Needs Assessment and Strategic Recommendations

The Independence Blue Cross Foundation's
Blue Safety Net Program

December 11, 2014

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Executive Summary

The Independence Blue Cross Foundation's Blue Safety Net Program awards grant funds to more than forty community health center sites providing free or affordable care to medically underserved people in Southeastern Pennsylvania. Since the program was implemented in 2011, over $7 million has been awarded, helping to increase access to health care in medically underserved communities, and providing critical support to the region's health care safety net.

The term "safety-net" first appeared as a concept in public use in 1981; but the term was not clearly defined and its meaning has evolved over the past three decades. The Affordable Care Act (ACA) finally clarified the meaning with use of the term "essential community providers," now defined in federal law: they are entities that serve predominantly low-income, medically underserved individuals. In this way, the ACA provides a simple structural definition for the safety net – it is the collection of essential community providers caring for low-income, medically underserved persons in the community. The Blue Safety Net program is an important source of financial support for the regional network of essential community providers.

The Drexel University School of Public Health (Drexel) conducted a Needs Assessment of the forty-three non-profit, private community health center sites that comprise the Independence Blue Cross (IBC) Foundation's Blue Safety Net Program. The IBC Foundation sought this Needs Assessment to better understand the impact of the program and to reengineer its Blue Safety Net grant program to address the needs of these community health centers following implementation of the Affordable Care Act (ACA), with the complementary aims of improving integration and coordination among health care safety net providers, assuring healthcare quality and efficiency, assisting centers with achieving sustainability, and assuring sound stewardship of Foundation funds. In conducting this assessment, Drexel sought to answer five overarching questions about the Blue Safety Net Program:

1. How is funding currently used, and reimbursement structured, to meet the needs of individual grantee's safety net population?
2. What is the role of Health Information Technology (electronic health records and participation in Health Information Exchange—HIE--

networks) in the operations of the Blue Safety Net grantees and how might that change in the future?

3. What are the implications of the Affordable Care Act and potential Pennsylvania Medicaid expansion on the Blue Safety Net grantees?

4. If IBC made additional funds available, how would grantees use those dollars to enhance the work that they do?

5. What could the IBC Foundation do differently—or additionally—in the administration and organization of the Blue Safety Net program to maximize its investment in the safety net?

Over a five-month period, Drexel reviewed all grantee funding and program reports, held focus groups with grantees, conducted key informant interviews, and administered an electronic survey to all grantees asking detailed program and funding questions. Following multiple levels of data analysis, Drexel developed the following set of recommendations for the IBC Foundation Board and staff to consider for the future direction of the Blue Safety Net Program.

1. Recommendations for funding of *individual grantees* in the Blue Safety Network.

In making funding decisions for individual grantees in the Blue Safety Net Program, the IBC Foundation should:

- Maintain its practice of allowing most grantees to identify and use grant funds at their discretion. This includes funding for general operating expenses and other self-defined needs.

- Designate up to 15% of grant funds to grantee organizations whose health center sites in combination provide care to more than 5,000 people per year for targeted program use.   Among the uses or initiatives which the IBC Foundation should consider targeting for funding are specialized medical program uses (e.g., enhanced integration of behavioral health services with primary medical care), and non-medical, enabling services (e.g., case management, translation services, transportation).

- Award grants for a two-year period. Given all of the changes occurring in the health care and insurance markets, grantees would be better served by planning and budgeting for the use of IBC Foundation funding over a two-year grant period. The biennial grant application should include grantee forecasting about insurance market changes that will,

or might, have a substantive effect on the grantee's finances and operations.

2. Recommendations for funding of *new* IBC-funded initiatives for the Blue Safety Network.

If <u>additional</u> grant funding by the IBC Foundation, beyond the current funding pool for grantees, becomes possible, then the following uses of those additional grant funds should be considered.

- <u>Technology support</u>: Development of Electronic Health Records, participation in the regional Health Information Exchange/network, and other shared training aimed at building grantees engagement with health information exchange networks.
- <u>Workforce development</u>: Training for social workers and medical assistants employed by Blue Safety Net grantees, and continuing education opportunities for clinical staff.
- <u>Organizational development</u>: Shared training opportunities for grantees in areas such as strategic planning, board development, health literacy, care coordination and chronic disease management.
- <u>Expand the Blue Safety Network</u>: The Foundation should identify potential new grantees to fund and support in communities in southeastern Pennsylvania with a large number of low-income and uninsured residents.

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Section I: Introduction

In the spring of 2014, the Independence Blue Cross (IBC) Foundation sought a Needs Assessment of the forty-three non-profit, private community health centers that comprise its Blue Safety Net Program. The Foundation's Blue Safety Net grantees provide health services to residents of medically underserved areas in Southeastern Pennsylvania. The IBC Foundation sought this Needs Assessment to better understand the impact of the program and to reengineer its Blue Safety Net grant program to address the needs of these community health centers following implementation of the Affordable Care Act (ACA), with the complementary aims of improving integration and coordination among health care safety net providers, assuring healthcare quality and efficiency, and assisting centers with achieving sustainability.

The safety net providers in the region have been making impressive efforts and important strides to expand service capacity and build infrastructure to engage in new business models. But the pace of change is challenging, the demands and marketplace expectations are still evolving, and the resources to manage change while continuing to deliver care are never sufficient. The range of health care site types—full-fledged Federally Qualified Health Centers (FQHCs), hospital based sites, small specialty sites and true "free clinics" makes organization and understanding of the safety net challenging. The IBC Foundation is an essential partner in helping safety net health cen1ters to "keep up" and deal with such competing demands. At this exciting time of ACA implementation and rapidly evolving models for health care delivery, the importance and value of IBC Foundation grants is very clear. This initiative aims to assure the most effective grant making possible with the greatest impact on the lives of those in need.

The IBC Foundation asked Drexel to answer several overarching questions about the Blue Safety Net Program:

1. How is funding currently used, and reimbursement structured, to meet the needs of individual grantee's safety net population?
2. What is the role of Health Information Technology (electronic health records and participation in HIE networks) in the operations of the Blue Safety Net grantees and how might that change in the future?

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3. What are the implications of the Affordable Care Act and potential Pennsylvania Medicaid expansion on the Blue Safety Net grantees?
4. If IBC made additional funds available, how would grantees use those dollars to enhance the work that they do?
5. What could the IBC Foundation do differently—or additionally—in the administration and organization of the program to maximize its investment in the safety net?

To answer these questions, the Drexel team conducted the following tasks over a five-month period:

- *Document Review.* Drexel reviewed all aspects of the Blue Safety Net program, including fiscal and program reports from grantees, funding histories, service data, and organizational strategic plans from grantees where available.

- *Focus Groups.* Drexel held 3 focus groups with groups of grantees during the summer of 2014 both to get background information and to inform the electronic survey that was developed.

- *Telephone interviews.* Drexel attempted individual phone interviews with those unable to attend focus groups.

- *Electronic survey.* Drexel developed a 32 question electronic survey given to all grantees asking about funding experience and priorities, health information and technology, future funding and technical assistance opportunities, training and education, health care reform, and the role of the IBC Foundation.

- *Data Analysis.* Following completion of the above, the Drexel team analyzed qualitative and quantitative data to develop recommendations.

Further information on data collection and analysis can be found in Section III.

Section II. Background

Overview of The Safety Net

The term safety net first appeared as a concept in public use on February 18, 1981, when President Reagan used it in a speech to a joint session of Congress – his first speech before Congress at the outset of his first term in office.   More than half the people in the country with incomes below the official poverty line either received no protection from what President Reagan termed the "social safety net" or received no more than a free lunch for their children on school days.[i]

At the same time, the Reagan Administration adopted the phrase "truly needy" to describe those whose benefits had to be protected from cutbacks. As a result, the programs that President Reagan exempted from budget reductions as a "safety net" for the truly needy assisted not only the poor but also many people who were not poor at all, including all elderly Americans and veterans regardless of their means. President Reagan declared: "We will continue to fulfill the obligations that spring from our national conscience. Those who through no fault of their own must depend on the rest of us, the poverty-stricken, the disabled, the elderly, all those with true need, can rest assured that the social safety net of programs they depend on are exempt from any cuts."[ii] In his budget message sent to Congress on March 10, 1981, President Reagan further described them as "the elderly and others who rely on the Government for their very existence," otherwise identified as the "deserving poor." [iii]

The meaning of health or social service safety net has evolved, and become even more diffuse, over the past 30 years. In the Institute of Medicine's (IOM) 2000 study entitled "America's Health Care Safety Net: Intact but Endangered," the IOM defined the safety net with these words:

> *The institutions and professionals that by mandate or mission deliver a large amount of care to uninsured <u>and other vulnerable populations</u> (emphasis added).[iv]*

Despite this apparent clarity of meaning, the IOM committee, which authored the study "observed a general lack of agreement and ongoing debate on which providers constitute the health care safety net." [v] The IOM went on to say that:

> *In most communities, there is a subset of the safety net that the committee describes as "core safety net providers." These providers have two distinguishing characteristics: (1) by*

legal mandate or explicitly adopted mission they maintain an "open door," offering access to services to patients regardless of their ability to pay; and (2) a substantial share of their patient mix is uninsured, Medicaid, and other vulnerable populations. By "substantial" the committee means providers who have a high market share of uncompensated care and high commitment to such care.[vi]

The committee went on to say that "there was a consensus that core safety net providers are those providers in a community whose disappearance would most hurt the poor and uninsured populations." [vii]Yet the IOM had to conclude that "there is no such thing as an official health care safety net"[viii] – just as there was no clear, single understanding of what comprised the Reagan-era "social safety net."

As a recent book, The Safety-Net Health Care System: Health Care at the Margins, by Gunnar Almgren and Taryn Lindhorst, noted, "No universally accepted definition of the safety net exists."[ix] Almgren and Lindhorst begin their book with a metaphorical reference.

Imagine that you are on a tightrope stretched between two poles. The person in front of you wasn't given a balancing pole to assist in the transit and fell part way across the rope. It is now your turn to walk out on the line. You received a pole, but now there are wind gusts. Will there be a net to catch you if you fall? Metaphorically speaking, each person in the United States who is not independently wealthy is walking a tightrope when it comes to his or her health.[x]

Because of poverty, discrimination, and simple bad luck, among other factors, "some people have fallen from the tightrope into the patchwork system of health care that is known as the U.S. health care safety net." [xi] Importantly, Almgren and Lindhorst "take an expansive approach to understanding the health care safety net – it is the system of care that serves a disproportionate share of impoverished *and otherwise vulnerable people*" (emphasis added). Whether to have an expansive view of who should benefit from the safety net – or put the other way, just how broad a population in need should the safety net target to serve – is a key element for decisions about investing in a community safety net system.

The Affordable Care Act finally clarified all this by adding a new understanding with use of the term "essential community providers," defined in federal law. There are several categories of essential community providers but they all share this in common: they are entities that serve predominantly low-income, medically underserved individuals. The Centers for Medicare and

Medicaid Services requires that health insurance plans that participate in the state insurance exchanges or marketplaces – known as Qualified Health Plans -- must include at least 30% of the essential community providers in the plan's provider network. The component parts of the safety net are now best understood as the essential community providers designated by the ACA (described in section 340B of the Public Health Service Act and section 1927(c)(1)(D)(i)(IV) of the Social Security Act). This is an important development. Gone are references to "truly needy," "deserving poor" or even to "vulnerable populations." The ACA provides a simple structural definition – the safety net is the collection of essential community providers caring for low-income, medically underserved persons in the community.

The Safety Net in Southeastern Pennsylvania

The health care safety net in the region is an assortment of many essential community providers, both private and public. In combination, more than 300,000 people in Southeastern Pennsylvania receive their primary health care at one of these essential community providers. The great majority of this care is delivered by the 12 private Federally Qualified Health Center (FQHC) organizations that receive grant funds from the U.S. Health Resources and Services Administration. These organizations are governed by boards whose majority are – and must be -- users of the primary care services provided by the FQHC.

The City of Philadelphia also provides FQHC services at 9 district health centers throughout the City. These FQHCs – both private and public -- serve all people, regardless of income or legal status. They depend on enhanced Medicaid funding, especially, along with the HRSA grants to subsidize care to low-income uninsured users who cannot afford to pay the full cost of care received. The care provided by the FQHCs is complemented by other essential community providers throughout the 5-county region, most of which are supported by the Blue Safety Net program.   These include a variety of nurse-managed centers, free medical health care sites, and dental and vision service sites.

The Philadelphia region has a rich and diverse health care safety net of public and private providers, supported by federal, state, local and private dollars. IBC's role in this safety net— both as a funder and as a programmatic partner—is critically important to maintain and sustain health care access to those in need.

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Section III: Methods

Because of the diversity in types of grantees that are funded through the Blue Safety Net program, Drexel began the project by organizing the grantees into several different clusters based on type of site, number of patients served, and geography. This clustering formed the basis of the different types of data collection and data analysis throughout the project.

Focus Groups

Three focus groups were held with grantees in July and August of 2014. Focus groups were organized based on clusters of patients served, geography and geography to enable ease of attendance and rich discussion.

In order to prepare for the focus groups, the Drexel team reviewed all interim and final grantee reports to compile information for moderators of the focus groups. A table with grantees separated into their clusters was assembled with information about mission, size of award, health care site model, geographical area, and past uses of funding (see Appendices). Existing partners in the community of each cluster were chosen to host the focus groups to provide credibility and a family surrounding to the focus groups. The Health Federation of Philadelphia, The North Penn Community Health Foundation, and the Public Health Management Corporation agreed to serve as hosts to the focus groups because of their public health leadership in the region. All of these organizations have strong relationships both with the Drexel team and to the grantees in the safety net.

Each had a sign in sheet for attendees and was audio recorded to support accurate note taking (see Appendices). At least two members from the Drexel team were present as each meeting as a facilitator and a note taker. The July 9th meeting was organized by The Health Federation of Philadelphia took place at their Philadelphia offices; their cluster was comprised of FQHCs who are current members of the Health Federation. The July 18th focus group was organized by the Public Health Management Corporation and took place at their Philadelphia office; their cluster was comprised of the sites which are a part of their network. The August 6th focus group took place at the North Penn Community Health Foundation in Colmar, Pennsylvania; their cluster was comprised of sites in Montgomery and Bucks County, many of which North Penn engaged with previously in strategic planning around the safety net.

Focus Group 1: July 9, 2014, Health Federation of Philadelphia
ChesPenn Health Services, Steven & Sandra Sheller 11th Street Family Health Services of Drexel University, Delaware Valley Community Health, Health Federation of Philadelphia, Spectrum Health Services, Puentes de Salud
Focus Group 2: July 18, 2014, Public Health Management Corporation
Grantee sites and staff from PHMC
Focus Group 3: August 6, 2014, North Penn Community Health Foundation
North Penn Community Health Foundation, Abington Health, Anne Sullivan Clinic, The Clinic, Gwynedd Mercy, Bucks County Health Improvement Partnership, HealthLink

The discussion in the focus groups was determined by the overall needs assessment objectives, with unstructured time built in for general grantee feedback and discussion. The topics of discussion were: value of current Blue Safety Net funding, new funding areas, support beyond funding, the ACA and safety net status, changes to application process, and specific topics to be addressed and language to be used in the electronic survey.

Phone Interviews

Following the focus groups, all grantees that did not participate in the focus groups were contacted in order to attempt a phone interview. Each grantee was called twice. Grantees who responded were asked questions similar to the discussion group topics. Notes were taken and added to a grantee interview table (see Appendices).

Electronic Survey

Using information compiled from reports, notes from focus groups, interview notes, and notes from meetings with IBC Foundation staff, the Drexel team created a comprehensive e-survey using online software, Qualtrics. The survey had 32 questions and addressed the following issues: funding experience and priorities, health information and technology, future funding and technical assistance opportunities, training and education, health care reform, and role of the IBC Foundation. The survey had multiple choice and open-ended questions. Of the 43 Blue Safety Net grantees, 37 participated in the survey.

Data Analysis

On completion of data collection, all the data for the surveys were downloaded from the Qualtrics database into a Microsoft Excel file. Blank responses were deleted. Some respondents took the survey multiple times, so duplicate responses were merged together. Additionally, because the same person completed the survey for multiple PHMC sites with nearly identical responses, the PHMC responses were merged. All data cleaning was performed in Microsoft Excel, and simple frequencies and percentages were used to compare survey responses.

Response frequencies were also examined for differences across two categorical variables: health care site size and health care site model. Tables 1 and 2 show the distribution of respondents across these categories. Again, simple frequencies and percentages were used to compare survey responses across categories. Due to the small sample size, statistical significance was not assessed.

Table 1. Survey respondents according to size of patient population.

<1,000 users	1,000-2,000 users	2,000-5,000 users	>5,000 users
Project HOME Augustinian Defenders of the Rights of the Poor Ann Silverman Community Health Clinic Youth Service, Inc. Covenant House Pennsylvania North Hills Health Center	Bucks County Health Improvement Partnership Adult Health Clinic HealthLink Medical Center Inc. Ginny Coombs Children's Health Center of VNA-Community Services, Inc. Puentes de Salud Congreso De Latinos Unidos	Einstein Healthcare Network-Community Practice Center The Clinic Health Center of Gwynedd Mercy University Community Volunteers in Medicine St. Mary Medical Center: Mother Bachmann Maternity Center and Children's Health Center Abington Health Children's Clinic PCOM Lancaster	Delaware Valley Community Health Steven & Sandra Sheller 11th Street Family Health Services of Drexel University ChesPenn Health Services Family Practice & Counseling Network Esperanza Health Center Public Health Management Corporation

Table 2. Survey respondents according to grantee type.

