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

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Foreword

There is no single way to develop a health center[1]. Some health centers achieve look alike status, and never seek federal funding. Others start from scratch and seek federal funding before beginning operations, while still others grow out of community efforts, hospital practices, public health departments, free clinics, family planning centers and private physician settings, and become federally funded health centers (or health center look-alikes[2]) as a next phase of their histories. While this guide can be used in any of these circumstances, the majority of those accessing this guide will be seeking funding or look alike status, so that will be the focus. In addition to this guide, it is recommended to review the Bureau of Primary Health Care's website on how to become a health center, at: **http://bphc.hrsa.gov/programopportunities/howtoapply/index.html**.

Pursuing a health center and choosing the right option depends on many things:

- Community needs (like health status, access and barriers to care)
- Support in the community for health center development
- Ability to create and sustain community governance
- Opportunities for service delivery coalitions to develop
- Current or potential qualifying federal shortage designations
- Available financing options for a new health center
- Community will to expend the effort necessary and commit to utilizing a new health center

In this guide, we break down the many considerations a community must take into account when contemplating a health center.

We will treat the recommended steps for assessing readiness to apply for health center status, and provide links to resources and tools that can be helpful. Organizations currently providing services to underserved populations and desire to develop a more comprehensive program that meets Section 330 of the US Public Health Service Act requirements will likely find this guide most helpful.

Remember, deciding whether or not to embark on starting a health center is an individual community decision. There are no one-size-fits-all models. In fact, the very essence of a health center is that is grows from, responds to, and is owned and governed by the very community it serves. While a health center must meet Program Requirements, each health center will take the form that best suits its community. Welcome to the family of health centers.

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1   Throughout this document, the term "health center" is used to denote community health centers, migrant health centers, homeless health centers, public housing primary care centers, and health center look alikes, and is used interchangeably, unless noted otherwise.

2   Health Center Look-Alikes meet all the requirements of funded health centers, and receive virtually all of the benefits, except for FTCA coverage and 330 funding. They are also sometimes referred to as non-funded health centers.

Section 1

What is a Health Center?

Health centers are a major part of health care delivery in the United States today. Most health centers are grantees of the Health Resources and Services Administration, Bureau of Primary Health Care, (HRSA/BPHC) under Section 330 of the US Public Health Service Act, and include community health centers, migrant health centers, health care for the homeless health centers, and public housing primary care centers. These are sometimes referred to by their authorizing section in the act: 330(e), 330(g), 330(h) and 330(i), respectively. Others are known as look alikes: they meet all the requirements of health centers and reap most of the benefits of health center status, but do not receive a federal grant.

As of the end of 2014, 1,287 health center organizations serve the US today, in every state, the District of Columbia, Puerto Rico, Guam, American Samoa, the Marshall Islands, the Northern Mariana Islands, the Federated States of Micronesia, and the US Virgin Islands. These health centers operate more than 9,000 sites and serve in excess of 22.87 million unique patients[3]. Without health centers millions of people who have public insurance (e.g., Medicaid, Children's Health Insurance Program), are uninsured or low-income would have limited access to preventive and primary health care, or would have to seek care in more costly settings, like emergency departments. Health centers consistently demonstrate quality health outcomes at costs well below national averages.

Section 330 funding is subject to Congressional approval. Historically support for health centers has been high, though budget constraints at the federal level can affect availability of funds for new organizations. Nevertheless, intensive technical support is available to communities through the National Association of Community Health Centers (NACHC) Health Center Growth and Development Program, state and regional Primary Care Associations (PCA), national associations supporting services to special populations, and HRSA/BPHC itself. Links to these organizations are available in this document.

Often health centers are referred to as FQHCs – Federally-qualified health centers. They are called this because they have been approved for reimbursement programs under Medicare and Medicaid – but strictly speaking, FQHC is a reimbursement model, not a place. To achieve this recognition, the organizations must meet rigorous governance, access, quality of care, service and cost standards, and in exchange for meeting these requirements, Medicare and Medicaid pay these organizations on a cost-based or cost-derived (usually higher) basis than published fee schedules. In addition, FQHCs have the opportunity to apply their reimbursement benefits to managed care enrollees under Medicaid.

Other benefits to health centers (whether funded or not) include:

- Ability to Participate in Public Health Service Act (PHS) 340B drug pricing program to purchase prescription drugs at discount, subject to application and approval (**http://www.hrsa.gov/opa**)

- Access to National Health Service Corps (NHSC) providers and resources (**http://nhsc.hrsa.gov**)

- The potential for out stationed Medicaid eligibility workers on-site, depending on the state in which the health center is located

- Access to the Federal Vaccine for Children (VFC) program (**http://www.cdc.gov/vaccines/programs/vfc/index.html**)

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3   HRSA national program data, http://bphc.hrsa.gov/uds/datacenter.aspx.

Funded health centers can also apply for malpractice coverage under the Federal Tort Claims Act (FTCA). A health center must complete a rigorous deeming application to receive malpractice coverage, and must adhere to standards of quality management throughout its deeming period. Information on FTCA can be found at **http://bphc.hrsa.gov/ftca/**.

In general, health centers are providers of primary and preventive health care to medically underserved populations. In addition to medical care, health centers must provide or arrange for dental care, behavioral health services, and "enabling" services – wraparound care, like case management, interpretation and transportation – that help patients get the care they need. Unlike other models of health care delivery, health centers focus not only on the health of individual patients, but also on the health of the entire community. This focus means that health centers differ from other settings in a number of ways. Needs assessment, program development, evaluation and the very definition of "community" are all framed in terms of a community's assets and needs as well as individual patient health. Health centers are also encouraged to become recognized Patient-Centered Medical Homes (PCMH)[4], which means that the center delivers care in a coordinated way with a focus on ensuring patients access the care they need. For more information on PCMH, visit **http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx**.

Health center services must be accessible to the target population (logistically and financially), comprehensive, and coordinated with social services. Also the health center remains accountable to the community it serves by involving community members and health center patients in program planning and corporate governance.

Whom Do Health Centers Serve?

The most common understanding of health centers is that they serve everyone, regardless of ability to pay. This is true, generally speaking. There are some groups of people, though, that health centers must serve.

Medically Underserved Area/Medically Underserved Population

Each health center, though, must serve at least one Medically Underserved Area (MUA) or Medically Underserved Population (MUP). These are federal designations. Later in this guide there will be information about how to apply for such designation, but a background on MUA/MUP is relevant now.

For MUA, there are four criteria:

1. Low primary care physician to population ratio
2. High infant mortality rate
3. High percentage of population living below the federal poverty level
4. High percentage of population aged 65 and over.

MUP requirements are similar, but focus on a subset of people within a geographic area, for instance low-income individuals. This designation option recognizes that some groups may experience exceptional difficulty accessing health care or have extraordinary health status challenges, even though the geographic community cannot meet the MUA requirement.

It is important to note that the health center must serve individuals who live in an MUA or are part of an MUP, but the center itself need not be physically located in the MUA. Moreover, this is an organizational requirement, not a site-based one: only one site of a multi-site health center must serve an MUA/MUP.

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4   As of the end of 2014, 69% of all health center sites were PCMH recognized.

