So You Want to Start a Health Center...?

A Practical Guide for Starting a Federally Qualified Health Center

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Community Health Centers

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National Association of Community Health Centers
Commonly Used Acronyms in The Health Center Industry

ADA	Americans with Disabilities Act
AHRQ	Agency for Healthcare Research and Quality
BBA	Balanced Budget Act
BHPr	Bureau of Health Professions
BPHC	Bureau of Primary Health Care
CDC	Centers for Disease Control
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services *(Formerly Health Care Financing Administration)*
DHHS	Department of Health and Human Services
FQHC	Federally Qualified Health Center
FLSA	Fair Labor Standards Act
FTCA	Federal Tort Claims Act
GME	Graduate Medical Education
HCPC Code	Health Care Financing Administration Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HPSA	Health Professions Shortage Area
HRSA	Health Resources Services Administration
ISDI	Integrated Service Delivery Initiative
ISDN	Integrated Services Delivery Network
JCAHO	Joint Commission *Formerly Joint Commission on Accreditation of Healthcare Organizations*
MCH	Maternal and Child Health
MCO	Managed Care Organization
MSO	Management Service Organization
MUA	Medically Underserved Area
MUP	Medically Underserved Population
NHSC	National Health Service Corps
OIG	Office of Inspector General
OPA	Office of Pharmacy Affairs
ORO	Office of Regional Operations
PACE	Program of All-Inclusive Care for the Elderly
PCA	Primary Care Association
PCMH	Patient-Centered Medical Home
PCO	Primary Care Office
PDPA	Prescription Drug Purchase Assistance Program
PHS	Public Health Service
PSO	Provider Sponsored Organization
RHC	Rural Health Clinic
ROR	Reach Out and Read
SCHIP	State Child Health Insurance Program
UDS	Uniform Data System
USAID	United States Agency for International Development
WIC	Women, Infants, and Children Program

Foreword

T here is no "one true path" to establishing a successful health center[1]. Some health centers function without ever obtaining federal funds or choose to pursue federal funding only after several years of operations. Sometimes existing organizations such as family planning clinics or health departments begin gradually offering more comprehensive primary care services and develop into health centers over a period of time. There are also communities that create new nonprofit organizations and apply for "new start' federal Section 330 community health center grant funding. This Guide is intended to be applicable under any of these circumstances.

Whether to pursue a health center and which option is right for a particular community will depend on many practical considerations. These include:

• The needs in the community (i.e. health status, barriers and access issues);

• The level of support (or resistance) likely to be found in the community and the approaches that will garner the most community support;

• The ability to develop and nurture the community governance that will be necessary for success;

• Whether there are existing resources (organizations and people) in the community that will help and with whom a service delivery coalition might be formed;

• Whether the community has or could qualify for federal shortage designations;

• The mix of financing options that make the most sense for the health center;

• The amount of effort that will have to be expended to accomplish the necessary tasks for starting a health center.

Since undertaking an effort such as starting a health center may seem a daunting task it will be important for planners to break things down into more manageable parts.

This Guide is intended to provide stepbystep directions for planning and implementing a new health center, including instructions on applying for federal designations and funding. Organizations that are currently providing some primary care services and are interested in developing a more comprehensive program that meets the Public Health Service Act, Section 330 requirements will also find the Guide very useful.

First, a brief introduction to some of the key aspects of health centers and some federal programs and designations that are associated with them is provided. Many of these topics will be discussed in greater detail in later sections. Throughout links to critical resources are included.

Remember as you approach deciding whether or not to embark on starting a health center, there truly is no one way or "one size fits all" model. The essence of a health center is that it grows out of, responds to, and is owned by the community it serves. While it is necessary to meet federal statutory requirements and program expectations, each health center will take on the form that works best in its own setting. As we say in the health center movement, "if you have seen one health center you have seen one health center"!

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[1] Throughout this monograph the term "health center" is used denote a Federally Qualified Health Center (FQHC) including community health centers, migrant health centers, homeless health centers and public housing primary care centers.

Chapter I

Health Center Basics

Health centers play a vital role in the delivery of health services to medically underserved people throughout the United States. These organizations are primarily Public Health Service Act Section 330 grantees including: Community Health Centers, Migrant Health Centers, Health Care for the Homeless Programs, and Public Housing Primary Care Programs.

These community-based "safety net" providers are also commonly referred to as ***Federally Qualified Health Centers (FQHCs)*** because they meet rigorous governance, quality of care, service, and cost standards, and they are qualified to receive enhanced reimbursement under Medicaid and Medicare law. Health centers that receive federal funding do so under Section 330 of the Public Health Service Act through grants administered by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Bureau of Primary Health Care (BPHC). Health centers that meet federal FQHC statutes and program expectations but do not receive federal Section 330 funds can be designated as FQHC Look-Alikes. These centers do have access to certain FQHC benefits (see discussion below).

There are more than 1,200 community-based health centers in operation today. Collectively, as of 2010, these centers serve as a health care safety net for some 23 million patients (over 5.8 million of whom are uninsured) through over 8,000 delivery sites in urban and rural underserved communities in all fifty states, the District of Columbia, Puerto Rico, Guam, Micronesia and the U. S. Virgin Islands.[2] Without health centers millions of people who are publicly insured (Medicaid; State Children's Health Insurance Program), uninsured and low income would have limited access to preventive and primary health care. At the same time these health centers produce demonstrated quality health results at costs well below the national average.

As a result of recent Congressional and Presidential support, now tempered by budget constraints, there are limited opportunities for communities to develop new health centers and to expand capacity and services at existing health centers. In response to these opportunities intensive technical support is being made available to communities by the National Association of Community Health Centers (NACHC) through the Health Center Growth and Development Program; State and Regional Primary Care Associations; national associations supporting services to special populations, and; the federal Bureau of Primary Health Care (BPHC). Contact information for the various technical assistance organizations can be found in the resource list in the back of this monograph.

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[2] National Association of Community Health Centers, 2010.

A. Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs) are private, not for profit or public entity organizations[3] that:

- Receive a grant under Section 330 of the Public Health Service Act. Major advantages of having FQHC designation include:

  a) Receiving cost based reimbursement for services provided to Medicare patients and cost-derived prospective payment for services provided to Medicaid patients including managed care enrollees;

  b) Participating in the PHS Act 340B Drug Discount Pricing Program to purchase prescription drugs at steep discounts;

  c) Access to National Health Service Corp providers and resources;

  d) The right to have out-stationed Medicaid eligibility workers on-site;

  e) Having access to Federal Vaccine for Children program; and other legal benefits. In addition to the benefits listed above, FQHCs _funded_ under Section 330 also have access to free medical malpractice insurance under the Federal Tort Claims Act (FTCA) program and a myriad of grant and loan opportunities for both service and capital expansions.

- Meet the statutory requirements for receiving Section 330 grant funds but do not receive grant funding. These centers are referred to as **FQHC Look-Alikes** (FQHC-LAs). They are eligible to take advantage of all of the benefits enjoyed by 330 grantees _except_ they cannot participate in the federal medical malpractice program, and they do not receive the federal Section 330 grant. FQHC-LAs are eligible to apply for 330 funding when it is available, and often fair well in the competition as they already are operational and meet FQHC statutory and programmatic requirements.

In the "general" sense health centers are providers of primary and preventive health care and enabling services to medically underserved populations. Unlike other models of health care delivery, health centers focus not only on improving the health of individual patients but improving the health status of the entire community**.** This communityoriented focus means that health centers differ from most traditional health care providers in a number of ways. Needs assessment, program development, evaluation and even the definition of "community" are all framed in terms of both community health needs and patient health. Health centers are also Patient-Centered Medical Homes (PCMH) in that care is delivered in a comprehensive, coordinated way and provided by a health care team. For more information on PCMH, visit **http://www.nachc.com/clinicalmedicalhomes.cfm**.

The services of a health center must be accessible to the target population (both logistically and financially), comprehensive, and coordinated with other social services. In addition, the health center remains accountable to the community that it serves by involving community members and health center patients (i.e. consumers) in program planning and organizational governance.

The authorizing legislation uses the term "health centers" to refer to the four programs that are authorized under and receive federal funding under Section 330 of the Public Health Service Act,[4] to provide comprehensive primary care services to "medically underserved populations." Programs included under this rubric are: Section 330(e) – community health centers serving medically underserved and low income people; Section 330(g) – serving migrant and seasonal agricultural workers and their families; Section 330(h) – serving homeless adults, families, and children; and Section 330(i) - serving residents of public housing.

This publication will address establishing a health center in the broad sense, as well as the process for obtaining Section 330 funding from HRSA's BPHC.

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[3] Public entity health centers have specific allowances for meeting governance and other FQHC program requirements. Refer to Policy Information Notice (PIN) 2010-01 for a definition of public entity on the BPHC website (**http://bphc.hrsa.gov/policiesregulations/policies/pdfs/pin201001.pdf**) and the discussion in Chapter IV.

[4] P.L. 104-299; P.L. 107-251.

B. Medically Underserved Areas and Populations

In order to qualify for FQHC status, whether receiving Section 330 funding, or as a Look-Alike, a health center must provide care to either a federally designated ***Medically Underserved Area (MUA) or Medically Underserved Population (MUP)***[5]. The process of applying for federal shortage designations will be discussed in Chapter III, but it is useful to understand the basics of MUAs/MUPs now. The criteria currently used when designating a Medically Underserved Area are:

1) The community has a low primary care physiciantopopulation ratio;

2) The community has a high infant mortality rate;

3) The community has a high percentage of the population living below the federal poverty level (FPL);

4) The community has a high percentage of the population aged 65 and over

The criteria for Medically Underserved Populations (MUP) are similar, but focus on the needs of specific population groups within a geographic area (i.e. low income). This designation recognizes that some populations within communities may experience exceptional difficulties in accessing health care and/or extraordinary negative health status, in spite of the fact that the overall community does not meet the MUA threshold.

It is important to note that the health center must serve populations that live in or are designated as medically underserved, but *the clinic site does not have to be physically located in the MUA/P.* In addition, this requirement is an organization-level one. this means that once any of the sites of the health center meets this criterion the entire organization is compliant. Opening new sites in other areas does not require additional MUA/P designations.

The shortage designation methodology is currently under review; interested communities should contact their State Primary Care Office (PCO), State Primary Care Association (PCA), Bureau of Primary Health Care (BPHC), the Bureau of Health Professions (BHPR) or NACHC to get the latest information before beginning data collection efforts. Information and a list of areas/populations already designated can be found on the BPHC website, **www. bphc.hrsa.gov** or at or on the shortage designation website at **http://bhpr.hrsa.gov/shortage/**.

C. Other Relevant Terminology

As local leaders undertake efforts to establish a health center, they will no doubt encounter terminology about various federal programs and designations that sound similar and can be easily confused. It is therefore worthwhile to provide a few definitions related to health centers. As with the MUA/MUP designations, some of these programs are changing.

Health Professional Shortage Area (HPSA) **http://hpsafind.hrsa.gov/** is a federal designation that refers to the shortage of health professional resources similar to the MUA/MUP. HPSA designation is used to allocate a number of resources including health care professionals who receive loan forgiveness (or repayment) or scholarships through the National Health Service Corps (discussed below) in return for working with eligible organizations in a given community. In addition, while not required, HPSA designation can be a critical factor in determining whether a health center receives FQHC 'look-alike' designation and/or Section 330 funding because it is an important need indicator. At this time there are three basic types of HPSA designations:

• **Primary Care HPSA** – designates a shortage of primary medical service providers;

• **Dental HPSA** – designates a shortage of primary care dentists; and

• **Mental Health HPSA** – designates a shortage of psychiatrists, clinical psychologists and clinical social workers.

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[5] Migrant Health, Health Care for the Homeless and Public Housing Primary Care sites do not have to have MUA/P designations to qualify for federal Section 330 funding as these special populations are considered to be medically underserved by definition. However, all Section 330(e) health centers must serve a federally designated MUA/P.

An area is designated as a HPSA based on the ratio of clinical service providers to the population of a specific geographic area or of a special population (e.g., low-income, Native American, Medicaid-eligible, etc.) within a geographic area.

Rural Health Clinics (RHC) are public or private, for-profit or not-for-profit health care providers that are located in rural, non-urbanized HPSAs or MUAs (MUP designation is not sufficient). The RHC must have a physician assistant or nurse practitioner/midwife onsite who provides RHC services at least 50 percent of the time the RHC is open, accept Medicaid patients and accept Medicare assignment payment rates. Certification as a RHC allows the organization to receive costbased reimbursement for Medicare and prospective payment for Medicaid services, but typically at a lower rate than FQHCs. RHCs are different from FQHCs. The information in this guide applies to FQHCs and FQHC-LAs. Information regarding starting a RHC should be sought from the HRSA Office of Rural Health Policy, **www.hrsa.gov/ruralhealth.**

D. Other Programs that Support Health Centers

There are a few other federal programs connected to health centers that merit explanation. Again, this is intended as an overview as many of these programs will be discussed in greater detail in later chapters.

National Health Service Corps (NHSC) (**http://nhsc.hrsa.gov/**) is a program of the HRSA, Bureau of Health Professions (BHPr) with a number of components, two of which are most relevant here: health professions scholarships and the loan repayment program. Health professions students may become eligible for scholarships that pay educational and related expenses in exchange for a promise to work in a HPSA for a specific period of time. Health professionals who have completed their education (and who might already be in practice) can receive assistance in repaying their educational loans if they work with approved organizations within a HPSA. Eligible organizations must be located in a HPSA. Interested organizations should contact their state PCO or PCA. Note that once designated as an FQHC or FQHC-LA the organization receives an automatic HPSA facility designation. This means that the health center site is eligible for accessing NHSC resources without going through a separate designation process. However, the HPSA score, i.e. the level of shortage that queues the center up for resources, is at the lowest qualifying level so it often makes sense to go through he HPSA process to improve the organization's position.

The ***Federal Tort Claims Act (FTCA)*** provides malpractice liability coverage to Section 330 funded health centers that have FTCA application approval. FTCA coverage was extended to Section 330 grantees after it was demonstrated to Congress that the malpractice claims history of health centers was significantly better than other parts of the health care industry, and that the amount of money spent on liability insurance by health centers was disproportionate to their insurance risk. FTCA provides federal malpractice liability coverage for health centers*, their Board members, employees including health center clinicians* and *certain contracted clinicians* for activities conducted within the scope of the health center's federally approved project at no cost to the organization. A health center may become eligible to participate in this program by meeting a set of criteria related to credentialing, quality assurance, and other quality performance measures and applying to BPHC to become "*deemed*" eligible. The **PAL 2011-05** *discusses the deeming process.* Contact NACHC for more information on FTCA, or visit the website at **http://bphc.hrsa.gov/ftca/**

The 340B Drug Pricing Program under the ***Public Health Service Act*** (***Section 340B*** of the Public Health Service Act) allows FQHCs (and certain other "covered entities") to purchase covered outpatient drugs for their patients at substantially discounted prices. Pharmaceutical manufacturers wanting to do business with state Medicaid agencies must sign an agreement with the U.S. Department of Health and Human Services indicating that they will give health centers at least the price discounts required by the law. A number of health centers now participating in this program have found that they are able to purchase covered outpatient drugs for their patients at significantly reduced prices, providing a savings to both the health center and the health center's patients. For more information about taking advantage of the discounts available through this program, contact NACHC or the HRSA Pharmacy Services Support Center ((301) 594-4353; **www.hrsa.gov/opa**).

Primary Care Associations (PCAs) are nonprofit associations representing *health center*s and other primary care (safety net) providers at state or regional levels. PCAs provide a variety of services in support of community-based primary care. Such services can include centralized clinician recruitment, technical assistance in a variety of clinical, management and governance areas, training, conferences and more. PCAs are actively involved in health policy at the state level. Some associations oversee a pooled program of liability or group health/medical insurance for their members; some manage statewide information systems or practice management networks. PCAs can be statebased or regional and are a valuable source of assistance and advice both for existing health centers and for communities interested in starting new health centers. Refer to the NACHC website for contact information (**www. nachc.com**) or the BPHC.

Primary Care Offices (PCOs) are components of state governments (generally located in State Health Departments) that receive funding from BHPr to provide planning and other services in support of communitybased primary care providers. PCOs work in partnership with the Primary Care Associations in activities such as analyzing and prioritizing need for primary care services; submitting requests for designation of areas and populations as MUAs/MUPs and HPSAs; assisting with recruiting and retaining clinicians in health centers and in other areas of need; and advocating for health centers within state health agencies. State PCO contact information is at **www. bhpr.hrsa.gov/shortage/pcos.htm**.

National Association of Community Health Centers (NACHC) is the primary national, nonprofit, professional membership and advocacy organization that represents health centers. NACHC's mission is: "To promote the provision of high quality, comprehensive health care that is accessible, coordinated, culturally and linguistically competent, and community directed for all underserved populations."

In addressing the needs of community-based health care providers and their patients NACHC:

- Serves as a major advocacy organization on issues that affect the delivery of health care for the medically underserved and uninsured;

- Provides education/training and technical assistance to community-based health care providers and consumer boards in support of their responsibilities to provide high quality, cost-effective health care;

- Develops and implements programs that stimulate public and private sector investment in the delivery of quality health care services to medically underserved communities; and

- Provides benefits and services to those centers that participate in NACHC as members. NACHC works in cooperation with affiliated PCAs.

Through the Health Center Growth and Development Program, NACHC provides training, education, technical assistance, and support to newly forming, newly funded and expanding health centers. Samples of many of the materials referred to in this handbook (i.e. personnel policies, by-laws, organization charts, job descriptions, etc.) along with Informational Bulletins, Issue Briefs and monographs providing technical assistance in key areas (financial management, governance, information technology, etc.) are available from NACHC. For more information, visit **http://www.nachc.com/hc-growth-development.cfm**.

E. Strategic Considerations: Before Deciding to Proceed

Before deciding to begin the effort to establish a Federally Qualified Health Center, you must understand the federal requirements associated with obtaining health center status (**http://bphc.hrsa.gov/policiesregulations/ policies/index.html**). These standards relate to health center governance, quality of care, services provided, and management and financial systems. Specifically, a health center must:

▶ Be a public or private not-for-profit organization.[6]

▶ Provide comprehensive, culturally competent, primary care (directly and/or by contract), and assure that their patients can access the care regardless of ability to pay, including:

- Primary medical care;

- Diagnostic laboratory and radiological services;

- Preventive services including: prenatal and perinatal, cancer and other disease screening, well child services, immunizations against vaccine preventable diseases, screening for elevated blood lead levels, communicable diseases and cholesterol;

- Eye, ear and dental screening for children;

- Voluntary family planning services;

- Preventive dental services;

- Emergency medical services;

- Pharmaceutical services, as appropriate to the particular health center;

- Referrals to other providers of medical and health-related services including substance abuse and mental health services;

- Patient case management services including referral and follow-up and accessing eligibility for and gaining access to Federal, State, and local support and financial programs for medical, social, housing and other related services;

- Enabling services including:
  i. Outreach;
  ii. Transportation;
  iii. Interpreter services;
  iv. Education about health services availability and appropriate use.

In addition, some health centers must provide additional supplemental services that are important to their patient populations and communities. For example, centers serving migrant seasonal farmworkers should be knowledgeable about the Environmental Protection Agency's Worker Protection Standards and pesticide risks and must provide occupational related health services such as pesticide screening and injury prevention programs related to pesticide and other occupational exposures as well as screening for and control of parasitic and infectious diseases.

Programs serving homeless individuals and families under 330(h) must also provide substance abuse services.

▶ Serve a federally designated medically underserved area or a medically underserved population. This includes people who face barriers in accessing preventive and primary care, dental and/or behavioral health services because of:

- Financial need, lack of health insurance, or inadequate insurance;

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[6] Public entities must demonstrate through specific documentation that they qualify under the Community Health Center Program (Policy Information Notice 2010-01). In addition they must demonstrate that they meet the health center governance requirements either directly or through a co-applicant arrangement. For more information go to **www.bphc.hrsa.gov**

- • Language or cultural barriers;

- • An insufficient number of health professionals/resources available in their community;

- • Health disparities in portions of the population;

- • Geographic distances and/or lack of transportation.

► Have adequate clinical and administrative leadership, systems and procedures to guide the provision of services and ongoing quality improvement programs.

► Have a schedule of fee discounts based upon the patient's ability to pay for patients with incomes at or below 200% of the Federal Poverty Level (FPL).

► Have a community-based board that independently exercises key authorities including:

- • Hiring, evaluating and, if necessary, dismissing the chief executive;

- • Adopting policies and procedures;

- • Establishing services, hours of operations;

- • Fee schedules, discount schedules, and adopting the annual budget;

- • Conducting strategic planning, quality assessment, and oversight and stewardship functions.

Importantly, the board must be representative of the community being served and <u>at least</u> 51% of board members must be regular consumers of the health center's services (i.e. use the health center for their regular source of health care)[7]. Further requirements of governing boards are discussed in Chapter IV on Governance.

► Have a management team that works with the governing board to achieve the mission of the health center and to ensure that the organization adapts to community needs and marketplace trends. The organization chart should have a line of authority from the board to a chief executive who is employed by the board. The management team is employed by the chief executive and should include individuals with the skills to provide leadership, fiscal management, clinical services and quality assurance, and management information system expertise.

► Have financial systems that provide for internal controls, safeguard assets, ensure stewardship of federal funds, maintain adequate cash flow to support operations, assure access to care, and maximize revenue from non-federal sources.

Within these requirements there are many options. A "new" health center could be a new organization starting from scratch or it could be an existing organization that "converts" its governance structure and/or operations to the health center model. The types of organizations that may wish to convert to a health center include FQHC "Look-Alikes", HIV/AIDS clinics, rural health clinics, public health departments, free clinics, hospital outpatient programs, other social service organizations, or even certain forprofit primary care practices.

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[7] Waivers of certain aspects of the governance requirements may be applied for special population funding programs including Migrant Health Centers, Health Care for the Homeless and Public Housing Primary Care. however centers receiving funding or designated in whole or part as Section 330(e) may not apply for any governance waivers.

Chapter II

Ensuring Broad Community Support and Investment

P resumably, community leadership is thinking of starting a health center because of the need for more accessible primary care by certain high need populations, and they have developed some vision of how that need might be met. As discussed in Chapter I, the goal of a health center is to improve the health of individuals and the health status of the overall community. More than any other type of health care provider, a health center must be mindful of the community's needs and structure its programs to meet those needs. This requires that the health center be planned and implemented not only with a thorough understanding of the community, but also with significant citizen involvement.

At the outset it should be noted that many resources are available to support community development activities through a state's Primary Care Association (PCA). In many instances the PCA will be able to provide information, guidance and expertise for individual community development activities. In addition, NACHC offers information, technical assistance, materials, and support to communities interested in developing health center*s.*

Obtaining the necessary community support and investment involves using some of the techniques of community organizing. Community organizing begins by developing a thorough knowledge of the community and then engages citizens in program planning and implementation. This chapter will also address the issue of involving health care providers in the planning process.

