2016 Annual Report

After-Hours Clinic

Carolyn Downs Family Medical Center

Country Doctor Community Clinic
Our Mission

To improve the health of our community by providing high quality, caring, culturally appropriate primary health care that addresses the needs of people regardless of their ability to pay.

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Dear friends,

As we work collectively to ensure the continuation of our mission in 2017, our primary focus continues to be securing funding and planning for construction of our new Dental Clinic on 19th Avenue.

Having achieved 85% of the private funding goal, we are now working to secure state funding, and pushing forward with construction over the next twelve months. The lack of affordable dental services continues to impact our patients’ well-being and long term oral health. We believe that providing health services for the whole patient, including their teeth and gums, is critical to comprehensive health care. This project will not only bring dental care to the patients of CDCHC, but also provide an improved environment for the patients seen by our WIC, HIV case management, maternity support, and diabetes education programs.

We are also working to continue to increasing access to patient care at our primary clinic sites as well as the After Hours Clinic which has seen an increase in the number of patients served in the last year. As we look to serve more patients, and offer more programs through the After Hours and Dental Clinics, our core principles and mission keep the organization grounded in maintaining a culture that is unique to CDCHC and key to providing culturally appropriate, affordable health care.

As a patient and the parent of a patient, I am grateful for the services provided through Country Doctor Community Clinic, Carolyn Downs Family Medical Center, and the After-Hours Clinic. Understanding the threats posed to our health care safety net is critical to our ability to shore up support for our State and Federal funding streams. This is a crucial time for our health centers and each of us has a role to play in helping to ensure that the value of these clinics to our communities is well understood by those who represent us.

Your support, past and future, has been an essential part of helping to maintain Country Doctor Community Health Centers. Along with my fellow board members, please accept our gratitude for your continued generosity.

Sincerely,

Morgan M. Dutton, Chairperson
Country Doctor Community Health Centers
Board of Directors
You Define Our Success – Thank You CDCHC Staff
During 2016 CDCHC focused its efforts on:

1. Increasing access to patient care
2. Maintaining the organization’s culture;
3. Demonstrating that the organization provides high quality care, and
4. Developing an effective infrastructure.
Increasing access to patient care

Successes

Patient Volumes

When all three sites are considered access to primary medical care grew only 2.45% - but grew by 20% at the After Hours Clinic. Attending visits provided at Swedish remained exactly the same between 2016 and 2015, while the number of behavioral health visits declined by 11%. The number of patients grew again – from 19911 in 2015, to 20166 in 2016, a 1.28% increase (compared to a .75% increase between 2014 and 2015), all attributable to the After Hours Clinic. The number of patients seen at the CDFMC site decreased by 5% (311 patients) – actually remarkable given the road construction that went on for much of the year. At CDCHC there was a 1% drop.

The number of times a patient was seen remained constant at 2.5 visits per year. This continues the trend of seeing fewer one-time-only patients – one of the goals of a Patient Centered Medical Home and one of the expectations of adding the After-Hours Clinic.

Implement expansion plan for Betty Lee, including capital campaign, to include dental clinic

“The Betty Lee project is clearly a multi-year project that will require significant attention in both 2016 and 2017. The challenge of successfully completing a capital campaign, securing a Master Use Permit, securing City funding and laying the groundwork for 2017 State funding will require intense staff focus during the year.” This was the challenge included in the 2015 Annual Report – and it has proven to be truer than anticipated when it was written. 2016 work ranged from biweekly meetings with the architect/contractor, to meetings with State legislators regarding the $2m needed from them, recruitment of kitchen cabinet members, and initiation of the capital campaign (including submittal of multiple grant applications to private foundations). By the end of the year we had achieved great success, achieving 85% of the capital campaign goal (when State funds are excluded). Multiple challenges remain – and are described below – but when completed the new facility will allow us to see more patients.

Challenges

Betty Lee:

Three significant challenges remain: securing the State’s contribution ($2m) to the project, containing construction costs within budget, and securing a building permit. While there are other challenges – such as securing the loan needed to construct the housing – failure to overcome any one of these challenges puts the entire project in jeopardy.
Maintaining the organization’s culture

Successes

Develop solution(s) to provider burnout

Maintaining providers who are committed to CDCHC, our patient population, and our communities is critical to preservation of the organization’s culture. To retain provider staff it was necessary to determine why a provider might decide to seek employment elsewhere. The Provider Retention Work Group (Clinical Site Directors, Clinic Managers and the Deputy Director) was established to look at the causes of provider dissatisfaction. A survey to both current and former providers was distributed asking: What is the one thing CDCHC could do to increase the quality of your life? What is the most important thing CDCHC could do to keep you working with us? What are the top 2-3 elements that are satisfying in your current work? What suggestions do you have for us as a community clinic to retain providers? 90% of providers surveyed responded, stating that they feel overwhelmed with the workload and the associated charting burden. Many providers remarked that charting is often done after hours at home and on the weekends.