Each state has a Primary Care Office (PCO) that assists with MUA/MUP designation, and state PCAs, and HRSA/BPHC also can provide assistance. Your target community or population may already have a designation. Current designation, and updates on designation criteria can be seen at **http://www.hrsa.gov/shortage/mua/index.html**. If there is no MUA/MUP designated for the health center to serve, one will need to be applied for, and the state PCA and PCO can assist with that (or even complete the application for you).

Health Professional Shortage Areas

A Health Professional Shortage Area (HPSA) is a federal designation that refers to a documented shortage of health professional resources similar to the MUA/MUP. HPSA designation is used to allocate many resources including health care professionals who receive educational loan forgiveness or repayment or scholarships through the National Health Service Corps (NHSC), in return for working in underserved communities at eligible organizations. [More on the NHSC follows.] While not required for health center status, HPSA designation can be an important factor in determining approval of the health center application because it is a well-regarded indicator of need in a community. HPSAs receive a score based on the intensity of need, which determines priority of assistance when requested. There are currently three basic kinds of HPSAs:

- Primary Care – indicating few primary care clinicians available to population

- Dental – indicating a shortage of primary care dentists

- Mental Health – indicating a lack of psychiatrists, clinical psychologists and clinical social workers

An area is designated as HPSA based on the ratio of clinical service providers to the population of a given geographical area or of a special population (e.g., low-income, Native American, Medicaid-eligible, non-English speaking) within that area, or not reasonably contiguous to that area (i.e., more than 30 minutes travel time away). There are other kinds of HPSAs, as well. For instance, once approved at a health center or look alike, the health center facility is automatically designated a HPSA, though only the lowest priority HPSA score applies; therefore it is often worthwhile to obtain a geographic or population HPSA designation as well. More information on HPSA designation is available at **http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/index.html**. To see if your community is already designated HPSA, visit **http://hpsafind.hrsa.gov**.

Special Populations

Many health centers choose to focus on special populations or certain subsets of the community at large. Three of these populations – migrant or seasonal agricultural workers, persons experiencing homelessness, and residents of public housing – have specific funding streams within Section 330 to support care to them. It can be a good idea to work closely with one of these populations if there is significant need in your community, as these individuals typically experience some of the greatest barriers to access to health care anywhere. There are other underserved populations in communities that can experience barriers – communities of color, the LGBT population, and Asian/Pacific Islanders, to name a few. HRSA/BPHC supports organizations that can provide technical assistance on reaching certain populations. These organizations are specifically charged with assisting communities in delivering care to their target populations, and it is recommended to take advantage of the excellent resources they have available. A list of current cooperative agreement partners and their target populations is available at: **http://bphc.hrsa.gov/qualityimprovement/supportnetworks/ncapca/natlagreement.html**.

Community at Large

The very notion of a community health center is that is serves the community in which it lives. The requirements of health center status also preserve the community focus, by requiring the governance of the organization to reflect the community, as well as be made up of a majority of actual, active patients[5] of the health center. In addition, a new health center will want to serve a broad spectrum of community members with a variety of payment sources (commercial insurance, Medicare, Medicaid, etc.) to ensure a stable and predictable revenue stream.

Health centers also respond to their community by keeping abreast of changing demographics, emerging health trends, and population shifts – and then planning and executing strategies to serve all. Providing care in languages other than English, monitoring disease hotspots (like influenza outbreaks or sexually transmitted infection spikes) and working in conjunction with local social service organizations and the faith community so the health center can be an integral part of a whole community's service offerings – in a way that makes care affordable and accessible.

In order to serve the local community, a health center will want to be sure to understand the local health care insurance market and obtain contracts accordingly.

Notably, health centers must provide care regardless of ability to pay, insurance status, immigration status, or any other reason.

Other Programs that Support Health Centers

Primary Care Associations (PCA) are nonprofit associations representing health centers and other primary care safety net providers at state and regional levels. PCAs provide a wide array of services to their members and to the primary care community. Some services include centralized clinician recruitment support, technical assistance on clinical, management, finance and governance matters, training, conferences, and more. PCAs are actively involved in health policy at the state and national levels as well. PCAs vary in the services they provide. Your state and regional PCA can be found at **http://bphc.hrsa.gov/qualityimprovement/supportnetworks/ncapca/associations.html**.

Primary Care Offices (PCO) are usually part of state government (often housed in the State Health Department). They receive funding through the Bureau of Health Workforce (BHW) to provide planning and other services in support of community based primary care providers. PCOs work in partnership with PCAs in areas including analyzing and prioritizing need for primary care services, submitting requests for MUA, MUP and HPSA designations, helping recruit and retain physicians and other clinicians in the state, and advocating for health centers within the State Government. Find your PCO at **http://bhpr.hrsa.gov/shortage/hpsas/primarycareoffices.html**.

National Association of Community Health Centers (NACHC) is the primary national, nonprofit, professional membership and advocacy organization that represents health centers. NACHC promotes the provision of high quality, comprehensive health care that is accessible, coordinated, culturally and linguistically competent and community directed for all underserved populations. In addition to advocacy on issues that affect the delivery of health care for the medically underserved and uninsured, NACHC:

- Provides education, training and technical assistance to community-based health care providers and patient-majority boards of directors in support of their missions and responsibilities

- Develops and implements programs that stimulate public and private sector investment in the delivery of quality health care

- Provides benefits and services to those centers that participate in NACHC as members, sometimes in conjunction with affiliated PCAs

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5   Parents or guardians of bona fide patients also qualify as patients for governance purposes.

- Operates the Health Center Growth and Development program, that provides additional, targeted training and assistance to newly forming, newly funded, and expanding health centers

NACHC offers many no-cost resources to communities interested in developing health centers, including sample documentation, information bulletins, issue briefs and monographs. They can be found at **http://www.nachc.com/hc-growth-development.cfm**.

Strategic Considerations Before Deciding to Proceed

Before deciding to begin the effort to establish a health center, understand the federal requirements associated with the status. They relate to health center governance, quality of care, services provided, and management and finance systems. The Program Requirements can be found at **http://bphc.hrsa.gov/programrequirements/index.html**. There are also other documents available at that website that explain the requirements.

One of the major defining characteristics of health centers is its governance. Under Program Requirements, the board must be representative of the community (in areas such as race, ethnicity, socioeconomic status, etc.) and a minimum of 51% of board members must be regular patients of health center services (i.e., use the health center as their regular source of health care[6]). More on governance is discussed later in this document.

Some other specific requirements that must be met include:

- Be a public or private non-profit organization[7]

- Serve an MUA or MUP

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

- Have a board-approved Sliding Fee Discount Policy and associated procedures based only on a patient's family size and income, that provides for discounts for people at or below 200% of the federal poverty level

- Provide comprehensive, culturally competent health care (directly or by contract), and ensure that patients can access care regardless of ability to pay, including:

  o Primary medical care

  o Diagnostic laboratory and radiology services

  o Preventive services, including prenatal and perinatal care, cancer and other disease screening, well child services, immunizations, screening for elevated lead levels, communicable disease and cholesterol

  o Eye, ear and dental screening for children

  o Voluntary family planning services

  o Preventive dental care

  o Emergency medical services

  o Appropriate pharmaceutical services

  o Referrals to other providers, including substance abuse and mental health services

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6   Waivers of certain aspects of governance requirements may be requested for special population funded health centers, including Migrant Health Centers, Health Care for the Homeless and Public Housing Primary Care centers. Note that if the health center receives any funding under the general health center statute (Section 330(e)), no waiver may be applied for.

