

FUNDED!

Now WHAT?

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If you have any questions, feel free to contact:

Pamela Byrnes, *Director, Health Center Growth & Development*
(860) 739-9224

pbyrnes@nachc.com

Or

Jaime Hirschfeld, *Health Center Growth & Development Specialist*
(301) 347-0470

jhirschfeld@nachc.com



NATIONAL ASSOCIATION OF
Community Health Centers

7200 Wisconsin Avenue, Suite 210
Bethesda, MD 20814
Phone 301.347.0400
Fax 301.347.0459
www.nachc.com

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Introduction

You get the call...**you are funded!** Break out the balloons and noisemakers, do the high-fives, then panic sets in. This is the most common reaction to finding out that you have been given the opportunity to open a new health center. Your organization is one of many new or expanded health center sites that will provide access to millions of new patients. That is a big responsibility and the health center¹ has to be up and running in just 120 days! Certainly if you are opening a satellite clinic you probably have some, if not many, of the systems established that you will transfer to the new site. A lot of effort will be placed on the best way to integrate the new facility into the existing operation. Those of you starting new health centers face a much more daunting task. Regardless, there is so much to do, and so little time.

This monograph is the second in a series of practical guides to starting health centers produced by the National Association of Community Health Centers (NACHC). The first “So You Want to Start a Health Center” walks you through the process of determining whether or not a health center is a good fit for a community and how to pursue federal designations and funding. Assuming success in getting federal support, the next question is “What do we do now?” There will be a lot happening all at once. Putting together a clinic is not a linear process.

While those starting out for the first time to implement a health center may find this monograph most helpful, the materials and outlines should also serve as important organizing tools for grantees opening new satellite clinics as well. Much of the information provided herein has been gleaned from years of experience of many people in the health center movement. Some have run health centers for years, others have been consultants to health centers, and some are staff of state/regional Primary Care Associations (PCAs). What is important to remember is that the material presented here is just a starting point for developing your clinic. Every idea, sample, checklist or form must be tailored to your unique needs and situation.

Each chapter of the monograph focuses on a different system of the health center: administration, governance, finance, human resources and recruitment, information systems, clinical, and facility. Each one begins with a statement of the over-arching principles that should be the guiding framework upon which the systems will be built and the tasks organized. This strategy will better position the organization to meet the changing health care needs in the community.

A series of critical tasks and goals are presented in each chapter with information on where to go for support. Included throughout are checklists of critical materials and activities, and examples of policies, procedures, and forms, among other helpful materials. Basically, if you need it we have attempted to include it.

¹ Throughout this monograph the term “health center” is used to denote an organization that receives section 330 Health Center Program grant funding including community health centers, migrant health centers, homeless health centers and public housing primary care centers.



Most of the resource materials, samples and templates are provided as links to websites to facilitate you accessing what you need and avoiding having this be a ten-volume monograph. We hope this format makes the materials easy to use. We sincerely thank our health center colleagues who helped inform this monograph. There are truly too many to name – suffice to say people have been generous in sharing their materials, successes and importantly, their foibles.

Finally, health center systems are constantly evolving. New technologies are being developed, new licensure and accreditation requirements, changing federal regulations and requirements abound. This moving target makes it difficult to ensure that the best assistance is being offered at all times. So, if you have something better, newer, easier to use...please let the Growth and Development Department at the National Association of Community Health Centers know so that we can update both the manuscript and the resource CD. We want to provide the very best support to those undertaking this important task, but we need your help!

Chapter 1

Getting Started

GUIDING PRINCIPLES

- *Design your Systems Right the First Time*
- *Pay attention to Complying With Program Requirements*
- *Ask for Help*

You've received your Notice of Grant Award (NGA), and, yes, the 120-day clock has started ticking. Throughout this exciting, rewarding and sometimes stressful process of meeting deadlines, setting up new systems, hiring and orienting new people what is really important is to **keep in mind the mission of the organization and the outcomes you wish to achieve—providing access to high quality, affordable health care to vulnerable people.** With some careful thought and planning and a lot of help you will meet your goals.

There are **eight areas or systems** which demand your attention in the first six months after receiving your Notice of Grant Award:

1. **Governance**
2. **Administration**
3. **Human Resources/ Recruitment & Retention**
4. **Finance**
5. **Clinical**
6. **Clinical Operations**
7. **Information Technology (IT)**
8. **Facility**

Each one of these areas is covered in more detail in its own chapter. We have also included a section on Emergency Preparedness as the events of recent years have demonstrated the importance of having systems in place from the start to deal with catastrophic and unexpected occurrences. When you identify and define the tasks in each area, keep in mind that the more you build your infrastructure with future needs and program expectations in mind the stronger the foundation will be. Monitoring systems for successful policy, management and care quality are critical and should be established “day one” of opening the doors of the clinic.

Do It Right the First Time

When you begin to develop your work plan and timeline and see how much needs to be done in order to get your new clinic up and running, you may be tempted to skip steps or do something important quickly rather than correctly. You may think a temporary fix will suffice and you can go back later and do it correctly, however, once the center is up and running there will be little time to go back to do it right.

Yes, setting up new systems is very intense and time consuming. But serving the patients and managing the myriad of details of actually running the center is even more so. There are numerous new and proven ways of designing your systems that can have unbelievable impacts on the efficiency, effectiveness and financial sustainability of your center. This is your golden opportunity to do appropriate research, analysis, planning and implementation so that everything you put into place will serve you well for years to come. Do yourself, your center and your community this favor: Do it right the first time. You won't be sorry.

Comply with Program Requirements

There are several existing tools that can be used as guides to assure you are designing and establishing your health center systems for success. Take a look at how your end product will be evaluated using these tools and design to meet these requirements. Don't forget to always consider your unique community and work these standards into your specific needs and situation.

1. **Federal Program Requirements** – This federal document describes the laws, regulations and Bureau of Primary Health Care priorities as well as aspects of health care programs associated with success. It provides the basis for health center grant application instructions, review criteria and program reviews. These requirements are intended to ensure that health centers not only survive but thrive. The program requirements give broad guidance to help you achieve the mission and goals of your health center <http://bphc.hrsa.gov/about/requirements/index.html>.
2. **Health Center Site Visit Guide** -- Each newly funded health center will generally receive a site visit from HRSA within 120 days of grant award. The Guide has an extensive checklist (<http://bphc.hrsa.gov/administration/visitguidepdf.pdf>) of specific questions about the health center's level of compliance with program requirements, and is well worth reviewing as the clinic development moves forward. In addition it includes discussions of how to move past basic compliance to improve performance and reach for greatness in each program area. When they come out, the site review team interviews key clinic staff and board members and reviews documents, policies, meeting minutes, and forms. The team will review the program's strengths and make program development recommendations. They will also make technical assistance recommendations. **Your grant award includes money for technical assistance – use it!**
3. **Uniform Data Systems Reporting (UDS)** – This is the annual report you will make to the BPHC/HRSA. It requires specific demographic data on your patients, operations data, financial information including revenues, clinical and financial measures and other indicators of how you are doing. The BPHC/HRSA uses this data to monitor your program and aggregates it with all other health centers to report to Congress and the President. (<http://bphc.hrsa.gov/healthcenterdatastatistics/index.html>). For more information on the UDS Report, see Chapter 5.

Accreditation/Recognition Initiative

Accreditation and/or Certification are the processes of requesting an independent review of your organization's performance against national quality and safety requirements. In October, 1996, the BPHC began an initiative to promote accreditation of health centers. The Accreditation Initiative is a continuing HRSA/BPHC activity that provides survey services of ambulatory care, behavioral health, laboratory services, and technical assistance and training for health centers. Separate from the Accreditation Initiative is HRSA's support of Patient Centered Medical Home (PCMH) recognition provided by the National Committee for Quality Assurance (NCQA). Additional

information regarding the NCQA PCMH recognition process can be found at <http://www.ncqa.org/> and in BPHC's Program Assistance Letter 2011-01 - <http://bphc.hrsa.gov/policiesregulations/policies/pal201101.html>.

Accreditation participation is voluntary and provides an opportunity for health centers to achieve accreditation through a nationally recognized accrediting body.

The Accreditation Initiative program is designed to:

- Increase health centers' competitiveness in the marketplace
- Provide a structure for health centers to integrate ongoing quality improvement into their daily operations
- Increase patient and staff safety and enhance health care quality

PAL 2009-12 Accreditation Initiative Update (<http://bphc.hrsa.gov/policiesregulations/policies/pdfs/pal200912.pdf>), describes the survey services, technical assistance and training available to Health Centers under the Accreditation Initiative.

PAL 2011-01 Patient-Centered Medical/Health Home Initiative (<http://www.bphc.hrsa.gov/policiesregulations/policies/pal201101.html>) describes the Patient-Centered Medical/Health Home (PCMH) Initiative, which supports and encourages health centers to gain recognition under the medical home program offered in partnership with the National Committee for Quality Assurance (NCQA). This PAL outlines the processes and requirements for applying for recognition and highlights the technical support available under the HRSA PCMH Initiative.

HRSA/BPHC contracts with the following two national accrediting organizations to provide survey services under the Accreditation Initiative:

1. **Accreditation Association of Ambulatory Health Care (AAAH)** - www.aaahc.org
2. **The Joint Commission (TJC)** (*formerly The Joint Commission on Accreditation of Healthcare Organizations*) – www.thejointcommission.org
3. **NCQA PCMH Recognition** – <http://www.ncqa.org/tabid/631/default.aspx>

Health centers must choose the organization with the services and supports that meet the quality needs of their organization.

Your new center will most likely not be ready for Accreditation visit for several years, but becoming familiar with the requirements is very useful in building your systems for the future. Below are some resources that will assist you in building your systems in preparation for future accreditation:

- **2011 Health Center Self Report Tool** - http://www.jointcommission.org/assets/1/18/2011_SRT.pdf
- **Health Centers' Most Challenging Standards** - http://www.jointcommission.org/assets/1/18/PRBSTDSM_in_2009.pdf
- **HRSA's Health Center Accreditation Resource Center** - <http://bphc.hrsa.gov/policiesregulations/accreditation.html>
- **HRSA Accreditation Initiative Resources** - <http://bphc.hrsa.gov/administration/comparisonchart.pdf>
- **The Joint Commission Accreditation Handbook for Ambulatory Care** - http://www.jointcommission.org/assets/1/18/2011_AHC_Hdbk.pdf

It cannot be stressed strongly enough that designing with accreditation in mind will save significant time and resources down the line. More importantly, it will assure that you put quality systems in place from Day one.

Ask for Help

It is important throughout the start up process to stay in contact with your Project Officer and update him/her with any changes and/or issues that you encounter. In addition, your state/regional Primary Care Association (PCA) can be an excellent source for information and assistance. To locate your local PCA, visit www.nachc.com/nachc-pca-listing.cfm. The National Association of Community Health Centers (NACHC) and the network of operating health centers in your area can also provide a wealth of information about setting up and running clinics for underserved populations. The BPHC has created a New Start Web Guide that contains a wealth of knowledge and can be accessed at: <http://bphc.hrsa.gov/technicalassistance/newstarts/>.

Centers serving special populations can get further guidance from national associations that focus on these groups including:

- **National Health Care for the Homeless Council -**
www.nhchc.org
- **National Center for Farmworker Health -**
<http://www.ncfh.org>
- **National Center for Health in Public Housing -**
www.nchph.org
- **Association of Asian Pacific Community Health Organizations –**
www.aapcho.org

A complete listing of special population organizations and further assistance is available through the Office of Training and Technical and Technical Assistance Coordination at: www.bphc.hrsa.gov/technicalassistance/tatopics/specialpopulations/index.html.

In addition, a complete listing of National Cooperative Agreements is available on the BPHC website: <http://www.bphc.hrsa.gov/technicalassistance/partnerlinks/natlagreement.html>

One of the best and most unique characteristics about the community health center movement is the willingness of staff and board members to help each other. Peer networking is the number one request from health centers when they need training, information or technical assistance. Community health centers are a unique provider type in the larger industry. No one knows what you are going through like someone who has also already gone through it. **Don't hesitate to contact your PCA, NACHC, your Project Officer or any health center when you need support or assistance.**

In addition, the BPHC's Office of Training and Technical Assistance Coordination (OTTAC) has created a website that includes a myriad of resources including the most recent PINs and PALs, frequently asked questions, resources and links to various partners. To access this robust website, visit <http://bphc.hrsa.gov/technicalassistance/index.html>.

Develop a Time-Framed Work Plan

Setting up a health center is a large, complex project. It is important to know who is responsible for each task and when it must be accomplished. Many of the tasks are concurrent and overlap. One tool that can help you develop a time-framed work plan is a Gantt chart.

A Gantt chart (www.ganttchart.com) is a graphical representation of activities in a project work plan and can be a useful project management tool. When the project is under way, this tool is used to indicate progress, such as when the task is actually started and when the task is actually completed. Comparison between estimated start and end and actual start and end should indicate project status on a task-by-task basis.

Gantt charts are easy to change, which is helpful. Charts may be adjusted frequently to reflect the actual status of project tasks, as almost inevitably, they change from the original plan. Gantt charts give a clear illustration of project status, but one drawback is that they don't indicate task dependencies - you cannot tell how one task falling behind schedule affects other tasks.

Sitting down and determining the tasks and time frames specific to your situation will give your project focus and direction. Assign each task to a specific person who can keep key people up to date on progress. To keep the Gantt chart from becoming too detailed and unmanageable, main tasks can be broken down into more detailed sub-tasks and charted separately.

Chapter 2

Governance

Guiding Principles:

- *Develop Mechanisms through Which the Board Can Understand and Exercise Its Authorities and Responsibilities*
- *Demonstrate Respect and Appreciation for the Contributions of Each Board Member*
- *Keep Your Board Well Fed – Mentally, Physically and Spiritually*

The cornerstone of a health center is its Board of Directors. Whether your organization is a private nonprofit or public agency, all health center governing boards have six major responsibilities:

1. Define and preserve the mission of the organization;
2. Make policy;
3. Safeguard the assets of the Center;
4. Select, evaluate and support the CEO;
5. Monitor and evaluate Center and Board performance;
6. Plan for the long-range future of the Center.

If this is a brand new health center (aka new start) a big challenge will be educating the Board of Directors about the rules and regulations of a health center. Basic requirements for composition and authorities can be found in the Health Center Program Requirements.

For new starts it is often the case that the focus of the new Board will need to be shifted from hands-on planning and grant writing, to a governing board that sets policy and does oversight.

If the new site is a satellite of an existing health center the challenging task will be to integrate and educate new members representing the new service area and underserved population(s).

In the intensity of setting up a new center it is very easy to neglect developing the Board of Directors. Boards do take a lot of care and feeding, but it is totally worth it! The effort that is put up front at the beginning of the project will pay off in the long run, as dynamic board development is the proven key to successful organizational sustainability and growth.

Board Composition and Recruitment

Developing a strong governing board is an investment process based on values and filled with opportunity for people who share those values to serve their community. Health centers often recruit out of a sense of haste or desperation to submit a full slate of board members who represent all segments of the community, and are at least 51% patients of the health center. Wonderful, well intentioned people, who were critical in the organizing and planning phase, may not be the appropriate people who can lead the organization to the next level.

Do not minimize the seriousness of being a board member. Approach recruiting new candidates with the attitude that this is an important undertaking that you feel would be a positive benefit to both him/her and to the organization. Do not minimize the commitment that is required. Let them know that there are standards for board performance and that the organization values its volunteers and expects them to give their time, their expertise and their support.

To accomplish the goals and objectives in your institutional plan, you will need board members who can contribute critically needed skills, experience, perspective, wisdom and time to the organization. You can create a board recruitment matrix based on the needs of the organization that will also incorporate the necessary membership changes generated by the new health center site. This matrix should include health center program requirements for board composition, identified skills and resources, representation from communities served by the health center, and community partners.

Current health center board members and senior staff believe the following core competencies are needed for a high performing Board Member²:

1. Has clarity on the mission and values of the organization
2. Participates actively and attends calls and meetings consistently
3. Engages at the state, regional and national level
4. Is active on committees and subcommittees – these are training grounds for new board leadership
5. Comes to board and committee meetings prepared, having done the necessary homework
6. Is in tune with the needs of the community
7. Has the ability to evaluate relevance and the application of emerging issues to the work of the board
8. Articulates the voice of the customer (i.e. patients and community), and service as an advocate for stakeholder groups
9. Maintains confidentiality
10. Understands how to channel and direct complaints
11. Keeps up with the times
12. Is able to manage the conflict between individual values/ interests and those of the health center

In addition, the competencies below will assist you in creating a high performing board. These competencies need not be possessed by each member, however, as a board there must be active participation by those members that bring the particular competency to the work of the board.

- **Tacit knowledge** - specific subject matter expertise that is helpful at a board level such as familiarity with law, finance, health policy, and the local community.
- **Emotional intelligence** - ability to be self aware and self regulate/adjust to facilitate interpersonal dynamics.
- **A passion for the mission**

² National Association of Community Health Centers – Proposed FQHC Governance Competencies & Benchmarks of High Performing Boards – September 2010

- **Advocacy** - making sure the needs of the community are reflected on the board.
- **Outreach** - ambassadors for the organization.
- **Community outreach** - local relationships, community support for the center and increasing the patient population.
- **Financial management** - understand the complex financial management environment of health centers (e.g. grants management versus third party reimbursement).
- **Fund raising** - raise the necessary resources to augment existing funding.
- **Strategic planning** - focus the energies of the organization in alignment with the community need.

The *HRSA/BPHC Governing Board Handbook* (http://ask.hrsa.gov/detail_materials.cfm?ProdID=720) has an **example of a board composition tool** to help evaluate the board's current composition, the ideal composition, and what positions you need to recruit to meet an ideal board composition. Don't totally eliminate potential recruits who may not fall into a matrix category. Some people have such interest, passion, or potential that they should be asked to join the board even if they don't fit neatly into the matrix. Be sure that the board recruitment policy accurately reflects the actual process the board uses.

Health center board member recruitment needs to be an ongoing process. It should be well planned with a strategy of constantly developing potential members. One suggestion is to establish a Board Development Committee rather than a Nominating Committee. Nominating Committees tend to meet just before a slate of candidates is due. A Development Committee has a much larger responsibility. This committee meets at least quarterly and is responsible for reviewing prospects, cultivating them, developing the board member handbook, conducting the orientation, and bringing names and profiles to the board for its review all year round.

Potential board candidate suggestions can come from board members and staff members. Once names have been identified the Board Development Committee should take as much time as necessary to find out as much as possible about the potential candidates. Talk to the individual who suggested the name, have lunch meetings with prospects, tours of the clinic, and/or visits to board meetings. Don't forget that the option of having someone first serve as a non-voting member on a board committee is a great opportunity to get to know how well they fit into the board dynamics.

Consumer Board Members

Every Health Center Board must be composed of **at least 51% consumers of the health center services**. A **consumer** is defined as one who uses the center's services as their principal source of primary healthcare. These include people who are parents, legal guardians and court-appointed caretakers of patients. Depending on the populations served, this may include people experiencing homelessness, non-English speaking people, people with mental illness, people with low literacy, migrant workers, people with disabilities, young people, elderly people, people of many races and ethnic backgrounds, as well as neighborhood working and professional people, farmers, business owners or other patients.³

A good way to develop new consumer Board representatives is through a "farm team". Potential consumer Board members are recruited onto a committee that includes 2 or 3 present Board member mentors. The Farm Team observes board meetings, participates in retreats and may even be sent to trainings and conferences with full Board members. After a year or more in training the potential new Board member has an understanding of the required commitment and work and knowledge of the health center operations and Board responsibilities. This decreases

³ Programs receiving funding specifically to serve only special populations identified by statute (homeless people, migrant-seasonal farm workers and public housing residents) can apply for a waiver from this requirement. Any request for a waiver of the patient majority requirements must include a compelling argument as to why the program cannot meet the statutory requirements, as well as alternative strategies detailing how the program intends to meet the intent of the statute for appropriate patient input.

the learning curve time significantly and increases both participation and the likelihood that the new member will stay. This approach works equally well with non-consumer board members.

It is **key to respect each person and his/her contributions** and to remember that the consumer majority board has proven to be the cornerstone of the success of CHCs for over 45 years. Don't assume that because someone is homeless that she/he won't understand the financial statements or that because someone has a mental illness that she/he won't have the best ideas for cutting edge personnel policies. A migrant worker or low literacy consumer may have brilliant ideas about marketing or quality assurance. **Use the patients' expertise to monitor and improve clinic services.** Let them select which committees they would like to be a part of, and let them know their expertise is appreciated. Similarly do not assume that because someone is a non-consumer with specific skills that they are more capable as Board members. Non-consumer board members need to understand the mission and values of the health center and learn how to work successfully with colleagues from all walks of life.

Remember that all board members are volunteers. Make sure information is presented in ways that allow everyone to understand without being a technical expert in the subject matter. The social worker or elected official may not understand complex financial statements. The farmer, young person or lawyer are not trained medical professionals, and may not understand complex clinical issues. The Board's role is the big picture and not the complex details. **Start with the big picture information and discussions; when more detail is needed invest in the necessary training.**

Health centers have also learned to accommodate their consumer board members' logistical needs. Some members may need language interpretation for meetings. The times of meetings must accommodate members' schedules, transportation can also be an issue. Some centers provide child care during meetings; providing food is always appreciated.

Board Orientation and Training

Orientation is a crucial part of building a strong Board of Directors. Newly recruited and enlisted board members who are quickly brought up to speed with the rest of the board members will be able to make useful contributions sooner. They will also not spend their first several meetings feeling lost or confused, which may contribute to lack of regular attendance.

The responsibility for developing and implementing an effective program of board orientation is shared between the Executive Director and the board itself. There must be a commitment to developing a well-informed board, one with the knowledge needed to lead an effective organization. Within the board, the responsibility can be delegated to the Board Development Committee. The Board Development Committee, working closely with the board chair and the executive director should plan a formal program of board orientation for new members. Some boards assign a mentor or "buddy" to support and encourage new members.

Board Orientation Timeline:

1. **During The Recruitment Stage** (Before election or appointment to the board) - The prospect receives an overview of the organization's mission and strategic plan, programs and services, and other background information. The prospect also receives a list of expectations of board members including number of meetings, committees, and length of board term and an idea of the time commitment required.
2. **New Member Orientation** (Immediately upon the election or appointment to the board) - After the new member has been brought onto the board, a detailed board member manual should be provided, which should include the following:
 - Bylaws
 - Articles of incorporation

- A thorough description of programs and services
- Overview of Health Center Program Requirements
- The current budget, last audited financial statements
- A list of board members and their addresses
- Lists of committees and any staff assignments
- Copies of minutes for the previous year
- A copy of the organization's strategic plan.

Also during this orientation, the following should be discussed (see sample checklist in the resource center):

- Program
- Finances
- History of the health center
- Strategic direction
- Board member roles and responsibilities (see sample board member job descriptions in the resource section)
- Board Operations

Board training does not stop once members are seated and oriented. Board members need to be kept informed of changing health care policies, periodically review and update their knowledge of board governance issues, and need opportunities to learn more about the organization's programs and people. Board training needs to be ongoing. At each board meeting time can be set aside to cover short topics of interest identified and prioritized by members. Scheduling an annual retreat is an effective way to make time for in depth strategic planning. The board can also be trained at this time on topics that are more complex and take more time.

Developing an annual Board Work Plan can help get the work done the Board has to do and ensure that there is time to do the things the Board wants to do. Also, as noted before, colleagues from other health centers are their best sources of information and nourishment. Create opportunities – and assure adequate resources - for board members to network with their peers by attending the state and regional PCA meetings, as well as national meetings hosted by NACHC and other related organizations.

Board Structure

Boards carry out much of their work in meetings. Because meetings of the full board cannot always accommodate in-depth discussion and analysis of key issues, boards often work through committees. **Committees are the backbone of the board.** They can more effectively and efficiently accomplish the work that needs to get done between board meetings, then report to the full board. The purpose of full board meetings should be primarily to exchange information and make decisions based on recommendations of the committees. The number of committees is related to the size of the health center and number of Board members. **Watch out for committee burn-out!** Here are some possible board committees⁴:

⁴ There are no required committees in the Health Center Program Requirements or statute.

