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A Case Study: Evaluating the Implementation of Eligibility Screening and Sliding Scale Payments in A Community Clinic

Carol Passley

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A Case Study: Evaluating the Implementation of Eligibility Screening and Sliding Scale Payments in A Community Clinic

by

Carol Passley

A Dissertation Submitted in Partial Fulfillment of the Requirements for the Degree

Of

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ACCEPTANCE

This dissertation was prepared under the direction of the *CAROL PASSLEY* Dissertation Committee. It has been approved and accepted by all members of that committee, and it has been accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Business Administration in the J. Mack Robinson College of Business of Georgia State University.

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The path from dreams to success does exist. May you have the vision to find it, the courage to get on to it, and the perseverance to follow it. Kalpana Chawla

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ABSTRACT

A Case Study: Evaluating the Implementation of Eligibility Screening and Sliding Scale Payments in A Community Clinic

by

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Nineteen percent of the Cherokee County, Georgia, population is uninsured, and the ratio of population size to the number of physicians is 2,950:1. It is evident from the data that there is a need for more health care practitioners in Cherokee County who can deliver adequate care to the residents of the county. Recognizing the need to help uninsured individuals in the county, a community clinic opened its doors in 2011 to address the gaps in care. However, over the years, the increase in the number of patients being seen without the financial ability to pay has resulted in the decreased viability of the clinic. The board of directors had to consider ways to improve its financial outcomes. One such way was to consider eligibility screening, with sliding scale payments based on the screening. The study was guided by one research question: How does one community clinic implement a process innovation that requires cultural and structural shifts to obtain and sustain financial viability?

INDEX WORDS: Eligibility, Screening, Community clinic, Uninsured, Underinsured, Health care

I INTRODUCTION

I.1 Problem

According to the Georgia Department of Public Health (GDPH, 2017), 19% of Cherokee County's 235,000 residents are uninsured, and the ratio of the population size to the number of physicians is 2,950:1. Recognizing the need to help individuals in the county who are uninsured, a community clinic opened its doors in 2011 to address the gaps in care. The clinic provides internal medicine services, pediatric care, basic gynecology care, laboratory services, and prescription services. However, the revenue generated by the clinic is unable to sustain current operations.

The clinic that was the setting of this study is a 501(c) 3 nonprofit organization that provides quality and affordable health care services to individuals who are uninsured and underinsured. The focus of the clinic is to provide primary medical care as well as health programs that encourage positive behavioral changes. The clinic employs nine part-time workers and has 31 volunteers: two nurse practitioners, one nurse-midwife, four medical doctors, 10 registered nurses, five administrative staff who assist in the front office, two registered dieticians, two interpreters, one medical assistant, two certified nursing assistants, and two community relations/grants liaisons. Of the individuals mentioned, three midlevel providers, two front office staff, one nurse, and one community relations liaison are paid on a part-time basis.

This not-for-profit community clinic in northwestern Georgia is experiencing financial difficulties because of its inability to generate sufficient revenue to keeps it doors open for the population it serves. Of note, the clinic's net operating loss for 2015 was more than $100,000. The clinic currently charges a fixed amount of $45 to all patients, regardless of their ability to pay, and it serves approximately 4,800 patients yearly, of which 1,072 are new patients to date.

Attempts were made to compare the cost structure of the clinic to other clinics throughout the state, but such a comparison was difficult to complete because most clinics are federally monitored and have an automatic computing algorithm in place for their electronic health systems. In addition, staff members at those clinics were unable to verbalize how the computation was used.

I.2 Demographics

The demographics of the patient population of the clinic are broken down by gender and ethnicity in Table 1.

Table 1 Demographic Information of the Patient Population of the Clinic

Gender	%
Male	35%
Female	65%
Race/Ethnicity	
Asian American	1%
African American	10%
Hispanic American	27%
European American	62%

With a significant part of the population of Cherokee County without health insurance and the decreasing financial viability of the clinic, the clinic leadership is considering implementing an eligibility process for patients to determine whether eligibility screening would improve its financial outcomes while it continues to provide care.

The clinic has explored additional ways to generate revenue, such as increasing the cost of laboratory services, but those increases have not impacted the negative financial outcomes significantly. In addition, the clinic used to be open 5 days per week, but it is now open only 2 days per week because of the ongoing financial constraints. The health care providers at the clinic see approximately 30 to 40 patients on each of the 2 days over their 8- or 12-hr shifts. Clinic staff have been turning patients away because of their inability to accommodate them

during the days that the clinic is open. It was apparent that the clinic needed to remain open to deliver the quality of health care that patients required.

I.3 Area of Concern

After giving careful consideration to the continued financial constraints and the recent reduction in services, the leadership team of the practice manager, the clinical manager, and board members decided to implement eligibility screening and sliding scale payments as one way to improve the clinic's financial situation in order to sustain the practice. Eligibility screening has been used in other clinic settings, but not in this clinic; therefore, the leadership team wanted to understand the effect that this change would have on financial viability, clinic efficiency, and employee satisfaction. Consequently, the purpose of the study was to understand the impact of implementing eligibility screening as a process innovation, which combines business application with a new route of cost effectively meeting the organization's initiatives. (Davenport 1993).

I.4 Importance of Keeping the Clinic Open

It was evident from the GDPH (2017) data that there is a need for more health care practitioners in Cherokee County to deliver adequate care. The leadership team at the clinic believe that the clinic acts as a safety net and that because the care being provided is vital and needed in Cherokee County, they want to continue providing those services. According to Ko, Murphy, and Bindman (2015), safety net providers dispense a "significant level of health care to uninsured, Medicaid, and other vulnerable patients" (p. S676). This belief was supported by Nadkarni and Philbrick (2003), who asserted that community clinics are among the facilities considered safety net agencies. Keeping this safety-net clinic open and financially viable became a priority for all.

I.5 Framing

This study followed a process innovation approach to assess the impact of implementing eligibility screening and sliding scale payments. Process innovation involves the complete redesign of a process that is augmented by technology and resources from the organization (Davenport, 1993). Considering that no existing prescribed application process was being used by the organization, implementation of eligibility screening involved structural and cultural changes.

To better explore the problems that the clinic was experiencing at the time of this study, a review of the literature was conducted. Key search terms included *the advent of community clinics, the barriers and areas of opportunities, defining eligibility screening, sliding scale,* and *organizational change*. The process innovation framework was applied to this study. The methodology is discussed in Chapter 3.

II LITERATURE REVIEW

II.1 Community Health Centers

Lefkowitz (2005) stated that community health centers were developed in 1965 to provide primary care to individuals who were poor and underserved in Boston, Massachusetts. Fiscella and Geiger (2014) remarked that to date, 1,200 community health centers have been formed to assist approximately 23 million low-income patients throughout the United States. These centers are considered health safety nets because they provide aid to low-income, uninsured people, but Cunningham, Bazzoli, and Katz (2008) stated that these centers are experiencing an increase in the need for care while simultaneously being unpaid for the care delivered.

Georgia has more than 90 community health centers in 67 counties throughout the state (Adamcak, Catalon-Scott, Freeh, & Poole, 2013). However, Cherokee County has only one community clinic to serve its population. How does a community clinic improve its financial outcomes if it wishes to remain open and care for individuals who are poor and underserved, given the financial constraints? What areas of opportunities could the clinic in Cherokee County explore to improve its financial outlook so that it could reopen for 5 days each week?

II.1.1 *Areas of Opportunities*

Fiscella and Geiger (2014) discussed five threats to community health clinics in their examination of ways that safety net providers could stay viable in the changing environment:

(a) federal funding and whether states will implement the changes, (b) states are not expanding Medicare and Medicaid, (c) development of accountable care organizations, (d) an increase in the number of underinsured patients, and (e) competition from advance care practitioners. However, a review of the literature identified many opportunities that community

clinics could explore to improve their financial outcomes. Fiscella and Geiger suggested several opportunities related to improving payment processes: (a) increasing Medicaid in states where expansion has occurred as a way to bring more revenue to the clinic, (b) improving the capacity of the clinic, and (c) transforming the payment system.

Allen, Davis, Hu, and Owusu-Amankwah (2015) examined the willingness of rural residents to pay for care, and they similarly concluded that the acceptance of Medicaid/Medicare expansion would be instrumental in increasing revenue to rural health clinics and private practices. Allen et al. also suggested using a sliding scale fee structure. Hall (2013) explored the barriers to caring for uninsured patients in a community specialist practice and determined that it can be difficult to decide which patients are truly in need of charity care. He suggested that another possible solution might be to implement an eligibility determinant, notwithstanding patients' ability to pay. However, how does eligibility screening happen, and how could a sliding scale fee schedule impact the financial outcomes of the clinic?

Despite the suggestions of Allen et al. (2015) as well as Fiscella and Geiger (2014) to accept Medicaid expansion as one way of increasing revenue, this clinic in Cherokee County could not attempt the Medicare/Medicaid expansion option because Georgia did not accept the Medicaid/Medicare expansion offered under the Affordable Care Act. In addition, accountable care organizations are federally affiliated, so members of the clinic's board of directors were not interested in exploring any option that was federally indicated.

However, the suggestion made by Allen et al. (2015) and Hall (2013) to implement eligibility screening as one measure of generating revenue was embraced. The leadership team then decided to explore a sliding scale fee option after completing patient eligibility assessment

screening as a way of transforming the payment system. Defining and exploring the tools used in the research was addressed.

II.1.2 *Eligibility Assessment Screening*

Eligibility screening was not offered at the clinic because of the inability of the clinic leadership to have a paid employee who could focus on completing the task. However, as more volunteers began to offer their time, clinic administrators thought that this time might be ideal to initiate the role. These individuals would be responsible for screening all patients for their ability to pay for services before they were seen by the practitioners; in addition, as they were seeing the patients, complete admission assessments would be undertaken to improve communication between and among the health care providers at the clinic.

To assess how eligibility screening is completed, a comprehensive review of the literature indicated that federal law requires that states participating in Medicaid must provide coverage for certain groups of people, namely, low-income families, pregnant women, children; individuals receiving supplemental security income, home, and community-based services; and children in foster care. A Modified Adjusted Gross Income document, which was developed by the federal government, is used to determine financial eligibility for Medicaid, and the approach considers the relationship between taxable income and tax filing to decide which applies (U.S. Department of Health and Human Services, 2017). The document informed this research, even though the clinic does not accept Medicare/Medicaid because it is a cash-only clinic and is not interested in any federal approach. Guidelines for the creation of an eligibility screening tool were established by the federal government and have the following indicators:

- State, name, and contact information of the individual completing the verification plan.

- State should choose the verification plan.
- Verification procedures for factors of eligibility.
- Financial.
- Nonfinancial.
- Additional factors of eligibility.
- Additional verification questions.

II.1.3 *Definition of Sliding Scale*

A sliding fee discount program originated from the concept of giving patients who are financially capable the ability to reimburse health care providers for their care. This concept was designed to address patients at or 200% below current federal poverty guidelines ("Discount Fee Schedule," 2017). Hall (2013) examined the perceived barriers that providers mentioned when asked to care for uninsured patients, and they identified two limitations: making the extra effort to determine which patients qualify for free care and arranging for services that patients need from other providers. Hall suggested that a sliding scale approach be considered to reduce such barriers.

II.1.4 *Additional Material Informing the Study*

Georgia conducts a training program to educate all community clinics on the process required to implement eligibility screening. The training is completed in a 2-hour session by a representative of the state. After the training, participants are considered eligibility specialists whose primary role is to complete the required forms accurately. The assessment is done to ascertain patients' financial ability to pay based on whether their income is 100% to 200% of the gross total income of the federal poverty level (FPL). Elements of the eligibility form must meet the requirements of the federal government and include the following information: financial

declaration, demographic screening, insurance information, and financial eligibility (GDPH, 2017).

II.1.5 *Financial Declaration*

On their initial visits to the clinic, patients must bring with them proof of income. This proof might include the two most recent W-2 forms, check stubs for 2 consecutive months, 2 most current years of completed tax returns, or a notarized letter from place of employment. Other types of paperwork needed might include a recent award letter from the social security or disability office, a statement from the department of labor showing unemployment benefits, or a statement from the department of family and children services. Only one of the items is required to prove financial eligibility.

II.1.6 *Demographic Screening*

Patients' names, including middle initials, must be entered completely on the assessment form to reduce the risk of administering care to the wrong patients. They must be able to provide telephone numbers or emergency contact numbers. Patients also must bring with them current and valid government-issued photo identification, such as a driver's license or a passport.

