



Striking a Balance

Administrative Cost-Sharing in School
Health Centers: A Feasibility Study.

Illinois Coalition for School Health Centers

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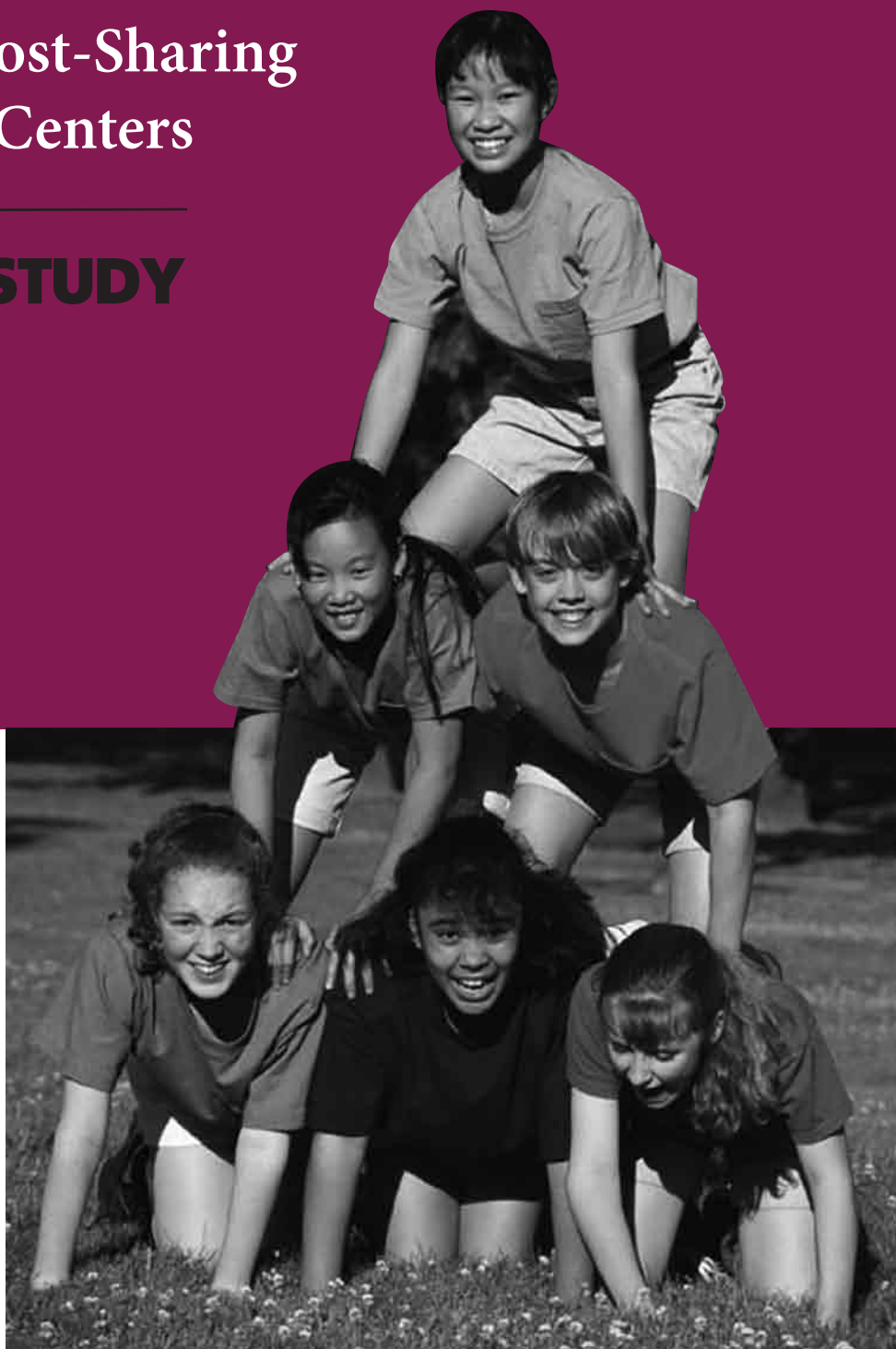
Administrative Cost-Sharing
in School Health Centers

A FEASIBILITY STUDY



Submitted by:
The Illinois Coalition of
School Health Centers

September 2005



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Executive Summary

Background

The Illinois Coalition for School Health Centers (ICSHC) is a group of 146 organizations and individuals working to improve the physical and mental health status of children and adolescents by advocating for the development, expansion and stabilization of school health centers. In the fall of 2004, a committee of ICSHC members and select leaders began studying centralized administrative cost-sharing as a means to address sustainability challenges facing the 49 school health centers in Illinois. The goal of the research is to assess the feasibility of increasing the efficiency and efficacy of administrative functions, by centralizing some administrative services across school health centers statewide, starting with a pilot in the Chicago area.

