

Integrated Clinical Services

Patients praise care, but changes must be made to reduce turnover and improve financial management

December 2019

Embargo until 12:01 a.m., Thursday, December 19, 2019

Notes:

1. This report does not yet include the audited division's response letter; the letter is due to the Auditor's Office by the end of the day on December 11. The final report will be provided to news media after we receive the response letter.
2. This report will be posted to the Auditor's website on December 19. Auditor Jennifer McGuirk and staff auditors Fran Davison and Nicole Dewees will present this report to the Board of County Commissioners at their December 19 Board meeting.
3. Jennifer, Fran, and Nicole are available to discuss this report with news media. Please call 503-988-3320 or email mandi.hood@multco.us to arrange meetings.



Multnomah County Auditor's Office
Jennifer McGuirk, Multnomah County Auditor

Table of Contents

Report Highlights.....	1
What We Found	1
Why We Did This Audit	1
What We Recommend.....	1
Introduction	2
Surveyed patients praised the health centers and the care they received	5
Turnover and uneven workload must be addressed.....	6
Demanding workload contributes to turnover.....	6
Increased demands on Mid County providers.....	7
Turnover increases the workload on remaining providers and impacts patients.....	12
Provider turnover is disruptive and costly	13
ICS needs to create a provider retention strategy	15
The Call Center is a bottleneck for non-English speakers.....	17
ICS must make changes to its financial structure and practices	18
ICS needs a financial director on its leadership team.....	18
ICS would benefit from having its own fund	18
Every revenue stream should be monitored.....	20
ICS needs to determine productivity goals that are aligned with its financial objectives.....	22
ICS needs stronger procedures of abnormal lab result communications	22
Recommendations.....	24
Objectives, Scope, & Methodology	25
Audit Staff	27
Response Letter	28

Report Highlights

What We Found

Multnomah County operates a Community Health Center program, also known as a Federally Qualified Health Center (FQHC), within Integrated Clinical Services (ICS), a division of the Health Department. The focus of our audit was on the primary care clinics within the Community Health Center. In our interviews with patients, they praised the care they received.

However, provider workload and turnover are uneven across the system, especially at the Mid County Health Center. Turnover should be addressed as it reduces patient access to providers, increases the workload on remaining providers, and is costly.

ICS needs a high-level financial decision-maker as part of the leadership team to help make operational decisions that impact the system financially.

Why We Did This Audit

This audit was included in the audit schedule by the previous Auditor. Auditor McGuirk continued the audit because ICS provides important services to our community. In particular, primary care clinics provide health services for people who experience barriers to accessing health care, including people who are experiencing poverty, uninsured, and/or homeless.

What We Recommend

ICS senior leadership should:

- Develop a provider retention plan and begin implementation.
- Partner with Health Department staff to analyze the impact of turnover, including costs.
- Address the differences in provider workload across the system.
- Change Call Center greeting so that announcements about what to press for different languages occurs in the most commonly used languages of their patient population.
- Hire a financial director with industry expertise to be part of the ICS leadership team.
- Work with Central Finance to create a special revenue fund.
- Evaluate provider productivity goals to ensure they are aligned with financial goals.
- Develop procedures to ensure that all patients are notified timely of any abnormal lab results.

Introduction

Multnomah County Integrated Clinical Services (ICS), a division of the Health Department, operates the Multnomah County Community Health Center, which provides health services for people who experience barriers to accessing health care, including people who are experiencing poverty, uninsured, and/or homeless.

The stated mission of Integrated Clinical Services is “Providing services that improve the health and wellness for individuals, families, and communities.” ICS describes their vision as:

Integrated, Compassionate, Whole Person Health. Their values are:

1. Quality and safety;
2. Person-centered and culturally relevant;
3. Engaged, expert, diverse workforce; and
4. Fiscally sound and accountable

Multnomah County operates a Federally Qualified Health Center

The county’s Community Health Center program is a Federally Qualified Health Center (FQHC), supported by the federal Health Resources and Services Administration (HRSA). The



North Portland Health Center Grand Re-Opening
Photo Credit: Cheyenne Thorpe

Health Center is accredited by The Joint Commission, an independent organization that accredits and certifies hospitals, community health centers, and many health care delivery organizations. Community Health Centers are community-based, patient-governed organizations that provide comprehensive primary care and preventative care, including health, oral health, and mental health/substance abuse services, regardless of ability to pay.

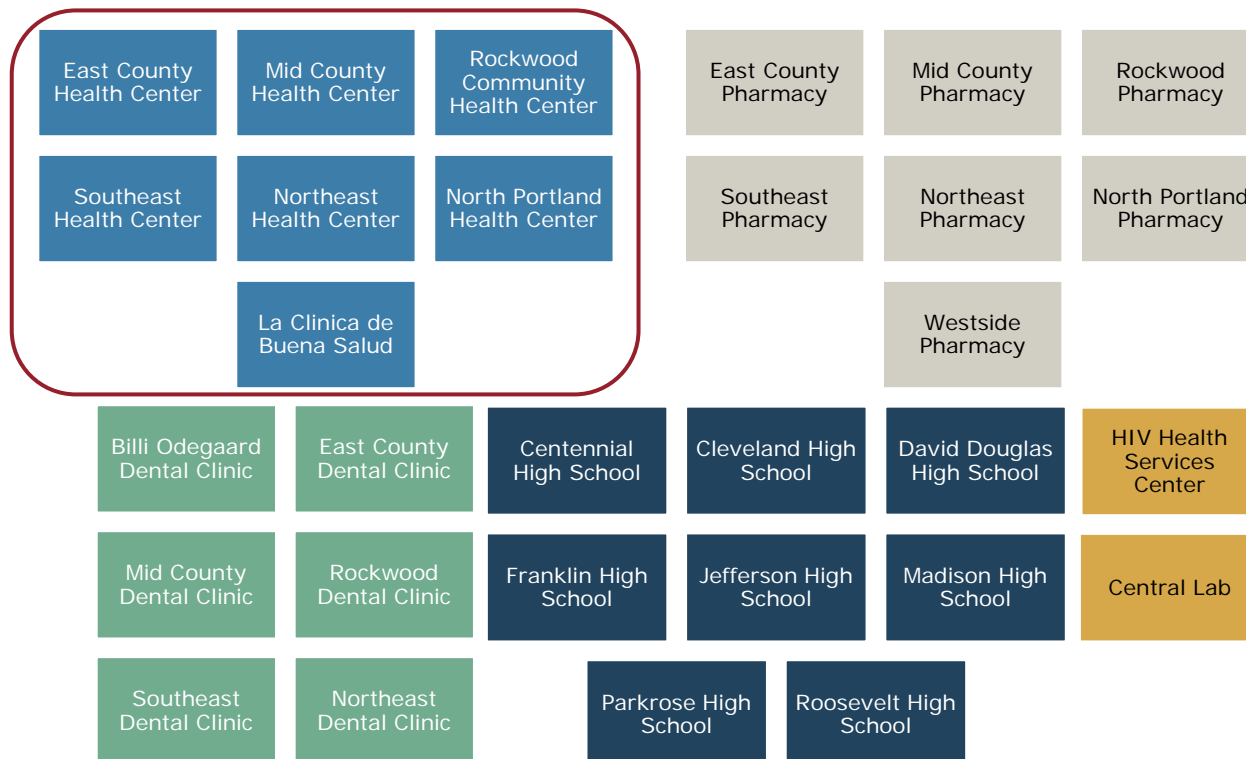
The Multnomah County Community Health Center provides clinical services in seven primary care clinics and eight student health centers (a ninth student health center, at Reynolds High School, is scheduled to open February 2020) and provides oral health and prevention services in six dental sites and at schools through the School Community Oral Health program. ICS also provides specialized care for HIV positive persons and operates support services for

