

Building Access to Community Health Services



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BUILDING ACCESS TO COMMUNITY HEALTH SERVICES

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As a community, if you have noticed problems in access to care and the availability of health services for specific populations within your community, you are probably wondering how to make changes. Just as building a house involves envisioning the design, surveying the project site, exploring financing options, hiring architects, and developing a blueprint, building access to community health services involves a similar process.

This toolkit will provide you with resources to get started on your project of building access to health care. Once you have identified the needs of your community, it will help you take the initial steps toward deciding how you can best meet those needs.

Section 1: Surveying The Project Site





THE COMMUNITY AND THE TARGET POPULATION YOU WILL SERVE

Whom will you serve? Why? The answers to these questions will drive the design of your program.

Federally funded health centers serve underserved populations. Populations may be underserved because they have barriers to care such as:

- Financial barriers to accessing care
- Cultural and/or linguistic barriers
- A lack of, or insufficient number of, health professionals or resources in the community
- Health disparities
- Homelessness
- Migratory or seasonal employment patterns
- Residence in public housing
- Lack of transportation
- School children lacking access to care



SERVICE AREA BOUNDARIES AND CHARACTERISTICS:

WHAT IS A SERVICE AREA?

A service area is a geographic area with precise boundaries. Service areas can be defined as whole counties, census tracts, political subdivisions, school districts or health and social service programs. You should describe the service area's location in the state, its geographic boundaries and size. Is the area rural or urban? Include the topography and climate in terms of how they impact access to health care.

CHARACTERISTICS OF THE SERVICE AREA:

In addition to the geographic definition of the service area, federal grants will ask you to describe the service area and the population in terms of:

- The target population: general community members, migrant/seasonal agricultural workers, residents of public housing, homeless persons, and/or low-income school children
- Unserved and underserved populations in the community
- Demographic data: population trends by age, race, ethnicity, gender, language, and income. Note culturally specific characteristics that impact access to and delivery of services
- Relevant geographic barriers to care
- Economic trends: unemployment rate, largest employers, changes in local industry

continued



CHARACTERISTICS OF THE SERVICE AREA (CONTINUED):

- Health insurance and managed care trends: Medicaid managed care enrollment, HMO enrollment, health insurance coverage
- Special health care needs of the target population(s): birth rates, mortality rates, leading causes of death, rate of chronic diseases such as AIDS, asthma, and diabetes.
- Federally-designated Health Professional Shortage Areas and Medically Underserved Areas and Populations

SURVEYING THE HEALTH STATUS OF THE COMMUNITY: NEEDS ASSESSMENT

You have defined your target population and its service boundaries, but what are its health needs? Does it lack access to health care? In what ways, and for whom? What evidence has led you to conclude that the community will support your project? In order to develop services that will meet the needs of your population, it is important that you conduct a needs assessment.

There are three general areas you should investigate:

1. The **demographics** of the target population
2. **Health status** indicators of the target population
3. The **access to care** currently available and areas of need.



Demographics: Sources include the U.S. census and state vital statistics

- Population trends by:
 - Age
 - Gender
 - Race
 - Ethnicity
 - Language
 - Income: What proportion of your target population is:
 - ▶ Below 100% of the Federal Poverty Level (FPL)
 - ▶ 100-149% of FPL
 - ▶ 150-200% of FPL
 - ▶ Over 200%
- What is the size of the population? Is it increasing? Decreasing?
- Are there special populations such as homeless, migrant workers, at-risk children?

Health Status indicators: Sources include state departments of public health and vital statistics, local health departments, cancer registries, and foundations (e.g., Diabetes Association):

- Birth rates, mortality rates
- Infant mortality rates
- Rates of low birth weight
- Entry into prenatal care
- Leading causes of death
- Rate of chronic diseases such as AIDS, asthma, and diabetes.



Access to Care: Sources of information include the state Medicaid agency, state and local government surveys, medical and nursing licensing boards, the state primary care association (PCA) and the state primary care office (PCO). Both the PCA and the PCO are organizations funded by the Bureau of Primary Health Care to support community health centers. The PCA is a private non-profit organization and derives a portion of its revenue from membership dues. PCAs tend to focus on advocacy for the safety net, technical assistance, community development, and networking (sponsoring conferences and list serves). PCOs, on the other hand, are state government agencies. Their focus tends to be more on data collection and designation of provider shortage areas.

- What environmental forces are at work in your market? Consider such issues as changes in Medicaid funding, changes in the local health care delivery system
- Economic trends in the community: unemployment rate, largest employers, changes in local industry
- Health insurance coverage and managed care trends
- Health professional shortages and availability of medical, mental health and dental providers, including those who will serve the target population

Section 2: Financial and Organizational Options





Now that a service area and the underserved population in your community (target population) have been identified, two questions have to be answered: who will do this (what organization) and how will it be funded.

FUNDING CONSIDERATIONS

Providing health care services to an underserved population is a major undertaking. Decisions will have to be made about the type of organization that is willing and appropriate to take on the challenge. A new health center can start from scratch or partner with an existing organization. The type of funding or certification program that fits best with your community may help determine which organizational option is most feasible.

There are two federal programs that can help develop access to health care in your community: federally qualified health center (FQHC) and rural health clinic (RHC). Each program has requirements about the type of area in which it is located.



FEDERAL HEALTH PROFESSIONAL SHORTAGE AREAS

A Federal Health Professional Shortage Area designation is needed if you want to obtain FQHC or RHC status (see below for definitions of FQHC and RHC). This designation is used to identify geographic areas or population groups with a shortage of primary health care services. Shortage area designations establish eligibility for more than 30 federal programs and are used to target millions of dollars in federal resources to improve access to health care in underserved areas.

