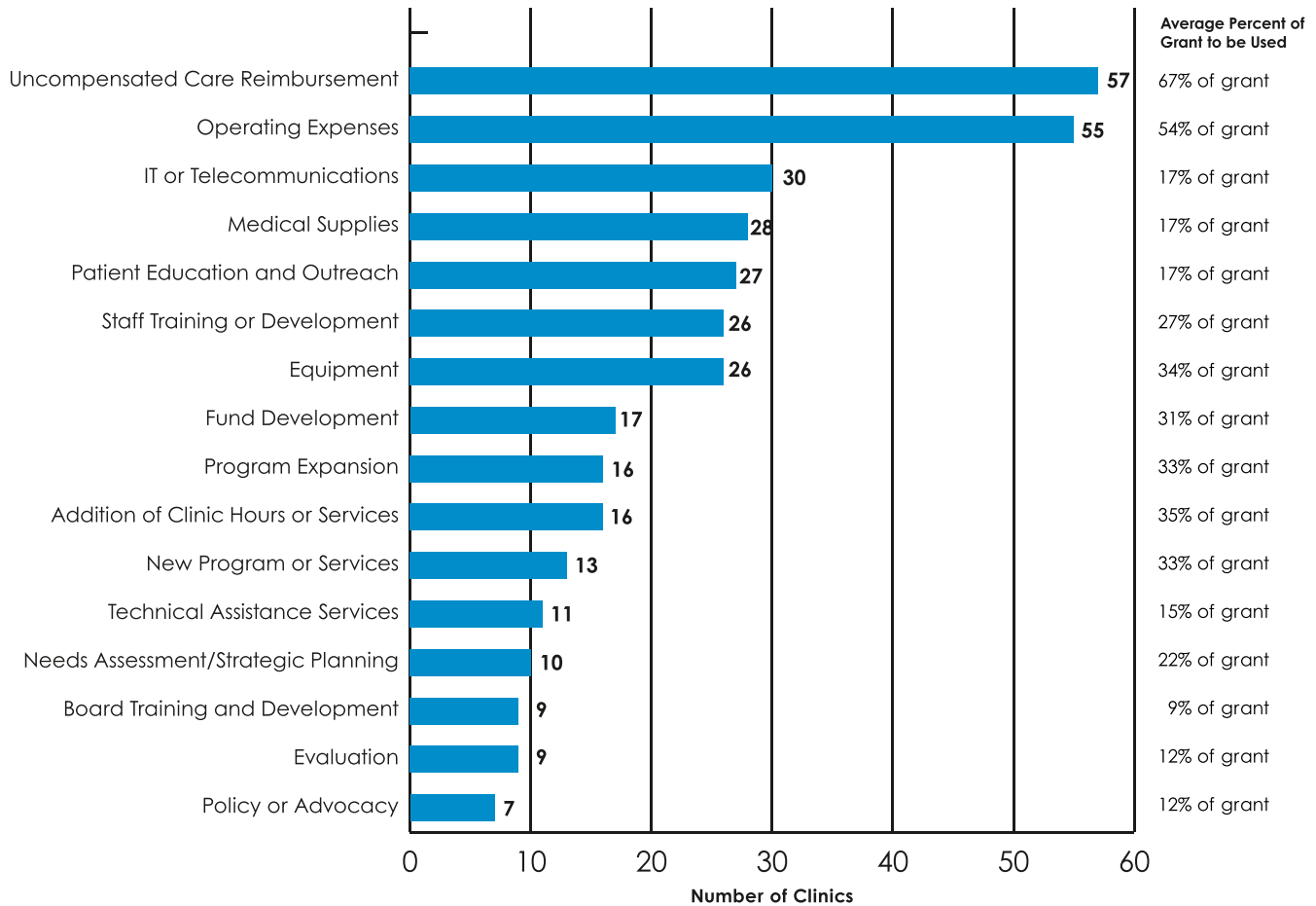


exhibit a

number of clinics using the clinic initiative grant for various purposes



Clinics that reported they will use the grant for fund development have a significantly higher percentage of uninsured patients than those who will not use the grant for this purpose. Clinics that plan to use their grant for board training/development and staff training/development have a significantly lower percentage of uninsured patients than clinics not planning to use the grant for these purposes. These results imply that clinics that see a higher percentage of uninsured patients are focusing on the fundamental need to raise funds and make ends meet, whereas clinics who see a smaller percentage of uninsured patients are able to turn to potentially less urgent (though important nonetheless) issues such as staff and board development.

