

FUNDED!

Now WHAT?

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If you have any questions, feel free to contact:

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INTRODUCTION

You got the call...**you are funded!** Celebrate today...and then be prepared to be overwhelmed. This is the standard reaction to learning that you have the opportunity to open a new health center – and you are not alone. Your organization is one of many new or expanded health center sites that will provide access to health care for millions of people. This is a big responsibility, and the health center¹ has to be up and running in just 120 days!

Certainly if you are opening a satellite location you probably have some, if not all, of the systems established that you will simply transfer to the new site. Most of your effort will be placed on the best way to integrate the new site into the existing operation. Regardless, there is so much to do, and so little time.

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

While those starting a health center for the first time may find this document most helpful, the materials and suggestions can also serve as important tools for grantees opening new satellite sites as well. It can also be a refresher course for health centers that have been in operation for years, or even decades. Much of the information provided here has been gleaned from years of experience of many people in the health center movement. Some have run health centers for years, others have been consultants to health centers, and some of staff of state/regional Primary Care Associations (PCAs). What is important to remember is that the material presented here is just a starting point for developing your health center. Everything presented can be tailored to your specific situation.

Remember, too, to look **first** to the implementation plan you submitted as part of your grant application. That plan has been reviewed thoroughly, and tested against compliance requirements for health centers. The Health Resources and Services Administration/Bureau of Primary Healthcare (HRSA/BPHC), the agency that approved your application and will be an ongoing partner in delivering care to your community, noted suggestions or recommendations for that plan has conditions on your Notice of Award (NoA), and should be followed.

¹ “Health center” denotes an organization that receives section 330 Health Center Program grant funding and includes community health centers, migrant health centers, homeless health centers, and public housing primary care centers.



With that in mind, this document is not focused on compliance with health center regulations, but rather is a set of promising practices and recommendations. Compliance with requirements is job one – especially the requirement that the health center be operational within 120 days of date on the NoA. And we strongly recommend establishing systems that will serve the health center in the long run.

This document has changed from earlier versions and is organized in nine areas:

- Governance
- Administration
- Human Resources and Recruitment
- Finance
- Clinical
- Operations
- Information Technology
- Facilities Management
- Risk Management

These areas are then broken into the following time-phases:

- First 120 days
- Rest of year 1
- Year 2 and 3

The biggest change is the addition of checklists that form a summary of the concepts presented in each section. These contain some ideas you can use – often immediately – to help actualize the work you are doing. Some are suggestions, some represent specialized resources, and some are quick reminder tools. They have been developed by the review team to help point you in the right direction. They are by no means exhaustive. Almost all of the resources are provided as web links to cost-free resources. We hope this format makes the materials easy to use; many are in the appendix.

We sincerely thank our health center colleagues who helped inform this document. There are truly too many to name – but they have been generous in sharing their materials, their successes, and importantly, their foibles.

Finally, remember that health center systems are constantly evolving. New technologies are under development, new licensure and accreditation standards, changing federal regulations and requirements abound. This moving target makes it difficult to ensure that the best assistance is offered at all times. So, if you have something better, newer, easier to use...please let the Training and Technical Assistance Department at NACHC know so we can update the document and accompanying resources. We want to provide the best support to those undertaking this important work, and we thank you in advance for your help.

Welcome to the health center movement.



OVERVIEW

Throughout the exciting, rewarding, and stressful period of the first 120 days after your NoA, you will be meeting deadlines, setting up new systems, hiring and orienting new staff, enrolling in reimbursement programs and with insurance companies, and making regulatory filings. It is important to **keep in mind the mission of your organization and the outcomes you wish to achieve – providing access to high-quality, affordable health care in your community.** With some careful planning and a lot of help, you will meet your goals.

Focus where focus is needed.

When a health center first launches, there is great temptation to jump immediately to the “fun stuff.” Everyone has an area where he or she likes to focus – be it quality management and performance improvement, finance, customer service and patient experience, or facilities management. All are important, yet in this stressful time, ensuring your focus is pointed on the needs of the organization is critical.

We noted in the introduction that this document is broken into time-phases. The recommendations in the first 120 days section point to suggestions on systems development that will have lasting effect long-term. The later time-phase sections focus on more advanced concepts, but that doesn't necessarily mean that they can't be tackled immediately if it is in the best interest of the organization. There is no magic formula – use your best judgment.

