OUTSOURCE CONSULTANTS

CASE STUDY

HEALTHCARE | COMMUNITY HEALTH (FQHC)

Half as many hang-ups. Calls 60% shorter. $650K back into patient care.

A Federally Qualified Health Center (FQHC) serving 47,000+ low-income patients in California runs medical, dental, vision, and mental health care on a sliding scale, which means overhead and patient care compete for the same dollar.

Nowhere was that competition more visible than the phones. The center's patient line takes as many as 40,000 calls a month across multiple languages, and it was failing on both sides of that equation: a prior outsourcing vendor could not handle the volume or the languages, one in ten callers abandoned before reaching an agent, and average handle times bloated the cost of every contact.

Outsource Consultants (OC) matched the FQHC to a vetted, language-matched partner, then stayed in the relationship through its Vendor Management Office (VMO): a hands-on team of OC CX advisors who govern the program on the client's behalf, keeping the partner accountable and the operation continually optimized, at no added cost for the life of the partnership.

The health center got expert vendor management without staffing it. Abandonment fell from 10% to 5%. Handle time dropped 60%. And the 28% cost reduction, $650K over the engagement, went where a safety-net provider's savings go: back to patient care.

50% lower

call abandonment, halved on a 30-40K call/month line

60% lower

average handle time, lowering the staffing each call requires

$650K unlocked

to the FQHC for patient care; 28% off the cost line

VERTICAL	SERVICES	FOOTPRINT	GOVERNANCE
Community health (FQHC)	**Multilingual scheduling, registration + insurance verification**	**Hybrid onshore + offshore, language-matched**	**VMO: monthly performance cadence**

THE STORY IN 20 SECONDS

THE PROBLEM

A prior vendor could not handle 30-40K monthly calls or the languages the community speaks; 1 in 10 patients abandoned before anyone answered.

THE MATCH

An independent match to a vetted, language-matched partner on a hybrid model, with scheduling, registration, and insurance verification in scope and OC's VMO governing from launch.

THE RESULTS

Abandonment halved, handle time down 60%, and $650K in savings redirected to sliding-scale care for 47,000+ patients.

THE CHALLENGE

When a community FQHC fails, patients lose care they can't get anywhere else

A community health center's phone line is not a support function. For 47,000 low-income patients, many managing care in Spanish, Russian, Ukrainian, or another language, it is the front door to medical, dental, vision, and mental health care they cannot get anywhere else. When one in ten calls on a 30,000-to-40,000-call monthly line ends in abandonment, thousands of patients a month are turned away by excessive hold times.

The center had already outsourced the phone line, and the prior vendor was failing it twice over: it could not scale to the volume, and it could not serve the languages the community actually speaks. Handle times ran long, which quietly multiplied the cost of every contact, because in a phone operation, minutes are money and long calls demand more staff for the same demand.

An underfunded safety-net provider cannot solve that challenge with budget, as tight margins prevent bigger investments. FQHCs simply don't have the budget to spare, they have to solve the challenge with fit.

At a safety-net provider, efficiency and access are the same number. Every wasted minute on the phone line is care the budget cannot fund somewhere else.

Matched to the patients, not just the metrics

The center engaged OC to run an independent search. OC screened its network of 300+ vetted BPO partners, each tracked on 100+ performance data points, against what an FQHC actually needs: healthcare scheduling experience, language-matched staffing for a multilingual patient base, the capacity to absorb 30,000-plus calls a month, and economics that work for a sliding-scale budget.

OC narrowed the market to a shortlist. The FQHC made the final selection from a host of expert options, giving the client full control of their preferred partner.

The scope was engineered as carefully as the match: inbound scheduling, registration, and insurance verification, run on demographic data only, with no medical or prescription history crossing the line. Access improved and the compliance surface shrank in the same move.

And OC's Vendor Management Office (VMO) stayed in: a standing cadence of expert oversight, benchmarking service level, abandonment, and handle time against the goals the center set, from launch onward. And at no added cost to the FQHC.