“We use the grant to support clinical services to a population that is uninsured and often undocumented. It was a strain on our other programs to cover this group without the additional core support from the Foundation.”

—Grantee

exhibit b

differences in percentage of uninsured patients based on how clinics will use the grant

Do you plan to use the grant for this purpose?	Response	Mean Percentage of Uninsured Patients
Board Training or Development*	Yes	29%
	No	49%
Staff Training or Development**	Yes	33%
	No	52%
Fund Development**	Yes	62%
	No	46%

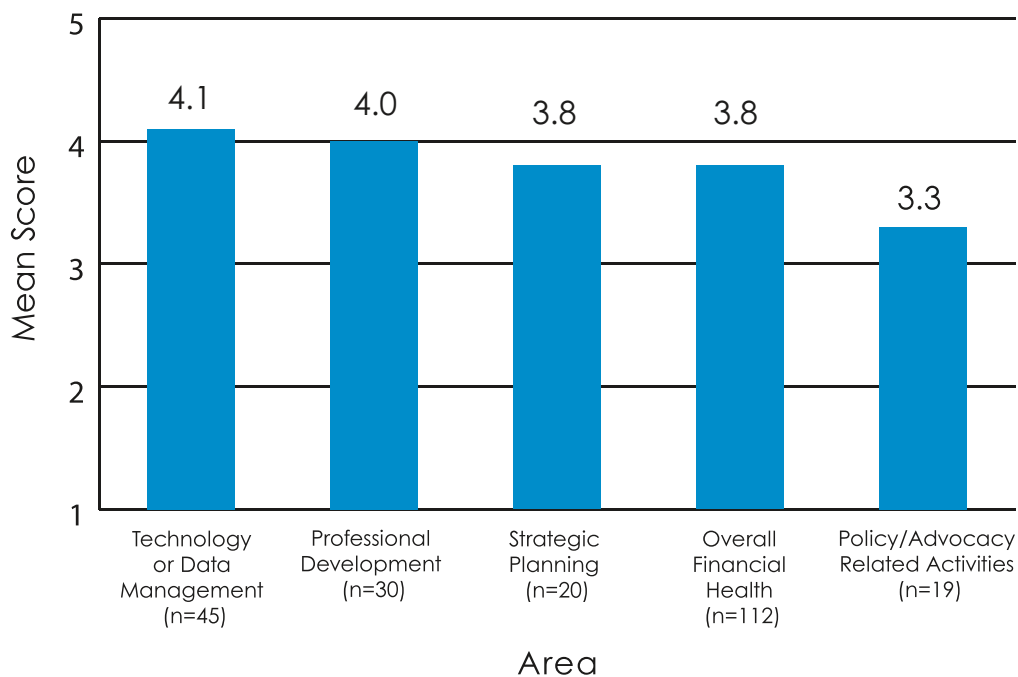
Significance levels: *=p<.1; **=p<.05

What level of impact do grantees anticipate their BSCF core support grant will have? The areas where clinics expect the grant will have the highest impact include technology and data management, and professional development. On a scale from 1 to 5, where 1 is “No Impact” and 5 is “Strong Impact,” these areas received an average score of at least 4.0. The area of lowest anticipated impact was policy/advocacy-related activities, with a mean score of 3.3, or just above “Moderate Impact.” In the follow-up study, evaluators will compare levels of anticipated impact with actual impact.



exhibit c

anticipated impact of the clinic initiative grant on areas of clinic operation



services and patient care

What effect does the Clinic Initiative grant have on expanding the safety net and increasing the capacity of clinics to serve more uninsured patients? To address this question, evaluators collected baseline information on current patient volume and perceptions of how service demand has changed recently.

Across all clinics, the average number of patient visits was 65,941 per year, and the average number of unduplicated patients was 20,208. Executive Directors report their clinics are now seeing more uninsured patients than in previous years. To accommodate an increase in patients, clinics are planning to expand physical facilities and service capacity.