Use this guide as a template – but every situation is different

This point cannot be overstressed. This is but a guide to promising practices. We strongly encourage you to **focus first on your implementation plan** (especially during the first 120 days, as it has been reviewed and notated to help you achieve compliance with health center regulations) and use this guide to supplement that effort. Use the resources and strength of your board of directors, community supporters, and your team to help prioritize the areas for success. Resources from NACHC, your PCA, your counsel and auditor, and consultants can help you tailor your efforts further.

Do it right the first time

Whether taking action on your implementation plan or operationalizing a promising practice, follow the adage: go slow to go fast. Make sure you are doing things right the first time. A temporary fix may suffice to get the ball rolling, but going back to fix systems later can take much more time than doing it correctly and comprehensively the first time. Also be aware that it takes no time at all for workarounds and temporary practices to become ingrained behaviors that can literally take years to undo.

Setting up systems is intense and time-consuming. But serving the community and managing the details of running the center is even more intense. There are many new and proven ways of designing systems that can have big impacts on efficiency, effectiveness and financial sustainability of the health center. This is your golden opportunity to do appropriate research, planning and implementation so everything you put into place will serve the center for years to come.

Comply with Program Requirements

This has been addressed before, but bears mention again. Within your first 120 days your health center must be in compliance with Program Requirements. Your implementation plan is the road map for assuring compliance. When taking action and establishing systems to assure compliance, always consider how the health center will be evaluated and be familiar with these systems when establishing your practices.

There are three major tools that will inform the compliance process, and also help you establish systems that will be beneficial for the long term.

1. **Federal Program Requirements.** Published by HRSA/BPHC and available online at <http://bphc.hrsa.gov/about/requirements/index.html>, describes the laws and regulations of the health center program. It provides the basis for all of the work of HRSA/BPHC from the submission of the grant, to operational expectations, to annual evaluation of performance. All of these requirements are designed to help health centers not only survive, but also thrive.
2. **Health Center Site Visit Guide.** One of the ways in which HRSA/BPHC monitors performance of health centers is through regular on-site visits (OSV). The same guide is used at every health center OSV to ensure that all health centers are held to the same standards. The checklist is available at <http://bphc.hrsa.gov/administration/visitguidepdf.pdf> and is well worth the time and effort to make sure the health center's systems and processes meet the guidelines. As a newly-funded health center, you will receive an OSV 10-12 months after receiving the NoA, at which the site review team interviews key health center staff and board members as well as reviews documents, policies, meeting minutes and forms. The team will review the program's strengths and make program development recommendations. If you need help establishing systems, policies and protocols, you can request technical assistance from HRSA/BPHC. **Your grant award includes funding for technical assistance – use it!**
3. **Uniform Data Systems (UDS) Reporting.** Every health center must submit an annual report to HRSA/BPHC, known as the UDS. It requires specific demographic information on your patients, operations data, financial information including revenues, clinical and financial measures, and other indicators of health center performance. HRSA/BPHC uses these data to monitor your program and aggregates it with all other health centers to report to Congress, the President and the general public. While you will not submit this report for some time, it is strongly recommended that you become familiar with the data elements you will need to submit, so you can be sure that your systems and processes collect the right information from the outset. Information about UDS is available at <http://bphc.hrsa.gov/healthcenterdatastatistics/index.html>.

Ask for Help

There are many resources to help you launch your health center operations smoothly. You will be assigned contacts within HRSA/BPHC who will remain your regular points of contact – a Project Officer (PO) and a Grants Management Specialist (GMS). Reach out to them with questions, as they can also help you identify technical assistance resources to help you get started. In addition, your state/regional PCA can be an excellent source for information and assistance. To locate your PCA, visit www.nachc.com/nachc-pca-listing.cfm. NACHC and thehealth CenHH network of operating health centers in your area can also provide a wealth of information about setting up and running clinics for underserved populations. HRSA/BPHC has created a Newly Funded Technical Assistance Web Guide that contains many resources. It can be accessed at: <http://www.bphc.hrsa.gov/technicalassistance/newguide/index.html>