There are two types of federal shortage area designations: Health Professional Shortage Area (HPSA) and Medically Underserved Area/Medically Underserved Population (MUA/MUP).



HEALTH PROFESSIONAL SHORTAGE AREAS (HPSA)

The HPSA designation system was initially intended to help establish eligibility for National Health Service Corps recruitment assistance. Several other federal programs now use it. HPSA designation can be determined for primary medical care, mental health, and dental services needs.

HPSA DESIGNATION COMPONENTS

Rational service area (whole county, multiple counties, sub-counties)

Population to provider ratio

Contiguous areas have services that are excessively distant, over-utilized, or inaccessible to the specific service area population.

DISCIPLINES

Primary health care

Dental health care

Mental health care

TYPES OF DESIGNATIONS

Geographic area

Population group (e.g., low income, migrant farm worker, homeless, Medicaid-eligible, language barriers)

Facility (e.g., FQHC, correctional institute)



MEDICALLY UNDERSERVED AREAS (MUA) AND MEDICALLY UNDERSERVED POPULATIONS (MUP)

The MUA/MUP system was developed to identify areas where Community and Migrant Health Centers should be located. It measures the degree of underservice in an area (MUA) or population (MUP). An area is designated as an MUA/MUP based on whether an area exceeds a score for an Index of Medical Underservice (IMU). The IMU is an index value based on:

- 1) Percent of population at 100% of the federal poverty level
- 2) Percent population at or over 65 years of age
- 3) Infant mortality rate
- 4) Providers per 1,000 population

WHICH DESIGNATION IS MOST APPROPRIATE FOR AN AREA?

Which designation to pursue depends on local needs and the type of assistance an area is seeking. Table 1 summarizes the major programs using Federal shortage designations. Each of these programs has additional requirements and application procedures.



TABLE 1: MAJOR PROGRAMS USING FEDERAL SHORTAGE DESIGNATIONS

AGENCY/PROGRAM NAME	DESIGNATION REQUIRED
<i>HRSA/Div of National Health Service Corps</i>	
Scholarship Program	HPSA
Federal Loan Repayment Program	HPSA
State Loan Repayment Program	HPSA
Grants to States for Community Scholarships	HPSA
<i>HRSA/BPHC/Div of Community and Migrant Health</i>	
Section 330 Health Center Grants	MUA or MUP
FQHC Look-Alike Certification	MUA or MUP
<i>Center for Medicare and Medicaid Services [CMS, formerly HCFA]</i>	
Medicare Incentive Payment Program	Geographic HPSA
Rural Health Clinics Eligible Area	Geo or Pop Group HPSA, MUA
<i>Appalachian Regional Commission</i>	
J-1 Visa Waivers	Geographic or Pop Group HPSA
<i>Conrad "State-20" Program (42 states)</i>	
J-1 Visa Waivers	HPSA, MUA, or MUP (at option of the state)
<i>State Health Departments</i>	
National Interest Visa Waiver	HPSA or MUA/MUP

You can check the website of the Bureau of Primary Health Care, at <http://www.bphc.hrsa.gov/> to see if your proposed service area already has these designations, and/or what office (your State Primary Care Office) to contact for more information.



RURAL HEALTH CLINICS (RHC)

The Rural Health Clinic program was established by Congress in 1977 under Public Law 95-210. The intent of the program is to increase availability and accessibility of primary health care services in rural areas by enhancing Medicaid and Medicare reimbursement. An RHC must be located in a designated Medically Underserved Area (MUA) or Health Professional Shortage Area (HPSA) in a non-urban area. The State Health Department is usually responsible for licensure and certification of an RHC.

A Rural Health Clinic can be privately owned, a non-profit organization or a public entity. It must be staffed at least 50% of the time by a mid-level provider (nurse practitioner or physician assistant) and provide outpatient primary health care.

RHC CERTIFICATION REQUIREMENTS

The requirements to get certified as an RHC are:

- The clinic is not located in an “Urbanized Area” as designated by the U.S. Census Bureau and the Secretary of Health and Human Services
- The clinic must be located in a Health Professional Shortage Area (HPSA) or Medically Underserved Area (MUA), generally determined by information from the State Health Department
- Services must be under the medical direction of a physician who is required to be on site once every two weeks

continued



RHC CERTIFICATION REQUIREMENTS (CONTINUED)

- The clinic must employ a mid-level practitioner at least 50% of the time that the RHC operates. Examples include a physician assistant, certified nurse midwife, or nurse practitioner
- The facility must be clean, universally accessible and meet appropriate state and local building, fire and safety codes
- Drugs and samples must be stored safely
- A minimum of six basic lab tests have to be provided on site
- There must be a current and applicable policy and procedure manual
- Drugs and medication samples must be stored safely
- The clinic must file an annual cost report with the Bureau of Primary Health Care
- Adequate medical records must be maintained for six years

BENEFITS OF AN RHC:

- There is no competitive grant process
- Ownership can be private, public, or non-profit
- A facility can be certified as an RHC at any time
- Medicare and Medicaid-covered services are reimbursed at an enhanced rate
- Services for Medicaid beneficiaries are reimbursed at 100% of reasonable costs



DISADVANTAGES OF AN RHC:

- There is no federal grant money for uninsured patients or operational expenses
- Medicare reimburses an RHC 80% of its all-inclusive rate. The patient is responsible for paying the 20% deductible
- The current Medicare rate as of May 2003 is approximately \$64.00 per encounter, which is typically a lower rate than the FQHC Medicare rate. The rate is increased each year by the Medicare Economic Index
- The delay in Medicaid and Medicare reimbursement can be 60-120 days
- Medicare HMO beneficiaries are not subject to RHC payment
- RHCs are not required to provide care to uninsured or underinsured persons



FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)

A Federally Qualified Health Center is a community health center that receives federal funding under section 330 of the Public Health Service Act to provide comprehensive primary care services to uninsured and underinsured populations. The first community health centers were established in 1966 under an amendment to the Economic Opportunity Act. Since 1975 community health centers have been funded under Title III Section 330 of the Public Health Service Act. Oversight of the Community Health Center Program is shared by the Bureau of Primary Care (BPHC) and the Centers for Medicare and Medicaid Services (CMS).

