The Mid-Atlantic Association of Community Health Centers

Guide for Developing a Community Health Center

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Chapter 1

The Basics of Federally Qualified Health Centers

- What is an FQHC?
- FQHC Look-Alikes
- FQHC Characteristics
- Benefits of Being an FQHC
- FQHC Locations
- The Future of FQHCs
- Online Guide Summary

WHAT IS AN FQHC?

FQHCs are federally supported community-based primary health clinics that provide services to medically underserved areas (MUA) all over the United States. They refer to all organizations receiving funding under a Public Health Service (PHS) Act 330 grant and can include:

- General Community Health Centers (CHCs)
- Public Housing Primary Care plans
- Migrant Health Centers (MHCs)
- Homeless Health Care Programs
- Urban Indian and Tribal Health Centers

With more than 1,000 community health centers in mostly urban and rural settings across the country, this network of clinics brings primary care to nearly 12 million patients, over one third of whom are uninsured. Funding for these health centers is acquired through competitive grants issued by the Department of Health and Human Services (DHHS), Health Resources and Services Administration (HRSA), Bureau of Primary Health Care (BPHC) and each is held to a rigorous standard of governance, quality and service.

FQHC Look-Alikes

The FQHC Look-Alike Program is an alternative for clinics unable to attain FQHC status. Though look-alikes do not receive 330 funds, they do follow many of the same guidelines as FQHCs and are still eligible for some benefits such as cost-based reimbursement under Medicaid and Medicare and access to the 340(b) Federal Drug Pricing Program.

FQHC Characteristics

The uniqueness of FQHCs lies in their structure and functional characteristics. In order for a health center to qualify as a federal community health center, it must:

- Have a public or private non-profit organizational model
- Be located in a Medically Underserved Area (MUA) or serve Medically Underserved Populations(MUP)

- Provide a comprehensive list of primary care <u>services</u>
- Offer a sliding scale <u>fee plan</u> to ensure assistance to all levels of income
- Include a <u>Governing Board</u>, made up of a majority of community members

A more extensive list of FQCH requirements can be found by clicking <u>here</u>

Benefits of Being an FQHC

One of the major benefits of being designated as an FQHC is receiving the 330grant funding. This capital can reach up to $650,000 for new-starts and it remains the primary financial resource for most FQHCs. In addition to this funding, FQHCs and FQHC Look-Alikes can take advantage of a series of added benefits including:

- up to $650,000 in new start money from 330 grant
- Enhanced Medicare and Medicaid reimbursement
- Medical malpractice coverage through the Federal Tort Claims Act
- Eligibility to purchase prescription and non-prescription medications for outpatients at reduced cost through the <u>340(b) Federal Drug Pricing Program.</u>
- Access to <u>National Health Service Corps</u>
- Access to the <u>Vaccine for Children</u> program
- Eligibility for various other federal grants and programs

Chapter 2

FQHC Start-up Part A - Mission and Strategy

When starting a new FQHC it is imperative that you have a well-defined mission statement and a carefully planned strategy for achieving your goals. Because the overall aims of these centers is to bring primary health care to those who most need it and to do so in the most equitable and efficient ways, this chapter covers the methods by which to identify your target population, recognize their particular needs, and develop a plan to address those needs.

Sections include:

- Identifying your community
    - MUA parameters
    - Cultural considerations
    - Special populations
    - Identification Methodologies

- Community Involvement

- Developing a Community Needs Assessment
    - Demographic and Health Status Trends
    - Managed Care and Utilization Rates
    - Barriers and Access to Care
    - Resource Availability

- Health needs assessment toolkit

- Making Strategic Considerations
  - Long-term and Operational Planning
  - Statewide Strategic Planning
  - Networking and Affiliations
  - Market Considerations in the Planning Process

Identifying your community

The most important first step in the creation of an FQHC is properly identifying the parameters of the community you intend to serve. FQHCs are designated to provide health care services to populations considered **medically underserved** (According to the BPHC this includes:
"all people who face barriers in accessing services because they have difficulty paying for services, because they have language or cultural differences, because there is an insufficient number of health professionals/resources available in their community…or people who have disparities in their health service status")

This definition encompasses a wide range of individuals and it is a health centers duty to define its population through the use of needs assessments, resource evaluation and prioritization of necessities in the community to be served. (For complete community needs information see Developing a Community Needs Assessment)

When assessing the traits of a health center's target population, emphasis should be placed on the specific **cultural considerations** of that community. Because many of the barriers underserved individuals face are related to cultural factors (i.e., language, gender, age, sexual orientation, socio-economic status, etc.) it is of utmost value that a health center gauge the diversity of its community on a broad scale and develop an informed plan that is respectful and appropriate for its client base.

A particular health center designation can be that of serving "**special populations.**" These groups of people, ordinarily medically underserved, are considered to have additional challenges in meeting their health needs. Special populations include: migratory/seasonal farm workers and their families, at-risk school children, residents of public housing, and the homeless. Health centers considered to be serving special populations still meet all the requirements of FQHCs, but make additional accommodations to address the added barriers of that population.

Identification Methodologies

The first step in defining your community is detailing your service area, or the geographic area which your center will be serving. This must be, but is not limited to, a medically underserved area. MUA and can be designated by county, census tract, or divisions that comprise an ordinary neighborhood. The area can also be measured by characteristics of the setting such as language issues, geographic barriers to access, transportation models, and other services available in the area.

For data relevant to defining your community use the links below or contact your Primary Care Association and State Department of Health who should also make regional/local data sources available to you.

- Census Data - For basic demographic information, income, housing, and poverty statistics
- MUA Designation Site - Provides MUA designation data by state, region, locale
- HPSA Link - Health Professional Shortage Areas query services gives information on HPSAs by region, state, or medical discipline
- PCA Directory - Contact the Primary Care Association in your State
- Medicaid State/Territory Site - Provides coverage stats and program information by State
- CDC Website - Offers data on disease and health status trends across the US
- BPHC Home - The Bureau of Primary Health Care website is an additional resource for all health centers and provides a variety of information

Another integral component in understanding your target community is analyzing the surroundings in which your health center will operate. A complete community analysis accounts for all of the various factors that make up the environment for a particular center. It includes consideration of the different sectors of a community (i.e. business, government, health care, etc.) along with their components and influences. For a sample of a community analysis outline, see the NACHC Sample Community Analysis Outline