7   Public entities must demonstrate through specific documentation that they meet the qualifications under the health center program. In addition, they must meet the governance requirements either directly or through a co-applicant arrangement. More information can be found at **http://www.bphc.hrsa.gov**.

- o Case management including referral and follow up

- o Determination of eligibility for Federal, State and local support and financial programs for medical, social, housing and other services

- o Enabling services including

  - ▪ Outreach

  - ▪ Transportation

  - ▪ Interpreter services

  - ▪ Health education

Some health centers must provide supplemental services important to their patient population and communities. For example, health centers serving migrant or seasonal agricultural workers should be aware of the Environmental Protection Agency's Worker Protection Standards and pesticide risks, and would normally provide appropriate pesticide exposure screening and treatment, as well as screening and treatment for certain parasitic and infectious diseases as part of focusing on that population.

Programs that serve primarily homeless individuals and are funded under Section 330(h) must provide substance abuse services directly.

Section 2

Establishing Broad Community Support

Community leadership is considering establishing a health center because they believe there is a need for more accessible health care services. We know that the goal of health centers is to improve individual and community health, and that more than any other kind of health care provider, health centers are mindful of their communities' needs and develop and design programs that are responsive to those needs. Planning for a health center should involve significant involvement from members of the community.

Earlier we discussed the support of PCAs in developing health centers. In many cases, they will be able to provide information, guidance and expertise for individual community development activities. NACHC also offers information, technical assistance and training to communities.

Engaging residents in program planning and implementation is key. This section addresses some of these principles.

Defining Community

One of the first critical efforts to undertake is defining what and whom the community comprises. Communities are more than geographies; they are made up of people. Some are defined culturally or ethnically and by differences in values, social institutions and patterns of social interaction. Geographic features that affect travel patterns and access (like rivers and interstate highways) shape communities in ways that do not always coincide with formal geographic or political divisions. For health centers, communities can also be defined by groups that have similar health care needs. No matter the kind of community a health center intends to serve, it still must have a geographic service area.

Service Area

Because of the unique traits of health centers – especially community responsiveness – the health center must propose to serve a geographic (sometimes called a "service") area. There must be at least one MUA or MUP contained within the service area of the health center and targeted by the health center for care. A health center should be available to serve other patients as well. Note that migrant, homeless and public housing programs must be targeted to populations who meet these criteria, and should be physically located so as to be convenient, and the health center should expect to target a significant portion of its resources and efforts to serving them.

The service area should be a rational and logical geographic area for the delivery of services. This can vary based on the population and the nature of the geography. Some programs serving migrant or seasonal agricultural workers, for instance, serve the entire state, while an urban program in a major city may be made up of just a few census tracts, ZIP codes, or even city blocks. In general a service area is defined by:

- Minor civil division
- Census county division
- Census tract (in metropolitan areas)
- A group of the above that constitute a "natural neighborhood"

A service area can also be defined by:

- A lack of transportation (particularly public transportation)
- Geographic barriers, such as a river, mountain range or highway
- Location in relationship to other service providers
- Travel time to other providers
- Cultural, ethnic or linguistic variables

Community Analysis

Understanding the assets and needs of a community is the basis for establishing support for a health center. This is more than just a quantifiable analysis of demographics, health status and care utilization (described later in this document). It is a broader analysis that paints a picture of how the community is structured and where facilitators and barriers to community health care are likely to emerge.

A sample community analysis matrix is in the appendix for use. It will help the community be as inclusive and thorough as possible in identifying sectors of a community, the groups and people that form those sectors, influencers and barriers. Remember that influencers and barriers are not always people – they can be trends that affect a certain sector in a certain way.

Here are some steps for conducting this analysis:

1. Identify the sectors of a community. These can include business, labor, government, faith community, health care, civic organization, educational institutions as well as others. A community may have other constituencies that make it unique – do not forget to include them.
2. List the organizations that make up that sector of the community.
3. Identify the influencers of that sector – the key individuals as well as the key trends.
4. Identify potential barriers.

Remember that in the case of individuals, today's barrier may be tomorrow's cheerleader, so remember to think of them as opportunities rather than brick walls. The table in the appendix will help you organize this information.

Community Participation

Once you have a list of contacts from the analysis, the next step is to start bringing people together to involve them in the effort. Remember one of the great keys to doing community-based work: people like to be asked to participate!

There are three main components to this process: getting the word out, holding public forums, and keeping people involved and motivated to do the work.

1. Getting the word out. Use contacts and people already familiar with the planning of a health center to speak to key individuals across sectors of the community. Decide who is going to speak to whom, and have a process for feedback.

   a. Train those who are going to speak about the health center project on not only the details of the project, but also tips on public speaking, and how to report questions back, especially if the question is a new one.

   b. It's always a good idea to use an approved presentation template – so that the audiences are getting the same message every time no matter who is giving the presentation.

2. Holding public forums. Personal invitations to public meetings are always better than relying on posters or other kinds of communication. Tips for a public forum include:

   a. Be sure the sponsor is a trusted member of the community

   b. Hold the meeting at an accessible and convenient time and location

   c. Invite the media If appropriate

   d. Offer assistance in attending the meeting: transportation, child care, translation, etc.

   e. Document attendance with a sign-in sheet that includes follow up contact information

3. Keeping people involved and motivated. Helping people know their efforts are worthwhile and making a difference is important.

   a. Assign clear and manageable roles and tasks.

   b. Build on success to maintain momentum.

   c. Build a feedback loop into every action or task. People must see that there are outcomes to their efforts.

   d. Use technology to maintain connection and to drive additional interest – platforms like Swarm, Facebook, Twitter and Foursquare[8], as well as traditional telephone, email and text messaging techniques – can be valuable communication tools.

Involving the Health Care Community

The involvement of the health care provider community is very important when starting a health center. Initial reactions to the effort can range from full-throated support to pure hostility – some providers will see the effort as creating competition. Increasingly, hospital systems are building referral networks, purchasing and establishing practices in their communities both to ensure a steady flow of patients for diagnostic and surgical procedures, and to establish systems for referral to prevent readmissions after hospitalization. In any event, the health center, once operational, will need to blend into the fabric of the health care community and complement existing systems of care.

Support from local providers will give a boost to the health center effort in the eyes of the public at large. It will also provide technical assistance to the planning effort. Although the number of non-user health care professionals on the board is limited by federal statute, they can serve on committees and serve as liaisons to other professionals in the community. Contact other health centers, local medical and dental societies, health departments, hospitals and private primary care providers to enlist their help.

Today's rapidly changing health care marketplace means that new health centers must plan for participation in managed care, coordinate care entities (CCE) and accountable care organizations (ACO) immediately. Medicaid systems nationally are increasingly leveraging managed care as a way to lock in state expenditures on Medicaid, and a contract will be required in order to be paid for Medicaid services. Medicare Advantage (MA) plans, which utilize managed care platforms for delivery of Medicare services, also proliferate in some areas. CCEs and ACOs can offer ready-made patient panels as well as opportunities for revenues based on quality health outcomes that can be essential for health center success. What's more, marketplace plans with subsidies under the ACA are usually organized as managed care plans. Pay particular attention to the following:

• How much of the private insurance market is in managed care?

