Identifying Workforce and Financial Characteristics of High-Performing Health Centers

Prepared by

Capital Link

STAR²CENTER
SOLUTIONS TRAINING AND ASSISTANCE FOR RECRUITMENT & RETENTION

Introduction

Health centers continue to aim for operational, financial, and service excellence to improve quality of care and employee satisfaction. Benchmarking operational and workforce metrics to national medians, industry guidelines, and high-performing health centers provides insight on opportunities for performance improvement.

This report, prepared by the Association of Clinicians for the Underserved and Capital Link, with support from the Health Resources and Services Administration (HRSA), was developed to provide guidelines for comparison as well as operational and workforce characteristics of the nation's highest performing Federally Qualified Health Centers (FQHCs). Using 2016 data collected from the databases of both organizations, this report provides community health centers with information and best practices for improving health center operations and, in turn, patient care.

Research Questions and Goals

With such a high quantity and variety of data, ACU and Capital Link designed a focused group of research questions with the objective of identifying the workforce characteristics of the High Performer group, and noting potential areas of replication and consideration for other health centers. The three areas of focus were:

1. Who are the High Performers?

Capital Link initially sought to define characteristics of high-performing health centers in *Hallmarks of High Performance: Exploring the Relationship between Clinical, Financial, and Operational Excellence at America's Health Centers*, a study supported by the Health Resources and Services Administration (HRSA) and released in 2015. The study examined the operating models, strategies, and practices of high-performing health centers to better understand the factors that work for and against the co-occurrence of strong clinical performance and financial sustainability.

Capital Link analyzed whether health centers that were recognized with 2014 HRSA clinical quality awards ("Quality Awardees") fared better or worse financially than other health centers (the control group). The study then focused on the highest quartile of the Quality Awardees, a "High Performers" subset of health centers that achieved both excellent clinical and financial performance. Examining the operating models of the High Performers offered insight and their results provide benchmarks toward which other health centers might strive to improve their performance.

The *Hallmarks of High Performance* study defined High Performers as health centers that fared better than others in key financial measures such as operating margin, days cash on hand, and current ratio. These High Performers achieved strong results by maximizing revenues through higher provider productivity, higher patient utilization and better collections, particularly of Medicaid revenue. They also had greater profitability through expense control, particularly personnel costs.

To validate the question of "Who are the High Performers?", the current study updated the prior analysis using 2016 data from Capital Link's database of audited financial statements and UDS information. In this report, High Performers are defined as health centers that:

1. Were recognized by HRSA with clinical quality awards in 2016, and
2. Ranked in the top 25% of FQHCs nationally in 2016 on several financial measures including operating margin and days cash on hand.

2. What are the Workforce Characteristics of High Performers?

The analysis then examined the workforce characteristics of these health centers using data from ACU's Solutions, Training, and Assistance for Recruitment and Retention (STAR²) Center. The STAR² Center data set includes a number of high-level metrics that analyze a health center's workforce strengths as a whole, including information on clinical quality, use of the National Health Service Corps, and more. Some of these data points were suited particularly well to this review, and were selected for inclusion in this report. These characteristics included tenure, full-time versus part-time staffing, and various aspects of team composition. Team composition examined both providers and support staff.

3. What are the Differences in Workforce Characteristics Between High Performers and Other Health Centers?

After identifying high-performing health centers based on quality, financial, and operational metrics, the analysis dug deeper into the workforce performance of these health centers. Workforce performance was not an identifying characteristic of High Performers since there is not one ideal mix of staff, set of productivity expectations, or ratio of support staff. Instead, the report examined the workforce characteristics of the High Performer group to note potential areas of replication and consideration for other health centers.

While there were limitations to this approach, this report serves as a starting point for identifying pathways for health center development. The aim was to validate the general understanding of successful workforce models in practice, and also to identify surprises that ran contrary to popular wisdom and previous research. There will not ever be one "right" way to staff all health centers for financial and operational success, but identifying the similarities of those that are thriving will help build understanding of success factors among the variety of models.

Another goal of this report was to identify future areas of research to better understand effective workforce models within the context of quality, financial, and operational success.

Description of Analysis Methods and Limitations

Capital Link's proprietary database includes 85% of 2016 financial audits and 100% of UDS data for over 1,300 national FQHCs. 139 of those health centers met or exceeded the above-defined criteria of High Performers based on quality, financial, and operational considerations. High Performers included health centers from 35 states and a mix of locations (rural and urban), representing the profile of health centers nationally.

Approximately 100 financial, staffing, and operational metrics were calculated and compared for the High Performers, Non-High Performers, and all national health centers. Key areas of differentiation were identified for further review based on Capital Link's productivity measures and specific workforce criteria defined by ACU.

