



ClinicNet: Capabilities and Opportunities



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EXECUTIVE SUMMARY

For the 770,000 uninsured individuals living in Colorado, the health care safety net is a critical health care resource, yet the overall status of a group of Colorado's health care safety net providers is largely unknown. Many safety net organizations and members of the health policy community, including the Colorado Health Institute (CHI), aspire to increase their understanding of the role these organizations play in providing health care service to the un- and underinsured families and individuals in Colorado's diverse communities.

Amendment 35 funding for clinics serving uninsured and indigent patients has provided additional impetus for understanding the population and service dynamics of one group of safety net clinics that share information and support one another under the umbrella of ClinicNet. This provider coalition requested that CHI conduct an evaluation of its members' ability to meet Amendment 35 Primary Care Fund requirements and suggest ways ClinicNet clinics can increase their visibility with state policymakers. This report presents the results of CHI's inquiry.

Through a series of structured questions, CHI staff interviewed clinic representatives with regard to the patients they serve and the resources available to provide services. Major findings of these interviews include:

- The majority of ClinicNet clinics use relatively advanced practice management software.
- Some clinics report difficulty in retrieving useful data from their software systems, regardless of the software's capacity.
- A significant number of clinics do not uniformly track patients' demographic information, including race, ethnicity and employment status.
- Few ClinicNet clinics met in toto the proposed eligibility rules to receive Amendment 35 Primary Care Funds (PCF) at the time they were interviewed.
- Significant data-related barriers exist for clinics seeking to qualify for a PCF allocation.
- Complying with certain proposed data collection rules would represent a shift in organizational philosophy for a small number of ClinicNet members.
- Clinics with an interest in applying for PCF likely will be able to qualify for the third round of funding (January 2007) if they do not currently qualify.

Options and opportunities for next steps involving ClinicNet clinics include:

- As a coalition, ClinicNet clinics will need to decide whether to uniformly report data as a bloc to increase their visibility with policymakers as well as make a more general contribution to the overall monitoring of the safety net in Colorado.
- Identifying grant opportunities or other forms of assistance for improving member clinics' information infrastructure would be a highly valued activity for increasing the clinics' visibility and role within the safety net system.
- Determining clear roles and functions of the ClinicNet coalition and educating its members about the potential benefits that accrue from these functions are vital first steps to increase visibility and enforce the coalition's importance in Colorado's safety net system.
- Promoting communication and interaction among members would help establish a group identity.
- The existing ClinicNet annual report could provide a more comprehensive snapshot of clinics' activities and contributions if data were uniformly inputted by all members.
- Establishing an Internet presence would promote a needed focal point for the coalition, increase its visibility and provide a mechanism for enhanced data reporting.

INTRODUCTION

For the 770,000 uninsured individuals living in Colorado, the health care safety net is a critical resource. The clinics, programs, hospitals and other organizations that make up the safety net provide medical, dental and mental health care homes and services to this population as well as other vulnerable groups, including the Medicaid patients who encounter difficulty obtaining medical care in spite of having coverage. Few health policy experts agree on an exact definition of what comprises the health care safety net, but its role in providing needed care is undisputed.

Working in tandem with the broader goal of establishing a safety net monitoring system in Colorado, CHI staff collected information from ClinicNet member clinics to meet several aims: (1) to assess the clinics' data reporting capacity; (2) to understand each organization's ability to comply with the Amendment 35 Primary Care funding rules; and (3) to provide insight into the options and opportunities available to ClinicNet clinics to enhance members' ability to collect and report data, increase their visibility and further the goal of establishing a safety net monitoring system for Colorado.

To these ends, CHI staff conducted a series of key informant interviews, asking a representative of each member clinic to respond to a set of structured interview questions. Fifteen organizations responded, of which 14 were able to provide relevant data. The resulting findings are a blend of qualitative and quantitative information intended to increase understanding of the role ClinicNet clinics play in shoring up Colorado's health care safety net. This report is divided into six content areas:

- A general description of ClinicNet and its member clinics;
- An assessment of ClinicNet clinics' data reporting capacity, including options and opportunities for future ClinicNet annual reports;
- A primer on Amendment 35 proposed rules and the requirements to qualify for Amendment 35 Primary Care Funds;
- An analysis of ClinicNet members' ability to meet these requirements, including a description of commonly mentioned barriers to qualify;
- Options and opportunities for meeting Amendment 35 requirements; and
- Other opportunities for enhanced data collection and coalition activities.

WHAT IS CLINICNET?

ClinicNet is a loosely affiliated coalition of safety net clinics and programs in Colorado that do not meet the requirements to be designated as a federally qualified health center (FQHC). ClinicNet's 22 members are highly diverse in terms of size, philosophy, services offered and populations served. Some member clinics exist only to serve the uninsured and the medically indigent. All either directly or indirectly provide primary care. Eleven clinics are free-standing, nine are affiliated with a family medicine residency program or a hospital-based program, one is a hybrid free-standing and academic-affiliated clinic, and one (Kaiser Permanente [KP] Connections) is an insurance-based program that does not operate as a free-standing clinic but rather accepts a select number of uninsured patients into the Kaiser Permanente system.

The majority of ClinicNet clinics are located in the Denver metro area and in other populous Front Range communities. Many of these safety net clinics, however, serve Coloradans in non-metropolitan areas of Colorado such as Grand Junction, Hugo, Frisco and Cañon City. The geographic diversity of ClinicNet clinics is reflective of their diverse patient populations and the local health care environments in which they are located.

Snapshot of patients served

Most patients served by ClinicNet member clinics can be categorized as the working poor. This being said, among all member clinics and programs, only a minority of patients is truly unable to pay a minimal co-payment for medical services provided. A significant number of patients are either enrolled in Medicaid or are eligible for Colorado Indigent Care Program (CICP) funding. ClinicNet members also serve a disproportionately large percentage of patients from minority populations, in large part because minority groups are overrepresented among the state's uninsured.

ClinicNet clinics often serve as the medical home of last resort for individuals who would otherwise delay care and/or use an emergency department as a source of primary health care. Some ClinicNet clinics are major providers of care to homeless individuals, although most refer homeless patients to homeless shelters and their affiliated programs. Many member clinics also provide services to transient and/or migrant and undocumented populations.

Service delivery models and fee structures

While not all ClinicNet clinics have their own bricks-and-mortar facilities, the majority do. Some percent of ClinicNet clinics provides medical outreach programs such as medical vans and staff "virtual" clinics. One organization, Doctors Care, operates a pediatric clinic and coordinates health care delivery

by serving as a virtual clinic where enrolled patients are matched with volunteer doctors via a centralized hub. This model is similar to the approach used by Project Access communities around the country that organize access to care for medically indigent patients.¹

The heterogeneity of ClinicNet clinics is reflected in their varying approaches to patient payment practices. Most clinics operate on an open-door policy where no patient is turned away based on his or her ability to pay. All clinics, to varying degrees, make an effort to locate a medical care provider for patients who fall outside their eligibility criteria.

The majority of ClinicNet clinics use some version of a sliding-fee scale to assign charges to patients based on ability to pay, and many model this fee scale on CACP guidelines. Some clinics request only a donation from patients, some set a fixed discount to self-declared needy individuals and others provide services free of charge. In sum, there is no common payment method used by ClinicNet members.

Funding sources/methods

Sources of funding vary significantly across coalition clinics, although certain commonalities do exist. A clear majority of ClinicNet members apply for and receive grant funding, usually on a yearly basis, even when other more stable sources of funding are available to pay for operating costs. Grants play different roles among the clinics, but even the relatively well-funded ClinicNet members use grants to stay in the black or to stem impending financial losses. While some clinics rely on a few large grants, others manage as many as 40 active grants at one time. The sustainability of using grant funding as a primary (or stop-gap) source of revenue was questioned by many key informants.

Another resource commonly used by the majority of clinics is volunteer health care clinicians. Given the financial status of the patient populations these clinics and programs serve, it is understandable that they must rely on the goodwill and generosity of individual physicians, especially specialists, to meet their patients' needs. Even clinics with organizational relationships that ensure access to a large referral pool of volunteer primary care and specialty clinicians must sometimes solicit additional pro bono services from physicians in the broader community to meet needs of the large and growing number of patients who cannot directly or indirectly pay the total costs of their care.

¹ Project Access is a federal initiative funded by the Health Resources and Services Administration (HRSA) in the U.S. Department of Health and Human Services (DHHS). For more information about Project Access, go to <http://www.bphc.hrsa.gov/cap/>

Patient payments, co-payments and income from billing Medicaid and Medicare and other public programs provide significant income to the majority of ClinicNet members. Because of the economic circumstances of the populations served, however, patient billing was reported to be an unreliable source of funding for the long-term sustainability of clinics.

DATA REPORTING CAPACITY

ClinicNet members' data reporting capacity was evaluated using three self-reported criteria: (1) the capacity of the data system to track patient information such as individual demographic characteristics and services provided; (2) the ease with which data are retrieved; and (3) the system's ability to easily produce patient reports, such as the number of times a particular type of service was provided, sources of revenue and utilization of services by patient characteristics.

The limited scope of this project necessitated a qualitative, question-driven rather than hands-on evaluation of each clinic's data system. As such, CHI's ability to assess the robustness of individual clinic data systems is incomplete, although this report provides increased insight into ClinicNet members' ability to collect, store and report patient-level data. In addition to asking questions about data systems, CHI staff also collected basic information on the types of routine reports each clinic currently produces and the level of data collected.