Possible Standing Committees	Typical Roles
Board Development	<ul style="list-style-type: none"> Ensures effective board processes, structures and roles, work plan, retreat planning, orientation, training, committee development, and board evaluation; Develops and implements ongoing Board recruitment activities
Quality Assurance	<ul style="list-style-type: none"> Reviews and participates in developing annual Health Care Plan; Monitors progress towards clinical performance measures and programmatic goals; Ensures implementation of a well-designed and effective Performance Improvement Plan; Monitors patient satisfaction and reviews and addresses patient grievances not resolved at staff level
Executive	<ul style="list-style-type: none"> Oversees operations of the board; Acts on behalf of the board during on-demand activities that occur between meetings - these acts are later presented for full board approval; Board chair, other officers and/or committee chairs Often leads the evaluation of Chief Executive May hear grievances brought against the Executive Director
Finance	<ul style="list-style-type: none"> Oversees development of the budget; Ensures accurate tracking/monitoring/accountability of funds; Ensures adequate financial controls; Often led by the board treasurer; Reviews major grants and associated terms
Fundraising	<ul style="list-style-type: none"> Oversees development and implementation of Fundraising Plan; Identifies and solicits funds from external sources of support, working with the Development Officer if available; Sometimes called Development Committee
Marketing	<ul style="list-style-type: none"> Oversees development and implementation of the Marketing Plan, Identifies potential markets, needs, and how to meet those needs Oversees the Needs Assessment process and information
Personnel	<ul style="list-style-type: none"> Guides development, review and authorization of personnel policies and procedures; Sometimes leads evaluation of the Chief Executive; Sometimes assists Chief Executive with leadership and management matters
Public Relations	<ul style="list-style-type: none"> Develops plans and process to represent the organization to the community; Enhance the organization's image, including communications with the media.

It is recommended that at the very least the Board has Executive, Finance and Quality Assurance Committees. As a rule of thumb when contemplating which committees to form think of committees as visual representations of what is important to the Board.

Temporary or Ad Hoc committees, also known as Task Forces, are designated by the board for specific short-term purposes. One of the benefits of such ad-hoc committees is that they are easy to dissolve and bylaws changes are not required.

Basic Processes

In the beginning it may be necessary for a new organization to meet more frequently than once a month. Using committees to get timely work done between regular meetings is a more effective use of time. The Executive Committee can be used to review policies for full board approval as they are developed. The Finance Committee should be actively involved in reviewing any changes that need to be made in the budget as the project progresses. **Each major committee can then report regularly to the full Board.** Board meetings will be more productive if an agenda is published ahead of time that focuses the board's attention on issues of policy and strategy, rather than management. Visit www.champsonline.org/ToolsProducts/CHCBoardResources/EffectiveMeetings.html for resources on effective board meetings.

Most important - keep board members informed of the progress of the new health center site. Let them know how things are going - both the successes and the problems. Board members are a great resource for getting the word out into the community about the availability of new services. Keeping them up to date allows them do their job more effectively.

Benchmarks for Boards⁵

Health center board members face an array of requirements, policies, budgets and standards. People serving on health center boards may not know what they're getting into, and likewise, health center leadership many not be clear about the support and expertise they should expect from board members. Communicating expectations to board members is an essential step to achieve boards that add value the work of the health center organization and services provided to communities. Likewise, benchmarks of good governance are guides for continuous improvement of boards.

Just like the health center executive, boards should be evaluated on annual basis. The list of Benchmarks of High Performing Health Center Boards below will assist you in annual evaluation of your board:

1. **Understanding of organizational mission:** The board as a collective group understands the mission and is able to keep the organization focused on the core mission.
2. **Understanding of their role:** The board members understand their roles focusing on policy and strategy and not micro-managing operations.
3. **Board work done outside of the meetings:** The board members take on committee assignments and most of the work is conducted outside of the main board meetings saving that time for substantive dialogue and decision making.
4. **Shared vision:** The board as a whole shares a common vision of what the organization can do for its community and the priorities that need to be addressed.
5. **Listening skills:** The members reflect strong listening skills both in the board meetings and in the community as voices of the customer.
6. **Shared respect:** There is shared respect for each other as well as for organizational leaders and staff.
7. **Understanding of group dynamics:** A high performing board is able to effectively manage its own group dynamics.
8. **Ability to keep up with the environment:** The board is able to remain current with the environment and the latest trends and forces that will have an impact on the organization.
9. **Trust:** There exists trust across the board for each other and the leadership.

⁵ National Association of Community Health Centers – Proposed FQHC Governance Competencies & Benchmarks of High Performing Boards – September 2010

10. **Adequate turnover:** The board is able to remain invigorated with new members through turnover behavior.
11. **Understanding of quality & margin:** The board is able to balance a commitment to quality with an understanding of the need to create a margin to sustain operations.
12. **Broad based:** A high performing board is able to bring together a broad skill base and varying perspectives.
13. **Consistent attendance:** Members consistently attend and participate in committee and board meetings.
14. **Effective Chair:** The role of the chair is effective in guiding the board. The role of the chair is understood by all and not built around a person.
15. **Promotes the organization outside of the board meetings:** Board members are constantly advocating for the organization within the community; they serve as the link between the organization and stakeholders.
16. **Deliberate succession planning:** The board plans for replacements as a natural and deliberate process including grooming board members through the work of committees and sub-committees.
17. **Board self-regulates and evaluates itself:** A high performing board reflects on its work and evaluates its performance and self-corrects when necessary.

Strategic Planning

Strategic planning determines where an organization is going over the next year or more (usually three years), how the organization is going to get there, and how it will know if it got there or not. The focus of a strategic plan is usually on the entire organization, while the focus of a business plan (for more on business plans see Chapter 5) is usually on a particular product, service or program.

Health centers must engage in active, ongoing planning processes. Planning should include both long-term strategic planning and annual operational planning. Strategic planning should establish long-term strategic goals, whereas operational planning focuses on short-term objectives within the context of the strategic plan.

Strategic planning should be based on collecting and analyzing data, as well as on input from diverse stakeholders: health center governing board members, staff at all levels, community members, clients and organizations involved in providing or paying for health care in the marketplace. Recipients of funding to provide services to residents of public housing must consult with residents as part of their planning and grant application processes.

Planning should include ongoing evaluation, feedback and adjustment based on environmental, operational, or clinical changes. While remaining flexible and allowing for response to new opportunities and pressures, plans should describe the health center's goals and priorities sufficiently to guide members of the organization in strategic and operational decision-making.

Strategic planning is the formal consideration of an organization's future course. All strategic planning should include at least one of these three key questions:

1. What do we do?
2. For whom do we do it?
3. How do we excel?

As a new organization, it is essential that you look towards the future and develop a plan for the whole organization. This plan should have a clear statement of where we are today and where we want to go.

The board should be involved in the process from the beginning. Board members should sit on the strategic planning committee and progress should be reported monthly at board meetings. Ultimately it is the board that must approve the strategic plan.

Appreciation

Remember that all board members are volunteers. They choose to give of their time and talents and a lot is expected of them, especially in the beginning of clinic start up. There are many ways to show appreciation. Listening to their ideas and thanking them for coming to each meeting is very easy, but rewarding to the member. Offering food at meetings is a common way to show respect and gratitude. Small items to designate a board member's participation such as lapel pins or plaques are nice. When a board member rotates off after years of service, a good-bye gift is often given. And having a little fun is a great way to keep board members happy and remind them of the benefits they get from serving on your board. An annual planning retreat can include time for conversation and fun as well as intense work. Acknowledging members in the community is a great way to show appreciation.

For resources on governance, visit NACHC's Governance Resource Center at: <http://www.nachc.com/hc-info-governance.cfm>.

Additional Governance Resources:

- **Board Assistance Publications**
http://www.vacommunityhealth.org/across_the_board.cfm
- **Community Health Association of Mountains/Plains States (CHAMPS)**
<http://www.champsonline.org/ToolsProducts/CHCBoardResources.html>
- **HRSA/BPHC: Health Center Governance General Information**
<http://bphc.hrsa.gov/governance/>
- **HRSA-Governing Board Handbook**
http://ask.hrsa.gov/detail_materials.cfm?ProdID=720
- **National Health Care for the Homeless Council: How to Develop a Consumer Advisory Board**
http://www.nhchc.org/NCAB/NCAB_Manual-rev-Jan10.pdf
- **Outreach Partners -Recruiting Farmworker Board Members: Consultation Product**
<http://outreach-partners.org/ta/planning>

PROSPECTIVE BOARD MEMBER INFORMATION SHEET

Name of prospective board member: _____

Title: _____

Organization: _____

Address: _____

City, State, Zip: _____

Telephone: Day _____ Evening _____ Mobile _____

E-mail: _____

Source of referral/information: _____

SPECIAL SKILLS

- | | |
|--|---|
| <input type="checkbox"/> Fundraising | <input type="checkbox"/> Marketing/Public Relations |
| <input type="checkbox"/> Personnel/Human Resources | <input type="checkbox"/> Technology |
| <input type="checkbox"/> Finances | <input type="checkbox"/> Legal |
| <input type="checkbox"/> Business | <input type="checkbox"/> Other: _____ |

PROFESSIONAL BACKGROUND

- | | |
|--|--|
| <input type="checkbox"/> For-profit business | <input type="checkbox"/> Non-profit organization |
| <input type="checkbox"/> Government | <input type="checkbox"/> Other: _____ |

EDUCATION

- | | |
|---|---|
| <input type="checkbox"/> Some high school | |
| <input type="checkbox"/> High school graduate | <input type="checkbox"/> Some graduate coursework |
| <input type="checkbox"/> Some college | <input type="checkbox"/> Graduate degree |
| <input type="checkbox"/> Undergraduate college degree | <input type="checkbox"/> Other: _____ |

Other affiliations: _____

Other board service: _____

Known levels of giving: _____

Other pertinent information: _____

JOB DESCRIPTION COMMUNITY HEALTH CENTER BOARD MEMBER⁶

Duties and Responsibilities of Individual Board Members

- To put the interest of the health center above any personal or business interest
- To maintain the confidentiality of board information
- To attend board meetings regularly and participate actively
- To serve on at least one committee
- To review information and data provided to the board and make informed decisions
- To exercise reasonable business judgment in the conduct of board business
- To participate actively in board issues by critiquing reports and providing innovative resolutions to problems
- To assure that the needs and interests of the community are represented in plans and decisions regarding services to be offered by the health center

Required Knowledge and Skills of Individual Board Members

- Understanding of the concept and operation of a health center
- Ability to read and understand standard financial statements
- Ability to work with others on the board and in a community setting
- Training and/or experience in one or more of the following areas is desirable:
 - Management
 - Community affairs
 - Marketing/ PR
 - Personnel management
 - Health care delivery
 - Financial management
 - Employee relations
 - Law.

⁶ U.S. Department of Health and Human Resources, Health Resources and Services Administration, Bureau of Primary Health Care, Bethesda, Maryland. *Governing Board Handbook*. 2000.

BOARD MEMBER ORIENTATION CHECKLIST

The governance committee should develop a checklist, similar to the following, for use by new board members indicating what they need to take responsibility for learning about during their first three months on the board.

Information	What to Do	Date Completed
Program	<ul style="list-style-type: none"> ✓ Tour of facilities ✓ Presentation by chief executive, key staff, video or other electronic media ✓ Written materials 	_____ _____ _____
Finances	<ul style="list-style-type: none"> ✓ Presentation by chief executive, chief financial officer or treasurer ✓ Review of recent financials ✓ Learn how to read and understand a financial statement 	_____ _____ _____
History	<ul style="list-style-type: none"> ✓ Read written materials 	_____
Strategic Direction	<ul style="list-style-type: none"> ✓ Review of strategic plan 	_____
Organizational Structure	<ul style="list-style-type: none"> ✓ Review of bylaws ✓ Review of organizational chart ✓ Introduction to key staff members 	_____ _____ _____
Board Roles	<ul style="list-style-type: none"> ✓ Review of written materials ✓ Discussion with board chair or whole board 	_____ _____
Board Member Responsibilities	<ul style="list-style-type: none"> ✓ Signed letter of agreement ✓ Signed conflict-of-interest policy 	_____ _____
Board Operations	<ul style="list-style-type: none"> ✓ Review of board manual ✓ Meeting with board chair ✓ Accept committee or task force assignment ✓ Attend board meetings 	_____ _____ _____ _____

Chapter 3

Administration/Management

Guiding Principles:

- *Generate Revenues as Quickly as Possible*
- *Make Sure You Are Covered Against Liability*
- *Balance Mission and Money*
- *Use Your Resources to Do It Right the First Time*
- *Write It Down*

A strong management team is essential to a new health center's success. Health centers not only face the usual challenges common to all leaders, but also the demands and stresses particular to the underserved populations and/or service area that the new clinic will serve. This is not a process for the faint of heart or the loner. Many hands are needed to get the work done. Leaders who delegate power, provide choice, develop competence in others, assign critical tasks and offer visible support are well on the way to developing a strong, vital organization. Coordination and communication are critical issues at every step and juncture in the process of setting up the health center.

Charged with carrying out creating a new access point to provide comprehensive health care services, management walk a fine line between meeting the mission and the strategic objectives of the organization and protecting the resources of the organization to ensure that it is financial viable and cost-competitive. Sometimes a nonprofit organization's management team gets so focused on the mission, program and services, they do not give appropriate attention to assuring there is money to carry out the mission. This means not only acquiring revenues, but also providing for the most efficient use of resources.

Between the time of grant submission and Notice of Grant Award, it is probable that things may have changed in the community and the program design. **Revisiting key project issues is a first step to getting the project on a fast track so it won't be derailed because it no longer fits the needs of the community or the organization.** Although the Grant Award is a "contract" with the Bureau of Primary Health Care and HRSA, it is possible to make necessary design changes if it is warranted. **Contact your Project Officer if necessity requires deviating from the original project design.**

Develop Functional Realistic Policies and Procedures

Clear policies and procedures are an essential component to the smooth operation of an organization. **A policy is a statement of principle, plan or course of action. A 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 day-to-day operation of the clinic. Policies and procedures are valuable tools for training and educating, so they should describe your reality.

There are numerous policies, procedures and protocols that you must develop in order to manage the many different aspects of the clinic. Every health center is expected to have written policies and procedures approved and in place that cover issues in the areas of Governance, Management, Finance, IT, Clinical and Operations. These specific policies are discussed in each of the individual chapters. In addition, the BPHC Health Center Site Visit Guide (referenced in Chapter 1) provides a self assessment tool that will assist you in not only preparing for the BPHC reviewers, but also ensure that you have the correct policies and procedures in place.

Policies and procedures are usually developed by the management staff and approved by the board of directors. There are some policies and procedures that are common in most health centers and some that will be specific to your situation only. Don't let the enormity of this task overwhelm you. Do use whatever templates or samples you can find; but don't just copy someone else's policies. *If you use another policy as a template, modify, revise, reword and rework it so it fits your organization and situation.*

In order to be in compliance with numerous corporate, legal and professional requirements, you must document that you are managing your business up to standards. This is an area where doing it right the first time is critical.

Revisit Days/Hours of Operation

It may be necessary to revise the health center hours of operation in the beginning as the center becomes fully operational. Until all the providers are on board (see Chapter 4 for more on recruitment) it may not be possible to have the full hours of operation including evening or weekends. Establishing an opening date and hours early will help with marketing the services of the health center to the community.

Remember that changing the organization chart, hours/days of operations and such are policy decisions that must be approved by the Board.

Outreach to the Community

As the health center is becoming fully operational, it is important to develop an outreach plan for your target population. Regardless of if you are developing the plan in house or with a consultant, you will need to consider the following:

- What are the venues/mediums for reaching your target patient population?
- Involve the board and other key stakeholders
- Develop a timeline for implementing the outreach plan
- Create a process for evaluation

For more information on how to develop an outreach plan, visit http://www.businessconsultingabc.com/Developing_and_Writing_A_Winning_Marketing_Plan.html.

Make sure to connect early with your local schools. Contact the Parent-Teacher Organizations to educate them on your services. Come up with creative ways to get kids and their families into the center. Building your patient base with children will ensure an immediate revenue flow and help support further growth of the center.

Identify Critical Contracts, Licenses, Memberships

Highest priority on the to-do list needs to be any contracts, licenses or memberships that need to be in place before seeing patients. Be prepared - sometimes it takes several months to complete an application process or negotiate a contract for services. Here are some of the possible time critical tasks to consider.

To Contract or Not To Contract

Sometimes it just may be more efficient and cost effective to contract for certain aspects of operating a health center. This may especially be true as the clinic is “staffing up”. It is important to analyze which tasks are best performed in-house and where it may make better sense to contract for services. Here is a list of some potential areas to consider contracting for services:

- Billing
- Information Technology
 - Setting up the Practice Management System (PMS) and Electronic Health Record System (EHR)
 - EHR and data hosting
 - IT Support Infrastructure
 - Data warehousing and report generation
- Medical records system and training
- Lab Protocols and Hazardous Materials Handbook
- Staff training
- Outreach
- Housekeeping
- Grounds Maintenance

It is always wise to have your legal counsel involved in contract development and execution. Contracts involving billing should address patient protections such as how patients with the inability to pay are addressed with and who retains the right to proceed to bill for overdue accounts.

State Clinic Licensure

All health centers must be licensed by and compliant with all state, county and local operating laws. In some states this may include going through a Certificate of Need process that requires demonstrating a need for a new health care facility to be licensed. This can take months to accomplish. Other states have limits on the number of licenses granted. It is critical to be knowledgeable about the process and constraints and to address them immediately. Remember, no matter what else you do, you cannot open your doors without an operating license!

Tax identification numbers (federal and state) – health centers must be nonprofit, tax exempt corporations or public agencies. HRSA’s Bureau of Primary Health Care (BPHC) defines tax exempt as 501(c)(3) status. Clarification of HRSA’s corporate status requirements for public entities can be found at <http://bphc.hrsa.gov/policies-regulations/policies/pal201001.html>.

For more information on tax exempt status visit the IRS website at:

- <http://www.irs.gov/charities/index.html>
- <http://www.irs.gov/publications/p557/index.html>

National Provider Identifier (NPI) - The NPI is a unique identification number for covered health care providers and is a 10-digit, intelligence-free numeric identifier. This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used

in lieu of legacy provider identifiers in the Health Insurance Portability and Accountability Act (HIPAA) standards transactions. For more information visit: <http://www.cms.gov/NationalProidentStand/>.

A healthcare provider may apply for an NPI in one of three ways:

1. Through a web-based application process. The web address to the National Plan and Provider Enumeration System (NPPES) is <https://nppes.cms.hhs.gov>.
2. If requested, give permission to have an Electronic File Interchange Organization (EFIO) submit the application data on behalf of the health care provider (i.e., through a bulk enumeration process). If a health care provider agrees to permit an EFIO to apply for the NPI, the EFIO will provide instructions regarding the information that is required to complete the process.
3. Fill out and mail a paper application form to the NPI Enumerator. Health care providers may wish to obtain a copy of the paper NPI Application/Update Form (CMS-10114) and mail the completed, signed application to the NPI Enumerator located in Fargo, ND, whereby staff at the NPI Enumerator will enter the application data into NPPES. This form is now available for download from the CMS website (<http://www.cms.gov/cmsforms/downloads/CMS10114.pdf>) or by request from the NPI Enumerator. Health care providers who wish to obtain a copy of this form from the NPI Enumerator may do so in any of these ways:

Phone: 1-800-465-3203 or TTY 1-800-692-2326

E-mail: customerservice@npienumerator.com

Mail: NPI Enumerator
P.O. Box 6059
Fargo, ND 58108-6059

National Health Service Corps (NHSC) Site - Your health center can become a NHSC approved site which will allow you clinicians who are eligible for loan repayment to fulfill their obligation at your center. For more information and to enroll, visit <http://nhsc.hrsa.gov/>.

Clinical Laboratory Improvement Amendments (CLIA) Licenses - The Centers for Medicare & Medicaid Services (CMS) regulates all laboratory testing (except research) performed on humans in the U.S. through the Clinical Laboratory Improvement Amendments (CLIA). In total, CLIA covers approximately 200,000 laboratory entities. The objective of the CLIA program is to ensure quality laboratory testing. Although all clinical laboratories must be properly certified to receive Medicare or Medicaid payments, CLIA has no direct Medicare or Medicaid program responsibilities. For more information visit: <http://www.cms.gov/clia/>

DEA Number - A DEA number is a series of numbers assigned to a health care provider (such as a medical practitioner, dentist, veterinarian) allowing them to write prescriptions for controlled substances. Legally the DEA number is solely to be used for tracking controlled substances. The DEA number, however, is often used by the industry as a general “prescriber” number that is a unique identifier for anyone who can prescribe medication. <http://www.deadiversion.usdoj.gov/index.html>

340B Drug Pricing Program – The 340B Program limits the cost of covered outpatient drugs to health center patients. To enroll in the 340B program, you must submit a request to the HRSA Office of Pharmacy Affairs (OPA) with Medicaid billing information (**See Chapter 5**) and the appropriate form. For more information, visit www.hrsa.gov/opa/.

Medicaid and Medicare (See Chapter 5)

Managed Care Organizations (MCO) - Managed Care Organizations (MCOs) are health care organizations that provide services to Medicaid, Medicare, or privately-insured recipients within a specific geographic region. These organizations contract with a network of providers to provide covered services to their enrollees, and therefore it is essential that you contract with the MCOs.

NACHC recommends the following criteria as guidelines that can be used during relationship discussions:

- 1. Pay for value:** Health Centers have a long track record of providing efficient and high quality care for patients resulting in overall savings to the system (and the managed care plan responsible for the patient care). Reimbursements from payers should reflect this as consideration on payment.
- 2. Governance:** As a by-product of primary care focused operations, Health Centers should be engaged in committees and initiatives with MCO's jointly to represent a voice in local policies and processes impacting the community. *However, contracts with MCO's should not compromise the autonomous authorities of the Health Center Board in any way.*
- 3. Patient Stability:** reasonable expectation to increase patient volumes; – obtain MCO's commitment to protect community health centers provider/patient relationship and agreement not to reassign patients (auto assignment) without the request of the patient or irreconcilable problems.
- 4. Sharing of Data:** Comparative data showing performance of your health center against other health centers (un-identified) and against non-health centers. Data measures, at a minimum, include cost (of all care for patients), quality and other performance measures. Further breakdowns of these are desirable to identify specific areas for improvement.
- 5. Endorsement and Promotion:** MCO's should encourage local models of integrated care with primary care, including health centers, at their bases.

Malpractice and other Insurance Coverage

Before the clinic doors open, having the right kind of insurance coverage in place is a critical task. There are many types of insurance coverage for a health center and this is one area where expert advice is crucial.

The minimum coverage needed before opening is:

1. Professional liability insurance covering clinicians (**malpractice insurance**)
2. **Corporate or general liability insurance** - covers the health center corporation and its employees for errors and omissions not related to professional services (i.e. person slipping on a wet floor),
3. **Workers Compensation** - employers are required to have to cover employees who get sick or injured on the job.
4. **Directors and Officers Insurance (D&O)** - covers the volunteer Board against personal liability for health center actions.

Other types of insurance coverage that should be seriously considered are business bonding for employees handling money and finances, and employment practices liability insurance (EPLI). EPLI covers businesses against claims by workers that their legal rights as employees of the company have been violated. This is the #1 reason why health centers (and other employers) are sued! EPLI provides protection against many kinds of employee lawsuits, including claims of:

- Sexual harassment
- Discrimination
- Wrongful termination
- Breach of employment contract
- Negligent evaluation
- Failure to employ or promote
- Wrongful discipline
- Deprivation of career opportunity

- Wrongful infliction of emotional distress
- Mismanagement of employee benefit plans

Professional Liability Insurance, or malpractice, is commonly purchased for each provider and covers up to \$1 million in damages for any individual claim and up to \$3 million for aggregate claims over the course of a year. For some health center providers who provide a higher volume or obstetrical services it might be advisable to increase the amount of coverage for both individual claims and the annual aggregate amount of claims. In some cases health centers have been able to form insurance purchasing groups that have increased the amount of coverage purchased and lowered the cost of obtaining that coverage (contact the state/regional PCA for information on availability).

Federal Tort Claims Act (FTCA) coverage is free of cost to Federally Qualified Health Center Grantees and most health centers find that they can significantly reduce or eliminate their malpractice insurance costs by electing to participate in the FTCA program. In making a decision regarding whether or not to obtain traditional private malpractice insurance or participate in FTCA, a center should analyze its need for any “gap” or “tail” coverage to ensure adequate insurance coverage during the transition to FTCA coverage. Malpractice insurance is principal; therefore, legal counsel is advised for health centers that do not have coverage under the Federal Tort Claims Act.