• What marketplace plans (with subsidies) are managed care?

• Is there significant (e.g., >25%) Medicaid managed care?

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8   Mention here is not considered an endorsement of any product.

- What percentage of Medicare beneficiaries are covered in MA plans?

- Which local hospital, laboratory testing companies, and radiology services work with which plans?

- Will the new health center be able to obtain contracts under these plans?

Thinking About Partnerships

Today's reality means that in some areas, the best option for a health center planning effort could be to approach an existing health center to expand into your community. If there are multiple health centers near you, this may mean approaching more than one. All in all this can represent delicate conversations – the planning group will be thinking in terms of owning its own health center, and if a partnership or expansion of an existing health center is the right choice for the community, seeking a partner organization that shares values will be key.

Other potential partners are out there too. County or city health departments, hospitals, free clinics or other provider groups may be the right partner to give a platform to launch a health center effort to help the underserved in the community. Leave no stone unturned when thinking about partners, as the right partner may be the one that did not seem to be so at a first meeting.

Section 3

Needs Assessment and Planning

At this point there may be consensus on a lack of access to primary care in the community or for certain populations in the community. That consensus, while critical, is not enough to plan and implement a health center. Program planning requires an excellent needs assessment. NACHC has a free publication, "Community Needs Assessment and Data-Supported Decision Making: Keys to Building Responsive and Effective Health Centers," that was developed with the support of HRSA/BPHC (**http://www.nachc.com/client/documents/2012%20Data%20Supported%20Decision%20Making.pdf**). That guide gives step-by-step instructions on conducting a needs assessment and as such, this guide will not repeat the steps here. Rather, this guide will discuss some of the broader aspects of needs assessment.

State and Community Planning Efforts

Certain states and communities undertake robust health planning efforts. In the past, NACHC and the state PCAs worked in conjunction to plan for health center development from coast to coast, identifying communities that were ripe for health center development. Many state PCAs have continued the effort and continue to update the process: they would have significant needs assessment data already compiled for a community planning effort, and may also be able to dedicate resources to your effort. These efforts may also link the potential health center with existing operational resources, like statewide information technology networks, that can inform the planning process.

Similarly, some major urban areas also maintain priority lists of communities that need primary care resources. If your area has a large public hospital, for instance, that institution would be well aware of areas that need primary care resources. Indeed, under the ACA, every non-profit hospital is required to complete a community needs assessment, and usually will make those findings available to other community groups. Information on these needs assessments can be found at **http://www.cdc.gov/chinav/index.html**.

Another key tool to leverage in planning efforts is the UDS mapper. UDS, short for Uniform Data Systems, is the report that all health centers must file annually with HRSA/BPHC. One key data point of this report is patient origin data by ZIP code, thatcode that the UDS mapper aggregates into map form. This tool will help you pinpoint the estimated number of individuals below 200% of the federal poverty level, and tie those individuals to existing health centers that serve them. It will also provide information on geographic reach, penetration and growth of Section 330-funded and look alike health centers, so you can have an idea where the residents of your community are seeking care today. Now, the UDS mapper does not capture information of patients seeking care in emergency departments, faith-based (non-funded) facilities, or private physician practices, but is nevertheless an excellent proxy for accessibility of services. Visit **www.udsmapper.org** to register (free of charge) and gain access to the wealth of information at that site.

HRSA maintains a web page for special populations healthcare resources (**http://bphc.hrsa.gov/qualityimprovement/supportnetworks/specialpopulations/**) that also includes links to cooperative agreement-supported groups that can be of service. Also, some groups that represent primarily clinicians have excellent resources available. Some of the key links are summarized below:

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

- Health Outreach Partners: **https://www.outreach-partners.org**

- Migrant Clinicians Network: **http://www.migrantclinician.org**

- Association of Clinicians for the Underserved: **http://clinicians.org**

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

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

- National LGBT Health Education Center: **www.lgbthealtheducation.org**

This listing is not comprehensive, but should give a starting point for research.

Setting Priorities and Planning

After following the data-driven analysis model in "Community Needs Assessment and Data-Supported Decision Making: Keys to Building Responsive and Effective Health Centers," the planning group will be armed with data and information to start a planning process in earnest. This document can be found at **http://www.nachc.com/client/documents/2012%20Data%20Supported%20Decision%20Making.pdf**.

Setting priorities is the first step in planning. In the data planning exercise, the planning group will have estimated unmet need in its proposed service area. But that does not provide the whole picture. It is unlikely that a new health center will be able to address all of the unmet need for primary care in any community, so available resources and programmatic aims will need to be prioritized. The quantitative data is the start, and qualitative feedback from the group about what the health care priorities are will help target resources and interventions. Perceptions about these priorities will likely differ among respondents, but that does not make any perception "wrong." Diversity of opinion among community leaders and planning group members make the process strong. Likely, members of the planning group will need to compromise on their areas of focus to develop a good health center.

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Section 4

Organization Models

Decisions will need to be made about the type of organization (e.g., starting from scratch vs. partnering with an existing health center, working with a public entity on a co-applicant model, etc.) the health center will be. Establishing a new corporate entity, filing with the Internal Revenue Service and state officials, and establishing a board and staff can be major undertakings. Likewise, to convert an existing corporation to a health center will almost certainly require changes to the board and by-laws, and maybe even articles of incorporation. Review with legal counsel to help determine the best path.

Three models will be discussed here, as they represent the most common models for starting new health centers: non-profit models, public entity models, and partnership models. More detailed information is included in the following HRSA/BPHC document: **http://bphc.hrsa.gov/programopportunities/lookalike/pdfs/pin201401.pdf**. Following are some considerations on those models:

Non-profit models

New Organizations – the health center could form a new non-profit organization[9]. As noted, this approach requires forming a corporate entity and filing for tax-exempt status under the US Internal Revenue Code, both of which can be completed with the help of legal counsel.

- A designated 501(c)(3) tax-exempt organization does not pay income tax on net revenue or donations. Donations given to the entity are tax deductible by the donor. These organizations have limitations on lobbying and must have an appropriate tax-exempt purpose (providing health care services to the underserved is one of them).

- A designated 501(c)(4) tax-exempt organization is primarily an education-based organization and can conduct unlimited lobbying. Donations are not tax deductible to the donor.

There are other tax exempt statuses under Section 501 of the Internal Revenue Code, as well, but they are typically not appropriate for operating health centers. While all of these are tax-exempt and meet the definition of non-profit, HRSA/BPHC strongly favors the 501(c)(3) model, and it is important to note that many foundations and other donors will only donate to these organizations. Each state has its own laws related to corporate entity filings, and it is highly recommended to consult with legal counsel and the state's corporate regulatory (usually the Secretary of State) about filing requirements.

Existing Organizations – if there is an existing organization in the community that could serve as the corporate vehicle (or for conversion of a community provider, like a family planning clinic, community action program or free clinic), it can save a lot of effort.

- The organization will need to meet Program Requirements for health centers (especially board of directors composition), which can mean replacing existing board members with user members and limiting the size of the board to between 9 and 25 members[10].

- Revising the mission of the organization may be required. For instance, a free clinic may have in its mission never to accept payment for care, or only to use volunteer clinicians, both of which would need to change.