ACU's STAR² Center contains a Data Profile tool for health centers to evaluate their data through a recruitment and retention lens. The profiles draw on a number of data sets and are designed to paint a picture of the workforce environment within each health center, and within the community that it serves. Data describing the organizations' internal profile are drawn from HRSA data such as UDS, as well as descriptive characteristics and utilization of other programs such as the National Health Service Corps. Service area data is based on community characteristics matched, as closely as possible, to the zip codes from which the health centers draw the most patients, up to 75% of their total patient population.

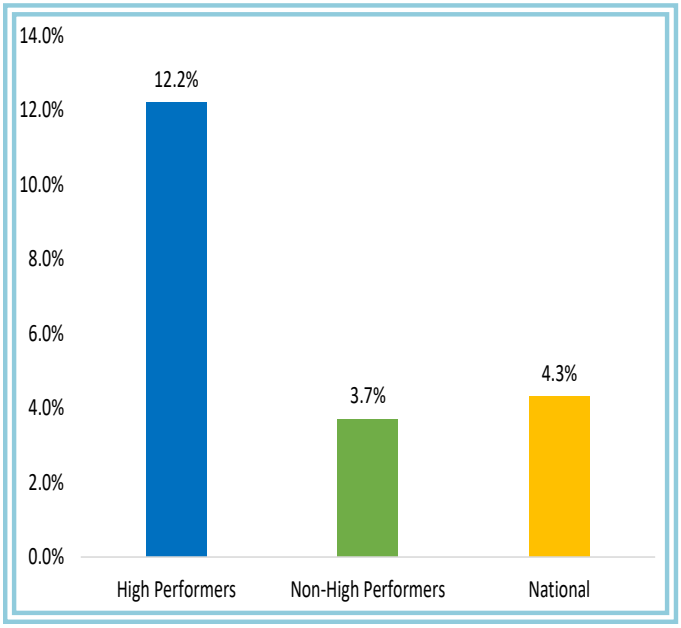
It is important to note that the STAR² Center does not attempt to identify top performers or create an 'ideal' profile, but rather to help focus efforts on areas most likely to improve the organization's situation. It is often the inter-relationship between factors that best highlights the issue or opportunity.

The analysis focused on the magnitude and direction of differences in the Capital Link operational measures and ACU workforce metrics between those that were flagged as high-performing health centers and non-high performing health centers.

Overview of Financial and Operational Characteristics

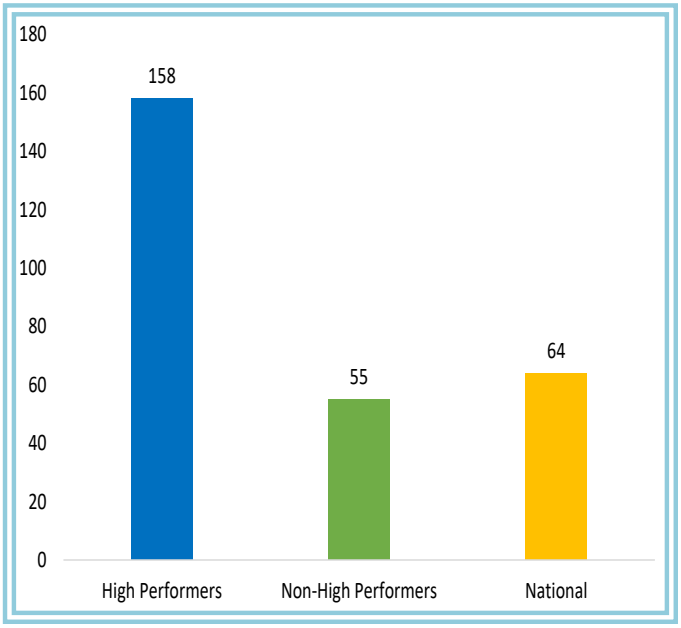
Since High Performers were defined by their top quartile ranking on key financial measures, there were few surprises about the characteristics of a strong health center. Their operating margins, liquidity (as measured by days cash on hand), and collections performance (as measured by days in receivables) were significantly better than their peers. High Performers also spent a significantly lower percentage of their revenues on employment-related expenses, and had more productive provider staff in terms of both visits and patients. One unexpected finding was that while High Performers in general had larger operating budgets than Non-High Performers, their staffing mix, including administrative and facility FTEs as a percentage of Total FTEs, was in line with Non-High Performers.