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community health centers, such as pharmacies and a lab. In calendar year 2018, ICS provided medical, dental, pharmaceutical, and other services to more than 66,000 vulnerable residents in Multnomah County. Clients represent a racially and ethnically diverse community, with approximately 46% best served in a language other than English. County health centers serve clients speaking over 100 different languages.

Integrated Clinical Services (ICS) Locations

Focus of our audit: primary care clinics



ICS operates a very large system of clinics

The Multnomah County Community Health Center is the largest FQHC in the state and on the large side among public agencies; both in Oregon and nationally, many FQHCs are non-profit organizations, not operated by governments.

In FY 2018, ICS had the most employees of any division in the county and, aside from Facilities and Property Management, one of the largest budgets.

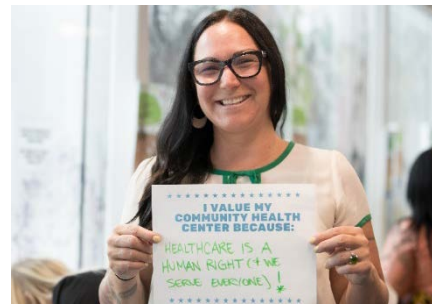
- The \$111.5 million adopted budget was funded almost entirely by Medicaid payments and grants, with an additional \$4 million provided by the General Fund.

As an FQHC, serving vulnerable populations in Multnomah County, ICS receives about \$9.5 million annually in a federal grant to help cover services for the uninsured and underinsured.

ICS may also be eligible for other health center related grant opportunities, if and when available.

The governance structure includes community members

The Multnomah County Community Health Center is governed, in part, by the Community Health Council, which is composed of community members, at least 51% of whom must be consumers of health center services. As a health center within a public agency, both the Board of County Commissioners and the Community Health Council share in governance responsibilities.



A Community Health Council member
Photo Credit: Motoya Nakamura

Objective

Our audit focused on primary care services provided in seven community health centers. We did not include the HIV clinic or the student health centers in our review. We focused on the following questions related to the primary care clinics:

- Is ICS following best practices to ensure high quality health care for the vulnerable residents of Multnomah County?
- Is ICS following best practices to maximize the financial viability of Multnomah County Health Centers?

Surveyed patients praised the health centers and the care they received

The Auditor's Office conducted phone interviews with patients to find out about satisfaction with their provider and clinic experience and about any concerns patients had. We conducted interviews in English and hired interpreters to conduct interviews in Cantonese, Spanish, and Russian.

We found that patients are very satisfied with their providers and had positive comments about their clinic experience.

Patients gave very favorable responses on questions related to provider and team satisfaction. These

provider satisfaction results mirror results from the annual Client Survey, conducted by ICS.

Patients expressed gratitude for the services received and when asked about areas for improvement, there were few suggestions, with several saying no improvements are needed. We also interviewed providers and clinic staff and found them to be passionate about their work, and that many find the work to be deeply rewarding.



Waiting room at La Clinica de Buena Salud
Photo Credit: Auditor's Office

Patient comments

The doctors are caring and passionate. I've been to providers at other systems and I feel like I get better care at the County – it's all about you, the patient.

Front staff is fantastic. The team is on top of my care.

I've been with my provider for 8 years – she's the most amazing provider I've ever had.

My clinic has a great atmosphere and all of the staff are nice and caring. It has a very homey feeling.

Turnover and uneven workload must be addressed

Demanding workload contributes to turnover

The physicians, nurse practitioners, and physician assistants who work as providers along with the team of caregivers and support staff have very demanding jobs - delivering comprehensive primary care services to medically underserved communities. The combined challenges of patients with complex needs, lengthy appointments, and time-consuming administrative work create demands that can result in provider turnover. Provider workload is complex and includes direct and indirect patient care, such as making referrals, contacting patients, and working with members of the health care team and other medical professionals.

Community Health Centers have patients with complex needs

Throughout the country, patients who receive care in community health centers often have complex needs, including multiple medical diagnoses and chronic conditions such as diabetes and asthma, and many have experienced untreated medical conditions, depression, addiction, homelessness, or trauma.

Some patient visits take longer than others

To meet financial targets, providers are expected to see 16 patients per eight hour work day. A centralized Call Center takes patient calls and schedules appointments for all clinics using a provider scheduling template with 18-20 slots. Visits are allotted to be 20 minutes each in most cases. Due to high no-show rates, the Call Center normally schedules providers to see more than 16 patients each day, and frequently all slots are scheduled.