Of the 14 applicable clinics that responded to the CHI questionnaire (Kaiser Permanente Connections was excluded because it does not operate a stand-alone safety net clinic), 13 reported using some form of practice management software separate from billing, while 11 reported either using this same software for billing and claims or having another form of billing and/or claims software. Ten of the clinics were able to identify the name and version of the software they used, which consisted of recognizable, brand-name packages such as MediTech or Centricity. Ten clinics also reported using some form of software to manage their office operations. One clinic reported keeping mostly pen-and-paper records while voicing a desire to obtain the tools and training needed to computerize its record-keeping and billing systems.

Billing and practice management software are the primary data systems used. Only two of the clinics currently have electronic medical records, although most reported a desire to purchase electronic medical record software and a few have taken steps in this direction. According to interviewees, deriving data and statistics from billing records and appointment histories allows for a fairly comprehensive view of clinic operations, including information on patient diagnoses and services provided.

Most clinics reported that retrieving data such as utilization statistics and patient demographic information is routine and, for the most part, occurs without difficulty. As a general rule, the ease and frequency with which a clinic is able to produce data and reports is directly proportionate to the clinic's size. This is likely due to a number of factors, including the increased ability of a larger clinic to absorb the costs of software and the greater likelihood that larger clinics have the resources to hire a dedicated data entry specialist. The limited administrative infrastructure of many clinics also makes it difficult for them to get to scale even as patient load and clinical resources increase.

A large majority of clinic staff interviewed appeared to be "tech savvy." Seven clinics had technology support available in-house, four had it through contracts or volunteers, while only one clinic indicated it had no particular source of technical support. Of the seven clinics that reported the Internet connection they use, all use DSL or broadband links. Only one clinic reported no access to the Internet at the clinic site. Similarly, only three clinics reported not having a local area network in the office (three did not respond to the questions concerning technical support and capacity).

The most commonly reported difficulties in retrieving data included creating specific queries to produce a particular report, a lack of training for staff and/or limitations to the software being used. Most clinic representatives indicated that while difficulties in retrieving data may exist, the data systems they use are capable of producing the reports they need, at least in theory.

Data collected

All clinics interviewed reported being able to track some basic demographic information about their patients.

- Of the 14 clinics that reported the types of data they collect, 13 collect near-complete or complete information about the age of their patients. All clinics collect gender data, while other patient characteristics are collected with more or less completeness.
- Only five of 14 clinics collect complete information on the race and ethnicity of their patients; three have some race/ethnicity data available; two do not collect these data, but can produce a rough count, while four clinics do not collect race/ethnicity data.
- Only three clinics collect patient information on primary language spoken, six can produce a rough estimate, while five currently do not collect this information.

- Similar trends were found with regard to information collected on employment status and living situation. Two clinics uniformly track whether patients are homeless, three had incomplete data, one had a rough estimate, and eight do not track this information. For employment status, three clinics have relatively complete data, two have some information, and nine collect no employment-related information.
- ICD-9 (diagnostic) and CPT-4 (procedure) codes are not entered by all clinics, nor entered uniformly by those that do. In general larger clinics, especially the family medicine residency clinics, tend to use ICD-9 and CPT-4 codes for recording diagnoses, procedures and other billable events more frequently than the smaller, freestanding clinics.

The ability of ClinicNet members to report trends about their patient population depends on what data they routinely collect. With regard to race, some clinics noted that their non-discrimination policy specifically discourages collecting race and ethnicity data. Similarly, other clinics indicated that privacy concerns affect their willingness to ask patients for employment or housing information. As with income, these concerns are more applicable with respect to undocumented patients.

Additional barriers to collecting patient data were reported. Many clinics indicated a desire to upgrade their existing patient management information systems, but the cost of new software and the demands placed upon staff in switching to a new system were often cited as barriers clinics would need to overcome. For example, People's Regional Clinic noted that enhancing its data capacity through the addition of new software would be a boon, but conducting the training needed for the clinic to effectively make use of the new software requires time and resources not currently available.

AMENDMENT 35 PRIMARY CARE FUNDS

Amendment 35, approved by voters in 2004, amends the Colorado Constitution by increasing the sales tax on cigarettes and other tobacco products. The revenue collected from this new sales tax is to be distributed according to guidelines specified in House Bill (HB) 1262, Statutes of 2005. Approximately 19 percent of the revenues will be distributed via a Primary Care Fund (PCF) to primary health care providers that meet requirements outlined in HB1262 and conform to the specific rules proposed by the Department of Health Care Policy and Financing (HCPF) and adopted by the Medical Services Board.

Each health care provider organization deemed eligible will receive a PCF allocation determined by the size of its share of the total number of documented uninsured and/or medically indigent patients. For

example, a clinic serving 5 percent of the total number of qualified patients reported by all eligible providers in a given year will receive 5 percent of that year's total PCF dollars.

The deadline to apply for the first payout is January 6, 2006. This first distribution will be based on clinics' qualified patient counts from calendar year 2004. A second round of funding will follow in March 2006 for new clinics based on their uninsured counts from calendar year 2005.

Amendment 35 PCF represents an important new source of revenue for safety net providers in Colorado. Because these funds are not distributed on a fee-for-service basis, and are relatively stable based on the continued consumption of tobacco products, their importance as source of revenue is significant. Ironically, the stability of these funds serves as an insurance policy for the sustainability of Colorado's health care safety net. Furthermore, these revenues have the potential to substantially expand safety net services and offset the uncompensated care costs associated with caring for uninsured and medically indigent patients.

REQUIREMENTS AND RULES

HCPF and the Medical Services Board recently adopted the rules and regulations that govern eligibility for the disbursement of PCF dollars. This section examines these rules and their implications for ClinicNet clinics. After each rule is described, the ability of ClinicNet members to conform to the rule and its most common challenges are discussed. This analysis refers only to those ClinicNet clinics that were interviewed and that are interested in applying for PCF dollars.

(1) Comprehensive primary care

Eligible clinics must demonstrate that they provide *comprehensive primary care* services on a year-round basis. As defined in statute, comprehensive primary care means either providing *or arranging for* the following services (at a minimum):

- Primary health care
- Maternity care, including prenatal care
- Preventive, developmental and diagnostic services for infants and children
- Adult preventive services, diagnostic laboratory and radiology services
- Emergency care for minor trauma
- Pharmaceutical services
- Coordination and follow-up for hospital inpatient care.

The term *year-round* means that a clinic must not be closed for a period to exceed one month per year on a scheduled basis.

To *arrange for* primary care means that a clinic must document an established referral relationship(s) with another provider(s) for all of the above services that it does not directly provide.

An *established referral relationship* is defined as a formal, written agreement in the form of a letter, memorandum of agreement or contract between two entities which includes:

- The comprehensive primary care and/or products (e.g., pharmaceuticals, radiology) to be provided by one entity on behalf of the other entity;
- Any applicable policies, processes or procedures;
- The guarantee that referred medically indigent patients shall receive services on a sliding fee schedule or at no charge; and
- Signatures by representatives of both entities.

A clinic that provides *pharmaceutical services* is one that “provides prescription drugs, or coordinates access to or arranges for [defined above] client to receive prescription drugs prescribed by the qualified provider on a sliding fee schedule or at no charge.”

Most ClinicNet members interviewed provide the majority of services listed in the regulatory requirement, and almost all have some form of referral relationship in place for services they do not provide. Many clinics, however, noted that even in cases where long-standing referral relationships have existed, a formal, written and signed agreement may not be in place. Additionally, clinics that specialize in one type of service or patient population (e.g., school-based, prenatal or pediatric clinic) may be less likely to have a formal agreement in place for services not applicable to their patient population. For example, because adult patients are not likely to seek care through a pediatric clinic, such a clinic is unlikely to have a formalized referral relationship covering adults.

The requirement for formal referral relationships as signed agreements was often cited as a barrier to being fully compliant with PCF rules. A small number of clinic representatives speculated that some of their current referral partners may not wish to formalize a referral relationship in order to retain control over the flow of uncompensated care patients they agree to serve.

In addition, this requirement necessitates that referral partners provide services on a sliding fee scale or free of charge. One reason this guarantee would be difficult to secure was that providers are unable or

unwilling to assure in writing that patients will receive care at a significant discount in the event that referral partner's financial circumstances might change.

(2) All age groups

Applicants must either directly provide or arrange for patients of all ages services listed under the definition of Comprehensive Primary Care. As noted above, *arrange for* in this case means documenting the existence of established referral relationships with other health care providers. Those ClinicNet clinics that focus on one patient population, such as Rocky Mountain Youth Pediatrics voiced concern about the requirement to provide access to care for patients of all ages.

(3) Patient access and fee assessment

Eligible clinics must accept *all* patients regardless of their ability to pay, and must either use a sliding fee schedule or provide services free of charge. A sliding fee scale/schedule is defined in the proposed rules as "a tiered co-payment system that determines the level of a patient's financial participation and guarantees that the patient financial participation is below usual and customary charges. Factors considered in establishing the tiered co-payment system shall be financial status and the number of members in the patient's family unit."

All ClinicNet members interviewed make efforts to ensure that patients who cannot afford to pay are either charged less, charged an amount they can afford or not charged at all. Most clinics use a multi-tiered sliding fee scale, while some provide discounts to patients using other methods.

Concern about this rule generally focused on the specific definition of a sliding fee schedule. In the case of North Colorado Family Medicine, which offers a 50 percent hardship discount to patients, it was unclear whether this two-tier system – that is, either full pay or half pay for self-pay uninsured patients – would qualify as a sliding fee schedule. CHI's understanding of the sliding fee scale requirement is that any method of ensuring a patient does not pay full price for services could be considered a sliding fee scale; the criteria to be used in determining compliance with this rule, however, are neither explicit nor currently available. Therefore, the judgment as to whether a clinic's fee scale is acceptable appears to be somewhat subjective and made on a case-by-case basis.