II.1.7 *Health Insurance Information*

Health insurance information ascertains the level of care that is necessary. Patients might not be aware that Medicaid has some insurance attributed to it, so it is imperative that Medicaid cards be seen and acknowledged by the assessor. Accordingly, financial eligibility is then computed based on the responses to indicators on the eligibility screening tool.

II.1.8 *Financial Eligibility*

Financial eligibility is computed in various ways, with the eligibility specialist (ES) having the right to adjust it as necessary based on the information provided. Once patients are

assessed (see Appendix A), the determination is made regarding whether or not they will pay for services and the amount that they will pay based on a sliding scale developed by the clinic (see Appendix B). The goal always is to assist patients in every way possible so that they receive the care that they need.

II.1.9 *Sliding Scale*

A sliding scale payment schedule was determined by the clinic. The clinic decided that patients whose financial assessment is between 25% and 49% below the FPL will pay $25 per visit, patients between 50% and 99% will pay $30, patients between 100% and 149% will pay $45 per visit, patients between 150% and 174% will pay $65, anyone assessed at 175% to 225% will pay $75 per visit, and anyone 225% above the FPL will pay $100. If patients are estimated to be below the 100^{th} percentile, they will receive their care for free, and they will be referred to other facilities for further assistance. Patients deemed eligible for free care will receive a gift card to pay for services.

II.2 Organizational Change and Process Innovation

Organizational change always brings the risk of resistance to the change. In the case of the clinic, there was the possibility that staff members and volunteers might not have, at least willingly, accepted the change. Understanding organizational change is essential, but how does it impact the staff? Day, Crown, and Ivany (2017) examined the impact of change on staff, and they suggested that adverse outcomes are avoidable. They commented that burnout is "a response to prolonged exposure to stressors and is a psychological syndrome to emotional exhaustion" (p. 5), and they highlighted the importance of supervisors in mitigating burnout.

Kotter (1995) argued that change agents can help employees to accept change. He stated that in order to lead organizational change successfully, change agents must go through

sequences of phases that are realized over an extended period. He proposed a sequence of steps to follow to help ensure a successful transition.

Ha (2014) offered a slightly different perspective from Kotter (1995) by focusing on the role of managing organizational change, stating that "organizational change management refers to planning, organizing, leading, and controlling a change process in an organization to improve its performance and achieve the predetermined sets of strategic objectives" (p. 1). He also commented that structural change is "the formal reporting relationships, procedures, controls and authority decision-making processes" (p. 99). Ha defined cultural change as mutual philosophies that organizations embrace that differentiate them from other organizations.

Davenport's (1993) process innovation model served as a useful framework to approach the proposed implementation of eligibility screening and the sliding scale payment schedule for the community clinic. Davenport asserted that making the aforementioned changes would require a process innovation with, similar to Ha (2014), associated structural and cultural changes. Davenport defined process innovation as the implementation of a business procedure with the "application of innovation to key process" (p. 1). He further stated that implementation of the process innovation most likely would involve cultural and structural changes for the organization. Davenport asserted that the primary component of innovation is to introduce radical change and that process innovation is a combination of work structure change and dramatic results. The technique is intended to "reduce cost or time and improve quality, flexibility, service levels, or other business objectives" (Davenport, 1993, p. 1). At times, process innovation might be perceived as process improvement, but Davenport sought to highlight the variances by emphasizing the difference between process improvement and process innovation (see Table 2).

Table 2 Davenport's Process Improvement Versus Process Innovation

	Improvement	Innovation
Level of change	Increment	Radical
Starting point	Existing process	Clean slate
Frequency of change	One-time/continuous	One-time
Time required	Short	Long
Participation	Bottom-up	Top-down
Typical scope	Narrow, within functions	Broad, cross-functional
Risk	Moderate	High
Primary enabler	Statistical control	Information technology (IT)
Types of change	Cultural	Cultural/structural

Davenport (1993) noted that process innovation is a "top-down" (p. 12) decision. This approach was relevant to the current study because the board of directors, practice manager, and clinic manager at the clinic were instrumental in exploring the implementation of eligibility screening as a radical approach to find ways to improve the financial status of the clinic.

Davenport (1993) identified five steps in the innovation process (see Figure 1):

1. Identify the process for innovation by observing what is currently occurring.
2. Identify change enablers such as IT.
3. Develop a business vision and process objectives.
4. Understand and improve existing processes.
5. Develop and prototype new processes.

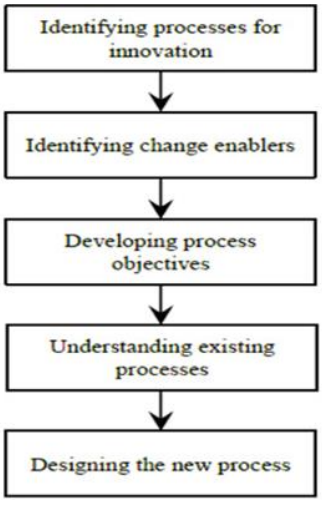

Figure 1 Davenport's high-level approach to process innovation.

Eligibility screening is a new, one-time plan that is broad in scope and will impact various staff members of the clinic. Davenport (1993) suggested that ideas to support initiatives should be solicited from all workers to ensure their support. The organizational chart in Figure 2 shows the structure of the clinic and the proximity of the leaders to the frontline staff as this rapid, broad, and cross-functional process innovation occurs.

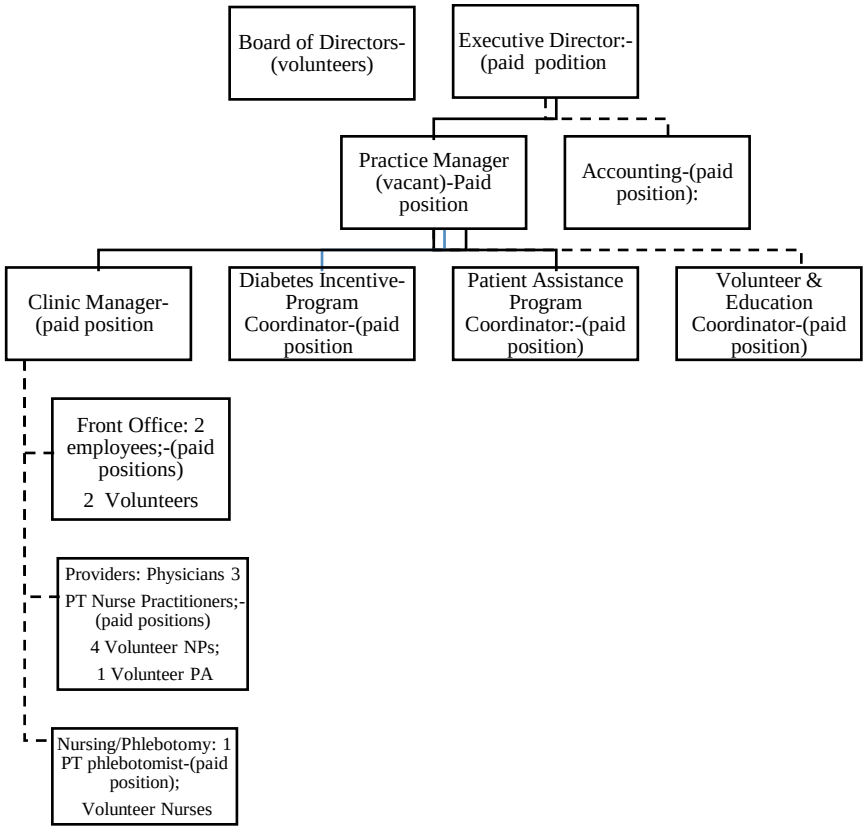

Figure 2 Organizational chart of the community clinic.

Staff members who might be affected by the change (highlighted by the dotted lines in Figure 2) are the nurse practitioners, front office employees, volunteers, volunteer coordinator, clinic manager, accounting personnel, and practice manager. This shows a likely cultural change and possibly a structural change. The change might result in an IT component that could affect cultural and structural aspects of the operation of the clinic because of opposition from or

apprehension of staff to the changes. Figure 3 illustrates the adapted visual representation of the process innovation approach of the community clinic. The leadership team suggested that eligibility screening could be implemented by using a change enabler, a concise spreadsheet that could be used as a tool to expedite the screening process to meet the objectives.

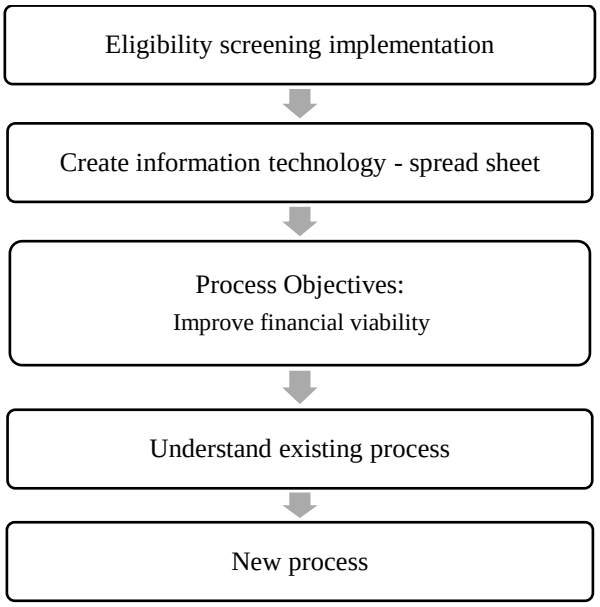

Figure 3 Davenport's high-level approach to process innovation with adaptation of Davenport's model of process of innovation.

The objectives of eligibility screening are to evaluate patients for their ability to pay for clinical services and then evaluate the financial repercussions for the clinic regarding its viability and sustainability from the revenue generated. In addition, evaluating the impact of eligibility screening on improving efficiency at the clinic and assessing employees' perceptions of the implementation will be undertaken. A thorough understanding of the current process must be undertaken as "understanding existing processes facilitates communication among participants" (Davenport, 1993, p. 137) and communication is essential to the development of the new process

because “the success or failure of the effort will turn on the particular people who are gathered together” (Davenport, 1993, p. 153).

II.3 Research Question

Based on the previously mentioned discussion and drawing from Davenport (1993), the study was guided by one research question (RQ): How does one community clinic implement a process innovation that requires cultural and structural shifts to obtain and sustain financial viability?

III METHODOLOGY

A single-case approach was used to study the implementation process and impact of eligibility screening. Several sources were used to obtain the data: (a) An audit of the clinic's financial data for 2 months preimplementation of eligibility screening was compared to financial data of office visit-patient paid on the clinic's financial report sheet for 3 months, and

(b) semistructured interviews of key personnel at the clinic. The interviews were recorded and then transcribed for analysis (see Appendix C).

In addition, the researcher documented the changes through field notes as a participant observer while also helping to formalize the changes and their implementation with the intended outcome of assessing the financial stability and operational efficiencies that ensued. Schensul, Schensul, and LeCompte (1999) defined participant observation as "the process of learning through exposure to or involvement in the day-to-day or routine activities of participants in the researcher setting" (p. 91). The researcher was privy to the day-to-day activities of the clinic.

As a participant observant, the researcher obtained vital information from the day-to-day interactions because of the desire to know and understand the implications of eligibility screening and the impact that the change might have on this clinic.

III.1 Case Study

The focus of this case study was a single community health clinic. Yin (2014) posited that case study research might "contribute to our knowledge of the individual, group, organizational, social, political, and related phenomena" (p. 4). This research might contribute to such aspects as practice, area of concern, and literature. Yin also defined case study as a "pragmatic examination that explores real spectacle, especially those without prescribed margins" (p. 16). This study was an "opportunity to observe and analyze" (Yin, 2014, p. 52) a single case, namely, the implementation process of eligibility screening at the clinic, and it was

grounded in a real-world environment that has no boundaries between "phenomenon and context" (Yin, 2014, p. 16).

III.2 Clinic Setting

The study was conducted in a small community clinic in northwestern Georgia. Cherokee County has a population of more than 200,000 people. Males comprise more than 49% of the population; females comprise 51%. The demographics of the county are as follows: 0.49% citizens are American Indian/Native Alaskan, 2% Asian American, 2% Multiracial/ Hawaiian, 6% Black/African American, and 89% European American. Based on the community assessment completed by the GDPH (2017), the top six health concerns are heart disease, cancer, mental health, respiratory disease, stroke, and hypertension.