We learned that some appointments require more than the standard 20-minute appointment time, for example:

- New patient visits - It is difficult to complete a new patient visit in 20 minutes. Providers have a lot to learn from a new patient as they gather information and get to know them, and patients may need extra time to explain their unique histories.
- Interpreted visits – Using an interpreter



Former Multnomah County Physician Assistant
Photo Source: Kate Willson

- can take 2 or more times longer than same-language visits because of time spent translating and clarifying.
- Those unfamiliar with medical treatment in the U.S. - For patients who lack familiarity with medical treatment used in the U.S., providers may need additional time to ensure patient understanding of instructions for medications and follow-up care.
- Trauma informed care – Providers may need extra time to build trust with patients who have experienced trauma, using trauma-informed approaches, such as looking at patients when they talk instead of typing, listening and repeating, not cutting conversation short, following up with the patient, etc.

Each of these situations can lengthen an appointment, causing the provider to fall behind in their schedule or be rushed. And, with electronic health recordkeeping, additional hours are needed to complete the patient chart. Some providers said that with charting (electronic medical record keeping) they needed 10 or more hours a day to complete the work.

For example, to paraphrase, one provider told us that:

She did a personal audit through the American Family Physician Association and found she was spending 60 hours a week on work, even though she was scheduled for 32. She even used the suggested shortcut phrases for electronic medical records and other recommended shortcuts, but still needed additional time to complete the work.

Increased demands on Mid County providers

Considering diverse populations, complex patient conditions, interpreted visits and workload, the demands on all providers are considerable. Yet, overall, the demands on Mid County providers are greater than for providers at other county health centers.

Mid County is a large, busy clinic with the most patient visits in the system. Compared to other county health centers, Mid County

- serves a larger number of refugees;
- has the highest number of visits requiring an interpreter;
- serves many patients with complex needs; and
- has a provider productivity (number of completed visits per day) second only to the East County clinic.

Further, high turnover at Mid County has had a negative impact on staff morale.

In spite of the many challenges, providers described their experiences at Mid County as being rich with culture and very rewarding.

EMBARGO UNTIL 12/19/2019**Refugees have unique needs**

Mid County is one of the refugee clinics for the state of Oregon, serving the largest number of refugee patients in the county system and having the most patient visits. Newly arrived refugees to the state of Oregon must complete a health screening within 90 days of arrival; many refugees complete the screening at the Mid County Health Center and many refugees choose to continue to receive care at the health center.



Map of Mid County staff home countries
Photo Source: Randy Cox

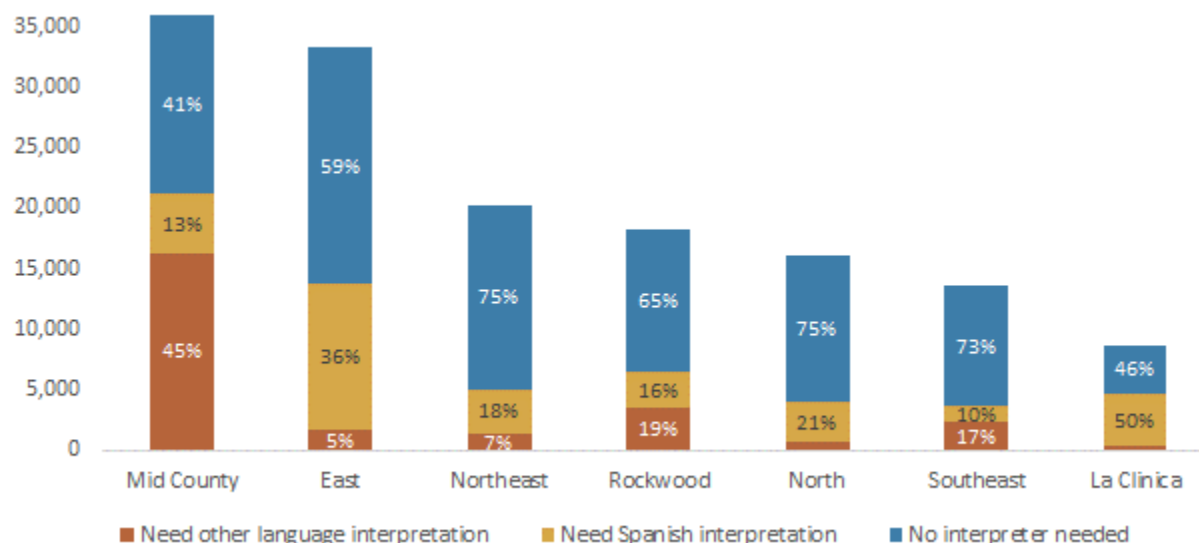
The situation of refugees is unique. Many have serious health conditions, many are best served in a language other than English and require interpreted services, and some may be unfamiliar with medical practices in the United States, all of which can lengthen a provider visit.

Mid County sees more patients requiring an interpreter

Mid County has the greatest number of interpreted visits and those visits take more time, sometimes twice as long or more. At Mid County, 59% of patient visits required an interpreter, compared with 41% at East County and 35% at Rockwood. While La Clinica, East County, and other clinics have a large number of Spanish-speaking interpreter needs, many providers and staff are fluent in Spanish. To paraphrase, one provider told us that less common languages take more time for interpretation and clarification.

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59% of Mid County visits require interpretation, compared with 34% at other clinics
 Patient visits by need for an interpreter, June 2018 – May 2019



Source: Data from ICS report "Empaneled Primary Care Patient Demographics" and graph by Auditor's Office, due to rounding, numbers may not total 100%

To paraphrase, one provider, who does not work at the Mid County Health Center, told us:

Roughly 30% of their patients require an interpreter. Those appointments take longer and bump into other appointments. This practitioner said they need to have non-interpreted visits to make up for the ones that take longer.

Since so many of the patient visits at Mid County require interpreters, providers do not always have non-interpreted appointments in their schedule to make up for appointments that need more time.

