FINANCIAL REVIEW OF PRIMARY CARE CLINICS IN VANCOUVER

DATA REPORT & INSIGHTS

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Created for:

The Vancouver Division of Family Practice

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INTRODUCTION

Project Overview/Goals

The Vancouver Division of Family Practice (VDoFP) aims to provide information, transparency, and decision support to member clinics and associates related to the financial landscape in primary care. To this end, the VDoFP has undertaken a market analysis to guide clinic owners in their decisions, evaluations about clinic finances, business model changes, and overall operational best-practices. This information could also provide a more holistic understanding for associates and locums looking to join clinics and increase their vested interest in the clinic's financial and operational wellbeing.

Considering the importance of diligent assessment of nuanced variations within and between clinics, the VDoFP Clinic Data Project team outsourced the analysis. As part of this project, the data of 15 clinics, selected by the Division, is leveraged to provide aggregate, normalized, comparative analysis. The end result not only benefits participating clinics to better understand their own financial performance as well as how they compare to their peers but also creates a summary for the Division that can be used to support other clinics through out the region.

The aim of this report is to present the insights gleaned from the aggregate financial data collected from the clinics that participated in the project. It is important to highlight that this report's observations and discussions employ a financial lens. Utility, intangibles, quality of care and patient outcomes, although important, have not been considered in this analysis.

Acronyms and definitions can be found in *Appendix A*.

METHODOLOGY

Given the sensitive nature of the information and the variations within and between clinics, clinic leads were asked to provide contextualized, clinic-specific information, which included:

- Income statements for a two-year period that included 2023, if possible
- Bookkeeping summaries, where available
- Billing totals for physicians and other providers, where applicable, and total clinic overhead contributed by each provider
- Average weekly provider workdays
- Context about the clinic operations
- Other explanatory information as necessary

Comparing clinics is challenging, in part, because clinics operating under the same "model" can differ in some respects. It is also important to differentiate between family practice activities and non-family practice activities (e.g. Dentistry, counselling, dermatology, research, etc.).

To help overcome the challenges associated with data processing and to help present insights, while also keeping individual information anonymous, a multipronged structured approach was employed:

I. Analysis and Categorization of Expenses

To facilitate the analysis amongst a broad group of clinics, clinic expenses were categorized into standardized groups, consistent with what is commonly observed in most family practice clinic financials. Some non-operating line items such as amortization and depreciation were removed as those values are tied to expenditures that aren't consistent with daily clinic operations (as seen on the right). However, reasonable equipment purchases were considered as fixed operating expenses to allow for realistic comparisons between clinics without expanding the analysis to Balance Sheet or Cash Flow Statement analysis.

Operating Revenues and Expenses

Fixed Expenses

- Space expense (lease, utilities, taxes, strata, etc.)
- Maintenance and repairs
- Janitorial, cleaning, and waste disposal
- Security/security system
- Parking
- Licenses, insurance, and permits
- Internet
- Computer, technology and IT
- Fax
- Telephone
- Equipment purchases or lease
- Website, advertising, and marketing
- Professional services
- Recruitment and retention
- Interest and bank charges
- Management and administration
- Miscellaneous

Location Agnostic Variable Expenses

- Wages, benefits, and bonuses
- EMR
- Software subscriptions
- Uniforms
- Courier services and postage
- Meals and entertainment

In-Clinic Variable Expenses

- Medical supplies
- Office supplies

Revenues

- Family Physician overheads
- NP overheads
- Other primary care revenue (Initiative funding, vaccine clinic, grants, etc.)

Non-Operating Revenues and Expenses

Expenses

- Bad debts
- Amortization & depreciation
- Loan repayment

Revenues

- Interest
- Donations
- Capital contribution

II. Isolation of Primary Care Activities

To further standardize comparisons, the obvious revenues and expenses from primary care related clinic activities were separated from those attributed to other revenue generating opportunities. For example, if a clinic collects revenue from a specialist or from renting a few rooms, those will be excluded from the primary care unit revenues. This methodology allows for a more appropriate examination of the potential and discreet profitability of the family practice unit. Some examples of what falls in each group are provided (right).

Income Stream Categorization	
Primary Care Unit Examples (included)	**Non-Primary Care Unit Examples (not included)**
• Family Physician activities (including incidental private payments) • Nurse Practitioner activities • PCN and similar funding for initiatives focused on general patient populations • Initiative funding focused on specific patient population • Other grants and subsidies from MOH, Division, etc.	• Rental income • Specialist activities (e.g. Surgeons, Internists, Psychiatrists, etc.) • Dermatology or Cosmetics activities • Non-PCN allied health activities • Research funding for academic studies

Best attempts have been made to separate primary care and non-primary care related financials. However, parsing out expenses in some cases has been challenging. For example, assigning expenses such as rent, utilities, management/director burden or staffing needs for different units or activities were not always straight forward. In these cases, we have relied on the clinic to guide relevant expense allocations, which may have resulted in some inconsistencies. Nevertheless, this method is likely the best option for standardizing the comparisons among all clinics.

III. Normalized by metrics

To keep values anonymous and to meaningfully compare clinic performance, key metrics have been used to normalize revenues, expenses, and profits. For example, reviewing performance as a function of Full Time Equivalency (FTE) of family physicians (FPs), physical space, or staff spending are valuable avenues for normalizing the clinic financials and to glean insights into how clinics perform compared to each other without divulging sensitive or identifiable information. Note that for the purposes of this report and analysis, to ensure uniformity, eight working half-days (in-clinic and/or remotely) was considered to represent FTE where more than one provider was working at a clinic.

IV. Hypothetical adjustments

To address the variability in overhead models so that they can be compared with as much fidelity as possible, all clinics are compared at a hypothetical effective overhead split of 30% or 25%. For example, if a clinic is operating as cost share, their financial outlook at the hypothetical overhead of 30% is calculated. As a result, hypothetical operating margins and financial metrics are projected as if a cost share clinic's physicians were contributing 30%

overhead. This approach, in essence, removes complexities associated with different overhead models and allows for "apples to apples" comparisons of the overall operations of the clinics on a more equal footing. Hypothetical comparisons have been clearly labeled and explained, wherever possible. As shown in the example below, only overhead collected, and not expenses, are affected in the hypothetical scenarios.

Example Comparison Using Normalized Metrics with a Hypothetical Overhead Scenario (Two Clinics)

	Current State		Hypothetical State (30% Overhead)	
Clinic 1- Overhead Split 65%-35%	Total provider billings =	$1,500,000	Total provider billings =	$1,500,000
	Total expenses =	$330,000	Total expenses =	$330,000
	Provider FTE =	5	Provider FTE =	5
	Total Overhead collected =	$525,000	Total Overhead collected =	$450,000
	Average FTE billings =	$300,000	Average FTE billings =	$300,000
	Average FTE Expenses =	$66,000	Average FTE Expenses =	$66,000
	Average FTE overhead =	$105,000	Average FTE overhead =	$90,000
	Net Income/loss =	$39,000	Net Income/loss =	$24,000
Clinic 2- Cost Share	Total provider billings =	$2,800,000	Total provider billings =	$2,800,000
	Total expenses =	$490,000	Total expenses =	$490,000
	Provider FTE =	7	Provider FTE =	7
	Total Overhead collected =	$490,000	Total Overhead collected =	$840,000
	Average FTE billings =	$400,000	Average FTE billings =	$400,000
	Average FTE Expenses =	$70,000	Average FTE Expenses =	$70,000
	Average FTE overhead =	$70,000	Average FTE overhead =	$120,000
	Net Income / Provider FTE =	$0	Net Income / Provider FTE =	$50,000
Legend	Blue text denotes categories that can be compared between clinics Black text denotes metrics that remain unchanged when comparing a clinic's actual state with its hypothetical state. This exercise is not intended to compare one clinic to another, but rather to observe how metrics shift within a single clinic under a standardized overhead model. Grey text denotes categories that are modified in hypothetical state			

V. Participating Clinics

A total of 15 Vancouver clinics have provided the required information and were included in this analysis. As shown below, the clinics represent different operating models, clinic size (exam rooms and square footage), and provider FTE. As mentioned previously, to ensure uniformity, eight working half-days (in-clinic and/or remotely) was considered to represent FTE, where more than one provider was working at a clinic.