Operating Margin



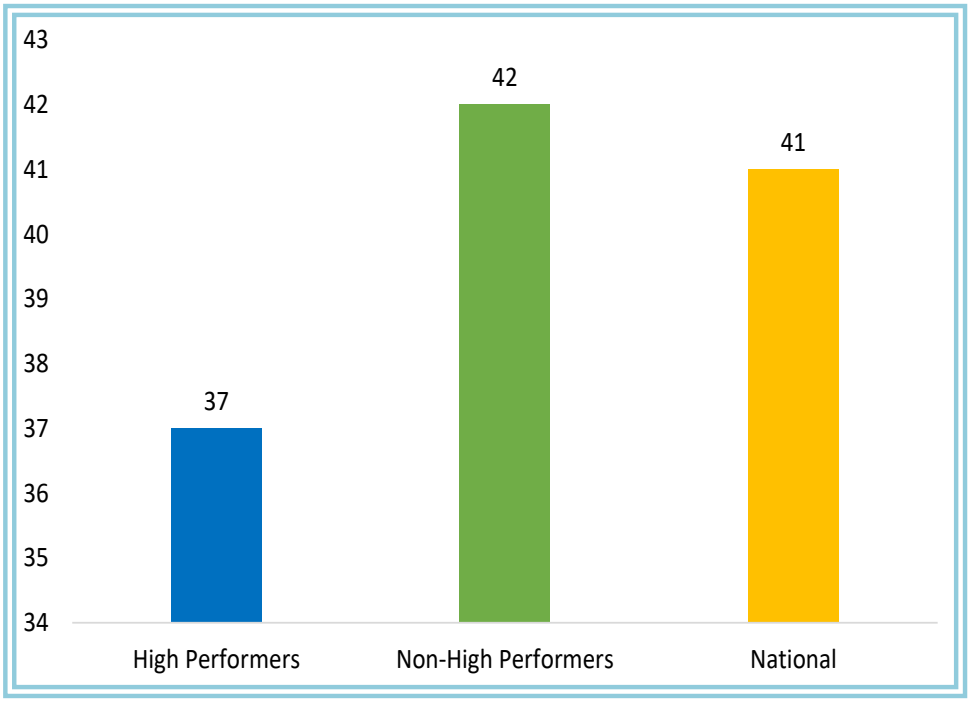
Operating Margin	High Performers (medians)	Non-High Performers (medians)	National (medians)
	12.2%	3.7%	4.3%

Days Cash on Hand



Days Cash on Hand	High Performers (medians)	Non-High Performers (medians)	National (medians)
	158	55	64

Collections: Days in Net Patient Receivables



Days in Net Patient Receivables	High Performers (medians)	Non-High Performers (medians)	National (medians)
	37	42	41

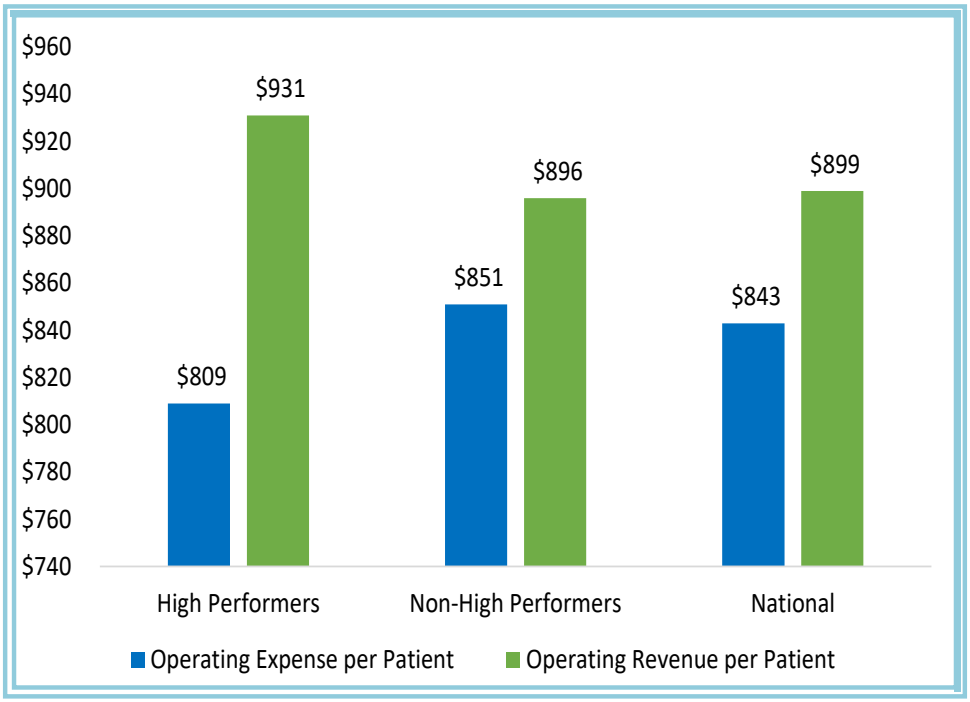
Revenue

High Performers earned a larger percentage of their revenue from net patient service revenue rather than from grants and contracts.