In addition to patient volume, clinics reported their level of agreement with a series of statements about patient care and coordination, with results provided on page 7. Clinics most commonly agree that “Patient follow-up care is coordinated in a timely manner.” The statement with the lowest level of agreement is “Our clinic operates at optimal efficiency.”

“It’s not just the poor anymore. We also have a lot of people that are middle class who do not have health insurance. We see everybody who comes in regardless of income level.”

—Grantee

exhibit d

clinics' internal coordination of patient care

Agreement with the following statements:	Average Score
a. Patient follow-up care is coordinated in a timely manner	3.6
b. We have effective treatment team case planning	3.5
c. Patient records are easily accessible to all providers in the clinic	3.5
d. We have effective communication systems in place around individual patient care	3.4
e. Our clinic operates at optimal efficiency	2.9

Items rated on a 5-point Likert scale (1=Do not agree, 3=Agree somewhat, 5=Strongly agree).

In-depth statistical analysis reveals that organizational capacity does not differ by the percentage of uninsured patients a clinic sees. Clinics that see a high percentage of uninsured patients are functioning as well in key organizational capacity areas—such as financial stability, patient coordination, and technology—as clinics seeing a low percentage of uninsured patients.

staffing and professional development

Clinics rely on a wide variety of staff position types and levels of support to run their operations. The average number of full-time employees (FTE) across all clinics is 91, the median is 48, and this number ranges from a minimum of one FTE to a maximum of 705 FTE. Many clinics also have a strong volunteer presence in order to help provide care and services.

Many Executive Directors reported in interviews that recruiting and retaining staff are key challenges they face in their clinics. Other staff-related challenges range from providing competitive levels of pay to finding bilingual and bicultural staff.

Clinics also reported the range of professional development opportunities they offer to clinic staff. While professional development opportunities are widely offered to all levels of staff, the total number of professional development hours available for staff per year is generally less than one week.

“It is hard to find providers who want to work for community clinics. Finding staff that is bilingual and bicultural is also a problem.”

—Grantee

“The plan keeps the board focused on why we’re doing what we’re doing—what our priorities are. It helps in decision making, increases productivity and keeps us focused on what we said we would do this year.”

—Grantee

“We were able to tie our Facilities Master Plan to our Strategic Business Plan and identify problems within the organization that were hindering our progress and impacting us financially. We were able to address issues that have sat unaddressed for years and resolve them.”

—Grantee

strategic planning

Almost all clinics (93 percent) have engaged in a strategic planning process within the past three years, and most said their plan had an impact on organizational goals and direction. Funders and nonprofits alike increasingly recognize that strategic planning processes are an important and necessary element of organizational effectiveness.