Most outsourcing does not fail in the selection. It fails in the first 180 days after go-live.

This engagement proved the point the hard way, and the next section tells that part honestly.

ABOUT THE ADVISOR

We matched the languages before the metrics

The old vendor couldn't handle the volume or the languages. So OC screened 300+ partners for Spanish and Russian lanes, healthcare scheduling experience, and pricing a sliding-scale budget can carry. The center picked from a shortlist that already fit.

We forced the fixes that saved year one

Turnover waves, billing messes, and a site change hit this program in its first year. Any one of them kills an unmanaged engagement. OC's VMO surfaced each problem early, pushed the partner to replace its account leadership, and renegotiated the terms: stating each center pays nothing for any agent who quits inside 30 days.

At an FQHC, efficiency is access

At an FQHC, every wasted dollar rations care. OC's fix shortened calls, so the same demand needs fewer staffed minutes, and the cost line fell 28% while abandonment halved. That returned $650K to the mission: visits, vaccines, and sliding-scale care.

INSIDE THE ENGAGEMENT

How the first year tested everything so success would follow.

Most case studies delete the hard part. This one is more useful with it in, because the hard part is where the advisory model shows its value to an FQHC program.

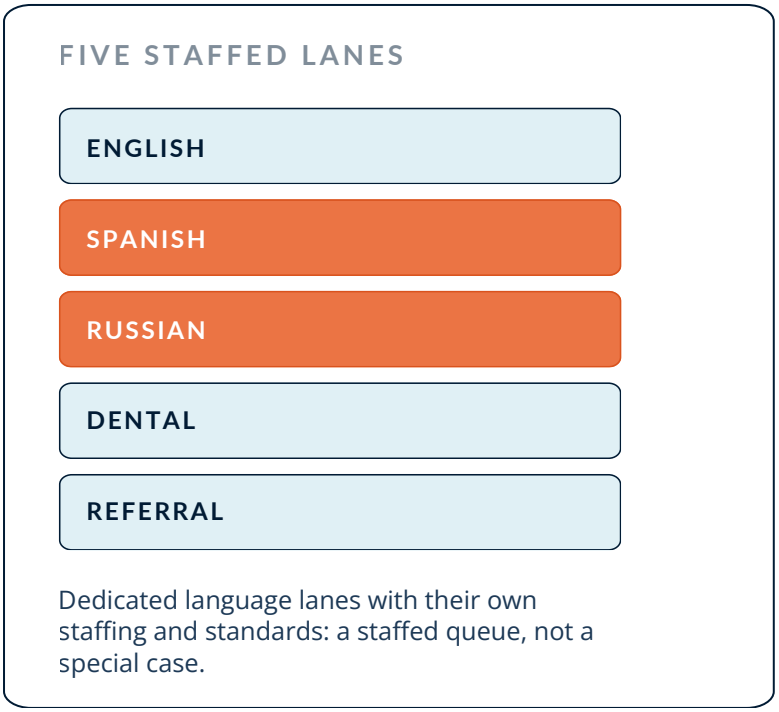
The turbulence, told straight

The first year threw real problems at the program: waves of agent turnover after a higher-paying employer opened near the delivery site, billing that took hours a month to reconcile, and a mid-launch site change. Any one of those ends an unmanaged vendor relationship. What happened instead is the point: OC’s VMO surfaced every issue early through its standing cadence, the partner replaced its account leadership, and terms were renegotiated so the center pays nothing for any agent who leaves within 30 days of training. Billing went from a monthly chore to clean, proactive, and credit-free. The relationship did not survive on goodwill. It survived on governance.

Access, operationalized in five lanes

The program runs dedicated lanes for English, Spanish, and Russian-speaking patients, plus dental and referral queues with their own standards, so a patient managing care in their own language is not a special case; they are a staffed queue.