Revenue Mix	High Performers (medians)	Non-High Performers (medians)	National (medians)
NPSR as a % of Total Operating Revenue	62%	58%	58%
Grant Revenues as a % of Total Operating Revenue	27%	36%	35%

With approximately 62% of revenue generated by net patient service revenues as a percent of total revenues, four points higher than their peers, they have maximized patient revenues and are less dependent on grants.

This difference is also reflected in the higher operating revenue and lower operating expense per patient found in the High Performer group, measuring $931 and $809, respectively. The Non-High Performers generated revenue per patient of $896 with a cost per patient of $851.



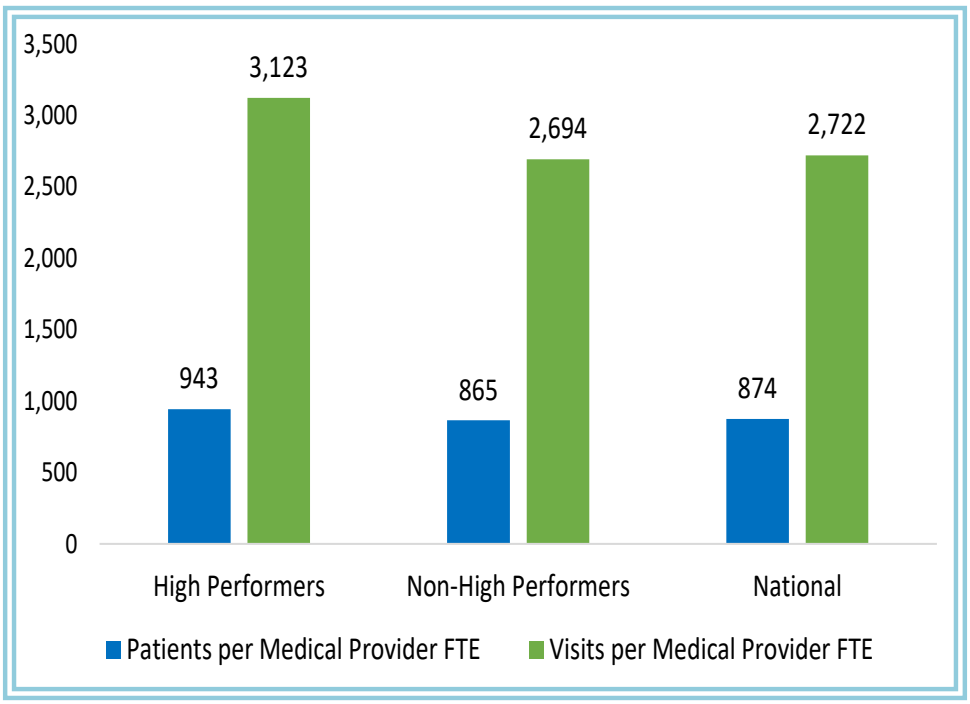
	High Performers (medians)	Non-High Performers (medians)	National (medians)
Operating Expense per Patient	$809	$851	$843
Operating Revenue per Patient	$931	$896	$899

Productivity

High Performers had larger patient panels per medical provider full-time equivalent employee (FTE) as well as more visits per provider FTE.

	High Performers (medians)	Non-High Performers (medians)	National (medians)
# of Patients per Medical Provider FTE	943	865	874
# of Visits per Medical Provider FTE	3,123	2,694	2,722

For High Performers, the number of patients per medical provider FTE was 943, compared to 865 for Non-High Performers and the number of visits per medical provider FTE was 3,123 compared to 2,694 for Non-High Performer health centers. The High Performers also exceeded national medians by a significant amount.