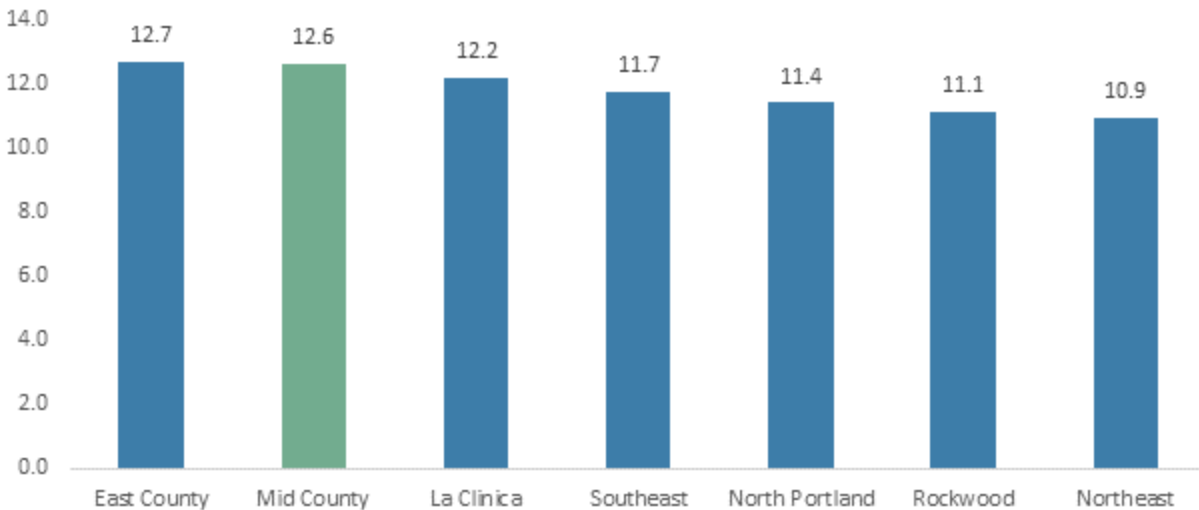
To paraphrase, a provider from Mid County told us:

There are many appointments with translators in the room and they don't get as much done during the appointment times. Many patients have complicated medical conditions, adding to time needed during the appointment. They said there is a lot of paperwork and not enough administrative time to complete all of the work.

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The provider completed visits per day is greater at Mid County than most other clinics, lagging only slightly behind East County

Completed Patient Visits per 8 Hour Day



Source: Completed appointments data from Epic and hours worked from SAP and Workday. The Auditor's Office totaled the number of completed appointments and divided by the number of hours worked (not including vacation, sick, or other leave) to come up with the average completed appointments per hour worked. This does not include new providers.

Completed visits per day is one measure of provider workload. Workload also includes many other duties and responsibilities performed by providers, such as making and responding to referrals, contacting patients, and communicating with other medical professionals.

While differences among clinics may seem small, it means that on average, East County and Mid County providers complete up to 300 hundred more patient visits per provider each year compared to those practicing at the other clinics. Those additional visits result in many additional hours of administrative work leading to extended hours for these providers.

To paraphrase, one Mid County provider told us:

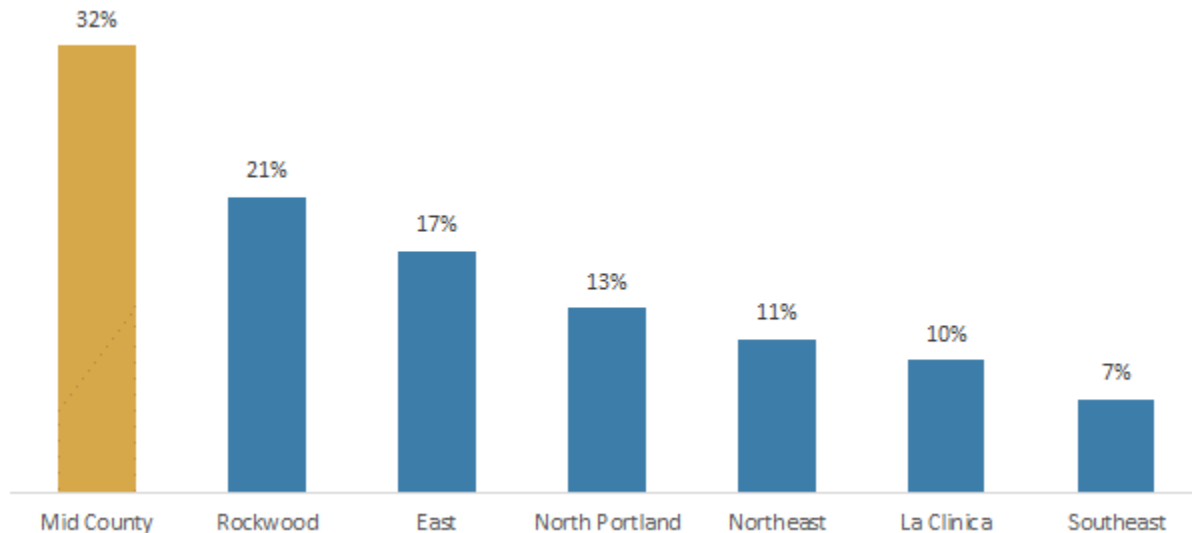
With complex patients and visits with interpreters, the workload is unsustainable. Twenty slots is common with the expectation that providers will see 16. The provider norm doesn't consider interpreted visits and patients with complex needs. Providers at other locations have more of a mix of patients.

EMBARGO UNTIL 12/19/2019**Turnover is much higher at Mid County**

We looked at turnover at the health clinics from January 2014 through October 2019, and the turnover at Mid County was much higher.

On average, nearly one-third of Mid County providers leave every year

Average Annual Turnover January 2014 - October 2019



Source: 2014-2018 data from SAP and January-October, 2019 data from Workday; analysis by Auditor's Office. Includes Physicians, Nurse Practitioners, and Physician Assistants

Despite pressures at Mid County, they have about the same number of clinical support staff per provider as the other health clinics. Considering interpreted visits, number of refugees, complex conditions and a heavier workload, Mid County providers have unique challenges when compared to providers working at other clinics. ICS should acknowledge and address this issue.

While Mid County has much higher provider turnover than other clinics, it is worth noting that Rockwood also has high provider turnover. Rockwood staff told us about how disruptive changes in management have been and reductions in clinical support staff have also been challenging. At a small clinic, like Rockwood, the impact of losing providers is much greater. One provider told us they are down a nurse, which means that providers must complete some of the tasks that a nurse would normally do, adding to their workload.

To paraphrase, one Rockwood provider told us,

The Rockwood clinic is down providers and down to one nurse. This makes the clinic short-handed and they aren't able to refer situations to a nurse or make a warm hand-off. This provider is concerned that they are short-staffed to the point of patient safety concerns.

Turnover increases the workload on remaining providers and impacts patients

When a provider leaves the county, care of their patients falls to other providers, increasing their workload. This is challenging in clinics where providers already have a full panel of patients under their care. In addition to increased workload, provider turnover can contribute to feelings of instability and decreased morale.

To paraphrase, one provider told us about leaving their practice.