Health centers must apply to HRSA to be covered, or “deemed,” as organizations that together with their employees are recognized as federal employees under FTCA for the purposes of claims for medical malpractice. Your project officer can assist you in explaining this process. This **process can take some time and it is important to have traditional malpractice insurance in place** until the process is completed and the health center is deemed.

Below are some resources on the application process:

- [2012 FTCA Application Presentation](#) – Replay number 800-337-5610
- [Calendar Year 2012 Requirements for Federal Tort Claims Act \(FTCA\) Medical Malpractice Coverage for Health Centers](#)
- [Federal Tort Claims Act \(FTCA\) Health Center Policy Manual](#)
- [FTCA Deeming User Guide](#)

As part of the application process, health centers must demonstrate that they have successfully implemented policies and procedures to minimize the risk of malpractice. In addition, health centers must provide HRSA with information on the initial and most recent credentialing and privileging dates of all licensed and certified health care providers. This policy applies to all health center practitioners, employed or contracted, volunteers and locum tenens, at all health center sites. Health centers must credential and privilege newly licensed and certified health care providers prior to the start of their service with the organization and then again at least every two years. **Please note:** FTCA coverage for health center providers covers only personal injury caused by negligent or wrongful acts or omissions that arise from the performance of medical, surgical, dental, or related functions that are within their scope of employment and within the health center’s federal scope of project.

For more information on FTCA including credentialing and privileging and quality assurance/ Improvement plans, see Chapter 6.

The Health Resources Services Administration has created a resource entitled: [Clinician’s Handbook on the Federal Tort Claims Act.](#)

Below are additional resources on FTCA:

- **HRSA/BPHC FTCA Website**
<http://bphc.hrsa.gov/ftca/>
- **For all Policies and Regulations Related to FTCA refer to:**
<http://www.bphc.hrsa.gov/policiesregulations/policies/qualityrisk.html>

Chapter 4

Human Resources/ Recruitment & Retention

Guiding Principles:

- *Develop a Staffing Up Strategy*
- *Prioritize Hiring the Clinicians*
- *Recruit with Retention in Mind*
- *Have Strong Human Resources Policies and Procedures in Place*
- *Communicate with Your Staff*

Create Systems That Encourage Capable, Confident Teams

People are one of the most valuable assets of a community health center. They are also the largest cost center a health center has. Well developed personnel systems will not only help you recruit the people you need to run the health center, but will also help them be more productive and happier. Valued employees stay longer. Recruiting and training new employees is time consuming and expensive. Retention saves the organization money.

Review the Organizational Chart

Take a look at the organization chart submitted with your application to assess whether or not it is current. An organizational chart is a communication tool. It helps managers and employees understand how the organization is structured, the relationship of various clinic functions and who does what. An organizational chart is no good to anyone if it contains untimely or inaccurate information, or if it is ignored. It is helpful to note on the chart what positions are vacant and when they will be filled. The organizational chart should be modified as staffing decisions are changed and it should be dated noting the date of board approval.

In reviewing your health center's organizational chart, ask yourself the following questions.

- Is the organizational chart streamlined enough so that issues can easily reach the appropriate party for resolution?
- Do we have appropriate supervision at all sites? Is staff at the sites able to relay information to central management?
- Is this the same organizational chart that we had when we were half our current size? Does it still apply?
- Do position responsibilities and reporting relationships make sense, or are they based on prior activities and no longer makes sense?

Develop a Strategy for “Staffing up”

Once you have a current organizational chart, you will want to develop a plan of which staff to hire first. Remember, according to the health center statute and HRSA regulations, **the CEO/Executive Director must be selected, evaluated, and removed (if needed) by the health center board.** It is recommended that the Chief Medical Officer/Medical Director and the Chief Financial Officer be employees of the Health Center. Lastly, the core team (at least 51%) of health center providers should be employees of the health center. Remember also that one of the emphases of the health center should be to provide economic benefit to the community - focus on hiring from within your community as much as possible.

Take a look at the time-framed work plan you have developed and decide which positions to add at various milestones to help accomplish the various tasks. If this is a new center, many of the clinical support staff will not be hired until 4-6 weeks before the clinic opens. It may be that the critical need in the first few weeks is an administrative assistant to help with all the paperwork or a nurse who can work on clinical protocols and procedures and medical supply ordering.

Below is a wide-ranging, but not inclusive, list of positions that a health center may choose to employ, along with sample job descriptions in the resource section. Although these are grouped clearly by department (Administrative, Financial and Clinical), there will most likely be crossover into multiple departments; crossover should be reflected on the organizational chart.

Administrative

- Chief Executive Officer (CEO)
- Compliance Officer
- Data Entry Specialist
- Development Director
- Executive Assistant
- Human Resources (HR) Director
- Chief Information Officer (CIO)
- Office Manager

Financial

- Chief Financial Officer (CFO)
- Accounting Manager/Controller
- Billing Supervisor
- Financial Counselor
- Patient Accounts Receivable
- Accountant/Bookkeeper
- Payroll Clerk
- Accounts Payable Clerk

Operational

- Chief Operating Officer (COO)
- Appointment/Scheduling Clerk
- Cashier
- Facility Manager
- Practice Manager/Site Manager
- Patient Registration Clerk
- Front Desk Supervisor
- Back Office Supervisor
- Medical Records Clerk
- Security Guard

Clinical

- Chief Medical Officer (CMO)
- Chronic Disease Manager
- Clinical Coordinator
- Dental Director
- Dentist
- Dental Hygienist
- Diabetic/ Health Educator
- Interpreter

- Licensed Practical Nurse (LPN)
- Medical Assistant (MA)
- Nurse Manager
- Nurse Midwife
- Nurse Practitioner (NP)
- Occupational Therapist
- Patient Care/ Assistance Program Coordinator
- Pharmacist
- Pharmacy Office Manager
- Physician
- Physician Assistant (PA)
- Psychiatrist/ Psychologist
- Quality Improvement (QI)/ Coordinator/Quality Assurance
- Registered Nurse (RN)
- Social Worker (LCSW)
- Triage Nurse

If this is a clinic that is already staffed, it will be necessary to review what additional positions are needed to expand to the full range of services. Some existing positions may need to be re-evaluated and modified to meet program needs.

Set a realistic recruitment timeline that reflects the amount of time it takes to advertise, interview and select an appropriate candidate. Although the grant application allows up to two years to reach full operational capacity you will want to begin providing the full range of services as soon as possible. Don't forget that the timing of hiring different positions will impact your budget and affect your cash flow. Make adjustments accordingly.

Prioritize Hiring the Clinicians⁷

You are in the business of providing health care services, and you cannot do this without clinical providers. Providers are also the ones who generate the money to keep the doors open and recruiting the right primary care providers are vital to the day-to-day operations of community health centers. Attracting highly skilled clinicians can be a slow process, but with proper planning and support from the local medical providers, your state/ regional PCA, and key community leaders, a successful recruitment plan can be implemented. The following steps provide some of the basics that should be incorporated into your physician (and other staff) recruitment plan. **Please note:** this plan can be used for both new health centers and those looking to expand. For additional details on each step, please refer to NACHC's Clinical Recruitment and Retention Toolkit - www.nachc.com/client/documents/CLINICAL%20RECRUITMENT%20AND%20RETENTION%20TOOLKIT_final1.6.11.pdf.

Step 1: Assess the need

Given the time and cost related to provider recruitment, it is essential that you determine your exact clinical staffing needs. The following can assist you in assessing your need:

- Review your service area
 - What is the population that the provider will serve?
- What providers are already serving the community?
 - This may have changed since you submitted your application.
 - Providers may have retired or limited the patients they see based on insurance coverage.
 - New providers may have moved in
 - The hospital may have hired Hospitalists
- Review national statistics for primary care demand
 - On average consumers visit their primary care physician 2.8 times per year and dentist 2.4 times per year.
 - Medicaid patients tend to see providers at a higher rate of 3.5 times per year and we know that seniors (Medicare beneficiaries) will require significantly more care than adolescents.
- Determine what type of provider is needed
 - Primary care specialty
 - MD, DO, DDS, DMD
 - Mid-level – are you seeking a nurse practitioner, physician assistant or dental hygienist?
 - Experienced provider or a new graduate?
 - Will you consider a foreign medical graduate (J-1 VISA)?
 - Does the provider need to speak a certain language/have certain cultural competencies?
- What are the responsibilities of the provider?
 - Scope of services
 - In clinic hours and number of patients to be seen
 - On call expectations
 - Administrative responsibilities

Once you have determined the number and type/ specialty of providers needed, you are ready to take the critical recruitment steps that follow.

⁷ Adapted from the Clinical Recruitment and Retention Toolkit Adapted with Permission from the *Recruitment & Retention Best Practices Model 2005*

Step 2: Identify and address potential barriers to successful recruitment and retention

The following checklist can assist you in identifying weaknesses or barriers to recruiting and retaining providers in your community. For each barrier, try to develop a strategy for removing or minimizing that barrier.

- Non-competitive compensation package (including salary and benefits)
- Required OB coverage and/or in-patient coverage
- Excessive call and coverage schedule
- No other local physicians to share on-call and after-hours coverage
- Lack of support by local providers
- Few professional opportunities
- Few professional opportunities for spouse
- Lack of basic consumer services and amenities within the community
- Lack of adequate housing
- Poor public school system
- Inadequate health center facility (lack of equipment, exam room, supplies)
- Operating inefficiencies of the facility, clinical operations, administrative approach
- Lack of sufficient staff and/or lack of adequately trained staff
- Turmoil in leadership, staff turnover and/or lack of organizational stability
- Lack of experienced practice managers in your office
- Poor clinic billing and coding practices.

Step 3: Consider outside resources that can enhance recruitment

The Office of Shortage Designation in the Health Resources and Services Administration (HRSA), Bureau of Health Professions develops shortage designation criteria and uses these data to decide whether or not a geographic area or population group qualifies to be designated as a Health Professionals Shortage Area (HPSA) or a Medically Underserved Area (MUA) or population (MUP).

The HPSA designation and the level of shortage indicated by the HPSA score, are a health center's entre to accessing providers of all kinds through National Health Service Corps. To inquire about the HPSA score for your community or health center, visit <http://bhpr.hrsa.gov/shortage> and search by state, county, and discipline.

In 2003, Reauthorization of the Consolidated Health Center Program instituted automatic HPSAs for every Federally Qualified Health Center (both grantees and Look-Alikes) in the country. As a result, all FQHCs benefit from a HPSA designation and all are eligible to participate in several programs. The automatic designation is set at the lowest score so to ensure being in a good qualifying position it is important to undergo a HPSA shortage study as well. The programs related to HPSA designation include:

National Health Service Corps (NHSC): The NHSC recruits primary care medical, dental, and behavioral health professionals who are dedicated to providing care to the nation's underserved communities. There are two principle means recruiting these health professionals through the NHSC; the NHSC Scholarship Program and the NHSC Loan Repayment Program.

NHSC Scholarship Program: This program provides scholarships for training health professionals, including primary care providers, who agree to serve in HPSA/MUA/MUP areas. As a rule, there is one year of obligated service for every year of training support. The NHSC pays tuition, required fees, and some other educational costs, tax free, for as long as four years and requires a minimum two year commitment. Educational costs may include books, clinical supplies, laboratory expenses, instruments, two sets of uniforms and travel for one clinical rotation. Recipients also receive a monthly living stipend (\$1,326 in 2010 – 2011) which is taxable. Upon completion of their educational training and completion of a residency training (family practice,

general pediatrics, general internal medicine, obstetrics/gynecology, or psychiatry, or general or pediatric dental) they are expected to begin work at an approved practice site in a high-need HPSA. For more information, go to: <http://nhsc.hrsa.gov/scholarship/>.

NHSC Loan Repayment Program: This program provides loan repayment opportunities for licensed primary care providers who have signed an employment contract with an NHSC-approved site to reduce or eliminate their health professions student debt. The full-time program starts with an initial award of \$50,000 for two years of service; the new half-time pilot program starts with an initial award of \$50,000 for four years of services. Participants may apply to extend their service until their debt is fully paid. For more information, go to: <http://nhsc.hrsa.gov/loanrepayment/>.

State Loan Repayment Programs (SLRP): In addition to the NHSC's SLRP, the Health Resources and Services Administration SLRP provides matching funds to more than 30 states to operate their own SLRP for primary care providers working in HPSAs. Eligibility requirements and benefits vary by state. Contact your State Office of Rural Health or State Primary Care Association for more information.

J-1 Visa Waiver Program (for International Medical Graduates/IMG): The J-1 Visa Program allows foreign medical school graduates to pursue post-graduate training in the United States. When training is complete, the graduates must return to their country of origin for a period of at least two years. A 1994 amendment to the Immigration and Nationality Act, however, created the J-1 Visa Waiver. With an approved J-1 Visa, IMGs may forego the mandatory return to his or her home country and remain in the United States to practice medicine in a HPSA or MUA. An IMG must serve in such an area for at least three years. At the end of the commitment, foreign-born physicians may apply for permanent residency status. For more information, contact your PCA/PCO.

Step 4: Gain support from your clinical and business community

Once you have determined what type of provider is needed, it is recommended that you have the involvement of the larger community, such as the external clinical (mental, dental, behavioral health) community and the business community. By gaining community support, you:

- Demonstrate the community's sincere interest in the new health center
- Begin building a patient base for the health center
- Make the new provider and his/her family feel more welcome in the community

If you do not formally involve the larger community, you may want to introduce the new health center and providers by placing an ad in the local newspaper and/or holding an open house once the site opens and the providers are onsite.

Step 5: Form the recruitment team

The recruitment team approach is one of the best ways to involve the community and reduce the amount of work for any one person. This team is not the same as the interview committee, but rather the group that works to bring candidates to the interview.

To apply the team concept effectively to recruitment, each member must be assigned a specific job. A member of the team or their approved delegate should cover the following functions:

- *Recruitment Coordinator*
- *Contact Person/Initial Interviewer*
- *Spouse/Significant Other Recruiter*
- *Reference and Credential Reviewers*
- *Promotion Developer*

Step 6: Define the practice opportunity

The recruitment process includes the candidate selling him/her **AND** the organization selling itself as a great place to work with a desirable community in which to live and raise a family with career opportunities for the provider and partner. Defining your opportunity will help you understand the strengths and weaknesses of your offer versus the competition; assist you with identifying candidates who are right for your opportunity; and help candidates better understand whether your opportunity and community is right for them. Take time to look at providers that are leaving other local practice venues. A person who is not comfortable in private practice or a hospital may end up being a perfect fit for you.

Describe the compensation package: Establishing a fair and competitive compensation arrangement for providers is essential to the continued growth and success of any community health center. Increasing local competition by organized medical groups, such as large group practices, and proprietary hospital corporations, will put pressure on health centers to offer both financial and professional incentives that will entice providers to practice in community health center environments.

Be aware of state, local and national competition for primary care providers. A health center must be prepared to emphasize what the organization uniquely offers, including the opportunity to work in a mission-driven organization, no owner/operator expenses, have flexible hours, and be a significant part of the community.

Compensation can vary, based on: specialty, training, years of work experience, additional skills, provision of OB or in-patient care, language skills, and willingness to take on other responsibilities, such as clinical quality improvement activities or other administrative responsibilities.

Flexibility is key to offering a compensation plan that not only is competitive in the local market, but is also tailored to meet the provider's compensation expectations and provide an incentive for productivity and delivery of quality care. Compensation packages can be as simple as a guaranteed yearly salary or as complex as a base salary, benefits, incentives and bonuses. Compensation arrangements are never permanent and should be periodically modified to protect the interest of all parties. Grants or contracts may affect the use of these funds for certain compensation plans. Examples of compensation approaches are noted below.

Straight salary: A fixed amount of money paid to the provider on a weekly, biweekly or monthly basis. It is simple to administer and may be used in combination with other plans. Although this method of compensation controls operating costs, it alone provides no incentive for productivity. The salary should be adjusted regularly to reflect economic conditions, the costs of providing services, and local competition.

Incentive-based salary: A compensation plan should ideally induce a provider to be a productive and contributing member of the health center. Some health centers offer financial incentives as part of their overall compensation packages. With incentives, the more a provider accomplishes or produces, the more pay or other benefits he or she receives. Incentives can be based on a variety of factors, including one or more of the following:

- Total revenue generated by the provider
- Patient face-to-face visits
- Total hours worked in direct patient care
- Net revenue of the CHC
- Hospital revenue generated by the CHC for in-patient admissions by the provider
- After-hours patient consultations
- Patient satisfaction survey results
- Clinical quality measures/indicators

It is important to note that incentive programs are a sensitive issue and it is important to have your legal counsel review the details of your incentive-based compensation program.

Fringe benefits: Fringe benefits are often a significant portion of a compensation plan. Some CHCs offer a flexible or “cafeteria-style” benefits plan, which allows the individual employee to select certain benefits instead of additional cash income. This system allows the organization to control costs while providing employees with the flexibility of choosing benefits that meet their particular needs. The following list contains examples of benefits other than salary that may be offered:

- Health insurance
- Dental insurance
- Life insurance
- Disability insurance
- Vision coverage
- Retirement or pension plan
- Tax-deferred annuity
- Vacation
- Holidays
- Sick leave
- Leave without pay
- Military leave
- Bereavement leave
- Maternity/paternity/adoption leave
- Educational leave (CME or CE)
- Sabbatical leave
- Compensatory time off
- Payment for jury duty
- Professional licensing fees
- Membership dues to professional societies
- Reimbursement for professional textbooks, manuals and journals
- Conference registration, travel and per diem for professional meetings
- Allowance for tuition, travel and per diem related to CME/CE
- Automobile expenses
- Cellular phone/“smart” phone

Below are some resources for salary surveys:

- **American Medical Group Association Compensation Survey -**
<http://www.cejkasearch.com/view-compensation-data/>
- **Merritt Hawkins 2008 Salary Survey of Primary Care Physicians -**
<http://www.merrithawkins.com/pdf/2008-mha-survey-primary-care.pdf>
- **NACHC’s Health Center Salary & Benefits Report© -**
<http://www.nachc.com/clinicalworkforceneed.cfm>

Step 7: Define your candidate

Now that you have defined who you are and what you have to offer, you must define to whom you want to offer the position. Who is the ideal person for your practice opportunity and for your community? What professional and personal traits does he or she possess?

This process is extremely important for a new health center as it not only helps solidify what you are looking for; it prepares the CHC for other phases of the recruitment process: searching for candidates and screening candidates.

Step 8: Create a recruitment budget

Physician recruitment is costly, both in dollars and time. A budget will give you an idea of all the different types of costs involved in the recruitment process over and above the compensation package. Some items to consider in developing a recruitment budget include:

- Promotion/Publicity
- Candidate Screening
- Site Visit and Personal Interviews
- Personnel

Step 9: Search for and generate a pool of candidates

Numerous sources are available to recruit physicians and are listed below. Each should be carefully considered for application in your community and to be sure that the particular recruitment effort is affordable.

Residency Programs/ Clinical Schools —Clinical and residency programs that focus on primary care such as family practice, obstetrics and gynecology, pediatrics, internal medicine, nurse practitioner, dentistry and psychiatry. A one-page announcement on your practice opportunity, which is suitable for posting on a bulletin board, can be sent to the directors of the various residency programs.

Other organizations – Sources for primary care providers include: primary care associations, primary care offices, state office of rural health, public health departments, National Recruitment and Retention Network (3Rnet), Area Health Education Centers (AHEC), national medical associations, National Health Service Corps, and preceptor programs.

State medical/ dental associations and local/ county medical/dental societies —These associations are excellent sources for physician recruitment. They can publish vacancies and provide lists of available physicians by specialty. In addition, they sponsor activities to increase their membership by recruiting recent graduates in the specialty areas in which you may be recruiting.

Advertising — Advertising can be an effective recruitment strategy, although expensive. There are several publications and media to consider including:

- Professional Journals
- Websites and other publications
- Newspaper ads.
- Direct mail.

Recruitment Firms — A number of placement bureaus and consulting firms specialize in recruiting physicians. If you decide to use a placement bureau, **shop around and read contracts closely** as they tend to be costly. There are usually two types of contract agreements:

1. Contingency – the health center does not pay unless a candidate is hired
2. Retained – the health center pays a set fee, at least a percentage of it upfront, to have the firm work on behalf of the organization.

The following are some other options to consider:

- Recruitment functions of your state or regional primary care association
- Retired military primary care providers. **The Uniformed Services Health Professional Placement (USHPP)** is the only contingency placement firm that works exclusively with military health care professionals seeking employment in their transition from the military into civilian practice. USHPP also presents military clinicians who are not retiring, but who have completed their military commitments. For more information, link to <http://www.valueinstaffing.org/>.
- Discounted recruitment services for health centers. For more information, visit <http://www.valueinstaffing.org/>.

Step 10: Screening candidates

Screening the candidates includes interviewing the candidate, spouse and family, checking references and credentials and conducting the site visit. The initial step in screening a candidate is usually done by phone. During that conversation:

- Provide an overview of the community, organization, and position.
- Determine the candidate's real interest, qualifications, and suitability for position, including whether salary and benefit expectations are within the range of the health center.

Before you invite the candidate to your community for an interview, check his or her references. This will save valuable time and money and avoid raising the expectations of the community unnecessarily. When checking references, it is important to:

- Ask for written and verbal references from those individuals listed by physician.
- Check references other than those provided by the candidate.
- Contact the medical director or administrator of the candidate's previous place of employment.
- Contact the chief of staff or administrator of the hospital where the candidate has had staff privileges.
- Contact the president of the local medical society.
- Have a member of the medical staff make telephone calls to other physicians for reference checks, if possible.
- If a relatively new provider, contact the director of the residency/clinical program
- The National Practitioner Data Bank should be queried (see the NACHC Issue Brief: *Updates to the National Practitioner Data Bank*, June 2010).

Keep in mind that a candidate may wish to relocate because he or she has some problems in the current community or place of employment, such as an inability to get along with patients and colleagues, substance abuse, or criminal behavior. Any applicant who appears anxious to join a practice without any investigation of the practice should be viewed with suspicion.

Step 11: Interviewing candidate(s)

Once the recruitment committee or administrator has identified a potential candidate that has met the criteria for further consideration and the references and credentials have been checked, the next step is inviting the candidate for an on-site visit and formal interview. Many healthcare facilities invite the spouse and family or significant other. Each facility must decide whether or not it will reimburse candidates for all or only part of the travel expenses.

Interviews and site visits are primarily focused on recruiting qualified candidates by emphasizing the positive aspects of your practice. However, this time must also be utilized to see if the candidate is compatible with your organization's mission, organizational culture, practice style, philosophy, personality and objectives. A good fit or match helps to insure a long-term relationship with the provider, your organization, and most importantly, for continuity of patient care. Remember that not every provider will fit into your organization's culture and mission. The goal is to find the right match.

Interview Questions for the Candidate

Interview questions assist in determining both whether a candidate meets the required qualifications and is a good "fit" for the position and the organization. Questions should be based on the job description, the qualities of the ideal candidate as developed by the Recruitment Committee, and required vs. preferred qualifications.

Note: Questions regarding the following may not be asked during the formal interview or informal, social settings: age, race, color, religion, national origin, physical disability, marital status, sexual orientation, military service, or parenthood/childcare arrangements.

The initial on-site interview is also an ideal time to determine the provider's salary and benefit expectations before negotiation. Often, negotiations determine course of the future relationship between the health center and the potential candidate. Therefore, it is important that the health center conduct a pre-negotiation assessment of the expectations of the candidate while also focusing on the health center's ability to accommodate those needs.

Step 12: Meet with the spouse (or significant other) and children

Most recruiters agree that in order to recruit a physician, the spouse or significant other and family also must be recruited. The spouse or significant other play critical roles in the physician's decision to work, live and remain in a community. Even if the physician finds the practice suitable, he or she is unlikely to accept the position if the community cannot meet the needs of the family.

A relationship must be established with the spouse or significant other during the initial telephone contacts before the visit, if possible. The professional and personal needs of the spouse can then be better addressed during the visit. Information on nearby colleges and universities, employment opportunities, housing and recreational and community activities can be forwarded to the spouse/significant other. A good way to introduce the physician's family to the community is by sending copies of the local newspaper to the family. You also should include a map or information from the chamber of commerce, community development authority or your state's visitor center.