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9   It is important to note that if Section 330 funding or look alike designation is desired, a for-profit model is not eligible for designation.

10 See the Program Requirements at **http://bphc.hrsa.gov/programrequirements/index.html**.

- There is a chance that existing agreements with other community providers would need to be reexamined, to make sure they comport to the requirements of health centers, especially procurement requirements of 45 CFR Part 75[11].

- Programs or services may need to be modified. For instance, an independent women's health centers providing mostly family planning would need to accept males, children and the elderly, or at the very least make arrangements for their care following appropriate HRSA/BPHC guidelines, which can be stringent.

- Policies and procedures will need to ensure that low-income populations do not experience a financial barrier to access to care.

- Existing organizations must have credibility in the community.

This discussion is not meant to dissuade communities from taking this approach. There are, however, critical steps that must be taken to assure the health center is in compliance with health center Program Requirements.

Public Agency Model

A governmental agency, like a local health department[12], can also seek health center status and funding. These organizations may receive waivers from certain personnel and financial controls, because they are parts of government entities. These operating units of government may be required by statute or ordinance to follow certain personnel and finance requirements, and there are procedures for the operating unit to be a health center and still follow those requirements. In addition, the governance requirements can be difficult to comply with, given that the governmental entity's leadership may be elected or appointed. To accommodate this situation, a public entity that cannot meet the governance requirements may apply under a "co-applicant" model.

There are many special considerations for public agency models that are specific to certain situations. If a public agency model is an option for a community, it is suggested you contact the state PCA or HRSA/BPHC for guidance on how to proceed under these arrangements. Also, NACHC has a free monograph on public centers, available at **http://www.nachc.com/client/documents/2014PublicCentersMonograph.pdf**.

Satellite of Existing Health Center

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 and community. Representatives from the service area and target population will have to be incorporated into the existing health center's Board of Directors.

Partnership Models

When developing an organizational model health centers can, and in fact should, develop partnerships 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 behavioral health care or a local dentist for oral care. An affiliation is an agreement that establishes a relationship between a health center and one or more entities.

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11   45 CFR Part 75 can be reviewed at **http://www.ecfr.gov/cgi-bin/text-idx?node=pt45.1.75&rgn=div5ap45.1.75_1521.ii**. Also, contact your auditor or state PCA for more information on compliance with this regulation.

12   This is by far the most common public entity health center model.

Legal counsel should be consulted when entering into any affiliation agreement. Affiliation agreements should address the following (this list is not exhaustive):

- The parties' affiliation objectives

- Risk to the health center's integrity or autonomy as a health center, especially regarding corporate structure and governance

- The following considerations:

  o Anti-kickback statutes

  o Antitrust regulations

  o Tax-exempt status of the health center

  o Medicaid and Medicare reimbursement issues

  o State law

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Section 5

Physical Space Considerations

The physical plant of a health center is a major consideration. It speaks to the ability of the health center to attract and maintain a patient base and the operational reality of providing primary health care services. Too small a facility will translate into an inability to attract sufficient patient volume to make the health center sustainable; too large a facility may become inefficient and have excess cost that a new health center cannot maintain; the right location is critical to make sure patients can find, access and use the health center facility easily.

Access and Location

The health center must be easy to reach and convenient for the patients the health center wishes to serve. Depending on the target population, it may make sense to locate near where people live, where they work, or where they access social networks, like churches, community centers, and the like. Usually, a major street, located among other businesses that serve the population, is a good idea. Public transportation access and parking are major considerations. A beautiful facility that is several blocks away from public transit routes or that has no available parking is not a good idea. The planning process will reveal the right location for the population.

Space or Building Considerations

When looking for space, plan for growth as successful start up operations may outgrow their space quickly. A health center may need to plan for expansion of:

- Provider offices, exam and treatment rooms, dental suites, and private spaces for behavioral health counseling

- Areas devoted to other health services, like reception, patient waiting and counseling, social work, laboratory and x-ray services, and pharmacy

- Administrative and clinical and information systems functions

Because each new health center will have its own circumstances related to physical space (including cost and availability), there is no one standard approach that all new health centers should adopt. Most health centers do plan for the following:

- Two to three exam rooms per medical provider (physician, nurse practitioner, physician assistant, nurse midwife). This allows for sufficient patient flow. Being on the ground floor (or in a building with adequate, and redundant, elevator service) is usually a good idea for those with mobility challenges.

- Two to three dental suites for each dental care team (which may consist of a dentist, dental hygienist, and/or dental assistant)

- One private space for each behavioral health provider, and a room for group sessions (if this is in your plan)

- A large meeting room to accommodate meetings of the board of directors, committees, and management. Some health centers make their spaces available to community groups as well.

It may make long-term sense to secure professional assistance from functional space planners to identify space and equipment required by health center operations and local licensing (if applicable). Space planners help both ensure adequate space is available, and prevent overbuilding.

One resource to help with space considerations is Capital Link (**www.caplink.org**), which is funded by HRSA/BPHC to help health centers in accessing capital financing for buildings and equipment. They can also provide extensive technical assistance with financial and market analyses, business plans and proposal development for capital projects, space design and project planning, debt financing and fundraising. Many of their services are free of charge to health centers.

Section 6

Developing Community Governance

When asked "what makes a health center a health center," the most common response includes the 51% patient-majority board of directors. This feature of health centers has withstood the test of time as the single feature of organizations that makes them stand out from other community based providers.

It is time and labor intensive to develop the right community governance, but worth it in the long run. This section will review highlights of governance requirements for health centers, roles and responsibilities of the board, organization of the work of a board, and legal issues that a community should consider – and review with competent legal counsel as the effort is underway.

Governance Requirements

Health Center Program Requirements, referenced extensively earlier in this document, spell out the standards health centers must meet. Again for reference, these Requirements are available at **http://bphc.hrsa.gov/ programrequirements/index.html**. Organizations that serve exclusively migrant or seasonal agricultural workers, persons experiencing homelessness and public housing residents may be able to apply for a waiver of the patient majority governance requirement, but that waiver may not supplant the intent that patients of the health center's services guide and direct the care that is offered. Health centers integrate into the communities they serve and processes to monitor the needs of a community must be woven into any request for waiver from governance requirements. HRSA/BPHC will look for an alternative mechanism for patient input in any waiver application. It is important to note here again that any organization applying for funding under Section 330(e) (community health center – not focused on a special population) is ineligible for the patient majority governance waiver.

The board of a health center is the ultimate authority and cannot be 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 board. In addition, the executive director or CEO of the health center must be directly employed by the board.

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. Federal Regulations specific to health centers require that boards have between nine (9) and twenty-five (25) members who are representative of the population served. The size should relate to the complexity of the organization and the diversity of the community served. It is encouraged that the by-laws stipulate a range of members so that additions and deletions do not require by-law changes, and be sure to compare the desired range with any state law applicable to board membership ranges. 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[13]:

A majority (at least 51%) of the board members must be individuals who use the health center as their regular source of health care. BPHC/HRSA, in PIN 2014-01, defines "patient" as "a current registered patient of the health center and must have accessed the health center in the past 24 months to receive at least one or more in-scope service(s) that generated a health center visit." "Visit" is further defined to be "documented, face-to-face contacts between a patient and a provider who exercises independent professional judgment in the provision of services to

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13   Governance requirements do not apply to an Indian Tribe or tribal or Indian organization.

the patient." Usually these members live or work within the health center's service area[14]. Many health centers have greater majorities of patient members - 80% or more is not uncommon – and there is no prohibition on all board members being patients, no matter their profession, socioeconomic status, or any other factor. They should also be representative of the patient population in terms of demographics. This is not a quota system, but all major groups served by the health center should have governance representation.