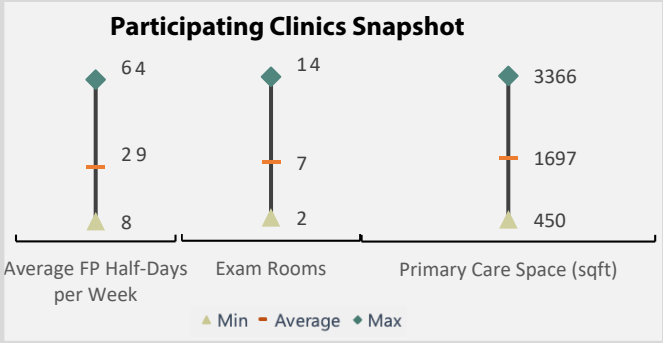
METHODOLOGY

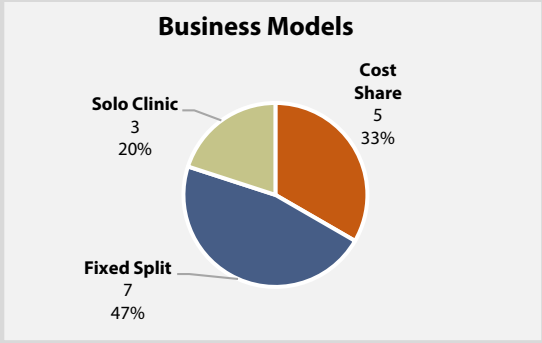
The participating clinics were at differing maturity stages; some have been in operations for decades and others were very early in their operations. It is important to highlight that one of the clinics only had representative financial information for a 10-month period; their data was thus extrapolated for a 12-month period, as accurately as possible, with support of the clinic. Further clinic information is provided below.

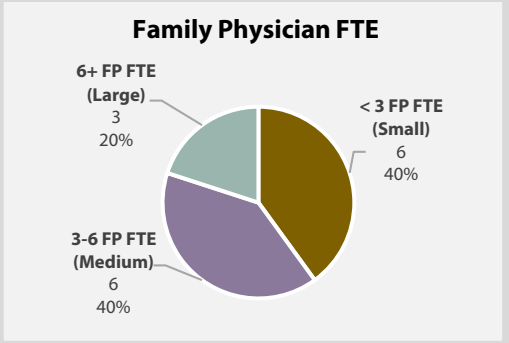
Lastly, it is important to highlight that four of the clinics (~27%) had Nurse Practitioners in addition to family physicians. At five of the clinics (~33%) there were meaningful non-primary care activities (dentistry, non-primary care allied healthcare, specialists, research, room rentals, etc.) that contributed to the overall clinic finances.

Clinic Information

PROFILE OF PARTICIPANTING CLINICS







VI. Presentation of Insights

A priority of this project was to help identify important financial metrics that shed light on the efficiency of clinic operations. To this end, various factors affecting the revenues and expenses of the participating clinics were assessed. The sections that follow explore insights related to clinic expense drivers, billing and business model differences, and net income potential of the participating clinics.

Various graphs and visuals have been used to showcase the findings while making every attempt to maintain confidentiality of participating clinics. The results are separated, where appropriate, based on business models (fixed split, cost share or solo clinics) and/or FTE of providers, usually FPs, as a measure of a clinic's functional size. A summary explanation of the graphs highlights some of the significant findings.

REVENUE

Sixty percent of the participating clinics relied on primary care activities to generate revenues, while the remaining 40% percent utilized some non-primary care activities for revenue generation. This section will focus on the primary care activities of participating clinics.

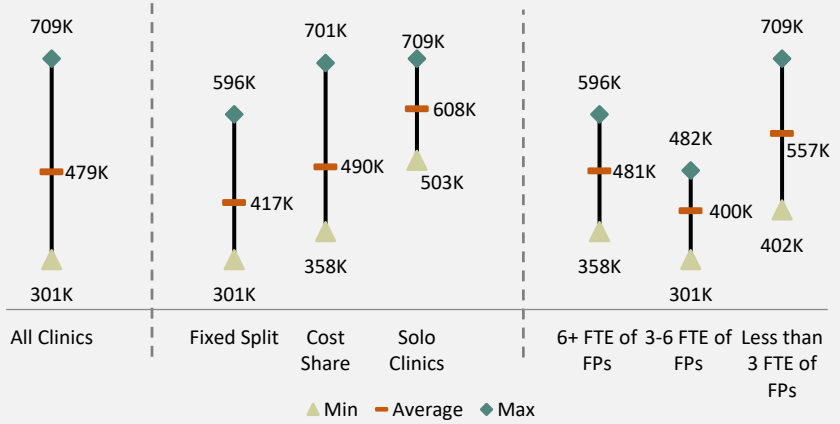
When considering primary care activities of participating clinics, the main source of clinic revenue is overhead contributions of the family physician (FPs) providers. Twenty percent of the clinics also generated primary care related overheads from non-FPs. Depending on the clinic's operating model, the FPs' billing efficiency significantly influences either the effective overhead of providers (in a cost share and solo clinic models) or the overall contribution amount per provider (in a fixed overhead settings).

Figure 1, shows the average FP billings of participating clinics. To ensure anonymity, all clinic billings have been aggregated and then normalized using one of the previously mentioned grounding metrics. Ranges and averages for all clinics as well as subset of clinics based on business model and physician size is summarized in **Figure 1 A,B**, **and E**. For each normalization method, the distribution of the clinics along the observed average billing range, based on their remuneration model and number of FPs, is also shown (**1 B,D, and F**).

Although the number of clinics in each of the differentiating categories are low, the observations may hint at some trends. Among the participating clinics, those operating under a fixed overhead split model show the lowest average billings per FP FTE. Solo clinics have the narrowest range and highest average per FP FTE, however, their billings normalized for clinic size (**1E**) lags those of the cost share clinics significantly, likely highlighting the lower opportunity for economies of scale. When considering the size of the clinics, those with less than three FTE of FPs, show a wide range but overall higher average billings per FTE.

FIGURES 1A–E: CLINIC BILLING ANALYSIS

1A. Range of Average FP Billings per FTE



1B. Distribution of Clinics' Average FP Billings per FTE

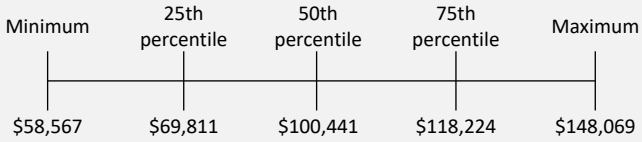
# Of Clinics In The Range	3	4	4	4
Remuneration Model	2 x Fixed Split 1 x Cost Share	3 x Fixed Split 1 x Cost Share	1 x Fixed Split 2 x Cost Share 1 x Solo Clinic	1 x Fixed Split 1 x Cost Share 2 x Solo Clinic
Size	1 x 6+ FTE 2 x 3-6 FTE	2 x <3 FTE 2 x 3-6 FTE	1 x <3 FTE 2 x 3-6 FTE 1 x 6+ FTE	3 x <3 FTE 1x 6+ FTE

Solo clinics include the highest FP FTE billings, while clinics with an overhead split include the lowest FP FTE billing. Smaller clinics have the widest range and highest average billing per physician, while clinics with 3-6 physicians have the lowest average billing.

FIGURES 1A–E CONT'D: CLINIC BILLING ANALYSIS

1C. Range of Avg FP Billing per 10K of Staff Expenditure

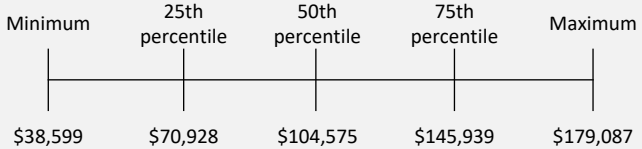
1D. Distribution of Avg FP Billing per 10K of Staff Expenditure



# Of Clinics In The Range	3	4	4	4
Remuneration Model	3 x Fixed Split	1 x Fixed Split 2 x Cost Share 1 x Solo Clinic	2 x Fixed Split 1 x Cost Share 1 x Solo Clinic	1 x Fixed Split 2 x Cost Share 1 x Solo Clinic
Size	3 x 3-6 FTE	2 x <3 FTE 1 x 3-6 FTE 1 x 6+ FTE	1 x <3 FTE 1 x 3-6 FTE 2 x 6+ FTE	3 x <3 FTE 1 x 3-6 FTE

1E. Range of Avg FP Billing per 100 sqft of Primary Care Space

1F. Distribution of Average FP Billings per 100 sqft of Primary Care Space



# Of Clinics In The Range	3	4	4	4
Remuneration Model	2 x Fixed Split 1 x Solo Clinic	3 x Fixed Split 1 x Solo Clinic	1 x Fixed Split 2 x Cost Share 1 x Solo Clinic	1 x Fixed Split 3 x Cost Share
Size	1 x <3 FTE 2 x 3-6 FTE	2 x <3 FTE 2 x 3-6 FTE	2 x <3 FTE 1 x 3-6 FTE 1 x 6+ FTE	1 x <3 FTE 1 x 3-6 FTE 2 x 6+ FTE

Figure 1C and 1D consider normalizing average billing by staff expenditure, to identify if higher expenditure of staff corelates with improved provider billing. The three business models show large overlapping ranges. Participating cost share clinics including the highest average billing per staff expenditure and fixed overhead split including the lowest. Clinics with 3-6 FTE show a large range that include both the highest and lowest average billings per staff expense.
Figures 1E and 1F normalize average billings by clinic space, which shows large overlaps between both the business models and clinic size segmentations. Cost share clinics include the highest provider billings, and fixed overhead split, the lowest. Larger clinics boast higher billing averages than other clinic sizes.