HRSA/BPHC also funds national organizations to provide training and technical assistance to health centers around serving special and vulnerable populations. Health centers can receive guidance from these organizations, including:

- **National Health Care for the Homeless Council** - www.nhchc.org
- **National Center for Farmworker Health** - <http://www.ncfh.org>
- **National Center for Health in Public Housing** - www.nchph.org
- **Association of Asian Pacific Community Health Organizations** – www.aapcho.org
- **The National LGBT² Health Education Center** – www.lgbthealtheducation.org

For a complete list of special and vulnerable population National Cooperative Agreements, visit: <http://bphc.hrsa.gov/qualityimprovement/supportnetworks/ncapca/natlagreement.html>.

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

In addition, HRSA/BPHC has created a website that includes many resources. Chief among these are Policy Information Notices (PIN) and Program Assistance Letters (PAL), as well as frequently asked questions documents, resources and links to various partners. This robust website is at: <http://bphc.hrsa.gov/technicalassistance/index.html>.

First 120 Days Checklist

This monograph now turns to checklists to help your health center become operational and establish processes and systems that will serve you for the long term. Remember again to review your implementation plan to identify items related to compliance – and use this guide to help identify promising practices. We have prepared these checklists and attendant narratives to help you get there. By no means is this list comprehensive. Every health center will have its own challenges to face and its own areas of strength on which to build. Our goal is to provide the newly funded health center with a roadmap to build a plan that will help you sustain your efforts in the years to come.

² Lesbian, Gay, Bisexual and Transgender



Checklist #1: Governance

Promising Practices

1. *Review Governance PIN with the board of directors*
2. *Create a monthly meeting calendar*
3. *Select General Counsel*
4. *Select Auditor*

Health center board members work hard, and much is expected from them. In January 2014, HRSA/BPHC issued PIN 2014-01, which outlines the health center governance requirements, and it is our strong recommendation that your board review them as a group as soon as possible. They can be found at: <http://bphc.hrsa.gov/policiesregulations/policies/pin201401.pdf>.³

Please remember that if the health center is funded under any special populations funding streams, it will have additional governance requirements.

The board must meet at least once per month. To ensure this happens, establish a fixed schedule of board meetings for the whole year. Some health centers have the meeting at the same time each month; others provide a variety of times and days of the week. Watch holiday calendars, and consider annual events like NACHC meetings, state/regional PCA meetings, etc. An example of a board calendar and other board management tools are available free of charge from boardsource.org, but you will need to establish a free account.

The board of directors is responsible for the care delivered to the health center's patients. That means not only the amount of care – meeting the needs of your community - but also the quality of that care. That means many things – the board must approve and review outcomes of the Quality Improvement Plan.

The board should also attend to the hiring of a general counsel and an auditor. The need for counsel is clear – the health center will have contracts to review and other legal work immediately. You will need special expertise in health center law and regulation, as well as local counsel to advise on the laws of your state and locality. An auditor will help you prepare for your required annual audit and help the health center comply with 45 CFR Part 75⁴ as it relates to financial management of the health center.

3 “CFR” refers to the “Code of Federal Regulations.” This citation refers to the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards, and is often referred to as the “Super-Circular,” as it replaced several documents that were called “Circulars.”

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Checklist #2: Administration

Promising Practices:

1. *Review and apply if necessary for licensure*
2. *Enroll for National Health Service Corps (NHSC) site approval*
3. *Apply for Federal Tort Claims Act (FTCA) deeming*
4. *Enroll for 340b drug discounts*
5. *Begin discussions with managed care entities*
6. *Develop management report package*

States and localities have different licensure requirements. You may need special business licenses or state licensure to operate as a health center. Likely you have already completed this prior to applying for your grant, yet it is worth making sure you have all the licenses you need in order to operate now.

The National Health Service Corps (NHSC) may be one of the health center's premier recruitment vehicles for medical, dental, behavioral health and mid-level providers. Many providers consult NHSC-maintained lists of vacancies as they seek practice locations upon completion of training. The health center will need to apply to be an NHSC-approved site to take advantage of recruitment and technical assistance. For more information, visit: <https://nhsc.hrsa.gov/>, and look for the regularly-updated site guide, which can change each cycle that applications are accepted⁵.