(4) Medically underserved area or population

Qualifying clinics must be located in a geographic area that is federally designated as either a medically underserved area (MUA) or medically underserved population (MUP), or they must demonstrate a lack

of adequate access to health care for members of their community. A guide to federal MUA and MUP designations can be found at <http://bhpr.hrsa.gov/shortage/muaguide.htm>.

Most ClinicNet clinics are located in medically underserved areas, although several interviewees expressed doubt that they are, and a few noted that they are not. Clinics not located in a MUA were uncertain about what to do to meet this particular requirement. A common concern among clinics not designated as a MUA or MUP was that the burden of demonstrating their patient population is underserved would add significantly to the resources needed to meet PCF requirements.

Clinics may qualify for PCF by providing evidence that their catchment area “lacks adequate health care services for low-income, uninsured persons.” The data required to make this case are not defined by statute or rule. HCPF has stated, however, that clinics may use U.S. Census data on the percent of patients in their service area or county with income at or below 200 percent of the federal poverty level (FPL). Other reliable population-based data also may be used, including health status indicators related to a clinic’s patient population. Clinics not located in a designated MUA or MUP expressed concern that this lack of clear guidance might result in either a heavy research burden because clinics do not know what data they need and therefore err on the side of “data overload,” or be disqualified for not having used the “right” data.

(5) Cost-effective care

Eligible clinics must demonstrate a history of providing care at reasonable prices. Having a track record of cost-effective care is defined in the rules as being able to document the provision of cost-effective comprehensive primary care for at least a consecutive 52-week period prior to submission of an application for PCF dollars.

Cost-effective care is defined as “delivering quality and appropriate comprehensive primary care at a reasonable average cost per patient visit.” Reasonable average cost is not defined, but may be in the future.

(6) Track Record

The *track record* requirement is the rule that perhaps presents the greatest challenge to clinics that want to qualify for the first round of PCF funding. As discussed earlier, many ClinicNet clinics do not currently have signed referral relationships with other providers, and more importantly, do not have any

formal referral relationship for certain services that patients would not reasonably seek through their clinic such as referral relationships on behalf of adult patients at a pediatric or school-based clinic.

Any clinic that did not provide comprehensive primary care as defined in the rules beginning roughly on or about January 6, 2005, will not qualify for the first round of funding. Although the definition of comprehensive primary care has existed for a number of years for other purposes, many clinics are frustrated that this rule, for this purpose, has the effect of excluding them from being eligible for a PCF allocation. The frustration results from the fact that these clinics believe they have provided quality services to low-income, uninsured patients during the past year, but lack the documentation of one or more components of comprehensive primary care as defined by the rules.

An implication of the *track record* rule is the need for better documentation of clinic relationships and quality processes on the part of clinics that do not currently qualify but want to in the future. A clinic that wishes to apply on January 6, 2007, must ensure it meets the comprehensive primary care requirements by January 6, 2006. A subjective evaluation of ClinicNet members' desire and ability to allocate the needed time and resources to comply with PCF eligibility requirements suggests this will be difficult, but not impossible.

(7) Screening for Medicaid, CHP+ and CICIP

Qualifying organizations must complete a screening that evaluates patients' eligibility for Medicaid, Child Health Plan Plus (CHP+) and CICIP funding. All but three ClinicNet clinics reported making consistent efforts to enroll patients in these public programs. The form that screening takes varies from one clinic to another. Some have on-site eligibility workers who conduct a basic screening, while others simply refer patients to an appropriate agency for eligibility determination purposes. Because all clinics that currently document patient income complete this preliminary step in determining eligibility, it is unlikely this rule will be a major barrier in qualifying for a PCF allocation.

(8) Quality assurance programs

Applicants must submit documentation of a quality assurance program to ensure *quality* comprehensive primary care services are being provided.

HCPF defines a quality assurance program as "A formalized plan and process designed to ensure the delivery of quality and appropriate comprehensive primary care in a defined medical setting." This requirement can be automatically met through accreditation from the Joint Commission on

Accreditation of Healthcare Organizations (JCAHO) or the Accreditation Association for Ambulatory Health Care (AAAHC). For clinics not accredited by these organizations, documentation of quality assurance protocols comprising the following will be accepted:

- Documentation of credentialing/re-credentialing of medical personnel;
- Surveying and monitoring of patient satisfaction;
- Documentation of a grievance process for patients, including how grievances are resolved;
- Documentation of clinic operating policies and scheduled performance monitoring;
- Documentation of medical record reviews to check for compliance with established policies and to monitor quality of care;
- Compliance with all state and federal regulations;
- Documentation of patient safety procedures; and
- Documentation of infection control practices.

Clinics are not required to have a formal quality assurance plan. Instead, they will be in compliance with this rule by documenting practices or procedures that assure compliance with the eight points specified above. For example, if a clinic's employee handbook describes a credentialing and re-credentialing process, it is not necessary to put it into a formal quality assurance plan; rather, the clinic may simply document that the practice is in place.

A majority of ClinicNet clinics interviewed reported having a quality assurance system or set of written goals in place. At least one clinic is JCAHO accredited, and all clinics reported having a minimum set of guidelines to which they adhere, including a basic set of quality assurance operating procedures.

The major issue related to this rule involves the time and administrative burden to document a clinic's quality assurance protocols. Smaller clinics are less likely to have documented quality assurance protocols in place and report doubts about being able to dedicate the necessary time and resources to do so before January 2006. Some of the clinic representatives expressed concern that the costs and effort necessary to come into compliance would outweigh the benefits of PCF dollars.

(9) 50 percent medically indigent, Medicaid and/or CHP+ patients

Eligible clinics must either be an FQHC or provide services to patients of whom at least 50 percent are either uninsured and medically indigent or enrolled in Medicaid or CHP+. Clinics serving 49 percent Medicaid patients and 2 percent uninsured patients are eligible, while those serving 45 percent uninsured patients and 55 percent privately insured patients are not. Percentages must be based upon a count of

unduplicated patients (as opposed to visits) and be verified by an outside entity. This rule is the ultimate litmus test for determining whether or not a clinic is eligible for funds.

For the purposes of the rule, a medically indigent person is defined as an uninsured patient receiving medical services from a qualified provider who:

- Has family income at or below 200 percent of the FPL;
- Is not eligible for Medicaid, the Children's Basic Health Plan, Medicare or any other government-sponsored health care coverage, including the Veterans Administration, active military (TRICARE or CHAMPUS) or the U.S. Public Health Service. CICIP is not considered government reimbursement for this provision; and
- Is not eligible for any third-party reimbursement.

A third-party payer is any entity or program with a legal obligation to pay for some or all health-related services rendered to a patient. Examples include Medicaid, the Children's Basic Health Plan, Medicare, commercial individual or employment-related health insurance, court-ordered health insurance, workers compensation, medical payments associated with auto insurance or long-term care insurance. CICIP is not considered a third-party payer.

An *unduplicated patient count* is "the sum of patients who have had at least one visit/encounter and received at least one of the services under the definition of comprehensive primary care during the applicable calendar year, but does not include the same patient more than once. The sum shall be calculated on a specific point-in-time occurring between the end of the applicable calendar and prior to the submission of the application. Each patient shall be counted once under only one payment source designation (third-party payer or medically indigent patient).

The patient's payment source designation shall be the payment source designation listed for the patient at the point-in-time in which the calculation is made. The sum shall not include:

- Counting a patient more than once if the same patient returns for additional services during the applicable calendar year;
- Counting a patient more than once if the payment source changed during the applicable calendar year;
- Persons receiving services through an outreach event, community education program, nurse hotline or other types of community-based events or programs and not documented on an individual basis;

- Persons receiving services from a large-scale effort such as mass immunization programs, screening programs and health fairs; and
- Persons whose only contact with the provider is to receive Special Supplemental Nutrition Program for Women, Infants and Children (WIC Program) counseling or vouchers.”

A *visit/encounter* is defined as a “face-to-face appointment with medical personnel (physicians, physician assistants, dentists, behavioral health workers, etc.) in which the patient received health-related services and/or products (e.g., pharmaceuticals or radiology) and the appointment is customarily billable to a third-party payer.”

An *outside entity* is defined as “a business or professional that is not classified as an employee of the provider or the department. The business or professional shall have auditing experience or experience working directly with the Medical Assistance Program or similar services or grants for medically indigent patients.”

All clinics interviewed serve a combination of Medicaid/CHP+ and uninsured patients equal to 50 percent or more of their patient population, although some clinics have not yet completed an externally verified count. It should be noted, though, that not all the clinics currently *document* patient income as a percent of FPL, and fewer still have these data available for past years. As a result, some clinics will be unable to document unduplicated patients at or below 200 percent of FPL during calendar years 2004 and 2005. This eligibility requirement was the barrier most often noted by ClinicNet interviewees, especially given that this requirement must be met using 2004 and 2005 data to qualify for the first two rounds of funding.

Neither the rules nor the application have established guidelines for documenting patient income at or below 200 percent of FPL. It appears that the form of proof is not limited to pay stubs, tax returns, bank statements, or other official or quasi-official documents such as a letter from an employer. Instead, clinics may ask patients for income verification as part of their registration process or in the form of a separate attestation.