A. Defining "Community"

Before setting out to build support for a new health center, it is worth spending some time talking about what and who the community is. Communities are made up of people, and are therefore defined by more than geographic or municipal boundaries. Communities can also be defined culturally or ethnically as well as by differences in values, social institutions, and patterns of social interaction. Geographic features that affect travel patterns and access also shape communities in ways that do not always coincide with formal geographic or political divisions. In the case of health cente*r*s, communities can also be defined by common health care needs, health problems, and problems that people share in accessing health care services. Further, when the goal is to create broad community investment, leadership and planners must reach out to the more extended social system and health service network in which the health center will operate. The first step in identifying the community is to define the service area of the health center.

Service Area

The service area is the geographic or "catchment" area that the health center is planning to serve. Because health cente*r*s must serve MUAs or MUPs in order to receive FQHC designation and/or Section 330 health center funding, it is important to keep the MUA/MUP designation guidelines in mind when defining the service area. **A federally qualified health center is not limited to serving individuals from within an MUA or MUP nor must it be physically located in the MUA[8].** In other words, the health center's service area or user population can be larger than the MUA/MUP. However, a health center must be accessible to all residents of its "approved" service area, especially those who are medically underserved, low income, or uninsured. Note that migrant, homeless, and public housing grant funds and FQHC-LA designees must be targeted to populations who meet these special population descriptions. Logic and reason suggest that since the MUA/MUP designation identifies populations in greatest need of services, the health center should be geographically located so as to ensure that those people have access and a considerable portion of its efforts and resources should be focused to ensure appropriate services are available.

A service area is a rational and logical geographic area for the delivery of health services. This can vary depending on the population being targeted and the nature of the geographic area. Some programs that serve migrant farmworkers cover entire states. Some urban programs in large cities have service areas made up of several census tracks or zip codes, or at times city blocks. In general, a service area is defined by:

- Minor civil division, or
- Census county division, or
- Census tract (in metropolitan areas), or
- Group of the above divisions or tracts that constitute a "natural neighborhood".

Or areas and groups that can be defined by:

- A lack of transportation, particularly public transportation;
- Geographic barriers to care such as mountain ranges, rivers or urban freeways;
- Locations of other service providers;
- Travel time between service providers;
- Cultural, ethnic or language variables.

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[8] The requirement to serve an MUA/MUP is an organization-level requirement. In other words, once an FQHC is meeting the obligation at any of their clinic locations they are considered to be compliant and further clinic satellites or services do not in themselves have to do so.

B. Community Analysis

Community organizing begins with analysis. This is not just a quantitative analysis of demographics and health care utilization as described later in this guide, but a broader analysis designed to paint a picture of how the community is structured and where the barriers and facilitators to organized community health care are likely to emerge.

1) A good analysis provides a social "map" of the community. Table 1 illustrates the components of such a map. It begins by identifying different sectors of the community – business, labor, government, religious, health care, voluntary/civic organizations, and so forth. The sectors listed in Table 1 are a suggested guide, but every community is different and the map should represent the community as thoroughly as possible. Remember, you are trying to develop as broad of a picture of the people and organizations that will potentially be involved in the health center so that you can assess clearly the needs in the community and the options for meeting those needs. In other words, this should be an inclusive activity.

2) Once the sectors have been identified, make a list of the people, groups and organizations that make up each sector – for example, all of the schools and school districts for the education sector.

3) Next, identify the key influences in each sector – key people and organizations as well as political and social trends.

4) Lastly, identify which components of the community are likely to be barriers or facilitators to a new health center and why.

The goal of this process is to be as thorough as possible. Groups that are economically disadvantaged, politically under-represented, or otherwise "invisible" in the community need to appear in the community analysis, along with the individuals and institutions that play a prominent role. Do not make the mistake of assuming that these groups have no organized influences. It may be a church, temple or mosque, community center or labor organization rather than the Kiwanis Club, but every group will have some person or organization that is familiar and respected. At the same time do not focus exclusively on disadvantaged groups simply because they are most likely to be the users of a health center. Remember the Chamber of Commerce and other business groups are a part of the community as well! When identifying influential individuals in the community, think both in terms of formal power—that a person can derive from their job or other official role—and *informal power* that comes from reputation, community involvement, wealth, social connections or a variety of other "unofficial" sources.

A community analysis is part brainstorming and part information-gathering. The group or coalition that has formed to begin working on a health center will be able to brainstorm an initial community map, but engaging community leadership and talking to people within the community will assist in making the map complete. Thus, the community analysis is also the first opportunity for getting more people involved.

TABLE 1
Sample Community Analysis Outline

Sector	Components	Influences
Business/ commercial organizations	▪ Major and minor employers; estimate number of employees, average wage and health insurance coverage ▪ Possible sources: Chamber of Commerce, state business census, interviews with business leaders; minority business groups	▪ Key business leaders, or particularly influential employers ▪ Businesses with health care relationships
Government	▪ Executive branch (mayors, county executives) ▪ Local legislative branch (city and county councils, Boards of health) ▪ State and federal elected representatives	▪ Executive branch (mayors, county executives) ▪ Local legislative branch (city and county councils, Boards of health) ▪ State and federal elected representatives
Labor organizations	▪ Unions ▪ Cooperatives	▪ Labor leaders and cooperative Board members ▪ History and current climate of business-labor relations
Health care (Medical, dental and behavioral health)	▪ Public and private health care providers ▪ Health insurers/HMOs ▪ Associations/societies for health care professionals, including minority organizations ▪ Continuing education programs for professionals ▪ Health Boards/departments (State and local) ▪ List full range of health care facilities and programs available, numbers of people served ▪ Hospitals, medical colleges, and institutional providers ▪ Community Mental Health Agencies	▪ Key health care administrators, leaders of professional associations, health Board members ▪ Environment of health care reform ▪ What is the relationship between medical providers? Any coalitions/ networks? ▪ How are different providers viewed in different segments of the community? ▪ Medical traditions in different parts of the community (e.g. non- traditional care)
Other social services agencies	▪ List full range of social service organizations, services provided, numbers of people served ▪ Community Action Programs(CAP)	▪ What services are/are not provided? ▪ What is the relationship between agencies? Any coalitions/networks?
Educational institutions	▪ School districts ▪ Individual schools with number of students ▪ Private/ religious schools with number of students ▪ Preschools with number of students ▪ Colleges, universities including schools of medicine, dentistry, nursing, and health sciences	▪ Key school Board, school district personnel ▪ School-based health initiatives ▪ Racial, ethnic, economic, class issues in the schools

TABLE 1 (continued)
Sample Community Analysis Outline

Sector	Components	Influences
Religious organizations	▪ Churches, temples, mosques active in civic affairs ▪ Interfaith councils or coalitions	▪ Key religious leaders • Describe how the community is distributed among religious affiliations • What are their social concerns/ activities
Voluntary and civic organizations	▪ Service organization-Kiwanis, Lions, etc. ▪ Ethnic or cultural organizations ▪ PTAs ▪ Self-help groups ▪ Athletic/sports groups	▪ Where are the community meeting places? ▪ Community-wide events and their sponsors
Agricultural organizations	▪ Farm Bureau, The Grange, 4H ▪ Extension services ▪ University Agricultural Departments and Extension Services	▪ Environmental health issues relating to agriculture ▪ Concerns about hospital survival, health provider availability
Media	▪ Newspapers, including non-daily papers, shopping guides, etc. Include editor/publisher, circulation, geographic area ▪ Radio and television stations, for target market/audience	▪ For each media outlet, note key contact people for health coverage, public service announcements, etc.
Community Based, Self Organizing Groups	▪ Coalitions, community/resident organized advocates ▪ Local action for a local problem e.g. starting a health center!	▪ As a community asset, folks who take informal leadership for community change.

Having identified the different components and influences in each sector, go through the list and ask:

• Is this group/person likely to be helpful in starting a new health center? Why?

• Is this group/person likely to be a barrier to starting a new health center? Why?

• Might this organization be a prospective partner in an integrated delivery system of which the health center will be a part?

• Can this person/group be enlisted to help with the effort to start a health center? If so, how?

• What is the best way to approach this group/person?

C. Community Participation

The map of the community will illustrate how to reach people. The next step is to start bringing people together and getting them involved in planning. Generating effective community participation is an art, and a labor-intensive one at that. Following are some tips for getting and keeping people involved in the planning, development and implementation processes.

Approaching People and Getting the Word Out — Let the community know about your plans.

1) Make a list of people to contact first, and divide responsibility for making these contacts among several people

2) Assemble a "speakers' bureau" of people who are willing to go out into the community and talk to different groups

3) Provide training and resources for people who go out and speak in the community. Assemble pre-packaged kits or conduct workshops to provide:

   •   Tips on public speaking;

   •   A suggested presentation outline;

   •   Hard facts that people can use to illustrate community health problems and the need for a health center;

   •   "Put your know-how to work to build the foundation of the center!" Provide a list of specific ways that interested members of an audience can become involved. Include facts, contact information, and enthusiasm.

Holding Public Forums — Word of mouth is the most effective means of getting the word out.

People have many demands on their time and will pay more attention to an invitation from a friend than to a flier or poster.

1) Be sure the sponsor of the meeting is trusted and respected by those whose attendance is important;

2) Hold the meeting in an accessible, familiar and recognized location, and at a convenient time;

3) If appropriate invite the media to attend. Provide them with information ahead of time about the meeting's purpose and agenda;

4) Remove barriers to attendance by providing transportation, child-care and language interpretation where necessary. If planning to make these services available make sure they are mentioned in the publicity;

5) Have a sign-in sheet or another method for keeping a record of attendees.

Keeping People Involved and Motivated — People need to know that their participation is making a difference!

1) Assign clear, specific and manageable roles and tasks, so that people won't feel like they are drifting or wasting their time.

2) Build on successes to maintain momentum.

3) Remove barriers to participation by providing transportation, childcare, and language interpretation when necessary.

4) Use telephone trees, written notices and verbal announcements at community gatherings to give people regular reminders about meetings and events. Make sure reminders are delivered in an effective and appropriate manner (e.g., don't use a telephone tree if some people don't have telephones).

5) Don't let people think that nothing can be accomplished until funding is secured. Finding money is important, but it isn't the only task to be accomplished.

6) Follow through is important. Follow-up on issues/questions identified during meetings or events. Maintain contact with community leaders and follow-up on assignments to assure completion and "close the loop."[9]

D. Involving the Health Care Provider Community

Involving health care professionals is very important when starting a health center. Even if it seems that a large segment of the provider community is ambivalent about or even hostile to the idea of starting a health center, the fact remains that the health center will need to fit into and complement the existing system of health care.

Involving key respected health care professionals can give legitimacy to the health center in the eyes of the general public and other health professionals, as well as provide valuable technical assistance. Although the number of health professionals on the board of a federally qualified health center is limited by federal statute, they can serve on committees, provide technical assistance and serve as liaisons to other professionals in the community.

It is particularly important that providers who are prominent in the community or who are already involved in issues affecting underserved populations are contacted. Whether or not these providers eventually become involved in planning, they are likely to feel slighted if they are not consulted early on. Several strategies are helpful for getting the professional health care community involved:

1) Contact other health centers in or proximate to the neighborhood and enlist their support. It may be easier to start a health center by convincing an existing health center to establish a new location.

2) Health departments, hospital administrators, professional societies, and state Medicaid agencies that may be able to indicate physicians currently serving Medicaid and low-income patients. Hospital administrators can be particularly important in rural areas.

3) Most medical and dental societies (usually county-based) will have an "uncompensated care" committee.

4) Focus on primary care providers, including physicians, dentists, nurse practitioners and midwives, physician assistants, dental hygienists, psychiatrists, psychologists, clinical social workers and pharmacists.

5) Reach out to providers in the community through health care provider organizations, professional associations and continuing education programs.

In today's rapidly changing health care market place, managed care is a special consideration for most health center*s*. Even new start centers must plan with managed care in mind. This is particularly true where Medicaid managed care is prevalent and where health center*s* may be required to form their own managed care networks or to contract with managed care organizations (MCOs) in order to receive Medicaid reimbursement. In assessing the health care environment pay particular attention to the role of managed care including:

• How much of the private insurance market and Medicaid/Medicare enrollment is included in managed care plans?

• Would a health center need to become involved in managed care in order to serve their target population?

• How would this work?

• Who would be the new health center's partners in a managed care network?

Considerable information on the managed care "landscape" is available from the state/regional PCAs and NACHC. There is also more discussion of managed care and the impact on reimbursement in Chapter VII: Business Planning (p. 27).

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[9] For a comprehensive guide to community development see the "Successful Practices in Community Development for New Health Centers, NACHC 2008 (www.nachc.org).

Chapter III
Needs Assessment And Planning

At this point, there may be consensus about a lack of access to primary care in the community or for certain populations such as the uninsured or Medicaid patients, but that most likely does not provide the information needed to actually plan and implement a health center. Good program planning requires good needs assessment. The NACHC publication *Community Needs Assessment and Data Supported Decision Making: Keys to Building Responsive and Effective Health Centers* can aide in this process (**www.nachc.com**).

Needs assessments involve defining the target population(s) and service area for the health center and then identifying, given the target population(s), what are the service needs that the health center should be prepared to meet?

Once these questions have been answered the planning process involves prioritizing the identified health needs, developing specific growth and resource plans for how the health center will meet those needs and undertaking implementation.

This chapter will provide an overview of needs assessment and planning at the community level, as well as state-level planning activities that can support communities. Also discussed is information on the various federal shortage designations and how to obtain them.

A. Participating in Statewide Planning Activities

Three important resources for developing a new health center and for identifying what information is available and how to locate it are the state/regional PCAs, the National Association of Community Health Centers, and the federal Bureau of Primary Health Care.

Through several initiatives and programs, the PCA has a myriad of resources and expertise to assist interested communities and organizations with planning, developing and implementing a new health center.

Community Development — The PCA (and in some instances the PCO) has resources to assist with community organizing and building citizen support. The National Health Service Corps also conducts a Community Development program for communities that are interested in FQHCs, RHCs and NHSC site approval.

Statewide Strategic Planning — Statewide Strategic Planning (SSP) is a NACHC process that PCAs, existing Section 330 grantees and potential new grantees undertake to identify needs in the state, and potential 330-funded initiatives for serving new populations and existing health center patients with an expanded array of services. It is critically important that communities expecting to implement a new health center participate in the SSP process. This SSP process will support long range and operational planning activities and implementation. As part of the SSP process:

1) Determine a methodology for identifying unmet need.

2) Estimate the number of new patients who could be served with new or expanded primary care access and services.

3) Estimate the related staffing, capital and operating costs for new sites/expanded services.

4) Investigate whether your PCA provides assistance for planning and implementation activities including detailed planning activities, governance considerations, grant assistance or recommendations for assistance resources, and recruitment and retention assistance.

Other Technical Assistance — The following organizations can provide assistance with conducting a needs assessment planning.

1) The National Association of Community Health Centers (**www.nachc.com**) has implemented the Health Center Growth and Development Program that targets assistance to communities interested in developing new health centers, newly funded Section 330 centers, and FQHCs looking to expand services and capacity. Technical support and training materials are available in all areas of health center clinical, administrative, finance and governance functions. Additionally, NACHC is a source of expertise on affiliations, structuring health center organizations, and understanding regulations and guidelines.

2) The Health Resources and Services Administration **www.hrsa.gov** and the Bureau of Primary Health Care **www.bphc.hras.gov** provide assistance for health center development.

3) Your Primacy Care Association or the State's Primary Care Office, can assist with information about health center networks in your state or region.

   • Administrative: several states also have established administrative networks, which may provide cost savings for IT (information technology) and/or key staff such as a CFOs and can also provide technical assistance;

   • Clinical networks are also available and may be a resource for clinical support, health care protocols and long-term retention consideration

4) The UDS Mapper is a web-based tool that is designed to help inform users about the current geographic extent of U.S. federally (Section 330)-funded health centers. The mapper provides tools and data that can assist in evaluating the geographic reach, penetration, and growth of the Section 330-funded Health Center Program and its relationship to other federally-linked health resources. The information available in the UDS Mapper includes estimates of the collective service area of these health centers by ZCTA, including the ratio of Section 330-funded health center patients reported in the Uniform Data System (UDS) to the target popu-

lation, the change in the number of those reported patients over time, and an estimate of those in the target population that remain unserved by Section 330-funded health centers reporting data to the UDS (but may be served by other providers). Users can also map U.S. Census data and see the locations of all federally (Section 330)-funded health center grantees and their access points, locations of other federally-linked providers (FQHC Look-Alikes, NHSC Sites, Rural Health Clinics, Tribal Organization Facilities, etc.), and shortage areas such as Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas/Populations (MUA/Ps). The UDS Mapper is free and available for exploration by everyone. To use the map and/or schedule a tutorial, visit **www.udsmapper.org**.

5) The Office of Special Population Health (**http://bphc.hrsa.gov/about/specialpopulations/index.html**) and national technical assistance organizations for special populations:

- National Advisory Council on Migrant Health (NACMH) -**http://bphc.hrsa.gov/about/nacmh/index.html**

- National Center for Farmworker Health- **http://www.ncfh.org/**

- Health Outreach Partners - **http://www.outreachpartners.org/**

- Migrant Clinician's Network – **www.ncfh.org**

- Migrant Health Promotion - **http://www.migranthealth.org/**

- National Health Care for the Homeless Council - **http://www.nhchc.org/**

- National Center for Health in Public Housing - **http://www.healthandpublichousing.org/**

- National Health Care for the Homeless Council - **http://www.nhchc.org/**

- Public Housing Primary Care - **http://www.healthandpublichousing.org/**

B. Identifying the Target Population(s)

Target Population — Unlike the expansive view of community used in Chapter II when talking about ensuring community investment, a much more narrowly defined *target population* is used for program planning purposes. The target population consists of a group of people within your defined service area who are unserved or underserved, i.e. not receiving or not having access to adequate, quality primary and preventive health care;[10] and who are as a result experiencing health disparities. The target population is most usually a sub-set of the total population in the Service Area. To identify the target population you need to obtain information on demographics and health status of the community, the amount of accessible health care for that population, and the barriers that people in the target population may encounter in trying to access health care services. Although the health center will provide care to all comers, the health center program will be designed specifically to meet the needs of the target population:

HEALTH DISPARITIES = WHAT SERVICES ARE NEEDED

ACCESS LIMITATIONS = HOW MANY OF WHAT TYPES OF PROVIDERS ARE NEEDED

BARRIERS TO CARE = SERVICE DELIVERY STRATEGY

Demographic information describes the population:

- Age and gender breakdowns: What are the percents of children, childbearing age women, and elderly?

- Is there a large number of poor[11]? Low-income[12]?

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[10] Unserved: Individuals living in areas designated as Health Professional Shortage Area (HPSA) who do not have access to primary care physicians or living in areas designated as Medically Underserved Areas/Populations (MUA/MUP.)

[11] At or below 100% of the Federal Poverty Level (FPL).

[12] Between 101% and 200% of the FPL.

- Is unemployment at a high rate or are there a large number of people employed at low wages and/or without health insurance?

- What is the rate of health insurance coverage? Is underinsurance (prohibitively high premiums or co-pays) a consideration in the population?

- What is the ethnic/racial make-up?

- Are there Special Populations?[13]:
  - Homeless people
  - Migrant or seasonal agricultural workers
  - Residents of public housing

Health status information indicates the health problems of the population which include but are not limited to:

- Inadequate or late entry to prenatal care;

- Incidence of teenage pregnancy, low birth weight and infant mortality;

- Rates of communicable disease incidence and/or deaths;

- Incidence of chronic illness such as diabetes, hypertension and heart disease;

- Incidence and mortality from cancer (overall, breast, colon, prostate);

- Rates of avoidable hospitalizations;

- Incidence of exposure to pesticides or lead poisoning;

- Incidence of dental caries and other oral diseases;

- Incidence of substance abuse and addictive behaviors;

- Incidence of depression and other mental health problems;

- Use of hospital emergency rooms for primary health care;

- Incidence of asthma in children and adults;

- Other health status indicators and risk factors specific to the target population.

Tables 2 and 3 provide more detail about each type of data and possible sources of information. Using this as a guide, prepare a description of the target population that is as detailed and accurate as possible.

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[13] These special populations are identified defined as such in the health center authorizing statute. It should be noted that depending upon the geographic location, there may be additional/different population groups that also experience poor health status and problems accessing health care such as: Native Americans; Alaskan Natives; Latino Americans; gay, lesbian, bisexual, and transsexual populations; people living with HIV/AIDS; residents of the Mississippi Delta; residents living along the U.S.-Mexico border, to name a few.

TABLE 2
Sources of Demographic and Health Status Information[14]

Indices	Sources of Information
Demographic indicators	
Age, sex, ethnic and linguistic distribution of the population	▪ U.S. Census ▪ PCA,PCO
Percentage of the population that is: ▪ Below 100% of poverty ▪ Between 100-149% of poverty ▪ Between 150% and 200% of poverty ▪ Over 200% of poverty	▪ U.S. Census for income distribution DHHS federal poverty guidelines, published annually ▪ PCA,PCO ▪ NACHC's REACH data ▪ BPHC Community Health Indicators HRSA, BHPr, OSD Population Estimates
Estimates of migrant population	▪ Office of Migrant Health ▪ State Migrant Education or Legal Services Offices ▪ PCA ▪ Atlas of State Profiles ▪ BPHC Community Health Indicators
Insurance coverage of different population groups	▪ State Medicaid agency ▪ PCA Surveys by market research firms, health care providers, and state/local governments on uninsured populations
Housing and employment trends	▪ PCA ▪ U.S. Census ▪ State Employment Security Office ▪ County/city planning agencies ▪ State Departments of Labor and Economic Development
Health Status Indicators	
Infant mortality and morbidity Low birth weight, entry to prenatal care Death rates	▪ State and local vital statistics report (all states and localities are required by law to compile and publish vital statistics) ▪ PCA, PCO
Incidence of communicable disease: sexually transmitted diseases, TB, HIV, vaccine-preventable diseases	▪ State health department records on transmittable diseases (mandated by Centers for Disease Control) ▪ PCA
Incidence of other health diseases	▪ Cancer registries ▪ Nonprofit organizations or foundations dedicated to certain diseases or condition (e.g., SIDS Foundation, Lung Associations, etc.) ▪ BPHC Community Health Indicators
Birth defect information	▪ State vital statistics reports
Environmentally-influenced conditions (such as pesticide exposure, lead poisoning)	▪ Local or state health department
Health indicators specific to the community	▪ State vital statistics reports ▪ Hospital discharge data ▪ State/county health department records

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[14] A summary of websites that provide various types of health and demographic data is located in resources section.