Step 13: Conducting a creative site visit

In addition to allowing for the formal interview process to occur, the on-site visit can help sell the opportunity to the provider and his/her family. Ideally, the site visit should be between two to four days and allow the provider ample time to meet key members of the clinical and local community, as well as explore the community on their own.

Who should the candidate meet with?

This may be challenging for a new health center as the staff may not be in place yet. Think strategically and select key community leaders and providers that will best represent the health center.

1. One-to-one meetings with other clinical staff provide an opportunity for honest discussion regarding the strengths and challenges of the practice. Inform your providers ahead of time to be balanced in their discussions. Hopefully, they are pleased with their practice. If not, you may need to do some work on retaining your present clinical staff.
2. Tour the hospital and meet key hospital staff members, especially the Administrator, Chief of Staff, and the Director of Nursing.
3. The candidate may want to meet with community leaders and clinical staff away from the health center.
4. Host a lunch/dinner between the potential candidate and the clinical leader and selected clinical staff.

What should the candidate and her/his family (as appropriate) see?

1. Tour and experience the community – first with an escort and then alone –allowing the candidate and spouse/significant other to see the pros and cons of your community. This might include a tour of homes for sale with a local realtor.
2. Visit the facility where the candidate would practice.
3. Tour other relevant health care facilities.
4. If there are school-age children, meet the school principal(s) and tour the school(s).
5. Visit places of particular interest to each candidate and spouse – ask them before the site visit.

Being creative in site visits demonstrates to the prospective provider you listened to what they value in their professional and personal lives. Even if you decide to stick to a conventional site visit, you could create a virtual site visit showing the provider the fun and relaxing things available in your community. In planning a site visit, be flexible.

Apply the information that you learned about the provider and his or her family to develop the itinerary for the site visit.

What should you plan to do with the provider and his/her family?

1. Ideally, plan a social gathering where candidates can meet other staff, board members, private providers, and community members.
2. If there is a spouse or significant other, you may want to arrange a dinner or outing with the clinical lead and his/her spouse or significant other. Allow the spouses to have open discussion regarding the realities of the practice (daily schedule, time arriving at home, call, etc).
3. Have the candidate and his/her family experience a popular activity in your area that might be of interest – horse-back riding, white water rafting, hunting, skiing, live theatre, etc.

Candidates may sometimes evaluate the quality of the job offer in terms of how successful the site visit is.

Follow-up after the visit

If you want to hire a provider, an offer can be made before he/she leaves the community. Many who are experienced and successful at recruiting have already discussed salary amounts and negotiating points such as sign-on bonuses and moving expenses with the CEO or CFO prior to the candidate's visit. You may consider having a contract ready to present to the candidate at the end of the visit if you feel it is a good match.

There should be little delay before contacting the provider following the on-site interview, no later than one week after their visit. A letter can be sent to the provider following the site visit documenting what was discussed. The CEO (or Clinical or HR Director if in place) should telephone to confirm the health center's interest in hiring the provider and to get a commitment from the individual. Once the provider makes a commitment, a signed agreement should be obtained.

There may be some negotiation that occurs prior to agreeing upon a final contract. The negotiator or whomever is responsible for contracting in your organization can handle this. An attempt should be made to be as specific and complete as possible without extensive wording. The final employment agreement might include, but is not limited to, details related to a starting date, amount allowed for moving/relocation costs, sign-on bonuses, productivity incentives, time allowances for academic appointments or clinical teaching, or administrative duties. Productivity and quality expectations should be included as well.

If you decide that your organization will not offer the individual the position, then a polite letter should follow to inform them of the decision.

If the provider will be relocating, someone should be responsible for assisting the provider and his or her family in the relocation process. Living accommodations, spouse's and children's interests, school registration, religious and social affiliations and/or banking concerns may all need attention.

Provider Employment Contracts

A **standard provider employment contract** helps eliminate some of the areas of competition that can happen in a clinic. While there can be some flexibility in terms of monetary items, a standard contract would provide a common basis of non-monetary items. Provider contracts are one very important area where it is **important to have an attorney review any contract** before it is signed. One place to get some basic physician contracting information is the American Medical Association – the AMA has an entire section devoted to physician agreements at <http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/organized-medical-staff-section/helpful-resources/physician-employment-agreements.page>.

Expectations for effective recruitment and retention

It is important to remember that once you have the staff in place – **you need to retain them!** The national average to recruit a new physician is approximately \$24,500, which includes staff time spent on recruiting efforts and travel costs for the candidate. This flat dollar amount doesn't include the intangibles — the experience of the physician,

the time it takes to build relationships with patients or the time and effort it takes to train and orient a new provider. So it is well worth it for a health center to take all reasonable measures to keep its providers on the job.

If you recruited a provider using the recruiting for retention approach, paying particular attention to matching the candidates' characteristics with the needs of your community and organization, you will already have done a considerable amount of retention building. In fact, by ensuring a good match between the provider and the organization and community, you have built a solid foundation for retention. The closer the provider and family's interests match that of the organization and the community, the more likely the provider and community will be satisfied with one another over the long run.

However, this is just the beginning of an effective retention program. Once the new primary care provider arrives on site, you must implement strategies that accomplish the following:

- Welcome and orient the new provider and spouse/significant other to the professional clinical community and to the broader community.
- Anticipate and address concerns or issues that may be contributing to discontent by the newly recruited provider or those of the family, to avoid the potential for the provider or family member to want to leave the community or the health center.
- Allow ample time for the provider to enjoy life beyond the practice.
- Provide a thorough orientation to the organization, clinical practice and the specific position.

Once in their position, the following needs to be part of a successful retention plan for all providers:

1. Health center systems and policies should support clinicians with the tools and systems essential to providing a work environment that promotes and sustains quality of care, including high patient satisfaction. This includes human resources (well trained and adequate numbers of staff), facility and infrastructure, organizational culture, and technology, including electronic medical records.
2. Management based collaboration, work structured to be meaningful and challenging, as well as a commitment to share information and ensure participation in decision-making are key strategies for a stable and productive staff committed to the mission and future of the health center.
3. A competitive compensation and benefit package that is kept current with the market and also supports long-term retention, and enhances productivity and quality. Appropriate incentive plans and deferred compensation plans which are compatible with fiscal resources, the health center mission and management philosophy, and are in accord with state and federal laws, should be explored as methods to maximize the retention of productive, quality and committed health professionals.
4. Regularly scheduled staff meetings that promote open communication, feedback, and problem-solving. (See section on effective communication later in this chapter)
5. Keep the after-hours and weekend on-call schedule reasonable – for example, one out of every three - four working days, one out of every three - four weekends, or one out of every three weeks is considered reasonable.
6. Provide adequate time and funding for CME/CE.
7. Provide for peer interaction outside the community through attendance at state and national health center organizations.
8. Develop telecommunication links to practitioners in other communities and to medical education and support resources if those are not readily available in the area.
9. Sponsor periodic social gatherings.
10. Find a niche for providers to improve retention. It helps to survey providers during the contracting process in order to identify areas of special interest, for example: performing procedures; focusing on a special area of practice, such as pediatrics; academics/teaching; or, medical informatics. If at all possible, offer opportunities to fulfill these special areas of interest or skill sets.

In NACHC's [Clinical Recruitment and Retention Toolkit Recruiting to Retain Primary Care Providers](#) you will find some tools for tracking provider retention and guides to enhance provider retention. These tools are designed to be easy to use and effective in fostering good provider retention. They include:

- **A solid retention plan.**
- **Provider orientation and provider support.**
- **Tools for tracking retention.**

Issues beyond control sometimes impact a clinician's decision to stay or leave a practice. Although seemingly simple, retaining the right personnel can make or break the success of a practice. For more information on what influences a provider's decision to stay at a practice, review this article from *Healthcare Finance News*:

<http://www.healthcarefinancenews.com/news/study-new-factors-affect-physician-recruitment-retention>

Human Resources

Now that you have a plan for recruiting your staff, you need to make sure you have solid human resources policies and procedures in place. **Human Resources (HR)** refers to the physical labor and mental abilities that the people in your organization contribute to provide services in the health center.

HR management includes a variety of activities:

- Deciding what staffing needs you have
- Recruiting and training the best employees
- Helping them be high performers
- Dealing with performance issues
- Ensuring your personnel and management practices conform to various regulations
- Managing employee benefits and compensation,
- Maintaining employee records and personnel policies.

Often new health centers assign various HR responsibilities to management and supervisory staff until they are large enough to afford a part- or full-time Human Resources person. Sometimes smaller health centers partner with other small centers or their PCA to hire a professional HR Director as a shared service.

There are many important HR issues that will contribute to a successful health center. We have outlined some of them below and you can also find additional resources in NACHC's HR Clearinghouse at <http://www.nachc.com/hrclearinghouse/>.

Employee Handbook

This is an invaluable tool to inform employees about the organization's **policies, procedures and practices** and to communicate expected **standards of performance and conduct**. A well-designed handbook can create a sense of consistency of practice that will enhance the employee's feelings of being treated fairly and serve as a reference guide to help managers and supervisors take appropriate actions in a given situation. An organization will more likely **avoid liability** in employee lawsuits if critical policies such as harassment and discrimination and the grounds and procedures for termination are communicated and the guidelines are followed regularly.

Although writing an employee handbook may seem like a big task if you are a new organization, keep in mind that **most of the material already exists in the informal and/or unwritten policies and procedures that direct the organization's daily activities**. The Employee Handbook should contain answers to the questions most frequently asked by employees and information about basic employment issues that all employees need to know.

For sample personnel policies visit:

<http://www.migrantclinician.org/mcn/human-resources/personnel-policies-procedures/index.html>

http://iweb.nachc.com/downloads/products/HR_11_08.pdf

<http://www.nachc.com/hrclearinghouse/resources-search.cfm?CID=2>

This list is a good place to start; there may be other policies pertinent to your organization that you will want to include in the Employment Handbook. There are many sample Employee Handbooks and policies that can be used as templates. But it is always important to tailor the document to the practices that make your organization special.

It is important to **include appropriate disclaimers** so that the handbook is not interpreted as an employment contract or lead the employee to think that it is a complete list of the organization's policies and procedures. It is highly recommended that an **attorney review** the Employee Handbook to ensure that the policies comply with all applicable laws, and that your disclaimers are adequate to protect you when the need arises. Many labor laws vary from state to state and what may be applicable to one employer may not be relevant to you or even meet your needs.

Every employee should sign a form acknowledging that they received and read the Employee Handbook and that they agree to abide by all of the policies in it and will ask for clarification from supervisors when needed. This form is kept in the individual's personnel file and is the organization's proof that the handbook was distributed. The same acknowledgement of receipt should be signed whenever the handbook is revised or new policies added.

An Employee Handbook is meant to be **a guide that will be reviewed and modified** periodically to ensure that it accurately reflects changing policies and practices of the organization, as well as changes in federal, state or local laws. It is the responsibility of the governing Board of Directors to annually review and approve the Employee Handbook.

For more information on the national labor laws, visit the following websites:

- **National Labor Relations Act –**
<https://www.nlr.gov/national-labor-relations-act>
- **Fair Labor Standards Act –**
<http://www.dol.gov/dol/audience/aud-employers.htm>

Job Descriptions

This is a **list of the responsibilities and functions** required in a particular position. Job descriptions are an integral part of the hiring and selection process. In hiring, well-written job descriptions can help you make good hiring decisions. And hiring the right team is critical for your future success.

Although a job description defines a job, it is not the job itself. It is important to make a job description practical by **keeping it dynamic, functional and current. This is particularly important in a startup where actual responsibilities of a given job are likely to change** as the clinic and organization develop. By carefully creating and maintaining job descriptions, you can track changes in your organization and the development of your people, and identify what staff needs you must meet to achieve your overall goals. Flexible job descriptions will encourage your employees to grow within their positions and learn how to make larger contributions. A good job description should also be an integral part of the performance evaluation. Job descriptions should be reviewed regularly and goals and objectives updated on a yearly basis.

A Job Description should include:

- Job Title
- Job Objective or Overall Purpose Statement
- List of Duties or Tasks to be Performed
Describe the Relationships and Roles the position holds within the organization

- Job Specifications, Standards and Requirements
- Job Location
- Equipment to be Used in the Performance of the Job
- Collective Bargaining Agreements (if applicable)
- Salary Range (if recruiting)

The Free Management Library http://www.mapnp.org/library/staffing/specify/job_desc/job_desc.htm provides you with information on how to create job descriptions and numerous other issues related to human resources at no charge.

Creating and Maintaining Personnel Files

The process of creating and maintaining employee personnel files is another painstaking and time-consuming endeavor. Most people don't like to do a lot of paper work, but taking the time will pay off in the long run. **Accurate and up-to-date personnel files can help track the workforce, organize hiring and retention, and reduce liability.**

Every employee should have a personnel file that is started on the date of hire. The employee's personnel file should only contain information pertaining to recruitment (employment application), selection (employment reference verification), duration of employment (evaluations, payroll records) and termination's (evaluations, employee warnings, and exit interviews).

Documents indicating medical information, sexual harassment claims, accident investigations, and any documents regarding ongoing legal claims should be kept in a file separate from the employee's personnel file.

Form I-9, verifying that the person is legally authorized to work in the United States, should be kept in a separate file from the employee's personnel and medical records. You can keep all the I-9s together in one file that contains only I-9 information in case there is a need to review them. The U.S. Citizenship and Immigration Service (USCIS) is entitled to inspect these forms. Employers are required to maintain I-9 forms for three years from date of hire, or one year after termination, whichever is later.

All personnel files should be treated with the respect due to the individual it represents. They should be **maintained in a secure setting** to ensure that access is limited. In most states, employees, and former employees, have the right to view their personnel files. The details of this access vary from state to state. If your state allows employees to see their files, you can insist that a supervisor be present to make sure nothing is taken, added or changed. There are also other employees who have a legitimate need to view the information in a personnel file. For example, a supervisor may need to review performance evaluations to decide whether to promote an employee, or the human resources manager may need to review an employee's salary information to decide what to pay a new hire in the same position. **Access to personnel files should be guided by personnel policies and federal and state laws.**

Maintaining a personnel file with accurate, timely, and relevant information and establishing mechanisms to ensure security and confidentiality will safeguard the privacy of employees and their relationship to the organization. In-discreet entries that do not directly relate to an employee's job performance and qualifications -- like references to an employee's private life or political beliefs; or unsubstantiated criticisms or comments about an employee's race, sex, or religion -- will come back to haunt you. A good rule of thumb: Don't put anything in a personnel file that you would not want a judge or jury to see.

Performance Appraisals

Few decisions are as important as selecting and promoting those employees who will contribute to an organization's success. Every manager would probably agree that performance appraisals are important, but they are often postponed or not done at all. If they are done for the wrong reasons and from the wrong perspective, such as only focusing on what people have done wrong, then they can damage work place trust, undermine harmony, and fail to encourage personal best performance. **The most important purpose or goal of performance appraisals is to improve performance in the future.** This applies not just for the employee, but managers as well who can benefit by getting valuable information from employees to help them make employee's jobs more productive. Your performance appraisals should be a very important tool that helps the organization identify the strengths and weaknesses of an employee, identify training needs and builds effective and productive teams.

Feedback is integral to successful performance appraisals. The feedback, however, should be a discussion. Performance appraisals that are approached in a constructive way, **using a cooperative dialogue approach, put the manager and employee on the same side of working towards improving performance.** Both the staff person and her/his manager have an equal opportunity to bring information to the dialogue. Feedback can also be obtained from peers, direct reporting staff, and customers to enhance mutual understanding of an individual's contribution and developmental needs. Individual performance objectives are measurable and based on prioritized goals that support the accomplishment of the overall goals of the total organization.

There are many performance appraisal systems designed and used in organizations that have been established to facilitate the giving and receiving of feedback. However many are not used or implemented properly and systems often measure what is easy, rather than what is important. **Challenge your creativity and design a performance management system that fosters real change in your organization.** Visit http://www.hr.ucdavis.edu/forms/Perf_Eval/000 for some samples and suggestions.

Communicate, Communicate, Communicate

Nothing will make more of a difference in the health center's smooth functioning and morale than keeping people informed and involved. Communication and problem solving in a group is important. **Good meetings can help facilitate the cooperation** needed to efficiently and effectively work together.

Good communication doesn't just happen. It's important to develop a regular schedule of staff meetings. Meetings will be more productive and effective if they are planned and conducted properly and many organizations develop ground rules for conducting meetings.

Below are eight ways to make meetings better⁸:

- 1. Be prepared.** Meetings are work, so, just as in any other work activity, the better prepared you are for them, the better the results you can expect.
- 2. Have an agenda.** An agenda can play a critical role in the success of any meeting. Be sure to distribute the agenda and any pre-work in advance. By distributing the agenda and pre-work before the meeting, participants can prepare for the meeting ahead of time. As a result, they will be immediately engaged in the business of the meeting, and they'll waste far less time throughout the meeting.
- 3. Start on time and end on time.** Everyone has suffered through meetings that went way beyond the scheduled ending time. If you announce the length of the meeting and then stick to it, fewer participants will keep looking at their watches, and more participants will take an active role in your meetings.

⁸ Conducting Effective Business Meetings, Dr. Kathleen Allen, Ph.D. and Peter Economy

4. **Have fewer (but better) meetings.** Call a meeting only when it is absolutely necessary. Before you call a meeting, ask yourself whether you can achieve your goal in some other way, perhaps through a one-on-one discussion with someone in your organization, a telephone conference call, or a simple exchange of e-mail. As you reduce the number of meetings you have, be sure to improve their quality.
5. **Include, rather than exclude.** Meetings are only as good as the ideas that the participants bring forward. Great ideas can come from anyone in an organization, not just its managers.
6. **Maintain the focus.** Meetings can easily get off track and stay off track. The result - not achieving their goals. Meeting leaders and participants must actively work to keep meetings focused on the agenda items. Whenever you see the meeting drifting off track, speak up and push the other attendees to get it back in focus.
7. **Capture and assign action items.** Unless they are held purely to communicate information, or for other special purposes, most meetings result in action items, tasks, and other assignments for one or more participants. Don't assume that all participants are going to take their assignments to heart and remember all the details. Instead, be sure that someone has agreed to take on the job of record keeping. Immediately after the meeting, summarize the outcome of the meeting, as well as assignments and timelines, and e-mail a copy of this summary to all attendees.
8. **Get feedback.** Every meeting has room for improvement. Be sure to solicit feedback from meeting attendees on how the meeting went right for them — and how it went wrong. Whatever the problems, you can't fix them if you don't know about them. You can use a simple form to solicit feedback, or you can simply informally speak with attendees after the meeting to get their input.

Staff Training

Staff training is an essential part of your retention plan. Training can be provided onsite at the health center or you may choose to send staff to trainings sponsored by other organizations such as the state/ regional PCA or NACHC. Ongoing training for your staff provides employees with:

- **Proper tools** to do the job so they can function at their highest standards
- **Current regulations and guidelines** that are constantly changing in health care;
- **Accountability**
- An opportunity to emphasize the organization's **mission, vision, structure and initiatives**
- **Retention** - turnover is not only expensive, but adds chaos in the organization and a sense of instability in the community
- **Consistency** between satellite sites
- **Standard performance measures** which have the added benefit that patients are more trusting because they feel that staff know what they are doing.

A commitment to a well-trained work force is not a one-time proposition. **Developing an on-going training program is important.** In the Practice Set-Up Checklist (<http://www.nachc.com/client/documents/FQHC%20Set%20up%20checklist.pdf>) there is a list of training topics for all staff, front desk and billing staff in the resource section.

Chapter 5

Finance

Guiding Principles:

- *Know What You Need to Survive*
- *Ensure That You Have Revenue Capabilities in Place*
- *Enroll in Medicare and Medicaid on the Earliest Possible Date*
- *Keep Track – Develop Monitoring Systems*

Health center program requirements require that the “health center maintains accounting and internal control systems appropriate to the size and complexity of the organization” and that has “systems in place that maximize collections and reimbursement for costs in providing health services.” This includes safeguarding the clinic’s assets, billing for services, developing and monitoring the clinic’s budget and reporting program data. This section will walk you through accessing your grant funds, enroll in Medicaid and Medicare, as well as how to operate your health center finance department. Financial systems are complex and extremely important to the viability of the health center, therefore, let this section be a guide for you and refer to the resources listed, your PCA, NACHC and other experts in the field for additional information.

Payment Management System

One of the first things that comes into your mind is “How do I get my grant money?” This is a very appropriate question. Payments occur through the HHS Division of Payment Management (DPM) - <http://www.dpm.psc.gov/>. This is fully automated and full service centralized grants payment and cash management system. DPM has a website that will walk you through the process of signing up for an account and the different reporting requirements. You can also contact your Grants Management Specialist listed on your notice of award (NOA).

Operating a Health Center Finance Department

Once you have the money in hand one of the most important duties of a community health center is managing the finances in a conscientious and appropriate way. **Developing, maintaining and overseeing finances cannot be over-emphasized**, as it can mean an organization’s failure or success. The key is developing a good system and finance department, which will:

- Ensure that adequate financial controls are in place
- Produce annual budgets that reflect goals and policies
- Include board approval of financial reports and investment policies
- Require monthly and quarterly review of financial reports
- Require review of audited statements
- Require review and revision of the budget periodically
- Include monitoring of organization’s cash flow
- Document all financial policies and procedures
- Require board members to be well-informed about organization’s finances

Chief Financial Officer (CFO)

The CFO is one of the most important components of the health center’s management staff and of the finance department. Therefore, it is essential that you hire the right person to oversee and manage the health center’s finances. Below you will find some core competencies that you will want your CFO to possess as well as an overview of what the CFOs role will be. **Remember this is just a starting point – every health center is different, so you may have some unique requirements.**

It is highly recommended that if the clinic CFO has no prior experience working specifically with health centers that he/she **attend a training seminar**. Although most of the accounting principles are the same, there are many issues specific to running a community health center that are unique. This is also a good way to **develop a network of experienced people that can be called upon when questions arise.**

The role of the CFO is to:

- Maintain the books and records of the health center
- Ensure compliance with all applicable laws and regulations
- Oversee all assets
- Provide information, insight and guidance as a key member of the management team in the strategic planning process
- Provide financial information to the board in conjunction with the management team
- Monitor and control billing to third parties and collection

- Act as a liaison to external parties in regard to financial information
- Develop and monitor budgets (including regulatory, internal management, and capital)
- Manage cash flow

Core competencies that a CFO should possess:

- Bookkeeping / accounting skills
- Preparation of financial statements
- Billing and collections
- Healthcare operational expertise – preferably with community health centers
- Grants management
- Treasury management (including financing)
- Interpersonal, negotiation, and supervisory skills
- Knowledge of information management

Depending on the size of your health center, other staff in the finance department can include:

- Accounting Manager/Controller
- Billing Supervisor
- Financial Counselor
- Patient Accounts Receivable
- Accountant/Bookkeeper
- Payroll Clerk
- Accounts Payable Clerk

Finance Policy and Procedure Manual

The Finance Policy and Procedure Manual is an effective financial management system. The manual is used as reference and is the foundation for all proper reporting and regulatory compliance. The manual provides a detailed explanation of how to process transactions and guides staff. Most importantly it provides for strong internal controls, the safeguarding of assets, segregation of duties, and accurate financial reporting. In addition, the manual ensures compliance with regulatory requirements.

The sections of the manual should include:

- Preparation of Financial Reports
- Chart of Accounts
- Cash Disbursements
- Cash Receipts
- Journal Entries
- Maintenance of Accounting Records
- Requisitioning, Purchasing and Receiving
- Accounts Payable
- Payroll

- Accounts Receivable
- Fixed Assets
- Billing
- Statistical Data Collection

For more information, see NACHC's publication on the Role of the Health Center CFO - http://iweb.nachc.com/Purchase/ProductDetail.aspx?Product_code=FM_10_07

Financial Management Systems

Health centers usually have the following three financial systems:

- 1. Accounting System** – this system encompasses your general ledger, accounts payable, cash receipts and financial statements. This system should provide you with accurate expense information, and therefore, you **MUST** have a proper structure for chart of accounts and posting of transactions.
- 2. Payroll System** – it is generally most cost effective to use an outside agency such as Paychex or ADP for payroll. The vendor must provide you with customized reports in a timely manner.
- 3. Patient Information System** – this system will handle all billing, accounts receivable and statistics. You will need to develop (or have developed) customized reports on revenue and statistical information.