At least five of the 14 clinics that could qualify for a PCF allocation do not currently require “hard” proof of income (such as a pay stub or tax return); rather, this information is collected on a voluntary, self-reported basis. In the case of Clinica Tepeyac and People’s Regional Clinic, patients are considered medically indigent based on their word.

Clinics participating in the interviews that do not collect income information cited a number of reasons why collecting these data from their patients could be difficult or undesirable. Smaller clinics in sparsely populated communities, such as People's Regional Clinic in Hugo, noted that asking patients for proof of income would be an undue intrusion of privacy given the clinic's close connection to the community. Pride and privacy concerns likely would lead some individuals to forego care. A smaller number of clinics reported they would not change their privacy practices, even if it meant they would be disqualified for PCF dollars.

Trust was a major issue mentioned with regard to undocumented patients. A number of clinics, especially those treating undocumented workers, indicated that these patients tend to be reluctant to share such identifying information for fear of being made known to authorities. One clinic explained that asking for "hard" proof of income might drive a significant number of its patients away.

Amendment 35 issues in review

To summarize, there are many data-related barriers that exist for ClinicNet members that wish to receive PCF funds. Compliance with the rules involves a number of challenges for the clinics including retrospective documentation of uninsured patients' incomes at or less than 200 percent of FPL; documenting acceptable quality assurance protocols; and obtaining signed referral agreements that assure comprehensive primary care services are available. Clinics not able to meet these requirements will find it necessary to quickly adapt to qualify for the January 6, 2006, deadline or subsequent deadlines that follow.

It should be stressed that many of the rules are subject to interpretation by HCPF and much depends on the way in which the department chooses to evaluate responses to each requirement. It is not possible to predict the number of clinics that will qualify for PCF funding during the first round. Enough concern was voiced by ClinicNet clinics, including those that seem well-suited to meet the requirements, that a significant number likely will not qualify for first-round funding and some may forego applying altogether. For many clinics, coming into compliance with PCF rules represents a significant investment of time and resources; for some, the resources are not available, and a smaller number believe the potential new revenue is not worth the investment.

Additionally, for a small number of clinics, compliance with PCF rules would necessitate a shift in operating philosophy. A number of clinics reported that assuring their patients remain *off the grid* is important to maintaining their stated values and mission. As a result, it was felt that coming into compliance with this rule would compromise the clinics' mission in a small number of cases. In reality,

the verification of patient income rule does not require disclosure of any individual patient-level income, but some interviewees suggested that the perception of loss of privacy could erode patient trust and confidence in the clinic. Although this was not a universal concern among clinics, some will take this factor into consideration when deciding whether to pursue PCF funding.

The *track record* rule, including the requirement to document patient income during 2004, represents a much greater barrier to qualifying for PCF funds in the first round. As noted earlier, the retroactive nature of the rules may serve to exclude a significant number of ClinicNet clinics.

OPTIONS AND OPPORTUNITIES

Findings from the key informant interviews illustrate the diversity and heterogeneity of ClinicNet members. Each clinic collects different data, uses different software and methods, operates according to a unique philosophy and set of practices, and is connected to a different community of outside organizations. Formulating and describing the options and opportunities available for such a diverse group with regard to improving data systems and increasing visibility will necessarily involve generalized next-step options. Nevertheless, steps can be taken that are feasible based on information gathered during the interviews and from completed questionnaires.

Increasing clinics' ability to collect and report data

An initial step the clinics could take in the area of data collection and reporting involves ensuring that basic demographic data are uniformly collected by all clinics including race, ethnicity, primary language spoken at home, employment status and living arrangement. The exact method used to accomplish this may vary from clinic to clinic, but agreeing to collect these patient-level demographic data, using uniform data definitions, would insure that the clinics report consistent statistics on the populations they serve. This information would be useful in the future when potential funders request demographic data and/or policymakers request precise information about who is being served.

- Consensus among the clinics about what data would help promote best practices and other useful information that can assist smaller clinics and avoid some of the burden of implementing new data collection activities one clinic at a time.
- Collecting uniform data would enable the reporting of aggregate data across clinics, assuming that this is an agreed-upon goal. Adding data elements incrementally or in small batches would avoid administrative burden and data-entry overload.

- Securing technical assistance for those clinics that want to change and/or upgrade management information system software is a key to improving the clinics' joint efforts to collect and report patient population statistics. As discussed previously, many clinics reported a desire to secure more advanced electronic tools such as an electronic medical record, but also reported needing financial assistance and training to do so.

Qualifying for PCF funding

Compliance with the rules governing PCF allocations is an undertaking that differs from clinic to clinic. Of the clinics interested in qualifying, many will need to implement new data collection and information systems that will enable them to report required data by January 6, 2006 or later, depending on their level of readiness.

Participation in the HCPF information sessions and the pre-bid conference helped answer questions and dispel some of the confusion voiced during key informant interviews. Again, collaboration and information sharing between the clinics would be a useful and productive activity for ClinicNet members. Discussing options, including data collection tools for documenting patient income information, would avoid duplicative and redundant efforts. Finally, clinics should consider informing patients of the new information needs to prepare them in a proactive and supportive way. Clinics can tailor new data collection activities to the specific needs and concerns of their patient populations while complying with PCF rules.

There are a number of steps that HCPF may wish to consider to ensure the maximum number of appropriate clinics qualify for and receive a PCF allocation. Among these:

- Develop more explicit guidelines after evaluating round one applications;
- Develop explicit descriptions of the data clinics may use to document underserved area for those not located in a federally designated MUA or MUP; and
- Take steps to ensure that the administrative processes in place to apply for PCF funds ensure program integrity without placing an undue burden on safety net clinics, particularly small, non-FQHC clinics.

Promoting the visibility and cohesiveness of ClinicNet clinics

As mentioned previously, a common sentiment expressed by most key informants was that ClinicNet is a very loosely knit coalition. Indeed, representatives of some clinics were initially unaware that they

were members. Improving members' sense of solidarity and belonging by promoting a shared identity would be an important first step in enhancing clinic visibility and promoting the importance of ClinicNet clinics among Colorado's health care safety net system.

To accomplish this shared vision and increase visibility, ClinicNet should consider explicitly defining its role and purpose relative to member clinics. This role could include the periodic reporting of uniform, aggregated population and utilization statistics, scheduling information-sharing sessions for member clinics, and sponsoring other activities that strengthen the voice and visibility of the clinics with funders and policymakers.

Another step that clinics may wish to consider is establishing and maintaining a Web site for information sharing, potentially including data collection and/or reporting functions. Such a Web site could serve as a viable portal for clinics that do not currently operate their own Web site and provide useful information about ClinicNet members' role as essential providers in Colorado's health care safety net system.

A ClinicNet Web site could also serve as a data collection tool and data repository. Developing a Web-based data reporting application would allow member clinics to collectively enter and analyze pertinent statistics routinely, thus creating a *safety net barometer* that tracks and measures that members feel are important to disseminate to a broader policy audience.

Finally, improving ClinicNet's current annual report is another important vehicle for increasing the visibility of member clinics. Based on completed interviews, CHI learned that the report does not currently contain full and uniform data on all clinics associated with ClinicNet. For example, not all clinics' financial data are represented in the most recent annual report. Because efforts in this area could be coordinated with other data collection efforts, including the safety net monitoring system currently being implemented by the Colorado Health Institute, the ClinicNet annual report could build on other important efforts to increase clinic visibility.

Monitoring the safety net

CHI is currently developing a system to monitor the solvency and sustainability of Colorado's health care safety net, an effort that will necessarily involve ClinicNet members that have expressed interest in finding better ways to tell their story. A key consideration in the monitoring project will be the weight of any administrative burden placed on safety net providers.

A Web-based data entry portal as discussed above is one possible option for efficiently collecting data from safety net clinics. Investment in such a system could minimize the data collection burden at the

individual clinic level, especially if efforts are made to automate data gathering while complying with HIPAA. An Internet-based data collection system such as those developed by some of the Project Access initiatives has been found to be an effective and efficient method for collecting, sharing and reporting data.

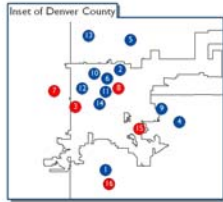
Regardless of the tool used, an important initial step in developing a safety net monitoring system will be for safety net stakeholders to collectively decide what data and indicators are essential to monitor. A discussion between CHI staff and the ClinicNet steering committee is an appropriate and necessary first step. This discussion should address the relevance of many different types of data and clinics' current and future capacity to collect them.