TABLE 3
Sources of Information on Access to Health Care

Information	Sources of Information
Insurance coverage of different population groups	▪ State Medicaid agency; ▪ State provider licensing agency; ▪ Surveys by market research firms, health care providers, and state/local governments on uninsured populations; ▪ Insurance status of patients of providers; currently serving the target population.
Access to care for Medicaid patients	▪ State Medicaid agency; ▪ State provider licensing agency; ▪ Survey of primary care providers: what percentage of their practice is Medicaid? ▪ Hospital Emergency room usage?
Access to care for uninsured patients	▪ Survey of primary care providers: do they have a sliding fee scale based on patient income? ▪ What percentage of their practice is sliding fee? ▪ Hospital emergency room usage?
Standards for health care utilization	▪ National Center for Health Statistics; ▪ BPHC

C. Access to Care

Once the service area and target population are described, access to health care and unmet need for services must be assessed. This is often as much an art as a science, but the following strategies can provide a good estimate. Table 3 provides some suggestions for obtaining information useful in estimating unmet need.

The initial step in identifying unmet need should be to contact the PCA to ascertain what methodologies may have been established as part of the SSP for identifying unmet need. If the service area and/or population have already been designated as an MUA/P and/or HPSA, some quantified need estimates may be available. This information is available from the state PCA and PCO.

Estimating Need — Assessing the target population will provide some information helpful in estimating the need for services. Using this information, an estimate of the demand for primary care services can be made using either a quick-and-easy method or a more involved one.

The quick-and-easy method: A good rule of thumb is that there should be about one primary care physician for every 1,200 to 1,500 patients.[15] This range provides a quick estimate of the number of full-time physicians needed for the target population. According to BPHC data, one dentist (and one dental hygienist) is required for every 1000 patients, and a mental health provider is needed for every 200-300 patients.

The more involved method:

1) Using the information gathered on the target population, **quantify the population** as accurately as possible in terms of size and demographic characteristics.

2) **Estimate the number of primary care encounters** needed by this population. Start with the fact that, on average, an individual generates 3.5 primary medical care visits per year. As appropriate, adjust the estimates based on:

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[15] Uniform Data System, Bureau of Primary Health Care, HRSA

- The age and gender distribution of the population (elderly and female patients generate more visits per year);
- The incidence of diseases such as HIV, TB or chronic care that will increase the need for care and more visits;
- Maternity rates;
- Environmental conditions affecting health.

3) **Compare these estimates** against actual service usage and adjust the estimates as appropriate.

- If there is already a health care provider in the community that is serving the target population, try to examine service utilization and diagnosis data from that provider for patients in the target population.
- If there is not a provider serving the target population, try to obtain information from other providers on service utilization and hospital discharges for the target population.
- Try to obtain information on service utilization for similar communities or target populations, particularly from health centers serving those communities or populations.

Table 4 provides information on national figures concerning physician office visits by specialty that may be useful.[16]

TABLE 4
Select National Averages: Health Resource Utilization

Annual number of office visits per 100 persons, 2008				
Physician Practice Characteristic	General & Family Practice	Internal Medicine	Pediatrics	Obstetrics & Gynecology
Number of Visits/ 100 Persons	75.1	51.2	175.2	66.5

Annual number of office visits per 100 persons, 2008 By gender and age			
Age	All	Female	Male
All Ages	320.1	375.7	262.1
Under 15	241.0	232.1	249.5
15 to 24	177.8	246.7	110.2
25 to 44	239.4	331.1	146.3
45 to 64	366.5	424.1	305.6
65 to 74	639.5	669.4	604.4
75 years and older	734.5	727.6	767.7

Source: *National Ambulatory Medical Care Survey: 2008 Summary Tables*

Assessing Available Resources — Estimating the availability of resources can be more or less difficult depending on the attitude of other health care providers toward the idea of a health center within their community. If providers and professional associations are supportive of a health center and forthcoming with information about their services and practices, the job will clearly be easier than if they are suspicious, uncooperative, or feel threatened. An important resource for assessing available provider resources is the state Primary Care Office.

When estimating the availability of primary care physicians, count doctors of allopathic and osteopathic medicine that practice in general/family practice, pediatrics, general internal medicine, and obstetrics/gynecology. For

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[16] Annual updates are available on the Centers for Disease Control website usually in June or July (**www.cdc.gov/nchs**).

dentistry include primary care dentists and not specialists; for mental health professionals include "core" providers including psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists and licensed marriage and family therapists (these latter categories may vary by state). In the discussion that follows, dentist and mental health professional may be substituted for the term "physician."

1) Conduct a survey to determine the number of primary care physicians and their accessibility to the *target population*[17]. Important information includes:

   - What is the total number of hours a week they spend in direct ambulatory patient care (not including administrative, hospital visits and lunch times)?

   - Do they regularly accept Medicaid patients - if so how many/what percentage of their direct ambulatory primary care time is devoted to them?

   - Do they have a regular and published sliding fee schedule of discounts based on income applicable to all patients? What percent of the practice?

   - What percentage of their practice is Medicaid; is charity care?

   - How long do new and/or established patients have to wait for an appointment?

   - Is the practice accessible by public transportation?

   - Does the practice take patients with limited English proficiency?

2) Estimate provider accessibility for the Medicaid and uninsured populations by totaling the percentage of each physician's practice that is reported as Medicaid, sliding-fee, or "charity" care. Do not rely on counting the number of physicians listed by the state Medicaid agency for estimating access to care. Many registered providers serve limited numbers of Medicaid patients, may have closed their practices to new patients, or may even be on the list for having served at least one patient at some point although they no longer do.

3) Do not include hospital physicians who work exclusively in inpatient settings; do not include time spent in administrative activities or in research.

4) Among the primary care providers exclude the proportion of their practice spent on specialty care. For example, gynecologists and pediatricians may spend some of their time doing surgery, which would be considered specialty care.

5) Obtain information on providers' availability in terms of *direct patient care hours* or *full time equivalencies (FTEs),* rather than office hours. See Table 5 for guidance on converting physician office hours to FTEs.

6) As appropriate include other primary care providers such as nurse practitioners, nurse midwives and physician assistants. In some communities these practitioners are an important source of care. However, the scope of services provided by such professionals is dependent on state law and can vary considerably.

Physician FTE Conversions — If a physician follows his or her patient's progress in the hospital, the number of *direct patient care hours* that the physician works will be greater than the number of office hours. When estimating total health care resources, the number of hours spent in direct patient care is important data. When conducting a provider survey, ask the physician:

- Do you follow your patients in the hospital?

- If so, how many hours do you spend altogether on direct patient care?

If information about office hours is available, or if conversion of direct patient hours into FTEs is necessary, use the following table to estimate FTEs for the different primary care physician specialties.

Never include a physician as more than one FTE.

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[17] This is most often done by telephone using a brief interview form. An office manager is frequently the most accessible and knowledgeable source. Providers can be identified through the phone book *or whatever means the target population would access the information.*

TABLE 5
Physician FTE Conversions

	Average Office Hours/ Week (Patient care)	Average Direct Patient Care Hours/Week (I.0 FTE)	Conversion Factor: Office Hours x Factor Direct Patient Hours
All primary care	30.8	50.1	1.6
General and family practice	35.1	49.9	1.4
Internal medicine	27.1	49.5	1.8
Pediatrics	31.9	46.0	1.4
Obstetrics and gynecology	29.2	55.5	1.9

Source: U.S. Bureau of Primary Health Care, "Guidance for Calculating Primary Care Physician Full-Time Equivalency," July 1993

Example #1: If a pediatrician reports that s/he works 35 office hours per week (actually seeing patients), and that s/he follows patients in the hospital, the total direct patient care hours would be:

35 office hours X 1.4 = 49 direct patient care hours

Since 1 FTE for a pediatrician is 46 hours, this provider would be 1.0 FTE

Example #2: If the only information available is that primary care providers in the community work 45 direct patient care hours per week on average, use the "all primary care" figure to calculate FTEs:

$$\frac{45 \text{ direct care hours}}{50.1 \text{ hours/FTE}} = 0.9 \text{ FTE}$$

Thus, each provider should be counted as 0.9 FTE. Time spent away from the office for continuing education, vacation, military leave, etc., can and should be deducted from the average direct patient care hours per week.

Note: There are no comparable conversion factors for dentists or mental health professionals.

Again, the important thing to consider is accessibility to services in terms of cost, transportation and language and not just numbers of providers.

Unmet need is the difference between the amount of primary care required by the population and the amount that is actually available.

D. Setting Priorities and Planning

Armed with accurate and comprehensive information, the health center planning process can begin in earnest.

The first step in planning is setting priorities. Although an estimate of unmet need for health services in the community has been accomplished, the needs assessment does not provide the whole picture. Chances are that a new health center is not going to be able to address all unmet need for primary care, so available resources and programmatic energy will have to be prioritized. This should be done using not only *quantitative* data about health problems, but also *qualitative* feedback from community leaders and members about what the health care priorities are in the community and among high need populations. Perceptions about health priorities may differ from the picture emerging from the demographic and epidemiological data, but this does not make perceived priorities "wrong." **Differing priorities will result in part because differences in culture, values and beliefs produce diverse definitions of "health."** For example, different values and beliefs about family planning will affect views

about health status and needs. When it comes to setting priorities, an inclusive, community-oriented approach to health must take this diversity into account, <u>along with</u> a solid needs assessment.

The planning process itself goes from the "broad brush" of long range strategic planning to the real "nitty gritty" of operational and financial planning.

Long Range Strategic Planning — allows a health center to look to the future and develop a vision of its role in a particular environment. This type of planning generally covers a period of three-to-five years. The vision developed during strategic planning is used as a blueprint for program development activities. There are many different approaches to strategic planning but all have in common linking mission, analyzing important external and internal factors, and developing broad goals and objectives in an *iterative* way that requires regular feedback on progress.

Operational and Financial Planning — provides for developing the overall structure of programs and finances of the organization. Once a health center is operational, Board involvement in this kind of planning is generally limited to review and approval of proposed plans and budgets. It is the responsibility of key staff to prepare and propose for Board approval the operational plans along with operating, capital and staffing budgets.

Program and Project Planning — sets the framework for implementing specific activities. In smaller organizations there may be little difference between this type of planning and Operational and Financial planning. Again, the actual work to prepare plans and budgets should be the responsibility of staff with approval by the Board.

E. Securing the Appropriate Federal Designations[18]

Once the initial needs assessment is completed and the planning process is being undertaken, you should identify federal programs and designations that your community is eligible for. Even if a health center does not receive federal Section 330 funding, federal designations can be extremely beneficial because they may provide the health center with a more advantageous method of reimbursement for Medicaid and Medicare patients and access to National Health Service Corps resources. Knowing which designations the health center and its community are eligible for is fundamental to moving forward with the priority setting and planning process. Following is a brief summary of where and how to apply for several federal designations*. **Many of these programs are currently changing; for current information contact your state/regional PCA, PCO or NACHC or visit www.bphr.hrsa. gov/shortage/.***

Medically Underserved Area or Population — It is required that the service area of an organization that wishes to apply for FQHC status or federal health center Section 330 funding includes an MUA or MUP. HPSA designation may be used in lieu of MUA status for obtaining Rural Health Clinic status (see HPSA below).

- *Apply to:* Office of Shortage Designation, Bureau of Health Professions, HRSA, usually in cooperation with the state PCO.

- *Requirements:* MUA/P designation is based on a composite score (the Index of Medical Underservice - IMU) compiled from four indicators: physician- to-population ratio, infant mortality rate, percentage of the population below the federal poverty level and percentage of the population over 65 years of age. MUP designation also uses the IMU, but substitutes the characteristics of the target population (minimum of 30 percent of the overall population in a service area for the percent of population below the FPL), as well as supporting documentation about special health needs within the target population.

- *For more information:* Guidance is available through the Office of Shortage Designation, and the state PCO or PCA. Listings of presently designated MUA/Ps are located on the BPHC website (**http://www.muafind.hrsa. gov/**).

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[18] The HRSA website includes contact information for all of the listed programs and designations. Start at **www.hrsa.gov**.

Health Professionals Shortage Area **—** Required for organizations that wish to employ NHSC providers; can also be used for obtaining Rural Health Clinic status. HPSA designation is an important factor in the Section 330 funding criteria.

- *Apply to:* Office of Shortage Designation, Bureau of Health Professions, HRSA, usually in cooperation with the state PCO[19].

- *Requirement:* A **geographic** Primary Care *HPSA* is an area with a physician-to-population ratio of 1:3500 or greater. A 1:3000 ratio is acceptable in areas with an unusually high need for primary health care, as illustrated by a high birth, infant mortality or poverty rate. Health care providers must be considered to have insufficient capacity (based on office visit rates, waiting times for appointments, or excessive emergency room use), or to be excessively distant or inaccessible. A **population** *HPSA* is a sub-population with a ratio of 1:3000 or greater.

- *Requirement:* A geographic Dental Health *HPSA* is an area with a dentist-to-population ratio of 1:4500 or greater. A 1:4000 ratio is acceptable in areas with unusually high need and for a population *HPSA*.

- *Requirement:* There are three options by which to calculate a geographic or unusually high need Mental Health *HPSA*. The methods vary based on the inclusion of "core" mental health professionals (i.e., psychiatrist, clinical psychologist, clinical social worker, psychiatric nurse specialist and licensed marriage and family therapist) in the calculation of the ratio. Organizations should contact the state PCO, or the Division of Shortage Designation. Please note new formulas are being developed for both MUA/P and HPSA designations.

- *For more information:* Guidance is available from the Office of Shortage Designation, and the state PCO and PCA. Listings of presently designated HPSAs are located on the BPHC website, **http://hpsafind.hrsa.gov/**.

In addition to the above HPSA categories, there are special exception and Governor request vehicles for obtaining designation. Check with the PCA, PCO and the Office of Shortage Designation for information about these approaches.

Federally Qualified Health Center (FQHC) **—** Allows an organization to receive prospective (PPS) Medicaid payments and cost-based Medicare reimbursement. FQHC's also are eligible for the Section 340B PHS Drug Pricing Program.

- *Apply through:* BPHC. The Application and Guidance for the application are available on the BPHC website (**www.bphc.hrsa.gov**).[20]

- *Requirement:* Federally Section 330 funded health cente*r*s are automatically eligible for FQHC designation. An entity not receiving Section 330 funding must demonstrate that it meets the statutory and regulatory requirements and program expectations governing community health centers to become designated as a FQHC "look-alike".

- *For more information:* Contact the BPHC, the PCA or NACHC.

National Health Service Corps (NHSC) **—** Site approval allows organizations to employ health care professionals who seek assistance with educational expenses through either a scholarship or loan forgiveness, available through the federal government and many state programs.

- *Apply to:* BHPr/NHSC, Rockville, MD. Information at **www.nhsc.hrsa.gov.**

- *Requirement:* The organization must be in a *HPSA* or have a facility HPSA designation*,* must agree to serve Medicaid patients and to serve Medicare patients without billing those patients in excess of what Medicare pays, and must have a sliding-fee schedule of discounts for people who are living below 200% of the FPL and without insurance. Organizations are placed on a priority list according to their HPSA priority score that is determined by the NHSC.

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[19] State PCOs are often vested with the responsibility for monitoring new applications and reapplications for designated areas so it is important to check with them regarding MUA/P and HPSA designations.

[20] If an organization is applying directly for federal Section 330 funding the guidance issued by BPHC as to when, where and how to submit the application should be followed.

- *Requirement:* Many states also have adopted supplemental state loan repayment programs that apply to primary care providers (physicians and non-physician providers such as Nurse Practitioners, Physician Assistants and Nurse Midwives), while some include dental and mental health professionals as well. Eligibility criteria vary by state. Interested organizations should contact the state PCO or PCA.

- *For more information:* Request a site application from the National Health Service Corps, Bureau of Health Professionals, **www.nhsc.hrsa.gov**.

Rural Health Clinic — Designation allows public and private, non-profit and for-profit providers to receive cost-based reimbursement for services provided to Medicare beneficiaries and prospective Medicaid payment rates for services provided to Medicaid recipients.

- *Apply through:* State health department.

- *Requirements:* The organization must be located in a rural, non-urbanized area that is currently designated as a MUA or HPSA, and have a nurse practitioner/midwife or physician assistant onsite at least 50 percent of the time the RHC is open and providing RHC services.

- *For more information:* Contact the State Health Licensing Department, State Office of Rural Health, the Field CMS Office, or the DHHS Office of Rural Health Policy **www.hrsa.gov/ruralhealth**.

The chapters that follow take you through the specific requirements of and approaches to planning and implementing your health center.

Chapter IV

Looking For a Home Organizationally and Physically

Because accessibility is a central concept in community based health care, identifying the health center's "home" requires some thought. Decisions will have to be made about the type of organization (whether or not to start from scratch with implementing a new health center or to partner with an existing organization) and the physical plant (building from the ground up or finding an existing place). Going through the incorporation and IRS filings, recruiting staff and developing policies and procedures are a huge job. Construction costs can seem daunting for a start-up organization with little funding. It may be tempting to simply work out use of available space in an existing organization or lease whatever office space requires the least amount of remodeling. For an existing organization that is converting to a health center, the existing space may or may not be adequate for expanded primary care (including dental and behavioral health) services. In any event, it is important to think carefully about organization, location, and space considerations before making a decision.

A. Organizational Considerations

A new health center may be a new organization or a conversion of an existing entity to a health center model. This is a fundamental and critical decision and should be weighed very carefully. Following are some considerations to keep in mind when assessing organizational options.

Non-Profit Model

New organizations — The center could form a new non-profit organization. This approach requires incorporating as a non-profit entity under state law and obtaining tax-exempt status under the U.S. Internal Revenue Code.

- U.S tax code designated 501(c)(3) tax-exempt organizations do not pay income tax on net revenue or donations, Donations given to the health center are tax-deductible for the donor. 501(c)(3) organizations are restricted in the amount of lobbying they can undertake.

- U.S, tax code designated 501(c)(4) organizations are primarily education based organizations and can participate in unlimited lobbying activities. Donations to them are not tax-deductible for the donor.

While both of the above tax statuses meet the definition of non-profit, the BPHC strongly favors a 501(C)(3) designation for FQHCs and Section 330 funded health centers. Choosing to go the alternate route will require strong justification. In addition, many foundations and other potential funders will give money only to 501(c)(3) non-profits.

State laws specify requirements affecting incorporation and actual requirements will differ from state to state. Contact the Secretary of the State for more information.

Existing organizations — If there is an existing organization in the community that serves as or could become the health center; it can save a lot of time and effort. This approach can also reduce the start-up financial burden by allowing the center to work with existing operational and administrative structures.

- Existing organizations range broadly from social service and community action programs that offer health services to hospital outpatient clinics, free clinics, and clinics that serve a limited population or provide select services;

- In taking this approach, federal statutory requirements and program expectations will need to be met by the existing center before it is able to become a FQHC;

- Often converting an existing organization requires reorganization of the Board of Directors, which can be a difficult process as it may mean that sitting board members will have to relinquish their seats to make room for the required consumer representatives;

- The mission of the existing organization will have to be examined and may need to be revised to be consistent with FQHC requirements and emphasis;

- Contractual relationships with other providers in the community will have to be evaluated, and possibly renegotiated, to ensure that the contracts comply with affiliation agreement regulations see discussion below);

- Programs and services may need to be enhanced or modified;

- Policies will have to be put in place if they do not exist to ensure that low income and uninsured people do not experience financial barriers to accessing care; and

- It is also vital that the existing organization have credibility with the target population(s).

This discussion is not meant to dissuade communities from taking this approach – merely to point out that there will be several critical steps that will need to be taken to make sure that the organization is compliant with federal health center regulations.

Public Entity Model

FQHC designation and Section 330 funding is also available to a health center operated as part of a government agency, such as a local health department. In this instance it may not be possible to meet all of the requirements for health centers because government agencies are subject to laws and regulations regarding personnel and financial controls. Because heads of public entities may be elected or appointed, meeting governance requirements can also present problems. In order to accommodate this situation, each federal fiscal year up to five (5) % of Section 330 health center funding can go to public organizations who are fully compliant with all of the composition and operating authority requirements of Section 330.

Due to operational and/or legal constraints, some public agencies may not be able to independently meet all health center requirements, and in these situations may comply with these requirements through a "co-applicant" arrangement. The public agency receives the section 330 grant or Look-Alike designation, however the Board of Directors is a separate organization that serves as the health center's governing board (the co-applicant). The public agency and the co-applicant are collectively referred to as the "health center" or "public health center." Quite frequently the public agency will actually employ all of the staff and manage the financial operations of the center. The co-applicant board retains all of the authorities to set policy, approve annual budgets, etc (see Chapter V for a full discussion of governing board authorities). The agency and the co-applicant must execute a co-applicant agreement that delineates how the requirements and authorities will be met between the two entities. Required documentation of public entity status is identified in Policy Information Notice 2010-01 - **http://bphc.hrsa.gov/policiesregulations/ policies/pdfs/pin201001.pdf**.

Satellites of Existing Fqhcs

Another approach is to identify an existing health center in a nearby community that would be willing to open a new clinical site in the target community. This option may also make it easier to obtain federal funds because an existing health center may compete more effectively for additional Section 330 funding and may be able to achieve efficiencies by sharing administrative or overhead support and systems capabilities. It is important that all federal regulations and statutes governing health centers are complied with and that the potential partner understands the needs and character of your target population(s) and community. Representatives from the service area and target population(s) will have to be incorporated into the existing health center's Board of Directors.

Partnering

In developing the organizational model health centers can, and in fact should, develop relationships with other community providers that include contracting and collaborating for services. This might be developing a partnership with a local community mental health center to provide the behavioral health program or a local dentist for oral health care. An affiliation is an agreement that establishes a relationship between a health center and one or more entities. Prior to participating in an affiliation, a health center should closely review the agreement with legal counsel who is familiar with FQHC regulations to assure that the organizational documents and contractual agreements:

1) Accurately reflect the parties' affiliation objectives;

2) Pose no risk to the health center's integrity or autonomy as an FQHC, specifically regarding corporate structure and governance;

3) Address:

- Anti-kickback statutes,
- Antitrust,
- Tax-exempt state of the health center,
- Medicaid and Medicare reimbursement issues, and
- State law.

It is important to become very knowledgeable about Policy Information Notices 97-27 (**ftp://ftp.hrsa.gov/bphc/docs/1997pins/97-27.pdf**) and 98-24 on affiliations (**ftp://ftp.hrsa.gov/bphc/docs/1998PINS/PIN98-24.PDF**).

B. Access and Location

Access is a core criterion for the health center. The location must be easy to reach and convenient for the population(s) you have made a determination to serve. Depending on the target population(s), it may make more sense to locate the health center near a residential area where people live, near major employers, or on a heavily traveled route between residential and commercial areas. Public transportation access is often a critical factor in determining where to put the health center.