FQHCs receive cost-based reimbursement for services to Medicare and Medicaid patients as a mechanism to increase primary care services to high-risk populations in underserved areas. They can receive federal grants for subsidizing care to uninsured patients. In addition to general grant dollars, FQHCs can also qualify for federal grants to serve special populations such as migrant and seasonal farm workers, homeless, residents of public housing, and school based health centers. A health center that meets federal FQHC requirements and program expectations, but does not receive federal Section 330 funds, can be designated as FQHC Look-Alike and have access to certain FQHC benefits such as enhanced reimbursement for Medicaid.

A federally qualified health center must be a public or private tax-exempt nonprofit entity. Conversion of an existing non-profit entity to a federally qualified health center structure is a critical decision that should be carefully weighed. Another option is to identify an existing FQHC in a nearby community that is willing to open a new clinical site in the target service area. An FQHC can also be operated as part of a government agency such as a local health department. In this case, special arrangements need to be made to meet the governance requirements of an FQHC.



BASIC ELIGIBILITY REQUIREMENTS

- Must be located in (or serve) a medically underserved area (MUA) or serve a medically underserved population (MUP)
- Must be a public or private nonprofit entity, including tribal, faith-based and community based organization
- Has a governing board (board of directors), a majority of which must be consumers of the center's health services, that independently exercises key authorities
- Has a management team that works with the governing board to achieve the mission of the health center
- Health centers must provide comprehensive primary care directly and/or by contract, 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
 - Family planning services
 - Preventive dental services
 - Emergency medical and dental services
 - Pharmaceutical services, as appropriate to the particular health center
 - Substance abuse services, especially if the program serves homeless individuals and families

continues



- Enabling services including:
 - i. Case management
 - ii. Assistance in obtaining financial support for health and social services
 - iii. Referrals to other providers of medical and health-related services including substance abuse and mental health services
 - iv. Outreach
 - v. Transportation
 - vi. Interpreter services
 - vii. Education about health services availability and access
- Must offer a sliding fee scale, accept Medicare, and provide culturally competent services regardless of ability to pay

BENEFITS OF AN FQHC:

- Receives Section 330 or Indian Health Service funds which significantly support expanded access to health care services to underserved populations
- Receives cost - based reimbursement for services provided to Medicare patients and enhanced (cost-derived prospective) payments for services provided to Medicaid patients
- Can participate in the Public Health Service Act Section 340B Drug Pricing Program
- Can access free medical malpractice insurance under the Federal Tort Claims Act (FTCA)
- Access to Bureau of Primary Health Care technical assistance
- Access to the federal Vaccines for Children Program

continues



BENEFITS OF AN FQHC (CONTINUED):

- Access to many other grant and loan opportunities for both service and capital expansion
- Health centers receiving federal funding are automatically eligible for certification as Medicaid and Medicare FQHCs; health centers not receiving federal funds must fill out an application through their Health Resources and Services Administration (HRSA) field office or online at <http://www.bphc.hrsa.gov> for FQHC look-alike designation

DISADVANTAGES OF AN FQHC:

- Highly competitive, complicated grant application process
- Competitive grant reapplications every 3-5 years
- Annual Financial Status Report (FSR) required
- Comprehensive data reporting required annually, (Uniform Data Set, or UDS)
- Comprehensive Primary Care Effectiveness Review (PCER) conducted by the Bureau of Primary Health Care at least every five years. JCAHO accreditation is an alternative.
- Higher level of staffing, both clinical and administrative/management, necessary to meet requirements



TABLE 2: COMPARISON OF RHC AND FQHC PROGRAMS

	RURAL HEALTH CLINIC	FEDERALLY QUALIFIED HEALTH CENTER
Location	Non-urban MUA or HPSA	MUA or MUP
Organizational Type	For-profit, nonprofit or public entity	Nonprofit or public entity
Governance Requirement	None	Majority user board of directors
Federal 330 Grant funding for operations	None	Yes
Services Provided	Basic primary care	Comprehensive primary health care, mental health, dental health care
Other services required	Basic lab	Pharmacy, lab (as appropriate), enabling services
Mid-level provider required	Yes, 50%	No
Enhanced Medicaid/Medicare reimbursement	Yes	Yes
Application Process	Certification any time	Competitive grant cycles
Access to free medical malpractice coverage (FTCA)	No	Yes
Program Evaluation	Annually	Primary Care Effectiveness Review (PCER) at least every five years or JCAHO accreditation



BUILDERS AND ARCHITECTS: COMMUNITY PARTNERSHIPS AND SPONSORING ORGANIZATIONS

As community leaders you have begun to develop a vision of how your community might meet the need for more accessible primary care services, particularly for the medically underserved populations. Your goal is to build a system that will improve the health of individuals and the health status of the overall community. These are big decisions that can have long-term influences not only on health care, but also on economic development opportunities and job availability in your community. It is critical to obtain community support and investment at both the planning and implementation stages.