Community Involvement

Community involvement is a feature that is present throughout the creation, establishment and operation of a health center. Community members are a crucial resource in the identification of need and planning for programs and expansion and should be included in a health center's start-up planning and continued development. Although connecting with the community is often the first step in planning a new health center, locating and retaining participants can be challenging. Some ideas to keep in mind for approaching and including community members in the FQHC process include:

- Assemble a list of all possible community contacts and assign the appropriate person to approach them
- Hold public forums to gain community opinion and support
- Use word of mouth to effectively spread information about meetings
- Consider language and cultural variations in holding your sessions (i.e., bilingual staff for Spanish-speaking populations)
- Make sure your forum locations are accessible to the community members both by time and transportation (consider offering transportation to and from meetings)
- Keep a record of contact information for those attending meetings and those who wish to continue their involvement
- Follow through on questions and concerns of the community, and maintain contact with key elements in the population

Determining a Community's Needs

As a follow up to "identifying your community," a CHC should conduct an in-depth analysis of a community's specific health needs. By this process, a health center will be able to determine both the services most required by the population as well as the areas in which disparities and difficulties linger.

The needs assessment takes into consideration data on various levels of interest discussed below:

- Managed Care and Utilization Rates
- Barriers and Access to Care
- Resource Availability
- Health Needs Assessment Toolkit

Demographic and health status trends are the most basic of elements in evaluating the needs of the community. An understanding of the make-up of the population and their specific health requirements will provide the CHC with a basis of information upon which to build its treatment programs and allocate its resources. Some of the basic demographic traits and their resource links are listed below:

- Age
    o U.S. Census Data
- Sex
    o U.S. Census Data
- Ethnic/Linguistic distribution
    o U.S. Census Data
- Poverty Percentages
    o DHHS Federal Poverty Guidelines
- Employment Data
    o State Departments of Labor
- Housing Information
    o State Departments of Economic Development
- Migrant Population Estimates
    o State Office of Migrant Health

Managed Care and Utilization Rates provide clues to the levels of health care access that exist within the community. Evaluating the coverage trends of your population and their tendency to seek care can clarify the areas of unmet need and inform programmatic and outreach activities. Methodology for assessing these characteristics may be available through your PCA as part of their SSP process. Some of the individual data can be found at the sources below:

- Insurance coverage and Medicaid rates
        Source: Maryland Medicaid Agency
                Delaware Medicaid Agency

- Health Care Utilization Data
        Source: National Center for Health Statistics

Barriers and Access to Care are elements that can be both formal measurements and perceptions of the community. They can include any detail that contributes or detracts from the ability of an individual to access the primary care delivery site. Some common barriers can include language, transportation, knowledge, fear, etc., and are often assessed through contact and data gathering from the community itself. Concrete barrier data, such as that relating to transportation schemes and linguistic characteristics, can be located from census and state-level sources but the most reliable resource is in the population itself.

Resource Availability determines the presence of health care resources within the community in terms of existing providers and service organizations. Often times a PCA will have primary care data available, but it is important to obtain as thorough a picture of the local health care landscape as possible. This includes measuring doctors, both generalists and specialists, gauging their direct patient care hours or full time equivalencies (FTE), and learning their market share of managed care and Medicaid patients. These data, detailed further in the Market Analysis and SSP methods, when compared with the health needs data of the community can demonstrate the true nature of unmet need within the underserved population.

Much of this general information can be obtained from health data sources discussed above such as State health departments and your PCA, but for a more precise and thorough analysis a health center should conduct its own detailed needs assessment.

Making Strategic Considerations

The strategy of a health center acts as the guiding principle in almost every aspect of its operations. Having identified the target community and assessed its needs, a health center must

- identify long-term and operational strategic plans
- network and develop affiliations with other area service providers
- consider the market environment in the planning process
- Statewide Strategic Planning

Strategic Planning

In identifying the long and short term goals of your health center, you must first prioritize programs according to both the needs of your community and the resources available to the health center. You should also take into account the priorities of the community itself by incorporating their input and feedback into the planning process.

When it comes to planning, there are two main areas for a health center to consider.

The first is **long-term strategic planning**, a process by which a health center develops a long-range proposal for its role in the community. The strategic proposal serves as a guide for establishment and implementation of health center programs and generally foresees activities in a five-year span. An essential element of long-term strategic planning is the integration of continuous evaluation and feedback into program

development. By tracking responses and changing needs, health centers can make the proper modifications needed to keep their programs current and effective.

The second planning system is annual or short-term operational planning. This model focuses on short-term goals within the context of the long-range plan. In other words, the operational plan provides a year-by-year comprehensible view into goals and strategies on a smaller, more logistically imaginable scale.

For both sets of strategies, planning should be based on input from various sources including:

- governing board members
- staff
- community members/patients
- healthcare funding organizations

As well, health centers should maintain current data on appropriately related topics such as the changing needs of the community or the climate of the healthcare market.

Tracking and evaluation is an indispensable component to any planning procedure. In order for strategic models to remain efficient and effective, a health center should develop systems for tracking the progress of their programs and evaluating the data in light of the changing needs of their client base. Different data collection schemes can be used for this process and it assists in the development and achievement of mission goals.

Statewide Strategic Planning

Statewide strategic planning (SSP) is a process by which primary care delivery sites (PCDS) can gauge the strategic initiatives and resources available in each state that will assist them in reaching the goals of the Presidential Health Center Initiative and NACHC's REACH (Resolution to Expand Access to Community Health) plan. Through a process of market analysis, needs assessment and operational assessments, PCDSs can project a Five-Year Growth and Expansion plan and make adjustments to previous strategic growth models in order to meet the President's and REACH goals of doubling the number of people served by health centers. FQHCs often collaborate with their state PCAs to determine these models and use a variety of sources and methods. This procedure is an important one, not only to help meet the overarching goals of recent health care initiatives, but to keep FQHCs current as to the needs, marketplace, and proper strategies useful to fulfilling their mission aims.

Networking and Affiliations

Linking a health center to its surrounding service providers is an effective way to secure the provision of required services as well as a way to create a safety net to better protect the health needs of the underserved. Because resources are often limited at health centers, developing a network of relationships with other area health care and social service suppliers ensure increased access to a vast array of health services and related assistance and support, such as housing and employment opportunities.

Affiliations can be made on an individual basis or health centers can join contractual network organizations that link health care providers such as hospitals, social service groups and specialty organizations. While formal affiliations are advantageous in the creation of a steady safety net, a health center must be sure that it maintains its governing board and adheres to FQHC requirements to be eligible for future federal funding.