The health center finance department will use these systems to generate various reports throughout the year. Therefore, it is essential that the financial management systems are set up correctly the first time!

Reporting and Monitoring

There are **many different indicators that shed light on financial health** status. Cash flow, accounts receivable, payer mix, patient volume, billing, expenditures to budget ratio and provider productivity are some to keep an eye on. It is important that the **CEO and CFO communicate regularly** (at least monthly, preferably weekly, sometimes daily) to monitor the center's financial status and progress. Remember that **many other systems affect finances** such as HR, insurance coverage, political and legal matters, so be sure to monitor and discuss these aspects of business as well.

In addition to regular, standard financial reports to the board, be sure to keep them informed about any current problems or upcoming issues. The board of directors is legally accountable for the financial health of the organization so be sure to facilitate their ability to carry out this responsibility.

In order to appropriately monitor, keep the board informed and prepared for the annual audit, clinic management needs **to develop written financial policies and procedures** for board approval. Compliance with your internal policies and procedures should also be regularly monitored to assure impeccable financial ethics and accuracy.

External Reporting Requirements

The following agencies will need to receive reports on a regular basis.

- Bureau of Primary Health Care
- State and Local Funding Agencies
- Medicaid/ Medicare Cost Reports
- Tax Returns
 - IRS
 - Form 990
 - Form 5500
 - State/ Local Tax Authorities

Internal Reporting Requirements

Health center management, the board of directors and finance committee will need to review financial reports on a regular basis that reflect the health center profit and loss, cash flow projections, patient flow and provider productivity. These reports will vary based on the audience (i.e. Executive Director/ CEO vs. Finance Committee)

Reports for Health Center Management - Daily or Weekly Basis:

- Encounters by individual provider vs. standard
- Visits by payer and payer mix
- Cash position
- Encounters – appointments kept vs. no-shows

Reports for Health Center Management – Monthly Basis:

- Revenue and expense statements by department/ program/site
- New users by payer
- Days in accounts receivable by payer source
- User trends-Medicaid to self-pay
- Managed care actuarial mix and utilization
- Contract revenue and receivable analysis
- Patient revenue per visit by payer source

Board of Directors – the finance department will need to generate monthly financial statements for the board. These statements should be in the same format each month for consistency and should include:

- Balance sheet – current year vs prior year
- Statement of operations
 - Current year vs. budget
 - Current year vs. prior year
- Report of patient visits
 - By payer source vs. budget and prior year
 - By provider type vs. budget and prior year
- Key financial indicators
- For more information on board reports, visit the Across the Board website, http://www.vacommunityhealth.org/across_the_board.cfm

Finance Committee – the committee will need to receive the board reports as well as the following:

- Cash flow projections – weekly vs. monthly
- Medicaid Managed Care analysis

For more information on reporting, refer to NACHC's publication on Board Reporting, http://iweb.nachc.com/Purchase/ProductDetail.aspx?Product_code=FM_8_07.

Uniform Data System (UDS)⁹

The UDS is a core set of information appropriate for reviewing the operation and performance of health centers that tracks a variety of information, including patient demographics, services provided, staffing, clinical indicators, utilization rates, costs, and revenues. UDS data are collected from grantees and reported at the grantee, state, and national levels.

The UDS report is a requirement for all health center grantees.

All new grantees that receive health center grant awards and are operational by October of the reporting year are required to submit UDS reports. Data are reported annually in the first quarter of the year. For example, for Calendar Year 2010, the UDS submission deadline was March 31, 2011.

The data is reviewed to ensure compliance, improve health center performance and operations, and report overall program accomplishments. It also helps to identify trends, enables HRSA to establish or expand targeted programs and identify effective services to improve the health of the health center patient population. UDS data also informs Health Center Program grantees, partners, and communities about the patients served by Health Centers.

For more information on the UDS Report visit <http://bphc.hrsa.gov/healthcenterdatastatistics/index.html>

OMB A-133 Audit

Health Centers are required to have an A-133 audit because they expend more than \$500,000 in federal funds per year. **Work with your board to retain a competent auditor to conduct your federally mandated annual audit.** Someone with experience auditing federal grant programs is preferable. Don't make the mistake of hiring an auditor who tries to help you skirt accounting or federal requirements; this can come back to bite you later. Often times other health centers in the area or your PCA are the best resources for audit firms.

For more information on the A-133 audit, visit

- **OMB Circulars -**
http://www.whitehouse.gov/omb/circulars_default
- **Federal Audit Clearinghouse Homepage: Guidelines for preparing an A-133 Audit -**
<http://harvester.census.gov/sac/>

Establishing a Grant File

It is imperative that the health center create a centrally located corporate file that houses all of the health center documentation related to its compliance with grant requirements. This file should contain the following:

- Application and Notice of Award (NOA)
- HRSA and BPHC correspondence
- HRSA Performance Review and other site review reports (i.e. The Joint Commission)
- Federal Financial Report (FFR)
- Semi-annual Reports (SAR)
- Audit Reports

The file should also include all grant related laws, regulations and policies as well as Policy Information Notices (PINS) and Policy Assistance Letters (PALs).

⁹ HRSA's Website – Health Center Data <http://bphc.hrsa.gov/healthcenterdatastatistics/index.html>

Understanding Health Center Reimbursement

The Health Center Program requires all health centers to have systems in place that maximize collections and reimbursement for costs in providing health services. This entails billing Medicaid and Medicare under the FQHC payment systems, collecting all applicable co-pays and deductibles, and contracting with private insurers as appropriate.

The 2010 UDS Data¹⁰ indicates that nearly 38% of the health center patient population is uninsured, almost 39% is covered by Medicaid, about almost 7% are covered by Medicaid, and about 14% is covered by private insurance.

Reimbursement Methodologies

Fee-For-Service

Under a standard Fee-For-Service (FFS) reimbursement methodology, the level of reimbursement is based on the actual services provided. Specific services are indicated using the nationally used Current Procedural Terminology (CPT) codes. The coding system was developed as a standard approach to communicate services, procedures and supplies amongst the health care industry. These 5-digit codes are required by federal law and are updated annually by the American Medical Association (AMA). It is essential keep the most current edition on hand for billing purposes in order to accurately reflect services rendered by providers within the health center.

For additional information on CPT codes visit the AMA's website at <http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.page>.

Per Visit Payment

Both Medicare and Medicaid reimburse FQHCs a predetermined amount for each qualifying patient visit. These rates are specific to each health center, and reflect a range of factors including historical costs, caps, etc. The health center receives the same rate for each visit, regardless of the specific type and quantity of services provided.

Capitation

Capitation is a fixed monthly amount the health center has agreed to be paid for each patient, or the contracted rate for each member assigned, sometimes referred to as “per-member-per-month” (PMPM) rate, regardless of the number or nature of services provided. The amount of revenue a health centers earns is dependent upon the number of enrollees, not the number of visits a patient has per month. Under the capitation agreement a Health Center can earn more revenue by increasing participation, controlling utilization, and providing fewer and/or less costly services. *It is highly recommended that health centers who wish to enter into a capitation agreement seek legal counsel and financial advice first.*

Payer Sources

Medicaid¹¹

Health centers currently serve 14 percent of all Medicaid beneficiaries, and generally, one-third of all health center revenue comes from Medicaid. Therefore, **it is important to understand the complexities of the Medicaid Prospective Payment System (PPS).**

The following is a brief overview of Medicaid PPS, but if this is not something you have prior experience with, **please take the time to learn and understand the ins and outs of this system.** State **Medicaid departments will regularly audit your account** and demand repayment if errors are uncovered. Do not let this happen to you! Contact your state Medicaid office, PCA or NACHC for technical assistance.

¹⁰ UDS 2010 Data Snapshot <http://bphc.hrsa.gov/uds/datasnapshot.aspx?year=2010>

¹¹ The National Association of Community Health Centers

PPS Payment System

The health center Medicaid PPS was established by Congress with the intent of ensuring appropriate payment for covered individuals while not forcing health centers to cross-subsidize Medicaid out of their federal grant funds. The system has the following characteristics:

- Is a bundled per-visit payment, not open-ended fee for service
- The payment rate is unique to each center's cost/scope (see how this calculated below) and is not a single universal rate
- The rates are set prospectively, with limited growth

Medicaid PPS Rate Setting

For new FQHCs, Medicaid PPS rates are set using one of the following methods:

- The rates established for the fiscal year for other centers or clinics located in the same or adjacent area with a similar case load or
- In the absence of such a center, in accordance with Medicare FQHC regulations and methodology
- Based on other tests of reasonableness as the Secretary may specify. This generally a projected or historical cost report.

For each fiscal year following the first year in which the entity qualifies as a FQHC, the State plan shall provide for the payment amount to be calculated as follows:

- Health centers will complete a Medicaid Cost Report for their first full year, and Medicaid will establish a baseline rate. For more information on cost reports – <http://www.cms.gov/center/fqhc.asp>.
- The state will reconcile the baseline rate with the interim rate. Adjustments will be made retroactively for any over or underpayments during the initial year.
- The baseline rate will be increased annually with the Medicare Economic Index (MEI) - <https://www.cms.gov/>

For more information on Medicaid PPS, refer to the following resources:

- **NACHC's Medicaid PPS website** - <http://www.nachc.com/medicaid-prospective-payment-system.cfm>
- **NACHC's presentation on Medicaid Scope of Service** - www.nachc.com/client/Medicaid%20FQHC%20PPS%202%202010.ppt

Also note that state Medicaid programs have the option to reimburse FQHCs using an Alternative Payment Mechanism (APM) instead of a PPS. In order to use an APM, it must meet two requirements:

- Result in payment at least as high as what would have been paid under PPS.
- Be agreed to by the individual FQHC receiving it.

Medicaid Managed Care

Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through an arrangement between a state Medicaid agency and managed care organizations (MCOs) that accept a set payment – “capitation” – for these services.

Health centers negotiate a rate with the managed care company, which pays them this rate directly. They then will need to bill the state for the difference between the negotiated rate and the PPS rate (called the “wraparound” amount). While the calculation of wrap-around differs among states, federal guidelines require that health centers must be paid at least quarterly for the wrap payment.

In most states, health centers submit monthly or quarterly reports to the state calculating wraparound payments. This is calculated by as follows:

$$\text{PPS Wrap Payment} = (\text{Medicaid Managed Care Visits} * \text{PPS Rate}) - \text{Medicaid Managed Care cash receipts}$$

For more information on contracting with Medicaid Managed Care companies, see the Chapter 3.

For additional information on Managed Care visit the National Association of State Health Policy (NASHP) website on “Managed Care” at <http://www.nashp.org/taxonomy/term/25>

Enrolling in Medicaid

Each state administers its own Medicaid program while the federal [Centers for Medicare and Medicaid Services](#) (CMS) monitors the state-run programs and establishes requirements for service delivery, quality, funding, and eligibility standards. You must enroll with your state Medicaid office in order to be eligible for reimbursement by Medicaid patients to your health center. As mentioned previously, once you are enrolled as an FQHC you are eligible for the Medicaid PPS rate, **so you should contact your state Medicaid office right away to obtain the enrollment forms**. You can locate information on your state Medicaid office at www.aphsa.org/Links/links-state.asp.

Each state has its own rules about when a health center may enroll, and when payment at the PPS rate becomes effective. For example, many states require that a health center has *completed* the Medicare enrollment process before it can submit a Medicaid enrollment application. Also, many states will not start to reimburse an FQHC under PPS until the date that the Medicaid enrollment application is approved, and will not make PPS payments on a retroactive basis. Therefore, many months can elapse between the date that a health center becomes operational and the date that it becomes eligible for PPS payment under Medicaid. **To minimize this time period, it is critical to submit both Medicare and Medicaid enrollment applications as soon as possible, and to closely monitor their progress through the approval process.** For more information on enrolling in Medicare and Medicaid, see HRSA’s Program Assistance Letter 2011-04, “Process for Becoming Eligible for Medicare Reimbursement under the FQHC Benefit” at: <http://bphc.hrsa.gov/policiesregulations/policies/pal201104.html>

Below are additional resources for Medicaid:

- **HRSA: Medicaid Reimbursement for Behavioral Health Services**
<http://bphc.hrsa.gov/policiesregulations/policies/pdfs/pin200405.pdf>
- **Children’s Health Insurance Program**
<https://www.cms.gov/home/chip.asp>
- **Instructions for obtaining a Medicaid Provider Number**
<http://www.cms.gov/home/medicaid.asp>

Medicare¹²

Generally 7% of health center revenue comes from Medicare. This section will focus on the how health centers are reimbursed through Medicare and how you can enroll in Medicare.

Medicare FQHC Rate Setting

The health center’s Medicare rate is set based on the following steps:

1. Health center completes 855A for each of its sites
2. Health center gets an interim rate of \$50 per visit and can begin billing
3. Health center completes a projected cost report for any 12 month period
4. Center receives and gets paid on an interim rate, and

¹² The National Association of Community Health Centers

5. Rates are then trended annually by MEI and the health center gets the lesser of its actual allowable cost per visit and the upper payment limit (UPL)
6. Medicare reconciles actual rate to beginning of FQHC billing automatically through a remittance advice
7. Health center completes a Medicare cost report every year

Under per visit payment system, FQHCs receive an all-inclusive amount for each covered visit, regardless of the specific services that were provided. Services covered under this all-inclusive per-visit amount include a range of primary care services, and services incident thereto, including physician, physician assistant, nurse practitioner, and certain other non-physician practitioner services such as clinical social worker and clinical psychologist services. They also include a range of preventive services as well as pneumococcal and influenza vaccines.

Under Medicare Advantage plans, FQHCs receive a wrap-around payment equal to the difference between what the Medicare Advantage plan pays the FQHC, and the all-inclusive per-visit amount the FQHC otherwise would receive under Medicare per visit payment system.

In addition to the services reimbursed under the all-inclusive rate, there are a few additional services for which Medicare will reimburse FQHCs separately. For these services, the health center must submit separate bills to Medicare under the names of the individual providers. Examples include the technical components of many preventive services, such as pap smears and prostate cancer screenings.

Enrollment in Medicare

As discussed above, **it is critical to submit your enrollment application to Medicare as soon as possible.** You may not submit the application prior to becoming operational; therefore, we recommend that you have the application dated and ready to mail on the first day of operations. Medicare payment under the FQHC system will not begin until the date that the application is approved, and is not retroactive; therefore, any delay in submitting or gaining approval for the application will result in a delay in receiving the FQHC payment rate under Medicare (and in many states, a similar delay under Medicaid.)

The enrollment application form is the Medicare 855A, which is available at www.cms.gov/MedicareProviderSupEnroll/. **Note that the application must be submitted on paper.**

At this time, health centers **cannot** enroll in Medicare online using the Provider Enrollment, Chain and Ownership System (PECOS). Note that PECOS will accept applications from FQHCs, but will reject them a few weeks later.

To determine where to submit your application, go to https://www.cms.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf.

The correct address is listed next to “Fiscal Intermediary” for your state. For more information on the Medicare enrollment process, see PALL 2011-04 at <http://bphc.hrsa.gov/policiesregulations/policies/pal201104.html>.

Once you have completed the appropriate forms and receive approval you will get an interim rate of \$50 per visit and can begin billing.

Below are additional resources on Medicare:

- **CMS: Medicare site**
<http://www.cms.gov/home/medicare.asp>
- **CMS FQHC Center**
<http://www.cms.gov/center/fqhc.asp>
- **Instructions for obtaining a Medicare Provider Number**
<http://www.cms.gov/home/medicare.asp>
- **Medicare Billing**
<http://www.cms.gov/MLN MattersArticles/downloads/SE1039.pdf>
- **Rural Health Clinics and Federally Qualified Health Centers Billing Guide**
<http://www.cms.gov/MLN MattersArticles/downloads/SE1039.pdf>

- **Process for Becoming Eligible for Medicare Reimbursement under the FQHC Benefit Program Assistance Letter 2011-04**
<http://bphc.hrsa.gov/policiesregulations/policies/pal201104.html>
- **Key Points from PAL 2011-04 Process for Becoming Eligible for Medicare Reimbursement under the FQHC - FAQ sheet**
<http://bphc.hrsa.gov/policiesregulations/policies/pdfs/pal2011-04keypoints.pdf>

Commercial Insurance

Commercial or Third Party Payers are also often referred to as employer paid health insurance. Examples of commercial insurance companies are Anthem and Medical Mutual. You will need to negotiate a contract for services with these companies to be reimbursed for providing services for their insured patients. For tips on negotiating these contracts, refer to this article <http://www.physicianspractice.com/display/article/1462168/1588180>.

In general, patients with commercial insurance will likely be above the 200% FPL which requires them to pay any portion of their charges that are not covered by their insurer. It is also acceptable to charge these patients co-pay during the time of their visit.

Self-Pay - Sliding Fee Schedule

Section 330 statute requires that health centers have a “schedule of fees or payments for the provision of its services consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation” AND have “a corresponding schedule of discounts to be applied to the payment of such fees or payments, which discounts are adjusted on the basis of the patient’s ability to pay.”

The health center schedule of discounts must conform to the following guidelines:

- Be made available for all individuals and families with an annual income below 200 percent of the poverty guidelines.
- Provide for a full (100 percent) discount for all individuals and families with an annual income below 100 percent of the poverty guidelines.
- Nominal fees may be collected from individual or families with an annual income at or below 100 percent of the poverty guidelines when imposition of such fees is consistent with project goals.

Below are additional resources on Sliding Fee Scales:

- **HRSA-Sliding Fee Scale Requirements**
<http://bphc.hrsa.gov/slidingfeescale/default.htm>
- **NHSC Discounted/Sliding Fee Schedule Information Package**
<http://nhsc.hrsa.gov/communities/pdf/FeeScheduleForm.pdf>
- **Poverty Guidelines, Research, and Measurement**
<http://aspe.hhs.gov/poverty/>

Billing and Collections

Section 330 statute further requires that “health centers have systems in place to maximize collections and reimbursement for its costs in providing health services, including written billing, credit and collection policies and procedures”. That is why it is essential that you have an effective system to collect the sliding fee payments (and other insurance copays) from the patients. If you **collect payment at the time of service** (just like a co-pay for insured patients), you avoid the costly staff time of billing later and you increase your rate of collection. Some clinics suffer severe financial consequences from providing inappropriate free care by failing to collect from their sliding fee patients. Patients value the care and the appointment schedule more fully and maintain their dignity if they are paying according to their ability. **No one benefits from non-collection.**

There must be a billing and collections policy in place that the Board of Directors has approved. This policy should include the following:

- Staff responsible for the billing and collections process
- The frequency that statements are sent to all patients. Statements should include the current month's new charges and any old balances, showing a total amount due.
- Plan for placing accounts on restriction (unless it is an emergency) if the account is 120 days past due, and the patient hasn't made any effort towards payment or arrangements for payment.
- Process for writing off bad debt
- Establishment of an installment plan

The Migrant Clinicians Network has developed a presentation on [The Art of Collections](#) that includes effective tips for how to set up your front desk and collecting fees from patients.

Another resource is NACHC's [Establishing and Collecting Fees for Health Center Services](#). This document is intended to clarify Section 330-required billing and collection requirements generally, with specific attention to issues that Health Centers frequently encounter in contracting with third party payors.

Diversify Revenues

Do not make the mistake of thinking the grant will cover all of your clinic's expenses. Most health centers generate about 30% of their revenue through state Medicaid payments and about 20% from their federal grant. **It is critical to be established / registered as a provider in your state's Medicaid program as soon as possible** (see earlier section on Medicaid). Remember that in most states, all delays in enrolling in Medicare and Medicaid result in delays in receiving Medicaid payment under the FQHC PPS system. Many health centers participate in enrollment procedures to assure any patient eligible for Medicaid coverage is actually enrolled.

This leaves the rest of your revenues that must be generated from other sources. Some states provide primary care dollars to health centers and other providers who serve the poor. Some county or even municipal governments also provide money for health centers. Other sources may include Medicare, private insurance, and grants from foundations or corporations, private donations, investment income and fundraising events.

Operational Budget¹³

Health center statute requires that "health centers have developed a budget that reflects the costs of operations, expenses, and revenues (including the Federal grant) necessary to accomplish the service delivery plan, including the number of patients to be served." Preparing an annual budget and the continuous monitoring of the budget allows the health center management and board to anticipate and prepare for the effects of change from year to year. The issue of payer mix illuminates one challenge to producing an accurate budget forecast. Projecting a budget begins with the determination of assumptions – both internal and external – and (if available) a review of historical visit volume, expenses, and revenue.

With that being said, all projections are really guesses, so do your research and analysis and base your guesses on the best information you can obtain. Monitoring the budget on a monthly basis will ensure the organization is apprised of the actual financial situation and will allow for adjustments in expectations and planning on ACTUAL numbers not projections.

There are three common approaches to building an operational budget, deciding on the exact approach depends on your organization, management style, and current environment.

¹³ The National Association of Community Health Centers

Zero-Based Budgeting

These are budgets that are built from the unit level up and each unit of revenue (visits, rates, grants) and costs (salaries, fringes) are created based on expected performance.

Advantages:

- Yields careful consideration of all items
- Allows center to measure the impact of specific items
- Allows for decision making at the lowest level

Disadvantages:

- Each part does not necessarily tie together as a whole
- Time consuming

Top-Down Budgeting

These budgets are built from the highest level down (total revenue, total expenses). Goals for the entire health center are applied to the total revenue and expenses and then the individual components (sites, programs) can adjust their budgets accordingly.

Advantages:

- Looks at the whole picture
- Allows for management to have large budget influence
- Measures realistic health center goals

Disadvantages:

- Can ignore more specific, important unit level issues

Incremental Budgeting

This form has prior year amounts trended based on expected performance.

Advantages:

- Incorporates historical data with expected trends
- Easy and quick to create

Disadvantages:

- Hard to trend from full-year vs point in time (i.e. FTE that started in the middle of the year)

Steps to Preparing an Organizational Budget

1. Prepare a Projected Visit Report – Focus on:
 - User trends
 - Payer mix
 - Provider productivity
2. Revenue Projections
3. Budget Expenditures
4. Bottom Line/ Budget Balance Sheet
5. Review

Pitfalls in budgeting:

- Not having enough detail
- Having key amounts that are not linked to each other
- Assuming that provider productivity will increase without justification
- Using gross revenue or inaccurate net revenue

- Assuming that payment under the Medicaid PPS rate and the Medicare all-inclusive per visit rate will become effective prior to the enrollment process being completed
- Forgetting about the facility's physical restraints
- Forgetting to project replaced of fixed assets over time
- Forgetting about the competition
- Focusing on too much detail
- Basing plans on potential grant funding opportunities
- Not monitoring actual results and variance from plans
- Not adequately planning for needed cash

Things to remember...

1. Run at least a worst-case scenario to analyze health center performance and financial viability
2. Do monthly projections on a monthly basis for variations in performance
3. Standard format makes it easier for EVERYONE (staff, board, banks, funders, etc)

Federal 330 Grant Budget

The **annual** Federal 330 budget that accompanies the grant application differs from the operational budget for the health center organization. The 330 budget **must** be related to the health center's scope of project activities, sites and services. It is a requirement that the annual grant budget be approved by the Board of Directors. Any other programs, sites or services that are not part of the federal scope of project are not to be included in the Federal 330 Grant Budget.

Key points in developing the 330 budget are:

- A 330 budget must balance - this means that revenues and expenses must equal each other.
- Revenue projections should be conservative, yet realistic, and be based on provider full-time equivalents (FTEs) and productivity with anticipated reimbursement rates.
- A 330 budget should be in-line with the prior years' actual experience, accounting for any known new programs or major operational changes.
- A 330 budget is a hybrid accrual/cash budget, since depreciation, in-kind contributions and bad debts are not included.

The 330 budget is submitted with the 330 grant application that is due 120 days before the beginning of the health center's grant year.

Business Planning

A business plan is a formal statement containing a set of business goals, the reasons why they are believed attainable, and the plan for reaching those goals. A business plan may also contain background information about the organization or team attempting to reach those goals.

The business goals may be defined for either for-profit or not-for-profit organizations. For-profit business plans typically focus on financial goals, including profit or creation of wealth. Non-profit business plans tend to focus on organizational mission, which is the basis for their non-profit, tax-exempt status, although non-profits may also focus on optimizing revenue.

A business plan differs from a strategic plan (see next section for more information on strategic plans). The business plan focuses on the financial outcomes of a project, program or service, whereas the strategic plan typically establishes goals and objectives with action plans detailing how the objectives will be accomplished. Business plans usually project over a five-year period, in contrast to a strategic plan which is often a three year plan.