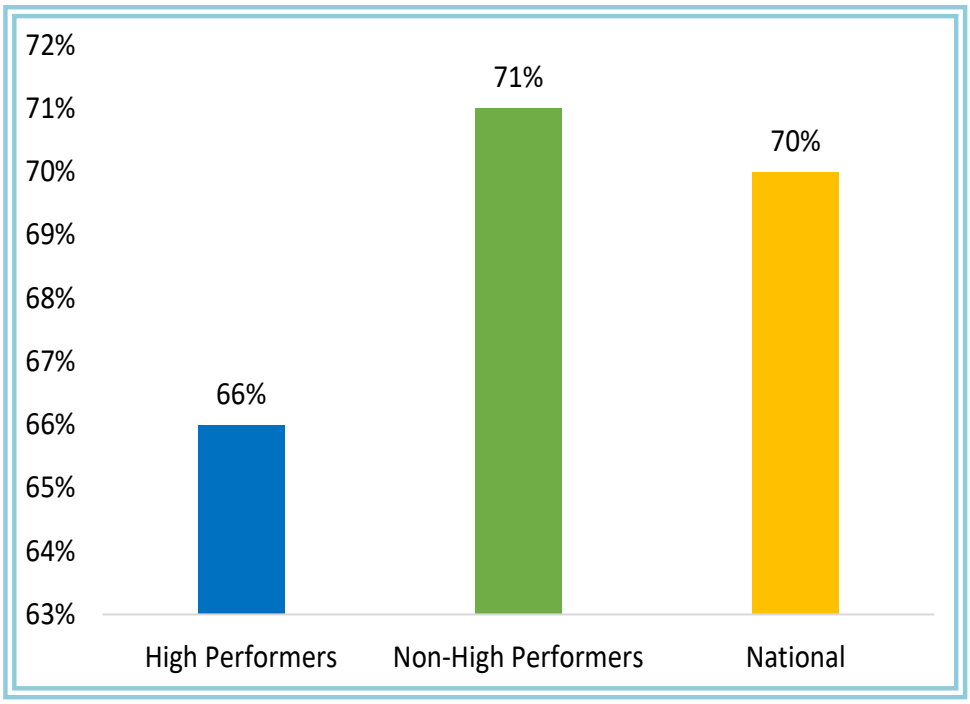


Personnel Expenses

Amidst various field concerns about compensation as a major factor in recruitment and retention, it is important to note that the High Performer group had a considerably lower rate of personnel-related expenses as a percent of operating revenue.

	High Performers (medians)	Non-High Performers (medians)	National (medians)
Personnel-Related Expense as a Percent of Operating Revenue	66%	71%	70%

While the Non-High Performers median of 71% was nearly in line with the Capital Link benchmark of 70%, the High Performer median of 66% was well below the recommended benchmark maximum. The better High Performer median metric is likely due to much higher revenues per patient combined with strong personnel cost management at high-performing health centers.



Compensation can be difficult to analyze at a national level, given the high degree of variation in different geographic areas and markets. One way to examine it is by comparing overall staff compensation at the health center to compensation at a non-health center of equal staffing. Medical Group Management Association compiles this data on hospitals, private practices, and other types of care settings.

	High Performers (medians)	Non-High Performers (medians)	National (medians)
Ratio of Average Pay per Medical Provider FTE Compared to Equal MGMA Staff Mix	.91	.90	.90

Review of the High Performers revealed that they paid medical provider FTEs salaries that were in line with Non-High Performers and national benchmarks. These initial findings offer a note of caution to health centers about focusing on the role of provider salaries on recruitment and retention to the detriment of other workforce concerns. The answer to recruitment and retention challenges is not always "pay the most in the area," and requires a holistic view of culture and processes. Some health centers have successfully made competitive salaries a part of their operations without sacrificing overall financial health, and could be good models for other operational structures that would allow health centers to remain competitive against other types of organizations with generally higher salaries.

Service Mix

It appears that the differences in relative personnel costs as a percent of revenues were not related to differing service models. High Performers had a surprisingly similar service mix compared to Non-High Performers and national centers overall.

	High Performers (medians)	Non-High Performers (medians)	National (medians)
Medical Patients as a Percent of Total Patients	89%	87%	87%
Dental Patients as a Percent of Total Patients	20%	20%	20%
Mental Health Patients as a Percent of Total Patients	5%	5%	5%
Other Patients as a Percent of Total Patients	2%	1%	1%

*Note: Totals over 100% due to patients duplication

Overview of Workforce Characteristics

High-performing health centers looked largely as they might have been expected to: higher ratio of support staff, longer clinician and leadership tenure, and higher compensation. There were some surprises, however, after teasing out the specific team composition, services provided, and tenure. In many cases, the High Performers results were slightly better than the benchmarks of other health centers; the right combinations seemed to make the key difference.

Overall Staffing Mix

The overall mix of staff types at a health center can offer insight into the types of services provided and potential team composition. This following table summarize the staff in each key area as a percentage of total FTEs at the health center. It demonstrates a similar overall staffing mix, in percentage terms, between High Performers, Non-High Performers, and national centers.