The work group concluded that increasing each appointment slot by 5 minutes to allow more time to address the patient’s needs and to complete charting during the visit should be tried. A 20 minute appointment schedule was piloted for 30 days - the core measurement tracked was provider productivity. After the first month the providers in the pilot reported feeling less rushed and running on time; productivity was a little better or unchanged.

The conclusion was that 20 minute visits improve provider retention while:

» Maintaining continuity of care and reducing costs associated with hiring new providers;
» Improving patient satisfaction due to on-time appointments and more time with the provider during the appointment;
» Improving same day access by creating time/space for RN conversion visits from triage/walk in schedule;
» Creating time for care team to address PCMH and value-based payment care gaps/quality goals;
» Creating time for providers to improve complexity/comprehensiveness of coding.
Demonstrating that the organization provides high quality care

**Successes**

Develop a QI system that will allow CDCHC to successfully participate in quality programs

With the movement of payors (both public and private) to pay-for-performance and incentive payment systems CDCHC took the time to explore its quality improvement system and make the changes needed to be successful under these payment reform systems. A new structure was rolled out to Leadership Team in mid-June that - with no increase in costs- will provide the infrastructure needed to maintain an effective quality improvement program. With the merger with OCHIN CDCHC now has the opportunity to adopt their reporting platform (Acuere), giving us the tools needed to successfully participate in new payment systems, while providing better patient care.

Develop/implement action plans to achieve each of the following clinical goals

A significant change in 2016 was limiting the number of clinical goals to just three. Only one of the three was achieved:

- Increase to 45% the number of patients aged 50 to 75 who had appropriate screening for colorectal cancer. By the end of 2016 46% of patients in this age range had been screened for colorectal cancer.

**Challenges**

Develop a QI system that will allow CDCHC to successfully participate in quality programs

Further work is needed on QI systems, including implementation of the Acuere system, better delineation of QI staff responsibilities, and a renewed focus on quality improvement fundamentals (such as Plan-Do-Study-Act cycles).

Achieve clinical goals

Two of the three clinical goals were not met:

- Increase to 60% of children who turn two during the year and have received all required vaccines. Only 43% of the children who turned two have been fully immunized. Currently a PDSA quality improvement cycle is in place to improve this measure. The data integrity issues which prevented effective outreach to patients needing immunizations have been resolved. This metric will remain a focus for 2017.

- Maintain at 80% those diabetic patients whose HbA1c levels are less than or equal to 9 percent. 76% of diabetic patients had HbA1c levels under 9 at the end of 2016, a drop from 81.5% at the end of the third quarter. While staff is working to determine the cause of this decline, this will remain a metric for 2017.
Developing an effective infrastructure

Successes

Maximize use of limited resources devoted to management functions. Significant change was made to the management structure of CDCHC in 2015. An evaluation of those changes found that they have been well received by staff and that the people filling new positions are doing a good job. The Human Resources staff designed and implemented supervisor trainings to support the many staff members who were promoted to supervisory positions with no previous supervisory experience.

An evaluation of the Clinical Work Group structure was conducted, including cost and satisfaction with the current structure. As a result of this evaluation the Clinical Work Group’s meeting time was reduced to once a month rather than twice a month.

Maximize use of limited resources devoted to IT functions. CDCHC used the services of our long-time IT consultant to conduct an assessment of current IT staffing and support. The results of the assessment were received by the end of the year and are currently under review. Once that review is complete, recommendations for changes will be shared with the Leadership Team and the Board.

Challenges

Analyze LT structure in terms of efficiency, cost; propose changes as needed; improve functioning of teams through teambuilding efforts. Analysis of the Leadership Team structure was not completed in 2016, but is included on the 2017 Leadership Team Work Plan. This will be accomplished by the end of the third quarter.
Significant Changes

Program

2016 saw an increase in primary care visits as a result of the After Hours Clinic which grew by 20%. The number of visits dropped slightly (1%) at the CDFMC site and remained virtually unchanged (an increase of 6 visits) at the CDCC site. While the medical program grew by 2%, the other health program declined by 24%, an overall decrease of 4% to 67,877 visits. The number of hospital visits was exactly the same in 2015 and 2016; behavioral health visits declined by 11%, the result of staff absence and turnover.