Market Considerations in the Planning Process

Though the market analysis process will be further detailed in the "Finance and Management" chapter, but it is valuable to emphasize that a health center must bear in mind the surrounding market climate when creating its strategic plans. With health care resources becoming scarcer and competition for fund increasing, an FQHC has to make informed decisions about resource allocation and program development. Each health center must maintain a high level of efficiency and keep costs at a minimum without sacrificing quality of services. Through consistent evaluation of management and delivery services, documentation of cost, quality and impact of services and efficiency efforts, health centers should be able to keep their costs in line with other providers and remain competitive in their market. To maintain this, market considerations must be a fundamental element of the planning process both short-term and long.

Chapter 3. FQHC Start-up Part B: Governance.

One of the distinctive characteristic of federally qualified health centers is the requirement of a governance board that has full authority and management over health center operations. The board is a policy-making body constituted primarily of community members and is a key component in keeping the health center answerable to the population it serves. Development of a community-based governance board is a priority for any new-start or expansion and must follow the specific conditions outlined in this chapter:

Assembling a Governing Board

- o Board Composition
- o Selection of Members
- o Training and Development

Board Functions and Responsibilities

- o By-laws and legal liability
- o Duties of the Board
- o Board Committees
- o Exceptions and Variations

General Board Requirements

The creation of a governing board should be one of the primary measures taken when starting a new health center. The establishment of an oversight body comprised of the very community being served is a uniquely advantageous aspect of FQHCs and its composition has very precise guidelines. According to section 330 provisions a health center must have a governing board that

- is composed of individuals, a majority of whom are being served by the center and who, as a group, represent the individuals being served by the center
- meets at least once a month
- determines the services which will be provided
- carries the legal and fiduciary responsibility for clinic operations and funding
- schedules the hours during which the services will be provided
- approves the center's grant application and annual budget
- participates in strategic planning and organizational goal management
- endorses the selection of the health center director
- establishes general policy for the center (except in cases of public entities)

Board Composition

The constitution of a governing board is intended to maintain a dynamic that advances the needs and priorities of the community being served. As such, the following composition regulations must be adhered to in the interest of supporting the community:

- FQHC boards must have between 9 and 25 members and size should be relative to the size and complexity of the organization
- A majority (at least 51%) of the board must be made up of consumers, those individuals who use the CHC as their primary source of health care and live/work in the service area
- Consumer board members should reasonably represent users of the health center in terms of race, ethnicity, gender, etc.; when funding is solely for "special populations" such as homeless or public housing service centers, the majority of consumers should be derived from the target population
- One half or less of non-consumer board members may be individuals who receive more than 10% of their income from the health care industry; exceptions can be made for healthcare workers who are themselves users of the health center in which case they are considered "consumers"
- Non-consumer members should be chosen for their expertise in areas relating to community affairs, financial, legal, social services, etc.
- Health center employees and relatives of employees are ineligible for participation on the board

Selection of Board Members

The selection of board members is a process highly influenced by the governing rules of the particular health organization. The by-laws, which must be approved by the health

center's governing board,   specify details pertaining to election, term limits, board leadership and responsibility. Again, of utmost importance is to ensure selection of members whose interest and background best embodies those of the community.

Board Training and Development

A beneficial and necessary part of governance board's establishment is the enhancement of board members skills, knowledge and participation through training and development efforts. It is essential that board member be sufficiently experienced with health center issues in order to make informed decisions about policies, financial arrangements and strategic planning. To foster knowledgeable participation, governing board members should be supplied with opportunities for orientation, educational training, self-evaluation, and identification of further development needs. The board itself is responsible for the organization and implementation of the necessary training.

Board Functions and Responsibilities

A health center governing board has a number of functions and responsibilities. It is not only beholden to promoting the community's wellbeing but is also legally accountable for making certain the health center operations follow proper federal, state and local regulations and remains financially viable.

Bylaws and Legal Liability

By-laws for a governing board will be established and approved by the board as one of its initial duties. These regulations should account for all aspects of a governing board's duties and should be sure to address:

- The health center mission
- Membership size, composition, responsibilities, terms of office, etc.
- Officer duties, selection process, terms of office, etc.
- Committee standing, membership, responsibilities, etc.
- Meeting schedules, location and recording/storage of minutes
- Safeguards against conflict of interest

The legal liability of a board often does not extend to its individual members, although as a collective they are responsible for the proper functioning of health center activities under state corporation laws. Many state laws require mainly that board members purse their duties "in good faith" with the community's best interest in mind. A few specific liability guidelines are as follows:

- It is the responsibility of the board members to ensure that the organization carry fulfill its mission in accordance with bylaws and state/federal funding guidelines
- Board members cannot be held personally liable for faulty business/financial decisions if they were originally made in good faith without a conflict of interest

- Conversely, members CAN be held personally liable if decisions are neglectful of responsibilities and are in violation of conflict of interest or federal/state regulations
- The board of directors should play a central in creating and employing a Corporate Compliance Program

Duties of the Board

As the primary authority of a health center's operations, governing boards have oversight duties relating to all aspects of FQHC functions. The following break-down covers the major aspects of board responsibilities and is directly referenced from the NACHC start-up guide (see references):

- **Human Resources**: The board establishes personnel policies and procedures, including selection and dismissal policies, salary and fringe benefit schedules and programs, employee grievance policies, and equal employment opportunity practices. The board also hires and evaluates the performance of the executive director.
- **Finance**: The board adopts policies for financial management practices including a system to assure accountability for center assets and resources, approves the annual budget, selects the independent auditor and accepts the audits, approves the payment and eligibility for services including criteria for fee discounts for individuals with incomes below 200% poverty
- **Planning:** The board engages in strategic planning to ensure that the center is prepared to success in a changing health care environment, continues to address identified community health service needs and pursues organizational goals and mission through the center's operations. The board approves the center's purpose, mission and roles.
- **Operations:** The board adopts operational policies including scope and availability of services, and quality-of-care audit assessment and improvement programs and policies.
- **Evaluation:** The board evaluates health center activities including the quality of patient care services, service utilization patterns, productivity of providers, patient satisfaction, achievement of project objectives, and development of a process for hearing and resolving patient grievances.
- **Legal**: The board must ensure that the health center is operated in compliance with applicable federal, state, and local laws and regulations. The board must protect the corporation from unnecessary liabilities and assure compliance with the DHHS/OIG Corporate Compliance Guidelines

Board Committees

Based on the size and need of a health center, a general governing board can be divided into committees charged with handling more detailed and specific tasks. They can approach such topics as budgets, program planning, operations analysis, etc. with more

focus and efficiency. In cases where bylaws permit it, board committees may even be able to include non-board members with specialized expertise. Committee development is a process unique to the needs of each individual health center, but some common committees include:

- Executive (only committee authorized to act on behalf of board)
- Finance
- Human Resources
- Quality Assurance
- Strategic Planning
- Development/Fundraising
- Marketing/Public Relations
- Education
- Nominating

In addition to standing committees that meet on an ongoing basis, governing boards also have the power to create temporary ad hoc committees designed to address one specific element at a given time. In accordance with state corporation laws, the activity of committees is generally limited to review and advisory functions. Executive committees are the exception, being an extension of the board itself with full authoritative capacity.