The Federal Tort Claims Act (FTCA) will, upon approval of the health center's "deeming"⁶ application, provide best-in-class malpractice coverage for the health center's providers and also cover the health center *administratively*, against any judgment arising from malpractice. Deeming is not guaranteed; you must apply and remain up to date on certain requirements to maintain the status. You should review the requirements and prepare for and file a deeming application as soon as you can. Remember to build compliance with FTCA requirements into your annual operating plan right away, whether you are deemed or not, as that will assist the health center in obtaining initial deeming. For more information, visit: <http://bphc.hrsa.gov/ftca/healthcenters/index.html>.

⁵ Typically, we would provide a link to the actual site guide; however, given that it is expected to be updated with each application cycle, we are limiting the link to the main NHSC page.

⁶ Approval to the FTCA is called "deeming" because once the application is approved, the health center's providers are legally "deemed" to be federal employees in the performance of their health center duties.

One of the benefits of becoming a health center is access to 340b drug pricing for pharmaceuticals and devices used in the delivery of care and as prescriptions given to patients. The health center must enroll with the Office of Pharmacy Affairs (OPA) for this benefit. A consideration: OPA only approves entry into the 340b program four times per year, so applying immediately is a good idea. For more information, visit: <http://www.hrsa.gov/opa/>.

The health center is required to have a management staff appropriate for its size and scope. Typically, this includes at a minimum a clinical director and a finance officer, but not always. Working in conjunction with your Project Officer, and following the health center's implementation plan, a management team can be assembled to meet the goals of the health center.

Finally, as a newly funded health center, there will be new reporting requirements, notably to HRSA/BPHC in the form of a UDS report that was introduced on page 4. The health center may also have funding and support from local foundations and others, who will want to know how you are performing. You should begin establishing a package of regular reports for management, the board, and outside entities. It is recommended that the health center immediately begin reviewing UDS reporting requirements and start capturing volume, financial, and health outcomes data in formats that will help the center file the annual UDS when it is due.



Checklist #3: Human Resources and Recruitment and Retention

Promising Practices:

1. *Develop referral sources for recruitment of support staff*
2. *Refine and develop job descriptions*
3. *Review wage/salary and benefits package for staff*
4. *Establish or revise employee manual*
5. *Design or refine on-boarding process*
6. *Review and understand requirements for health center hiring*

Everyone's heard the saying, "Our people are our most important asset." In the case of a health center, it's absolutely true. Any business focused on selling a service as its product must have the best possible team, with the best skills, the most advanced methods of customer care and a finely-tuned sense of mission and purpose that will position the organization for success.

While much focus is placed on the recruitment and retention of providers, recruiting and retaining support staff (like nurses, front desk, and medical assistants or nursing assistants) can often take a back seat. In reality, hiring these personnel can be more difficult than finding providers! We know that a health center's success is often predicated on the work that these support staff do in the health center each day and recommend that your human resources (HR) department identify schools, training organizations and other referral resources that can help the health center recruit for support team members.

Any HR professional will tell you that an employee's success at any job begins not on the employee's hire date, but rather on the day the company drafts the job description. Complete, results-oriented job descriptions help all health centers attract and retain the best talent they can, because everyone is clear about the expectations on day one.

For health centers starting from scratch, setting realistic and competitive wage and salary scales is something that should be done right away. Not paying market wages will have short and long-term negative impacts on the health center. Plus, there's a ripple effect: high turnover will lessen provider satisfaction as well. We recommend that HR and Finance work closely together to help pinpoint the right salary/wage levels that are competitive for your marketplace.

Similarly, the benefits package is an area you must review immediately. While you may not be able to make changes to the benefits offered right away, having a plan in place to offer competitive benefits to your staff will go a long way toward recruiting and retaining staff people. One benefit that is recommended is a retirement savings vehicle, like a 401(k) or 403(b) program, or something similar. All of the large local health care organizations (hospitals, nursing homes, etc.) will offer them, and the health center will be at a competitive disadvantage if it does not offer one itself. Furthermore, the discipline of budgeting for employer contributions to retirement programs from the beginning is highly recommended.