Federally Qualified Health Center	Free Clinic	Specialty Care	Other
Congreso De latinos Unidos	Augustinian Defenders of the Rights of the Poor	Kids Smiles	Project HOME
Delaware Valley Community Health	Ann Silverman Community Health Clinic	The Eye Institute @ Salus University	North Hills Health Center
Steven & Sandra Sheller 11th Street Family Health Services of Drexel University	Youth Service, Inc.	Eagles Youth Partnership	Ginny Coombs Children's Health Center of VNA- Community Services, Inc.
ChesPenn Health Services	Covenant House Pennsylvania		Einstein Healthcare Network- Community Practice Center
Family Practice & Counseling Network	Bucks County Health Improvement Partnership Adult Health Clinic		Health Center of Gwynedd Mercy University
Esperanza Health Center	HealthLink Medical Center Inc.		St. Mary Medical Center: Mother Bachmann Maternity Center and Children's Health Center
Public Health Management Corporation	Puentes de Salud		Abington Health Children's Clinic
	The Clinic		PCOM Lancaster
	Community Volunteers in Medicine		

Section IV: Findings

Through document review, focus groups, interviews and the survey, Drexel collected multiple levels of data and information about the current Blue Safety Net Program. Findings related to the five overarching questions of the Needs Assessment are discussed below; detailed data and survey results are available in Appendix A.

1. How is IBC funding currently used, and reimbursement structured, to meet the needs of individual grantee's safety net population?

The majority (62%) of Blue Safety Net grantees used some general operating costs to run their centers, including salary support for clinical, social work and administrative staff, IT support, and capital expenditures. A smaller amount of current funding supports program-specific activities including translation services, medical equipment, and continuing education and training for staff.

Figure 1: How Grantees are Using IBC Foundation Funds
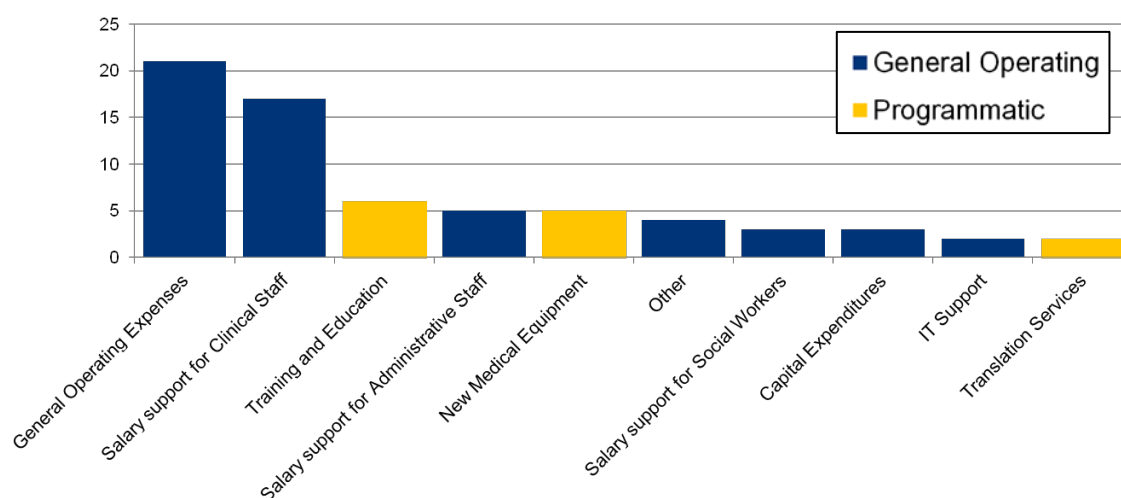
When analyzed according to health care site model, an equal number of specialty care centers reported general operating as reported programmatic uses of funding. In all other models, more centers reported general operating.

Figure 2: How Grantees are Using IBC Foundation Funds by Health Care Site Model
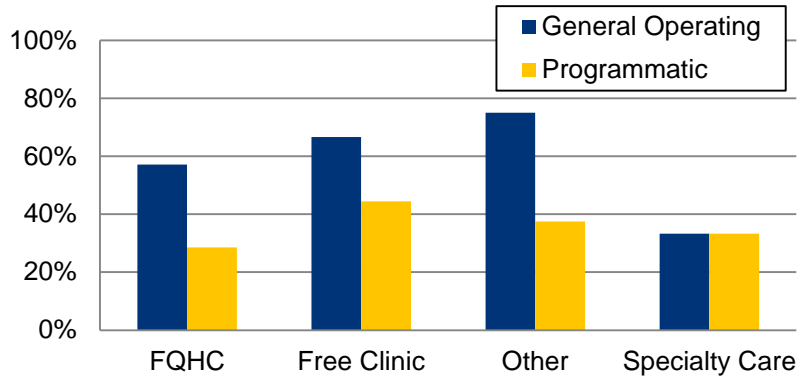
When clustered according to health care site size, the ratio of sites reporting use of funding for general operating vs. programmatic uses was greater for smaller sites (less than 1,000 users and 1-2,000 users) than for larger sites (2-5,000 users and more than 5,000 users)

Figure 3: How Grantees are Using IBC Foundation Funds by Health Care Site Size
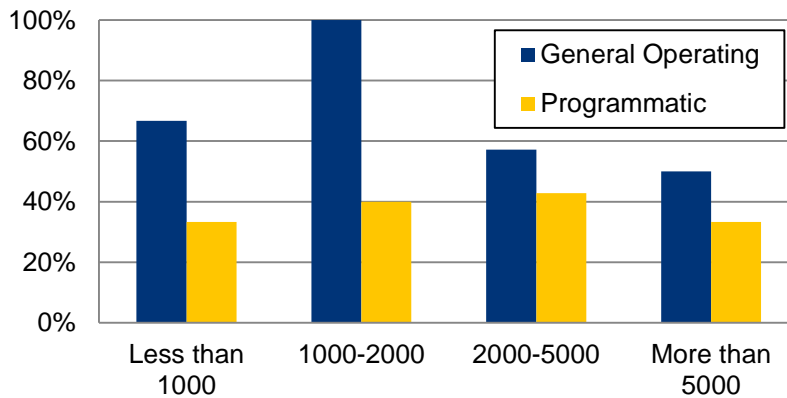
Most grantees require and accept some form of payment for services, including self-pay, IBX private insurance, other commercial insurance and Medicaid. When clustered according to health care site model, we saw that free clinics accept only "free" services, whereas all other models (FQHC, Specialty care, and other) tended to accept all forms of payment (free,

Medicaid, self pay, IBC commercial insurance, and other commercial insurance). FQHCs were least likely to offer free services.

When clustered by size of patient population, small sites (less than 1,000 users) were much more likely to only provide free services. The likelihood of accepting other forms for payment increased with increasing patient load, and the largest sites (more than 5,000 users) were least likely to offer free services.

Figure 4: Types of Payment Accepted by Grantees by Health Care Site Size
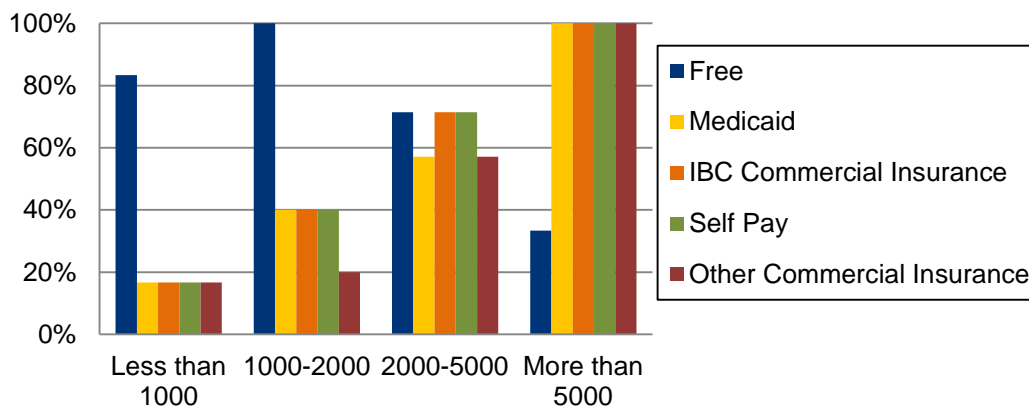
2. What is the role of Health Information Technology (electronic health records and participation in Health Information Exchange networks) in the operations of the Blue Safety Net grantees and how might that change in the future?

Electronic Health Records

The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 established the Medicare and Medicaid Electronic Health Care Record (EHR) Incentive Programs, which provide incentive payments to eligible professionals as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology. These incentive programs have had varying effects on Blue Safety Net grantees, with no effect at all on free clinics that accept neither Medicaid nor Medicare. Overall, there is a range of information technology needs and capacity among grantees, mostly regarding the use of health information technology.

Across all grantees, funding or technical assistance for new systems or implementation would be welcome. In particular grantees were interested in receiving additional financial support for fees associated with membership in a Health Information Exchange. Eighty-three percent (23) of Blue Safety Net grantees use some form of an electronic health record in their centers. Of those, 13% (3) have used IBC funds to support their EHRs. Thirty-seven percent of the total (10) plan to use IBC funds in the future to support their EHRs.

Sites that see fewer patients were less likely to use EHRs. When clustered according to health care site model, 100% of FQHCs, specialty health care sites, and other sites used EHRs, while only 44% of free clinics used EHRs.

Figure 5: Grantee Use of Electronic Health Records (EHRs) by Health Care Site Model
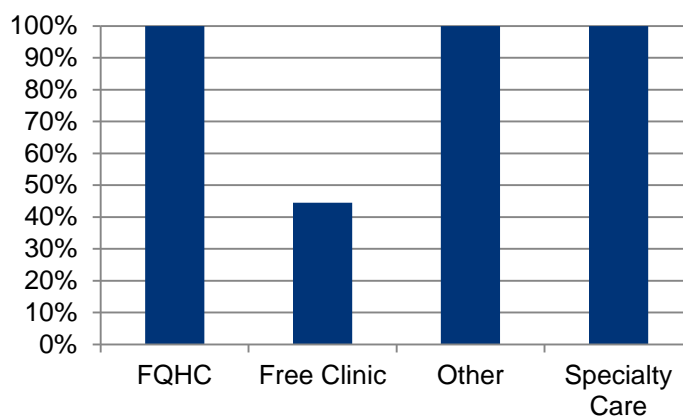
When clustered according to health care site model, FQHCs and free clinics were most likely to intend to use IBC money for EHR support. No specialty care health care sites planned to use the money in this way.

Health care sites with less than 1,000 patients were least likely to intend to use future IBC money for EHR support. Among those with more than 1,000 patients, smaller health care sites were more likely to plan to use IBC money for EHRs.

Figure 7: Grantees' Intentions to Use Future IBC Foundation Funding for EHR Support by Health Care Site Size

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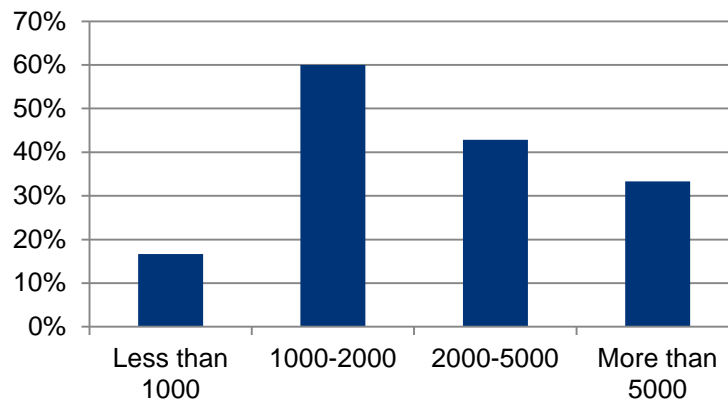
<u>Health Information Exchange (HIE) networks</u>

Electronic health information exchanges (HIEs) allow doctors, nurses, pharmacists, other health care providers and patients to appropriately access and securely share a patient's vital medical information electronically—improving the speed, quality, safety and cost of patient care. There are several HIEs functioning now in the region, most notably the HealthShare of Southeastern PA, which was formed as collaboration between stakeholders in Bucks, Chester, Delaware, Montgomery, and Philadelphia counties.

Of the Blue Safety Net grantees, 30% are part of an HIE. Of those not already part of an HIE, 32% are interested in joining an HIE in the future, and 26% currently have the organizational capacity to join an HIE. Overall, larger health care sites—and particularly FQHCs—were more likely to participate in HIEs.

3. What are the implications of the Affordable Care Act and potential Pennsylvania Medicaid expansion on the Blue Safety Net grantees?

While the first year of implementation of the ACA has begun to have an impact on the general population of the region, it is still too early to truly see the affects of increased or changed coverage on the Blue Safety Net grantees. Grantees are unclear as to how the upcoming Pennsylvania Medicaid expansion will impact them, recognizing that they will likely see changes in their patient load or payor mix but those changes have not yet been seen. As such, it is premature to project what, precisely, those changes will be and how they might impact the need for funding and what funds are used for.

Regardless, however, of what these inevitable changes bring, it is clear that there will continue to be a strong need for a health care safety net for several groups of people: non-citizens now will be ineligible for the exchanges or Medicaid, people waiting for coverage to start, and those who are insured but might not be able to afford deductibles or co-payments. Whatever the future brings, IBC's investment in its safety net is critical to maintain.

4. If IBC made additional funds available, how would grantees use those dollars to enhance the work that they do?

Grantees were overwhelming in their responses of the need for the continued ability to use Blue Safety Net funding for general operating expenses. Grantees stressed that funding for general

operating expenses is valuable and unique and allows grantees to focus on the basics of caring for patients while also allowing for innovation. Larger sites were more likely to plan to use IBC foundation funding differently in the future, likely reflecting a lesser dependence on IBC Foundation funds for general operating expenses and the ability to target dollars for new areas of programming.

The following programmatic areas were identified by grantees as areas they would invest additional dollars in were the IBC Foundation to expand funding of the Blue Safety Net program:

- Counseling and case management
- Training and continuing education
- Capital expenses
- Integration of behavioral health into primary care
- Research and development for new services areas
- New uses of technology and support of existing technology requirements
- Specialty care
- Applying for accreditation

5. What could the IBC Foundation do differently—or additionally—in the administration and organization of the program to maximize its investment in the safety net?

Grantees reported high satisfaction with the overall administration of the Blue Safety Net program and the IBC Foundation's staff clear commitment to the health care safety net. Grantees appreciate the accessibility of IBC Foundation staff, their interest in and knowledge of their programs, and see them as a collaborative partner in providing health care services to populations in need.

On an administrative level, grantees are appreciative that the administrative requirements are not onerous and that grant applications and reporting are "well worth" the dollars they receive. Grantees would welcome a longer funding cycle to better enable longer-term planning and staffing, as well as a clearer identification of funding priorities and decisions between the IBC Foundation and grantees, particularly if those priorities change from year to year.

Finally, grantees appreciate the ability to come together at grantee meetings or conferences and would welcome further opportunities to do so, both for general networking with similar types of

grantees or on specific content areas of interest.

Potential Topics for Future Blue Safety Net Trainings or Conferences	
Healthcare Management Topics	Role of Community Health Workers
	Patient Centered Medical Home Accreditation Process
	Evaluation And Measurement Models
	EMR Implementation
	New Trends in Health Care Delivery
	Mobile Health Delivery
	Best Practices: A Review of Behavioral Health Integration
Policy Topics	Immigration Issues and Laws
	Integration of Evolving Medicaid Expansion in PA
	Affordable Care Act
	Impact Of Diabetes On The Cost Of Health Care
Programmatic Topics	Updates on Medical Disease Entities
	Trauma Informed Practice For Case Managers Working With Teens And Their Families
Sustainability Topics	Opportunities for Collaboration
	Sustainability For Independent Health Care Sites
	Contacting and Cultivating Donors

Section V: Recommendations

1. Recommendations for Funding of *Individual Grantees* in the Blue Safety Network

Discretionary use of grant funds: The information that Drexel collected from both the surveys of Blue Safety Net grantees and three focus groups leads to one clear conclusion. The IBC Foundation should maintain its practice of allowing grantees to identify and use grant funds at their discretion. This includes funding for general operating expenses and other self-defined needs. As noted previously, grantees place great value on funding by the IBC Foundation precisely because of the flexibility of use that the grant program provides to them.

This recommendation is also consistent with the construct of the Blue Safety Net-work.   Blue Safety Net grantees differ markedly in the number of people who rely on them for health care. They differ substantially in the complexity and depth of their administrative structures, and in their reliance on health information technology. They differ in the demographics of the patients they care for, and in the types of communities where they provide this care. Last, they differ in their business model, based on whether or not they participate in public and private health insurance plans. These factors argue for a flexible grant funding model.

This is especially true at this stage of the program. By providing grant funding over the past decade, the IBC Foundation has helped to develop a regional network of health care centers – a health care safety net-work -- of varying size, complexity, and operational models, all linked by one principal characteristic – a shared mission to provide services to persons who cannot afford (or otherwise attain access to) needed health care. Some of these health care centers dearly depend on Blue Safety Net funding to keep operating. All use it to further this common mission. And because it can be used at the discretion of the grantee to advance the common mission of the network, Blue Safety Net funding achieves maximum practical grantmaking utility from a health care delivery network perspective.

Designating some funds for targeted program use by large capacity grantees: It might seem logical that the smallest capacity grantees could benefit from funding targeted to building administrative and IT capability; but that is really not the case. Small health care centers, and especially free health care centers, would likely be harmed by a change in the grantmaking model to target funds for administrative and/or IT capacity

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building. The simple reason is that these things would not necessarily be of greatest utility or priority for these organizations. On the other hand, large capacity grantees – those whose health center sites in combination provide care to more than 5,000 people per year – could be expected to dedicate some IBC Foundation grant funds to specific programmatic uses. We recommend that no more than 15% of grant funding to these organizations be designated for specific uses or initiatives at this time. Among those uses or initiatives which the IBC Foundation should consider targeting for funding, based on information collected in the surveys we received and analyzed, are:

- Specialized medical program uses (e.g., enhanced integration of behavioral health services with primary medical care), and
- Non-medical, enabling services (e.g., case management, translation services, transportation)

Over time, the amount of Blue Safety Net funds going to large capacity grantees that is targeted to specific programs or initiatives might increase, if the initial experience proves beneficial. This would also serve to balance -- at least in a small way -- the Foundation's generalized support for the Blue Safety Network (the discretionary use funding as described above) with a very legitimate expectation that some funds be used for specific purposes that the Foundation deems of high importance. It also makes logical sense in that targeting funding in this manner only to large capacity grantees would assure that the benefits are directed at health care centers serving the largest number of people, thereby achieving maximum utility from the targeting.