However, these averages are lower than those of the other categories when considering billings normalized for clinic size (**1E**). Those with more than 6 FTE of FPs, show the narrowest range and higher average billings clinic size. The clinics with 3 to 6 FTE of FPs on average lag others in billing (per FTE) when normalized for clinic size or staff expenditure.

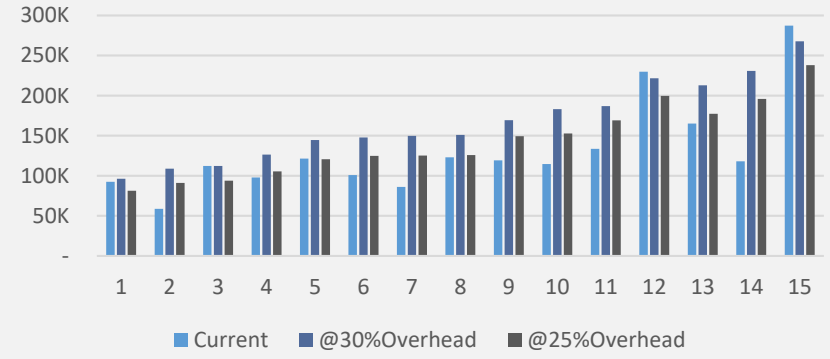
It is important to highlight that these differences may not be indicative of trends among larger clinics, given the ranges within each grouping and the limited number of participating clinics.

To help level the field, hypothetical overheads of 30% and 25% were applied to the FP billings from each clinic. In these cases, the non-FP overheads and other revenues for the clinics were assumed to remain unchanged. **Figure 2A** showcases the differences between the current overheads and the hypothetical ones. Since all participating clinics would generate a positive net income from primary care activities (data not shown), other sections of **Figure 2** highlight the composition of the clinics' overall revenues per FP FTE when a hypothetical 30% overhead is applied to FP billings **(B**) and the range of average primary care revenues per $10K of primary care staffing expense under this (30%) overhead scenario (**C**).

It is important to note that the clinic numbers provided in sections A and B are generated by sorting the clinics based on different metrics and do not represent the same clinics (i.e. clinic 1 or 2 or 14 or X in A may be different than clinic 1 or 2 or 14 or X in B).

FIGURES 2A–C: CLINIC OVERHEAD ANALYSIS

2A. Comparisons of Primary Care Revenue Ranges by Business Model in Current and Hypothetical Scenarios per FP FTE



2B. Composition of Revenues With 30% Overhead per FP FTE

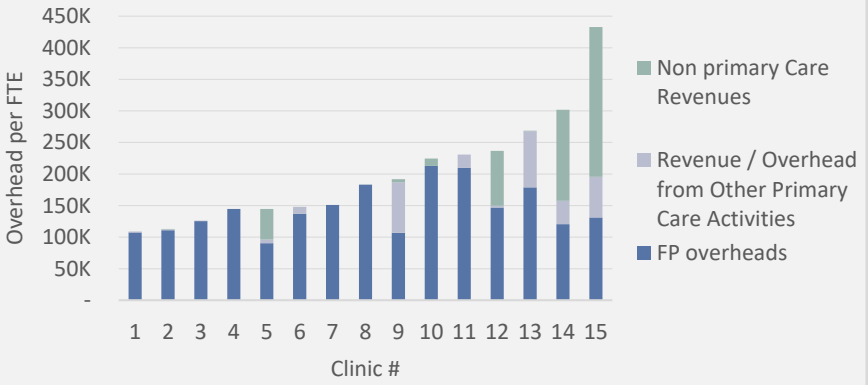


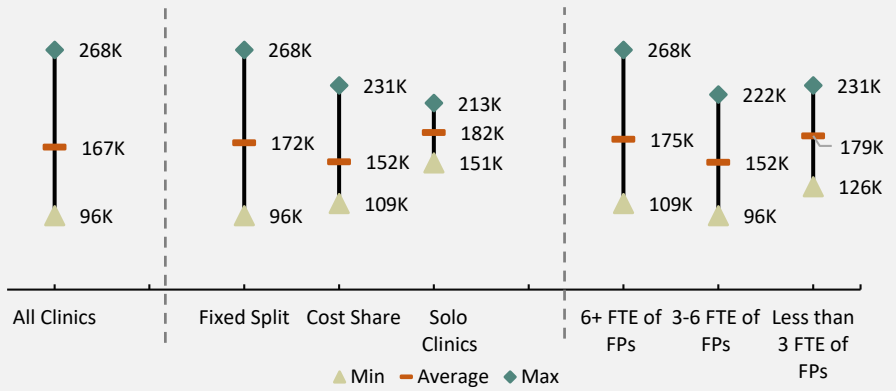
Figure 2A compares the average clinic overheads in current conditions, at 30% overhead, and at 25% overhead scenarios, to highlight how current effective overheads may differ. 2B demonstrates the composition of clinic revenues when a 30% overhead has been applied to only primary care activities. As shown, there is significant differences among clinics for revenue generating activities.

REVENUE

As shown in **Figure 2 (A** to **C)** the overall primary care revenues are impacted by both the provider overheads and the income or loss of non-primary care activities. On average, participating solo clinics fare a bit better per FTE of FPs than those employing fixed splits or cost share. When considering the number of providers, participating clinics with less than 3 FTE of FPs generate higher average primary care revenues than other categories, closely followed by those with more than 6 FTE of FPs.

FIGURES 2A–C CONT'D: CLINIC OVERHEAD ANALYSIS

2C. Revenues from Family Practice Overheads with 30% Overhead per FP FTE



Although the ranges overlap, on average solo clinics and those with <3 FP FTEs generate more family practice revenue per FP FTE than other business models and clinic sizes respectively.

SECTION HIGLIGHTS – REVENUE

- Revenue is directly tied to overall billing in this analysis, with higher billers resulting in greater revenue
- Solo clinics have the highest average billing, followed by cost share clinics
- Clinics with fewer than three physicians have the highest billing, followed by those with 6+ physicians
- Larger clinics have higher billing per unit of space, perhaps as shared spaces and square footage are more effectively spread across providers

EXPENSES

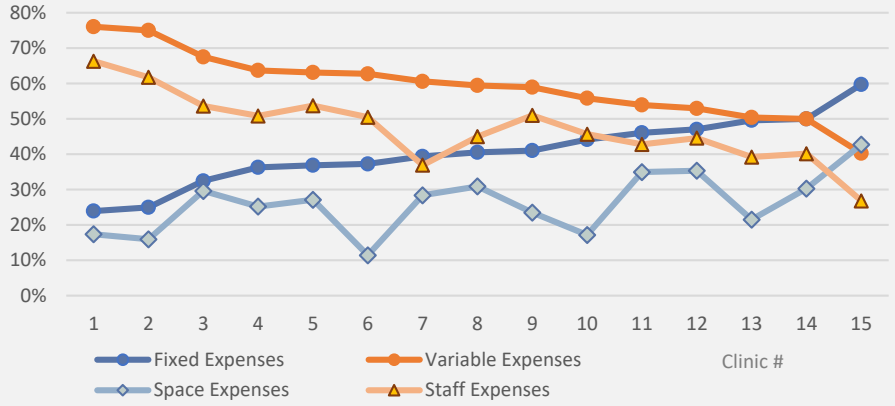
Exploring expenses of the participating clinics can also provide important insights influencing operational efficiency and overall clinic performance. To better compare the clinics, fixed and variable expenses and their largest drivers were considered individually. As shown in **Figure 3**, participating clinics varied significantly in the composition of their expenses. Some had relatively low fixed expenses while others had high proportional fixed expenses. It is important to point out that some (groups of) physicians owned the clinic space while other did not. Among owners, there were variability on their approach to rent, with some charging the clinic approximate market values for rent while others only charged for taxes and strata fees. This may account for some, but likely not all, of the variability seen in **Figure 3A**. Despite individual differences between the clinics, when aggregated, average proportion for the top five expenses seen across clinics were relatively stable (**3B**).