C. Space Considerations

In looking for space, try to plan for growth as successful start-up operations may grow considerably during the initial years. This means that the health center will need to plan for expansion of:

- Administrative, clinical and information systems functions;

- Areas devoted to specific functions such as reception, clinical records, patient waiting and counseling, laboratory and x-ray; and

- Provider offices, patient exam and treatment rooms; and, if applicable, dental operatories and offices for behavioral health counseling.

Because each new health center will have its own particular circumstances pertaining to physical space (including basic considerations such as cost and availability), it is difficult to say that there is one standard approach that all new health centers should adopt. However, most health centers do plan for:

- Two-to-three exam rooms for each medical provider (physician, nurse practitioner or physician assistant). This layout allows for efficient triage and patient flow. In addition, it is always desirable to be on the ground floor to best accommodate people with limited physical mobility (if the clinic is not on the first floor access must be assured through an elevator or the like);

- Two-to-three operatories for each team of a dentist and dental hygienist;

- One office for each mental health professional with at least one space large enough for group sessions; and

- A meeting room that serves as a place for Board meetings, educational and staff meetings, and a gathering place for community groups.

It may be cost-effective in the long term to secure professional assistance from an experienced functional space planner to help identity the space and equipment required by health center operations. Space planners can not only ensure that adequate space has been allocated for each of the health center's major functions, but can help avoid costly oversights, exclusions and overbuilding.

Capital Link **www.caplink.org** is a non-profit organization partially funded by the Health Resources and Services Administration to assist health centers in accessing capital for building and equipment projects. They provide extensive technical assistance with financial and market feasibility studies, business plan and proposal development for capital projects, space design and project planning, debt financing, and fundraising. Because they are partially funded by HRSA, many of their services are free for Section 330 funded health centers.

Chapter V

Developing Community Governance

Community based governance is the feature that makes health center*s* distinctive and is one of their strongest attributes. Developing community governance can be labor-intensive, but it is what keeps the health center accountable to the community it serves. This chapter will discuss the following:

- Governance requirements for Federally Qualified Health Centers (funded and Look-Alike)

- Board of Directors roles and responsibilities

- Use of board committees

- Particular issues in establishing and nurturing community based governance

- Legal issues affecting board operations and liability

A. Federal Governance Regulations

Governance Requirements — Federal authorizing legislation for health centers is found in Section 330 of the Public Health Service Act. Implementation of the act is carried out by the Heath Services Resources Administration through the Bureau of Primary Health Care. These entities set policy and regulation requirements.

The Health Center Program Requirements clearly defines governance requirements for health centers (**ftp://ftp. hrsa.gov/bphc/docs/1998pins/PIN98-23.PDF**). Note that there are waivers to these board composition requirements available to health care for the homeless, public housing and migrant health center grantees.[21] Consult the BPHC for these exceptions. It is important to remember the intent of the consumer participation requirement in cases where an allowable governance exception exists. Health centers are meant to be integrated into the communities they serve so it is important to ensure that a regular process for engaging the community and monitoring the needs of the community is established when a waiver of governance requirements is applied for. BPHC will look for an alternate mechanism for consumer input into the governance process when deciding whether or not to grant a waiver.

The board of a health center is the ultimate authority and cannot be hamstrung or limited in exercising its authorities. That means that any agreements or collaborations with other organizations cannot restrict or influence the board's ability to do its job. A health center board is self-perpetuating, i.e. only they can choose who sits on the board. No other organization can have a controlling voting block, veto-power, or any other mechanism that detracts from the autonomous authority of the health center board. In addition, the executive director of the health center must be directly employed by the board, i.e. there must be a direct line of authority from the board to the executive director.

Composition — The number of board members must be specified in the bylaws of the organization. This can be either a specific number or a limited range. The federal regulation specific to FQHCs (Section 330 funded and Look-Alikes), PIN 98-23 (**ftp://ftp.hrsa.gov/bphc/docs/1998pins/PIN98-23.PDF**) require that boards have between nine (9) and twenty-five (25) members who are representative of the population(s) served. The size should relate to the complexity of the organization and the diversity of the community served. It is encouraged that the bylaws stipulate a range of members so that additions and deletions do not require by-law changes. Also it is best to have more than nine members so that if one person has to drop off the health center does not fall out of compliance with the statutory requirement.   In addition, the FQHC board must meet the following requirements[22]:

- A majority (*at least* 51%) of the board members must be individuals who use the health center as their regular source of health care. These members should live or work within the health center's service area.[23] Many health center boards have greater majorities of consumer members - 80% or more is not uncommon.

- No more than one half (50%) of the non-user board members may be individuals who derive more than 10 percent of their annual income from the health care industry. This definition is broad including, for example, a receptionist in a dental office, as well as health professionals. However, being a health center consumer trumps everything - if someone is a patient it does not matter how they earn their living, they count as a consumer member.

So, for example: the board is made up of 13 people. At least 7 of these have to be health center consumers. That leaves 6 non-consumers so no more than 3 can be "health care earners".

- The remaining members of the board should be representative of the community served, and should be experts in community affairs, local government, finance, legal affairs, or other areas of expertise relevant to the HC's functioning.

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[21] Governance requirements do not apply to an Indian tribe, tribal or Indian organization

[22] These rules do not apply to health centers operated by Indian Tribes or Tribal Organizations. In addition, as noted earlier, waivers on Board composition requirements may be applied for in the cases of Migrant, Homeless, and Public Housing health centers.

[23] A parent, foster parent, court appointed guardian or caretaker or legal sponsor of a legal Immigrant who is a patient can stand in as a consumer board member.

- The consumer board members should reasonably represent the patient population served in terms of demographic factors such as race, ethnicity and gender. This does not mean a quota system - just that in order to truly be a consumer board all patient groups should have someone at the table.

- Health Centers funded or designated a LAL under more than one Section 330 program must demonstrate appropriate representation from the populations being served.

- No board member may be an employee of the health center, or the spouse, child, parent, brother or sister of a health center employee by blood or marriage.

Roles and Responsibilities — The Board of Directors (or Governing Board) is the principal policy-making body of the health center. It is autonomous, bound only by its legal responsibilities under its charter and bylaws and its contractual obligations to governmental agencies and other funding sources. The Board of Directors of a health center is charged with the responsibility of assuring that the mission of the center is carried out through its strategic plan and services. This is an implied and extremely important obligation to the broader community in which the health center is located – an obligation to accomplish the objectives of the health center.

As the health center's policy-making body, the Board of Directors (board) must distinguish its policy-making authority and responsibility from the authority and responsibility of the health center's executive director and staff. The executive director and staff implement and execute the policies set by the board. The board delegates the day-to-day operational responsibilities to the executive director. This means that the board must observe, question and monitor the operational functions of the health center, but it must refrain as much as possible from direct participation in those functions or risk becoming micro-managers.

The basic responsibilities of a board include:

- *Finance:* The board sets policies for financial management practices including a system to assure accountability for center assets and resources, approves the annual budget, selects the independent auditor and accepts the audits, approves payment and eligibility for services including criteria for fee discounts for individuals with incomes below 200% of poverty.

- *Legal:* The board must ensure that the health center is operated in compliance with applicable federal, state and local laws and regulations. The board must protect the corporation from unnecessary liabilities and assure compliance with the Office of the Inspector General of the Department of Health and Human Services. The board also has to approve the annual Section 330 funding or LAL application.

- *Human Resources:* The board establishes personnel policies including selecting, hiring and periodic evaluation of the Executive Director, compensation including wage and benefit schedules, continuing education, employee grievance policies, termination policies, equal employment opportunity practices and Department of Labor requirements. Note again that the board's responsibility is to establish policies and approve procedures – not to engage directly in implementing them.

So, for example: The board approves compensation benefit packages and wage bands for various staff positions (i.e. family practice nurse practitioners pay scale is $65,000 - $80,000). The executive director decides how much within each pay category an individual will be paid (i.e. B. Jones, FPNP will be paid $72,000).

- *Operations:* The board adopts operational policies including scope and availability of services, location and hours of services, and quality of care audit assessments and improvement programs and policies.

- *Evaluation:* The board evaluates health center activities including the quality of patient care services, service utilization patterns, productivity of providers, patient satisfaction, and achievement of project objectives.

- *Planning:* The board engages in strategic planning to ensure that the center is prepared to succeed in a changing health care environment, continues to address identified community health service needs, and pursues organizational goals and mission through the center's operations. The board approves the health center's purpose, mission and roles.

- *Resource Development:* The board is responsible for fundraising and for approving programmatic improvements and/or new programs through grants from federal, foundation or other revenue sources.

These specific responsibilities will be assigned to committees of the Board of Directors.

Board Committees: Depending on the size of the board and the health center, it may be helpful to create committees to handle specific tasks. Committees allow for a more detailed analysis of topics such as budgets, evaluations or program analysis before they are addressed by the full board. If the bylaws permit, committees may also include non-board members, such as people with specialized expertise. Adding non-board members to committees also spreads the work and helps avoid board member burn-out. Using non-board members on committees is a good way to involve volunteers who may eventually serve on the board.

State corporation laws will often limit the range of activities that the board can delegate to its committees. In general, committees should have only review and recommendation authority. When a committee (i.e., executive committee) is authorized to act for the full board, the authority <u>must be</u> stipulated in the organization's bylaws.

There are no rules about how a board should organize its work. Governance works best when the committee structure facilitates carrying out the board responsibilities. With this in mind, committees that <u>may be</u> specified with responsibilities broadly noted in the bylaws are: an Executive Committee, Finance Committee, Governance Committee and Quality Assurance Committee.

The brief committee descriptions that follow are a guide to the roles of standing committees and ad hoc committees. Ad hoc committees are organized and responsive to specific, often time-limited issues. In a new health center, for example, a human resources committee will be charged with establishing personnel policies. Once these are approved by the board of directors, the functional responsibility of the committee is usually reduced to an annual review of the policies. If the personnel committee is an ad hoc committee, when the tasks of the committee are completed members can be released to focus on other priority issues of the board.

Advisory committees, if stipulated in the bylaws, provide a vehicle for the board to add energy and expertise to the board to address specific issues without relying solely on the volunteer board.

Executive — The Executive Committee is empowered to act for the full board in matters that require immediate action or do not involve major questions of policy or funding. It is also the coordinating committee that organizes the board's work and the activities of the other committees. The Executive Committee is usually composed up of the officers of the board (i.e. president, vice president, secretary, treasurer) and chaired by the board president. When a health center determines that chairs of the other standing committees should be included on the executive committee, this must be stipulated in the bylaws. The staff liaison to the Executive Committee is the Executive Director or Chief Executive Officer.

Finance — The board treasurer usually chairs the Finance Committee. This committee has fiduciary responsibility for the health center and takes preliminary action on budgets, including grants and financial matters, reviews financial reports, and makes recommendations regarding financial procedures and controls. The staff liaison is the organization's Finance Director or Chief Financial Officer.

Governance — The Governance Committee has a substantial charge in the stewardship of a health center in that it is responsible for sourcing, recruiting and orienting board members, implementing and revising bylaws, board self-assessment, and other activities that are involved in maintaining the work of the board.

Quality Assurance — The Quality Assurance Committee reviews and recommends risk management policies, protocols and policies governing the provision of patient services, the quality assurance plan developed by staff, and assessments and clinical audits performed by staff. It also reviews and recommends the clinical privileges of health center provider staff. The staff liaison is the Chief Medical or Chief Clinical Officer.

Human Resources (Personnel) — This committee reviews and recommends personnel policies, salary and fringe benefit programs, and handles employee grievances if board involvement becomes necessary and board bylaws provide for such involvement. *It is important that the situations in which the board might get involved in staff grievances are very restricted and clearly defined.* Generally it is only matters involving grievances against the

executive director and related to accusations of illegal behaviors, emotional or physical abuse, or the like. The staff liaison is the Human Resources Director or Chief Operating Officer.

Strategic Planning — Setting the course for the organization's future is a critical aspect for any organization in these rapidly changing times. A Strategic Planning Committee should, on a regular basis, review market and internal information to understand trends and potential activities that should be undertaken and then, importantly, assure that implementation occurs.

Development/Fundraising — This committee oversees planning and coordinating fund-raising efforts. For example, the board may decide to implement an annual fundraising event or establish a capital improvement committee when embarking on a facility improvement or construction project. The staff liaison is the Development Director, Grants Manager, or Executive Director.

Marketing/Public Relations — A Public Relations Committee may be particularly important for organizations that must "sell" themselves or their services in the community. The Development and Public Relations Committees are sometimes combined into an External Affairs Committee.

These are generally *standing committees* which means that they exist on an ongoing basis. It should be noted that health centers are not required to have all of these committees. In fact, it is important not to overtax board members by having them serve on too many committees. As the health center grows and becomes more complex it is natural for the board to diversify and add committees. Ad hoc committees and advisory committees provide vehicles for the board to add energy to the board and address specific issues without relying solely on the volunteer board. An *ad hoc* committee can be established for a specific purpose and dissolved as soon as the need has been met. For example, the board may establish a capital improvement committee when embarking on a facility improvement or construction project. It is also not required that a health center have all of the management positions identified above. Smaller health centers will delegate multiple roles to fewer staff.

Board Development: Effective community governance requires nurturing. Community based boards are diverse because they draw from the entire community and bring together professionals and nonprofessionals. This means that <u>all</u> board members—even those who are knowledgeable about health care or are experienced at serving on boards—will need training on how to work together. Diversity training is often crucial to enable people from different backgrounds to communicate and work together effectively and respectfully. Non-professionals may need to develop their understandings of health care and technical issues. Professionals must be able to work with non-professionals as peers. Everyone must understand the roles and responsibilities of a board member. The local United Way agency or volunteer clearinghouse may provide board training; the state PCA and NACHC can be contacted for assistance.

As with any volunteer, a board member must know that his or her participation is making a difference. Having clear and manageable tasks helps to ensure that people feel useful. The board should plan for continuing training and education of individual members. In organizations starting from scratch, board members involved from the beginning may have a tendency to "micro-manage" operations once the health center becomes operational. This may be due to the fact that board members are often the only source of labor power before staff is hired, and the transition from a board managed to a staff managed organization is a period when roles and responsibilities may be unclear. It is important that staff and board members explicitly discuss the transfer of roles and responsibilities as the health center transitions from planning to development to implementation. Similarly board members who started the health center can have a hard time incorporating newer members and granting them equal footing. Bringing in an experienced board trainer is very useful during these transitions.

An existing non-profit entity that is considering converting its structure and operations to a health center may need to make changes in the board's composition in order to make it community based and sufficiently autonomous. Developing a Board of Directors with at least 51 percent of members who are active health center users may mean adding or replacing a significant number of existing board members. This transition can be delicate. Diversity training and other formal board development activities will help the new board come together.

Legal Issues: New board members often want to know if they are legally liable for the health center's activities. State corporation law governs legal liability. Seek legal advice to learn about the laws in the health center*'s* state. In general, most state laws require that a board member perform his or her duties "in good faith" with the best interests of the not-for-profit corporation in mind and with "such care as an ordinarily prudent person in a like position would use under similar circumstances." This allows the board considerable latitude in making decisions, delegating authority and decision-making, and relying on the expertise of others.

Liabilities — Board members cannot be held personally liable for business or financial decisions if these decisions are informed and do not constitute a conflict of interest. This means that board members generally are not personally liable for decisions that were reasonable when made but which have undesirable outcomes. They <u>can</u> be liable for the consequences of decisions if they neglect their responsibilities as board members, such as failing to attend meetings, to review financial reports, or to make reasonable inquiries before approving proposed actions. Board members can be personally liable in matters involving a conflict of interest or violations of local, state or federal criminal laws.

Health Center Mission — Board members are responsible for making sure that the organization carries out its mission as outlined in the articles of incorporation and bylaws and to state and federal funding sources.

Employee Benefits and Compensation — Board members are responsible for ensuring that the organization complies with local, state and federal laws and regulations. Board members should pay particular attention to compliance with the federal tax laws and with federal laws regarding employee benefits and pensions as those statutes can impose personal liability on an organization's managers (including board members) for violations.

Corporate Compliance — A health center's Board of Directors plays an integral role in developing and implementing the health center's Corporate Compliance Program. Adopting a board resolution documenting the health center's commitment to compliance and decision to adopt a formal compliance program is an excellent starting point for the process. This endorsement demonstrates the board's approval of the program's framework and recognition of the resources that will be required to develop and maintain the program. In addition to adopting this resolution board members have specific requirements that they must meet to ensure compliance with applicable laws and regulations. On an ongoing basis the board must monitor the implementation and operation of the compliance program to ensure its effectiveness.

Compliance Program for Individual and Small Group Physician Practices, **http://oig.hhs.gov/authorities/docs/physician.pdf** *(65 Fed. Reg. 59434 et. seq., October 5, 2000)*

The federal Volunteer Protection Act of 1997 grants immunity from personal liability to those who volunteer for nonprofit organizations. It is intended to encourage volunteerism and facilitate volunteer organization recruiting by reducing the legal liability risks to individuals who choose to serve. The law does not allow punitive damages to be awarded against a volunteer unless the harm was caused by willful or criminal misconduct, or a conscious, flagrant indifference to the rights and/or safety of the claimant.

Not-for-profit organizations usually can indemnify their board members against losses incurred as a result of serving as a board member. This means that the organization will pay the costs associated with defending a legal action against the board members. The circumstances under which a board member can be indemnified are a matter of state law and are usually specified in the organization's bylaws. Because legal costs can pose a substantial financial burden on the organization, non-profits purchase Directors and Officers insurance for their board members. The state PCA should be able to provide more information about this and may have a group-purchasing program. It should also be noted that the Federal Tort Claims Act (FTCA), which provides medical malpractice coverage for participating health centers, provides protection for all employees and board members as long as all conditions of FTCA are met.

This issue is addressed in greater detail in Chapter VIII. Again, legal counsel should be obtained concerning the right to indemnification and the appropriate insurance coverage. In addition, local counsel should be asked to advise you regarding applicable state immunity statutes that may offer some protection to not-for-profit corporation board members who serve on a voluntary basis, as health center board members do.

Chapter VI
Human Resources

A. Staffing Needs

Health centers have a unique team leadership structure that includes the Board of Directors as the policy-making body, administrative leadership that includes the Executive Director and Finance Director and clinical leadership that includes the Medical and Dental Directors, and in some cases Pharmacy Directors and Behavioral Health Directors. Larger centers may also have Human Resource Directors, Chief Operating Officers, Development Directors, and/or Information Technology Directors. Because it is the Executive Director who is directly responsible to the Board and who, through board authority, is responsible for hiring and supervising all other employees, the Board will logically first search for an Executive Director.

Some health centers have physician-oriented provider staffs with nursing support staff. Among these, some focus on hiring Family Practitioners to take advantage of the broad age-span they treat while others prefer age-specific providers such as Pediatricians and Internists. Alternately, some health centers utilize Advanced Practice Nurse Practitioners (APRN) and/or Physician Assistants (PA) with physicians available for complex cases and consults. The estimate of unmet need will help to project how the health center needs to be staffed to meet both the quantity and specific service needs of the target population(s). Availability of different types of practitioners and resources available to the center will influence the form of the operations model. The following considerations can assist in planning and recruiting staff.

Phased-In Approach — A "phased-in" approach to hiring is most advisable for a number of reasons. Whenever possible leadership positions should be filled before non-leadership positions, and people hired for leadership positions should be given the opportunity (and be expected) to hire the best people available for the other positions. Also, the revenues needed to support the preferred staffing complement will likely be realized in an incremental way and it is not wise to "over-commit" limited resources too soon. It is important to remember that health care providers generate revenues so getting clinical staff up and going is critical.

Planning Efforts — NACHC and the state/regional PCAs can provide valuable assistance to a health center's resource planning efforts, including specific staffing considerations. They have experience working with communities to implement new health centers and therefore have considerable knowledge relative to staffing and other resource requirements. The Bureau of Health Professions in HRSA is also an important resource.

Vision — In forming the vision of what the health center should "look like" when it is fully developed, it is useful to seek the advice of other health centers. This can help develop a "road map" to follow as the health center evolves. A list of health centers is available from the state PCA, BPHC and NACHC.

Special Needs — If the target population(s) has special language, cultural or other needs, contact representatives, especially in the community, who are best able to help identify and address those needs. Several national organizations are available to assist with technical assistance with cultural competency - contact NACHC or the HRSA Office of Special Population Health. For resources and contact information you can also go to **http://bphc.hrsa.gov/technicalassistance/tatopics/specialpopulations/index.html**.

Of course the health center will need staff other than health care providers. Administrative, financial, medical support and social services personnel will have to be identified and recruited. Again, in projecting how many of each kind of staff person will be needed talk with the state PCA, NACHC, and other health centers. Remember, developing the staff for the health center is critical to the success of the center and will be an on-going task throughout the life of the health center.

B. Hiring, Employing, and Terminating Staff

If establishing a new not-for-profit organization, establish clear policies to govern the organization's practices for hiring, employing and dismissing staff. The importance of establishing legal, clear and fair policies in employment practices cannot be overstated.

Human Resource Policies form the basis of all personnel actions. These policies should be written in such a way as to provide clear policy direction for all employees. Because the new organization will grow over time and will likely take on new responsibilities as it grows (which means new staff and new staff functions) it is important to remember two things:

Specificity Provision — Human Resource Policies should be specific only for those things that are common to all employees. Board approved human resources policies and procedures are the foundation of the Human Resources Manual that will be distributed to each employee. Notable policies include:

• Equal employment provisions;

• Harassment provisions; and

• Probationary periods, pay periods and paydays, holiday, sick and vacation provisions, standard of conduct or "work rules" and discipline, complaint or grievance resolution provisions; safety provisions; and termination provisions.

Documents such as clinical protocols, principles of practice, various operations manuals, and wage/salary scales are particular to individual positions or types of employees. These documents will need to be developed and updated regularly by management staff.

Review and Revision — Human Resource Policies, and related documents such as wage/salary scales and fringe benefit programs, will need an annual review and revision at a minimum and regular review and revision as market conditions and state employment laws change.

Human Resource Policies must be reviewed by an attorney experienced with non-profit organizations for compliance with the state's employment laws, employer and employee rights and responsibilities prior to the board of directors' acceptance and approval. For resources on major human resources topics such as policies and procedures, hiring and credentialing and benefits, visit NACHC's HR Clearinghouse at **http://www.nachc.com/hrclearinghouse/**.

C. Recruiting and Retaining Clinicians

Recruiting clinicians is a constant and essential component of health center operations. Today's market for primary care, dental and mental health clinicians and pharmacists is highly competitive and health centers are constantly challenged to "stay ahead of the curve." While the task is sometimes daunting given the stiff competition and the limited financial resources that most health centers have, there are things that health centers can do to "gain an advantage" in today's market.