They were told they would need to reassign their patient panel to other providers before they left, but this provider said that all of the other providers were too busy to see additional patients.

To paraphrase, another provider talked about the negative impact on patients.

They said that turnover leads to poor continuity of care and is especially difficult for patients with complex health needs.

Turnover reduces patient access to the primary care provider

When providers take on transferred patients it may limit access for their assigned patients, who may not be able to schedule with their primary care provider when they need an appointment. Reduced access is exacerbated by a policy that does not allow appointments to be scheduled more than two weeks out. Patients who need to get an appointment may be scheduled with any available provider, if their primary care provider is unavailable, which is contrary to the care model. Multnomah County is recognized as a primary care medical home, accredited as a certified primary care medical home model. Among other criteria, each patient is assigned to a primary care provider who works in a team of professionals with the patient to coordinate care. The core attributes of the model include care that is patient centered, comprehensive, and coordinated - with access to care using a systems-based approach to quality and safety.



North Portland Health Center
Photo Credit: Cheyenne Thorpe

Provider turnover contributes to continuity of care concerns

When a provider leaves a practice, patient care can be disrupted.

According to the American Academy of Family Physicians, the term continuity of care describes ongoing health care management over time, rooted in a patient-provider relationship in which the provider knows the patient history

and can integrate new information and decisions from a whole-person perspective. Providers voiced concerns related to continuity of care when turnover causes patients to be re-assigned, making it difficult for providers and patients. And, for the newly assigned provider, an unknown patient can be like a new patient visit with time needed to review chart notes and get to know the patient and the medications and treatments the patient has experienced.

To paraphrase, one provider highlighted continuity of care as a weak spot.

The provider told us that there are too many patients and too few providers at some clinics. When providers leave, other providers have to step in, disrupting continuity of care and making it very difficult to care for patients.

While we found few specific instances of poor quality of care resulting from provider turnover, some providers expressed concerns about patient outcomes related to changing providers. High turnover among providers could result in a risk to patients, which can be an area of risk for the county.

Turnover leads to poor patient experiences

In patient interviews, one patient emphasized a need to stabilize providers.

Provider turnover is associated with worse patient experiences of care. Patients generally do not like changing their primary care provider, which can be distressing. Transitions take time to build trust. Providers said turnover is difficult for any patient but it is particularly hard on those with complex needs – which many county patients have.

Patient comment

I've gone through several doctors since my doctor left. Doctors are changing all the time. The doctors have mostly been good, but with the new providers I have to start all over again telling my story. I hope I don't have to change doctors again.

Provider turnover is disruptive and costly

In addition to being disruptive, provider turnover can pose a threat to the financial well-being of a clinic, making a business case for provider retention efforts. It is difficult to estimate the cost of provider turnover in community health centers, because the costs may not be tracked or made public, although estimates for losing and replacing providers in private practices are reported to be one to three times the annual provider salary. Provider turnover may pose an even greater burden for community health centers, due to constrained budgets and workload demands.

Termination and Replacement - Costs associated with termination include administrative time and payout of any benefits, and cost of filling the position while it is vacant, such as

hiring on-call staff. And, although difficult to quantify, losing personnel means lost institutional knowledge the provider is taking with them. Costs associated with replacement include management time spent in recruitment and interviewing, and administrative time spent promoting positions and coordination efforts.

Bringing on new staff - Once a provider is hired, there are personnel costs associated with onboarding new staff, required county training, department specific training, and training related to the position, all of which includes both management and new employee time. The medical director also spends time meeting with new providers and overseeing credentialing. Supervisory time is also needed when bringing a new employee up to speed.

Lost productivity – Productivity drops when an experienced provider is replaced with a new or less experienced provider. New providers are given a ramp-up period of up to several months, during which time they have lower target number of patients to see, depending on the employee. This can result in several months of reduced productivity and may be especially true with recent graduates or inexperienced providers who have had less time in a clinical setting.

New providers lower overall productivity of the system



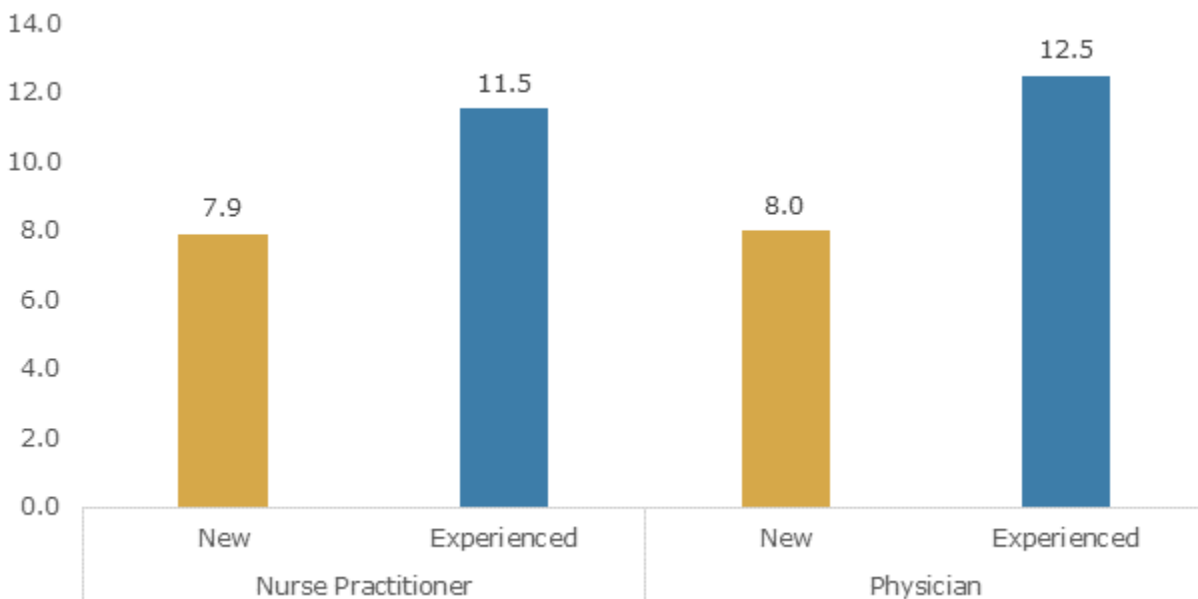
Mid County Health Center farmers market.
Photo Credit: Motoya Nakamura

Our analysis of provider productivity shows that tenured practitioners are more productive than their new counterparts, seeing more patients, thus bringing in additional billing revenue. For example, on average, a nurse practitioner who has been with the county for over one year may see 11-12 patients per day compared to their new counterpart who may see eight patients; an experienced physician may see 12-13 patients per day, compared to their new counterpart who may see eight patients per day.

