Allegan County Community Health Center Planning Project

Final Report

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- Site Visit Guide

September, 2012

HMS Associates
Getzville, NY

Allegan County Community Health Center Project

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Executive Summary

The Allegan County Health Department received a grant from the federal Health Services and Resources Administration, Bureau of Primary Health Care, in September 2011 to conduct a study on the need for a Federally Qualified Health Center (FQHC) in Allegan County, Michigan. Federally qualified health centers must serve, in whole or part, a federally designated Medically Underserved Area or Medically Underserved Population. Medically Underserved Areas/Populations are areas or populations designated officially by Health Services and Resources Administration as having: too few primary care providers; high infant mortality; high poverty; and/or high elderly population. Medically Underserved Areas/Populations designation is an eligibility factor for receiving Federally Qualified Health Center status. Allegan County is a Medically Underserved Area and as such may qualify for Federally Qualified Health Center development. This project had a three-fold focus:

- Examine these needs more closely, especially by area or quadrant of the county referred to herein as Allegan County Primary Care Planning Areas (PCPA) and thereby identify priorities and unmet needs.
- Examine several organizational options for a Federally Qualified Health Center and recommend the preferred organizational structure.
- Examine the operational requirements of a Federally Qualified Health Center and develop protocols addressing such requirements.

The project was guided by an eleven member Steering Committee which met four times in person and twice by telephone conference call with staff support provided by HMS Associates, Getzville, NY. Presentations on progress were made to the Allegan County Board of Commissioners in July and September 2012 and representatives of the Michigan Primary Care Association and Michigan Center for Rural Health provided information to the Board on primary care and Rural Health Clinic issues important in rural Michigan.

Consistent with the approved grant application, a needs assessment process was completed which used a key informant internet survey and telephone interview process to gather community perceived needs. An extensive analysis at the community level took place which examined demographic features, reproductive health and mortality data, and avoidable general hospital inpatient use. The net result was the selection of central and southeastern Allegan County as the areas most in need of additional health center services.

Four health care organizations in the county expressed interest in exploring the development of Federally Qualified Health Center services for those communities. Those organizations were reviewed relative to different approaches to Federally Qualified Health Center development, such as change of scope, new access point or Look-a-like structures. A Request for Information covering eight key topics was issued by the Steering Committee and one organization, the Allegan Health Group, Inc., stepped forward with a strong interest in exploring further development.

Various governance models and requirements, financial analyses and operational needs of Federally Qualified Health Centers were reviewed in detail with Allegan Health Group and its subsidiary health care corporations. The Allegan Health Group, Inc. will continue its due diligence responsibilities and determine the best course of action toward Federally Qualified Health Center development by February 2013.

Community Engagement Plan

The public has been involved in the project from its inception. This has occurred through the meetings of the Steering Committee, contact with various organizations, and individually through the needs assessment process and discussion of the project at two open meetings of the county Board of Commissioners.

Future community engagement responsibilities will reside with both the Allegan Health Group and the Steering Committee, which is led by the County Health Department. It is expected that both organizations will use their existing publicity structures to provide information on the status of development efforts as they become finalized.

This may include issuing press releases or other types of public announcements through a variety of media, examining the potential to use social networking techniques to keep the general public apprised of progress, and notices to organizations serving low income and underserved populations and to those populations directly about the potential development of health center services in the area.

As noted above, the Allegan Health Group, Inc. will continue to explore the best approach to health center development. It is anticipated that as plans evolve into actions that can be translated into dates for opening new services, community engagement activities will become more active.

Allegan County Community Health Center Planning Project

Progress Report 1
Needs Assessment

August, 2012

HMS Associates
Getzville, NY

Introduction

The Allegan County Health Department received a grant from the federal Health Services and Resources Administration, Bureau of Primary Health Care, in September 2011 to conduct a study on the need for a Federally Qualified Health Center (FQHC) in Allegan County, Michigan. Federally Qualified Health Centers, also referred to as Community Health Centers, are community-based and patient-governed organizations that provide comprehensive primary care services to medically underserved communities and vulnerable populations regardless of their ability to pay[i]. They must be private, charitable, tax-exempt nonprofit organizations or public entities. Federally Qualified Health Centers and Federally Qualified Health Center Look-Alike designations require two actions, one from the United States Department of Health and Human Services (USDHHS), Health Services and Resources Administration that "recommends" that the organization meets the eligibility and program standards of the Health Center Program and one from the United States Department of Health and Human Services, Center for Medicare and Medicaid Services that is more related to fiscal management and reporting.

federally qualified health centers must serve, in whole or part, a federally designated Medically Underserved Area or Medically Underserved Population. Medically Underserved Areas/Populations are areas or populations designated officially by Health Services and Resources Administration as having: too few primary care providers; high infant mortality; high poverty; and/or high elderly population. Medically Underserved Areas/Populations designation is an eligibility factor for receiving federally qualified health center status. Allegan County is a Medically Underserved Area and as such may qualify for federally qualified health center development. It is the intent of this project to:

- Examine these needs more closely, especially by area or quadrant of the county referred to herein as Allegan County Primary Care Planning Areas (PCPA) and thereby identify priorities and unmet needs
- Examine several organizational options for an federally qualified health center and recommend the preferred organizational structure
- Examine the operational requirements of an federally qualified health center and develop protocols addressing such requirements

Upon completion of the study it is envisioned that leadership to implement the results of the study will be identified as well as the steps needed to pursue federally qualified health center development.

This progress report summarizes findings to date regarding the needs assessment phase of the project and provides background materials on the two remaining phases of the project.

The core finding is that needs vary significantly by community. The variation in community findings for each component and

subcomponent of the methodology is described in the subsequent section on needs assessment.

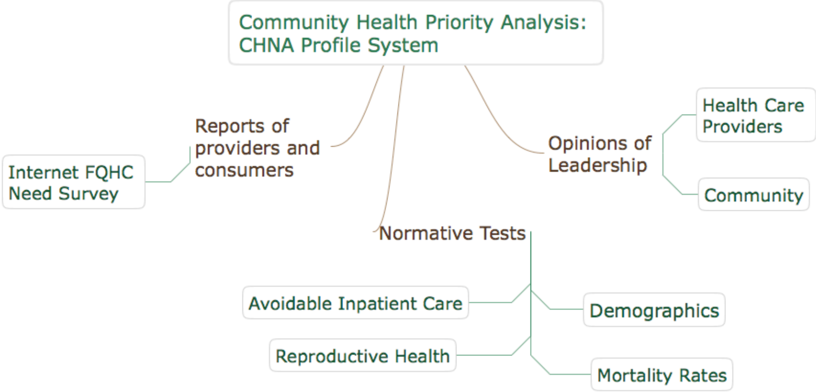
From the overall need perspective, the southwestern and central areas demonstrate the highest need for federally qualified health center services, with an average overall score of 15; the southeastern and northwestern areas have moderate need with an average overall need score of 11 and the northeastern community demonstrates the lowest level of comparative need with an overall need score under 8. The examination of service capacity in these areas will help to further define unmet needs.

1. Needs Assessment

A. Methodology

HMS utilizes its proprietary Community Health Needs Assessment Profile System, a needs assessment triangulation process which integrates quantitative and qualitative data to yield high priority needs at the community level. A salient feature of the HMS approach is the use of relevant Michigan and Allegan County based benchmarks for determining need at the sub-county or community level within quantitative data sets[ii], such as, demographic profiles, avoidable hospital inpatient use, mortality rates or reproductive health indicators. Community level analyses integrate various data elements through the Community Health Needs Assessment Profile System, identify potential priority needs and streamline implementation efforts by identifying specific needs by locale or target group and associated impact measures.

Exhibit 1 – HMS Associates Community Health Needs Assessment Methodology



B. Primary Care Planning Areas

HMS Associates has used five types of data, available at the small area level, i.e., zip code, minor civil division (MCD) or Census Block Group, to develop a set of primary care planning area definitions.

Two of the five data sets are zip code based and pertain to the utilization of either hospital inpatient services at general hospitals located in Michigan or Allegan General Hospital Emergency Department services. These data sets guided the selection of communities based on patterns of use of those health care services. The patterns were then compared to data in three MCD based datasets, including five Allegan County Transportation (ACT) Community Service Areas, the Health Personnel Shortage Area (HPSA) designations, and population concentrations at the block group level (2010 Census).

The result was discussed with Steering Committee members via telephone in March and five primary care planning areas were identified. These areas, their zip code compositions and estimated 2010 Census populations are listed below in Exhibit 2 – Allegan County Primary Care Planning Area Characteristics. It should be noted that areas outside of the county boundaries are included in these communities due to the need for minimum population size, health care service use patterns and consistency in definitions.

Exhibit 2 – Allegan County Primary Care Planning Area Characteristics

Northwest
Pop: 65,389

Northeast
Pop: 49,246

Central
Pop: 17,374

Southwest
Pop: 21,289

Southeast
Pop: 35,617

C. Community Health Center Priorities

Priority Communities and Overall Need

The quantitative assessment focused on need at the community level and as noted earlier, demonstrated that the central and southwestern communities had the highest need or priority for consideration of additional federally qualified health center services. This was based on aggregate negative findings for demographic, reproductive health, need for improved primary care and mortality based indicators. The southeastern and northwestern communities

demonstrated moderate need or priority and the northeastern communities demonstrated low need levels.

Overall need scores for each community were approximately:

Central – 14
Northeast – 8
Northwest – 10
Southeast – 12
Southwest – 16

Most comparative high need scores for the four components of the quantitative scoring system were found in the southwest or central primary care planning areas. An exception was the high demographic score for the northwest community. The extent to which each component contributed to the overall need score is illustrated in Exhibit 3 – Need Scores by Component and Community.

Exhibit 3 – Need Scores by Component and Community

	Central	Northeast	Northwest	Southeast	Southwest
Mortality Need Score	3.8	1.3	2.0	3.3	4.8
Primary Care Improvement Need Score	4.0	1.7	1.7	3.7	4.0
Reproductive Health Need Score	3.2	2.4	2.7	2.8	3.8
Demographic Need Score	3.5	1.8	3.3	2.5	4.0

High score indicates high need.

Demographics

Demographics have a high influence on community health status. Poverty or low income populations generally show much poorer health status than moderate to high income individuals and hence poverty itself is a key determinant of comparative community health. Two poverty measures were included: families below poverty and families below poverty with children. Additional variables include women of child bearing age, and the elderly. People in these two categories use primary care health care services at rates much higher than other population groups and hence the greater proportion in a community, the greater the need. They also have greater need for a variety of primary care supportive health services

such as parent education, case management, and advocacy. These services are often offered by federally qualified health centers.

The southwest community ranked highest in need on demographic poverty and elderly population variables. The northwest community ranked highest on women of child bearing age. These findings are listed in Exhibit 4 – Demographic Findings.

Exhibit 4 – Demographic Findings

Need Score

	Central	Northeast	Northwest	Southeast	Southwest
Families Below Poverty, With Kids	4	1	3	2	5
Families Below Poverty	4	1	3	2	5
People 65 and Over	3	1	2	4	5
Women of Child Bearing Age (14 to 44)	3	4	5	2	1

High score indicates high need.

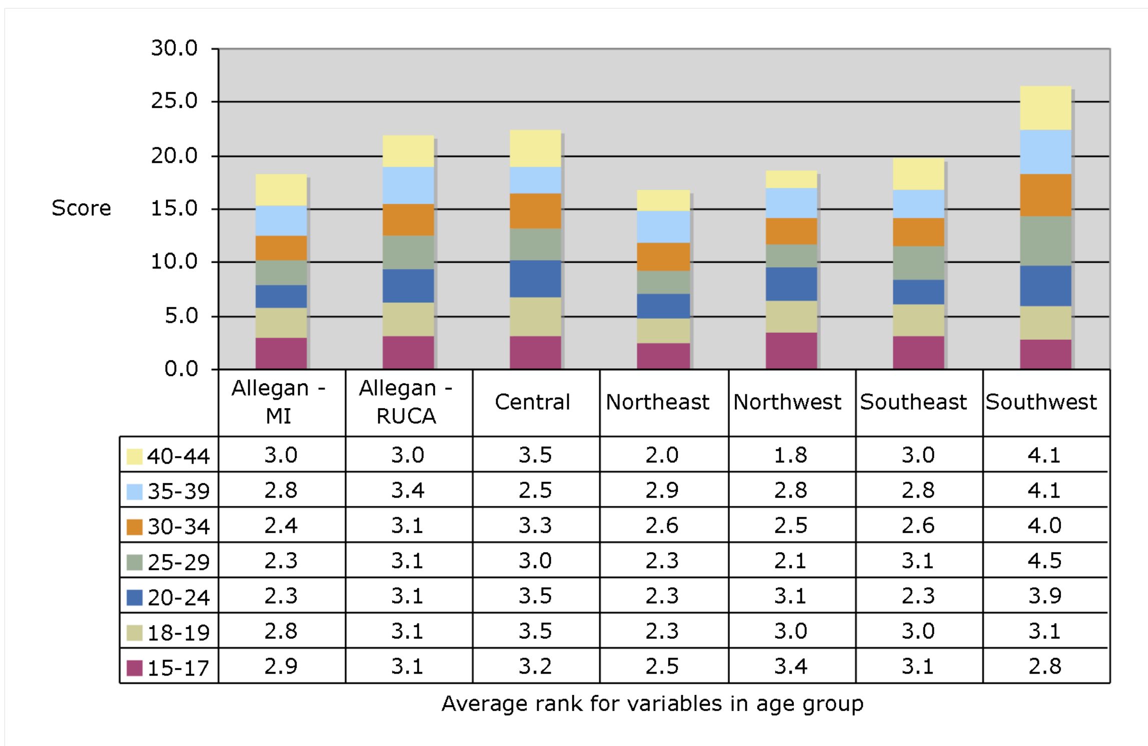
Community	Total Population 2010 Census	Women of Child Bearing Age (14 to 44)	People 65 and Over	Percent of Families Below Poverty	Percent of Families Below Poverty, With Kids
Allegan	111,408	18.9%	13.0%	8.5%	6.8%
Central	17,374	18.8%	13.8%	11.5%	9.3%
Northeast	49,246	19.9%	10.8%	5.7%	4.1%
Northwest	65,389	20.9%	13.6%	9.2%	8.1%
Southeast	35,617	18.4%	14.1%	7.6%	6.1%
Southwest	21,289	18.1%	15.4%	15.4%	12.5%
Underservice	76,600	18.7%	13.0%	9.2%	7.4%

Reproductive Health

The primary care and preventive health care services philosophical underpinnings of federally qualified health centers require that a full range of reproductive health care services be available to center patients and the communities they serve. Reproductive health related programs and services set the stage for healthy lifestyles. As such, reproductive health related statistics are major need indicators for federally qualified health center programs. This analysis included an extensive set of indicators for seven different women of child bearing age cohorts. This level of detail helps to pinpoint reproductive health service needs by age group and community and to some extent, service type.

The southwest community had the highest reproductive health need score followed by the central, southeast, northwest and northeast communities. Allegan County compared more favorably to all Michigan counties than Michigan counties with a similar rural-urban commuting area[iii] (RUCA). However, no age group average rate was in the high need category of 5. These findings are depicted in Exhibit 5 – Reproductive Health Need Component Findings by Women of Child Bearing Age Group and Community.

Exhibit 5 – Reproductive Health Need Component Findings by Women of Child Bearing Age Group and Community
2008 to 2010 Data Set



	Allegan - MI	Allegan - RUCA	Central	Northeast	Northwest	Southeast	Southwest
40-44	3.0	3.0	3.5	2.0	1.8	3.0	4.1
35-39	2.8	3.4	2.5	2.9	2.8	2.8	4.1
30-34	2.4	3.1	3.3	2.6	2.5	2.6	4.0
25-29	2.3	3.1	3.0	2.3	2.1	3.1	4.5
20-24	2.3	3.1	3.5	2.3	3.1	2.3	3.9
18-19	2.8	3.1	3.5	2.3	3.0	3.0	3.1
15-17	2.9	3.1	3.2	2.5	3.4	3.1	2.8

For most age groups, eight variables were included in this analysis and detailed findings for the county and the five primary care planning areas are contained in Exhibit 6 – Reproductive Health Need – Detailed Findings. In all instances, the variable measure was the percent of live births. Caution should be used when interpreting the significance of ranks for low volume birth age groups, specifically, the 15 to 17 and 40 to 44 age groups.

Continued on the next page.....

Exhibit 6 – Reproductive Health Need – Detailed Findings

Age Group	Variable	Allegan MI Rank	Allegan RUCA Rank	Central	Northeast	Northwest	Southeast	Southwest
15-17	Births	2	3	4	1	3	2	5
	Father's Age <18	5	5	4	1	5	2	3
	Father's Age 18-19	2	2	4	3	2	5	1
	Low Birthweight - 1500 to 2500 grams	2	2	2	3	5	4	1
	Month PNC Began - 1st Trimester	2	2	3	2	1	5	4
	Mother Uses Tobacco	2	2	4	2	1	5	3
	Mother"s Education <12 Years	3	4	3	2	5	1	4
	Out of Wedlock	3	3	2	5	3	4	1
	Payer Medicaid	5	5	4	1	5	2	3
	Premature Births <37 Weeks	1	1	2	5	4	1	3
	Variable Average Rank	2.9	3.1	3.2	2.5	3.4	3.1	2.8
18-19	Births	2	2	3	1	2	4	5
	Father's Age <18	2	1	5	2	4	3	1
	Father's Age 18-19	5	5	4	2	4	1	3
	Low Birthweight - 1500 to 2500 grams	2	1	5	1	4	2	3
	Month PNC Began - 1st Trimester	2	1	1	3	2	4	5
	Mother Uses Tobacco	2	2	4	3	1	5	2
	Mother"s Education <12 Years	2	3	3	2	5	1	4
	Out of Wedlock	2	3	1	5	3	4	2
	Payer Medicaid	4	5	4	1	3	5	2
	Premature Births <37 Weeks	3	4	5	3	2	1	4
	Variable Average Rank	2.8	3.1	3.5	2.3	3.0	3.0	3.1
20-24	Births	2	3	5	1	3	2	4
	Low Birthweight - 1500 to 2500 grams	2	3	4	5	3	2	1
	Month PNC Began - 1st Trimester	3	2	3	4	2	1	5
	Mother Uses Tobacco	1	2	5	3	1	4	2
	Mother"s Education <12 Years	4	5	3	1	4	2	5
	Out of Wedlock	2	2	4	1	3	2	5
	Payer Medicaid	2	3	3	1	4	2	5
	Premature Births <37 Weeks	2	3	1	2	5	3	4
	Variable Average Rank	2.3	3.1	3.5	2.3	3.1	2.3	3.9
25-29	Births	4	4	2	5	3	4	1
	Low Birthweight - 1500 to 2500 grams	2	4	4	3	2	1	5
	Month PNC Began - 1st Trimester	2	1	4	2	1	3	5
	Mother Uses Tobacco	1	1	4	2	1	3	5
	Mother"s Education <12 Years	2	3	3	1	4	2	5
	Out of Wedlock	1	2	3	1	2	4	5
	Payer Medicaid	1	3	2	1	3	4	5
	Premature Births <37 Weeks	3	3	2	3	1	4	5
	Variable Average Rank	2.3	3.1	3.0	2.3	2.1	3.1	4.5
30-34	Births	4	5	2	5	4	3	1
	Low Birthweight - 1500 to 2500 grams	2	1	4	5	3	2	1
	Month PNC Began - 1st Trimester	2	2	4	3	2	1	5
	Mother Uses Tobacco	1	2	3	2	1	4	5
	Mother"s Education <12 Years	4	4	3	1	4	2	5
	Out of Wedlock	1	3	4	1	2	3	5
	Payer Medicaid	1	4	4	1	3	2	5
	Premature Births <37 Weeks	2	2	2	3	1	4	5
	Variable Average Rank	2.4	3.1	3.3	2.6	2.5	2.6	4.0
35-39	Births	4	4	1	5	3	4	2
	Low Birthweight - 1500 to 2500 grams	2	3	1	5	2	4	3
	Month PNC Began - 1st Trimester	3	1	4	3	1	2	5
	Mother Uses Tobacco	1	1	5	2	1	3	4
	Mother"s Education <12 Years	4	5	2	1	4	3	5
	Out of Wedlock	2	3	3	1	4	2	5
	Payer Medicaid	2	4	2	1	4	3	5
	Premature Births <37 Weeks	3	2	2	5	3	1	4
	Variable Average Rank	2.8	3.4	2.5	2.9	2.8	2.8	4.1
40-44	Births	3	3	2	3	1	5	4
	Low Birthweight - 1500 to 2500 grams	4	3	5	3	1	1	3
	Month PNC Began - 1st Trimester	2	2	5	1	2	3	4
	Mother Uses Tobacco	2	1	2	2	1	4	5
	Mother"s Education <12 Years	4	4	3	1	4	2	5
	Out of Wedlock	2	1	2	2	1	4	5
	Payer Medicaid	2	4	4	2	3	1	5
	Premature Births <37 Weeks	4	4	5	2	1	4	2
	Variable Average Rank	3.0	3.0	3.5	2.0	1.8	3.0	4.1

Need for Improved Primary Care

The need for improved primary care was measured by the extent to which residents of Allegan County and its Primary Care Planning Areas used general hospital inpatient services in hospitals located in Michigan State for ambulatory care sensitive conditions, often referred to as primary care preventable hospital admissions. The date set for the analysis was very current, October 2010 through September 2011.

Primary Care Improvement Component scores for the central, southwest and southeast communities were similar and indicated high need for improved primary care capacity for those communities. Both the central and southwest communities had high scores of 4 and the southeast community was close behind with a score of 3.7. The central community is note worthy because of the higher ranks for higher volume inpatient care users such as people 22 to 64 and 65 years of age and over and the very low statewide and rural-urban commuting area rank for the county as a whole. This community's rates for these age groups in comparison to Michigan county statewide rates were not remarkable. Data for this component are depicted in Exhibit 7- Need for Improved Primary Care Component – Findings by Age Group and Community.

Exhibit 7 - Need for Improved Primary Care Component – Findings by Age Group and Community

Score

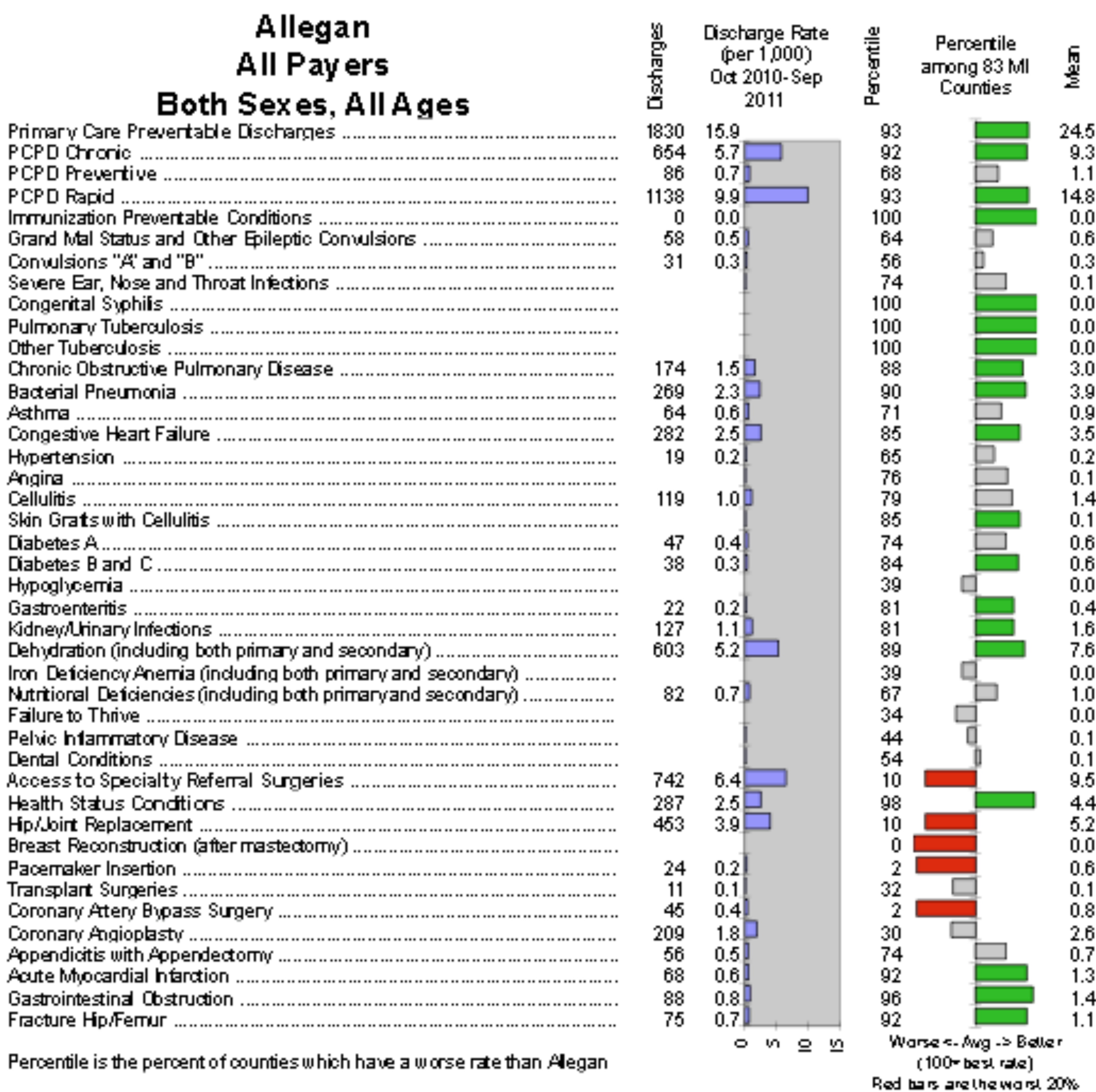
14
12
10
8
6
4
2
0

	Allegan - MI	Allegan - RUCA	Central	Northeast	Northwest	Southeast	Southwest
65+	2	1	5	3	1	4	2
22 to 64	1	2	4	1	2	3	5
0 to 21	1	1	3	1	2	4	5

Rank

An example of the detailed analyses illustrating preventable medical condition inpatient discharges, access to specialty referral surgeries, and health status for Allegan County is shown in Exhibit 8 – Need for Improved Primary Care Services Profile. Such data is available and will be useful in further documenting need by community.

Exhibit 8 – Need for Improved Primary Care Services Profile – Allegan County



Allegan
All Payers
Both Sexes, All Ages

Condition	Discharges	Discharge Rate (per 1,000) Oct 2010-Sep 2011	Percentile	Percentile among 83 MI Counties	Mean
Primary Care Preventable Discharges	1830	15.9	93		24.5
PCPD Chronic	654	5.7	92		9.3
PCPD Preventive	86	0.7	68		1.1
PCPD Rapid	1138	9.9	93		14.8
Immunization Preventable Conditions	0	0.0	100		0.0
Grand Mal Status and Other Epileptic Convulsions	58	0.5	64		0.6
Convulsions "A" and "B"	31	0.3	56		0.3
Severe Ear, Nose and Throat Infections			74		0.1
Congenital Syphilis			100		0.0
Pulmonary Tuberculosis			100		0.0
Other Tuberculosis			100		0.0
Chronic Obstructive Pulmonary Disease	174	1.5	88		3.0
Bacterial Pneumonia	269	2.3	90		3.9
Asthma	64	0.6	71		0.9
Congestive Heart Failure	282	2.5	85		3.5
Hypertension	19	0.2	65		0.2
Angina			76		0.1
Cellulitis	119	1.0	79		1.4
Skin Grafts with Cellulitis			85		0.1
Diabetes A	47	0.4	74		0.6
Diabetes B and C	38	0.3	84		0.6
Hypoglycemia			39		0.0
Gastroenteritis	22	0.2	81		0.4
Kidney/Urinary Infections	127	1.1	81		1.6
Dehydration (including both primary and secondary)	603	5.2	89		7.6
Iron Deficiency Anemia (including both primary and secondary)			39		0.0
Nutritional Deficiencies (including both primary and secondary)	82	0.7	67		1.0
Failure to Thrive			34		0.0
Pelvic Inflammatory Disease			44		0.1
Dental Conditions			54		0.1
Access to Specialty Referral Surgeries	742	6.4	10		9.5
Health Status Conditions	287	2.5	98		4.4
Hip/Joint Replacement	453	3.9	10		5.2
Breast Reconstruction (after mastectomy)			0		0.0
Pacemaker Insertion	24	0.2	2		0.6
Transplant Surgeries	11	0.1	32		0.1
Coronary Artery Bypass Surgery	45	0.4	2		0.8
Coronary Angioplasty	209	1.8	30		2.6
Appendicitis with Appendectomy	56	0.5	74		0.7
Acute Myocardial Infarction	68	0.6	92		1.3
Gastrointestinal Obstruction	88	0.8	96		1.4
Fracture Hip/Femur	75	0.7	92		1.1

Percentile is the percent of counties which have a worse rate than Allegan

Conditions with less than ten discharges are not displayed.

Mortality Need Indicators

Major causes of death of Allegan county and primary care planning area community residents were studied for 2007 through 2009 for four different age cohorts: Under 24 years of age, 25 to 54 years of age, 55 to 74 years of age and 75 years of age and older. As with

several other general metrics, the southwest and central primary care planning area s had the highest scores with the southeast community coming in third. Major cause of death indicators generally relate to the presence of chronic disease and are considered to be “trailing” indicators in that for chronic disease they represent the results of long standing unhealthy lifestyles and are not reflective of positive lifestyle changes in the population and increased use of preventive health care services. Exhibit 9 depicts mortality related findings. Caution should be used when interpreting the significance of the Under 24 years of age data due to very low numbers of deaths.

Exhibit 9 – Mortality Component Findings by Age Group and Community

Score (0–20)

Rank	Allegan - MI	Allegan - RUCA	Central	Northeast	Northwest	Southeast	Southwest
75 YOA +	2	1	2	1	3	4	5
55 to 74 YOA	2	2	4	2	1	3	5
25 to 54 YOA	1	2	4	1	2	3	5
Under 24 YOA	3	3	5	1	2	3	4

Analyses by community occurred at the cause of death level as well. Exhibit 10 provides a sample output for Allegan County for people over the age of 75. This data will also be useful for further documentation of need.

Continued on next page.....

Exhibit 10 – Sample Mortality Profile Output

Allegan

Cause		Deaths	Rate	Percentile	Mean	Standard Deviation
Total	7749.5	483	7749.5	66	8012.2	791.4
Accidents: Total	208.6	13	208.6	29	171.6	51.8
Accidents: Motor Vehicle	16.0			79	31.8	33.2
Accidents: Drowning	0.0			100	1.0	2.8
Accidents: Falls	112.3			14	72.4	42.3
AIDS	0.0			100	0.2	1.0
Cancer	1385.2	86	1385.2	60	1417.1	217.8
Cancer: Buccal Cavity and Pharynx	21.4			31	16.4	17.7
Cancer: Digestive Organs	331.6	21	331.6	56	346.8	87.9
Cancer: Respiratory System	299.5	19	299.5	81	393.2	104.1
Cancer: Trachea/Bronchus/Lung	283.5	18	283.5	85	383.9	101.5
Cancer: Breast	74.9			59	78.4	35.7
Cancer: Genital Organs	230.0	14	230.0	7	157.3	51.6
Cancer: Urinary Organs	69.5			62	83.3	45.8
Cancer: Other & Unspecified Sites	187.2	12	187.2	31	167.2	57.0
Cancer: Lymphatic & Hematopoietic Tissue	171.1	11	171.1	50	174.4	55.1
Cardiovascular Disease	2775.7	173	2775.7	89	3310.1	500.3
Heart Disease	1941.4	121	1941.4	93	2474.2	385.5
Acute Rheumatic Fever	0.0			100	0.0	0.4
Chronic Rheumatic Fever	10.7			48	10.7	11.2
Hypertensive Heart Disease	107.0			40	95.9	64.7
Acute Myocardial Infarction	304.8	19	304.8	82	520.8	257.9
Other Ischemic Heart Disease	722.0	45	722.0	93	1094.9	294.0
Diseases of Pulmonary Circulation	37.4			37	32.3	22.7
Other Diseases of the Heart	759.4	47	759.4	34	719.6	181.8
Hypertension	123.0	8	123.0	20	88.2	48.7
Cerebrovascular Disease	609.7	38	609.7	33	595.7	182.2
Arteriosclerosis	16.0			67	49.3	87.3
Other Diseases of the Circulatory System	85.6			59	102.7	51.1
Chronic Lower Respiratory Disease	545.5	34	545.5	49	541.8	135.3
Cirrhosis of the Liver	21.4			61	27.1	22.2
Complications of Pregnancy	0.0			100	0.0	0.0
Conditions in the Perinatal Period	0.0			100	0.0	0.0
Congenital Anomalies	0.0			100	2.7	5.7
Diabetes Mellitus	165.8	10	165.8	83	240.1	90.9
Gastritis et al	26.7			43	24.2	17.3
Homicide & Legal Intervention	0.0			100	0.8	2.4
Influenza	5.3			28	6.8	17.4
Nephritis et al	187.2	12	187.2	40	170.5	60.0
Pneumonia	288.8	18	288.8	12	200.7	82.6
Septicemia	64.2			56	71.0	40.4
Sudden Infant Death Syndrome	0.0			100	0.0	0.0
Suicide	0.0			100	19.1	17.4
Tuberculosis	0.0			100	0.7	2.8
All Other	2075.1	129	2075.1	15	1807.5	286.9

Mortality Rate (per 100,000) (Gross) 07-09 Avg (75+)
0 500 1000 1500 2000 2500 3000

% of 83 MI Counties with an equal or higher rate
0 = highest rate
Worse <-- Avg --> Better
Red bars are the worst 20%
Green bars are the best 20%

Figures less than 25 should be interpreted with caution.