Move to a multi-year funding cycle: The health care market is in a period of dynamic change. As noted, it is particularly unclear at this time what effect an expansion of Medicaid coverage for low-income, non-disabled adults in Pennsylvania will have on Blue Safety Net grantees. It is not clear what form the Medicaid expansion will take – either Governor Corbett's Healthy PA initiative, an expansion of Medicaid as envisioned by the Affordable Care Act, or some unknown third-way. What is known is that benefit change letters were sent by the Department of Public Welfare in mid-November to 800,000 adult Medicaid enrollees. These notices identified "options" for coverage that might be available. Sometime in December the newly renamed Pennsylvania Department of Human Services will notify all adult Medicaid enrollees which benefit package they will receive as their Medicaid coverage, effective January 1.   What is not known is what will next occur, after Governor Wolfe has taken

office. This uncertainty is relatively temporary, but the effects of these developments will have financial implications for most of the Blue Safety Net grantees, all to be determined. This will occur within the broader context of uncertainty about national changes in the health care industry and regional changes in the insurance market, in the form of payment reforms, institutional consolidations/mergers, etc. Given all of this change, grantees would be better served by planning and budgeting for the use of IBC Foundation funding over a two-year grant period. The biennial grant application should include grantee forecasting about insurance market changes that will, or might, have a substantive effect on the grantee's finances and operations. Grantees could be expected to update this forecast on an annual, mid-cycle timeframe, thereby assuring that the Foundation has a relatively current understanding of the regional health care/insurance market from the perspective of its network of grantees.

In support of this change, and to assist the Foundation in understanding the changing marketplace and forecasting effects on its network of grantees, the Foundation should consider developing close working partnerships with the Health Federation of Philadelphia (http://www.healthfederation.org), the Pennsylvania Association of Community Health Centers (http://www.pachc.com) and the Free Clinic Association of Pennsylvania (http://www.freeclinicspa.org). The organizations assist and represent the interests of all of the Blue Safety Net grantees, and as such could be useful in informing the Foundation about (1) real-time developments and trends affecting health centers serving low-income, medically underserved persons in the region, and (2) in particular, the impending expansion of the Medicaid program.

2. Recommendations for funding for *new* IBC-funded initiatives in the Blue Safety Network

The previous grantee-specific recommendations presume an overall grant funding pool that will remain relatively unchanged from the current experience. If additional grant funding by the IBC Foundation becomes possible, then the following uses of those additional grant funds should be considered.

Technology support: Additional funding should be targeting to the development of Electronic Health Records, participation in the regional Health Information Exchange/network, and other shared training aimed at building grantees engagement with health information exchange networks. This support will not be purposeful for all Blue Safety

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Net grantees; but it will be very useful for the larger health care centers; and this utility will likely increase with the expansion of the Medicaid program.

Workforce development: Complementing its financial support of training the nursing workforce, the Foundation should use additional grant funds to provide training for social workers and medical assistants employed by Blue Safety Net grantees. The Foundation could also provide funding for continuing education opportunities for clinical staff.

Organizational development: The Foundation should consider providing shared training opportunities to its grantees in areas such as strategic planning, board development, health literacy, care coordination and chronic disease management.

Expand the Blue Safety Network: The Foundation should identify potential new grantees in communities in southeastern Pennsylvania with a large number of low-income and uninsured residents. Irrespective of Medicaid enrollment changes, there will remain a need to provide health care to low-income, medically underserved people in the region. This will include non-citizens, those who temporarily find themselves with no other viable means of attaining access to care (because of loss of employment and other unanticipated events), and those who remain underinsured and simply cannot afford to pay (fully) for care at the point of service. Drexel identified southeastern Pennsylvania areas with rates of people living in poverty exceeding 5.7%. The existing network does not extend to meet the need for affordable health care in all of these places. Additional funding could be used to help address this need, particularly in the counties surrounding Philadelphia. Closer working relationships with the health center associations noted above might be useful in this regard, in helping to identify (or develop) additional service delivery sites.

[i] Rosenbaum, David E., "Reagan's Safety Net Proposal: Who Will Land, Who Will Fall," New York Times, March 17, 1981.
[ii] Ibid.
[iii] Ibid.
[iv] Institute of Medicine Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers. 2000. America's Health Care Safety Net: Intact but Endangered. National Academy Press, Washington, D.C., page 21.
[v] Ibid., 21.
[vi] Ibid., 21-22.
[vii] Ibid., 22.
[viii] Ibid., 22.
[ix] Almgren, Gunnar and Lindhorst, Taryn. 2012. The Safety-Net Health Care System: Health Care at the Margins. Springer Publishing Company, New York, NY, page 22.

[x] Ibid., 1.
[xi] Ibid., 2.

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Glossary

Health Care Site Size – In this needs assessment, health care site size was defined by the number of patients treated in one year. Health care site size was used to cluster the health care sites during data analysis.

Health Care Site Model – In this needs assessment, health care site model was defined by type of care model provided to patients. The health care site model was used to cluster the sites during data analysis.

Free Clinic – In this needs assessment, free clinics were defined under health care site model as the sites that provide care to the community at no cost.

Specialty Health Care Site – In this needs assessment, specialty health care sites were defined under health care site model as the sites that provide only specialty care, such as dentistry and ophthalmology.

Federally Qualified Health Center – As defined by the Health Resources and Services Administration, Federally qualified health centers (FQHCs) include all organizations receiving grants under Section 330 of the Public Health Service Act (PHS). FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.

Other Health Care Sites – In this needs assessment "other health care sites" were defined under health care site model as the sites that did not fit into the other cluster groups, FQHCs, Specialty health care sites, or Free Clinics.

Discretionary Funding – Funding granted to the grantee without specific conditions for its use; funds that the grantee can decide how to spend according to its own needs/goals.

Operational Costs – Funding used by the grantee to contribute towards the general operating costs of running their health care site, including salary support for clinical, social work and administrative staff; general IT support; and capital expenditures.

Programmatic Costs – funding used by the grantee to fund a specific program, excluding general operating costs, such as upgrading an EHR system, bringing in a new translator, or offering a specific training to clinical staff.

Electronic Health Record – An electronic health record; a digital version of a patient's paper chart. The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 established the Medicare and Medicaid EHR Incentive Programs, which provide incentive payments to eligible professionals as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology.

Health Information Exchange – As defined by HealthIT.gov, Electronic health information exchange (HIE) allows doctors, nurses, pharmacists, other health care providers and patients to

appropriately access and securely share a patient's vital medical information electronically—improving the speed, quality, safety and cost of patient care.

Appendices

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Appendix A. Survey Instrument

Blue Safety Net Grantee Needs Assessment

Thank you all for your participation in the focus groups and interviews that took place over the summer. The ideas and opinions from those conversations informed the following needs assessment. Future direction of this grant program may be influenced by the outcomes of this assessment so it will be important for your participation to inform the process. We look forward to reading and analyzing your responses and thank you for giving your time and expertise to this project.   Any responses from this assessment will be held in confidence by the team at the Drexel University School of Public Health. Names and contact information are requested for follow-up questions. All data represented to the IBC Foundation will be de-identified.   The survey should take between 20-40 minutes to complete. If you need to stop during the course of the survey, your responses will not be lost. Your browser will automatically save your answers which you can restart when you continue. If you need to go back, use the back buttons at the bottom instead of your browser buttons. If you have any questions about the survey, please contact Eleanor Lippmann, Program Manager at the Drexel University School of Public Health, elippmann@drexel.edu, 267-359-6022.

Organization and/or site name

Contact person and email address for follow up

Funding Experience/Priorities

In past grant years, how have you used the funding provided by IBC Foundation? Please check all that apply
- ❑ Salary support for Social Workers (1)
- ❑ Salary support for Clinical Staff (2)
- ❑ Salary support for Administrative Staff (3)
- ❑ IT Support (4)
- ❑ Capital Expenditures (5)
- ❑ Training and Education (6)
- ❑ Translation Services (7)
- ❑ New Medical Equipment (8)
- ❑ General Operating Expenses (9)
- ❑ Building Remodel/Renovations (11)
- ❑ Other (10) _____

What types of payment does your organization/clinic accept? Please check all that apply.
- ❑ Free, no payment for services (1)
- ❑ Self Pay (2)
- ❑ Medicaid (3)
- ❑ IBC Commercial Insurance (4)
- ❑ Other Commercial Insurance (5) _____
- ❑ Other types of payment (6) _____

How have you used funding from IBC Foundation to help your patients access specialty care (Radiology, Cardiology, etc)? Please check all that apply.
- ❑ We have not used IBC Funding for specialty care (1)
- ❑ Paid for specialty care services elsewhere (2)
- ❑ Provided specialty care onsite (3)
- ❑ Paid for social workers/case managers to make referrals (4)
- ❑ Other (5) _____

If you used IBC Foundation funding to help your patients access specialty care,what types of services have you funded (directly or indirectly)?
- ❑ Diagnostic Care (e.g. radiology, lab) (1)
- ❑ Behavioral Health Services (2)
- ❑ Physical Therapy (3)
- ❑ Podiatry (4)
- ❑ Dental Services (5)
- ❑ Social Work & Case Management (6)
- ❑ Surgery (7)
- ❑ Dialysis (8)
- ❑ Occupational Therapy (9)
- ❑ Pediatrics (10)
- ❑ Cardiology (11)
- ❑ Other (12) _____

Health Information and Technology

Does your organization use Electronic Health Records (EHRs)?
❍ Yes (1) _____
❍ No (2) _____

Has any part of your EHRs been supported by IBC Foundation funds?
❍ Yes (1) _____
❍ No (2) _____

Do you anticipate using IBC Foundation funding assistance for EHRs in the future? If yes, please specify how.
❍ Yes (1) _____
❍ No (2) _____

There are several health information exchanges in the Philadelphia area that allow electronic sharing of medical record information between and among providers. For example, the HealthShare Exchange is working across to provide primary care providers with timely information on patients who are discharged from the hospital, and the Virtua exchange shares health care data among a number of local primary care and hospital systems including CHOP.

Are you part of a Health Information Exchange (HIE) network? If yes, which one?
❍ Yes (1) _____
❍ No (2) _____

If you are not currently part of a HIE network, would you be interested in joining one?
❍ Yes (1) _____
❍ Maybe (2) _____
❍ I am already a part of a network (3)

Does your organization/clinic have the capacity to join a HIE?
❍ Yes (1) _____
❍ Maybe (2) _____
❍ I am already a part of a network (3)

How do you see IBC Foundation supporting the creation of a HIE network?

Future Funding and Technical Assistance Opportunities

Do you intend to use your funding differently in the upcoming grant year? If yes, how?
❍ Yes (1) _____
❍ No (2) _____

In our focus group meetings, we heard recurring references to the need for financial support from the IBC Foundation related to the following purposes. Please rank the following purposes in order of importance for IBC Foundation support:
_____ Primary care for non-citizens (1)
_____ Primary care for any persons who are uninsured and unable to pay (2)
_____ Behavioral health services (3)
_____ Care Management (4)
_____ Health information technology (any type) (5)
_____ Primary care for persons who experience a gap in, or waiting period for, health insurance coverage (6)

If IBC Foundation designated additional funding for a specific project at your clinic/organization, what project would that be? Please check all topics that apply.
❑ Integration of behavioral health services (1)
❑ Accessing specialty care (2)
❑ Research & Development for new services (Community Needs Assessment, Outcomes Evaluation, etc.) (3)
❑ Applying for accreditation (Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Patient Centered Medical Home (PCMH) Federally Qualified Health Center (FQHC), etc.) (4)
❑ New uses of technology in healthcare (Electronic health records, Health information exchanges, etc) (5)
❑ Organization Development Assistance (strategic planning, board development, health literacy services, etc.) (7)
❑ Other (6) _____

What kind of technical assistance could IBC Foundation provide or fund for your clinic or organization? Please check all that apply.

- ❑ Financial management (1)
- ❑ IT support/training (2)
- ❑ Accreditation assistance (3)
- ❑ Grant Writing (4)
- ❑ Outcome measurement (5)
- ❑ Continuing education (6)
- ❑ Organizational management (7)
- ❑ Sharing best practices (8)
- ❑ Billing systems (9)
- ❑ Brokering purchase of services (Technology, Translation Services, etc.) (10)
- ❑ Sharing funding opportunities (11)
- ❑ Other (12) _____

What non-medical services would your clinic/organization like to offer directly, for which IBC foundation funding would be helpful? Please check all that apply.

- ❑ Translation services (1)
- ❑ Benefits counseling (2)
- ❑ Case management (3)
- ❑ Transportation (4)
- ❑ N/A (5)
- ❑ Other (6) _____

Are there other innovative projects for which IBC Foundation funding would be helpful? If so, please describe below.

Training and Education

In the past, what kind of training/education did you provide to your staff using IBC Foundation funding?

- ❑ We have not used IBC Foundation funds for training/education (1)
- ❑ Evidence-based practices (3)
- ❑ Program planning (4)
- ❑ Policy development (5)
- ❑ Continuous Quality Improvement (6)
- ❑ Health literacy (7)
- ❑ Health communications (8)
- ❑ Interpersonal/Workplace communications (9)
- ❑ Community engagement (10)
- ❑ Ethics (12)
- ❑ Budgeting and financial management (13)
- ❑ Health equity/disparities training (14)
- ❑ Cultural Diversity and Sensitivity Training (15)
- ❑ Grant writing (16)
- ❑ Basic epidemiology and biostatistics (17)
- ❑ Trauma-informed care (18)
- ❑ Safety in the workplace (21)
- ❑ First Aid/CPR (22)
- ❑ Microsoft Office Word (24)
- ❑ Microsoft Excel (25)
- ❑ Diffusing Hostile Situations (29)
- ❑ Understanding research data (30)
- ❑ Other (2) _____

Do you anticipate using IBC Foundation funds for training/education in the future? Please check all that apply.

- ❑ We do not plan on using IBC Foundation funding for training/education (28)
- ❑ Evidence-based practices (4)
- ❑ Program planning (5)
- ❑ Policy development (6)
- ❑ Continuous Quality Improvement (7)
- ❑ Health literacy (8)
- ❑ Health communications (9)
- ❑ Interpersonal/Workplace communications (10)
- ❑ Community engagement (11)
- ❑ Ethics (13)
- ❑ Budgeting and financial management (14)
- ❑ Health equity/disparities training (15)
- ❑ Cultural Diversity and Sensitivity Training (16)
- ❑ Grant writing (17)
- ❑ Basic epidemiology and biostatistics (18)
- ❑ Trauma-informed care (19)
- ❑ Safety in the workplace (22)
- ❑ First Aid/CPR (23)
- ❑ Microsoft Office Word (25)
- ❑ Microsoft Excel (26)
- ❑ Diffusing Hostile Situations (30)
- ❑ Understanding research data (31)
- ❑ Other (29) _____

What types of continuing education does your clinic/organization staff require?

- ❑ Continuing Medical Education (CME) (3)
- ❑ CHECH for Certified Health Education Specialists (4)
- ❑ Continuing Nursing Education (CNE) (5)
- ❑ CEUs for Social workers (6)
- ❑ Other (7) _____

IBC Foundation currently funds a nursing scholarship/education program. What other staff at your clinic/organization could benefit from that type of scholarship/education program? Please select all that apply.

❑ Medical Assistants (1)

❑ Social Workers (2)

❑ Health Educators (3)

❑ Licensed Practical Nurse (4)

❑ Other (5) _____

Health Care Reform

How do you anticipate the ACA will affect your payer mix?

How do you anticipate Medicaid expansion affecting your clinic/organization operations and patient population?

Are there requirements of the ACA that your clinic is having difficulty implementing for which IBC Foundation funding could be helpful?

Is your clinic/organization attempting to become a Patient Centered Medical Home through NCQA accreditation? If yes, how could the IBC Foundation support these efforts?

❍ Yes (1) _____

❍ No (2) _____

Role of IBC Foundation

Beyond funding, what role could IBC Foundation play in improving service integration/coordination at your clinic/organization?

Beyond funding, what role could IBC Foundation play in working towards financial sustainability of your clinic/organization?

In the past, IBC Foundation hosted conferences with a specific purpose/theme. What topics would be of interest to your clinic/organization?

What changes would you recommend making to the application and award process?

Please complete the following statement: "The Blue Safety Net Program is extremely important to public health in the region because...

Please use this text box to write any additional information you would like to share with us as we make recommendations to IBC Foundation about the Blue Safety Net Program. We welcome comments about your experience and remind you that all information shared with IBC Foundation will be completely de-identified.

Thank you very much for your participation.