One of the first steps for health centers to take in developing successful recruitment strategies is to know who can help them. The National Health Service Corps (**http://nhsc.hrsa.gov**) can be a significant help in recruiting providers and offering assistance with placing primary, dental and mental health clinicians and repaying professional education loans. There are eligibility rules for both providers and health centers. Interested health centers should consult their PCAs, PCOs, NACHC, and the Bureau of Health Professions (**www.bphr.hrsa.gov**).

Many PCAs and PCOs provide assistance to health centers in recruiting clinicians. Services include advertising practice opportunities, referring candidates, assisting in developing employment agreements, and organizational consulting in developing health center-specific recruitment plans. Some states have programs similar to the NHSC

scholarship and loan repayment programs and, in most instances, the state PCA and PCO are involved with these programs.

In the final analysis, however, the responsibility for hiring and retaining clinicians lies with the individual health center. In order to be successful, a health center should keep the following things in mind.

1) Know the market and what it is paying. Even if compensation provided by the health center*'s* competition cannot be matched, be aware of the "going rates." Salary surveys conducted by groups like the Medical Group Management Association (**www.mgma.com**), NACHC and other healthcare trade organizations can be very useful in this regard.

2) Know how to market the health center. This means giving some careful thought to how to put the health center's "best foot forward" when developing written promotional material. It is often worthwhile to invest in some professional consultation to help decide how to best present the health center to prospective employees.

3) If viable candidates are available when recruiting for a particular position, act fast. The competition is stiff and the current wisdom is that waiting to contact someone who has contacted the health center seriously jeopardizes the chances for success, particularly with "instant access" now available. Become involved in health professions education programs within the area and the state. This is a longer-term proposition but research shows that students who are exposed to health centers during their education are more likely to choose health centers as career paths.

4) When interviewing candidates, look for the best fit between the candidate and the practice opportunities in the health centers. This may mean not taking any "warm body" simply because of a sense of desperation. There are good candidates and bad candidates, and hiring a bad candidate can turn out to be more detrimental than not hiring anyone in the short term. Finding a "best fit" also means knowing about and helping to meet a candidate's family needs, including a spouse's/partner's professional and social needs, the candidate's and/or family's recreational and social needs, and educational opportunities for children. Don't overlook housing needs. Also be sure to alert other health care organizations in the area that you are hiring. A candidate who does not fit for someone else may be perfect for you.

5) The match between the needs of the health center*'s* patients and the community with the skills and abilities of the candidates under consideration is critical. This often means looking closely at a candidate's ability to provide the necessary services and willingness to work successfully with the diversity of people that the health center serves. Maximizing the extent to which there is mutual compatibility between candidates and target populations will maximize patient satisfaction and provider retention.

6) Remember that a health center's providers must meet Federal Tort Claims Act (FTCA) (**http://bphc.hrsa.gov/ftca/**) requirements in order for the center to obtain free malpractice coverage under FTCA. The center will need to check and verify licenses, educational credentials, and the provider's record (if any) in the National Practitioner Data Bank (**www.npdb_hipdd.hrsa.gov**).

7) Lastly, understand that the recruitment process is never-ending. The health centers that are most successful in recruiting are the ones that never stop recruiting. Stay active in recruitment, stay informed of market conditions, stay positioned to take advantage of unexpected opportunities, and stay prepared in the event of sudden change as the health care industry is full of sudden changes. And remember, once the health center has a complement of high quality providers, work to **retain** them—ensure that there is not only an effective <u>recruitment</u> program, but also a responsive <u>retention</u> program. It's less expensive and much less disruptive to health center operations and to patient care and satisfaction to keep existing clinicians than to replace them.

Chapter VII
Business Planning

Now that the community, service area, target population, program planning and services have been considered, it is necessary to translate "services" into "volumes", "expenses", and "revenues", and to plan how the health center will achieve financial viability. This chapter will look at business planning for a health center.

Business planning is more than just budgeting. It is a planning process that is highly recommended for any organization or community that is considering the initiation of a health center. The following highlights are the key aspects of business planning and expense and revenue considerations for financial projections.[24]

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[24] Some of the information identified for the Business Plan may have already been gathered during the needs assessment and/or MUA/P, HPSA designation surveys.

A. Why Develop a Business Plan?

Under the best conditions, being financially successful when starting a new health center is difficult and requires careful planning. Even primary medical care organizations with some operating history may find the health center structure and care delivery model to vary substantially from its prior experiences. The process of constructing a business plan forces an objective, critical and unemotional look at the proposed project. The business plan in its finished form should provide a tool to help manage future operations. Importantly, it will also provide a means to communicate key ideas to other organizations, especially possible financing sources.

B. Business Plan Components

The business plan should be organized in a manner to clearly describe the **PURPOSE** of the initiative, the **MAR-KET**, and to document the **"ASSUMPTIONS"** that planners have made by means of primary market research. It should review the key operating aspects, which are the services and features that make the project distinctive—also referred to as the **"BUSINESS STRATEGY"** of the health center. It must describe how the business will be managed (including governance) and organized. The plan must include sound **FINANCIAL PROJECTIONS**, based on the documented assumptions, and contain an **ACTION PLAN** that outlines the steps to implementation. Lastly, the options for leadership, i.e., a **CONTINGENCY PLAN,** in the event that operations fall short of projected targets should be discussed. Once each of these plan components has been completed, a compilation of the critical operational and organizational aspects of the proposed health center project can be assembled into an **EXECUTIVE SUMMARY**.

A business plan is intended to improve the opportunities for success. Like a blueprint, if well done it can provide for long-term organizational durability and stability. Note that the following discussion focuses on a business plan for primary medical care. Should a health center also propose to furnish dental and behavioral (mental health and substance abuse) services, program-specific Business Plan components should be prepared for each of these service lines. The state PCA, NACHC or the BPHC should be able to provide relevant financial and operational data regarding these services.

The Purpose

State the goals and objectives of the project health center. The factors that led to the decision to develop the health center should be reviewed: opportunity, request of other organizations, interest by the citizens, invitation to collaborate, lack of adequate access to primary and preventive care services, high needs of certain population group(s), need for additional providers, quality of services currently offered, etc. A thorough discussion of those issues that motivated the development of the health center and what health center leadership intends to accomplish should be examined.

The Market and Research

Document the trends in health care in the local community and at the state and federal levels. Some experts would maintain that this is the most critical component of the business plan. Factors that should be covered include the characteristics of the target population(s). It is important to document each and all of the population groups (also known as "market segments") to be targeted by the health center—noting age, gender, ethnicity, health status, income level, whether (adequately) insured, existence of groups designated by BPHC as special populations; competitors that provide similar services to those of the proposed health center and the services (not) available; relationships among and between healthcare providers; payment methods and trends in payment levels; influence of managed care; and the legislative and regulatory environment. All of the external aspects beyond the control of the health center that will undoubtedly influence operations and with which leadership will have to reckon should be identified and discussed.

Primary market research, i.e. surveying people and organizations within the target service area, is meant to ensure the validity of key assumptions that will influence subsequent components of the plan—particularly the financial projections. Having identified the target service area and population(s), the business plan must estimate that percentage of the target population(s) that will actually demand services from the health center, and recognize the competition for similar services offered by other providers. This estimate (or "market share") should be made for the period of years covered by the financial projections.

The survey of key constituents should seek information about the preferred location, range of services, charges for services and methods of communication most effective in reaching the target population(s). Important additional information to obtain includes how the health center should distinguish its operations from other similar providers (sometimes referred to as "market positioning"). The information gathered from the market research should yield an idea of how many people (what percent) of the target population(s) will actually seek care at the health center. Some of the information gathered during the needs assessment and MUA/P/HPSA designation surveys should also be incorporated into the estimate of market share. How extensive should the research be? Experts in the field offer the following: "don't assume anything." The following provide two examples for estimating market share:

Market Share Estimation:

Assumptions:

- 1% per year population growth

- 52% female, 48% male, 51% non-White

- 16% of the population < 100% of FPL*; 37% of the population < 200% FPL

*FPL = Federal Poverty Level

TABLE 6
Population Distribution Market Share Example

Age Distribution	Percent of Pop	Year 1	Year 2	Year 3
<15	27%	2,964	2,994	3,024
15-24	12%	1,317	1,331	1,344
25-44	26%	2,854	2,883	2,912
45-64	18%	1,976	1,996	2,016
65-74	12%	1,317	1,331	1,344
75 +	5%	549	554	560
Total	100%	10,977	11,089	11,200

TABLE 7
Total Market Share Example

Percent Market Share	Year 1	Year 2	Year 3
30%	3,293	3,327	3,360
40%	4,391	4,436	4,480
50%	5,489	5,544	5,600
60%	6,586	6,653	6,720
70%	7,684	7,762	7,840

The Business Strategy

Having gained the intelligence from the market description/definition and market research exercises, health center leadership should come to an agreement and document how their organization will distinguish itself from other similar providers—what services will be provided and how they will be provided to attract persons from the target population(s). A final decision on facility location and features should not be made until research information has been made available. The intelligence gained from talking with other health and human service agencies and public or private agencies of influence within the community will assist leadership in determining the need for and/or benefits to be gained by involving these organizations in a collaborative venture. Networks, partnerships, or joint ventures (while preserving the principles of health center governance required by federal regulations) could provide much-needed expertise and resources in support of the developing health center and should be seriously evaluated. Over time these collaborations can provide for economies of scale in purchasing and management.

Management And Organization – Planners should complete this information to the extent possible:

1) **The proposed management team** – the chief executive, chief medical and chief financial officers. Their experience, backgrounds and skills should be highlighted and resumes attached to the business plan. If individuals are unknown, a description of required and desired experience and capabilities should be recorded.

2) **The health center*'s* organizational structure.** Two organization charts are recommended: one that depicts the relationship between the Board of the health center, its committees and senior management; and one that clearly demonstrates the relationship between senior management and all of the health center functions and staff. The organizational structure and charts are meant to display the channels of communication and coordination, and the lines of accountability, responsibility and authority between and among all staff and leadership. The organizational structure and charts should also reflect the premise that management is charged with health center operations, while governance is charged with setting health center policy and direction. (Refer to the description of Governance in Chapter V.)

3) **The extent to which outside professional assistance (or consultants) will be necessary and the roles and functions they will be required to assume.** A newly forming health center will need to rely on technical assistance from experts in various aspects of operations and management. The BPHC now requires newly funded 330 centers to set aside 2% of their grant award specifically for purchasing technical assistance (TA). While it may be difficult for a new center to envision spending scarce resources on outside expertise, it is clearly the case that money spent early on good TA can mean the difference between viability and failure down the line.

4) **The members of governance (or the Board of Directors/Trustees) by name. Name those individuals that are in positions of leadership**, e.g., the chair, vice-chair, treasurer, secretary, committee chairs, etc., and other key individuals who may be participating (e.g., in committee activities), but who are not Directors. Describe the (professional) credentials of the Board members and other individuals; their status as active patients of the health center; whether they live or work in the targeted service area; their status as a member of a high-need or special population group; their ethnicity, gender and age; and for non-consumer board members whether they earn more than ten percent of their annual income from the healthcare industry.

Financial Projections

Once the forecast of patient volumes, clinical and supplemental services, provider and support staffing (including management) have been made, a minimum three-year financial projection must be developed. Prepare monthly income (or profit and loss) Statements and Quarterly Balance Sheets & cash flow estimates for year one and two and annually thereafter. Planners should avoid the mistake that some business plans make of omitting forecasted balance sheets and cash flow projections.

Documented Assumptions

For each of the major financial projection variables, it is critical to remember that the health center will not begin with the full estimated volume of patients or visits immediately upon opening its doors. There will be a significant "ramp up" period over the first six months or so of operations. This ramp up must be incorporated into the projections for patient and visit volumes, provider staffing, and expenses and revenues.

Many of the assumptions below have already been defined during the needs assessment and early planning period.

Volume

1) ***Define the Target Service Area —*** Use relevant political subdivisions (census tract; city, town, township, county boundaries), include all or part of the MUA/P, keeping in mind that the size of the area should be appropriate to realistically provide preventive and primary care services and impact health status.

2) ***Define the Target Population —*** Persons within the Service Area that services Persons within the Service Area that the health center program is being designed specifically for including high-need or special populations (may be particular group(s) — culturally isolated and English language limited, uninsured, low-income, residents of public housing, homeless, at-risk youth, etc.).

3) ***Define the Demographics of the Target Population —*** Identify age/gender distribution, poverty status, (un- and under-) insured status, publicly insured (i.e. Medicaid, SCHIP, Medicare), and health status (community health indicators such as death rates, communicable diseases, maternal/child health morbidity) of the population to be served by the health center.

4) ***Determine Market Share —*** Survey Target Population to assess interest in or need for primary and preventive care services to be provided by a new health center. Potential market share are those responding in the affirmative, less some percent that will not use health center services. [Dividing potential share by average productivity of providers yields maximum provider staffing level. If maximum level exceeds budget capacity, information is valuable for planning for future growth in subsequent years.]

    Alternatively, and as a check on the assumption of potential Market Share, estimate the supply of primary care services provided by existing physician and mid-level primary care providers. Determine the number of providers, survey the providers to determine capacity/willingness to accept Target Population, project provider supply based on average patient panel (1,200 - 1500 per provider, both physicians and nurse practitioner/physician assistants). The difference between Target Population and capacity of current providers is volume of patients unserved or leaving the service area and is the potential market share Planners should be realistic (conservative) in forecasting market share. It is also important to note that the Patient Centered Medical Home (PCMH) model of care is increasingly being adopted by health centers. This approach will change the way care is provided from an individual provider to care teams. this in turn will impact projections of productivity and care volume. Using the PCMH model from the start is a very good approach. For more information on PCMH, visit **http://www.nachc.com/clinicalmedicalhomes.cfm**.

5) ***Project Annual Demand for Primary Care (visits and/or encounters) —*** Refer to potential market share and estimate (using most recent Census data - **http://2010.census.gov/2010census/data/**) the age and gender distribution of the population to be served. Multiply the number of persons in each age/gender group by the average number of encounters per year demanded. According to the **National Ambulatory Medical Care Survey (NAMCS), 2008, there were 3.2 office visits per person per year.** NAMCS (**http://www.cdc.gov/nchs/ahcd.htm**) also provides data on average numbers of encounters per year by age, gender, race/ethnicity and geographic location

    The National Center for Health Statistics (NCHS) data indicate that those persons living below 100% of the FPL experience 20% more primary care encounters. Historical data also indicate that where only Family Practice physicians are present in a community, the overall level of demand for primary care services is as much as 25% less than where Internal Medicine, Pediatric and OB/Gyn physicians are present. Managed care (HMOs) can reduce the demand for encounters by as much as 20% for the population enrolled.

The table below provides a set of sample data for the purpose of demonstrating how to estimate market share.

TABLE 8
Encounters per year

Age/Race/Gender	Female	Male	White	Black
<15	1.9	2.0	2.0	1.5
15-24	2.0	1.1	1.7	1.2
25-44	2.8	1.7	2.4	1.6
45-64	3.9	2.9	3.5	3.2
65-74	5.3	5.1	5.3	4.8
75 +	6.9	6.6	6.9	6.1

As an example, assuming a 40% market share among each age group as illustrated in Table 6 and average encounter rates for each age/race group from Table 8, the number of encounters can be projected using the following:

TABLE 9
Market Share of Visits Example

Age Distribution	Percent Market Share	Year 1	Year 2	Year 3
<15	40%	2,193	2,216	2,238
15-24	40%	790	799	806
25-44	40%	2,397	2,422	2,446
45-64	40%	2,687	2,715	2,742
65-74	40%	2,687	2,715	2,742
75 +	40%	1,449	1,463	1,478
Total	40%	12,204	12,332	12,455

It is also necessary to project the demand for ancillary services that the health center plans to provide, i.e., the number of laboratory, radiology, pulmonary and cardiology (or EKG) tests that will be provided, as well as the number of prescriptions for medications that will need to be filled. On the basis of visits that resulted in a test being provided or ordered, the NAMCS suggest that nearly 40% of visits generate laboratory tests (approximately one-half can be provided in the office); about one-in-four visits generate radiology procedures (approximately one-third can be provided in the office), and 3% of visits generate EKG testing. In general he NAMCS reports suggest that one-third of all visits have one medication prescribed, 28% have two and 17% have three prescriptions.

It is also recognized that new health centers will have a period of ramping up to full capacity as the center begins operations and goes through its initial implementation period. During this time it is understood that provider levels may be less than the expectation. Centers serving special populations, those located in sparsely populated and remote areas, and centers serving populations with more complex and intensive health care needs may have different staffing complements than the average health center. These factors should be taken into account when calculating projected patient and visit volumes as well as expected expenses and revenues.

Expenses

1) ***Project staffing, particularly provider staffing*** – Physician and mid-level staffing requirements can be calculated by estimating potential market share and then dividing that number by the average annual number of patients for whom a primary care physician or mid-level will be responsible. An average annual number of patients for providers can be projected within a range of 1,200 - 1,500. The higher the number of children and elderly, the lower the average annual patient group or "panel"; the fewer specialists in the community, the lower the annual patient panel. This is because each age and gender group demands a different number of encounters each year and without physician specialists more services are offered by primary care providers.

The other method for determining optimum staffing is to estimate the number of encounters to be demanded by the patient group, and divide that number by the average annual productivity for the type of primary care provider. According to the Medical Group Management Association (MGMA) (**www.mgma.com**), on average, primary care providers generate the following:

Specialty [MGMA]	Average Annual Ambulatory Encounters
Family Practice without OB	4,300-4,400
Family Practice with OB	4,500-4,700
Internal Medicine (General)	3,600-3,700
Pediatrics (General)	4,800-5,000
Obstetrics/Gynecology	3,200-3,300
Physician Assistant	3,400
Advanced Practice Nurse	2,800
Certified Nurse Midwife	1,700

These encounters do not include hospital visits or surgery. Planners should be mindful that currently the minimum Medicare cost-reporting productivity benchmark as a FQHC is 4,200 ambulatory encounters per year per full-time physician and 2,100 encounters per year per full-time mid-level provider (or 6,300 per team of 1.0 physician and 1.0 mid-level—note that mid-level providers are usually factored as one-half of a physician FTE for productivity and compensation). Some states have adopted minimum productivity standards for Medicaid as well. The state PCA can provide this information.

It is important to determine the "provider model" in order to accurately project the number of providers needed, e.g., Family Practice providing Pediatric and Obstetric services, Family Practice providing adult and no Obstetric services, Internal Medicine providing adult services and with mid-level providers, etc. Note that some Internal Medicine physicians are also trained in the area of Pediatrics and others can be trained with an emphasis on primary care. Some health centers with large elderly populations are also employing the services of Gerontologists to meet the special health and chronic medical needs of persons over age 65. State PCAs can also provide health center data on numbers of patients and encounters per full-time equivalent provider.

2) ***Estimate providers' compensation packages -*** Good reference sources to obtain current information include local hospitals, MGMA, state/ regional PCAs, and NACHC. Competition for primary care providers is intense, and wages, salaries and fringe benefit packages are constantly being enhanced to support recruitment and retention efforts. Health center leadership must consider base salary, incentive and possibly sign-on or relocation bonuses, loan repayment, and fringe benefit (often exceeding 20% of salary) packages that provide an ample allowance for Continuing Professional Education (including travel) for physicians and midlevels. Federal, state and local taxes, group insurance (life, health, dental, disability) plans and retirement contributions represent the major non-salary staff costs. Available health center data indicate that provider compensation represents on average 30%-35% of total operating expenses.

3) ***Estimate clinical and administrative (including management) support staff -*** Typically, support staff is budgeted based on the number of full-time equivalent providers that they will be required to assist. The number of support staff per FTE provider (with mid-levels factored a .50) can vary based on the range of services offered by the health center, i.e., those with a laboratory, radiology and pharmacy service will have more support staff. Planners should contact other health centers, health center practice management networks where they exist, refer to MGMA, and the state/ regional PCAs and NACHC for comparable data. In the year 2009, the BPHC reported 2.4 clinical and 2.9 administrative (including facility) support staff per each 1.0 FTE provider.[25]

4) ***Determine support staff compensation: salaries/wages and fringe benefits*** for support staff should be based on actual average wage rates (and typical fringe benefit plans) in the local area or job market and regional data for positions not represented in the local area—NACHC and many state/regional PCAs also conduct

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[25] Clinical support staff was defined as patient support staff. Administrative includes management and support, IT, facility, and fiscal and billing staff. The 2009 UDS had subcategories for administrative staff. Providers include only physicians.

compensation surveys. Shortages of nursing, other professional and technical staff, and pharmacy personnel have recently caused upward pressure on wages. Health center planners must be mindful of market conditions and employ realistic wage and benefit costs when completing their projections.

Fringe benefit costs (see above) can easily exceed 20% of wages, and total personnel cost estimates should include an appropriate amount for employment taxes (FICA, FUTA, Medicare, state and local income, etc.). Projections should account for health center leadership's decision to provide for off-site training and education for support staff—especially important for clinical staff that is licensed, certified or registered and will/may have continuing education requirements to satisfy ongoing licensure, etc. Available health center data indicate that staff compensation on average represents approximately 40%-50% of total operating expense.

NOTE: Should a health center decide/need to contract for and not directly employ certain staff, those related expenses should be included as part of another expense category, usually Contract Professional or Patient Care for providers and Contract Labor or Service or Non-Patient Care for support staff.

See Table 10, below for an example of a worksheet to project provider and support staff and related costs.

5) Available health center data show that the remaining 15%-30% of annual health center expense is comprised of a large number of individual items. ***Each item of expense should also be projected based on the amount per billable encounter and in total for each of the three fiscal years.*** Financial planners should be mindful that, like salaries, wages and fringe benefits, other expense items can vary based on the geographic location of the health center. Additionally, there will most likely be non-recurring costs related to planning, development and start-up of the health center in the first year that will not be recorded in subsequent years.

MGMA has, and PCAs may have comparable data with which to project these other expense items. See Table 11 for a format example for budgeting other expenses. Contact the state PCA, HRSA Field Office, the BPHC or NACHC for data with which to compare cost per encounter and cost per user (per year). Should the projected cost per encounter or user (in any of the years, for each of the scenarios created) differ substantially from these normative data, financial planners should re-examine the assumptions for the major categories of expense.

