



Data Warehouse Tool Instructions and Codebook

Fiscal Year 2006/2007 Survey

Revised: February 12, 2008

Funded by the W.K. Kellogg Foundation

**All rights reserved. No part of this document may be reproduced or utilized in any form or by any means, electronic or mechanical, including photo copying, recording, or by any information storage and retrieval system, without permission in writing from the Michigan Public Health Institute (MPHI).*

TABLE OF CONTENTS

General instructions.....1
Who should fill out this survey?1
Reporting unit2
Definitions of commonly used terms2

Item by item definitions and instructions

Section A: General information about your Center3
 Primary care information3
 Center information4
 Contact information5
 Fiscal year5
 Volume.....5

Section B: Patient demographic information6

Section C: Clinical diagnoses and services.....8
 Medical diagnoses and services8
 Nursing diagnoses and interventions10
 Services offered11

Section D. Quality indicators14

Section E: Academic activities and staff demographics14
 Center staffing.....15

Section F: Operating expenses.....15
 Personnel FTE and expenses15
 Other non-personnel operating expenses19

Section G: Billing information.....24
 Charges and charitable adjustments.....24
 Accounts receivable and bad debt.....24

Section H: Revenue.....25
 Patient care revenue25
 Other operating revenue.....26
 Non-operating revenue.....27
 Negotiated contracts and managed care plans27

Section I: Other and survey feedback28
 Evaluation28

Attachment
 A: Sample format for line C10.....29

GENERAL INSTRUCTIONS

The Data collection period will be announced via email and on our website – please refer to: www.nursingcenters.org.

Completed surveys should be mailed or emailed to:

Krysten Pierce
Michigan Public Health Institute
2440 Woodlake Circle, Suite 100
Okemos, MI 48864
kpierce@mphi.org

*If you have any questions or need clarification as you are filling out the survey, we would like to hear from you. You may contact Clare Tanner, Research Scientist at: ctanner@mphi.org, (517) 324-7381. If after looking at your data we have any questions about how the items were interpreted or estimated, we will call you to clarify. We would rather have valid data the first time through! **Also please contact us if you are questioning whether you are able to report sufficient data to make participation useful. We can let you know which items are absolutely essential to making participation worthwhile.** Finally, any feedback you have while filling out the tool will be very helpful for us in updating subsequent versions of the tool and clarifying the codebook.*

- I. Throughout the survey there are questions that ask you to choose among responses by marking an “X” on the corresponding line or in the corresponding box. There are also questions that require you to enter a response directly. Please answer all questions to the best of your ability – *do not leave items blank*.
- II. ***If you are unable to provide a response*** to a given question or item, please use the following missing value codes to indicate why you are unable to respond:
 - CR (“Can’t report”): Please use this code if you do not collect the information, are unable to access the information, or if you are just unable to report in the manner asked.
 - NA (“Not applicable”): Please use this only if the question is not applicable to you.

WHO SHOULD FILL OUT THIS SURVEY?

This survey requests information for a database of Nurse Managed *primary care* Centers. If your Center does not meet the definition (below) of being a **Nurse Managed Health Center that provides primary care**, please do not complete this survey. However, if your NMHC provides primary care, and other services as well, please do include *all* activities in your answers. In other words, we **do** want to hear about activities the Center provides *in addition* to primary care.

Nurse Managed Health Center (NMHC): a legal entity providing primary care services in a center with the following characteristics:

- Managed by nursing,
- A majority of care is provided by Advanced Practice Nurses (APNs)
- Has a defined mission/purpose, goals, and maintains financial records.¹

Primary care: the provision of *integrated, accessible health care services* by clinicians who are *accountable* for addressing a large *majority of personal health care needs*, developing a *sustained partnership with patients*, and practicing in the *context of family and community*.²

Finally, if your Center was recently opened and you are unable to report a full year's data on volume, revenue and expenses, please wait until next year to participate in this survey.

REPORTING UNIT

The reporting unit for this survey is the Center. A NMHC is defined as a legal entity providing primary care services as defined above. An entity (e.g., School of Nursing) may provide services at multiple locations. For some, each location may be considered its own Center; for others one Center may encompass primary care services offered at multiple locations.

- If each location *offers billable primary care services the majority of which is performed by an APN and has its own set of service and financial records*, they should be reported as separate Centers filling out one survey for each.
- If on the other hand, *primary care services performed at multiple locations are combined in one set of "books,"* complete only one survey, but please indicate the number of main and satellite locations and mobile units included in lines A18 and A19.

DEFINITIONS OF COMMONLY USED TERMS (in alphabetical order)

Advanced practice nurse: These are registered nurses with advanced training and education; most hold a Master's degrees in nursing and have passed one or more national licensing exams in order to practice. Further, ongoing education and/or testing is required for specialty license maintenance. The following are considered APNs:

- Nurse practitioners (NP),
- Clinical nurse specialists (CNS),
- Certified nurse-midwives (CNM), and
- Nurse anesthetists (CRNA).

Billable: A service could be billed for, using the appropriate Current Procedural Terminology (CPT) code. Billable services must always be documented in the patient's medical record. Note

¹ If your Center does not maintain financial records separately from your parent organization, it is OK to fill out the survey. However, please indicate on question 14, that the Center does not maintain separate financial records.

² Molla Donaldson, Karl Yordy, and Neal Vanselow (*Editors*). 1994. *Defining Primary Care: An Interim Report*. Committee on the Future of Primary Care, Division of Health Care Services, Institute of Medicine. Washington, DC: National Academy Press. (Available: <http://www.nap.edu/books/NX004380/html/>)

the criterion of providing billable services, does not mean that the Center must bill for services – only that the services provided are theoretically billable. Nor does billable imply that a service is necessarily always reimbursable by any particular payor.

Patient: Patients are individuals who have at least one billable visit during the reporting year with a Center provider.

- If the term *unduplicated* is used, the question is asking for a count of all patients seen during the reporting year – but not counting any patient more than once, no matter how many times s/he was seen.

Do NOT include:

- Other than in lines C31-C38, that ask specifically about group services, do **not** include patients receiving services that are not billable and documented in the patient’s record (such as participants in group or community based programs, if they are not documented in the patient’s record and potentially billable).

Provider: Individuals who provide billable direct care services to patients and assume primary responsibility for assessing the patient and documenting services in the patient’s record. NOTE: This includes providers who are employed, contracted or in-kind.

Visit: Visits are defined as billable documented face-to-face contacts between a provider and a patient. A visit may take place in the Center or at any other location in which the Center supported activities are carried out. Mass screenings at health fairs or mass immunization drives are not considered visits. Group visits are considered visits only if the provision of services is documented in each patient’s health record and each patient can be billed for the service.