III.3 Data Collection, Sample, and Analysis

Two months of preimplementation financial data were collected from March 2017 to April 2017 and compared to data from May to July 2017. The clinic has 39 individuals, including volunteers, who work/volunteer at any given time. Of the 39 participants, only 18 volunteers were actively participating in any activities at the clinic; the other 13 individuals volunteered sporadically and were difficult to contact. Therefore, 26 individuals were recruited for the study, and 11 individuals agreed to be interviewed. Four of the 11 individuals were volunteers, and seven were employees. Table 3 shows that two front office staff, one executive director, one volunteer coordinator, one nurse practitioner, one volunteer doctor, one registered nurse, one licensed practical nurse, two volunteer registered nurses, and one volunteer nurse midwife were interviewed.

Table 3 Composition of Study Sample

Interviewee role at clinic	#	Volunteer	Employee
Front office	2		2
Executive director	1		1
Volunteer coordinator	1		1
Nurse practitioner	1		1
Doctor	1	1	
Registered nurse	1	2	1
Licensed practical nurse	1		1
Nurse mid-wife		1	

This researcher reviewed all transcriptions for themes by looking for main or similar comments in the various responses and color coding similar comments, as suggested by Ryan and Bernard (2003). Use of the wordlist concept highlighted by Ryan and Bernard involved creating a list and then counting the number of times that words or similar words were apparent. This protocol was followed by creating and coding categories that held common themes. Themes were reviewed, defined, and coded for agreement. The final process involved using examples to highlight the themes.

Two other individuals collaborated by individually reviewing and coding the transcriptions for categories and themes from the same material (see Appendix D). The reliability of the findings was established using Fleiss's Kappa. Fleiss (1971) explained that the kappa considers the "measurement of agreement between any constant numbers of raters where there is no relationship between the raters judging the various subjects" (p. 378). Zapf, Castell, Morawietz, and Karch (2016) explored the best statistical assessment tool for interrater reliability in different situations. After comparing Fleiss's Kappa with Krippendorff's alpha, Zapf et al. determined that because both coefficients offered flexibility, they were capable of managing two or more raters and categories. However, Zapf et al. recommended that Krippendorff's alpha be used whenever data are missing or high nominal data are used. Consequently, Fleiss Kappa intercoder reliability was used because no data were missing and the nominal data were

moderate. The calculated Kappa showed a moderate agreement of $\kappa = 0.50$ and a 78% agreement (Landis & Koch, 1977; see Table 4).

Table 4 Fleiss's Kappa

N coders: 3
N cases: 19
N decisions: 57

Fleiss's kappa	Observed agreement	Expected agreement
0.5	0.789	0.579

The data were then imported into NVivo for further analysis. Each line of each interview transcription was manually read and coded to 27 node titles (see Appendix E) to correspond with the interview guide questions. In this study, categories had multiple meanings, and content was coded to multiple nodes when relevant because of the nature of responses from a single interview with meaning in more than one category. Five parent nodes were created as broader content themes:

1. Q01-Q02. Clinical Role Position Balance.
2. Q03-Q06. Objective - Eligibility Screening.
3. Q07-Q12. Implementation - Eligibility Screening.
4. Q13-Q16. Challenges and suggestions.
5. Q17. Anything else.

Twenty-seven nodes with subcategories were moved to become subcategory nodes under the five parent nodes. The result was five parent nodes and 159 subcategories. Coding reports were retrieved and compiled from this node structure. In general, the coding strategy was to provide reminders within various nodes rather than attempt to code every line of text to every

node possible. The researcher coded for context and was able to capture more content than might have been necessary. This process saved time having to look for context when the final analysis was made from the reports. There are many ways to interpret data, and coding is a subjective, not exhaustive, process. In this study, categories had multiple meanings, so the content was coded as multiple nodes when relevant.

Initially, the researcher presumed that each interview would last 45 to 60 minutes because of the number of questions presented; however, each interview lasted only an average of 15 minutes because some of the interviewees did not respond to all questions. Examples of some of the interview items follow: “What was the objective(s) of eligibility screening?” “Please describe the process before the eligibility screening.” and “What impact has the eligibility screening had on staffing?”

The interview responses reflected the efficiency and satisfaction indicators; the field data informed the other data. At the time of the study, health care staff at the clinic saw approximately 20 new patients each week, for a total of 160 individuals over 8 weeks. Six eligibility screening specialists randomly completed the eligibility screening each week, and this researcher collected the data by conducting all interviews and then transcribing the responses.

IV FINDINGS

Execution of the eligibility screening and sliding scale payment implementation process was fluid and new to the clinic, making the collection of data challenging. Therefore, a time line with three phases (see Figure 4) was used to highlight the participant observations made by this researcher throughout the study. Phase I comprised the 2-hour training session and subsequent meetings, Phase II involved creation of the tool for the sliding scale assessment and the implementation process, and Phase III was the advancement in tool usage and interviews for post hoc assessment of the implementation.

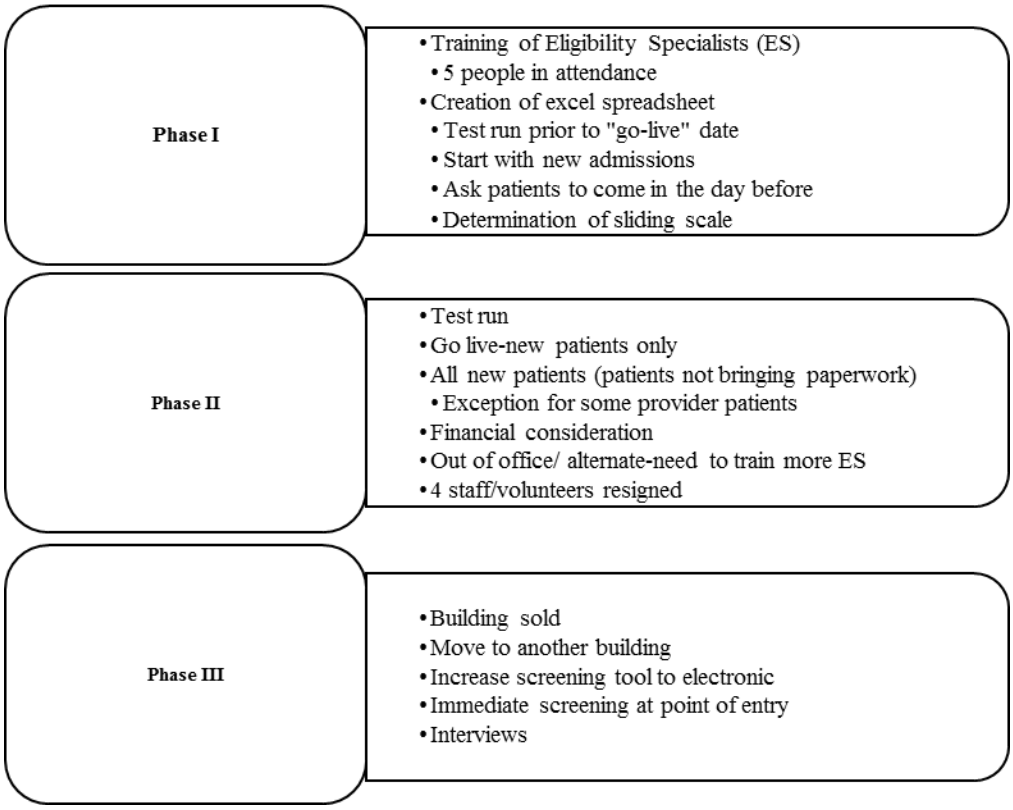

Figure 4 Time line of eligibility screening and sliding scale payment implementation.

IV.1 Observations

IV.1.1 *Phase I*

The initial event was the training session for the eligibility specialist. It began with five individuals in attendance. Two of the attendees were volunteer registered nurses, one of whom attended the training via conference call. The other attendees were the volunteer coordinator, practice manager, and the presenter. The clinical manager was invited to attend the discussion after the training session because she had already been trained.

The training, which was 2 hours long, was completed in person by the presenter from the GDPH, but there also was an option to have the training completed over the telephone. The presenter provided handouts for the training session, and the same information was transmitted electronically to the attendee on the telephone. The presenter proceeded to discuss the handout. It should be noted that the material for the training session was not available prior to the meeting because of government regulations requiring that it had to be distributed the day of the training.

One observation made at the time of the training involved the training material. Although the information was important, it was noted that there was no succinct way to gather the data from the material. For example, it is expected that staff collect information such as (a) marital status of the patient, (b) number of dependents, and (c) family income from earned and unearned sources (might be acknowledge from various sources).

However, where does one document the information collected? How could one consistently manage the process so that all staff could become familiar with the information that is needed to implement eligibility screening and sliding scale payments? After the initial session, another meeting was convened with the clinical manager about the appropriate date and time to begin implementation of the new process, parties who might be involved, ways to introduce the initiative, need for a data collection tool, and determination of the sliding scale amounts.

Appropriate date and time. The group discussed the appropriate date and time to begin the eligibility screening and sliding scale payment implementation. They stressed the importance and urgency of the implementation, and they wanted to move forward as quickly as possible. Therefore, it was agreed that the test run and go-live date would be within 2 weeks of the training session. The front office staff had to be notified quickly about the changes because the process would significantly impact them. The clinical manager and this researcher were tasked with meeting staff, educating them, and seeking input.

Other decisions included that only new patients to the clinic would serve as the starting point of the initiative, a test run should be completed prior to the actual go-live date to ascertain areas of opportunities. In addition, it was agreed that patients would be asked to come in the day before their appointments so that all paperwork could be checked and screening completed. However, when this approach was attempted in the test run session, three patients cancelled their appointments. Therefore, it was decided by the clinical manager that the patients would come in 1 hour earlier than their appointments to complete the procedure.

Parties involved. Considering the role of the front office staff and the decision that they should be informed about the screening and sliding scale payments first, it is important to highlight the multiple contacts that they would have in the execution of the implementation strategy. Figure 5 highlights the multiple contacts that they were responsible for and any missing parts that might have been crucial to the financial outcome of the clinic. They were responsible for calling the patients prior to their coming into the office, they were the first point of contact when the patients came into the clinic, they ensured that the necessary documents were available and appropriately completed, and they also directed the patients to the eligibility specialist and after they were seen by the providers.

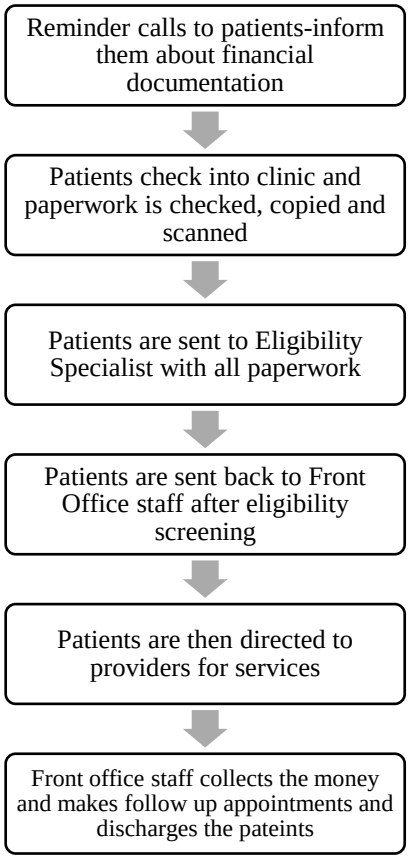

Figure 5 Current workflow of front office staff.

Initiative introduction. Seeing the importance of and reliance that this researcher would have on the front office staff, the researcher met with all the front office staff to explain the intentions of the clinic and their role in the implementation process. They were offered the opportunity to contribute to the development of the process innovation tool and to give feedback and suggestions on ways to improve the tool and workflow. Davenport (1993) called this approach “organizational prototyping” and highlighted that it was designed to “shape the organizational environment or to revise the technology” (p. 156). Davenport noted that prototyping is intended to excite and test new processes. Therefore, the sliding scale screening and the payment evaluation were new processes with which the staff were very engaged and were open to implementing and accepting the structural change in the workflow.

Data collection tool and determination of sliding scale amounts. It was agreed that creation of a spreadsheet would address the lack of tangible methods of collecting information from the training material. The task of creating the Excel spreadsheet was given to this researcher and became the genesis of this process innovation initiative. To complete implementation of the screening, the payment schedule highlighting the dollar amount to be paid based on income had to be decided.