D. Unmet Service Needs

Unmet Service Needs were examined through two different methods:

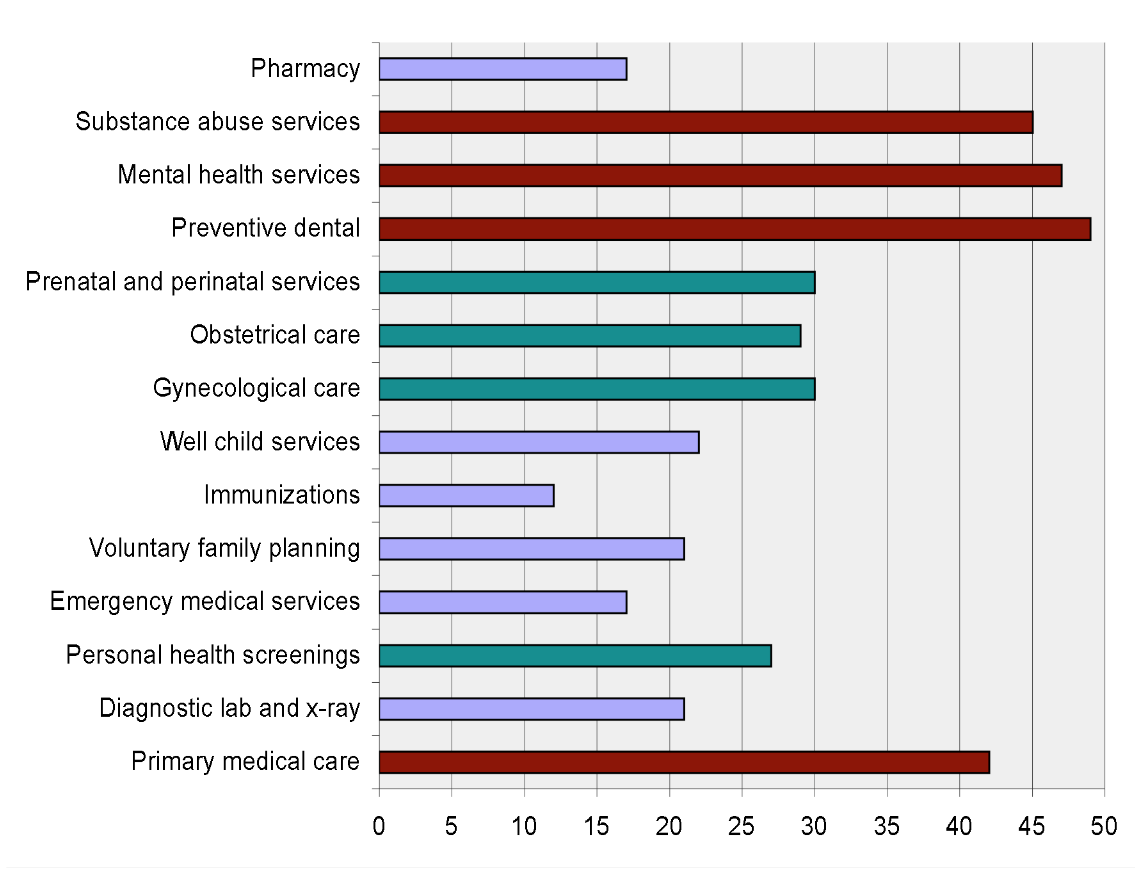
- An informal internet survey of members of the Allegan County Multi Agency Coordinating Council and additional health and human service providers
- Telephone conversations with key community and health care service leaders

Internet Survey

The survey focused on examining perceptions of unmet need for federally qualified health center services. It was conducted during the last two weeks of May 2012. Through June 1, 2012, 46 people responded. Approximately 3 out of 4 respondents were female and one out of four was male. Approximately 11 out of 20 were employed in the human services area, 6 out of 20 in health, mental health or health related, and 3 out of 20 were not employed in any of the areas referenced above. There was an equal proportion of Allegan County residents and non-residents and 35% of county respondents have lived in the county for 5 years or more. Many county resident respondents were from either southeast or northwest Allegan County.

Four services received the highest unmet need rating: preventive dental, mental health, substance abuse and primary care. Prenatal and perinatal care, obstetrical care, gynecological care and personal health screenings received the next highest unmet need ratings. Exhibit 11 displays the results of the service unmet need question.

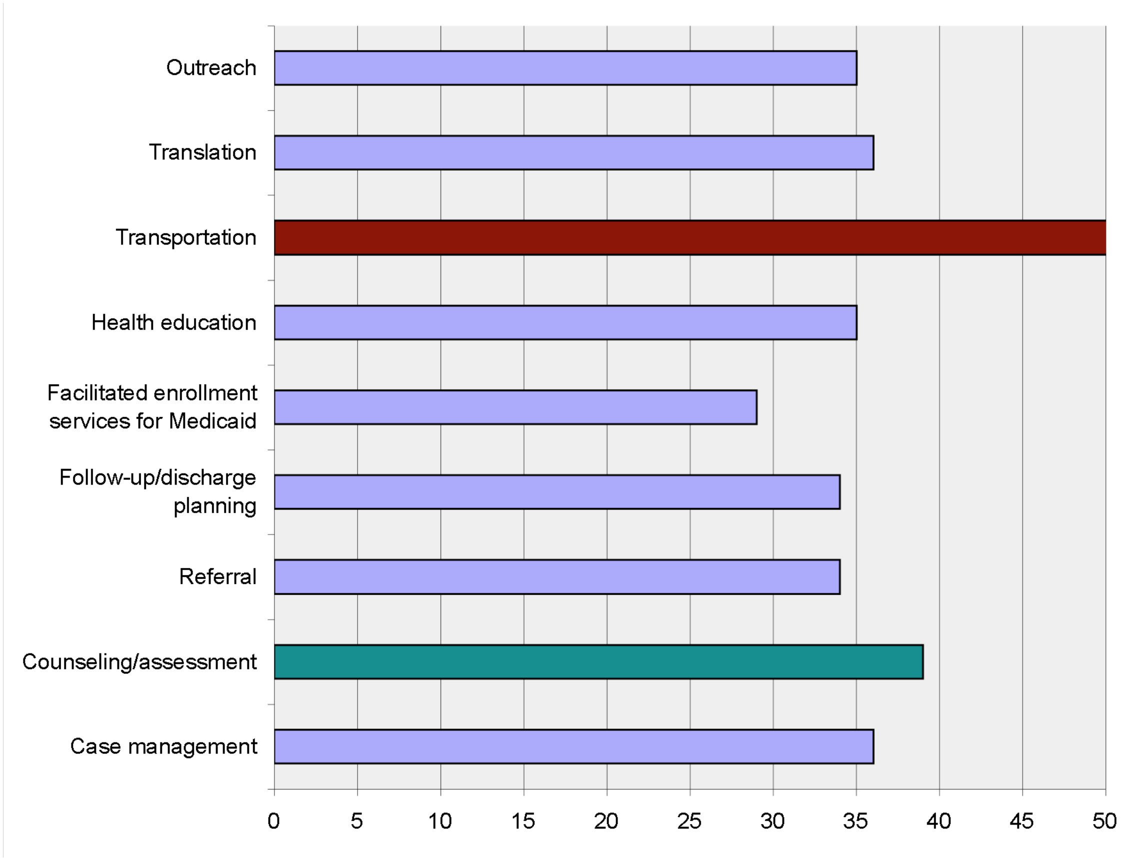
Exhibit 11 – Survey – Unmet Service Needs



Unmet Need Score

Two supportive services received the highest unmet need ratings: Transportation and general counseling or assessments for a variety of services. Other supportive services received comparatively similar ratings. Exhibit 12 displays the results of the supportive service unmet need question.

Exhibit 12 – Survey – Unmet Supportive Service Needs

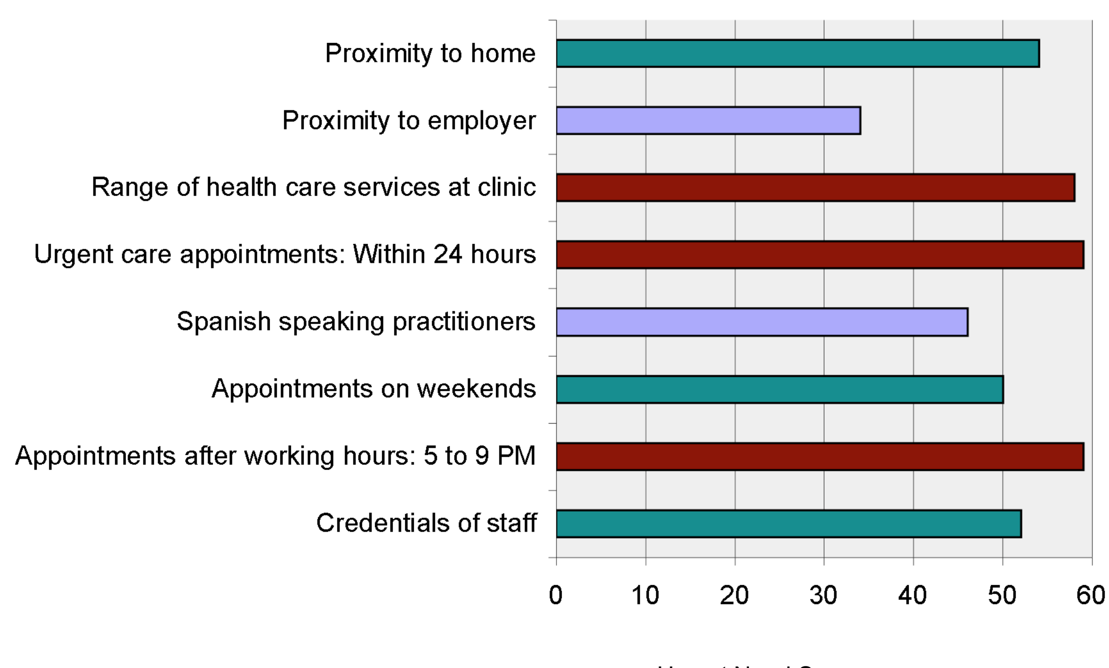


Unmet Need Score

Three access to care related concerns received the highest ratings and included: after hour appointments, urgent care appointments and range of services. Proximity of services to home and work as well as credentials of staff were important but less important. Health screenings received the next highest unmet need ratings. Exhibit 13 displays the results of the service characteristic question.

Continued on the next page.........

Exhibit 13 – Unmet Need Service Characteristics



Unmet Need Score

Telephone Interviews

Leadership from county government, selected health care organizations and the Steering Committee were contacted over the past several months. Comments made during these telephone interviews were similar to those reflected in other analyses: higher need in the southwest and to a lesser extent the southeast and central areas, major transportation obstacles, access to care for mental health and substance abuse, and especially, the need for services for the uninsured and underinsured. Of key importance was the need to have further discussions with primary care related capacities in Allegan County including the Allegan General Hospital and its affiliates, Intercare Community Health Center, the United Way and its free clinic, and the Renewed Hope free clinic.

2. Organizational Roles

This segment of the project will address the key question of who should take the lead in developing federally qualified health center capacity in the high need areas. A variety of issues will be examined to identify the preferred corporate structure(s) for federally qualified health center development.

Existing primary care service providers will be considered as potential components of a new service delivery model that would provide comprehensive health center services and satisfy section 330 requirements. This could take many forms and the alternatives

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and opportunities can be vetted through the requisite discussions regarding collaboration and coordination of services. Based upon current service area dynamics, preliminary avenues to consider include:

1) Evaluating the willingness of a federally qualified health center network on the periphery of the proposed service area to expand its reach into the service area through collaboration or integration with existing resources

2) Considering the potential for a CAH (Critical Access Hospital) located within the proposed service to modify its governance model and service delivery to become 330 compliant and collaborate and/or integrate with other local resources

3) Examining the Public Entity with Co-Applicant model for Allegan County Health Department in conjunction with the Critical Access Hopsital and/or other local primary care providers

4) Identify or create a new 501(c)(3) entity willing to take the steps necessary to obtain 330 compliance, provide the required services and meet the needs of the target population while collaborating with existing primary care resources

The following areas will be explored as needed during these discussions:

- Corporate Requirements
- By-laws, Policies, Procedures
- Administration
- Service Delivery Model
- Staffing and Recruitment
- Sites
- Equipment
- Utilization + Financial projections
- Quality Assurance Plan
- Contracts and Affiliations
- Michigan Requirements
- Long Term Viability Plan

It is anticipated that considerable attention will be directed at the extent to which existing organizations can bring together capacities which address these requirements. A major concern, and perhaps the main concern, will be the financial aspects of the potential sponsor.

3. federally qualified health center Benefits

Federally qualified health center benefits are detailed in the endnotes. These will also be discussed during the next phase of the project with interested parties.

4. Next Steps

- Discussion with interested parties
- Examination of financial considerations
- Model selection
- Next meeting
  - Thursday, July 12, 2012
  - 1 to 3 PM
  - Allegan, MI

5. Federally Qualified Health Center Implementation Considerations

- Timetables
- State and federal considerations

---

[i] Summary of Federally Qualified Health Center Features, Abstracted from *A Manual on Effective Collaboration on Critical Access Hospitals and Federally Qualified Health Centers*, April 2010, prepared by HMS Associates for the US Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy. It can be found at: www.hrsa.gov/ruralhealth/pdf/qhcmanual042010.pdf.

Section 2 Federally Qualified Health Centers from A to Z:

DEFINITION

Federally Qualified Health Center is a designation of the Center for Medicare & Medicaid Services (CMS) and entitles qualified organizations to set reimbursement rates controlled or influenced by CMS. Section 1905(I)(2)(B) of the Social Security Act identities three types of Federally Qualified Health Center : (1) those receiving a grant, directly or through sub-recipient arrangements, under section 330 of the Public Health Service Act; (2) those determined to meet the requirements of a grant but do not receive Federal funding (i.e., Federally Qualified Health Center Look-Alikes); and (3) an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638) or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act for the provision of primary health services.

For the purposes of this manual, Federally Qualified Health Centers are specific to those organizations receiving a grant under section 330 of the Public Health Service Act and those organizations, based on the recommendation of the Health Resources and Services Administration, that meet the requirements for receiving a grant (i.e., Federally Qualified Health Center Look-Alikes). Federally Qualified Health Centers designated under the Indian Self-Determination Act or by an urban Indian organization are not applicable to this manual.

Federally Qualified Health Center and Federally Qualified Health Center Look-Alikes, also referred to as Health Centers, are community-based and patient-governed organizations that provide comprehensive primary care services to medically underserved communities and

vulnerable populations regardless of their ability to pay. They must be private, charitable, tax-exempt nonprofit organizations or public entities. Federally Qualified Health Centers and Federally Qualified Health Center Look-Alike designations require two actions, one from the Health Resources and Services Administration that "recommends" that the organization meets the eligibility and program standards of the Health Center Program and one from CMS that is more related to fiscal management and reporting.

Federally Qualified Health Centers that are awarded a grant under the Health Center Program, as authorized in section 330 of the Public Health Service Act (42 U.S.C. 254b), receive funding for one or more of the following types of section 330 programs:

- Community Health Center Programs, funded under section 330(e);
- Migrant Health Center Programs, funded under section 330(g);
- Health Care for the Homeless Programs, funded under section 330(h); and
- Public Housing Primary Care Programs, funded under section 330(i).

Federally Qualified Health Center Look-Alikes do not receive grant funding under the Health Center Program, however, they must meet all statutory requirements under section 330 of the Public Health Service Act. Federally Qualified Health Center Look-Alikes designation requires two actions, one from the Health Resources and Services Administration that "recommends" that the organization meets the eligibility and program standards of the Health Center Program and one from the Centers for Medicare and Medicaid Services that is more related to fiscal management and reporting. Additionally, at the time of applying for Federally Qualified Health Center Look-Alikes designation, the organization may not be owned, controlled, or operated by another entity. Federally Qualified Health Center Look-Alikes can access some but not all of the program related benefits of Federally Qualified Health Centers that are described later in this section. Federally Qualified Health Center Look-Alikes may have stronger incentives to collaborate with Critical Access Hospitals than Federally Qualified Health Centers because of their lack of grant funds to support services to the uninsured and underserved and more probable need for community benefit support from Critical Access Hospital structures.

Health Centers offer a variety of programs to the communities they serve. They are required to provide comprehensive primary care services as well as supportive services (i.e. health education, translation, transportation, etc….) that promote access to care. In addition, Health Centers may provide additional clinical and non-clinical services that support primary care. Such programs may include the Special Supplemental Nutrition Program for Women, Infants and Children, or services specifically designed for children with special needs or people living with HIV or AIDS.

Although this document focuses specifically on the primary and preventive health care capacities of Federally Qualified Health Centers, it should not be overlooked that in addition to providing those services as discrete components of health care services, they may also offer a broad range of supportive services that populations with low incomes often need. Consequently, they are not only a portal to effective primary care preventive health services but also potentially to other health and social services.

KEY FEATURES

Designation

The process of developing compliant structures and capacities to meet health center requirements is complicated and costly. It includes needs assessment, preparing applications for Health Professional Shortage Area, Medically Underserved Area and Medically Underserved Population designations, developing compliant corporate structures, drafting service delivery plans or capacities, and preparing grant or Federally Qualified Health Center designation applications.

Need

Federally Qualified Health Centers must serve, in whole or part, a federally designated Medically Underserved Area or Medically Underserved Population. Medically Underserved Areas/Populations are areas or populations designated officially by the Health Resources and Services Administration as having: Too few primary care providers; High infant mortality; High poverty; and/or High elderly population. Medically Underserved Area/Medically Underserved Population designation is an eligibility factor for receiving Federally Qualified Health Center status.

Health Services

Federally Qualified Health Centers must provide primary care services and, as may be appropriate for particular centers, additional health care services necessary for adequate support of the required primary care services. The following clinical services must be provided directly, through contractual agreement, or through formal referral arrangements:

- Primary medical care
- Diagnostic lab and x-ray
- Screenings
- Emergency medical services
- Voluntary family planning
- Immunizations
- Well child services
- Gynecological care
- Obstetrical care
- Prenatal and perinatal services
- Preventive dental
- Mental health services (referral)
- Substance abuse services (referral)
- Specialty services (referral)
- Pharmacy

The following non-clinical services must be provided directly, through contractual agreement or through formal referral arrangements:

- Case management
- Counseling/assessment
- Referral
- Follow-up/discharge planning
- Facilitated enrollment services for Medicaid, Children’s Health Insurance Program, and other public insurance programs
- Health education
- Transportation
- Translation
- Outreach

Federally Qualified Health Centers often provide services beyond the core requirements based on an assessment of the needs of the population and the availability and accessibility of services in their area.

Federally Qualified Health Centers must provide access to their full range of services to all health center patients regardless of ability to pay. They are required to have a discounted fee schedule for patients whose incomes are below 200 percent of the federal poverty level and full discounts for people with incomes at or below 100 percent of the federal poverty level. Federally Qualified Health Centers must provide care in a manner that is culturally and linguistically competent.

Health Centers maintain appropriately credentialed and licensed providers (as applicable and necessary) to carry out their full range of services. Health Centers must offer their services at times and locations that assure accessibility and meet the needs of the population being served.

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In addition, Health Centers must provide professional coverage during hours when the health center is closed. Health Center physicians are expected to have admitting privileges at one or more referring hospitals to follow hospitalized patients. Where this is not possible, arrangement for hospital-based coverage and services must be established. Health Centers are also required to have an ongoing quality improvement/quality assurance program that includes clinical services and management and that maintains the confidentiality of patient records.

Management and Finance

Federally Qualified Health Centers must establish and maintain collaborative relationships with other health care providers, including other health centers, in the service area of the center. This requirement and several other clinical requirements help to ensure continuity of patient care, essentially requiring arrangements or "collaboration" between health care service providers.

Federally Qualified Health Centers must maintain a fully-staffed management team that is appropriate for the size and needs of the center. They must exercise appropriate oversight of billing and collections, have appropriate financial management and control policies, and have systems in place for collecting data and program reporting.

Governance

A core component of Federally Qualified Health Centers relates to the governing board requirements. The governing board must have a majority (minimum 51 percent) of members who are patients of the Health Center and who, as a group, reasonably represent the patient population. In addition, there are restrictions on the percent of non-patient board members who earn 10 percent or more of their incomes from healthcare-related industries. Board members should bring areas of expertise that are relevant to Health Center operations and a community presence. Federally Qualified Health Center governing boards must maintain appropriate authority to oversee the operations of the Health Center, including: Establishing policies; Approving budgets; Selecting services provided; and Selection, dismissal, and performance evaluation of the Executive Director.

KEY BENEFITS TO THE HEALTH CENTER

Grant Funds

Section 330 Health Center grant funds offset the costs of uncompensated care for the uninsured and underinsured and for key enabling services. Organizations that receive a section 330 grant for the first time receive "New Start" funding of up to $650,000 annually. Additional HRSA and BPHC grant funding for service and capacity expansion may become available to existing Section 330 funded health centers.

Minimum per Encounter Medicaid or Medicare payment

Both Federally Qualified Health Center grantees and Federally Qualified Health Center Look-Alikes are covered by payment methodologies that guarantee Health Centers a minimum per encounter payment for services provided to Medicaid and Medicare beneficiaries.

Federal Medical Malpractice Coverage (Federal Tort Claims Act Coverage)

The intent of the Federal Tort Claims Act is to increase the availability of funds for the provision of direct primary care services by reducing administrative costs associated with malpractice insurance premiums that health care centers have to fund. Health Centers that are "deemed" under the Federal Tort Claims Act receive federal protection for malpractice allegations made against the center for services and providers included in their federal scope of project. This coverage applies to deemed Health Center grantees only, and is not available to Federally Qualified Health Center Look-Alikes.

340B Drug Pricing – Prescription Drug Discounts

Significant savings on pharmaceuticals may be accessed by participating entities. Federally Qualified Health Center grantees and Federally Qualified Health Center Look-Alikes are among the entities that may participate in the program.

Loan Guarantees

Loan guarantees may be extended or made by non-federal lenders for the construction, renovation and modernization of medical facilities that are owned and operated by Section 330 Health Centers. This only applies to Federally Qualified Health Center grantees, not Federally Qualified Health Center Look-Alikes.

Other Federal or National Programs

Federally Qualified Health Centers and Federally Qualified Health Center Look-Alikes qualify for Health Professional Shortage Area designation, which confers a basic eligibility to apply for National Health Service Corp personnel (scholars, loan repayors or ready responders) as well as eligibility to be a site where a J-1 Visa Waiver physician can serve. Rural areas often experience difficulties in the recruitment and retention of physicians. Due to these difficulties, many communities turn to the recruitment of foreign medical graduates with J-1 Visa Waivers to fill their physician vacancies. This program helps Federally Qualified Health Centers recruit physicians.

Grant funding, medical malpractice coverage and Heath Personnel Shortage Areas designations appear to have the greatest positive financial relevance for collaboration between Federally Qualified Health Centers and Critical Access Hospitals.

Health Center Impacts on Rural Uninsureds' Use of Hospital Emergency Departments

A study conducted in 2009 on rural communities in Georgia, showed that Federally Qualified Health Centers in rural counties reduce Emergency Department use by the uninsured. Counties without a Health Center clinic site had 33 percent higher rates of uninsured all-cause Emergency Department visits per 10,000 uninsured population compared with community Health Center counties. Higher Emergency Department visit rates remained significant after adjustment for factors associated with high Emergency Department use, specifically, percentage of population below poverty level, percentage of black population, and number of hospitals.

HISTORY

In the mid-1970s, Congress permanently authorized neighborhood health centers as "Migrant Health Centers" under sections 329 and "Community Health Centers" under section 330 of the Public Health Service Act. This signaled a movement towards the development of independent health centers governed by a majority of consumers of health center programs. On a related primary care access track, Congress passed the Rural Health Clinic Services Act of 1977 (Public Law 95-210) which provides cost-based Medicare reimbursement for a defined set of core physician and non-physician outpatient services.

Throughout the 1970s, the number of health centers grew from 158 in 1974 to 802 in 1980. In the latter part of the decade, Federal support for health centers diminished but not as much as for other "War on Poverty" programs. In the early 1980s, these Community and Migrant Health Centers received more funding.

In 1989, the Federally Qualified Health Center program was established by the Omnibus Budget Reconciliation Act. This act provided for reimbursement of reasonable costs for legislatively specified Federally Qualified Health Center services covered by Medicaid. The Omnibus Budget Reconciliation Act of 1990 enacted Medicare reimbursement of reasonable costs and recognized the importance of Federally Qualified Health Center Look-Alikes, which met the requirements under section 330 of the Public Health Service Act but did not receive Federal grants for operation.

The 1990s saw a much greater degree of interest on the part of the Federal Government in developing programs that could more consistently maintain providers in rural communities. At present, over 1,200 health centers and Federally Qualified Health Center Look-Alikes are operational. Federally Qualified Health Center Look-Alikes grew both in number and importance during this time period and program focus included primary care in sparsely populated and frontier areas. There are a total of 1,126 health centers with 7,610 service sites, 3,442 of which are located in rural counties.

[ii] Multiple data sources were used in this analysis and included:

1. 2010 US Census – Population
2. Vital Statistics, State of Michigan Birth and Death Certificate Data Abstracts, Births for the period 2008 through 2010, Deaths for the period 2007 through 2009, Vital Records and Health Statistics Section, Michigan Department of Community Health and Allegan County department of Health.
3. Hospital Inpatient Discharge Data Abstract, October 2010 through September 2011, Michigan Hospital Association and Allegan General Hospital.
4. All analyses were prepared by HMS Associates, Getzville, NY

[iii] The rural-urban commuting area (RUCA) codes classify U.S. census tracts using measures of population density, urbanization, and daily commuting. The most recent RUCA codes are based on data from the 2000 decennial census. The classification contains two levels. Whole numbers (1-10) delineate metropolitan, micropolitan, small town, and rural commuting areas based on the size and direction of the primary (largest) commuting flows.

Similar RUCA Counties – Other Urban:

- Allegan
- Barry
- Cass
- Clinton
- Ionia
- Lapeer
- Livingston
- Newaygo
- Shiawassee
- Van Buren

See http://www.ers.usda.gov/data/ruralurbancommutingareacodes/

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Allegan County Community Health Center Planning Project

Progress Report 2 Sponsorship and Governance

August, 2012

HMS Associates
Getzville, NY

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Commentary

The Allegan County Health Department received a grant from the federal Health Services and Resources Administration, Bureau of Primary Health Care, in September 2011 to conduct a study on the need for a Federally Qualified Health Center in Allegan County, Michigan. Federally Qualified Health Centers, also referred to as Community Health Centers, are community-based and patient-governed organizations that provide comprehensive primary care services to medically underserved communities and vulnerable populations regardless of their ability to pay[i]. They must be private, charitable, tax-exempt nonprofit organizations or public entities.

Federally Qualified Health Centers must serve, in whole or part, a federally designated Medically Underserved Area or Medically Underserved Population. Medically Underserved Areas/Populations are areas or populations designated officially by the Health Resources and Services Administration as having: too few primary care providers; high infant mortality; high poverty; and/or high elderly population. Medically Underserved Area/Medically Underserved Population designation is an eligibility factor for receiving Federally Qualified Health Center status. Allegan County is a Medically Underserved Area and as such may qualify for Federally Qualified Health Center development. It is the intent of this project to:

- Examine these needs more closely, especially by area or quadrant of the county referred to herein as Allegan County Primary Care Planning Areas and thereby identify priorities and unmet needs
- Examine several organizational options for a Federally Qualified Health Center and recommend the preferred organizational structure
- Examine the operational requirements of a Federally Qualified Health Center and develop protocols or recommendations addressing such requirements

These phases are summarized in Exhibit 1.

Exhibit 1 – Federally Qualified Health Center Planning Project Structure

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Methodology

This report addresses the second phase of the planning project which was designed to examine several organizational options for Federally Qualified Health Center development and recommend the preferred organizational structure and approach.

As noted in the approved Community Health Center grant application, several organizational options and approaches were to be explored[ii]. As the assessment evolved, these options were grouped into two main categories related to Federally Qualified Health Center organizational sponsorship including Corporate Status (which type of organization will be the corporate "sponsor" or operator of the Federally Qualified Health Center) and Feasibility and Benefits. These categories were further divided into major subcategories which formed the basis for assessing model and sponsorship preference.

These categories and subcategories are depicted in Exhibit 2.

Exhibit 2 – Preference Selection Components

CORPORATE STATUS

A major distinction was made between existing organizations as potential sponsors and the need to create brand new organizational structures and capacities. A preference for the use of existing health care service structures was expressed by several key individuals during the interview process because of the need to better utilize rather than duplicate existing capacities and resources and the complexity of forming brand new not-for-profit health care service provider corporate entities. Hence, subsequent activity on sponsorship focused on existing entities.

The existing structure analysis was further divided into three main categories:

1. Federally Qualified Health Center capacities located in Allegan County or Federally Qualified Health Centers identified as potential partners by steering committee members
2. Public health or mental health care service providers
3. Not-for-profit health care service providers in Allegan County

Organizations based in Allegan County which potentially met these criteria included:

- Allegan County Government
- Allegan Health Group, Inc., Allegan, MI and its subsidiaries

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- InterCare Community Health Centers, Inc., a Federally Qualified Health Center with Allegan County in its service area and a full time clinic in Pullman, Lee Township, Allegan County
- United Way of Allegan County, Inc., Allegan, MI, in potential partnership with Cherry Street Federally Qualified Health Center with corporate offices in Grand Rapids, Kent County, MI on the northeast border of Allegan County
- Renewed Hope Free Clinic, Inc., Allegan, MI

Further review of Allegan County as the potential operator of the Federally Qualified Health Center was suspended because it appeared that the County's interest should be further examined only if existing health care providers were not interested in pursuing the establishment of a new site in the central or eastern portions of the county, per the needs assessment. The availability of county operated primary care services in Cass and Van Buren Counties and their relationship to federally qualified health centers, however, will be examined further.

Consequently, the four remaining organizations became the focus of subsequent analyses addressing feasibility and benefits.

FEASIBILITY and BENEFITS

This component of the assessment was designed to explore organizational readiness to pursue changes needed to establish new Federally Qualified Health Center services in Allegan County. It was discussed at both the Federally Qualified Health Center Planning Project Steering Committee meeting and the Allegan County Board of Commissioners Planning Session on Thursday, July 12, 2012 in Allegan, MI. Of note, two other potential state rural health and Federally Qualified Health Center planning and advocacy resources made presentations at the County Commissioners Planning Session. They were:

- Michigan Primary Care Association, Andrea Charlton, Community Health Planning Manager
- Michigan Center for Rural Health, John Barnas, Executive Director Michigan Center for Rural Health

This component examined key implementation issues such as the type of federal regulatory action required relative to different approaches to service development, the actual interest level of the potential sponsor, the governance considerations that are core requirements of a Federally Qualified Health Center and existing capacity. Exhibit 3 depicts these variables and subtopics.

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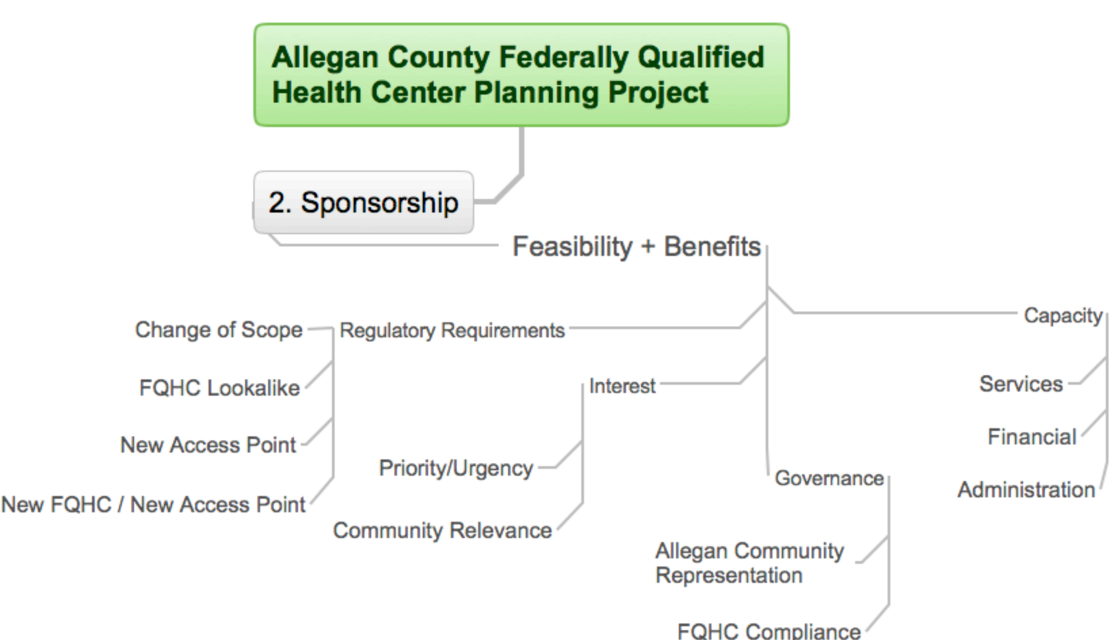
Exhibit 3 – Feasibility and Assessment Preliminary Model



The next step was to collect information from the four potential sponsors. A Request For Information was sent to these four entities on or about July 17, 2012 with a request for completion no later than July 31, 2012. This request was meant to augment data gathered from these organizations on their respective interests beginning in May, 2012, with a variety of follow-up conversations with the consultants. The Request For Information is repeated on the next page in Exhibit 4.