- **Number of visits:** This is a count of visits with a given type of patient, or for a particular service, etc. during the reporting year. This is different from number of unduplicated patients because individual patients might be seen – and thus counted – more than once.

ITEM BY ITEM DEFINITIONS AND INSTRUCTIONS

Section A: General information about your Center

Primary care information

- A1. Please indicate if your Center provides primary care defined as above (under “Who should fill out this survey?”). If the answer is “No,” please do not complete this survey. However there may be other ways you can participate in the National Network for Nurse Managed Health Centers. Please see our website at: www.nursingcenters.org, or feel free to contact us by phone at: (517) 324-8345.

Also, so that we may better understand the universe of Nurse Managed Health Centers, please tell us what type of care your Center does provide in the box provided.

- A2. If your Center was just opened during the reporting period and you are only able to provide data for a partial year, please do not fill out the survey – we look forward to your participation next year!

A3. Self-explanatory

A4. If your Center does not focus on a specific population please check “None of the above.”

Center information

A5. Center name: Provide the legal name of your Center

A6-A9. Provide the legal address of your Center

A10. Website: Provide the website address for your Center, if available.

A11. Ownership organization(s): Please name the organization(s) that owns your Center (this could be a school of nursing/university, hospital/health system, a joint venture of multiple organizations, etc.). If this is an independent practice owned by one or more providers, please enter, “provider-owned.”

A12. Type of ownership organization: Please mark the type of ownership organization that most appropriately describes the organization that owns your Center.

- Provider owned is an independent practice owned by one or more providers.

A13-16. Ownership organization address: Provide the legal address of your ownership organization(s).

A17. Independent financial records: Does the Center track revenue and expenses for its activities independently from the ownership organization?

Questions A18 and A19 ask for a categorization of service locations. Include only sites in which billable services are regularly offered by APNs. Please do not count any location or site in more than one category.

Stationary sites: are those in which billable services are offered consistently and on a regular basis by APNs *at the same location*. This may include:

- A permanent unit providing services to a defined geographic area or population
- Another site, such as a homeless shelter, migrant camp, etc. if the Center has established and staffs a clinic on a regular, scheduled basis.

Do NOT include:

- Locations where patients may be visited by providers but where the grantee has not established a Center (such as private homes, hospitals, nursing homes, etc.).

Mobile van: Self-explanatory

A18. Main sites: The location of billable, primary care service provision considered to be “main” by the Center itself. Compared to satellite sites, main sites would have longer hours of operation, and a higher patient volume. Most “main” sites will be “stationary;”

however there are a few Centers in which mobile units provide most or all primary care of the Center.

A19. Satellite sites: A health care facility/unit operated under the auspices of a main health center, but is not located on the main site. The satellite site provides primary care services to patients, but has fewer scheduled hours and a lower volume than the main site.

A20. Self explanatory

Contact information

A21. Contact person: The Center Director or someone designated as an appropriate contact for your Center.

A22. Self explanatory

A23. Self explanatory

A24. Survey data contact person: Please list the person we should call if we have any questions about the data provided in this survey. If this is the same as the person listed in line A21, please enter “same” for items A24-A26.

A25. Self explanatory

A26. Self explanatory

Fiscal year

A27. Reporting year: Data in this survey are to be reported for the 2006/2007 fiscal year (FY06/07). This is to be a period of 12 consecutive months (even if you were closed part of that time). It is also permissible to submit either calendar year 2006 or 2007 if this is easier.

Please fill out all four boxes so that we may know what 12 month period the data cover. Use two digit numbers for month and year. For example if your fiscal year is the same as the calendar year, you would enter: beginning month – 01, beginning year – 06, ending month – 12, ending year – 06.

Volume

See additional information regarding the definitions of patients and visits provided on page 3.

A28. Total number of unduplicated patients: Patients are individuals who have at least one billable visit during the reporting year with a Center provider. Provide the total number of unduplicated patients during FY06/07. For example, you may have 900 total visits in the reporting year, but only *300 unique unduplicated patients*.

A29. Total number of visits: Visits are defined as billable documented face-to-face contacts between a provider and a patient.

Section B: Patient Demographic Information

For lines B1 through B29 please provide the number of unduplicated patients for each demographic category. The sum of patients for each demographic category (gender, ethnicity, race, age, education, primary insurance) should not exceed the total number of unduplicated patients provided on line A28.

- See the definition of unduplicated patients on page 3.
- If you are unable to report detailed demographic information in this way, please enter “CR” *and* place an “X” in the boxes corresponding to the categories of patients you *do* serve.

B1. Self explanatory

B2. Self explanatory

B3. Hispanic: Those people who classify themselves in one of the specific Spanish, Hispanic, or Latino Census categories -"Mexican, Mexican Am., Chicano," "Puerto Rican," or "Cuban" -as well as those who indicate that they are "other Spanish/Hispanic/Latino." Persons who indicate that they are "other Spanish/Hispanic/Latino" include those whose origins are from Spain, the Spanish-speaking countries of Central or South America, the Dominican Republic or people identifying themselves generally as Spanish, Spanish-American, Hispanic, Hispano, Latino, and so on (Census Bureau, available: http://quickfacts.census.gov/qfd/meta/long_68188.htm).

B4. Non-Hispanic: People who do *not* classify themselves as Hispanic.

B5. Self Explanatory

Race: The concept of race as used by the Census Bureau reflects *self-identification* by people according to the race or races with which they most closely identify. (The definition of race as well as all categories in lines B6-B12 are available at:

http://quickfacts.census.gov/qfd/meta/long_68184.htm.)

B6. White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. It includes people who indicate their race as "White" or report entries such as Irish, German, Italian, Lebanese, Near Easterner, Arab, or Polish.

B7. Black/African American: A person having origins in any of the Black racial groups of Africa. It includes people who indicate their race as "Black, African Am., or Negro," or provide written entries such as African American, Afro American, Kenyan, Nigerian, or Haitian.

- B8. American Indian/Native Alaskan: A person having origins in any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment.
- B9. Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. It includes "Asian Indian," "Chinese," "Filipino," "Korean," "Japanese," "Vietnamese," and "Other Asian."
- B10. Native Hawaiian/Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. It includes people who indicate their race as "Native Hawaiian," "Guamanian or Chamorro," "Samoan," and "Other Pacific Islander."
- B11. Two or more races: People may have chosen to provide two or more races either by checking two or more race response check boxes, by providing multiple write-in responses, or by some combination of check boxes and write-in responses.
- B12. Other race: Includes all other responses not included in the "White," "Black or African American," "American Indian and Alaska Native," "Asian" and "Native Hawaiian and Other Pacific Islander" race categories described above. Respondents providing write-in entries such as multiracial, mixed, interracial, Wesort, or a Hispanic/Latino group (for example, Mexican, Puerto Rican, or Cuban) in the "Some other race" category are included here.
- B13. Unknown race: Self-Explanatory

Age: Please indicate the number of unduplicated patients falling into each age category.