By the time the VMO's standing review cadence began, abandonment was running at 3% against the 5% goal the center set: better than the published result, in the operation's first measured stretch.



Dedicated language lanes with their own staffing and standards: a staffed queue, not a special case.

The center kept buying more

Confidence compounded into scope. The footprint more than doubled from launch, and the mandate grew from scheduling into referral management and dental support.

Over the same stretch, the organization itself expanded to roughly 11 locations serving its region; growth the center earned, on an access foundation that finally held. And the strongest endorsement is the quietest one: the center's leadership now refers peer organizations to OC.

THE RESULTS

Real metrics the board can rely on

Read the results as one equation, because at an FQHC they are. Abandonment fell from 10% to 5%, which on a 30,000-to-40,000-call line means thousands more patients a month reaching scheduling, registration, and insurance verification instead of a dial tone. Handle time fell 60%, which lowered the staffing each call requires, which is where the 28% cost reduction came from: $326K in the first year, $650K across the engagement. The center did not buy cheaper access. It bought better access that cost less, and the difference funds sliding-scale care.

They kept adding lanes

What began as a scheduling rescue grew into a multi-lane, multi-language program spanning registration, insurance verification, referral management, and dental support, on a footprint that more than doubled. Programs do not grow like that unless the front door is finally working.

ABANDONMENT, HALVED

BEFORE — 10%

AFTER — 5%

From 10% to 5%: thousands more patients a month reaching scheduling instead of a dial tone.

BY THE NUMBERS

47K+

low-income patients served through the front door

5 Patient Service Lanes

including Spanish and Russian language queues

2X

footprint growth from launch

$650K

returned to sliding-scale care

Four ways to read this outcome

Different leaders read this story against different numbers. All four readings are correct.

IF YOU OWN THE BUDGET

28% cost reduction that did not penalize patient access anywhere

The savings mechanism was efficiency, not corner-cutting: shorter calls needed fewer staffed minutes for the same demand, and abandonment fell while the cost did. $650K at a sliding-scale provider is not a small windfall. It is visits, vaccines, and dental chairs.

IF YOU OWN ACCESS

Lowering patient abandonment is capacity expansion

Cutting abandonment from 10% to 5% on a 30-40K call line reaches thousands more patients a month without adding a single location. For a growing multi-site organization, a front door that scales is the prerequisite for everything else. The savings were never the point; what you do with them is.

IF YOU OWN THE EXPERIENCE

Patient care in the patient's own language

A patient calling about a sliding-scale appointment in Spanish or Russian should reach someone who serves them in that language, first try. Dedicated language lanes with their own staffing turned that from a value statement into a queue structure. Dignity at the front door is an operations decision.

IF YOU OWN TECHNOLOGY + RISK

The compliance surface expertly managed

The scope runs on demographic data only; no medical or prescription history crosses the line, which shrinks the compliance surface by design rather than by policy. And every healthcare BPO in OC's network is vetted for HIPAA readiness before recommendation, with BAA process, SOC 2 reporting, and incident-response documentation available on first request.

THE TAKEAWAY

Three things to take from this story

01 **At a safety-net provider, FQHC efficiency impacts broader patient access.** The same dollar cannot fund keeping patients on hold and a dental chair at once. Fix the phone line's economics and the FQHC program can reinvest the savings, making a difference in patient access and elevated care.

02 **Multilingual access is requisite staffing, not an optional patient service.** Language-matched lanes with their own queues and standards are what serving a community actually looks like on a phone system.

03 **The first year is where outsourcing lives or dies.** This program hit real turbulence and held, because OC's VMO caught every issue early and forced real fixes. Build that in before you need it.

Your front door is either reaching your patients or rationing them. There is no neutral.

A 30-minute conversation with our healthcare CX advisors will tell you which one you have, and what abandoned calls are costing your mission. No cost, no obligation, no pitch deck.

Let's Talk

outsource-consultants.com 888.766.4482

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