Exceptions and Variations

In some cases, there are exceptions and variations to the health center governance board rules. Those health centers serving special populations (i.e. section 330g, 330h, 330i) are permitted to request a waiver for any or all governance requirements, so long as they present a strong argument as to why the requirements cannot be met and provide for alternative strategies of meeting the intent of the governance rules. All other community health centers (section 330e) are not eligible for any such waiver regardless of their additional funding for special populations.

Chapter 4

FQHC Start-up Part C: Clinical Program

- Governing Body and its Requirements
- Assembling a Governing Board
- Board Functions and Responsibilities

The clinical program of a health center must provide all of the aspects of care and attention needed to ensure increased access and quality of care amongst the underserved. Services must be appropriate, available, and tailored to the needs of the particular community, an achievable

goal with the proper clinical system. This chapter focuses on the wide range of features needed in an effective health center clinical program, including:

    a. System of Care
        i. Services – required, additional, specialized
        ii. Health care continuum – referral arrangements for hospitals, specialists
        iii. Contracting for needs not met by CHC
        iv. Health care model – healthcare goals and objectives based on priority and resource consideration

    b. Service Delivery Models
        i. Location/hours/transport considerations (includes after-hours arrangements)
        ii. Type of services/ service-providers – definitive set based on requirements and additional needs

    c. Clinical Staff
        i. Establishing Leadership
        ii. Staffing
        iii. Recruitment, retention, hiring/terminating
        iv. Additional staff considerations – continued education, licensure renewal arrangements, etc.

    d. Clinical policies, procedures, and tracking systems
        i. System based on medical records, policies/procedures in compliance with expectations of accrediting agency
        ii. Fostering access and continuity of care through procedure

Services -

In creating a system of care, the basic outline is determined by the services required of an FQHC. Each health center acts first and foremost as a primary care center, but the greater goal of an FQHC is in ensuring increased access to the entire continuum of care as well as services aimed at improving the status of its community. This can be achieved through the provision of all required services, specialized services, and linkages to a range of health care services.

By grant requirement, all health centers must provide the following, either directly or through contract arrangement:

Basic Health Services:

- Primary care
- Diagnostic laboratory and radiologic services
- Preventive services (including prenatal/perinatal services)
- Cancer and other disease screening
- Well child services
- Immunizations against vaccine-preventable diseases
- Blood lead level screening
- Communicable disease
- Cholesterol
- Eye, ear and dental screening for children
- Family planning
- Preventive dental services
- Emergency medical and dental services
- Appropriate pharmaceutical services

Social Services and additional services:

- case management
- assistance with financial support for social and health services
- referrals to substance abuse and mental health services
- outreach
- transportation
- interpretive assistance
- health education, where appropriate

Specialized services can include additional considerations made for special populations and those with specific health needs. For example, those health centers serving migrant health workers could create added programs to address environmental/occupational health hazards, or a focus on mental health services for health centers serving homeless populations. Non-special population health centers can also make adjustments to program services according to the added needs of their population; for instance, a community with high HIV prevalence may require increased disease and screening services. The priorities and specialized services should ultimately be determined by the needs of the community and the availability of resources.

Health Care Continuum

Though the foremost role of health centers is to provide primary care, they are expected to facilitate access to the entire range of health care services through a continuum of care. Linkages with local health care provider networks as well as a comprehensive system of referral and case management can increase efficiency and quality in service provision. The offer of continuous care also extends to after-hours services. At the very least, health centers should provide telephone access to physicians after office hours and should establish mechanisms for delivering needed services through other providers and health networks.

Contracting for Health

Referral arrangements for complete coverage measures should be made through contracting with hospitals and specialists in the area. These procedures are to ensure that patients of a health center have their complete health needs met even if the necessary service is not provided directly at the center.

Contracts and agreements with alternate providers should be made in writing and according to BPHC expectations should state:

- time period during which agreement is in effect
- specific services covered
- any special conditions under which services are provided
- terms and mechanisms for bill payment
- additional requirements such as data reporting, adherence to CHC standards, and others as needed

Health Care Planning

As with any operational system, the clinical program should develop a comprehensive health plan by a process of careful consideration and effective prioritization. Health care planning requires creating goals and objectives aimed at addressing the needs of the community while properly allocating limited resources. To do this in the clinical setting, a health center should properly identify needs and follow through with the establishment of programs and services that are achievable, reasonable, and appropriate. A method of performance measurement should be included in the clinical plan as a means of assessing and improving quality of care.

Major topics contained in a health care plan can include:

1. Key Health Issues –
   Identify and prioritize health issues noted in the needs assessment according to life cycle and special needs that may be present

2. Goals and Objectives –
   Create realistic and achievable plans for addressing barriers to care and health care gaps as noted in the needs assessment. Present your goals in an organized manner that is best suited for your setting. Some possible categorizations include: Special Populations/ Needs, By Life Cycle, Chronic Conditions, Mental Health, etc

3. Quality Assurance and Performance Measurements –

All health plans should include comprehensive methods for monitoring and improving care functions. Measures should cover the quality of service, care, work life and cost efficiency and be evaluated by benchmarks such as:

- Clinical outcome measures
- Health disparities collaborative
- Accreditation standards – see chapter 7
- Relative value units
- Other factors specific to your setting and population

4. Addressing Health Disparities –

   Demonstrate how the health care program will speak to the disparities currently present in the community by clearly outlining plans to reduce barriers and increase access to care

5. Staff Recruitment and Retention – see below

6. Risk management Plan – see chapter 5

Service Delivery Models

Owing to the diversity of a health center's population, service delivery models must account for a wide range dynamics such as population resource availability, transportation, and marketplace characteristics. These variations can dictate such details as location, service hours, mix of services and types of providers. The subsequent service delivery models are examples set forth by the Bureau of Primary Health Centers:

Location: Health centers must provide services at locations and times that ensure services are accessible to the community being served, details to be decided by the governing board. Most FQHCs operate at fixed locations while others offer services in appropriate locations such as homeless shelters and migrant farm worker camps. Most health centers engage in outreach efforts to bring patients into the center including the use of personalized transportation services such as vans and busses.

