

APPENDIX A: RESEARCH ON EXISTING ADMINISTRATIVE COST-SHARING MODELS

Phone interviews were conducted with six administrators from collaborative school health models across the country (Denver Health and Hospital Authority; School-Community Health Alliance, Michigan; Seattle Health Department; Learning Well – Indianapolis; Multnomah County Oregon Health Department; Miami-Dade County Coalition) and three administrators engaged in administrative cost-sharing models among community health centers in Chicago and throughout Illinois (the Alliance of Chicago Community Health Services, LLC and CQuest America, Inc.) The following two tables summarize the key points from the interviews. Further detail is then provided on 3 of the 8 models: the School-Community Health Alliance, Michigan; The Alliance of Chicago Community Health Services and CQuest America.

School Health Center Administrative Cost-Sharing Models in the U.S.

Site	Pre-Requisites	Centralized Services	Required Resources	Benefits	Lessons Learned
Denver Health and Hospital Authority (HHA) ?? 12 SBHCs ?? Only community health center contract in City ?? Government entity that contracts with the City of Denver to do health department function	?? Mayor mandated that HHA pick up existing 3 SBHCs when Robert Wood Johnson money ran out	?? Billing ?? Data ?? Registration shared with network of specialty and inpatient services ?? Reports ?? Administrative tasks ?? Medical Director and medical supervision ?? Quality Improvement	?? Sponsor only provides staff or funding to cover staff	?? Publicity for sponsoring agency ?? “Feel good” about contribution to children’s health care ?? Sponsors get more efficient delivery system ?? Children will have access through HHA to specialty and inpatient services ?? More money into direct service by streamlining management ?? Saves money by centralizing	?? Need a strong leader/advocate ?? One on one meetings with CEOs of sponsoring agencies most effective ?? Funders are powerful advocates ?? Look at this as a merger of corporations
School-Community Health Alliance: Michigan ?? (501(c) 3 with 11 member Board voted in by membership of Coalition) ?? 62 health centers	?? Impetus for collaborating was loss funding in 2001 – with parent advocacy state	?? Generates all reports ?? Billing (process, post, conduct appeals process if necessary) ?? Trouble shoot with state and	?? Desire to enter ?? Have data to share ?? Use same encounter form (but may be customized to sponsoring	?? Cheaper (especially for large hospitals) to pay monthly fee to Alliance than to hire own billing person or billing service ?? All types of SBHCs are now on board – at first big hospitals joined but now	?? Take Coalition from informal to formal so state and legislators will view as a powerful entity ?? Hire a person with a billing background ?? Legal people are critical to the collaboration process

<p>?? 18 currently part of Alliance</p>	<p>reinstated funds ?? Everyone had to start billing – resounding theme from state “if you billed it would be better” ?? Funds from the State Department of Public Health to hire billing expert</p>	<p>insurance companies ?? Data collection ?? Advocacy ?? Technical assistance and training on use of system but also on flow issues ?? Enrollment in Medicaid ?? List-serve</p>	<p>agency) ?? \$10,000 for data base ?? \$200 per month for use of system ?? Computer with internet capacity</p>	<p>even “mom and pop” see benefits. Have recouped their initial investments ?? Managed Care Plans are approaching Alliance to collaborate ?? Governor’s Office is taking them seriously ?? Each site can look like a separate physician’s office</p>	<p>(meet with each sponsoring agency’s legal people separately or CEO with legal counsel) ?? Started with a shared data base – would never do again ?? Provide training to all levels of people in SBHC ?? Quarterly meetings with administrators to keep everyone informed and involved ?? Internet system requires less start up dollars and becomes cheaper with more membership</p>
<p>Seattle Health Department ?? 5 sponsoring agencies (went from 14) ?? 2/3 of funding comes from city property levy ?? 15 SBHCs (all 10 high schools regardless of economic level have SBHC and 5 middle schools)</p>	<p>?? City of Seattle required that all SBHCs bill and look for economies of scale (2 sponsors backed out and others – mostly FQHCs took over sponsorship)</p>	<p>?? Administrative oversight with Health Department ?? Repository of data ?? Centralized QI</p>	<p>??</p>	<p>??</p>	<p>?? One on one meetings with sponsors effective ?? Seattle School Summit raised awareness and forced people to come to the table, discuss issues and make decisions</p>
<p>Learning Well – Indianapolis ?? 501 (c) 3 in 2002 ?? 58 school-based sites (28 have NPs, MAs, and .01 physician; 30 are RN clinics)</p>	<p>?? Pledge of 5.5 million from Health Foundation to address children’s health</p>	<p>?? Data collection ?? Advocacy ?? Determine where new sites will be established and help identify partners ?? Evaluation</p>	<p>?? Computer with internet access ?? Equipment and staff (staff and medical supplies reimbursed by Learning Well)</p>	<p>??</p>	<p>?? After 2 years of meetings of school and health experts – Foundation realized that needed one centralized agency if you wanted to bring partners together ?? MIS person on staff is</p>

			for staff) ?? Staff supervision provided by sponsoring agency ?? \$1 million start-up money from Foundation for 501(c) 3		critical – to research software and train SBHCs ?? Have all providers represented on governing board ?? Web-based system affordable, little start-up costs and can be customized
Multnomah County, Oregon Health Department ?? 13 SBHCs	?? SBHCs were originally developed under umbrella of Health Department (joint effort between HD and largest school district)	?? Centralized administrative office for SBHC program – program manager. Lead NP, clinical supervisor for RNs, system’s manager and operation’s manager (supervises facilities and Administrative Assistants) ?? Self-directed teams at sites with no lead person ?? Have monthly all SBHC staff meetings with break-out sessions ?? Centralized billing for entire health department (which is part of larger statewide	??	??	??

		community health network)			
Miami-Dade County ?? Florida Coalition very loose	?? Possible Medicaid Transformation bill for FL, which will privatize all of Medicaid ?? This is a common issue to all CEOs of sponsoring agencies and may be the needed impetus for collaboration				?? Bulk purchases was not a good incentive to bring people together ?? Disparate sponsors were unwilling to give up ownership on any level

Community Health Center Administrative Cost-Sharing Models in Illinois

Site	Pre-Requisites	Centralized Services	Required Resources	Benefits	Lessons Learned
<p>Alliance Chicago ?? LLC ?? Network of 4 Chicago-based community health centers that administer 24 sites and serve over 65,000 people annually</p>	?? Part of the network	?? Clinical QI ?? Electronic health record system ?? Training and education ?? Lab testing ?? Immunization	?? Members are dues-paying health centers who have joined the network	?? Share resources ?? Integrate services ?? Save time and money ?? More efficiently deliver quality health care	?? Securing start up funds was challenging ?? The 'dog' is the electronic medical record, which leads to quality improvement. The billing is the 'tail'. ?? LLC takes on mission of partners and provides a safe harbor for them to make money and develop services
<p>Illinois Primary Health Care Association (IPHCA) ?? Nonprofit trade association ?? Administers to 41 members, 314 sites, and over 800,000 people annually ?? I-Net network allows IPHCA to coordinate and share practice management information</p>	?? FQHC or "look alike"	?? Centralized practice management system for billing, appointments, encounter form, reports ?? Claims processing ?? Data collection ?? Advocacy ?? Technical assistance and training on use of system but also on flow issues ?? Group purchasing for clinical labs, employee background checks+	?? \$1,000-5,250 per year for membership fee (depends on size of budget) ?? \$38,000 for annual costs of I-Net ?? \$7,750 one time set up fees	?? Technical assistance ?? Coordinate education/training ?? Advocate and publicize for members ?? Fiscal management services ?? Assistance with staff recruitment and training ?? Assistance with securing funding sources	?? Takes a lot of time of time to be the central administrator ?? Process of standardizing was painful but beneficial ?? Don't see benefit of sharing medical records ?? Establishing financial classes was a challenge ?? Form standardization and development of the encounter form was challenging ?? A barrier was the logistics regarding getting the decided upon practice management system

SCHOOL-COMMUNITY HEALTH ALLIANCE MICHIGAN

Website: <http://www.scha-mi.org/>

The following information was obtained from the School-Community Health Alliance Michigan web site.

Background¹

The School-Community Health Alliance of Michigan (SCHA-MI) is a collaboration of individuals and organizations that represent and support school-based health centers and programs across the state of Michigan. SCHA-MI believes that all Michigan children and youth have a basic fundamental right to access and receive comprehensive primary health care and prevention services.

The mission of SCHA-MI is:

- ?? To advocate and promote school-based school-linked health and prevention services.
- ?? To educate the community, educational, social and political leadership about the health needs of children and youth.
- ?? To engage broad-based community and legislative support.
- ?? To provide a forum for professional and agency support, education, training, resource development and networking for members.
- ?? To enhance and strengthen partnerships.