A manual or handbook, based on your employment policies and procedures (and reviewed by your counsel!) helps all supervisors, and the board of directors, be sure they are treating everyone fairly in the workplace. A major area of potential liability, employment practices should always be applied in an equal manner to those equally situated. It cannot be stressed enough the value in making sure your health center does not treat people differently from an employment perspective. NACHC's learning management system, My NACHC, has sample employment policies and handbooks as well as an HR community. Visit <http://mylearning.nachc.com> to search the plethora of resources.

Finally, having your on-boarding, and indeed the regular employee training program, including information about your new status as a federally funded health center, is something that should be done right away. Your health center is required to be sure that you are offering care without regard to the ability to pay, and your care is provided in a culturally-appropriate way, etc. The staff needs to know how to communicate this with patients, and if these requirements are relatively new to the organization's staff, they deserve appropriate training on these topics immediately.

One of the program requirements (Number 19) establishes that no employee may be a family member of one of the members of the board of directors, whether by blood, marriage, or adoption. The health center should review any family relationships that exist with board members, and take appropriate action to ensure that it is in compliance. In addition, the health center should become familiar with other requirements for hiring within the health care sector. Understanding state licensure of nurses, physicians and other personnel, how to check the database of excluded entities, and verifying legal authority to work in the United States are all areas that require attention. The database of excluded entities is maintained by the Office of Inspector General (OIG) at the Department of Health and Human Services (HHS), and information as well as access to the database can be found at: <https://oig.hhs.gov/faqs/exclusions-faq.asp>.

Checklist #4: Finance

Promising Practices

1. *Make appropriate governmental filings*
2. *Ensure Medicare Federally-qualified Health Center (FQHC) and Medicaid enrollments complete*
3. *Review 45 CFR Part 75*
4. *Determine approach to billing*
5. *Ensure appropriate banking accounts are established*
6. *Review General Ledger (G/L) systems for accounting, treasury management, payroll, patient billing, inventory/capital equipment tracking*
7. *Prepare G/L for filing of Medicare and Medicaid cost reports and tax filings*
8. *Review PIN 2014-02*
 - a. *Review and develop a fee schedule*
 - b. *Review Sliding Fee Discount Program (SFDP), ensure it is approved by the board, and conduct training for board and staff*
 - c. *Develop health insurance payer contract review protocol*

There are many governmental filings that a newly-funded health center will have to make. For instance, every health center needs an organizational National Provider Identifier (NPI) number. This number is used for many purposes with federal, state and private payer organizations. Ensure the health center has an appropriate NPI number immediately. To apply for the organization's NPI number, visit <https://nppes.cms.hhs.gov/NPPES/Welcome.do>. Individual providers also need an NPI number. As this number travels with the provider, in most cases a new provider you hire will already have one. In the event he or she does not, they can apply at the same web site.

Similarly, every health center must enroll with the Centers for Medicare and Medicaid Assistance (CMS) using the 855A form, for each site it operates. Providers must also enroll, but use the 855I form. HRSA/BPHC has issued PAL 2011-04 (<http://bphc.hrsa.gov/policiesregulations/policies/pdfs/pal201104.pdf>) that discusses these filings in detail. Even if the health center sees very few Medicare patients, enrolling right away is something that every health center must do, because state Medicaid agencies cannot process an FQHC Medicaid enrollment without the approval of Medicare. The 855A can be found at <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855a.pdf>. The 855I form is found at <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855i.pdf>. The health center and all providers who write prescriptions must be registered with the Drug Enforcement Agency (DEA). These registrations are designed to prevent diversion of drugs. The application is available at <https://www.deadiversion.usdoj.gov/webforms/>. There are other filings that the health center will have to make, but these are among the most critical, and should be done immediately.

You have probably thought about your grant application as being “to become an FQHC.” FQHC status is conferred by the approval of the 855A form. As soon as you submit the 855A for the health center, prepare the state’s Medicaid FQHC enrollment package. Consult with your state Medicaid agency, but most will not accept the FQHC enrollment package until you have the approved 855A in hand. Be ready to send (or hand-deliver, or send via overnight mail) the state’s FQHC reimbursement application IMMEDIATELY. This is because the vast majority of states only reimburse at FQHC rates from the date the application is received by them⁷. Delaying to complete the application translates into lost revenues to your health center.