The clinical manager and the executive director decided on the distribution of the amounts for the sliding scale. This researcher was unable to ascertain how the amounts were decided and was unable to determine if the amounts would impact the revenue significantly. However, Phase II of the initiative began.

IV.1.2 *Phase II*

Conceptualization of the tools to be used to gather the data was shaped (see Table 5) during the 2-week period, and esthetic changes were made based on this researcher's observation. Three iterations of the tool were required, feedback was solicited from each member of staff, including staff who would be using it directly at each step of the process, and the final version was tested in paper form.

Table 5 Example of Eligibility Screening Tool

Community Clini			***FPL***	*Amt paid*
Gross Earned Income + Gross Unearned Income+ Total Family Income				
Patient Name	DK			
Are you Married			**YES**	**No**
# Family Size18-21 (In college) including self				
Gross Earned	check if applicable			
Wages + tips (30 days/4 wk				
2 Current W2 Y/N				
2 Months consecutive checks				
Last year's 1040				
Written notorized letter				
Bank Statement				
Separation letter				
DOL letter				
DFCS letter				
Self Employed Pay				
Minus expenses, rent, utilities,adver			$	-

The front office staff discovered that there had to be a discreet way to note the cost to the patients, so that on their return to the front office, it would only be obvious to the staff. One staff member suggested that a notation be made in the patients' charts, and another staff member created various price point indicators (see Appendix F) based on the fee schedule, along with indicators to note that some patients also were receiving diabetes care.

During the test run, five decisions were made:

1. Location where the screening would occur.
2. Whether an interpreter would be in place.
3. Data collected.
4. Duration of the observation.
5. Financial observations.

Location where the screening occurred. It was decided that the ES would share a room, which is directly behind the front office, with another staff member. The front office staff had

readily available access to the room because of the proximity to the front office. During discussions on how patients' assessments would occur, it was decided that patients would see the ES first and then return to the front office. Although the room was convenient for the front office staff, it was a challenge because of the potential for having patient privacy violated because both providers needed to gather personal information from patients. This problem was solved temporarily with an informal agreement that the staff would wait until the assessments were completed before engaging with other patients and that a more convenient area would not be determined until the clinic moved to the new location and would be addressed in Phase III during the workflow.

Use of an interpreter. A significant number of patients were Spanish speaking, so interpreting was challenging for this researcher. Even though the clinic had staff members who could speak Spanish, it was difficult to have someone available to assist whenever needed. Periodically, someone was available to assist, and the use of online translation tools was often necessary. Since then, the clinic has recruited a volunteer whose responsibility is to serve as translator. Another person fluent in Spanish was hired to assist with the screening, a decision that represented structural change within the organization.

Data collected. It was decided to monitor the following indicators from the audit tool: gender, ethnicity, race, county, insurance status, Medicaid status, insured or underinsured, FPL, and amount to be paid for services. These indicators were chosen from the training material given by Georgia and would provide the most vital information necessary to make informed decisions for the clinic.

The decision to monitor all aspects of the screening indicators transpired because the office visit indicator from the financial data will capture the amount each patient paid, while the

FPL highlights the number of patients who are at or below the FPL. In addition, gender, ethnicity, race, county might be beneficial to leaders to be aware of the composition of their patients. Patients who have insurance and Medicaid insurance cannot be seen at the clinic and are asked to see their primary physicians.

Duration of the observation. The need to increase the revenue generated by the clinic was immediate, so the decision was made to rapid cycle the screening process. Data were collected for 3 months and compared to the financial data for the previous 2 months. The thought was that the first month would be the period when areas of opportunities would be discovered and addressed, and the other 2 months would have a hardwired process addressed by the financial observations made.

Financial observations. To ensure that there would be an accurate indicator to measure the financial impact of eligibility screening, an assessment of the financial information of the clinic was gathered. It was agreed that office visits on the monthly financial statement would be satisfactory. The accountant was asked to submit that information so that a concurrent comparison could be made.

After all the relevant decisions were made, the go-live started on Week 2 with new patients only. It was discovered that the patients were reluctant to bring their financial paperwork in, sometimes because they were not sure about the required paperwork. In addition, as the process advanced into all patients being screened, it was discovered that there were patients with unique relationships that had to be addressed directly with providers. These patients were temporarily exempted from the screening process.

It also was ascertained that conflicting information was being given to the staff, a problem that was addressed with all parties involved. For example, when patients did not bring

in their paperwork and were not seen by the ES, the front office staff were informing patients that they could continue paying the flat fee of $45 until they provided the paperwork. This was contrary to the goal of the initiative, because some patients were not willing to bring in their paperwork, and the status quo would continue. After further discussions with the leaders, it was decided that all patients would be seen by the ES, regardless of having or not having the required paperwork. This decision made communication consistent.

One concern verbalized by staff was the need to have a consistent person who would be able to complete the screening after the volunteers left or if someone had to take some time off. Although seven individuals could complete the eligibility screening, the decision was made to continue to recruit more staff trained in eligibility screening to ensure that someone would always be available to complete the task as the screening process grew. However, the individuals who were recruited as volunteers either were not able to volunteer enough time or resigned the volunteer opportunity. Therefore, most of the screening was completed by this researcher until another person could be recruited.

During this period, the practice manager and a volunteer who was recruited to assist with the eligibility screening resigned. A few weeks later, the executive director and a front office staff also resigned. Was the departure of staff a sign of burnout? Staff members expressed concerns about the lack of staff, hours of operations, and uncertainty about the future of the organization, but they were still willing to assume new roles and responsibilities to keep the structural workflow element of the clinic intact.

The departures of staff might have affected the organizational structure because of the reduced number of staff members available, but it did not appear to impact the workflow directly because the clinical manager was very knowledgeable and motivating to everyone. The volunteer

coordinator also was willing to help in any capacity. Tavakoli (2010) suggested that "organizational change may lead to distress and resistance" or "may produce eustress and positive reactions" (p. 1795). Davenport (1993) noted that for an implementation to be successful, leaders must manage behaviors and be sensitive to "employees' attitudes and perception" (p. 167). This type of leadership was demonstrated by the immediate leaders, who were sensitive to staff concerns and were instrumental in moving the team forward by leading by example. This leadership behavior was validated by Day et al. (2017), who asserted that supervisory support and job control might be instrumental to reducing burnout.

IV.1.3 *Phase III: Postdata Gathering and Report*

During the study, one physical change was the sale of the building that accommodated the clinic and the subsequent move to a new building. The sale and move created some anxiety among the staff because they were not sure who would help to move the equipment and whether the clinic would remain open or expand its hours of operations. Meetings were held with staff to discuss the move and to allay their concerns; however, the situation was still turbulent because sufficient people were not present to assist with logistics. Staff also expressed concerns about the future of the clinic during the meetings.

Also in this phase, advancing the use of the screening tool to electronic format was attempted. However, it became difficult to complete because on the day that it was attempted, there was a high volume of patients, many of whom bought their paperwork, precipitating the need to process the patients quickly for the providers. Therefore, electronic usage of the tool was postponed until an alternative approach could be considered or retried, but it was never advanced because of Internet connectivity issues experienced after the move to the new building. In addition, time limitations prevented any further reattempts.

With the physical move of the clinic, the layout of the clinic was reconfigured, so an alternative approach to screening patients using the eligibility screening tool was attempted. Figure 6 shows the approach that was attempted after the move to the new clinic area and underlined the immediate screening of patients at point of entry versus the prior approach of sending patients to another area after entering the clinic.

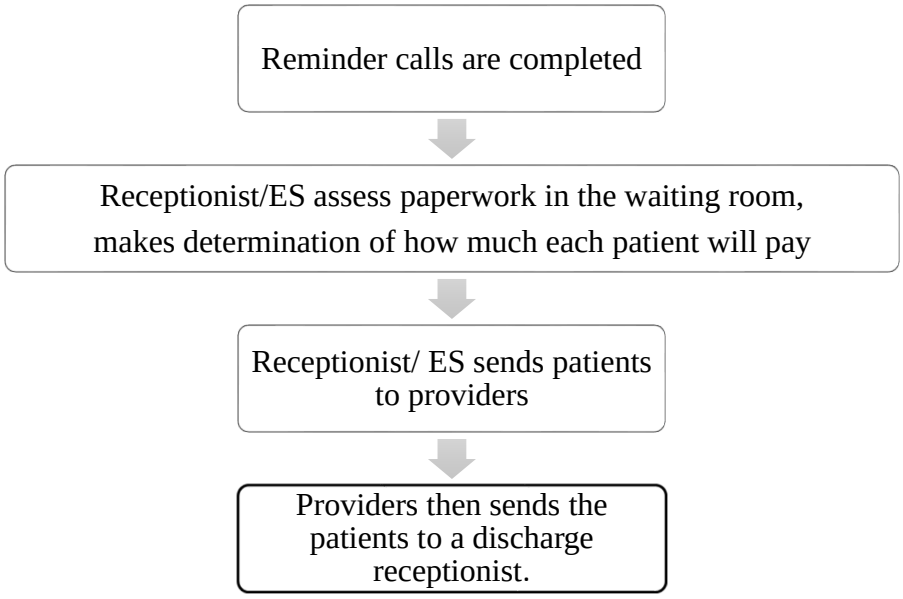

Figure 6 Proposed workflow postimplementation.

The process was very quick and had the potential to improve efficiencies; however, there was the likelihood of having privacy violations because personal information was communicated while other patients were in the waiting area. Therefore, the patients were asked to go behind an enclosed area of the front office (point of entry) to complete the screening, which would give them privacy. Figure 7 is the final workflow that underscored the eligibility screening being completed on admission in a private area, not the waiting room, while still making the workflow efficient.

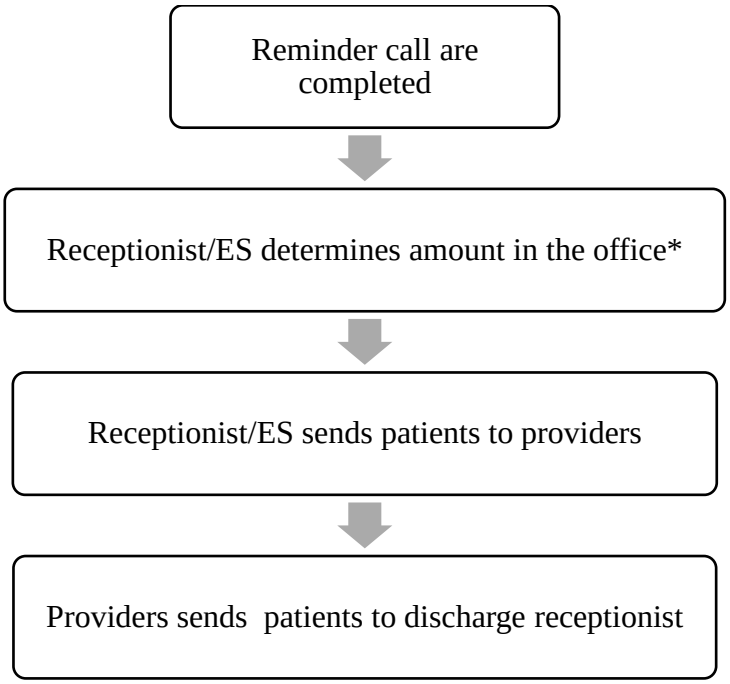

Figure 7 Final workflow for the clinic.

Note. *Change in location of screening from waiting area to front office.

Because of the many components involved in this case study secondary to the creation of an assessment tool, implementation of the sliding scale payment, relocation of the clinic, and the loss of staff, it was important to ascertain staff feedback on the process, the tool, the workflow, and the challenges. Therefore, feedback from practitioners, staff, and volunteers was instrumental in providing insight into staff perceptions. Consequently, an assessment of staff opinion of the changes was analyzed using an interview instrument adapted from the *TransforMed Practice Interview Guide* (Jaén et al., 2010).

IV.2 Interview Responses

Eleven staff and volunteers participated in the interviews, with each interview lasting approximately 15 minutes. Four of the interviewees were volunteers, and seven were employees. The participants were encouraged to share their observations of the eligibility screening and

sliding scale implementation process. Four themes emerged as the interviewees expressed their views, and excerpts from the replies are offered to validate the indicators:

- Process comprehension.
- Impact of cultural and structural change.
- Teamwork-collaboration.
- Financials.

The clinic environment was small, so to better understand the themes, demographic information is discussed first because it informed the themes.