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Exhibit 4 – Request For Information

HMS Associates
Getzville, NY
www.askhms.com

Allegan County Federally Qualified Health Center Planning Project
Request For Information

Background
As you know, the Allegan County Federally Qualified Health Center Project Steering Committee has been exploring the need for additional federally qualified health center services in Allegan County. The results of the multi-community health needs assessment have been reviewed and HMS Associates, the project's consulting staff, has continued discussions with organizations in Allegan County regarding their interest in developing federally qualified health center programs in high need areas of the Allegan County, especially its central and southeastern portions. Potential models for federally qualified health center program development have been reviewed and models or approaches which draw upon and augment existing primary care capacities rather than create totally new structures are the favored course of action.

The purpose of this email is to expand on earlier conversations and seek more information from you on your organization's actual plans to develop such services in Allegan County, to the extent practicable, at this point in your own internal planning processes and discussions. Four organizations in the county have expressed varying degrees of interest in federally qualified health center development and more information is needed about current discussions and plans for the planning project to move forward.

A list of key considerations is attached and your comments on each topic are appreciated. Key concerns relate to sponsorship and partners, experience with federally qualified health center requirements, community governance, readiness to operate a new full time site, how such an action compares with other priorities, type of federal regulatory actions required, the potential for start-up related support for new site development, and the extent to which your approach will help to advance of system of needed health care services in Allegan County over the long term. It is recognized that plans discussed in the last few months may have changed and discussions may still be quite fluid at this time. Yet, the federally qualified health center planning process will end in about six weeks and further assistance needs to be targeted at the best approach and hence a response by email (gregorybonk@me.com) is appreciated by July 31, 2102.

Contact Greg Bonk, HMS Associates at (716) 868 – 6448 or via email, if you have any questions.

8/2/12 – Page 1 of 3 – RFI-FQHC – HMS Associates

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HMS Associates
Getzville, NY
www.askhms.com

Allegan County Federally Qualified Health Center Planning Project
Request For Information

1. Name of Organization:

2. Contact Person:

3. Contact Information (Phone/email):

4. Key Considerations
   a. Sponsorship and partners

   b. Experience with federally qualified health center requirements

   c. Type of federal regulatory actions required (Change of Scope – FQHCs only, FQHC Look-alike, FQHC New Access Point)

   d. Community governance (extent to which Allegan County representation on your board or governance structure will be modified and assure 51% service user requirement)

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Allegan County Federally Qualified Health Center Planning Project
Request For Information

e. Readiness to operate a new full time site (administrative, clinical including personnel, equipment and locations, and financial)

f. How such an action compares with your organization's other priorities and the timeframe you envision for initiation of operation (2012, first half 2013, second half 2013, 2014)

g. Potential for start-up related financial or community benefit support for new site development

h. How such an action advances a system of needed health care services in Allegan County over the long term.

Findings

Conversations or voice mail messages took place with all four organizations during the subsequent time period and one – Allegan Health Group, Inc. – provided a written response to the questions raised and demonstrated a highly relevant approach to Federally Qualified Health Center development. Consequently, it is the consultant's recommendation that it should work specifically with the Allegan Health Group, Inc. and its partners on its plans to develop a Federally Qualified Health Center capacity focusing on central and eastern Allegan County and report on the status of such efforts at the Steering Committee's final meeting on Monday, August 24, 2012.

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[i] Summary of Federally Qualified Health Center Features, Abstracted from *A Manual on Effective Collaboration on Critical Access Hospitals and Federally Qualified Health Centers*, April 2010, prepared by HMS Associates for the US Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy. It can be found at: www.hrsa.gov/ruralhealth/pdf/qhcmanual042010.pdf.

Section 2 Federally Qualified Health Centers from A to Z:

DEFINITION

Federally Qualified Health Center is a designation of the Center for Medicare & Medicaid Services (CMS) and entitles qualified organizations to set reimbursement rates controlled or influenced by CMS. Section 1905(l)(2)(B) of the Social Security Act identities three types of Federally Qualified Health Center : (1) those receiving a grant, directly or through sub-recipient arrangements, under section 330 of the Public Health Service Act; (2) those determined to meet the requirements of a grant but do not receive Federal funding (i.e., Federally Qualified Health Center Look-Alikes); and (3) an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638) or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act for the provision of primary health services.

For the purposes of this manual, Federally Qualified Health Centers are specific to those organizations receiving a grant under section 330 of the Public Health Service Act and those organizations, based on the recommendation of the Health Resources and Services Administration, that meet the requirements for receiving a grant (i.e., Federally Qualified Health Center Look-Alikes). Federally Qualified Health Centers designated under the Indian Self-Determination Act or by an urban Indian organization are not applicable to this manual.

Federally Qualified Health Center and Federally Qualified Health Center Look-Alikes, also referred to as Health Centers, are community-based and patient-governed organizations that provide comprehensive primary care services to medically underserved communities and vulnerable populations regardless of their ability to pay. They must be private, charitable, tax-exempt nonprofit organizations or public entities. Federally Qualified Health Centers and Federally Qualified Health Center Look-Alike designations require two actions, one from the Health Resources and Services Administration that “recommends” that the organization meets the eligibility and program standards of the Health Center Program and one from CMS that is more related to fiscal management and reporting.

Federally Qualified Health Centers that are awarded a grant under the Health Center Program, as authorized in section 330 of the Public Health Service Act (42 U.S.C. 254b), receive funding for one or more of the following types of section 330 programs:

- Community Health Center Programs, funded under section 330(e);
- Migrant Health Center Programs, funded under section 330(g);
- Health Care for the Homeless Programs, funded under section 330(h); and
- Public Housing Primary Care Programs, funded under section 330(i).

Federally Qualified Health Center Look-Alikes do not receive grant funding under the Health Center Program, however, they must meet all statutory requirements under section 330 of the Public Health Service Act. Federally Qualified Health Center Look-Alikes designation requires two actions, one from the Health Resources and Services Administration that “recommends” that the organization meets the eligibility and program standards of the Health Center Program and one from the Centers for Medicare and Medicaid Services that is more related to fiscal management and reporting. Additionally, at the time of applying for Federally Qualified Health Center Look-Alikes designation, the organization may not be owned, controlled, or operated by another entity.

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Federally Qualified Health Center Look-Alikes can access some but not all of the program related benefits of Federally Qualified Health Centers that are described later in this section. Federally Qualified Health Center Look-Alikes may have stronger incentives to collaborate with Critical Access Hospitals than Federally Qualified Health Centers because of their lack of grant funds to support services to the uninsured and underserved and more probable need for community benefit support from Critical Access Hospital structures.

Health Centers offer a variety of programs to the communities they serve. They are required to provide comprehensive primary care services as well as supportive services (i.e. health education, translation, transportation, etc.…) that promote access to care. In addition, Health Centers may provide additional clinical and non-clinical services that support primary care. Such programs may include the Special Supplemental Nutrition Program for Women, Infants and Children, or services specifically designed for children with special needs or people living with HIV or AIDS.

Although this document focuses specifically on the primary and preventive health care capacities of Federally Qualified Health Centers, it should not be overlooked that in addition to providing those services as discrete components of health care services, they may also offer a broad range of supportive services that populations with low incomes often need. Consequently, they are not only a portal to effective primary care preventive health services but also potentially to other health and social services.

KEY FEATURES

Designation

The process of developing compliant structures and capacities to meet health center requirements is complicated and costly. It includes needs assessment, preparing applications for Health Professional Shortage Area, Medically Underserved Area and Medically Underserved Population designations, developing compliant corporate structures, drafting service delivery plans or capacities, and preparing grant or Federally Qualified Health Center designation applications.

Need

Federally Qualified Health Centers must serve, in whole or part, a federally designated Medically Underserved Area or Medically Underserved Population. Medically Underserved Areas/Populations are areas or populations designated officially by the Health Resources and Services Administration as having: Too few primary care providers; High infant mortality; High poverty; and/or High elderly population. Medically Underserved Area/Medically Underserved Population designation is an eligibility factor for receiving Federally Qualified Health Center status.

Health Services

Federally Qualified Health Centers must provide primary care services and, as may be appropriate for particular centers, additional health care services necessary for adequate support of the required primary care services. The following clinical services must be provided directly, through contractual agreement, or through formal referral arrangements:

- Primary medical care
- Diagnostic lab and x-ray
- Screenings
- Emergency medical services
- Voluntary family planning
- Immunizations
- Well child services
- Gynecological care
- Obstetrical care

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- Prenatal and perinatal services
- Preventive dental
- Mental health services (referral)
- Substance abuse services (referral)
- Specialty services (referral)
- Pharmacy

The following non-clinical services must be provided directly, through contractual agreement or through formal referral arrangements:

- Case management
- Counseling/assessment
- Referral
- Follow-up/discharge planning
- Facilitated enrollment services for Medicaid, Children's Health Insurance Program, and other public insurance programs
- Health education
- Transportation
- Translation
- Outreach

Federally Qualified Health Centers often provide services beyond the core requirements based on an assessment of the needs of the population and the availability and accessibility of services in their area.

Federally Qualified Health Centers must provide access to their full range of services to all health center patients regardless of ability to pay. They are required to have a discounted fee schedule for patients whose incomes are below 200 percent of the federal poverty level and full discounts for people with incomes at or below 100 percent of the federal poverty level. Federally Qualified Health Centers must provide care in a manner that is culturally and linguistically competent.

Health Centers maintain appropriately credentialed and licensed providers (as applicable and necessary) to carry out their full range of services. Health Centers must offer their services at times and locations that assure accessibility and meet the needs of the population being served. In addition, Health Centers must provide professional coverage during hours when the health center is closed. Health Center physicians are expected to have admitting privileges at one or more referring hospitals to follow hospitalized patients. Where this is not possible, arrangement for hospital-based coverage and services must be established. Health Centers are also required to have an ongoing quality improvement/quality assurance program that includes clinical services and management and that maintains the confidentiality of patient records.

Management and Finance

Federally Qualified Health Centers must establish and maintain collaborative relationships with other health care providers, including other health centers, in the service area of the center. This requirement and several other clinical requirements help to ensure continuity of patient care, essentially requiring arrangements or "collaboration" between health care service providers.

Federally Qualified Health Centers must maintain a fully-staffed management team that is appropriate for the size and needs of the center. They must exercise appropriate oversight of billing and collections, have appropriate financial management and control policies, and have systems in place for collecting data and program reporting.

Governance

A core component of Federally Qualified Health Centers relates to the governing board requirements. The governing board must have a majority (minimum 51 percent) of members who are patients of the Health Center and who, as a group, reasonably represent the patient population. In addition, there are restrictions on the percent of non-patient board members who

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earn 10 percent or more of their incomes from healthcare-related industries. Board members should bring areas of expertise that are relevant to Health Center operations and a community presence. Federally Qualified Health Center governing boards must maintain appropriate authority to oversee the operations of the Health Center, including: Establishing policies; Approving budgets; Selecting services provided; and Selection, dismissal, and performance evaluation of the Executive Director.

KEY BENEFITS TO THE HEALTH CENTER

Grant Funds

Section 330 Health Center grant funds offset the costs of uncompensated care for the uninsured and underinsured and for key enabling services. Organizations that receive a section 330 grant for the first time receive “New Start” funding of up to $650,000 annually. Additional HRSA and BPHC grant funding for service and capacity expansion may become available to existing Section 330 funded health centers.

Minimum per Encounter Medicaid or Medicare payment

Both Federally Qualified Health Center grantees and Federally Qualified Health Center Look-Alikes are covered by payment methodologies that guarantee Health Centers a minimum per encounter payment for services provided to Medicaid and Medicare beneficiaries.

Federal Medical Malpractice Coverage (Federal Tort Claims Act Coverage)

The intent of the Federal Tort Claims Act is to increase the availability of funds for the provision of direct primary care services by reducing administrative costs associated with malpractice insurance premiums that health care centers have to fund. Health Centers that are “deemed” under the Federal Tort Claims Act receive federal protection for malpractice allegations made against the center for services and providers included in their federal scope of project. This coverage applies to deemed Health Center grantees only, and is not available to Federally Qualified Health Center Look-Alikes.

340B Drug Pricing – Prescription Drug Discounts

Significant savings on pharmaceuticals may be accessed by participating entities. Federally Qualified Health Center grantees and Federally Qualified Health Center Look-Alikes are among the entities that may participate in the program.

Loan Guarantees

Loan guarantees may be extended or made by non-federal lenders for the construction, renovation and modernization of medical facilities that are owned and operated by Section 330 Health Centers. This only applies to Federally Qualified Health Center grantees, not Federally Qualified Health Center Look-Alikes.

Other Federal or National Programs

Federally Qualified Health Centers and Federally Qualified Health Center Look-Alikes qualify for Health Professional Shortage Area designation, which confers a basic eligibility to apply for National Health Service Corp personnel (scholars, loan repayors or ready responders) as well as eligibility to be a site where a J-1 Visa Waiver physician can serve. Rural areas often experience difficulties in the recruitment and retention of physicians. Due to these difficulties, many communities turn to the recruitment of foreign medical graduates with J-1 Visa Waivers to fill their physician vacancies. This program helps Federally Qualified Health Centers recruit physicians.

Grant funding, medical malpractice coverage and Heath Personnel Shortage Areas designations appear to have the greatest positive financial relevance for collaboration between Federally Qualified Health Centers and Critical Access Hospitals.

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Health Center Impacts on Rural Uninsureds' Use of Hospital Emergency Departments

A study conducted in 2009 on rural communities in Georgia, showed that Federally Qualified Health Centers in rural counties reduce Emergency Department use by the uninsured. Counties without a Health Center clinic site had 33 percent higher rates of uninsured all-cause Emergency Department visits per 10,000 uninsured population compared with community Health Center counties. Higher Emergency Department visit rates remained significant after adjustment for factors associated with high Emergency Department use, specifically, percentage of population below poverty level, percentage of black population, and number of hospitals.

HISTORY

In the mid-1970s, Congress permanently authorized neighborhood health centers as "Migrant Health Centers" under sections 329 and "Community Health Centers" under section 330 of the Public Health Service Act. This signaled a movement towards the development of independent health centers governed by a majority of consumers of health center programs. On a related primary care access track, Congress passed the Rural Health Clinic Services Act of 1977 (Public Law 95-210) which provides cost-based Medicare reimbursement for a defined set of core physician and non-physician outpatient services.

Throughout the 1970s, the number of health centers grew from 158 in 1974 to 802 in 1980. In the latter part of the decade, Federal support for health centers diminished but not as much as for other "War on Poverty" programs. In the early 1980s, these Community and Migrant Health Centers received more funding.

In 1989, the Federally Qualified Health Center program was established by the Omnibus Budget Reconciliation Act. This act provided for reimbursement of reasonable costs for legislatively specified Federally Qualified Health Center services covered by Medicaid. The Omnibus Budget Reconciliation Act of 1990 enacted Medicare reimbursement of reasonable costs and recognized the importance of Federally Qualified Health Center Look-Alikes, which met the requirements under section 330 of the Public Health Service Act but did not receive Federal grants for operation.

The 1990s saw a much greater degree of interest on the part of the Federal Government in developing programs that could more consistently maintain providers in rural communities. At present, over 1,200 health centers and Federally Qualified Health Center Look-Alikes are operational. Federally Qualified Health Center Look-Alikes grew both in number and importance during this time period and program focus included primary care in sparsely populated and frontier areas. There are a total of 1,126 health centers with 7,610 service sites, 3,442 of which are located in rural counties.

[ii] Service Delivery Model: The Needs Assessment will include an inventory of all public and private primary care resources currently available within the proposed service area to meet the needs of the target population. Initially each organization included in the inventory will be considered as a potential component of a new service delivery model that would provide comprehensive health center services and will satisfy section 330 requirements. This could take many forms and alternatives and opportunities can be vetted through the requisite discussions regarding Collaboration and Coordination of services. Based upon current service area dynamics, preliminary avenues to consider include:

1) Evaluating the willingness of a community health center network on the periphery of the proposed service area to expand its reach into the service area through collaboration or integration with existing resources

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2) Considering the potential for a Critical Access Hospital located within the proposed service to modify its governance model and service delivery to become section 330 compliant and collaborate and/or integrate with other local resources

3) Examining the Public Entity with Co-Applicant model for the Allegan County Health Department in conjunction with the Critical Access Hospital and/or other local primary care providers

4) Identifying or creating a new 501(c)(3) entity willing to take the steps necessary to obtain section 330 compliance, provide the required services and meet the needs of the target population while collaborating with existing primary care resources.

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Allegan County Community Health Center Planning Project

Progress Report 3 Operational Issues

August 27, 2012

HMS Associates
Getzville, NY

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HRSA Health Center Site Visit Guide Dated October, 2011

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Commentary

The Allegan County Health Department received a grant from the federal Health Services and Resources Administration, Bureau of Primary Health Care, in September 2011 to conduct a study on the need for a Federally Qualified Health Center in Allegan County, Michigan. Federally Qualified Health Centers, also referred to as Community Health Centers, are community-based and patient-governed organizations that provide comprehensive primary care services to medically underserved communities and vulnerable populations regardless of their ability to pay[i]. They must be private, charitable, tax-exempt nonprofit organizations or public entities.

Federally Qualified Health Centers must serve, in whole or part, a federally designated Medically Underserved Area or Medically Underserved Population. Medically Underserved Areas/Populations are areas or populations designated officially by the Health Resources and Services Administration as having: too few primary care providers; high infant mortality; high poverty; and/or high elderly population. Medically Underserved Area/Medically Underserved Population designation is an eligibility factor for receiving Federally Qualified Health Center status. Allegan County is a Medically Underserved Area and as such may qualify for Federally Qualified Health Center development. It is the intent of this project to:

- Examine these needs more closely, especially by area or quadrant of the county referred to herein as Allegan County Primary Care Planning Areas and thereby identify priorities and unmet needs
- Examine several organizational options for a Federally Qualified Health Center and recommend the preferred organizational structure
- Examine the operational requirements of a Federally Qualified Health Center and develop protocols or recommendations addressing such requirements

These phases are summarized in Exhibit 1.

Exhibit 1 – Federally Qualified Health Center Planning Project Structure

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Methodology

This report addresses the third and final phase of the planning project and was designed to examine the operational requirements of a Federally Qualified Health Center and to develop commentaries or recommendations addressing such requirements. Numerous operational areas were explored, with the Allegan Health Group, Inc., the existing not for profit corporation operating health care services in Allegan County, in the best position to pursue federally qualified health center designation. In the previous phase of this project, the Allegan Health Group, Inc. provided a written response to the questions raised in the Request for Information on an interest in developing a community health center application and therein demonstrated a highly relevant potential approach to Federally Qualified Health Center development. This report describes the consultants' work with the Allegan Health Group on refining its intent to continue to examine issues attendant to the operation of a Federally Qualified Health Center capacity focusing on central and eastern Allegan County.

It is noted that the Allegan Health Group's interest thus far is considered non-binding and numerous operational issues must be addressed in detail in order for it to move forward with any formal Federally Qualified Health Center proposal. That being said, as referenced in other parts of this report, it is the consultant's opinion that the Allegan Health Group's current management and service provision structure mirrors many Federally Qualified Health Center requirements and puts it in a strong position to implement a comprehensive system of primary care and preventive services which expands access to the county's underserved populations, attracts needed federal resources and fully meets federal requirements.

Guidance was provided to the Allegan Health Group, Inc. on several key topics related to the operation of a Federally Qualified Health Center. For discussion purposes, these topics are grouped into three main categories which address:

1. Compliance and Viability
2. Service Delivery
3. Quality

Each category has several topics and/or subtopics which conform to operational areas outlined in the original grant application, adjusted to be more consistent with planning grant reporting requirements issued by HRSA earlier this year. These may warrant further modification as additional federal guidance is issued on planning grant reporting requirements. Categories, topics and subtopics are illustrated in Exhibit 2.

At the outset, it should be noted that Federally Qualified Health Center development by the Allegan Health Group, Inc., is fortuitous in that the organization has a management and clinical infrastructure already in place and, in the consultants' opinion, the wherewithal to readily adjust itself to meet Federally Qualified Health Center Section 330 requirements. This dramatically reduces if not eliminates additional infrastructure investment and there is no duplication of effort or costs in support of the objective of developing access to Federally Qualified Health Center services in the planning area.

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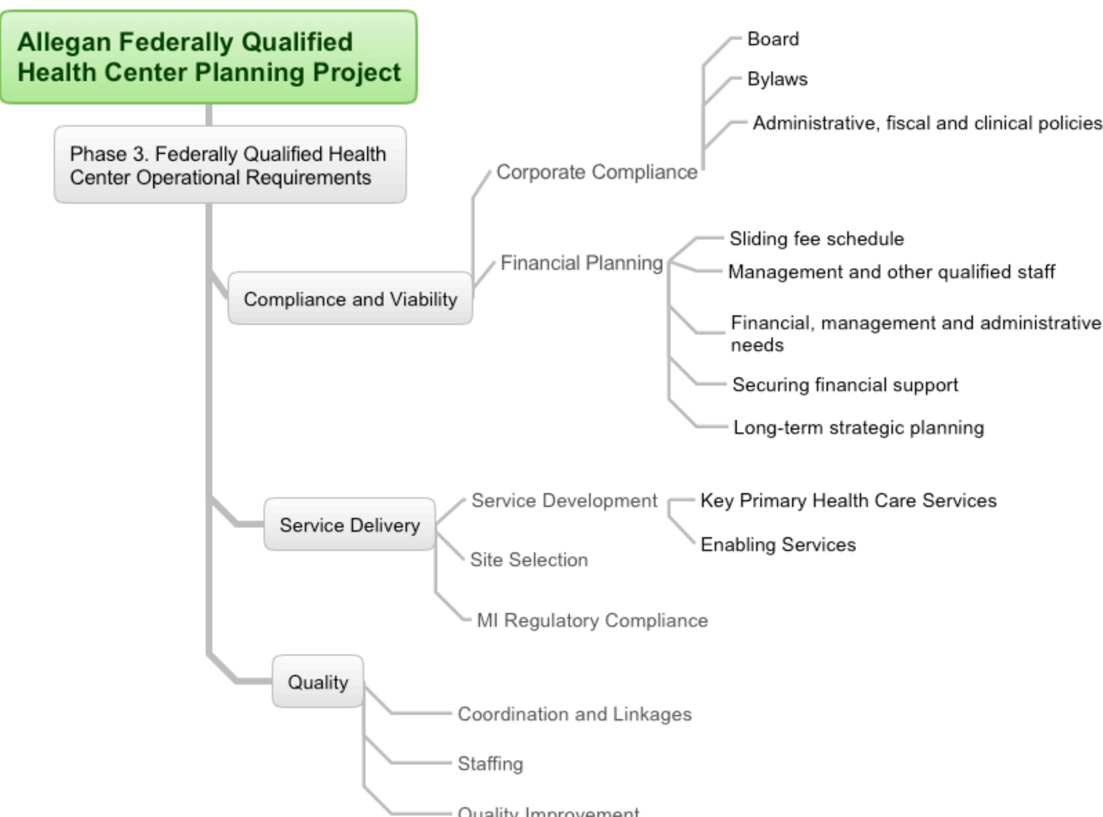
Duplicating or introducing new costs into a small, rural market area like Allegan can often create long-term unintended consequences for a community focused on accomplishing short-term objectives.

Of equal importance are the challenges the Allegan Health Group, Inc. will face in the establishment of a Federally Qualified Health Center capacity in Allegan County. In the consultants' opinion, the existing structure of the Allegan Health Group, Inc. mirrors many federal requirements, yet the exact nature, type and timeframe for resolving challenges must be more closely examined by Allegan Health Group and its financial and legal agents for necessary due diligence.

Recognizing that there is a great deal of work involved in health center development and insurmountable obstacles may emerge, it is worth referencing a back-up plan to health center development. The Allegan Health Group has committed to conclude their feasibility evaluation before February 2013. If the decision is to not pursue sponsorship of a federally qualified health center application, the steering committee will reconvene at that time, review alternatives to improve capacity for treating the underserved population and explore other potential options for heath center sponsorship within the community.

Exhibit 2 – Operational Issues



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Compliance and Viability – Corporate Compliance

Governing Board

Federally Qualified Health Center requirement – The Health Center governing board maintains appropriate authority to oversee the operations of the center, including:

- holding monthly meetings;
- approval of the health center grant application and budget;
- selection/dismissal and performance evaluation of the health center CEO;
- selection of services to be provided and the health center hours of operations;
- measuring and evaluating the organization's progress in meeting its annual and long-term programmatic and financial goals and developing plans for the long-range viability of the organization by engaging in strategic planning, ongoing review of the organization's mission and bylaws, evaluating patient satisfaction, and monitoring organizational assets and performance;* and
- establishment of general policies for the health center.

Discussion

The Allegan Health Group, Inc. is an existing non-profit corporation with a Board of Directors comprised of 6 members. With two current non-profit subsidiaries (Allegan Professional Health Services and Allegan General Hospital), the Allegan Health Group Board is experienced in the health care industry. The membership of the Allegan Health Group Board will need to be expanded numerically to meet Federally Qualified Health Center Section 330 requirements and simultaneously modified to reflect a variety of characteristics.

The Federally Qualified Health Center requirements for governance, including composition and required authorities, have been shared with the Allegan Health Group leadership. Discussions with the consultants have also addressed the governance complexities of Federally Qualified Health Centers which also operate Critical Access Hospitals.

Bylaws

Federally Qualified Health Center requirement – The Health Center governing board maintains appropriate authority to oversee the operations of the center, including ongoing review of the organization's mission and bylaws.

Discussion

Sample bylaws from a current Federally Qualified Health Center grantee which operates a Critical Access Hospital were discussed with Allegan Health Group leadership. Additional due diligence is required by the Group to assure compliance with requirements of other state and federal governmental bodies.

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Administrative, Fiscal and Clinical Policies

Federally Qualified Health Center requirement - The requirements here are sub-parts of provisions contained under Management/Finance and Governance, HRSA published guide/summary of Health Center Program Requirements. See Attachment A - HRSA Health Center Site Visit Guide dated October, 2011.

Discussion

Policies need to be reviewed for compliance and as needed transformed from site-specific to network or system policies and then be reviewed and approved by the Board. Contracted services, if needed, are subject to review and evaluation and are fully under the control of the Health Center board of directors. Going forward, the HRSA Health Center Site Visit Guide will be particularly helpful in assessing readiness and identifying needed changes as "the devil is in the details."

Compliance and Viability – Financial Planning

Sliding Fee Schedule

Federally Qualified Health Center requirement – The Health Center has systems in place to maximize collections and reimbursement for its costs in providing health services, including written billing, credit and collection policies and procedures.

Health center has a system in place to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay. This system must provide a full discount to individuals and families with annual incomes at or below 100% of the poverty guidelines (only nominal fees may be charged) and for those with incomes between 100% and 200% of poverty, fees must be charged in accordance with a sliding discount policy based on family size and income. No discounts may be provided to patients with incomes over 200% of the federal poverty level.

Discussion

Charges are consistent with locally prevailing rates. This ensures both the maximization of reimbursement and that individuals with out of pocket responsibilities are paying a competitive rate. Allegan Professional Health Service have an HRSA compliant Sliding Fee Schedule discounted charge program based on Federal Poverty Guidelines, adjusting for family size, ensuring access to all patients regardless of ability to pay. The potential applicant understands that increased involvement by the Board of Directors would be required if operating under the FQHC program in establishing fees, policies and assuring that public knowledge of the discount program is adequate.

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Key Management and Other Qualified Staff

Federally Qualified Health Center requirement – The Health Center maintains a fully staffed health center management team as appropriate for the size and needs of the center. Prior review by HRSA of final candidates for Project Director/Executive Director/CEO position is required.

Discussion

The Allegan Health Group leadership has begun identifying potential candidates for the Executive Director, Chief Financial Officer and Chief Clinical Officer positions.

Financial, Management and Administrative Needs

Discussion

The Allegan Health Group, Inc. and its subsidiaries have existing capacities to address these needs. Some areas will need more shoring-up then others but a key area, billing, appears to need little change. The Allegan site has been a Rural Health Clinic, and the Rural Health Clinic and Federally Qualified Health Center billing requirements are nearly identical. In addition, the technical knowledge needed to transition to federal billing resides internally.

Allegan General Hospital administrative capacities such as its general ledger accounting system with multiple entity capabilities and payroll processing offers an additional opportunity for cost efficient support services.

Securing Financial Support

Discussion

To date no other federal or state funding sources have been identified. However, Allegan General Hospital, the subsidiary of the applicant entity which has also participated as a steering committee member, is highly supportive of the concept of creating access to center services in the geographic area and has expressed a willingness to explore means to support the proposed applicant. The support could take the form of a Community Benefit Agreement and or providing some of the shared services discussed previously on an in-kind basis. Such relationships have occurred in several rural communities throughout the nation.

Long-term Strategic Planning

Discussion

The potential applicant has indicated that the exploration of Federal Qualified Health Center development is one of the organization's highest priorities and will seek to continue its financial feasibility and organizational impact analysis and begin the required corporate restructuring, as deemed appropriate, in 2013.

Service Delivery – Service Development

Key Primary Health Care Services

Federally Qualified Health Center requirement - The Health Center maintains a core staff as necessary to carry out all required primary, preventive, and additional health services as appropriate and necessary, either directly or through established arrangements and referrals. Staff must be appropriately credentialed and licensed.

The following clinical services must be provided directly, through contractual agreement, or through formal referral arrangements:

- Primary medical care
- Diagnostic lab and x-ray
- Screenings
- Emergency medical services
- Voluntary family planning
- Immunizations
- Well child services
- Gynecological care
- Obstetrical care
- Prenatal and perinatal services
- Preventive dental
- Mental health services (referral)
- Substance abuse services (referral)
- Specialty services (referral)
- Pharmacy

Discussion

The Allegan Professional Health Services is the major primary care component of the Allegan Health Group and its sites are staffed by directly employed, duly licensed and credentialed provider teams consisting of 8.5 Family Practitioners, supported by 7 Physician Assistants. The providers care for patients of all life-cycles, including Pediatrics. If necessary, referral arrangements are in place for Internal Medicine consults. Currently, Obstetrical/Gynecological services are available by referral but only outside the proposed service area. However, in January of 2013, Allegan General Hospital (AGH) will have Ob/Gyn services available on-site in Allegan. Referrals and support arrangements between these organizations will be seamless.

For patients for whom language or culture could pose a barrier, Allegan Professional Health Services has culturally sensitive video translation services available on-site.

Enabling Services

Federally Qualified Health Center requirement - The Health Center provides all required enabling health services and additional health services as appropriate and necessary, either directly or through established written arrangements and referrals.

The following non-clinical services must be provided directly, through contractual agreement or through formal referral arrangements:

- Case management

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- Counseling/assessment
- Referral
- Follow-up/discharge planning
- Facilitated enrollment services for Medicaid, Children's Health Insurance Program, and other public insurance programs
- Health education
- Transportation
- Translation
- Outreach

Discussion:

As indicated in the prior section, Allegan Professional Health Services directly provides primary care to all life cycles through a core staff of directly employed providers. Allegan Professional Health Services personnel assist patients with applications to qualify for the network's sliding fee discount program. Patients seeking assistance with completing Medicaid enrollment applications are referred to the billing department at Allegan General Hospital. Allegan County has transportation services available for Medicaid recipients that are arranged through a caseworker. As mentioned previously, culturally appropriate video translation services are available at the Allegan Professional Health Services sites.

Allegan Professional Health Services will need to evaluate if additional steps need to be taken in order to ensure that lack of adequate transportation does not present a barrier to receiving appropriate and timely care.

Service Delivery - Site Selection

Federally Qualified Health Center requirement – The Health Center provides services at times and locations that assure accessibility and meet the needs of the population to be served.