Strengths and Challenges: One of the strengths of the school health center approach to health care is its multidisciplinary nature, blending medical care with preventive and mental health services. This strength, however, poses an ongoing funding challenge. No single source of funding covers the cost of the comprehensive

package of services provided by this unique health care delivery model. Depending on the range of services, the yearly cost of running a school health center in the Chicago area can run from \$200,000 - \$400,000. Though public resources are significant for most school health centers, federal and state policies do not provide adequate support or recognition to ensure the growth and sustainability of this health service delivery model. Shrinking public and private dollars have resulted in increasing pressure on school health centers to supplement grants with patient revenue. These unique programs with little to no administrative staff make it difficult to be efficient and effective at generating patient revenue, which requires skills, training, and experience in practice management and business. The significant percentage of uninsured students has also made it critical to write grants to supplement revenues. High-level administrative tasks require dedicated time, potentially decreasing time spent on direct service to students if done by clinical staff. In addition to the fiscal challenges, school health centers are struggling with potential dilution of the model, lack of evaluation and administrative burn-out.

Solution: Administrative Cost-Sharing

Given that a number of the challenges facing school health centers today are closely tied to efficient administration, a centralized system for certain tasks can be a possible solution. In particular, experienced full-time administrative staff that can streamline information, focus solely on generating revenue and provide services to multiple centers will lead to increased revenue and improved sustainability. Moving centers from tracking appointments and encounter data on paper to direct computer entry will also increase efficiency and productivity, while providing increased opportunities for quality improvement. Economies of scale will also allow for the purchase of information technology that is often too expensive or too complex for small centers to handle. And the greatest benefit will be the ability of clinical staff to focus more time on direct patient services.

Administrative cost-sharing involves a group of health centers forming a contractual agreement to centralize key administrative responsibilities such as practice management, including scheduling, electronic encounter forms and billing; negotiation with private insurance and managed care entities; data collection and reporting; quality improvement; electronic medical records; bulk purchasing; human resources; and grant writing.

Recommendations

Information gathered through phone interviews, focus group and surveys over the course of eight months forms the basis for the recommendations in this report.

The Illinois Coalition for School Health Centers has identified the creation of a centralized administrative system for Illinois school health centers as a way to address many of the challenges that may affect the future of this important health care delivery system. Such a system could provide centers with a) centralized data collection, reporting and a system for quality improvement; b) billing services, including negotiation services with private insurance companies and managed care entities; and c) practice management (patient registration and scheduling).

By creating and implementing a centralized system, ICSHC anticipates that client services will be enhanced, quality of services will be improved and revenues will be increased. We specifically anticipate the following outcomes:

- Enhanced client services by allowing clinical staff to focus on direct patient care and shifting administrative duties to skilled workers who do not have patient responsibilities;
- Quality improvement through efficient and accurate data collection, data analysis, and program modification;

- Increased revenues through cost savings resulting from economies of scale that allow for lower administrative costs and reducing duplication of efforts;
- Increased revenues due to improved efficiency of billing;
- Strengthened advocacy efforts to promote school health centers, resulting from greater sharing of data regarding outcomes.

To achieve this goal, ICSHC proposes a planning process to implement a pilot in the Chicago area. We will begin by hosting a summit March 2006 to:

1. provide information on centralized administrative systems for school health centers;
2. prioritize services to be provided; and
3. agree on the roles and responsibilities for a planning group that begins to meet after the summit.

ICSHC will appoint a planning group after the summit, which will meet between April 2006 and February 2007, with a report due in March 2007 to recommend the core components for the centralized administrative structure.

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Introduction

The Illinois Coalition for School Health Centers (ICSHC) is comprised of 146 organizations and individuals who strive to improve the physical and mental health status of children and adolescents through the development, expansion, and stabilization of school health centers. ICSHC accomplishes its mission through advocacy, education, networking and professional development.

In the fall of 2004, a committee of ICSHC members and select leaders began studying centralized administrative cost-sharing as a means to address sustainability challenges facing the 49 school health centers in Illinois. The goal of the research is to assess the feasibility of increasing the efficiency and efficacy of administrative functions, by centralizing some administrative services across school health centers statewide, starting with a pilot in the Chicago area. This report summarizes the committee's findings.

Overview of School Health Centers

Over the last three decades, communities across the country have created school health centers (SHCs) to address the increasingly complex health issues facing children and youth. SHCs, which can include school-based or school-linked centers, are located directly in a school or in close proximity to school property, and are administered as partnerships between schools and local medical, mental health, and/or social service providers.

SHCs are considered safety net providers because they provide health care to children and adolescents who would otherwise have limited access to services. An encounter with the SHC is often the first experience a student may have with a health care provider. In addition to overcoming access issues, SHCs blend medical care with preventive and psychosocial services and organize broader school-based and community-based health promotion efforts. These facilities provide cost savings and play a vital role in providing preventive services that reduce the potential for engagement in high-risk behaviors at an early age.