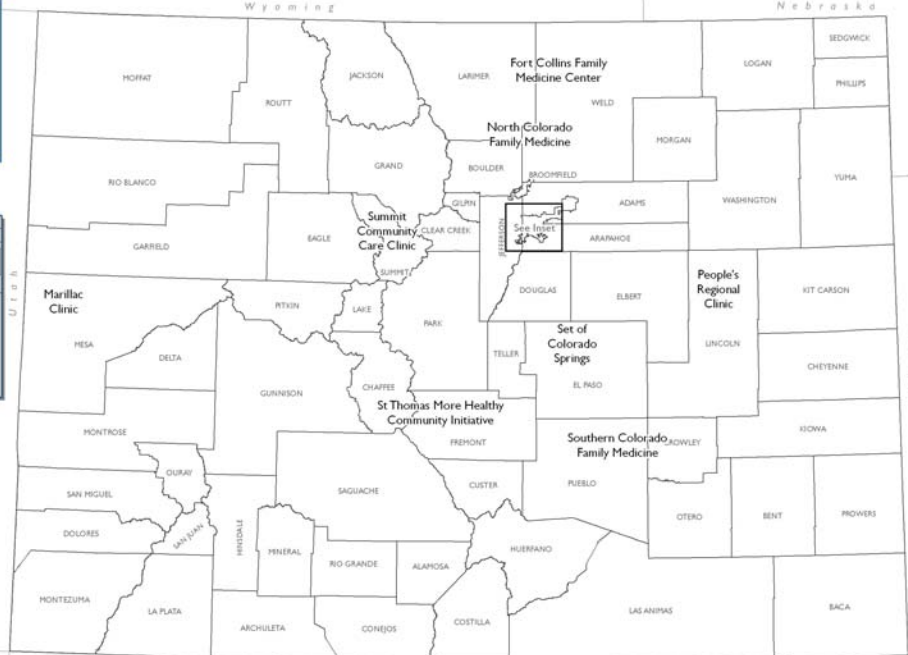
Colorado ClinicNet Clinics



- Not Interviewed
- Interviewed



- 1 Doctors Care
- 2 Inner City Health Center
- 3 Adventist Community Services
- 4 Aurora Nurse Midwives
- 5 Community Health Services
- 6 Denver Rescue Mission
- 7 Estes Street Community Care
- 8 High Street Primary Care Ctr.
- 9 Kaiser Permanente
- 10 La Clinica Tepeyac
- 11 Rocky Mountain Youth Pediatrics
- 12 St Anthony Family Medicine (West)
- 13 St Anthony Family Medicine (North)
- 14 St. Joseph Family Practice Center
- 15 Clinic of Colorado Family Residency at Rose
- 16 Swedish Family Medicine Residency



Map prepared by the Colorado Health Institute
 1576 Sherman St., Ste. 300
 Denver, CO 80203-1728
 303.831.4200
www.coloradohealthinstitute.org

Aurora Nurse Midwives

Address: 1400 S. Potomac
Street, Suite 225,
Aurora, CO 80012

Contact Person: Christy Purcell

Founded: 1998

Title: Business Manager

Hours: M-F 8:00-5:00
Answering service 24/7

Phone: 303.873.5245

Fax: 303.873.5240

E-mail: Christy.Purcell@healthonecares.com

Service Area: Primarily Aurora (Arapahoe and Adams Counties). The second largest source of patients is Commerce City.

Description: Aurora Nurse Midwives (ANM) is a clinic for pregnant women (including high-risk pregnant women) that functions as a department of the HealthONE Medical Center of Aurora. The clinic employs nurse midwives who are provided back up by physicians from the Medical Center.

Type of Facility: Separate clinic facility associated with HealthONE.

Target Population: Any woman in need of prenatal or delivery services. Users must have insurance or pending Medicaid. ANM serves many undocumented and transient patients.

Mission Statement: No specific mission statement given.

Additional Programs and/or Services:

- Physician consultation 24 hours a day
- Family planning
- Well-woman services
- Pre-conception services
- Birthing services

Clinica Tepeyac

Address: 3617 Kalamath Street
Denver, CO 80211

Contact Person: Ozzie Lozano

Founded: 1995

Title: Clinic Manager

Hours: Adult Care

Phone: 303.458.5302 x 306

T 6:00-9:00 pm; Th 1:30-
3:30 pm, 6:00-9:00 pm

Teen Clinic

T 9:00-12:00 pm

Pediatric

W 1:30-3:30 pm, 5:00-
8:00 pm

Fax: 303.433.7452

E-mail: olozano@clinatepeyac.org

Service Area: Varies. Most patients are from Aurora and Thornton. One patient comes from Frisco and one from Pueblo. The City of Denver and Denver County are typically excluded due to alternative resources in these areas.

Description: Clinica Tepeyac is a freestanding primary care clinic that serves primarily the Latino community within the Denver Metro Area. All medical staff volunteer, and two of four support staff are also volunteers.

Type of Facility: Freestanding, fixed location clinic; one contracted mammogram van once per month

Target Population: Open to anyone and everyone, but treats primarily uninsured Latinos (95%).

Population:

Mission Statement: "Along with providing high-quality health services, Clinica Tepeyac's primary objective is to empower families to be proactive with regard to their own health. By educating families about preventive health and doing it in a culturally proficient manner, Clinica Tepeyac is transforming the way in which health services are delivered to underserved communities."

Additional Programs and/or Services:

- Reach and Teach Community Education (recruits/trains bilingual community members to spread prevention messages)
- Milagros Youth Program (assistance in succeeding in school, careers in health fields, health prevention messages)
- Diabetes management program (support and education)

Community Health Services

Address: 4675 E. 69th Avenue
Commerce City, CO 80022

Contact Betty Pepin

Person:

Founded: 1978

Title: Executive Director

Hours: Commerce City
MW 8:00-6:30, TThF 8:00-4:30
Westminster (Baker)
MWThF 8:00-4:30, T 10:00-6:30

Phone: 303.853.3279

Fax: 303.289.7378

E-mail: bpepin@acsd14.k12.co.us

Service Area: No geographic restrictions. Most patients at the Commerce City location are from Commerce City. Most patients at the Baker location are from Westminster. Some patients come from Aurora, Brighton, northeast Denver and unincorporated areas of Adams County.

Description: Community Health Services is a freestanding, nonprofit set of clinics that partner with school districts 14 and 50 to provide care to school-age youth.

Type of Facility: Two freestanding fixed-location clinics and four smaller satellite clinic locations inside area schools. Satellite clinics are one-room and do not function year-round.

Target Population: Any child/youth from birth to 21 years of age, primarily from school districts 14 and 50 but not limited only to students.

Mission Statement: "The mission of Commerce City Community Health Services (CHS) is to improve the health and well-being of infants, children and youth. CHS operates within the community and collaborates as an advocate for families to provide accessible and high-quality primary care and school nursing services, with an emphasis on preventative health care, health promotion and health education particularly to the high risk and underserved."

Additional Programs and/or Services:

- Four standard car seat checks per month
- Mental health programs
- Outreach programs
- Chopper Topper
- Immunization clinic each Wednesday afternoon
- In-school nursing services

Denver Rescue Mission

Address:	1130 Park Avenue West, Denver, CO 80205	Contact Person:	Kathy Collins
Founded:	1892 New Life Program: 1987	Title:	Clinic Manager
Hours:	M-F 8:30-10:30, 2:30-4:30	Phone:	303.294.0157
Fax:	303.294.9314	E-mail:	kcollins@denrescue.org
Service Area:	Primarily Denver County. Some patients come from outlying locations such as Longmont, Boulder and Wellington.		
Description:	Denver Rescue Mission's medical services program offers a wide variety of medical, dental, chiropractic and vision screening services to enrollees in the mission's New Life Program and a more limited selection of services to the general public.		
Type of Facility:	Small, volunteer clinical operation that primarily serves enrollees in the Denver Rescue Mission's assistance programs		
Target Population:	Preference is given to the ~200 enrollees in the New Life Program run by the mission. Some services are available to the public as well: <ul style="list-style-type: none">• Dental extractions twice per month• Assistance with finding grants for dental/medical services (e.g. dentures)• Chiropractic services• Optical processing• Hearing screenings/hearing aids• Limited medical screening for simple acute care.		
Mission Statement:	"The Denver Rescue Mission's chief goal is to meet people at their physical and spiritual points of need. We provide food, shelter and clothing, along with practical programs of education, Christian teaching and work discipline with the aim of returning the poor, needy and homeless to society as self-sufficient, productive citizens."		
Additional Programs and/or Services:	<ul style="list-style-type: none">• Eyeglasses, optical processing• Assistance for patients seeking grants for services (such as dentures)• Chiropractic services		

Doctors Care

Address: 191 E. Orchard Road, **Contact Person:** Bebe Kleinman
Suite 120 NE
Littleton, CO 80121

Founded: 1985 **Title:** Executive Director

Hours: M-F 9:00-5:00 **Phone:** 303.730.1313
After-hours emergency
calls and answering

Fax: 303.730.2090 **E-mail:** bkleinman@drscare.org

Service Area: Douglas and Elbert Counties, Arapahoe County west of Parker Road.

Description: Doctors Care serves low-income and medically underserved individuals in Arapahoe (up to Parker Road), Douglas and Elbert Counties as well as Medicaid or Colorado Access patients from any locale. It is comprised both of a freestanding clinic where patients under age 30 may receive primary care from volunteer physicians and of a network of 400+ volunteer primary care (75) and specialty doctors (325+) to whose individual practices patients are referred. Patients directed to the Doctors Care program may choose to be screened for Medicaid eligibility (administered by an eligibility technician), to apply for the Doctors Care referral plan or to pay in full (though the cost of care is subsidized by Doctors Care) for sick or well visits without signing up for any program.

Type of Facility: One fixed-location freestanding pediatric clinic and a "virtual clinic," a referral service involving a large number of volunteer doctors, where Doctors Care program patients are seen in private doctors' offices.

Target Population: To qualify for the Doctors Care sliding-fee scale, patients must have no private or Medicaid/Medicare insurance, be low-income (<300% FPL) and few assets. Patients at the fixed-location pediatric clinic may have Medicaid, CHP+, Colorado Access, or be uninsured.

Mission Statement: "To provide access to affordable health care, through a coalition of health care providers, to the medically underserved in South Metro Denver."

Fort Collins Family Medicine Center

Address: 1025 Pennock Place
Fort Collins, CO 80524

Contact Person: Mark Schifferns

Founded: 1978

Title: Program Administrator

Hours: M-F 8:30-5:00
On-call 24/7

Phone: 970.495.8819

Fax: 970.495.8891

E-mail: mas9@pvhs.org

Service Area: Primarily Larimer County. Some patients from Weld and more eastern counties, also Wyoming, Nebraska and Boulder County.