The 24% decrease in the Other Health program was due to the decrease in Eligibility Assistance visits from 8,198 in 2015 to 4,603 in 2016, a result of far fewer ACA-related screening visits provided. The number of health maintenance visits grew, primarily the result of a 24% increase in shelter visits. Maternity support services visits increased by 29%, and nutrition counseling by 51%. The WIC program decreased by 13%, and wellness classes by 48% - the result of the retirement of the Tai Chi class teacher.

Demographics

After significant change in 2014 and 2015, in 2016 the change in insurance coverage was minimal – a slight (2%) drop in the number of uninsured to 18%, the same percentage drop in Medicaid, and an increase in private insurance coverage of 4% (to 23%). At the After Hours Clinic the payor mix shifted from Medicaid (a drop of 5%) and self-pay (a drop of 2%) to private insurance (an increase of 7%) perhaps the result of greater numbers of referrals from the Swedish system.

The only demographic shifts greater than 5% occurred at the After Hours Clinic, in ethnicity - a decrease of 9% in the number of Caucasian patients seen and a corresponding increase in the number of Hispanic patients seen - and in income - a 5% increase in the number of patients earning more than 200% of Federal Poverty. The changes at the CDFMC and CDCC sites were minimal (a 3% decrease at both sites in the number of patients earning less than 100% of Federal Poverty, and an overall increase of 4% in the number earning more than 200%). 22% of the patients seen at the CDFMC site are homeless (this does not include patients seen in the shelters); 18% of the patients seen at the CDCC site are homeless; 10% of the patient seen at the After Hours Clinic are homeless.

The number of patients who speak a language other than English remained constant at 20%, representing 37 different languages. By site this varies from 32% at the CDFMC site, 16% at the CDCC site, and 9% at the After Hours Clinic. The top five languages spoken other than English are Spanish, Amharic, Tigrinya, Somali and Vietnamese.
Program Visit Statistics

**Total Program Visits:** 67,877

<table>
<thead>
<tr>
<th>Medical Visits:</th>
<th>54,326*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carolyn Downs Site</td>
<td>18,904</td>
</tr>
<tr>
<td>Country Doctor Site</td>
<td>24,396</td>
</tr>
<tr>
<td>AHC</td>
<td>7,872</td>
</tr>
<tr>
<td>Hospital Services</td>
<td>1,035</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>2,119</td>
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* Included in these visits are 4,927 Health Care for the Homeless primary care visits at the CDCC site, 4,685 at the CDFMC site, and 919 at the AHC.

<table>
<thead>
<tr>
<th>Other Health Visits:</th>
<th>13,551</th>
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<tbody>
<tr>
<td>Eligibility Screening/Assistance</td>
<td>4,603</td>
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<tr>
<td>Health Maintenance†</td>
<td>2,598</td>
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<tr>
<td>HIV Support Services</td>
<td>2,030</td>
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<tr>
<td>Maternity Support Services</td>
<td>477</td>
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<tr>
<td>Maternal/Child Depression</td>
<td>508</td>
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<tr>
<td>Nutrition Counseling</td>
<td>241</td>
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<tr>
<td>WIC</td>
<td>2,647</td>
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<tr>
<td>Tai Chi/Wellness Classes</td>
<td>261</td>
</tr>
<tr>
<td>Retinal Eye Screening</td>
<td>186</td>
</tr>
</tbody>
</table>

† Included in these visits are 2,101 Health Care for the Homeless health maintenance visits provided at the shelters.

2016 Revenue Sources

- Patient 69%
- Federal 16%
- City 8%
- County 1%
- Private 3%
- Other 2%

2016 Expenses

- Admin 11%
- Program 89%
Patients by ethnicity

- 43% Caucasian
- 20% Black
- 24% Hispanic
- 7% Asian
- 6% Other

Patients by income level

- Over 200%: 31%
- 200%: 9%
- 150%: 15%
- 100% and below: 45%

Federal Poverty Level
Carolyn Downs Family Medical Center

Patients by ethnicity

- 43% Hispanic
- 24% Black
- 20% Caucasian
- 5% Asian
- 4% Other

Patients by income level

- 100% and below: 62%
- 150%: 21%
- 200%: 8%
- Over 200%: 9%
Country Doctor Community Clinic

Patients by ethnicity

- 52% Caucasian
- 13% Black
- 23% Hispanic
- 7% Other
- 5% Asian

Patients by income level

- Over 200%: 21%
- 200%: 11%
- 150%: 21%
- 100% and below: 47%
- Under 100%: 11%
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COUNTRY DOCTOR
community health centers

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