Hours: The hours of operation in a health center should aid access to services and should include early morning, evening or weekend hours. As mentioned above, plans should extend to include services after hours.

Mix of Services: The mix of services offered by health centers is influenced by several factors including demographic, epidemiologic, resource and marketplace. The best mix of service must be determined

individually for each health center and should aim to address the community needs in an efficient and appropriate manner.

Type of service provider: The type of service providers at a health center depends on the mix of services provided at the center. Various disciplines and levels of providers should be utilized where appropriate, but it is the responsibility of a health center to maintain a core primary care team while making specialists and alternate services accessible. The health center staff should also be properly educated on the specific cultural needs of the community.

Clinical Staff

Establishing Leadership

Leadership among the clinical staff is a necessary strength for every health center. This usually takes the form of a clinical director who works closely with the health management team as well as the governing board to maintain a tight clinical program. The typical clinical director is a physician, though some programs hire different types of clinicians. The major responsibilities of the clinic leadership are:

- to provide leadership and management for all health center clinicians (employees, contractors and volunteers)
- work as an integral part of the management team
- establish, strengthen and negotiate responsibilities between the health center and other clinicians, provider organizations and payers in its marketplace
- to represent the interests of the community and health center patients

Staffing: general staff considerations including the types of staff and broad approaches to staffing

Staffing a health clinic can be a challenging and time-intensive task. Because of the rigorous requirements and limited resources of a health center, clinic staff should be carefully selected both for the skills and for the personal capabilities that would enable them to operate in such a setting. The task of staffing both medical and non-medical employees is an ongoing project for any health center and the following are some considerations to make in planning your staff:

- Take a step-wise approach to staffing, filling the leadership positions first, if possible. These individuals can then assist in the recruitment of remaining staff

- Various agencies can serve as resources in the staffing process, including the Bureau of Primary Health Care, the National Association of Community Health Centers and your local PCA. Other established health centers can also be helpful in providing advice on area staffing challenges and successful methods
- Select candidates that can best serve your target populations, keeping in mind the cultural, language and other needs of the community
- Don't forget that administrative and social service staff can be just as important to a health center's operations as medical personnel, so make the proper considerations in total staff structure
-

Recruitment and Retention

Recruitment and retention of quality staff is of fundamental importance to any successful health center. Due to the competitive nature of today's health care market, along with the resource limitations of community health centers, aggressive recruitment/retention strategies must be developed to attract and maintain staff. The National Health Service Corps offers assistance with placing clinicians and can be an important asset in provider recruitment. For details on procedure and eligibility, health centers should contact their PCA, PCO, or the Bureau of Health Professions. The PCA/PCO can also offer aid in advertising openings, referring possible hires, and assisting with organizational employment design. In addition to the support offered by these organizations, a health center must take steps to increase their appeal for recruitment and retention including:

- Be familiar with the going rates of health care salaries, and balance benefits to most closely match health center's competitors. For salary information contact your local PCA
- Develop strategies to market your health center to potential hires through promotional materials and professional consultation
- Work to match the needs of both your health center and potential clinicians as closely as possible. A health center should not only offer its community the best fit candidates for the job, but should also consider the opportunities and skills that the health center can offer the clinicians as a way of maximizing services as well as retention
- For free malpractice coverage, keep up to date on requirements needed to meet the **Federal Tort Claims Act**

- Create a comprehensive benefits package to support long-term retention and increase productivity
- Include the staff in management collaboration efforts as a way to increase involvement in decision-making, gain valuable feedback, and commit them to the health center mission and future
- Keep recruitment efforts active to take advantage of opportunities and be prepared in time of unexpected staff changes

Staff Development

Offering staff development opportunities is a way for health centers to bolster retention while keeping the capabilities of staff current to the needs of the center. These opportunities can take the form of training workshops, continuing professional education, and affiliations with teaching programs and are designed to maintain credentialing and licensing and continually cultivate the skills of health center employees.

Clinical Operation Systems

Policy and Procedures

The clinical policies and procedures of a health center should reflect the current guidelines established by health agencies such as the Agency for Health Care Policy and Research and should describe:

- Hours of operation
- Patient referral and tracking systems
- Clinical protocols
- Risk management procedures
- Patient satisfaction guidelines
- Consumer Bill of Rights
- Patient grievance procedures

Tracking and Appointment Systems

A health center clinical tracking and information system must be based around patient medical records and should:

- Ensure confidentiality protection of records

- Promote thorough documentation and quality of care

- Incorporate recall methods for routine preventive services and chronic   disease management

- Allow tracking of patients who are referred to specialist and other off-site services

- Supply data and information into a health center's quality improvement program

Proper budget allocations should be made to keep information systems updated and efficient through increased technology structures.   Effective clinical tracking methods can increase the quality of care in a health center and help better serve its patients.

Appointment systems are another way to improve patient flow and access to services. Appropriate scheduling and communication models can foster continuity of care, minimize waiting time and no-shows and could provide for emergency problems and call/walk-in patients. Feedback and input from clinic staff can assist in the identification of problems and the formulation of solutions to patient appointment protocols.

Chapter 5

FQHC Start-up Part D: Finance and Management

- Creating a Business Plan
- Financial Tracking
- Instituting Management
- Management Systems
- Market Analysis
- Statewide Strategic Planning

As with any organizational structure, a community health center must remain viable in today's market in order to succeed and move forward. Careful attention to finance and management specifics will help a health center maximize its utility, remain competitive in its market and ultimately broaden its scope of services and locations. The essential components for finance and management of a health center include:

e. Creating a Business Plan
    i. Statement of purpose
    ii. Market Analysis
    iii. Strategy
f. Financial Tracking
    i. Financial Projections
    ii. Budget and Accounting
    iii. Billing and Collections

          iv.   Audits and Internal Controls

      g.   Instituting Management

          i.   Structure and Duties

          ii.   Relationship to Board

          iii.   Role in strategic planning

      h.   Management Systems

          i.   Information Management

          ii.   Risk Management

Creating a Business Plan

A health center business plan provides a structured view of the overall goals of a CHC by clearly outlining intended targets and strategies to meet them. While it facilitates the grant process and also serves as leverage when pursuing alternate financing opportunities, the real advantage of a business plan is to help the health center prioritize its needs and lay foundations for achieving objectives. To this end, a business plan should be clear, concise, and realistic while still representing the mission of a health center.

