Strategic Change at Whitman-Walker Health

Introduction

Don Blanchon, Chief Executive Officer of Whitman-Walker Health (WWH), explained why he had spent the last several years transforming WWH. For its first 25 years, WWH was an HIV/AIDS service organization focused on a low-income, LGBT, and predominantly African-American population. Over the last seven years, WWH transitioned into a primary care-based community health center and a patient-centered medical home to respond to changes in patients’ needs and the local environment. WWH was located in a community that was diverse ethnically, racially, socioeconomically, and in sexual orientation, and was emerging from a rapid period of redevelopment.

Try finding a “poor or underserved” neighborhood in Washington DC—there aren’t many left. It no longer makes sense to build your strategy around caring for the poor and underserved in this city—that would limit you now to about three small neighborhoods, and even they are no longer underserved as other FQHCs [Federally Qualified Health Centers] have or are expanding in those neighborhoods.

Because the goal of the Affordable Care Act of 2010 was to achieve near-universal health coverage, Blanchon believed that traditionally underserved patients would have a widely expanded choice of providers in an increasingly competitive health care marketplace. However, the implications of this change, and how the health center would deal with it, left senior management with unresolved strategic questions. It was also a topic that deeply divided his workforce. As Blanchon put it,

There is staff tension over our efforts to expand the patient base and the services offered. People are here for different personal reasons, and some are only here because they want to work at a safety net. But our primary reason for existence is to make our patients healthy and able to live full and productive lives. WWH does not exist to cure poverty or start a revolution. That is beyond our reach as a single nonprofit. We should want to provide the best care to all comers regardless of socioeconomic status.

In 2014, WWH was planning to move from an overcrowded space in need of updating to a new, upscale building nearby. Senior leadership was also considering providing new consumer-
oriented services such as Botox injections, massage therapy, a travel medicine clinic, and convenient retail products at the pharmacy that would serve both its traditional population as well as new, privately-insured patients who had become more prevalent in WWH’s neighborhood in recent years. The strategic thinking was that WWH’s business model needed more revenue diversification to hedge against an over-reliance on federal health payments. Senior management viewed the center’s government support (Medicaid and grants) as a base upon which to build “retail” services in which clinical staff already had special expertise. However, some staff were deeply concerned that such efforts would take WWH further from its roots as a provider for LGBT and low-income populations, particularly those with HIV.

**Whitman-Walker History**

Whitman-Walker Health began in 1973 as the Gay Men’s VD clinic, a part of the Washington Free Clinic, and was financed largely through philanthropy and local government grants for specific programs, such as housing or legal aid. It became independent in 1978 and was renamed Whitman-Walker Clinic (WWC) with a focus on LGBT health care. As the HIV/AIDS epidemic advanced through DC and the nation in the 1980s, WWC became a leading responder, providing direct services, information, and counseling to individuals diagnosed with AIDS. Over the years, WWC added services such as anonymous testing, a housing program, food bank, legal services, a dental clinic, and research through clinical trials, funded largely through local public and private grants. When Congress passed the Ryan White CARE Act in 1991, WWC began receiving federal funding to support their AIDS service activities.

More recently, as HIV/AIDS awareness, diagnosis, and treatment improved and individuals were living longer, providing services to them became more expensive. According to the DC Department of Health, while the number of HIV/AIDS cases and deaths continued to decline, the number of people living with HIV/AIDS increased by approximately 50% from 2002 to 2006.2


WWC was founded as a “membership” organization, which meant that its board consisted of volunteer representatives of the various programs provided as well as the marginalized populations served by WWC (programs included LGBT health services, HIV/AIDS services for low-income African-Americans, legal aid, etc.). Members served as powerful advocates for their programs and populations; however, they were not necessarily focused on traditional governance responsibilities such as strategic planning, financial stewardship, and oversight of the Executive Director.

Jim Graham, a charismatic gay lawyer and AIDS activist, led the Clinic for its first 20 years. Graham achieved national acclaim for WWC’s success in caring for the most vulnerable HIV/AIDS victims at a time when the epidemic was claiming the lives of many in their prime. In

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1 Botox injections can help treat lipodystrophy, or facial wasting, among HIV patients and can also be used for aesthetic purposes.
1998, Mr. Graham was elected to a four-year term on the DC Council, to which he was re-elected three times. After his 1998 departure for the Council, there was considerable leadership turnover and financial stress at WWC.