Description: Fort Collins Family Medicine Center is a 6-6-6 family medicine residency program associated with Poudre Valley Hospital.

Type of Facility: Separate clinic facility in addition to facilities at Poudre Valley Hospital.

Target Population: General population of medically indigent in Fort Collins. Predominantly Medicaid, medically indigent, self-pay, underinsured and uninsured patients.

Mission Statement: No specific mission statement given.

Additional Programs and/or Services:

- Prenatal program for indigent/underserved mothers/babies
- Counseling and wellness services
- Social work
- Financial counseling (for enrollment in CHP+ and other programs)
- Psychiatry through the Northern Larimer Health District
- Nutrition services
- Pharmaceutical consultations
- Prescription assistance in association with the Health District

Inner City Health Center

Address: 3405 Downing Street
Denver, CO 80205

Contact Kraig Burleson

Person:

Founded: 1983

Title: Executive Director

Hours: M-F 8:00-5:00
Sat. 9:00-12:00 (Pediatric only,
only during school year)

Phone: 303.291.3730

Fax: 303.296.3484

E-mail: kraig@innercityhealth.com

Service Area: Primarily (60%) City of Denver, Denver County and metro area. Many patients from Five Points and Commerce City, some from Arapahoe and Jefferson counties.

Description: Inner City Health Center (ICHC) serves low-income, medically indigent and uninsured patients from all over the Denver Metro Area. ICHC relies on both volunteer and on-staff physicians to meet its patients' needs, especially serving patients from Five Points and Commerce City.

Type of Facility: Free-standing, fixed location clinic.

Target Population: Low-income, uninsured and medically underserved individuals and families. ICHC treats many diabetic patients.

Mission Statement: "Inner City Health Center is a private, nonprofit, volunteer-based health care facility committed to improve the health of low-income and medically uninsured families. Our primary motivation is to express our love for Jesus Christ, our love for people, and our deep concern for their physical, emotional and spiritual well being.
Within a Christian atmosphere of respect, caring and valuing of relationships, Inner City Health Center will:

- Provide the highest quality health care for the whole person;
- Provide opportunities for job training and employment for residents of the neighborhoods we serve; and
- Act as a bridge for creating opportunities between the suburbs and the inner city for creating relationships across cultural, racial, socio-economic and spiritual barriers. "

Kaiser Permanente Connections

Address: 10350 E. Dakota Avenue,
Denver, CO 80231

Contact Person: Nancy Sonnenfeld

Founded: 1990

Title: Program Coordinator

Hours: Depends on the facility
that is patient's medical
home, 24/7 answering
service

Phone: 303.344.7342

Fax: 303.344.7772

E-mail: nancy.strauss@KP.org

Service Area: Denver and Boulder counties, with occasional patients from outside these areas.

Description: Kaiser Permanente (KP) Connections is a program that seeks to provide access to Kaiser insurance and to its network of physicians for a number of low-income, uninsured patients. The program does not operate in a separate facility; rather, patients are seen in Kaiser facilities as regular members subsidize the care.

Type of Facility: Not a discreet facility. KP Connections patients have access to Kaiser Permanente facilities.

Target Population: Low-income, uninsured persons; one-third reserved for current Kaiser members who are at risk of losing access to Kaiser and who may not qualify for other programs, e.g., Medicaid. Patients are generally drawn from community partners programs such as transitional housing programs, first-time homeowners associations, etc.

Mission Statement: The Connections program does not have its own mission statement, but its mission is to provide affordable access to health care. Kaiser's mission statement is effectively: "Improving the health of our communities."

Additional Programs and/or Services: Patients have access to any applicable programs run by Kaiser Permanente

Marillac Clinic

Address: 2333 North 6th
Grand Junction, CO 81501

Contact Steve Hurd

Person:

Founded: 1988

Title: Executive Director

Hours: M-F 8:00-5:00
Afternoons are
unscheduled/open access

Phone: 970.243.7803

Fax: 970.255.1711

E-mail: Steve.hurd@stmarygj.org

Service Area: Mesa County exclusively. Most patients are from 81501 zipcode, second largest source is 81504 zipcode.

Description: Marillac Clinic is a freestanding, nonprofit clinic sponsored by the Sisters of Charity of Leavenworth. The clinic operates on a coordinated/integrated health care model, providing primary health care and mental health care services out of the same facility. The clinic also provides state-of-the-art dental care.

Type of Facility: Freestanding fixed-location integrated mental health, dental care and primary care facility supported by St. Mary's Hospital. All services are located in the same building on the same floor.

Target Population: Patients must have incomes less than 200% federal poverty level (FPL), must be uninsured, and must have no other form of contract medical care.

Mission Statement: "We will, in the spirit of the Sisters of Charity, reveal God's healing love by improving the health of the individuals and communities we serve, especially those who are poor or vulnerable."

Additional Programs and/or Services:

- Medication assistance program
- Has own medication formulary
- Volunteer vision care

North Colorado Family Medicine

Address: 1600 23rd Avenue,
Greeley, CO 80634

Contact Person: Rhonda Gooding

Founded: 1972

Title: Clinic Manager

Hours: M-F 8:00-5:00

Phone: 970.356.2424

Fax: 970.346.2774

E-mail: Rhonda.gooding@bannerhealth.com

Service Area: Primarily Weld County. Patients mostly come from Greeley, Evans, Ault, Eaton and Milliken; some come from Johnstown, Platteville and Kersey.

Description: North Colorado Family Medicine is a family practice residency program that serves patients both in an inpatient setting and in the program's outpatient clinic. One resident per year is located in Greeley's FQHC (Sunrise Community Health Center), and one resident is located in Wray during his or her second and third years.

Type of Facility: Separate clinic facility associated with Banner Health and the Northern Colorado Medical Center.

Target Population: Anyone. Patients are mostly Medicaid, Medicare and uninsured.

Mission Statement: "To provide quality patient care in a supportive, collaborative environment that celebrates education as a life-long process. To prepare family medicine residents for comprehensive practice in rural and underserved communities."

- Additional Programs and/or Services:**
- Group diabetes clinic
 - Involved with Relay for Life
 - Athletic physical clinic
 - Provides all OB/GYN services for health department's prenatal clinic
 - Provides majority of OB/GYN services for Sunrise FQHC

People's Regional Clinic

Address: 134 6th Street
P.O. Box 93,
Hugo, CO 80821

Contact Person: Karen Kovar

Founded: 1996

Title: Clinic Manager

Hours: M-F 9:00-12:00, 1:00-5:00

Phone: 719.743.2472

Fax: 719.743.2853

E-mail: jnkkovar@earthlink.net

Service Area: Lincoln, Elbert, Kit Carson and Washington counties. Most patients come from Lincoln.

Description: People's Regional Clinic is a small, independent clinic that was founded as an alternative to existing health care options in the area.

Type of Facility: Freestanding fixed-location clinic; one service location

Target Population: Anyone – mostly Medicaid and Medicare

Population:

Mission Statement: No official mission statement, but People's Regional Clinic's mission is "to serve people who need help"

Additional Programs and/or Services: Help in placing patients on assistance programs run by pharmaceutical companies

Rocky Mountain Youth Pediatrics

Address: 1601 East 19th Avenue, #6300,
Denver, CO 80218

Contact Carole Saylor

Person:

Founded: 1978

Title: Operations Manager

Hours: M-F 8:30-5:00

Phone: 303.869.2179

On-call 24/7

Fax: 303.869.1906

E-mail: carolesay@aol.com

Service Area: Primarily Denver Metro Area. Small number of patients from as far as Fort Collins, Fairplay, Green Mountain Falls, Colorado Springs; some from Aurora as well.

Description: Rocky Mountain Youth Pediatrics (RMYP)/Rocky Mountain Youth Clinics is a nonprofit organization that operates three freestanding pediatric clinics in Denver, Thornton and Aurora. In addition, RMYP runs a clothing bank, food bank, literacy project and many other programs, including health education, assistance with enrollment to Medicaid/CHP+ and two mobile units. RMYP also provides services to other clinics.

Type of Facility: Three freestanding fixed-location clinics; two mobile units.

Target Population: Anyone from age 0 to 21. Focuses only on children and adolescents with inadequate or no medical insurance.

Mission Statement: (From annual report):

"The Rocky Mountain Youth Clinics is a network of physicians, nurses and other health care professionals with one shared goal – to provide care to children and adolescents in need.

This nonprofit organization is dedicated to caring for the youth of Colorado, regardless of their insurance status or family's ability to pay...."

Additional Programs and/or Services:

- Clothing bank
- Food bank
- Literacy project
- Health education
- Assistance with Medicaid/CHP+ enrollment
- Medical services to group homes and schools
- Social services

Saint Anthony Family Medicine

Address: 4231 W. 16th Avenue
Denver, CO 80204

Contact Person: Beth Elland

Founded: 1970

Title: Director of Community Partnerships

Hours: M-F 8:30-10:30, 2:30-4:30

Phone: 303.629.4049

Fax: 303.595.6656

E-mail: Bethelland2@centura.org

Service Area: Primarily Denver County; also Adams County, some from Jefferson and Westminster counties.

Description: Saint Anthony Family Medicine is a community-based family medicine residency program with two locations for outpatient care.

Type of Facility: Two clinical facilities associated with Saint Anthony's Hospital.

Target Population: General population of the areas in which each service location is situated. A high number of uninsured, medically indigent patients in addition to Medicaid and Medicare.