Communities are made up of people. They can be defined culturally or ethnically as well as by differences in values, social institutions, and patterns of social interaction. Communities can also be defined by common health care needs, health problems, and problems that people share in accessing health care services. Geographic features that affect travel patterns and access can also shape and define a community. All these issues need to be taken into consideration when the goal is to create broad community investment in your project.

In addition to involving citizens in building your community health services, it is equally important to reach out to the health service network and extended social service system in your area. Who are the health care providers in your service area? All these organizations are potential partners and supporters: federally qualified health centers, rural health clinics, local public health departments, hospitals, private providers, pharmacies, lab and x-ray providers, outpatient mental health providers, social service providers (such as Area Agencies on Aging), school systems, or providers under the Women, Infants and Children (WIC) program.



There are many questions that need to be asked as you design your project. How will your organization fit into the community and its health care delivery system? Who needs to be involved so services are coordinated? What resources can you call on to help with planning? How do you know if the proposed project is the right solution? Will the community support the efforts and have an investment in the decision? The more you involve and work with other people, groups and organizations the better will be the answers to these and many other questions.

A cost-effective solution that is appropriate and responsive to the needs that have been identified in your community requires coordinating and integrating many activities. The sooner you can identify and involve the right people to help you, the better your project will be. Generating effective, meaningful community participation is a labor-intensive effort. There are agencies and organizations that can provide information, guidance, and expertise in community development activities.

This is a beginning list of potential places where you might find resources that could help in designing and building your community health services. Get creative! The best combination of people and resources will look different in every situation.

LOCAL

- Businesses and commercial organizations like the Chamber of Commerce
- Schools, colleges, universities
- Faith-based organizations
- Service organizations

continues



LOCAL (CONTINUED)

- Agricultural organizations such as the farm bureau, extension services, grange, 4H clubs
- Government officials such as mayor and county executives, city and county councils, boards of health
- Media such as newspapers, radio, TV (to help get the word out)
- Hospitals
- Public health department
- Private health care providers
- Medical and dental societies
- Community mental health agencies

STATE

- Primary care association
- State primary care office
- Office of rural health
- Department of health
- State elected representatives
- Health insurers/HMOs
- Continuing education programs for health care professionals
- Associations/societies for health care professionals
- Schools of medicine, dentistry, nursing and health sciences



NATIONAL

- National Association of Community Health Centers (NACHC)
- Health Resources and Services Administration (HRSA)
- Bureau of Primary Health Care
- Federal Office of Rural Health Policy



ORGANIZATIONAL HOME

Just as in any building project, site and location are critical decisions to be made when designing and building access to health care. Site and location refer not only to the physical plant, but also to where responsibility for implementing the project will rest - the project's "organizational home". There are many options that must be carefully considered and balanced with the need in your community.

Whether to start from the ground up with a new organization or work with an existing organization is a decision that should be weighed very carefully. Developing a new non-profit organization requires incorporating as a non-profit under state law and obtaining tax-exempt status under the U.S. Internal Revenue code, also known as 501(c)(3). An existing organization has the advantage of operational and administrative structures in place that can save a lot of time and effort.

If the area where you want to provide services is in a rural Health Professional Shortage Area (HPSA) or federally designated Medically Underserved Area (MUA), a Rural Health Clinic (RHC) can be operated by:

- A freestanding non-profit organization
- A public health district
- A non-profit hospital
- A for-profit hospital
- A privately owned business



A federally qualified health center (FQHC) must be governed by a public or private non-profit entity, including tribal, faith-based and community-based organizations. It could be a new non-profit organization, or an existing organization. Some of the options for locating a FQHC within an existing organization include:

- Social service and community action programs that offer health services
- Hospital outpatient clinics
- Free clinics
- Clinics that serve a limited population
- Part of a government agency such as a local health department
- Clinic sponsored by a faith-based organization

Every FQHC organization must meet federal governance requirements. The governing board of a federally qualified health center is legally responsible for ensuring that the clinic is operating in accordance with applicable federal, state and local laws and regulations and is financially viable. An FQHC must have a governing body that:

- Is composed of individuals, a majority of whom are served by the center and who represent the individuals served by the center
- Meets at least once a month
- Selects the services provided by the health center
- Determines the hours during which services will be provided
- Approves the center's grant application and annual budget
- Approves the selection of the director for the center
- Establishes general policy for the center (specific exceptions are made in the case of public entities)

Section 3: The Blueprint: Developing a Business Plan





IMPORTANCE OF A BUSINESS PLAN

WHAT IS A BUSINESS PLAN?

A business plan is the managerial game plan that will help you to develop your new center or expand your existing center. It is a proposal that you can take to your board, community organizations, or funders. Like an architect's blueprint, it will define the steps you need to take to accomplish your goal. Business plans are generally used when starting up a new business, a new line of business, or to implement an organization's strategic plan.

Is a business plan required for an application to obtain section 330 funds? A business plan for the development and operation of the specific FQHC project is required in the grant application, and the content of this plan is derived from the overall business plan of the organization described here.

WHY WRITE A BUSINESS PLAN?

1. Writing a business plan gives you the opportunity to distill your ideas about the project. In order to write it, you will need to answer questions such as, "who are your partners?" "What is the likelihood of breaking even?" "How will you implement your ideas?" "What specific steps will you take and in what order?"
2. To prepare a budget for the business plan you will do the analysis necessary to understand your financial position, the likelihood of surviving the first year, what it will take to break even, and if you can be successful financially.
3. A business plan gives you a thoughtful proposal to help you make the case for your project to funders, to your board of directors, to the community supporting you, and other stakeholders.