Services generally available at a SHC can include any combination of the following: physical health, mental health, risk assessment, health education, and dental care. Confidential services are afforded to adolescents, guided by state laws. These comprehensive services are delivered via an interdisciplinary team of health care professionals, typically comprised of a nurse practitioner or physician assistant, mental health provider, administrative personnel, and a physician.

SHCs across the nation are supported by a patchwork of funding including local, state, and federal public health and primary care grants, community and family

foundations, donations, and reimbursement from public and private health insurance. Schools typically provide in-kind donations of space, maintenance, utilities, and teacher and administrative support.

Research has shown that SHCs contribute to fewer school absences, lower drop-out rates, increased knowledge about health, decreased cigarette and marijuana smoking, reduced loss of work time for parents, higher compliance with immunization and physical examination requirements, decreased teen pregnancy, improved identification and treatment of mental health needs, and reduced hospitalizations and ER visits.

Status of School Health Centers in Chicago

There are currently over 1500 school health centers operating in the United States, 49 of which are in Illinois. Nationally, the first school health centers opened in the early 1970s in St. Paul, Minnesota and Dallas, Texas. In Illinois, the first center opened in 1982 at Austin Community High School on Chicago’s Westside. In 1985, the Illinois Department of Human Services invested in the model and provided initial funding for five new centers in East St. Louis, Kankakee and Chicago.

Twenty-eight of Illinois’ SHCs are located in Chicago-area public schools (19 high

schools, 1 middle school, and 8 elementary schools). All 28 school health centers provide the following basic tools of primary preventive care: comprehensive health assessments; anticipatory guidance; immunizations; treatment of chronic and acute illness; lab services; and prescription services. The majority of sites offer a variety of mental health and counseling services as well as health education. Twenty-three centers offer reproductive health services, pregnancy tests, and STD screenings and treatment. Four centers provide on-site dental services.

The following community agencies sponsor SHCs in Chicago and Suburban Cook County:

SPONSORING AGENCIES IN CHICAGO AND COOK COUNTY	# of SHCs
Hospitals (<i>Advocate Illinois Masonic Medical Center, Children’s Memorial Hospital, Rush University Medical Center, Mercy Hospital, Swedish Covenant Hospital</i>)	8
Cook County Bureau of Health Services	5
Community Health Centers (<i>TCA Health, Inc., Lawndale Christian Health Center, Erie Family Health Center, Access Community Health Network, Alivio Medical Center, and Heartland Health Outreach</i>)	8
Universities (<i>University of Illinois at Chicago Neighborhoods Initiative—Division of Community Health and Loyola School of Nursing</i>)	3
Social Service agencies (<i>Youth Guidance and Aunt Martha’s Youth Services</i>)	2
School District (<i>Maine Township High School District 207</i>)	1
Health Department, High School District, and Hospital (<i>Evanston Health Department, Evanston Township High School District, and Evanston Hospital</i>)	1

The Illinois Department of Human Services (IDHS) collects data from certified school health centers around the state and reported that in the 2003-2004 school year, 21 Chicago-area school health centers provided services to 13,723 students for a total of 39,876 visits. Of these visits, 79% were for physical health services, 20% for mental health services and 1% for dental services. An additional 29,482 students received health education. During the same school year, the demographic profile of students enrolled in Chicago-area school health centers was 45% African American, 28% Hispanic, 8% Caucasian, 4% Asian/Pacific Islander, 1% Mixed Race and 14% were classified as other.

Over 70% of the Chicago-area school health center population is either Medicaid/KidCare enrollees or uninsured. Using data collected from 21 sites, insurance status is broken down as follows: Medicaid/KidCare 38% (8,658 students); uninsured 36% (8,190); private insurance 15% (3,439); unknown 11% (2,613).

Challenges Facing School Health Centers

Federal and State Policies—Though public resources are the primary funding sources for most school health centers, federal and state policies do not provide adequate support or recognition to ensure the growth and sustainability of this health service delivery model. For example, in Chicago, the Illinois Department of Human Services, through the federal maternal and child health block grant and state tobacco settlement dollars, provides operational funding for 24 out of 28 Chicago-area school health centers and 40 out of 49 centers statewide. This funding, however, covers only a portion of the health centers' overall costs. Though the funding level to centers has been relatively stable, the fiscal situation facing the nation and, particularly Illinois, may put this funding in jeopardy. The effects of the state's fiscal crisis have already affected SHCs. Since 2000, the state of Illinois has been unable to allocate new funds to school health centers. Without an increase in this funding stream, existing centers have not been able to expand needed services and struggle to maintain existing services as operational costs rise annually. In addition, underserved communities are unable to secure funds to establish new centers.