IV.2.1 *Demographics*

The results of the participants' responses to clinical roles and position balance included role at the clinic, length of time working at the clinic, knowledge of staff-to-nurse ratios, and perceptions of how the ratios impacted their work. The length of time working at the clinic ranged from 1.5 years to 3 years; the average length of volunteer time ranged from 5 months to 3 years. Five interviewees had previous roles at the clinic, and five had none; one person was a volunteer who became employed by the clinic. In addition, five of the eight employees could articulate the staff-to-volunteer ratio. This information is important to note because the individuals who could accurately articulate the information were actively involved in the day-to-day operations and the implementation, and they were fully aware of the needs of the clinic.

Four of the 11 interviewees verbalized that volunteers did not impact their work, but seven felt that volunteers made an impact, highlighting that a significant number of interviewees believed that having volunteers was impactful to the work being done. In addition, an equal number of the interviewees were aware of the volunteer-to-staff ratio. Many of the staff/volunteers who had been with the clinic for a long period of time and had been in various

roles believed that volunteers impacted their work. They suggested that the clinic leadership could increase the number of volunteers and hire more staff because the perception of the lack of personnel might have contributed to the ability of the clinic to increase revenue. Further discussions are presented as the themes emerged. The interviewees were identified numerically as Interviewee 1 to Interviewee 11.

IV.2.2 *Process Comprehension*

Kotter (1995) suggested that organization are not very good at making changes; therefore, the use of Kotter's eight errors in organizations was interwoven into the interview analysis as a method of analyzing any observed organizational changes. Thus, the interview responses underscored that the majority of participants were aware of the objective and impact of implementation process of the eligibility screening. The results in Table 6 are a combination of responses to the questions, "What was the objective(s) of eligibility screening?" and "To what extent do you believe that the objective of this initiative was met?"

All 11 individuals responded to these questions, and a significant number of them stated that the screening was done to assess the patients on their economic status. The majority of the interviewees mentioned that the screening was done for financial gain. Their responses supported three of Kotter's (1995) eight errors. Errors 1, 3, and 4 (1: establishing a sense of urgency, 3: creating a vision, and 4: communicating the vision) created a sense of urgency regarding financial deficits by encouraging members of the organization to be aware of the vision of the organization and to articulate such vision easily. It was evident that most respondents were aware of the objectives, so they were able to easily articulate the objectives of screening while offering suggestions for improvement.

Interviewee 3 stated that the screening was done “to identify patients who truly were struggling to afford an office visit cost because of their current income level.”

Interviewee 4 stated that “the objective was to try to help more patients below the family poverty line. They are not able to afford care and any hospital emergency room or urgent care.”

Table 6 Objectives of Eligibility Screening

Objective of eligibility screening	11 participants	100%
Sliding scale based on patient economic status	8	73%
Do not know	3	27%
Extent objective was met	7	64%
Did not know	4	36%

Interviewee 11 summarized that the innovation was completed “to identify a reasonable and affordable dollar amount that each patient can afford to contribute for care provided. Also, how would this impact the financial status of the clinic.”

The majority of the interviewees believed that the objectives were met and thought that it was successful. Interviewee 3 emphatically felt that the objective was “100%, it was met. We now have a really good understanding of patients that come through this door...” In addition, although she perceived that identifying the patient population who were receiving care was a successful outcome, she also felt “that opens up a whole other set of challenges.”

When Interviewee 3 was asked to explain that statement, the response was, “It’s more of a challenge for supportive staff, meaning admin, I guess if you want to call it that, to make up those funds from the community in terms of donors, in terms of grants, but I wouldn't trade it.” Interviewee 3 discussed the challenges to staffing and funding as other areas of concern. Consequently, these challenges were further explored in this research, along with garnering suggestions for improvements.

Most respondents mentioned a flat fee office visit as the process before the implementation. Interviewee 9 stated that “the process was that you paid a $45 flat fee” as they accurately responded to whether they could verbalize the process before the implementation. When asked about the impact of change by screening patients for their ability to pay postimplementation, a significant number of the respondents were able to verbalize the financial screening and sliding scale payments implementation process and believed that the objectives of the implementation and screening process had been met.

Interviewee 9 commented, “They just bring their information ... financial information in, and they talk to one of the financial counselors and they decide how much their visit will be from that point on.”

This statement was validated by Interviewee 3, who said that “when patients come in, their income is assessed, they’re placed into the federal poverty level, and based on that an office visit, fee is assigned.

Interviewee 4 described the process:

> The process after is from new patients to establish patients. Patient need to put in their financial paperwork even pay stubs or taxes from the previous year. What we do is we ask the patient a couple questions in a survey. We calculate the annual, and the monthly, and the household income and how many patients, how many persons live in household. And from that we calculate and from that we’ll decide if the visit will be $25, $30, $45, $65, or gonna be a free care.

IV.3 Effects of Change

Deshpande and Webster (1989) defined organizational culture as “a pattern of shared set of values and beliefs that help individuals understand organizational functioning and thus provide them norms for behaviors in the organization”(p. 4). Vu (2017) defined structural changes as “the reallocation of productive resources among sector” (p. 1) and that the structure might include the organization’s hierarchy, chain of command, job configuration and

administrative techniques, production process, and performance measures and evaluations (Ha, 2014). Therefore, managing structural and cultural changes in any organization is sometimes difficult, but Kotter (1995) suggested that most successful organizational changes occur once everyone examines the changes.

Managing organizational changes as the innovation occurred was pivotal to the outcomes of the organization. It was pivotal because staff behaviors and reactions determined their acceptance of the innovation. Therefore, the relationship between organizational change and process innovation was explored.

Questions were asked to explore the impact and cultural aspect of the change on the workflow. Using a 5-point Likert type scale ranging from 1 (*not at all impactful*) to 5 (*extremely impactful*), the respondents were asked to quantify their responses. Table 7 displays the interviewees' perceptions of the impact of the research on the clinic and their explanations of the responses. Most of the interviewees scored believed that the process innovation had a positive impact on the organization. One interviewee stated that the process provided clarity about the community being served, highlighting a cultural change within the organization because they were more aware of the patient population being served.

Table 7 Impact Scale and Recommendations

	Total no. of interviewees	Respons e rate %
Impact clinic – explain		
Do not know	1	9%
Scale 3 – explain	1	9%
Scale 4 – explain	3	27%
Scale 5 – explain	4	36%
Recommend be done differently – why	8	
Automated process	1	9%
Do not know	1	9%
Marketing	1	9%
New patient scheduling & processing	3	27%

Sliding scale adjustment	1	9%
Sponsorships	1	9%
Training	1	9%

Interviewee 2 noted:

> It's W2 numbers, it's quantitative, so we now have a real clear picture of our market segments, we have a real clear picture of our community, and who comes here, and who needs to help, and that's something we didn't quite have before, and with that when we write for grants, or we write for programs we can write for the people that we're seeing to help them better.

Interviewee 3 also was concerned about structural and cultural aspects of the change because it impacted the staffing and day-to-day operation of the clinic:

> Now we have to have someone designated to do the screening. I think that was one of the biggest challenges at first because the status quo is so nice to just keep going with, and any time you change process, it just disrupts that equilibrium so much. So finding people who were willing, people who can do it quickly and confidently, and then not impact the overall flow of what their job entailed. And so that, from my perspective as an outsider looking in, was one of the biggest things that changed.

Davenport (1993) addressed this cultural shift of having individuals complete eligibility screening by proposing that in order to generate more reliable "internal linkages between functions entails not only changing structure but also bridging cultural differences and upsetting traditional power balances" (p. 175). Ha (2014) asserted that organizations might have to create and "implement one or a combination of strategies to achieve the set objectives" (p. 96). Interviewee 3's response illustrated the concept of structural and cultural changes, as demonstrated by the designation of an individual to complete the eligibility screening and implementation. Placement of the ES to complete the screening supported the structural change while "bridging" the culture of the organization by not "impacting the workflow."

The respondents also recommended that addressing a new way to schedule and process patients might have been instrumental to the screening and implementation process and might have changed the structure of the admission process. They offered several recommendations:

- "We just need to make sure that we stay on top of everybody bringing in their documentation so that we can offer them the sliding scale,
- "For a first time patient or new patient, probably we can do that the day before or previously that at least it can run faster and smoothly"
- "Probably, the other thing is ask the patients to come instead an hour or even maybe an hour and thirty minutes it's depending. But this is education, so basically, I can say that one day before or maybe half an hour before the appointment so we can run smoothly through our clinic day.

IV.3.1 *Impact of Eligibility Screening and Sliding Scale Implementation*

Steps were taken to involve staff in the implementation and screening process by incorporating feedback into the creation of the audit tool, and asking for assistance with the payment markers as well as the logistics involved in placing the patients while interviewing them. Kotter's (1995) Error 5 suggested involving staff in the process as a way of empowering others. However, the majority of the interviewees perceived that they were not involved in the screening and sliding scale implementation (see Table 8), with six interviewees stating that they were not involved in the implementation process. In addition, two interviewees reported no changes in their roles and responsibilities, three interviewees felt that the initiative had no impact, and four believed that it had a positive impact on them.

Table 8 Implementation of Eligibility Screening and Sliding Scale Schedule

	Total no. of interviewees	Yes	No
Involvement in implementation process	9	3	6
Changes in job role	5	3	2
Impact of changes	7	4	3
Articulate steps prior to and after implementation	7	Prior: 4	After: 3

On the other hand, Interviewee 7 noted:

> Initially, I believe it really impacted their workflow as they knew it. That it added extra stress because it was unfamiliar. And that they, maybe felt like they couldn't do it because it was time and unknown. So that was a negative. I think that it caused a lot of

> stress; again, any new change does. But now with it in place, it does not seem to impact the workflow as it used to.

Davenport (1993) believed that because of the "risk and rewards" (p. 177) of process innovation, it is important that structural change, along with defined roles and responsibilities, be apparent for the initiative to be successful. Nevertheless, this information was not overwhelmingly evident from the responses, as evidenced by the number of staff who did not report that they were involved in the implementation process, saw any changes in their roles, or believed that the changes were impactful. One might ask whether were all barriers to participation by staff and volunteers scrutinized. Kotter (1995) suggested that one approach that might have been effective was to remove any barriers to individuals' involvement because their roles could have been significant to ensuring better outcomes.

Still, Interviewee 3 stated that the initiative had a positive impact:

> It now made me feel more confident in speaking to people, like sponsors, donors, community members, about our clinic. Before I was just saying, "Oh we treat the uninsured." But now I can talk about, well we're treating the working poor, and these are the percentages. These are not just people who choose to not work, and I think that's been the most liberating part for this.

Interviewee 4 also expressed happiness and gratitude for the initiative and perceived that it had significantly impacted patients:

> I'm very happy, because we're here to help the patients. It's what we do. It's the function of the clinic. It's that you help the patient not only physically because you are here to alleviate the feeling of helpless. That's exactly what we do.

IV.4 Teamwork-Collaboration

Error 2 of Kotter's (1995) suggestions of getting the leadership team involved in transformation, illustrated the importance of having powerful teams that would be instrumental in leading organizational change. Interviewee 3 commented on the level of collaborative approach, noting that "I know that it did require management, I mean executive director, clinic

manager, and then front office to work together and get that established." On the other hand, Interviewees 7 and 9 responded, "I think everybody's on board" and "I think we work well together," respectively. Six interviewees believed that there was collaboration among the staff, and five were able to articulate that information was shared during meetings and training sessions, even though the interviewees did not perceive that they were well informed about the process change.

Interviewee 5 expressed that collaboration facilitated completion of the eligibility screening and sliding scale implementation, in addition to underscoring that they were educated about the implementation through meetings and training, even though only a few respondents were able to articulate differences between the old and new processes:

> We didn't have a former [standard] process. Basically, we started from zero, from scratch. Created daily process and how to do it and how to do the management through this and teaching the staff and teaching everybody how to do it. We've been doing this since March. Now it's August, and we can see the implementation was excellent.

Several interviewees expressed surprise about the discoveries from the initiative. Table 9 shows the top three indicators identified by the interviewees: (a) patients' responses to the implementation (36%), (b) demographics of the community who used the services (27%), and (c) patients who had insurance (18%).

Table 9 Indicators of Surprise During Implementation

	Total no. of interviewees	Response rate %
Patient response	4	36%
Demographics	3	27%
Insurance impact	2	18%

Two interviewees commented on patients' responses to the implementation. Interviewee 7 said, "I think it's a great, a great benefit that we can offer our patients. Because I know that not all of our patients are able to pay the same as other patients."