The primary value of a business plan will be to create a written outline that evaluates all aspects of the economic viability of a business venture, including a description and analysis of business prospects.

Reasons for writing a business plan include:

- A business plan could be developed for growth, using the health center's strategic plan as the planning tool
- A business plan can assist a Health Center in navigating complex changes to its operations, environment, and development
- Opening a new site or service, startup and financial feasibility
- A business plan provides the analysis behind the decision to enter into a new venture
- Support a loan application
- Raise equity funding
- Evaluate a new service or expansion
- Define agreements between partners

Parts of a business plan include:

- Executive Summary
- Organization Summary
- Project Description
- Project Objectives
- Market Summary - Market and Environmental Analysis
- Goals & Objectives
- Financial Plan
- Evaluation

Developing a business plan can help ensure the organization meets its objectives in a way that preserves viability and improves financial performance.

For addition information, refer to the Clinical and Financial Performance Measures - <http://bphc.hrsa.gov/about/performanceasures.htm>

Strategic Planning

(See Chapter 2 - Governance)

Additional Information for the Financial Health of Your Health Center...

As you can see, the financial issues of a community health center are extremely complex, even more so than a hospital. Fortunately the National Association of Community Health Centers (**NACHC**) **regularly holds Health Center Financial and Operations Management seminars**, which gets into all the nuts and bolts of a financial system. NACHC has also published a financial training manual for FQHCs called Accounting Policy, Procedures, and Operations Manual. Information about workshop schedules and publications can be found on the NACHC website at www.nachc.com. In addition, your state and regional PCAs also have trainings on financial and operations management.

Chapter 6

Clinical

Guiding Principles:

- *Build in Best Practices Standards From Day One*
- *Appreciate and Support Clinical Care Givers*

At the center of every Health Center is a **patient-centered health care delivery system**. The health center's clinical team addresses the health needs of the population in the service area including preventive services, early diagnosis and treatment, acute and chronic care, mental health, dental, and other care on an inpatient and outpatient basis as deemed appropriate by the team. This comprehensive model of care that is patient centered and population focused is based on standards that promote fairness, quality, and satisfaction. There are two main key ingredients necessary to make an outstanding clinical program - dedicated and caring health professionals and a clinical system focused on quality, best practices and continuous improvement.

Clinical Personnel

Role of the Chief Medical Officer

The Chief Medical Officer (CMO) plays a key part in the clinic management team. CMOs face the challenge of overseeing a myriad of organizational efforts and requirements for improving quality of care, patient safety and customer satisfaction. Health centers must have a CMO with **skills in leadership, management, problem solving, communication, negotiation and consensus building**. In addition to a regular day-to-day clinical practice, CMOs are expected to:

- Provide leadership and management for health center clinicians whether employees, contractors or volunteers
- Work as an integral part of the management team
- Interact regularly with the governing board
- Establish, strengthen and negotiate relationships between the health center and other clinicians, provider organizations and payers in its marketplace

This is undoubtedly a demanding role, not to be taken lightly. There are peer networks of CMOs (some are sponsored by your PCA and NACHC) and training programs through organizations such as NACHC (<http://www.nachc.com/clinicalfornewmedicaldirectors.cfm>) and the [American College of Physician Executives](#) that support CMOs. **Many physicians, although willing to take on the role of CMO, have little training** in managing clinic personnel, funding, accreditation, and ever-changing policies and regulations. Don't just throw them into the lion's den! This is a challenging and important role in a community health center and they need training and support to do a good job. **Build time into your CMOs schedule to get the training she/he needs; build this into your budget**. You will want this critical management position to be filled by a person with a long term commitment to the organization. Treat the CMO with respect, as a team partner and retention will be likely.

Additional Clinical Staff/ Core Services to Be Provided

In addition to the Chief Medical Officer, you will need to hire additional clinical staff based on the services you will be providing. The health center statute requires that health centers provide “all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established written arrangements and referrals.” It is extremely common for health centers to contract for oral health and behavioral health (especially in the beginning).

There are no specific requirements about how many people or what positions you should hire. It will depend on how your program is structured and what services you offer directly and what you decide to contract for. For example, some clinics use RNs only for triage and follow up and use MAs for direct clinician support. Below are some examples of the clinicians that you will need to hire as you begin to “staff-up”:

- Chronic Disease Manager
- Clinical Coordinator
- Dental Director
- Dentist
- Diabetic/ Health Educator
- Licensed Practical Nurse (LPN)
- Medical Assistant (MA)
- Nurse Manager
- Nurse Midwife
- Nurse Practitioner (NP)
- Patient Care/ Assistance Program Coordinator
- Pharmacist
- Pharmacy Office Manager
- Physician
- Physician Assistant (PA)
- Psychiatrist/ Psychologist
- Quality Improvement (QI)/ Coordinator/Quality Assurance
- Registered Nurse (RN)
- Social Worker (LCSW)
- Triage Nurse

Remember, there can be a fine line between having the right number and type of people to do an effective job and personnel costs that blow out the budget. The **average ratio of support staff to provider for community health centers in 2009** was 2.4 direct medical support per medical provider, and 2.9 patient support staff (front office) per provider.

Encouraging staff **flexibility in the roles they undertake and the hours they work** helps retain dedicated, creative employees with the patient's best interests at heart. For more information on staff retention methods, refer to Chapter 4.

Once you have the right people in place, training them properly is crucial. **The key to lasting organizational success and sustaining a competitive advantage is a high-performing workforce. Clinician providers need training too.** For more information on staff training, refer to Chapter 4.

Who's In Charge Here?

A large stumbling block to effective and efficient operations of the clinical is the question of whose job it is. Many CEOs believe clinical operations are the responsibility of the CMO, since it is a clinical system. Many CMOs believe it is the responsibility of the CEO, since it is an administrative system. Both are correct. **Clinical operations are both administrative and clinical in nature.**

Designing and managing the operations systems directly linked to patient care require both clinical and administrative expertise. A clinician may want to focus on providing care to patients, but if an administrator, who has never provided care designs the scheduling system, it may not meet the clinician's needs. Likewise, if a clinician, who has never managed the finances, designs the scheduling system, it may inadvertently have a negative impact on the clinic's revenues. Both clinical and administrative staff must **understand the impact each system has on each other system** and be committed to full integration.

One way to resolve this dilemma is to **hire one clinician with administrative experience** to manage the clinic operations. **Another model is a partnership between the CEO and CMO** where they work closely together to design and manage these operations.

FTCA and Program Requirements

Chapter 1 discusses in detail the importance of medical malpractice insurance as well as the FTCA process. This section will focus on the credentialing, privileging and quality assurance piece of FTCA. As part of the application process, health centers must demonstrate that they have successfully implemented policies and procedures to minimize the risk of malpractice. Two of the required policies and procedures include:

- A Credentialing and privileging Policy And Procedure; and
- A Quality Assurance/Improvement Plan.

Credentialing and Privileging Plan

Credentialing is the process of assessing and confirming the training, experience, and competence of a licensed or certified health care practitioner. **Privileging is the process of authorizing the specific scope and content of patient care services** they can perform in your clinic after reviewing their clinical qualifications. These checks are critical to minimize the clinic's liability and to assure that your clinicians can be accepted to practice at your local hospital, granted membership in professional organizations and licensed in your state, if they are recruited from another state.

Your clinic should **have a credentialing and privileging plan that defines the standards for verifying education and licenses of the clinical staff you hire**. This formal process should include querying the National Practitioner Data Bank and meet the standards of national accrediting agencies such as The Joint Commission (TJC) and the Accreditation Association for Ambulatory Health Care, Inc., (AAAHC) as well as the Federal Tort Claims Act (FTCA). (See Chapter 1 – Getting Started for more information on Accreditation)

Verification of a specific credential often must be from a primary source to determine the accuracy of a qualification reported by an individual health care practitioner. Examples of primary source verification include, but are not limited to:

- Direct correspondence
- Telephone verification
- Internet verification
- Reports from credentials verification organizations

This is a technical and time consuming process involving some liability. **It can be assigned to an appropriate staff member or contracted to an outside vendor** specializing in this service. Remember – technology is such that people now have the ability to create real-looking fake diplomas. All diplomas, certificates, etc, should be received from the certifying institution, NOT from the provider.

[**PIN 2001-16 Credentialing and Privileging of Health Center Practitioners**](#), explains that regular verification of the credentials of health care practitioners. In addition, HRSA has also put out [**PIN 02-22 Clarification of Bureau of Primary Health Care Credentialing and Privileging Policy Outlined in Policy Information Notice 01-16**](#), which further explains the rule that all Health Center practitioners, employed or contracted, volunteers and locum tenens, at all health center sites be credentialed and privileged.

Note: For purpose of the FTCA deeming, [**PAL 2011-05 New Requirements for Medical Malpractice Coverage Deeming under the Federally Supported Health Centers Assistance Act for Calendar Year 2012**](#) requires that the Health's credentialing list include all the independent licensed or certified health care personnel employed and or contracted directly by the health center.

As part of their Risk Management Series, [**NACHC's Information Bulletin #9, Credentialing and Privileging of Health Center Clinicians: Tips To Help Navigate the Legal Pitfalls**](#), outlines the following:

- Health centers' obligations to credential and privilege all of their practitioners
- Applicable guidance issued by the Bureau of Primary Health Care ("BPHC")
- Potential risks and liabilities should a Health Center fail to credential and privilege as required
- Tips on establishing procedures for ensuring compliance with this obligation

Quality Assurance/Improvement Plan

Performance measurement and quality improvement activities are critical elements for excellence in the health care industry.

Performance improvement is a system that promotes change and provides an effective environment for continuous improvement while meeting patient expectations.

Quality improvement (QI) refers to conducting activities aimed at improving processes to enhance the quality of care and services.

Quality assurance (QA) refers to a broad spectrum of evaluation activities aimed solely at ensuring compliance with pre-established quality standards. Quality Assurance activities can identify and help establish priorities for potential quality improvement projects. QI and QA approaches can build on and complement one another.

Elements of a Quality Assurance Plans should include:

- Patient satisfaction and access
- Quality of clinical care
- Quality of the work force and work environment
- Cost and productivity
- Health status outcomes
- Performance measurements using standard performance measures and accepted scientific approaches that compares results with comparable providers serving similar populations at the state and national level
- Improvement goals and progress
- Responses to advances or changes in clinical care
- Utilization management and maximizing value, quality improvement of appropriate specialty, pharmacy, hospital and other services

In the competitive industry of health care, the successful clinics are the ones who are constantly reviewing and upgrading standards that include improved safety, effective outcomes, patient-centeredness, timeliness, efficiency, and equity. **All health centers must have a governing board approved, written quality assurance plan that includes both clinical services and management issues and that documents performance and improvement.**

Health center quality improvement systems should have the capacity to examine topics such as:

- Patient satisfaction and access
- Quality of clinical care
- Quality of the work force and work environment
- Cost and productivity; and
- Health status outcomes

Centers are encouraged to establish performance standards in concert with other health centers serving similar populations. In analyzing performance data, health centers should compare their results with other comparable providers at the state and national level, and set realistic goals for improvement. Periodic reassessment enables health centers to measure progress toward these improvement goals and respond to advances or changes in clinical care. Since successful utilization management is an effective means of delivering appropriate services and maximizing value, quality improvement studies addressing utilization management of appropriate specialty, pharmacy, hospital and other services is key.

Additional Resources for Quality and Clinical Measures:

- **Agency for Healthcare Research and Quality (AHRQ)**
<http://www.ahrq.gov/qual>
- **Community Health Association of Mountain /Plains States**
<http://www.championline.org/ToolsProducts/ClinicalResources/QualityImprovementTools.html>
- **HRSA Quality/Performance Improvement and Risk Management Training**
<http://bphc.hrsa.gov/policiesregulations/quality/index.html>
- **Institute for Healthcare Improvement**
<http://www.ihf.org/ihf>
- **National Public Health Performance Standards**
<http://www.phf.org/pmqi/nphpsp.htm>
- **National Quality Measures Clearinghouse (NQMC)**
<http://www.qualitymeasures.ahrq.gov/>
- **National Quality Forum**
<http://www.qualityforum.org>
- **National Committee for Quality Assurance**
<http://www.ncqa.org/>
- **The Paths to High Performance Grantee TA Call**
Presentation slides:
<http://bphc.hrsa.gov/technicalassistance/trainings/highperformance06072011.pdf>
To listen to the mp3 file of the call:
<http://bphc.hrsa.gov/technicalassistance/taresources/qualityjourneyreplay060711>
Transcript:
<http://bphc.hrsa.gov/technicalassistance/taresources/qualityjourneytranscript060711>
- **Public Health Foundation-Performance management and QI Programs**
[http://www.phf.org/programs/Pages/default.aspx?showResources=false&subcategory=Performance%20Management%20and%20Quality%20Improvement%20\(PMQI\)](http://www.phf.org/programs/Pages/default.aspx?showResources=false&subcategory=Performance%20Management%20and%20Quality%20Improvement%20(PMQI))

Patient Satisfaction

Patient Satisfaction allows the health center to understand how patients value the services they receive. HRSA has developed a survey to provide health centers with information on how their patients' view the services that were provided. Health centers can use the results to design and track quality improvement over time, as well as compare themselves to other Health Centers. The survey is available in both English and Spanish, and can be found at: <http://bphc.hrsa.gov/policiesregulations/performanceasures/patientsurvey/satisfactionsurvey.html> .

Patient-Centered Medical Home (PCMH)¹⁴

The Patient Centered Medical Home (PCMH) is an approach to providing comprehensive primary care. The PCMH will broaden access to primary care, while enhancing care coordination. Separate from Accreditation is HRSA's support of Patient Centered Medical Home (PCMH) recognition provided by the National Committee for Quality Assurance. Additional information regarding the NCQA PCMH recognition process can be found at <http://www.ncqa.org/> and in BPHC's Program Assistance Letter 2011-11 - <http://bphc.hrsa.gov/policiesregulations/policies/pal201101.html>.

Clinicians practicing in the highest level medical home will:

1. Take personal responsibility and accountability for the ongoing care of patients
2. Be accessible to their patients on short notice for expanded hours and open scheduling
3. Be able to conduct consultations through email and telephone
4. Utilize the latest health information technology and evidence-based medical approaches, as well as maintain updated electronic personal health records
5. Conduct regular check-ups with patients to identify looming health crises, and initiate treatment/prevention measures before costly, last-minute emergency procedures are required
6. Advise patients on preventative care based on environmental and genetic risk factors they face
7. Help patients make healthy lifestyle decisions
8. Coordinate care, when needed, making sure procedures are relevant, necessary and performed efficiently.

In 2007, the [American Academy of Family Physicians](#), [American Academy of Pediatrics](#), [American College of Physicians](#), and [American Osteopathic Association](#) released the following *Joint Principles of the Patient-Centered Medical Home*:

- **Personal physician:** each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
- **Physician-directed medical practice:** the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- **Whole person orientation:** the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for arranging care with other qualified professionals.
- **Care is coordinated and/or integrated,** across specialists, hospitals, home health agencies, and nursing homes.
- **Quality and safety** are assured by a care planning process, evidence-based medicine, clinical decision-support tools, performance measurement, active participation of patients in decision-making, information technology, and other measures.
- **Enhanced access** to care is available (e.g., open scheduling, expanded hours and new options for communication).
- **Payment** must recognize the added value provided to patients who have a PCMH. For instance, payment should reflect the value of "work that falls outside of the face-to-face visit," should support adoption and use of health information technology for quality improvement, and should recognize case mix differences in the patient population being treated within the practice.

¹⁴ NCQA

Additional Resources on PCMH:

- **BPHC Program Assistance Letter 2011-01**
<http://www.bphc.hrsa.gov/policiesregulations/policies/pdfs/pal201101.pdf>
- **CHAMPS Patient-Centered Medical Home (PCMH) Information and Resources**
<http://www.championline.org/ToolsProducts/CrossDiscResources/PCMH.html>
- **HRSA Clarification of Credentialing and Privileging Policy**
<http://bphc.hrsa.gov/policiesregulations/policies/pdfs/pin200222.pdf>
- **NCQA Medical Home Recognition**
<http://www.ncqa.org/tabid/631/default.aspx>
- **PCMH Resource Center**
http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483
- **The Commonwealth Funds' May 2010 Issue Brief: Providing Underserved Patients with Medical Homes: Assessing the Readiness of Safety-Net Health Centers**
http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2010/May/1395_Coleman_providing_underserved_patients_med_homes_ib.pdf
- **Medical Home Implementation Quotient Assessment (MHIQ)**
www.transformed.com/mhiq/welcome.cfm
- **National Academy for State Health Policy (NASHP) "Medical Home and Patient-Centered Care"**
<http://www.nashp.org/node/28>
- **NCQA 2011 Medical Home Assessment Tool**
www.pcdc.org/resources/patient-centered-medical-home/pcdc-pcmh/ncqa-2011-medical-home.html
- **Outlook Assoc./Qualis Health**
<http://www.qualishealth.org>
- **Patient-Centered Patient Centered Collaborative (PCPCC)**
<http://www.pcpcc.net/patient-centered-medical-home>
- **Patient-Centered Medical Home Assessment (PCMH-A), Public Copy**
www.qhmedicalhome.org/safety-net/upload/PCHM-A_SNMHI_092710.pdf
- **PCMH Checklist**
www.aafp.org/online/en/home/membership/initiatives/pcmh.html
- **Primary Care Development Corporations Obtaining Patient-Centered Medical Home Recognition: A How To Manual**
<http://www.pcdc.org/resources/patient-centered-medical-home/pcdc-pcmh/obtaining-patient-centered.html>
- **Safety Net Medical Home Initiative**
<http://www.qhmedicalhome.org/safety-net/change-concepts.cfm>
- **TransforMED**
<http://www.transformed.com/resources/PCMH.cfm>

Pharmacy

Another one of the benefits of being a 330 grantee is access to the 340B Drug Pricing Program. The 340B Drug Pricing Program is managed by the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs (OPA) and limits the cost of certain medications to 330 grantees. Participation in the program is voluntary, but results in significant savings estimated to be 20% to 50% on the cost of pharmaceuticals for safety-net providers.

Some health centers chose to offer pharmacy services from day one, while others add the benefit later. Registration for 340B is done on a quarterly basis, based on the following submission deadline schedule:

- **December 1** for the quarter beginning January 1
- **March 1** for the quarter beginning April 1
- **June 1** for the quarter beginning July 1
- **September 1** for the quarter beginning October 1

Health Centers are required to use the [Office of Pharmacy Affairs 340B Program Registration Form for Covered Entities](#).

Pharmacy Service Delivery Options (most common)

- In-house Pharmacy
 - Traditional
 - Telepharmacy
 - Management company operated
- Contracted Pharmacy
 - **As of March 5, 2010 Covered entities are permitted to use multiple contract pharmacies or may supplement in-house pharmacies with contract pharmacy services.**
 - For additional information on the new ruling click here to be directed to the Federal Register [Notice Regarding 340B Drug Pricing Program—Contract Pharmacy Services](#)
- Community retail
- Mail order
- In-house (Prescriber) Dispensing

Chapter 7

Clinical Operations

Guiding Principles:

- *Patient Safety and Quality Care Always Come First*
- *Doing the Right Thing at the Right Time*
- *Put Someone in Charge*

As you put together the clinic and all the systems that make it function smoothly, it becomes clear that there are some tasks and processes that cut across all departments. **Clinic operations cover all the rules, policies and procedures that move patients in and out of the system** most effectively.

Patient safety, your revenue flow, staff satisfaction, and patient satisfaction are all positively affected when patients, information and materials move through the clinic in a timely and efficient way. Your reputation as a quality health care resource depends on this. When patients experience care that is uncoordinated, impersonal, and unsupportive or see providers who feel unprepared and too rushed to meet the educational, clinical, and psychological needs of the patients and their families, they often don't come back and will tell others in the community about their experience at your clinic. Don't let this happen.

The key to smooth clinic operations is a focus on the patients. Satisfied patients (think customers here) are ones that leave the clinic feeling that their needs were met and they were treated with respect and dignity. Avoid or change processes, which are arranged around the needs of staff, departments or the organization at the expense of patient care.

The key questions to ask when developing systems of care and the processes to deliver that care are:

- When is the most appropriate time to give this care?
- Where should this care ideally take place?
- How can care be most effectively delivered?

This section will illustrate how the clinical operations systems are critical to quality patient care, staff and patient satisfaction and financial sustainability. DO IT RIGHT THE FIRST TIME!

When is the most appropriate time to give this care?

Accessibility is high on the list of factors that attract patients to a particular practice. **Improving access is all about increasing the ability of the system to predict and absorb demand (patients' requests for care) and matching it to the supply of provider time available.** If the demand is greater than the supply, there is a delay in providing care. If the supply is greater than demand, providers are sitting around and valuable clinic resources are wasted. When supply and demand are balanced there is no backlog of appointments and no delay in providing care. This is the challenge all scheduling systems face.

Patient scheduling is an art and there are numerous systems for getting patients in to see the clinic's providers, some more effective than others. **Integrating your scheduling system into your computerized practice management program can be a big help in coordinating multiple provider schedules.** Many clinics use the **modified-wave scheduling** format where patients are double-booked at the front end of each hour and the last appointment of the hour is left open for catch-up. Often similar types of office visits are grouped together. Reviewing the schedule several days prior to the appointment day provides an opportunity to make adjustments and changes. A full appointment book is the measure of success in this method. Unfortunately, it may mean that patients have to wait for the next available appointment, which could be days or weeks, if they want to be seen. Each day nursing staff must triage patients with urgent problems that need to be seen sooner. This **conventional scheduling system manages demand instead of treating patients.**

Many clinics are starting to use the **Open Access System that can relieve scheduling pressure and increase productivity and response to patients' needs.** Pioneered by the [Institute for Healthcare Improvement](#), open access scheduling **anticipates patient needs by estimating patient demand. Patients are offered appointments for the same day they call.** About 70% of patients like the idea of coming in the same day they call.¹⁵ Open Access can still accommodate the fewer number of patients who prefer scheduling appointments further in advance. Usually each day starts with about 25-30% of appointment slots filled and patients who call throughout the day are offered appointments the same day. Open access scheduling differs from a walk-in clinic in that every patient receives an appointment for a specific time. Those who call late in the day are offered appointments the following day.

Open Access **responds to patient's needs**, based on their preferences. It's all about who your community is. This **requires flexibility** because demand may vary by the day of the week or season. An added benefit of Open Access scheduling is that it **cuts down on the "no-shows"**.

As a new start clinic you may have the advantage in implementing an Open Access system right from the beginning. Well-established clinics may need to do more work first to educate staff about the Open Access system and to estimate the practice's current demand and capacity for appointments.

Plan for the Expected

Health care providers are under a lot of pressure to see a certain number of patients every day. **It is important, especially for new practitioners, to get training in how to prioritize complicated patients.** Patients come with a multitude of problems often not related to what shows on the schedule. Work with the CMO to develop a plan for prioritizing what can be accomplished within the framework of the scheduled time and reschedule other problems as necessary.

The same planning ahead of time can be applied to patients with chronic medication management. If you develop a comprehensive program for patients with chronic conditions you can avoid those calls at 4:45 pm on a Friday afternoon.

¹⁵ Institute for Healthcare Improvement

Where should this care ideally take place?

Where services are provided is an important factor in patient accessibility. Services can be provided “off-site” in a satellite or through a contractor and they can be provided “on-site” in the clinic facility. When considering the best place to provide patient care **a good principle is to move the patient the least amount possible.** In the clinic setting this may mean doing vital signs in the exam room instead of an intake station and bringing adjunct services such as lab and patient education at the end of the visit to the patient in the exam room, rather than moving them around to various locations.

If it is necessary **to outsource services** such as dental or mental health or use a satellite location, **consider who your community is.** Is the off-site location accessible to the population you are serving? What is the transportation system? What is the proximity to the main clinic if the patient needs to be referred back for follow-up or needs lab work?

Office design can have a significant impact on patient flow and efficiency. If the system is designed and focused on the patient and not just the needs of the staff and providers, then the goal is to move them around the least possible amount or not at all. **Take a walk through your clinic as if you were a patient. Look for bottlenecks and eliminate barriers** that could get in the way of a smooth patient flow. Is signage clear and in appropriate languages for your patient population? Are there items stored in the hallways that get in the way? Is it obvious where a patient should go when they leave the exam room?