One area that cannot be overstated is compliance with 45 CFR Part 75 on financial management of federally-funded programs starts on day one of approval. That means that the health center is responsible for tracking of funds, purchasing protocols, the single audit provisions under what is referred to by auditors as the “Yellow Book standard” and many other things. The “Yellow Book Standard” refers to the Generally Accepted Government Auditing Standards, and is so named because it has traditionally been published in book form that is yellow in color. By virtue of the Section 330 grant, the health center must have an annual audit that conforms to these standards. The standards are available at <http://www.gao.gov/yellowbook/overview>. Selecting an auditor early (as we recommended in the governance section) will help you be in compliance with these standards and your auditing firm can provide resources to help the health center establish processes right away that will avoid problems later.

Patient and insurance company billing is a major function of the finance department. It would be nice to know that 100% of bills issued to payers will be paid in a timely fashion and at the amounts health centers bill. However, that is almost never the case. Denied claims, for any number of reasons, can represent not only a glitch in the system as it has been implemented at the time, but also an opportunity for improvement. Denials can occur for many reasons. Electronic systems can malfunction and cause a denial. Changes in payer acceptable coding can cause denials. Improperly verified insurance coverage – possibly the most common cause of claims denials across all payers – will definitely cause a denial of claim. A system for denials review is essential.

One major question that health centers face is whether to operate the billing function in-house or to contract for the service with a billing company. Both have their benefits and drawbacks. In-house billing keeps control of this major function at your very fingertips. You can monitor and review outcomes every day. However, it leaves a health center vulnerable to loss of staff, and requires the team to study and implement every billing change that comes along. Outsourced billing alleviates the staffing and training requirements, though a health center runs the risk of not being the billing company’s chief priority. Sometimes outsourced billing companies go after only “low hanging fruit” – claims that are easy to bill and highly likely to result in quick payment (like Medicaid fee-for-service claims), and let corrected denial rebilling sit by the wayside.

The health center will need various banking accounts in order to operate. It is highly recommended that the health center have various accounts (one for the receipt of federal dollars, one for payroll disbursements, one for accounts payable, one for insurance payments and one for other revenues, for instance) to facilitate the tracking of dollars received and their expenditure. Reviewing the appropriate regulations with your banker will help the bank create the right set of accounts for your entity.

The health center’s G/L must perform many functions for the center’s finance operation. Reviewing its structure will help the health center create the right reporting that ensures compliance with federal regulation and other reporting requirements. While your independent auditor cannot set up the G/L for you, the firm can advise on how to structure the G/L so you and they can get information back in formats that make audit field work smooth and give you clarity on the health center’s financial position.

Review PIN 2014-02, available at: (<http://bphc.hrsa.gov/policiesregulations/policies/pdfs/pin201402.pdf>).

⁷ Check with your state Medicaid agency, as this can vary.

This PIN covers patient billing, establishing a fee schedule, review of poverty status, registration documentation, and application of required discounts. A couple of the key areas for you to focus on immediately are discussed below, but please remember that these are examples and suggestions for immediate focus. The health center is responsible for understanding and applying the entire PIN.

The PIN requires health centers to use a cost-based approach to developing its fee schedule. Health centers should study its actual cost of providing services and consider locally-prevailing rates. These are complex analyses that go beyond the scope of this monograph, and health centers are encouraged to consult with financial advisors, PCAs, or cooperative agreement-supported organizations for further assistance. Please note that the fee schedule applies to services regardless of payer.

A payer contract review protocol will help the health center evaluate insurance contracts that are presented to leadership. Establishing insurance contracts is critical – especially in the post-Affordable Care Act world. Different contracts will pay different amounts for the same procedures; finance, leadership and the board of directors must understand the nuances among the various payers. How can you know if the revenues from a given contract will be sufficient to support accepting the contract? Knowing and tracking the health center’s cost per visit and revenue per visit (by payer) will help the health center identify “good” contracts vs. those that are reimbursing at a loss. Just because a contract reimburses at a loss does not necessarily mean that the health center should not accept the contract. If the health center has a large number of patients covered under a contract, the health center will have leverage with the insurer to negotiate improved rates in the future. The finance department should have a process in place to review contracts – from the agreement’s fee schedule to billing requirements to expected receipt of revenues – to be able to advise leadership and the Board about the proposed agreement and the effects of entering into it.