The SCHA-MI responded to the needs of school health centers after the state of Michigan cut all funding for school health centers because they were not generating any revenue. In addition, the legislature was unhappy with the lack of billing done and lack of reporting information being collected.

The already existing School-Community Health Alliance (consisting of a group of representatives from school health centers) met to determine what they could do in response to the state's mandate. The SCHA-MI made a joint decision to help school health centers begin billing for services. They asked the state to sponsor the initial start-up costs including the set-up and training of the necessary systems and personnel at the SCHA-MI. The SCHA-MI told the state that in return for three-years of monetary support in the amount of \$50,000, they would streamline the approach by researching and presenting school health centers with different billing support system options, advocating on behalf of the school health centers, and coaching health center personnel. The state agreed to the SCHA-MI's requests and provided the funding.

The School-Community Health Alliance of Michigan receives its funding from a variety of sources. The primary source being the W.K. Kellogg Foundation, which funds SCHA-MI as a part of their national "School-Based Health Care Policy Program".

¹ Source: School-Community Health Alliance Michigan website, retrieved February 2005

Membership²

Participating health centers could be state funded or non-state funded center but they all had to be state certified. In addition, state health centers have to submit three contracts including a Business Associate Agreement, Confidentiality Agreement, and Service Agreement in order to participate.

Network/Technology³

After surveying participating schools, a billing database was chosen. An internet-based database was chosen so that consistent information could be shared among school health centers. The database allowed reports to be generated and information tracked that would be useful to individual health centers, SCHA-MI and state. SCHA-MI sent out a “Contact Information Form” to gather input and information from school health centers for the design of the database.

The SCHA-MI determined that in order to participate in the establishment of billing processes, school health centers had to come to agreements in a number of areas. Participating health centers agree to the following: pay a fee upfront to set-up their database, pay a monthly subscriber fee for participation, put every encounter/transaction into the database system, and utilize a Common Encounter Form consistently.

When setting up the billing systems, there were a number of obstacles including: problems with information systems, determining potential partners, overcoming the reluctance of some school health center personnel, and the fact that there was no state requirement for reimbursement. One major challenge was forming relationships with Medicaid and other health providers to help establish the necessary systems and obtain proper certification. Other challenges were setting up the database and software, and credentialing school health centers. The SCHA-MI worked to address all of these areas. The SCHA-MI met with Medicaid representatives and individuals from the state Health Plan Association to set up the system. One important criteria that needed to be developed, was a specific billing code for school health centers so they could bill Medicaid and other insurance providers for services.

Once most of the initial challenges were addressed and systems set-up, the SCHA-MI piloted the billing program in a small number of health centers. All participating school health centers received training (coordinated and/or provided by the Alliance) in four areas before “going live”: business analysis, database set-up, front office operation/scheduling, and back office operation/billing. When a school health center “goes live”, there is a trainer on-site during the first day to assist with a variety of tasks and issues that may arise. Following this, there is a post go-live training session and Custom Report Generator training.

Based on their experiences, the SCHA-MI has learned that it is important to start with a core group of school health centers. The SCHA-MI has also learned that special attention and care to following areas are very important: collection of information (processes, systems, and requirements), provider enrollment (processes, systems, and requirements), tracking and reporting needs, conducting needs assessment, and establishment of a common database.

² Source: School-Community Health Alliance Michigan website, retrieved February 2005

³ Source: School-Community Health Alliance Michigan website, retrieved February 2005

SCHA-MI charges members a minimum of \$100 per user/month to have access to support services. This includes the following:

- ?? Software to bill efficiently through a networked alternative service provider server operated by the Michigan Primary Care Association.
- ?? A billing service provides technical assistance to the school-based and school-linked health centers and serves as a resource with managed care entities along with the state Medicaid office
- ?? Reports including the total number of claims submitted per payer type, amount of care and the payment rate by payer type as well as generate required state reports

MDServe

MDServe is an internet based practice management tool that offers electronic billing through Netwerkes.com. The company serves primarily FQHCs and community health centers. Michigan Primary Care Association (MPCA) and the SCHA-MI currently administer the program through Virtual CHC. There is no on-site server necessary to run the program and it can be used on older PC models. The program is HIPAA compliant and upgrades are automatic. The program can replace Healthmatics and Clinical Fusion in SBHCs.

Alliance Billing Service

The Alliance has added a full-time staff member to handle the billing and act as Technical Assistance to the centers. The billing committee, consisting of members from each center, has convened to discuss the specific needs of each center. From these meetings, the Alliance has been able to set up a common encounter form and specific reporting elements to be used the MDServe program. Each center will enter their own billing charges and the Alliance will batch and transmit the claims and handle all remittance posting. The MDServe program will allow the Alliance to run the state reports required from the centers, as well as track reimbursements and non-billable services.

ALLIANCE OF CHICAGO COMMUNITY HEALTH SERVICES

Website: <http://www.alliancechicago.org>

The following information was obtained from the Alliance of Chicago Community Health Services website.

Background⁴

The Alliance of Chicago Community Health Services is a group of community health centers working together "to share resources and integrate services to more efficiently and effectively deliver accessible, quality health care".

The Alliance's main focus is on the following initiatives: Clinical Quality Improvement (CQI), Electronic Health Record System (EHRS), Immunization, Training and Education (T&E), Development Lab Testing.

⁴ Source: AllianceChicago website, retrieved January 2005

The Alliance is structured as a Limited Liability Corporation (LLC) and governed by a Board of Managers which includes the Executive Director of each of the four member health centers, plus the Chief Executive Officer, Chief Medical Officer, and Chief Financial Officer. Each of the member Centers is governed by a Board of Directors, comprised at least 51% by service users.

Funders include: Bureau of Primary Health Care (under ISDI, Integrated Information and Communication Technology Development Program), National Science Foundation, Michael Reese Health Trust, Chicago Community Trust, Prince Charitable Trusts, Blue Cross Blue Shield, Chicago Area Immunization Coalition, Chicago Department of Public Health.

Alliance Members, Funders, and Partners and Affiliates:

- 1) Members are dues-paying health centers who have joined the Alliance network.
- 2) Funders give money to support Alliance programs.
- 3) Partners and Affiliates work with Alliance members to carry out programs, though they do not necessarily provide funding.

Staffing structure: Network-level staff include the Chief Executive Officer, Chief Medical Officer, Chief Financial Officer, Chief Information Officer, Director of Clinical Quality Improvement, and Director of Training and Education.

The member Centers have a total staff of 596 people, including 217 health professionals (e.g., physicians, nurse practitioners, nurses, dentists, case managers, and mental health/ substance abuse care providers).

The Alliance budget is approximately \$1.95 million annually. Individual Alliance Centers manage budgets from \$10 million to \$17 million.

Membership⁵

The Alliance of Chicago Community Health Services is a network of four Chicago based Community Health Centers serving primarily low-income and uninsured patients. The four CHCs include: Heartland Health Outreach, Near North Health Service Corporation, Erie Family Health Center, and Howard Brown Health Center. The network serves 65,000 men, women, and children annually at 24 sites (10 primary care related, and 14 others, such as mental health, substance abuse and dental facilities; women, infant and children offices; school-based clinics; soup kitchens; and homeless shelters), throughout Chicago

Network/Technology⁶

The group received the three-year Integrated Service Delivery System (ISDI) grant, and the Alliance was born with four members – Erie Family Health Center, Heartland Health Outreach, Howard Brown Health Center and Near North Health Service Corporation. The group developed joint programs in health education, diabetes, osteoporosis, and HIV; a network-wide referral system; and a shared after-hours call schedule

⁵ Source: AllianceChicago website, retrieved January 2005

⁶ Source: AllianceChicago website, retrieved January 2005

In 1995, medical directors from several local health centers began holding informal monthly breakfast meetings in an effort to share best-practices information. Eventually, the clinics' executive directors began to meet as well. By 1997, a formal link was established when, as a group, they applied for a grant from the Bureau of Primary Health Care's (BPHC) Integrated Services Development Initiative (ISDI) which encourages centers to form networks to strengthen their services and marketplace competitiveness.

The grant request was successful and they received the three-year ISDI grant, and the Alliance was born with four members - Erie Family Health Center, Heartland Health Outreach, Howard Brown Health Center, and Near North Health Service Corporation. The group developed joint programs in health education, diabetes, osteoporosis, and HIV; a network-wide referral system; and a shared after-hours call schedule.