SOME IMPORTANT GUIDELINES:

1. Identify your audience. Who are you writing the plan for? Are you writing it for your board of directors? In preparation for your grant application? For other funders? Make sure that you keep your audience and its needs in mind when you write the plan.
2. Keep the business plan clear and concise. Use a clear outline which is easy to navigate. Use simple language whenever possible. Use action words.
3. Give your reader the facts. Make evidence-based assertions, using data to back them up. Use graphs, tables and other exhibits generously.



ELEMENTS OF A BUSINESS PLAN

Here is a simple outline of a business plan that can help you get started:

1. Executive summary
2. Background
 - a. History of the organization and its mission
 - b. Management, operations and governance
 - c. Market description and analysis
3. The proposal: The nature of the service you wish to provide
4. Financial forecast
5. Supporting documents (appendix)



EXECUTIVE SUMMARY

The executive summary is a synopsis of the business plan. It is the most important part of the business plan because it is the most frequently read section of the plan and it is the reader’s “first impression” of you and your organization. Although it appears first, you should write the executive summary after you finish the majority of the plan. Generally, it should be no longer than one page.

BACKGROUND

History of the organization and its mission. This section should include a discussion of what led to the creation of the organization as well as the reason for the current plan to expand. It will usually involve a description of the lack of access to health care in the local area or other conditions that gave rise to the formation of the health center. You should include a concise summary of the history of the organization as well as its mission. If the organization is yet to be established, describe the type of organization that will sponsor the project, and the planned incorporation process and timeline.

Be sure to consider the audience when writing this section. The more familiar it is with your center, the less detail is needed. However, if your audience is unfamiliar with community health centers, you may need to give more background. For example, you may need to explain what a Federally Qualified Health Center is and how Medicaid funding works in your state.

Explain the governance of your center or organization. If your intended audience is unfamiliar with FQHCs and RHCs, explain the federal requirements for consumer participation on the board. What is the composition of your board? Does it have committees? How do they operate? If you are starting a new center, what is your plan for board composition and committee structure?



MANAGEMENT AND OPERATIONS

Describe the health center's current or proposed operations. Be sure to avoid jargon for readers who are unfamiliar with the acronyms. You should cover the following topics:

- Programs and services. Describe the services you provide, such as prenatal care, primary care, dental care, mental health, WIC, interpretation, and social work.
- Facilities. Give the square footage and number of exam rooms, location, proximity to transportation, and other organizations that will serve the same population.
- Users. Describe the number of users and their demographics (age, gender, ethnicity/race, primary languages spoken), etc. Use graphs and charts to document the number of visits per year, the number of visits per user, and insurance coverage of the population.
- Hours of operation
- Management team. Describe its experience, weaknesses, evidence of past success, and description of duties. Include organizational chart and biographies.
- Staffing. Include full time equivalents (FTE) for physicians, nurse practitioners, physician assistants (PA), RNs, and other support staff. Describe your recruitment process.
- Network affiliations and referral relationships. With which hospitals, specialists, laboratories, and imaging centers do you have referral relationships? What organizations do you currently provide services to, or propose to serve? Are these arrangements formal or informal?
- Managed care relationships. With which managed care plans do you contract? What are your payment arrangements (e.g., capitation, fee for service)? For what portion of your population do you receive capitation?

continued



MANAGEMENT AND OPERATIONS CONTINUED

- Information technology (IT) capacity. How do you propose to use information technology to make your operation more efficient and improve quality? What practice management system do you use? What IT support do you have (i.e., number of FTE)? Describe your hardware and software. What training is available for staff?



MARKET DESCRIPTION AND ANALYSIS

In this section, you should describe the market environment of your center and analyze the opportunities for expansion. Using the needs assessment of the community that you developed, make the business case for your proposal. Draw the connection between the deficits you found (e.g., lack of access for a given population) and the need for the services you propose to offer. Give supporting evidence in order to make the point to your reader that the new services are necessary and will be supported by the population.

You should answer questions such as:

- What is your target population?
- What are its health needs?
- What portion of those needs is unmet? Why?
- What services do you propose to offer? For example, will you offer prenatal care? WIC? Mental health? Dental services?
- What other services are available to your target population? Of those services, which are competitive with your proposal? Which are supportive?
- What environmental forces will impact your market share? Consider such issues as changes in Medicaid funding, changes in the local health care delivery system, the demographics of your target population (growing or declining in numbers) employment, and the economy.

continued



MARKET DESCRIPTION AND ANALYSIS (CONTINUED)

What evidence has led you to conclude that the market will support your project? Back up your arguments with data. Whenever possible give the reader charts and graphs. You should consider such data as:

- Demographic data: population trends by age, race, ethnicity, gender, language, and income.
- Economic trends: Unemployment rate, largest employers, changes in local industry.
- Health insurance and managed care trends: Medicaid managed care enrollment, HMO enrollment, health insurance coverage.
- Health status of the population: Birth rates, mortality rates, leading causes of death, rate of chronic diseases such as AIDS, asthma, and diabetes. Health Professional Shortage Areas (HPSAs).

Note: For more information, see Capital Link's "Creating a Business Plan for a Community Health Center Capital Project", <http://www.caplink.org>.



THE PROPOSAL

Organize your business plan by identifying the major goals, and then developing objectives for each goal and activities for each objective. Make sure the proposal is consistent with the needs identified in the market analysis.

- The plan: What do you propose to do? Why will it be successful? How will it be good for the organization, the center, or the population served? How does it fit with the mission of the organization?
- What are your objectives? Define them in specific, realistic, measurable terms.
- Timeline: Give expected timeframe, start date, completion date, and dates that objectives must be achieved.
- How will the infrastructure enable implementation of the plan? Address functional areas such as human resources, facilities, information technology, and clinic operations. **Cover all the areas listed above in management and operations, describing them in detail for your new clinic, such as:**
 - Services you will provide
 - Staff to be hired and the process by which you will recruit , hire and orient them
 - Space needs, floor plan, facility management
- Who is responsible for each goal, objective or activity?
- What is your timeline for completing each activity?
- How will you measure each objective?