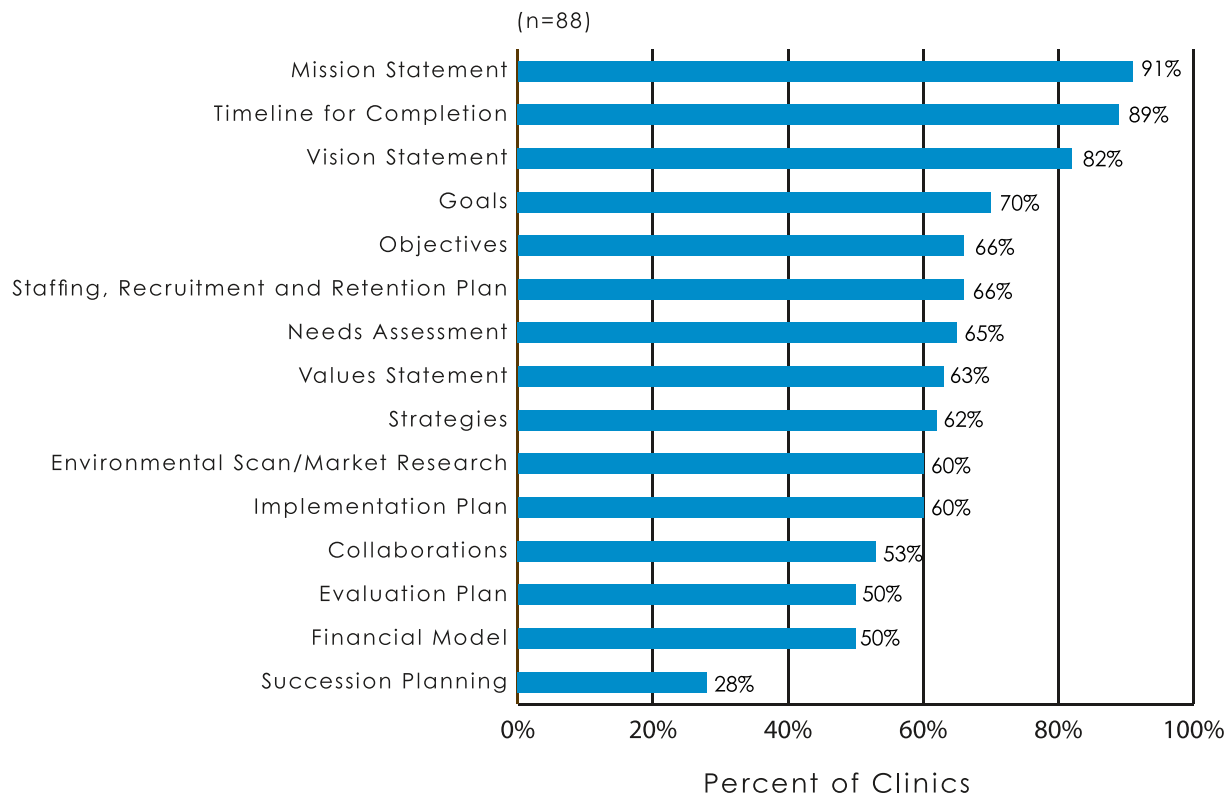
However, the robustness of strategic planning processes varies across clinics. Among organizations that participated in a strategic planning process, only 87 percent involved the Board of Directors, and only 88 percent resulted in a written document. These two factors—board involvement and the existence of a written document—were related to high overall organizational capacity, whereas whether or not an organization had simply gone through a strategic planning process was not found to be related to high organizational capacity.

Organizations whose Board of Directors was involved in the strategic planning process scored significantly higher on several capacity composite scores as compared to organizations whose Board of Directors was not involved in the process. These key capacity areas are technology, advocacy, and financial management. These same organizations also rate their organization's financial health significantly higher than organizations that did not have Board involvement in the strategic planning process. Similarly, organizations with a written strategic plan scored significantly higher on composite scores in the areas of technology, advocacy and financial stability, as compared with organizations whose process did not result in a written document.

The specific content of written strategic plans also varies widely. Please see exhibit e, page 9.

exhibit e

components included in clinic's strategic plans

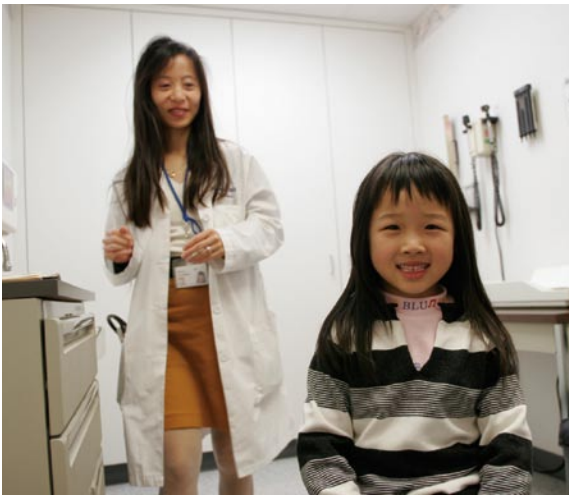


technology and data management

Over two-thirds of clinics (69 percent) currently have an electronic patient management system. Those with such systems report that they track various pieces of information. The most common functions that data management systems perform are tracking patient information (77 percent) and patient billing (72 percent). Much less common are systems that track follow-up on referrals (32 percent), patient care outcomes (23 percent), and health education and non-care outcomes (18 percent). On average, clinics report their data management systems are meeting their needs less than “Moderately Well.” Parent corporations rated their data management systems significantly higher than community clinics. On a scale from 1-5, the mean score for community clinics was 2.5, and the mean score for parent corporations was 3.0 (ANOVA, $p < .1$).