Interviewee 9 replied:

> I feel it's a good thing. There are people who can afford to pay more than the $45, and there are people who can only pay $45 and then maybe they only pay ... can only pay $20, and that helps a lot.

Interviewee 3 expressed surprise about the demographics of the county, stating that "I think the major surprise is just how many were at the 130th percentile [of the FPL], and that made me feel tremendously awful because of knowing what that means."

Interviewee 3 expanded on that statement:

> You know we have 241,000 people in Cherokee County, 19% are estimated as uninsured. Yeah, that's 45,000 people. And we see maybe over 1,000 each year, and there's not very many other clinics in this area that are free and charitable. So that was probably the most shocking.

Some of the interviewees expressed surprise that patients who were aware that they could not be seen at the clinic because they had insurance had, in fact, been using the clinic. Interviewee 4 remarked, "Surprises when you've seen a patient for so many years, and they have insurance. So this is like a shock for you because obviously they've been using our services; they're not using their private insurance, or Medicaid, or Medicare."

IV.5 Short- and Long-Term Challenges

Table 10 highlights the composition of the feedback on short- and long-term challenges. The interviewees' responses to the questions were similar in nature. Fifty-five percent of the interviewees perceived that having more staff and volunteers would address short-term changes, and 36% perceived that finding and maintaining staffing and volunteers would be long-term challenges.

Interviewee 11 noted that "having more volunteer or paid providers, so that the clinic can be open at least 5 days/week. To be available more to customers [patients]."

Meanwhile interviewee 4 commented:

> Resources. I can say those are the short-term and long-term [challenges]. Resources, grants, and donations, because you can see in our studies that the family poverty line sometimes is below 185% of the family poverty line and we would like to continue doing the services, but if we don't receive the type of external help, obviously we're not going to have any income."

Interviewee 5 summarized the short- and long-term challenges:

> There's a lot of challenges for us. Challenges to get the grants that we need, to find the people to be able to have the time to write the grants, as well as helping here, when we need help here. As far as long term, getting the providers that we need, and the volunteers that we need. Provider volunteers, so that we can stay afloat and be more cost efficient. Challenges are sometimes, like I said, we don't have enough volunteers when we have a very busy day, and other times we have a million volunteers when we really don't need them.

Table 10 Short- and Long-Term Challenges

Patients' challenges and suggestions	No. of interviewees	Response rate %
ST challenges for clinic – why		
Clinic availability/efficiency	4	36%
Patients	2	18%
Resources – funding/financial stability	5	45%
Staffing and volunteers	6	55%
LT challenges for clinic – why		
Growth	3	27%
Patient care follow-up/patients	2	45%
Providers	4	36%
Resources – funding/financial stability	6	54%
Staffing and volunteers	4	36%

IV.5.1 *Suggestions: Short- and Long-Term Challenges*

The questions asked in this section were as follows: What suggestions do you have for the clinic to address these short-term challenges? What suggestions do you have for the clinic to address the long-term challenges? Suggestions recommended by the interviewees to address short- and long-term challenges are displayed in Table 11. The highest accumulated values for short-term challenges were network-partnership/outreach (54%), marketing (36%), and communication (27%).

Interviewee 11 proposed that the clinic explore "advertising and networking with health healthcare system, [and] partner with other hospitals to assist their uninsured patients."

Interviewee 3 suggested that the clinic should begin "collaborating with other organizations to do maybe like a health fair… I'd really like to see how they promoted it and how they got their marketing to have such a strong turnout."

Interviewee 3 offered additional comments targeting outreach, stating that "so fundraising in a different capacity. We have created a little partnership with a local business person who sells things and they give back 10-20% of what they sell to the clinic, so creating little things like that."

Another said, "Getting out in the community. We need some outsourcing with hospitals."

Table 11 Suggestions for Short- and Long-Term Challenges

Suggestions address ST challenges	No of interviewees	Response rate %
Communication with patients	3	27%
Federal funding	2	18%
Marketing	4	36%
Networking – partnerships/outreach	6	54%
Suggestions address LT challenges		
Budgeting/revenue sources	3	27%
Marketing	2	18%
Mission and vision/strategic planning	3	27%
Networking – partnerships/outreach	4	36%
Patients	2	18%
Staffing and volunteers	4	36%

The leading suggestions for the clinic to explore to address long-term challenges were staffing and volunteers (36%) and networking and outreach (36%). Although having a strategy to recruit more volunteers and increasing staffing emerged as the primary recommendation, it should be noted that outreach was a common thread in all of the short- and long-term suggestions.

Interviewee 5 said:

> I think that we could do better about screening maybe the volunteers, and I think we could be more efficient in our use of the way that we select volunteers, if possible. And

> maybe get more volunteers that are consistent, like a hospital volunteer would be. Have more of a set duty or role, would be more efficient.

Interviewee 11 recommended "applying for grants and reaching out to CEOs, CFO, CNO in large health care organizations, especially the neighboring hospital and businesses."

The final theme was the financial aspect. Improving the financial outcomes of the clinic was the genesis for this research, and although exploring federal funding and addressing budgetary/revenue sources were mentioned as suggestions to address short- and long-term challenges, they were not considered paramount to the interviewees. However, this researcher examined the financial data of the clinic as the implementation and sliding scale payment initiative ensued, and the results of the data collection are addressed next.

IV.6 Financial Implications

The data from 92 patients collected between March and July are displayed in Figures 8 and 9. Initially, only new patient data were collected, but as the weeks went by, data on all patients were collected to calculate all patients' payment amounts. Data were collected on gender, race, county, insurance status, and Medicaid status. Also collected were data after the calculation of the sliding scale on whether the patients were uninsured or underinsured, the FPL, and the sliding scale amount that each patient would pay.

Figure 8 displays a graph of the number of patients and the FPL of the patients who presented at the clinic. It should be noted that after the eligibility screening, most of the patients consistently presented between 100% to 135% of the FPL. Figure 8 displays the dollar value associated with patients at the FPL. Based on the pricing guide, these patients were charged $30 to $45 per visit. It became evident to this researcher that during the eligibility screening, there would not be a significant increase in revenue to the clinic compared to the clinic charging a flat

fee of $45 prior to implementation of the sliding scale because the majority of the patients were already paying the initial flat rate of $45.

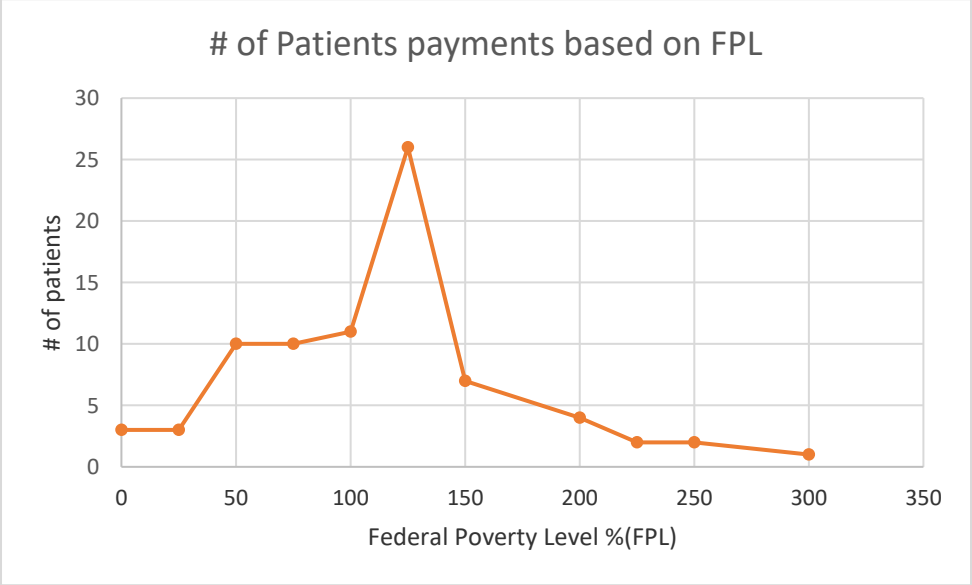

Figure 8 FPL of patients.

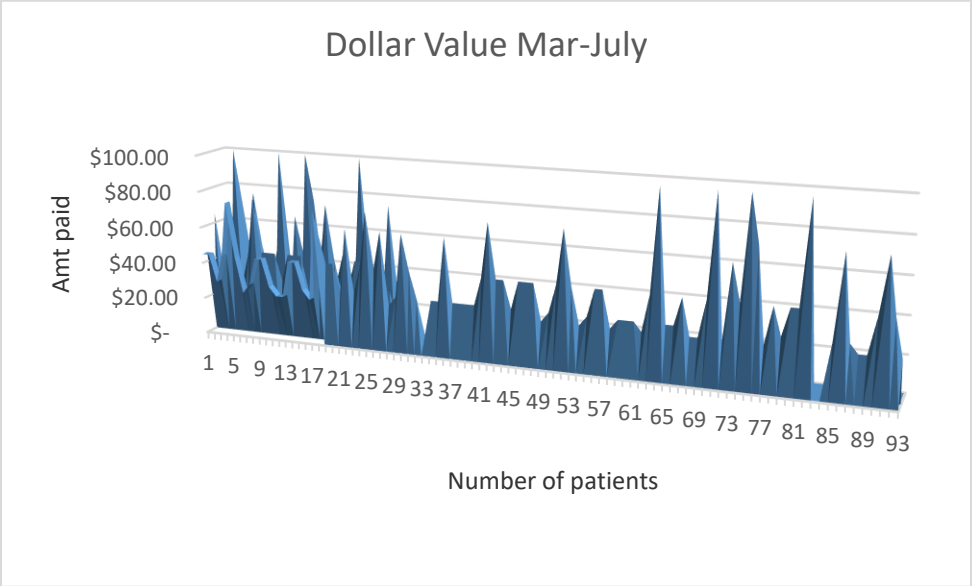

Figure 9 Amount patients paid for services.

The actual financial information for the clinic was obtained from the accountant and is presented in Figure 10. The information was completed to ascertain whether or not the eligibility screening and sliding scale implementation had any impact on revenue generation. The graph

illustrates the financial data of office visits-patients paid from January through June and represents the financial impact pre- and postimplementation of the eligibility screening and sliding scale implementation. An analysis of the graphs illustrated the start of the initiative on March 13, 2017, the decrease in revenue for April that was attributed to patients' apprehension of the process and their ability to get the appropriate paperwork to validate their incomes, and the subsequent increase for the following months as the patients became more trustful of the screening.

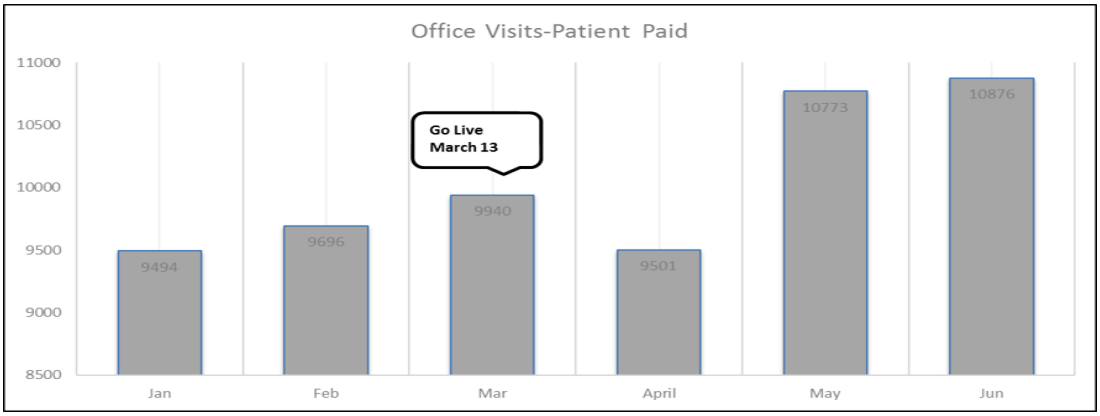

Figure 10 Financial data of the community clinic-office visits-patient paid.

Further analysis of the graph determined that it would be challenging to surmise that if everything remained the same, the increase would not have occurred because the increases were minimal. Therefore, it is difficult to conclude that the eligibility screening and sliding scale implementation contributed to the increase in revenue because the increase was not significant.

IV.7 Discussion

The study was guided by one RQ: How does one community clinic implement a process innovation that requires cultural and structural shifts to obtain and sustain financial viability? The results sought to address this RQ. This section summarizes the findings through Davenport's (1993) process innovation lens.