FINANCIAL ANALYSIS AND FORECAST: PROJECTING REVENUES AND ESTIMATING EXPENDITURES

In this section, you will make the business case for the financial viability of your plan for the new clinic site. It is critically important for you to understand the expenditures, revenues, cash flow, and break-even point of the new site, and by developing your budget you will gain this understanding.

REVENUE:

The first step is to understand the revenues you will receive. Typical revenue sources for community health centers are:

- Medicaid revenue. This may include:
 - Fee for service Medicaid payments from the state
 - Fee for service Medicaid payments from a health plan
 - Capitation for Medicaid patients from a health plan
 - Enhanced (cost-derived prospective payments)
- Medicare revenue. This may be capitated, fee-for-service or an all-inclusive rate.
- Private insurance. May be capitated or fee-for-service.
- Contracts
- Self pay
- Grants, including Bureau of Primary Health Care (BPHC)



Estimating Patient Revenues: How do you know what patient revenues to expect? First, you need to understand the productivity of your providers

Calculate provider and staffing ratios:

To plan for staffing of your new clinic site you can begin with the size of the target population to be served, the facility size and established standards for staffing ratios. If the facility size is fixed, the number of available exam rooms per provider should be assessed to assure that productivity standards can be met. Specifically, you will estimate the number of patients to be seen by the various providers you intend to employ, as well as the number of support staff per provider.

Begin with the productivity of each provider type. How many patient visits per year do you expect an MD to have? How many visits per nurse practitioner? How many visits per dentist and per behavioral health provider? Data compiled from existing health center Uniform Data Sets (UDS) include average provider staffing, productivity and support staff ratios.

This data is available on the website of the Bureau of Primary Health Care, <http://www.bphc.hrsa.gov/> (home page). The UDS data can be found at <http://www.bphc.hrsa.gov/uds/data.htm>. The website has summary data from health centers and is an excellent source of information. In addition to national averages, you can find data for your region or state as well.

For example, of 843 grantees reporting in 2002, the average percent of selected providers and encounters in their organization, and average productivity by provider type was:



TABLE 3: PROVIDERS*

Provider Type	% Of providers	% Total encounters	Encounters per FTE
Family practitioners	9.6 %	21.7%	4,002
General practitioners	1.0%	2.6%	4,484
Internists	4.8%	10.6%	3,883
Ob/Gyn	1.6%	3.4%	3,698
Pediatricians	4.4%	10.2%	4,100
NPs/PAs	11.3%	17.9%	2,828
Certified nurse midwives	1.3%	1.7%	2,335

*Note: Other “providers” listed in the UDS data, but not shown here, include nurses, laboratory personnel, “other medical personnel, and x-ray personnel

You can also begin with the population you will serve and from there determine the number of visits you expect to provide. From the UDS data you can find the average number of encounters per person in the population seen by community health center grantees. In 2002, there were

- 3.4 Medical encounters per user per year
- 2.3 Dental encounters per user per year
- 6.8 Mental health/substance abuse encounters per user per year
- 2.8 Other professional encounters per user per year
- 3.0 Enabling encounters per user per year



Suppose that Clinic ABC believes that it can serve 4,800 users in its new clinic with medical visits. At 3.4 encounters per user per year, the clinic would need to provide 16,320 visits. What staffing level does it require, and what revenue will it receive for the visits? Let's begin first with the staffing level:

TABLE 4: CLINIC ABC AVERAGE NUMBER OF VISITS PER FTE

Provider type	Average number of visits/yr/FTE	FTE	Total visits
MD	4,000	2.0	8,000
NP	2,790	3.0	8,370
<i>Total</i>	<i>5.0</i>	<i>16,370</i>

Now let's add the revenue expected from each of the visits. To do this, you must estimate your payer mix – the proportion of patients funded by various payers, such as Medicaid, Medicare or commercial insurance. You need either historical or projected trends for the percentage of visits that will be compensated by each payer. It may be helpful to use a work sheet such as this using your own data:



TABLE 5: PAYER MIX FOR CLINIC ABC

Payor	Average # of patients per year	Percent of total
<i>Medicaid</i> fee for service	1,250	25%
Best Health Plan – <i>Medicaid</i> capitation	650	13%
XYZ Health Plan – <i>Medicaid</i> fee for service (FFS)	350	7%
Medicaid Total	2,250	45%
Acme Health Plan – <i>Commercial</i> FFS	400	8%
Commercial Insurance Total	400	8%
<i>Medicare</i> managed care capitated	0	0
<i>Medicare</i> managed care FFS	0	0
<i>Medicare</i> non-managed care	500	10%
Medicare Total	500	10%
<i>CHIP</i> non-managed care	150	3%
<i>CHIP</i> managed care capitated	100	2%
<i>CHIP</i> managed care FFS	0	0
CHIP Total	250	5%
Self pay	1,600	32%
Grand Total	5,000	100%

Taking your estimated mix, calculate the average revenue per visit and then from it, the total revenue you can expect from patient visits:



TABLE 6: REVENUE

Revenue Calculation by Visit for Non-Capitated Users

Payer	Average # of visits per year	Average revenue per visit	Expected revenue per payor per year
Medicaid fee for service	5,440	\$100	\$544,000
Medicare	1,700	\$75	\$127,500
Self pay	5,440	\$25	\$136,000
Commercial	1,360	\$60	\$81,600
Total	13,940	\$73	\$1,016,000

For capitated contracts, you need to know the number of users served under each contract. To calculate the capitation rate, multiply the number of enrollees for whom you receive capitation by the monthly capitation rate, and then multiply by 12 for an annual rate. For example:

$$\begin{array}{r}
 4,000 \text{ Medicaid capitated enrollees} \\
 \times \underline{\quad \$13 \text{ per month}} \\
 \$52,000 \text{ per month} \\
 \times \underline{\quad 12 \text{ months}} \\
 \$624,000 \text{ per year}
 \end{array}$$

Now add in the capitation revenue and grant revenue.