- See the definition of unduplicated patients on page 3.

- B14. Self explanatory
- B15. Self explanatory
- B16. Self explanatory
- B17. Self explanatory
- B18. Self explanatory
- B19. Self explanatory
- B20. Self explanatory
- B21. Self explanatory
- B22. Self explanatory
- B23. Self explanatory

Primary healthcare coverage: Indicate the number of patients served by category of *primary* healthcare coverage (if any) as of the last visit during the reporting period. Primary insurance is defined as the plan/program that the Center would bill first for services rendered.

- See the definition of unduplicated patients on page 3.
- If your Center serves patients with insurance, but does not bill for services, please indicate this in line B29, under “Other.”

B24. Medicaid: Self explanatory

B25. Medicare: Self explanatory

B26. Other government: Includes Veterans Administration, county health plans, and any other federal, state, or local government source that is not a commercial plan

B27. Commercial healthcare coverage: Self explanatory

B2x. Service contract: The number of patients covered by a contract that would not be considered a capitated plan. (An example could be a contract with an employer to provide on-site occupational health to employees, WIC services, contracts to provide student physicals, flu vaccines, etc.)

- This item is really meant to cover only those arrangements that do not fall under typical health coverage plans or reimbursement

Do NOT include:

- Patients covered by capitated contracts
- Federal or other grants

B28. Uninsured: Patients with no healthcare coverage

B29. Other: Patients covered by something other than categories in lines B24-B28. Please specify what this coverage is in the space provided.

B30. Limited English proficiency: patients who are best served in a language other than English or with sign language.

- See the definition of unduplicated patients on page 3.
- If you do not have an accurate count of the Center’s unduplicated patients that fit this category, estimate the percentage of patients with limited English proficiency.
- You do *not* need to enter both a number and percentage.

Section C: Clinical diagnoses and services

Medical diagnoses and services

For questions C1 through C9, please provide the number of *visits* for each diagnostic category.

- See the definition of visits provided on page 3.
- Include only the diagnoses corresponding to the ICD-9-CM codes listed.
- Draw on all diagnosis fields available (primary and secondary).

- C1. Diabetes mellitus: Include all diagnoses in which the first three digits of the ICD-9-CM code are “250” (for example 250.00, 250.11, and all other 250.xx).
- C2. Obesity: Include the diagnoses for obesity corresponding to ICD-9-CM codes 278.0, 278.00, and 278.01.
- C3. Depression: Include diagnoses coded as 311 “Depressive disorder, not elsewhere classified.”
- C4. Non-tobacco substance abuse disorder: Includes:
- Alcohol dependence syndrome, ICD-9-CM code 303, including all 4th and 5th digit specifications
 - Drug dependence, ICD-9-CM code 304, including all 4th and 5th digit specifications
 - Nondependent abuse of drugs, ICD-9-CM code 305, including all 4th and 5th digit specifications *except* 305.1 (tobacco use disorder/tobacco dependence).
- C5. Tobacco use disorder: Include the diagnosis for tobacco use disorder/tobacco dependence corresponding to ICD-9-CM code 305.1.
- C6. Hypertension: Include diagnoses of essential hypertension corresponding to ICD-9-CM codes 401.0, 401.1, and 401.9.
- C7. Asthma: Include diagnoses corresponding to ICD-9-CM code 493, including all 4th and 5th digit specifications.
- C8. Supervision of normal pregnancy: Include health maintenance visits coded v22.0 (supervision of normal first pregnancy) and v22.1 (supervision of other normal pregnancy).
- C9. Please provide number of visits during FY06/07 for the top 20 most common diagnoses, not including those already listed in lines C1-C8. Please list diagnoses in descending order of frequency.
- Draw on all diagnosis fields available (primary and secondary).
- C10. This question asks for the number of visits by CPT code. This may be a computer printout or electronic spreadsheet. Follow the format of Attachment A or you may fill in and provide Attachment A.

Nursing diagnoses and interventions

- C11. Nursing diagnoses: Documentation of patient diagnosis using one of the standardized nursing languages listed.
- If your Center uses a standardized nursing language to record patient diagnosis, please list your 30 most frequent nursing diagnoses, and the number of visits for each in FY06/07.
 - If your Center does not use a standardized nursing language to record patient diagnosis, check “None” and enter “NA” in the table for sub-question “a.”
- C12. Nursing interventions: Documentation of caregiver actions taken using a standardized nursing language.
- If your Center uses a standardized nursing language to record caregiver actions, please list your 30 most frequent nursing interventions, and the number of visits for each in FY06/07.
 - If your Center does not use a standardized nursing language to record interventions, check “None” and enter “NA” in the table for sub-question “a.”

In lines C13-C15 enter the number of visits in FY06/07 by broad categories listed. If you track this information, please enter it even if you do not use a nursing language.

- If you have actual visit volume, please enter it in the middle column and do NOT estimate percentages.
- If you do not track this information, but feel you could estimate with accuracy, please provide an estimate of the percentage of visits involving each broad category of activity.

- C13. Health Teaching, Guidance, and Counseling: Activities that range from giving information, anticipating client problems, encouraging client action and responsibility for self care and coping, to assisting with decision making and problem solving. The overlapping concepts occur on a continuum with the variation due to the client’s self-direction capabilities (Omaha System Intervention Scheme, available: <http://omahasystem.org/shminter.htm>).

Similarly, using Nursing Intervention Classification (Dochterman & Bulechek, 2004),³ this category includes:

- Health teaching: Assisting the patient to understand information related to a specific disease process or health related concern.
- Counseling: The use of an interactive helping process focusing on the needs, problems, or feelings of the patient and significant others to enhance or support coping, problem solving, and interpersonal relationships.

- C14. Case management: Includes:
- Coordinating care and advocating for specified individuals and patient populations, across settings to reduce cost, reduce resource use, improve quality of health care,

³ Joanne McCloskey Dochterman and Gloria M. Bulechek, 2004. Nursing Interventions Classification (NIC), 4th Edition. Mosby.

and achieve desired outcomes (Dochterman & Bulechek, 2004, Nursing Interventions Classification/NIC).

- Activities of coordination, advocacy, and referral. Involve facilitating service delivery on behalf of the client, communicating with health and human service providers, promoting assertive client communication, and guiding the client toward use of appropriate community resources (Omaha System Intervention Scheme, available: <http://omahasystem.org/shminter.htm>).

C15. Surveillance:

- Purposeful and ongoing acquisition, interpretation, and synthesis of patient data for clinical decision making (Dochterman & Bulechek, 2004).
- Activities of detection, measurement, critical analysis, and monitoring to indicate client status in relation to a given condition or phenomenon (Omaha System Intervention Scheme, available: <http://omahasystem.org/shminter.htm>).