Further exploration of the variability in observed ranges for fixed and variable expenses among the participating clinics are summarized in **Figure 4**.

The observed financial summaries corroborate the pain points regularly elevated by clinics and highlights the importance of efficiently leveraging the staff and space resources. **Figure 4A,** shows that on average participating clinics spent approximately 51K on staffing per FP FTE. This roughly equates to the salary of one FTE of staff with an hourly rate of $24. The summaries also demonstrate the relatively low impact of supplies and other variable expenses on overall financial outcomes.

FIGURES 3A–B: CLINIC EXPENSE COMPOSITION

3A. Fixed/Variable Expenses and Main Expense Drivers as a Portion of Total Primary Care Expenses



3B. Average Proportions of Common Top 5 Clinic Expenses

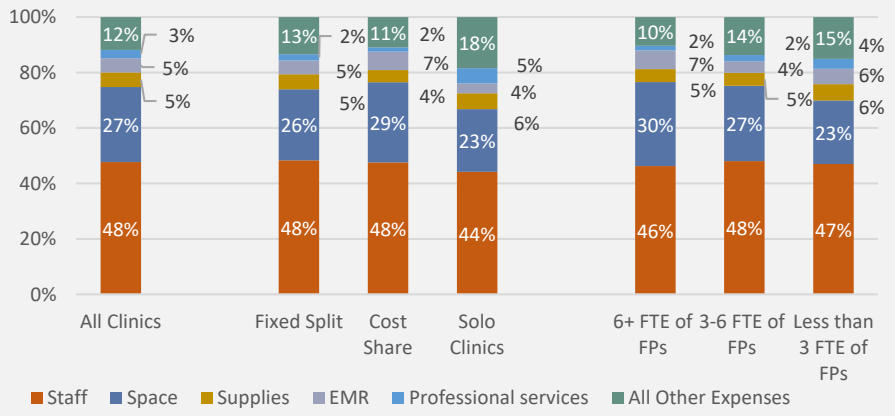


Figure 3A shows the general trends for total variable and fixed expenses as well as the trend for the main driver of each category, staff and space expense, respectively. 3B shows the average proportion of common expenses for all participants and for each subgrouping. As shown the top two expenses for clinics are staff (48% on average) and space (27% on average).

EXPENSES

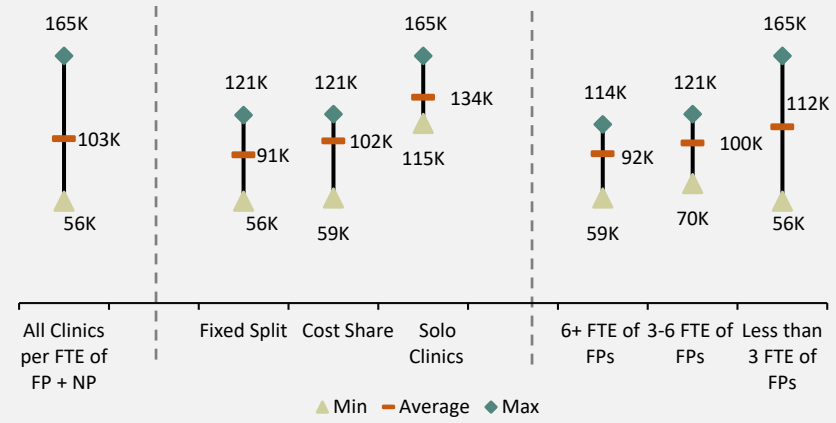
When considering expenses, two different grounding FTE measures were utilized. One, which has been employed throughout this report, normalizes the expenses based on FTE of FPs only (**4C**). However, given that the expenses should also be amortized over all primary care providers, a better grounding metric would be to normalize expenses based on total number of primary care provider FTE, which comprises of both FPs and NPs for some clinics (**4B**). This is the only instance where these related grounding metrics show different trends, and both are included for completeness. As shown in **Figure 4B**, expenses per FTE (of all providers) highlights the economies of scale present at larger clinics, where the average expense for clinics with more than six FTE of FPs ($92k) is lower than those of smaller clinics. Clinics with fixed overhead also show lower average expense per FTE ($91k) compared to other remuneration models.

FIGURES 4A–E: CLINIC EXPENSES PER PROVIDER

4A. Average Primary Care Expenses per FTE and Primary Care Exam Rooms

		Per FP FTE	Per total Primary Care (FP+NP) FTE	Per Primary Care Exam Room
Fixed Expenses	Space	$ 28,953	$ 27,200	$ 16,405
	Telephone, Fax, Internet	$ 2,061	$ 1,955	$ 1,132
	Cleaning, Repairs, and Maintenance	$ 2,969	$ 2,682	$ 1,635
	Professional services	$ 3,261	$ 3,036	$ 1,763
	Other Fixed Expenses	$ 8,834	$ 8,087	$ 5,057
Variable Expenses	Staff	$ 50,940	$ 47,921	$ 28,463
	EMR and Software Subscriptions	$ 6,124	$ 5,693	$ 3,533
	Medical Supplies	$ 2,963	$ 2,701	$ 1,700
	Office Supplies	$ 2,742	$ 2,556	$ 1,497
	Other Variable Expenses	$ 1,270	$ 1,211	$ 717
	Total	$ 110,118	$ 103,042	$ 61,903

4B. Primary Care Expenses per Primary Care (FPs & NPs) FTE for Different Business Models and FP FTEs



4C. Primary Care Expenses per FP FTE for Different Business Models and FP FTEs

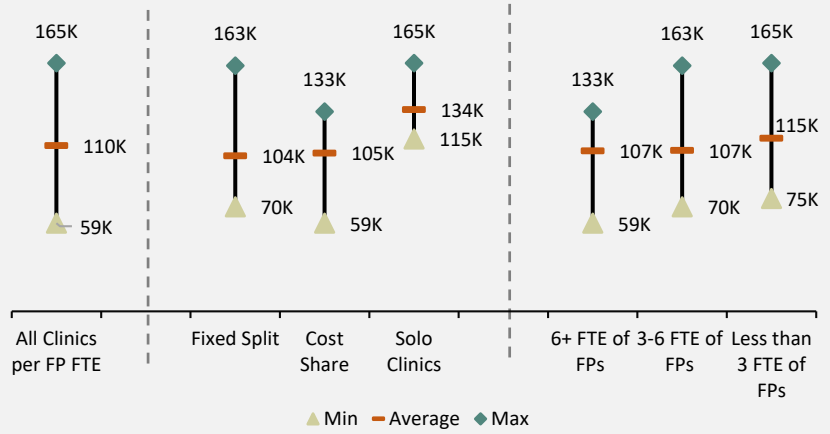


Figure 4A shows the average cost per FP FTE at a clinic is $110K, with each FTE consuming about $51K in staff expense, and $29K in space expense. Average cost per FTE reduces when including NPs because, in effect the denominator has increased by NP FTEs. Note, these methods are used to normalize the expenses for easier comparisons. 4B and C, show the expense range for FTE of FPs + NPs and only FPs respectively. In both cases, expenses per FTE for solo clinics are the highest, with less opportunity for economies of scale. Since in practice, expenses are amortized over all providers, 4B, likely represents a more representative range experienced by clinic providers.

EXPENSES

Figure 4C highlights how the trends would skew if the expenses were not amortized over the entire provider population. Since not all clinics employ NPs, **Figure 4C** is not as informative, in this instance, however it may point to the impact of expense amortization over even a marginally higher number of providers.

Figure 4D and **4E** demonstrate that clinics with less than three FTEs of FPs lag larger clinics in averages for both fixed (**4D**) and variable expenses (**4E**). Among participating clinics, those employing fixed split remuneration models, on average performed better than cost share and solo clinics on both fixed and variable expenses. This may suggest, these clinics pay special attention on reducing expenses to remain competitive.