Serious financial and internal management problems came to a head in 2004, prompting the Executive Director to resign in December of that year. In May 2005, the organization was unable to make payroll. WWC’s Board voted to make $2.5 million in cuts, which included laying off approximately one-fourth of its paid staff and discontinuing the food bank and two housing programs. WWC also discovered that it was unintentionally overbilling for laboratory services, and correcting the issue limited revenue even further. To ensure that WWC continued to provide services to the DC community, the DC city government ultimately provided $2.2 million in additional HIV/AIDS grant funding over a 15-month period. In addition, WWC received another $750,000 of philanthropic support from the community, which included a major contribution from CareFirst, a local Blue Cross Blue Shield health plan.

At that time WWC’s Board evaluated its options and recognized that they needed to move beyond being an AIDS service organization totally dependent on government grants and private fundraising. After visiting a successful LGBT health center in Baltimore (Chase Brexton Health Care), the Board decided that WWC should become a Federally Qualified Health Center (FQHC). This model would enable WWC to provide primary medical care and increase revenue by accepting payments from clients with both public and private insurance. Some members of the Board supported the transition to a FQHC because they thought it was the best financial option, while others believed that it returned WWC to their mission of serving the LGBT community, not all of whom were HIV-positive. The Board also commenced a long search for a new Executive Director.

The organizational bylaws had to be changed, and the Board had to become compliant with FQHC requirements. This entailed shrinking the board by almost half, to roughly 25 members, and adjusting the composition to become more reflective of both the diversity of the patients and of the community served by WWC. These changes did not alter the Board’s deep commitment to serving the LGBT community. However, the modifications did require that the Board meet monthly and adopt professional board practices, all of which helped it to become more strategically-oriented, collegial, and less operationally-focused.

WWC’s board hired Don Blanchon in May 2006, two and a half years after the former Executive Director had resigned. Blanchon had diverse health care management experience prior to coming to WWC (see Exhibit 1). Despite the widely publicized evidence of internal problems at WWC, Blanchon decided to take the job for both personal and professional reasons. Blanchon had lost his brother to HIV and felt committed to WWC’s mission. Blanchon recalled,

I considered the job high risk, high reward. I knew that it would take someone like me—an outsider—to do the things the Board wanted to do. If I could make it work, it would be

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the coolest thing I could do with my vocation and would honor both my brother and the community I now call home.

**Don Blanchon’s First 90 Days as CEO**

The plan to transition to a FQHC had to be put on hold as Blanchon found himself dealing with far more immediate problems within his first 90 days. On his second day on the job, he became a central player in a contentious union negotiating session with the Board. On day three, he was informed that the Clinic would not make payroll on the 15th of the month. Soon after, he received a letter from the Health Resources Services Administration (HRSA) stating that WWC had overbilled the government and owed $2.7 million. Then WWC’s audit firm informed the Board’s Audit Committee that the firm was unable to complete its work on the 2005 audit due to inadequate financial records. Moreover, WWC’s financial audits filed for calendar years 2003 and 2004 did not meet federal reporting standards and needed to be restated prior to finalizing the 2005 audit. Further examination revealed serious internal control issues including lack of standard processes for accounting for cash collections, accounts payable, accounts receivables, and documenting employee hours. Ultimately, the 2005 audit took 18 months to complete, found 23 violations of standard financial practices, and designated WWC as “high risk.” These audit matters cost WWC both time and money—two resources that were in very short supply at that time.

One of the ways WWC had subsidized operating losses over the years was by selling off real estate assets bequeathed to it by patients under WWC care when they died. The value of Washington real estate rose rapidly throughout the late 1990s and early 2000s, and, consequently, these real estate gains masked the financial impact of continuing programs at WWC long after the grants that supported them expired. However, WWC was running out of assets to sell. CFO Chris Holleman described the financial situation when Blanchon took over:

> There was a desperate need to reevaluate the business model. The infrastructure was extraordinarily bloated. It was much like a trust fund situation—people were not going to look but just assumed the trust fund is there. Then it started running low. When Don got here, it was down to threat-level midnight.

At the same time, Blanchon faced a difficult environment in which to bring about change. Some of WWC’s workforce and a few key LGBT community leaders considered Blanchon, a heterosexual male with limited connections to DC’s LGBT community, to be an outsider and were dubious of his intentions for WWC. Challenges arose immediate as two senior leaders and other individual staff openly challenged his authority as the new CEO in the first 90 days of his service. Blanchon ultimately removed these two leaders and then faced community backlash for the decision, including anonymous WWC sources claiming that he was homophobic.