Statement of Purpose

In the statement of purpose a health center clearly outlines its goals and objectives with respect to health center operations and future projections. By creating this initial element of the business plan, a CHC can develop a structured tool to help maintain focus on its ultimate aims and organize its functions according to those ends. A thorough examination of factors leading to the initiation of the health center can guide the creation of the purpose statement.

Market Analysis

A health center market analysis is an indispensable tool in the business planning process. Gathering proper information on the surrounding industry climate will enable a health center to become a competitive health care market participant. Only by knowing the needs and characteristics of the market can a health center maximize its share. The major areas of data to consider in this process are:

- Demographic and Health Status Data: Describes the area population in terms of general demographic data (age, gender, etc.), socio-economic factors (housing, employment, etc.) and health status (disease trends, etc.). It is useful to collect data that is both specific to the target group and gives an overview of the general population surrounding a health center.

- Geographic Data: Illustrates the area from which the health center receives patients in terms of counties, zip codes, census tracts or other characteristics

- Location and Transportation: Consider the location of the health center with respect to available modes of transportation for the underserved population

- Market Competitors: Identify the surrounding health care providers that offer similar services to the community health center including providers of primary care, dental, mental health, social services, etc.

- Growth Trends: Comparisons of demographic, geographic and provider data over time can help show the growth trends in a health center's area and assist in making projections for future programs and services

- Market Trends: Gauging the market trends that could affect a health center's business will help keep the CHC ahead of the curve in business planning. Look at items such as changes in healthcare delivery or payer systems, new or changing employer industries, and other factors that impact CHC market share.

Market Analysis Resources:

- Summary Data Sheet
- NACHC
- MACHC

Strategy

Once the health center goals and market assessments have been established, it is the responsibility of management to devise strategies for setting the health center apart from the rest of its competitors. This can be done through the formation of a comprehensive business plan that lays out the processes needed to:

- attract the target population
- maintain health center financial viability
- establish links with area health networks
- project future expansion and program development
- exploring new markets and products

Based on the strategies put forth in this segment, management must develop a thorough work plan that details the specific activities, target dates, and individual position responsibilities. This implementation plan is a necessity when seeking health center status.

As a supplement to the above, a contingency plan that accounts for unforeseen events that a health center might come across should also be assembled.

Financing:

Financial Projections

When working with limited funding sources, as health centers often due, it is imperative to maintain a firm handle on the expense structure of the organization. To do this, health centers often make financial projections based on a variety of elements (such as patient volume predictions, clinical and supplemental services, provider and support staffing, etc.) and use these findings to make strategic financial decisions. Though there are many ways to calculate and analyze fiscal forecasts, health centers can refer to this segment of the NACHC FQHC start-up manual as a preliminary guide:

Budget and Accounting

The maintenance of appropriate budgetary and accounting measures is a vital facet in securing a health center's fiscal and programmatic success. In accounting, a CHC must develop a system that follows Generally Accepted Accounting Principles (GAAP) carefully tracks organizational finances. Systems should be designed to meet the specific needs of a particular health center and must allow for the production of periodic financial reports. These reports are reviewed by the proper management staff and board members and offer an accurate view of the current financial state and the future potential of the health center.

The budgeting process is a collaborative effort between the suitable members of management, staff and the governing board and is aimed at successfully allocating health center funds towards programs and services that deliver on the objectives of the mission. In creating an effective budget plan, the financial team must incorporate the financial projections (as outlined above) with a careful account of all current and prospective funding sources while paying close attention to the changing characteristics of the market and target population. A health center should also always provide contingency strategies within the regular budget plan that addresses potential emergencies. Budget reports must be reviewed and adjusted regularly and annual presentations made to and approved by the governing board.

Billing and Collections

At the core of each community health center's mission is the promise of service to those who need it regardless of their ability to pay. While this is a primary goal of all FQHCs, a health center must not overlook the importance of adequate billing and collection methods to gather funds from those individuals that do pay on the sliding scale. Maximizing efficiency in this area can add to a health center's revenue sources and help maintain its financial stability. Considering the high level of insurance and managed care participation in today's health care market, collecting on health center bills becomes a chief necessity. To make the best use of this revenue channel, health centers work to:

- Create an adequate and competitive fee schedule
- Maintain prompt and accurate third party payer billings
- Bill patients according to schedule of discounts and in accordance with local rates
- Follow up on uncollected fees in a timely manner
- Participate in the proper insurance programs for your population
- Join favorable cost-based reimbursement programs
- Incorporate electronic billing and insurance verification systems

The ultimate billing and collection systems must be written and board-approved and as with all health center initiatives, the proper cultural considerations should be made to lower any barriers to access that payment may pose.

Audits and Internal Controls

In tandem with the budgeting and billing structures, a CHC must have proper internal controls in place to closely track the financial health of the organization. These internal controls can be developed by the management and board team as the financial tracking systems are developed.

In addition to financial controls, every health center should make arrangements to have an annual independent financial audit conducted using the most recent federal guidelines for non-profit institutions. This report should include information on the health center's compliance to GAAP and should make suggestions for improvements where needed.

All adjustments and controls must be made in agreement with grant requirements and board approval.

Structure and Duties (mgmt)

The management team of a health center provides the structure and guidance needed to achieve success. Depending on the capacity of a health center management should have leadership in the form of an Executive/Program Director, Clinical Director, Chief Financial Officer and Chief Information Officer, though some roles and responsibilities can be combined as needed. Some responsibilities of the Management roles are:

- Executive Director/Program Director – provides overall administrative leadership for a health center and in smaller setting often embodies the other major leadership roles, direct link to governing board and is responsible for moving CHC towards board-established long-term aims

- Clinical Director – responsible for clinical leadership and development of programs and services

- Chief Financial Officer – provides leadership in financial arenas and is responsible for fund recruitment and effective business planning

- Chief Information Officer – offers leadership in creation and implementation of information systems, responsible for ensuring efficient flow of information to increase access

Each member of the management team should have the appropriate training for their specific roles and the organizational relationship of these roles must be maintained in the business plan provided to the board. As the size and needs of the health center change, the management structure should also evolve to stay ahead of organizational demands.