Federal dollars are currently not a viable funding option for the majority of school health centers. To access federal funds, school health centers must meet all requirements of a Federally Qualified Health Center (FQHC). These include services across the lifespan and having a board of directors that is made up of a majority of consumers. The requirements are prohibitive for most school health centers that are not part of a larger FQHC. In the Chicago area, only 11 out of 28 health centers are eligible for these federal funds and nationally the figure is 20%. Even those school health centers that are FQHCs, however, face challenges accessing federal grant funds. Because SHCs are not viewed as unique providers, SHCs must compete against other federally qualified health centers, very different delivery models, which offer much greater capacity.

Medicaid is often cited as a potentially significant source of financial support for school health centers because centers are often located in low-income, underserved communities with a disproportionately larger publicly insured population. Existing federal and state policies, however, make it

difficult for many school health centers to maximize Medicaid's benefits. For example, a special Medicaid reimbursement mechanism exists for FQHCs, providing them with cost-based reimbursement, compensation that more accurately reflects the cost of providing health care. Non-FQHC school health centers, though they deliver the same services to the same population, are not afforded this enhanced reimbursement rate. In Illinois, a large scope of school health center services such as mental health, health education, and basic prevention and wellness activities are not part of the Medicaid reimbursement structure. Additionally, many of the staff critical to a school health center's interdisciplinary team of professionals, including licensed clinical social workers and psychologists, professional counselors, nutritionists, health educators and nurses, are not eligible to receive reimbursement for services provided under Medicaid. Another challenge relative to maximizing Medicaid dollars is the fact that many of the children and adolescents accessing SHCs are uninsured or undocumented and as such are ineligible for reimbursement.

The free care policy stating that Medicaid cannot be billed for services provided free to non-Medicaid users also inhibits many

school health centers' ability to collect revenue. Many health centers are unable to bill private insurance companies and some commercial insurer's who participate in Medicaid managed care programs because they routinely send home Explanations of Benefits (EOB) to subscribers. The often confidential nature of care provided to adolescents in school health centers, such as reproductive health and mental health services, is threatened by this policy because an EOB sent home could result in a breach of the adolescent's privacy. Federal and state funded Title V agencies are not required to comply with this free care policy, setting a precedent for exemptions.

Billing—The history of billing and collecting patient care revenues in school health centers is relatively brief. Many of the original health centers did not bill for services because they were well-financed by private foundations and public health grants. Shrinking public and private dollars have resulted in increasing pressure on school health centers to supplement grants with patient revenue. This does not come without its challenges. School health centers provide services regardless of a student's ability to pay, but must bill everyone if they bill

Medicaid or they will be in violation of the free care policy rule. Determining student insurance status can be time consuming and difficult, given the need to contact family. The importance of determining insurance status and billing must be weighed against the provision of confidential services to adolescents. Reimbursement levels for all non-FQHC centers are below actual costs of care, reducing the incentive on SHC staff to spend time billing.

School health centers that do bill generate higher total revenue, but successful billing and collection necessitates higher revenue to support hardware, software, staff, and ongoing training. In many cases, school health center staff does not have adequate knowledge or skills in the areas of Current Procedural Terminology (CPT) and International Classification of Diseases (ICD) coding and practice management. They do not generally have budgeted positions or funds available to hire practice managers nor do they have computer and internal systems in place to implement adequate practice management systems. Some centers have their billing done by their fiscal sponsor, which relieves some of the administrative burden, yet increases billing errors and reduces follow-up on rejected claims.

The rapid growth in managed care, particularly the shift to Medicaid managed care and the increased coverage for low income and uninsured children through the State Children's Health Insurance Program (Illinois programs: KidCare and FamilyCare), has and will continue to significantly impact the billing potential of school health centers. Some of the challenges presented by managed care include; lack of understanding by managed care organizations about what school health centers are and are not; belief that school health centers are not a legitimate part of the U.S. health care delivery system; contracts not including preventive or mental health services; fees less than what the program got from Medicaid before managed care; administrative burdens on staff; and time-consuming credentialing. Ultimately, school health centers must weigh the challenges associated with billing versus the potential revenue to be gained and often decide that it is not cost-effective nor in the best interest of patient care to spend time and effort on billing.

Potential Dilution of the Model—One of the strengths of the school health center approach to health care is its multidisciplinary nature, blending medical care with preventive and mental health services. This strength, however, poses an ongoing fund-

ing challenge. No single source of funding covers the cost of the comprehensive package of services provided by this unique health care delivery model. Depending on the range of services, the yearly cost of running a school health center in the Chicago area can run from \$200,000 - \$400,000. Centers supplement operating costs with fundraising for philanthropic dollars from individuals, corporations, and foundations, as well as third-party billing. Finding these supplemental dollars during a time when public funds are decreasing has become increasingly challenging and school health centers often find themselves competing against each other for the same dollars. Given limited resources, most SHCs, both locally and nationally have had to pare back services to some degree, not only jeopardizing the uniqueness of the model but also depriving children and adolescents, who have come to rely on the centers, of critical health and mental health services.