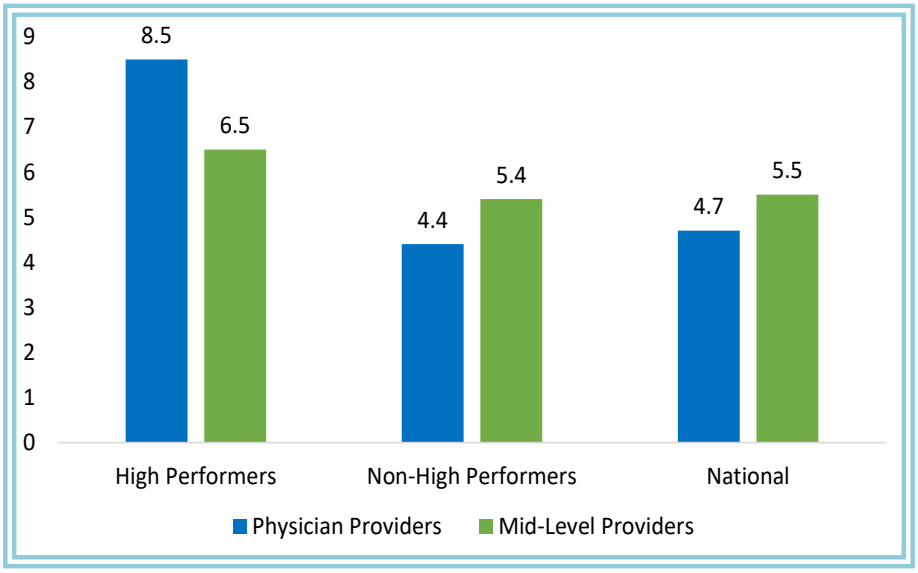
One surprising finding was the slightly lower percentage of enabling services staff for High Performers since Capital Link's prior study had indicated that those centers with a larger portion of enabling services often perform better. Further analysis and consideration should be given to the complex connection between types of services, cost per patient for each service, and required staffing mixes to accommodate both issues.

	High Performers (medians)	Non-High Performers (medians)	National (medians)
Medical FTEs	35%	34%	35%
Patient Support Staff FTEs	16%	16%	16%
Dental FTEs	7%	7%	8%
Enabling FTEs	8%	9%	9%
Mental Health FTEs	3%	3%	3%
Administrative FTEs	38%	37%	37%

*Note: Totals over 100% since figures are medians

Provider Mix

The specific provider mix was further analyzed, as summarized in the following chart and table:



	High Performers (medians)	Non-High Performers (medians)	National (medians)
# of Physician Providers	8.5	4.4	4.7
# of Mid-Level Providers	6.5	5.4	5.5
# of Total Providers	15	9.8	10.2
% of Physician Providers	57%	45%	46%
% of Mid-Level Providers	43%	55%	54%
% Total Providers	100%	100%	100%

With a median of approximately nine physician and seven non-physician providers, High Performers had a higher mix of physicians (57%) than non-physician providers (43%), while the Non-High Performer group had slightly more non-physician providers (55%) than physicians (45%). This finding was a little out of sync with a common trend in the marketplace to look toward non-physician providers of various types because they are seen as more "cost-effective" given the disparity in their salaries. Further research should be done to understand other factors contributing to these differences on a state and individual health center level and determine if specific staffing models may be more effective in certain communities.

It is interesting to note that on a national level, the provider mix was more skewed toward non-physician providers, similar to the Non-High Performers.

Support Staff

High Performers had slightly higher ratios of primary care support, which tracks the ratio of nurses and other medical personnel to medical provider FTE, at 2.1 compared to 1.9 for the Non-High Performers and for national health centers overall.

	High Performers (medians)	Non-High Performers (medians)	National (medians)
Nurses and Other Medical FTE per Medical Provider FTE	2.1	1.9	1.9

This finding supports other research in the field about effective team models, and could have a great effect on other recruitment and retention considerations not currently quantitatively measured, like provider burnout. The greater implications of this type of metric deserves an in-depth analysis with individual health centers to explore the intangible benefits and challenges of higher support ratios, along with the financial implications. This initial glance seems to indicate that higher support ratios may not have a strong negative impact on a health center's financial performance.

Full-Time Staff

The trend in the marketplace is to staff with an increasing percentage of part-time providers as a method to retain clinicians. This analysis revealed that the High Performers had more full-time staff than Non-High Performers for both physicians and non-physician providers. The differences were not large, but this finding points to a need for further exploration of the financial and operational benefits of relying on a full-time staff of providers. This issue may not have a clear "right" or "wrong" answer, but should be better understood to help health centers make better choices based on more tangible benefits and costs.