As a newly-funded health center, you have access to funds that will help subsidize the cost of care to uninsured and underinsured people. Discounts can only be based on family size and income. To protect the integrity of the federal investment, these funds may only be used in accordance with the health center’s verification of certain information, and then applying discounts in keeping with its own, board-approved, sliding fee discount program. Review PIN 2014-02 for tips on establishing and managing your SFDP.

Checklist #5: Clinical

Promising Practices

1. *Establish provider privileging process.*
2. *Board approves permanent privileges.*
3. *Determine laboratory needs (contract vs. in-house, stat labs)*
4. *Obtain license for any non-CLIA-waived testing*
5. *Form quality improvement (QI) committees*
 - a. *Staff committee*
 - b. *Board committee*
6. *Set performance requirement accountabilities for providers*
7. *Review required health center services and optional services on Form 5 of the application*
 - a. *Direct services available regularly*
 - b. *Referral services provided under a formal referral process*

Clinical care is at the heart of the health center movement, yet often is assumed to be operating correctly. The health center's Chief Medical Officer (CMO) or clinical director is the cornerstone of the care, and has certain responsibilities to make sure that care is of the highest quality. This starts with a provider privileging process. When a provider joins the health center, and at least every two years thereafter, he or she must apply for the privilege to practice at the health center. These privileges are highly specific. They should go to the level of distinct procedures that the practitioner wishes to perform. A system whereby the CMO (at a minimum) reviews the request for privileges with the applying provider is highly recommended. Ultimately, the board of directors grants permanent privileges to a provider to practice. It is recommended that the health center policies permit the CMO to grant temporary privileges to newly-hired providers until the board of directors can meet to finalize. Note the board must approve the policy that allows the granting of temporary privileges.

Care to health center communities is more than providers delivering one on one visits. Health centers need arrangements for laboratory services, radiology, and other ancillary care that patients require. Some health centers provide all of these ancillary services themselves; most, however, enter into contract arrangements for them. There is no one-size-fits-all solution to these matters – the health center must determine for itself the right way to deliver access to these services. In rural or frontier or remote communities, more of these may need to be offered directly on site. Be sure that contracts for these services are compliant with federal requirements that care be available without regard to ability to pay and on sliding scale, which is outlined in HRSA/BPHC PIN 2014-02. Also review PIN

2008-01, which has information on this topic. Whether you contract for a laboratory or start one in the health center, there will be a need for certain clearances by the HHS through CMS. This program is known as Clinical Laboratory Improvement Amendments, or CLIA, which is a program that regulates all laboratory testing (except research) on humans in the United States. More information is available at <https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/index.html?redirect=/clia/>. Regulations can range from a simple authorization to use CLIA-waived tests in the course of practice, all the way to comprehensive site visits and accreditation as a low, moderate or high-complexity laboratory facility. Consider carefully the requirements of CLIA as the health center ramps up laboratory services. Radiology also can bring with it state requirements for licensure as well as significant building code requirements.

The health center board of directors is responsible for the quality improvement program, and a staff person is designated (often the CMO or a nurse) to manage quality and performance improvement. Ensure that the designated staff person has the support and the time to dedicate to this most important function. Sometimes health centers operate two QI committees – one at the staff level and one at the board level. In other cases, there is only one joint committee, with board members serving alongside staff members. No matter the kind of committee the health center chooses, the board must receive regular reports on quality of care. The health center's implementation plan is one road map to establishing or revising the health center's QI plan.

The health center's clinical program also includes productivity, and monitoring the performance of providers. Job descriptions and provider employment contracts that clearly outline the expectations for productivity performance as well as quality outcomes make performance conversations much easier to handle. Clarity and agreement on what is expected from everyone – the provider's responsibilities to the health center and the health center's responsibilities to the provider – is the goal.