The following are examples of surveillance:

- Blood pressure management
- Screening at-risk individuals for depression using a standardized scale
- Monitoring BMI of individuals at risk for obesity or on a weight management plan
- Diabetes management
- Blood sugar monitoring

Services offered

For questions C16 through C27, indicate whether your Center offers the listed services by marking an “X” in the appropriate column.

C16. Age appropriate immunizations: Centers perform immunization according to the schedule recommended by the Centers for Disease Control that can be found at: <http://www.cdc.gov/nip/menus/groups.htm#child>.

C17. Cervical cancer screening: Centers perform cervical cancer screening in accordance with guidelines as recommended by ACOG (American Cancer Society, January 2004. ACS Cancer Detection Guidelines available: http://www.cancer.org/docroot/PED/content/PED_2_3X_ACS_Cancer_Detection_Guidelines_36.asp):

C18. Breast cancer screening: Centers **recommend and refer** patients for breast cancer screen based on the breast cancer screening guidelines as recommended by American Cancer Society (American Cancer Society, January 2004, available: http://www.cancer.org/docroot/PED/content/PED_2_3X_ACS_Cancer_Detection_Guidelines_36.asp).

C19. Colon cancer screening: Centers **recommend and refer** patients for colon cancer screen based on the colon cancer screening guidelines as recommended by American Cancer Society (American Cancer Society, January 2004. ACS Cancer Detection Guidelines available:

http://www.cancer.org/docroot/PED/content/PED_2_3X_ACS_Cancer_Detection_Guidelines_36.asp).

- C20. Smoking cessation services: Smoking cessation services include but are not limited to integrated smoking cessation techniques, availability of smoking cessation aids, professionally facilitated smoking cessation groups and individual sessions with smoking cessation counselors.
- C21. Family planning services: Centers provide complete family planning services including but not limited to: access to several contraception options, STD testing and treatment, access to prenatal care, referral to OB/GYN care where clinically indicated.
- C22. Post-partum care: Centers provide post partum care including assessment of return of reproductive organs to pre-pregnant state, contraception options, STD testing and treatment and cervical cancer screening.
- C23. Mental/behavioral health services: Services to promote mental/behavioral health and wellness, including:
- Screening for emotional problems, mental illness, and/or addictive disorders
 - Therapy, counseling or other treatment
 - Substance abuse treatment or counseling
 - Services may be provided by a primary care provider *or* a licensed behavioral health provider (e.g., clinical social worker, psychologist, psychiatrist, psychiatric nurse specialist, marriage/family therapist, mental health nurse practitioner)
- C24. Transportation: Centers provide method of transporting patients to the Center for an appointment. This includes but is not limited to Center-owned cars and vans, public transportation tokens or cab fare.
- C25. Community education: Centers provide community wide educational opportunities for all community members and/or only patients receiving primary care from the Center.
- C26. Community screening events: Centers provide or participate in disease screening events such as blood pressure screenings, diabetes screenings etc.
- C27. Other access and outreach services: Centers should list those offerings that do not fit into the above categories but none the less support the mission of nurse managed Centers such as flu vaccine administration for the community, speakers bureau activities for community organizations etc.
- C28. Urgent care: Care for situations that require same day or next day visits, such as urinary tract infections, respiratory infections, injuries, etc.
- C29. Twenty-four hour coverage: Provider availability 24 hours a day, seven days a week, by pager, phone, or face-to-face option.

C30. Self explanatory

For questions C31 through C38, indicate in the appropriate box if your Center provides the listed group services, and if provided, enter the number of patients served during the reporting year for each service.

Group services: Educational and/or support services on a specific topic area offered to multiple patients at one time. Group services may be a one-time service or may be a reoccurring service over a specific time period (e.g., group meets once a week for six weeks).

- Some of your Center’s group programs may fit in multiple categories – please select the most appropriate one. For example, a diabetic group class could fit under disease education, chronic disease management, or health promotion, depending on the curriculum. Do **not** categorize such a program under multiple categories – choose the best one.
- Individual participants should only be counted **once** per group program. For example, if your Center runs an 8-week prenatal education class, count the individual participants in the class only once and **not** for each session s/he attends.
- If the same individual participant attends multiple group programs, **do** count the individual for each program s/he attends. For instance, if a participant attends both a disease education program and a prenatal education program, that person should be counted for each.

C31. Chronic disease management: Group services offered to patients with chronic diseases such as diabetes, hypertension, obesity, cardiovascular disease, asthma, depression, and others. Group sessions should cover education, support, and information on how to manage the patients’ disease.

- If education is the only service, report it below in line C32 – it does not qualify as management.
- In the last column, please specify which diseases you offer this for.

C32. Disease education: Group services providing education related to specific diseases, but which do not include the management of the disease.

- In the last column, please specify which diseases you offer this for.

C33. Health promotion: Group services providing support and education to patients for health promotion related topics. Examples of health promotion topics include physical activity, weight control, smoking cessation, nutrition, etc.

- Please specify the health promotion topics

C34. Mental/behavioral health: Group services providing education and support to promote mental and behavioral health and well-being. Examples of mental health group services include therapy and support in areas such as: stress management, substance abuse, grief and loss, addiction, depression, mental health disorders, etc.

- Please specify the type of mental/behavioral health group programs you have.

- C35. Parenting: Group services designed to enhance the child-rearing skills and support of parents/caregivers, and may include: discussion of parenting techniques, approaches, strategies, and child care issues for parents.
- C36. Prenatal education: Group education programs covering topics such as health and nutrition during pregnancy, labor and delivery, beginning lactation, and post partum care of mother and baby.
- C37. WIC: Nutrition and health counseling services provided through the Special Supplemental Food Program for Women, Infants and Children.
- C38. Other group service: Please specify any other type of group service your Center provides but is not listed above, and indicate the number of participants during the year.

Section D: Quality indicators

Section D has been deleted. INC is collecting quality indicators from a subgroup of Centers using a different tool. For more information, please contact us.

Section E: Academic activities and staff demographics

In lines E1 through E11 enter the total number of each type of student who had educational experiences in the Center during FY06/07 (enter “0” if none).

Educational experience: is defined as a required learning or clinical experience or part of a specific course or independent study. One-time observation or modeling experiences are *not* considered educational experiences.

Minority number: In the second column enter the number of students of each type during FY06/07 who are from a minority racial or ethnic background. For purposes of this survey, minority refers to anyone from a Hispanic or non-white background.