Demonstrating Positive Health and Educational Outcomes—To date, school health centers and funding initiatives have focused primarily on patient care, resulting in limited documentation and a lack of solid evaluation data illustrating the value of the medical and non-medical care delivered. In 2004, the National Assembly on School-Based Health Care convened a meeting of experts in the fields of health and education to explore the relationship between on site school health care provision and academic performance. Participants

underscored the complexities involved in evaluating this relationship due to the confounding environmental variables affecting both health and academic outcomes. Nevertheless, the issue of sustainability rests on demonstrating the value of school health centers to legislators, funders, and other key stakeholders.

Administrative Burden and Burnout—

The interdisciplinary team delivering services has a wide-range of responsibilities, playing a much broader role than is typical of most health care practitioners. These responsibilities often include: providing medical and mental health services; coordinating care with students' personal physicians and/or managed care plans; functioning as liaisons between parents, teachers, and students; acting as community advocates for children; and conducting health promotion activities at school and in the community. As more focus and importance is being placed on billing and data collection, school health center staff members are being required to also take on practice management and business roles. To be efficient and effective in these areas requires skills, training, and experience beyond those which most staff has been prepared. These administrative tasks also require dedicated time, which could be potentially spent on direct service to students.

Illinois Coalition for School Health Centers: Strategies for Meeting Challenges

The foundation for a school health center network was first established in 1996 when school health centers in the state met as a group to identify a strategy for addressing managed care contracting. In 1997, SHCs and advocates gathered to officially form the Illinois Coalition for School Health Centers (ICSHC), which is currently housed at the Illinois Maternal and Child Health Coalition.

Since its initial meeting in 1996, ICSHC has marshaled the collaborative strength of its membership to win numerous victories for Illinois SHCs. Highlights include:

- Establishment of a Medicaid provider code for SHCs allowing them to bill the Illinois Department of Healthcare and Family Services (formerly Illinois Department of Public Aid) for services
- Appropriation of an additional 2 million dollars from the state's tobacco settlement funds for the SHC Program budget line item under the Illinois Department of Human Services (IDHS), resulting in the opening of several new SHCs
- Securing a consistent percentage of core funding by the State of Illinois for school health centers
- Implementation of a standardized site maintenance agreement for all SHCs in Chicago Public Schools

In addition to policy advancements, ICSHC has also been successful in advancing the work of school health centers in such areas as: meeting technical assistance and training needs of school health centers; creating a network to enhance resource sharing and communication; and providing professional development and networking opportunities for school health center staff and supporters. These activities have contributed to the increase of SHCs from 17 in 1996 to 49 in 2005. Through its long-standing role as a convener of SHCs and an advocate with public and private funders, ICSHC is uniquely positioned to explore and promote an administrative cost-sharing structure for its membership.

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Administrative Cost-sharing

The powerful results achieved by the collaborative efforts of the Illinois Coalition for School Health Center membership demonstrates that working together as a larger group can result in greater outcomes. Community health centers have been leaders in adopting collaborative strategies and have been forming alliances for many years as a way to improve services. School health centers have only recently begun to engage in these ventures. The focus of all of these alliances, both among community health centers and school health centers, has been on administrative cost-sharing,

Administrative cost-sharing occurs when a group of health centers who form a contractual agreement to centralize key administrative responsibilities. Examples of specific administrative functions that may be centralized include:

- Practice management, including scheduling, electronic encounter forms and billing
- Negotiation with private insurance and managed care entities
- Data collection and reporting
- Quality improvement
- Electronic medical records
- Bulk purchasing, including supplies, lab testing and medication
- Human resources, including supervision, criminal background checks and hiring
- Grant writing

These contractual agreements or alliances have often resulted in the formation of networks that are managed by a separate entity. The design and structure of these entities often vary with respect to corporate structure, scope of services, and funding sources. Various corporate structures that have been used include 501(c)3, 501(c)4, 501(c)6 and Limited Liability Company (LLC). The 501 structures are all income tax exempt with different abilities to engage in political lobbying as well as different abilities to accept tax-deductible contributions from donors. The LLC structure is for-profit and tax paying, allowing for the forming organizations to be the voting members of the corporation. The LLC structure is most often used when products are being developed that may be sold to customers beyond the initial members that formed the LLC.

Community health centers began forming alliances for shared administrative functions in the early 1990's in response to decreased funding from both public and private sources. These alliances have been successful in reducing financial burdens on individual

health centers and increasing revenues while maintaining quality patient care. Sharing administrative responsibilities and transferring the oversight of these tasks to a central entity has also allowed individual community health centers to focus more of their clinical staff time directly on patient care. Fiscal supporters of the initiation and development of administrative cost-sharing models include private foundations as well as federal agencies, (specifically the Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care (BPHC)), and state and city governments.