TABLE 10
Staff/Volume/Cost Deal

PERSONNEL BY MAJOR SERVICE CATEGORY		YEAR 1 PROJECTED				YEAR 2 PROJECTED					YEAR 3 PROJECTED				
		FTEs		Comp Cost	Encounters	Users	FTEs		Comp Cost	Encounters	Users	FTEs		Comp Cost	Encounters	Users
		1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
1	Family Practitioners															
2	General Practitioners															
3	Internists															
4	OB-Gyns															
5	Pediatricians															
6	Other Specialty Physicians															
7	Podiatrists															
8	**Total Physicians (Sum lines 1-7)**	0	0	$ 0	0	0	0	0	$ 0	0	0	0	0	$ 0	0	0
9	Nurse Practitioners															

1. FTEs for employed staff; based on health center FTE different than 2,080
2. FTEs for contracted staff; based on health center FTE definition, if different than 2,080
3. Include cost of all employed/contracted positions — Include Fringe
4. Include billable encounters for both paid and contracted staff

TABLE 10 (continued)
Staff/Volume/Cost Deal

PERSONNEL BY MAJOR SERVICE CATEGORY		YEAR 1 PROJECTED					YEAR 2 PROJECTED					YEAR 3 PROJECTED				
		FTEs		Comp Cost	Encounters	Users	FTEs		Comp Cost	Encounters	Users	FTEs		Comp Cost	Encounters	Users
		1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
10	Physician Assistants															
11	Nurse midwives															
12	**Total Mid-Level Providers (Sum lines 9-12)**	0	0	$ 0	0	0	0	0	$ 0	0	0	0	0	$ 0	0	0
13	Nurses (RN, LN, LVN)					■					■					■
14	Other Medical Personnel (CMAs, Nurse Techs, etc.)					■					■					■
15	Laboratory Personnel			■		■			■		■			■		■
16	Radiology Personnel			■		■			■		■			■		■
17	**Total Medical Care Services (Sum lines 8,12, 13-16)**	0	0	$ 0	0	0	0	0	$ 0	0	0	0	0	$ 0	0	0
18	Dentists															
19	Dental Hygienists															
20	Dental Assistants, Techs				■	■				■	■				■	■
21	**Total Dental Services (Sum lines 18-20)**	0	0	$ 0	0	0	0	0	$ 0	0	0	0	0	$ 0	0	0
22	Psychiatrists															
23	Mental Health Specialists (including Clinical Psychologists, Clinical Social Workers & other Professional Mental Health Staff.					■					■					■
24	Substance Abuse Specialist Services (including CPs, CSWs and other Professional SA staff.					■					■					■
25	**Total Mental Health Services (Sum lines 22-24)**	0	0	$ 0	0	0	0	0	$ 0	0	0	0	0	$ 0	0	0

1. FTEs for employed staff; based on health center FTE different than 2,080
2. FTEs for contracted staff; based on health center FTE definition, if different than 2,080
3. Include cost of all employed/contracted positions — Include Fringe
4. Include billable encounters for both paid and contracted staff

TABLE 10 (continued)
Staff/Volume/Cost Deal

	PERSONNEL BY MAJOR SERVICE CATEGORY	YEAR 1 PROJECTED					YEAR 2 PROJECTED					YEAR 3 PROJECTED				
		FTEs		Comp Cost	Encounters	Users	FTEs		Comp Cost	Encounters	Users	FTEs		Comp Cost	Encounters	Users
		1	2	3	4	5	1	2	3	4	5	1	2	3	4	5
26	Other Professional Staff (Including OT, PT, etc.)					■					■					■
27	Optometrists															
28	Pharmacists and Staff				■					■					■	
29	Total Other Med Services (Sum lines 26-28)	0	0	$ 0	■		0	0	$ 0	■		0	0	$ 0	■	
30	Case Managers					■					■					■
31	Education Specialists					■					■					■
32	Outreach Workers				■					■					■	
33	Transportation Staff				■					■					■	
34	Other Staff Enabling				■					■					■	
35	Total Enabling Services (Sum lines 30-34)	0	0	$ 0	0	0	0	0	$ 0	0	0	0	0	$ 0	0	0
36	Administrative Staff (CEO, CFO, Medical Director)				■					■					■	
37	Facility Staff				■					■					■	
38	Support Staff (e.g. MS, Billing, Reception, Intake, Medical Records, etc.)				■					■					■	
39	Total Admin. & Facility (Sum lines 36-38)	0	0	$ 0	■		0	0	$ 0	■		0	0	$ 0	■	
40	Total (Sum lines 17,21,25,29,35,39)	0	0	$ 0	0	0	0	0	$ 0	0	0	0	0	$ 0	0	0

1. FTEs for employed staff; based on health center FTE different than 2,080
2. FTEs for contracted staff; based on health center FTE definition, if different than 2,080
3. Include cost of all employed/contracted positions — Include Fringe
4. Include billable encounters for both paid and contracted staff

TABLE 11
Other Expense & Total Expense

Expense by Category	Year 1 Projected	Year 2 Projected	Year 3 Projected
Drugs/Medications			
Medical/Surgical Supplies			
Dental Supplies			
Laundry			
Professional Liability Insurance			
Other Insurance (Gen'l Liab, P&C)			
Recruitment			
Rent/Lease: Building			
Utilities			
Building Repair/Maintenance			
Building Housekeeping			
Depreciation: Building			
Medical/Dental Equipment			
Depreciation: Med/Dent Equipment*			
Rent: Med/Dent Equipment			
Non-Med/Dent Equipment			
Depreciation: non-Med/Dent Equip**			
Rent: non-Med/Dent Equipment			
Admin/Office Supplies			
Postage/Delivery			
Interest-Loans			
Taxes			
Prof. Fees: Medical			
Prof. Fees: Legal			
Prof. Fees: Acctg/Audit			
Prof. Fees: Consultant			
Telecommunications/Telephone			
Information Systems Expense			
Clinical Lab Supplies			
Outside Lab Fees			
Radiology Supplies			
Outside Radiology Fees			
Other Ancillary Supplies			
Other Ancillary Fees			
Transcription Services			
Interpreters			
Patient Transport			
Education/Training			
Board: Meetings			
Misc. Other Expense			
Promotion			
Total Other Expense (Sum of the above)	$ 0	$ 0	$ 0
Total Comp. Cost (From TABLE 10., Line 40)	$ 0	$ 0	$ 0
Total Expense (Sum Total Other Expense and Total Comp. Cost)	$ 0	$ 0	$ 0
Cost per Encounter *** (Divide Total Expense by Encounter Total - TABLE 10., Line 40)	$0	$0	$0
Cost per User *** (Divide Total Expense by User Total - TABLE 10., Line 40)	$ 0	$ 0	$ 0

* Medical equipment includes Laboratory and Radiology.
** Non-medical equipment includes furniture.
*** Do not include Total Enabling Services Users or Encounters.

Revenues

This section describes the following kinds of revenues:

- Fee-For-Service (FFS)

- Managed Care—Non-Medicaid

- Managed Care—Medicaid

- Other Non-Patient Sources of Revenue: Government Funding, Foundations, and Corporate or Employee Giving Plans

In order to forecast revenue, it is necessary to **project the percentage of patients whose care will be paid for by Medicaid, Medicare, private insurance (including managed care entities) or by the patient.** Based on poverty and income statistics for the Target Population, estimate that percentage of patients without insurance and/ or with inadequate insurance that will be able to pay the full charge and what percentage will need to have their fees discounted. The survey mentioned above under Market Research should include a question regarding the insurance status.

One method to assist in estimating this "payer mix" is the following[26]:

- Medicaid or unable to pay (discounted fees) = Persons <100% FPL;

- Medicaid or unable to pay (discounted fees) = Persons 100% - 200% FPL;

- SCHIP = children under age 18 between 200% - 300% FPL;

- Commercial Insurance or self-pay (no fee discount) = Persons >200% FPL;

- Medicare (if <100% FPL also Medicaid) = Persons >65 years;

- Uninsured = Difference between persons <200% and Medicaid;

- Underinsured = Persons with catastrophic health insurance, with high annual deductibles or coinsurance, or insurance that does not pay for primary care services.

Most patients will come to the health center with some form of insurance coverage, including Medicaid, SCHIP or Medicare, but recent data show that as much as 40% of patient visits are by uninsured people. Some uninsured and underinsured patients will be able to pay for some portion of the cost of their care. Some patients, including Medicaid patients, will be in managed care entities that pre-pay a fixed or "capitated" monthly payment. In order to maximize the revenue collected from patients, without presenting a financial barrier to care, it is important to plan for patient revenues from all available sources. Because of the differences between traditional fee-for-service and managed care, these two general types of patient revenues must be considered separately. For more information on financial and operations management, visit NACHC's Finance and Operations website at: **http://www.nachc.com/hc-info-financial-operations.cfm**.

Fee-For-Service (FFS)

"Fee-for-service" means that the patient or an insurance company reimburses the health center based on the services provided and the fees or charges are based on the service(s) or procedure(s) rendered. In determining fees that are reasonable and appropriate to the community, planners may obtain assistance from other health centers, health center networks where they exist, or the state PCA. However, fees should always be based on a solid understanding of the health center's costs. The following steps can offer assistance to project the health center's fee-for-service patient revenues:

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[26] Many states have expanded eligibility for public insurance programs and/or offer publicly supported ways to purchase commercial insurance. For example, in some states parents of SCHIP children can buy in to the program. It is important to be aware of the various 3rd party insurance mechanisms available to your target population in order to correctly project payer mix.

1) ***Project the Health Center's Total Costs***. Using the budget prepared with Table 10, estimate the total operating costs. Include only the annual depreciation related to capital expenditures such as building acquisition or improvement and equipment and costs that must amortize or "spread-out" over time. An accountant can assist in identifying expense items to be depreciated and amortized.

2) ***Project the Number of Patient Encounters***. See the discussions above under volume and provider staff, and calculate the health center's total projected patient encounters based on total physician, certified nurse practitioner, midwife, and physician assistant FTEs.

3) ***Calculate Average Cost Per Encounter***. The average cost per encounter is a budgeting tool. Calculate the amount that the health center would have to collect per patient encounter in order to "cover" its costs.

4) ***Establish a Fee Schedule.*** Discussion of the methods for developing a fee schedule is beyond the scope of this document; health centers can obtain assistance by contacting other health centers, health center networks where they exist, the state PCA, NACHC and private consultants. Health center charges for services should be consistent with the prevailing and customary charges for similar services within the local community. By any other measure, health center charges should be "competitive."

It is recommended that health center charges, net of adjustments, exceed the health center's costs for providing each and all services. However, it is also recognized that health center operating costs often exceed the costs of similar non-health center providers—due to the range of services required, the health center program requirements, and the realization that a health center will provide care to all patients in need of the full range of health center services regardless of their ability to pay. Health center charges should in all instances be set at an amount in excess (15%-20%) of the fee-for-service payment the health center can expect to receive from each of its major payers.

Planners should be aware that because of these considerations health center costs may exceed charges and any difference will have to be addressed by supplemental reimbursement from the federal Medicare and state Medicaid programs, from public and private grants, contributions and other forms of financial support. Fee schedules should be increased yearly in an amount equal to the inflation rate or equal to the increase in overall costs—although large yearly increases could well place a health center in a non-competitive position.

5) ***Determine the Payer Mix***. Using information from the needs assessment and from the REVENUE section above, estimate the percentage of patients whose care will be paid by Medicaid, SCHIP, Medicare, private insurances (e.g., commercial, worker's compensation), public (e.g., medical assistance, contracts with local public health), and directly by the patient. Based on poverty and income statistics for the Target Population, estimate the percentage of those patients without (adequate) insurance that will be able to pay the full charge and the percentage that will need to have fees discounted.

6) ***Determine Adjustments to Charges.*** In general, adjustments to charges are the difference between the amount a provider charges for a service or procedure and the (lower) amount that a payer recognizes as an approved amount. Adjustments to private insurance charges are typically in the range of 15%-20%, while patient pay charges subject to the sliding fee scale could be adjusted by as much as 100%.

In order to ensure that fees for uninsured and underinsured patients are affordable, the health center should have a *schedule of discounts* for charges. More commonly known as a *sliding fee scale,* this determines how much a patient pays for a service based on his or her income and family size.[27] By comparing the fee schedule with income information for the target population, estimate how much the health center will collect in fees from this patient group. This is not a scientific process–it involves some guesswork. Contact other health centers, health center networks, a consultant, the PCA or NACHC for assistance.

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[27] By law, the sliding fee schedule for a federally funded health center or an FQHC must not include any subsidy for patients at or above 200 percent of the Federal Poverty Level [FPL]. While all patients must be charged the same amounts for the same services, patients at or below 100 percent of FPL would only be responsible for a "nominal" fee where one exists.

Sliding fee scale discounts should also be applied to patient deductibles, coinsurances and those patient pay amounts that insurance companies determine to be in excess of the amount that they approve for payment or for non-covered services. Sliding fee scale discounts are not synonymous with bad debt (which is considered an element of expense). The difference between the two terms: the former cannot afford to pay; the latter can, but don't pay.

Because Medicaid and Medicare reimburse health center*s* at an all-inclusive per visit rate, based on the cost of operations (or Medicaid may reimburse health center*s* based on a cost-driven, prospectively determined rate or price), the adjustments to charges will equal the difference in the amount between charges and costs. In other words, the adjustments to charges may be a positive rather than a negative number where health center costs per visit are greater than the charge per visit. Medicare has established an upper limit or "cap" beyond which it will not pay health center "reasonable and allowable" costs per visit (subject to Medicare's reimbursement principles). Some state Medicaid agencies also limit the payment for certain cost elements (e.g., overhead).

Financial planners should contact other health center*s,* health center networks, the state PCA, a consultant, the state Medicaid agency or the Field Office of the Centers for Medicare & Medicaid Services (CMS) (**www. cms.gov/regionaloffices/**) to determine payment rates. In 2011, the all-inclusive per visit payment rate for Medicare was approximately $109 for rural health center*s* and $126 for urban health center*s* - **http://www.cms. gov/MLNMattersArticles/downloads/MM7101.pdf**.

7) ***Estimate the Collection Rate***. For each payer category, estimate the percent of the adjusted charges that the health center anticipates collecting. Collections from each payer will vary and collections from self-pay patients will most likely be much lower.

8) ***Project Patient Revenues.*** See Table 12 for an example of a format to project fee-for-service, including cost-based/ PPS revenues, adjustments and collections.

TABLE 12
FFS & Cost-Based Revenue Detail Worksheet

	Year 1 Projected	Year 2 Projected	Year 3 Projected
A. Payor Mix Encounters			
1. Medicaid (____%)			
2. Medicare (____%)			
3. Commercial (____%)			
4. Other Public (____%)			
5. Sliding Fee Scale (____%)			
6. Total Encounters (Sum Lines A.1.-A.5.)			
B. Average Charge (assume 2% increase per year if unknown)	$_____	$_____	$_____
C. Cost Per Encounter (a) (Exhibit H)	$_____	$_____	$_____
D. Gross Revenue			
1. Medicaid (A.1. x C.)			
2. Medicare (A.2. x C.)			
3. Commercial (A.3. x B.)			
4. Other Public (A.4. x B.)			
5. Sliding Fee Scale (A.5. x B.)			
6. Total Gross Revenue (Sum Lines D.1.-D.5.)			
E. Adjustments (b)			
1. Medicaid (0%) (D.1.)*			
2. Medicare (0%) (D.2.)*			
3. Commercial (-15% to -20%) (D.3. x E.3.)			
4. Other Public (-___%) (D.4. x E.4.)			
5. Sliding Fee Scale (0%) (D.5. x E.5.)			
6. Total Adjustments (Sum Lines E.1.-E.5.)			
F. Revenue After Adjustments			
1. Medicaid (D.1. - E.1.)			
2. Medicare (D.2. - E.2.)			
3. Commercial (D.3. - E.3.)			
4. Other Public (D.4. - E.4.)			
5. Sliding Fee Scale (D.5. - E.5.)			
6. Total Net Revenue (Sum Lines F.1.-F.5.)			
G. Collections (c)			
1. Medicaid (100%) (F.1. x G.1.)			
2. Medicare (85%) (F.2. x G.2.)			
3. Commercial (80%) (F.3. x G.3.)			
4. Other Public (75%) (F.4. x G.4.)			
5. Sliding Fee Scale (20%) (F.5. x G.5.)			
6. Total Collections (Sum Lines G.1.-G.5.)			

(a) Some Medicaid programs pay for Dental and Behavioral Health on a FFS basis (not PPS or cost-based).
(b) Contractual Adjustment is the difference between the charge and amount recognized/approved by payors.
(c) Collection rates need to account for patient deductibles and co-payments.
* Minus amounts in excess of the Medicare and Medicaid PPS (if applicable) per visit limits.

Managed Care—Non-Medicaid

Increasingly—by choice and by necessity—health center*s* are becoming involved in managed care. Managed care is a method of linking the delivery of health care services and financing in an effort to control costs. Stated most simply, managed care means providing a *defined set of services for a defined patient group within a defined pay-ment amount*. Usually a health care provider enters into a contract with a managed care entity (MCE), defined to include managed care organizations (e.g., MCO) as well as Primary Care Case Management (PCCM) contracts, and receives a pre-paid monthly fee or "capitated payment" for every enrolled patient. The health care provider is then required to provide a contractually defined range of services for these patients and to report to the MCE on the services actually provided. The challenge for the health care provider is to negotiate contract terms that ensure that the total capitated payments, at a minimum, cover the cost of services provided. Most health center*'s* initial experience with managed care is for Medicaid patients. As an introduction to this complex topic, following is a brief discussion of the financial basics of managed care and some of the ways a health center might be involved in managed care.

Despite the wide variety of financial arrangements that are possible in managed care, there are a few principles that form the basics of managed care arrangements:

- Case management or "gate-keeping" is used to control utilization of services, especially more expensive physician specialty, inpatient, and other hospital services;

- There is a focus on preventive and primary care;

- There is an attempt to shift financial "risk" to providers through pre-paid capitation as the preferred method of payment.

It is important to understand the principle of *capitation* as a means of payment. The managed care entity (usually an HMO) contracts with a payer (e.g. the state for Medicaid) and covers (or *enrolls*) individuals who are eligible. The managed care entity conducts statistical calculations (called *actuarial analyses*) that attempt to predict the amount and type of services that an average covered individual will need. The plan then pays providers on a *per capita* basis, which means that for every enrolled individual there is a set monthly pre-payment made for those specific covered services each provider has agreed to furnish. The same payment is made whether the enrollee receives some, a lot, or no services in any given month.

Financial risk comes into play because the actual enrollee may need more services than "average." Managing the use of more expensive services, such as emergency room, inpatient hospital and specialty physician services is critical. It has long been believed by many in health care that the appropriate provision of comprehensive primary care services can effectively reduce utilization of more costly hospital and specialty services. When all is said and done accepting risk means: If the services provided to enrollees cost more than the total capitated payments re-ceived for those enrollees, the provider incurs a deficit that must be made up from other sources; if all the required services provided to enrollees cost less than the total capitated payments, the provider records a surplus.

Under managed care there are various payment and risk-sharing schemes in which health center*s* can participate. The most common of these are described below.

- *Fee-For-Service (FFS)* — Under a fee-for-service arrangement the health center contracts with a managed care organization and negotiates a fee schedule for the services it is contracted to provide. The health center then receives fees for providing the agreed-upon services to enrolled patients. The health center provides gate-keeping services but there is no additional payment to the FFS payment. While this arrangement minimizes risk it also limits potential financial gain.

- *Limited Capitation* — Under this arrangement the health center receives a capitated payment in advance (or prepaid) for a limited set of services (e.g., outpatient primary care services only) for assigned patients who are enrolled in the managed care entity. Frequently this approach is accompanied by an arrangement to share in any savings that are realized through the appropriate provision of primary care and reduction in more expensive physician specialty and hospital services. That is, the primary care provider is rewarded for keeping costs low while still providing necessary and appropriate services. Capitation payments are sometimes subject to a "with-hold" of a percentage of the monthly pre-payment amount. Withhold amounts are used to pay for excessive

(as defined by the plan) use of high-cost hospital or other services or unapproved "out of (approved provider) network" services, etc., or returned to the contracted provider if use of these higher-cost services is less than that budgeted by the plan.

- *Primary Care Case Management* — Under this arrangement the health center receives a fixed amount on a monthly basis to <u>manage</u> the primary medical care provided to an eligible individual.

- *Full Capitation* — Under this arrangement, the health center receives a capitated payment in advance and assumes <u>total responsibility for the provision of all defined services</u> (with some exceptions for catastrophic events and chronic conditions) <u>to all enrolled patients</u> including hospitalization, physician specialty services, pharmaceuticals, etc. This arrangement is probably not feasible for most health centers because of the large number of enrolled patients required in order to assume (or "spread") this level of risk and the significant resources and expertise demanded by the assuming full responsibility (care management, claims administration, utilization and quality management, etc.). However, health center*s* in many states are joining forces and forming organizations that are capable of assuming this level of risk. NACHC, the state and regional PCAs and the Bureau of Primary Health Care are valuable resources for health centers that are interested or engaged in developing managed care organizations.

Throughout this deliberation of the possible managed care arrangements it is critical for health centers to adhere to a few key principles.

Closely examine the assumptions that underlie any actuarial calculations that are used to predict utilization among potential patients. The health status and health care needs of your patient population are very likely to be different from the generally insured population.

1) Know and understand current costs and patient utilization patterns in as much detail as is possible in order to know whether participation at different levels of reimbursement and risk is prudent.

2) Be sure the scope of required services is clearly defined in order to determine whether payment will be adequate.

3) Do not assume risk for services that cannot be controlled directly by the health center, a member of a health center network or a managed care organization working on behalf of health center*s*.

What this means for planning revenues in a managed care environment is fairly straightforward. Based upon the capitation rate to be received for the set of services that the health center has agreed to provide, as well as a reasonable estimate (if not a firm projection) of the number of enrolled patients assigned to the health center, calculate capitation revenues by multiplying:

Capitation rate x number of assigned enrollees = total capitated payments

Since capitated payments are generally made on a monthly basis this calculation provides the monthly capitated (or prepaid) revenues—often referred to as PMPM or per member per month.

For budgeting purposes calculating managed care revenues is simpler than the more traditional method of calculating FFS revenues illustrated in Table 13. The significant difference is that under a fee-for-service arrangement total revenues are projected as payments made after a service has been provided to a patient (net of adjustments and collection rate percentages), whereas capitated revenues are forecasted by multiplying the capitation payment by the number of projected enrollees, whether or not they receive services. Thus, calculating adjustments from full charges and collection rates become unnecessary steps under a prepaid arrangement. However, calculating expenses can become very complicated under managed care. Key components of calculating projected expenses include estimating the percentage of enrolled patients who will actually use services during the contract period, the type and volume of services that patients will require, and the costs of services that the health center does not provide directly but may have an obligation to cover.