Discussion:

The Allegan Professional Health Services currently operates three permanent, year-round, primary care sites in Allegan, Otsego and Gobels, Michigan. The sites would potentially be the locations of Federally Qualified Health Center services.

The Allegan site, certified as a Rural Health Clinic in 2003, is situated in the population center of the service area and functions as the "hub" of the primary care network with the greatest number of providers and the most comprehensive hours of operation. The Otsego and Gobels sites are located southeast and south of Allegan, respectively. The geographic dispersion of the sites provides convenient access throughout the service area where patients both live and work so that travel barriers are minimized – particularly for the low-income and other vulnerable populations for whom transportation can be problematic.

The Allegan site has weekend hours (8:00 a.m. – 12:00 p.m. on Saturdays) and provides urgent care/walk-in hours until 6:00 p.m. on weekdays. All three locations have their first available appointment slot at 7:30 a.m., adding flexibility with the early morning option.

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Service Delivery – Michigan Regulatory Issues

As an approved operator of health care services in the state of Michigan, the Allegan Health Group, Inc. or its affiliates meet many existing requirements. Yet, regulations promulgated by the state of Michigan addressing the operation of Federally Qualified Health Centers need to be more closely examined.

Quality – Coordination and Linkages

Federally Qualified Health Center requirement - Health Center physicians have admitting privileges at one or more referral hospitals, or other such arrangements to ensure continuity of care. In cases where hospital arrangements (including admitting privileges and membership) are not possible, the Health Center must firmly establish arrangements for hospitalization, discharge planning, and patient tracking.

Discussion

Allegan Professional Health Services providers have admitting privileges at Allegan General Hospital and inpatient care is provided by the hospitalist program at Allegan General Hospital. Systems are in place for admission notification, discharge planning, tracking and the sharing of health information necessary for the ongoing treatment of patients.

In order to ensure that care can be managed across the full continuum, Allegan Professional Health Services also has referral arrangements in place with a variety of specialty providers including Cardiology, Neurology, Oncology, Urology, Orthopedics, Podiatry, Dermatology, General Surgery and Vascular Surgery. Additionally, arrangements exist with Mental Health providers employed by Allegan General Hospital and with a dental practice located on the hospital campus.

Referrals are accepted regardless of ability to pay or insurance status by its affiliate Allegan General Hospital for inpatient and outpatient services and providers/programs sponsored by Allegan General Hospital which are Orthopedics and Mental Health. Allegan Professional Health Services should seek to obtain formal, written agreements with the remaining providers reinforcing the commitment to accept all referrals regardless of ability to pay and honoring the Allegan Professional Health Services discount schedule.

Quality - Staffing

Federally Qualified Health Center requirement – The Health Center maintains a core staff as necessary to carry out all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established arrangements and referrals. Staff must be appropriately credentialed and licensed.

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Discussion:

The Allegan Professional Health Services sites are staffed by directly employed, duly licensed and credentialed provider teams consisting of 8.5 Family Practitioners (FPs) supported by 7 Physician Assistants. The FPs care for patients of all life-cycles, including Pediatrics. An appropriate array of nursing, other medical care personnel and administrative support staff participate in the provision of care and related business functions. The clinical staffing plan is appropriate for the proposed number of patients, including the ability to absorb additional capacity, and is appropriate for the characteristics and needs of the community and target population.

Allegan Professional Health Services has a centrally located Executive Director and a Clinical Manager that oversees the activities of nursing and other clinical support staff at the three locations. A central billing office handles billing and collections and an Information Technology Support Specialist maintains the clinical and business functionality of the practice management system.

Quality - Quality Improvement

Federally Qualified Health Center requirement – The Health Center has an ongoing Quality Improvement/Quality Assurance (QI/QA) program that includes clinical services and management, and that maintains the confidentiality of patient records. The Quality Improvement/Quality Assurance program must include:

- a clinical director whose focus of responsibility is to support the quality improvement/assurance program and the provision of high quality patient care;
- periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the health center; and such assessments shall:
- be conducted by physicians or by other licensed health professionals under the supervision of physicians;
- be based on the systematic collection and evaluation of patient records; and
- identify and document the necessity for change in the provision of services by the health center and result in the institution of such change, where indicated.

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Discussion

There is a Quality Improvement/Quality Assurance program currently in place at APHS. Risk management and patient confidentiality safeguards are in place and there is periodic assessment and analysis by clinical staff. Designation as an FQHC or Look-alike would require the appointment of a clinical director with the responsibility to further develop the QI/QA plan that includes management as well as clinical functions. The opportunity exists to share resources with Allegan General Hospital so that it can be done cost effectively and best practices can be shared. This area should be strongly considered for future technical assistance.

Concluding Commentary

As noted in other sections of this report, the actual process to develop and operate a Federally Qualified Health Center is the real heavy lifting of this project. The consultants' experience with other health care organizations, which have successfully developed new Federally Qualified Health Centers is that such processes are indeed difficult and resource intensive and many unanticipated but not insurmountable obstacles often emerge.

The Allegan Health Group's interest in such actions is indeed a very positive sign that health care services to underserved and hard to reach populations will be expanded in the county. Additional due diligence has to be performed by the Health Group and extensive discussions need to take place at the board and clinical levels of this organization. The significant benefits of the Federally Qualified Health Center program, in terms of financial support for services and populations not typically covered by payers, cost reduction elements for medical malpractice and medications and access to federal dollars designed to support needed services to this population should continue to be discussed. It is expected that the Allegan board and clinical staff will conclude its examination of these matters by early 2013 or sooner if federal funding cycle requirements are issued in advance of that date.

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[i] Summary of Federally Qualified Health Center Features, Abstracted from *A Manual on Effective Collaboration on Critical Access Hospitals and Federally Qualified Health Centers*, April 2010, prepared by HMS Associates for the US Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy. It can be found at: www.hrsa.gov/ruralhealth/pdf/qhcmanual042010.pdf.

Section 2 Federally Qualified Health Centers from A to Z:

DEFINITION

Federally Qualified Health Center is a designation of the Center for Medicare & Medicaid Services (CMS) and entitles qualified organizations to set reimbursement rates controlled or influenced by CMS. Section 1905(l)(2)(B) of the Social Security Act identities three types of Federally Qualified Health Center: (1) those receiving a grant, directly or through sub-recipient arrangements, under section 330 of the Public Health Service Act; (2) those determined to meet the requirements of a grant but do not receive Federal funding (i.e., Federally Qualified Health Center Look-Alikes); and (3) an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638) or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act for the provision of primary health services.

For the purposes of this manual, Federally Qualified Health Centers are specific to those organizations receiving a grant under section 330 of the Public Health Service Act and those organizations, based on the recommendation of the Health Resources and Services Administration, that meet the requirements for receiving a grant (i.e., Federally Qualified Health Center Look-Alikes). Federally Qualified Health Centers designated under the Indian Self-Determination Act or by an urban Indian organization are not applicable to this manual.

Federally Qualified Health Center and Federally Qualified Health Center Look-Alikes, also referred to as Health Centers, are community-based and patient-governed organizations that provide comprehensive primary care services to medically underserved communities and vulnerable populations regardless of their ability to pay. They must be private, charitable, tax-exempt nonprofit organizations or public entities. Federally Qualified Health Centers and Federally Qualified Health Center Look-Alike designations require two actions, one from the Health Resources and Services Administration that “recommends” that the organization meets the eligibility and program standards of the Health Center Program and one from CMS that is more related to fiscal management and reporting.

Federally Qualified Health Centers that are awarded a grant under the Health Center Program, as authorized in section 330 of the Public Health Service Act (42 U.S.C. 254b), receive funding for one or more of the following types of section 330 programs:

- Community Health Center Programs, funded under section 330(e);
- Migrant Health Center Programs, funded under section 330(g);
- Health Care for the Homeless Programs, funded under section 330(h); and
- Public Housing Primary Care Programs, funded under section 330(i).

Federally Qualified Health Center Look-Alikes do not receive grant funding under the Health Center Program, however, they must meet all statutory requirements under section 330 of the Public Health Service Act. Federally Qualified Health Center Look-Alikes designation requires two actions, one from the Health Resources and Services Administration that “recommends” that the organization meets the eligibility and program standards of the Health Center Program and one from the Centers for Medicare and Medicaid Services that is more related to fiscal management and reporting. Additionally, at the time of applying for Federally Qualified Health Center Look-Alikes designation, the organization may not be owned, controlled, or operated by another entity.

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Federally Qualified Health Center Look-Alikes can access some but not all of the program related benefits of Federally Qualified Health Centers that are described later in this section. Federally Qualified Health Center Look-Alikes may have stronger incentives to collaborate with Critical Access Hospitals than Federally Qualified Health Centers because of their lack of grant funds to support services to the uninsured and underserved and more probable need for community benefit support from Critical Access Hospital structures.

Health Centers offer a variety of programs to the communities they serve. They are required to provide comprehensive primary care services as well as supportive services (i.e. health education, translation, transportation, etc….) that promote access to care. In addition, Health Centers may provide additional clinical and non-clinical services that support primary care. Such programs may include the Special Supplemental Nutrition Program for Women, Infants and Children, or services specifically designed for children with special needs or people living with HIV or AIDS.

Although this document focuses specifically on the primary and preventive health care capacities of Federally Qualified Health Centers, it should not be overlooked that in addition to providing those services as discrete components of health care services, they may also offer a broad range of supportive services that populations with low incomes often need. Consequently, they are not only a portal to effective primary care preventive health services but also potentially to other health and social services.

KEY FEATURES

Designation

The process of developing compliant structures and capacities to meet health center requirements is complicated and costly. It includes needs assessment, preparing applications for Health Professional Shortage Area, Medically Underserved Area and Medically Underserved Population designations, developing compliant corporate structures, drafting service delivery plans or capacities, and preparing grant or Federally Qualified Health Center designation applications.

Need

Federally Qualified Health Centers must serve, in whole or part, a federally designated Medically Underserved Area or Medically Underserved Population. Medically Underserved Areas/Populations are areas or populations designated officially by the Health Resources and Services Administration as having: Too few primary care providers; High infant mortality; High poverty; and/or High elderly population. Medically Underserved Area/Medically Underserved Population designation is an eligibility factor for receiving Federally Qualified Health Center status.

Health Services

Federally Qualified Health Centers must provide primary care services and, as may be appropriate for particular centers, additional health care services necessary for adequate support of the required primary care services. The following clinical services must be provided directly, through contractual agreement, or through formal referral arrangements:

- Primary medical care
- Diagnostic lab and x-ray
- Screenings
- Emergency medical services
- Voluntary family planning
- Immunizations
- Well child services
- Gynecological care
- Obstetrical care

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- Prenatal and perinatal services
- Preventive dental
- Mental health services (referral)
- Substance abuse services (referral)
- Specialty services (referral)
- Pharmacy

The following non-clinical services must be provided directly, through contractual agreement or through formal referral arrangements:

- Case management
- Counseling/assessment
- Referral
- Follow-up/discharge planning
- Facilitated enrollment services for Medicaid, Children's Health Insurance Program, and other public insurance programs
- Health education
- Transportation
- Translation
- Outreach

Federally Qualified Health Centers often provide services beyond the core requirements based on an assessment of the needs of the population and the availability and accessibility of services in their area.

Federally Qualified Health Centers must provide access to their full range of services to all health center patients regardless of ability to pay. They are required to have a discounted fee schedule for patients whose incomes are below 200 percent of the federal poverty level and full discounts for people with incomes at or below 100 percent of the federal poverty level. Federally Qualified Health Centers must provide care in a manner that is culturally and linguistically competent.

Health Centers maintain appropriately credentialed and licensed providers (as applicable and necessary) to carry out their full range of services. Health Centers must offer their services at times and locations that assure accessibility and meet the needs of the population being served. In addition, Health Centers must provide professional coverage during hours when the health center is closed. Health Center physicians are expected to have admitting privileges at one or more referring hospitals to follow hospitalized patients. Where this is not possible, arrangement for hospital-based coverage and services must be established. Health Centers are also required to have an ongoing quality improvement/quality assurance program that includes clinical services and management and that maintains the confidentiality of patient records.

Management and Finance

Federally Qualified Health Centers must establish and maintain collaborative relationships with other health care providers, including other health centers, in the service area of the center. This requirement and several other clinical requirements help to ensure continuity of patient care, essentially requiring arrangements or "collaboration" between health care service providers.

Federally Qualified Health Centers must maintain a fully-staffed management team that is appropriate for the size and needs of the center. They must exercise appropriate oversight of billing and collections, have appropriate financial management and control policies, and have systems in place for collecting data and program reporting.

Governance

A core component of Federally Qualified Health Centers relates to the governing board requirements. The governing board must have a majority (minimum 51 percent) of members who are patients of the Health Center and who, as a group, reasonably represent the patient population. In addition, there are restrictions on the percent of non-patient board members who

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earn 10 percent or more of their incomes from healthcare-related industries. Board members should bring areas of expertise that are relevant to Health Center operations and a community presence. Federally Qualified Health Center governing boards must maintain appropriate authority to oversee the operations of the Health Center, including: Establishing policies; Approving budgets; Selecting services provided; and Selection, dismissal, and performance evaluation of the Executive Director.

KEY BENEFITS TO THE HEALTH CENTER

Grant Funds

Section 330 Health Center grant funds offset the costs of uncompensated care for the uninsured and underinsured and for key enabling services. Organizations that receive a section 330 grant for the first time receive "New Start" funding of up to $650,000 annually. Additional HRSA and BPHC grant funding for service and capacity expansion may become available to existing Section 330 funded health centers.

Minimum per Encounter Medicaid or Medicare payment

Both Federally Qualified Health Center grantees and Federally Qualified Health Center Look-Alikes are covered by payment methodologies that guarantee Health Centers a minimum per encounter payment for services provided to Medicaid and Medicare beneficiaries.

Federal Medical Malpractice Coverage (Federal Tort Claims Act Coverage)

The intent of the Federal Tort Claims Act is to increase the availability of funds for the provision of direct primary care services by reducing administrative costs associated with malpractice insurance premiums that health care centers have to fund. Health Centers that are "deemed" under the Federal Tort Claims Act receive federal protection for malpractice allegations made against the center for services and providers included in their federal scope of project. This coverage applies to deemed Health Center grantees only, and is not available to Federally Qualified Health Center Look-Alikes.

340B Drug Pricing – Prescription Drug Discounts

Significant savings on pharmaceuticals may be accessed by participating entities. Federally Qualified Health Center grantees and Federally Qualified Health Center Look-Alikes are among the entities that may participate in the program.

Loan Guarantees

Loan guarantees may be extended or made by non-federal lenders for the construction, renovation and modernization of medical facilities that are owned and operated by Section 330 Health Centers. This only applies to Federally Qualified Health Center grantees, not Federally Qualified Health Center Look-Alikes.

Other Federal or National Programs

Federally Qualified Health Centers and Federally Qualified Health Center Look-Alikes qualify for Health Professional Shortage Area designation, which confers a basic eligibility to apply for National Health Service Corp personnel (scholars, loan repayors or ready responders) as well as eligibility to be a site where a J-1 Visa Waiver physician can serve. Rural areas often experience difficulties in the recruitment and retention of physicians. Due to these difficulties, many communities turn to the recruitment of foreign medical graduates with J-1 Visa Waivers to fill their physician vacancies. This program helps Federally Qualified Health Centers recruit physicians.

Grant funding, medical malpractice coverage and Heath Personnel Shortage Areas designations appear to have the greatest positive financial relevance for collaboration between Federally Qualified Health Centers and Critical Access Hospitals.

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Health Center Impacts on Rural Uninsureds' Use of Hospital Emergency Departments

A study conducted in 2009 on rural communities in Georgia, showed that Federally Qualified Health Centers in rural counties reduce Emergency Department use by the uninsured. Counties without a Health Center clinic site had 33 percent higher rates of uninsured all-cause Emergency Department visits per 10,000 uninsured population compared with community Health Center counties. Higher Emergency Department visit rates remained significant after adjustment for factors associated with high Emergency Department use, specifically, percentage of population below poverty level, percentage of black population, and number of hospitals.

HISTORY

In the mid-1970s, Congress permanently authorized neighborhood health centers as "Migrant Health Centers" under sections 329 and "Community Health Centers" under section 330 of the Public Health Service Act. This signaled a movement towards the development of independent health centers governed by a majority of consumers of health center programs. On a related primary care access track, Congress passed the Rural Health Clinic Services Act of 1977 (Public Law 95-210) which provides cost-based Medicare reimbursement for a defined set of core physician and non-physician outpatient services.

Throughout the 1970s, the number of health centers grew from 158 in 1974 to 802 in 1980. In the latter part of the decade, Federal support for health centers diminished but not as much as for other "War on Poverty" programs. In the early 1980s, these Community and Migrant Health Centers received more funding.

In 1989, the Federally Qualified Health Center program was established by the Omnibus Budget Reconciliation Act. This act provided for reimbursement of reasonable costs for legislatively specified Federally Qualified Health Center services covered by Medicaid. The Omnibus Budget Reconciliation Act of 1990 enacted Medicare reimbursement of reasonable costs and recognized the importance of Federally Qualified Health Center Look-Alikes, which met the requirements under section 330 of the Public Health Service Act but did not receive Federal grants for operation.

The 1990s saw a much greater degree of interest on the part of the Federal Government in developing programs that could more consistently maintain providers in rural communities. At present, over 1,200 health centers and Federally Qualified Health Center Look-Alikes are operational. Federally Qualified Health Center Look-Alikes grew both in number and importance during this time period and program focus included primary care in sparsely populated and frontier areas. There are a total of 1,126 health centers with 7,610 service sites, 3,442 of which are located in rural counties.

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Allegan County Community Health Center Planning Project

Appendix 1 Key Informant Interviews

August, 2012

HMS Associates
Getzville, NY

Participants

Fourteen telephone interviews were conducted during the needs assessment component of the project, the majority of which occurred in late April, 2012. The interviewees represented ten key organizations serving Allegan County residents across a spectrum of health and human services. Two county commissioners provided insights on the needs of their constituents. These individuals are:

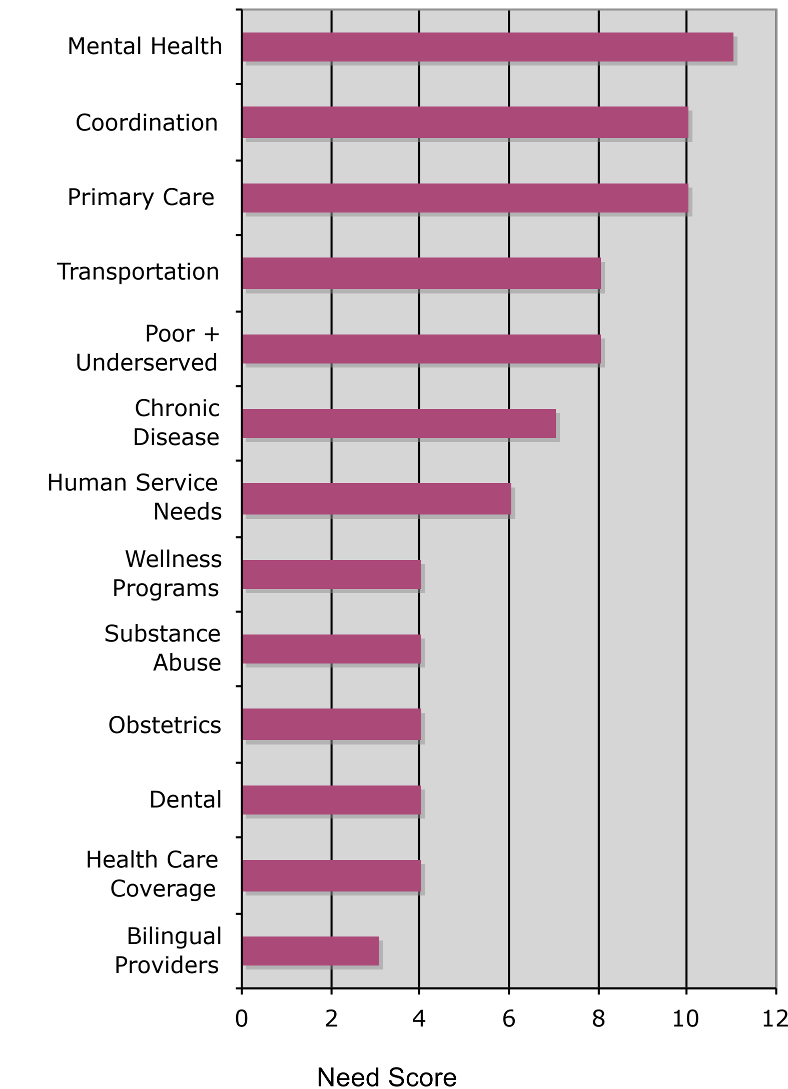
- Jeanette Hoyer, L.P.C., Executive Director, Pathways, Holland, MI
- Laurie Schmitt, Assistant Superintendent of Instructional Services, Allegan Area Educational Service Agency, Allegan, MI
- Dan Wedge, Allegan County Transportation Director, Allegan, MI
- Mimi Gabriel, Executive Director, United Way of Allegan County, Allegan, MI
- Maryann Huff, Director Allegan County Mental Health Services, Allegan, MI
- Mark DeYoung, District #4 Commissioner, Chairman, Allegan County Board of Commissioners, Allegan, MI
- Teresa Price, Executive Director, Sylvia's Place, Allegan MI
- Velma Hendershott, Chief Executive Officer, InterCare Community Health Center, Inc, Bangor, MI
- Jon Campbell, District #10 Commissioner, Allegan County Board of Commissioners, Chairman, Finance Committee, Allegan, MI
- Lisa Letts, Interim ED Manager, Allegan General Hospital, Allegan, MI
- Shirley Sutton-Rop, Chief Clinical Officer/VP Patient Services, Allegan General Hospital, Allegan, MI
- Marcia Beare, Renewed Hope Free Clinic, Inc., Allegan, MI
- Erin Radke, Executive Director, Family Planning & Women's Health Of Allegan County, Allegan, MI
- Fred Parson, Renewed Hope Free Clinic, Inc., Allegan, MI

Interviews lasted approximately 45 minutes and were open-ended rather than restricted to a particular set of detailed questions. Participants were asked to describe their roles or organizations and then to identify current or emerging unmet needs. Minimal prompting took place because the methodology sought general impressions on needs rather than information on any specific type of need.

Findings

As with most interviews, the majority of comments pertained to organizational roles and capacities. Comments on needs were noted and grouped into 13 categories using content analysis techniques and health center services. High need areas were mental health, primary care, and coordination of care; Moderate need areas pertained to transportation, access to care for the poor and underserved, chronic disease and human services; Other needs included health care coverage, obstetrics, substance abuse, wellness programs and bilingual providers. Exhibit A-1 depicts these findings.

Exhibit A – 1. Key Informant Telephone Interview Findings



When one considers the range of responsibilities of federally qualified health centers, it is clear that these community leaders recognize that improved access to primary care is needed for the poor and underserved but especially to people with mental illness. Several programs have been examined as potential solutions to this problem and health center development efforts consider this area as a potential priority. It is one of the key current federal priorities of the health center program at this time as well. Coordination of care is also a key tenant of the health center philosophy and many health center programs such as the "Patient Centered Medical Home" provide additional funding for health centers which offer expanded coordination of care programs. See discussion on coordination of care in Appendix 3 – Allegan County Board of Commissioners' Interests

Several respondents also referenced transportation as a key need. Apart from the population centers, many residents live in areas with minimal public transportation. Those without private vehicles or not eligible for special transportation programs are challenged when it comes to addressing their health care needs and keeping medical appointments. Health centers have limited funding for transportation purposes, so as the local program evolves, consideration should be given to studying how such funds might advance access to care most efficiently for health center patients.

Allegan County Community Health Center Planning Project

Appendix 2 Internet Questionnaire

August, 2012

HMS Associates
Getzville, NY

Allegan County - Primary Care Needs Study

1. Age

	Response Percent	Response Count
Under 18	0.0%	0
18 to 44	**51.1%**	**24**
45 to 64	44.7%	21
65+	4.3%	2
	answered question	**47**
	skipped question	**0**

2. Are you female or male?

	Response Percent	Response Count
Female	**72.3%**	**34**
Male	27.7%	13
	answered question	**47**
	skipped question	**0**

Allegan County Community Health Center Planning Project - Appendix 2 - Internet Survey Results

The survey focused on examining perceptions of unmet need for health center services. It was conducted during the last two weeks of May 2012. It was conducted through the internet and members of the Allegan County Multi-Agency Coordinating Council and other individual identified through the County Health Department. Through June 1, 2012, Forty-seven people responded. Approximately 3 out of 4 respondents were female and one out of four was male. Approximately 11 out of 20 were employed in the human services area, 6 out of 20 in health, mental health or health related, and 3 out of 20 were not employed in any of the areas referenced above. There was an equal proportion of Allegan County residents and nonresidents and 35% of county respondents have lived in the county for 5 years or more. Many county resident respondents were from either southeast or northwest Allegan County.

3. Are you employed in the health care, prevention, behavioral health, dental care or human services areas? If so, please check those that apply:

	Response Percent	Response Count
Health care	28.3%	13
Prevention services	6.5%	3
Behavioral health	2.2%	1
Dental care	2.2%	1
Human services	**54.3%**	**25**
None of these	15.2%	7
	answered question	**46**
	skipped question	**1**

4. Are you a resident of Allegan County?

	Response Percent	Response Count
Not a resident	**48.9%**	**23**
Resident for less than two years	2.1%	1
Resident for 2 to 5 years	12.8%	6
Resident for more than 5 years	36.2%	17
	answered question	**47**
	skipped question	**0**

5. In what area of the county do you reside?

	Response Percent	Response Count
City or Town of Allegan	16.7%	4
Northeast Allegan County	12.5%	3
Southeast Allegan County	29.2%	7
Southwest Allegan County	8.3%	2
Northwest Allegan County	**33.3%**	**8**
	answered question	**24**
	skipped question	**23**

6. Please rate the following services based on your view of the need for additional capacity, i.e., more doctors, nurses, health, mental health, or dental health related practitioners or clinics.

	High unmet need	Unmet need	Supply is adequate	Rating Average	Response Count
Primary medical care	**42.1% (16)**	26.3% (10)	31.6% (12)	2.11	38
Diagnostic lab and x-ray	11.4% (4)	37.1% (13)	**51.4% (18)**	1.60	35
Personal health screenings	20.0% (7)	37.1% (13)	**42.9% (15)**	1.77	35
Emergency medical services	13.9% (5)	19.4% (7)	**66.7% (24)**	1.47	36
Voluntary family planning	11.8% (4)	38.2% (13)	**50.0% (17)**	1.62	34
Immunizations	5.6% (2)	22.2% (8)	**72.2% (26)**	1.33	36
Well child services	8.3% (3)	44.4% (16)	**47.2% (17)**	1.61	36
Gynecological care	22.2% (8)	**38.9% (14)**	**38.9% (14)**	1.83	36
Obstetrical care	22.9% (8)	37.1% (13)	**40.0% (14)**	1.83	35
Prenatal and perinatal services	19.4% (7)	**44.4% (16)**	36.1% (13)	1.83	36
Preventive dental	**55.3% (21)**	18.4% (7)	26.3% (10)	2.29	38
Mental health services	35.9% (14)	**48.7% (19)**	15.4% (6)	2.21	39
Substance abuse services	37.8% (14)	**45.9% (17)**	16.2% (6)	2.22	37
Pharmacy	13.2% (5)	18.4% (7)	**68.4% (26)**	1.45	38
				answered question	**41**
				skipped question	**6**

7. Please rate the following supportive services based on your view of the need for additional capacity:

	High unmet need	Unmet need	Supply is adequate	Rating Average	Response Count
Case management	27.8% (10)	**44.4% (16)**	27.8% (10)	2.00	36
Counseling/assessment	27.8% (10)	**52.8% (19)**	19.4% (7)	2.08	36
Referral	31.4% (11)	**34.3% (12)**	**34.3% (12)**	1.97	35
Follow-up/discharge planning	23.5% (8)	**52.9% (18)**	23.5% (8)	2.00	34
Facilitated enrollment services for Medicaid	18.9% (7)	**40.5% (15)**	**40.5% (15)**	1.78	37
Health education	28.6% (10)	**42.9% (15)**	28.6% (10)	2.00	35
Transportation	**66.7% (26)**	7.7% (3)	25.6% (10)	2.41	39
Translation	27.0% (10)	**43.2% (16)**	29.7% (11)	1.97	37
Outreach	31.4% (11)	**37.1% (13)**	31.4% (11)	2.00	35
				answered question	**39**
				skipped question	**8**

8. In general, please indicate in which area(s) of the county additional services are most needed. Check all that apply:

	Response Percent	Response Count
City or Town of Allegan	38.2%	13
Northeast Allegan County	50.0%	17
Southeast Allegan County	52.9%	18
Southwest Allegan County	**88.2%**	**30**
Northwest Allegan County	47.1%	16
	answered question	**34**
	skipped question	**13**

9. Please indicate which population groups are most in need of additional primary care service:

	Response Percent	Response Count
People with no insurance	**87.8%**	**36**
People who are "underserved" with minimal insurance	82.9%	34
People with low incomes	80.5%	33
People eligible for Medicaid	43.9%	18
Children	48.8%	20
Women of child-bearing age	29.3%	12
Teenage parents	31.7%	13
Adults	26.8%	11
Seniors	31.7%	13
People with special needs (Please specify, e.g., minorities, mental health, substance abuse, homeless, migrants, victims of domestic violence)	46.3%	19
	answered question	**41**
	skipped question	**6**

10. Please rate the importance of the following aspects of primary care services:

	Highly important	Important	Not important	Rating Average	Response Count
Credentials of staff	39.5% (15)	**57.9% (22)**	2.6% (1)	2.37	38
Appointments after working hours: 5 to 9 PM	47.5% (19)	**52.5% (21)**	0.0% (0)	2.48	40
Appointments on weekends	44.4% (16)	**50.0% (18)**	5.6% (2)	2.39	36
Spanish speaking practitioners	26.3% (10)	**68.4% (26)**	5.3% (2)	2.21	38
Urgent care appointments: Within 24 hours	**55.3% (21)**	44.7% (17)	0.0% (0)	2.55	38
Range of health care services at clinic	**56.8% (21)**	43.2% (16)	0.0% (0)	2.57	37
Proximity to employer	13.9% (5)	**66.7% (24)**	19.4% (7)	1.94	36
Proximity to home	43.6% (17)	**51.3% (20)**	5.1% (2)	2.38	39
				answered question	**40**
				skipped question	**7**

11. Please take a moment to share any general comments you have about health care needs in Allegan County.

	Response Count
	7
answered question	**7**
skipped question	**40**

Allegan County Community Health Center Planning Project

Appendix 3
Board of Commissioners Questions

August, 2012

HMS Associates
Getzville, NY

Background

The Allegan County Board of Commissioners reviewed a report and presentation on the results of the federally qualified health center needs assessment conducted by HMS Associates, Getzville, NY on Thursday, July 13, 2012. The presentation also addressed the overall objectives of the project and its major next steps.

During that session, the commissioners requested additional information on four topics:

- Methodology used and validity of data collected through health needs assessment process and rationale and explanation of how decisions were made in light of that methodology.
- Defining how coordination of care occurs now and how it will be improved in the long-term and how coordination of care supports the primary focus of getting individuals access to primary care.
- Background information on what other counties have done and models they have used (i.e. Van Buren/ Cass, etc.)
- Include detailed financial data, longevity, and availability of any funding sources.

They also requested that all acronyms be spelled out in the report for greater clarity.

Needs Assessment[1]

Needs assessments can take a variety of forms and are determined by several factors including:

- Cost
- Relevancy
- Availability
- Validity

Surveys are generally the most costly, especially those involving face-to-face interviews such as the US Census or Behavioral Risk Factor Telephone Interviews. Costs not only apply to the design of the survey instrument and the mode of survey collection - that is, in person, telephone, mail or Internet – but, and most importantly, the number of completed interviews. Most surveys address more qualitative issues than those previously referenced. They are designed to reflect a community's opinion on particular topics.

Confidence interval findings and sampling methods are most critical in understanding and applying survey results. For example, a survey may show a 10% difference; 40% of the people liked a candidate and 50% did not, but although that difference is a large margin it may not be statistically significant and more reflective of a chance rather than accurate finding. Sample size here is critical. In the consultants' opinion, data from surveys with less than 500 respondents should be

[1] Gregory Bonk, President, HMS Associates, authored a publication for the Robert Wood Johnson Foundation, Networking for Rural Health National Program, directed by AcademyHealth, Wash. DC, 2000 which featured a Chapter on Needs Assessment. See www.academyhealth.org/files/ruralhealth/bonk.pdf

used cautiously to help inform and provide additional perspectives and guide future assessments if warranted, rather than represent hard and fast conclusions. Above all, its value needs to take into account the extent to which it is validated by other types of information.

