

By Suzanne Smith Dickinson



## FROM MANAGED CARE NETWORKS ARE CONNECTING

“Health center networks are really just extensions of its members,” says John Gressman, CEO of the San Francisco Community Clinic Consortium (SFCCC) in California. “They are health centers joined together to create strategies that will further support and advance each health center individually and collectively. They are natural forums for organizations seeking expansion of services through collaboration and cooperation with like-minded organizations.”

For SFCCC, changes in state funding for the uninsured was the catalyst of its inception in 1982. “All the centers had to negotiate their own contracts and rates and it became burdensome and inequitable,” Gressman says. “Eight Bay area centers formed a consortium to negotiate on behalf of the group with great

success. From there, the consortium began to maximize its grant funds through group purchasing.” It now has ten member centers and provides support for programs varying from technical assistance to health care for the homeless, to HIV services, to community outreach.

“Our partner health centers focus on the health of their patients while we focus on the health of the health center,” Gressman says.

Christopher Viavant, Managing Director of Utah Health Choice Network in Salt Lake City, a member of the Health Choice Network (HCN) based in Miami-Dade, Florida, says joining an existing organization made the most sense for seven diverse centers negotiating with the Utah Medicaid Office. “We started working on a way to create a single structure to negotiate on behalf of the centers in 2001,”

he says. “There were other strategies we wanted to implement, such as electronic health records (EHRs) and we were introducing pharmacy services in several sites.” The group of Utah Federally Qualified Health Centers (FQHCs) ranged in size from a large urban center in Salt Lake City, to the nation’s smallest federal grantee located in the frontier area of the state. “Needless to say, it became a question of economies of scale and how best to achieve that.”

HCN began in Florida in 1996 with five centers in the Miami-Dade area and one in Fort Myers. The network, a product of the Primary Care Health Consortium (formed to tackle managed care negotiations and headed up by the late Betsey Cooke), focused on information technology (IT) and financial services in the beginning. Today it has members in New Mexico,



# WELCOME TO MANAGING CARE HEALTH CENTERS AND SERVICES

Nebraska, Iowa, Kansas, Hawaii, and Florida and supports a number of IT-based services, such as EHRs and practice management systems, as well as financial and other systems/areas of FQHCs, such as human resources.

“We looked at several options,” Viavant says. “HCN was a good fit with a solid IT component and a proven track record.” While he says Utah Health Choice is a “wholesale” member (purchasing services from HCN and reselling to its own members), the structure of HCN is what makes it work for them. “There are effective conflict resolution and contractual requirements in place.” As part of its membership, the Utah group holds two seats on the HCN Board of Directors.

The Community Health Center Network (CHCN) in Alameda County, California, has similar roots in

managed care contracting. According to CEO Ralph Silber, the network was created in the early 1990s as an entity that could take risks and charge service fees to cover costs in the managed care arena instead of individual health centers. Today, they have contracts with three Health Maintenance Organizations, covering 35,000 members.

“The idea behind networks is to support our member health centers in providing and expanding health care,” Silber says. “We take our direction from a Board comprised of member CEOs who are better able to identify what their centers need to become more efficient and effective.” He says the next step for CHCN is quality improvement (QI) — broadly speaking. “We are looking at implementing QI initiatives that will assist health centers to better provide care and integrate health services. We

are seeing more focus on QI activities from the Health Resources and Services Administration (HRSA), so we are paying more attention to those efforts as well as evidence-based medicine (EBM) and health outcomes.”

In Maryland, Salliann Alborn, CEO of the Community Health Integrated Partnership (CHIP), says her organization was formed by a group of forward-thinking health center administrators. They wanted to take advantage of the opportunity that HRSA’s Integrated Service Delivery Initiative (ISDI) presented in developing their own managed care organization when Maryland transitioned its Medicaid population to mandatory managed care under an 1115 waiver.

In addition, the founding eight FQHCs wanted to collaborate on other



**“The idea behind networks is to support its member health centers in providing and expanding health care.”**

operational improvement projects such as information systems, credentialing and JCAHO accreditation. ISDI funding was an excellent vehicle for creating a formal network structure. When the Bureau of Primary Health Care (BPHC) launched the Health Disparities Collaboratives (HCDs), it was a natural progression for the Network to facilitate this work on behalf of its member health centers, she says. “With ISDI grant money we were able to build an infrastructure.”

With a BPHC Shared Integrated Management Information Systems (SIMIS) grant, CHIP was able to install a common practice management system in seven of its centers and centralize the management of the system. “Using data derived from the registration, scheduling and billing components, we initiated a benchmarking program to identify areas for improvement. Using industry standards we have successfully developed strategies that lead to improved performance,” Alborn says. “With the expansion of our information technology systems into electronic health records, funded in part by HRSA and the state of Maryland, we continue to offer health centers, through our shared services model, the latest in health care management tools, as well as the support services to maximize the utility of these systems.

### **A STRONG FOUNDATION**

There are currently about 80 health center networks operating in the country, according to Gressman. Each network is different, he says, because networks reflect the needs of the health centers it supports. Yet each network is similar in that it supports the needs of the health centers. “Networks are, for the most part, local organizations,” he explains. “The needs of the health centers in San Francisco are different than those in, say, Los Angeles. Even though both are in California, the environments are very different and a network needs to reflect the environment of its members and their patients.”