Managed Care—Medicaid

In states that have implemented managed care for Medicaid recipients (that may also include enrollees in the State Child Health Insurance Program or SCHIP), Medicaid MCEs sub-contract with health center*s* to furnish covered services to enrollees, and states are required to make supplemental payments to health centers. These supplemental payments must equal the difference, if any, between the payments received from the managed care plan by the health center for treating the enrollees and the payment that the health center would be entitled to for those services provided the enrollees under Medicaid Prospective Payment System (PPS). States are required to determine if the Medicaid PPS reimbursements that the health center*s* are entitled to exceed the amounts received by the health center*s* from the MCEs and to pay the difference to the health centers. This payment amount is often referred to as "wrap-around" reimbursement.

These wrap-around payments apply <u>only</u> to covered services provided by FQHCs sub-contracting under any of the payment schemes described above. For non-covered services (e.g., inpatient services), health center*s* are eligible only to receive payments negotiated with the MCEs (and no supplemental payment will be received). Note that health center*s* subcontracting with Medicare MCEs are not eligible to receive wrap-around supplemental payments from the Medicare MCE, regardless of the payment scheme agreed to by the health center*s.*

An important difference in Medicaid managed care payment arrangements and those with commercial plans is that the state Medicaid offices often put an upper limit on the amount that they will pay the MCE under their contract. In this case the PMPM rate between the MCE and the health center is more or less a dictated amount – or at the very least a negotiation that takes place within a very narrow set of options.

To project revenues under Medicaid managed care arrangements, use Table 13. (Revenue Detail Worksheet), since, regardless of the payment scheme, health center*s* will receive cost-based wrap-around supplemental payments for each visit of a Medicaid MCE enrollee.

Many health center*s* have found that collaborating with other providers in order to participate in managed care is more advantageous than "going it alone." These linkages are often structured to share financial risk and can be "horizontal" (i.e., with other similar primary care providers) or "vertical" (e.g., with providers of specialty outpatient, ambulatory surgery, and hospitals for inpatient care), or both. Linking with other providers is important in order to provide the necessary set of services to a large enough patient panel or group and to ensure the appropriate provision of more expensive services. Health center*s* throughout the country have found some success in linking with other providers.

See Table 13 for an example of a format to project non-Medicaid capitated revenues.

TABLE 13
Capitation Revenue Detail Worsheep

	Year 1 Projected	Year 2 Projected	Year 3 Projected
A. Number of Enrollees			
1. Medicare			
2. Other Public (e.g., CHIP)			
3. Commercial HMO			
4. Total Enrollees **(Sum Lines 1-3)**			
B. Average Member Months			
1. Medicare			
2. Other Public (e.g., CHIP)			
3. Commercial HMO			
4. Total Member Months **(Sum Lines 1-3)**			
C. Average Monthly Capitation **(less Withhold)**			
1. Medicare			
2. Other Public (e.g., CHIP)			
3. Commercial HMO			
D. Capitation Revenue			
1. Medicare (B1 x C1)			
2. Other Public (B2 x C2)			
3. Commercial HMO (B3 x C3)			
4. Total Capitation Revenue **(Sum Lines 1-3)**			

Do not include managed care enrollees for which health center will be paid fee-for-service (FFS) or a Primary Care Case Management (PCCM) fee--use Table 12. FFS / Cost-based Revenue Detail Worksheet.

Include Medicaid managed care patients on Table 12. FFS / Cost-based Revenue Detail Worksheet.

"Other Public" managed care plans include public programs not considered part of Medicaid.

"Average Monthly Capitation" should be the weighted average of capitation amounts for each age / gender category.

There are many important and complicated considerations when entering into managed care arrangements and there is high-quality technical assistance available to health center*s* from NACHC, the state and regional PCAs, and the Bureau of Primary Health Care.

Once total expenses, FFS, and capitated revenues from patient care services have been projected, it is possible to determine just how much money will be needed from other sources such as public and private grants, in order to meet the health center*'s* total operating costs (see the following sections Government and Other Grant Funding). This last calculation will complete the steps to finalizing the Financial Projections component of the Business Plan. Because of the significant number of assumptions that contribute to the creation of the Financials, it is highly recommended that financial planners prepare "worst-case," "best-case," and "most-likely" financial projections (including Income Statement or P&L, Balance Sheet and Cash Flow) for the minimum three year period.

Other Sources Of Revenue

Most health center*s* that target economically disadvantaged communities and their residents will need to secure additional funding to defray the costs of care, supplemental, and supportive services to the uninsured and underinsured. Financial planners should assess the need for additional sources of "non-patient care revenues," i.e., grant funding, philanthropy, contributions, etc. The health center*'s* income statement should include forecasts of these other revenues. The following includes a brief discussion of some public and private sources of funding.

Government Funding – Federal

The Public Health Service Act has a "portfolio" of funding sources for which health center*s* may compete. As described in Chapter I, the basic funding for health center*s* is awarded under Section 330 of the Public Health Service Act including:

• Community Health Centers 330(e);

• Migrant Health Centers 330(g);

• Health Care for the Homeless 330(h);

• Public Housing Primary Care 330(i);

Health center*s* receiving money under one category of Section 330 funding may be eligible for other 330 funds. For example, a health center funded under the Community Health Center program (330(e)) may also receive funding for a Health Care for the Homeless project (330(h)). In addition, BPHC regularly offers funding opportunities for health center grantees to add sites through expansion grants and/or to add services or capacity to existing sites.

Organizations that do not currently receive 330 funding can apply either:

• When the federal government announces "new start" funding for health center*s*; or

• If they choose to compete against an existing, funded health center when its project period expires and it seeks renewed funding.

It should be noted that 330 funding for new organizations requires the provision of the full range of primary health care services, including primary medical, dental and behavioral health services. Funding opportunities available through PHS are announced in the Federal Register and can also be found by searching the Bureau of Primary Health Care website (**http://bphc.hrsa.gov**).

There are other sources of federal funds for health center*s*; the most important ones are discussed below. As of the publication of this manual, these are distinct funding streams.

Ryan White Comprehensive AIDS Resources Emergency Act (**http://hab.hrsa.gov/**) — This act authorizes grants for primary care services for persons with HIV. Preference is given to eligible applicants experiencing an increase in the burden of providing services to persons with HIV. Evidence of increased burden includes: (a) an increase in the number of AIDS cases; (b) the rate of increase in such cases; (c) the lack of available early intervention services; (d) the number of cases of other sexually transmitted diseases, and; (e) the number of cases of tuberculosis and of drug abuse. The funds can be used to cover counseling, testing, some clinical and diagnostic services, and referrals to other appropriate service providers. There is also funding available for planning and implementing primary health care services that may be used for developing a health center. Exploring opportunities for funding through this program could potentially provide early seed money for a health center project.

Title X Family Planning Services (**http://www.hhs.gov/opa/familyplanning/index.html**) — Title X of the Public Health Service Act provides grants for public and non-profit agencies to provide family planning services to low-income persons. Organizations receiving funds are required to provide a broad range of family planning methods. Health center*s* are eligible for Title X funds generally indirectly through a state agency or other recipient.

WIC Program (http://www.fns.usda.gov/wic/) **—** The Special Supplemental Food Program for Women, Infants and Children (WIC) provides food, nutrition education and access to health care for low income pregnant, postpartum and lactating women, and children up to five years of age who are at nutritional risk. The program is federally funded through the Department of Agriculture and administered by state health departments. A number of health center*s* receive funding to administer the WIC program. The WIC statute was recently amended to require improved coordination between health centers and WIC, especially for "new start" health center*s*. Since one of WIC's goals is to link at-risk women and children with ongoing primary health care the program is a natural complement to a health center*'s* services. Many WIC programs and health center*s* are co-located.

Maternal and Child Health Program (http://mchb.hrsa.gov/programs/) — Title V of the Social Security Act authorizes grants to assure access to quality health services for underserved mothers and children, and to provide specialized services for children with special health care needs. Since 1981 these funds have been provided in the form of block grants to the states. State, county and local health departments frequently contract with health center*s* to provide MCH services.

<u>Government Funding – State</u>

Many states have implemented programs to support both existing and newly developing health centers.

Incubator Programs - provide program planning, feasibility studies and start-up funds to assist communities in starting ne health centers. While not all states have such programs they are growing in number. Contact the state PCA to determine if there is one in your area.

State Budget Line-Items - many states have budgeted funding for supporting health center's care to the uninsured and low income people. Some states specific types of care (i.e. pharmaceutical, children's oral health, etc.) while other states provide general operating subsidies that mirror the federal Section 330 program. Again the state/regional PCAs can provide information about the type of state funds that are available.

<u>Private Grant-Makers</u>

Private grant-makers are another important source of revenue. Foundations differ greatly in their size and the scope of their giving; some foundations focus on giving for particular areas of interest (e.g., health care, the arts, education), in a certain geographic region, or for specific purposes (e.g. capital improvement, research, specific services). Foundations generally fall into the following categories:

Independent foundations **–** generally receive their funds from a single source such as a family or individual.

Community foundations **–** are supported by and operated for the benefit of a specific community. Contributions come from many donors; a governing body that represents community interests administers the "giving activities". United Way agencies are an example.

Operating foundations **–** use their funding to provide a service or conduct research and do not generally award grants to other organizations.

Conversion foundations *(Community Health Trust Funds)* – are a subset of community foundations resulting from either non-profit insurance or health care providers or mutual funds converting to for-profit status (e.g. Blue Cross converting to for-profit) or non-profit insurers or providers being purchased by for-profit companies. In these cases the assets of the non-profit are considered to be "community assets" and are usually turned into a community foundation dedicated to health care. The size of these foundations varies dramatically from several million dollars to billions of dollars.

Corporations, another source of private funding, make grants through a number of different mechanisms:

Corporate foundations – receive funds from an endowment or annual contributions from the corporation's profits, but are legally independent from the corporation. An independent Board that often includes corporate officials administers them. Some hospitals and multi-hospital systems now have separate foundations.

Corporate giving programs – consist of grants or in-kind awards given by the corporation directly. The program follows established corporate giving guidelines and is usually administered by an in-house staff person with oversight and direction from the organization's Board of Directors or another designated governing body. Corporate foundations and giving programs often focus their giving in the geographic areas where the company has its operations or in areas of interest related to the corporation's mission.

Employee giving programs – are established programs for employees to make donations to the organization of their choice often with a matching gift from the corporation.

How does a health center find out which of these grant-makers are good prospects for its organization? There are many published guides and indexes to grant-makers. Probably the most comprehensive source of information on grant-makers is the Foundation Center, a national non-profit organization that collects and distributes information on foundations.

The Foundation Center publishes a voluminous collection of resource guides that cross reference foundations, grant recipients, and specific grant awards by subject area and state. These guides provide information about a foundation's mission, assets, Board members, giving criteria and application procedures. Also listed are all grants awarded by a foundation in the most recent fiscal period, including recipients, grant amounts and purpose. There are also other state- or subject- specific grant guides.

These publications are available to the public through the Foundation Center Cooperating Collections Network, a collection of libraries, community foundations and other non-profit organizations which house the Foundation Center publications as well as other materials and resources. The Foundation Center is also increasingly making its resources available through the Internet at **http://www.fdncenter.org**.

Information specifically regarding grants for health care-related purposes is also available through the Grant-Makers in Health (GIH). GIH provides listings of all health-related grant-makers and the types and amounts of grants given. They can be found online at **http://www.gih.org**.

When applying to foundations or corporate giving programs it is important to **do your homework.** Some grant-makers give awards to a broad array of organizations and interests while others have a very narrow focus; some require a formal application while others prefer a brief letter of request. Grant guides and foundation indexes provide information on contacts, giving guidelines and application procedures. Once a potential donor organization has been identified**,** call directly and request giving guidelines, an application form, and a copy of the grant-maker's most recent annual report.

For a variety of reasons general operating funds are often the most difficult to secure. The local United Way is an important place to look for operating funds, although the availability of United Way funds for new organizations is sometimes limited. It pays to be creative when thinking about ways to raise operating funds. For example, rather than requesting general operating support from local businesses, request that a business assume responsibility for some of the health center's specific costs, such as the telephone or utility bill.

Implementation Plan

Organizations that are seeking health center status, especially entities that are not currently operating as primary care providers, need to develop (or have developed by experienced staff or consultants) a <u>detailed work plan that identifies the specific activities, individual responsibilities and target dates</u> for all tasks that will be required to initiate operations as a health center.

The list of tasks can be daunting—even to the most experienced health center managers—and is beyond the scope of this document. The major categories of activities should include: Legal & Governance, Clinical, Finance, and Management. Good sources of assistance can include other health center*s,* health center networks where they exist, stare/regional PCAs, NACHC, the BPHC and consultants. Implementation Plan development can be challenging to health center leadership and planners especially if experienced staff have not yet been engaged. If the organization is not yet operational the financial resources to develop such a Plan will present an additional challenge. Leadership should work to secure the necessary fiscal support from interested public and private groups or agencies to conduct this phase of planning.

Contingency Plan

Finally, those individuals responsible for developing the Business Plan should outline in some detail the contingencies or unforeseen events that the health center might encounter during the period of time covered by the Plan (and most especially in the start-up year), and alternative approaches for managing those events.

Typically contingency planning is meant to describe the anticipated reactions of management and the Board of the health center in the event that the assumptions used in constructing the Business Plan and its various components were in error. This is particularly important if those erroneous assumptions might result in the health center being unable to achieve the Financial Projections. While Contingency Planning is not meant to explore every potential miscalculation, it is intended to describe the potential major variances in health center (financial) performance from those that were identified in the Plan and Projections and how leadership will respond. For example, will the Board:

1) Consider a redefinition of the health center*'s* service area (i.e., target market) or the targeted population(s) (i.e., market segments)?

2) Consider a change in the array of services offered or enhance the current service offerings?

3) Direct management to make recommendations regarding the health center*'s* charges, costs, staff or staffing, uses of cash?

4) Direct management to revise the health center*'s* marketing communications strategy by which the health center informs or advises its key constituents?

5) Consider the exploration of partnerships or strategic alliances with other health center*s* or provider organizations within the health center*'s* local community?

6) Consider contractual relationships with purchasers or managed care entities?

The value to the health center of creating both Implementation and Contingency Plans is immeasurable. They can also be an asset to health center leadership in its solicitation of financial support from other entities and agencies as they demonstrate a level of knowledge, capacity and proficiency that foundations and other grant-making organizations often require. Fund development experts advise that grant-makers and contributors are more likely to support organizations that can demonstrate fiscal stability, if not growth, than those that depend on their financial support for mere survival.

Lastly, it should be noted that a comprehensive, well-prepared Business Plan would provide much of the information needed by an organization that intends to file an application for grant funding with the Bureau of Primary Health Care.

Chapter VIII
Before You Open Your Doors: Insurance

Obtaining the appropriate kinds and amounts of insurance for a health center is a critical and elemental step in being able to provide health center services. *This discussion is provided as a general discussion of* **health center** *insurance; it is not intended to provide legal advice in the purchase of insurance. Any* **health center** *considering the purchase of insurance should seek expert advice.*

Basically, there are three kinds of insurance that a health center must have: *Professional Liability Insurance* for clinicians; *Corporate Liability Insurance;* and *Directors and Officers Liability Insurance.*

Professional Liability Insurance covers professional staff working in clinical capacities for acts or omissions that cause harm to patients and/or their families. Health centers commonly purchase insurance for each provider that covers up to $1 million in damages for any individual claim and up to $3 million for aggregate claims over the course of a year. For some health center providers who provide a higher volume of obstetrical services it might be advisable to increase the amount of coverage for both individual claims and the annual aggregate amount of claims. In some cases health centers have been able to form insurance purchasing groups that have increased the amount of coverage purchased and lowered the cost of obtaining that coverage (contact the state PCA for information on availability).

With enactment of the Extension and Amendments to the **Federal Tort Claims Act (FTCA) Coverage for Health centers** (P.L. No. 104-73 3) in December 1995, the availability of malpractice coverage for health centers free of cost under the Federal Tort Claims Act was permanently extended to health centers with significant improvements and clarifications. As a result most health cente*r*s find that they can significantly reduce or eliminate their malpractice insurance costs by electing to participate in the FTCA program.

A health center becomes eligible for participation in this program by becoming "deemed" eligible following a review of information on its quality assurance and credentialing systems, among other things. Each year BPHC issues a guidance for applying for FTCA that includes the application materials that must be completed before a health center can be deemed eligible to participate. This PIN is available on the BPHC website at **http://bphc.hrsa.gov/**. Once a health center is deemed eligible the center must decide whether to participate in FTCA. If the center elects to participate in FTCA, the center, its Board members, staff and possibly certain other individuals are covered for acts that occur within the center's approved "scope of federal project" and employment or contractual agreements with providers. **There is no cost to the center for FTCA participation.**

Even if FTCA is used as the primary liability coverage, a center should analyze its need for any "gap" or "tail" coverage to ensure adequate insurance coverage during the transition to FTCA coverage. With the 1995 improvements, FTCA offers health cente*r*s an important tool for reducing costs if they elect to use it. No health center should discontinue its current liability coverage, however, without careful analysis and legal advice on whether FTCA is the right option. Centers should contact NACHC or BPHC for more information on how the FTCA program works.

Corporate Liability Insurance covers the health center corporation and its employees for acts or omissions not arising out of the provision of professional services. A commonly cited example of situations covered by this kind of insurance is that of a person slipping on ice on health center property, breaking a hip and then suing the health center for not clearing the ice. Generally it is a good idea to carry an amount of corporate liability insurance that will cover the assets of the corporation. The health center must also evaluate the need to insure, and at what coverage amounts, for other potential risk exposure, (e.g., property and casualty, computer hardware and software, fidelity bonds, vehicle liability, etc.). Again, health cente*r*s should secure expert advice in making these decisions.

Directors' and Officers' Liability is insurance for the health center's Board of Directors. A health center*'s* Board is responsible for acting prudently in fulfilling its fiduciary responsibility, for developing complete and appropriate policies for governing the health center, and for ensuring that these policies are heeded in the conduct of the health center's business. In rare cases the personal assets of people who volunteer as health center Board members can be at risk in case of a lawsuit. Directors' and Officers' (or "D & O") Liability Insurance provides coverage for the Board, both corporately and individually, in case a lawsuit is brought against the health center's Board for acts or omissions that are in conflict with the Board's fiduciary responsibility. As with corporate liability insurance it is generally a good idea to maintain insurance amounts to cover the assets held by the corporation.

Simply put, it is critical that you ensure that the assets and the Directors of the corporation are protected!

There are two other terms that are important to clarify at this point:

1. ***Claims Made Policies*** cover claims that are made against the health center as long as the health center continues carrying insurance from the same insurance company. This means that if a health center with *claims made* insurance changes insurance companies it may have to purchase tail coverage in order to be sure that acts or omissions that occurred <u>before</u> the change of companies are still covered by the previous insurance company. Sometimes the new insurance company will cover "prior acts" which can reduce or eliminate the need to purchase tail coverage.

2. ***Occurrence Insurance Policies*** cover any act or omission that occurred when the insurance policy was in effect and coverage does not terminate upon policy cancellation. Today, *claims made* policies are the norm and *occurrence* policies are rare**.**

In any event, health cente*r*s must have appropriate insurance coverage: ***do not open the doors to the* health center *without adequate insurances.*** For help with insurance issues contact the state/regional PCA or NACHC.

Chapter IX

Information Technology/Data Systems

A health center's information technology system (IT) serves many purposes—from patient appointment scheduling and billing to ongoing needs assessments and continuous quality improvement (CQI). IT systems have become increasingly complex in recent years and several companies specialize in computer systems for health center organizations. New data warehouses and centralized software sharing systems for health centers are recent innovations. While the whole topic of computers and information systems may seem mind-boggling and to some people unnecessary for a small health center that is just beginning, it is fair to say that no health center should be without a computer-based information system that is able to handle four basic functions:

1. Patient appointment scheduling and management;

2. Staff scheduling;

3. Billing for services and managing claims to third party payers;

4. Reporting on service utilization, patient outcomes and changes in patient information.

Many health centers are now implementing electronic medical records, utilizing PDAs and other handheld computers for scheduling, patient case management, completing encounter forms and linking direct care to billing and practice management systems. **Electronic Health Records and integrated IT systems should be implemented from the start regardless of the size of the health center.** Health centers in remote and rural areas are investing in tele-health technologies enabling access to specialists in real time consultation.

While the scope of this publication does not allow for a detailed and comprehensive discussion of IT systems, there are some basic principles that can be useful and some information that should be available before beginning a search for an information system. For a detailed examination of this subject contact NACHC. It may also be useful to talk to other health service organizations in the community and particularly to other health centers or health center networks to find out what IT systems they are using. State PCAs may also know what software is being used by health centers in their state or region.

Currently the BPHC is encouraging health centers to participate in integrated networks as a means for ensuring access to the latest IT. More reasonable costs and hopefully a higher level of technical support from identified IT vendors are two important benefits from network participation.

The information system is a fundamental and critical tool that not only assists management in daily operations of the center but also ensures that the Board receives timely and comprehensive information so they can fulfill their governance and fiduciary responsibilities. With multiple programs and payers, grants management, managed care arrangements, etc. no health center can afford to go without a good computer system. And, however expensive and time-consuming identifying and implementing a computerized IT system is during the early period of operations, converting a manual system later on is always more expensive and inefficient. Increasingly information systems are forming the basis of real-time practice management and clinical decision-making.

In general the functions of a health center's information system are categorized as *operations functions* and *management functions:*

Operations functions — are those aspects of information processing that allow health center staff to operate the health center efficiently and effectively on a daily basis. These are the functions that are most apparent to and most affected by staff and patients. Patient registration and scheduling systems and billing systems are two examples of critical operations functions of a health center's IT system.

Management functions — are the reporting of information that allows health center management and Board to evaluate the center's activities and to make necessary operational changes. Patient demographics, utilization information and provider productivity are examples of management functions that are critical.

1) When considering the best way to meet management and operations information system the following questions should be included:

- In addition to basic primary care services are there other (either traditional or non-traditional) services the health center is planning to provide such as case management, pharmacy, laboratory or radiology services. The IT system should provide the ability to account correctly for the costs of these services, produce billing for these services on a timely basis, and provide utilization information that will allow effective management of these services.

- What kind of patient information needs to should be recorded and reported? These characteristics would include at a minimum:

    o Income;

    o Insurance coverage;

    o Race and ethnicity;

    o Age and gender;

    o Primary and other diagnoses for each encounter.

It is not enough to know that the IT system will store all the information that health center management and clinicians might want. The IT system must deliver reports that are needed and must support timely and accurate production of operations information such as scheduling and billing.

2) When considering different systems ask for a demonstration of the capacity of the system in a real-life, real-time setting that is as close to the health center's own situation as possible.

Federally funded health centers are required to report detailed information using a standard format. This format is called the Uniform Data System (UDS). Federally funded health cente*r*s must be able to track data and generate reports consistent with the UDS requirements and formats, and should develop their information systems accordingly. Contact HRSA to request a copy of the UDS manual. It is also available on the BPHC website.