The CDC, National Center for Chronic Disease Prevention and Health Promotion, has free software, Patient Flow Analysis (PFA) that clinics can use to collect data for statistical documentation and graphical representation of a clinic session. A well-designed PFA study, with little disruption in the clinic session, can produce tables with the following data:

- Patient arrival as related to appointment time;
- Patient service time as related to patient’s time in the clinic by visit type;
- Number of patients and mean personnel cost per patient by visit type and subclass;
- Personnel utilization in the clinic by task;
- Time and cost for each clinic station by visit type and total visits;
- And each person who worked in the clinic.

For more information visit:

www.cdc.gov/reproductivehealth/ProductsPubs/PFA_support/WIN_PFA/WinPFADataCollectMan.pdf

Below are some resources on exam room design:

- **AAFP -**
<http://www.aafp.org/fpm/2007/0500/p46.html>
- **Capital Link –**
www.caplink.org
- **Midmark -**
<http://www.midmarkclinicalsolutions.com/>

How can care be most effectively delivered?

Streamline Check-In

To help **keep the check-in process from bogging down it's important to carefully review the forms patients have to fill out** at check-in. Make sure they are truly necessary and well designed so that patients can complete them relatively quickly and easily. Don't be guilty of sometimes using paperwork to keep patients busy so that the system can catch up. If at all possible – pre-register patients. One option is to have someone registering patients by phone several days before their scheduled appointments.

Streamlining registration also gives the clinic the capacity to collect co-pays at check in. This can help the checkout process, which is often complicated by the need to manage referrals and schedule follow-up appointments.

Streamline Checkout

Even though checking out is the last step in the patient visit it still can be a bottleneck in your patient flow. A slow or confusing process can tie up staff time that could be better spent on other tasks or generate subsequent patient phone calls to the office.

One of the most time consuming tasks is making appointments for referrals. Depending on the insurance type, some specialists may allow patients to call for referral appointments and many expect the referring office to call. If the front office staff is cross-trained, they can support each other when things get backed up.

The following principles have been developed that characterize **an effective patient visit**:

- Don't Move the Patient
- Start All Visits on Time
- Create Broad Work Roles
- Exploit Technology
- Ruthlessly Eliminate Waste
- Match Capacity to Demand
- Increase Clinician Support
- Get All the Tools You Need
- Plan for the Expected
- Do Today's Work Today
- Organize Patient Care Teams
- Communicate Directly

Revenue Cycle

The revenue cycle starts from the time that a patient calls to schedule an appointment for a service, to the time when the health center gets fully and sufficiently paid for that service. The revenue cycle is critical to patient satisfaction, patient care, and appropriate payment. Scheduling, registration, cash collection, workflow, and staff education all benefit from senior managers who are employing technology and process change to improve this crucial aspect of the business of Health Center services.

NACHC's [Financial Management Series, Information Bulletin 5](#) offers recommendations on how to improve cash flow through revenue cycle processes, and presents a range of processes that are part of a broadly defined revenue cycle of turning Health Center service delivery into cash.

The revenue cycle should include procedures regarding the following:

- **Front Desk** - Management should consider understanding the impact of the front desk on the outcomes in collected dollars. Information captured correctly reduces errors with patient statements and insurance claims, which results in quicker payments.
- **Registration** - The health center should have written procedures to assure there is proper completion of the registration form or registration entry. These tasks need to be clearly defined and as self-explanatory or as routine as possible to reduce the amount of personal interpretation.
- **Exam Room** (provider visit) - Everyone in the health center is responsible for billing and collections. Providers need to understand the impact of properly recording visit information, both on the encounter form and in the medical record.
- **Cashier/Appointment Scheduling/Checkout** - The health center's practice management system should be structured such that information about patient visits can be entered at the time of the visit. This is important as it allows for a communication with the patient that should establish clarity about what the patient owes the Health Center.
- **Billing Department** - The billing department is the "hub" of sending statements and claims, and the check-and-balance department for how others perform in the revenue cycle process. It is important to remember that the billing manager is a key member of the management team.

Additional Resources for Practice Management:

- **Advanced Access**
<http://www.ihl.org/IHI/Topics/OfficePractices/Access/HowToImprove/>
- **RACI**
http://www.pmforum.org/library/tips/pdf_files/RACI_R_Web3_1.pdf
- **Institute for Health Care Improvement-Office Visit Cycle**
<http://www.ihl.org/IHI/Topics/OfficePractices/Access/Measures/Office+visit+cycle+time.htm>
- **NNOHA Website: Practice Management Resources**
http://www.nnoha.org/?site_id=1213&page_id=46010&id_sub=46010
- **Office Visit Cycle Time**
<http://www.ihl.org/IHI/Topics/OfficePractices/Access/Measures/Office+visit+cycle+time.htm>
- **TransforMED –publication –Increased Efficiency**
<http://www.transformed.com/workingPapers/Huddles.pdf>
- **Clinical Measures**
<http://bphc.hrsa.gov/about/performanceasures.htm>

Risk Management

Risk Management is a big topic that encircles just about every part of a health center. To get started, it may be helpful to review a number of Risk Management Information Bulletins produced by NACHC over the past few years. Here are some suggestions on where to begin:

General Risk Management:

- [An Introduction to Risk Management](#)
- [Implementing a Risk Management Program for Your Health Center](#)
- [Developing Comprehensive Standards of Conduct](#)
- [Beyond FTCA: Purchasing Insurance Coverage to Protect Your Health Center from Liabilities](#)
- [Tips for Managing Facility Development Risks](#)

Employment:

- [Managing Employment-Related Risk](#)
- [The Fair Labor Standards Act](#)
- [Credentialing and Privileging of Health Center Clinicians – Tips to Help Navigate the Legal Pitfalls](#)
- [Managing Employment Discrimination and Harassment](#)
- [The Americans with Disabilities Act](#)

Section 330 Requirements:

- [The “Do’s” and “Don’ts” of Contracting for Behavioral Health Services](#)
- [How to Minimize Liabilities Associated With After-Hours Coverage](#)

Occupational Safety and Health Act (OSHA)¹⁶

The **Occupational Safety and Health Act** is a federal law which governs occupational health and safety in the workplace and to ensures that employers provide employees with a workplace free from recognized hazards, such as exposure to toxic chemicals, excessive noise levels, mechanical dangers, heat or cold stress, or unsanitary conditions. There are specific regulations that apply to medical offices regardless of the number of employees, these include:

- **Bloodborne Pathogens and Needlestick Prevention** - This is the most frequently requested and referenced OSHA standard affecting medical and dental offices. Some basic requirements of the OSHA Bloodborne Pathogens standard include:
 - A written exposure control plan, to be updated annually
 - Use of universal precautions
 - Consideration, implementation and use of safer engineered needles and sharps
 - Use of engineering and work practice controls and appropriate personal protective equipment (gloves, face and eye protection, gowns)
 - Hepatitis B vaccine provided to exposed employees at no cost
 - Medical follow-up in the event of an “exposure incident”

¹⁶ A Guide to Compliance with OSHA Standards

- Use of labels or color-coding for items such as sharps disposal boxes and containers for regulated waste, contaminated laundry and certain specimens
- Employee training
- Proper containment of all regulated waste
- **Hazard Communication** - The hazard communication standard is sometimes called the “employee right-to-know” standard, because it requires that the employee has access to hazard information. The basic requirements include:
 - A written hazard communication program
 - A list of hazardous chemicals (such as alcohol, disinfectants, anesthetic agents, sterilants and mercury) used or stored in the office
 - A copy of the Material Safety Data Sheet (MSDS) for each chemical (obtained from the manufacturer) used or stored in the office
 - Employee training
- **Ionizing Radiation** - This standard applies to facilities that have an x-ray machine and requires the following:
 - A survey of the types of radiation used in the facility, including x-rays
 - Restricted areas to limit employee exposures
 - Employees working in restricted areas must wear personal radiation monitors such as film badges or pocket dosimeters
 - Rooms and equipment may need to be labeled and equipped with caution signs
- **Exit Routes** - These standards include the requirements for providing safe and accessible building exits in case of fire or other emergency. It is important to become familiar with the full text of these standards because they provide details about signage and other issues. OSHA consultation services can help or your insurance company or local fire/police service may be able to assist you. The basic responsibilities include:
 - Exit routes sufficient for the number of employees in any occupied space
 - A diagram of evacuation routes posted in a visible location
- **Electrical** - These standards address electrical safety requirements to safeguard employees. OSHA electrical standards apply to electrical equipment and wiring in hazardous locations. If you use flammable gases, you may need special wiring and equipment installation. In addition to reading the full text of the OSHA standard, you should check with your insurance company or local fire department, or request an OSHA consultation for help.

For complete information on OSHA's general industry standards, visit the OSHA website at www.osha.gov or the OSHA Standard for Medical and Dental Offices Manual - www.oshamanual.com/medical_OSHA.html.

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) addresses the security and privacy of health data. The standards are meant to improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in the U.S. health care system.

As mentioned, HIPAA reflects a move away from cumbersome paper records and an increased emphasis on the security and privacy of health data. But the magnitude of the complex changes it requires can sometimes be overwhelming for healthcare providers, compliance officers and others in the health center. Below are some resources to assist you in understanding HIPAA itself as well as how it affects your electronic health records.

- **CMS' HIPAA Website -**
<http://www.cms.gov/hipaageninfo/>
- **HIPAA.com –**
www.hipaa.com
- **NACHC Issue Briefs:**
www.nachc.com/client/Issue_Brief_HIPAA_ARRA_Changes_3_2010.pdf
http://iweb.nachc.com/downloads/products/RM_24_09.pdf
- **U.S. Department of Health & Human Services -**
<http://www.hhs.gov/ocr/privacy/>
- <http://aspe.hhs.gov/datacncl/adminsim.shtml>

Chapter 8

Emergency Management

Guiding Principles

- *Use an all-hazards approach to prepare and respond to emergencies and disasters of all types and sizes***
- *Coordinate your plan with the local health department and key partners, such as hospitals, local Red Cross chapters, and other health centers in the area***
- *Preparedness begins with you and is essential to organizational planning and response***

Emergencies happen – **all the time** – and even small ones can have a big impact on a health center. Although the word ‘emergency’ tends to conjure thoughts of September 11, Hurricane Katrina, H1N1, and other newsworthy events, everyday occurrences such as fires, floods, ice storms, and power outages can severely limit a health center’s ability to provide health care to its patients.

This section will provide a basic overview of emergency management, guidance on getting your health center and your staff prepared, a summary of funding and programmatic expectations as well as resources to guide you in learning more.

What is Emergency Management?

There are four phases of emergency management – **mitigation, preparedness, response** and **recovery**. Each is described in more detail below:

Mitigation – this is the process of identifying the threats specific to your location (such as an earthquake in California, a tornado in Nebraska, or a hurricane in Florida) and taking actions to reduce the impact of them. Health centers should conduct a Hazard Vulnerability Analysis (HVA) to identify which hazards are a threat and the severity of the impact if they occur. Once the hazards have been identified, there are two categories of mitigation used to minimize the effect:

- **Structural** – this is reinforcing, bracing, anchoring, bolting, strengthening, or replacing any part of a building that may be damaged and cause injury during a disaster. Examples of this include bolting a building to its foundation in earthquake prone areas, having a tornado shelter (or at very least a basement) in parts of the country that experience frequent tornados, and reinforcing roofs in places that are at risk of hurricanes.
- **Nonstructural** – these are actions to reduce the threat to safety caused by the effects of disasters on the contents within the building. Examples of this include securing bookshelves and other tall furniture to walls, installing shatter resistant glass in windows, and securing the top and bottom of compressed gas cylinders with a safety chain.

Preparedness – this encompasses the actions that you take before an emergency happens to help prepare your health center to respond to that emergency. This is the phase in which health centers develop their **Emergency Management Plans (EMPs)**, work with local partners to determine the **health centers' role in the community** during an emergency, coordinate **training** for staff, and conduct **drills and exercises** to test the plan.

Response – these are the actions that you and your health center take to address the immediate and short-term impact of the emergency. In this phase, the Emergency Management Plan is activated and all activities are focused on **saving lives** of your staff, patients, and community members, **protecting your property** such as your building and the medical records, data, and other vital records in it that cannot be easily re-created, and **meeting basic human needs** of your staff, patients, and community.

Recovery – this is the process to get back to 'business as usual' or as close to it as possible as quickly as possible. The recovery actions start at almost the same time as the response but will likely take much longer. In this phase, it is important to document **what happened** and **how it affected your health center** (both in terms of damage to your building and equipment and/or the time and supplies it took to respond to the emergency) as well as any **lost revenue** due to disruption of services. It is also really important to recognize that the disaster may have impacted staff and their families, too. Providing **mental health support** for your staff can help them rebuild their lives or process what they experienced during the disaster.

Where Do I Start???

Now that we have covered the basics of emergency management, it is time to move onto getting your health center and your family prepared for an emergency.

Get Buy-In: Just like many other processes, emergency management is most effective when senior leadership believes in the importance of it and leads by example. If you are having trouble getting buy-in from some senior staff in your health centers, here are just a few of the reasons why it is so important for health centers to get involved and stay involved in emergency management:

- Remind them that emergency management doesn't just mean events like September 11 or Hurricane Katrina but also includes every day events that can severely impact the healthcare system in the communities in which they occurred.
- Emergencies happen whether people and health centers are prepared for them or not. Responding to and recovering from disasters is not always a choice when they happen in your community. It is much easier to mount

an effective response and recover faster and more fully when people and organizations are prepared for them. This is especially important for health centers which maintain services and access for your patients, keep revenue streams running, and payroll flowing.

- People will go to your health center during a disaster. Studies have found that often people affected by a disaster go to the most familiar source of health care for help. For many people in many communities, this means the health center – and history has shown this to be true.
- Hospitals in your community will likely be overwhelmed during a large scale disaster and other healthcare facilities are needed to provide non-critical treatment of minimally injured or non-acutely ill patients.
- Your patients will have chronic diseases and need medication refills, require ongoing treatment to maintain their health, and develop illnesses that need treatment, even in times of disaster. If left untreated, some of these conditions can develop into acute illnesses with worse outcomes for patients and more intensive treatment required.
- Your health center is the link to vulnerable populations in your community – you speak their languages, understand their cultures, have developed a relationship with these folks based on trust, and know where they live and how to reach them. Your health center can help to be sure the needs of your patients are included in community wide planning and response by collaborating with vital partners such as the health department and hospitals in your area.

Assign responsibility: Now that you have support, it is important to appoint an **Emergency Management Coordinator** to coordinate all of the emergency management activities. Most Emergency Management Coordinators also have other roles within the health centers – it is common to see the Chief Operating Officer, Facility Manager, or Clinic/Site Director assume the additional title of Emergency Management Coordinator. Some of the duties assigned to the Emergency Management Coordinator include:

- Chair the Emergency Management Committee or serve as the lead in another committee that has assumed responsibility for emergency management activities.
- Facilitate the completion of a Hazard Vulnerability Analysis (HVA) and review/revise annually.
- Coordinate the development of the Emergency Management Plan and review/revise at least annually and after any weaknesses found through a drill/exercise or an actual emergency.
- Represent the health center in local, regional, and statewide emergency management meetings. There are many meetings in every state so be sure that the meetings your health center attends focus on medical and public health – they may be called Emergency Support Function 8 or ESF-8 (a federal emergency support activity relating to health.) The Primary Care Association in your state probably has a seat on the statewide Advisory Committee so you don't need to add that one to your calendar but be sure to participate in any PCA Emergency Management Committee meetings – you will learn a lot from the other centers in your state.
- Work with local and regional partners to coordinate your plan with that of your city, town, or county. Key partners include your local health department, area hospitals, other non-profit and human service agencies as well as nearby health centers.
- Facilitate the development of Memoranda of Agreement with key partners to clearly outline expectations and available resources during a disaster.
- Schedule staff training and drills and exercises.
- Prepare quarterly report on emergency management progress and activities in your health center for the Board of Directors.

Some health centers create a stand-alone **Emergency Management Committee** while others include emergency management to the list of responsibilities of existing committees such as Safety or Quality Improvement. However you decide to do it, it is important that the committee has a clear understanding of the necessary activities as well

as report progress regularly to both the senior management and Board of Directors. Some of the emergency management duties of a committee include:

- Support the Emergency Management Coordinator in the completion of an HVA and Emergency Management Plan. This might include dividing up the sections among the committee, researching existing emergency management structures in your community, developing recommendations about health center roles, and identifying resources.
- Identify at least one member to serve as back-ups for the Emergency Management Coordinator.
- Determine training needed by staff to fully implement the Emergency Management Plan. Suggestions on topics are provided later in this document.
- Determine the areas of focus for drills and exercises.

Identify Risks and Develop Plan to Address Them - As mentioned earlier, it is really important to evaluate the potential for certain events and both your health center's preparedness to respond to these events as well as the severity of impact. A very good way to organize and prioritize all this information is to complete a **Hazard Vulnerability Analysis** (HVA). Kaiser Permanente offers a sample HVA - <http://www.njha.com/ep/pdf/627200834041PM.pdf>.

There are four types of events that should be evaluated: **naturally occurring** (i.e., hurricane, tornado, flood, wildfire), **human related** (i.e., workplace violence, bomb threat, terrorism), **technologic** (i.e., power outage, water failure or contamination, HVAC failure, transportation disruption), and **hazardous materials** (i.e., large chemical exposure, large hazmat spill, radiological exposure – both intentional and accidental). For each of these categories, you should consider the following questions:

- How likely is the event to occur based the known risk and historical data?
- Could people die or be injured if it happened?
- Would our health center and/or the equipment inside be damaged if it happened?
- Would we have to close our health center? If so, for how long?
- How prepared are we currently to respond if it happened?
- How will critical employees get to the health center?
- Do we have what we would need to respond? Do we have a plan? Have we tested the plan?
- Is there someone that can help us if it happened? Do we have any agreements for supplies or resources if it happened?

A number of available templates capture responses on likelihood, impact, and preparedness for hazards in each of the categories mentioned above. Using a combination of probability and severity, these templates will calculate risk each event. Some things might be highly probable but not very severe while others are not very likely but if they occurred, could have a huge impact on your health center and community. Identifying the risk will help to focus your priorities and guide your plan development.

Now that you know what you are at risk for, it is time to develop the **Emergency Management Plan**. There are a number of very good templates (see resources section for details) that you can use to help you build your own plan. Every plan should be **based on the risks** identified, broadly focused on **all-hazards** instead of just one or two, include the **four phases of emergency management**, and address **operational and financial stability** during and after a disaster. In addition, plans should contain a process for **staff training**, and build in an **exercise program** to test the plan. The time to find weaknesses in your plan is NOT during a disaster!

Now that your plan is underway, it is a good time to check in with the key municipal or county agencies to be sure that your plans will fit in with theirs. Partnership is king in emergency management and it is essential to **collaborate with your local public health and emergency management contacts** to arrange for access to transportation, medical supplies, equipment, and pharmaceuticals during an emergency. In some communities, health

centers have been left out of the local planning process and the distribution of resources because they are not sitting in the planning meetings and haven't educated their local partners about the kinds of things that they can do in an emergency. There is an old saying in emergency management, "a disaster is NOT the time to hand out your business card." In other words, **get to know your key partners now** so they can help when you need them.

As you work with your local agencies, the Emergency Management Coordinator and Committee should clearly define the **roles that your health center can play** in a disaster that affects your entire community. Here are some roles that may fit in your health center planning:

- Triage patients
- Treat minimally injured patients at health center or local hospital
- Provide culturally competent, linguistically able provider/support staff for alternate care sites
- Distribute medications or vaccines to patients, staff, and community members
- Provide mental health support to patients, staff, the overall community and response personnel
- Provide disease or syndromic surveillance
- Dispatch mobile medical or dental vans to areas impacted by disaster
- Serve as conduit of information to patients and community
- Outreach to your target population to help them access the information and resources they may need following a disaster

The actual roles that your health center decides to play will depend on the needs of the community and the capacity of your health center. **Be realistic and practical** when developing this list.

As you begin to walk the walk, it is good to talk the talk, too. In your work with local partners, you will hear about the [National Incident Management System](#), or NIMS. This is a way of handling emergencies of all sizes. States and localities are expected to build their plans using this framework and complete a number of training courses that help planners and responders understand NIMS processes. In some states, if a health center gets funded for emergency management activities directly or through their Primary Care Association, they are also required to complete this training. Check with your PCA contact to see if your state is one that expects health center staff to take these courses.

One of the main features of NIMS is a way of organizing staff to respond to a disaster. This is called **Incident Command System**, or ICS, and it is important that you understand what this is, how it fits into your health center, and include components of NIMS in your emergency management plan and activities. It is also helpful to review the **Hospital Incident Command System**, or HICS. This will have a lot of cross-over for health centers. It is also important to note that is **flexibility** about how health centers implement ICS. In smaller centers, one person may fulfill two or three roles.

For a health center to effectively activate their plan and respond to a disaster, **staff training and education** is vital. Time is money and both are in scarce supply at most health centers. Many training sessions are offered at no cost, a number are online, and you may find local partners, like Red Cross, that will come to your health center to help train your staff. Here are some suggestions:

- Basic overview of emergency management for all staff
- Overview of Incident Command System (ICS) for all staff (NIMS course IS 100 or equivalent)
- Intermediate ICS for staff with positions in the ICS structure in your health center (NIMS course IS 200 or equivalent)
- National Incident Management System training for senior leaders and department managers (NIMS 700)
- National Response Plan for the Emergency Management Committee (NIMS 800)
- Psychological First Aid for Non-Mental Health Providers

- Donning and doffing Personal Protective Equipment (PPE) for all front line staff and providers
- Basic infection control and universal respiratory etiquette for all front line and non-clinical staff
- Personal preparedness for all staff

Your Health Center is Prepared – Is Your Staff?

The plan developed for your health center could be the best on the face of the earth but if your staff is not prepared to stay or return to work, the plan is virtually worthless. Remember to incorporate **personal preparedness** support for your staff as you prepare your health center for emergencies. People are more likely to stay at or come in to work if they know that their families are safe and cared for.

Personal preparedness has been boiled down to three steps by the American Red Cross and FEMA – get a kit, make a plan, and be informed.

Get a Kit: Everyone should have a kit that includes at least **3 days of food and water plus any health sustaining medication** on hand in case a disaster strikes and grocery stores and pharmacies are closed. There are a number of checklists available to guide the building of kits. You can help your staff by posting checklists for a personal kit, planning personal preparedness events during National Preparedness Month, displaying the contents of a sample kit, and sending weekly emails reminding staff to pick up a few items while grocery shopping to help build it slowly and spread out the expense. If budget allows, it is also helpful to provide small incentives for your staff by purchasing some items in bulk, like flashlights, whistles, permanent markers, and so on.

Make a Plan: Lead by example and encourage senior leadership to put their plans together first. Provide basic information about personal preparedness to staff and offer some easy to use templates for making family plans. Look to partner with other organizations in your community who are experts in personal preparedness, like your local Red Cross chapter or local health department staff.

Be Informed: Provide staff with information about general risks, such as power outages, pandemics, and extreme weather as well as events that are specific to your local area. The point is not to panic people but empower them to take action to protect themselves and their families from harm.

Other Sources of Funding for Emergency Preparedness

There are two main federal programs that fund emergency management efforts for public health and medical facilities. The [Hospital Preparedness Program](#) (HPP) through the Assistant Secretary for Preparedness and Response (part of the Department of Health and Human Services) and the Centers for Disease Control and Prevention [Public Health Emergency Preparedness Program](#) (PHEP) both go to the state health department and then the state health department usually sub-contracts out with hospitals, health care facilities, and local health departments.

Health centers and Primary Care Associations have been included in this funding in many states, but not all. Contact your PCA to find out how these funds are distributed in your state and if there are any funds available to your center. If not, you may be able to access these resources through your local health department.

Expectations and Standards

If all of the arguments for why health centers need to get prepared in this section have yet to persuade you, perhaps this will – the Bureau of Primary Health Care (BPHC) has developed [Emergency Management Program Expectations, Policy Information Notice \(PIN\) 07-15](#). The activities outlined in this section will compliment the expectations and help get you on your way to meeting them.

In addition to Bureau expectations, both The Joint Commission (TJC) and the Accreditation Association for Ambulatory Health Care (AAAHC) have standards around emergency management. If your health center is already accredited, or if you are considering pursuing this status in the future, it is a good idea to look over the sections on emergency management. Many of the standards dovetail with the BPHC expectations and are main components of any comprehensive emergency management program.