Other methods include the use of "indicators or measures" related to the topic of the assessment which can be obtained in existing data sets; such as, data from birth and death certificates. They are used to assess actual differences in populations and provide a view of comparative need; that is, is a community's need greater than or less than other communities. These methods are generally far less costly but in many instances available data may be too "old" or do not directly address the needs assessment topic. Hence, current needs assessment methodologies favor the use of both types of data to help counter-balance the weakness each poses on its own. Surveys provide current data but unless extensive and expensive, offer a "limited" view of community sentiment. On the other hand, existing data are generally at best indirect measures of needs assessment topics.

The validity of needs assessment methodologies can be examined from two dimensions:

Face validity – does it reflect a generally held view of an accurate statistic or question.

Concurrent validity – do the measures or findings generated by the approach converge or diverge from those measures used in other generally accepted methods or findings generated by generally accepted methods.

The HMS approach combines both existing data and survey approaches as recommended by many needs assessment experts and is based primarily on concurrent validity concepts. The quantitative data from existing data sets is used to assess relative need by Allegan community – the major focus of the methodology. The HMS Associates methodology takes into consideration statistics on:

- Demographic characteristics of the community which influence the need for primary care services
- Health of pregnant women and infants,
- Health status of the community as measured by statistics on death rates
- Health service use rates

This approach results in a ranking of community by comparative need and is a type of assessment required by the federal government.

This study used two surveys:

- Individual open ended telephone interviews with 14 community leaders and
- An Internet survey of 47 different individual more broadly representative of the community.

Participants were identified through the Allegan County Health Department or Project Steering Committee.

The intent of this component of the needs assessment was to gather opinions and perceptions on needs which can be used to augment or inform project participants of the community's view of federally qualified health center service needs. This will also provide additional insights to the organization which pursues health center funding. The survey techniques are used to validate or provide insights on other types of needs not addressed in existing data sets.

Basically, the quantitative portion ranked communities based on statistical indicators of need thereby identifying those most in need of services in a manner most consistent with federal needs methodologies. The survey data is used to help the organization which sponsors the health center application target its programs at the most needy. Both the telephone and Internet survey results and the discussion by the commissioners seemed to relate to the importance of services for the mentally ill and coordination of care.

This information, as well as other information deemed important by the sponsoring agency, should be used by the sponsoring organization in designing the emphasis of its own unique health center programs. In other words, the survey finding is descriptive more so than prescriptive.

Coordination of Care

Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities. This is often managed by the exchange of information among participants responsible for different aspects of care.[2]

The practice often identifies patients with specific conditions, including high-risk or complex care needs and conditions related to health behaviors, mental health or substance abuse problems

Coordination of care management emphasizes:

- Pre-visit planning
- Assessing patient progress toward treatment goals
- Addressing patient barriers to treatment goals
- Reconciles patient medications at visits and post-hospitalization
- Electronic-prescribing

The practice assesses patient/family self-management abilities, works with patient/family to develop a self-care plan and provide tools and resources, including community resources and clinicians counsel patients on healthy behaviors.

The practice also tracks, follows-up on and coordinates tests, referrals and care at other facilities (e.g., hospitals) and especially follow-up with discharged patients.

[2] United States Department of Health and Human Services, 2007, Agency for Healthcare Research and Quality

Federally qualified health centers emphasize coordination of care as a means for improving health care outcomes and restraining unnecessary costs. Indeed there is a special demonstration program where health centers receive a fee per patient for care management within the context of a patient centered medical home.

Other Models

Michigan has a unique program for expanding access to oral health programs – preventive and restorative dental services - to people with low incomes. Michigan Community Dental Clinics, Inc. (MCDC) is a not-for-profit management services corporation, established in 2006, to allow the successful Dental Clinics North (DCN) model for delivery of public health dental services to expand to other areas of Michigan.[3]

Michigan Community Dental Clinics utilizes electronic patient records, digital radiography, state of the art dental equipment and compensation methods that encourage productivity, efficiency, and cost control. The result is a network of public health dental clinics that resemble private practice providing timely, much-needed services to a greater number of people. In addition, the financial model for the dental program is designed to break even so that the local Health Department does not have to provide support to the dental clinics.

The target populations served by the clinics are adults and children on Medicaid, as well as low income, uninsured individuals whose income is below 200% of the Federal poverty level. Non-Medicaid clients are offered a reduced fee schedule.

Surplus funds allow for the establishment of the Dental Assistance Fund which is used to supplement the cost of care on a sliding percentage, based upon an individual's income.

Michigan Community Dental Clinics assists local Health Departments establish dental clinics by:

1. Designing new clinic facilities or remodeling existing facilities.

2. Providing specifications for equipment and supplies needed to provide care.

3. Manage the clinic facilities by:

    a. Providing the electronic patient record, using the Dentrix Enterprise Software Program

    b. Billing Medicaid for services rendered

    c. Hiring all clinic personnel

    d. Providing direction for the operation of the clinic

4. Assisting local Health Departments with integration of oral health education and prevention programs and other local Health Department services.

[3] See: http://www.midental.org/about-us-25/

This program is in operation in St Johns, Charlotte, and Three Rivers, MI among other sites.

Federally qualified health centers must provide directly or through referral dental health services. The health center sponsor should consider this capacity as it details its' plans to meet the health center dental care requirement.

Financial Data

The financial feasibility of federally qualified health centers is defined by the health center's ability to generate funding which exceeds expenses. If funding is insufficient to cover expenses then the health center which bears the financial risk in its entirety is operating at a financial loss or deficit and its future is contingent on its ability to increase funding or decrease expenses.

The financial feasibility analysis for the federally health qualified center for the planning project, as noted in the presentation to the Commissioners in July, 2012, consequently had to start with the identification of the potential sponsor. The consultants have had several discussions with representatives of the Allegan Health Group, the preferred sponsor for health center development, throughout the past several months to examine this critical dimension and such discussions have been favorable. The final determination of financial liability rests with the Allegan Health Group and its financial agents. Aspects of the study which address financial planning are included in Report #3 – Operational Requirements.

It must be noted that should Allegan Health Group pursue designation as a federally qualified health center, the United States Department of Health and Human Services, Health Resources Services Administration, Bureau of Primary Health Care and the Centers for Medicare and Medicaid services will closely review its financial plan and approve the financial plan before the project can move forward.

The health center program was started in the 1960s as a key part of the War on Poverty and has received support from both sides of the aisle. Health centers can also qualify for many federal grant programs supporting services to the underserved.

"To date no other federal or state funding sources have been identified. However, Allegan General Hospital, the subsidiary of the applicant entity which has also participated as a steering committee member, is highly supportive of the concept of creating access to center services in the geographic area and has expressed a willingness to explore means to support the proposed applicant. The support could take the form of a Community Benefit Agreement and or providing some of the shared services discussed previously on an in-kind basis. Such relationships have occurred in several rural communities throughout the nation." Report #3 – Operational Requirements.

Allegan County Community Health Center Planning Project

Appendix 4 Behavioral Risk Factor Survey

August, 2012

HMS Associates
Getzville, NY

2008 - 2010								
	Allegan			Significance				
Question	Number	%	Confidence Interval (C.I.)	Michigan	CHAIR 7	CHAIR 6	CHAIR 5	CHAIR 4
Disability	287	15.7	(11.5-21.1)	Yes	0.50	0.65	Yes	0.74
Cigarette Smoking: Current Smoking	286	27.1	(20.9-34.3)	Yes	Yes	0.84	0.42	0.42
Cardiovascular Disease: Ever Told Any Cardiovascular Disease	285	5.6	(3.7-8.6)	Yes	-0.10	Yes	0.63	0.37
Angina or Coronary Heart Disease: Ever Told Angina or Coronary Heart Disease	285	2.6	(1.4-4.9)	0.83	0.04	0.87	0.22	0.43
Health Status: General Health, Fair or Poor	286	10.7	(7.2-15.5)	0.71	-0.25	0.73	0.69	0.27
Cigarette Smoking: Never Smoked	286	49.0	(41.9-56.1)	0.69	0.89	0.76	0.76	0.37
Colorectal Cancer Screening Among Adults 50 Years and Older: Had Sigmoidoscopy in Past 5 Years or Colonoscopy in Past 10 Years	112	71.8	(61.7-80.1)	0.61	-0.25	Yes	0.50	-0.31
Alcohol Consumption: Heavy Drinking	279	7.8	(4.5-13.1)	0.61	0.48	-0.12	0.67	0.15
Heart Attack: Ever Told Heart Attack	286	3.0	(1.6-5.4)	0.54	-0.21	0.63	0.38	0.17
Oral Health: Lost 6+ Teeth	192	10.7	(7.2-15.7)	0.52	0.11	0.98	0.22	-0.26
Poor Physical Health on at Least 14 Days in the Past Month	282	8.3	(5.6-12.2)	0.51	-0.21	0.28	0.33	-0.13
Health Care Access: No Personal Health Care Provider	285	9.0	(5.3-15.0)	0.48	-0.41	0.70	0.43	0.38
Seatbelt Use: Always Uses a Seatbelt	161	84.5	(74.5-91.0)	0.46	0.38	-0.37	0.20	0.03
Arthritis: Ever Told Arthritis	157	27.2	(20.2-35.6)	0.39	-0.31	0.01	0.11	-0.01
Asthma: Still Have Asthma	286	7.6	(4.5-12.7)	0.39	-0.10	-0.18	0.06	-0.12
Weight Status: Overweight	274	38.5	(31.7-45.9)	0.35	0.10	-0.18	0.19	0.04
Asthma: Ever Told Have Asthma	287	13.0	(8.8-18.8)	0.34	-0.17	-0.41	0.05	-0.21
Weight Status: Not Overweight or Obese	274	30.7	(24.5-37.7)	0.33	0.57	-0.09	0.37	-0.27
Immunizations Among Adults Aged 65 Years and Older: Had Flu Vaccine in Past Year	68	64.2	(51.0-75.5)	0.32	0.30	-0.37	0.10	0.25
Immunizations Among Adults Aged 65 Years and Older: Ever Had Pneumonia Vaccine	70	62.5	(49.2-74.2)	0.30	0.17	-0.26	0.29	0.15
Diabetes: Ever Told Diabetes	287	10.9	(7.0-16.8)	0.26	0.18	-0.36	-0.23	0.36
Activity Limitation on at Least 14 Days in the Past Month	283	5.5	(3.0-9.8)	0.26	-0.28	-0.02	0.14	-0.14
Cervical Cancer Screening Among Women Aged 18 Years and Older: Had Appropriately Timed Pap Test	110	82.4	(72.2-89.4)	0.21	-0.15	0.26	0.03	-0.15
Social and Emotional Support: Rarely or Never Receive Needed Social and Emotional Support	280	5.9	(3.2-10.6)	0.17	0.07	-0.32	-0.13	-0.28

Life Satisfaction: Dissatisfied or Very Dissatified	280	5.0	(2.3-10.4)	0.17	-0.30	-0.13	0.02	0.02
Cigarette Smoking: Former Smoking	286	23.9	(18.7-30.1)	0.16	-0.19	-0.48	-0.38	-0.46
Health Care Access: No Health Care Access During Past 12 Months Due to Cost	287	14.7	(9.8-21.6)	0.14	0.02	-0.41	-0.14	0.29
No Leisure-Time Physical Activity	287	25.8	(20.0-32.7)	0.14	0.48	-0.22	-0.36	-0.12
Drove Motor Vehicle After Drinking	161	1.5	(0.2-10.1)	0.09	0.00	-1.54	-0.03	-0.07
Oral Health: Dental Visit in Past Year	192	72.6	(64.0-79.8)	0.03	-0.03	-0.39	-0.23	-0.12
Breast Cancer Screening Among Women Age 40 and Older: Had Clinical Breast Exam and Mammogram in Past Year	91	56.2	(43.2-68.4)	0.02	-0.15	-0.11	-0.38	-0.25
Poor Mental Health on at Least 14 Days in the Past Month	283	11.2	(6.9-17.7)	-0.05	0.21	-0.35	-0.25	-0.35
No Health Care Coverage Among Those Aged 18-64 Years	310	15.4	(10.7-21.6)	-0.06	0.09	-0.43	-0.26	-0.02
Stroke: Ever Told Stroke	287	2.9	(1.6-5.4)	-0.08	0.15	-0.20	-0.69	-0.15
Weight Status: Obese	274	30.7	(24.4-37.8)	-0.08	0.16	-0.60	-0.35	-0.11
Alcohol Consumption: Binge Drinking	282	16.8	(12.0-23.1)	-0.10	-0.25	-0.54	-0.54	-0.13
No Routine Checkup in Past Year	281	32.3	(25.7-39.7)	-0.11	-0.27	-0.36	-0.26	-0.01
HIV Testing Among Adults Aged 18-64 Years: Ever Had an HIV Test	207	37.9	(30.5-45.9)	-0.12	0.11	-0.34	-0.50	-0.45

Values
Number indicates number of respondents that completed the question.
% equals percent of respondents that responded affirmatively
CI equals confidence interval range for significance (null hypothesis) at the .05 level.

Significance Columns
Yes means that Allegan value does not overlap with state or other CHAIR area.
Confidence Interval difference is significant at the .05 level.
When yes is not marked, the higher the number the greater potential for significant difference

Use caution when ascribing significant difference to numbers not marked with yes

Source of Data: Micihigan BRFSS
Source of Methodology: HMS Associates, Getzville, NY . All rights reserved. Not for distribution without written permission.
Preliminary. May 2012

MICHIGAN TOTAL		Community Health Assessment and Improvement Regions (CHAIR)							
		CHAIR 7		CHAIR 6		CHAIR 5		CHAIR 4	
%	C.I.	%	C.I.	%	C.I.	%	C.I.	%	C.I.
23.7	(23.0-24.3)	20.2	(18.4-22.1)	22.0	(19.2-25.1)	25.0	(22.2-28.0)	22.1	(19.7-24.7)
19.7	(19.0-20.4)	17.6	(15.7-19.7)	18.5	(15.5-21.9)	21.2	(18.2-24.5)	21.3	(18.5-24.5)
8.9	(8.6-9.3)	6.1	(5.3-7.1)	11.6	(9.5-14.0)	9.0	(7.5-10.8)	8.0	(6.7-9.5)
4.8	(4.5-5.1)	3.2	(2.7-3.9)	5.9	(4.6-7.5)	4.0	(3.1-5.1)	4.4	(3.6-5.5)
14.6	(14.1-15.2)	10.9	(9.5-12.4)	16.9	(14.2-20.1)	16.5	(14.0-19.4)	14.3	(12.0-17.0)
54.8	(53.9-55.6)	57.7	(55.3-60.2)	58.5	(54.4-62.6)	58.5	(54.4-62.6)	55.0	(51.6-58.3)
64.5	(63.4-65.6)	71.2	(67.8-74.3)	55.8	(49.9-61.4)	62.3	(57.6-66.8)	70.9	(66.5-74.9)
5.4	(5.0-5.8)	5.0	(4.0-6.2)	5.8	(4.1-8.2)	3.8	(2.5-5.6)	5.4	(3.9-7.3)
4.6	(4.3-4.9)	3.0	(2.5-3.7)	6.0	(4.5-8.0)	5.0	(3.9-6.3)	4.3	(3.4-5.5)
13.8	(13.3-14.4)	8.9	(7.7-10.3)	18.7	(15.6-22.3)	14.0	(11.8-16.6)	9.8	(8.2-11.6)
10.8	(10.3-11.3)	8.7	(7.5-10.1)	11.5	(9.4-13.9)	11.6	(9.6-13.9)	9.4	(7.8-11.5)
12.5	(11.9-13.2)	8.6	(7.1-10.5)	16.5	(13.2-20.4)	14.2	(11.6-17.2)	13.8	(11.3-16.9)
88.3	(87.5-89.0)	89.4	(87.0-91.4)	84.2	(79.2-88.2)	89.2	(85.8-91.9)	88.1	(84.7-90.8)
31.5	(30.5-32.5)	27.2	(24.6-29.8)	31.8	(27.3-36.8)	32.2	(28.1-36.6)	30.8	(27.1-34.7)
10.1	(9.6-10.6)	8.4	(7.1-9.9)	8.7	(6.7-11.4)	9.8	(7.9-12.1)	8.7	(7.0-10.8)
35.3	(34.5-36.1)	35.4	(33.0-37.8)	35.4	(31.3-39.7)	33.7	(30.3-37.2)	34.9	(31.8-38.2)
15.6	(15.0-16.2)	13.6	(12.0-15.5)	13.2	(10.6-16.3)	15.7	(13.3-18.4)	14.0	(11.8-16.7)
33.8	(33.0-34.6)	37.2	(34.7-39.8)	34.2	(30.1-38.5)	36.9	(33.3-40.6)	31.9	(28.8-35.2)
68.9	(67.8-70.0)	71.1	(67.6-74.4)	63.1	(56.7-69.1)	70.2	(65.3-74.6)	71.6	(67.0-75.8)
67.1	(66.0-68.3)	68.2	(64.5-71.6)	65.7	(59.4-71.4)	70.8	(65.9-75.2)	69.2	(64.3-73.7)
9.5	(9.1-9.9)	8.8	(7.7-10.2)	9.8	(7.8-12.3)	9.9	(8.3-11.8)	7.9	(6.6-9.5)
7.0	(6.6-7.4)	5.1	(4.2-6.2)	6.8	(5.4-8.6)	7.7	(6.1-9.8)	6.2	(4.9-7.9)
79.3	(78.2-80.3)	80.9	(77.5-83.9)	73.7	(66.8-79.7)	78.1	(73.3-82.1)	80.0	(75.4-83.9)
7.1	(6.7-7.6)	4.5	(3.5-5.7)	6.1	(4.4-8.6)	7.0	(5.3-9.3)	6.1	(4.6-8.0)

6.3	(5.9-6.8)	4.5	(3.5-5.8)	6.0	(4.3-8.4)	6.8	(5.1-9.1)	6.7	(5.1-8.8)
25.6	(24.9-26.2)	24.7	(22.7-26.7)	23.0	(20.0-26.4)	23.2	(20.6-25.9)	23.7	(21.3-26.3)
13.4	(12.8-14.0)	12.6	(10.9-14.6)	13.5	(10.8-16.7)	12.5	(10.1-15.4)	10.9	(8.9-13.3)
24.3	(23.6-25.0)	21.0	(19.2-23.0)	27.8	(24.3-31.6)	26.5	(23.3-29.9)	23.6	(21.0-26.5)
2.7	(2.3-3.0)	2.3	(1.5-3.5)	1.4	(0.5-3.5)	2.4	(1.2-4.9)	1.7	(0.9-3.2)
73.8	(72.8-74.7)	75.2	(72.4-77.9)	74.6	(69.8-78.8)	70.7	(66.4-74.6)	75.6	(71.7-79.1)
54.6	(53.4-55.9)	54.3	(50.4-58.1)	51.1	(44.5-57.6)	55.9	(50.5-61.1)	54.3	(49.2-59.4)
10.8	(10.3-11.4)	8.7	(7.4-10.3)	10.1	(8.0-12.7)	11.9	(9.6-14.6)	10.5	(8.6-12.7)
15.1	(14.5-15.7)	13.1	(11.4-15.0)	14.1	(11.3-17.4)	16.3	(13.8-19.1)	13.0	(10.8-15.5)
2.8	(2.6-3.0)	2.0	(1.6-2.7)	3.5	(2.4-5.1)	2.8	(2.0-3.8)	2.2	(1.6-3.1)
30.9	(30.1-31.6)	27.4	(25.2-29.7)	30.4	(26.6-34.5)	29.4	(26.2-32.9)	33.1	(29.9-36.5)
16.6	(15.9-17.3)	15.9	(14.0-18.0)	15.6	(12.5-19.4)	15.6	(12.5-19.4)	14.3	(11.9-17.4)
32.3	(31.5-33.1)	31.6	(29.3-34.1)	33.7	(29.6-38.2)	33.9	(30.4-37.6)	35.5	(32.2-38.9)
37.8	(36.9-38.8)	34.3	(31.6-37.1)	35.3	(30.5-40.4)	38.0	(33.9-42.3)	37.3	(33.6-41.2)

Health Center Site Visit Guide

For HRSA Grantees

OCTOBER 2011

The Health Center Site Visit Guide is a review instrument used by the Health Resources and Services Administration (HRSA) to assess an organization's compliance with key section 330 Health Center Program requirements as well as a resource to assist grantees in identifying areas for performance improvement. Health centers may also use this Guide as a self assessment resource as it provides a series of prompting questions to assess both program requirements and performance improvement areas.

The Bureau of Primary Health's (BPHC) user-friendly Technical Assistance (TA) website http://www.bphc.hrsa.gov/technicalassistance/index.html also provides a variety of resources that support both the program requirements and performance improvement areas outlined within this site visit guide. Resources include but are not limited to easy access to HRSA/BPHC policy documents, an organized listing of TA resources, training opportunities (webinars, meetings, conference calls, etc.) and links to the websites of BPHC Cooperative Agreement partners that provide training and TA for all health centers, assistance to health centers serving special populations (e.g., migrant and seasonal farmworkers, homeless, residents of public housing) or disadvantaged populations (e.g., LGBT, elderly), and assistance to health centers with specific services or needs (e.g., oral health, children in schools, capital development). **Please note that the BPHC TA website is continually updated as new TA opportunities arise, and health centers and consultants are encouraged to check the website frequently.**

In addition, BPHC's Technical Assistance contractor, Management Solutions Consulting Group, Inc. (MSCG) provides a Consultant Resource Center available at http://www.mscginc.com/Resources. The Resource Center is a repository of vetted sample documents shared by consultants, as well as publications from BPHC, NACHC, and other BPHC Cooperative Agreement partners. Documents are arranged categorically within the Resource Center and it is recommended that consultants use and share **only** these documents and publications with BPHC grantees. If there are other items consultants wish to add to the Resource Center, they must first be vetted before they can be used onsite via the process outlined in Resource Center. Please note that all documents that are not HRSA/BPHC publications and are found within the MSCG Consultant Resource Center were made possible by contract number HHSH232200864001C from the Health Resources and Services Administration (HRSA), Bureau of Primary Health Care. The contents of such documents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA.

We hope you find the Health Center Site Visit Guide a useful resource tool as we work together to improve the health of the Nation's underserved communities and vulnerable populations.

NOTE: The Health Center Site Visit Guide is updated annually. Therefore, please delete all previous versions of this guide that you may have downloaded and use only the most current version available on the BPHC website at http://www.bphc.hrsa.gov/policiesregulations/centerguide.html.

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SECTION II: SERVICES

No.	Title	Program Requirement	Page[^]
2	**Required and Additional Services**	Health center provides all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established written arrangements and referrals. **Note:** Health centers requesting funding to serve homeless individuals and their families must provide substance abuse services among their required services.	6
3	**Staffing**	Health center maintains a core staff as necessary to carry out all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established arrangements and referrals. Staff must be appropriately licensed, credentialed and privileged.	11
4	**Accessible Hours of Operation / Locations**	Health center provides services at times and locations that assure accessibility and meet the needs of the population to be served.	15
5	**After Hours Coverage**	Health center provides professional coverage during hours when the center is closed.	16
6	**Hospital Admitting Privileges and Continuum of Care**	Health center physicians have admitting privileges at one or more referral hospitals, or other such arrangement to ensure continuity of care. In cases where hospital arrangements (including admitting privileges and membership) are not possible, health center must firmly establish arrangements for hospitalization, discharge planning, and patient tracking.	17

[^] NOTE: To access the desired page, press the Control button on your keyboard and click on the applicable page number.

SECTION II: SERVICES			
No.	**Title**	**Program Requirement**	**Page^**
7	**Sliding Fee Discounts**	Health center has a system in place to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay. • This system must provide a full discount to individuals and families with annual incomes at or below 100% of the Federal poverty guidelines (only nominal fees may be charged) and for those with incomes between 100% and 200% of poverty, fees must be charged in accordance with a sliding discount policy based on family size and income.* • No discounts may be provided to patients with incomes over 200 % of the Federal poverty guidelines.*	18
8	**Quality Improvement / Assurance Plan**	Health center has an ongoing Quality Improvement/Quality Assurance (QI/QA) program that includes clinical services and management, and that maintains the confidentiality of patient records. The QI/QA program must include: • a clinical director whose focus of responsibility is to support the quality improvement/assurance program and the provision of high quality patient care;* • periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the health center; and such assessments shall: * ○ be conducted by physicians or by other licensed health professionals under the supervision of physicians;* ○ be based on the systematic collection and evaluation of patient records;* and ○ identify and document the necessity for change in the provision of services by the health center and result in the institution of such change, where indicated.*	21

SECTION III: MANAGEMENT AND FINANCE			
No.	**Title**	**Program Requirement**	**Page^**
9	**Key Management Staff**	Health center maintains a fully staffed health center management team as appropriate for the size and needs of the center. Prior review by HRSA of final candidates for Project Director/Executive Director/CEO position is required.	25
10	**Contractual/Affiliation Agreements**	Health center exercises appropriate oversight and authority over all contracted services, including assuring that any subrecipient(s) meets Health Center Program requirements.	26

SECTION III: MANAGEMENT AND FINANCE			
No.	**Title**	**Program Requirement**	**Page^**
11	**Collaborative Relationships**	Health center makes effort to establish and maintain collaborative relationships with other health care providers, including other health centers, in the service area of the center. The health center secures letter(s) of support from existing Federally Qualified Health Center(s) in the service area or provides an explanation for why such letter(s) of support cannot be obtained.	28
12	**Financial Management and Control Policies**	Health center maintains accounting and internal control systems appropriate to the size and complexity of the organization reflecting Generally Accepted Accounting Principles (GAAP) and separates functions appropriate to organizational size to safeguard assets and maintain financial stability. Health center assures an annual independent financial audit is performed in accordance with Federal audit requirements, including submission of a corrective action plan addressing all findings, questioned costs, reportable conditions, and material weaknesses cited in the Audit Report.	29
13	**Billing and Collections**	Health center has systems in place to maximize collections and reimbursement for its costs in providing health services, including written billing, credit and collection policies and procedures.	33
14	**Budget**	Health center has 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.	36
15	**Program Data Reporting Systems**	Health center has systems which accurately collect and organize data for program reporting and which support management decision making.	37
16	**Scope of Project**	Health center maintains its funded scope of project (sites, services, service area, target population, and providers), including any increases based on recent grant awards.	42

SECTION IV: GOVERNANCE			
No.	**Title**	**Program Requirement**	**Page^**
17	**Board Authority**	Health center governing board maintains appropriate authority to oversee the operations of the center, including: • holding monthly meetings; • approval of the health center grant application and budget; • selection/dismissal and performance evaluation of the health center CEO; • selection of services to be provided and the health center hours of operations; • measuring and evaluating the organization's progress in meeting its annual and long-term programmatic and financial goals and developing plans for the long-range viability of the organization by engaging in strategic planning, ongoing review of the organization's mission and bylaws, evaluating patient satisfaction, and monitoring organizational assets and performance;* and • establishment of general policies for the health center. **Note:** In the case of public centers (also referred to as public entities or agencies) with co-applicant governing boards, the public center is permitted to retain authority for establishing general policies (fiscal and personnel policies) for the health center **Note:** Upon a showing of good cause the Secretary may waive, for the length of the project period, the monthly meeting requirement in the case of a health center that receives a grant pursuant to subsection (g), (h), (i), or (p).	45
18	**Board Composition**	**Board Composition:** The health center governing board 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 in terms of demographic factors such as race, ethnicity, and sex. Specifically: • Governing board has at least 9 but no more than 25 members, as appropriate for the complexity of the organization.* • The remaining non-consumer members of the board shall be representative of the community in which the center's service area is located and shall be selected for their expertise in community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social service agencies within the community.* • No more than one half (50%) of the non-consumer board members may derive more than 10% of their annual income from the health care industry.* **Note:** Upon a showing of good cause the Secretary may waive, for the length of the project period, the patient majority requirement in the case of a health center that receives a grant pursuant to subsection (g), (h), (i), or (p).	49

SECTION IV: GOVERNANCE			
No.	**Title**	**Program Requirement**	**Page^**
19	**Conflict of Interest Policy**	Health center bylaws or written corporate board approved policy include provisions that prohibit conflict of interest by board members, employees, consultants, and those who furnish goods or services to the health center. • No board member shall be an employee of the health center or an immediate family member of an employee. The Chief Executive Officer may serve only as a non-voting ex-officio member of the board.*	53

NOTE: Portions of program requirements notated by an asterisk "*" indicate regulatory requirements that are recommended ***but not required*** for grantees that receive funds solely for Health Care for the Homeless (section 330(h)) and/or the Public Housing Primary Care (section 330(i)) Programs.

APPENDICES		
Appendix		**Page**
A	Cross-Cutting Reference Documents and Websites	55
B	Optional Program Requirement/Performance Improvement Summary Grid	56
C	Health Center Performance Measures	57
D	Capital and Other Grant Progress Review	65

SUMMARY OF UPDATES TO HEALTH CENTER SITE VISIT GUIDE		
Please note—the following key changes have been made to the Health Center Site Visit Guide in accordance with updates and clarifications of the Health Center Program Requirements, HRSA/BPHC policy, and the Health Center Required Performance Measures. **In general, throughout the Site Visit Guide, portions of all Requirement and Performance Improvement prompting questions and Appendices have been expanded, updated and/or clarified, therefore users of the Site Visit Guide are reminded to delete/discard all previous versions and use only this most current version.**		
Section	**Requirement**	**Change**
II. Services	Staffing Requirement	The language in the last sentence of this program requirement has been clarified to state that "Staff must be appropriately licensed, credentialed and privileged." The related statutory references have also been expanded. Program requirement prompting questions have been updated and expanded to reflect this change as well.
	Sliding Fee Discounts	Slight grammatical corrections as well as consistent references to the "Federal poverty guidelines" have been made to the language of this requirement. Program requirement and performance improvement prompting questions have been clarified and expanded as well.
III. Management and Finance	Program Data Reporting Systems	The uniform clinical and financial performance measures reported through the UDS and included within the health center's new or continuation application, continue to provide grantees with the opportunity to establish quality and performance goals for their organization and patient populations and demonstrate progress against these goals. As noted in last year's Site Visit Guide, building off these performance measures, consultants will: • Assess the health center's capacity to accurately collect and organize data for program reporting and support management decision making from a compliance standpoint. • Assess the grantee's progress in terms of performance improvement on the selected required Clinical and Financial Performance measures. Consultants MUST continue to identify one to two required measures to analyze during the site visit (see Appendix C for complete list of required measures, including the NEW and REVISED measures that will be reported on beginning with 2011 UDS data collection).
	Contractual/Affiliation Agreements	Performance Improvement prompting questions have been added for this program requirement as none were provided previously.

<table>
<tr><th colspan="3">SUMMARY OF UPDATES TO HEALTH CENTER SITE VISIT GUIDE</th></tr>
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<tr><th>Section</th><th>Requirement</th><th>Change</th></tr>
<tr><td>IV. Governance</td><td>Conflict of Interest</td><td>The language of this program requirement has been corrected to state that “The Chief Executive may serve only as <u>a non-voting</u> ex-officio member of the board. The term “non-voting” had been omitted in error in previous versions.</td></tr>
<tr><td>Appendix B</td><td colspan="2">The former Appendix B “Recommended Reference Documents” has been eliminated (Appendix B is now the “Optional Program Requirement/Performance Improvement Summary Grid”).
Instead, key HRSA/BPHC and/or other Federal policies, reference documents or online resources related to each of the 19 Program Requirement and/or Performance Improvement Areas have been incorporated into the “Documents/Resources to Review” list which appears above each of the Program Requirement or Performance Improvement Areas as applicable.
Consultants and/or health centers are encouraged to utilize the BPHC TA website and MSCG Consultant Resource Center to access additional documents or resources beyond those noted in the Site Visit Guide as needed.</td></tr>
<tr><td>Appendix C</td><td colspan="2">The summary and detail of Appendix C: Health Center Program’s Performance Measures has been updated to reflect calendar year 2011 HRSA/BPHC Uniform Data System (UDS) reporting requirements which will include several new as well as revised clinical performance measures.
The new clinical measures which focus on adult weight screening and follow up, weight assessment and counseling for children and adolescents, tobacco use and cessation, and asthma pharmacologic therapy, were selected because they are highly relevant to patients served by health centers.
The new and revised measures are aligned with the U.S. Department of Health and Human Service’s meaningful use measures that eligible providers will report on starting in 2011. (described in the Medicare and Medicaid EHR Incentive Program Final Rule dated July 28, 2010).</td></tr>
</table>

SUMMARY OF UPDATES TO HEALTH CENTER SITE VISIT GUIDE		
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Section	**Requirement**	**Change**
Appendix D	Appendix D, formerly titled "Appendix E: American Recovery and Reinvestment Act (ARRA) Grant Progress Review" has been updated and expanded to include guidance on reviewing capital and other grant activities related to both ARRA and the Patient Protection and Affordable Care Act (ACA). As a requirement of ARRA and ACA funding, health centers must report on their progress on creating or retaining jobs, increasing new patients and visits, and completing capital improvement projects as a result of each award as appropriate. Consultants will use this supplement to review progress on implementing ARRA and ACA grant funded activities, document contributing or restricting factors to progress **(including touring and photographing visual progress as appropriate)** and identify TA needs as necessary.	