Appendix B. Survey Results

UNDERSTANDING THE BLUE SAFETY NETWORK

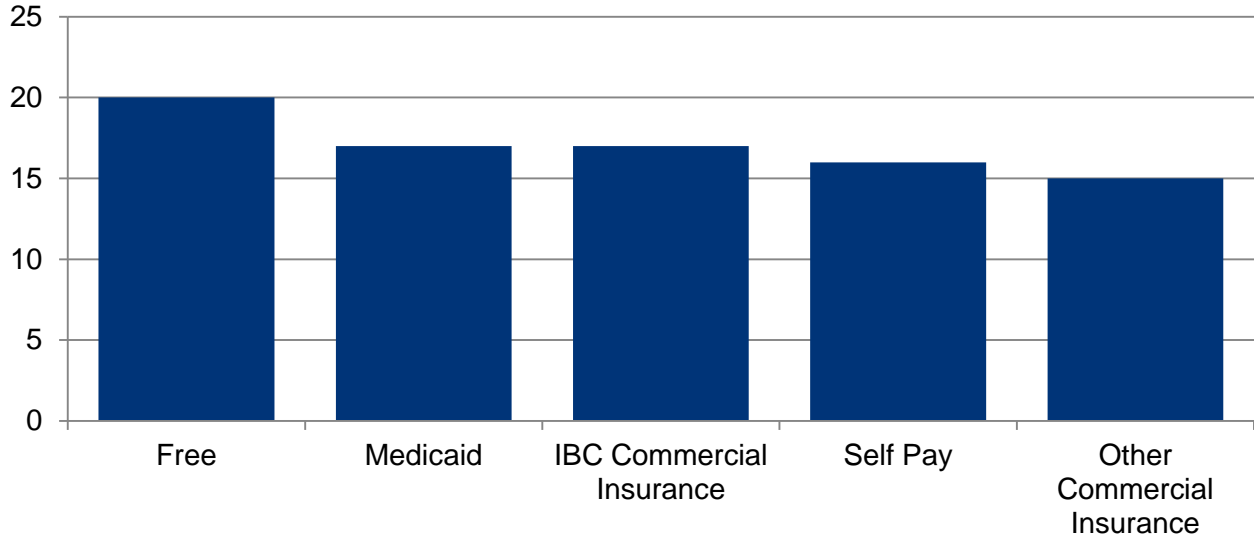Figure 1. Types of Payment Accepted by Grantees

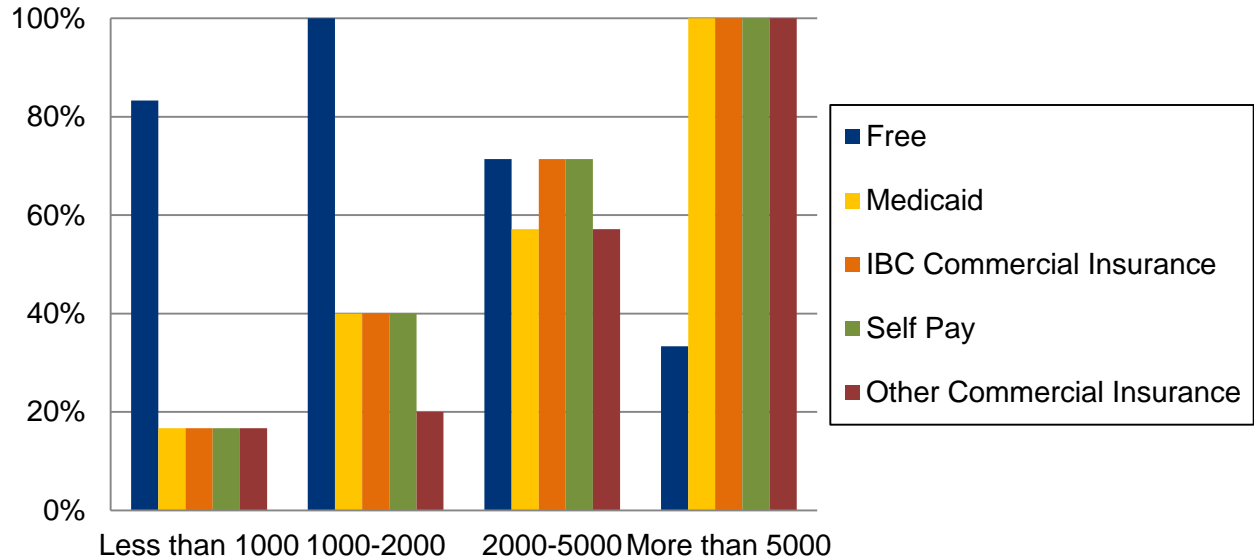Figure 2. Types of Payment Accepted by Grantees by Patient Load

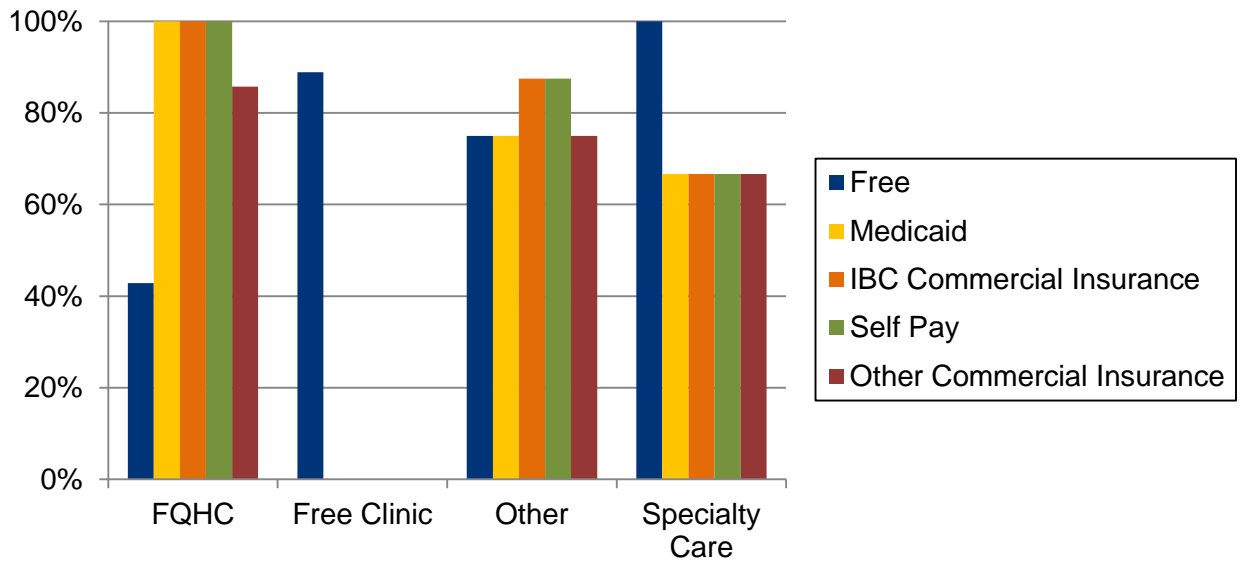Figure 3. Types of Payment Accepted by Grantees by Clinic Model

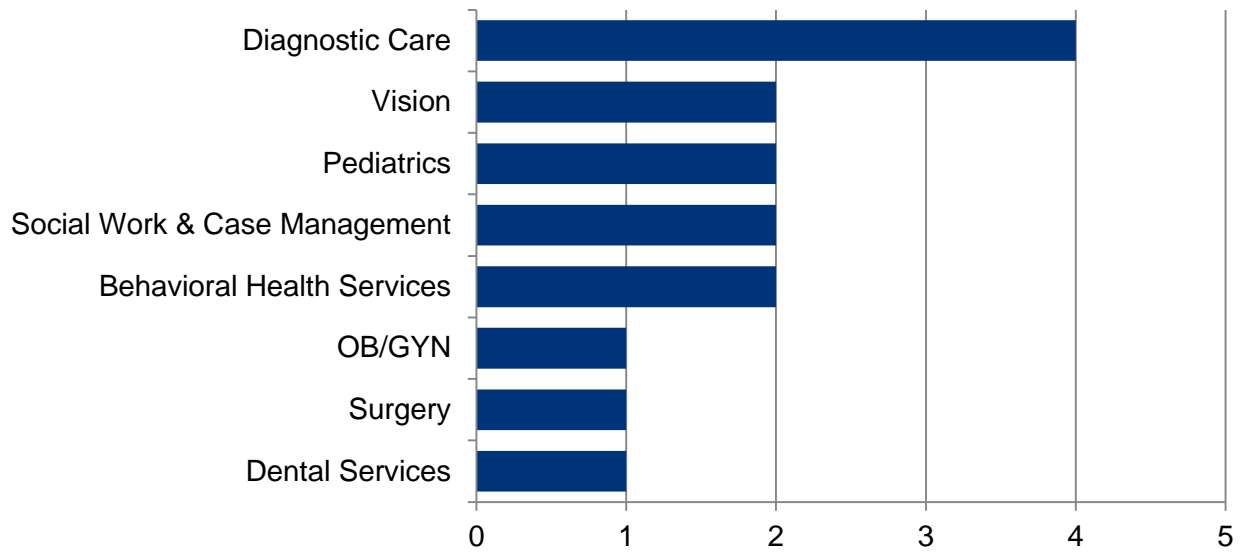

Figure 4. Types of Specialty Care Funded by Grantees

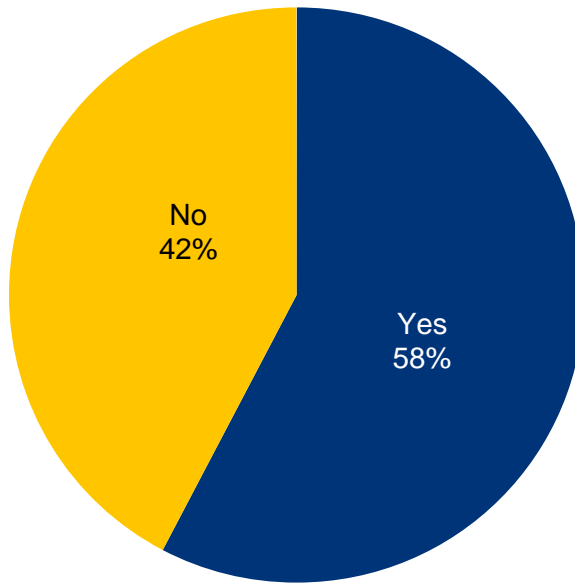Figure 5. Percent of Grantees Endeavoring to Acquire PCMH Accreditation

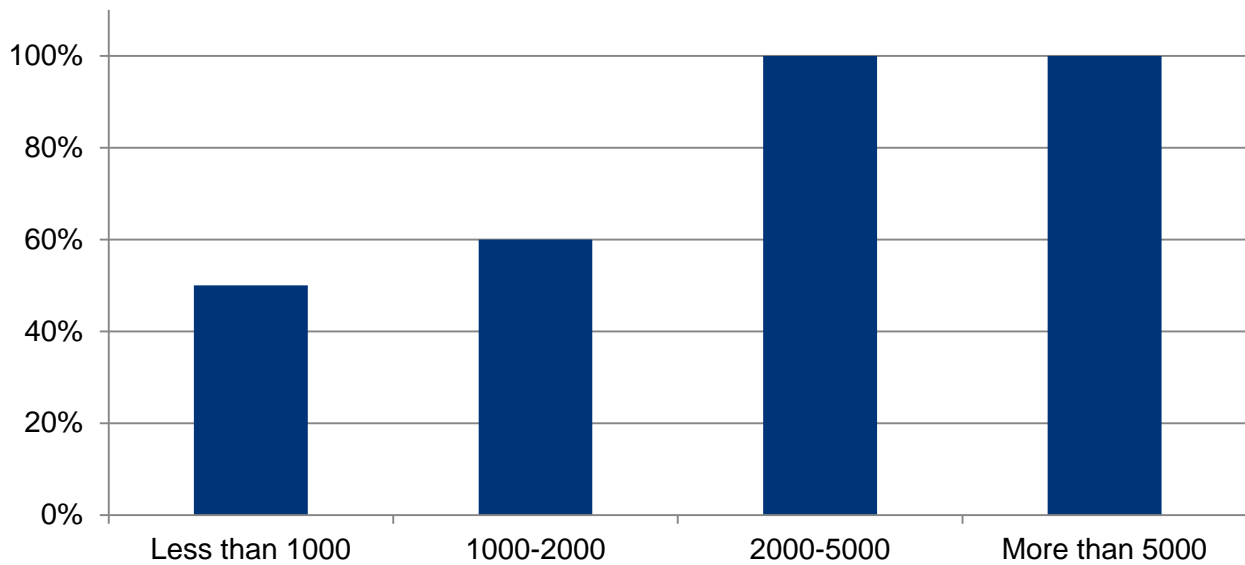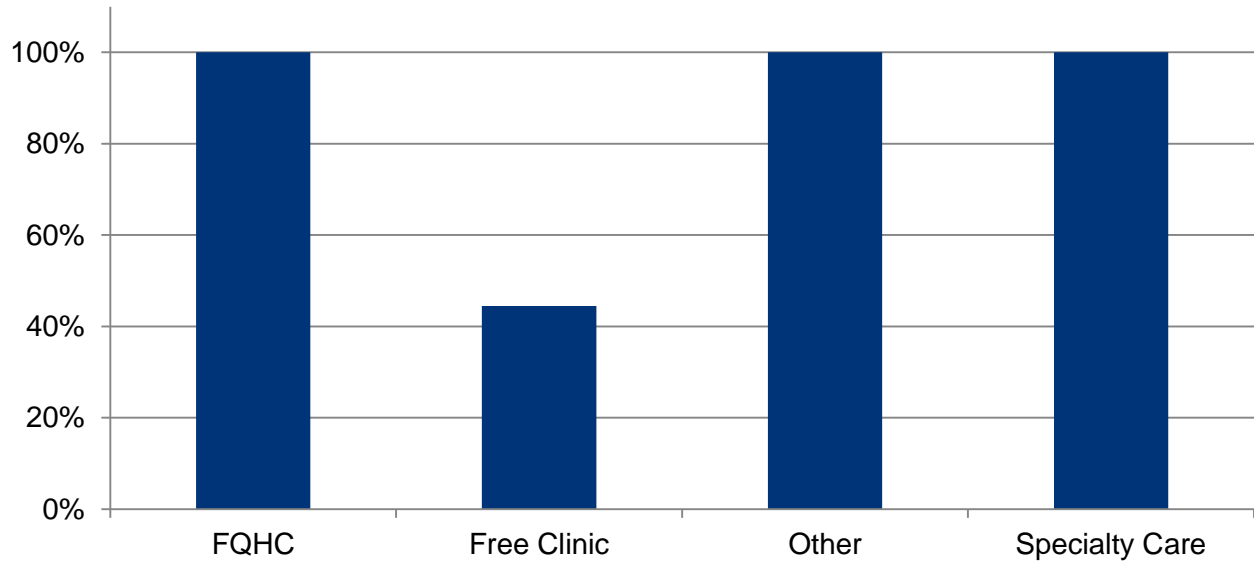Figure 6. Grantee Use of Electronic Health Records (EHRs) by Patient Load

Figure 7. Grantee Use of Electronic Health Records (EHRs) by Clinic Model

GRANTEE USE OF BLUE SAFETY NET FUNDING

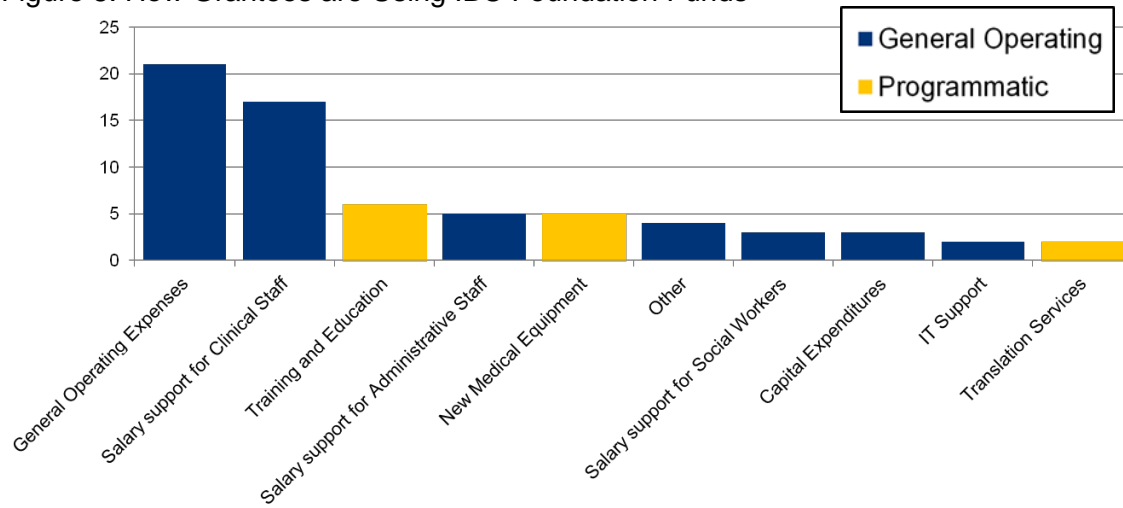Figure 8. How Grantees are Using IBC Foundation Funds

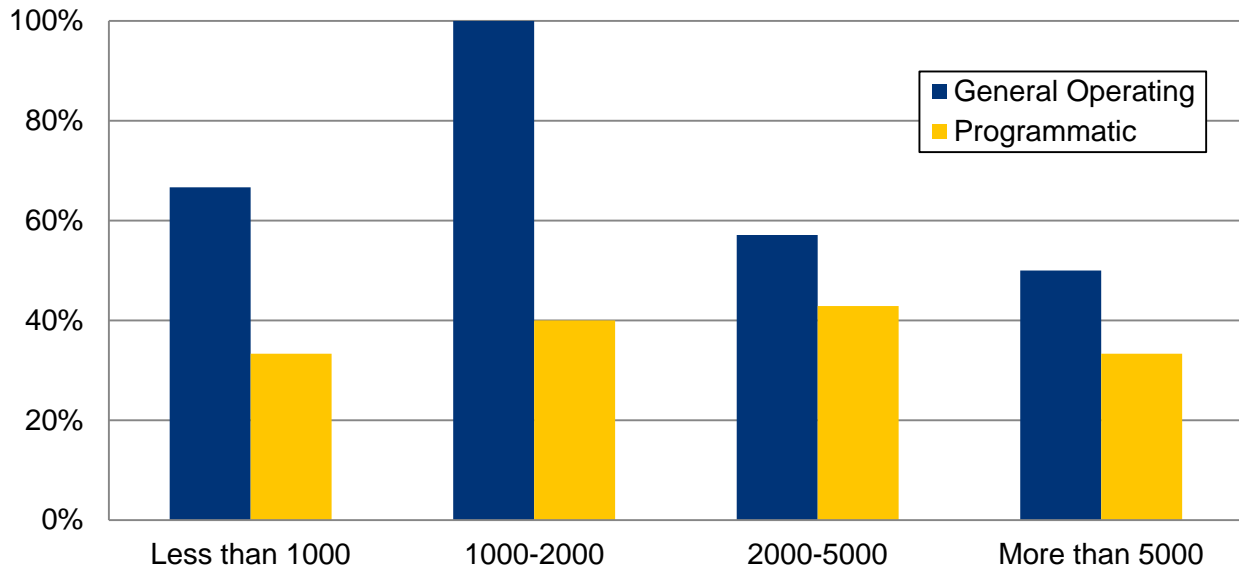Figure 9. How Grantees are Using IBC Foundation Funds by Patient Load