No more than one half of the nonpatient board members may be individuals who derive more than 10% 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 patient trumps everything - if someone is a patient it does not matter how he or she earns a living, they count as a patient member.

For example, if the board is made up of 13 members, at least seven must be patients. That leaves six non-patients, so no more than three can earn more than 10% of their annual income from the health care industry.

The remaining members should be broadly representative of the community served, and should be experts in community affairs, local government, finance, legal affairs, marketing or public relations, or other areas of expertise relevant to the health center.

It is important to note that no board member may be an employee of the health center[15] or the spouse, child, parent, brother or sister of a health center employee by blood, marriage, or adoption. By including marriage, this includes in-laws, and extends to same- and opposite-sex marriages.

Roles and Responsibilities of the Board

The Board of Directors (or Governing Board) is the principal policymaking 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 policymaking body, the Board of Directors (board) must distinguish its policymaking 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 daytoday 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.

There are seven primary areas in which a board has responsibilities:

1. Finance. The board sets policy for financial management practices including a system to ensure accountability for center assets and resources, approves the annual budget, selects the independent auditor (and accepts the audit), approves payment and eligibility for services including the Sliding Fee Discount Program for individuals with incomes below 200% of the federal poverty level, the fee schedule, and other items.

2. Legal. The board ensures that the health center is operated in compliance with applicable federal, state and local laws and regulations. The board protects the corporation from unnecessary liability and ensures compliance in accordance with the priority areas of the Office of Inspector General of the Department of Health and Human Services. The board also approves the annual Section 330 application or look alike status renewal. For information on the Office of Inspector General, visit **https://oig.hhs.gov**.

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14 A parent, foster parent, court appointed guardian or caretaker or legal sponsor of a legal Immigrant who is a patient qualifies as a patient member.

15 The executive director or CEO may be considered an ex-officio member of the board, though does not count in determining patient majority or in meeting any other requirement of governance.

3. Human Resources. The board establishes personnel policies including selecting, hiring and periodic evaluation of the CEO[16], compensation including wage and benefit schedules, continuing education, employee grievance policies, equal employment opportunity practices and Department of Labor requirements (Federal and State), as well as any local hiring requirements. The board's responsibility is to establish policy, not to engage in implementing these policies.

4. Operations. The board adopts operational policies including scope and availability of services, locations, hours of operation, and quality of care standards, improvements and outcomes.

5. Evaluation. The board evaluates health center activities including the quality of care, provider productivity, patient satisfaction and achievement of project objectives.

6. Planning. The board engages in strategic planning regularly, and receives reports on health center progress. The board also approves the health center's purpose, mission, vision and values.

7. Resource Development. The board is responsible for fundraising and approving programmatic improvements through grants from federal, state, foundation and other sources. This includes approval of an initial application to BPHC/HRSA, and all subsequent applications.

The goal of this involvement is to make sure the board of directors is active and abreast of developments and challenges the organization is facing, and is prepared to make policy recommendations to ensure the mission of the organization – providing health care services to target populations – is achieved.

Organization of the Board's Work

A health center board has a lot of work to do! Most health centers find it valuable to organize themselves into certain committees, so that a subset of board members becomes intimately familiar with certain areas of operation, sharing their in-depth review with the full board. These committees may be standing committees – they are always constituted, and have specific areas of focus identified in the by-laws, or can be ad hoc committees, charged with undertaking a specific, time-limited task (like bi-annual strategic planning). A health center may also have advisory committees, composed of other community members, or non-governing board member patients, to provide additional insight into health center operations. Some common committees, and their typical purviews, are highlighted in the appendix.

Legal Issues

One of the major responsibilities, briefly mentioned above, is compliance. Corporate compliance starts with the adoption of a resolution establishing a formal Corporate Compliance Program. It demonstrates the board's approval of a program's framework and recognizes that board members have specific obligations in dedicating resources to assure compliance. Regularly, the board must monitor the implementation and operation of the compliance program to ensure its effectiveness.

Health centers fall under the Office of Inspector General's framework for Individual and Small Group Physician Practices. A link to the Federal Register notice relating to Small Group Physician Practice is available at **http://oig. hhs.gov/authorities/docs/physician.pdf**.

Nonprofit organizations usually can indemnify their board members against losses incurred as a result of service as a board member. This means that the organization will bear any cost associated with defending a legal action against a board member, including judgment or settlement. The circumstances in which a board member can be indemnified are a matter of state law and are usually specified in the by-laws. Legal counsel should be consulted on this matter.

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16 CEO or Executive Director are the most common titles for the staff head of the organization. Where CEO is used, it is understood that it can stand for Executive Director or similar title as designated as the chief staff officer.

Business Planning

The health center planning group has considered community, service area, target population, locations and matters of organizational governance. Now it turns to business planning, to determine the viability of a health center organization. This business plan will be the critical tool in determining a health center's future. To make a business plan, it is necessary to translate services into volume, revenues and expenses, and plan for financial viability. This section will review an overview of business planning, and a number of helpful tables and tools are in the appendix.

Note that business planning is more than just making a budget. This kind of planning, which projects volumes and utilization, as well as forecasts revenues and costs, is really a must for any organization considering health center development. Much of the information needed for the business plan was obtained during the needs assessment phase, though it may need to be supplemented at this point.

Market Share

Perhaps the most important estimate that will be made during business planning is just how many people will seek services at the center. During the planning phase it can be easy to assume a "build it and they will come" mentality – but does the planning group really understand the competitive environment in which it plans to operate? A potential health center would undertake primary market research – surveying people and organizations within the target service area (and population) to ensure the validity of key assumptions that influence later components of the plan. The potential volumes will drive financial projections that will determine whether the health center is a viable entity.

This research seeks information about the location, range of services, charges and best communication methods to drive utilization of the health center. It is also important to understand how this potential health center can distinguish itself from the competition – what would cause a potential patient to disrupt her existing provider relationship and choose this center? This is an inexact science, but err on the side of conservatism – if it seems that 10,000 people will choose to use the health center, work from an assumption that 5,000 or 6,000 actually will do so.

This estimate becomes the health center's "market share." Tools for calculating market share are in the business planning section of the appendix.

Business Strategy

Once the potential market share is understood, the business planner turns next to how those individual will be served. This is where the planning group documents how the health center will differentiate itself from its competition. This differentiation discussion should be completed before a physical location is chosen – because often times, location is the single most important differentiator possible.

This is also where qualitative research comes into play. In learning about the community's needs and wants in a health care provider, the planning group possibly heard commentary about availability during non-traditional hours, care in other languages, and other kinds of suggestions. This is where the planning group would cement their decisions about what kind of health center the organization will be at least initially. Remember that it will be the responsibility of the board to understand changes in the community, so that in the future, these assumptions may change. That kind of change is good – it is a sign that the health center organization is healthy and truly responsive to the community it serves.