Relationship to Board

As with other aspects of health center operations, the governing board has rule over the establishment of a management team. Most often, the board selects and hires an executive director who then will establish the management organization with the guidance and interests of the board in mind. The executive director, over which the board also retains dismissal power, serves as the direct link between the governing body and the rest of the health center management and staff team.   Given that the executive director is ultimately accountable to the decisions of the board, he/she is often in close contact with the governing body when making decisions that will impact the direction and operation of the health center.

Role in Strategic Planning

Management plays a central role in the CHC's annual and long-term strategic planning process. Bringing together board, staff and community members, the management team provides the necessary leadership in developing a comprehensive health center strategy. Due to their proximity to and understanding of daily health center operations, leadership is in a prime position to offer critical recommendations towards progress. The team is also responsible for making adjustments to the annual operating plan as they deem necessary to achieving the goals set forth by the board.

Information Management

An organized and accessible data information system is vital to the fluidity and quality of health center operations. These models must extend to include all aspects of clinical, financial and organizational information including data collection, storage, back-ups, organization and exchange. Proper information systems can improve internal monitoring, quality assurance measures, access coordination, statistical data reporting, and planning procedures.

In the clinical setting, health centers should utilize International Classification of Diseases (ICD) codes, Current Procedural Terminology (CPT) and relative value units (RVU) to keep service and cost data and analysis current with today's practices. Along with these essential elements, clinical information management systems must:

- allow for timely and accurate reporting of health and program statistics
- offer figures on service production and costs
- increase management and coordination of health care access
- feed into quality assurance and utilization management programs
- protect the confidentiality of all patient information

For Financial information management, the goal is to introduce a system that:

- tracks, analyzes and reports key figures related to revenue generation, expenditures, and costs
- supports accounting functions including reimbursement mechanisms
- is adaptable to the changing health care market
- produces cost information relevant to the development of financial strategies

With the availability of powerful and cost-effective information system technologies, more and more health centers are employing electronic data management methods. Though up-front costs may be high, health centers are urged to consider the integration of technology for long-term advantages in efficient

and effective data management. Each health center should incorporate systems appropriate to its size and complexity and keep programs updated as resources allow.

Risk Management

Instituting risk management policy and procedure is a requirement of all health centers and is a logical component in protecting the interests of the organization, its staff and its patients. Risk management protocols should be incorporated into the general policies of a health center and should address:

- potential and actual risks
- regulatory compliance
- fire and life safety procedures
- quality assurance and improvement
- bonding
- insurance
- professional and general liability
- OSHA (Occupational Health and Safety Administration) standards and procedures
- Clinical Laboratory Improvement Amendments policies and procedures

Health centers are offered liability coverage under the Federal Tort Claims Act (FTCA)

Chapter 6

Funding a Health Center

- 303 Grant Application Procedures
- Alternative Funding Sources
- Grant Renewal and Supplementation
- PIN and PALS

330 Grant Application Overview

Securing a federal grant to fund a health center can be a competitive and time-intensive task; it demands careful attention to detail and a well-planned presentation of project goals and methods. With the establishment of the President's New Access Point Initiative more federal dollars are available than ever before. At the same time, those seeking FQHC status have multiplied so it is imperative to present a solid grant application when seeking funding. A thorough business plan and project outline along with the demonstration of how the new center will increase primary care access is among the most important ingredients in the grant application. By clearly illustrating the presence of need and the detailed methods by which the health center will increase access to primary care, the application can gain a competitive edge.

Though there is no simple way of completing the grant process, here are some insider Tips for FQHC Grant Applications (from the TACHC).

The grant application itself can be found through the HRSA field office.

And for BPHC-issued advisories on the 330 application process, see the PINs and PALs section below.

Renewing health center applications can be just as demanding a process as obtaining initial funding, but is accomplishable by presenting how the CHC has addressed the needs of the community, increased access to primary care, met the BPHC service requirements and is keeping ahead of the changing market elements.   The renewal application can be found at:

Alternative Funding Sources

Although federal funds offer health centers a considerable sum of money, alternative sources of funding are still needed to help defray the cost of providing services to underserved and uninsured populations. CHCs already receiving the general 330 (e) Community Health Centers funding may be eligible to receive additional 330 funds designated for special populations such as Migrant Health and Health Care for the Homeless.

Additional Government Grant Sources:

- Ryan White Comprehensive AIDS Resources Emergency Act
- Title X Family Planning Services
- WIC Program
- Maternal and Child Health Program
- Community Access Program (CAP)
-

Another large area of resources is non-governmental grant makers which can include independent, community and operating foundations or corporate and employee giving programs. Many of the funds that come from these alternate foundations can be competitive and must be sought out by each individual health center. Often the state PCA or PCO can assist in locating the proper funding sources for a particular CHC and two great web resources are:

The Foundation Center – offers resource guides that cross reference foundations, grant recipients, and specific grant awards by subject area and state

Grant-Makers in Health – provides information on grants specific to health care

Obtaining Federal Designations

Before any funding decisions can be made, FQHC applicants must obtain the proper federal designations to make them eligible for government grants. Securing federal designation is an advantageous exercise because it can allow for benefits even if FQHC status is not achieved. The following is a summary of various designations provided by NACHC.*

- Medically Underserved Area or Population: Required for those seeking FQHC status or 330 funding. HPSA status can be used in lieu of MUA for rural health centers.
    - o Apply to: Division of Shortage Designation, BPHC, HRSA in cooperation with state PCO
    - o Requirements: based on composite score from four indicators – physician-to-population ratio, infant mortality rate, % of pop. below poverty level, % of pop. over 65 years of age. Areas that meet these requirements and have already been designated may not include recent shifts in population so petition for designation where appropriate
    - o For more information: Contact the Division of Shortage Designation, HRSA Field Office, State PCO or PCA. Listings of current MUAs can be found on the HRSA website

- Health Professionals Shortage Area: Required for those who wish to employ NHSA providers; can also be used for obtaining Rural Health Clinic status and is important for 330 funding criteria
    - o Apply to: Division of Shortage Designation, BPHC, HRSA in cooperation with state PCO
    - o Requirements: a geographic HPSA is an area with a physician-to-population ratio of 1:3500 or greater or 1:3000 in areas of unusually high primary care need. Health care providers must be considered to have insufficient capacity or be inaccessible. Population HPSA is a sub-population with a ratio of 1:3000 or greater.
        - ▪ Dental: geographic Dental Health HPSA determined by 1:4500 ratio, 1:4000 in areas of high need
        - ▪ Mental Health: these ratios can vary based on the method used to determine mental health professionals, so contact the state PCO for further assistance