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New providers are less productive than experienced ones

Completed patient visits per 8 hour work day



Source: Data from ICS, SAP, and Workday; analysis by Auditor's Office

When new providers join a practice, it is probable that they will need several months to achieve the productivity of the provider who has left. If ICS could prevent some departures, they could maintain higher rates of productivity overall and benefit from cost savings, as well as having patients who are more satisfied because they can stay with their provider.

ICS needs to create a provider retention strategy

During the time of our audit, ICS had no plan in place to retain providers and reduce preventable turnover. Along with productivity, provider retention is critical to the sustainability of the system and should be part of overall financial planning.

To ICS' credit, leadership told us they have put in place activities and strategies to address provider retention and reduce burnout, including leadership opportunities, peer support, and a Provider Forum to help with the communication challenges of a large system. However, in our discussions with staff, no one mentioned these initiatives.

Turnover is common in community health centers, yet, since medical teams are key to clinics, reducing turnover must be a priority. During our audit, we focused on provider retention. While providers leave organizations for many reasons, some departures may have been preventable.

Management told us that providers who come to work at community health centers often do so for the loan payback benefit provided by working in an FQHC, and after a few years, leave for private sector positions. That may be true for some. However, we learned that at least some departing providers took positions at other health centers where the patient populations are similar. Those providers left for similar positions in organizations that share the mission of the county to serve underserved communities and might have been willing to stay with Multnomah County.

Some providers told us that the heavy workload, along with poor communication from management, and management not considering provider insights led to their departure.

To paraphrase, one provider told us

Working with the diverse patient population was a joy but the workload was overwhelming and the message from the top was that providers are not doing enough. When providers voice their concerns, they are not taken seriously.

Provider retention programs can increase provider satisfaction and go a long way toward retention efforts. Some key strategies include:

- Acknowledge the good work providers are doing – this can be key for providers.
- Make retention a priority of leadership with shared accountability for the well-being of clinical staff.
- Conduct stay interviews. Regularly interview providers and ask how they are doing, and what can be done to help them. Ask how long they plan to stay. Interviews can help people feel listened to and give them a voice. Regular check-ins are common in the first year, but more should be done in the following years.
- Establish a wellness program to help with provider resiliency.
- Take provider input into account around decision-making, especially changes that impact providers.
- Provide leadership or mentoring opportunities or the chance to serve on internal work groups of particular interest.
- Ensure management staff are demonstrating effective communication and making employees feel valued.

While we focused on provider retention specifically, we acknowledge that all clinic staff have difficult, demanding, and often stressful jobs and that efforts should be made to retain all health center personnel.

The Call Center is a bottleneck for non-English speakers

Patients must schedule appointments through the Call Center and are unable to call the health centers directly, even when they have questions for their medical team.

Call Center options given only in English and wait times for interpreters can be high

The Call Center greeting is in English during hours of operation and in English and Spanish after hours. When we talked to patients during our survey, we learned that non-English speakers have trouble navigating the Call Center. For those who do not understand English, this can be confusing and frustrating. Further, we learned that some patients have had to wait as long as 45 minutes for an interpreter or to speak with someone. Some patients told us they have to rely on family or friends to help them make appointments.

Several patients were frustrated by the wait time and the limited access to their primary care provider. Because of the ICS policy not to allow appointments to be scheduled more than two weeks out, patients may have to call repeatedly several days in a row to get an appointment with their primary care provider. Some said they are told they must call at 7:30 a.m. when the Call Center opens to get an appointment with their provider before that provider's schedule fills up.

Patient comments

It is very hard, very difficult to get an appointment. I have to go through several steps by the time they actually connect me. The Call Center is all in English and I don't know English. By the time I get connected a lot of time has passed.

My son helps – I have no idea how long it takes.

I must call at 7:30 or there are no appointments left.

I had to wait 30 – 60 minutes just to know there were no appointments available. They said I have to call at 7 a.m. to get an appointment.

ICS must make changes to its financial structure and practices

ICS needs a financial director on its leadership team

Best practices state that organizations should hire a financial director once they exceed \$10 to \$20 million in revenue. While the Health Department Financial Director provides financial expertise to ICS, this position is not dedicated to ICS and is not a member of the ICS leadership team. In FY 2020, ICS has budgeted revenues of \$130 million, which means that it is in significant need of this position. Rather than a financial director, or similar position, a financial project manager is currently responsible for budgeting, monitoring monthly reports, and supporting forecasting of revenue.

According to the accounting firm, Deloitte, the role of a financial director is to:

- “Execute strategic and financial objectives.
- Provide financial leadership in determining strategic business direction.
- Balance capabilities, talent, costs and service levels to fulfill the finance organization’s core responsibilities.”

The current project manager does not have the assigned authority to perform any of the necessary responsibilities mentioned above, nor do they have a seat at the leadership table. ICS’s structure differs from other FQHCs, as many in the region have a financial director, chief financial officer, or a similar position on their executive team, such as Benton and Linn Counties and Virginia Garcia Memorial Health Center in Washington and Yamhill Counties.

Significant transformation is occurring in health care policy at the federal, state, and local levels, such as the next iteration of coordinated care organizations, and changes in the federal immigration regulations on public charge are in flux. It is critical that ICS have a full understanding of its financial situation in order to effectively monitor the need for changes to operations and financing. The system must be prepared to respond quickly to changes. According to a 2017 report by healthcare experts, which ICS commissioned, “The County’s current budgeting, financial accounting and reporting system significantly hinder ICS’s ability to monitor its operating and financial performance, as well as ensure more effective use of resources to achieve its mission.”

ICS would benefit from having its own fund

Much of ICS’s revenue – Fee-for-service Medicaid and Alternative Payment Method (APM) capitated Medicaid payments – come to ICS through the General Fund and grant money comes

to the Federal/State Fund. Since ICS does not have a separate special revenue fund, it is difficult to:

1. Comply with the Health Resources and Services Administration (HRSA).

The 2017 Health Center Program Site Visit Report from HRSA found that federal money is not being monitored separately and “project costs are not consistent with Federal Cost Principles and the terms and conditions of the award.” A separate fund may help ICS better monitor this money to comply with HRSA.