Blanchon described the situation:

> I was not at all prepared for the emotional side of what I was getting into. I was not gay, not HIV-positive, not part of the HIV/AIDS or LGBT social network, and not well-known in local political circles. I realized I can’t know it with my heart.
WWC’s Chief Operating Officer (COO), Naseema Shafi, recounted the general sentiment among employees and members of the community at the time:

> It seemed that there was a feeling that he’s straight, trying to make Whitman-Walker straight, trying to make us a FQHC which seemed to outsiders to be straight. There was not an understanding of why we were transitioning.

Blanchon also struggled with a culture that had roots as a community organization, aspects of which were valuable but also contributed to the financial problems facing the Clinic.

> I discovered that the currency in this organization was not money but relationships—and that power was derived in this currency by whom you know both within WWH and in local political circles. There are good aspects of this: compassion, strong community relationships, and intimacy. But it doesn’t lend itself to normative business objectives such as professionalism, accountability to patients, operating discipline, and financial sustainability.

Blanchon took several steps within the first 90 days to foster a more professional and responsible culture. He started an 8:30 a.m. leadership call every morning to establish increased accountability among the senior leadership team; he established his own work hours between 8:30 a.m. to 6:00 p.m. He held one-on-one meetings with staff members to hear their concerns and get to know them. He demonstrated the importance of respecting employees’ time by starting and ending meetings on time. He kept his door open at all times to demonstrate accessibility, and he made rounds of WWC’s clinical operations at least once a day.

COO Shafi recounted watching Blanchon make the daily rounds:

> All of Don’s behavior was so strategic in retrospect. He knew exactly what he was doing. He would walk around everyone’s desks at 3:00 on a Friday afternoon when people would show their true colors.

### 2007–2009: Transformation to a Federally Qualified Health Center

Blanchon was concerned about how to implement the FQHC vision:

> I had to make a decision about how quickly to transition to a primary care FQHC. If the changes were too fast, people would be left behind and create resistance, potentially creating organizational collapse. We planned for a major organizational change to occur about every 6–9 months, but the financial circumstances required that we move as quickly as possible.

As Blanchon worked to change the culture, he also forged ahead with the transition to a FQHC. The clinic also needed to acquire primary care capacity; it had only five employed practitioners, all specialists in infectious disease and not credentialed by commercial insurers. Given the very public financial crises of the last several years, recruitment of primary care physicians on the open market was unlikely to be successful. Fortuitously, the Washington Free Clinic had been
experiencing financial problems, as well, and was unable to remain financially viable as an independent organization. With one primary care physician employee, three physician extenders, and a large volunteer medical staff, the Clinic had primary care capacity but a shrinking patient base comprised of the nearby Latino/a community. Blanchon worked out an agreement with the Clinic to bring all 12 of its employees and the roughly 1000 patients it served to WWC, thus preserving the Free Clinic employees’ jobs and their patients’ access, while also establishing the necessary primary care capacity at WWC.

With primary care in place in January 2007, WWC received the designation of a Federally Qualified Health Center Look-Alike.\(^4\) With the FQHC-LA designation, WWC received a higher Medicaid reimbursement rate than it could as a Medicaid fee-for-service provider. It also started contracting with individual commercial insurers. In December 2007, with substantial financial support from the city, WWC began implementation of an electronic health record system, which served to standardize the care protocols for primary care, among other objectives. As WWC transitioned to a focus on primary care, the Clinic dropped some of the formerly grant-supported services such as housing and transportation assistance, and outsourced pharmacy management.

However, WWC continued to struggle financially as the economic recession hit in 2008. With the recession, philanthropic donations, and public reimbursement and grants decreased, while uncompensated care increased. In addition, creditors demanded cash repayment of certain long-term loans now due; with the financial crunch, refinancing was not an option. In early 2008, Blanchon laid off approximately 20% of the center’s 275 employees to reorganize around a health center business model. In December of 2008, he laid off another 25% of the workforce, this time largely eliminating non-direct care management roles, thereby reducing the staff to around 135 full-time employees. At the same time, senior leadership chose to hire some new direct patient care staff in areas critical to the new direction of primary care that WWC had embarked upon. WWC established a new clinical case management program that required more expensive staffing by registered nurses instead of licensed social workers who had been the case management staff under the former WWC model. WWC also expanded staff in behavioral health and primary care. Staff morale was extremely low during and after these two rounds of layoffs, and some employees openly questioned Blanchon’s leadership.