TABLE 7: AVERAGE ANNUAL REVENUE

Patient Revenue:

Fee for service (includes Medicaid, self pay, commercial, and Medicare) \$1,016,000

Revenue from capitation: Calculate number of enrollees x capitation rate \$624,000

Grants

BPHC federal grant \$600,000

Other grants

Other revenue

Community fundraiser \$5,000

Total \$2,245,000



EXPENDITURES

Your expenditures will include operating expenses and capital expenditures.

Operating expenses. Typically, operating expenses include:

- Employee salaries and benefits
- Professional liability insurance
- Staff training and travel
- Board training and travel
- Medical supplies
- Dental supplies (if dental services are provided in-house)
- Pharmacy
- Clinical laboratory
- Radiology and imaging
- Other ancillary services
- Non-patient-care contracts, such as janitorial services, telephones, pagers, computer software and maintenance
- Patient care contracts, such as mental health services or dental services if they are not provided by the organization
- General administration, such as office supplies
- Building and occupancy (e.g., rent, utilities)
- Furniture and equipment
- Administrative supplies and services
- Depreciation



Capital expenses: Typical capital expenses include:

- Office equipment, e.g., computers, copiers
- Exam room equipment and furniture
- Medical, dental, lab and pharmacy equipment
- Remodeling costs
- Employee salaries and benefits:

Provider staff:

Use the provider ratios you calculated under the revenue section to estimate the salaries you will pay. In our example, Clinic ABC is going to begin with 2 MDs and 3 NPs. We will multiply their salary by their FTE to obtain the cost:

TABLE 8: ABC CLINIC PROVIDER SALARIES

Provider type	FTE.....	Salary/FTE	Total salary
MD	2.0	\$100,000	\$200,000
NP	3.0	\$60,000	\$180,000
Total	5.0	\$380,000



Support staff:

Generally, support staff includes case managers, educators, outreach workers, interpreters, other enabling service staff, administration staff, facility staff, and patient services support staff.

Determine the ratio of support staff to FTE that you will need. Other reference sources include the Bureau of Primary Health Care's website (<http://www.bphc.hrsa.gov/>) contains average ratios based on UDS data. The Medical Group Management Association (MGMA), an organization for medical group practice managers, has similar data for group practices. Their website is <http://www.mgma.com/>.

See also Section 4, Staffing the Clinic

Calculating space needs:

Survey data by MGMA (see above) are a good source for average space needs per provider. In addition here are some approximations of space needs that you can use as a rough guide for initial estimates:

Providers: You can start with two to three rooms per provider, but be sure to consider their schedules and the benefit of exam room sharing that could result from non-overlapping schedules.

Exam rooms = approximately 100 square feet (sf) each



Clean utility = at least 100sf

Dirty utility = at least 100sf

Front desk = 200-250 sf

Medical records = 100-200 sf

Procedure room = 120 sf

Waiting area = approximately 400 sf

Office = 80-100 sf

Additionally, you may want to include conference room(s) and a staff break room

Once you have determined the size of the space you need, estimate the cost per square foot, and then add that to your expenditures.

See also Section 4, The Facility

PUTTING IT ALL TOGETHER: THE FINANCIALS

Now that you have a good estimate of both revenues and expenses, you can develop a budget for your first year. Doing so will allow you to know whether you can break even and when, whether your revenue is sufficient, and whether the project, as you envision it, can sustain itself. The National Association of Community Health Centers (NACHC, <http://www.nachc.com>) has additional resources to assist you in financial planning.

Section 4: Framing The Building – Major Structural Components





The complexity and comprehensiveness of your health system design will, to some extent, be dependent on which program you choose.

A Rural Health Clinic (RHC), which mainly provides an enhanced reimbursement mechanism for Medicaid and Medicare patients, is the least restrictive. There are specific Medicare guidelines governing the Rural Health Clinic Program. State surveyors use interpretive guidelines to ensure that RHCs are in compliance with the technical requirements of the RHC program. For more information about Rural Health Clinics contact The National Association of Rural Health Clinics, <http://www.narhc.org/>.

A federally qualified health center (FQHC) receives a monetary grant under the Public Health Service Act Section 330 to expand health care services to the neediest communities. These are significant grants that can appreciably increase access to health care in your community. However, the operating requirements are also significant. In addition to primary health care services, FQHCs must also provide mental health and dental services, directly or through contracts.

FQHCs are thoroughly reviewed at least every five years by the Bureau of Primary Health Care. Some health centers opt for accreditation by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) instead. For more detailed information about FQHC requirements contact the Bureau of Primary Health Care, <http://bphc.hrsa.gov/>, or the National Association of Community Health Centers, <http://www.nachc.com/>.

In order to provide an adequate level of service that meets FQHC program expectations, there are some major structural components to your project that need considerable thought and planning.



THE FACILITY

In designing your facility, it is important to plan for growth. A successful operation may grow considerably during the initial years. It is much easier to find or build a space that has the capacity for expansion in the future rather than moving. Professional assistance from an experienced architect or functional space planner in designing a clinic or remodeling an existing space can be cost effective in the long run.