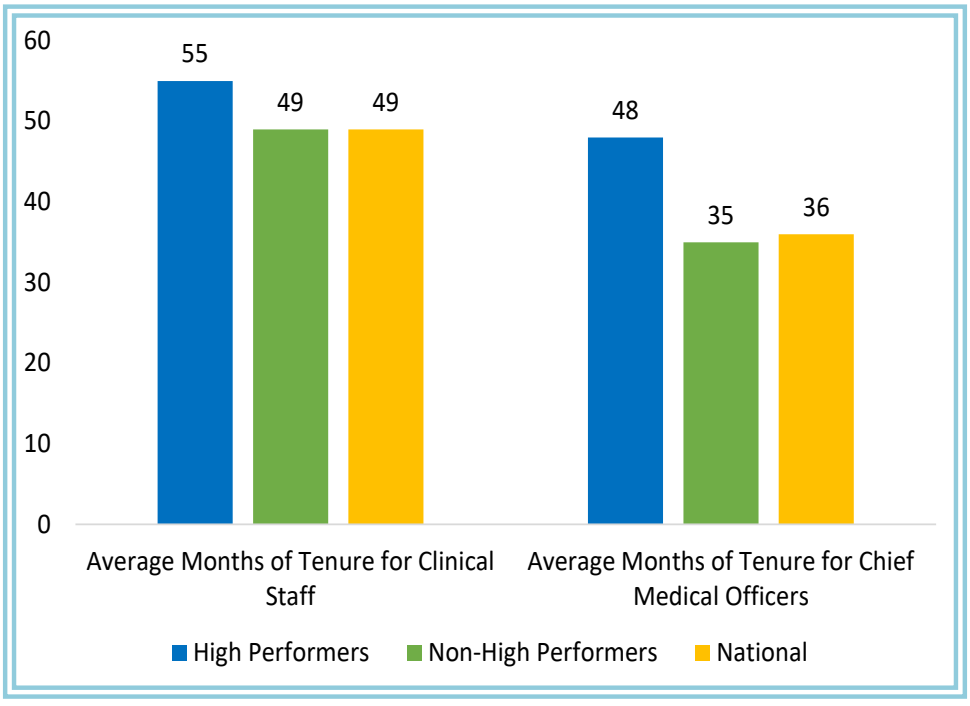
STAR² Center data analyzes the ratio of the number of people employed in a discipline compared to the number of FTEs for that discipline at each health center. The higher the number, the more part-time staff are being utilized to fill those roles. A "1" indicates that all staff are full-time.

	High Performers (medians)	Non-High Performers (medians)	National (medians)
Primary Care Physicians	1.32	1.46	1.44
Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives	1.22	1.27	1.27
Dentists	1.20	1.30	1.30
Psychiatrists, Psychologists	1.33	1.30	1.30
Licensed Clinical Social Workers	1.14	1.14	1.14

High Performers employed fewer part-time staff in the physician category than their peers. As a whole, the group employed slightly more full-time staff as nurse practitioners, physician assistants, certified nurse midwives, and dentists. They employed full-time licensed clinical social workers at the same rates as others.

Clinician and CMO Tenure

Reviewing the length of employment trends for clinicians and chief medical officers (CMOs) at health centers yielded some interesting results as noted in the following chart and table:



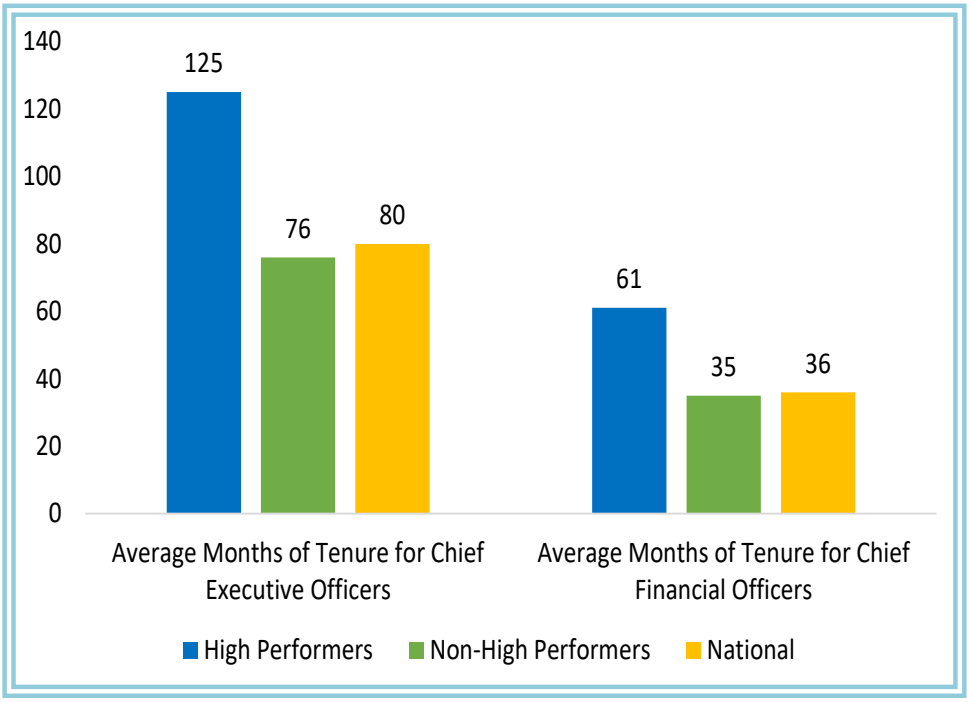
	High Performers (medians)	Non-High Performers (medians)	National (medians)
Average Months of Tenure for Clinical Staff	55	49	49
Average Months of Tenure for Chief Medical Officers	48	35	36