Considering, even marginal improvement in operations can have a financially significant impact, larger clinics focused on optimizing the utilization of their resources may hold an advantage over smaller and mid-size clinics.

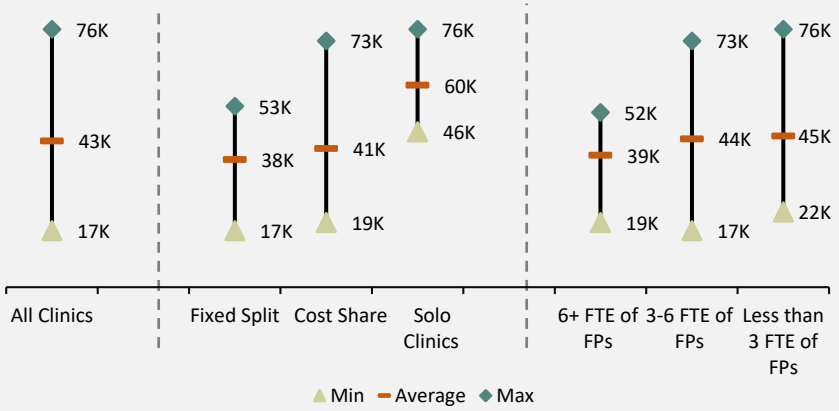
To further explore these trends, the breakeven overhead for FPs in participating clinics were estimated and compared.

SECTION HIGLIGHTS – EXPENSES

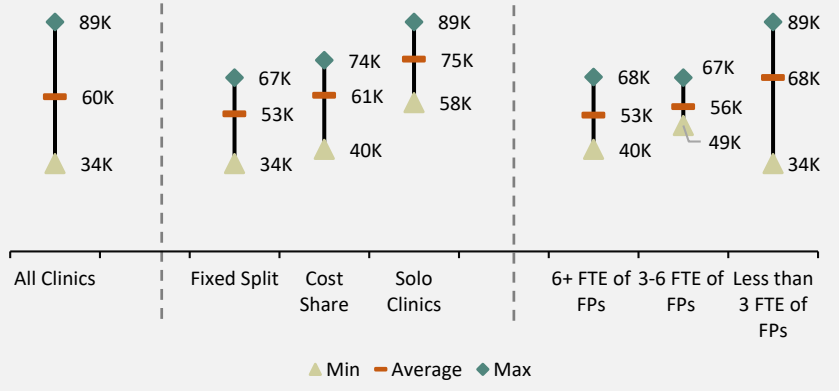
- The top two expenses for clinics are staff (48% on average) and space (27% on average).
- Overall expenses per FTE are highest at solo clinics, and clinics with less than three FTE
- Average primary care expenses per FP FTE at a clinic are 110K (space at 29k, and staff at 51K)

FIGURES 4A–E (CONTINUED): CLINIC EXPENSES PER PROVIDER

4D. Fixed Expenses per All Primary Care (FP+NP) FTE for Different Business Models and FP FTEs



4E. Variable Expenses per All Primary Care (FP+NP) FTE for Different Business Models and FP FTEs



The fixed expenses for cost share clinics show the broadest range, while solo clinics have the highest average fixed expenses per provider FTE. The former likely as a result of inefficient space use, while the latter is likely due to limited economies of scale. Solo and small clinics, on average, experience the highest variable expenses.

BREAKEVEN OVERHEAD

To calculate clinic breakeven overhead, we determined the FP revenue/overhead needed to offset primary care expenses, after application of other primary care revenues (e.g. grants, NP and allied health overhead). The resulting required FP overheads were then divided by overall FP billings. **Figure 5** shows the summary of the analysis.

It may be valuable to point out that breakeven values are used for comparison purposes only. It is not reasonable to expect any clinic to operate at breakeven values. There are annual variability in expenses that may necessitate reserving a buffer when considering individual clinic finances. Additionally, clinic owners take on non-trivial risks and contribute many hours to ensure sustainability of their clinics. Our calculation does not take into account the risk premium that clinic need/should take in form of profit.

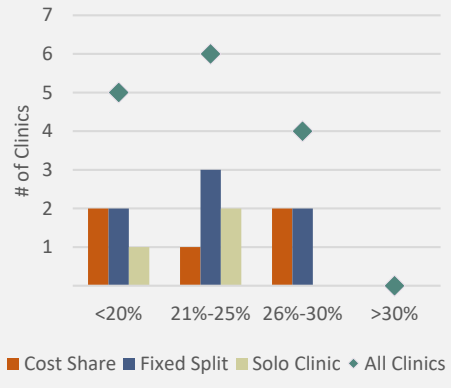
With these caveats, the results showcase the significant differences that may exist between individual clinics in terms of overhead needed to breakeven (**5C**). Lower breakeven overheads were observed in some clinics employing each business model (**5A**). Overall, solo clinics seem to have favorable breakeven overheads, mostly due to efficient provider billings. Clinics with three to six FTE of FP on average had higher breakeven overheads than other clinics, due to both lower billing averages and higher costs per FTE of FP (**5B**).

SECTION HIGLIGHTS – BREAKEVEN OVERHEAD

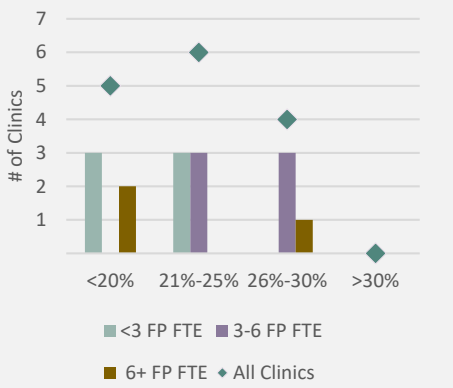
- Large clinics, on average, have the lowest breakeven overhead
- Cost share and solo clinics have slightly below average breakeven overhead

FIGURES 5A–C: BREAKEVEN OVERHEAD ANALYSIS

5A. Breakeven Overhead Ranges for Clinic's Primary Care Activities By Overhead Model



5B. Breakeven Overhead Ranges for Clinic's Primary Care Activities By FP Numbers



5C. Breakeven Overhead Averages for Primary Care Activities For Different Clinic Types

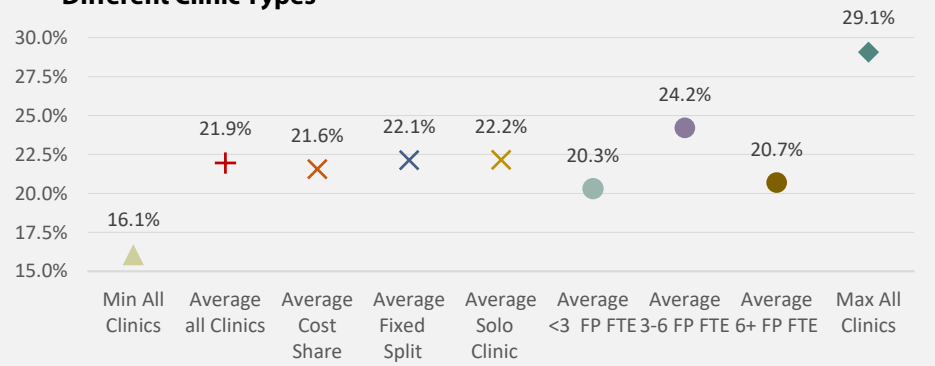


Figure 5A and 5B represents histograms of the breakeven overhead ranges for overhead models and FP FTEs respectively. 5C shows the average overhead for all clinics as well as each subgroupings. The average breakeven overhead is 21.9%, ranging from 16.1% to 29.1%. Clinics with <3 FTE have the lowest average breakeven overhead, closely followed by those with 6+ FTE, while clinics with 3-6 FTE have the highest.