New Start Site Visit Note to Consultants

For New Starts (organizations receiving Federal section 330 support for the first time), which may or may not have been operating a primary care clinic prior to grant award, it is HRSA's expectation that full operational capacity, in terms of the projected staffing, sites, services and patient levels presented in the New Access Point application, will be achieved within 2 years of receiving Federal section 330 support and that the third year of funding will represent the project at full operational capacity for a 12-month period of time. Full operational capacity for a center should be determined using the projected provider levels required by the center to operate at its full level of services (i.e., at the full-range of services required by section 330 statute, regulations, and Health Center Program Requirements).

While the 19 requirements included in this guide apply to all health centers (existing grantees and New Starts), throughout their review consultants are requested to pay particular attention to the specific compliance and performance improvement status and technical assistance needs of New Start organizations that may be providing primary care services for the first time.

SECTION I: Need

Program Requirement 1: NEEDS ASSESSMENT

1.A Program Requirement

Authority: Section 330(k)(2) and Section 330(k)(3)(J) of the PHS Act)
Documents/Resources to Review: 1) Most recent Needs Assessment(s); 2) Service Area Map.

Requirements	Questions	Yes/No
Health center has a documented assessment of the needs of its target population, and has updated its service area when appropriate.	Does the grantee have a written needs assessment?	
	Does the grantee have a clearly defined service area?	

1.B Performance Improvement

Additional Documents/Resources to Review: 1) HRSA/BPHC Service Area Overlap Policy Information Notice 2007-09 (for site visits with service area overlap concerns); 2) UDS Mapper tool, available online (requires login) at http://www.udsmapper.org; 3) HRSA Geospatial Data Warehouse.

	Prompting Questions for Performance Improvement Discussions	Response
1	Is the needs assessment comprehensive in terms of encompassing the entire service area and/or target population(s)? If not, should it be modified or expanded?	
2	When was the last needs assessment completed or updated?	
3	Has the grantee updated their service area based on recent data (e.g., annual patient origin data)? If not, is this recommended?	
4	If updated, was the assessment reviewed and approved by the Board? If yes, when?	
5	What priority needs were identified?	
6	What action(s) was taken to address them?	
7	Does the grantee's defined service area take into account geographic, demographic and/or other relevant factors?	
8	Are there any concerns or issues around service area overlap?	

SECTION II: Services

Program Requirement 2: REQUIRED AND ADDITIONAL SERVICES

2.A Program Requirement

Authority: Sections 330(a) and 330(h)(2) of the PHS Act

*Documents/Resources to Review:*1) Clinical Practice Protocols and related Operating Policies and Procedures; 2) Documentation of services provided via formal written agreements and/or via formal written referral arrangements; 3) Health center's official scope of project for services (EHB BHCMIS Form 5A); 4) HRSA/BPHC Scope of Project Policies; 5) HRSA/BPHC HIV/AIDS Testing, Care and Treatment Program Assistance Letters.

Requirements	Questions	Response
Health center provides all required primary, preventive, and enabling health services (defined in section 330(b)(1)(A) of the PHS Act) and provide additional health services (defined in section 330(b)(2)) as appropriate and necessary, either directly or through established written arrangements and referrals. ***Note:*** Grantees that receive (section 330(h)) funding to serve homeless individuals and their families must provide substance abuse services among their required services.	Please indicate if the services are provided:	
	• Directly by the grantee (**D**)	
	• By formal written agreement (**A**) (grantee pays/bills)	
	• By formal (**F**) written referral arrangement (grantee does not pay/bill but maintains responsibility for the patient's treatment plan and will be providing and/or paying/billing for appropriate follow-up care based on the outcome of the referral)	
	• By informal (**I**) referral (grantee does not pay)—**Informal referral arrangements <u>are not</u> acceptable for the provision of a required service, nor are they included in the scope of project.**	
Required health center services include:	• Not provided (**N**)	

	Clinical Services	Response
1	General Primary Medical Care	
2	Diagnostic Laboratory	
3	Diagnostic X-Ray	
4	Screenings	
4.a.	Cancer	
4.b.	Communicable diseases	
4.c.	Cholesterol	

Requirements		Response
4.d.	Blood lead test for elevated blood lead level	
4.e.	Pediatric vision, hearing, and dental	
5	Emergency Medical Services	
6	Voluntary Family Planning	
7	Immunizations	
8	Well Child Services	
9	Gynecological Care	
10	Obstetrical Care	
11	Prenatal and Perinatal Services	
12	Preventive Dental	
13	Referral to Mental Health *(Grantee does not pay for the services) Note:* All health centers are required to provide mental health services at minimum, by formal referral arrangement(s). However, if they choose to do so, centers may also provide these services directly or via formal written agreements as Additional (Optional) Services.	F
14	Referral to Substance Abuse *(Grantee does not pay for the services)) Note:* All health centers are required to provide substance abuse services at minimum, by formal referral arrangement(s). However, if they choose to do so, centers may also provide these services directly or via formal written agreements as Additional (Optional) Services.	F
15	Referral to Specialty Services *(Grantee does not pay for the services)*	F
16	Pharmacy	
17	Substance Abuse services *(Required only for grantees receiving funding for Health Care for the Homeless; optional for other grantees)*	
17.a.	Detoxification	
17.b.	Outpatient treatment	
17.c.	Residential treatment	
17.d.	Rehabilitation (non hospital settings)	
Non-Clinical Services		
1	Case Management	
1.a.	Counseling/Assessment	

Requirements		Questions	Response
1.b.	Referral		
1.c.	Follow-up/Discharge Planning		
1.d.	Eligibility Assistance		
2	Health Education		
3	Outreach		
4	Transportation		
5	Translation *(Required for grantees serving a substantial number of patients with limited English proficiency)*: For grantees providing translation services:		**Yes/No**
	a	Does the type of interpretation/translation service(s) provided appear to be appropriate for the size/needs of the grantee (e.g., bilingual providers, onsite interpreter, language telephone line)?	
	b	Are the Registration Form, Sliding Fee Scale, After Hours contact instructions and other pertinent documents or messages provided to patients in the appropriate languages?	
6	Substance Abuse related Harm/Risk Reduction services—e.g., educational materials, nicotine gum/patches. (Required only for grantees receiving funding for Health Care for the Homeless; optional for other grantees.)		
I	**For all required services (listed above), provided by an outside organization/provider, either through a formal written agreement or a formal written referral arrangement:**		**Yes/No**
	a	For services provided via formal written agreement(s), does the written agreement (e.g., MOA, MOU, contract) in place between the health center and outside organization/provider describe: • how the service will be documented in the patient record? • how the grantee will pay and/or bill for the service? • how the grantee's policies and procedures including the applicability of a sliding fee discount schedule?	
	b	For services provided via formal written referral arrangements: • An MOU, MOA, or other formal agreement exists that at minimum describes the manner by which the referral will be made and managed, and the process for referring patients back to the center for appropriate follow-up care. • The referred service (no necessarily via the same provider) is available equally to all health center patients, regardless of ability to pay. • The referred service is available on a sliding fee discount schedule for all health center patients. • Tracking and follow-up care for referred patients is provided by the health center.	
	c	Has the license of the outside provider been verified?	
	d	Has the certification of the lead provider been verified?	
II	Are all Required Services listed in scope provided on a sliding fee discount schedule?		

2.B Performance Improvement

Additional Documents/Resources to Review: 1) HRSA Culture, Language and Health Literacy Resources; 2) HRSA Clinical Resources; 3) HRSA Office of Pharmacy Affairs Resources; 4) HRSA/BPHC Special Populations PINs and PALs.

Prompting Questions for Performance Improvement Discussions		Response
Which of the following Additional (optional) services does the grantee provide? Indicate how they are provided:		
•	Directly by the grantee (**D**)	
•	By formal written agreement (**A**) (grantee pays/bills)	
•	By formal (**F**) written referral arrangement (grantee does not pay/bill but maintains responsibility for the patient's treatment plan and will be providing and/or paying/billing for appropriate follow-up care based on the outcome of the referral)	
•	By informal (**I**) referral (grantee does not pay. Grantee refers a patient to another provider who is responsible for the treatment plan and billing for the services provided and no grant funds are used to pay for the care provided. In addition, in such informal arrangement, the other provider is not required to refer patients back to the grantee for appropriate follow-up care. Informal referral arrangements are not included in the official scope of project).	
•	Not provided (**N**)	
Clinical Services		
1	Urgent Medical Care	
2	Dental Services:	
2.a.	Restorative	
2.b.	Emergency	
3	Behavioral Health Services:	
3.a.	Treatment/Counseling	
3.b.	Developmental Screening	
3.c.	24-Hour Crisis	
4	Substance Abuse Services	
5	Comprehensive Eye Exams and Vision Services	
6	Recuperative Care	
7	Environmental Health Services	

Prompting Questions for Performance Improvement Discussions			Response
8	Occupational-Related Health Services *(generally applies to grantees serving migrant and seasonal farmworkers):*		
8.a.	Screening for Infectious Diseases		
8.b.	Injury Prevention Programs		
9	Occupational Therapy		
10	Physical Therapy		
11	Podiatry		
12	Rehabilitation (Non-Hospital Settings)		
13	Specialty Service (Specify)		
14	Other Service (Specify)		
Non-Clinical Services			
1	WIC		
2	Nutrition (not WIC)		
3	Child Care		
4	Housing Assistance		
5	Employment and Education Counseling		
6	Food Bank/Meals		
7	Other (Specify)		
I	Are all Additional Services listed in scope provided on a sliding fee discount schedule?		
II	Regarding cultural competency:		
	a	Are there cultural competency training opportunities for the staff?	
	b	If yes, how frequently are these trainings offered? If no, are there plans to establish these trainings?	
	c	Are the following employees bilingual: Operator, Front Desk staff, Cashier?	
III	If the health center provides on-site emergency services:		**Yes/No**
	a	Is a crash cart on site?	
	b	If yes, is content-compliance monitoring documented?	

Prompting Questions for Performance Improvement Discussions			Response
	c	Does the grantee have written protocols for "in-house" emergency care?	
	d	Is the staff adequately trained and currently certified in emergency procedures?	
	e	Do procedures exist for the orderly transfer of patient to the hospital via EMS?	
IV	Is the grantee's pharmacy provider:		**Yes/No**
	a	Located in-house or off-site?	
	b	If off-site, is it owned by the grantee?	
	c	A participant in the Federal Drug Pricing (340B) program?	
V	If the grantee provides pharmacy services either on-site or through an off-site provider that it owns or manages:		**Yes/No**
	a	Has a clinical committee established a formulary to ensure cost-effective prescribing?	
	b	Is there a policy regarding acceptance, stocking, logging, and recording of dispensed sample medications?	
VI	Regarding specialty services:		
	a	What is the level of specialist availability for referrals?	
	b	Are there written procedures and tracking mechanisms in place for specialty referrals?	
	c	Is there a system for following-up on missed specialty care appointments?	
	d.	If the grantee provides any specialty services directly, are these services clearly recorded in the scope of project?	

SECTION II: Services

Program Requirement 3: STAFFING

3.A Program Requirement

Authority: Section 330(a)(1), (b)(1)-(2), (k)(3)(C), and (k)(3)(I) of the PHS Act

Documents/Resources to Review: 1) Staffing Profile; 2*)* Provider Contracts, Agreements, and any Subrecipient Arrangements related to staffing (as applicable); 3) Credentialing and Privileging Policies and Procedures; 4) HRSA/BPHC Credentialing Policies (Policy Information Notices 2002-22 and 2001-16).

Requirements	Questions	Yes/No
Health center maintains a core staff as necessary to carry out all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established arrangements and referrals. Staff must be appropriately licensed, credentialed and privileged.	Is the core staff, (those responsible for carrying out both clinical and non-clinical services) appropriate for serving the patient population in terms of size and composition?	
	Are all health center providers appropriately credentialed to perform the activities and procedures detailed within the health center's approved scope of project? *Appropriate documentation must include written confirmation of credentialing (i.e., primary source verification of provider licensure, registration, or certification) for all licensed or certified health center practitioners, employed or contracted, volunteers and locum tenens, currently providing services at all health center sites.*	
	Are the health center's credentialing and privileging policies and procedures adequate so as to assure that all health center providers are/will be appropriately licensed, credentialed and privileged to perform the activities and procedures detailed within the health center's approved scope of project? *These policies and procedures must address credentialing and privileging for all licensed or certified health center practitioners, employed or contracted, volunteers and locum tenens, currently providing services at the health center and its sites.*	

3.B Performance Improvement

Additional Documents/Resources to Review: 1) Personnel Manual; 2) Personnel Files Checklist/Matrix; 3) Position descriptions; 4) Staff evaluation forms; 5) Provider contracts; 6) Orientation guide for new staff; 7) Employee satisfaction surveys; 8) HRSA Workforce and National Health Service Corps Resources

Prompting Questions for Performance Improvement Discussions			Response
1	Budgeted vs. actual staffing levels		
	a	What is the budgeted FTE provider staffing for the current calendar year?	
	b	What is the actual FTE provider staffing?	
	c	What is the budgeted FTE administrative staff for the current calendar year?	
	d	What is the actual FTE administrative staff?	
2	Personnel Policies / Employee Handbook		

Prompting Questions for Performance Improvement Discussions			Response
	a	Does the center have a personnel manual?	
	b	When was it most recently approved by the Board?	
	c	Does each new employee receive a copy of the personnel manual?	
	d	Do employees receive policy updates as available?	
3	Personnel Files		
	a	Are personnel files maintained in a secure location with restricted access?	
	b	Are there rules on accessing and releasing information from personnel files?	
	c	Is access to the files recorded?	
	d	Is there a standard format for non-clinical personnel files, for clinical personnel files, and for terminated personnel files?	
	e	Are personnel's medical files maintained in location separate from patient medical records?	
4	Position Descriptions (PDs)		
	a	Are PDs maintained in a central location?	
	b	Are PDs written for all categories of staff?	
	c	Do all PDs have a standard format?	
5	Job Descriptions		
	a	Do employees have a current job description?	
	b	Have employees signed their job description?	
	c	Are employees' jobs consistent with their descriptions?	
6	Performance Evaluations		
	a	Are evaluations conducted at least annually?	
	b	Is there a standard form used for evaluations?	
	c	Do the employees sign the evaluations?	
	d	Do the supervisors sign the evaluations?	
	e	Do the evaluations include a place for employee comments?	
	f	Is there an employee appeal and/or grievance process?	
7	Clinical Staff		
	a	Is a provider with training in pediatrics available to see patients during all normal operating hours?	

		Prompting Questions for Performance Improvement Discussions	Response
	b	Is a provider with training in OB/Gyn available to see patients during all normal operating hours?	
	c	Is a provider with training in adult primary care available to see patients during all normal operating hours?	
	d	Are clinical staff being hired in a timely manner?	
	e	Is there adequate leave and funding for continuing professional education?	
	f	Is there a provider recruitment and retention plan in place, if not does provider recruitment and retention need to be addressed?	
	g	Are QI/QA/CQI responsibilities included in medical staff members' job descriptions?	
8	Provider Credentialing and Privileging		
	a	Is there a formal provider credentialing and privileging process (for insurance companies and other third-party payors as well as clinical privileges)?	
	b	Has the Board approved this process?	
	c	Are providers required to complete the privileging process before starting to see patients?	
9	Do employment contracts address:		
	a	Contract length?	
	b	On-call requirements?	
	c	Cross coverage requirements?	
	d	Compensation and incentives?	
	e	Continuing education?	
	f	Moonlighting?	
	g	Conflict of Interest and Non-compete provisions?	
	h	Malpractice coverage?	
	i	Provider expectations (number of patients to see, etc.)	
10	Is there a standardized orientation for new employees?		
11	Is there a standard format for agendas and minutes from staff meetings?		
12	Employee Satisfaction Surveys		
	a	Does the center conduct employee satisfaction surveys?	
	b	If yes, how does the center respond to information gained from the surveys?	

SECTION II: Services

Program Requirement 4: ACCESSIBLE HOURS OF OPERATION / LOCATIONS

4.A Program Requirement

Authority: Section 330(k)(3)(A) of the PHS Act

Documents/Resources to Review: 1) Hours of Operation; 2) Most recent EHB BHCMIS Form 5B: Service Sites [*Note that the form lists only the TOTAL number of hours per week each site is open, not the specific schedule;* 3) Service Area Map with site locations noted; 4) HRSA/BPHC Scope of Project Policies.

Requirements	Questions	Yes/No
Health center provides services at times that assure accessibility and meet the needs of the population to be served.	Are the times that services are provided appropriate to ensure access for the population to be served?	
Health center provides services at locations that assure accessibility and meet the needs of the population to be served.	Is the location(s) at which services are provided accessible to the population to be served? **Note:** Health centers that receive targeted funding for Public Housing Primary Care (PHPC) should be able to document that service sites are immediately accessible to the targeted public housing communities.	

4.B Performance Improvement

Additional Documents/Resources to Review: Most recent EHB BHCMIS Form 5C: Other Activities/Locations

	Prompting Questions for Performance Improvement Discussions	Response
1	Are there additional times that the grantee could be open that would increase accessibility for the population to be served?	
2	Are the hours of operation posted in the appropriate languages for the population(s) served?	
3	Is the internal/external signage (including exit signs) clear, properly placed, and sufficient in number?	
4	Is the size of the facility adequate for the population to be served?	

SECTION II: Services

Program Requirement 5: AFTER HOURS COVERAGE

5.A Program Requirement

Authority: Section 330(k)(3)(A) of the PHS Act

Documents/Resources to Review: 1) Health center's policies and procedures and/or agreements for after-hours coverage; 2) HRSA/BPHC Health Center Collaboration Program Assistance Letter 2011-02.

Requirements	Questions	Yes/No
Health center provides professional coverage during hours when the center is closed.	Is professional coverage for medical emergencies available to health center patients after the center's regularly scheduled hours through clearly defined arrangements?	

5.B Performance Improvement

	Prompting Questions for Performance Improvement Discussions	Response
1	What specific mechanisms/arrangements does the health center have for after hours coverage (e.g., does it include the health center clinicians, does it use other community clinicians)?	
2	Do all patients receive a written or verbal explanation regarding the procedures for accessing emergency medical/dental care after hours?	
3	Does the general phone system provide information on how to access emergency care after hours?	
4	Is any written information about accessing care after hours provided in the appropriate languages/literacy levels of the health center's patient population?	
5	Is the answering service and/or provider able to communicate in the appropriate languages to serve the population?	
6	Does the coverage system have established mechanisms for patients needing care to be seen in an appropriate location and assure timely follow-up by health center clinicians for patients seen after-hours?	

SECTION II: Services

Program Requirement 6: HOSPITAL ADMITTING PRIVILEGES AND CONTINUUM OF CARE

6.A Program Requirement

Authority: Section 330(k)(3)(L) of the PHS Act

Documents/Resources to Review: 1) Hospital Admitting Privileges Agreements/Documentation; 2) Most recent EHB BHCMIS Form 5C: Other Activities/Locations (hospitals where health center providers have admitting privileges should be noted on the form); 3) HRSA/BPHC Health Center Collaboration Program Assistance Letter 2011-02.

Requirements	Questions	Yes/No
Health center physicians have admitting privileges at one or more referral hospitals, or other such arrangement to ensure continuity of care. In cases where hospital arrangements (including admitting privileges and membership) are not possible, the health center must firmly establish arrangements for hospitalization, discharge planning, and patient tracking.	Do the health center's physicians admit and follow hospitalized patients?	
	If not, is there a formal, written agreement outlining arrangements for:	
	• Hospitalization?	
	• Discharge planning?	
	• Patient tracking?	

6.B Performance Improvement

		Prompting Questions for Performance Improvement Discussions	Response
1		Do the formal written agreements with the hospital(s) address:	
	a	Compensation for services rendered?	
	b	Admission notification?	
	c	Discharge follow-up?	
	d	Exchange of information?	
2		How is continuum of care ensured for homeless and/or migrant/seasonal farmworker patients?	
3		When health center physicians do not follow patients in the hospital, how is continuity of care ensured?	

SECTION II: Services

Program Requirement 7: SLIDING FEE DISCOUNTS

7.A Program Requirement

Authority: Section 330(k)(3)(G) of the PHS Act and 42 CFR Part 51c.303(f)

Documents/Resources to Review: 1) Schedule of Fees/Charges for all services in scope; 2) Sliding Fee Discount Schedule/Schedule of Discounts (often referred to as the "sliding fee scale"); 3) Implementing policies and procedures for Sliding Fee Discount Schedule; 4) Sliding fee signage and/or notification methods; 5) Most recent Federal Poverty Guidelines; 6) HRSA/BPHC Scope of Project Policies.

NOTE: Portions of program requirements notated by an asterisk "*" indicate regulatory requirements that are recommended ***but not required*** for grantees that receive funds solely for Health Care for the Homeless (section 330(h)) and/or the Public Housing Primary Care (section 330(i)) Programs.

Requirements		Questions	Yes/No
1	Health center must assure that no patient will be denied services due to their inability to pay for such services.	Are all health center patients provided services regardless of ability to pay?	
		Does the health center have an established sliding fee discount schedule(s)?	
		Are there signs in the lobby and at the front desk or other mechanisms for communicating the availability of the sliding fee discount schedule for eligible low-income patients?	
2	Health center has a system in place to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay. Under this system:	Does the health center's schedule of fees and corresponding sliding fee discount schedule(s) cover the cost of all services (i.e., medical, dental, mental health, etc.) within the approved scope of project?	
		Is the sliding fee discount schedule(s) based on a schedule of fees or payments that is consistent with locally prevailing rates or charges and designed to cover the reasonable costs of operation?	
		Does the health center have written board approved policies and implementing procedures that support the sliding fee discount schedule program and which assure that it is applied equally to all eligible patients?	
		Is the sliding fee discount schedule based on the most recent Federal Poverty Guidelines?	

Requirements			Questions	Yes/No
3	a	Individuals and families with annual incomes at or below 100% of the Federal poverty guidelines must receive a full discount. (Only nominal fees may be charged.)*	Do individuals and families at or below 100% of the Federal poverty guidelines receive a full discount, other than perhaps nominal fees?	
	b	Individuals and families with incomes between 100% and 200% of the Federal poverty guidelines must be charged a fee in accordance with a sliding discount policy based on family size and income.*	Are individuals and families between 100% and 200% of the Federal poverty guidelines charged a fee (partial discount) according to a sliding fee discount schedule(s) based on family size and income?	
	c	Individuals and families with incomes over 200% of the Federal poverty guidelines may not receive discounts.*	Are individuals and families above 200% of the Federal poverty guidelines charged a non-discounted rate?	

7.B Performance Improvement

Additional Documents/Resources to Review: 1) Sliding Fee Application Form/Eligibility Criteria; 2) Self-Declaration Form (if applicable); 3) Payment agreement form (if applicable).

Prompting Questions for Performance Improvement Discussions			Response
1	Are the following items available in languages and/or literacy levels appropriate to the patient population?		
	a	Signs in the lobby and the cashier's desk announcing the availability of discounts?	
	b	Description of the how the sliding fee discount schedule (SFDS) works?	
2	Are all patients evaluated during registration to determine eligibility for insurance and/or related third party coverage and assisted with applying for such coverage, as appropriate, prior to and/or as part of determining their eligibility for the sliding fee discount?		
3	If the health center charges a nominal fee to individuals below 100% of poverty, is the fee reasonable and aligned with program goals?		
4	Is the health center’s schedule of fees/payments and corresponding SFDS and any nominal fees, reviewed and updated on an annual or other regular basis as appropriate? Note that at minimum, the SFDS must be revised annually to reflect annual updates to the Federal Poverty Guidelines.		
5	To apply for the SFDS, the patients are required to complete an application form that:		
	a	Requests their name?	
	b	Reflects or requires documentation of family size?	

Prompting Questions for Performance Improvement Discussions			Response
	c	Lists all forms of income as defined in the related board approved SFDS policy(ies)?	
	d	Includes a statement about the consequences of providing false information?	
	e	Requires the patient's signature?	
	f	Requires a staff person's verification and signature?	
	g	If the grantee serves a substantial number of patients with limited English proficiency or low literacy levels, is the SFDS form explained verbally and/or in the appropriate language?	
	h	If the health center serves special populations with unique characteristics and needs (e.g., homeless, migrant/seasonal farmworkers) are eligibility and documentation requirements appropriate for these populations?	
6	For services the health center provides via a formal written referral arrangement where the health center does not pay (i.e., Form 5A, Column III), does the agreement between the health center and the referral provider include conditions which require that the service is available to all health center patients regardless of their ability to pay and offered on a SFDS? Is the health center afforded an opportunity to review the outside provider's sliding fee discount schedule?		
7	Does the center provide medically related supplies or equipment (e.g., dentures, durable medical equipment, etc.) that are directly tied to the provision of a particular health center service, but are not typically included within the service charge, on some type of sliding fee discount schedule?		
8	Does the health center utilize more than two or three separate sliding fee discount schedules (e.g., primary care, dental, behavioral health)? If so, are these multiple SFDSs routinely evaluated to ensure that they do not inadvertently create a barrier to care?		
9	Are billing and collections for amounts owed based on the sliding fee discount schedule, conducted in an efficient, respectful and culturally appropriate manner to assure that administrative procedures do not themselves present a barrier to care, and that patient privacy and confidentiality is protected throughout the process?		

SECTION II: Services

Program Requirement 8: QUALITY IMPROVEMENT / ASSURANCE PLAN

8.A Program Requirement

Authority: Section 330(k)(3)(C) of the PHS Act, 45 CFR Part 74.25 (c)(2), (3) and 42 CFR Part 51c.303(c)(1-2)
Documents/Resources to Review: 1) Quality Improvement /Quality Assurance (QI/QA) plan and related policies and procedures (including Incident Reporting System and Risk Management Policies); 2) Clinical Director's job description; 3) HIPAA-Compliant Patient Confidentiality Policies and Procedures; 4) Clinical Care Policies and Procedures; 5) Clinical Information Tracking Policies and Procedures; 6) HRSA/BPHC Federal Tort Claims Act (FTCA) Health Center Policy Manual (if applicable).

NOTE: Portions of program requirements notated by an asterisk "*" indicate regulatory requirements that are recommended ***but not required*** for grantees that receive funds solely for Health Care for the Homeless (section 330(h)) and/or the Public Housing Primary Care (section 330(i)) Programs.

		Requirements	Questions	Yes/No
1	Health center has an ongoing Quality Improvement/ Quality Assurance (QI/QA) program that:		Does the health center's QI/QA program:	
	a	Includes clinical services and management.	Address both clinical services and management (inclusive of all services in scope e.g., primary care, dental, behavioral health, etc.)?	
	b	Maintains the confidentiality of patient records.	b.1. Maintain a clinical record for every patient receiving ongoing care at the health center?	
			b.2. Ensure that medical records are properly secured during times when the medical record staff is not present?	
			b.3. Include procedures to enable patients to give consent for release of medical record information?	
			b.4. Include appropriate procedures for signing-out patient records?	
			b.5. Include a follow-up procedure to pursue unreturned medical records?	
	c	Includes a **clinical director** whose focus of responsibility is to support the QI/QA program and the provision of high quality patient care.*	c.1. Have a clinical director? *Note: clinical directors may be full or part time staff and should have appropriate training/background (e.g., MD, RN, MPH, etc.) as determined by the needs/size of the health center.*	

Requirements			Questions	Yes/No
			c.2. Have a clinical director with clear primary responsibility for carrying out the QI/QA program across the health center, including working with other individual(s) or committee(s) as appropriate?	
	d	Includes periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the health center.*	Include periodic assessments of the appropriateness of both the utilization and quality of services?	
2	These assessments (see d, above) shall:		Are these assessments (see d., above):	
	a	Be conducted by physicians or by other licensed health professionals under the supervision of physicians.*	Conducted by physicians or licensed health professionals under physician supervision?	
	b	Be based on the systematic collection and evaluation of patient records.*	Based on the systematic collection and evaluation of patient records?	
	c	Identify and document the necessity for change in the provision of services by the health center.*	Used to identify and document necessary changes?	
	d	Result in the institution of such change, where indicated.*	Used to inform and change the provision of services if necessary?	

8.B Performance Improvement

*Additional Documents/Resources to Review:*1) Risk Management Policies and Procedures; 2) Incident Report Forms, Reporting, and Tracking; 3) Safety Officer and Safety Committee Descriptions; 4) Medical Record policies and procedures; 5) HRSA/BPHC Quality Improvement/Quality Assurance Program Assistance Letters regarding Accreditation and Patient Centered Medical/Health Home Initiatives; 6) HRSA Quality Improvement Resources; 7) ECRI Institute Clinical Risk Management Program provided on behalf of HRSA (available to health center grantees and free clinics); 8) HHS OIG Quality and Compliance Resources; 9) HRSA Health Center Patient Satisfaction Survey.

Prompting Questions for Performance Improvement Discussions		Response
1	Was the QI/ QA plan reviewed and approved by the Board? When?	

Prompting Questions for Performance Improvement Discussions			Response
2	Is the health center currently accredited or will the health undergo accreditation from a national organization such as the Accreditation Association of Ambulatory Health Care (AAAHC) or the Joint Commission (TJC, formerly known as the Joint Commission on Accreditation of Healthcare Organizations)?		
3	Is the health center participating in the HRSA Patient-Centered Medical/Health Home (PCMHH) Initiative to gain recognition under the medical home program offered in partnership with the National Committee for Quality Assurance (NCQA)?		
4	Are the roles and responsibilities of the following clearly defined in the QI/QA plan?		
	a	The Board	
	b	Management Staff	
	c	Clinical Director	
5	Does the QI/QA plan address all operations areas of the health center, incorporating indicators for:		
	a	Clinical issues?	
	b	Environmental issues?	
	c	Management issues?	
	d	Financial issues?	
	e	Patient experience?	
6	Regarding reports:		
	a	Are the results of QI audits reported to appropriate Board or staff committees, nursing, pharmacy, providers, etc.?	
	b	Is there an effective method to assure information reported is accurate, timely and available in formats to allow board, staff, and other stakeholders to make informed decisions?	
7	When deficiencies are identified:		
	a	Are there follow-up reports to the Board?	
	b	Are Action Plans implemented to correct the deficiencies?	
8	Regarding medical records:		
	a	Is there an individual qualified by training or experience responsible for the supervision and direction of the medical records system?	
	b	Are portable immunization or prenatal records made available to the patients?	

Prompting Questions for Performance Improvement Discussions			Response
	c	Is there a standardized content and organization for medical records?	
	d	Is the medical record system compliant with HIPAA?	
	e	If the health center does not have Electronic Health Records (EHR), is the medical record storage area adequate for the current and future growth needs of physical charts?	
	f	Are the needs of any/all special populations targeted by the health center integrated into the QI/QA program?	
9	Risk Management		
	a	Is there a Safety Committee and / or Safety Officer?	
	b	Is there a written procedure to report/track incidents/potential risks? Does it state who is responsible to track and report?	
	c	Are incidents analyzed, patterns observed and improvements made to reduce future risks?	
	d	Does the center meet the requirements to be deemed eligible for FTCA professional liability coverage?	
	e	Is there any pending litigation under FTCA?	
10	Does the grantee have appropriate insurance coverage in place for the following (either via FTCA or another provider/source):		
	a	General liability?	
	b	Directors and officers liability?	
	c	Malpractice, including any tail or gap coverage?	
	d	Property?	
	e	Business interruption/revenue loss?	
	f	Automobile/ vehicle?	

SECTION III: Management and Finance

Program Requirement 9: KEY MANAGEMENT STAFF

9.A Program Requirement

Authority: Section 330(k)(3)(H)(ii) of the PHS Act and 45 CFR Part 74.25 (c)(2),(3)
Documents/Resources to Review: 1) Health center organizational chart; 2) Key management staff position descriptions and biographical sketches; 3) Key management vacancy announcements (if applicable).

Requirements		Questions	Response
1	Health center maintains a fully staffed health center management team as appropriate for the size and needs of the center. Prior review by HRSA of final candidates for Project Director/Executive Director/CEO position is required.	Does the health center have a Chief Executive Officer or Executive Director/Project Director?	
		Is the management team's size and composition appropriate for the size and needs of the health center?	
		Is the team fully staffed, with each of the positions listed above filled as appropriate? ***Note:*** If the grantee has an open position for or pending change in Project Director, the PO and/or consultant may wish to remind the grantee that this is a "Prior Approval Request" that a change in Project Director must be submitted/ processed via the EHB Prior Approval Module and to contact their Project Officer for further information as needed.	

9.B Performance Improvement

Prompting Questions for Performance Improvement Discussions		Response
1	What is the composition of the management team (e.g., does it include a Clinical Director, Chief Financial Officer, Chief Operating Officer and Chief Information Officer or other key management staff)?	
2	Are key management staff directly employed by the health center? If not, what arrangements are in place for these staff?	
3	Are key strategic planning goals tied to the performance evaluations for senior management staff?	
4	What is the Chief Financial Officer's professional background?	
5	Regarding the Clinical or Medical Director/CMO:	

Prompting Questions for Performance Improvement Discussions			Response
	a	Does he/she advise the CEO and Board on clinical issues, including QI/QA?	
	b	Does he/she have the lead responsibility to hire/dismiss clinical staff?	
	c	Does he/she have sufficient time in his/her weekly schedule to adequately carry out the dual responsibilities of provider and administrator?	
6	Are methods in place to ensure competency in key positions?		
7	If the health center has multiple sites, what systems are in place to manage/coordinate operations among the sites?		
8	Are there opportunities for improved communication, interaction, or support between the Key Management Team and the Governing Board?		