**2009: The Catania Hearings**

In late 2008, WWC’s financial condition combined with the last round of firings prompted a local city councilman who was also gay, David Catania, to launch an investigation of WWC and particularly Blanchon’s leadership. Catania requested that Blanchon appear before a DC Council hearing in January 2009, where he accused the CEO of “gross negligence and malfeasance” and

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\(^4\) FQHC “look-alike” status means that the community health center meets all of the federal requirements for recognition as a federally qualified health center (e.g., provides comprehensive primary care without regard to ability to pay, to all individuals in a service area, at one or more permanent delivery sites) but does not receive federal funding from the Health Resources and Service Administration (HRSA). For more information, see http://bphc.hrsa.gov/about/lookalike/index.html.
proposed that he should be replaced. Catania also suggested that Blanchon’s actions reflected his intention to end WWC’s commitment to the gay community. Blanchon appeared at the hearing and responded to hours of intense hostile questioning.

Many staff members recall sitting together on the day of the hearing watching the live video of the Council’s hearing. Blanchon’s unshakable support of WWC throughout the hearing reaffirmed a number of employees’ support for his leadership. Rachel McLaughlin, Director of Quality Improvement, recalled,

I wouldn’t like Don as much as I do now if I hadn’t seen him go through that personal shaming. It takes a strong person to get through that. He had also done a lot of other great things—he had to move a lot of money around just to make sure we got paid.

One long-time staff member recalled:

When Don went before Catania—that was when everyone came together and had his back for the first time. Catania was testing Don’s leadership and testing everyone who was here. To have that questioned—why we were here and what we were doing—brought us closer.

COO Shafi recognized the significance of that moment:

It was an incredibly important moment for us. We came together as a team to support Don when previously many were always looking at Don unsure of what he was doing.

An independent audit ultimately demonstrated that Catania’s accusations were unfounded. And at a second hearing in May 2009, Catania and WWC achieved a political outcome that allowed WWC to move forward with Blanchon at the helm.

2010–2013: Improvements in Patient Quality and Financial Stability

By 2009, WWC was billing third party payers fairly consistently. With the increased revenues and decreased expenses from programmatic changes and employee layoffs, WWC almost broke even for the first time in 2009. The Clinic also began to see an increasing number and broader socioeconomic mix of patients (see Exhibits 2 and 3). By 2013, the new business model was steadily profitable with a significant change in revenue sources (see Exhibit 3) and payer mix (see Exhibit 4). At the same time, WWC’s patients also exhibited high quality health outcomes, and patients expressed high satisfaction with their care at WWC (see Exhibits 5 and 6). Exhibit 7 shows the details of the WWH changes in financial performance over the period 2008–2012.

In April 2011, Whitman-Walker Clinic changed its name to Whitman-Walker Health (WWH). Blanchon explained that this renaming was intended to more accurately reflect the changes at the health center:

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From my perspective, “clinic” had a specific meaning when we were named that a few decades ago, but it has practically a different meaning now. It’s limiting. “Clinic” is seen as performing one service, one given time during the day. There are connotations of being a place of last resort, stigma of socioeconomic factors. It’s a focus on sickness and not prevention, which is what we do now as a primary health center.  

With all of these positive advancements, staff morale also began to increase as employees began to see how their work was impacting the community. One of the center’s staff explained how employees began to see the impact of their work:

There is a recognition now that your contribution, work, and commitment to give a patient a good experience means that a patient has a good experience—which means that the patient comes back—which means more revenue for Whitman-Walker—which means we’re all doing better because of your work.

Looking Ahead: The Affordable Care Act and Beyond

As WWH experienced more positive financial performance and higher patient and staff satisfaction, the internal environment began to feel stable for the first time since Blanchon took over. However, with the passage of the federal Patient Protection and Affordable Care Act of 2010 (ACA), major long-term changes threatened the stability of WWH. First, under the ACA, almost all of the DC population would be insured, and these individuals would have more choice in where they went for care.

The FQHC model meant a strong dependence on government funding both for patient service revenues (e.g., Medicaid) and grants (HRSA and local community grants). The Board and senior management team felt that WWH needed to further diversify its revenue sources, including its service scope and its payer mix, by pursuing more privately insured patients. COO Shafi described the financial situation:

Right now we’re financially stable, but all it takes is one change to make us less stable. This year it was the Medicaid change in reimbursement for the pharmacy. All it took was one letter in late 2012, and then we face a $1.2 million revenue gap on the first day of the new year.