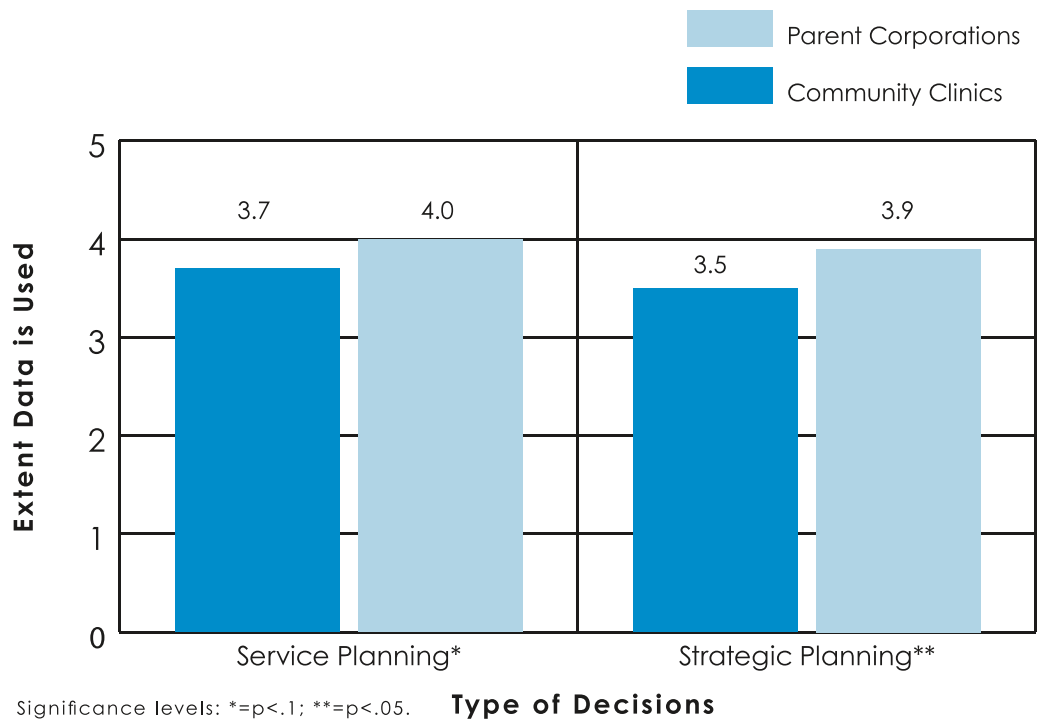
“We have a rudimentary database and are using the Blue Shield of California Foundation money to collect better data. We have data broken down by clinic and we know basic demographic information. We'd like to have more detailed information on specific information about what people are being treated for.”

—Grantee



Parent corporations use data significantly more often than community clinics to make decisions about strategic and service planning. These baseline results indicate there is room for improvement in the use of data for decision-making, especially for community clinics. On a scale from 1 (Not at All) to 5 (Extremely Often), clinics indicated the extent to which they use data in multiple areas: financial planning, service planning, organizational strategic planning, and patient care and coordination. Exhibit f on page 10, shows the mean score for parent corporations was higher than the mean score for community clinics in service planning and strategic planning.

exhibit f
clinics' use of data to make decisions



advocacy and policy-related activities

Almost all clinics reported they engage in advocacy or policy-related activities through their membership in a community clinic consortia or other network. About three-quarters of survey respondents said they engage in some form of advocacy beyond participation in the networks, or include advocacy in their formal mission or goals. These numbers are relatively high and indicate that almost all clinics, to some degree, are advocating on some issues.

However, only 27 percent of clinics actually have an advocacy-specific program.

exhibit g

clinics' advocacy and policy related activities

	Percentage of Clinics Participating	
	Yes	No
Is your organization a member of a community clinic consortia or other networks that participate in advocacy/policy-related activities?	92%	8%
Aside from the community clinic consortia, does your organization participate in any mission-related advocacy/policy-related activities?	78%	22%
Are public policy and/or advocacy part of the organization's mission or goals?	73%	27%
Does your organization have any advocacy/policy specific programs?	27%	73%

The 27 percent of clinics that do have a specific advocacy/policy-related program have significantly higher budgets than organizations without these types of programs. The mean total expenses for clinics with such a program is \$12.3 million, whereas the mean total expenses for clinics that do not have an advocacy program is \$7.4 million (ANOVA, $p < .05$).