Providers at high-performing health centers had an average tenure of 55 months, 12% higher than the 49 months for Non-High Performers and national health centers. However, the tenure of CMOs at High Performers was 37% higher than its peers at about four years compared to three years for the others.

While not an extensive analysis, this finding indicates that successful health centers potentially benefit from lower turnover and the associated costs of recruiting new staff. This metric could also point to meaningful operational differences that entice providers to stay. The data point itself is a bit complex as it examines an average of months that providers stay in their exact position, and can be skewed if they change positions within the organization or if a few providers have unusually long tenure. These slight complications highlight the need to better understand points of interest and how the various workforce characteristics of an organization help contribute to longer provider tenure.

Senior Leadership Tenure

Through UDS, health centers also report on average months of tenure for their chief executive officers (CEOs) and chief financial officers (CFOs). Similar to the results for clinical staff, the highest performers have senior leadership with longer tenure than their peers.



	High Performers (medians)	Non-High Performers (medians)	National (medians)
Average Months of Tenure for Chief Executive Officers	125	76	80
Average Months of Tenure for Chief Financial Officers	61	35	36

High Performer's average tenure for CEOs was over 10 years, about 60% higher than for Non-High performers and national health centers. Average tenure for CFOs was five years for High Performers compared to about three years for its peers.

On the whole, High Performers had much higher tenure for CEOs, CMOs, and CFOs. This kind of leadership tenure can lead to a more stable organization with a C-Suite who have demonstrated excellence in their positions. A lot is left to be understood about the specific influences of leadership on a strong organization, but there can be no doubt that effective leaders help develop an effective organization. If tenure for these positions can eventually be tied to that excellence, then health centers will have more models for strong performance.

Conclusion

This baseline study of the crosswalk between financially and operationally high-performing health centers and workforce measures identified some interesting characteristics of strong workforce within a health center. A deeper study of a smaller focus group of health centers, either through data analysis or training opportunities, may shed light on the factors that create a stable workforce that impacts the financial and operational strength of health centers. There remain questions about at how workforce issues directly influence financial and operational health within a health center.

While there is not a one-size-fits-all replicable model health centers can implement to achieve high performance across workforce, operational, and financial functions, health centers can implement benchmarking practices to track trends and identify areas of improvement.

The research indicates that many health centers likely do not need major changes to individual factors like compensation. Small improvements to a number of variables that work together to create a more attractive organization can ultimately be the key to success. This could include staffing mix, reimbursement, compensation, strong financial systems, longevity of clinicial and management tenure, and many more that exist on a local, state, or national level. Health centers should understand the unique combination of dynamics at play on an individual organizational level, develop processes to track performance, and identify right-size solutions based on their specific needs. Finding the right balance of solutions requires work, but many health centers are leading the way in that effort.

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About Us

Capital Link

Capital Link is a national, non-profit organization that has worked with hundreds of health centers and Primary Care Associations for over twenty years to plan for sustainability and growth, access capital, improve and optimize operations and financial management, and articulate value. Established through the health center movement, Capital Link is dedicated to strengthening health centers—financially and operationally—in a rapidly changing marketplace. Capital Link provides an extensive range of services to health centers and PCAs, customized according to need, including: Growth Planning, Capital Planning and Financing Assistance Services; Metrics and Analytical Services; and Performance Improvement Services. For more information, visit www.caplink.org.

The Association of Clinicians for the Underserved

The STAR² Center is a project of the Association of Clinicians for the Underserved (ACU). ACU is a transdisciplinary membership organization working on behalf of the National Health Services Corps (NHSC) and clinicians who provide care to the underserved. In July 2014, ACU received a national cooperative agreement to develop a clinician workforce center for recruitment and retention at community health centers. In partnership with the federal Bureau of Primary Health Care, ACU created the STAR² Center (pronounced Star Center) to provide free resources, training, and technical assistance to the health centers facing high workforce need. For more information, visit http://www.chcworkforce.org/about-us.