Figure 10. How Grantees are Using IBC Foundation Funds by Clinic Model
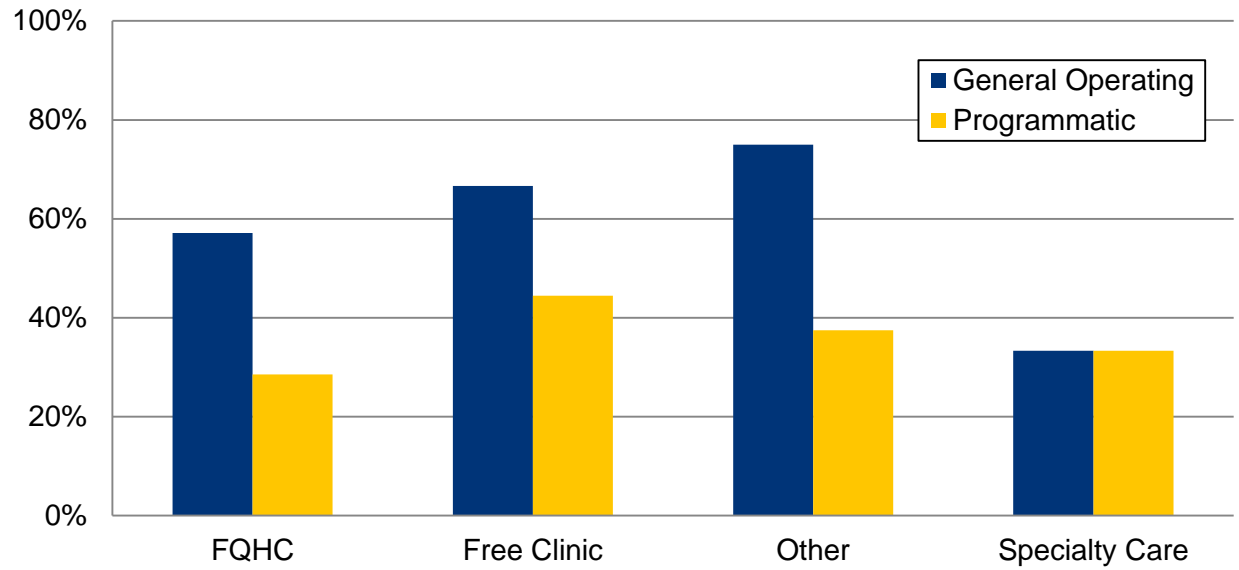
Figure 11. How Grantees are Using IBC Foundation Funds to Help Patients Access Specialty Care

Paid for social workers/case managers to make referrals
7%

Transportation
4%

Other
7%

Provided specialty care onsite
15%

Paid for specialty care services elsewhere
0%

Have not used IBC Funding for specialty care
67%

Figure 12. How Grantees are Using IBC Foundation Funds to Help Patients Access Specialty Care by Patient Load

- None
- Provided specialty care onsite
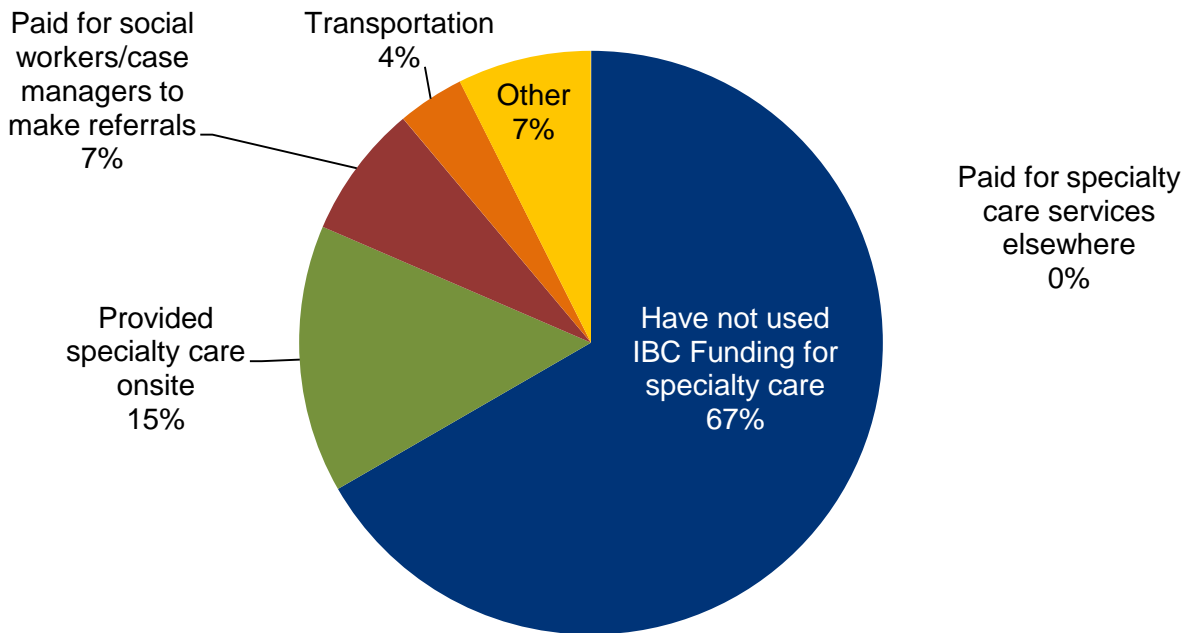- Paid for social workers/case managers to make referrals

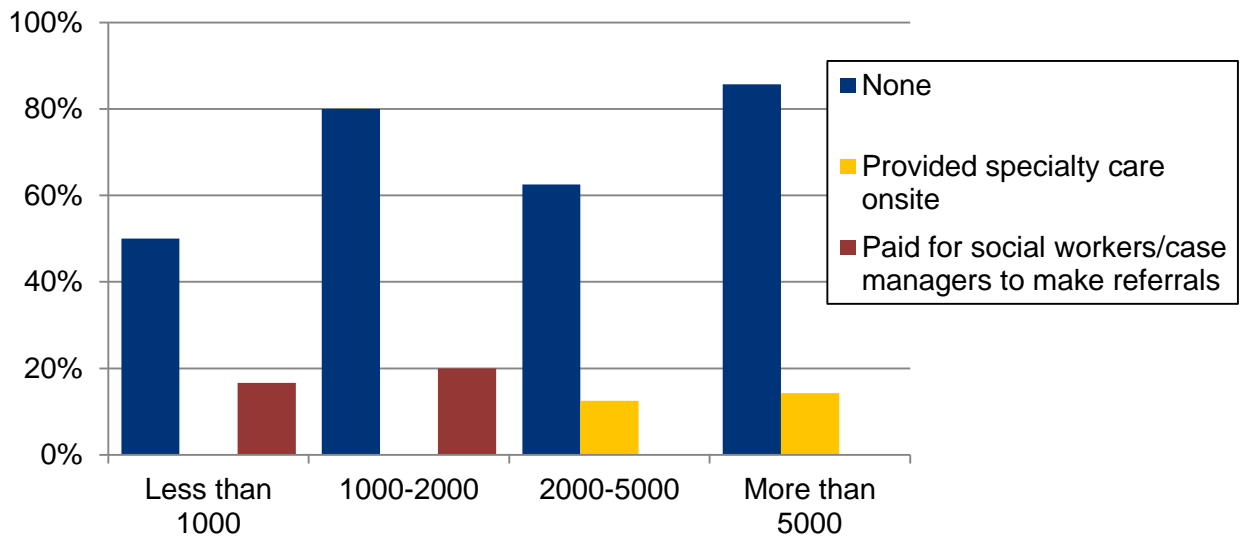Figure 13. How Grantees are Using IBC Foundation Funds to Help Patients Access Specialty Care by Clinic Model
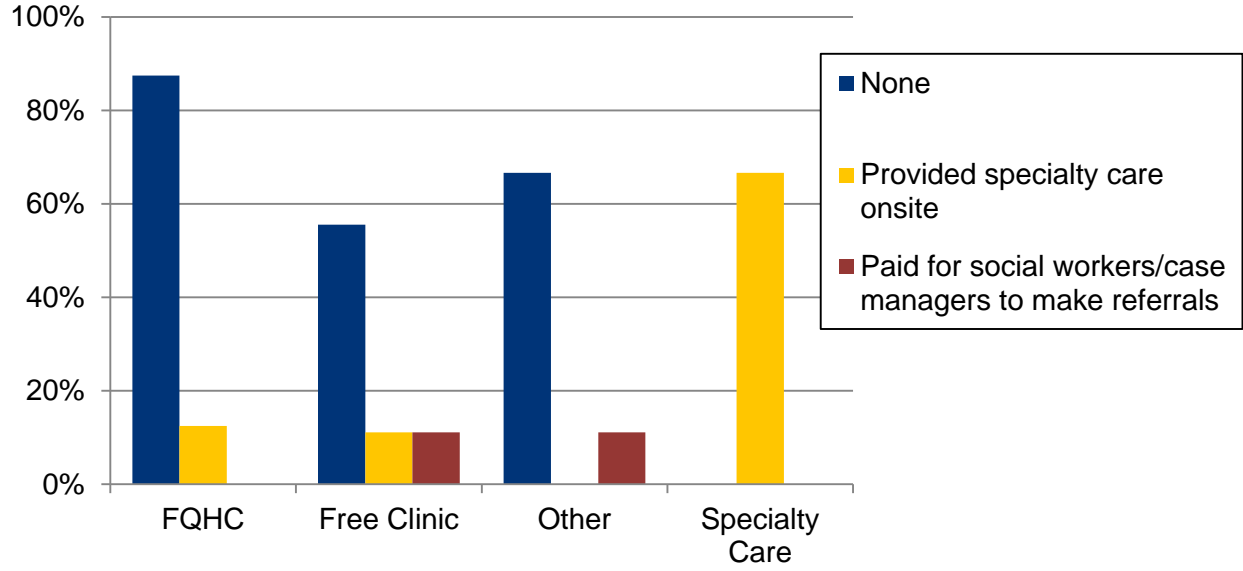
Figure 14. Past Use of IBC Foundation Funding for Training/Education
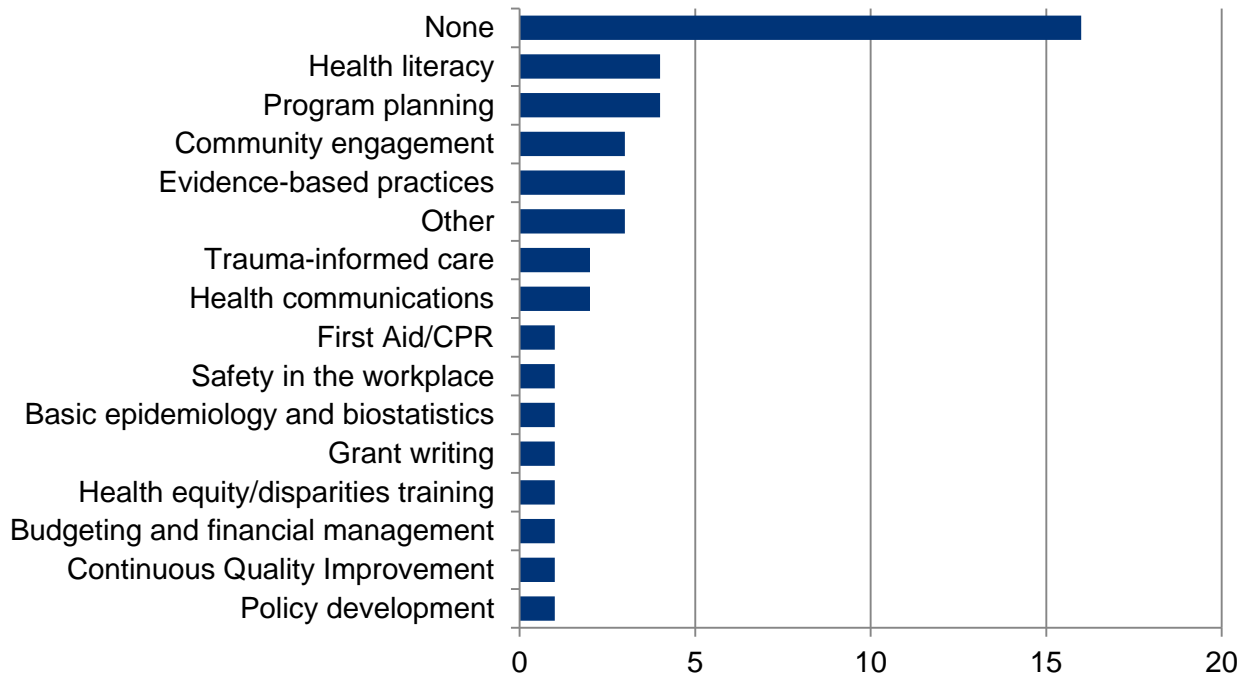
FUNDING INTENTIONS OF BLUE SAFETY NET GRANTEES

Figure 15. Grantees' Intentions to Use Future IBC Foundation Funding Differently

Figure 16. Grantees' Intentions to Use Future IBC Foundation Funding Differently by Patient Load
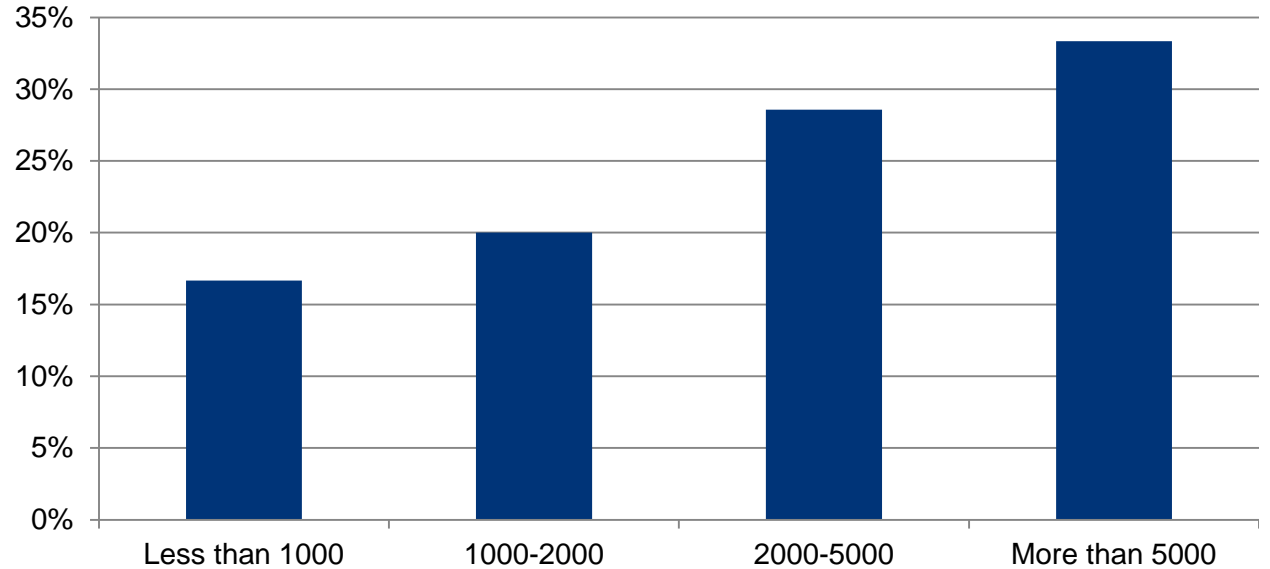
Figure 17. Grantees' Intentions to Use Future IBC Foundation Funding for EHR Support by Patient Load
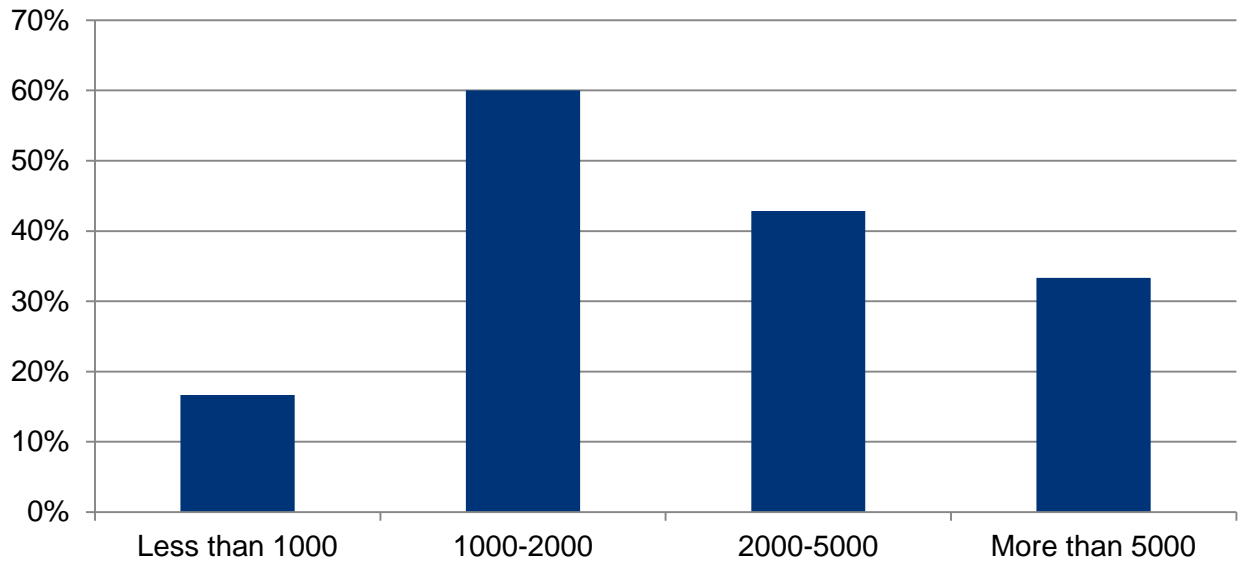
Figure 18. Grantees' Intentions to Use Future IBC Foundation Funding for EHR Support by Clinic Model
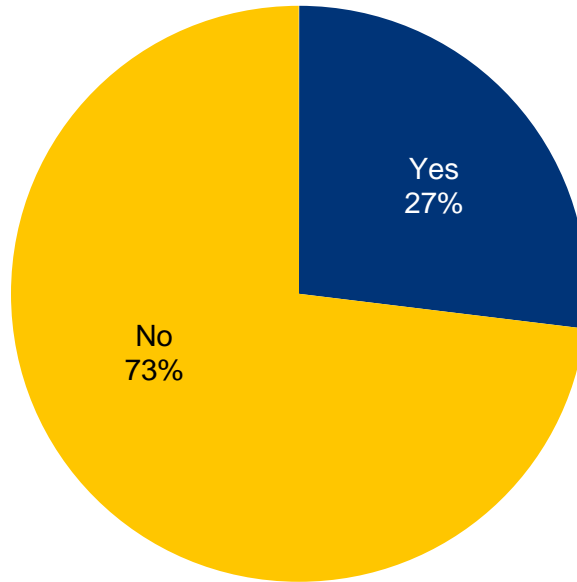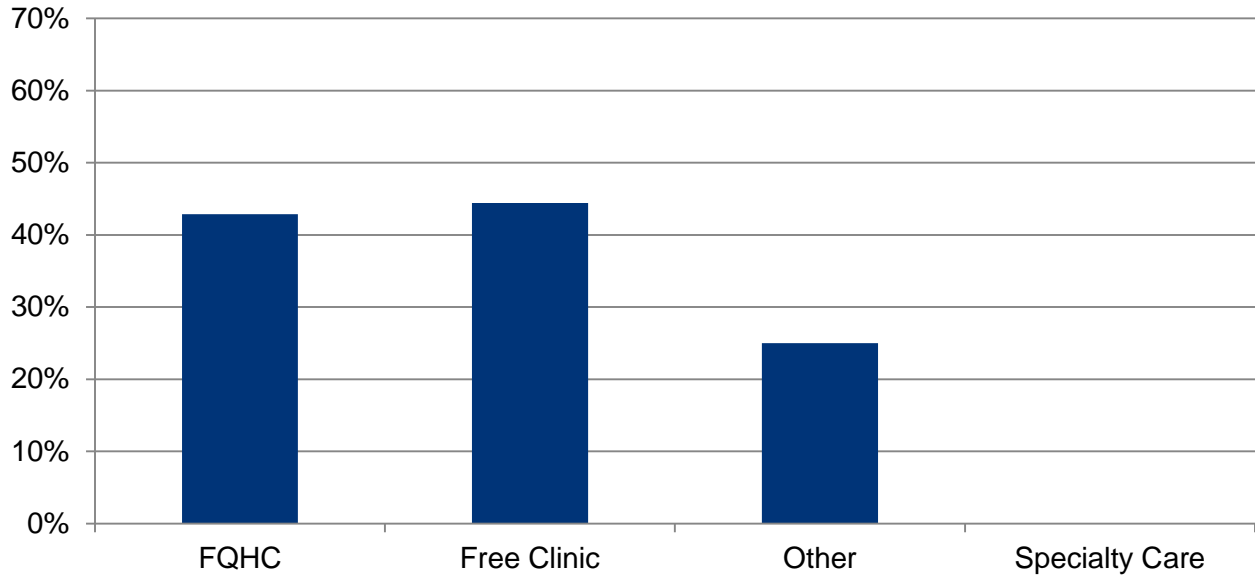
Figure 19. Grantees' Intentions to Use Future IBC Foundation Funding for Training/Education