Clinics who do engage in advocacy or policy-related activities more commonly participate in coalitions or are involved with community planning and organizing than grassroots organizing or direct outreach to constituents. There is no convention for the amount of staff time these organizations devote to advocacy activities. Under one-quarter of respondents (22 percent) devote more than 24 staff hours every month to advocacy, while about 35 percent spend eight hours of staff time or less per month.

“If we had more resources, we would do more advocacy. It is sometimes frustrating to see what is coming down and not be able to spend the time in making an impact.”

—Grantee

“I think it’s the fundamental flaw that our uninsured mix is going up and our expenses are going up. There is a constant situation where expenses are exceeding revenues by just the virtue of the mass. Medi-Cal reimbursement rates increase at a flat rate of 2 percent per year while expenses go up 8-12 percent a year. Since our primary source of revenue is Medi-Cal, expenses exceed revenues very quickly unless we can increase the Medi-Cal rate through a rate adjustment process. The system is designed for financial failure.”

—Grantee

financial management and stability

Clinics have a variety of sources of unrestricted income in addition to their Clinic Initiative grant, including federal grants, other foundation grants, and donations from individuals. Over half of survey respondents receive individual donations and/or other unrestricted foundation grants. One-third of grantees say at least a portion of their federal government grants are unrestricted. In interviews, Executive Directors mentioned The California Wellness Foundation, the Women’s Foundation of California, and various family trusts as other sources of unrestricted grants.

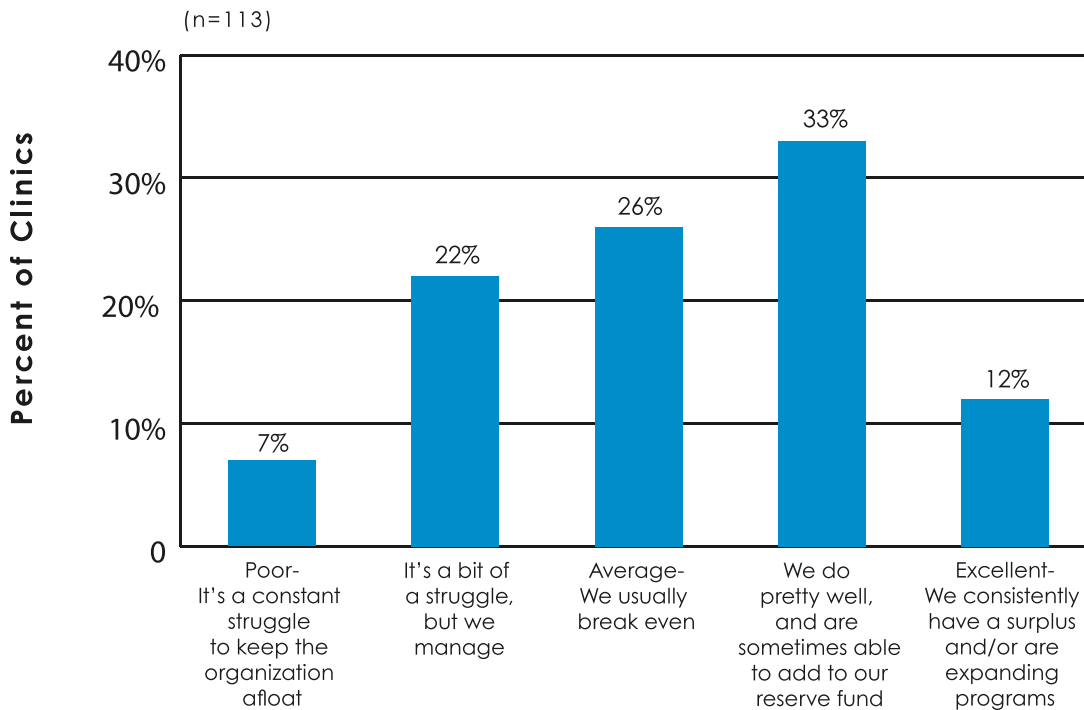
The largest source of funds is third-party reimbursements, with clinics reporting an average of almost half of their income from this source. Federal, state, and local government grants together comprise about 25 percent of clinic income.