Mission Statement: "We extend the healing ministry of Christ by caring for those who are ill and by nurturing the health of the people in our communities. "

Additional Programs and/or Services: Some specialist referrals

Saint Joseph Family Practice Center

Address: 2005 Franklin Street,
Midtown 2, Suite 200,
Denver, CO 80205

Contact Person: Dyna Kay

Founded: 1985

Title: Manager

Hours: M-F 8:00-5:00

Phone: 303.318.2005

Fax: 303.318.2040

E-mail: Kayd@exempla.org

Service Area: Largely Denver and Adams Counties, also Jefferson County and Evergreen. Generally serves the Denver and front range area.

Description: Saint Joseph Family Practice Center is a family medicine residency program that is part of the Exempla/St. Joseph system. In addition to training future family practice physicians, one of its unwritten missions is to strive never to turn away any patient for lack of ability to pay.

Type of Facility: Separate clinic facility associated with/connected to Saint Joseph's Hospital

Target Anyone

Population:

Mission "To foster health and healing for the community we serve"

Statement:

Additional Programs and/or Services:

- Diabetes collaborative involving pharmacy and family practice residents
- Database tracking diabetic patients to ensure continuity of care

Summit Community Care Clinic

Address: Summit County Road
1005,
Frisco, CO 80443

Contact Person: Deb Crook

Founded: 1996

Title: Director of Public Health
Nursing

Hours: M 1:00-4:00
WF: 9:00-3:00+

Phone: 970.668.4181 (direct)

Fax: 970.668.4115

E-mail: debbiec@co.summit.co.us

Service Area: Primarily Summit county. A small number of patients also come from neighboring counties.

Description: The Summit Community Care Clinic (SCCC) is a volunteer-based clinic housed in Summit County's Public Health Nursing office. SCCC provides care to the un- and underinsured working poor residents of Summit County and neighboring areas. The clinic's vision currently is to become a freestanding 501(c) 3 nonprofit with a sustainable business model.

Type of Facility Fixed-location clinic; one service location

Target Population The working poor; patients must live or work in Summit county.

Mission Statement "To provide low-income and underinsured people living or working in Summit County with primary and preventive health care at a cost they can afford."

Additional Programs and/or Services

- Outreach program
- Eligibility assistance for Medicaid, CHP+ and other community programs
- Coded "Care Card" that describes what patients are eligible for – Summit Community Care takes codes 1-4, local doctors take 5-7

Appendix B: Data Sheets

SERVICES DIRECTLY AND INDIRECTLY PROVIDED BY CLINICNET CLINICS

	Doctors Care	Inner City Health Center	Adventist Community Services	Aurora Nurse Midwives	Community Health Services	Denver Rescue Mission (for residents only)	Estes Street Community Care	High Street Primary Care Ctr.	Kaiser Permanente Connections	La Clinica Tepeyac	Marillac Clinic	People's Regional Clinic	Rocky Mountain Youth Pediatrics	SET of Colorado Springs	St Thomas Moore Healthy Community Initiative	Summit Community Care Clinic	Fort Collins Family Medicine Center*	North Colorado Family Medicine*	Southern Colorado Family Medicine*	St Anthony Family Medicine*	St. Joseph Family Practice Center*	Univ. of Colorado Family Residency at Rose*
PRIMARY CARE																						
General Primary Med. Care	A/C	A		B	A	A			x	A	A	A	A			A	A	A		A	A	
Diagnostic lab (technical)		C		C	N	C			x	A	C	C	A			C	A	A		B/C	B	
Diagnostic x-ray (technical)		C		C	C	C			x	B	C	C	C			B	A	A		C	B	
Diagnostic tests/screenings	A/C	A		C	A	C			x	B	C	C	C			A/B	A	A		B/C	B	
Emergency medical services	A/C	C		A	C	C			x	C	A/C	C	C			C	C	A		C	B	
Urgent medical care	A/C	C		A	C	C			x	C	A	A	A			?	A	A		A	A	
24-hour coverage	A/C	A		A	A	C			x	C	C	C	A			C	A	A		A	A	
Family planning	A/C	A		A	A	C			x	C	C	A	A			A	A	A		A	B	
HIV testing/counseling	A/C	C		A	A	C			x	A	C	C	C			A	A	A		A/C	A	
Testing for blood lead levels	C	A		C	A	C			x	A	C	C	A			?	A	A		A	B	
Immunizations	A	A		C	A	C			x	A	A/C	C	A			A	A	A		A	A	
Following of hospital patients	C	A		A	A	C			x	B	A	A	A			N	A	A		A	A	
OB-GYN																						
Gynecological care	C	A		A	C	C			x	N	A	A	A			A/C	A	A		A	A	
Prenatal care	C	A		A	C	C			x	N	B	C	N			C	A	A		A	A	
Antepartum fetal assessment	C	A		A	C	C			x	N	B	C	N			C	A	A		A	A	
Ultrasound	C	A		A	C	C			x	N	C	C	C			C	A	A		A	A	

Appendix B: Data Sheets

	Doctors Care	Inner City Health Center	Adventist Community Services	Aurora Nurse Midwives	Community Health Services	Denver Rescue Mission (for residents only)	Estes Street Community Care	High Street Primary Care Ctr.	Kaiser Permanente Connections	La Clinica Tepeyac	Marillac Clinic	People's Regional Clinic	Rocky Mountain Youth Pediatrics	SET of Colorado Springs	St Thomas Moore Healthy Community Initiative	Summit Community Care Clinic	Fort Collins Family Medicine Center*	North Colorado Family Medicine*	Southern Colorado Family Medicine*	St Anthony Family Medicine*	St. Joseph Family Practice Center*	Univ. of Colorado Family Residency at Rose*
Genetic counseling/testing	C	C		A	C	C			x	N	C	C	C			C	A	C		A/C	C	
Amniocentesis	C	C		C	C	C			x	N	C	C	N			C	?	C		C	C	
Labor/delivery professional care	C	C		A	C	C			x	N	C	C	N			C	A	A		A	A	
Postpartum care	C	A		A	C	C			x	N	B	C	N			A/C	A	A		A	A	
SPECIALTY MEDICAL CARE																						
Directly observed TB therapy	C	C		C	C	C			x	N	C	C	N			C	C	C		C	C	
Respite care	C	C		C	C	A			x	N	C	C	N			N	C	C		C	C	
Other	-	C		C	C	-			x	N	-	-	-			-	-	-		-	-	
DENTAL CARE																						
Preventive	C	A		C	C	A			x	N	A	C	A			C	C	C		C	N	
Resorative	C	A		C	C	A			x	N	A	C	C			C	C	C		C	N	
Emergency	C	A		C	C	A			x	N	A	C	C			C	C	C		C	N	
Rehabilitative	C	A		C	C	A			x	N	A	C	C			C	C	C		C	N	
MENTAL CARE																						
Mental health treatment/counseling	A/C	C		C	A	A			x	C	A	C	C			A/C	A	A		A/C	C	
Developmental screening	A	C		C	C	A			x	C	C	C	A			C	A	A		A/C	A	
24-hour crisis intervention/counseling	C	C		C	C	A			x	C	C	C	C			C	C	A		N	C	

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	Doctors Care	Inner City Health Center	Adventist Community Services	Aurora Nurse Midwives	Community Health Services	Denver Rescue Mission (for residents only)	Estes Street Community Care	High Street Primary Care Ctr.	Kaiser Permanente Connections	La Clinica Tepeyac	Marillac Clinic	People's Regional Clinic	Rocky Mountain Youth Pediatrics	SET of Colorado Springs	St Thomas Moore Healthy Community Initiative	Summitt Community Care Clinic	Fort Collins Family Medicine Center*	North Colorado Family Medicine*	Southern Colorado Family Medicine*	St Anthony Family Medicine*	St. Joseph Family Practice Center*	Univ. of Colorado Family Residency at Rose*
Substance abuse treatment/ counseling	C	C		C	C	A			x	C	A/C	C	C			C	A	A		A/C	C	
Other substance abuse services	C	C		C	C	A			x	C	C	-	C			C	C	N		N	C	
Comprehensive MH/SA screening	A/C	C		C	C	A			x	C	A	C	C			C	A	A		A/C	C	
Other	-	A		C	A	-			x	-	-	-	-			-	-	-		-	-	
OTHER PROFESSIONAL SERVICES																						
Hearing screening	A	A		C	A	C			x	C	C	A	C			C	A	A		A	A	
Nutrition services (other than WIC)	A/C	A		C	C	C			x	C	C	C	C			C	A	C		A	C	
Occupational/ vocational therapy	C	C		C	C	C			x	C	C	C	C			?	C	C		C	C	
Physical therapy	C	C		C	C	C			x	C	A/C	C	C			A/C	C	C		C	C	
Pharmacy - licensed/staffed by RP	AB C	C		C	C	C			x	C	A/C	C	B			C	C	C		C	C	
Pharmacy - provider dispensing	AB C	C		C	A	C*			x	C	A	A	N			A	A*	C		C	C	
Vision screening	A	A		C	A	A			x	C	A/C	C	A			C	A	A		A	A	
Podiatry	C	C		C	C	C			x	C	A/C	C	C			C	C	C		C	C	
Optometry	C	C		C	C	C			x	C	C	C	C			C	C	C		C	C	
ENABLING SERVICES																						
Case management	A	A		A	A	A			x	A	A	C	A			?	C	C		A	A	
Child care (during visit)	N	N		C	C	C			x	C	C	C	N			N	C	N		N	N	