Those successes led to a second ISDI grant in 2000, which enabled the Alliance to hire network positions such as a Chief Executive Officer, Chief Information Officer, Director of Clinical Quality Improvement, and Director of Training and Education. Clinical and technology integration intensified, laying the groundwork for an electronic health record system.

In 2003, the Alliance was one of six groups nationwide that received an Integrated Information and Communication Technology Development grant, which funds EHRs implementation. The Alliance also received its third ISDI grant, this one for human resources and EHRs skills training. The Electronic Health Record System (EHRs) is a computerized version of the traditional, paper-based medical record. The EHRs fosters efficiency and enhances clinical quality improvement, thus enabling the Alliance and other community health centers to better serve their at-risk patients.

Trainings for participating members cover a variety of topics including development of information technology skill sets, clinical reviews, and cultural competency. The goal is to provide all Center staff with the skills needed to use the EHRs. Alliance members participate free of charge; non-members pay a fee to participate.

With regards to vendors, the Alliance works with Qwest Communications, On-Shore, and MegaWest (now Companion) practice management software/billing system through IPHCA.

Additional key points from interviews with Frances Ginther and Susan Bennett at the Alliance

Frances Ginther, former Executive Director, Alliance, 12/3/04

Susan Bennett, Title, Alliance, Date

- ?? LLC for 4 health centers; takes on mission of the partners but provides a safe harbor for them to make money and develop services
- ?? Getting people to collaborate; creating a work-able governance structure was a barrier
- ?? Focus on: clinical quality improvement defined as change management and creation of an information technology environment
- ?? Securing the start-up funds was a challenge
- ?? Difference between traditional practice management and an electronic medical record:
Practice management - registers the patients, schedules an appointment, creates an

encounter paper form that is carried through the visit, everything that happens after that is put on the paper form, this form is given to the back office (financial) which is used to determine charges.

Electronic Medical Record (EMR) - doesn't create a paper form. Everything is recorded in the computer, a paper bill is created and sent to billing, but they are working on moving this to electronic as well. Getting EMR info to practice management isn't working easily. Getting demographics from practice management system to create EMR is working.

ILLINOIS PRIMARY HEALTH CARE ASSOCIATION AND CQUEST AMERICA, INC.

Website: <http://www.iphca.org/>

The following information was obtained from the IPHCA website.

Background⁷

The IPHCA was established in 1982 as a non-profit trade association. IPHCA has two offices, one in Chicago and one in Springfield. The IPHCA board of directors is composed of one director from each organizational member. Board members are nominated for and elected to the board annually. IPHCA has approximately 35 staff members working in a number of departments. Funding for IPHCA is received from various state and federal grants.

IPHCA represents Illinois' Community Health Centers (CHCs). 41 members administer 314 sites, including 247 primary care sites, and serve over 800,000 people annually. All participating CHCs have multidisciplinary practices working in areas that typically experience a shortage of physicians and other health professionals.

The mission of IPHCA is to “improve the health status of medically underserved populations by fostering the provision of high-quality, comprehensive health care that is accessible, coordinated, community-directed, culturally-sensitive, and linguistically competent”.

Administrative Cost Sharing⁸:

Website: <http://iphcasimis.net/default.htm>

Background

The I-Net Program Network is the means through which IPHCA coordinates and shares practice management information for its member health centers. IPHCA is funded through the Bureau of Primary Health Care (BPHC) Shared Integrated Management Information System Initiative (SIMIS). As a result, it works to achieve improved coordination, greater efficiency, enhanced quality, effective information analysis, increased access, greater economies of scale, and a larger market share. IPHCA also uses the network to improve communication and working

⁷ Source: Illinois Primary Health Care Association web site, retrieved February 3, 2005

⁸ Source: Illinois Primary Health Care Association web site, retrieved February 3, 2005

relationships between health centers. To achieve this, IPHCA developed a statewide practice management network for Illinois CHCs known as I-Net.

The goal of the I-net network is to provide significant cost savings and benefits to participating health centers as a result of being a part of a SIMIS system. The network provides the following advantages IPHCA participating members:

- ?? Strengthen organizational capabilities and expertise.
- ?? Better preparation for strategic planning and resource allocation as a result of the collection and storage of raw data in the IPHCA Data Warehouse and through the Market Place Analysis.
- ?? Establishment of a claims submission clearinghouse, operated from IPHCA's central location in Springfield.
- ?? Reduction in the cost of maintaining individual systems for participating members by providing on-site support for hardware problems, as well as online and phone support.
- ?? Promotion of a free exchange of ideas and information between participating members through electronic messaging, direct telecommunications capabilities and videoconferencing.
- ?? Provide cost savings to participating members through economies of scale.

Formation Process Timeline⁹

Mid - 2000: IPHCA formed a committee of members, CHC information technology professionals, and IPHCA staff to develop a Request for Proposal (RFP) to obtain a software vendor. Six companies responded and the committee ultimately chose Companion Technologies as the software vendor for IPHCA's SIMIS Network.

November 2000: IPHCA applied for and received funding from the Bureau of Primary Health Care (BPHA) for the Illinois SIMIS system, later branded the "I-net network".

March 2002: The first community health center "went live" on IPHCA's SIMIS Network.

Technical Overview of Network¹⁰

IPHCA's SIMIS Network is designed around a centralized server located in Springfield. The server is an IBM RS/6000 running IBM Unix AIX 4.3.3. In its current configuration, the server can sustain up to 30 separate A/R databases with up to 1,500 users. The central server resides at a secure location that is temperature and humidity controlled. Nightly backups are performed Monday through Saturday, and each day these backup tapes are transported off site for disaster recovery purposes. A monthly archival backup is also performed, and all archives are stored in a safety deposit box of a local bank.

Each participating CHC connects to the I-net network's Wide Area Network (WAN) through a fractional T1. The fractional T1 connects to IPHCA's primary T1 trunk line, which terminates at the central server. The WAN infrastructure consists of one robust 3640 Cisco router and

⁹ Source: Illinois Primary Health Care Association web site, retrieved February 3, 2005

¹⁰ Source: Illinois Primary Health Care Association web site, retrieved February 3, 2005

individual 1751 Cisco routers at the main location of each CHC. Beyond this line of demarcation, it is the responsibility of members to connect any of their remote locations.

IPHCA has contracted with AT&T to design and maintain the I-net network WAN. The Managed Network Services contract provides remote telephone and on-site support 24 hours a day, 7 days a week. While IPHCA owns all of the equipment within the network, AT&T provides maintenance for the hardware.

A mobile training center is used to provide on-site End User Training. The training center includes two terminal servers, two Ethernet hubs, and twelve dumb terminals. PCs from the health centers can be attached to the training environment if the center desires training using the Megaview terminal emulation software versus dumb terminals. The on-site training has proved extremely beneficial in holding down the cost of travel expenses.

Status of Implementation of I-Net Network¹¹

Phase 1: The following agencies represent 49 sites and over 110,000 patients and are live on the I-net network: Chicago Health Outreach, Christopher Rural Health Planning Corporation, Community Health Emergencies Services Inc., Community Health Improvement Center, Infant Welfare Society, Rural Health Inc., Southern Illinois Health Care Foundation, Uptown International Center

Phase 2: IPHCA has executed contracts with the following: Asian Human Services, Aunt Martha's Youth Service Center, Central Counties Health Centers Inc., Chicago Family Health Center, Circle Family Care, Heartland Community Health Clinic, Shawnee Health Service
**The implementation process began in October 2003, and all of the above agencies, which represent 20 sites are scheduled to be live by September 2005.*

Phase 3: IPHCA has executed contracts with additional community health centers and the implementation will begin in the summer of 2004.

Implementation Process¹²

Approximately 7 weeks of planning, preparation, and end-user training is required prior to "going live". Following is an overview of the steps of the process:

1. Executed contract.
2. Pre-site visit.
3. Telecommunications installed.
4. End user training.
5. User ids.
6. Table file training.
7. End user training.
8. Data conversion.
9. Go live.
10. Follow-up training.

¹¹ Source: Illinois Primary Health Care Association web site, retrieved February 3, 2005

¹² Source: Illinois Primary Health Care Association web site, retrieved February 3, 2005

11. Hand off.

Estimated Costs to Participating Agencies¹³

All I-net Network participants access the server in Springfield via a fractional T1 at the main site. Each site is responsible for the connectivity between the main site and their remotes. IP addressing is assigned by IPHCA, and the participating members must adhere to the IP standards. Each site has one A/R, which means that any reporting is done by location code versus A/R.