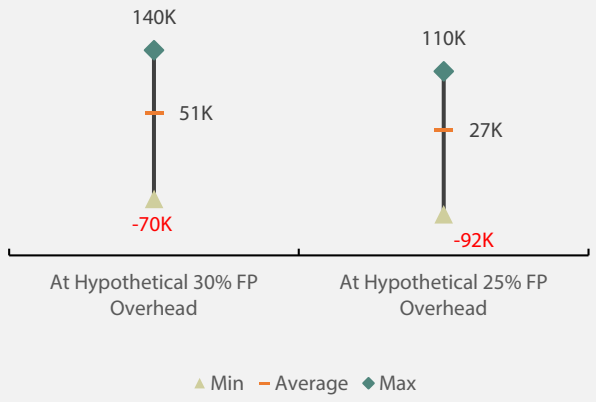
NET INCOME

The summary of the participating clinics' data points to the complexity and interconnectedness of the factors that determine the financial viability of clinics of different sizes and business models. This section considers the financial sustainability of the participating clinics under hypothetical overheads of 30% and 25% applied to physician billings. Similar to previous sections, other primary care revenues such as overhead from NPs and other practitioners, grants and initiative fundings are assumed to remain the same as they appear in clinics' financials.

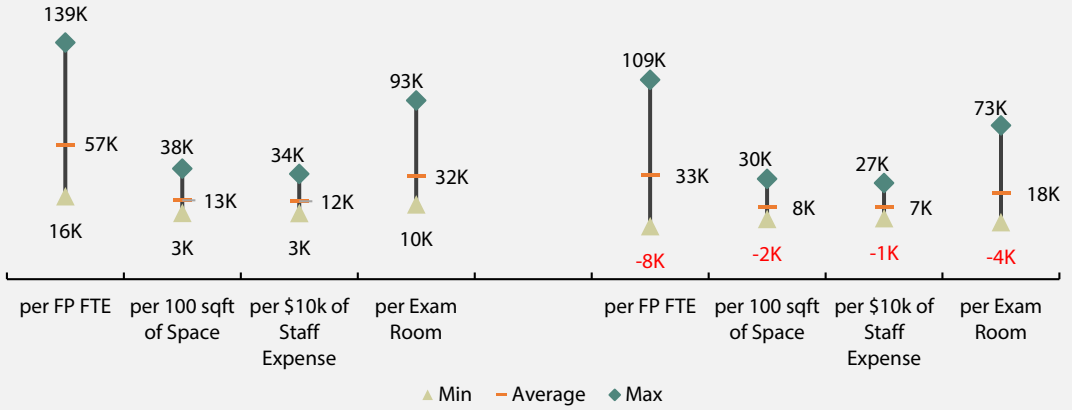
To present a complete picture, **Figure 6A** summarizes the clinic net income from all clinic activities, since some clinics financials are significantly impacted by other non-primary care activities. **Figure 6B** and **Figure 7** focus on the primary care activities as they are more relevant to the objectives of this project.

FIGURES 6A–B: NET INCOME ANALYSIS

6A. Net Income from All Activities per FP FTE



6B. Net Income from Primary Care Activities Per Normalization Criteria



Net income ranges from all activities (6A) includes a negative number, as one of the participating clinics generated a loss from a non-primary care stream. 6B shows the net income from primary care activities under hypothetical 30% and 25% FP overheads. On average, clinics would achieve a positive net income in both the 30% and 25% overhead scenario. However, more clinics would operate at a loss in the 25% overhead scenario.

The data suggests that when considering all clinic activities, even at 30% FP overhead, at least some clinics operate at a loss. However, when considering only primary care activities all clinics show a positive net income, suggesting other non-primary care activities in some clinics negatively affect clinic financials. However, the outlook for clinics changes at 25% FP overhead, with some becoming financially unsustainable. This threshold suggests, even without expectations to generate a profit or risk premium, a non-trivial number of clinics in Vancouver couldn't afford to offer a 25% overhead to their providers and still operate with a profit (or breakeven). To better understand the clinics' financial sustainability under the hypothetical overheads, the net income per FTE of FPs under each scenario were compared, as shown in **Figure 7**.

NET INCOME

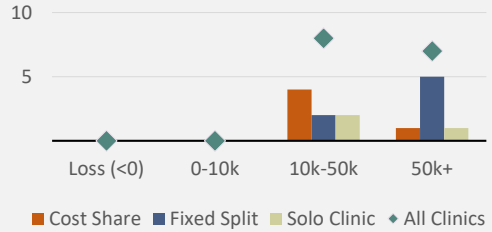
As shown in **Figure 7**, all participating clinics would operate with a positive net income of at least $10K per FTE of FPs, if the FPs were to pay 30% overhead. This would suggest that the clinics would be able to reserve some funds for a modest buffer and still function sustainably. When overheads are reduced to 25%, three of the 15 clinics (~20%) would operate at a loss and another two clinics would generate less than $10K per FTE of FPs; It could be argued that if the clinics were to increase overheads, to reserve a modest buffer, at least some of these clinics may operate at a loss. It is, therefore, important for any clinics considering an overhead reduction to review their financials diligently to ensure continued sustainability.

SECTION HIGLIGHTS – NET INCOME

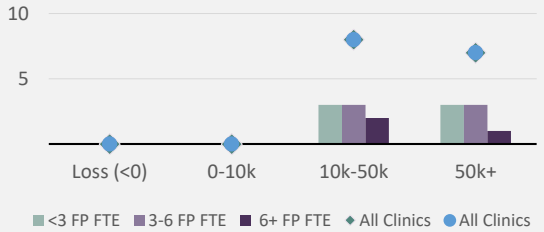
- All clinics achieve a positive net income from their primary care activities at a hypothetical 30% FP overhead
- Some clinics operate at a loss as a result of their non-primary care activities
- Some clinics would not break even if they offered a 25% overhead split

FIGURES 7A–D: A NET INCOME ANALYSIS BY OVERHEAD MODEL AND SIZE

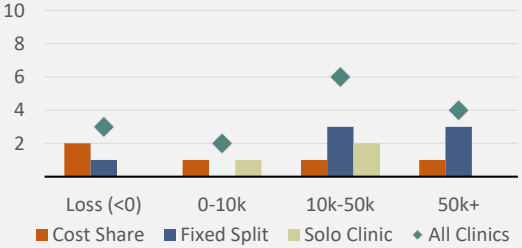
7A. Primary Care Net Income at Hypothetical 30% FP Overhead per FP FTE By Overhead Model



7B. Primary Care Net Income at Hypothetical 30% FP Overhead per FP FTE By Provider Numbers



7C. Primary Care Net Income at Hypothetical 25% FP Overhead per FP FTE By Overhead Model



7D. Primary Care Net Income at Hypothetical 25% FP Overhead per FP FTE By Provider Numbers

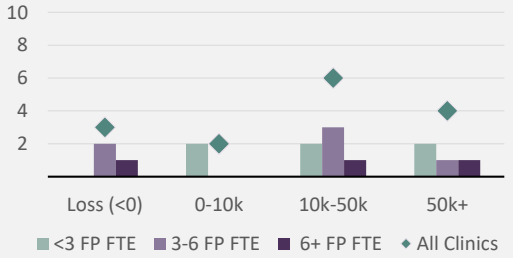


Figure 7A and 7B show the net income at hypothetical 30% fixed overhead per FP FTE for each overhead model and physician FTE cohorts respectively. 7C and 7D show the comparable net incomes at hypothetical 25% fixed overhead per FP FTE for each overhead model and physician FTE. The histograms show that with a hypothetical 30% overhead, all participating clinics would generate over $10K of net income per FP FTE. With a hypothetical 25% overhead, three of the clinics would operate at a loss and another two would generate less that $10k of net income. These calculations do not account for operating buffer, future capital expenses, the clinic owner(s) risk premium or other non-operating expenses and, therefore likely, overestimate the net income.

OPERATING MARGIN

Net income can contextualize the potential size of the clinic's profits, but not profitability. Operating margin instead calculates how much profit is generated from every dollar of clinic revenue and is a valuable metric that provides an added measure of a clinic's financial efficiency.

As shown in **Figure 8E**, with a hypothetical 30% overhead, clinics currently employing a fixed split model showed a higher operating margin (37.2%) compared to cost share (29.2%) and solo clinics (26.1%). Larger clinics with more than six FTE of FPs show the highest operating margins at 30% overhead (36.4%), compared to those with less than three FTE of FPs (34.5%) and three to six FTE of FPs (28.1%), likely due to the better economies of scale that accompany larger clinics.

Not surprisingly, although the general trends remain similar, the operating margins are significantly reduced when hypothetical overheads were changed to 25% (**8E**). Moreover, like the trends seen with net income, this change in hypothetical overhead also results in far less sustainable financial outcomes for all clinics, with three clinics (20%) operating with negative margins and an additional three (20%) having lower than 10% operating margins (**8C** and **8D**).