While community health centers have been forming alliances for administrative cost-sharing since the 1990's, school health centers have only recently begun to explore this model. Six organizations across the nation (Colorado, Michigan, Washington, Indiana, Oregon and Florida) currently providing centralized administrative services directly to school health centers were interviewed for this report. Each model varied in size, scope of services, and structure, with some emphasizing practice management services including billing, and others providing human resources and training. Some common elements did emerge, particularly the centralization of data collection. Most of the organizations related that the impetus to form a collaborative structure was either mandated by their main funding organization or was the result of a catastrophic event, such as withdrawal of state funding. Like the community health centers interviewed, all of the school health center alliances reported having improved efficiency and increased revenues, resulting in more time for direct services by the clinicians.

4

Information Gathering

Methodology

The goal of the ICSHC administrative cost-sharing project is to explore the feasibility of centralizing administrative services across school health centers in Illinois in order to enhance their efficiency and efficacy and reduce the increasing financial burdens they face. To achieve this goal, research was conducted to identify viable local and national administrative cost-sharing models, ascertain how their successes, challenges, and operational nuances could inform the development of a pilot with Chicago-area school health centers to implement centralized administrative cost-sharing strategies, and determine the specific technical assistance and training needed to implement such a model.

In fall 2004, the ICSHC assembled a steering committee consisting of three Coalition members to guide the project. Committee members and ICSHC staff assisted two independent consultants, Laura McAlpine and Brenda Bannor, in the design of a comprehensive information gathering framework and accompanying data collection strategies, which included telephone interviews, focus groups, and surveys. The steering committee met monthly to craft interview and focus group protocols, identify appropriate interviewees, and review findings.

Over the course of eight months, the consultants conducted 18 telephone interviews. Interviewees were selected for their expertise and experience both in school health and administrative cost-sharing. Specifically, consultants spoke with: two representatives from the National Assembly on School-Based Health Care; one representative from the Illinois Department of Human Services; six administrators from collaborative school health models across the country; three administrators engaged in administrative cost-sharing models among community health centers in Chicago and throughout Illinois; an attorney with expertise in community economic development; a local expert on school health centers; and five school health center representatives whose sites are sponsored by community health centers and as such are involved in centralized administrative systems. The interview protocol was intended to illicit information regarding the basic structures and design of existing cost-sharing models, types of centers that participate in these models, processes undertaken to establish centralized services, resources needed to start and maintain the model, barriers and challenges encountered, and measures of success (See Appendix B for interview protocol).

In November 2004, a focus group was conducted with nine staff members representing eight Chicago-area school health centers in order to gather local feedback for the project. Participants were asked to identify significant administrative challenges facing their health centers, administrative tasks they thought were possible to do jointly with other centers and potential barriers to collaboration across centers. Participants were also asked to rank administrative tasks relative to importance and difficulty.

In December 2004, a survey was sent electronically to 19 Chicago-area school health centers whose staff was unable to participate in the focus group. Nine staff, representing fifteen health centers, responded. Survey questions were consistent with focus group protocol.

Key Findings

Lessons Learned from Existing Models: Informant Interviews

Interview responses indicated that the following issues were necessary to consider when exploring centralized administrative services: a) addressing elements necessary to create a successful collaboration; b) identifying and prioritizing administrative services to be provided; c) choosing an organizational structure that will allow for future growth; d) selecting appropriate technology to support the services; and e) securing necessary funding for planning and start-up.

Elements of a Successful Collaboration – Building trusting relationships between and among the separate school health centers was seen as central to a successful collaboration. Careful, intentional planning was a lesson noted by each of the six school health center alliances and the two community health center alliances that were interviewed. It was also observed that the collaboration needs to establish a strong foundation and have a facilitated planning structure that is representative of all the members, with multiple opportunities for meeting and making decisions. The success of the planning process relies on cultivating relationships with a wide range of

stakeholders, including school health center personnel, administrators, representatives from sponsoring agencies and main funders of school health centers, both public and private.

An example of the importance of key stakeholders coming together is the School-Community Health Alliance in Michigan. The impetus for the collaboration was the decision by the state to stop funding school health centers. The School-Community Health Alliance successfully organized parents and the state agreed to reinstate funding on the condition that centers billed for services. When the Michigan Alliance looked at why the school health centers were not billing, they found that most of the SHC claims were not reimbursable and traditional billers were not getting the requisite returns for them to be interested. As a result of careful planning involving the Governor, other public officials, and the school health centers, the School-Community Health Alliance now provides a centralized system for billing, data collection and technical assistance.

Another identified element of a successful collaboration was the ability to share information among members while ensur-

ing that the collaboration is anti-trust and HIPAA (Health Insurance Portability and Accountability Act) compliant and that proper confidentiality agreements have been obtained from the necessary parties. One approach to address this element is to form a separate entity that provides centers with purchased services. For example, the Alliance of Chicago Community Health Services (“The Alliance”) was founded in 1995 as an LLC to work with a group of community health centers to facilitate the sharing of resources and integration of services. The Alliance is a network of four Chicago-based community health centers (Heartland Health Outreach; Erie Family Health Center, Howard Brown Health Center; Near North Health Service Corporation) that administer 24 sites and serve over 65,000 people annually. Their main focus for centralized administrative services is clinical quality improvement, electronic medical records, immunization registry, training and education, and lab testing.