IV.7.1 *Identification of Process Innovation*

The researcher, using the model of Davenport's (1993) process of innovation, developed a spreadsheet to capture data during eligibility screening after senior leadership at the clinic expressed an interest in changing the way that patients were charged to see providers. Davenport submitted that the objective of process identification is to determine and define consequences. Therefore, implementation of the eligibility screening and sliding scale was explored to determine the impact on the clinic, financial or otherwise.

Davenport (1993) also noted that process innovation is a "top-down" (p. 12) decision, and this was precisely what occurred. The decision to explore the initiative was made by the board of directors, executive director, practice manager, and clinic manager to investigate the implementation of eligibility screening. The interviewees were aware of the leadership's urgent objective, as they articulated it, thereby demonstrating the vision. The involvement and support of the leadership team were described by Kotter (1995) as "change requires creating a new system, which in turn always demands leadership" (p. 60).

Identify the process for innovation by observing what is occurring. Identifying the current process was not difficult because staff members were able to articulate that even though previous attempts had been made to start the eligibility screening, they had not been successful because they did not have one individual dedicated to completing the screening. Therefore, the previous process was that all patients paid a flat fee of $45.

Interviewee 3 described the process before the implementation:

> So a patient would call in, we would ask if they were a new patient, they would say, "Yes." They would be told that it's a $45 office visit and that we took a deposit of $20 and then that was applied toward the cost of that visit.

Identify change enablers such as IT. During the training session, it was noted that there was no succinct way to gather the data from the material being delivered. A data collection tool

was needed, in addition to determining the sliding scale amounts. Davenport (1993) stated that "the consideration of change enables must consider both what is possible and the constraints imposed by current technology" (p. 47). After discussions with the clinic leadership team, it was decided that an Excel spreadsheet would suffice as an appropriate tool for collecting the data because it was readily available and familiar technology, thereby meeting becoming Davenport's requirement of being possible.

The impetus for using a spreadsheet was ease of use of the application, ability to print the sheet if needed, and minimal cost. In addition, the process could be automatic and informational, indicators identified by Davenport (1993) as needed to support a business in realizing its goals. The spreadsheet was a succinct way of capturing data and had the potential to have filters in place that could automatically calculate the sliding scale payment rate. The information being taught about eligibility screening had more clarity and was better understood after the tool was in practice.

Develop a business vision and process objectives. From the outset, the leadership team of the practice manager, the clinical manager, and board members decided that the vision was to implement eligibility screening and sliding scale payments as one approach to improving the clinic's financial situation. However, the leadership team also wanted to understand the effect that the process change would have on financial viability, clinic efficiency, and employee satisfaction. It was important that all the key people understood the vision and objective of the initiative; therefore, this information was communicated to all at meetings and individually. Feedback also was sought on how to begin the process.

Interviewee 5 commented:

> I think we had a meeting. I was told about it, that we were going to be doing this new program and why we were going to be doing it, for more of efficiency and the sliding scale would be better. So, we were told in a meeting.

This mode of conveying the vision was supported by Davenport (1993), who stipulated that it is important for customers to understand the perspectives concerning a proposal. Therefore, when the interviewees were asked about their knowledge of the objectives of the initiative, one interviewee responded, "To identify a reasonable and affordable dollar amount that each patient can afford to contribute for care provided. Also, how would this impact the financial status of the clinic."

However, when asked whether they had been involved in the implementation, most interviewees stated that they were not. This negative response might have been attributed to the fact that four people who were involved initially at the launch of the process change had resigned their positions, thereby affecting the structural aspect of the clinic.

Understand and improve existing processes. A thorough understanding of the current process was undertaken because according to Davenport (1993), "Understanding existing processes facilitates communication among participants" (p. 137) and that communication is essential to the development of the new process because "the success or failure of the effort will turn on the particular people who are gathered together" (p. 153). However, because no previous process had been in place for completing eligibility screening and sliding scale implementation, the focus was on the structural and cultural aspects of the implementation.

Therefore, the role of front office staff in implementing the change was pivotal in the decision to inform them and collaborate with them on the screening and sliding scale payments. They had multiple contacts with the patients, and they played a vital role in the execution of the implementation strategy. Ha (2014) stated that the transformational structural change occurs

when “the ability of firms to quickly respond to alterations in both external and internal environments does not only depend on their technical optimization, but also on their ability to mobilize and manage human and physical resources through structural transformations” (p. 100). Consequently, it was important to give staff the opportunity to contribute to the development of the eligibility screening tool and to give feedback and suggestions on how to improve the tool and workflow. Ha also addressed cultural shifts by suggesting that “by redesigning work, some unnecessary tasks may be eliminated, or tasks may be redesigned or reallocated in such a way to avoid task duplications, avoid waste of resources in duplicating work, and improve productivity and performance” (p. 97).

The response from Interviewee 3 supported Ha’s (2014) suggestion that a designated individual complete the eligibility screening and implementation, and redesign the workflow and the innovation tool. Placement of the individual also supported the structural change of the screening while “bridging” the culture of the organization:

> Now we have to have someone designated to do the screening. I think that was one of the biggest challenges at first because the status quo is so nice to just keep going with, and any time you change process, it just disrupts that equilibrium so much.

The interviewees also felt that there was collaboration among the staff.

Interviewee 7 said:

> I think everyone was very well involved and willing to help, and do what needed to be done. When you weren’t available then, someone else would be able to do it, or whatever. I think everyone was very positive about it and worked.

Interviewee 7, who took on the additional responsibility of assisting with the eligibility screening, indicated that the additional responsibility did not impact her by stating, “The only change would be me being an eligibility specialist, and being able to actually be interviewing the patients and doing the sliding scale. Not really any impact.”

Researcher: “So it doesn’t matter that you sometimes have to do both at one time?”

Interviewee 7: “It doesn’t, no.”

Develop and prototype new processes. Three iterations of the tool were devised, and feedback was solicited from each member of staff, including front office staff members who were directly using it. At each step of the process, staff members were involved, and it was discovered that there had to be a subtle way to mention the cost to patients. The office staff collaborated and developed the instrument that is currently in use. Kotter (1995) embraced the idea of “empowering, changing systems and structures” (p. 61) while recognizing and rewarding employees for the improvements. Recognition of the contributions of front office staff was demonstrated through collaborating with them on the creation of the eligibility tool, price point indicators and the logistics was beneficial to the outcomes as all are still in use at the clinic.

Continued use of the innovation (i.e., Excel spreadsheet) became so efficient that an attempt was made to move to an electronic format. However, it became difficult to complete on the chosen day because of the high volume of patients who bought their paperwork and it was difficult to process patients quickly for the providers. That approach was placed on hold; however, when it was revisited, staff decided not to use the electronic approach, something that might have been considered resistance to change. Ha (2014) suggested that change agents could redesign the organizational structure while also being mindful that it would not overload the staff. Otherwise, they could resist the change if they could see no visible benefits. Therefore, this researcher made the decision not to consider the electronic approach, and staff expressed satisfaction with the innovation.

Interviewee 4 noted, “I’m very happy with the whole experience. That was awesome. The eligibility process was something that we needed to establish as a free clinic and a low-income clinic.”

Another staff member (Interviewee 3) expanded on that statement:

> The clinic had done the sliding scale in the past and one of the reasons why it stopped was because it was in jeopardy of closing its doors. So that's always the concern, even now, is that it's exposing the elephant in the room, but personally I feel in a moral and an ethical way that we are on a better track, and if we’re here to prevent unneeded hospitalizations or ER visits, we've got to do our duty to give people what they can afford and if they can only afford $10, then isn't that our moral obligation to make it happen?

IV.7.2 *Contribution to Practice*

Results of this case study contributed to the literature by highlighting how this community clinic explored eligibility screening and sliding scale implementation as a way of determining whether they could generate increased revenue. Based on the financial data received from the organization, it was difficult to conclude that the eligibility screening and sliding scale implementation significantly impacted the revenue: The gains were minimal and started prior to implementation, making it difficult to surmise that implementation of eligibility screening and sliding scale contributed to an increase in revenue.

However, the staff and volunteers were happy with the outcome because it gave them the ability to speak objectively of the patient population when applying for grants or when seeking contributions. They were able to accurately identify patients’ need for assistance and distribute grants, gift cards, and medication accordingly because the patients were required to bring their financial information on their first visits to the clinic. The screening also organized the flow of patients and was instrumental in making better use of space after the move to the new building, such as providing the ES with a private area with a concise admission progression. This change

might have produced “eustress and positive reactions or stress of fulfillment” (Tavakoli, 2010, p. 1795).

IV.7.3 *Contribution to Framing*

This cas**e** study contributed to the framing of this research through a process innovation lens. A collaborative initiative to create a process for innovation led to the development of an eligibility screening tool and its implementation to screen patients to determine the amount that they will pay for services provided to them. Clinic staff perceived that there was improvement to the process, namely, that the new workflow and tool which might be used by other organizations.

IV.7.4 *Contribution to the Area of Concern*

Amalgamation of process innovation and cultural and structural changes might not have been adequate to impact the outcome. The process innovation, that is, the eligibility screening and sliding scale initiative, was received well by the interviewees, despite the multiple structural changes in staff and volunteers. The interviewees appeared to be very committed to the patients and the clinic, but more changes might be needed for any tangible financial outcomes to be evident. Based on the financial data, the rates being charged for services were inadequate to increase revenue generated at the clinic and might be one indicator that the clinic should revisit in order to determine an appropriate dollar amount.

IV.7.5 *Limitations*

Being a participant observer might have been a limitation because it created the risk of getting too involved and giving biased data. Another limitation was the duration: The study only allowed for 5 months observation of the organization and process. A longitudinal approach to examining changes and process might emphasize the impact of the changes.

IV.8 Conclusion

This study provided valuable insight into the attempts of a small, nonprofit community clinic to implement eligibility screening and a sliding scale payment schedule to generate revenue. This researcher concluded that because this case study was dynamic and multifaceted, there was no clearly defined approach to address the cultural and structural impact of eligibility screening. As a participant observer, the researcher identified a common thread expressed by staff as the need to increase staffing and volunteers. Staffing and volunteers also trended at the top for the interviews. In addition, the interviewees' responses included increasing the number of providers, patient population, marketing, and resource funding.

Being a participant in the case study also gave this researcher the opportunity to understand the cultural and structural shift, such as commitment and workflow, in this organization. Staff members and volunteers appeared to be very committed to the clinic, and they wanted it to succeed, despite the turnover in staff and volunteers. They wanted to provide care and find resources for their patients, two of the biggest challenges for them as the organization experienced financial difficulty.

Hence, the three-pronged approach suggested by staff might be beneficial for the board of directors and clinic leadership to consider. As suggested by the staff, the leadership team could begin by establishing partnerships with small businesses, hospitals, and physicians' offices to address the immediate need for revenue. Another approach could involve direct targeted marketing in communities within 10 miles of the clinic and a concerted effort to recruit more providers and nurse volunteers. Ultimately, the clinic leadership should consider accepting federal funding, as suggested by Allen et al. (2015) as well as Fiscella and Geiger (2014), because health care for underserved individuals is desperately needed in the United States.