- E1. Self explanatory
- E2. Self explanatory
- E3. Self explanatory
- E4. Self explanatory
- E5. Self explanatory
- E6. Self explanatory
- E7. Self explanatory
- E8. Self explanatory
- E9. Self explanatory
- E10. Self explanatory
- E11. Self explanatory

- E12. Faculty practice site: When faculty members from your school of nursing, whose primary responsibility is in the academic unit, utilize the Center as a practice site.

- Faculty who were 50% (or more) allocated to the academic unit should be included.
 - If your Center serves as a faculty practice site, please provide details by answering questions a-c.
 - For question c, minority refers to anyone from a Hispanic or non-white background.
- Do NOT include:
- Adjunct or other faculty whose primary academic responsibility is the precepting of students in the Center

Center staffing

This section asks you to report the total number of full or part time providers and staff practicing at and/or employed by the Center during FY06/07. Include:

- Providers or staff who: are directly employed, were contracted, or whose time is volunteered or contributed in-kind.
- Providers and staff who worked during part of the year or part-time.

In the second column, please report the number of minority providers or staff during FY06/07

- Minority refers to anyone from a Hispanic or non-white background.

E13. Providers: Individuals who provide billable direct care services to patients and assume primary responsibility for assessing the patient and documenting services in the patient's record.

E14. Staff: Include all *non-provider* staff who were employed or contracted or who provided in-kind services during FY06/07.

Section F: Operating expenses

Personnel FTE and expenses

The remainder of the survey asks for financial information. Many definitions of financial data items are drawn from the Medical Group Management Association (MGMA) Cost Survey Questionnaire and are used with permission.⁴ It is hoped that this will facilitate comparison of nurse managed health Centers with other types of primary care practices.

Summarize both compensated, contracted, and uncompensated personnel in the tables in this section. For each type of provider or staff, indicate the FTE of employed personnel and contracted personnel in the first two columns. Note that values entered in lines F1 through F9 must total to the values entered in line F10. Similarly, values entered in lines F11 through F20 must total to the values entered in line F21.

⁴ "Appendix B: Terms Used in Report," MGMA Cos Survey: 2004 Report Based on 2003 Data. Used with permission from the Medical Group Management Association, 104 Inverness Terrace East, Englewood, Colorado 80112-5306; 303.799.1111. www.mgma.com. Copyright 2004.

If the Center does not employ or contract with providers of a given type, enter “0” for FTE and cost. It is permissible to leave these cells blank as well, *so long as total amounts are entered*. If cells with entries add up to column totals, *we will impute blank cells to be 0*.

Paid FTE: To calculate FTE, add together the number of full time (1.0 FTE) with the number of part time provider or staff. The FTE computation for part time providers can be derived by dividing the total hours paid for in a week by the number of hours the Center considers designates as a workweek (historically 40 hours). For example, an APN works 30 hours per week in a Center that designates 40 hours as full-time. The FTE calculation is .75 FTE (30 hours divided by 40 hours). For those providers who have worked only a portion of the fiscal year, calculate the total hours paid for and divide by 2080. A provider working full time for three months only would be .25 FTE (520 hours divided by 2080).

- **Special note**: Under no circumstances can a provider or staff members count more than 1.0 FTE no matter how many hours worked or how many categories they may fit.
- If a staff member fills more than one role in the Center, for example if the person works half time as a coder and half time as clerical staff, separate the FTE by role. Put .5 FTE of this person in the coder/biller category and .5 FTE in the clerical staff category.
- Similarly, if a provider fills a dual role, divide the FTE according to roles performed. For example, if a Nurse Practitioner is the Center Director, and spends half of her time providing patient care services, enter half of her FTE in line F1 (Advanced Practice Nurse) and the remaining half of her FTE in line F11 (General Administration).

Contracted FTE: Contracted providers and staff are those who provide services on site but are not employees of the Center and do not receive fringe benefits. Contracted providers/staff have a formal written contract with the Center that describes the relationship between Center and provider/staff, services offered on site, and the pre-determined reimbursement amount for services rendered.

- The calculation of contracted FTE is the same as that for paid FTE (see above).
- Contracted providers would generally include collaborating physicians in NMHCs.
- A defining characteristic of contracted staff is that the hours works (FTE) are easily identified and reported. If the FTE cannot be accurately reported then the cost for such services should probably be reported under contracted services as appropriate. For example, if your Center purchases billing and collection activities, you probably cannot determine the FTE necessary for the time the billing company provides. These costs should be reported as Billing and Collection Services on line F25.

Total expense refers to *all forms of compensation for ALL the FTE counts in the paid and contracted columns*, including:

- Salary: Compensation in the form of salaries, bonuses, incentive payments, research contract revenue, honoraria, and profit distributions and voluntary employee salary deductions used as contributions to 401(k), 403(b), or section 125 plans.
- Fringe benefits: The employer’s share of FICA and unemployment insurance taxes; employer’s share of health, disability, life, and workers compensation insurance; employer payments to defined benefit and contribution 401(k), 403(b), and nonqualified retirement plans; deferred compensation paid or expensed during the year; dues and memberships in professional organizations and state and local license fees, etc.

- Amount paid according to contracts for contracted providers/staff.
- Fee for service fees paid to consulting providers (i.e., pathologists, radiologists, and others).
- **Special note:** Separate into appropriate categories the total cost of providers or other staff who perform multiple roles. For example, if you have a Center Director who spends half her time practicing as a Nurse Practitioner, place the NP portion of salary/fringe/etc. in line F1 and place the administration portion of salary/fringe/etc. under general administration, line F11. Similarly, if you have a staff person that is both a biller and receptionist, divide the total cost between lines F16 and F17.

Do NOT include:

- Expense reimbursements
- Costs for purchased provider and/or non-provider consultation services for capitation clients/patients. These costs should be included in Managed Care Expenses (purchased services).
- The potential cost for salary expenses for in-kind or donated provider/staff time. The value of these donations should be included in the last column, titled “In-kind market value.”

In-kind FTE: In this column, report the FTE of providers and staff whose services are donated to the Center (i.e., their salary is paid by another organization, such as a school of nursing – or they are volunteering their time). The rationale for collecting this information is that Centers operate with a variety of staffing models, including volunteers, and staff provided free of charge by other organizations. Some Centers require a mix of paid and in-kind staff to remain viable.

- The calculation of in-kind FTE is the same as that for paid FTE, as described above on pages 15-16.
- **Special note:** Under no circumstances can a provider or staff members count more than 1.0 FTE no matter how many hours worked or how many categories they may fit.

In-kind Market Value: Estimate the value of the FTE donations by provider and staff type as reported in the previous column.

- To compute the market value of in-kind and/or volunteer time, multiply the in-kind/volunteer FTE by the average total cost for individuals of the same provider or staff category. Be sure to include the estimated cost of salary *and fringe benefits*.

Report FTE and Costs (as described above) by provider category in lines F1-F9.