Appendix B: Data Sheets

	Doctors Care	Inner City Health Center	Adventist Community Services	Aurora Nurse Midwives	Community Health Services	Denver Rescue Mission (for residents only)	Estes Street Community Care	High Street Primary Care Ctr.	Kaiser Permanente Connections	La Clinica Tepeyac	Marillac Clinic	People's Regional Clinic	Rocky Mountain Youth Pediatrics	SET of Colorado Springs	St Thomas Moore Healthy Community Initiative	Summit Community Care Clinic	Fort Collins Family Medicine Center*	North Colorado Family Medicine*	Southern Colorado Family Medicine*	St Anthony Family Medicine*	St. Joseph Family Practice Center*	Univ. of Colorado Family Residency at Rose*
Discharge planning	C	N		A	C	C			x	C	A	C	N			N	C	B		N	N	
Eligibility assistance	A	A		C	A	A			x	C	A	A	A			A	A	A		A	A	
Environmental health risk reduction	A/C	N		C	A	A			x	A	A	C	N			N	A	A		A	N	
Health education	A	A		A	A	A			x	A	A	A	A			C	A	A		A	A	
Interpretation/translation	A	A		A	A	A			x	A	A	A	B			?	A	A		A	A	
Nursing home/assisted-living placement	C	C		C	N	A			x	N	C	A	N			C	A	*		A	N	
Outreach	C	A		A	A	A			x	A	A	C	N			A	C	N		A	N	
Transport	C	C		C	C	C			x	A	C	A	C			C	C	N		B/C	N	
Out-stationed eligibility workers	N	C		C	C	C			x	A	C	N	N			N	C	N		N	N	
Home visiting	N	N		C	C	C			x	A	C	C	N			C	A	A		A	A	
Parenting education	A/C	N		A	A	A*			x	N	C	A	A			C	A	C		A	A	
Specialty education program	A	N		A	C	A			x	A	A	C	A			C	A	C		?	N	
Other	A	-		C	-	-			x	-	-	-	-			-	-	-		-	-	

Key:

A = Provided by clinic

B = Referral, clinic pays

C = Referral, clinic does not pay

N = Not provided or referred / not addressed

X = Not applicable (KP Connections only)

? = No response

- = Nothing specified for "other"

Appendix B: Data Sheets

PATIENT DEMOGRAPHIC DATA AVAILABLE AT CLINICNET CLINICS

Clinic Name	Age	Gender	Race/ Ethnicity	# Best Served in Non-English	Whether Homeless	Work Status	Patient Income
Doctors Care	3	3	3	3	2	2	Y
Inner City Health Center	2	3	2	0	2	2	Y
Adventist Community Services							
Aurora Nurse Midwives	3	3	3	3	3	3	Y
Community Health Services	3	3	2	0	0	0	Y
Denver Rescue Mission	x	x	x	x	x	x	x
Estes Street Community Care							
High Street Primary Care Ctr.							
Kaiser Permanente Connections	3	3	0	1	0	0	Y
La Clinica Tepeyac	3	3	1	1	0	0	A*
Marillac Clinic	3	3	3	1	1	3	Y
People's Regional Clinic	3	3	0	0	0	0	A
Rocky Mountain Youth Pediatrics	3	3	1	0	2	0	Y, A
SET of Colorado Springs							
St Thomas Moore Healthy Community Initiative							
Summit Community Care Clinic	3	3	3	3	0	3	Y
Fort Collins Family Medicine Center*	3	3	2	1	0	0	Y
North Colorado Family Medicine*	3	3	3	1	0	0	N
Southern Colorado Family Medicine*							
St Anthony Family Medicine*	3	3	0	1	0	0	Y
St. Joseph Family Practice Center*	3	3	0	0	3	0	V
Univ. of Colorado Family Residency at Rose*							

Key:

0 = No data at all
 1 = No formal collection, but rough estimate available
 2 = Collected, but only from some patients or extrapolated
 3 = Collected routinely on all patients
 * Family Practice Residency clinic

For patient income:

N = Not tracked
 A = Personal attestation
 Y = Documented proof
 V = Voluntary only

Appendix B: Data Sheets

SOFTWARE AND IT INFRASTRUCTURE AT CLINICNET CLINICS

	Fax	Copier	Computer(s)	Operating System	Internet	Connection Type	Clinic Email Address	Email Addresses For	LAN in Office	Clinic Website	Practice Mgmt. Software	Billing/Claims Software	Accounting Software	Office Management Software (OMS)	OMS Clinic-wide/integrated	OMS Integrates Multiple Locations	EMR/EHR	Other Patient or Encounter Software	Input to CIIS	Staff Computer Literacy	Staff for Software	Technical Support	Tech Support: Contract, Volunteer, In-house	
Doctors Care	Y	Y	Y	Windows XP	Y	DSL	Y	Y	Y	Y	Med Assist (2004)	Med Assist	Quick Books Pro	Outlook	Y	N/A	N	Doctors Care Database	Y	Y	Y	Y	Contracted	
Inner City Health Center	Y	Y	Y	Windows XP 2003 & Older Versions	Y	Broad band	Y	Y	Y	Y	Medical Manager and Easy Dental	WebMD	Shelby 5.4	Outlook 2003, MS Office Suite 2003	N	N	N	-	Y	Y	Y	Y	Volunteer and Contracted	
Adventist Community Services																								
Aurora Nurse Midwives	Y	Y	Y	IDX, Windows 2000	Y	T-2	Y	Y	Y	Y	IDX	IDX	N	Windows 2000	Y	N/A	N	Hospital Information System	N	Y	Y	Y	In-house	
Community Health Services	Y	Y	Y	Windows XP Professional	Y	?	N	Y	Y	N	Centricity 2004	Centricity 2004	Peachtree 2005	Centricity 2004	Y	Y	N	-	N	Y	Y	Y	In-house	
Denver Rescue Mission	Y	Y	Y	?	Y	?	Y	Y	N	N	Custom SQL DB	N/A	Great Plains 8.0	Outlook XP	Y	N/A	N	Excel spreadsheet	N	Y	Y	Y	In-house	
High Street Primary Care Ctr.																								
Kaiser Permanente Connections	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
La Clinica Tepeyac	Y	Y	Y	?	Y	DSL	Y	Y	Y	Y	Y	N	Y	Y	Y	N	?	Eclipse	N	Y	Y	Y	?	
Marillac Clinic	Y	Y	Y	Windows 2000 Professional	Y	?	Y	Y	Y	?	Medi-tech version 3.24b	Medi-tech version 3.24b	Quick Books 2002	Outlook 2002	Y	N/A	N	Various and Excel spreadsheets	N	Y	Y	Y	In-house	

Appendix B: Data Sheets

	Fax	Copier	Computer(s)	Operating System	Internet	Connection Type	Clinic Email Address	Email Addresses For	LAN in Office	Clinic Website	Practice Mgmt. Software	Billing/Claims Software	Accounting Software	Office Management Software (OMS)	OMS Clinic-wide/integrated	OMS Integrates Multiple Locations	EMR/EHR	Other Patient or Encounter Software	Input to CIIIS	Staff Computer Literacy	Staff for Software	Technical Support	Tech Support: Contract, Volunteer, In-house
People's Regional Clinic	Y	Y	Y	Windows	N	N	N	N	N	N	N	Y-O	Quicken Home & Business 2005	N	N/A	N/A	N	-	N	Y	Y	Y	Volunteer
Rocky Mountain Youth Pediatrics	Y	Y	Y	Windows 98/XP	Y	DSL	Y	Y	N	Y	Y	Y	Quick Books	N	N/A	N/A	N	-	Y	Y	Y	N	N
SET of Colorado Springs																							
St Thomas Moore Healthy Community Initiative																							
Summit Community Care Clinic	Y	Y	Y	Windows 2000	?	?	N	Y	Y	N	Y	N	N	Outlook	?	N/A	N	Public Health/Health Information Common Client Update Program (HICCUP)	?	Y	Y	Y	In-kind from county
Fort Collins Family Medicine Center*	Y	Y	Y	?	Y	DSL	Y	Y	Y	Y	Meditec LSS	Meditec LSS	Meditec LSS	Y	Y	N/A	Y	-	N	Y	Y	Y	In-house
North Colorado Family Medicine*	Y	Y	Y	?	Y	?	N	Y	Y	Y	PCN	PCN	PCN	Outlook	Y	N/A	Y	-	Y	Y	Y	Y	?

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	Fax	Copier	Computer(s) Operating System	Internet Connection Type	Clinic Email Address Email Addresses For LAN in Office	Clinic Website	Practice Mgmt. Software	Billing/Claims Software	Accounting Software	Office Management Software (OMS)	OMS Clinic- wide/integrated	OMS Integrates Multiple Locations	EMR/EHR	Other Patient or Encounter Software	Input to CIIIS	Staff Computer Literacy	Staff for Software	Technical Support	Tech Support: Contract, Volunteer, In-house
Southern Colorado Family Medicine*																			
St Anthony Family Medicine*	Y	Y	Y Windows XP	Y T-1	N Y ?	N	Epic 2005 Hyper space	Epic 2005 Hyper space	N - provided by St Anthony finance	Outlook + Epic	Y	Y	N	-	N	Y	Y	Y	In-house: Centura/St. Anthony
St. Joseph Family Practice Center*	Y	Y	Y ?	? ?	Y Y ?	Y	Meditec LSS	Meditec LSS	Meditec LSS	Outlook	Y	Y	N	LSS	N	Y	Y	Y	In-house
Univ. of Colorado Family Residency at Rose*																			
Swedish Family Medicine Residency*																			



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