SECTION III: Management and Finance

Program Requirement 10: CONTRACTUAL / AFFILIATION AGREEMENTS

10.A Program Requirement

Authority: (Section 330(k)(3)(I)(ii), 42 CFR Part 51c.303(n), (t)), Section 1861(aa)(4) and Section 1905(l)(2)(B) of the Social Security Act, and 45 CFR Part 74.1(a)(2)))

Documents/Resources to Review: 1) Contracts for core providers, including key management staff if applicable (e.g., CMO, CIO, CFO); 2) Contracts or MOAs/MOUs for other substantial portion(s) of the project; 3) Subrecipient Agreement(s) if applicable; 4) Any other key affiliation agreements if applicable; 5) Procurement policies and procedures; 6) HRSA/BPHC Affiliation Agreement Policy Information Notices (PINs 97-27 and 98-24); 7) Federal procurement grant regulations (45 CFR Part 74.41-74.48)) applicable to all contractual arrangements in scope.

	Requirements	Questions	Yes/No
1	Health center exercises appropriate oversight and authority over all contracted services.	Do any of the grantee's contracts or affiliation agreements have the potential to:	
		a. Threaten the grantee's integrity?	
		b. Limit its autonomy?	

	Requirements	Questions	Yes/No
		c. Compromise its compliance with Federal program requirements in terms of corporate structure, governance, management, finance, health services, and/or clinical operations?	
2	Health center assures that any subrecipient(s) meets the Health Center Program requirements ***Applies only to grantees s with subrecipients***	**For grantees with subrecipient arrangements ONLY:** Does the grantee have assurances in place that the subrecipient organization complies with all Health Center Program statutory and regulatory requirements?	

10.B Performance Improvement

Additional Documents/Resources to Review: HRSA/BPHC Health Center Collaboration Program Assistance Letter 2011-02.

		Prompting Questions for Performance Improvement Discussions	Response
1	Do the health center's contractual arrangements:		
	a	Contain appropriate provisions around the activities to be performed, time schedules, the policies and procedures to be followed in carrying out the agreement, and the maximum amount of money for which the grantee may become liable to the contractor under the agreement?	
	b	Require the contractor to maintain appropriate financial, program and property management systems and records and provide the health center, HHS and the U.S. Comptroller General with access to such records?	
	c	Require the submission of financial and programmatic reports to the health center?	
	d	Comply with any other applicable Federal procurement standards set forth in 45CFR Part 74 (including conflict of interest standards)?	
	e	Include a provision that such contract is subject to termination (with administrative, contractual, and legal remedies) in the event of breach by the contractor?	
2	Does the Governing Board review, and if necessary approve all new affiliations so as to maintain appropriate oversight over all sites and services within the federally approved scope of project?		
3	Is the health center able to address any specific legal or fiscal concerns related to new or renewed affiliation agreements, including contracts, with their own legal counsel and/or auditor?		

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SECTION III: Management and Finance

Program Requirement 11: COLLABORATIVE RELATIONSHIPS

11.A Program Requirement

Authority: Section 330(k)(3)(B) of the PHS Act
Documents/Resources to Review: 1) Letters of Support; 2) Memoranda of Agreement/Understanding; 3) HRSA/BPHC Health Center Collaboration Program Assistance Letter 2011-02.

	Requirements	Questions	Yes/No
1	Health center makes effort to establish and maintain collaborative relationships with other health care providers, including other health centers, in the service area of the center.	Does the health center work to establish and maintain collaborative relationships with other health care providers in its service area, in particular other health centers?	
2	The health center secures letter(s) of support from existing Federally Qualified Health Center(s) in the service area or provides an explanation for why such letter(s) of support cannot be obtained.	If there is another Federally Qualified Health Center(s) (FQHC) in the health center's service area, was the grantee able to secure letter(s) of support from the FQHC for its most recent Service Area Competition or other competitive grant application?	
		If the health center was unable to get letter(s) of support from the service area FQHCs, did it explain why and is it working to improve or implement collaborative relationships with these FQHCs?	

11.B Performance Improvement

Additional Documents/Resources to Review: 1) UDS Mapper tool, available online (requires login) at http://www.udsmapper.org; 2) HRSA/BPHC Health Center Emergency Management Program Expectations PIN 2007-15.

		Prompting Questions for Performance Improvement Discussions	Response
1		How could the grantee strengthen its working relationships with area:	
	a	Other nearby health centers (Section 330 supported, FQHC Look-Alike, Free Clinics, etc.)?	
	b	Public health departments/entities?	
	c	Private providers?	
	d	Rural Health Clinics?	

Prompting Questions for Performance Improvement Discussions			Response
	e	Hospitals?	
	f	Other community stakeholders, including social service providers?	
2	If the grantee was unable to secure a letter of support from the existing FQHC(s) in the service area, what steps could the grantee take to improve this relationship?		
3	Does the grantee have any collaborative relationships that support its emergency preparedness and management plan/activities?		

SECTION III: Management and Finance

Program Requirement 12: FINANCIAL MANAGEMENT AND CONTROL POLICIES

12.A Program Requirement

Authority: Section 330(k)(3)(D), Section 330(q) of the PHS Act and 45 CFR Parts 74.14, 74.21 and 74.26

Documents/Resources to Review: 1) Most recent independent financial audit and management letter, including Audit Corrective Action plans based on prior year audit findings, if applicable; 2) For New Starts: Most recent monthly financial statements if a first audit has not been completed; 3) Financial Management/Accounting and Internal Control Policies and Procedures; 4) Office of Management and Budget Circular A-133 Office of Management and Budget Circular A-133.

Requirements			Questions	Yes/No
1	Health center maintains accounting and internal control systems that:		Are the grantee's accounting and internal control systems:	
	a	Are appropriate to the size and complexity of the organization.	Appropriate to the organization's size and complexity?	
	b	Reflect Generally Accepted Accounting Principles (GAAP).	Reflective of GAAP?	
	c	Separate functions in a manner appropriate to the organization's size in order to safeguard assets and maintain financial stability.	Designed to separate functions in a manner appropriate to the organization's size in order to safeguard assets?	
			Designed to separate functions in a manner appropriate to the organization's size in order to maintain financial stability?	

Requirements			Questions	Yes/No
2	Health center assures that:			
	a	An annual independent financial audit is performed in accordance with Federal audit requirements. *Note: A complete audit includes:1) Auditor's Report; 2) A-133 Compliance Supplement; and 3) Reports to Board/Management letters issued by the auditor.*	Is an audit performed annually, in accordance with Federal requirements, including the A-133 Compliance Supplement?	
	b	A corrective action plan addressing all findings, questioned costs, reportable conditions, and material weaknesses cited in the Audit Report is submitted.	*If Applicable:* Did the grantee's corrective action plan address all findings, questioned costs, reportable conditions, and material weaknesses found in the Audit Report?	
			Does the Board review the grantee's corrective actions regularly?	

12.B Performance Improvement

Additional Documents/Resources to Review: 1) Chart of Accounts; 2) Encounter Report; 3) Provider Productivity Report; 4) Balance Sheet; 5) Income Statement; 6) Most recent Health Center Required Financial Performance Measures/UDS Report (see Appendix C for further detail); 7) Most recent Income Analysis (Form 3); 8) Corporate compliance plan (if applicable); 9) HRSA/BPHC Financial Recovery Plan Policy Information Notice 2002-18.

Prompting Questions for Performance Improvement Discussions			Response
1	Is there a monthly cash budget for the health center with monthly projections for at least 12 months?		
2	Are monthly financial statements prepared for review by the Finance Committee and Board?		
3	Do the statements include a(n):		
	a	Comparative balance sheet?	
	b	Income statement showing variances from budget?	
	c	Report on encounter activity compared to budget by payor type?	
	d	Report on monthly provider productivity	
	e	Comparative report on the status of receivables (either an aging summary or a report of days of income in receivables or both?)	
4	Do the last three monthly financial statements reveal:		
	a	Adequate cash on hand/working capital?	
	b	A reasonable level of accounts receivable?	
	c	A reasonable level of accounts payable?	
5	Are expenses appropriately allocated to:		

Prompting Questions for Performance Improvement Discussions			Response
	a	Cost centers?	
	b	Multiple funding sources?	
	c	Multiple sites?	
6	Regarding disbursements:		
	a	Does the health center have written purchasing and cash disbursements policies?	
	b	Is there a reasonable separation of disbursement duties?	
	c	In some manner, is every disbursement reviewed and approved by two people?	
	d	Is this two-person review and approval documented?	
7	Regarding the chart of accounts:		
	a	Is it adequate to yield good financial statements?	
	b	Does it provide adequate income data by major payer with discount and allowance information and expense information at an acceptable object level?	
8	Are the accounting procedures adequate to result in financial statements that reflect the financial results from operations, including:		
	a	Accounting for patient services revenues and accounts receivable?	
	b	Preparing monthly estimates for:	
		• Contractual allowances?	
		• Allowances for doubtful accounts?	
		• Grants and contracts receivable?	
		• Wrap around settlements for Medicaid Managed Care?	
		• Settlements and other receivables?	
		• Prepaid expenses?	
	c	Capturing:	
		• Accounts payable?	
		• Accrued payroll?	
		• Uncompensated absences?	
		• Deferred and unearned revenue?	
		• Depreciation expense?	
		• Bad debt write-off?	
9	Does the health center know the expected breakeven point for operations in terms of patient volume and mix to ensure viable fiscal operations?		

Prompting Questions for Performance Improvement Discussions			Response
10	Does the health center update its operational plan in the event actual experience is not meeting projections, i.e., number of patients to be seen in the calendar year, total revenues, productivity goals/number of encounters by type (medical, dental, mental health), and other elements from the UDS report?		
11	Regarding Managed Care Contracts:		
	a	Are all health center providers approved providers? If not, why not?	
	b	Is health center staff aware of all managed care contracts in place and the degree of financial risk associated with each?	
	c	Does the health center's practice management system enable it to manage the risks/ rewards?	
	d	Are there clear requirements for prior authorization and utilization of specific panel specialists?	
	e	Are written policies and procedures in place that describe the utilization review process and management of this data?	
	f	Who is responsible for keeping up with and monitoring the managed care contracts and review of data reported?	
	g	Is the health center and/or its providers listed in the enrollment documents/website for all of the Managed Care Organizations with which it is participating?	
12	For each of the following payor groups: Medicaid, Medicare, CHIP, Self-Pay, and Private Insurance:		
	a	What is the projected penetration rate on an annual basis?	
	b	What is the projected penetration rate on a monthly basis?	
	c	What has been the actual monthly penetration rate experience to date?	
13	Does the health center record gross charges in the patient registration system and appropriate adjustments based on allowances for payor types in order to report the correct patient accounts receivable by payor source?		
14	Does the health center have access to a line of credit to assure availability of operating cash?		
15	Regarding the annual audit:		
	a	How is the auditor selected? Is an RFP issued?	
	b	What is the role of the Board in selecting an auditor?	
	c	Does the Board review and approve the annual audit?	
16	Are full fee for service charges recorded for every encounter regardless of payer source (including for capitated services) and appropriate allowances being recorded in offsetting accounts?		
17	Regarding signatory policies:		
	a	Who are the authorized signers?	
	b	Who primarily signs checks?	
	c	Is more than one signature required to clear financial transactions?	

Prompting Questions for Performance Improvement Discussions			Response
	d	Is there a dollar threshold established for requiring more than one signature? What is it?	
	e	Do policies prohibit signing checks made payable to self?	
18	Regarding efficiency and provider productivity: *Note: HRSA/BPHC does not enforce specific productivity guidelines (e.g., 4200/2100) so as not to promote incentives that are inconsistent with the purpose of the Health Center program (e.g., discourage providers from using regular visits as opportunities to provide preventive services, discourage providers from using more efficient and patient-friendly approaches to care, such as phone consults and e-mail). Instead of measuring provider productivity, HRSA reviews cost per patient as one of the required Health Center Performance Measures (see Appendix C) to evaluate efficiency, consistent with the medical home model.*		
	a	Is efficiency and/or provider productivity tracked and reported on a regular basis?	
	b	Does the Medical/Clinical Director receive productivity report data and discuss the data with the CEO, CFO, and individual providers?	
	c	Is the provider productivity adequate per the:	
		• Any benchmarks established by the health center itself?	
		• Health center's projected revenue?	
		• National Medicare/Medicaid benchmarks?	
	d	Do provider contracts reflect any expected efficiency/productivity expectations?	
	e	Is compliance with the Fair Labor Standards Act as amended, applicable?	

SECTION III: Management and Finance

Program Requirement 13: BILLING AND COLLECTIONS

13.A Program Requirement

Authority: Section 330(k)(3)(F) and (G) of the PHS Act

Documents/Resources to Review: 1) Policies and procedures for credit, collection, and billing; 2) Encounter form; 3) Most recent income analysis (Form 3); 4) HRSA/BPHC Program Assistance Letter 2011-04: Process for Becoming Eligible for Medicare Reimbursement under the FQHC Benefit.

Requirements			Questions	Yes/No
1	Health center has systems in place to maximize collections and reimbursement for its costs in providing health services.		Does the grantee participate in or to make every reasonable effort to participate in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), and any other public assistance programs that are available to its patients?	
			Does the grantee have Medicare and Medicaid provider numbers?	
			Does the grantee make every reasonable effort to collect reimbursement for services provided to persons covered by private health insurance?	
			Does the grantee make reasonable efforts to secure payment from patients for amounts owed for services based on their established sliding fee discount schedule in a manner that assures that no patient will be denied services based on an inability to pay?	
2	These systems include written policies and procedures addressing:		Does the grantee have written policies and procedures for:	
	a	Billing	Billing?	
	b	Credit	Credit?	
	c	Collections	Collections?	

13.B Performance Improvement

Additional Documents/Resources to Review: 1) Most recent Health Center Required Financial Performance Measures/UDS Report (see Appendix C for further detail); 2) Centers for Medicare and Medicaid Services (CMS) FQHC Resource Information.

Prompting Questions for Performance Improvement Discussions			Response
1	Encounter Form		
	a	Does the health center have an encounter form?	
	b	Does the encounter form include all billable services (on-site and off-site)?	
	c	Does the encounter form reflect the scope of practice of each provider?	
	d	Do the ICD and CPT Codes reflect the most current updates?	
	e	Do the ICD and CPT Codes meet State billing coding requirements?	
	f	Are all encounters recorded in the MIS within 24 hours of service? If not, what is the lag time?	
	g	Is a procedure in place to identify and find missing encounter forms on a timely basis?	
	h	Are off-site encounters reported and billed on a timely basis?	
	i	How does the grantee know if all off-site activity is being reported?	
2	Medicaid and Medicare		

Prompting Questions for Performance Improvement Discussions			Response
	a	Are all sites that are considered either "permanent" or "seasonal" under the grantee's scope of project enrolled individually in Medicare with their own CMS certification number (CCN)?	
	b	Are Medicare and Medicaid billed electronically?	
	c	If not, how does the grantee address systems problems that arise?	
	d	Have the interim PPS rates been set? If yes:	
		• What is the interim PPS rate for Medicare?	
		• What is the interim PPS rate for Medicaid	
		• Do these rates appear reasonable?	
	e	Are Medicare and Medicaid and other material third party payers billed at least weekly?	
	f	What is the billing procedure?	
3	Other Third-Party Billing		
	a	Are "cross over" patients billed to the secondary payer within a week of payment by the primary payer? If not, what is the lag time?	
	b	If a third party billing is not responded to in 30 days, are effective follow-up procedures done?	
4	Self-Pay		
	a	Is payment at the time of service encouraged?	
	b	If patients cannot pay at time of service, are there policies and procedures in place to address this (e.g., grace periods, payments plans, etc.)?	
	c	If self-pay billings are not paid in 30 days, what is done?	
	d	What is done with accounts that are 90 days delinquent?	
	e	If the health center enters into a contract with an outside organization to carry out particular health center policies and procedures related to billing and collections, is the health center able to ensure that program requirements continue to be met (e.g., health center can maintain sufficient control and oversight over the contracted services, including monitoring their impact on the patients/community, and amending the contract, as needed, etc.)	
5	Accounts Receivable		
	a	How many days of net revenue are tied up in accounts receivable?	
	b	Are the indicators acceptable or are receivable collections lagging?	
	c	Are rejected claims corrected and resubmitted within a week? If not, what is the lag time?	

SECTION III: Management and Finance

Program Requirement 14: BUDGET

14.A Program Requirement

Authority: Section 330(k)(3)(D), Section 330(k)(3)(I)(i), and 45 CFR Part 74.25

Documents/Resources to Review: 1) Annual Budget; 2) Operating Plan; 3) Most recent Health Center Required Financial Performance Measures/UDS Report (see Appendix C for further detail).

Requirements	Questions	Response
Health center has 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.	Does grantee maintain an annual budget and related operating/ business plan?	
	Has the annual budget and related operating/ business plan been approved by the Board? If so, when?	
	How often does the Board review variance from the operating plan/ budget to ensure it continues to reflect the costs necessary to accomplish the service delivery plan?	

14.B Performance Improvement

Additional Documents/Resources to Review: 1) Capital Plan (if applicable).

Prompting Questions for Performance Improvement Discussions		Response
1	Does the grantee have a capital plan?	
2	Has the capital plan been approved by the Board? If so, when?	
3	Does the annual budget appear reasonable and appropriate in terms of accomplishing the service delivery plan, in particular the project number of patients to be served?	

SECTION III: Management and Finance

Program Requirement 15: PROGRAM DATA REPORTING SYSTEMS

15.A Program Requirement

Authority: Section 330(k)(3)(I)(ii) of the PHS Act

Documents/Resources to Review: 1) Most recent UDS report and UDS Health Center Trend Report; 2) Most recent Clinical and Financial Performance Measures (see Appendix C for further detail); 3) Strategic Plan; 4) Annual Operating Plan; 5) HRSA/BPHC UDS Reporting Information; 6) HRSA Federal Financial Report Information (FFR) Resources.

Requirements		Questions	Response
Health center has systems in place which:			
a	Accurately collect and organize data for program reporting.	Does the grantee have appropriate systems and capacity in place for collecting and organizing the data required for UDS and FFR reporting?	
		(If applicable) Has grantee submitted UDS by deadline?	
		Does the grantee have appropriate systems and capacity in place for collecting and organizing the performance data required in the Clinical and Financial Performance Measures Forms (submitted with the annual renewal applications)?	
b	Support management decision making.	Is information from the grantee's data reporting and needs assessments used to inform and support management decision making?	
		Does grantee have a long-term (3 year) strategic plan?	
		Has the strategic plan been approved by the Board? If so, when?	

15.B Performance Improvement

Additional Documents/Resources to Review: 1) Appendix C of Site Visit Guide; 2) Quality Improvement/Quality Assurance Plan; 3) HRSA Health Information Technology Resources.

	Prompting Questions for Performance Improvement Discussions			Response
1	In reviewing the health center's Clinical Performance Measures, identify **one to two required clinical measures** *(see Appendix C for the complete list of required measures)* to focus on during the site visit. The following criteria are suggested to assist in selecting the most appropriate measures: • *Will the health center be in jeopardy if the current and projected trend of the performance measure does not change?* • *Which measure(s) impacts the largest number of patients?* • *Is there significant room for improvement? For example, is there a significant gap between the grantee's goal and their current performance? Or is there a significant gap between the grantees performance and the performance of other health centers with similar client populations and resources (as noted in the Health Center Trend Report)?* • *Is there a negative historical trend (as noted in the Health Center Trend Report) for the performance measure that suggests an*	**For the 1 to 2 Clinical Performance Measures selected for review, please address the following:**		
		a	What were the reasons for selecting the measure(s)?	
		b	How is the health center doing (i.e., trend) with respect to the performance measure(s)? ***If appropriate, consultants are encouraged to present trend data in graph or chart formats.***	
		c	Are there any factors (internal, external, etc.) contributing to and/or restricting the grantee's performance on these measure(s)?	
		d	What has the health center done or proposed to do to improve performance on the measure(s) (if appropriate) and are these steps/actions feasible?	
		e	What additional steps/actions are recommended for the grantee to address any restricting factors and to improve performance on the measure(s)?	

Prompting Questions for Performance Improvement Discussions				Response
	intervention is necessary to turn the direction of the performance trend? • *Is the grantee committed to developing and implementing an action plan to improve performance on the selected measure?*	f	What role and/or technical assistance could BPHC or other partners provide to assist the grantee in improving performance on the measure(s), if applicable?	
2	In reviewing the health center's Financial Performance Measures, identify **one to two required financial measures** *(see Appendix C for the complete list of required measures)* to focus on during the site visit. The following criteria are suggested to assist in selecting the most appropriate measures: • *Will the health center be in jeopardy if the current and projected trend of the performance measure does not change?* • *Which measure(s) impacts the largest number of patients?* • *Is there significant room for improvement? For example, is there a significant gap between the grantee's goal and their current performance? Or is there a significant gap between the grantees performance and the performance of other health centers with similar client populations and resources (as noted in the Health Center Trend Report)?* • *Is there a negative historical trend (as noted in the Health Center Trend Report) for the performance measure that suggests an*	**For the 1 to 2 Financial Performance Measures selected for review, please address the following:**		
		a	What were the reasons for selecting the measure(s)?	
		b	How is the health center doing (i.e., trend) with respect to the performance measure(s)? ***If appropriate, consultants are encouraged to present trend data in graph or chart formats.***	
		c	Are there any factors (internal, external, etc.) contributing to and/or restricting the grantee's performance on these measure(s)?	
		d	What has the health center done or proposed to do to improve performance on the measure(s) (if appropriate) and are these steps/actions feasible?	
		e	What additional steps/actions are recommended for the grantee to address any restricting factors and to improve performance on the measure(s)?	

		Prompting Questions for Performance Improvement Discussions			Response
		intervention is necessary to turn the direction of the performance trend? • *Is the grantee committed to developing and implementing an action plan to improve performance on the selected measure?*	f	What role and/or technical assistance could BPHC or other partners provide to assist the grantee in improving performance on the measure(s), if applicable?	
3	Regarding the Clinical and/or Financial Performance Measures:				
	a	How often does the clinical staff review the Clinical Performance Measures?			
	b	How often does the management/financial staff review the Financial Performance Measures?			
	c	How often does the Board review the Clinical And Financial Performance Measures?			
	d	Does the management information system supply data required for developing and monitoring the Clinical and Financial Performance Measures?			
	e	Are the measures monitored and integrated into the QI/QA/Management program? How?			
4	At what stage is the grantee in the strategic planning process (i.e., long term strategic plan, short term strategic plan, operating/business plan, capital plan)?				
All of the following questions address the Practice Management Information System (PM) or other Health Information Technology (HIT):					
5	General Capacities:				
	a	Does the health center operate its own PM/HIT or collaborate with another organization on PM/HIT?			
	b	Does the PM/HIT have a Health Center/ FQHC module?			
	c	Have all modules purchased for the PM/HIT been activated?			
	d	Indicate if the following PM/HIT applications are operated by the center (C), by another entity (E), or not automated (N):			
		• Billing			
		• Capitation management			
		• General ledger			
		• Registration			
		• Scheduling			
		• Patient tracking			

Prompting Questions for Performance Improvement Discussions			Response
		• Referral tracking	
		• Records	
		• Pharmacy	
		• Word processing	
		• E-mail	
		• Internet access	
		• Spreadsheet	
6	Support and Maintenance		
	a	Does the Center have a contract with a software vendor for patient registration to support the maintenance and other support needs?	
	b	If not, how does the grantee address systems problems that arise?	
7	Policies: Are there documented PM/HIT policies and procedures that address:		
	a	Data collection	
	b	Organization	
	c	Storage	
	d	Maintenance	
	e	Security	
	f	Presentation	
	g	External access	
	h	Transfer of information	
	i	Technology and deployment?	
8	Back-up		
	a	Are there appropriate data backup procedures?	
	b	Is backup data stored off-site?	
	c	What is the frequency of transfer off site?	
9	Reports		
	a	Are there reports available to meet the needs of:	

Prompting Questions for Performance Improvement Discussions			Response
		• Management staff	
		• The Board	
		• Billing staff	
		• Clinical staff	
	b	Is the grantee familiar with UDS reporting requirements?	
	c	Is the PM/HIT able to generate the data needed to meet UDS reporting requirements?	
	d	Is there a specific method to ensure that the UDS data is accurate?	
	e	Is the grantee familiar with FFR reporting requirements?	
	f	Is the PM able to generate the data needed to meet FFR reporting requirements?	
	g	Is there a specific method to ensure that the FFR data is accurate?	
10	Future Needs		
	a	Is there a system in place for assessing future HIT needs?	
	b	If the grantee has an Electronic Health Record (EHR) in place, is it working towards meeting national Meaningful Use standards?	
	c	If the grantee does not have an Electronic Health Record (EHR), does it plan to obtain one?	

SECTION III: Management and Finance

Program Requirement 16: SCOPE OF PROJECT

16.A Program Requirement

Authority: 45 CFR Part 74.25

Documents/Resources to Review: 1) Most recent Health Center UDS Trend Report; 2) Form 1A from most recent section 330 grant application (to review patient projections); 3) Health center's official scope of project (EHB BHCMIS Forms 5A, 5B and 5C); 4) Form 2 Staffing Profile from most recent section 330 grant application; 5) HRSA/BPHC Scope of Project Policies.

Requirement	Questions	Response
Health center maintains its funded scope of project (sites, services, service area, target population and providers), including any increases based on recent grant awards.	Has the grantee experienced any significant decreases in their funded scope of project in terms of:	
	Number of overall patients served?	
	Number of special populations (for which the grantee receives targeted funding) patients served?	
	Providers and/or services available (e.g., loss of providers and/or required or additional services)?	
	Sites (e.g., closures)?	
	Has the grantee received any additional BPHC grant awards in the last 5 years (e.g., New Access Point, Service Expansion, Expanded Medical Capacity, etc.)? If yes, have they successfully implemented the newly-funded activity (i.e., reached the projected patient or encounter levels, expanded services, opened new sites, added an EHR, etc.)? **NOTE:** See Appendix D for additional requirements for reviewing ARRA and/or ACA-funded activities which may impact scope of project.	

16.B Performance Improvement

Additional Documents/Resources to Review: 1) HRSA/BPHC Service Area Overlap Policy Information Notice 2007-09; 2) UDS Mapper tool, available online (requires login) at http://www.udsmapper.org.

Prompting Questions for Performance Improvement Discussions			Response
1	Based on the purpose/scope of the grant award received (NAP, SAC, other competitive awards, as applicable) are there market conditions that were not reflected in the grantee's application plans that have or may affect or impede goals for:		
	a	Growth in the number of patients?	
	b	Growth in the number of patient visits?	
	c	Addition of new service(s)?	
	d	Addition of new provider(s)?	
	e	Addition of new site(s)?	
	f	Other expansions / improvements (e.g., EHR implementation, construction, etc.)?	
2	Regarding current capacity:		

		Prompting Questions for Performance Improvement Discussions	Response
	a	What is the capacity of the facility for medical and dental services?	
	b	Based on the center's market plan, when will the facility be at full capacity?	
	c	Are plans in place to expand the facility to meet the center's market projections?	
3	Regarding any planned expansions in terms of service area and/or sites:		
	a	If/what are the planned expansion areas?	
	b	Have the following been included in the planning phase:	
		• Staffing needs, including when to bring on appropriate management staff; i.e., Medical Director, CFO, billing, and collection staff?	
		• Establishing Medicaid and Medicare numbers to bill and collect?	
		• Funding sources to support the planned expansion?	
		• Purchasing and/or implementing a patient registration and billing system?	
		• Analysis of any service area overlap concerns?	
	c	**New Starts Only:** What things are left to be done that the grantee thinks are necessary to promote an effective New Start operation?	
	d	**Recent New Access Point Grantees (New Start or Satellites) Only:** For new sites, is the physical site/facility occupied or are plans in place to ensure the facility can be up and running as needed and required in a timely manner?	
4	Out-of-Scope Activities/Other Lines of Business		
	a	Is the center involved in any out-of-scope activity(ies) (e.g., renting space to another organization, providing services not included in section 330 scope of service)?	
	b	If yes, does the center have liability coverage separate from FTCA for this out of scope activity/service/site?	
	c	If yes, is the revenue generated from any out of scope/other lines of business activities sufficient to support direct costs of the activity(ies) plus a reasonable share of overhead to ensure that section 330 funds and other grant-related income are not used inappropriately to support costs outside the approved scope of project?	

SECTION IV: Governance

Program Requirement 17: BOARD AUTHORITY

17. A Program Requirement

Authority: Section 330(k)(3)(H) of the PHS Act and 42 CFR Part 51c.304

Documents/Resources to Review: 1) Corporate/Board Bylaws; 2) Minutes of Recent Board Meetings; 3) Governance Policies and Procedures; 4) Board Annual Meeting Schedule; 5) If Applicable: Form 6B: Waiver of Governance Requirements from most recent SAC or New Start NAP application for eligible grantees; 6) Co-Applicant Agreement (for public center grantees).

NOTE: Portions of program requirements notated by an asterisk "*" indicate regulatory requirements that are recommended ***but not required*** for grantees that receive funds solely for Health Care for the Homeless (section 330(h)) and/or the Public Housing Primary Care (section 330(i)) Programs.

	Requirements	Questions	Yes/No
Health center governing board maintains appropriate authority to oversee the operations of the center, including:			
a	Holding monthly meetings **Note:** Upon a showing of good cause the Secretary may waive, for the length of the project period, the monthly meeting requirement in the case of a health center that receives a grant pursuant to subsection (g), (h), (i), or (p). (section 330(k)(3)(H) of the PHS Act)	Does the board meet monthly? **†Answer "Waiver" if the grantee has a waiver for this requirement and respond to question for grantees with waivers below.**	
		Does the health center maintain minutes of the Board meetings?	
		Do the minutes appropriately document major issues/actions for the health center?	
		Health Centers with Approved Waivers ONLY: Are appropriate strategies being implemented to ensure regular oversight, if the Board does not meet monthly?	
b	Approval of the health center grant application and budget;	Does the Board review and approve the annual health center (renewal) application and budget?	
		Is this review and approval documented in the Board minutes?	
c	Selection/dismissal and performance evaluation of the health center CEO;	Does the Board conduct an annual review of the CEO's performance, with clear authority to select a new CEO and/or dismiss the current CEO if needed?	

† Waivers may only be requested by applicants requesting/receiving targeted funding ***solely*** to serve migrant and seasonal farmworkers (section 330(g)), people experiencing homelessness (section 330 (h)), and/or residents of public housing (section 330(i)) and that are **NOT** requesting general (Community Health Center - section 330(e)) funds. **These grantees are still required to fulfill all other statutory Board responsibilities and requirements.**

Requirements		Questions	Yes/No
		Is this review documented in the Board minutes?	
d	Selection of services to be provided and the health center hours of operations;	Does the Board review and approve the services (both Required and Additional), as well as the location and mode of delivery of those services in the approved scope of project?	
		Does the Board review and approve the hours during which services are provided at health center sites, ensuring that these are appropriate and responsive to the community's needs?	
		Is this review and approval documented in the Board minutes?	
e	Measuring and evaluating the organization's progress in meeting its annual and long-term programmatic and financial goals and developing plans for the long-range viability of the organization by engaging in strategic planning, ongoing review of the organization's mission and bylaws, evaluating patient satisfaction, and monitoring organizational assets and performance;* and	Does the Board measure and evaluate the health center's progress in meeting annual and long term clinical and financial goals?	
		Does the Board engage in strategic and/or long term planning for the health center?	
		Does the Board review the health center's mission and bylaws as necessary on a periodic basis?	
		Does the Board receive appropriate information that enables it to evaluate health center patient satisfaction, organizational assets, and performance?	
		Are these activities documented in the Board minutes?	