Choosing the Right Infrastructure – The end result of a planning process for centralizing administrative services is the identification and prioritization of administrative services, the appropriate organizational

structure to facilitate collaboration, and a detailed organizational and governance plan, including budget estimates. Key informants discussed the importance of having the Chief Executive Officers and the legal staff of the SHC fiscal sponsor at the early stages of the planning process in order to have their concurrence on the structure and the written agreements that needed to be put in place. This was particularly true for three of the SHC alliances interviewed: the Denver Health and Hospital Authority, which operates centralized services for 12 SHCs; the Seattle Health Department, operating 15 SHCs; and the School-Community Health Alliance in Michigan, which provides centralized services for 18 SHCs.

A significant next step after prioritizing the services and choosing the appropriate legal operating structure centers on staffing and technology. The administrative services chosen are likely to require highly skilled and specialized staff. It is also important to establish the logistics regarding the correct technology, often finding the right support for data storage, transmission, information technology (IT) support, servers, and record maintenance. Certain services also require developing standardized forms and practices, including clear financial status policies and procedures.

The Alliance has focused their administrative services on the development of an electronic medical record. This will provide computerized decision support at the point of care with prompts to the provider showing both the clinical care guidelines for the medical condition as well as the history of lab tests and treatment that the patient has been given. The provider will input data during the visit and see the medical record without going through a paper chart. After the visit, the information in the electronic medical record will be used for billing, reporting and quality improvement. The Alliance has long-term plans to interface their database with the laboratory conducting all tests, the state immunization registry and other relevant outside contacts. Given the complexity of this endeavor, the Alliance hired skilled information technology experts to develop the electronic medical record, as well as trainers to teach the providers how to work with the new system.

Another example of choosing services and the appropriate structure is the Illinois Primary Health Care Association (IPHCA), which responded to a need by some of its community health center members who were losing their practice management system when the company providing the service shut down. After studying the technology and skills needed to provide the service, IPHCA formed CQuest America, Inc., which is an information technology consulting firm specializing in the development, implementation and support of data information systems and networks. This not-for-profit corporation currently provides 14 members of IPHCA with a centralized practice management system.

Interviews were also conducted with staff from four school health centers that are within larger community health center organizations receiving centralized administrative services through either The Alliance or CQuest America, to assess how well these

systems were working for school health centers. In all four instances, the school health centers were duplicating data entry by using both Clinical Fusion, a practice management system required by IDHS, and the system provided by The Alliance or CQuest America. While they all reported the need for the centralized administrative services, no one system had yet been developed for school health centers that met their unique needs, and given their location within larger systems, using two systems and duplicating efforts was still better than using none. Staff interviewed stress the importance of a user-friendly data system that is designed for school health centers, meets the reporting requirements of the state and their fiscal sponsor, and minimizes duplication.

Obtaining Funding – Securing funding was identified as a necessary component to the planning and initial implementation phase. Local and national private foundations were instrumental in funding the planning and start-up of the administrative cost-sharing alliances that were interviewed, with funding later coming from federal sources such as the Bureau of Primary Health Care.

Interest by Chicago-Area School Health Centers: Focus Group/Survey Findings

The results of the focus group and surveys with school health center personnel were fairly consistent, identifying billing, collaborative grant writing, managed care negotiation and data collection as the prioritized administrative services. When asked to rank by importance the types of administrative tasks that could be shared by school health centers, respondents from both groups ranked billing as the most important administrative task and collaborative grant writing as second. The focus group participants ranked managed care negotiation, quality improvement, and relationships with Medicaid and HMOs as the third through fifth most important tasks to share with other school health centers, respectively. Survey respondents ranked grant writing technical assistance; managed care negotiation; and program development, research, and evaluation as the third through fifth most important tasks, respectively.

When asked an open-ended question about their most significant administrative challenges, both survey respondents and focus group participants identified billing, quality improvement, negotiating contracts, human resources issues, evaluation, data collection, managed care, and funding. When asked which of these tasks are possible to do jointly with other school health centers, both groups included essentially the same list of tasks. When asked about the barriers

that might keep their school health center from participating in centralized administrative services, focus group participants responded fiscal sponsors, fees, lack of available funding, and limited time to work on this collaboration. Survey respondents indicated that sponsoring agencies, school districts, expenses, and logistical concerns are the barriers that could keep their school health center from participating in centralized administrative services.