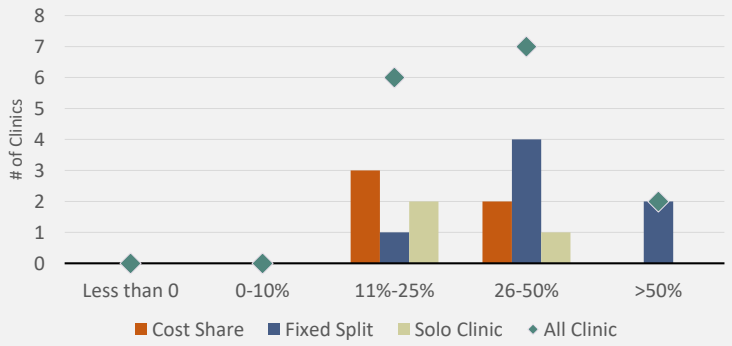
Participating clinics employing fixed split remuneration show large variations in their operating margins, however a majority of them operate at a higher-than-average margin. Similar trends were seen for clinics with more than six FTE (**8A** to **D**). These variations may be exaggerated due to one or two clinics undergoing changes.

SECTION HIGLIGHTS – OPERATING MARGIN

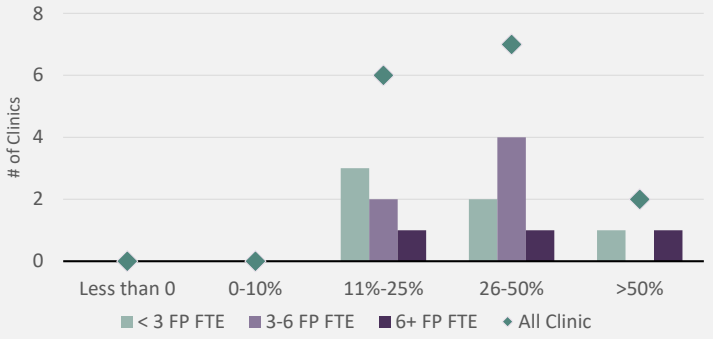
- Operating margins can be useful to determine how efficiently a clinic manages cost to generate profit from operations
- Those with fixed overhead splits and over six FTE of physicians were more likely to have higher operating margins
- Cost share clinics were more likely to have lower margins

FIGURES 8A–E: OPERATING MARGIN ANALYSIS

8A. Primary Care Operating Margin Ranges at Hypothetical 30% FP Overhead By Business



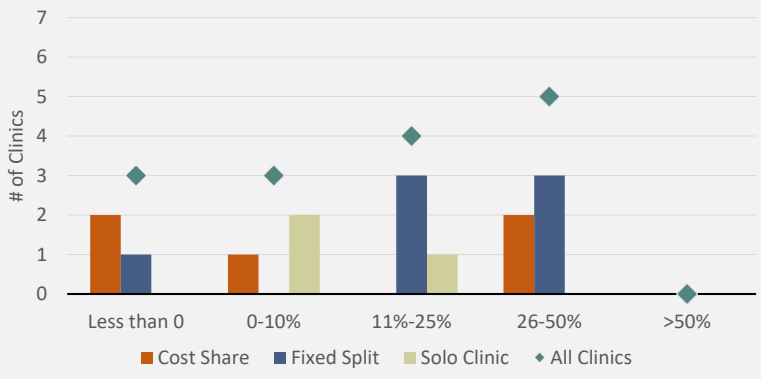
8B. Primary Care Operating Margin Ranges at Hypothetical 30% FP Overhead By Provider Numbers



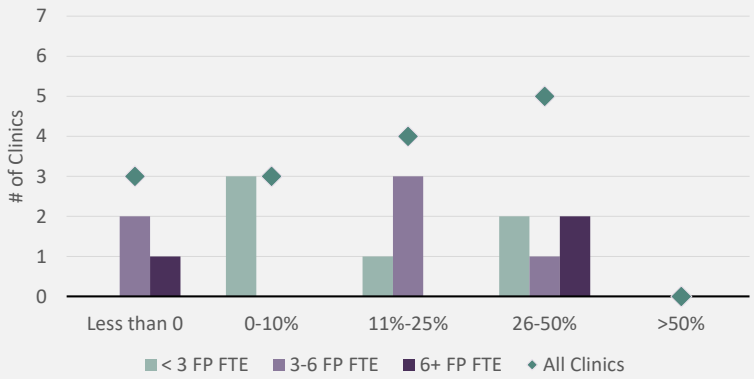
Among the participating clinics, those with fixed overhead splits and over 6 FTE of physicians were more likely to have higher operating margins, while cost share clinics were more likely to have lower margins.

FIGURES 8A–E (CONTINUED): OPERATING MARGIN ANALYSIS

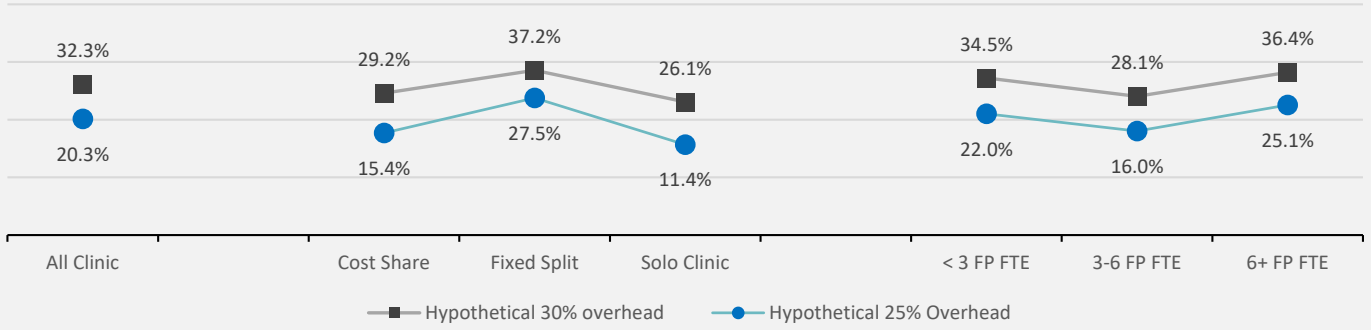
8C. Primary Care Operating Margin Ranges at Hypothetical 25% FP Overhead By Business



8D. Primary Care Operating Margin Ranges at Hypothetical 25% FP Overhead By Provider Numbers



8E. Comparisons of Average Operating Margins at Hypothetical Overheads of 30% vs 25%



Similar to results of 30% overhead, 8A and 8B, with hypothetical 25% overheads, clinics with fixed overhead splits and over 6 FTE of physicians were more likely to have higher operating margins. 8E shows the average operating margin for all clinics as well as sub-category averages based on operating model and physician FTEs in both 30% and 25% overhead scenarios. Solo clinics experience the most significant drop in operating margin when switching from 30% to 25% hypothetical overhead, and larger clinics enjoy the highest operating margins in both overhead scenarios.

GENERAL TRENDS AND INSIGHTS

Improving Revenue Drivers

Provider billing levels play a pivotal role in determining clinic success, often correlating with above-average outcomes. Among clinics ranking in the top five for billing per FTE, four also ranked within the top five for net income, and three were among the top five for operating margin. Billing is a consequential factor influencing profitability, optimizing this metric can help clinics create a "breathing room" when navigating challenges related to other suboptimal indicators.

A few of the participating clinics also engage in additional non-primary care activities. For half of these clinics, such activities enhanced their profit margins, while for the other half margins declined. In some instances, such activities may be necessary for securing initiative funding, despite potentially reducing overall profit margins. Additional activities can significantly bolster a clinic's financial performance when executed effectively. Without proper planning and oversight, they can also undermine a clinic's financial performance.

Leveraging Cost Drivers

A review of clinic financials indicates that staff and space expenses represent the largest cost components for clinics in Vancouver. Clinics that optimize these resources, while maintaining similar billing efficiencies and panel complexities, demonstrate greater financial sustainability.

On average, participating clinics spent approximately $51K on staffing per FP FTE. This roughly equates to the salary of one full-time of staff with an hourly rate of $24, pointing to the approximate 1:1 ratio of provider to MOA FTE observed in many clinics. Yet, this figure varies depending on how clinics utilize their staff. Notably, staff expense is not directly linked to profitability but influences other performance metrics. Staff expense variations are also challenging to decipher. In some clinics, low staff costs may signal efficient use of resources but in other cases it may point to inefficiencies due to understaffing.