Total Estimated Annual Costs – more detailed information follows		
Annual Charges	ISDN Available	ISDN Not Available
Management Service Agreement (MSA)	\$20,645	\$20,645
Fractional T1	\$16,800	\$16,800
Line System for Redundancy	\$600 (ISDN)	\$420 (POTS)
POTS for AT&T Maintenance	\$420	\$420
Total Annual Charges	\$38,465	\$38,285
One Time Charges		
Data Conversion	\$7,500	
ISDN Install	\$150	
POTS Install	\$100	
Total One Time Charges	\$7,750	
Total Estimated Annual Costs	\$46,215	\$46,035

Additional Costs	
User Licenses	Annual cost: \$600 (one license per 350 patients; 1:350)
IPHCA Membership Fees	Annual cost: \$1,000-\$5,250
Printer Devices	Each printer: \$200-\$500
Data Conversion	Installation: \$5,000-\$10,000
Potential Costs	
Serial Communication Port Server	\$2,300-\$4,600
Additional Wiring	Unable to estimate

The Management Service Agreement (MSA) currently carries an annual fee of \$20,645. The MSA is paid in quarterly installments of \$5,161.25 each. An annual increase, effective the first of October each year, is implemented based on the government's reporting of the Consumer Price Index (CPI).

¹³ Source: Illinois Primary Health Care Association web site, retrieved February 3, 2005

The issuance of user licenses will be based on the number of total patients served as indicated on the site's most current UDS report.

- ?? User licenses are issued at a 1:350 ratio. For example, if the site's current UDS reports 33,932 total patients served, 97 user licenses would be issued.
- ?? This is calculated simply by dividing the total number of patients served by 350.
- ?? If the site anticipates that the number of user licenses issued is not sufficient, additional user licenses are available. The cost is \$600 annually for each end user license requested. IPHCA will periodically re-evaluate this procedure to verify that the number of licenses issued is relevant to the current needs of the participating health center.

While the cost of hardware and maintenance is paid by IPHCA, the fees for phone line services are paid by the participants. Estimated line charges are as follows:

- ?? Fractional T1 (128 CIR 256 Burst) – The fractional T1 is used for data transmission from the site to the central server. Estimated costs are \$1,400 monthly (\$16,800 annually).
- ?? Dedicated POTS Line for AT&T Maintenance – The dedicated POTS line will be used by AT&T when dialing into the system to troubleshoot, or to configure your router for either routine maintenance or resolving problems on the network. The estimated one-time charge for installation is \$100, and thereafter \$35 monthly (\$420 annually).
- ?? Line for System Redundancy – An ISDN line is required if available in the area. Estimated installation of the ISDN line is a one-time charge of \$150, and the estimated line fee is \$50 monthly (\$600 annually). If ISDN is not available in the area, a POTS line is required.
- ?? A POTS line provides only approximately five users access to the system while the fractional T1 line is down. It is intended to allow sites to have access to the system during an emergency outage. This would allow one person to enter appointments, one billing person to access account information and post charges or payments, one person to run administrative reports, one person to retrieve client account information, and one person to access any critical medical information of clients. (Note that if an ISDN is not available, two POTS lines will be needed – one for AT&T maintenance, the other for system redundancy).

Printer Devices – For the MegaWest software, system printers are connected via an Ethernet interface. The preferred equipment is an HP JetDirect device. These can be purchased either as a stand-alone external device for an Okidata printer or Genicom printer, or can be an internal card for HP LaserJet printers.

- ?? The estimated cost for these devices is from \$200 to \$500 per printer, depending on the model that will be used on the system. Companion Technologies does not recommend directly connecting a printer to either a PC or a terminal. While Companion will attempt to make this configuration work, they cannot make any guarantees.

Data Conversion – As data conversion is the site's responsibility, each site must work with Companion Technologies to receive an estimate and for the details on data conversion. However, the estimated cost for data conversion is a one-time charge between \$5,000 and \$10,000.

- ?? There are three data conversion options available:
 1. Demographics only.

2. Demographics with balance forward.
3. Full data conversion.

?? Generally, option #1 is the least expensive, and option #3 is the most expensive. Most sites chose the “demographics only” option, and keep their legacy system to pay down accounts. Unfortunately, there is no way for the balances to be broken out based on Revenue Code, which makes it difficult to determine where the money is to be allocated to the costs of the center.

Potential Additional Costs – Based on the existing configuration of a site, additional costs may be incurred. Those identified after Phase I include:

- ?? Serial Communication Port Server – If sites are using terminals, a serial communication port server will be required. DigiPort is the preferred equipment. While Companion Technologies will attempt to make any existing equipment work, please keep in mind that if the preferred equipment is not used, Companion may not be able to assist your site with communication issues. The estimated cost of a 16 port DigiPort server is \$2300; a 32 port DigiPort server is estimated at \$4600.
- ?? Additional wiring – A site must be wired with Category 5 wiring or better. All PCs that access the SIMIS server must be able to have an IP address assigned. The MegaView terminal emulation software is used to access the system via a thin client Telnet session. In addition to the Category 5 wiring, any additional wiring that is needed to extend D-marks for the fractional T1, ISDN, and POTS lines is the responsibility of the site. We have no way of estimating these costs; please contact a cabling vendor for an estimate.

IPHCA pays for the following services on behalf of I-net network participants:

- ?? Server hardware
- ?? Server hardware maintenance
- ?? Frame relay hardware
- ?? Frame relay 24/7/4 network monitoring and support
- ?? Frame relay hardware maintenance
- ?? Companion Technologies software support
- ?? Software table file and end user training
- ?? Daily, weekly, monthly, and yearly archive of data
- ?? CPT and ICD9 annual table code updates
- ?? IPHCA also has three full-time staff dedicated to the SIMIS project and to providing support to the SIMIS sites. Companion already certifies one staff, and a second staff member is in the process of obtaining certification.

Additional key points from interviews with Shelly Duncan and Belinda Guyton at IPHCA

Shelly Duncan, Vice President of Community Health Services, IPHCA, 10/28/04

Belinda Guyton, Vice President of Practice Management Systems & Director of System Operations, CQuest America, 1/24/05

- ?? IPHCA owns and manages a practice management service which grew out of the clinics that needed such a system

- ?? Practice management system is a system used by a medical practice to manage appointments, billing, record what to place in a visit (encounter form information), and generate reports.
- ?? Take a lot of time to be the centralized administrator
- ?? Process of standardizing was painful but beneficial
- ?? Start with groups that already standardize processes or policies to lay a solid, common foundation
- ?? Don't see the benefits yet of sharing medical records.
- ?? Planning to go from 15 sites to 70 sites
- ?? A barrier was the logistics regarding getting the decided upon practice management system set up.
- ?? Establishing financial classes was a challenge (e.g., deciding how much time prior to sending bills to collection).
- ?? Form standardization and development of the encounter form was a challenge because it caused some back and forth work.

APPENDIX B: Interview Participants and Interview Protocol

Interview Participants

Jodie Adler, Community Economic Development Law Project
Steve Bardi, Multnomah County Oregon Health Department
Susan Bennet, Alliance of Chicago Community Health Centers
Terri Braddock, Rural Health, Inc.
Deb Brinson, School-Community Health Alliance: Michigan
T.J. Cosgrove, Seattle Health Department
Shelly Duncan, Illinois Primary Health Care Association
Raul Garza, Aunt Martha's School Linked Health Center
Frances Ginther, Alliance of Chicago Community Health Centers
Belinda Guyton, Illinois Primary Health Care Association
Vyki Jackson, IDHS, School Health Program Coordinator
Linda Juszczak, National Assembly on School-Based Health Care
Paul Melinkovich, Denver Health and Hospital Authority
Chris Moffatt, Senn High School
John Schlitt, National Assembly on School-Based Health Care
Patti Stauffer, Miami-Dade County Coalition
Donna Stephens, Learning Well, Inc.
Amy Valukas, Erie Family Health Center

Interview Protocol: Questions regarding administrative cost-sharing

1. Describe the types of health centers that have joined the centralized project – number of client visits/month served, sponsoring agency, services delivered, annual budget, amount of revenue from billing prior to joining the centralized system.
2. What percentage are mental health visits and are they able to bill for those services?
3. Describe the barriers that needed to be overcome/negotiated in the process of setting up the centralized system – were some barriers specific to the type of center?
4. Describe the level of decision-making that is needed to join the centralized system and share the information – head of the health center, administrator at the sponsoring agency and/or head of the sponsoring agency?
5. How were issues of confidentiality addressed? Issues of competition?
6. If centralized billing is happening, how were they able to cut red tape and gain acceptance of an outside billing agency?
7. With implementation, what continues to be a challenge of a barrier to success?
8. How do you measure success of the system?