PROGRAMMATIC INTERESTS OF BLUE SAFETY NET GRANTEES

Figure 20. Grantee Interest in Possible Areas of Technical Assistance to be Provided by IBC Foundation
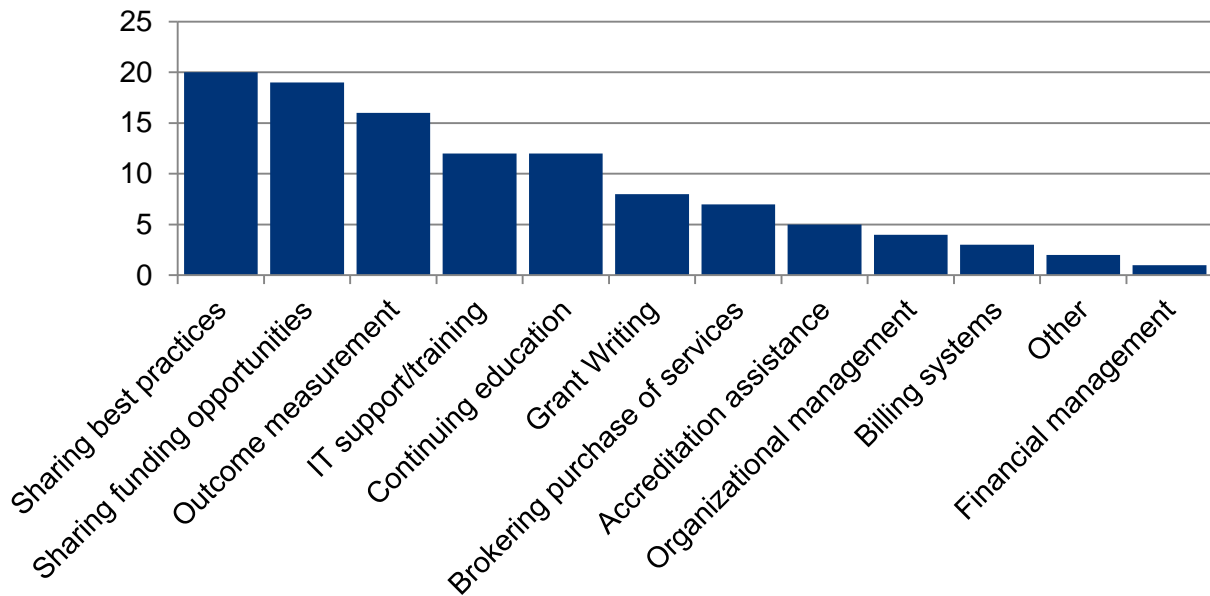
Figure 21. Non-Medical Services Not Currently Offered by Grantees That Could Benefit From IBC Funding
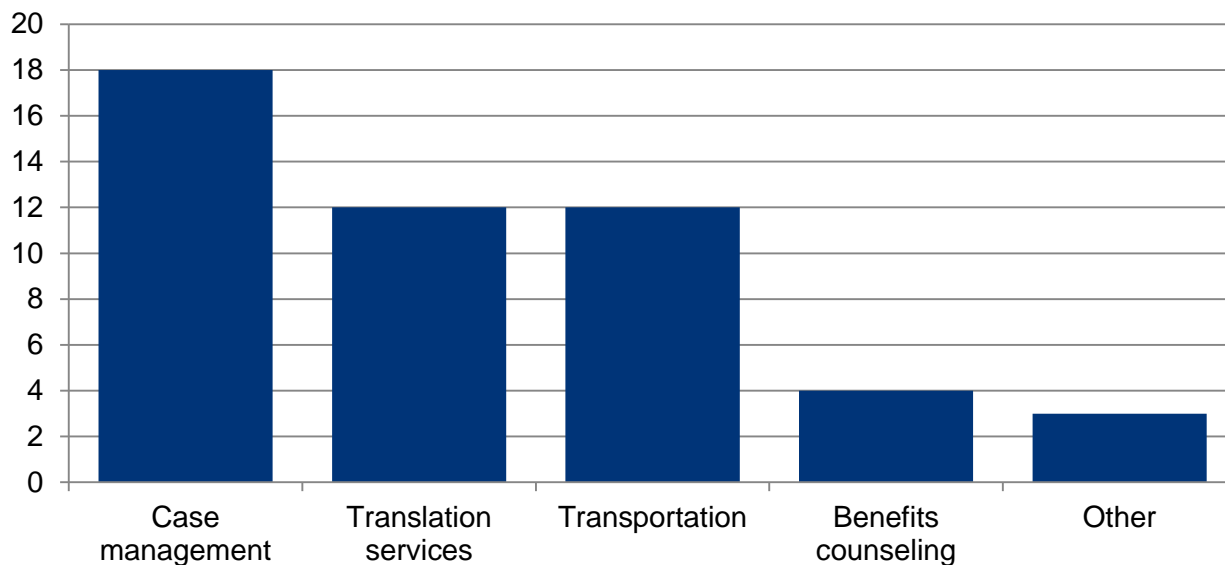
Figure 22. How Grantees Would Use Special Project Funding from IBC Foundation
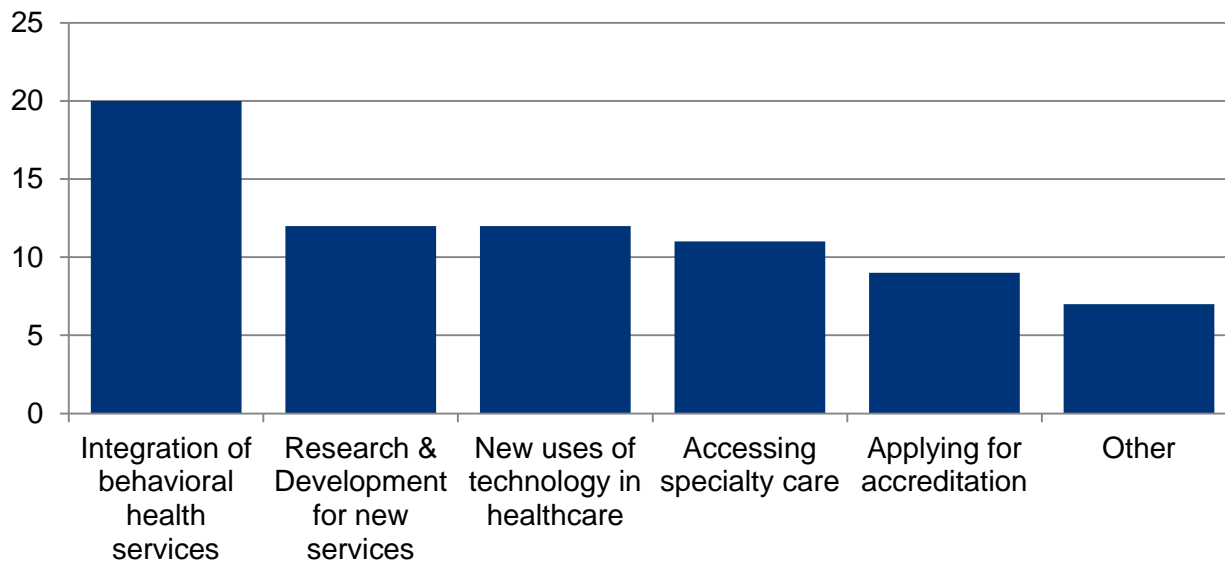
Table 1. How Grantees Rank the Importance of Uses of IBC Blue Safety Net Funding

Purpose	Average Rank
Primary care for any persons who are uninsured and unable to pay	1.91
Primary care for non-citizens	3.30
Behavioral health services	3.43
Primary care for persons who experience a gap in, or waiting period for, health insurance coverage	3.43
Care Management	3.74
Health information technology (any type)	5.17

EDUCATION & TRAINING NEEDS OF BLUE SAFETY NET GRANTEES

Figure 23. Grantee Interest in Potential Areas of Training/Education Using IBC Foundation Funds

Figure 24. Continuing Education Needs of Grantee Staff
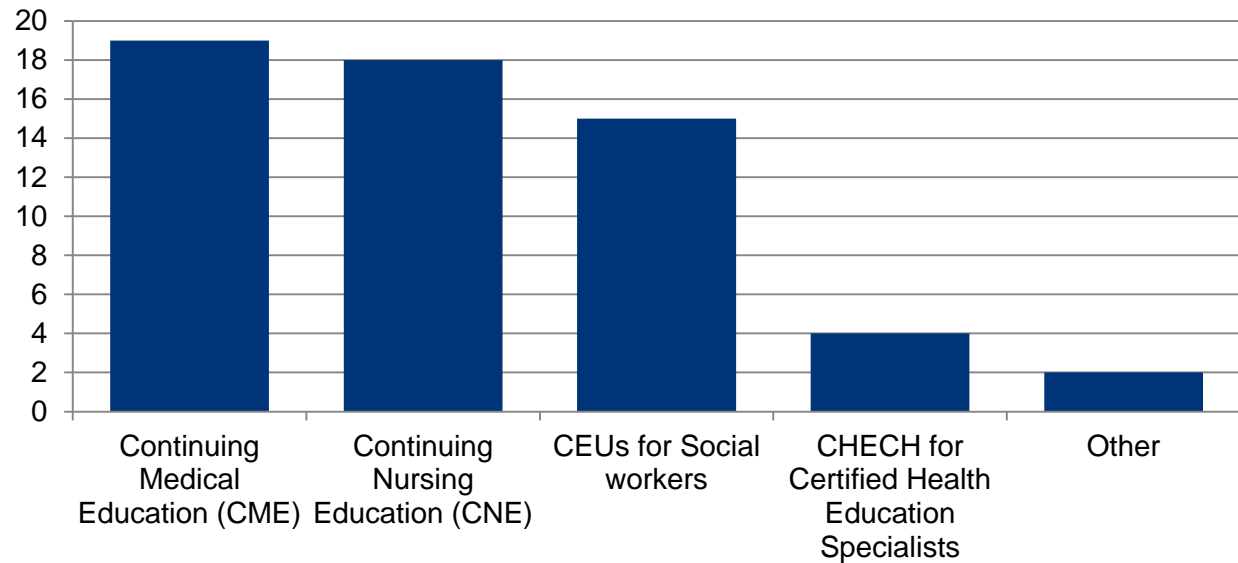
Figure 25. Grantee Staff That Could Benefit from Scholarship/Education Program Like Nurses for Tomorrow
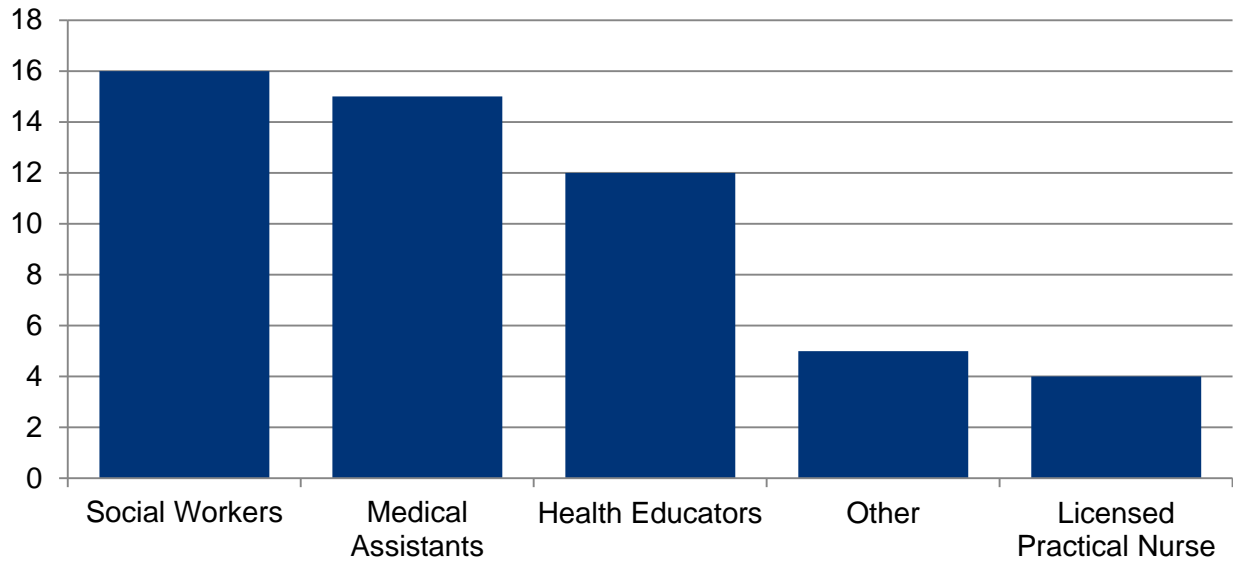
USE OF HEALTH INFORMATION EXCHANGE NETWORKS