3) When looking at information systems, always keep two questions in mind:

- Will the system allow design of customized reports easily without the assistance of the company's programmers?

- Will the system produce data in a format that is easily analyzed by "off-the shelf" software (e.g., spreadsheet programs and statistical packages)?

4) Finally, it is certain that the health center's information system needs will change over time and the information system is going to have to change as well to meet those needs. It is most important to make sure that augmenting or replacing systems is part of the initial discussion with IT vendors and part of the health cente*r's* ongoing financial planning process.

5) For much more detail on shopping for, evaluating, purchasing and using information systems, the following NACHC resources should be reviewed:

- *Health Information Technology Website* - **http://www.nachc.com/Health%20Information%20Technologies%20(HIT).cfm** This site provides tools and resources to assist health centers in the selection and successful implementation of various health information technologies (HIT).

- *Health Center Information Systems: Strategies for Success.* This is a plain-language guide which discusses criteria for evaluating IT systems; planning for future needs; developing requests for proposals for systems and evaluating the responses from vendors; and helpful hints in implementing or upgrading information systems.

- *Initiating Excellence: A Guidebook for Assessing the Impact of Community Health Center Financial Systems.* This publication is a guide for health center staff to use in understanding the growing and critical role that financial systems play in controlling day-to-day operations (i.e., operations functions) and in developing business, health care, and long-range strategic plans (i.e., management functions).

Chapter X

Conclusions and Recommendations

A. Planning with Standards in Mind

There are several published standards that can provide guidance in planning a new health center. Whether the health center is a new organization or is transitioning from an existing entity to the health center model and structure, it is important to look at the various standards used both by the Bureau of Primary Health Care and by the health care field in general.   There also are listings of agencies, organizations, and websites that provide information and support to new and existing health centers. A few of the standards are described below.

The Program Requirements for Health Centers — describes the program requirements for *health centers* that receive Section 330 funding from the HRSA/BPHC and who are designated as FQHC Look-alikes. These guidelines are also available in Spanish and can be found on the BPHC website.

The Medicaid Health Plan Employer Data and Information Set (HEDIS) — is a standardized set of measures to assess the performance of Medicaid managed care plans. The HEDIS was developed through a public-private partnership under the auspices of the National Committee for Quality Assurance (NCQA), **www.NCQA.org**.

*The BPHC web site (***http://www.bphc.hrsa.gov***)* — provides considerable resources and linkages concerning quality standards and measures for providing high-quality, culturally competent services to multi-ethnic populations. It is important to check information regularly regarding BPHC programs and guidelines as new rules and clarifications are released frequently.

Other industry standards — on management and clinical operations are available through organizations such as the American Medical Association (AMA), **www.ama-assn.org/**, the Medical Group Management Association (MGMA), **www.mgma.com**, and American Group Practice Association (AGPA), **www.amga.org/**. The Joint Commission, **www.jointcommission.org**, formerly the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) and the Accreditation Association for Ambulatory Health Care (AAAHC), **www.aaahc. org**, are two organizations that accredit ambulatory care organizations including health centers. Joint Commission accreditation is increasingly common – and expected – for federally funded health centers. Review of those standards can assist new starts in setting up appropriate systems from the beginning. NCQA is taking a primary role in accrediting health centers as Patient-Centered Medical Homes.

B. Where to Go for Help

In addition to published references there are many organizations that can be contacted for help. A few organizations that have been mentioned throughout this document should be contacted early in the planning process. All of the organizations listed below can provide up-to-date information on federal program requirements, funding availability and shortage designations.

- The Bureau of Primary Health Care, of Policy and Program Development;

    This is the Bureau in the Health Resources and Services Administration that administers the federal 330 Public Health Services Act. As such, it has responsibility for implementing health center regulations and requirements, grant applications and awards, monitoring health center operations and clinical care, developing new starts, and all regulatory areas pertinent to a health center.

Two critical lines of communication between grantees or would-be grantees are Policy Information Notices (PIN) and Policy Assistance Letters (PAL). BPHC describes them as follows:

➢ Policy Information Notices (PINs) define and clarify policies and procedures that grantees funded under Section 330 must follow.

➢ Program Assistance Letters (PALs) summarize and explain items of significance for health centers, including, for example, HRSA program implementation activities, recently enacted laws, final regulations, and/or new HHS initiatives.

These resources can be accessed through: **www.bphc.hrsa.gov/policy**. The notices and letters are sorted by categories and dates within a category. Pin 05-19, for example, was written in 2005, and this is number 19 in the '05 series.

• State and Regional Primary Care Associations

• State Primary Care Offices

• The National Association of Community Health Centers, Inc.

➢ Health Center Growth and Development Program, located under *Information* at **www.nachc.com**, is a comprehensive program designed to provide technical assistance in the form of materials, state-wide and regional trainings and webinars on all aspects of health center growth and development

Other useful information and materials may be available from the following organizations:

• National Center for Farmworker Health – **www.ncfh.org**

• National Health Care for the Homeless Council – **www.nhchc.org**

• National Center for Health in Public Housing – **www.nchph.org**

A final comment: This manual was originally written (in 1996) at a time of considerable change in the political and health care environments. At the state level, health care reform initiatives and the growth of Medicaid managed care were significantly altering the landscape for health centers. At the national level, nearly all of the programs mentioned in this manual were being scrutinized for possible changes and reform. Currently the environment for health centers presents not only tremendous opportunities but significant challenges: a plan to increase the number of health center access points by 1200 and double the number of patients served by health centers over the next ten years. At the same time, significant potential funding cuts and fundamental changes to Medicaid are being debated. All is to say the environment is never stagnant, challenges abound, but regardless there are millions of people across the country that do not have access to quality, affordable health care.

The National Association of Community Health Centers is confident that health centers are up to the task! NACHC stands ready to assist health centers in ensuring their future success and in meeting our common mission to provide access to quality health care for all people.

Good luck and good health!

TABLE 14
Checklist

This checklist summarizes the steps and processes described in Chapters II through IX of this manual. Not all of these steps will be necessary or appropriate for every organization and they are not necessarily undertaken in this order.

A. Phase I: Needs Assessment and Reality Check

❑   Contact state/regional PCAs, PCO, NACHC and BPHC/DHCD for information and to establish a communication linkage

❑   Define community

❑   Identify service area

❑   Solicit broad community involvement

❑   Perform community analysis

❑   Solicit involvement of health care providers and other sponsors/partners

❑   Identify target high need population(s)

❑   Estimate health status and need for health care services for the target population

❑   Assess health care resources available to target population

❑   Estimate unmet need for services

❑   Identify community health priorities

❑   Apply for federal shortage designations:

    ❑   Medically Underserved Area/Population

    ❑   Health Professional Shortage Area: primary care, dental health, mental health

B. Phase II: Organization Development and Business Plan

❑   Develop community-based board

❑   Develop a strategic plan

❑   Develop operating plans and budgets

❑   Identify service package

❑   Identify an organizational home:

    ❑   "Convert" an existing non-profit organization

    ❑   Establish a new non-profit corporation

    ❑   Partner with an existing federally funded health center

    ❑   Identify a public agency as a "co-applicant"

❑ Identify a physical home

❑ Assess staffing needs

❑ Accomplish a "Business Plan"

> ❑ Describe the "purpose," and define the "goals and objectives"
>
> ❑ Define the "market" and conduct the "market research"
>
> ❑ Describe the "business strategy"
>
> ❑ Describe the "management" and the "organization"
>
> ❑ Create the "financial projections" – consider multiple scenarios
>
> ❑ Develop the "implementation plan"
>
> ❑ Develop a "contingency plan"
>
> ❑ Identify MIS/Data system needs and solutions

C. Phase III: Go Operational

❑ Recruit staff

❑ Arrange for necessary insurances

❑ Apply for Federally Qualified *Health Center* "look-alike" status and/or Section 330 funding

❑ Identify other funding sources (federal, state, private and public) and make requests

Chapter XI

Resources And Websites

A. Private Organizations

Accreditation Association for Ambulatory Health Care (AAAHC)
www.aaahc.org
AAAHC is the preeminent leader in developing standards to advance and promote patient safety, quality and value for ambulatory health care through peer-based accreditation processes, education and research. Accreditation is awarded to organizations that are found to be in compliance with the Accreditation Association standards.

Association of Asian Pacific Community Health Organizations (AAPCHO)
www.aapcho.org
AAPCHO promotes culturally competent, linguistically accessible, and affordable primary health care services to Asian American and Pacific Islander populations across the country by means, for example, of developing patient guidance in languages including Chinese, Korean, Laotian, Samoan, Tagalog, Vietnamese, and English.

Center for Health and Health Care in Schools (CHHCS)
www.healthinschools.org
A nonpartisan policy and program resource center located at The George Washington University School of Public Health that advises health care providers on how to provide cost-effective and accountable health programs in schools.

The Joint Commission *(Formerly JCAHO)*
http://www.jointcommission.org/
The Joint Commission is an independent, not-for-profit organization that develops standards, evaluates the compliance of organizations against these benchmarks, and provides health care accreditation.

Medical Group Management Association (MGMA)
www.mgma.com
As a professional organization for medical group practice managers and leaders, MGMA provides education, information, and networking opportunities in areas including leadership, compensation, strategic planning, and marketing strategies.

Migrant Clinicians Network (MCN)
www.migrantclinician.org
A national clinical network of health care providers who serve migrant farmworkers and other underserved mobile populations. The Network has resources to share in subject areas that include environmental, diabetes, and eye care.

National Assembly on School-Based Health Care (NASBHC)
http://www.nasbhc.org/
NASBHC advocates for national policies, programs, and funding to expand and strengthen school based health centers, while also supporting the movement with training and technical assistance.

National Association of Community Health Centers (NACHC)
www.nachc.com
NACHC serves and represents the interests of America's health centers through education and training of health center staff and boards, technical assistance, advocacy, partnerships, and networking.

National Center for Cultural Competence (NCCC)
http://nccc.georgetown.edu/
The center provides training, technical assistance, and consultation, in addition to developing products and tools. The "Guide to Planning and Implementing Cultural Competence Organizational Self-Assessment" is a way to plan for incorporating cultural competence within an organization.

National Center for Farmworker Health (NCFW)
www.ncfh.org
NCFW provides information services and products to organizations and individuals serving the farmworker population.

National Dissemination Center for Children with Disabilities (NICHCY)
www.nichcy.org
NICHCY is a central source of information on disabilities in infants, toddlers, children, and youth, and creates State Resource Sheets that identify organizations and agencies within each state that address disability-related issues.

National Health Care for the Homeless Council, Inc.
www.nhchc.org
The Council publishes and conducts research on both policy issues and operational concerns of homeless health care projects, and works in collaboration with the Health Care for the Homeless Clinicians Network to provide educational and support services for professional staff working homeless health care and mental health programs.

National Rural Health Association (NRHA)
www.nrharural.org
As a membership organization, NRHA provides publications, resources, advocacy, educational opportunities, and research to improve the health of rural Americans and to provide leadership on rural issues through advocacy, communications, education, and research.

B. Public Organizations

Bureau of Primary Health Care (BPHC)
www.bphc.hrsa.gov
The bureau provides grant support to health centers – including community and migrant health centers, school-based health centers, and Public Housing Primary Care Programs – to increase access to health care for underserved people. Bureau activities also include collecting data, conducting research, monitoring grantees, providing policy guidance, and collaborating with other agencies around health care delivery systems for medically underserved and vulnerable populations.

> **Office of Grants Management**
> http://www.hrsa.gov/grants/index.html
> Assists organizations in preparing applications, manages the grants process, and issues the Notice of Grant Award documents.

> **Malpractice, Risk Management and Patient Safety Hotline**
> Call for the latest information on how to prevent claims, improve quality, manage malpractice risk, and respond to patient concerns.   Risk Management Consultants will respond within 30 minutes if not available immediately between the hours from 8 a.m. to 6 p.m. Eastern. During all other hours, please leave a message and your call will be returned promptly.
> Contact Information 517.703.8464 or toll-free at 888 466-4272

Centers for Disease Control and Prevention (CDC)
www.cdc.gov

The CDC protects the health and safety of people by developing and applying disease prevention and control, environmental health, and health promotion and education activities. Centers within CDC include: National Center for Chronic Disease Prevention and Health Promotion; the National Center for Health Statistics; the National Center for HIV, STD, and TB Prevention; National Center for Infectious Diseases; the National Immunization Program; and the National Institute for Occupational Safety and Health. Products available to health centers include publications, videos, and software.

Centers for Medicare and Medicaid Services (CMS)
http://cms.hhs.gov
CMS provides insurance to over 74 million Americans through Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). CMS performs quality-focused activities, including regulation of lab testing (CLIA) and implementation of various provisions of the Health Insurance Portability and Accountability Act (HIPAA), and develops numerous publications and manuals on day-to-day operating instructions, policies, and procedures based on regulations, models, directives, and guidelines.

Community Health Status Indicators Project (CHSI)
http://www.communityhealth.hhs.gov/
Is a HRSA-funded collaboration among the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Health Officials (NACCHO), and the Public Health Foundation (PHF) to provide county-level health assessment information for all 3,082 U.S. counties.

Health Resources and Services Administration (HRSA)
www.hrsa.gov
The federal agency whose mission is to improve and expand access to quality health care to low income, uninsured, isolated, vulnerable and special needs populations

Bureau of Health Professions (BHPr)
www.bhpr.hrsa.gov
BHPr works to assure access to quality health care professionals in all geographic areas and to all segments of society. BHPr supports a number of programs the encourage health professionals to serve in communities where the need is greatest.

The Data Bank
http://www.npdb-hipdb.hrsa.gov/topNavigation/aboutUs.jsp
The Data Bank, consisting of the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB), is a confidential information clearinghouse created by Congress to improve health care quality, protect the public, and reduce health care fraud and abuse.

HRSA Information Center
www.ask.hrsa.gov/
Identifies publications, resources, and referrals on health care services for low-income, uninsured individuals, and those with special needs. Several publications include: "Governing Board Handbook," "Principles of Oral Health Management for the HIV/AIDS Patient," and "A Guide to Substance Abuse Services for Primary Care Clinicians.

National Health Service Corps (NHSC)
http://nhsc.hrsa.gov/
NHSC assists communities with recruitment and retention, site development, practice management, and quality assurance activities.

Shortage Designation Branch – MUA, MUP, HPSAs
http://bhpr.hrsa.gov/shortage/
This branch develops and implements criteria and procedures for designating areas and populations having a shortage of primary health care services.

HIV/AIDS Bureau (HAB)
www.hab.hrsa.gov
Is the largest single source (next to the Medicaid and Medicare programs) of Federal funding for HIV/AIDS for low-income un- and underinsured individuals. The Bureau provides funding under the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, which includes grants for HIV Early Intervention Services, HIV service planning, HIV training and education programs for health care providers, and technical assistance.

National Diabetes Information Clearinghouse and National Diabetes Education Program (NIDDK)
http://www2.niddk.nih.gov/
NIDDK conducts and supports basic and clinical research on many of the most serious diseases affecting public health.

National Guideline Clearinghouse (NGC)
www.guideline.gov
Is a public resource for evidence-based clinical practice guidelines. NGC is sponsored by the Agency for Health-care Research and Quality in partnership with the American Medical Association and American Association of Health Plans.

National Immunization Program
http://www.cdc.gov/vaccines/
This program within the CDC provides patient and provider immunization education materials, including anthrax and smallpox information, flu bulletins, vaccine information statements and supply updates. The NIP also supports state immunization projects that may include community health centers.

National Institute of Mental Health (NIMH)
www.nimh.nih.gov/
NIMH provides research reports and information, including patient education materials, about the diagnosis and treatment of mental disorders.

> **Vaccines for Children Program**
> http://www.cdc.gov/vaccines/programs/vfc/default.htm
> As a division of the NIP, the Vaccines for Children program buys vaccines for children in certain groups who can't afford to buy vaccines. Doctors can get these vaccines for their patients who qualify by joining the VFC program in their state.

Office of Rural Health Policy
http://www.hrsa.gov/ruralhealth/
This office promotes better health care services in rural America by working within government at the federal, state, and local levels, and with the private sector – with associations, foundations, providers and community leaders.

Substance Abuse and Mental Health Services Administration (SAMHSA)
www.samhsa.gov
SAMHSA provides information and patient education materials, including some in Spanish, in the National Clear-inghouse for Alcohol and Drug Information; guidance to parents and caregivers; information on model programs tested in communities and schools.

C. Information on Special Populations

2011 Directory of National Statewide and Local Homeless Advocacy Coalitions
http://www.nationalhomeless.org/directories/directory_advocacy.pdf

Association of Farmworker Opportunity Programs (AFOP)
www.afop.org
AFOP provides job training, pesticide safety education, emergency assistance, and an advocacy voice for the people who prepare and harvest our food.

Bureau of Indian Affairs (BIA), Regional Offices
http://www.bia.gov/groups/webteam/documents/interactiveresource/idc-002651.swf

Children's Defense Fund – State Data
http://www.childrensdefense.org/child-research-data-publications/us-state-child-data.html

The Department of Housing and Urban Development (HUD) Database on Public Housing Residents
http://www.huduser.org/portal/datasets/assthsg.html

The Kids Count Census Data Online
http://www.kidscount.org/census/
This site consists of population data about age, gender, households, families, and housing units from the Census Short Form (Census SF1) and social, economic, and housing data from the Census Long Form (Census SF3).

Medicare Health Outcomes Survey (HOS)
https://www.cms.gov/hos/
The Medicare Health Outcomes Survey (HOS) is the first patient reported outcomes measure used in Medicare managed care. The goal of the Medicare HOS program is to gather valid, reliable, and clinically meaningful health status data in the Medicare Advantage (MA) program for use in quality improvement activities, pay for performance, program oversight, public reporting, and improving health. All managed care organizations with MA contracts must participate.

National Center for Education Statistics – The Public School Locator
http://nces.ed.gov/ccd/schoolsearch/

The National Agricultural Workers Survey (NAWS)
http://www.doleta.gov/agworker/naws.cfm
The NAWS is an employment-based, random survey of the demographic, employment, and health characteristics of the U.S. crop labor force. The information is obtained directly from farmworkers through face-to-face interviews. Since 1988, when the survey began, over 53,000 workers have been interviewed.

Native Hawaiian Data Book
http://www.oha.org/index.php?option=com_content&task=view&id=102&Itemid=175
This publication provides statistical data on Native Hawaiian communities throughout the state, offering a numerical representation of the social and economic status of the Native Hawaiian population. Statistics ranging from education levels to income profiles provide a clearer picture of the current status of the Native Hawaiian community.

School Health Policies and Practices Study (SHPPS)

The School Health Policies and Practices Study (SHPPS) is a national survey periodically conducted to assess school health policies and practices at the state, district, school, and classroom levels.
http://www.cdc.gov/HealthyYouth/shpps/index.htm

D. Sources of State, Local and Area Data

Bureau of Labor Statistics (BLS)
www.bls.gov
The Bureau of Labor Statistics collects, analyzes, and disseminates essential economic information to support public and private decision-making.

CDC

Data and Statistics
http://www.cdc.gov/DataStatistics/

Epidemiology Program
http://www.cdc.gov/epo/

FastStats: A – M
http://www.cdc.gov/nchs/fastats/Default.htm

Resources
http://www.cdc.gov/other.htm
Additional Data Sources and Health Partners

The DataWeb/ DataFerrett
http://www.thedataweb.org/
DataFerrett is a unique data analysis and extraction tool-with recoding capabilities-to customize federal, state, and local data to suit your requirements. (FERRETT stands for Federated Electronic Research, Review, Extraction, and Tabulation Tool.) Using DataFerrett, you can develop an unlimited array of customized spreadsheets that are as versatile and complex as your usage demands.

FedStats
http://www.fedstats.gov/aboutfedstats.html
FedStats, provides access to the full range of official statistical information produced by the Federal Government without having to know in advance which Federal agency produces which particular statistic. With convenient searching and linking capabilities to more than 100 agencies that provide data and trend information on such topics as economic and population trends, crime, education, health care, aviation safety, energy use, farm production and more, FedStats is your one location for access to the full breadth of Federal statistical information.

FedWorld
http://www.fedworld.gov/
This online locator service for a comprehensive inventory of information disseminated by the Federal Government.

Healthy People
http://www.healthypeople.gov/2020/default.aspx
Healthy People provides science-based, 10-year national objectives for improving the health of all Americans.

National Association of Public Health Statistics & Info Systems
http://www.naphsis.org
NAPHSIS provides national leadership and advocacy to ensure the quality, security, confidentiality and utility of vital records and health statistics, as well as their integral role within health information systems, for monitoring and improving public health.

National Association of Health Data Organizations (NAHDO)
https://www.nahdo.org/
NAHDO is a national non-profit membership and educational association dedicated to improving health care data collection and use.

National Center for Health Statistics
http://www.cdc.gov/nchs/surveys.htm

National Networks of Libraries of Medicine
http://nnlm.gov/
The mission of the National Network of Libraries of Medicine (NN/LM) is to advance the progress of medicine and improve the public health by providing all U.S. health professionals with equal access to biomedical information and improving the public's access to information to enable them to make informed decisions about their health.

> **Health Information on the Web**
> **http://nnlm.gov/hip/**

USA.Gov
www.usa.gov
As the U.S. government's official web portal, USA.gov makes it easy for the public to get U.S. government information and services on the web.

US Census Bureau

> **Health Insurance**
> **http://www.census.gov/hhes/www/hlthins/hlthins.html**
> The Census Bureau collects health insurance data using three national surveys: the Current Population Survey's Annual Social and Economic Supplement (CPS ASEC), the American Community Survey (ACS) and the Survey of Income and Program Participation (SIPP).

> **Poverty**
> **http://www.census.gov/hhes/www/poverty/poverty.html**
> The Census Bureau reports poverty data from several major household surveys and programs.

> **State Data Centers (SDC)**
> **http://www.census.gov/sdc/**
> SDC Program makes data available locally to the public through a network of state agencies, universities, libraries, and regional and local governments.

> **Subjects A – Z**
> **http://www.census.gov/geo/ZCTA/zcta.html**

> **Zip Code Level Statistics**
> **http://www.census.gov/epcd/www/zipstats.html**

> **Zip Code Tabulation Areas (ZCTAs)**
> **http://www.census.gov/geo/ZCTA/zcta.html**
> ZIP Code Tabulation Areas (ZCTAs) are a statistical geographic entity produced by the U.S. Census Bureau for tabulating summary statistics from the 2010 Census, first developed for Census 2000. This entity was developed to overcome the difficulties in precisely defining the land area covered by each ZIP Code, which is necessary in order to accurately tabulate census data for that area.

E. GIS Mapping Data

Geographic Information Systems (GIS) at CDC
http://www.cdc.gov/gis/

GeoData.Com
www.geodata.com

Geographic Information Systems
http://www.gis.com/