WWH’s new building was located in the U Street/Logan Circle area in Washington, DC, which had experienced tremendous growth and gentrification over the past decade, particularly in the past couple of years. With new condos, apartments, restaurants, and retail stores popping up in the neighborhood, WWH had an opportunity to attract a new group of patients as their convenient neighborhood health provider.

In response to the changes in the health care environment and neighborhood, the Board and senior management worked to develop a new strategy. Blanchon described the strategy as

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7 DC Medicaid made a change in reimbursement for the selling of anti-retroviral medications in pharmacies in 2013.
pursuing a “hybrid FQHC model” which would add an additional revenue stream from retail/direct to consumer services. Blanchon also saw this change as critical to adhering to its mission to serve the LGBT population. He explained,

I see WWH as a safe haven and affirmation of care for metro DC’s LGBTQ community. I don’t want WWH to chase additional visits from Medicaid or any one payer base at the expense of losing connection to the LGBTQ community.

He continued,

Consumerism is the logical extension of the ACA coverage expansion. People talk about watershed moments—this is it. It’s all about how good you are and how patients experience WWH. Why wouldn’t we open at 7:00 in the morning? We’re already paying the light and heating bills then. Seniors would love it. And why not run until 9:00 at night? If the volume is there, why not? The health and wellness programming we provide should be available before and after work. Otherwise, we are not serving our patients and ultimately not fulfilling our mission.

Quality Improvement Director Rachel McLaughlin acknowledged that patient quality of care was about far more than health outcomes:

Patients love it when their nurses and providers call them and when people are polite. It’s what brings people back.

Senior leadership considered what new services the health center could offer to better meet consumer needs and to diversify the sources of revenue. In 2013, they achieved Patient-Centered Medical Home recognition, through which they sought to improve patient access through team-based care, increase the focus on preventive health services and chronic disease management, and improve the integration of medical and behavioral health.

However, there remained some trepidation about the impact of a “hybrid FQHC” model on both staff and the traditional client base. One staff member summarized the concerns, which had already surfaced with the decision to move to a new building and might be exacerbated by a more “consumer-oriented” service scope:

My fear is that some of folks who have been with us for many years may say, “wow, this isn’t for me.” There are folks that call this place home and are used to it all, including the drafts and the tiles. Maybe walking into a new giant lobby doesn’t look like home. I hope that we don’t lose these people.

Arguing that the changes are for the better, Dr. Ray Martins, CMO, asserted,

Lots of people are here for specific reasons and are advocates for specific communities. If they can’t see the implications of doing something for everyone, I have a problem with that. The new building provides a space that patients deserve. Not just new patients but also our existing patients. People will see us differently and will see the quality of care differently. It will change people’s perception.
Senior management and the Board also anticipated major changes in the local health care marketplace following the ACA and the growing affluence of the Washington, DC, area. Specifically, WWH foresaw that the health care choices for most DC residents would increase considerably as large health systems began sponsoring new primary care providers to serve the surrounding, increasingly gentrified neighborhood. Local hospital systems, including MedStar and George Washington Hospital, had already begun to expand their primary care practices and set up offices in new commercial and residential areas of the city. As CFO Chris Hollerman described,

Our biggest competitive threat is competition with deep pockets. If we do what we’re trying to do with the new building—go from good to great in customer service—we will absolutely compete on quality. We will also compete on convenience. But this is a David and Goliath game. MedStar can plop down wherever it wants.

WWH would also be competing with five neighboring community health centers that were also likely to engage in activities to retain and attract patients.

WWH was likely to eventually have to pick one of the six large health systems operating in the DC area as its strategic partner. The speed of change, however, was in question. DC was decades behind the transforming markets in other parts of the country, where consolidation, Accountable Care Organizations, prepaid medical groups, and bundled or capitation-based payment systems were rapidly taking over. As Blanchon explained,

Everything in DC is political—which means that solutions will represent the lowest common denominator, where there is minimal change and compromise at the expense of innovation. We still don’t even have Medicaid managed care for the most expensive populations here.

At this point, WWH represented a desirable partner to most of the six systems (except for the religiously-affiliated institution which would not be well-aligned with WWH’s mission). WWH faced the question of whether the health center should actively seek to build a collaborative partnership now, or wait for further developments while building its own reputation and primary care market share.