2. Compare ICS’s performance to other FQHCs.

A 2017 report by a consultant that ICS hired stated that they were unable to untangle ICS’s finances from the rest of the county.

3. Easily determine how much General Fund support ICS receives.

Currently, much of ICS’s revenues come from the Alternative Payment Model (see text box), which goes into the General Fund. This gives the appearance that ICS receives a significant amount of support from the General Fund, when in reality, the General Fund supplies ICS with very little revenue in relation to the program as a whole.

4. Build up reserves to set aside for lean times.

With changes happening at the federal, state, and local levels, ICS would be well served to have reserves available to ensure continued services if revenues fall suddenly.

5. Make it easier for supporters to start a foundation. Some FQHCs supplement their income with donations made to a foundation. In fact, some organizations told us that they could not operate without their foundation. A foundation’s donations would be easier to track if ICS had its own fund. This would give donors greater assurance that their money was being used for ICS, rather than somewhere else in the county.

What is the Alternative Payment Model (APM)?

ICS receives a monthly payment for primary care patients (called per member per month) on Medicaid who are assigned to one of their health clinics, regardless of how many times they are seen by a provider. If someone does not have an appointment or a Care STEP (care and services that engage patients) in two years, the patient is classified as **assigned but not seen**, and ICS will no longer receive a monthly APM payment for this person. Additionally, if patients move to a non-ICS clinic, they will fall off the APM rolls.

We recognize that creating a special revenue fund would be time consuming, but it would ultimately be worthwhile, as the financial stability of ICS affects its ability to serve the healthcare needs of vulnerable people in Multnomah County. Once the demands of Workday, the County’s new financial system, become more manageable, we recommend that Central Finance and ICS work together to create a special revenue fund.

Every revenue stream should be monitored

Without a financial director for ICS, there is no one specifically in charge of making sure that every revenue stream is being monitored and maximized. The following are areas that need consistent monitoring. We applaud ICS's decision to hire a revenue cycle manager, but this position focuses on specific sources of revenue and is not a substitute for a financial director who oversees the big picture of the finances.

1. Fee-for-service

In FY 2018, the ICS primary care clinics took in \$14 million in fee-for-service payments, which is 24% of primary care revenue. Fee-for-service charges are based on medical codes that providers use to document the care they provided.

In early 2018, senior management initiated an effort to improve the accuracy of the medical

codes used by providers, so ICS could more accurately capture the revenues associated with providing care for more complex health issues. At the end of 2018, messaging from upper management gave some providers the impression that proper coding no longer mattered. This left many providers confused and frustrated about the extra documentation they had done to support accurate medical codes. In fact, proper medical coding does matter, and is an important way for ICS to generate revenues. The incorrect messaging to providers may have cost the county money. Ensuring ICS provides consistent, clear messaging about coding is another reason to add a financial director to the upper management team.



North Portland Health Center
Photo Credit: Cheyenne Thorpe

2. Assigned, but not seen

We recognize the efforts by ICS staff to connect with the assigned, but not seen patients; those patients who have not had an appointment or care STEP in two years.

Management told us that these efforts are very labor intensive and not worth the effort. However, we estimated the costs associated with outreach and compared it with the revenue generated and determined that these efforts are financially worthwhile and should be continued.

3. Leakage report

This report shows patients who have seen a provider outside of a Multnomah County clinic, which means that ICS will stop receiving a per member per month payment. At the time of our audit, managers would review this list, but no one was using this information to try to bring patients back or determine why patients leave ICS.

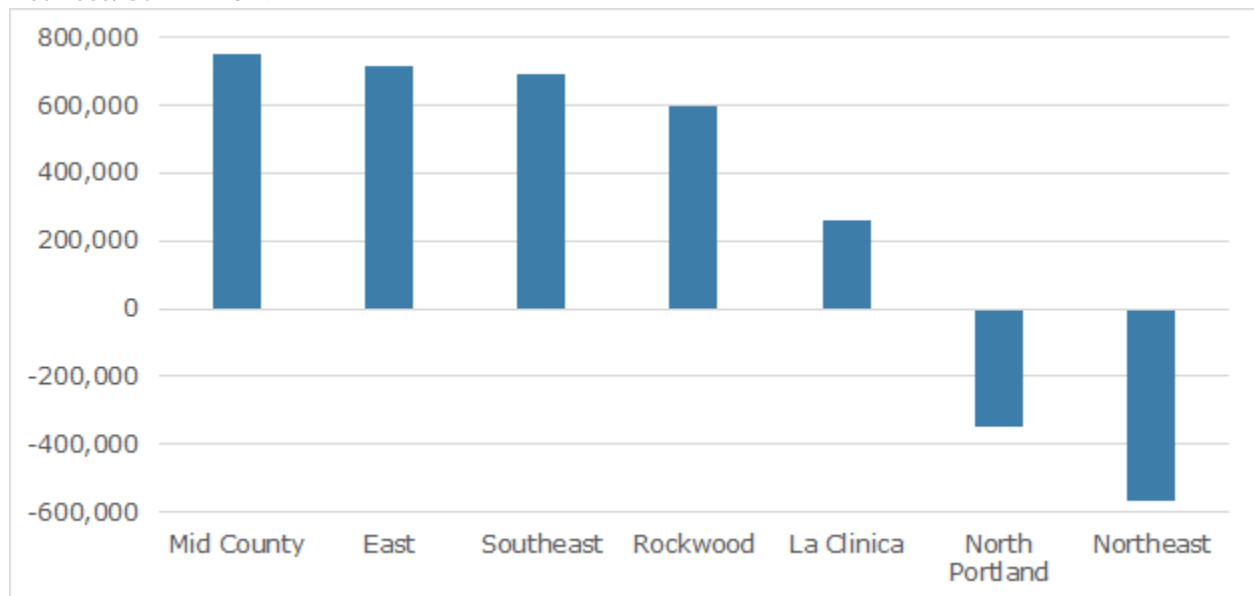
In Multnomah County, new community health centers have opened or expanded in the past few years, primarily on the east side. Some of ICS's patients have left to go to these clinics. With the expansion of Medicaid, many patients are no longer limited to safety net clinics; they can often choose from many medical providers. This means that ICS is competing against some systems, such as Providence and OHSU, which offer hospitals and other services including specialists and birthing options. Since ICS loses money when patients go elsewhere, it is essential for ICS to be competitive to continue to operate in its current model. It is important that ICS determine why patients leave by reaching out to patients on the leakage report. While ICS may not be able to bring patients back, it can learn more about how to prevent future patients from leaving.