- **Providers:** Individuals who provide billable direct care services to patients and assume primary responsibility for assessing the patient and documenting services in the patient’s record.

F1. **Advanced Practice Nurses:** These are registered nurses with advanced training and education. Most hold a Master’s degrees in nursing and have passed one or more national licensing exams in order to practice. Further, ongoing education and/or testing is required for specialty license maintenance. Include:

- Nurse Practitioners (NP) – be sure to include NPs with a mental health specialty here
- Clinical Nurse Specialists (CNS) – be sure to include Psychiatric Nurse Specialists

- Certified Nurse Midwives (CNM)
- Nurse Anesthetists (CRNA)
- If an APN, also serves in an administrative capacity, be sure to estimate the portion of FTE and costs for each function and report them in the appropriate lines. For example, if a NP making \$100,000 in salary and fringe spends 30% of her time for administration and 70% on patient care, report .7 FTE and \$70,000 on line F1; and .3 FTE and \$30,000 on line F11.

F2. Physician: Self explanatory, but do not include Psychiatrists. Psychiatrists should be included in line F6.

F3. Physical Therapist: Self explanatory

F4. Dentist: Self explanatory

F5. Social Worker: Self explanatory

F6. Mental/Behavioral Health Provider: Licensed health professionals providing counseling, mental/behavioral treatment, and support services, including:

- Clinical social workers
- Marriage/family therapist
- Psychiatrists
- Psychologists

Do NOT include the following (which should be reported in line F1):

- Mental health nurse practitioner
- Psychiatric nurse specialist

F7. Optometrist: Self explanatory

F8. Podiatrist: Self explanatory

F9. Other provider: Please specify any other types of providers that are employed by your Center. Summarize paid FTE, contracted FTE, total cost, in-kind FTE, and in-kind market value in the appropriate columns.

- Include only providers – see the definition of provider above on page 17.

F10. Total Center providers: Ensure that entries made in lines F1-F9 sum to the values entered here in line F10.

Report FTE and Expenses (as described above) by non-provider staff category in lines F11-F20.

F11. General administration: Includes office managers, Center Directors, financial staff and other administrative staff.

- If a provider, such as an APN, also serves in an administrative capacity, be sure to estimate the portion of FTE and costs for each function and report them in the appropriate lines. For example, if a NP making \$100,000 in salary and fringe spends 30% of her time for administration and 70% on patient care, report .7 FTE and \$70,000 on line F1; and .3 FTE and \$30,000 on line F11.

F12. Registered nurses: Self explanatory

- F13. Licensed practice nurses: Self explanatory
- F14. Medical assistants: Self explanatory
- F15. Outreach worker: Includes medical and non-medical personnel who provide outreach services (e.g., information, educational services, screenings, etc.) to the community.
- F16. Clerical staff: Includes secretaries, receptionists, medical transcriptionists, and other clerical staff members.
- F17. Coders/billers: Self explanatory
- F18. Information technology: This includes all personnel involved in maintaining and updating computers, software, electronic health records, servers, and other technology related roles.
- *Note*: if you do not know the FTE for these roles, you most likely contract for the service(s) rather than the personnel. If this is the case, include these costs below, in line F29), rather than here.
- F19. Housekeeping, maintenance, security: This includes all personnel involved with cleaning the Center, maintaining the building, grounds, and equipment, and providing security to the Center.
- *Note*: if you do not know the FTE for these roles, you most likely contract for the service(s) rather than the personnel. If this is the case, include these costs below under “Building and occupancy” (line F30), rather than here.
- F20. Other (specify): Please specify any other types of non-provider staff that are employed by your Center. Summarize paid FTE, contracted FTE, total cost, in-kind FTE, and in-kind market value in the appropriate columns.
- F21. Total non-provider Center staff: Ensure that entries made in lines F11-F20 sum to the values entered here in line F21.

Other non-personnel operating expenses

This section collects data on non-personnel operating expenses.

- Operating expenses: Expenses incurred in the process of providing health care services to patients.

Do NOT include:

- Non-operating expenses: Expenses arising from activities not associated with the rendering of healthcare services to patients. Examples include: taxes, expenses related to the management of long-term investments and endowments, losses on sales of equipment or real estate. Non-operating expenses should be reported on line H16.

For each listed category of operating expenses, enter the following information:

Expense: The amount to be entered in the expense column is the sum of actual expenses incurred during the year for each cost category.

In-kind market value: For any goods or services that are donated to the Center and contribute to the operations of the Center, please estimate the amount that the Center would have had to pay to purchase the good or service. (For instance, some Centers operate in a University building, provided free of charge by the university. Such a Center should estimate all the costs that are saved by virtue of receiving the donation of space and enter this amount in line F30. They may include not only rent, but also utilities, maintenance, and/or security. Another example would be information technology services provided by the School of Nursing: the amount that the Center would otherwise have to spend to purchase these services should be entered as in-kind.)

Comments: This column is optional and is for your use in providing us with information about the quality of the data entered (for instance if you had to estimate any amounts, if you could not separate cost items, if you have in-kind expenses but do not know the value, etc.).

Summarize actual and in-kind expenses for the following categories of operating expenses:

F22. Consultants: Consultants are professionals engaged on a sporadic basis to provide specific *non*-patient care services to the Center (e.g., billing/coding experts hired to provide guidance or train staff).

F23. Medical/surgical supplies and pharmaceuticals: Supplies for general practice use. Include the following here:

- Cost of drugs, vaccines, etc. used in providing medical services *and* provided/sold to patients for primary use outside the Center
- Cost of supplies and instruments used in providing medical services
- Cost of laundry and linens.

Do NOT include:

- Cost of specialized supplies dedicated for exclusive use in other department or ancillary departments (e.g., radiology, laboratory, etc.)
- Cost of equipment subject to depreciation (put this in line F24 if it is for general use, or line F29 if it is related to information & technology).

F24. Clinical and non-clinical equipment and furniture: Cost of equipment and furniture in general use in the practice.

Include:

- Rental, maintenance and depreciation cost of furniture and equipment used in reception areas, exam and treatment rooms, provider offices, and administration areas.

Do NOT include:

- Expenses related to information technology equipment, including data-processing, computer and telecommunications equipment, furniture, and hardware. Report these costs on line F29.
- Cost of supplies entered on line F23.