The senior management team knew that more change was ahead. As Naseema Shafi, the COO, remarked,

Don is incredibly visionary. He knew we needed to be a community health center to be financially stable. It took us until 2009 to get there and see some of the benefits. He’s been very forward thinking about what’s coming next. [...] We knew that Patient-Centered Medical Home was out there, that the Affordable Care Act was coming. When the President was reelected, the writing was on the wall. We have to keep going because health care is moving.

However, big questions remained: What should the next destination be for WWH and how should it get there?
Exhibit 1: Don Blanchon Biosketch

Don Blanchon began his tenure as executive director of Whitman-Walker on May 1, 2006. Before that, he spent nine years with Schaller Anderson, a national health care management and consulting firm that specializes in public-sector programs. During that time, he held positions of increasing authority, including CFO and CEO of Maryland Physicians Care, a $325 million multi-product health plan owned by four Maryland-based non-profit community health systems. From 2004 to 2006, Blanchon served as vice president for Medicaid and Medicare programs for Schaller Anderson.

Earlier in his career, Blanchon served as vice president for strategic planning for Health Services for Children with Special Needs, a specialty health plan in Washington, DC. He also spent five years as a budget examiner in the executive office of the president at the federal Office of Management and Budget.

Blanchon, a native of Foxborough, MA, holds a bachelor's degree in biochemistry from Bowdoin College and a master's in public health and public affairs from Columbia University. He lives in Washington, DC, with his wife and their two children.

2005 visit data estimated at 6 per patient; actual number not known

Exhibit 3: WWH Patient Socioeconomic Characteristics, 2012

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<th>Percentage</th>
<th>Income as % FPL</th>
<th>Percentage</th>
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<th>Gender</th>
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<td>Female</td>
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<td>Transgender</td>
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Exhibit 4: WWH Revenue Sources 2005 and 2013

Exhibit 5: Payer Mix of WWH Patient Service Revenue, 2005 and 2013

Note: Medicare covers 10%, and Medicaid 25% of residents of Washington, DC
### Exhibit 6: WWH Patient Satisfaction and Quality Indicators

#### WWH Patient Satisfaction Results (2010)
- 89% of patients rated care as "good" or "very good"
- 83% of patients often or always feel comfortable and welcomed
- 83% of patients often or always feel their providers help them understand test results and conditions
- 83% of patients often or always feel that their providers spend enough time with them

#### WWH Quality Indicators (2010)
- 87% of HIV-positive patients are on antiretroviral medications (ARVs)
- 78% of HIV-positive patients on ARVs have controlled viral loads
- 79% of female patients have had pap smear in previous 36 months
- 69% of diabetic patients have well-controlled cholesterol (LDL less than 100)

#### WWH Quality Indicators (2012)
- 95% of patients living with AIDS are on prescribed antiretroviral (ARV) medications
- 92% of patients living with HIV on prescribed ARV medications
- 86% of patients living with HIV have suppressed viral loads
- 65% of patients living with diabetes have controlled blood sugar levels (national benchmark is 40%)
- 74% of female patients received cervical cancer screening according to standard guidelines (national benchmark is 58%)
- 68% of hypertensive patients have a controlled blood pressure (national benchmark is 63%)
### Exhibit 7: WWH Financial Results 2008–2012

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<td><strong>Revenue</strong></td>
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<td><strong>Expenses</strong></td>
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<tr>
<td><strong>Total Support Services</strong></td>
<td>5,231,822</td>
<td>4,851,700</td>
<td>4,170,802</td>
<td>4,186,777</td>
<td>5,394,284</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td>29,493,531</td>
<td>24,338,784</td>
<td>19,698,868</td>
<td>17,556,958</td>
<td>21,361,540</td>
</tr>
<tr>
<td>Changes in net assets from operations</td>
<td>2,661,265</td>
<td>2,346,667</td>
<td>1,086,417</td>
<td>-750,567</td>
<td>-4,054,206</td>
</tr>
<tr>
<td>Gain in sale of real estate</td>
<td>90,000</td>
<td>3,402,068</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net assets at beginning of year</td>
<td>8,329,237</td>
<td>5,982,570</td>
<td>4,896,153</td>
<td>5,556,720</td>
<td>6,208,858</td>
</tr>
<tr>
<td>Net assets at end of year</td>
<td>10,990,502</td>
<td>8,329,237</td>
<td>5,982,570</td>
<td>4,896,153</td>
<td>5,556,720</td>
</tr>
</tbody>
</table>