Figure 26. Participation in Health Information Exchange (HIE) Networks among Grantees
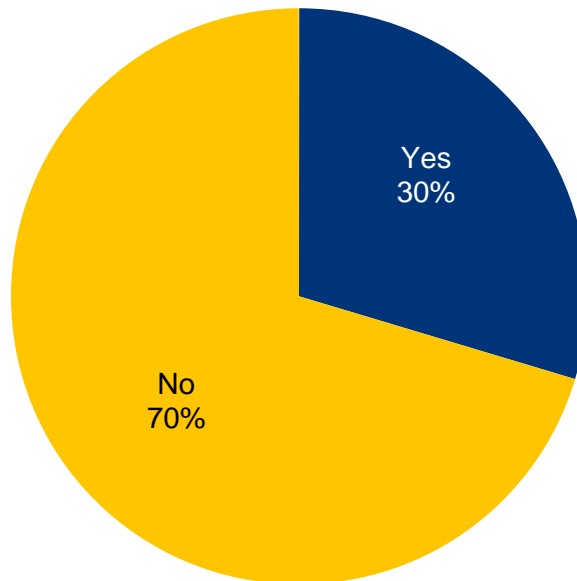
Figure 27. Participation in Health Information Exchange (HIE) Networks among Grantees, by Patient Load
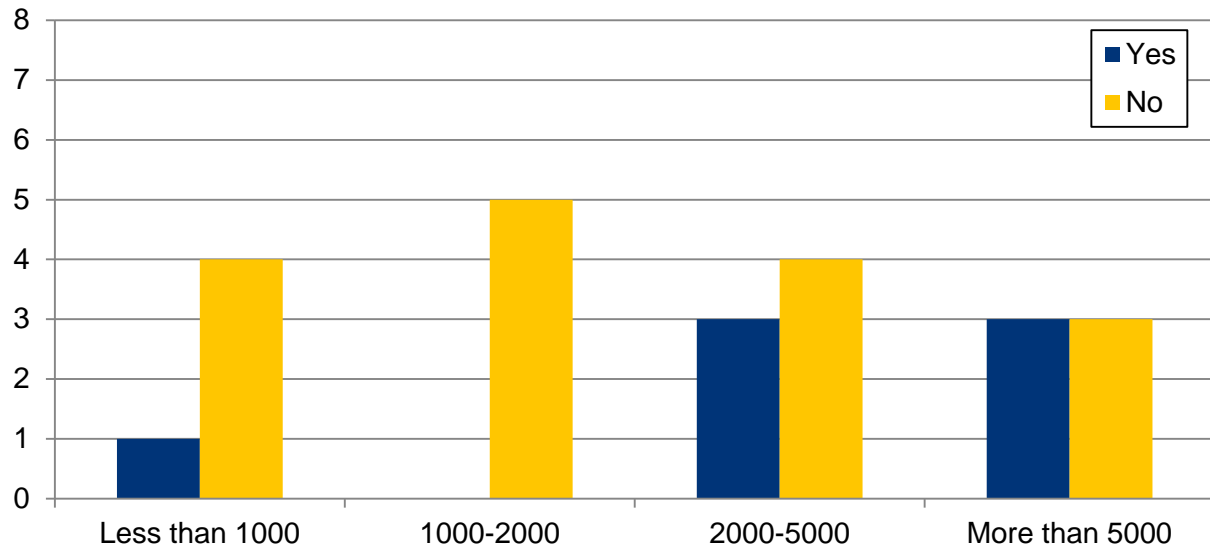
Figure 28. Participation in Health Information Exchange (HIE) Networks Among Grantees, by Clinic Model
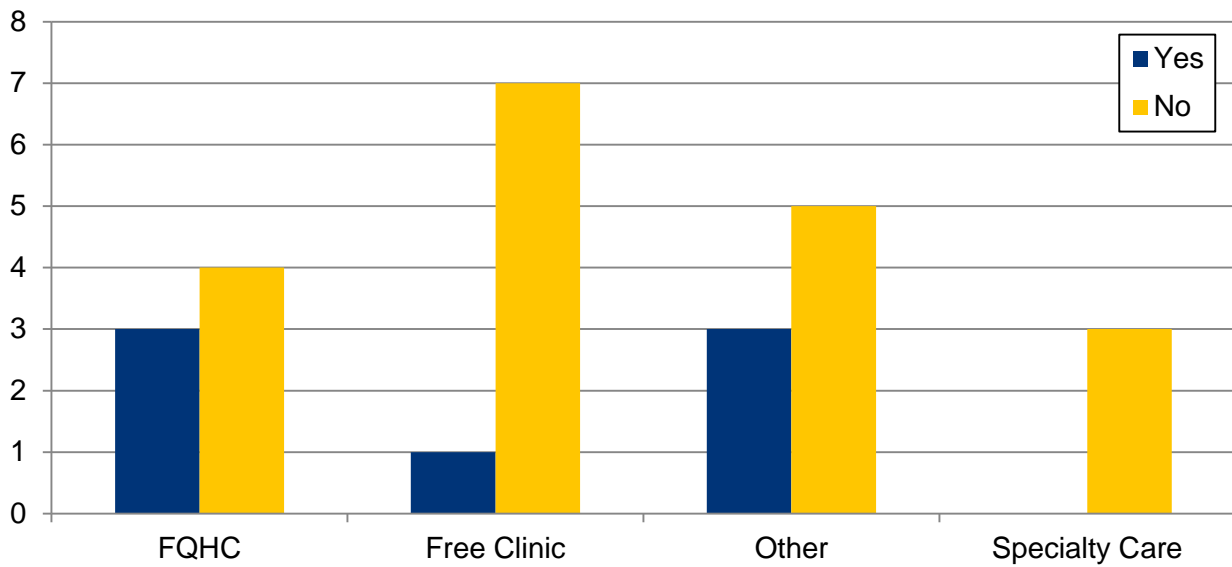
Figure 29. Interest and Capacity to Join an HIE Among Grantees Not Currently a Part of One

Yes Interest & Yes Capacity 16%

Yes Interest & Maybe Capacity 16%

Maybe Interest & Yes Capacity 10%

Maybe Interest & Maybe Capacity 58%
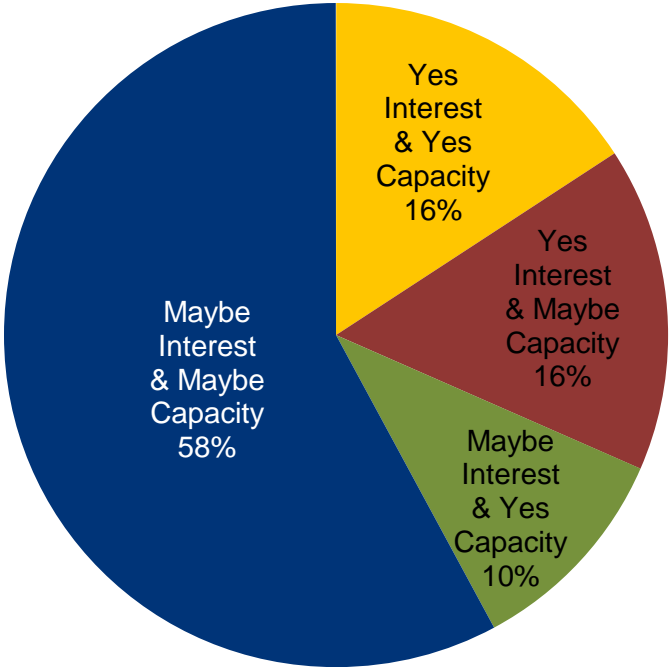
Appendix C. Maps

Figure 1. Blue Safety Net Grantees and Percent Poverty by Census Tract

Figure 2. Blue Safety Net Grantees and Percent Uninsured by Census Tract

Figure 3. Blue Safety Net Grantees and Number Uninsured by Census Tract

Legend

✚ Safety Net Grantees

Number Uninsured

0 - 190
191 - 389
390 - 675
676 - 1137
1137 - 2257

Appendix D. Focus Group and Interview Notes

FOCUS GROUP BACKGROUND RESEARCH

Table 1: North Penn Community Health Foundation Cluster

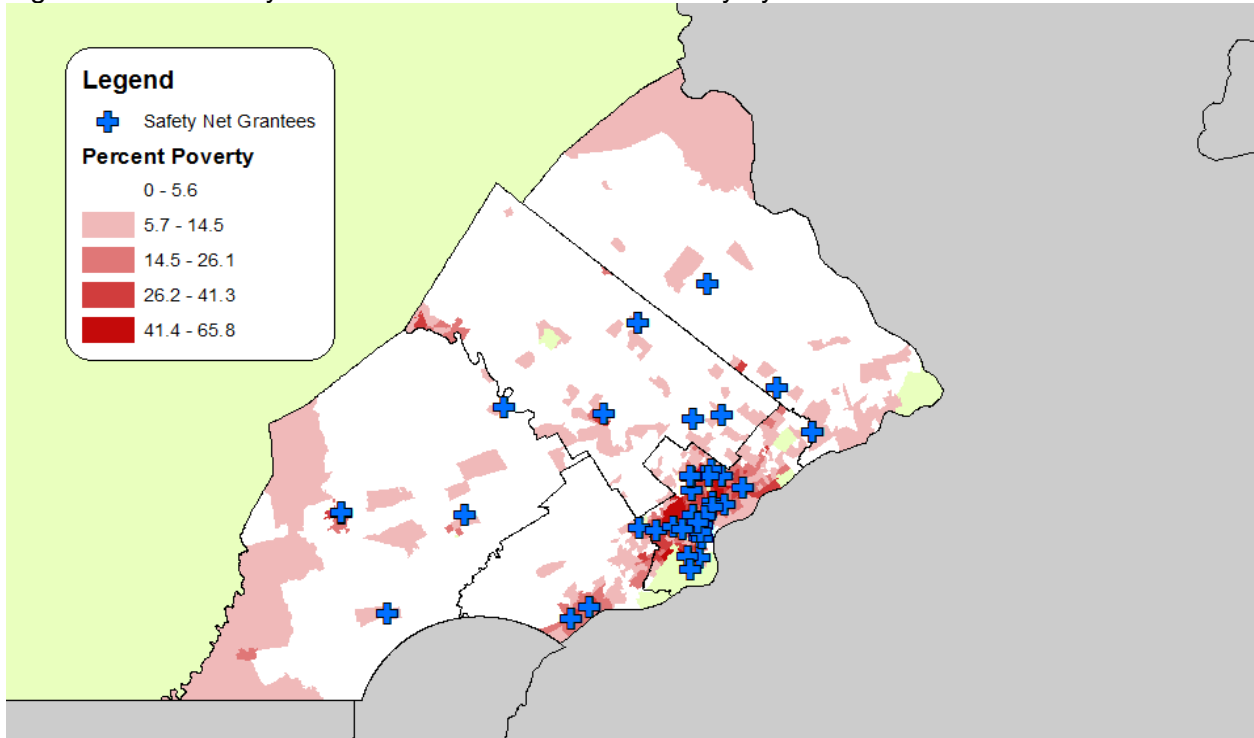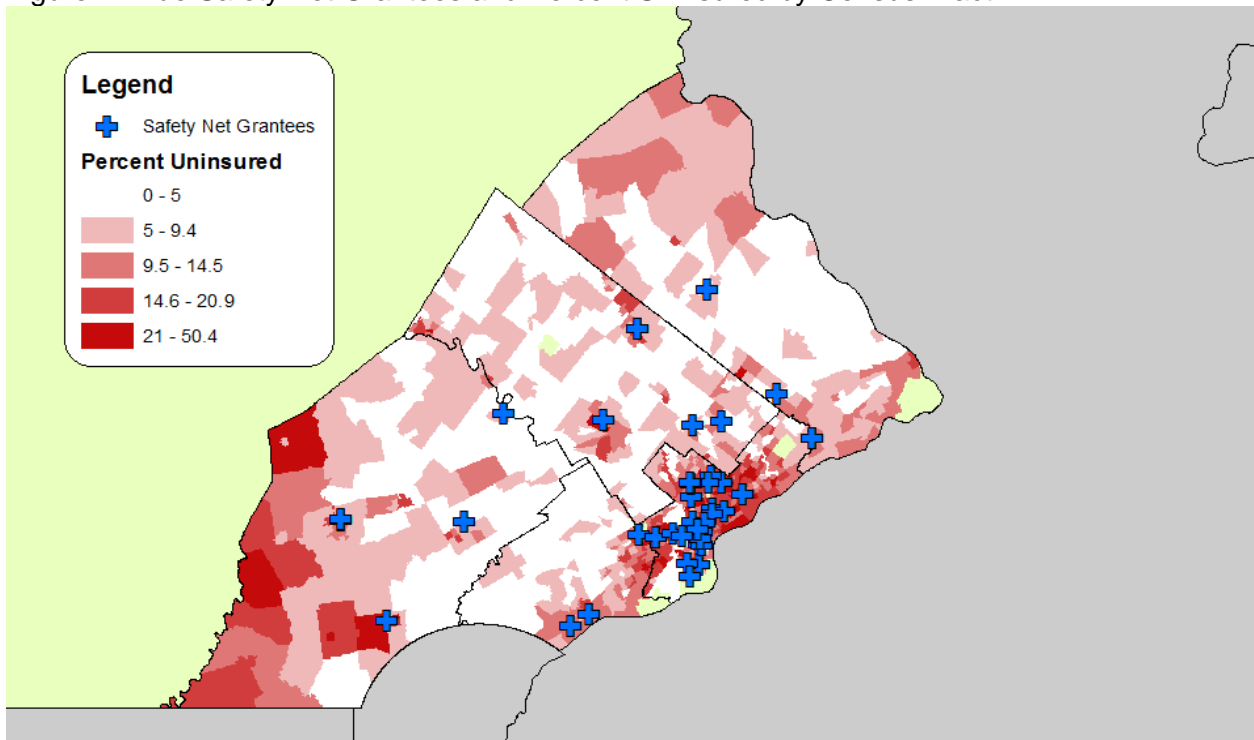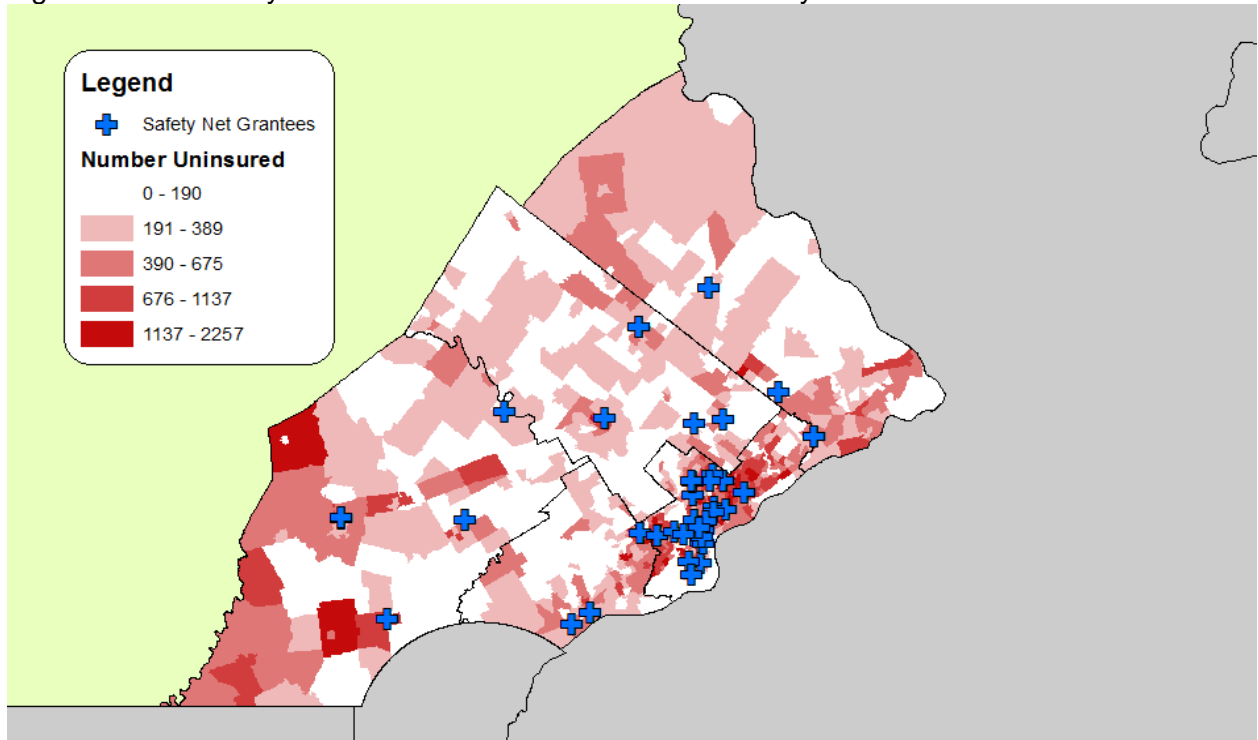|	Catchement Area	IBC Grant	Accomplishments w/ $$	Challenges
North Hills Health Center of Abington Memorial Hospital	Glenside, PA	$50,000	Nurse Practitioner Salaries at the North Hills Health Center	We have been challenged by the number of patients requiring translation and thus longer visits, sometimes more than an hour. While this approach is comprehensive it limits the number of patients that can be seen in a day. The complexity of patients at the center continues to be a challenge, as well as the number of patients presenting, who have just lost health insurance. The full utilization of the EMR in our center has been challenging. There is an increase in patient visit time, and some technological challenges. Medical Office Assistant (MOA) was unable to pass certification test; NPs had to lengthen visits to perform MOA duties.
Children's Clinic (North Penn Visiting Nurse Association, North Penn VNA Primary Care Clinic)	Philadelphia region	$50,000	We provide pediatric primary care, dental and social work services (personal navigator). The clinics will continue to improve on quality indicators such as adolescent health care, age appropriate immunizations, affordable oral health care and facilitate access to appropriate social services for our clients.	
Delaware Valley Community Health Inc., Norristown Regional Health Center	Norristown	$100,000	Supplemented operating expenses for the Norristown Regional Health Center (NRHC) to provide primary medical services to the underserved populations in Montgomery County. The clinical areas have been expanded and a residency program has been added to increase provider access.	Though services are in demand the number of uninsured patients have caused a financial strain on the organization for the last several years. In 2012, DVCH made the painstaking decision to close dental services. DVCH must secure a larger insured base.
Gwynedd-Mercy College Adult Health Center	Lansdale	$75,000	Bolster staff from 5 (3 NPs, 1 RN, 1 LPN) to 8 (5 NPs, 2 LPNs, 1 CNS); Demonstrate the effective management of chronic illness and infectious diseases (quality of life questionnaires and pt satisfaction surveys); Educate future nurses about the importance of serving vulnerable populations	Due to an increase in patient visits, the number of patients requiring lab studies, and the increase in the hours of operation to 40 hours/week, costs associated with the delivery of care (i.e., lab services, nurse practitioner services, mental health services, and medical assistant services)
VNA Community Services, Inc., Ginny Coombs Children's Health Centers	Abington & Norristown	$50,000	improve quality (increase percent of children having annual routing well-child check, completing referrals for lab work, specific goals related to Asthma control)	EHR - there have been some unexpected challenges related specifically to an unavailable interface with the statewide immunization database causing a good amount of rework for VNA staff. Staff members came to this process at different levels of readiness for change.

Table 2: Health Federation Cluster

	Catchement Area	County	Clinic Model	Clinic Size (# patients)	IBC Grant 2012	Accomplishments w/ $$	Challenges
ChesPenn Health Services, Inc., Family Health Center of Coatesville	Coatsville	Chester	FQHC	3,426	75,000	This grant enabled us to provide quality primary care to **_155 uninsured patients_** (2.85 visits a year, representing a total of **_440 encounters)_**; this is care that these patients would otherwise not have been able to access.	Staff Turnover, Increase in un-insured population, lack of bilingual staff in Chester County
La Comunidad Hispana Health Center	Southern Chester County	Chester	FQHC	2339	75,000	Funding covered our costs to provide medical care at 469 patient visits over the past year (at a cost of $159.75 per visit).	No show rate/Scheduling
ChesPenn Health Services, Inc., Center for Family Health at Eastside	Chester	Chester	FQHC	5725	100,000	The $100,000 received from IBC for this past fiscal year enabled us to provide quality primary care and dental care to **_210 uninsured patient_**s (2.49 visits a year, representing a total of **_523 encounters)_**; this is care that these patients would otherwise not have been able to access.	Increase in number of un-insured, opening of retail pharmacy in neighborhood
ChesPenn Health Services, Inc., Center for Family Health at Community Hospital	Chester	Chester	FQHC	5,501	Shared with above	Same as above.	Same as above.