4. Clinic Performance

We looked at the net loss/gain for each primary care clinic, and found that North Portland and Northeast are losing money. While ICS is not in the business of making money, it should examine why these clinics are losing dollars and what that means in terms of an overall strategy.

The Northeast and North Portland Health Centers are losing money

Net Loss/Gain FY2019



Source: Data from ICS, graph by the Auditor's Office

ICS needs to determine productivity goals that are aligned with its financial objectives

ICS senior leadership looked at other FQHCs and other jurisdictions to learn about their productivity goals. Based on this review, they determined that all primary care providers would continue to have a goal of 16 completed patient visits per day. Most providers do not meet this goal. Given that 47% of the primary care clinic revenue comes from APM (monthly payments for primary care clients on Medicaid assigned to one of their health clinics), it seems that the productivity goals should be tied more to keeping members engaged with the clinic and seeing new patients.

In fact, after APM started, ICS leadership did reduce the number of patient appointment slots, but when there was a financial shortfall in 2017, they increased the number of patient



North Portland Health Center
Photo Credit: Cheyenne Thorpe

appointment slots to its previous level. However, it appeared that no analysis has been done to know if the financial shortfall and the reduced appointment slots are actually related. The shortfall may be related to fact that ICS ramped up its hiring of staff in response to the Medicaid expansion associated with the Affordable Care Act, but the number of patients did not increase as much as expected. When we asked senior leadership if financial analysis was done to determine if the 16 visits are financially necessary,

they told us that no analysis had been done. While it is possible that 16 patient visits is reasonable and financially necessary, we recommend that ICS analyze the relationship between the number of slots, provider productivity, and fee-for-service revenues needed to be financially viable.

ICS needs stronger procedures of abnormal lab result communications

ICS has procedures for communicating critical lab results. However, for abnormal lab results, it is at the providers' discretion about when, or if, they contact the patient. An example of an abnormal, but not critical lab result, would be a diagnosis of hepatitis C.

ICS should have policies in place about how quickly patients should be notified of their abnormal lab results. Not having policies in place may result in poor patient outcomes and could put the county at risk of lawsuits, as has happened at other county health clinics in the country.

Recommendations

We recommend that the Integrated Clinical Services Division of the Health Department, no later than April 1, 2020:

1. Change Call Center greeting so that announcements about what to press for different languages occurs in the most commonly used languages of their patient population.
2. Develop procedures to ensure that all patients are notified timely of any abnormal lab results

We recommend that the Integrated Clinical Services Division of the Health Department, no later than December 31, 2020:

3. Develop a provider retention plan and begin implementation.
4. Partner with Human Resources staff to analyze the impact of turnover, including costs.
5. Address the differences in provider (physicians, nurse practitioners and physician assistants) workload across the system by implementing strategies, such as:
 - a) Assign patient panels based on patient complexity;
 - b) Create different productivity targets for the different provider types;
 - c) Negotiate with funding entities on interpreted visits as a performance goal with the intent of getting additional funding for longer times required by interpreted visits; and/or
 - d) Add an additional provider to high volume clinics.
6. Have the Health Department Director, the Director of Business Operations, and the Director of ICS work together to hire a financial director with health care industry experience to be part of the ICS leadership team. This position should be responsible for ICS financial decisions and given the authority to direct Business Services staff.
7. Evaluate provider productivity goals to ensure they are aligned with financial goals.

We recommend that the Integrated Clinical Services Division of the Health Department, no later than December 31, 2021:

8. Work with Central Finance to create a special revenue fund.

Objectives, Scope, & Methodology

Audit objectives:

Our audit focused on primary care services provided in seven community health centers. We did not include the HIV clinic or the student health centers in our review.

- Is ICS following best practices to maximize the financial viability of Multnomah County Health Centers?
- Is ICS following best practices to ensure high quality health care for the vulnerable residents of Multnomah County?

To accomplish these objectives we:

- Studied the requirements of Federally Qualified Health Centers
- Analyzed budgets and other information
- Conducted 113 interviews, comprising staff and managers, outside agencies, and managers from other local FQHCs
- Conducted a survey of patients in English and supervised interpreted surveys in Cantonese, Russian, and Spanish
- Researched literature on provider burnout and turnover
- Attended Community Health Council monthly meetings
- Toured each Multnomah County Health Center
- Talked with consultants and other experts

For this audit, we analyzed personnel and financial data for the time period of January 1, 2014 to December 31, 2018 from SAP, the county's enterprise resource planning system. Based on the annual review of SAP datasets by the county's external auditor, our office has determined that the data were sufficiently reliable for the purposes of this report. We also reviewed personnel data from January 1, 2019 to August 15, 2019 in Workday, the county's new enterprise resource planning system. The external auditor has not yet reviewed Workday, so we deem the data to be of undetermined reliability. We used Workday data in conjunction with SAP data, so that the results are not dependent on Workday. The charts that contain Workday data:

1. New providers are less productive than experienced ones- This chart includes 6 months of SAP data (July 1, 2018 – December 31, 2018) and 6 months of Workday data (January 1, 2019 – June 30, 2019). Most providers worked very similar hours in the two time periods, giving additional credence to the validity of Workday data.
2. Completed Patient Visits per 8 Hour Day- This chart includes 6 months of SAP data (July 1, 2018 – December 31, 2018) and 6 months of Workday data (January 1, 2019 – June 30, 2019). Most providers worked very similar hours in the two time periods, giving additional credence to the validity of Workday data.

3. Average annual turnover- This chart includes five years of SAP data (January 2014 – December 2018) and 10 months of Workday data (January 2019 – October 2019). The numbers of staff are similar in SAP and Workday data, giving credence for its reliability. Additionally, Workday data makes up a small percentage of the total data used.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings, and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

EMBARGO UNTIL 12/19/2019

Audit Staff

Fran Davison, Principal Management Auditor

Nicole Dewees, Principal Management Auditor

EMBARGO UNTIL 12/19/2019

Response Letter