9. How much funding was required for start-up of the system? How much funding is required for on-going support of the system?
10. What issues arose when the Alliance was named as the site for the centralized billing? Was the Alliance handling billing? If so, did any other organization wish to take on that role? How has it affected the work of the Alliance, positively or negatively, and in what way?
11. How much additional income did they bring in using the centralized billing process?
12. How did the Alliance present it to centers – did you have a marketing strategy?
13. What are centers charged for the service?
14. What was the timeframe from the original idea to implementation?
15. What kind of legal agreements were involved in this model?

APPENDIX C: FOCUS GROUP AND SURVEY DATA

Illinois Coalition for School Health Centers Focus Group and Survey Responses December 2004-January 2005

Focus Group: November 12, 2004

Focus Group participants (n=9): Carol Wardlaw/Crane, Juan Valbuena/Lake View, Mary Beth Flurry/Amundsen, Diane Smith/Orr, Marla Goldsmith/Roosevelt, Ingrid Forsberg/Dunbar, Craig Cathcart/Swedish Covenant, Sue Murray/Swedish Covenant, Chris Moffat/Senn

Focus Group facilitators: Blair Harvey/ICSHC, Karen Berg/ICSHC, Laura McAlpine/ICSHC, Paulette Corley/ICSHC

Survey Respondents (n=9): Amy Valukas (Frazier, Jose de Diego, Ryerson), Frank Belmonte (Maine East), Therese Hanigan (Maine East), Kathy Swartwout (Evanston), Stacy Zachman (Clemente), Regina Ortiz (Smyth, Suder, YWLCS), Cynthia Boyd (Smyth, Suder, YWLCS), Cindy Mears (Arai), Carole Hobson (Austin, Beethoven, Bond, Bogan-DuSable, Morton East)

1. What are your most significant administrative challenges:

Focus Group Responses:

- ?? Being a satellite site
- ?? Lack of CPS support – data for school outcomes
- ?? Billing – knowing codes to maximize payment
- ?? Update encounter forms - respond to code changes
- ?? Negotiating contracts with third party payers
- ?? Uninsured and undocumented clients
- ?? KidCare and Medicaid enrollment
- ?? Certification/re-certification
- ?? Computer system – hardware and software
- ?? Data for outcomes documentation
- ?? Low cost medical supplies and medications
- ?? Human resources issues
- ?? Relationship to schools – marketing

Survey Responses

- ?? Leadership/staff development on site (multiple site management issues), HR issues, QI, evaluation, data collection, managed care, billing for mental health services.
- ?? My most significant administrative challenge is allocation of my time to the development of programs at the health center. In addition to my duties in school based health, I also have a busy patient practice, run the child protection service for our hospital, and teach residents and medical students.
- ?? 1.Schools and health centers have different missions and while they *should* be compatible they sometimes are not. Staff who have traditionally worked in a care setting have a difficult time moving between two fundamentally different contexts. I am most interested in fully integrated programs and it is hard work to get there. 2.Fiscal issues particularly in those schools that have a diverse payer mix. 3.In order to be able to sustain SBC they need to function like a business

enterprise and this sometimes conflicts with our need to insure that kids have easy access to health services. 4.Sometimes decentralized administration is not cost-effective.

- ?? 1. Funding. 2. Billing. 3. Coordination/communication with systems (Public Health /CPS/ Principal/ LSC).
- ?? The challenges of working through methods to achieve sustainability, particularly in schools with diverse payor mixes, and with families not providing evidence of insurability.
- ?? My most significant challenges are balancing the time needed for clinic administrative responsibilities and being the only full time health provider in the clinic. Our medical director and residents are here 2, ½ days per week but I see patients at these times too. We have a full time Mental Health worker and a full time secretary.
- ?? #1 Grant writing for program expansion is by far our biggest challenge. We do not have any staff member with the time to do this. #2 Billing. While we presently (finally!) have a system in place to bill Medicaid, the task continues to be time consuming. We do not have a system in place for billing private insurers and will never be able to do this without major administrative expansion. #3 Facilitation of school-provided services: Our high school provides us with such services as IT support, custodial and maintenance services. It is a continual hassle to “beg” for assistance when it is needed. Most of this is due to budget and staffing restraints of the school.
- ?? Billing, Grant writing.
- ?? Trying to obtain and maintain funding for staff positions. Obtaining positions for clerical staff to complete data entry, financial registration, ordering office supplies, preparing charts and encounter forms and assistance with required reports. Obtaining accurate information from parents regarding financial classification. Having enough time and expertise to seek grants, conduct research and program development.

2. What administrative tasks are possible to do jointly with other school health centers:

Focus Group Responses:

- ?? Marketing
- ?? Purchasing – medical and office supplies, medications
- ?? Billing
- ?? Managed care negotiation
- ?? Relationships with Medicaid HMOs
- ?? Program development, research and evaluation
- ?? Grant writing technical assistance
- ?? Collaborative grant writing
- ?? KidCare and Medicaid enrollment
- ?? Quality improvement
- ?? Health education, dental, mental health
- ?? Forms
- ?? IT support

Survey Responses:

- ?? Differs, depending on sponsoring organization, but I think billing, grant writing, QI, evaluation, purchasing, training/TA.
- ?? Developing partnerships could easily facilitate research and funding. Also, outreach programs could be duplicated at multiple sights.
- ?? I am not particularly interested in this option for general administration since we are a part of a university system. Perhaps QA might be one. Peer review. Program audits. Negotiations with CPS, the state and other entities. I am sure there are others for free standing programs.

- ?? I'm not sure since we are so engrossed with Children's Memorial (CMH). Some of the communication issues. Billing wouldn't work since we are with Children's. Buying of supplies is pretty good since we get reduced rates from CMH. Perhaps sharing a psychologist or psychiatrist. Research would be great to share, but whose IRB would be used and would each hospital school clinic participating have to get IRB approval from their sponsoring hospital?
- ?? Within the same health center network (i.e. UIC School Health Initiatives), data management can be performed as a centralized function, and quality assurance monitoring, possibly advisory boards. These are functions specific within a particular institution that oversees several school health centers. For a broader picture between school health centers, lobbying with legislation for state funds for school health centers, and negotiating with insurance providers for coverage of students receiving care at school health centers.
- ?? Developing partnerships could easily facilitate research and funding and grant writing. Also, outreach programs could be duplicated at multiple sights.
- ?? #1 [grant writing] and #2 [billing] above could possibly be shared with another health center depending on how the logistics were arranged.
- ?? Several. Almost all of the following list (see #4 and #5) to some extent.
- ?? Identifying possible grant funding and submitting applications for RFPs. Quality improvement projects. Sharing personnel to do KidCare and Medicaid applications. Projects related to marketing school-based health centers.

3. What barriers would keep your center from participating in centralized administrative services?

Focus Group Responses:

- ?? Fiscal sponsor won't give up billing, supplies
- ?? Fiscal sponsors do billing since it is small, but they might stop if the number of places to bill or number of clients billing increases
- ?? Yearly fee
- ?? Different level of need for administration
- ?? Competition for funders
- ?? Lack of outside incentive or funded mandate
- ?? Time to focus on this collaboration

Survey Responses:

- ?? My sponsoring agency would most likely not allow my participation in a centralized billing. I think that we would be interested in the managed care piece, but I would not be the one negotiating for our agency, so that would put up barriers. I don't utilize the most common SBH data system (CF) at 2 of my sites. Would probably not have need for shared purchasing.
- ?? Our complex relationship with the school district, Advocate Medical Group and Youth Guidance. Each organization has a slightly different agenda. Despite this, those of us who work at the health center share a similar vision. I also think that such centers should develop programs based on the individual needs of the students at the school. As long as centralized administrative services allowed for creative programming, I think that it would work well.
- ?? We currently centralize under the NI administration and some aspects are coordinated through Mile Square. If I did not consider those, my answer might be me. I would need a better understanding of what the benefits would be.
- ?? Children's (CMH) administration/systems.
- ?? Actually most of our administrative services are centralized under Dr. Boyd.
- ?? Our clinic administration is a partnership between Youth Guidance, Advocate Medical Group, and Maine District 207. Each organization has different administrative responsibilities in the clinic. This arrangement sometimes offers many challenges. I think having a centralized

administrative service may actually help solve many of the challenges we face. I am sure other SBHC's face many of the same challenges. A challenge in having a centralized administrative service (state?) would be that each clinic runs differently and there seems to be a big difference between CPS SBHC's and SBHC's in the suburbs.