Resources for More Information

There are many resources available to help you get started. Visit the websites listed below for templates, online trainings, and information. Be sure to make contact with your PCA about emergency management if you haven't already done so – they will probably be able to tell you about local or state resources to help you in this work. Lastly, NACHC's Director of Emergency Management, Mollie Melbourne is available to assist you. Mollie can be reached at: mmelbourne@nachc.com or at (203) 256-2773.

- **Centers for Disease Control and Prevention**
<http://www.bt.cdc.gov/>
- **Community Health Association of Mountain/Plains States (CHAMPS)**
<http://www.champsonline.org/ToolsProducts/CrossDiscResources/EmergencyPreparedness.html>
- **Emergency Preparedness 101 for Health Center Dental Providers (Webinar) National Network for Oral Health Access**
<http://www.nnoha.org/practicemanagement/webinars.html>
- **Essential components of emergency management plans at Community Health Centers**
[http://www.nachc.com/client/Essential Components of CHC EM Plans October 10.pdf](http://www.nachc.com/client/Essential%20Components%20of%20CHC%20EM%20Plans%20October%2010.pdf)
- **FEMA: National Information Management System Resource Center**
<http://www.fema.gov/emergency/nims/index.shtm>
- **Ready.gov**
<http://www.ready.gov/>

Chapter 9

Information Technology

Guiding Principles:

- *Design System for Tomorrow's Needs*
- *Meaningfully Use an EHR System*
- *Integrate Everything*

In today's high tech world there are **extensive opportunities to improve your business and your patients' health status outcomes using technology**. Just a few years ago, full clinic use of computers for data collection and reporting was considered advanced. Now you can have integrated practice management systems, electronic health records, computerized kiosks for patient self-check in and health education, patient portals, vending machines for pharmaceuticals, phone systems that auto-dial appointment reminders and connect staff through walkie-talkie headsets (ala The Gap), notification beepers (ala restaurants), satellite-based telemedicine for consultations and performing procedures, internet transfer of x-rays etc., electronic face to face meetings

If you are starting from scratch with a new clinic, you have the opportunity to structure your practice for maximum success both now and for the future. Since this is not a technology manual, **this chapter will touch on some basics** to get you started in the use of information technology in your clinic. Please **take the time to research other ways to use technology to benefit your patients, staff and community**. As in many areas, other health centers, your PCA, Health Center Controlled Networks (HCCNs) and NACHC are all great resources.

Meaningful Use¹⁷

The Medicare and Medicaid EHR Incentive Programs provide a financial incentive for the “meaningful use” of certified EHR technology to achieve health and efficiency goals. By putting into action and meaningfully using an EHR system, providers will reap benefits beyond financial incentives—such as reduction in errors, availability of records and data, reminders and alerts, clinical decision support, and e-prescribing/refill automation. For more information on how HIT can improve quality outcomes, refer to NACHC’s Issue Brief http://iweb.nachc.com/downloads/products/HCCN_15_10.pdf.

What is “Meaningful Use”?

Simply put, “meaningful use” means providers need to show they’re using certified EHR technology in ways that can be measured significantly in quality and in quantity.

The following are the three main components of Meaningful Use:

1. The use of a certified EHR in a meaningful manner, such as e-prescribing.
2. The use of certified EHR technology for electronic exchange of health information to improve quality of health care.
3. The use of certified EHR technology to submit clinical quality and other measures.

The criteria for meaningful use will be staged in three steps from 2011-2015. For more information on these stages, steps, and criteria visit https://www.cms.gov/ehrincentiveprograms/30_Meaningful_Use.asp.

An excellent resource that was created to assist health care providers with quickly achieving meaningful use are the Regional Extension Centers (RECs). RECs are designed to make sure that primary care clinicians get the help they need to use EHRs.

RECs will:

- Provide training and support services to assist doctors and other providers in adopting EHRs
- Offer information and guidance to help with EHR implementation
- Give technical assistance as needed

The rest of this chapter will focus on the systems you need in place, the selection and implementation process as well as more detail on meaningful use and incentive payments.

Practice Management System (PMS)

PMS is a category of software that deals with the day-to-day operations of a medical practice. Key functions include:¹⁸

- Operations & Financial Management
 - Appointment Scheduling
 - Patient Demographics
 - Sliding Fee Calculation
 - Insurance Eligibility Verification

¹⁷ CMS Website on Meaningful Use - https://www.cms.gov/ehrincentiveprograms/30_Meaningful_Use.asp

¹⁸ Lardiere, M. (June 2010). NACHC Powerpoint “Practice Management & EHR Systems for Community Health Centers”

- RVU Analysis
- Managed Care Organizations (MCO) Contract Analysis
- Patient Cycle Time Tracking
 - Allows for the creation of milestones, e.g. patient arrives at front desk, patient registration complete, patient called to the back, vitals complete, provider enters the room, provider completes the visit, patient checkout, so that centers can track patient flow both in real time and in management reports
- Revenue Cycle Management
 - Charge & Payment Entry
 - A/R Management
 - Claims Processing
 - Processing Credit Card Transactions

In order to meet the organization's strategic goals the health center's management and clinical team must be supported by a practice management system that has the capacity to provide information in order to function and progress effectively. Without proper data the organization cannot determine changes needed to adapt to a changing environment.

Electronic Health Records (EHR)

EHRs are a comprehensive and robust system that not only supports the collection of data and documentation of patient care information, it also allows for flexible reporting and aids in decision support for the provider.

It is important to remember when looking at the functionality of an EHR, be sure to reference the criteria listed on the CMS Website on Meaningful Use - https://www.cms.gov/ehrincentiveprograms/30_Meaningful_Use.asp and remember, use of an ONC-ATCB certified system (<http://www.cchit.org/products/onc-atcb>) is required for the first step of meaningful use.

Other key functions include:¹⁹

- Complete Patient Visit Documentation
 - Nurse Triage
 - Patient Histories
 - Review of Systems
 - Progress Notes
 - Other pertinent information for service coding
 - Orders
 - Electronic Prescribing (or paper)
- Clinical Decision Support
 - Real-time Drug/Allergy Interaction
 - Adherence to Evidence Based Medicine
- Capture & Reporting of Discreet Patient Data
- Ability to Interface Labs, Hospitals and Other Community Providers
- Ability to Scan Paper Documents and “FILE” into Chart

¹⁹ Lardiere, M. (June 2010). NACHC Powerpoint “Practice Management & EHR Systems for Community Health Centers”

EHRs are no longer the future; they are the present. As a new start clinic, you can institute electronic medical records initially and train staff and clinicians to use them as they are hired. Health centers that have EHR systems have increased efficiency and lowered costs as well as improving patient care.

NACHC, in conjunction with HRSA has developed *Tools for Implementing EHR*. They are available on their website at <http://nachc.com/Tools%20for%20Implementing%20EMRs.cfm>.

It is important to note that virtually all of the modern PMS and EHR systems in the community health center marketplace offer fully integrated systems – the PMS and EHR share databases; thus the health center avoids duplicate data entry and is able to perform analyses with data from both systems.

Electronic Dental Records

The use of electronic records is dramatically affecting the dentistry profession. Digital technology, the advancement of networked computing and the digitization of information, will continue to change the profession of dentistry in numerous ways—from the clinical to continuing education and, from practice management transactions such as payment and marketing to e-commerce.

Software programs allow electronic transmission of patient records with sound, text and images to dental specialists for second opinions and preauthorization for insurance purposes. Instead of written descriptions with tooth charts, digital clinical photographs may be attached. For more information on Electronic Dental Records, visit the American Dental Association's website at www.ada.org.

Selection and Implementation Process

Electronic Health Records (EHR) and Practice Management Systems (PMS) are essential for organizational optimization in Health Centers today. As with the health center program in general, there are many unique features and reports that need to be pre-established features of both EHR and PMS systems (i.e. UDS Data and other HRSA Data, Sliding Fee, FQHC Reimbursement Rates, and Custom Reports). It is because of these unique requirements that health center management must be cognizant of which vendors and which products are chosen for implementation.

However, procuring these systems is probably **the most expensive individual purchases** you will make. It is also a decision that you will have to live with for some time. So it is critical to put the time and effort into making an informed choice based on your organization's needs. **Use a consultant** who has knowledge and information about systems that work in community health centers to help you make decisions about the best system for your organization. **Develop a timeline** with each step **and cost estimate** included to assure that you can meet your deadline and budget for system start up. **Form a team who can spearhead the process**. The team should be managed by a Project Team Leader and include the following representatives of Health Center staff: Clinical and Executive Leadership, Finance, Quality, Operations and IT. The following steps should be taken in the selection and implementation process:

1. Internal and External Assessment
2. RFP Process
3. Pre-installation training
4. Installation and Set-up
5. Post-Installation Training and Testing
6. Post-go-live User Support

Internal and External Assessments

Before you start, evaluate where the organization is now and where you want to go with managing information.

- Review your organizational mission, values and strategic plan
- Define your program goals and data collection / manipulation objectives
- Assess your clinical/office environment for capabilities and needs
- Inventory staff experience with data collection and management
- Evaluate your clinical flow
- Evaluate the current computer system
- Evaluate current staffing levels to assume additional work load
- Evaluate your current facility
- Identify and evaluate outcomes applications and vendors that fit your clinical/office environment
- Evaluate your financial resources and perform a cost-benefit analysis

There are **many challenges to implementing an information system** in a health center including:

- Varied reporting requirements which are subject to change at any time
- Limited capital and technical resources
- It is a relatively specialized niche and few vendors are knowledgeable about the CHC market
- Lack of standardization of data, terms, payers, etc.

An information system for a health center should have minimum functionality (in addition to being ONC-ATCB certified) including:

- Patient demographic information capture
- Billing information capture
- Generation of claims submission forms
- Reimbursement information capture
- UDS and management reporting
- Appointment scheduling
- Productivity reporting
- Quality assurance and utilization management
- Managed care capabilities
- Special program data management
- Eligibility verification
- Clinical data management
- Clinical pathways and protocols
- Electronic medical records (or the capability of adding them later)

Resources for System Selection and Implementation

NACHC has created a website dedicated to HIT that houses a myriad of resources on implementation, selection, definitions, vendor evaluations, etc. You can access this website at [http://www.nachc.com/Health%20Information%20Technologies%20\(HIT\).cfm](http://www.nachc.com/Health%20Information%20Technologies%20(HIT).cfm).

You can also find additional resources on system selection and implementation at:

CMS Meaningful Use Website

https://www.cms.gov/ehrincentiveprograms/30_Meaningful_Use.asp

HRSA EHR Selection Guidelines for Health Centers

<http://www.hrsa.gov/healthit/ehrguidelines.html>

HRSA Health IT Adoption Toolbox

<http://www.hrsa.gov/healthit/toolbox/HealthITAdoptiontoolbox/SystemImplementation/index.html>

ONC-ATCB Certified EHR Technology

<http://www.cchit.org/products/onc-atcb>

Request for Proposals (RFP)

Developing a Request for Proposals **listing your needs and requirements and going through a review of bids before purchasing a system is essential**. A committee made up of information technology, finance, and program staff can help participate in drafting the RFP and evaluating proposals. NACHC or your PCA may have information about possible vendors to receive your RFP, knowledgeable consultants and other health centers who have issued proposals or purchased systems. Because the RFP is the foundation of the program design, you **may want to hire a consultant who specializes in RFP development**.

Installation and Set-Up

An information system is **not only a software package, but also the equipment and systems to run it**. This includes computers and operating systems such as Windows or UNIX, printers, and networking capabilities to connect computers to each other which can be through the internet or internally as an intranet. This is another area where **a consultant can be invaluable** in helping make appropriate decisions for the organization.

Purchasing and installing computer equipment can be time consuming. Additional wiring, internet and phone costs, if necessary, are additional tasks and costs that need to be considered.

Initial Training and Testing

Once a decision has been made and software installed, staff must be trained. This will probably take several sessions. You want to be sure the staff is comfortable and capable of using the system properly. Different aspects of the system must be tested prior to actual operation to be sure they are functioning correctly. **Allow plenty of time for training and testing**. There is nothing worse than providing care to patients and then not being able to bill for the work done.

Health Center Controlled Networks (HCCN)²⁰

There are many benefits to joining an existing Health Center Controlled Network (HCCN) versus purchasing an EHR independently. The biggest benefit to joining a network is that a health center can gain valuable insights from collaborative efforts towards adopting and implementing health IT. The lessons learned from other member organizations' experiences can facilitate the start of health IT adoption. In terms of a health IT implementation, participation in a HCCN allows greater access to a higher level and larger depth of expertise, thereby reducing the cost and burden of locating and hiring experienced personnel. To find a network visit, <http://findanetwork.hrsa.gov> and for more information on HCCNs, go to <http://www.hrsa.gov/healthit/toolbox/HealthITAdoptiontoolbox/OpportunitiesCollaboration/controlnetworks.html>.

HCCNs typically focus on functional areas where operational mass drives economies of scale or those that require:

- High-cost
- Personnel with Highly Specialized Training and/or
- Procurement of Large Infrastructure Systems

Examples of core HCCN areas and functions include:

- **Information Systems:** IT Department and Infrastructure Development and Management, Data, Communications, Education/Training, Support, Reporting, Electronic Health Records, Practice Management Systems, Health information Exchanges
- **Clinical:** Health Education, Clinical Guidelines and Dental Management, Staffing, Documentation, Ancillary Services, Continual Quality Improvement/Clinical Systems Improvement, Research
- **Finance:** Claims Processing, Accounting, Policies and Procedures, External Audit, Staff Education/Training, Billing/Revenue Management
- **Administrative:** Human Resources, Purchasing, Corporate Compliance, Medicare/Medicaid Compliance, Program/Service Development, Resource Development, Education/Training, Communication, Governance, Marketing, Strategic Planning, Quality Improvement
- **Managed Care:** Credentialing, Contracting, Utilization Management/Utilization Review

Incentive Payments and Meaningful Use²¹

Medicare and Medicaid are currently offering financial incentives to providers who can demonstrate that they are making “meaningful use” of certified EMR technology. In addition to these financial incentives, these providers are also receiving additional benefits such as reduction in errors, availability of records and data, reminders and alerts, clinical decision support, and e-prescribing/refill automation.

Incentive payments are made to individual providers, as opposed to the FQHC. This is the case even if the EHR-related expenses that resulted in the incentive payments were paid for by the health center. Providers may choose to give their incentive payments to their health center, through a process known as “assignment.” However, providers are not required to assign their payments. Health Center providers will get their payments through Medicaid: while both Medicare and Medicaid will be offering incentive payments to eligible providers to use EHRs, all providers must choose to receive payments from only one of these programs. Because of the way they are reimbursed, health center providers are only eligible to receive payments through Medicaid.

²⁰ <http://www.hrsa.gov/healthit/healthcenternetworks/>

²¹ CMS Website on Meaningful Use - https://www.cms.gov/ehrincentiveprograms/30_Meaningful_Use.asp

Payments will cover up to 85% of allowable costs and are spaced out over 6 years: These payments may cover up to 85 percent of “allowable costs” for the **acquisition, implementation (including training), upgrade, maintenance**, and use of a “certified electronic health record” system, and will be made over a 6-year period. For more information on certified EHR’s visit the ONC-ATCB Certified EHR Technology website at <http://www.cchit.org/products/onc-atcb>.

The maximum payment per provider is \$63,750: a provider’s “allowable costs” may not exceed \$25,000 in the first year that he or she requests payment, and \$10,000 for each of the next 5 years; thus the maximum allowable 6-year costs per eligible professional will be \$75,000 (\$25,000 plus 5 times \$10,000), and the maximum federal payment will be \$63,750 per eligible professional (85 percent of \$75,000) over a period of six years.

To be eligible for the incentive payments, the providers must be a physician, dentist, certified nurse mid-wife, nurse practitioner, or a physician assistant who is practicing in a health center that is led by a PA. For a health center to be considered to be “PA-led,” at least one of the following requirements must be met:

- A PA must be the primary provider in the health center: or
- A PA must serve as a clinical or medical director at a clinical site of practice

To apply for these payments, contact your state Medicaid agency. The policies and timelines for applying vary by state. However, the final year for submitting initial applications is 2014. To be eligible, the provider must demonstrate that he or she is “engaged in efforts to adopt such a certified HER system” in their first year, and that they are using it through use of certain billing and reporting methods in years 2 through 6.

Certification for the Medicare and Medicaid EHR Incentive Programs

Standards, implementation specifications, and certification criteria for EHR technology have been adopted by the Secretary of the Department of Health and Human Services. To view a list of certified systems, visit <http://onc-chpl.force.com/ehrcert/EHRProductSearch?setting=Ambulatory>.

For more information on meaningful use, visit CMS’ website on Meaningful Use: https://www.cms.gov/ehrincentiveprograms/30_Meaningful_Use.asp.

Here are some additional resources for Health Information Technology:

Community Health Centers and Electronic Health Records handbook
http://nwhf.org/images/files/Electronic_Medical_Record_Handbook.pdf

CMS: HER Incentive Programs
<http://www.cms.gov/EHRIncentivePrograms/>

EMR, EHR, HIT and HIPAA open forum
<http://www.emrandhipaa.com>

HHS Office of the National Coordinator for Health Information Technology (includes Regional Extension Centers, Beacon Communities)
http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov_home/1204

HRSA Electronic Health Record (EHR) Selection Guidelines
<http://www.hrsa.gov/healthit/ehrguidelines.html>

HRSA HIT Website
<http://hrsa.gov/healthit/>

HRSA HIT and Meaningful Use regional Workshops

<http://www.hrsa.gov/healthit/meaningfuluse/workshops.html>

HRSA-Office of Health Information Technology and Quality

<http://www.hrsa.gov/healthit/index.html>

HRSA/OHITQ Current and Archived Webinars on HIT/EHR topics

<http://www.hrsa.gov/healthit/toolbox/webinars/index.html>

HRSA/OHITQ Webinar: Tips on Workflow Analyses During an EHR Implementation

<http://www.hrsa.gov/healthit/toolbox/webinars/webinarvideos.html#overview-ehr-implementation>

Making IT Happen: Strategies for Implementing the EMR - EHR

http://www.himss.org/content/files/davies/Davies_WP_Implementation.pdf

Medical Records (Includes EHR) HRSA- EHR Selection Guidelines for Health Centers

<http://www.hrsa.gov/healthit/ehrguidelines.html>

NACHC's HIT Website

[http://www.nachc.com/Health%20Information%20Technologies%20\(HIT\).cfm](http://www.nachc.com/Health%20Information%20Technologies%20(HIT).cfm)

Technology Support for Nonprofits

<http://home.techsoup.org/pages/default.aspx>

Chapter 10

Facility

Guiding Principles:

- *Accessibility*
- *Acceptability*
- *Functionality*

When selecting and designing your health center facility, **keep in mind the patient's perspective.** The building should facilitate a seamless transition from entry into the facility all the way through the patient visit. To this end, **be certain the facility meets applicable regulations and guidelines for the services you offer** as an indicator that the health center provides quality programs. If you do not have a contractor or architect with health care experience, then they will need to purchase the book "Guidelines for Design and Construction of Hospital and Health-care Facilities" (<http://www.fgiguideines.org/>) to verify that their renovations meet national standards. In addition to the willingness to make meeting guidelines a priority, as a "community" health center it is imperative that the health center **facility represents a culturally sensitive and patient friendly atmosphere, oriented to meet the patient's needs.**

With that in mind, location and building design are also important. The **building should be mission-focused, which is easily accessible and inviting to the population you are serving.** A "State-of-the-Art" facility should at least **meet national standards, local code and safety standards.** The parking lot should be well laid out with easy in and out and handicap parking well marked. If public transportation is available in the community, the building should be close to a bus line and/or rail system. If possible, **locate your facility in close proximity to other services not provided in-house such as a pharmacy, lab, hospital, mental and dental health services.** This assists the patient and facilitates the establishment and growth of community partnerships with those complementary services.

Remodeling and Expansion Issues

In designing your facility, it is important to **plan for growth and/or changes in the size and/or type of programs offered**. If feasible, it is less complicated and more cost effective to find or build functional space that meets the needs of the community now and has the capacity for expansion in the future rather than to opt a short-term “fix” now and plan for expansion in the next facility. **Professional assistance from an experienced architect or functional space planner** in designing a clinic or remodeling an existing space **can be cost effective** through greater efficiency in operations and designing to provide for expansion needs and potential program changes down the road. One such entity that assists health centers with this process is Capital Link.

Capital Link (<http://www.caplink.org>), is a national nonprofit consulting organization that provides extensive technical assistance to health centers throughout the capital development process in an effort to strengthen their abilities to plan and carry out successful facility projects. Capital Link works in partnership with primary care associations, consultants and other entities interested in improving access to capital for health centers. In addition to pre-development planning and providing financial assistance services, Capital Link has several free publications available (<http://www.caplink.org/FreePubs1.html>):

- “Creating a Business Plan for a Community Health Center Capital Project”
- “Capital Funding Options for Rural Community Health Centers” (beneficial for urban CHCs)
- “Developing a Health Center”
- “Capital Project Case Study”

Some additional expansion resources are:

Capital Link: Tips for Managing Facility Development Risks

A renovation or construction project may seem risky for a health center, but there are guidelines and to reduce liability exposures, manage risks, and reach the vision of a new, updated, and expanded facility.

http://www.caplink.org/resources/RM_25_10%20Construction%20Risk.pdf

Primary Care Development Corporation - Expansion

<http://www.pcdcny.org>

Industry Standards

The health center and the architect should be familiar with industry standards that pertain specifically to healthcare facilities. Some references (see Internet Resources) include:

- Health Insurance Portability and Accountability Act (HIPAA) – Administrative Simplification:
 - Standardized electronic transmission of common administrative and financial transactions (such as billing and payments)
 - Unique health identifiers for individuals, employers, health plans, and health care providers
 - Privacy and security standards to protect the confidentiality and integrity of individually identifiable health information
- Centers for Disease Control – Infection control standards
- U.S. Occupational Health and Safety Administration (OSHA) – Safety standards (evacuation routes...etc)
- Local Health Department – Inspection prior to move-in
- Local Fire Department – Codes, Facility inspection and the Certificate of Occupancy (CO) requires sign-off from the Fire Marshall. (The health center may not have full control of the facility without the CO)

- The American Institute of Architects – “Guidelines for Design and Construction of Hospital and Healthcare Facilities.” Architect provides punch lists and close-out documents.

In addition to these standards, it would be beneficial for your health center staff to remember **the four themes for ideal practice as outlined by the Institute for Healthcare Improvement (IHI)**, which suggests providing an unbeatable access to care for patients, deep and personal patient interactions, the utmost reliability in clinical care and practice vitality in terms of finances, physician and staff satisfaction, and innovation. All of these characteristics are better served with appropriate and efficient functional space within the health center.

Functional Space

Every community circumstance is unique, though historically there have been traditional elements common to many clinics. The main areas within the traditional basic model are the Reception Area, Patient Check-In/Check-Out, Clinical, Laboratory, and Administration. The individual functional spaces within these areas typically include:

- Two to three exam rooms for each medical provider and a well-equipped procedure room for every two to three providers. 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

However, **as technology pervades the health center industry, flexibility in healthcare facility planning design and construction is beginning to replace the traditional guidelines** for room concepts. With the advent of EMR, EHR and concepts like Ideal Micro Practices that attempt to eliminate the need for paper files, some functional areas and the need for some staff, health centers more than ever need to be cautious when planning the functional space. To account for some of these changes while allowing for a traditional layout, your health center may start with a basic set-up that would accommodate paper or electronic. However, keep in mind that with changes in technology often comes changes in facility design and layout.

Internet Resources

[Capital Link](#)

[RSMeans – Reed Construction Data](#) – Quick cost estimator for your project cost (*Note: very preliminary estimate. This data should not be used to guide your planning*)

[Bureau of Primary Health Care](#)

[Health Insurance Portability and Accountability Act](#)

[Centers for Disease Control](#)

[U.S. Occupational Health and Safety Administration](#)

[State Health Departments](#)

[The American Institute of Architects](#)



Conclusion

The National Association of Community Health Centers is confident that you and your health center are up to the task of being up and running in 120 days! NACHC stands ready to assist you now and in the future to ensure the success of health centers in meeting our common mission to provide access to quality health care for all people.

Good luck and good health!