SUMMARY OF RESULTS FROM SURVEYS AND FOCUS GROUP			
Importance of Administrative Tasks		Difficulty of Administrative Tasks	
Focus Group	Survey	Focus Group	Survey
Billing	Billing	Billing	Managed Care negotiation
Collaborative grant writing	Collaborative grant writing	Managed Care negotiation	IT support
Managed Care negotiation	Grant writing technical assistance	Relationships with Medicaid HMOs	Billing
Quality improvement	Managed Care negotiation	Collaborative grant writing	Relationships with Medicaid HMOs
Relationships with Medicaid HMOs	Program development, research, and evaluation	Purchasing – medical and office supplies, medications	Collaborative grant writing

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Analysis and Recommendations

Given that a number of the challenges facing school health centers today are closely tied to efficient administration, a centralized system for certain tasks can be a possible solution. In particular, experienced full-time administrative staff that can streamline information, focus solely on generating revenue and provide services to multiple centers will lead to increased revenue and improved sustainability. Moving centers from tracking appointments and encounter data on paper to direct computer entry will also increase efficiency and productivity, while providing increased opportunities for quality improvement. Economies of scale will also allow for the purchase of information technology that is often too expensive or too complex for small centers to handle. And the greatest benefit will be the ability of clinical staff to focus more time on direct patient services.

The Illinois Coalition for School Health Centers has identified the creation of a centralized administrative system for Illinois school health centers as a way to address many of the challenges that may affect the future of this important health care delivery system. Such a system could provide centers with a) centralized data collection, reporting and a system for quality improvement; b) billing services, including negotiation services with private insurance companies and managed care

entities; and c) practice management (patient registration and scheduling).

By creating and implementing a centralized system, ICSHC anticipates that client services will be enhanced, quality of services will be improved and revenues will be increased. We specifically anticipate the following outcomes:

- Enhanced client services by allowing clinical staff to focus on direct patient care and shifting administrative duties to skilled workers who do not have patient responsibilities;
- Quality improvement through efficient and accurate data collection, data analysis, and program modification;
- Increased revenues through cost savings resulting from economies of scale that allow for lower administrative costs and reducing duplication of efforts;
- Increased revenues due to improved efficiency of billing;
- Strengthened advocacy efforts to promote school health centers, resulting from greater sharing of data regarding outcomes.

Key Elements for Successful Implementation

Leadership: Strong leadership is critical in order to bring key people to the table and to maintain an ongoing dialogue. Collaboration requires the joint support of disparate fiscal

sponsors. To achieve this end, it is important to convene multiple layers of leaders in the Chicago area and Illinois who have experience and credibility in the arena of school health centers in order to gain the trust of these fiscal sponsors and the school health center staff.

Structure: The entity that provides the centralized services will need staff that are expert in both information technology and administrative practices. The structure will need flexibility to allow for future expansion, with possible inclusion later of electronic medical records, regional alliances, and for-profit entities developing and distributing products. Managing data will be one of the larger tasks of the centralized service and the use of application service providers (ASPs: companies that supply software applications and software-related services over the internet) may be a cost-effective way to provide this service in order to create a customized, accessible mechanism for data sharing across the various centers in the alliance.

Funding: Initial funding is required to promote a deliberative and inclusive planning process. Subsequent funding will be needed to support the skilled staff and technology to start the services. Sustainability can only be achieved after a solid infrastructure has been established.

Next Steps

With its long history as a successful convener of and advocate for school health centers in Illinois, the Illinois Coalition for School Health Centers is uniquely positioned to lead, facilitate, and implement the centralized services. ICSHC will request funding support for the planning process from the Illinois Department of Human Services and Chicago-area funders, as well as explore possible federal funding sources.

ICSHC proposes a planning process for the development of a Chicago-area pilot that will begin September 1, 2005. The planning goal will be to design a centralized administrative system with implementation targeted for September 1, 2007. Key stakeholders will be invited to participate in individual and joint planning meetings. These stakeholders will include but not be limited to: Illinois Department of Human Services, Illinois Department of Healthcare and Family Services, fiscal sponsors of Chicago-area SHCs; Chicago Public Schools, private foundations that currently promote SHCs, Chicago-area SHC staff and statewide SHC representatives.

Implementation strategies will include hosting a summit in March 2006 to:

- 1) provide information on centralized administrative systems;
- 2) prioritize services to be provided; and
- 3) develop roles and responsibilities for a planning group that will be convened after the summit.

ICSHC will appoint the planning group, which will meet between April 2006 and February 2007. The group will create a report that outlines a Chicago-area pilot with future expansion statewide, due in March 2007, which will recommend the core components for the centralized administrative structure, including:

- Corporate structure
- Scope of services
- Financial plan, including fundraising, user fees and overall budget
- Staffing

ICSHC will re-convene a second summit in March 2007 to present recommendations, with centralized system implementation begun by September 1, 2007.

6 Appendix

Please visit our website at www.ilmaternal.com for the appendix which includes the following:

- A. Research on Existing Administrative Cost-Sharing Models
- B. Interview Participants and Interview Protocol
- C. Focus Group and Survey Data
- D. Government Funding and Support
- E. Corporate Structures to Support Administrative Cost-Sharing
- F. Software/Vendors
- G. Glossary