	Requirements	Questions	Yes/No
f	Establishment of general policies for the health center. **Note:** In the case of public center grantees (also referred to as public entities or public agencies, e.g., State, county, or local health departments) with co-applicant governing boards, the public center is permitted to retain authority for establishing general policies (fiscal and personnel policies) for the health center (section 330(k)(3)(H) of the PHS Act and 42 CFR 51c.304(d)(iii) and (iv)).	Does the Board establish general policies and procedures for the health center that are consistent with program and grants management requirements? Examples of specific health center policies and procedures that should be approved and monitored by the Board include but are not limited to: board member selection and dismissal procedures, employee salary and benefit scales, employee grievance procedures, equal opportunity practices, codes of conduct, fee schedules for services, criteria for sliding fee discounts, financial policies that assure accountability for health center resources, and avoidance of conflict of interest. ✦***With the exception of fiscal and personnel policies in the case of public agency grantees.***	
		Do the health center bylaws specify the following: • Health center mission. • Authorities, functions, and responsibilities of governing board as a whole. • Board membership (size and composition) and individual member responsibilities. • Process for selection/removal of board members. • Election of officers. • Recording, distribution and storage of minutes. • Meeting schedule and quorum. • Officer responsibilities, terms of office, selection/removal processes. • Description of standing committees (which may include but are not limited to, executive, finance, quality improvement, personnel, and planning committees) and the process for the creation of ad-hoc committees. • Provisions regarding conflict of interest. • Provisions regarding dissolution of the grantee corporation if necessary.	
		For Public Agency Grantees with Co-Applicant Arrangements ONLY: Does the public agency grantee have a formal agreement with the co-applicant board that stipulates:	

✦ In a co-applicant arrangement, the public agency (the grantee of record –e.g., the city health department) is permitted to retain responsibility for establishing general policies (fiscal and personnel policies) when constrained by State law in the delegation of certain government functions to private entities. The co-applicant structure, therefore, creates an arrangement that still adheres to the statutory intent of section 330 (allowing the majority of the health center's policy setting authorities to be carried out, to the greatest extent possible, by the patient/community-based (co-applicant) health center governing board) while satisfying local or State law pertaining to the public center. Thus, no justification is required for arrangements in which the public agency retains authority for the establishment of fiscal and personnel policies.

Requirements		Questions	Yes/No
		Roles, responsibilities, and the delegation of authorities of each party in the oversight and management of the public health center?	
		Any shared roles and responsibilities of each party in carrying out the governance functions?	

17.B Performance Improvement

Additional Documents/Resources to Review: 1) Sample of Board packets from recent meetings; 2) Annual Board orientation and training schedule; 3) List of Board Committees; 4) Meeting Schedule for Board Committees; 5) Board Recruitment plan; 6) Corporate Compliance Policies and Procedures (Compliance Officer, Compliance Committee); 7) HHS OIG Corporate Compliance Resources; 8) HRSA/BPHC Affiliation Agreement Policy Information Notices (PINs 97-27 and 98-24).

Prompting Questions for Performance Improvement Discussions			Response
1	Monthly Board Packets		
	a	Are monthly packets sent to Board members in advance of the meeting?	
	b	Do the packets include reports and recommended actions from Board committees?	
2	Is there a standard format for agendas and minutes for Board meetings?		
3	Do the bylaws specify expectations regarding meeting attendance and related policies for removal of inactive board members?		
4	When were the bylaws last reviewed and approved by the Board?		
5	Corporate Compliance: Has the Board:		
	a	Approved a corporate compliance plan?	
	b	Established a compliance committee?	
	c	Appointed a corporate compliance officer?	
6	Which Senior Management staff attends the Board meetings?		
7	Does the Board:		
	a	Implement a self-evaluation process? If yes, how frequently?	
	b	Review and approve the annual audit? (This question is also listed under 12B, Financial Management and Control Policies)	
	c	Is there an Annual Work Plan/Operational Plan reviewed by the board that is linked to the approved Strategic Plan and/or Clinical and Financial Performance Measures?	
8	Regarding the CEO/Project Director, does the Board:		
	a	Have a CEO/Project Director Recruitment and Retention Plan?	
	b	Have a Succession Plan in the event of a CEO/Project Director vacancy?	

Prompting Questions for Performance Improvement Discussions			Response
	c	Annually review staff compensation levels (i.e., salary, fringe benefits and incentives, as applicable), including those of the CEO/Project Director and other key staff, in the context of the grantee organization's size, complexity, location, and/or other factors?	
	d	Maintain documentation on how it established and approved salary levels and/or total compensation packages, in particular for the CEO/Project Director?	
9	Does the health center have any parent-subsidiary arrangements, in particular, when health centers exist as a subsidiary of another entity? If yes, what are its powers (e.g., appointment to the Board)? Note that the "parent" entity may not reserve or withhold powers that the health center governing board must exercise under the relevant statute and implementing regulations, as noted in sections 17.A and 18.A.		
10	**For Public Center Grantees with Co-Applicant Arrangements ONLY:**		
	a	Are there any performance improvement issues in terms of the implementation of shared roles and responsibilities (articulated in the co-applicant agreement) between the public center and co-applicant governing board?	
	b	If there is a high level of shared responsibility between the public agency and the co-applicant governing board in the operation of the public center and does the co-applicant agreement include provisions for dispute resolution?	

SECTION IV: Governance

Program Requirement 18: BOARD COMPOSITION

18.A Program Requirement

Authority: Section 330(k)(3)(H) of the PHS Act and 42 CFR Part 51c.304

Documents/Resources to Review: 1) Composition of Board of Directors/Form 6A: Board Composition from most recent Continuation (SAC or BPR) or New Start NAP application; 2) Corporate Bylaws; 3) Board member application and disclosure forms; 4) ***If Applicable:*** Form 6B: Waiver of Governance Requirements from most recent SAC or New Start NAP application.

NOTE: Portions of program requirements notated by an asterisk "*" indicate regulatory requirements that are recommended ***but not required*** for grantees that receive funds solely for Health Care for the Homeless (section 330(h)) and/or the Public Housing Primary Care (section 330(i)) Programs.

<table>
<tr><th colspan="2">Requirements</th><th>Questions</th><th>Yes/No</th></tr>
<tr><td colspan="3">The health center's governing board meets the following requirements:</td><td></td></tr>
<tr><td rowspan="2">a</td><td rowspan="2">A majority of the board members are individuals ("consumers" or "patients"; also previously known as "users") served by the organization.</td><td>Do a majority (at least 51%) of the Board members receive services (i.e., are registered patients) at the health center?
[†]Answer "Waiver" if the grantee has a waiver for this requirement and respond to question for grantees with waivers below.</td><td></td></tr>
<tr><td>Health Centers with Approved Waivers ONLY: Are appropriate alternative strategies being implemented to ensure consumer/patient participation and input (given board is not 51% consumers/ patients) in the direction and ongoing governance of the organization?</td><td></td></tr>
<tr><td>b</td><td>As a group, these "patient" or "consumer" board members represent the individuals being served by the health center in terms of demographic factors such as race, ethnicity, and sex.</td><td>As a group, do the "patient/consumer" Board members reasonably represent the individuals who are served by the health center in terms of race, ethnicity, and sex?
Answer "Waiver" if the grantee has a waiver for this requirement and respond to question for grantees with waivers above.</td><td></td></tr>
</table>

[†] Waivers may only be requested by applicants/grantees requesting/receiving targeted funding ***solely*** to serve migrant and seasonal farmworkers (section 330(g)), people experiencing homelessness (section 330 (h)), and/or residents of public housing (section 330(i)) and that are **NOT** requesting general (Community Health Center - section 330(e)) funds. **These grantees are still required to fulfill all other statutory Board responsibilities and requirements.**

	Requirements	Questions	Yes/No
		The following question applies ONLY to grantees that receive targeted funding to serve migratory and seasonal farmworkers, individuals experiencing homelessness, and/or residents of public housing (sections 330(g), (h), and/or (i) respectively). At a minimum, there must be at least one board member that is representative of each of the special populations for which the health center receives section 330 funding. Does the Board include a representative(s) from and/or for each of these special populations group(s), as appropriate? *Note: Special population "advocates" that are not drawn directly from the special population (e.g., currently homeless individual) should be individuals that have personally experienced being a member of, represent, have expertise in, or work closely with the special population and thus can clearly communicate the needs/ concerns of the target population and represent this population on the board (e.g., formerly homeless individual, homelessness advocate, etc.).* *In addition, while the inclusion of "advocate" would meet the requirement for multi-funded (i.e., a health center that receives section 330(e) in addition one or more special populations funding stream) health centers to have representation of all the populations for which the health center receives funding, these advocates would not be included in calculating whether the governing board has met its overall patient/consumer-majority requirement unless they were also health center patients. Additionally, while advocates may represent special populations on the board as outlined above, all health centers should continue efforts to achieve representation by patients/consumers who are members of the targeted special population.*	
c	The board has at least 9 but no more than 25 members, as appropriate for the complexity of the organization.*	Does the Board have between 9 and 25 members?	
		Does the current board size comply with the health center's bylaws which must define either a specific number of board members or define a limited range?	

	Requirements	Questions	Yes/No
		Is the size of the board appropriate for the complexity of the organization and the diversity of the community served?	
d	The remaining non-consumer members of the board shall be representative of the community in which the center's service area is located and shall be selected for their expertise in community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social service agencies within the community.*	Are the remaining Board members representative of and/or drawn from the grantee's community and service area?	
		Does the Board include a member (or members) with expertise in any of the following:	
		• Community affairs?	
		• Local government?	
		• Finance?	
		• Legal affairs?	
		• Trade union or labor relations?	
		• Business?	
		• Social Services?	
		• Health?	
e	No more than one half (50%) of the non-consumer board members may derive more than 10% of their annual income from the health care industry.*	Do more than 50% of the non-patient/consumer Board members derive more than 10% of their annual income from the health care industry?	

18.B Performance Improvement

Additional Documents/Resources to Review: 1) Board Recruitment and Retention Plan; 2) Board orientation and training information.

		Prompting Questions for Performance Improvement Discussions	Response
1		Does the health center have:	
	a	A Board recruitment and retention plan, which will help ensure Board development and stability?	
	b	An orientation program for new board members?	
	c	Plans for ongoing board member training?	
2		Does the overall expertise among the Board members appropriately reflect the health center's scope in terms of services/needs, target population, and service area?	
3		If possible, has Board composition/recruitment taken into account other key demographic factors such as socioeconomic status and age, in terms of reasonably representing individuals served by the health center?	

Prompting Questions for Performance Improvement Discussions	Response

SECTION IV: Governance

Program Requirement 19: CONFLICT OF INTEREST POLICY

19.A Program Requirement

Authority: 45 CFR Part 74.42 and 42 CFR Part 51c.304(b)
Documents/Resources to Review: 1) Corporate Bylaws; 2) most recent update of Conflict of Interest policy and related procedures; 3) Procurement policies and procedures.

NOTE: Portions of program requirements notated by an asterisk "*" indicate regulatory requirements that are recommended ***but not required*** for grantees that receive funds solely for Health Care for the Homeless (section 330(h)) and/or the Public Housing Primary Care (section 330(i)) Programs.

Requirements		Questions	Yes/No
Health center's bylaws or written, corporate-board-approved policy includes provisions that:			
a	Prohibit conflict of interest by board members, employees, consultants and those who furnish goods or services to the health center.	Do the bylaws or another policy include this provision(s)?	
b	State that no Board member shall be an employee of the health center or an immediate family member (i.e., spouse, child, parent, brother or sister by blood, adoption, or marriage) of an employee.*	Is any current Board member(s) an employee of the health center or an immediate family member of an employee?	
c	State that the Chief Executive may serve only as a non-voting, ex-officio member of the Board.*	Does the CEO participate as a voting member of the Board?	

	Requirements	Questions	Yes/No
d	Address such issues as: • disclosure of business and personal relationships, including nepotism, that create an actual or potential conflict of interest; • extent to which a board member can participate in board decisions where the member has a personal or financial interest; • using board members to provide services to the center; • board member expense reimbursement policies; • acceptance of gifts and gratuities; • personal political activities of board members; and • statement of consequences for violating the conflict policy.	Do the bylaws or any separate conflict of interest policies and procedures include and/or address these provisions? *Note that when section 330 grantees procure supplies and other expendable property, equipment, real property, and other services, the health center's conflict of interest policy must specifically address the following:* • *The health center grantee must have written standards of conduct governing the performance of its employees engaged in the award and administration of contracts.* • *No health center employee, board member, or agent may participate in the selection, award, or administration of a contract supported by Federal funds if a real or apparent conflict of interest would be involved. Such a conflict would arise when a health center employee, board member or agent, or any member of his or her immediate family, his or her partner, or an organization which employs or is about to employ any of the parties indicated herein, has a financial or other interest in the firm selected for an award.* • *The board members, employees, and agents of the health center grantee shall neither solicit nor accept gratuities, favors, or anything of monetary value from contractors, or parties to subagreements. However, recipients may set standards for situations in which the financial interest is not substantial or the gift is an unsolicited item of nominal value.* • *The standards of conduct must provide for disciplinary actions to be applied for violations of such standards by board members, employers, or agents of the health center grantee.*	

19.B Performance Improvement

	Prompting Questions for Performance Improvement Discussions	Response
1	Are annual conflict of interest statements required from board members and key management staff?	
2	If yes, are the required statements on file?	
3	Does the Board allow related party transactions to take place? If yes, please describe.	

APPENDIX A: Cross-Cutting Reference Documents And Websites	
Cross-Cutting Reference Documents	
1	Authorizing Legislation of the Health Center Program: Section 330 of the Public Health Service Act (42 U.S.C. §254b) http://www.bphc.hrsa.gov/about/requirements/index.html
2	Program Regulations (42 CFR Part 51c and 42 CFR Parts 56.201-56.604 for Community and Migrant Health Centers) http://www.bphc.hrsa.gov/about/requirements/index.html
3	Grants Regulations (45 CFR Part 74) http://www.bphc.hrsa.gov/about/requirements/index.html
4	Health Center Program Requirements Overview Slides http://www.bphc.hrsa.gov/about/requirements/index.html
5	BPHC Policy Information Notices and Program Assistance Letters (PINS and PALS) http://www.bphc.hrsa.gov/policiesregulations/policies/index.html
6	Enhancements to Support Health Center Program Requirements Monitoring Program Assistance Letter 2010-01
7	New Start Health Center Web Guide (forthcoming) http://www.bphc.hrsa.gov/technicalassistance/index.html
Useful Websites	
1	Health Resources and Services Administration (HRSA) website http://www.hrsa.gov/
2	HRSA Bureau of Primary Health Care (BPHC) website http://bphc.hrsa.gov/
3	HRSA BPHC Technical Assistance (TA) website http://www.bphc.hrsa.gov/technicalassistance/index.html
4	Management Solutions Consulting Group, Inc. Consultant Resource Center http://www.mscginc.com/Resources *Please note that all documents that are not HRSA/BPHC publications and are found within the MSCG Consultant Resource Center were made possible by contract number HHSH232200864001C from the Health Resources and Services Administration (HRSA), Bureau of Primary Health Care. The contents of such documents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA.*

APPENDIX B: Optional Program Requirement/Performance Improvement Summary Grid

The following grid may be helpful in noting where a grantee stands on each requirement. A color-coding or lettering system may be used, such as:

Y	Grantee is compliant with the requirement.	**N**	Grantee is not in compliance with the requirement.
F-U	Grantee is compliant, but follow-up is needed.	**R**	A recommendation for performance improvement has been offered.

Comp.	**Perf Impr.**	**Requirement**	**Comments** (e.g., reason for non-compliance, summary of performance improvement recommendation)
		1. Needs Assessment	
		2. Required and Additional Services	
		3. Staffing	
		4. Accessible Hours of Operation / Locations	
		5. After Hours Coverage	
		6. Hospital Admitting Privileges and Continuum of Care	
		7. Sliding Fee Discounts	
		8. Quality Improvement / Assurance Plan	
		9. Key Management Staff	
		10. Contractual/Affiliation Agreements	
		11. Collaborative Relationships	
		12. Financial Management and Control Policies	
		13. Billing and Collections	
		14. Budget	
		15. Program Data Reporting Systems	
		16. Scope of Project	
		17. Board Authority	
		18. Board Composition	
		19. Conflict of Interest Policy	

APPENDIX C: Health Center Performance Measures

In order to support the provision of high quality patient care, HRSA-funded health centers are expected to have ongoing quality improvement/assessment programs that include clinical services and quality management. To this end, the Health Center Program incorporates systems of quality assessment, quality improvement, and quality management that focus provider responsibilities on improving care processes and outcomes. In concert with performance improvement initiatives within the broader health care community, the Health Center Program incorporates quality-related performance measures that place emphasis on health outcomes and demonstrate the value of care delivered by health centers.

The Health Center required performance measures were thus selected to provide a balanced and comprehensive representation of health center services, clinically prevalent conditions among underserved communities, and the population across life cycles. Their use is familiar to the majority of health center grantees that have extensive experience working to improve the quality of perinatal, chronic, and preventative care services. Further, the performance measures are aligned with those of national standard setting organizations, and are commonly used by Medicare, Medicaid, and health insurance/managed care organizations to assess quality performance. The alignment of the performance measures across the Uniform Data System (UDS) and the grant applications (NAP, SAC, and BPR) also provides grantees with the opportunity to establish quality and performance goals for their organization and patient populations, and assess their progress toward these goals over time. The alignment furthers HRSA's objective to collect data in a way that minimizes grantee reporting burden, and helps document the value of the Health Center Program.

The required measures within Appendix C are reported by all grantees in the UDS and are included along with additional measures, in the Clinical and Financial Performance Measures Forms completed as part of the Fiscal Year 2012 Service Area Competition (SAC) and Budget Period Progress Report (BPR) applications. Please note that several New and Revised performance measures that will be included in calendar year 2011 UDS reporting are also included in the list below:

- In preparing FY 2012 SAC applications or BPR submissions, applicants were encouraged, but NOT REQUIRED, to provide baselines or other data for these NEW Clinical Performance Measures. All existing grantees as well as any newly funded applicants will be required to report on these new measures in their 2011 UDS Reports.
- The REVISED Clinical Performance Measures were NOT included in the FY 2012 SAC or BPR forms to allow existing grantees to report progress on the unrevised versions of these measures. However, applicants were advised that they may begin collecting and reporting information on the revised measures in the SAC or BPR application if desired. All existing grantees as well as any newly funded applicants will be required to report on these revised measures in their 2011 UDS Reports.

For the most recent information on UDS reporting, visit http://www.hrsa.gov/data-statistics/health-center-data/index.html and for additional information on the performance measures, visit http://www.bphc.hrsa.gov/policiesregulations/performancemeasures/index.html.

Clinical Performance Measure Detail

Outreach/Quality of Care Measures

Percentage of pregnant women beginning prenatal care in the first trimester

Numerator: All female patients who received perinatal care during the program year (regardless of when they began care) who initiated care in the first trimester either at the grantee's service delivery location or with another provider.

Denominator (Universe): Number of female patients who received prenatal care during the program year (regardless of when they began care), either at the grantee's service delivery location or with another provider. Initiation of care means the first visit with a clinical provider (MD, NP, CNM) where the initial physical exam was done and does not include a visit at which pregnancy was diagnosed or one where initial tests were done or vitamins were prescribed.

Percentage of children with 2nd birthday during the measurement year with appropriate immunizations

Numerator: Number of children in the "universe" who received all of the following: 4 DTP/DTaP, 3 IPV, 1 MMR, 3 Hib, 3 HepB, 1VZV (Varicella), and 4 Pneumococcal conjugate, prior to or on their 2nd birthday, among those children included in the denominator.

Denominator (Universe): Number of children with at least one medical encounter during the measurement year, who had their second birthday during the measurement year prior to or on December 31, who did not have a contraindication for a specific vaccine. This includes children who were seen for the first time in the clinic prior to their second birthday, regardless of whether or not they came to the clinic for vaccinations or well child care.

REVISED Percentage of children with 2nd birthday during the measurement year with appropriate immunizations

Numerator: Number of children who received all of the following: 4 DTP/DTaP, 3 IPV, 1 MMR, 3 Hib, 3 HepB, 1VZV (Varicella), 4 Pneumococcal conjugate, 2 HepA, 2 or 3 RV, and 2 influenza vaccines prior to or on their 2nd birthday whose second birthday occurred during the measurement year, among those children included in the denominator.

Denominator: Number of children with at least one medical visit during the reporting period, who had their second birthday during the reporting period, who did not have a contraindication for a specific vaccine.

Percentage of women 21 -64 years of age who received one or more Pap tests to screen for cervical cancer

Numerator: Number of female patients 24-64 years of age receiving one or more Pap tests during the measurement year or during the two years prior to the measurement year, among those women included in the denominator.

Denominator (Universe): Number of female patients 24-64 years of age as of December 31 of the measurement year who were seen for a medical encounter at least once during the measurement year and were first seen by the grantee before their 65th birthday.

NEW Percentage of patients age 2 to 17 years who had a visit during the current year and who had Body Mass Index (BMI) Percentile documentation, counseling for nutrition, and counseling for physical activity during the measurement year

Numerator: Number of child and adolescent patients age 2 to 17 years who had Body Mass Index (BMI) Percentile documentation, counseling for nutrition, and counseling for physical activity during the measurement year, among those patients included in the denominator.

Denominator: Number of child and adolescent patients age 2 to 17 years as of December 31 of the measurement year, who have been seen in the clinic at least once during the measurement year.

NEW Percentage of patients age 18 years or older who had their Body Mass Index (BMI) calculated at the last visit or within the last six months and, if they were overweight or underweight, had a follow-up plan documented

Numerator: Number of adult patients age 18 years or older who had their Body Mass Index (BMI) calculated at the last visit or within the last six months *and*, if they were overweight or underweight, had a follow-up plan documented, among those patients included in the denominator.

Denominator: Number of adult patients age 18 years or older as of December 31 of the measurement year, who have been seen in the clinic at least once during the measurement year.

NEW Percentage of patients age 18 years and older who were queried about tobacco use one or more times within 24 months

Numerator: Number of patients age 18 years and older who were queried about tobacco use one or more times within 24 months, among those patients included in the denominator.

Denominator: Number of patients age 18 years and older who had at least one medical visit during the measurement year and have been seen for at least two office visits ever.

NEW Percentage of patients age 18 years and older who are users of tobacco and who received (charted) advice to quit smoking or tobacco use

Numerator: Number of patients age 18 years and older who are users of tobacco and who received (charted) advice to quit smoking or tobacco use, among those patients included in the denominator.

Denominator: Number of patients age 18 years and older seen who are users of tobacco and who had at least one medical visit during the current year and have been seen for at least two visits ever.

NEW Percentage of patients age 5 to 40 years with a diagnosis of persistent asthma (either mild, moderate, or severe) who were prescribed either the preferred long term control medication or an acceptable alternative pharmacological therapy during the current year

Numerator: Number of patients age 5 to 40 years included in the denominator with a diagnosis of persistent asthma (either mild, moderate, or severe) who were prescribed either the preferred long term control medication (inhaled corticosteroid) or an acceptable alternative pharmacological therapy (leukotriene modifiers, cromolyn sodium, nedocromil sodium, or sustained released methylxanthines) during the current year.

Denominator: Number of patients age 5 to 40 years with a diagnosis of persistent asthma (either mild, moderate, or severe) and who had at least one medical visit during the current year and have been seen for at least two visits ever.

Health Outcomes/Disparities Measures

Percentage diabetic patients whose HbA1c levels are less than or equal to 9 percent

Numerator: Number of adult patients age 18 to 75 years of age with a diagnosis of Type 1 or Type 2 diabetes whose most recent hemoglobin A1c level during the measurement year is ≤ 9%, among those patients included in the denominator.

Denominator (Universe): Number of adult patients age 18 to 75 years of age as of December 31 of the measurement year with a diagnosis of Type 1 or Type 2 diabetes, who have been seen in the clinic at least twice during the reporting year and do not meet any of the exclusion criteria.

REVISED Percentage diabetic patients whose HbA1c levels are less than 7 percent, less than 8 percent, less than or equal to 9 percent, or greater than 9 percent

Numerator: Number adult patients age 18 to 75 years with a diagnosis of Type 1 or Type 2 diabetes whose most recent HbA1c level during the measurement year is <7%, <8%, ≤9%, or >9%, among those patients in the denominator.

Denominator: Number of adult patients age 18 to 75 years as of December 31 of the measurement year with a diagnosis of Type 1 or Type 2 diabetes, who have had a visit at least twice during the reporting year and do not meet any of the exclusion criteria.

Percentage of adult patients with diagnosed hypertension whose most recent blood pressure was less than 140/90

Numerator: Patients 18 to 85 years of age with a diagnosis of hypertension with most recent systolic blood pressure measurement < 140 mm Hg and diastolic blood pressure < 90 mm Hg.

Denominator (Universe): All patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension and have been seen at least twice during the reporting year, and have a diagnosis of hypertension before June 30 of the measurement year.

Percentage of births less than 2,500 grams to health center patients

Numerator: Women in the "Universe" whose child weighed less than 2,500 grams during the measurement year, regardless of who did the delivery.

Denominator (Universe): Total births for all women who were seen for prenatal care during the measurement year regardless of who did the delivery.

NOTE: The Prenatal Health and Perinatal Health performance measures (*Percentage of pregnant women beginning prenatal care in the first trimester and Percentage of births less than 2,500 grams to health center patients*) are the only Clinical Performance Measures that can be marked "*Not Applicable*" on an ongoing basis. Such designation requires justification regarding referral and tracking practices (required regardless of applicability) in the Comments field of the performance measure forms. These performance measures cannot be marked "*Not Applicable*" if data for the measures was provided in the most recent SAC, NAP, or BPR. Applicants that assume primary responsibility for some or all of a patient's prenatal/perinatal care services (those who have selected the first or second columns on Form 5A for these services) are required to include and report on these performance measures.

Additional Clinical Performance Measures

In addition to the above required UDS clinical measures, health centers must include one Behavioral Health (Mental Health or Substance Abuse) AND one Oral Health performance measure of their choice in the Clinical Performance Measures Form. In the BPR and SAC (for existing grantees applying to serve their current service area), grantees are expected to report on their previously developed behavioral and oral health performance measures.

- If new behavioral and/or oral health performance measures are being developed, grantees may utilize patient or agency-centered measures, based on the specific type/level of oral health or mental health/substance abuse services offered by the health center and/or on the mode of service delivery the center utilizes for these services (i.e., provided directly or via a formal written referral arrangement). For example, health centers may wish to focus on areas such as behavioral health screening, treatment, and referral or behavioral health patient outcomes. Such measures can be based on services provided by behavioral health or by primary care providers.

- When developing oral health measures, both BPR and SAC applicants are reminded that oral health screening is a required primary care service (as part of "Preventive Dental) and that the minimum requirement for behavioral health service is a formal referral.

Financial Viability/Cost Performance Measure Detail

Total cost per patient
Numerator: Total accrued cost before donations and after allocation of overhead

Denominator: Total number of patients (UDS Lines: T8AL17CC/T4L6A for existing grantees)

Medical cost per medical visit
Numerator: Total accrued medical staff and medical other cost after allocation of overhead (excludes lab and x-ray cost)

Denominator: Non-nursing medical encounters (excludes nursing (RN) and psychiatrist encounters). (UDS Lines: T8AL1CC + T8AL3CC/T5L15CB – TT5L11CB for existing grantees)

Change in net assets to expense ratio

Numerator: Ending Net Assets – Beginning Net Assets

Denominator: Total Expense
Note: Net Assets = Total Assets – Total Liabilities

Working capital to monthly expense ratio

Numerator: Current Assets – Current Liabilities

Denominator: Total Expense / Number of Months in Audit

Long term debt to equity ratio

Numerator: Long Term Liabilities

Denominator: Net Assets

NOTE: Only applicants that identify as Tribal, Urban Indian, or Public Center (formerly referred to as Public Entity grantees) are able to select "Not Applicable" for an audit related performance measure (*Change in Net Assets, Working Capital and/or Long Term Debt to Equity*). These applicants may choose to include substitute measures limited to the scope of Federal project (e.g., surplus or loss as a percent of total cost).

Other (Optional) Clinical or Financial Performance Measures

In addition to the required Clinical and Financial Performance Measures (including the self-defined oral and behavioral health measures) noted above, SAC and BPR applicants may choose to identify and include other measures relevant to their health center and/or target population. For example, grantees may add Clinical Performance Measures that focus on the quality of care for a key service or services provided to patients, including particular special populations served. Any additional Financial Performance Measures must focus on the organization's financial performance. All such measures must be quantitative (defined by a numerator and a denominator), and their progress must be tracked over time.

APPENDIX D: Capital and Other Grant Progress Review

Background: The American Recovery and Reinvestment Act (ARRA), signed into law February 17, 2009, provided nearly $2 billion in grants to health centers to support the Act's goals of job preservation and creation, economic recovery, help to people most impacted by the recession, increased economic efficiency, long-term economic investment in infrastructure, and the preservation of essential services. Health centers receiving funding under ARRA are required to submit quarterly reports on programmatic progress on these grants. ARRA grants to health centers have included approximately:

- $500 million for New Access Points (NAP) and Increased Demand for Services (IDS) awards to support new and existing health center grantees to meet spikes in uninsured populations by offering extended hours, expanding services, and/or increasing numbers of providers.
- $850 million for the Capital Improvement Program (CIP) to support the construction, repair, and renovation of health center sites nationwide, including the purchase of new equipment or health information technology, and expanding the use of certified electronic health records (EHR).
- $500 million for the Facility Investment Program (FIP) to address significant and pressing capital improvement needs in health centers, including modernization, renovation, and construction, while creating employment opportunities in underserved communities over a two-year period.

The Patient Protection and Affordable Care Act (Affordable Care Act), signed into law on March 23, 2010, provides $1.5 billion to support major construction and renovation at health centers nationwide. Affordable Care Act (ACA) grants have or will include the following:

- $732 million for Capital Development projects to 144 additional applications that had originally been submitted under FIP.
- $200 million ($50 million per year for four years) for construction, renovation, and/or equipment through the School-Based Health Centers Capital (SBHCC) program. The SBHCC program awarded $95 million for 278 grants in FY 2011 (the FY 2011 awards included the available FY 2010 funding).
- $600 million (estimated) for the Capital Development – Building Capacity Grant Program for renovation, expansion, and/or construction of a facility.
- $100 million (estimated) for the Capital Development – Immediate Facility Improvements Program to address immediate and pressing capital needs in existing health centers.

Note to Consultants: *As part of the site visit preparation process, the BPHC Project Officer for each Capital Grant should be included to provide information on the current status of each grant project and related issues. These Project Officers should be notified of the dates of the expected site visit as well.*

Documents and Items to Review Prior to and/or During Site Visit:

- Current ARRA Health Center Quarterly Report (HCQR) and/or Quarterly Progress Report (QPR)
- Federal ARRA Section 1512 reports for all ARRA grants (http://www.federalreporting.gov/)
- Notices of Award for all Capital Grants (such as C81, C80, C8A, C8B, C12) to review scope of approved work including any updates and changes to the project(s)
- For Capital Grants with construction, alterations, or renovations, visually tour/review the progress of construction or alterations/renovations and if possible, take photos to attach to the site visit report
- For Capital Grants with equipment purchases, compare the equipment listed in the approved budget with the equipment purchased
- For CIP grants, review progress on implementing health information technology (HIT) or electronic health record (EHR)

Awards		Questions	Response
a	Increased Demand for Services (IDS) and New Access Point (NAP) Awards	As a result of the ARRA award, what goals or objectives has the grantee accomplished from its IDS and NAP grants since the last Quarterly Report, including but not limited to: • new sites opened; • number of new patients that received services; • number of visits new patients received; • number of new uninsured patients that received services; and • number of jobs retained or created?	
		What factors, if any, are contributing to OR restricting the performance and success of the ARRA-supported activities?	
		What support and/or technical assistance could BPHC or other partners provide to assist the grantee in improving the progress or completion of ARRA activities, if applicable?	

<table>
<tr><th colspan="2">Awards</th><th>Questions</th><th>Response</th></tr>
<tr><td rowspan="5">b</td><td rowspan="5">Capital Grants: including C81 Capital Improvement Program (CIP), C80 Facility Investment Program (FIP), C8A Capital Development (CD), and C12 School-based Health Center Capital (SBHCC) grants. Also includes one-time funding for minor construction activities included within New Access Point (NAP) grants</td><td>As a result of the grant award, what goals or objectives has the grantee accomplished with its Capital Grant(s) since the last Quarterly Report, including but not limited to:
• new equipment purchased;
• construction completed and/or new sites opened;
• alterations/renovations completed; and/or
• HIT and/or certified EHR implemented?</td><td></td></tr>
<tr><td>What factors, if any, have impacted the expected project completion date for each project based upon a review of the most current project schedule?</td><td></td></tr>
<tr><td>What factors, if any, have impacted the implementation of HIT equipment and/or certified EHR (as applicable to the type of award)?</td><td></td></tr>
<tr><td>Will each project be completed by the project period end date?</td><td></td></tr>
<tr><td>What is the status of the following since the last Quarterly Report submission:
• Reporting requirements and other submissions, such as the final design letter, construction contract, etc., if applicable;
• Local building permits; and/or
• Bidding of the construction contract?</td><td></td></tr>
</table>

Awards		Questions	Response
		Have there been any significant updates/modifications to the awarded project(s), such as: • A change in the physical location of the project(s); • A change in the scope of work to be performed and/or the design/layout of the project(s); • An increase in the overall cost of the project(s); • A decrease in the overall cost of the project(s) due to favorable bidding that may result in some reallocation of grant funds; and/or • A change in the status of the non-Federal funding support needed for the project(s) (if the project(s) are not fully funded by a BPHC Capital grant)?	
		What support and/or technical assistance could BPHC or other partners provide to assist the grantee in improving the progress or completion of grant(s) activities, if applicable?	