On average, clinics rate their own financial health as just above average, as shown in exhibit h, on page 13, even though almost one-third (28 percent) of survey respondents had an operating deficit at the end of the most recent fiscal year. In interviews, Executive Directors indicate they generally feel their organizations are finding ways to make ends meet. Parent corporations rated their overall financial health significantly higher than community clinics did. On a scale of 1 to 5, parent corporations’ mean score was 3.5, while community clinics’ mean score was 3.0 (ANOVA, $p < .05$).



exhibit h

overall clinic financial health



Financial health can also be measured by the stability of an organization's funding sources over time and by the organization's ability to increase existing, or attract new, funding sources. Grantees reported whether, in the past two years, the amount they received from each category of funding source had remained the same within 10 percent, had increased more than 10 percent, or had decreased by 10 percent. Overall, clinics have stability in their funding sources. Over 85 percent of clinics said their funding sources in each category have either increased or remained the same. Perhaps most encouragingly, about 30 percent of grantees say their foundation grants and third-party reimbursements have increased at least 10 percent in the past two years. State and local government is the funding source where the most clinics report a decrease over the past two years: 13 percent of clinics say this income source has decreased.

"This year we had our smallest surplus. A couple of factors have contributed to that. We focused on expenses and saw what was there. We standardized a lot of operations. We looked at our revenues to see if we were billing for all the services we were providing—we realized we were not. We were also able to get computers and now we see more patients with about the same amount of staff."

—Grantee

“As we have had financial difficulties in the past, the revenue from this grant has created a better feeling of financial well-being among senior staff that allows us to focus on other revenue increasing activities rather than ‘paying the bills.’ This allows us to do our jobs more effectively.”

—Grantee

Grantees reported they have been able to leverage new funding sources with their BSCF Clinic Initiative grant. Only a few months into the grant period, over 40 percent of survey respondents said they in fact had been able to leverage new funding sources because of the Clinic Initiative grant

collaboration

Information on collaborations was collected via interviews only. All but one organization reported collaborating and seeing value in working with other organizations. Clinics reported collaborations around specific health issues in their community and also around advocacy. Some specific health issues that Executive Directors mentioned collaborating on include HIV/AIDS, diabetes, mental health, and substance abuse. Some organizations also reported collaboration around data management best practices. Additionally, clinics have pooled together as a group to access funding that they would not have been eligible to receive individually.

“We are firm believers in collaboration because of our limitations. We collaborate around outreach for HIV/AIDS. We have collaborations with universities around a child development program. We collaborate with six other agencies in a mental health program. We are also part of a huge IT collaboration around our practice management system.”

—Grantee

conclusions and next steps

The findings from this baseline assessment of 2006 BSCF Clinic Core Support Initiative grantees provides a profile of clinics' current capacity to serve uninsured patients and to function as effective organizations. These clinics are truly providing the safety net in California: on average, about half of their patients are uninsured, and this number is on the rise as the costs of employer-based health care are increasingly passed on to employees, leaving some to opt out of healthcare plans. And while many clinics plan to use their BSCF Clinic Initiative grant to offset financial shortfalls they face by serving more and more uninsured patients, it is ultimately through organizational capacity-building that they will create sustainable change in their organizations to serve a higher percentage of uninsured patients effectively over time.

Building organizational capacity is indeed the other primary use to which clinics are putting their BSCF core operating support grant. This baseline assessment reveals where grantees fall on a continuum of organizational effectiveness as measured by indicators of capacity. With respect to strategic planning, while almost all clinics report having a plan, not all have undergone the process with the same degree of rigor and leadership. Areas in which there are particular opportunities for clinics to build their capacity are technology and data management, advocacy and policy-related activities, and office equipment.

BSCF's investment in core operating support is predicated on the belief that organizations need flexible resources that allow them to self-determine priorities for maintaining or enhancing their functioning. While undoubtedly some of the uses of this support will have one-time limited benefit, it also appears that many organizations, if not all, will use some of the investment to build sustainable capacity that will continue to reap benefits over time. Subsequent phases of the Clinic Core Support Initiative evaluation will measure these changes to capture the value of BSCF's investment for internal, statewide, and field-level audiences.



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