Other expenses, including those outside of staff and space costs, should also be closely monitored. In some cases, these additional expenses exceed $40K per physician FTE. While such costs may be justified for services like allied health, they can also signal excessive spending that requires further investigation.

Clinic Breakeven Overhead

The average breakeven overhead among participating clinics is 22.4%, indicating the percentage of a clinic's billings that must be allocated to operational expenses for the clinic to achieve zero net income. Based on the data, if participating clinics were to employ a 25% overhead split, 20% of the clinics would operate at a loss and an additional 20% would generate net incomes of less than $10k per FTE of FPs, leaving them little breathing room to overcome unexpected expense increases or provider practice changes. A further reduction in overhead splits to 20% would cause 47% of clinics to operate at a loss and another 13% with net income of less than $10K per FTE of FPs.

GENERAL TRENDS AND INSIGHTS

It is important to note that the calculation of breakeven only considers operational expenses. Amortization, depreciation, loan payments, risk premiums and other elements impacting a clinic's overall financial health are omitted from breakeven calculations. Reasonably, private clinic owners typically aim for profits exceeding the breakeven threshold to justify the risks undertaken and additional expenses. With the introduction of Longitudinal Family Physician (LFP) payment model, some clinics may be able to reduce overheads. Clinics considering an overhead reduction should forecast their financial performance under likely potential scenarios and incorporate a reasonable buffer to ensure continued sustainability.

Operating Models

Operating models influence both financial and operational outcomes. Among the participating clinics, those with overhead splits demonstrate a slightly higher breakeven overhead (23.2%) compared to cost-sharing (21.6%) or solo clinic models (21.9%). Primary care billing per provider also varies based on business models, with solo clinics achieving the highest average billing per FTE (~$631K), followed by cost-share clinics (~$490K) and overhead-split clinics (~$380K). On the expense side, economies of scale appear to benefit overhead-split models, resulting in the lowest total expenses per FTE ($~100K) compared to cost-share (~$105K) and solo clinics (~$132K). Net income, operating margins, follow similar trends, highlighting the relative efficiency of overhead-split clinics.

Clinic Size

Clinic size also has a profound impact on financial performance. Clinics with fewer than three physicians exhibit the highest average billing per FP FTE (~$557K), although this may be influenced upwards by the solo clinic earnings (averaged at ~$608K). Clinics with 6+ physicians show average billings of $481K per FP FTE and those with three to six physicians generate ~$400K per FP FTE. Although this project only considered the financial outcomes, and did not focus on underlying cause(s) for these variances, it is possible that solo and small clinics in this study may represent survivorship bias. Perhaps those solo offices who were not significant billers were not sustainable on their own, and they have since either moved or closed, or they simply did not have bandwidth or interest to participate in this initiative.

Smaller clinics often rely on high individual billers who prefer autonomy, while larger clinics consolidate resources to optimize efficiency. Larger clinics benefit from economies of scale, as reflected in their higher operating margins (36.4%) with hypothetical 30% overhead compared to those with less than three (34.1%) and between three to six FPs (28.1%) respectively. Clinics with 6+ FTE of FPs also show the lowest average expenses per total primary care providers (~$91K) compared to those with 3-6 FTE of FPs (~$102K) and those with less than 3 FTE of FPs ($112K). Similarly, net income per FTE is highest for clinics with 6+ physicians, emphasizing the advantages of scalability in achieving financial sustainability.

OPPORTUNITIES AND NEXT STEPS

Insights from this analysis were meaningful and peaked curiosity about what a larger dataset could reveal. To glean further insights, there are a few ways we would recommend expanding this progress.

Participating Clinics - Annual Analysis

- Re-analyzing and following these participating clinics for two to three years would reveal interesting trends in rising costs and changes in the business environment. This could more clearly identify long term drivers of profitability or risks to sustainability.
- Using a few years of data for analysis might remove any discrepancies or outlier years for clinics. This analysis could not only compare the metrics by subgroupings over different reporting periods, the trends seen for individual clinics would also be valuable information for clinics.

Additional Clinics

- Other Vancouver clinics – Expansion of the sample size from 15 could increase the accuracy and significance of the findings. This could begin a benchmarking exercise for all Division clinics to understand typical or average values to operate within.
- Lower Mainland – Expansion of the region to include clinics outside the City of Vancouver could provide meaningful information about the similarities and differences of primary care clinics operating in different areas of the Lower Mainland. Again, this expansion may increase the significance of findings.
- Provincial analysis – Expansion of this type of analysis to different health regions across the province could meaningfully show the differences between operating in different geographic regions of the province. This might also explore differences found in urban vs. rural regions, and how business opportunities and challenges may differ.

Future Topics for Additional Depth of Analysis

Future iterations could provide opportunity to further explore topics that were not included in this project.

- Staff expenditure could be explored further by comparing the staff numbers to provider ratios, comparing staff wage ranges, and mapping staff seniority amongst their MOA compliment. Additionally exploring staff turnover would uncover some of the true costs of poor retention, as well as identify how to operate with maximum staff efficiency.
- Clinic size could be explored further if larger clinics (eight+ FTE) want to participate. This would better allow the exploration of economies of scale in very large primary care clinics, to find the potential benefits of 'mega-clinics'. This analysis would depend on finding large clinics to participate.
- Space costs could be explored further, including historical leasehold improvement costs, lease price increases, and the potential benefits and comparisons of lease versus ownership of space.
- Billing efficiency as well as the makeup of billing totals on the LFP, and how panel complexity and volume may play a role, would be worth exploring when trying to improve top line revenue.

Expansion and continuation of this project to additional clinics and regions would provide meaningful information for both individual clinics and for regional and provincial decision makers. Elevating real information relating to the cost of primary care in BC can better support our primary care clinics and providers and allow them to continue the important services they provide our communities.

CONCLUDING REMARKS

This analysis demonstrates that various revenue and expense drivers influence net income and ultimately determine a clinic's performance. On the expense side, staffing and space expenses far outweigh other categories in their impact. Ensuring efficient recourse utilization is important for profitability. On the revenue side, clinics with high billing levels per FP FTE will have more "breathing room" and can compensate for underperforming metrics and better manage unexpected challenges. Not surprisingly, participating clinics that ranked in the top five with respect to billing, four of them were also in the top five of net income and three of them were in the top five for operating margin. Additionally, improving overall billings, perhaps through intentional recruitment of productive billers with appropriate incentives may be worthwhile. These efforts should occur in conjunction with influencing other metrics such as MOA performance or improving clinic utilization rates. In all cases, examining metrics associated with billing efficiency should be one of the elements that is top of mind for clinics looking to improve financial outcomes.

Interestingly, all participating clinics demonstrate uneven performance across different metrics. Most clinics overperform on some metrics, and underperform on others, leaving their clinic at a somewhat of an average state, and operating at less than full potential from a financial perspective. Notably, none of the participating clinics outperformed across all metrics, underscoring the inherent challenges and balancing act involved in operating a successful medical clinic.

APPENDIX A – ACRONYMS AND DEFINITIONS

Some language in this report refers to common terms in primary care. For clarity and reference, some acronyms have been explained and key terms defined below.

Acronyms

FP – Family physician

FTE – Full Time Equivalent. In this analysis, providers working 8 half days per week was considered 1.0 FTE.

LFP – Longitudinal Family Physician Payment Model

MOA – Medical Office Assistant

MoH – Ministry of Health

NP – Nurse Practitioner

Overhead – The part of a family physician's total billing that they contribute to the clinic for operational costs (staff, rent, supplies, etc.) Further detail defined on the right.

PCN – Primary Care Network

Primary care space – Clinic space dedicated to primary care services usually consisting of exam rooms, reception, hallways, and offices used by FPs and NPs. If clinics have other services, best efforts have been made to proportionally identify the primary care portion of space.

Key Definitions

Primary care clinics often run by collecting revenue from providers working at the clinic to cover costs of operating. This revenue can be captured many ways, three of which were outlined in this report.

<u>Remuneration Models</u>

- **Fixed Split** – All providers at the clinic pay a fixed percentage of their earnings toward clinic overhead. For example, 30% of their billings may be their contribution, often referred to as a *70/30 overhead split*.
- **Cost Share** – Clinic costs are split between providers at the clinic. Providers otherwise keep all of their billings once the clinic expenses have been covered.
- **Solo Clinic** – As there is only one provider in a solo clinic, they are responsible for all expenses. However, they also get to keep all of their billings once the expenses are paid.