- Cost of equipment for ancillary services – such as laboratory, radiology, physical therapy, etc. These should be entered as “Other” on line F34.
- F25. Billing and collection services: Cost for purchased billing and collection services from an outside organization as opposed to hiring and developing staff to conduct billing and collections within the Center.
Do NOT include:
- Cost of contracted coders/billers reported on line F17.
- F26. Malpractice insurance: Includes premiums paid or the self-insurance cost for malpractice and professional liability insurance for Center providers.
- F27. Managed care expenses (purchased services): Fees paid to health care providers and organizations external to the Center for services provided to capitation patients under a capitation contract. Include:
- Payments to external providers, and non-providers professionals, clinical laboratory, radiology, and imaging, hospital inpatient, emergency, ambulance, out of area emergency and pharmacy services, etc.
 - Accrued expenses for “incurred but not reported” claims for purchased services for capitation patients for which invoices have not been received.
- F28. Management/parental organization fees: Fees paid for management or other services to parent organization or hospital. Fee may be a fixed amount, percent of collections, or negotiated amount. Include:
- Fees paid to hospital, School of Nursing, or parent organization for management, administrative, and/or related support services.
 - Cost allocated to the Center from a parent organization. These may also be called, “indirect costs,” “shared service costs,” “Dean’s fees,” etc. They may be arbitrarily assigned to the Center, the result of negotiations between the Center and parent organization, or the result of some sort of cost accounting system.
 - Market value of any management services provided by a parental organization free of charge – if this contribution was not recorded as an in-kind staff contribution. Note that this could include payroll services, benefits negotiation and other human resource support, grant writing support, support with contract negotiation and writing grants, among others.
- Do NOT include:
- The cost of management, support, or administrative staff employed by the parent organization if these costs were reported under personnel. Note that the decision on whether to report such costs here in line F28 rather than under appropriate personnel lines depends on whether FTE data are accurate and easily obtainable.
 - Market value of in-kind management services if this was estimated under staff or another service category.
- F29. Information technology: Cost of practice-wide data processing, computer hardware and software, and telecommunication services. If your School of Nursing or parent

organization provides IT support and technology with no cost to the Center, place the market value the contributions in the second column. Be sure to include:

- Cost for local and long-distance calling - including lines for fax machines and internet connections
- Cost of paging and answering services
- Cost of computers, software and hardware purchased in the reporting year.
- Rental and/or depreciation cost of major data processing, computer and telecommunications furniture, equipment, hardware and software subject to capitalization
- Hardware and software repair and maintenance contract cost
- Cost of data processing services purchased from an outside service bureau
- Cost of data processing supplies and minor software and equipment not subject to capitalization
- Cost of maintenance, support, and repair for electronic health records

Do NOT include:

- Costs of specialized information services and equipment for exclusive use in other departments (i.e., radiology, clinical laboratory, etc.). These should be reported under, "Other," on line F34.
- Cost of contract programmers or IT Center staff that are accounted for under personnel in line F18.

F30. Building and occupancy: Cost of rent/mortgage and general operation of buildings and grounds. If any of these costs are not borne by the Center, estimate the value of these in-kind services in the second column. Building and occupancy expenses include:

- Rental, operating lease and leasehold improvements for buildings and grounds
- Depreciation costs for building and grounds
- Interest paid on loans for real estate used in practice operations
- Cost of supplies, materials, and/or contracted services used for housekeeping and maintenance
- Cost related to building repairs
- Cost for security system and/or contracted security services
- Cost for water, heat, gas, electrical power and other utilities.

Do NOT include:

- Interest paid on short term loans
- Interest paid on loans for real estate not used in practice operations such as non-clinical office space in practice owned properties.
- Any contracted or staff costs related to building and occupancy reported under personnel on line F19.
- Cost of producing revenue from sources such as parking lots or leased office space from practice owned properties

F31. Marketing and promotion: Cost promotion, advertising and marketing activities, including patient newsletters, information booklets, fliers, brochures, yellow page listings and public relations consultants.

- F32. Insurance for property and equipment: Include:
- Cost of insurance premiums for property insurance including fire, theft, flood, casualty, general liability, officers and directors liability, reinsurance, etc.
 - Cost of insurance premiums to cover any equipment including computer, clinical capital equipment, furniture, etc.
 - In-kind value of insurance if another organization is covering these costs (for instance if occupancy is a donated service and the insurance on the premises is covered by the owner of the property)
- Do NOT include:
- Professional liability insurance premiums reported on line F26.
- F33. Administrative supplies/office expenses: Cost of printing, postage, books, subscriptions, administrative and medical forms, stationery, bank processing fees, and other administrative supplies. Include purchased transcription services. If any of these items are donated, include an estimation of the market value in the second column.
- Do NOT include:
- Expenses included in the estimation of in-kind management services provided by a parent organization (line F28).
- F34. Other: Any other operating costs not listed elsewhere. Please specify the item(s), supplies, or service(s), and provide the total cost for all other expenses. Examples of items not included elsewhere include:
- Fees for services not included elsewhere, such as legal, accounting or management services not included under staff.
 - Professional fees associated with joining professional or national membership organizations, licensing fees associated with renewing provider and practice licenses, or cost for continuing education for Center providers and staff.
 - Managed care fees associated with being part of a managed care plan
 - Cost of supplies equipment, etc. for ancillary services such as laboratory, radiology, optical, physical therapy, etc.
 - Charitable contributions, employee relations events, interest on loans, recruiting and hiring costs
 - Travel costs not accounted for elsewhere
- Do NOT include:
- Purchased services for capitation patients under the terms of contract with managed care organizations. These should be included in line F27.
 - Federal or state income taxes – which should be included below as a non-operating cost in line H16.
 - Other costs considered to be non-operating costs (see definition of operating expense above on page 19; also see explanation of line H16 below
 - Principal paid on loans – which is not reported anywhere on this survey
- F35. Total non-personnel operating expenses: Values here must equal the sum of entries made in lines F22-F34.

Section G: Billing Information

Charges and charitable adjustments

This section asks you to enter total gross charges and adjusted charges for all patient care activities.

FFS: Charges for services to fee-for-service (FFS), discounted FFS, and non-capitated patients for all payors.

- Include charges for *all patients not covered by a capitated contract* (including the uninsured, patients who self-pay according to a sliding fee scale, patients served as part of a non-capitated service contract, as well as those covered by traditional FFS insurance).
- Also include FFS charges as allowed under the terms of a capitated contract (in other words, services that are not covered by capitation contracts, but are allowed to be charged on an FFS basis).

Capitated: Charges for covered services to patients covered by capitation contracts.

- G1. Total gross charges: This includes charges at the full value, at the Center’s undiscounted rates, for all patient care. Please enter the total in the last column. If you are able, please break out total gross charges by whether the patients are covered as part of a capitated contract or not. (Include uninsured patients under FFS.)
- Total gross charges for capitated patients are also known as “FFS equivalent gross charges.”
- G2. Adjusted charges: Whether for capitated or non-capitated patients, adjusted charges refer to the amount of revenue expected after charitable and other adjustments are made.
- Adjusted charges for FFS patients is also called, “amount billed.” This would be computed as gross FFS charges minus adjustments to FFS charges.
 - For capitated patients, this amount is often referred to as “gross capitation revenue” or the per member per month capitation payments plus copayments. Also include bonuses and incentive payments for good capitation contract performance, and portions of the capitation withholds returned to a practice as part of a risk sharing agreement.
- G3. Adjustments for uncompensated/charitable care: This would include charitable, professional courtesy or employee adjustments. Charitable adjustments will include care that is not billed at all, and also any discounts or sliding fee adjustments.