Collaborations should also be determined during this phase. Deciding to collaborate for certain services – like dental care, for instance – will have a major impact on the rest of the planning process. Take care in determining that a service will only be available by collaboration, however. In the case of a required service[17], loss of a collaborator can make compliance with minimum expectations for health centers very difficult.

Management and Organization of the Health Center

During the business planning phase of health center development, it will be time to make some decisions about who is going to govern the health center, who will operate the health center, and the need for external assistance or support for getting started. While all the decisions may not be ready to be made, knowing what decisions will be on the horizon will be helpful for the health center's first board of directors.

1. Members of the board of directors. These should be identified by name, with care taken to make sure that the patient majority requirement as well as other board requirements will be met. It may also be helpful to determine who will serve in positions of board leadership at the outset.

2. The proposed management team. Who will serve as the CEO, or will a search need to be conducted? A chief medical officer and chief financial officer should also be identified, as both will be required immediately in order to get operations going quickly. If these individuals are unknown, the planning group should craft job descriptions, or at a minimum, a statement of desired characteristics to guide selection. This is also an opportunity to propose an organizational structure for inside the health center, including an organizational chart.

3. Need for outside assistance. It is common for a newly formed health center to need consulting services to help get started, or even to help design parts of the program for approval. It is not uncommon for health centers to expend 2% or more of their initial funding on external consultants to help create policies and procedures, think through operational plans, or just to complete start up tasks that the staff does not have time to do.

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17 Refer to Program Requirements to understand required services.

Section 8
Planning to meet health care standards

A newly forming health center will want to start out planning to provide high quality care. The planning process is the right time to start considering standards of care that the health center will meet. Fortunately there are many sources to help with this planning. One of the best resources a planning group will have is a clinical leader who is well versed in evidence-based medicine. This individual will be able to help interpret health care standards to the planning group in a way that makes them easy to adopt and implement.

Health centers focus on primary health care services and outcomes. That means focusing on periodic physician care, chronic disease care, and wellness care. These are reflected in the listings of required services available in Program Requirements, and can always be expanded upon with approval.

The Primary Care Medical Home (PCMH) standards were referenced earlier in this guide, and form an excellent basis for the kinds of care a health center will provide. Included in these standards are recommendations for care coordination, regular reminders and follow up plans for patients, and ideas for how to ensure patients receive all the care they need.

In addition to the Program Requirements and PCMH standards, the following are some guidelines a new health center may wish to consider in planning its care:

- Medicaid Health Plan Employer Data and Information Set (HEDIS). These are a standardized set of measures to assess the performance of Medicaid managed care plans (and are often also used by commercial plans). They were developed by the National Committee for Quality Assurance, and can be found under **www.ncqa.org**.

- Quality Family Planning (QFP) Guidelines. The Centers for Disease Control and Prevention (CDC) issued new guidelines for family planning – for both women and men – in 2014. They can be accessed at **http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm**.

- Standards relating to ambulatory health care operations are available from the Joint Commission (**http://www.jointcommission.org/accreditation/ambulatory_healthcare.aspx**) and from the Accreditation Association for Ambulatory Health Care (AAAHC) (**http://www.aaahc.org**).

- Prenatal care standards are available from **http://womenshealth.gov/pregnancy/you-are-pregnant/prenatal-care-tests.html**.

- Pediatric care standards, following the American Academy of Pediatrics Bright Futures model (which is mentioned in the ACA) are available at **https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/Pages/default.aspx**.

This list is not exhaustive, but will provide a starting point for some of the most common health care standards a new health center will want to follow.

Section 9
Human Resources

Earlier in this document the specific role of the board of directors as related to human resources was discussed. That role is but the beginning of the human resources function of a health center. This leadership structure – with a board having distinct responsibilities in the human resources area – is one of the areas that sets health centers apart from other organizations. Usually human resources, aside from selecting a CEO, is completely delegated to management.

Every health center will likely have a CEO, a chief clinical officer, and a finance officer. As health centers grow, they may have chief operations officers, human resources directors, a chief information officer, a head of quality improvement, and other leaders. Under Program Requirements only the CEO reports to the board, but the board is still intimately involved in planning the staffing model of the center. In this section, some issues related to human resources are considered.

Staffing Needs and Clinician Recruitment and Retention

Each health center will have its own staffing needs. While every health center will need licensed independent practitioners[18] in order to provide patient care, the rest of the staffing model of the health center will be up to the project plan the health center creates. The types of practitioners that a new health center plans to employ will depend on the quantity and specific service needs of the population to serve.

In any event, the new health center should plan for appropriate clinical support staff (nurses, medical assistants, registration/check in, referral processing staff, dental assistants, behavioral health intake clerks, clinic secretary, health educators, to name a few) in order to deliver the care the community wants and needs.

Recruiting and retaining clinicians is as much art as science. The first step is understanding where help is available. One of the best sources for clinical recruitment and retention for a health center is the National Health Service Corps (NHSC). NHSC can be a significant help in recruiting providers and offering assistance in placing primary, dental, and mental health clinicians and repaying professional education loans. There are stringent eligibility rules for both providers and health center. It is recommended that health centers interested in NHSC recruitment contact the Corps (**www.nhsc.hrsa.gov**) as well as their state PCA.

The PCA can help with more than just connection to the NHSC. Many state PCAs maintain databases of vacancies in their states, and can help health centers create recruitment plans.

Another area not to overlook for clinician recruitment is the local hospital community and medical schools and residency programs, dental schools and schools of psychology. Hospitals may be seeking outpatient practice opportunities for clinicians they wish to recruit to the community, and training programs are always looking for rotation sites or shadowing locations for students, residents and interns. If there is a medical or dental residency program in your area, linking with that program right away can help the health center form a long-term pipeline for candidates. One innovative program, the nation's first residency program for nurse practitioners, is being run in a community health center. It can be found at npresidency.com.

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18 Licensed independent practitioners (physicians – both MD and DO, Advance Practice Nurses, Dentists, Clinical Psychologists, and sometimes Physician Assistants, Dental Hygienists and Clinical Social Workers, depending on the state) are individuals who because of their licensure may exercise independent clinical judgment and provide health care services without supervision.

In addition, many National Cooperative Agreement partners (some mentioned earlier in this document with links to their sites) assist in clinician recruitment. The main page for these partners can be found at **http://bphc.hrsa.gov/qualityimprovement/supportnetworks/ncapca/natlagreement.html**.

Staffing Ramp Up

Another area that health centers need to consider is the ramp up, or phase in period. Looking at the business plan, the health center will undoubtedly have a period of time over the first few years of operation that patient volumes are growing. The health center should have a ramp up plan that takes this growth into account. Do not overcommit the resources of the health center by staffing for full production at day one.

Recruitment of provider staff is a key area that a planning group should consider. Will the health center be located in an area that is easy to attract providers to? Or will recruitment and retention be an ongoing challenge? In the ramp up plan, the health center should think about employing a slight excess of provider staff if recruitment is expected to be challenging. The clinician recruitment cycle flows on the academic cycle in many cases, so expect that clinicians thinking about a career shift, or seeking a position directly from training will start their searches around September or October, with an expectation of executing contracts around April or May, and then starting a position in July or August.