Silber agrees that a network is at its best when it is a creature of its members and its environment. “It’s not a cookie-cutter thing,” he says. “A solid network knows the health center environment, its partners, and the community needs.”

According to Viavant, if you are looking to form or join a network solely to save money by sharing HIT or other services, “you’re looking in the wrong place. You can’t look just at the money aspect,” he says. “The idea of a network is to optimize your overall return — what’s in the patient’s best interest, how can we best serve the patient’s needs?” He says interested parties should be looking at a network as an overall benefit to each organization, not a money-making organization when they join. “It’s not about cost savings as much as

it is an organizational commitment to develop strategic plans that will enhance patient care. When you join, you have to join — you have to compromise with other members and be committed to the group.”

### **SERVING THE GREATER GOOD**

Gressman says when a center joins a network it’s like giving something up to get something greater in return. “Everyone gets value added,” he says. “Then again, that’s the challenge in a network. Everyone may not get what they want, but they all get what they need. You have to pay mutual attention to every member and, collectively, set priorities through a strategic plan that everyone can live with.”

With today’s technology, Alborn says traditional boundaries have been erased. “Technology advancement is one of the greatest things going on,” she says. “Options for health centers are plentiful and [as part of a network] they can now take on projects they may not have been able to do individually.” Networks have the ability to seek out and employ the expertise for which a single health center may not have the resources. “Then that expertise is available to everyone,” she says. “A network offers a common centralized forum to discuss challenges and seek out solutions.”

While many of the existing health center networks emerged from Medicaid managed care negotiations, others sprang from a collective need to compete in the marketplace and offer competitive wages for specific personnel, such as finance or IT or human resources. In Florida, HCN started off sharing a CFO by “tossing

in” to meet the salary requirements of the level of expertise they needed. HCN President and CEO Kevin Kearns was that shared employee in early 1996. “At the time I was working at Family Health Centers of Southwest Florida in the Fort Myers area as a CFO and the centers in the Miami-Dade area were in need of one.” Kearns was contracted out to the group as a CFO consultant while Health Choice Network CEO Betsey Cooke was contracted to Fort Meyers for other administrative support. “It worked out well for everyone and laid the groundwork for sharing other services,” Kearns says.

At the time, both of the health center service areas were implementing fiscal IT systems — and both were running into problems. In the course of the mutual consulting agreement, they decided to officially unite and share the IT burden. “I became the Chief Information Officer (CIO) of the Network and we had the fiscal IT system up and running in the summer of ’97,” Kearns says. “We went ‘live’ with a practice management system the following fall and had every member health center online by January of 1998.”

The Community Health Access Network (CHAN) in New Hampshire was formed in 1995 to address a state “pay for performance” initiative. “That basically meant implementing an EHR system,” says CEO Kirsten Platte. By 2000, CHAN had implemented its first system in its five member sites. “We started with a server in each site to host the electronic system,” she says, “but it became cost-prohibitive fairly quickly.” Today more than 300,000 patients records are stored on 36 servers

located in the CHAN offices and 100 percent of the member providers are compliant with the system. “It has resulted in measurable time and cost reductions and has been a morale booster for staff at the centers to know they are not alone — that they have peers available that are doing the same type of work.”

While the idea of forming a network may sound as easy as a group of health centers banding together to tackle a single issue or share a single service, there is more to it than that.

Cost is always a factor, according to Viavant. “HCN started with contracts that said members would support the cost because there was an overall concern that groups with only third-party funding for a network would not be able to sustain the program once that money dried up.” In Utah, he says they relied on a lot of in-kind services and donations for equipment, facilities, and expertise to support the centers’ investment. “Now we are ready to grow into a fund-seeking organization to build on what we have now,” he says. “In that way it was good for us to join an established network. The existing structure was a great launching pad for obtaining additional money to move forward.”

But there are additional concerns besides money when looking at building or joining a network. “One thing you need to be wary of is starting a network based on a stressor,” Gressman says. “If



“It worked out well for everyone and laid the groundwork for sharing other services.”

there are specific problems that need to be solved — such as accounting or staffing — and it affects the minority of the interested parties, it is difficult to maintain a network once the stressor is eliminated.” Setting bylaws, having contracts, and setting short- and long-term strategic goals in the beginning will help pave the road to a successful network.

### READY RESOURCES AND EXPERTISE

An added bonus of many of the networks now operating is the infrastructure and wealth of information they hold for new access points and new start health centers. “As a new start, you don’t have to reinvent the wheel,” Silber says. “Networks already have access to the resources needed to go from ‘I have a grant’ to seeing patients. It allows new sites to use their federal grant more efficiently — more on operations, less on finding services.”

Alborn agrees, noting that networks, by virtue of their structure, are building platforms for expansion. “Networks can help centers acquire the tools needed to manage costs, expand delivery, and meet federal and other professional requirements,” she says. “The health center environment is going to change in the next five years. Health centers will need the infrastructure to be competitive. Networks have much of it in place already and can provide a lot of that infrastructure.”