Accounts receivable and bad debt

- G4–G8. Accounts receivable: Amounts owed to the practice by patients, third party payers, employer groups/unions BEFORE adjustments for payment reductions. Please summarize gross FFS charges according to the number of days spent in accounts

receivable. Accounts receivable is initiated at the time an invoice is submitted, and ends when the account is paid, turned over to a collection agency, or written off as bad debt.

Include:

- FFS charges only

Do NOT include:

- Capitation payments owed
- Bad debt
- Charges for services that have been provided but not yet billed

G9. Bad debt: The difference between adjusted charges and actual revenue.

Include:

- Losses on settlements for less than the billed amount
- Accounts assigned to collection agencies or written off as not collectible
- In the case of accrual accounting, the provision for bad debt

Section H: Revenue

Patient care revenue

Enter patient care revenue by payor source. If possible, for items H1-H8, break the total revenue by each source down by whether the source is a fee for service (FFS) arrangement or a capitated contract. **Only include actual revenue, net of all adjustments and bad debt, write offs, etc.**

Fee for service (FFS) revenue: Revenue collected from patients and third-party payors for services provided to FFS, discounted FFS, and non-capitated Medicare/Medicaid patients. This is the revenue remaining after patient refunds and checks returned to patients. If the practice used accrual basis accounting, this should equal gross FFS charges minus adjustments to FFS charges minus bad debts due to FFS activity.

Capitation revenue: Revenue received in a fixed per member payment to pay for all covered goods and services due to capitation patients

Patient care revenue sources include:

H1. Medicaid: Self explanatory

H2. Medicare: Self explanatory

H3. Worker's compensation: Self explanatory

H4. Other government: Includes Veterans Administration, County Health plans, and any other federal, state, or local government source that is not a commercial plan

H5. Commercial healthcare coverage: Self explanatory

H6. Service contract revenue: Revenue for contracted patient care services that are not included above under capitation revenue. (An example could be a contract with an

employer to provide on-site occupational health to employees, WIC services, contracts to provide student physicals, flu vaccines, etc.)

Do NOT include:

- Revenue for capitated contracts covered above
- Federal or other grants as listed below in line H10

H7. Self pay (insured): This includes patient copay amounts, deductibles, and any time that an insured patient chooses to pay directly for care (e.g., for flu vaccinations).

H8. Self pay (uninsured): The amount that uninsured individuals are able to pay personally for their care

H9. Total patient care revenue: This is a sum of all patient care revenue entered in lines H1-H7.

Other operating revenue

This table asks you to report operating revenues using two categories: grants and other.

H10. Total grants: Include total grant award for the reporting period. If data are available, break revenues down into the following categories:

- a. Bureau of Primary Health Care grants
- b. Bureau of Health Professions grants
- c. Other federal grants
- d. State
- e. Local grants
- f. Private foundation grants

Do NOT include:

- Any revenue sources listed as a service contract above
- Donations included in line H15.

H11. Other operating revenue: Please enter all operating revenue sources other than those reported in lines H1-H10. Specify all sources of other operating revenue. This may include:

- Revenue from sales of pharmaceuticals, medical supplies, equipment, consulting or project management services

Do NOT include:

- Non-operating revenue – see examples listed below in the explanation of lines H14 and H15.

H12. Total other operating revenue: This is a sum of grants and other operating revenue sources on lines H10 and H11.

H13. Grant amounts other than patient care: Please check yes if any grant amounts reported on line H10 are for activities other than direct patient care.

Non-operating revenue

This section requests that non-operating revenue be provided in two categories: subsidy and other. In addition, non-operating costs are subtracted in order to obtain total net non-operating revenue.

- H14. Total subsidy: Financial support for operating costs from a parent organization (such as a health system, university, school of nursing, etc.). If data are available, break subsidy sources down into the following categories:
- a. University/School of Nursing
 - b. Healthcare System
 - c. Other: If an amount is entered for other, please specify source.
- H15. Other: Sum all other net, non-operating revenue, also specify sources and break out. Examples of other non-operating revenue may include:
- Donations (monetary gifts, including those from patients)
 - Investment income (interest and investment revenue such as interest, dividends, and/or capital gains earned on savings accounts, endowments, capitation revenue, etc.)
 - Other non-operating revenue (includes, rental revenue, capital gains on sale of equipment/real estate, interest paid by insurance companies for failure to pay claims on time, bounced check charges, revenues from other business ventures such as a billing service or parking lot)
- Do NOT include:
- In-kind (non-monetary) donations. These should be listed as an in-kind expense.
- H16. Non-operating cost: On this line sum non-medical costs, including taxes, maintenance costs for rental or other income producing property, losses on sales of real estate or equipment, all direct costs related to business ventures reported in line H15, as long as these are not also included in “total operating costs.”
- H17. Total net non-operating revenue: Add subsidy (line H14), other non-operating revenue (line H15), and subtract non-operating expenses (line H16) to obtain this amount.

Negotiated contracts and managed care plans

- H18. In the box provided, please list the names of health plans and organizations/agencies/etc. with which you have negotiated managed care and/or service contracts.

Section I: Other and survey feedback

- I1. Health information technology: indicate if you use a practice management system, electronic health record, and/or electronic chronic disease registry by marking all that apply.
- I2. Mark the accounting method used by the Center:
- Accrual: Revenue and expenses are booked based on events that change net worth (e.g., revenues when the event occurs i.e., office visit, rather than when bill is paid). This method requires bookkeeping to track receivables and payables.
 - Cash: Revenue is booked when it is received. Expenses are booked when they are paid. In this method a credit transaction is not recorded until paid – there are no payables or receivables.
 - Modified Cash: Cash basis of accounting, but includes items such as the capitalization of assets (depreciation) and the accrual of income taxes
- I3. Self explanatory
- I4. Self explanatory
- I5. Acknowledgements: We like to list the name and location of participating centers on our report, and possibly at other venues where we present the data. Please let us know if we may list your center. We do not identify individual centers as the source of any specific data.
- Also, it has been suggested that one way to market the survey is to provide contact information of others who have responded in the past. Potential participants could then discuss the experience of participation with others. Please let us know if you would like to serve as a “reference” in this capacity.
- I6. Self-explanatory

Evaluation

If your Center participated in the INC Data Warehouse survey last year, please answer questions I7, a-d to help us with our evaluation.