APPENDICES

Appendix A Template of Eligibility Screening Tool

Community Clinic					**FPL**	*Amt paid*
Gross Earned Income + Gross Unearned Income+ Total Family Income						
Patient Name						
Are you Married					**YES**	**No**
# Family Size18-21 (In college) including self						
Gross Earned	check if applicable					
Wages + tips (30 days/4 wks						
2 Current W2 Y/N						
2 Months consecutive checks						
Last year's 1040						
Written notorized letter						
Bank Statement						
Separation letter						
DOL letter						
DFCS letter						
Self Employed Pay						
Minus expenses, rent, utilities,advertising					$	-
Social Security	**Yes**	**No**				
SSDisability						
SSRetirement						
SSSurviors Benefit						
						$ -
Unemployment	Yes	No	$	-		
Food Stamp (NA for GVHCP)	Yes	No				$ -
Gross Unearned					$	-
Contributions from others			$	-		
Child Support	Yes	No	$	-		
Workers Compensation	Yes	No	$	-		
						$ -
Deductions if needed (bordering)						
Employment Credit		$ 90.00		***$0.00***		$0.00
Childcare Credit (up to $200 < 2yrs)		$ 200.00		***$0.00***		$0.00
Childcare Credit (up to $175 > 2yrs)		$ 175.00		***$0.00***		$0.00
Child support credit		$ 50.00		***$0.00***		$0.00
Total Family Income					$	-

Appendix B: Sliding Scale Assessment Tool

Annual 2017 Poverty Guidelines for the 48 Contiguous States

Household/ Family Size	$25 25%	$25 50%	$30 75%	$30 100%	$45 125%	$45 150%	$65 175%	$75 200%	$75 225%	$100 250%	275%	300%
1	3,015	6,030	9,045	12,060	15,075	18,090	21,105	24,120	27,135	30,150	33,165	36,180
2	4,060	8,120	12,180	16,240	20,300	24,360	28,420	32,480	36,540	40,600	44,660	48,720
3	5,105	10,210	15,315	20,420	25,525	30,630	35,735	40,840	45,945	51,050	56,155	61,260
4	6,150	12,300	18,450	24,600	30,750	36,900	43,050	49,200	55,350	61,500	67,650	73,800
5	7,195	14,390	21,585	28,780	35,975	43,170	50,365	57,560	64,755	71,950	79,145	86,340
6	8,240	16,480	24,720	32,960	41,200	49,440	57,680	65,920	74,160	82,400	90,640	98,880
7	9,285	18,570	27,855	37,140	46,425	55,710	64,995	74,280	83,565	92,850	102,135	111,420
8	10,330	20,660	30,990	41,320	51,650	61,980	72,310	82,640	92,970	103,300	113,630	123,960
9	11,375	22,750	34,125	45,500	56,875	68,250	79,625	91,000	102,375	113,750	125,125	136,500
10	12,420	24,840	37,260	49,680	62,100	74,520	86,940	99,360	111,780	124,200	136,620	149,040
11	13,465	26,930	40,395	53,860	67,325	80,790	94,255	107,720	121,185	134,650	148,115	161,580
12	14,510	29,020	43,530	58,040	72,550	87,060	101,570	116,080	130,590	145,100	159,610	174,120
13	15,555	31,110	46,665	62,220	77,775	93,330	108,885	124,440	139,995	155,550	171,105	186,660
14	16,600	33,200	49,800	66,400	83,000	99,600	116,200	132,800	149,400	166,000	182,600	199,200

Monthly 2017 Poverty Guidelines for the 48 Contiguous States

Household/ Family Size	25%	50%	75%	100%	125%	150%	175%	200%	225%	250%	275%	300%
1	251	503	754	1,005	1,256	1,508	1,759	2,010	2,261	2,513	2,764	3,015
2	338	677	1,015	1,353	1,692	2,030	2,368	2,707	3,045	3,383	3,722	4,060
3	425	851	1,276	1,702	2,127	2,553	2,978	3,403	3,829	4,254	4,680	5,105
4	513	1,025	1,538	2,050	2,563	3,075	3,588	4,100	4,613	5,125	5,638	6,150
5	600	1,199	1,799	2,398	2,998	3,598	4,197	4,797	5,396	5,996	6,595	7,195
6	687	1,373	2,060	2,747	3,433	4,120	4,807	5,493	6,180	6,867	7,553	8,240
7	774	1,548	2,321	3,095	3,869	4,643	5,416	6,190	6,964	7,738	8,511	9,285
8	861	1,722	2,583	3,443	4,304	5,165	6,026	6,887	7,748	8,608	9,469	10,330
9	948	1,896	2,844	3,792	4,740	5,688	6,635	7,583	8,531	9,479	10,427	11,375
10	1,035	2,070	3,105	4,140	5,175	6,210	7,245	8,280	9,315	10,350	11,385	12,420
11	1,122	2,244	3,366	4,488	5,610	6,733	7,855	8,977	10,099	11,221	12,343	13,465
12	1,209	2,418	3,628	4,837	6,046	7,255	8,464	9,673	10,883	12,092	13,301	14,510
13	1,296	2,593	3,889	5,185	6,481	7,778	9,074	10,370	11,666	12,963	14,259	15,555
14	1,383	2,767	4,150	5,533	6,917	8,300	9,683	11,067	12,450	13,833	15,217	16,600

Appendix C: Interview Guide

Thank you for taking the time to speak with me. As we conclude this research, I would like your perception of the implementation of the eligibility screening process. The interview will take approximately 45-60 minutes. Is it okay for me to record you?

Adapted from TransforMED Practice Interview Guide, Annals of Family Medicine, 2010

Community Clinic Interview Guide
Would you please tell me your role at the clinic? a. **What previous roles, if any, have you had?**
2. Are you an employee or volunteer? a. How long have you worked/volunteered at the clinic? b. What is the balance between paid and volunteer staff? c. How does that affect your work?
3. What was the objective(s) of eligibility screening**?** To what extent do you believe that the objective of this initiative ***was met?***
a. **How informed are the staff/ involvement-building culture and structure** 4. Please describe the process before the eligibility screening? 5. Please describe the process after the eligibility screening implementation? **On a scale of 1-5, how would you respond to the question below?** **5-Extremely, 4-Very, 3-Moderately, 2-Slightly, 1-Not-at-all** 6. To what extent has the process change impacted the clinic? a. Please explain why you gave it the score you did? b. What would you recommend be done differently and why?
7. Were you involved in the creation or implementation of the process? a. Prior to the patients coming to the clinic? b. Once the patients come into the clinic? 8. Describe any changes in your job role. **a.** Describe the impact the changes made you? 9. **Describe the level of collaboration among** the staff? a. Describe any expected difference between the former process and the new process? How was information shared across the clinic?
10. **Describe any surprises you had because of t**he eligibility screening process? a. How did you feel about it?
11. What impact has the eligibility screening had on staffing? 12. What impact has the eligibility screening had on work flow?
13. In your opinion, what are the short-term challenges for the clinic, and why? 14. In your opinion, what are the longer-term challenges for the clinic, and why?
15. What suggestions do you have for the clinic to address these short-term challenges? 16. What suggestions do you have for the clinic to address the long-term challenges?
17. Is there anything else that you would like to add?

Appendix D: Themes Generated From Interviews

Process comprehension

- process comprehension understand process
- comprehension of process

Change

- impact of change
- confidence in process reflect values of clinic
- flexible-adapting to change

Teamwork-collaboration

- collaboration minimal impact
- collaboration, changed behavior
- types of team

Financial

- Payment Finance
- Income process fee
- decision on FPL
- payment schedule suggested improvement
- articulate process fee
- increase revenue
- revenue, funding
- revenue generation

CHALLENGES AND OPPORTUNITIES

- partnership volunteers
- more volunteers, staff, providers
- more volunteers more providers
- partnership, volunteers
- volunteers, more providers

Final Themes

Themes and subthemes				
Themes	Process comprehension	Effect of change	Teamwork	Financial
Subthemes	Eligibility streamlined	Streamed lined	Establish/Adapt process	Additional resources

Appendix E: Nodes Created From Interview Guide

Twenty-seven node titles were created in NVivo to correspond with the interview guide questions

1. Q01. Role at clinic
2. Q01a. Previous roles
3. Q02. Employee or volunteer
4. Q02a. How long at clinic
5. Q02b. Balance paid and volunteer staff
6. Q02c. How balance affects your work
7. Q03. Objective of eligibility screening
8. Q03a. Extent object was met
9. Q04. Process before ES
10. Q05. Process after ES implemented
11. Q06 –Q06a. Scale 1-5 Impact clinic - explain
12. Q06b. Recommend be done differently – why
13. Q07. Involvement creation implementation
14. Q07a. Steps prior to patients coming to clinic
15. Q07b. Steps once patients came into clinic
16. Q08. Changes in your job role
17. Q08a. Impact of changes on you
18. Q09. Level of collaboration among staff
19. Q09a. Differences former & new process
20. Q09b. How information shared across clinic

21. Q10 -Q10a. Surprises ES process – feel about it

22. Q11-Q12. Impact ES on staffing and workflow

23. Q13. ST challenges for clinic – why

24. Q14. LT challenges for clinic – why

25. Q15. Suggestions address ST challenges

26. Q16. Suggestions address LT challenges

27. Q17. Anything else

Five parent nodes were created as broader content themes.

1. Q01-Q02. Clinical Role Position Balance

2. Q03-Q06. Objective - Eligibility Screening

3. Q07-Q12. Implementation - Eligibility Screening

4. Q13-Q16. Challenges and suggestions

5. Q17. Anything else

NODE LISTING OF CODING REPORTS Total: 5 coding reports with 159 subcategories Titles sorted alphabetically

Interview Questions

1. Q01-Q02. Clinical Role Position Balance (6 subcategories) • Q01. Role at clinic (2 subcategories) - Employee - Volunteer • Q01a. Previous roles (4 subcategories) - Clinic - previous roles - None - Other experience - Volunteer • Q02. Employee or volunteer (2 subcategories) - Employee - Volunteer • Q02a. How long at clinic (3 subcategories) - 1-5 years - Less than 1 year - Not asked • Q02b. Balance paid and volunteer staff (5 subcategories) - 11 empl - 60 vol - 50% empl - 50% vol - 75% empl - 25% vol - 9 empl - a few vol - Do not know

• Q02c. How balance affects your work (3 subcategories) - Does not affect my role - Efficiency and workflow - Recommendations (3 subcategories) o Hire more staff o Increase pay o Volunteers (5 subcategories) ▪ Assignments ▪ Expenses ▪ Recruitment ▪ Retention ▪ Scheduling

2. Q03-Q06. Objective - Eligibility Screening (6 subcategories) • Q03. Objective of eligibility screening (4 subcategories) - Clinic financial returns - DIP grant-funded program - Do not know - Sliding scale based on patient economic status • Q03a. Extent object was met (2 subcategories) - Issues - suggestions - Successful • Q04. Process before ES (6 subcategories) - Additional charges - As need basis - Cannot describe - Flat fee office visit - No screening - Working relationships • Q05. Process after ES implemented (7 subcategories) - Cannot describe - Donations - sponsorships - Fees for additional services - Financial screening - Improved scheduling - Rules enforced - Sliding-scale payments • Q06 -Q06a. Scale 1-5 Impact clinic – explain (4 subcategories) - Do not know - Scale 3 - explain - Scale 4 - explain - Scale 5 - explain • Q06b. Recommend be done differently – why (7 subcategories) - Automated process - Do not

know - Marketing - New patient scheduling & processing - Sliding-scale adjustment - Sponsorships - Training

3. Q07-Q12. Implementation - Eligibility Screening (10 subcategories) • Q07. Involvement creation implementation (2 subcategories) - No - Yes • Q07a. Steps prior to patients coming to clinic • Q07b. Steps once patients came into clinic • Q08. Changes in your job role (2 subcategories) - None - Responsibilities • Q08a. Impact of changes on you (3 subcategories) - None - Positive - Skeptical • Q09. Level of collaboration among staff • Q09a. Differences former & new process (2 subcategories) - Former process - New process • Q09b. How information shared across clinic (5 subcategories) - Grant writers - Meeting - Not shared - Script - Training • Q10 -Q10a. Surprises ES process - feel about it (3 subcategories) - Demographics - Insurance impact - Patient response • Q11-Q12. Impact ES on staffing and workflow (6 subcategories) - Learning process - None or little impact - Patient viewpoint - Roles staff vs volunteers - Stress - Workload

4. Q13-Q16. Challenges and suggestions (4 subcategories) • Q13. ST challenges for clinic – why (13 subcategories) - Clinic availability - Efficiency - Financial stability - revenue sources - Growth - Mission and vision - Patient care follow-up - Patients - Protocols - procedures - Providers - Questionnaires - Resources - funding - Staffing and volunteers - Workload

• Q14. LT challenges for clinic – why (11 subcategories) - Build census - Clinic availability - Financial stability - Growth - Mission and vision - Patient care follow-up - Patients - Providers - Resources - funding - Sliding-pay scale - Staffing and volunteers • Q15. Suggestions address ST challenges (13 subcategories) - Common vision - Communication with patients - FQHC - Marketing - Networking - partnerships - New facility - Outreach - Outsource -

Patient accountability - Revise screening process - Revise sliding-scale and time needed - Staff and volunteers - Tracking • Q16. Suggestions address LT challenges (16 subcategories) - Budgeting - Communication with patients - FQHC - Marketing - Mission and vision - Networking - partnerships - New facility - Outreach - Outsourcing - Patient care follow-up - Patients - Revenue sources - Revise questionnaires - Revise sliding-scale and time needed - Staffing and volunteers - Strategic planning

5. Q17. Anything else

Appendix F: Example of Price Point Indicators Created by Staff

Used for patients receiving diabetics care

Used for all other patients

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VITA

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