- ?? Cost and logistics would certainly be our biggest barrier. We have no money at present for paying someone to help us with administrative services. Competing priorities between SBHC's could also be a problem. Administrative services would need to be fairly balanced between SBHC's so that the sharing SBHC's each got equal time. We would also need to seek approvals from our partnering agencies.
- ?? One of our clinic barriers is the fact that we are not run by a hospital. We might have some unique needs i.e., there might be some barriers to developing relationships with Medicaid HMOs and managed care negotiations.
- ?? 1. Purchasing of medical supplies, office supplies and equipment, medications and laboratory services. County has county-wide contracts which prevent me from buying outside of the established contracts. Because of the buying power the costs to the county is much lower. 2. Billing – County has a special encounter rate set based on the inter-governmental transfer of funds between federal and state. This prevents me from directly negotiating with HMOs and managed care.

4. Rank by importance the administrative tasks listed on the sheet (tasks identified in question #2), with 1=most important to share with other school health centers.

5. Rank by difficulty the administrative tasks listed on the sheet (tasks identified in question #2), with 1=most difficult to share with other school health centers.

Summary of Results from Questions #4 and #5 – Top 5				
	Importance of Administrative Tasks		Difficulty of Administrative Tasks	
	Focus Group	Survey	Focus Group	Survey
1	Billing	Billing	Billing	Managed care negotiation
2	Collaborative grant writing	Collaborative grant writing	Managed care negotiation	IT support
3	Managed Care negotiation	Grant writing technical assistance	Relationships with Medicaid HMOs	Billing
4	Quality improvement	Managed Care negotiation	Collaborative grant writing	Relationships with Medicaid HMOs
5	Relationships with Medicaid HMOs	Program development, research, and evaluation	Purchasing – medical and office supplies, medications	Collaborative grant writing

4. Rank by importance the administrative tasks listed on the sheet (tasks identified in question #2), with 1=most important to share with other school health centers.

	Focus Group Results		Survey Results	
	Mean	Mode	Mean	Mode
Marketing	7.5	9	9.7	13
Purchasing – medical and office supplies, medications	7.2	3, 11 (tie)	8.9	4,8,11,12 (tie)
Billing	3.5	1, 2 (tie)	3.8	3
Managed care negotiation	4.3	1, 2, 4 (tie)	5.7	9
Relationships with Medicaid HMOs	6.8	8, 10 (tie)	7.1	6,10 (tie)
Program development, research and evaluation	8.4	9, 13 (tie)	6.4	3,9 (tie)
Grant writing technical assistance	7.5	2, 13 (tie)	5.6	2
Collaborative grant writing	3.5	1, 3, 5 (tie)	4.8	1
KidCare and Medicaid enrollment	8.6	6	6.7	4
Quality improvement	5.6	6	7.3	11
Health education, dental, mental health	7.1	7, 9 (tie)	7.7	5,8,12 (tie)
Forms	10.2	11	8.9	5
IT support	8.6	7, 10 (tie)	7.3	2,6,13 (tie)

5. Rank by difficulty the administrative tasks listed on the sheet (tasks identified in question #2), with 1=most difficult to share with other school health centers.

	Focus Group Results		Survey Results	
	Mean	Mode	Mean	Mode
Marketing	11.3	Each response was different	8.3	3,7,12,13 (tie)
Purchasing – medical and office supplies, medications	6.3	Each response was different	6.8	4
Billing	3.2	1	4.7	2,3,7 (tie)
Managed care negotiation	3.8	2	3.1	1
Relationships with Medicaid HMOs	3.8	3	5.7	4,10 (tie)
Program development, research and evaluation	6.7	Each response was different	8.7	9
Grant writing technical assistance	8.8	5, 13 (tie)	6.9	3,5,10,11 (tie)
Collaborative grant writing	6.1	7	6.6	3,6,12 (tie)
KidCare and Medicaid enrollment	8.4	7	9.1	9
Quality improvement	8.3	4	8.2	6
Health education, dental, mental health	7	3	7.6	5,7,8,11 (tie)
Forms	10.4	11, 12 (tie)	9.8	13
IT support	6.7	4	4	1

6. If administrative tasks that you listed in question #2 are not in the chart for question #4 and #5, where would you put them on a scale of 1 to 13, ranking by importance and difficulty for each task?

Survey Responses:

- ?? Time Allocation Importance #1-3 Difficulty #1-3
- ?? Difficult to answer with this scale. This is an unusual survey tool.
- ?? Responsibilities Importance 1-3 Difficulty 1-3
- ?? None

7. Other Comments:

Survey Responses:

- ?? This was hard to do because I can't see how the FQHCs could accomplish this without impacting their cost and therefore their rate of reimbursement. Why would I want to do this? We are particularly odd because we are part of a university, so purchasing and managed care negotiations would not be considered. There are some things that I think would be helpful but they are not along the line of what this survey is requesting. Good luck.
- ?? Purchasing – medical and office supplies, medications – we use Children’s pricing; Managed care negotiation – few of our patients are in managed care; Grant writing technical assistance – we get sort of from Children’s foundation; Collaborative grant writing – this is a great idea but it could get sticky with so many institutions; KidCare and Medicaid enrollment – we do this; Quality improvement – we recently did the project with CDC and ICSBHC; Health education, dental, mental health – we have all this except a consulting Psychiatrist. We usually refer to C4 or Lakeshore, if Psych is needed; Forms – for us they have to be approved by Children’s; IT support – Children’s for some reason will not support this

APPENDIX D: GOVERNMENT FUNDING AND SUPPORT

HRSA – BUREAU OF PRIMARY HEALTH CARE

Background/Context¹⁴

The mission of the Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care (BPHC) is to increase access to comprehensive primary and preventive health care and to improve the health status of underserved and vulnerable populations. Health care activities and initiatives for the BPHC include aging, black lung, border health, clinical quality, community health centers, federal tort claims act and health centers, Hansen's Disease, health care for the homeless, health center data, health center technical assistance, healthy communities access program, migrant and farmworker health, pharmacy affairs, primary care associations and primary care offices, public housing primary care, radiation exposure screening and education, and school-based health.

Community Health Centers Initiative

Community Health Centers (CHCs) were first funded by the Federal Government as part of the War on Poverty in the mid-1960s. Currently, the CHC Federal grant program is authorized under section 330 of the Health Centers Consolidation Act of 1996.

CHCs provide primary and preventive health care services for people living in rural and urban medically underserved communities. CHCs exist in areas where economic, geographic, or cultural barriers limit access to primary health care for a substantial portion of the population; and they tailor services to the needs of the community. The primary activities of CHCs include:

- ?? Provide primary and preventive health care, outreach, and dental care services.
- ?? Provide essential ancillary services such as laboratory tests, X-ray, environmental health, and pharmacy services as well as related services such as health education, transportation, translation, and prenatal services.
- ?? Provide links to welfare, Medicaid, mental health and substance abuse treatment, WIC, and related services.
- ?? Provide access to a full range of specialty care services.

CHCs are a catalyst for economic development, generating jobs, assuring the presence of health professionals and facilities in underserved areas, and utilizing local services. In FY 2000, the CHC investment generated over \$3 billion in revenues for impoverished underserved communities across the country. Measures of accomplishment:

- ?? Administered grants to over 700 community-based public and private nonprofit organizations that develop and operate CHCs, and in turn support over 3,000 clinics.
- ?? Supported CHCs that serve over 11 million people in FY 2000, of whom 66 percent live below the poverty level.
- ?? CHCs demonstrate cost effective responsiveness, empower underserved communities, reduce infant mortality rates, lower hospital admission rates and length of hospital stays

¹⁴ Source: BPHC web site, retrieved December 29, 2004

for patients, lower Medicaid patients' health costs, and provide care for specific conditions that meets or exceeds protocols for the general population.

- ?? Supported Integrated Services Delivery System (ISDI) grantees to improve the quality and reduce the cost of health care services for underserved, uninsured people.
- ?? Administered new Facilities and Managed Care loan guarantee programs, as well as a national technical assistance strategy in partnership with the National Association of Community Health Centers and the Primary Care Associations in Massachusetts, North Carolina, Texas, and Illinois.

Collaborative Linkages:

The CHC Program coordinates cooperative agreements and grants with National, State, and regional health and primary care organizations, which are key to developing and implementing primary care resource strategies.

Appropriations:

In FY 1996, the community and migrant health center appropriation was consolidated to include the homeless and public housing programs. Funding for CHCs is approximately 85 percent of the consolidated appropriations, which follow:

FY 1997 \$802.0 million	FY 2000 \$1.018 billion
FY 1998 \$825.0 million	FY 2001 \$1.17 billion
FY 1999 \$925.0 million	FY 2002 \$1.3 billion

Future challenges:

Developing networks and comprehensive integrated delivery systems is critical to health services delivery success. Collaborating with public and private partners to obtain capital and infrastructure resources is necessary to develop and maintain primary health care capacity in the most underserved areas.