- o For more Information: Contact the Division of Shortage Designation, HRSA Field Office, State PCO or PCA. Listings of current HPSA designations can be found on the HRSA website

- Federally Qualified Health Status (FQHC): Allows prospective Medicaid payments and cost-based Medicare reimbursement and eligibility for Section 340B PHS Drug Pricing Program
  - o Apply through: HRSA field office and find guidance through PIN/PAL documents at the BPHC site
  - o Requirements: 330-funded CHCs are automatically designated as FQHC status. For those not receiving funding they can be eligible for FQHC "look-alike" status by meeting regulatory and statutory requirements and program expectations for CHCs
  - o For more information: Contact the HRSA Field Office, state PCA or NACHC

- National Health Service Corps: status allows organizations to hire health care professionals seeking assistance with educational expenses through govt. loan forgiveness programs
  - o Apply to: HRSA Filed Office/NHSC Office
  - o Requirements: The Clinic must be in an HPSA, must agree to serve Medicaid/Medicaid patients without billing them in excess of what the programs pay, and must have a sliding-fee schedule of discounts for people who are living below 22% of the FPL without insurance. Many states also have supplemental state loan repayment programs for health care provider programs so check with the state PCO or PCA
  - o For more information: request a site application from your HRSA field office

- Rural Health Clinic: Allows Medicare and Medicaid cost-based reimbursement eligibility for public and private non-profit and for-profit providers
  - o Apply through: State Health Department
  - o Requirements: The organization must be located in a rural, non-urbanized area that is currently designated as an MUA or HPSA and have a nurse, midwife, or physician assistant present at least 50% of the time it is open for services
  - o For more information: Contact the State Health Licensing Dept., State Office of Rural Health, the Field CMS Office or the DHHS Office of Rural Health Policy

*reference and contact PCO, HRSA, PCA for most current program information

PINs and PALs

Policy Information Notices (PIN) and Program Assistance Letters (PAL) are documents issued periodically by the Bureau of Primary Health Care that outline specific requirements, procedures and practices relating to the establishment and operation of Federally Qualified Health Centers. They are an excellent resource for new-starts as well as existing or expanding health centers and often outline the precise steps needed to create a successful FQHC. Among the most important PINs to be aware of are:

- **Scope of Project Policy**: describes the health center project by the five core elements of services, sites, providers, target population, and service area
- **Affiliations PIN**: provides guidance on creating affiliations with other health providers in an effort to improve access to primary care for the underserved
- **Governance PIN**: describes the implementation of governance requirements for all 330-funded programs
- **Requirements for FY Funding for New Access Point Grants**: clearly states all the necessary steps in pursuing funding for the establishment of a new community health center

Chapter 7

Establishing a Location and Organization

- Strategic considerations
- Organizational Models
- The Capital Link Connection

Location and Space

To determine the site and size of a health center accessibility and projected volume must be the top issues to consider. Because the foremost goal is to bring primary care to those who are not receiving it, access is central to the location of a health center site. Be sure to take stock of all options available and choose the one that is most convenient to a majority of the target population. Use the information gathered during needs and market assessments to pinpoint a prime location and remember that situating centers near other well-traveled areas (such as near major employers or shopping centers) is often a good idea. In some cases, new access points can be located at the spot where a health center may have existed formerly which can be an opportune venture. Just be sure that the location is still appropriate for the surrounding community and investigate possible obstacles that may have led to the shutdown of the original health center.

Once a general area for the FQHC site has been selected, the actual size of the location should be based on the expected needs of the community and services to be provided by the CHC. Volume projections and management/board decisions on care services must guide this process and it is helpful to remember these common suggestions:

- calculate space for not only examination and treatment rooms, but also for administration, patient waiting, reception, and record-keeping
- provide 2-3 exams rooms per care provider to facilitate patient flow
- include a meeting room for board, staff, and community group meetings
- if feasible, provide some space for additional expansion of services to accommodate increasing patient populations

New-Start vs. Expansion

When initiating a new access point, there are essentially two major ways of proceeding. Candidates can either apply as a new start health center and begin from scratch, or collaborate and branch off an existing CHC as an expansion site.

Some benefits and challenges of each include:

New Start Benefits:

- High level of autonomy in decision-making
- Community input and local planning takes precedence
- Location and services can be guided solely by needs/desires of the health center

New Start Drawbacks:

- May take time to attract patients to new center
- Logistical aspects may be more difficult for starts
- Administrative responsibilities significant to handle alone

Expansion Benefits:

- could save time and effort by utilizing existing infrastructure and service models
- existing familiarity and legitimacy in community
- BPHC gives funding preference to expansion application

Expansion Drawbacks:

- decision-making autonomy may be decreased

- coordination/collaboration with larger center may be challenging
-

Regardless of the individual advantages/disadvantages listed here, the most important thing to consider when deciding on a mode of application is the best interest of the community. Choose the model of application that will best serve the target population and secure the most access to primary care services.

Non-Profit Organizational Model

The option of incorporating into a non-profit is often the best choice for those starting a new health center and is a natural option for those branching off of established FQHCs. Incorporating as a non-profit varies from state to state but the main feature is obtaining tax-exempt status under the US Internal Revenue Code. The two applicable non-profit status types are:

- **501(c)(3)**: do not pay income tax on net revenue and donations are tax-deductible for the donor. Some restrictions on lobbying activities exist. This is the preferred designation of the BPHC and variations require explanation.
- **501(c)(4)**: Donations are not tax-deductible for the donor but there are not restrictions on lobbying

Health Care Accreditation

Obtaining health care accreditation is a way by which heath centers can increase their presence as leading institutions of primary care in their communities. Accreditation services essentially monitor the performance of health centers according to a high level of quality standards in an effort to support the continuous improvement of health care services. Being an accredited institution demonstrates a commitment to top-rated health care standards, offers an added degree of legitimacy to the community health center, and can help to increase the CHCs edge in its market. The main accrediting organizations for community health centers are:

JCAHO ("Jayco") – Joint Commission on Accreditation of Health

AAAHC - Accreditation Association for Ambulatory Health Care

The Capital Link Connection

Capital Link is a non-profit organization that offers assistance to health centers in accessing principal for investment in building and equipment projects. Because Capital Link is partially funded by the Bureau of

Primary Health Care, many of its services can be utilized free of cost by 330-funded health centers. Their assistance spans such areas as:

- space design and planning
- business plan and proposal development
- technical help with financial and market analysis
- debt financing
- fundraising

For more on Capital Link, speak with MACHC or view the Capital Link Website and their Online Brochure