Although every community circumstance is unique there are some elements common to most clinics including:

- Two to three exam rooms for each medical provider (physician, nurse practitioner, physician assistant). Layout should be carefully planned to allow for efficient triage and patient flow. The ground floor is always more desirable to accommodate people with limited physical mobility.
- 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.
- A meeting room that can serve as a place for board meetings, educational and staff meetings, and a gathering place for community groups.
- Office spaces for administration and providers
- Areas for specific functions such as reception, clinical records, patient waiting and counseling, laboratory and x-ray



STAFFING THE CLINIC

Personnel expenses are a major portion of a health center budget. There is a greater expectation of administrative capacity in an FQHC than in an RHC or a small doctor's office, due to the complexity of the FQHC program. Federal grant supported health centers usually have an executive director, finance director and clinical leadership that includes the medical and dental director. Larger health centers may also have human resource directors, chief operating officers, and/or information systems directors.

Whenever possible leadership positions should be filled first with the expectation that the leaders will hire the best people available for the other positions. It will most often make sense for the Board to first search for an executive director. The executive director is directly responsible to the Board and is responsible for hiring and supervising all other employees.

Some health centers have physician-oriented provider staff with nursing support staff. These can be family practitioners that treat a broad age range or age-specific providers such as pediatricians and internists. Many health centers, in addition to physicians, utilize advanced practice nurse practitioners and/or physician assistants as an integral part of the provider team. The types of populations and health problems in the community, availability of different kinds of practitioners, and health center resources will determine the clinic staffing.

Other support staff such as administrative, medical support and social services personnel will have to be identified and recruited. There are no specific requirements about who or how many you should hire. It will depend on how your program is structured. The average ratio of support staff to provider for community health centers in 2002 was 1.62 direct medical support per medical provider, 1.42 direct dental support per dentist, and 1.14 patient support staff (front office) per provider.



OPERATIONAL ISSUES: DEVELOPING POLICIES AND PROCEDURES

Clear policies and procedures are an essential component to the smooth operation of an organization. A policy is a statement of a principle, plan or course of action. The procedure is the sequence of steps to be followed to implement the policy. Written policies and procedures establish clear, legal and fair guidelines for all aspects of the business and the day-to-day operation of the clinic. Policies and procedures are usually developed by management staff and approved by the board of directors. FQHCs generally have written policies in the areas of administration, personnel, governance, clinical, information systems, management and finance.

As a new organization, you should, as a minimum, have the following policies:

- Personnel policies and procedures
- Billing and collection policies and procedures
- Procurement policies and procedure
- Travel policy
- Accounting policy and procedure manual
- Patient confidentiality policy and procedure
- Non-physician supervision protocols
- Health maintenance protocols by age group
- Other clinical protocols appropriate to clinical practice
- Continuing professional education policy
- Patient grievance policy and procedure
- Quality management policy and quality plan
- Credentialing policy and procedure

Section 5: Funding Your Project





RURAL HEALTH CLINICS (RHC)

There are no specific grant funds for operation of a Rural Health Clinic. RHCs must go through a certification process to be eligible to apply for an enhanced reimbursement for Medicaid and Medicare patients. Contact your state health division for more information about the certification process. One of the best ways to help fund a Rural Health Clinic is to develop community support. Hospitals and other medical and social services organizations can be allies in developing health care services. Some communities have developed taxing districts to fund increased access to health care. If your organization is a non-profit 501(c)(3) you can research and apply to private foundations and other public agencies for grant programs that apply to your situation. Grant availability will vary widely with your location and circumstances.

FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)

The Bureau of Primary Health Care, Consolidated Health Center Programs authorized under section 330 of the Public Health Service Act provides grant support for new health care access points in the neediest communities. Public or private non-profit entities may apply for a grant for operational support under any of these programs:

- Community Health Centers – section 330(e)
- Migrant Health Centers – section 330(g)
- Health Care for the Homeless – section 330(h)
- Public Housing Primary Care – section 330(i)
- Healthy Schools, Healthy Communities – section 330(e)



These are very competitive grants and applicants must be able to:

- Demonstrate that all persons will have ready access to the full range of required primary, preventive, enabling and supplemental health services, including oral health care, mental health care and substance abuse services, either directly on-site or through established arrangements without regard to ability to pay;
- Demonstrate that at the time of application (or a plan for compliance within 90 days of grant award) that they can comply with the requirements of section 330;
- Demonstrate that the site(s) will be operational and services will be initiated within 90 days of a grant fund.

Applying for a federally qualified health center grant is a time consuming and challenging process. It takes many hours of meetings and planning to develop a clear and comprehensive program that meets the federal grant criteria. A health needs assessment for the service area and the target population needs to be developed. A community strategic planning process must be coordinated and integrated with appropriate collaborations and partnerships to develop a service delivery model that is comprehensive. The organization applying for the grant must demonstrate that it has the experience and expertise to address the identified health care needs and that it meets the federal governance requirements.



In addition to the time it takes to plan your health service delivery model and develop the community support for it, writing the grant proposal is a significant investment of time and money. Most first-time applicants hire an experienced grant writer to help write the proposal. Depending on how much time community members contribute, a grant writer can spend 150–250 hours preparing a grant proposal. This can cost anywhere from \$10,000–\$25,000. This sounds like a lot, but the investment can mean up to \$650,000 a year in grant support for operation of a community health center. Some organizations apply for interim financing or raise local support to develop their program and write the grant application.

Sources for more information about funding opportunities for health centers can be found at your state Primary Care Association, the National Association of Community Health Centers <http://www.nachc.com/>, the Health Resources and Services Administration, <http://www.hrsa.gov/>, and the Bureau of Primary Health Care <http://bphc.hrsa.gov/>.