Integrated Services Development Initiative (ISDI)¹⁵

One of the goals of BPHC's reinvestment in CHCs is to establish integrated service delivery programs to improve the quality of health care provided while reducing the costs of services for underserved, uninsured people. The development of federally supported networks through the Integrated Services Development Initiative (ISDI) has been an evolutionary process that began with the funding of Integrated Service Networks in 1994. These projects were for the purpose of integrating a delivery system for more successful health center participation in managed care. In 1997, the emphasis of the ISDI shifted toward integrated delivery systems that were designed to increase the efficiency and effectiveness of health centers through the sharing of specific functions. In 1998 and 1999, ISDI funds were made available to support two types of projects – Managed Care Networks (MCNs) and Practice Management Networks (PMNs).

In response to the experiences of the earlier federally supported networks, in 2000, ISDI funds were directed toward support of PMNs. The majority of the projects awarded ISDI funds in 2000 were for developmental activities – to facilitate the integration of delivery systems as well as for

¹⁵ Source: BPHC web site, retrieved December 29, 2004

planning activities – to allow federally supported programs to assess areas of potential collaboration. For fiscal year 2001, the emphasis of the ISDI will be focused on networks that support the integration of services or improve health centers ability to compete in their marketplaces through networks.

Consistent with the Bureau of Primary Health Care's (BPHC) goal of "moving toward 100 percent access and 0 health disparities," the vision of the ISDI includes the creation and further development of networks of safety net providers to ensure access to health care for the medically underserved, including the uninsured and underinsured. Through awards made in previous funding cycles of the ISDI, it has been demonstrated that BPHC-supported networks have played a vital role in the ability of health centers to maintain and enhance their base of patients with payers (e.g., Medicaid, Medicare). Further, the support of health center controlled networks has continued to provide evidence of increased efficiencies gained through the integration of delivery systems. To date, networks have enhanced health centers' ability to provide quality care to uninsured as well as other underserved patients in a cost-effective and high quality manner.

Networks that receive ISDI funds have flexibility in determining their activities. Each network is unique, depending on its State environment, marketplace, collaborators, and interests. The following are the core areas that activities of integration are centered around:

Administrative: Through the integration of administrative functions, networks seek to increase economies of scale and cost efficiencies. Several networks have established joint purchasing of supplies and equipment, saving money that can be directed to patient care. Others focus on human resources activities, recognizing efficiencies in position description development, and negotiation of fringe benefit packages.

Clinical: Clinical integration can achieve improved consistency and quality of care. Networks have developed quality improvement programs, established specialty referral groups, and standardized disease management protocols. Several are working on implementation of electronic medical records.

Managed Care: Networks have assisted their collaborating members with utilization review, provider contract, and rate negotiations with managed care organizations (MCOs) and State Medicaid agencies. Management of the business partnership between health centers and Medicaid MCOs is an ongoing activity for networks working toward managed care integration.

Financial: Financial integration can achieve increased efficiency and effectiveness. Networks are working on activities such as centralizing billing functions, generating common financial statements, and performing financial forecasting for members.

Information Systems (IS): Information systems are essential for providing access to and managing accurate, comprehensive clinical and financial data. Milestones in a project typically include an integrated, common data set among a network of health centers, the hiring of a Chief Information Officer (CIO), successful installation of all central hardware and software, and complete commitment to health center staff training and software support.

Shared Integrated Management Information System (SIMIS)¹⁶

In 1997, the BPHC convened a panel of experts in clinical practice management systems, with the goal of developing recommendations for how the BPHC can best support community health centers. The group concluded that a major barrier to cost-competitiveness is the lack of information management. Subsequently, the Shared Integrated Management Information System (SIMIS) initiative was developed to improve the ability of community health centers to collect, manage and use information, in order to improve its ability to be more cost-competitive.

The goal of the Bureau of Primary Health Care in encouraging Shared Integrated Management Information System (SIMIS) projects is to strategically align health center information systems with business objectives in an effort to meet demands driven by competition in the marketplace. SIMIS focuses on building common practice management systems among multiple health center organizations for the purposes of sharing and integrating their business and technology functions.

The SIMIS initiative began in 1998, in an effort to assist community health centers to approach economies of scale means to implementing practice management technology through either State or marketplace health center networks.

The purpose of this guidance is to provide a framework for the evaluation of the proposed integration of SIMIS. This guidance outlines a process of reviewing the goals and objectives of SIMIS and the Bureau of Primary Healthcare, gathering relevant information from SIMIS regarding their current information systems environment, and evaluating the proposed future SIMIS environment.

Funding Opportunities

Currently, there are no open funding opportunities for Quality Improvement (QI) or technology. It is important to check the HRSA website on a regular basis for new opportunities. The open funding opportunities follow. In general, funding opportunities are open to public and private non-profit entities, including faith-based and community based organization, and for-profit entities. It is important to review the funding announcement applicant guidelines for additional specific information on eligibility.

Website: <http://www.hrsa.gov/grants/preview/default.htm>

HRSA-05-111 HEALTH CENTER CONTROLLED NETWORKS

The purpose of grants under this opportunity are to serve as catalysts for the planning, development, and implementation of reengineered health care delivery systems that can assist in increasing access to care, enhancing efficiency of health centers and improving the performance and value of health centers. Deadline: To be determined.

HRSA-05-104 HEALTHY COMMUNITIES ACCESS PROGRAM (HCAP)

The purpose of this opportunity is to provide assistance to communities and consortia of health care providers and others to develop or strengthen integrated community health care delivery systems that coordinate health care services for individuals who are uninsured or underinsured,

¹⁶ Source: BPHC web site, retrieved December 29, 2004

and to develop or strengthen activities related to providing coordinated care for individuals with chronic conditions who are uninsured or underinsured. Deadline: June 14, 2005.

APPENDIX E: CORPORATE STRUCTURES TO SUPPORT ADMINISTRATIVE COST-SHARING

501(C)(3) – Charitable Organizations¹⁷

These organizations are non-profit, exempt from taxes, and can accept contributions from individuals and organizations that are tax deductible. 501(c)3 organizations have limitations for lobbying and political involvement. An organization may qualify from exemption from federal income tax if it is organized and operated exclusively for one or more of the following purposes: charitable, religious, educational, scientific, literary, testing for public safety, fostering national or international amateur sports competition, or the prevention of cruelty to children or animals. The general nature of activities is determined by the mission and description of the organization.

The U.S. Internal Revenue Service (IRS) determines whether or not a corporation is tax-exempt, and applications can be filed using Form # 1023, Application for Recognition from Exemption Under 501(c)(3) of the Internal Revenue Code, with a \$150 or \$500 filing fee. Annual returns are required to be filed using IRS Form 990. The organization must be organized as a trust, corporation, or association. The organization must file for an Employee Identification Number (EIN) or Form SS-4, Application for Employee Identification Number. Included in the application must be a copy of organizing documents, including the Articles of Incorporation; Bylaws (not required, but accepted); description of activities; and financial data: receipts and expenditures (sources and amounts) for current year and the 3 preceding years (or for the number of years organization has been in existence, if less than 4 years); balance sheet for the current year; if have not begun operation, a proposed budget for 2 full accounting periods and current statement of assets and liabilities acceptable.

501(C)(4) – Civic Leagues and Social Welfare Organizations¹⁸

These organizations fall under the category of social welfare organizations and are considered income tax exempt. Individual and corporate contributions are not tax deductible, and the organization can do lobbying. Common types of organizations are civic leagues, social welfare organizations, and local associations of employees. The organization must function for nonprofit purposes and the general nature of activities for 501(c)(4)s are the promotion of community welfare, and charitable, educational or recreational activities. 501(c)(4)s must be able to furnish proof that the organization will further the common good, not just a specific group of people.

IRS application Form #1024, Application for Recognition from Exemption Under Section 501(a), is used when filing for this status. An Employee Identification Number (EIN) or Form SS-4, Application for Employee Identification Number is needed. Also copies of organizing documents: Articles of Incorporation, Articles of Association, Constitution, or other enabling documents; Bylaws (not required, but accepted); description of activities; financial data: receipts and expenditures (sources and amounts) for current year and the 3 preceding years (or for the number of years organization has been in existence, if less than 4 years); balance sheet for the current year; if have not begun operation, a proposed budget for 2 full accounting periods and

¹⁷ Source: IRS web site, retrieved February 3, 2005

¹⁸ Source: IRS web site, retrieved February 3, 2005

current statement of assets and liabilities acceptable. The organization must file IRS Form 990 annually.