ChesPenn Health Services, Inc. Center for Family Health at Upper Darby	Upper Darby	Delaware	FQHC	3,520	75,000	Report missing - but enabled them to provide primary care to un-insured and apply for NCQA accreditation as a patient centered medical home.	Delayed opening of dispensary until ACA clarified, rise in un-insured population
Delaware Valley Community Health, Inc., Fairmount Primary Care Center	North Philadelphia/Fairmount	Philadelphia	FQHC	9,086		N/A	
Delaware Valley Community Health, Inc., Maria de los Santos Health Center	North Philadelphia	Philadelphia	FQHC	17442		The walk-in population at MDLS has increased by 100% since the new center's opening in 2008 which resulted in a dedicated, on site, walk in clinic opening in 2010 along with the hiring of an additional healthcare provider. The laboratory was doubled in size in 2011 due to demand for these services. IBC funding was crucial in all of this happening.	
Drexel University, 11th Street Family Health Services	North Philadelphia	Philadelphia	FQHC	4807		The funds provided through IBC have enabled the center to sustain vital evidence based programs that improve the health status of the patients but are not reimbursable under current insurance plans. We have been able to collect outcome data on the programs and begin to pilot model programs used to effect changes in policy.	

Esperanza Health Center, Health and Wellness Center in Hunting Park	North Philadelphia	Philadelphia	FQHC	7,377		The IBC Foundation grant made a significant difference for Esperanza Health Center during a time of rapid growth in 2012, by enabling us to provide comprehensive primary health care and support services to our uninsured patients, and through support for the hiring of key staff members to launch innovative new, community-based health and wellness programs and to expand social services at our Hunting Park facility, which opened in December 2011.
Family Practice & Counseling Network, Abbottsford Falls Health Center	Northwest Philadelphia	Philadelphia	FQHC	18607	100,000	IBC has supported our capacity to spearhead new programs while we geared up create them as sustainable positions. For example, in the past year IBC enabled us to hire a Primary Care Coordinator NP at the Abbottsford-Falls site. It is her responsibility to assure access to primary care, support the nurse practitioners and support the integration of primary care with the other disciplines. This person now provides primary care three days a week, her visits are billable and the position is sustainable.

Mazzoni Center Family & Community Medicine	Philadelphia	Philadelphia	Other Health Centers	4076	40,000	By adding a part-time clinician, partially funded by the IBC Foundation, Mazzoni Center increased the amount of available patient appointments offered to under/non-insured individuals. This generous support allowed Mazzoni Center to expand the clinical capacity of our practice and treat more patients within our target population of LGBT and underserved individuals in the greater Philadelphia area.	40% un-insured population
Project H.O.M.E., St Elizabeth's Community Health Center	North Philadelphia	Philadelphia	FQHC	346	25,000	This tremendous contribution enables Project HOME to develop the business and clinical processes necessary to become a Federally Qualified Health Center Look-Alike or New Access Point. A key step in this transition process (in addition to purchasing an EHR/PM system as mentioned above) is for Project HOME to become credentialed with various 3rd party payors serving our geographic target area and target population. Once we have the capacity to bill 3rd party payors, we can ramp up primary care services to full-time. Project HOME created a new position to oversee this growth (Vice President, Healthcare Services) and plans to bring on additional mid-level providers	The transition from a free clinic to a Fee for Service clinic and that credentialing process has been impacted by the delay of the clinic renovations. In addition, the clinic needs to identify an Electronic Health Record system and that decision is planned to be made in May.

					to provide more hours of direct service.	
Puentes de Salud	South Philadelphia & Center City	Philadelphia	Other Health Centers	1800	N/A	

Table 3: PHMC Cluster

	Catchement Area	IBC Grant	Accomplishments w/ $$	Challenges
Congreso de Latinos Unidos, Congreso Health Center	North Philadelphia	50,000 (2012)	(2012) The IBC Foundation grant has allowed us to implement the All Scripts Electronic Health records for the Congreso Health Center. Implementation of the electronic health records has allowed the Health Center staff to track chronic disease management, coordinate and integrate health care services, quickly retrieve medical information, and create reports.	delayed notification of IBC grant, hiring bilingual staff, skepticism in community of nurse-managed care
Mary Howard Health Center	Philadelphia	50,000	The IBC Foundation grant has : 1.) allowed us to provide comprehensive care for uninsured chronically ill patients who may otherwise not receive treatment or over-utilize more expensive modes of care such as hospital emergency rooms 2.) provided information and training critical for helping our clinical team remain abreast of current care practices as well as environmental changes	Transient patient population
PHMC Care Clinic	North Philadelphia	50,000	Through January 2013, the clinic increased the number of patient encounters by 18% over the prior year, with a complimentary increase in the number of uninsured patients.	
PHMC Health Connection	North Philadelphia	50,000	The number of unduplicated clients continued to grow in 2012 (2,278) over 2011 (2,077), even in the very limited space. The clinic has opened earlier in the morning to allow for additional access until the new building opens with expansion to 13 exam rooms versus the current three exam rooms in July, 2013	
Rising Sun Health Center	Northeast Philadelphia	50,000	The number of unduplicated clients continued to grow in 2012 (1,988) over 2011 (1,862), even in the very limited space. The move to the new location in a nearby strip mall with greatly enlarged space is scheduled for July, 2013.	

Table 4: BCHIP Cluster

	Catchement Area	IBC Grant	Accomplishments w/ $$	Challenges
Ann Silverman Community Health Clinic	Central Bucks	$60,000	The IBC Foundation grant has enabled the organization to continue it's mission of providing free medical, dental and behavioral health care by supporting the cost of key staff positions that enable the clinic to coordinate over 200 volunteers and nearly 4,000 patient visits in both the clinc and the community- (operational expenses?)	major staff turnover
Bucks County Health Improvement Partnership - Lower Bucks Adult Health Clinic	Lower Bucks	$75,000	During the first three months of our fiscal year beginning in July 2013, the LB Clinic saw 27 to 38 new patients monthly. Between October and January, the average number of new patients seen was 55.75. We have held four training sessions with DataNet staff teaching the BCHIP Clinic staff how to use specific modules within the software. We have added one volunteer physician	implementation of EHR has taken more time than expected
HealthLink Medical Center	Bucks & Montgomery Counties	$75,000	In the first two months of 2012, there were 818 visits; HealthLink had 277 more in 2013. This increase can be attributed to the clinic's new extended operating hours (as a result of the recommendations of our Wharton Optimization Study), as well as the addition of a part-time Nurse Practitioner to HealthLink's staff. HealthLink has also begun utilizing a new language translation service - Language Services Associates.	decrease in dental visits due to limited volunteer availability
St Mary Medical Center Foundation, Mother Bachmann Maternity Center Children's Health Center	Bucks & Montgomery Counties	$75,000	The 2011 Independence Blue Cross Blue Safety Net grant has allowed St. Mary to provide additional staffing in the Children's Health Center and the Mother Bachmann Maternity Center to meet the increased need of the growing low income and immigrant population in Bensalem and surrounding communities. Our clinic service areas have seen a 100% increase in its poverty level since 2007.	original application asked for $100,000 transient patient population increase in OB services in underinsured women
The Clinic of Phoenixville	within 10 mile radius of Phoenixville		This grant allowed us to provide a projected 9,400 patient visits during 2012 to people without medical insurance. During that time period we provided approximately 8,000 free laboratory tests (70 different types) to our patients. We also coordinated the provision of approximately $85,000 <u>per month</u> in free medications to our patients by way of our Pharmacy Assistance Program. We have implemented a remote video counseling program for individuals with addictive diseases. Our two attending physicians are currently seeing 30 Suboxone patients who suffer from opioid dependencies. In addition, our food pantry continues to provide free food to our patients on a daily basis.	patient population will consist of those in the 'doughnut hole' without PA Medicaid expansion 2012 strategic plan took longer than expected, will be folded into 2013 plan

Table 5: Other Clinics Cluster

	Category	Catchment Area	Parent Organization/ Network	Community Services	Health Services	Population	County
Chester County Community Dental Center	Dental/Vision Clinic	Chester County	none	dental education outreach	exams, x-rays, cleanings, fillings, priodontal/endodontic treatmen, crowns, oral surgery, dentures	low-income, uninsured, underinsured children and adults	Chester
Community Volunteers in Medicine	Family Health Center	Chester County	none	case management; referrals to social services; health education outreach	dental preventative care, restorative care, and emergencies; primary medical care, specialty care, mental health, & women's health	low-income, uninsured children and adults	Chester
Salus University- The Eye Institute	Dental/Vision Clinic	Elkins Park	Salus University	none	vision screenings, eye exams, distributing glasses	adults	Montgomery
Albert Einstein Health System — Community Practice Clinic	Adult Health Center		Albert Einstein	none	initial care & ongoing assessment, immunizations, radiology, phlobotomy, pharmacy		Philadelphia
Aria Health Center Clinic	Family Health Center	Northeast Philadelphia	Aria- 3 hospitals	?	?	?	Philadelphia
Augustinian Defenders of the Rights of the Poor, Unity Clinic	Adult Health Center	Philadelphia	ministry with one primary clinic and outside supportive and educational	ESL classes, law clinic, after-school tutoring program, art and music classes	basic medical care and screening		Philadelphia
Covenant House Pennsylvania, CHOP Connections Clinic	Maternal/Child Health Center	Philadelphia	clinic affiliation with CHOP, hosted at Covenant House	street outreach, emergency housing, legal services, education/vocation al support	screenings and supportive services by pediatrician specializing in adolescent medicine	homeless, runaway, and trafficked youth	Philadelphia
The Eagles Charitable Foundation, Eagles Eye Mobile	Dental/Vision Clinic	Philadelphia area	Philadelphia Eagles	none	diagnostic exams, providing eyeglasses	children in public schools with high poverty rates	Philadelphia
Kids Smiles Inc. West Philadelphia Dental Center	Dental/Vision Clinic	West Philadelphia	Kids Smiles Inc	health education outreach	dental exams, cleanings, sealants, root canals	children in underserved areas	Philadelphia
North Philadelphia Health System – St. Joseph's Hospital	Adult Health Center	North Central Philadelphia	North Philadelphia Health System- two hospitals	none	emergency/critical care, primary care, drug/alcohol detoxification, rehabilitation, psychiatry, surgery	residents of North Central Philadelphia	Philadelphia
Philadelphia College of Osteopathic Medicine, PCOM Healthcare Center	Family Health Center	West Philadelphia	PCOM	none	primary care, specialty care, family medicine, women's health, pediatrics	families in the Philadelphia area	Philadelphia
St Catherine Laboure Medical Clinic	Family Health Center	Germantown	none	none	exams, disease management, medication	uninsured individuals in the Germantown area	Philadelphia
Youth Services, Inc.	Maternal/Child Health Center	Philadelphia	none	parenting education, truancy prevention,	emergency care for infants & children, medical exams, STD testing	children, youth, and families	Philadelphia

FOCUS GROUP MEETING NOTES

Notes 1: Health Federation Focus Group

IBC Foundation Focus Group
July 9, 2014
HFP

Attendance:
Drexel: Dennis Gallagher, Jen Kolker, Brad Smith, Ellie Lippmann, Rachel Peters, Rebecca Sax
Emily Nichols, Family Practice and Counseling Network
Karen Breitmayer, ChesPenn Health Services
Patty Gerrity, Drexel 11th St Health Clinic
Natalie Levkevitch, Health Federation Philadelphia
Patty Deitch, Delaware Valley Community Health
Phyllis Kater, Spectrum Health Services
Steve Larson, Puentes de Salud

Value of funding:
- Helps with revenue shortfall and general operating expenses
- Easy reporting structure
- They don't dictate what we do, we just transfer goals to the application
- The format allows for R & D and innovation, like a patient centered medical home

How can IBC improve the program:
- Be clear about what things they won't fund. Have a conversation before an application is rejected
- Clarity on how funding amount is decided
- Definition of a safety net
- Addressing specialty care
- Investment in education for medical assistants
- Convene lower level staff to network and share resources

What are your funding priorities:
- Medical home - case management and social workers, funding beyond medical care, following up with patients outside of the clinic
- Ongoing costs for EHR – upgrades or capital purchasing
- The patients that don't have chronic disease or other reportable priorities, they fall through the cracks
- Address the burden of change management and the resources it requires*

What topics should be included on the Needs Assessment:
- How will the ACA affect your payer mix?
- Highlight uses for funding?
- What types of training/conversations topics would be useful when convening without the funder
- Is there any shared interest in receiving technical assistance?
- What are unfunded mandates

Notes 2: North Penn Focus Group

IBC Foundation Focus Group
August 6th, 2014
NPenn/BCHIP

Attendance:
Drexel: Jen Kolker, Dennis Gallagher, Rebecca Sax
North Penn- Russ Johnson, Aran Zouela
Abington Health- Kitty Fitzgerald, Mary Dressler-Carre
Anne Sullivan Clinic- Peggy Dator
The Clinic- Thomas Byrd, Michael R
Gwynedd Mercy- Bernadette Walsh, Denise Vanacore
Bucks County- Sally Fabian
HealthLink- May O'Brian

Value of funding:
- Unrestricted funds show that IBC is truly interested in taking care of people in the community regardless of legal/SES/insurance status

How can IBC improve the program:
- Increasing the funding cycle to more years
- Provide training on outcome measurements
    - For IBCF and other funding requirements
- Help clinics develop resources for treating challenging populations
- Provide training for clinics on how to choose vendors/services (eg EMR, translation)

What are your funding priorities:
- 3 populations: undocumented residents, patients transitioning in or out of MA, carriers of high deductible insurance
- Creating and maintaining EMRS- only as good as the vendor
- New focus on integration of behavioral health

Relationship between IBC Foundation/insurance/free clinics
- Some clinics began taking IBC insurance after receiving IBCF funding
    - Transition from free clinic to taking insurance
- The work of free clinics save IBC (and other insurance companies) money by keeping patients out of ER's through free preventative/urgent care

Issues with potential Medicaid expansion:
- Doctors accepting MA patients will have to adjust to higher patient load
- Some free clinics will need to become FQHC's, some will stay free- depends on core populations

Notes 3: PHMC Focus Group

IBC Foundation Focus Group
July 18, 2014
PHMC

Attendance:
Drexel: Jennifer Kolker, Rebecca Sax
Frank Killian- Director of Finance and Regulatory Affairs PHMC Health Network
Nancy Rothman- PHMC Health Network (consultant)
Stephanie Waxman- Quality Manager for Specialized Health Services
Rafael Dieppa- Director of Health Services
Melissa Fox- PHMC

Value of funding:
- Increased staffing
    o IBC connection introduced nurses from intern program
- Unrestricted funds make sure basics are covered
    o Gives freedom to continue good work and look for better ways to provide care
- Ease of application
    o While still being clear and reflective

Potential positive changes for IBC:
- Integration of mental health services into funding priorities
- IBC could support EHRs through funding existing infrastructure (Nancy) or clinical education around IT
    o General support for targeted EHR funds

Support beyond funding:
- Current conferences and networking opportunities are appreciated
- IBC could provide forum for grantees to share how they are utilizing grant money for programs
    o Common challenges/strategies
- Clinics/administration would appreciate feedback from IBC on objectives and funding priorities

The ACA and safety net status:
- Concern that funders think safety net services are no longer needed
- Increased focus on younger patients with chronic illnesses without resources to manage care
    o Continuing education for providers would be helpful to understand this population
- Interest in telemedicine to overcome barriers to care
    o Could be used to facilitate communications between ERs and specialists to reduce costs

What topics should we include in the needs assessment:
- Providing care to employees in high-stress environment
- Workforce information and training needs
- Patient engagement
- Connection between IBC programs

Notes 4: Other Clinic/Organization Phone Interview

CLINICS/ORGANIZATIONS WHO DID NOT ATTEND FOCUS GROUPS & DATES CONTACTED BY DREXEL SPH
TEAM:

Chester County Community Dental Center- 7/25/14
Community Volunteers in Medicine- 7/25/14
Salus University – The Eye Institute- 7/25/14
Albert Einstein Health System – Community Practice Clinic- 7/25/14
Aria Health Center Clinic- 7/25/14
Augustinian Defenders of the Rights of the Poor Unity Clinic- 7/29/14
Covenant House – CHOP Connections Clinic- 7/28/14
Eagles Charitable Foundation – Eagles Eye Mobile- 8/4/14
Kids Smiles West Philadelphia Dental Center- 7/28/14
North Philadelphia Health System – St Joseph's Hospital- 7/28/14
Philadelphia College of Osteopathic Medicine (PCOM) Healthcare Center- 7/28/14
St Catherine Laboure Medical Clinic- 7/28/14
Youth Services, Inc.- 7/29/14

DE-IDENTIFIED NOTES FROM CLINIC/ORGANIZATION INTERVIEWS:

Feels strongly about keeping operational grants. Administrators are interested in learning best practices from other clinics/grantees. Has not seen major impact from ACA. Is having difficulty finding EHR compatible with free clinic model. Wants to be able to highlight innovative nature of volunteer-centered model.

Does not expect changes to payer mix with ACA; free clinic, serves immigrant population. 3-5% of patients may be eligible for insurance, but having accounts receivable would be a huge operation -- they would not have the capacity to accept any insurance. They appreciate that the money is available for general operating expenses, but would also like additional money designated for innovation (they are considering transitioning to EHRs and need support). They would appreciate additional support in terms of training medical translators, risk management for practitioners. Would really like IBC to convene grantees to learn best practices, particularly regarding EHR implementation. No specific ideas for survey.

The ACA will likely not affect their services much. They really appreciate the personal relationship they have with Lorraina Marshall-Blake, Sheila, and Heather from IBC Foundation. They like that the foundation reaches out to them to ask questions about their application, rather than just denying it. They caution against moving towards funding innovation, because everybody wants to fund innovation, but nobody wants to fund the scaling and operationalizing of innovation. The operating expenses are what they need most. They really like the idea of convening grantees to teach and learn and share. Also, they think it would be great if IBC Foundation could reach across to the for-profit/Highmark side of IBC to have their presence at these convenings. There are likely well-meaning people on the corporate side that don't understand the challenges that grantees on the nonprofit side are facing. One challenge they've had is that many people give out misinformation about what is covered by CHIP, Medicaid, etc.

Clinic is struggling with implementing EHRs, specifically collecting BMI. Could use extra funds to get technical assistance for staff training. Would like to be asked about meeting with other grantees. Using

funds from IBC to change infrastructure, work flow, core team to apply for PCMH. Clinic does not see as many uninsured patients but Medicare decision could change their payer mix.