Adequate provider staffing is a key area of focus for new health centers (and for existing centers). Some health center experts recommend staffing for about 115% of expected productivity, and setting the expectation that additional provider and provider support staffing will come on board when the health center is consistently outperforming volume expectations by 10% (i.e., every week for six weeks).

Creating a Competitive Staffing Environment

For clinicians, as well as for all positions in the health center, offering a competitive employment package is no longer a luxury. It is essential in the marketplace if the new center wishes to attract and retain a high caliber workforce. Here are some tips for recruitment and retention of the entire staff of the health center:

- Market competitive wage/salary. The successful health center will study local prevailing rates and propose to the board of directors a salary band that allows recruitment of the best candidates[19]. In the past some have maintained that health centers cannot and should not attempt to meet prevailing rates, but in today's competitive environment, this is no longer a viable strategy.

- Market the health center. A newly forming health center can offer lots of advantages to staff members. The opportunity to be in "on the ground floor" of setting up the practices and growing along with the patient population can be most satisfying. Developing standardized scripts and recruitment materials can help a whole team of health center supporters be recruitment advocates.

- Act fast when identifying a candidate for a position. Assuming the health center can afford the addition and the position is necessary for the operation and growth of the enterprise, no not hesitate. In a world of instant communication, the organization that contacts a candidate first, consistently and effectively will win the candidate.

- Fit is everything. Candidates must share the values of the organization, and have a commitment to serving the underserved. It is far preferable to have a vacancy in a position than it is to have a poor hire. Plus the rest of the team will appreciate the commitment to the mission. One way to do so is to have teams of health center staff interview potential candidates, so they can get a sense of what it would mean to work with them each day.

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19 Remember, the board of directors must approve salary bands, but the CEO (or designate) determines the actual rate within the band.

- If the health center is deemed under the FTCA, any clinicians (and nurses and other licensed personnel) will need to meet the requirements of FTCA, including licensure and education verification and checking the practitioner's history of adverse action. The latter can be seen at the National Practitioner Data Bank, at **http://www.npdb.hrsa.gov**.

- All employees and contractors of the health center must be checked against the OIG's exclusions list. Any health care entity that receives reimbursement under Medicare and Medicaid must ensure they are not employing or contracting with anyone on the exclusions database, or risk heavy sanction. Indeed this verification occurs not only at the point of hire or contract, but must be reviewed periodically as well. Some organizations review the database monthly. The database is available at **http://exclusions.oig.hhs.gov**.

Retention is a major factor for health centers as well, not only for clinicians but for all staff. Health centers must consider carefully their competitive environment. Note that salary level is but one factor – though the lower the wage or salary, the bigger a factor it is. Benefits, retirement savings vehicles and staff bonus programs, tied to performance, as well as a voice in the workplace are all key factors that can help good employees stay.

Section 10

Information Technology

A health center's information technology system (IT) serves many purposes – from patient appointment scheduling and billing to ongoing needs assessments and quality improvement and performance improvement. IT systems are increasingly complex, and there are several systems that are specialized for health center operations.

IT systems are generally categorized into two areas: operations functions and management functions:

- Operations functions are those aspects of data and information processing that allow health center staff to work efficiently every day. This includes patient registration and scheduling, visit documentation, billing systems, and telephone systems[20].

- Management functions include reporting of data and outcomes that allow the health center leadership (board and staff) to evaluate the health center's activities and make any changes necessary. Patient utilization information, health status outcomes on an aggregated basis and provider productivity are examples of management functions.

Electronic Health Records

Data warehouses and centralized software sharing systems (sometimes known as an ASP model – ASP standing for "application service provider") are becoming the norm. HRSA/BPHC supports Health Center Controlled Networks (HCCN), many of which offer shared IT system support. Information on HCCNs can be found at **http://www.hrsa.gov/healthit/networkguide/**. An HCCN serving your area may be able to help plan for IT development.

It likely goes without saying that a newly forming health center should plan to launch an electronic health record (EHR) from the very beginning. Avoiding a conversion to electronic systems later will save a major organizational transformation. What's more, in planning for space needs, starting out with an electronic health record means not building space for traditional paper medical records, and means dedicating adequate resources to computer equipment, cabling, wireless capacity, and low voltage service throughout the health center.

When selecting an IT system for the new health center, make sure the system can provide all the required data elements that a health center needs. Chief among these is the UDS Report – Uniform Data System – that all health centers file annually with HRSA/BPHC. It is recommended when considering an IT system that a health center interview many customers about their experiences with the system, and specifically ask about UDS preparation. If the IT system is not configured properly, completing this voluminous report will be a herculean effort.

Remember as well to consider future scalability of an IT system. The small physician practice system that is very simple for providers to use may not be able to keep pace with planned growth in the health center, nor produce the detailed reports required under PCMH, UDS and other funder programs.

For tips on selecting an IT system, contact the PCA, NACHC, and visit **www.healthit.gov**, specifically the page dedicated to selecting the right IT vendor, **http://www.healthit.gov/providers-professionals/faqs/how-do-i-select-vendor**.

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20 Modern telephone systems are in effect Information Technology systems, as all but the most basic systems operate on a VOIP (Voice Over Internet Protocol) basis, and can provide detailed reports on call volume, time, routing, etc.

Other IT Systems in the Health Center

There's more to IT systems than EHRs and telephone systems, of course. A health center will need standard office processing suites (word processing, spreadsheet and perhaps statistical modeling programs), finance systems and perhaps HR systems. This document will not consider standard office suites, but will touch on finance systems and HR IT systems.

Finance Systems

A new health center will need to establish good financial controls, and one of the ways this is accomplished is through the general ledger and accounting system. It is recommended that a new health center contact other health center chief financial officers for advice on selecting a finance system that works, all the while considering integration with the EHR system for patient accounting.

A financial system will need to have accounting, treasury and inventory control functions, and be able to be adjustable in terms of the chart of accounts.

HR Systems

A robust HR system may be an excellent investment for a new health center. These systems can help with time-keeping, salary history, tracking of benefit time, and eligibility to work in the United States. Some payroll vendors offer ASP model HR systems that can be easily configured and come at low cost, compared with implementing a full-scale system.

Section 11

Conclusions

This guide and its appendices offer advice and some potential ways a health center planning group can move forward. As stated in the beginning – there is no one right way to complete this task. Every community is different, and every person has different priorities. The goal in a health center planning process is to design a community-based health care intervention that will address the needs of the population. A well-functioning planning group will succeed in this effort.

We leave you with final advice: do not be afraid to ask for help. More than 1,300 health center organizations around the country have done what you are doing, and the family of health centers stands ready to assist. This guide has pointed planning groups toward many written documents, and has repeatedly referred planning groups to the state or regional PCA. Please do not hesitate to reach out to them.

Some final sources for assistance. HRSA/BPHC maintains many sources of technical assistance for health centers and organizations that wish to become health centers. The May 2015 technical assistance guide for newly funded health centers can be particularly helpful, and is available at **http://bphc.hrsa.gov/qualityimprovement/newguide.html**. In addition, a search for technical assistance on the main BPHC/HRSA website will also return relevant results, with frequent updates. The main BPHC/HRSA web page is at http://bphc.hrsa.gov.

Congratulations on the effort to become a health center, and we look forward to welcoming you to the family of health centers around the country.