501(C)(6)

These organizations are generally a chamber of commerce or trade association, and they are income tax exempt. They are coming together to improve their line of business and are usually made up of for-profit entities. 501(c)6s can work to enact laws that that advance the common interests of members. Individual contributions not tax deductible. No part of the net earnings may benefit any private shareholder or individual and the organization may not be organized for profit or engage in any activity that is generally profit-making. The organization must be supported primarily by membership dues and other income from activities.

Applications may be made using IRS Form 1024, Application for Recognition from Exemption Under Section 501(a). Also needed are an Employee Identification Number (EIN) or Form SS-4, Application for Employee Identification Number and copies of organizing documents: Articles of Incorporation, Articles of Association, Constitution, or other enabling documents; Bylaws (not required, but accepted); description of activities; financial data: receipts and expenditures (sources and amounts) for current year and the 3 preceding years (or for the number of years organization has been in existence, if less than 4 years); balance sheet for the current year; if have not begun operation, a proposed budget for 2 full accounting periods and current statement of assets and liabilities acceptable. The organization must file IRS Form 990 annually.

Limited Liability Corporations¹⁹

The ownership rules allow for an unlimited number of members. There is generally no personal liability of the members for obligations of the business. The entity is not taxed, as the profits and losses are passed through to the members. Operating agreement sets forth how the business is to be managed and a manager can be designated to manage the business. Members typically contribute money or services and receive an interest in profits and losses. Nonprofit organizations cannot be LLCs.

To apply, if a single member LLC, Form 1040 (federal), Form LLC-1.15 (state of Illinois) and \$300 is required. If a multiple member LLC, Form 1065 (federal), Form LLC-1.15 (state of Illinois) and \$300 is required. Below is a summary of some of the key points.

	501(C)3	501(C)4	501(C)6	LLC
Overview	Charitable organizations	Civic Leagues and Social Welfare Organizations	Business leagues, Chamber of commerce or trade association	Limited Liability Corporation
Purpose/Nature of Activities	Charitable, religious, educational, scientific, literary, testing for public safety, fostering national or international amateur	Promotion of community welfare; charitable, educational or recreational.	Coming together to improve their line of business – usually made up of for-profit entities	

¹⁹ Source: Small Business Kit for Dummies, 2004

	sports competition, or the prevention of cruelty to children or animals.			
Tax status	Exempt	Exempt	Exempt	Profits are taxed
Contributions	Tax deductible	Not tax deductible	Not tax deductible	Not tax deductible
Lobbying	No	Yes	Yes, related to purpose of organization	
Federal Application Form	1023	1024	1024	Single member: Form 1040; Multiple member: Form 1065
Federal Annual Return	990	990	990	

APPENDIX F: SOFTWARE/VENDORS

Companion Technologies (used by IPHCA)²⁰

Website: <http://www.companiontechnologies.com/>

- ?? Headquarters: Columbia, South Carolina
- ?? Privately held organization working with the health care industry to provide information management solutions for almost 30 years
- ?? 600 employees, 21 offices, 4,000 system installations nationwide
- ?? Clinical Practice Management Products: MegaWest Medical Management Suite, Companion PM (introduced in March 2004 to replace MegaWest)
- ?? Became official subsidiary of Blue Cross Blue Shield of South Carolina in 195 then acquired MegaWest Systems in 1997.
- ?? Software features various modules including accounts receivable, accounts payable, insurance claims processing, patient registration, reporting, and systems security. In addition a specialty module for community health centers is available that racks and organizes statistical data needed to complete UDS and other report requirements for FQHCs.
- ?? Companion Technologies is currently the software of choice for 53 community health centers nationwide, being utilized in over 170 center sites.

Cquest America, Inc. [IPHCA created this entity as a nonprofit 501(C)(4)]²¹

Website: <http://www.cquestamerica.org/default.htm>

- ?? Non-for-profit consulting firm providing the following services: software development, network services, equipment and maintenance, help desk support, on site support, project management and administrative services, training and data conversion.
- ?? IPHCA/IDPH developed Cornerstone system to integrate maternal and child health services in Illinois
- ?? After the success of Cornerstone, IPHCA developed Cquest America, a nonprofit 501(C)(4), to separate its business operations from its trade association activities.

McKesson Health Solutions (used by IPHCA/Cquest)

Website: <http://healthsolutions.mckesson.com/wt/hsol.php>

Qwest Communications (used by the Alliance to store servers)

Website: <http://www.qwest.com/>

On Shore (used by the Alliance to ensure back and forth of the records are maintained)

Website: <http://www.onshore.com/>

MDServe (used by SCHA-MI)²²

Website: <http://www.mdserve.com/>

- ?? Healthcare software development firm

²⁰ Source: Companion Technologies web site, retrieved February 2, 2005

²¹ Source: Cquest America web site, retrieved February 2, 2005

²² Source: MDServe web site, retrieved February 3, 2005

Netwerkes.com (SCHA-MI)²³

Website: <http://netwerkes.com/>

?? Provides a variety of services including claims processing, billing, and case management

Virtual CHC (SCHA-MI)

Website: <http://www.mPCA.net/cgi-bin/lyris.pl?site=virtualchc>

?? Seems to be a host site

²³ Source: Netwerkes web site, retrieved February 3, 2005

APPENDIX G: GLOSSARY²⁴

501(C)(3): A tax exempt, not-for-profit charitable organization that operates for one or more of the following purposes: charitable, religious, educational, scientific, literary, testing for public safety, fostering national or international amateur sports competition, or the prevention of cruelty to children or animals. Tax exempt status is granted by the Internal Revenue Service. Contributions made to these organizations are tax deductible.

501(C)(4): A tax exempt, not-for-profit civic league or social welfare organization whose primary activities are promoting community welfare, charitable, educational, or recreational. Tax exempt status is granted by the Internal Revenue Service. Contributions made to these organizations are not tax deductible due to the ability of the organization to lobby.

Bureau of Primary Health Care (BPHC): A division of the Health Resources Services Administration whose mission is to access comprehensive primary and preventive health care and to improve the health status of underserved and vulnerable populations.

Data Warehouse: A central database that stores collected data from users in a network that is integral to the operation of a business entity.

Database: A collection of data organized and stored so that it can be easily retrieved.

Electronic Health Record System (EHRS): An electronic version of a medical record that allows easy access and sharing of patient information among different health care providers.

Federally Qualified Health Center (FQHC): Health centers that receive Section 300 funding and are eligible for cost-based reimbursement from Medicare and Medicaid.

Go Live: A term used to denote the time period when a web based operation has begun to function.

Integrated Service Development Initiative (ISDI): An project supported by the Bureau of Primary Health Care to reduce the cost of services and improve the quality of health care provided by Community Health Centers through the coordination and sharing of patient information through networks.

Integrated Services Network (ISN): Refers to entities that share and coordinated multiple components of the care continuum.

Integrated Services Digital Network (ISDN): A connection that supports the transmission of a variety of communication methods at a relatively high rate.

²⁴ Sources: Bureau of Primary Health Care web site, retrieved February 16, 2005; IRS web site, retrieved February 16, 2005; Webopedia web site, retrieved February 16, 2005

Limited Liability Company (LLC): A business structure in which there can be an unlimited number of owners or members who are not personally liable for the results of the business. The entity is not taxed because the profits and losses pass to the owners or members.

Managed Care Network (MCN): A group of health care providers that work together to provide services to patients.

Managed Care Organization (MCO): An entity that provides health insurance benefits to enrolled individuals subject to specified contractual guidelines.

Management Service Agreement (MSA): A contractual document used to specify the provisions of a relationship between two parties.

Management Information System (MIS): A computerized data collection structure that organizes information for use in business planning and organizational operations.

Practice Management Network (PMN): An integrated computerized system usually supported by the use of a software package that allows health centers in a network to share information about patients including medical records, billing, and scheduling.

Plain Old Telephone Service (POTS): Refers to the standard telephone service rather than digital communication lines such as an ISDN that communicate greater amounts of data at faster speeds.

Server: A central device that provides services to other computers or users in a network.

Shared Integrated Management Information System Initiative (SIMIS): A project supported by the Bureau of Primary Health Care to help community health centers share information.

T1: A digital connection that can support the high-speed transmission of data through the phone line. These connections are generally used by small and medium sized business outlets.

Uniform Data System (UDS): Electronically collected and transmitted data provided by health centers to the Bureau of Primary Health Care. Patient information includes demographic, socioeconomic, and treatment plan. Health center information includes structure, service provision statistics, and financial operations.

Wide Area Network (WAN): A computer network that spans a large geographical area.