The largest and most important task is reviewing the health's services on Form 5A of the application. When approved as a health center, the organization is responsible for making sure that required services are available to the community, regardless of ability to pay and other factors. Most health centers achieve this by offering all required services in-house, but that is not a requirement. If the health center opts to contract for required services from other organizations or optional services that are in-scope, no matter if the grantee pays for the referral or not, the health center must have a formal, written, referral agreement that at a minimum outlines the referral process, quality assurance, and communication back, as well as ensuring that there are no barriers to access to care for the population (financial or otherwise).



Checklist #6: Operations

Promising Practices:

1. *Establish system for sending and receiving medical records information*
2. *Establish/review process for supply ordering/receiving/storage*
3. *Establish patient satisfaction system*
4. *Establish system for patients and staff to report incidents*
5. *Review patient flow to ensure maximal efficiency*
6. *Train all staff on sliding discount scale and barriers to access to care*
7. *Establish HIPAA privacy practices*
8. *Determine staffing model to support delivery of care*

Operations is a key area of the health center that can have dramatic impact, positive and negative, on outcomes. Getting operations right the first time demands attention to detail and special focus to make sure systems are put in place right the first time.

One of the first tasks that must be tackled is the ability to receive health information about your patients from other providers and get it into the hands of a treating provider at your health center. Be sure to develop a system that can make sure that happens in a timely and effective manner.

When providers see patients, they must have the right supplies and equipment available to them to perform their examinations and render treatments. A system for ordering, receiving, ordering and maintaining inventory is essential.

Patient flow is another area that will require constant attention. A solid system established immediately will facilitate patients' being ready for providers to see, and forms the backbone of good customer service and patient satisfaction.

One performance metric you will have to report on regularly, to the board as well as to HRSA/BPHC, is your patient satisfaction. It is highly recommended that you begin measuring patient satisfaction immediately to obtain the first baseline. Use a validated survey instrument and capture data in a way that you can compare satisfaction by provider, by location and by service line. One free resource is the Agency for Healthcare Research and Quality (AHRQ), which has the CAHPS (Consumer Assessment of Healthcare Providers and Systems) surveys available for use. There are many versions of these tools available depending on the type of healthcare entity. The survey for use by health centers can be downloaded from <https://cahps.ahrq.gov/index.html>.

In the HR section above, we noted that training for staff on how health centers operate including the availability of a scale of sliding discounts is essential. As the center identifies training opportunities for its team, be sure to review Program Requirements and PINs, especially PIN 2014-02, since virtually all health center employees will need to be aware of these requirements in performing their daily duties.

The Health Insurance Portability and Accountability Act (HIPAA), guarantees patients certain rights and also gives them certain responsibilities. Among the rights a patient has includes the right to review their records and have assurances that their protected health information (PHI) is indeed protected. Health care providers, including health centers, can be liable for fines and corrective action in the event PHI is not properly protected or is disclosed even if disclosure is accidental. Most health care organizations designate a single individual, a privacy officer, who is responsible for ensuring that all privacy guidelines are followed and proper training is done. That individual is also the point of contact and takes the lead in the unlikely event there is an allegation of breach of privacy.

A proper staffing model will help improve efficiency and ensure that the health center meets its goals for providing care to the community as well as gives the right level of support to the provider team. Support means much more than just nurses or medical assistants, however. It includes billing and front desk staff along with direct patient care support personnel.

Checklist #7: Information Technology

Promising Practices:

1. *Select/install/contract with Electronic Health Records (EHR) system*
2. *Establish HITECH (Health Information Technology for Economic and Clinical Health) security procedures*
3. *Test EHR for reporting (especially UDS)*
4. *Establish/improve email systems including secure messaging*
5. *Ensure redundant internet connectivity*
6. *Create emergency operating procedures*
7. *Determine decision-support requirements*
8. *Determine staff authority levels*
9. *Implement secure faxing system for medical records*
10. *Review telephone system for adequacy*
11. *Determine Health Information Exchange availability/membership*

In today's world, Information Technology has gone from managing a few desktop computers to being the backbone of the health center. Even if your organization is not "tech savvy" today, you will be adding new systems sooner than you think. A robust information technology function will make sure that you do so in a cost-effective way that also maintains compliance with regulations.

One of the first questions you will face is whether the health center will launch an electronic health record system right away. Choosing the right system is important, and will create a mind-boggling cascade of other decisions. As with many things, there's no one right way to do this. Health centers can own and operate an EHR in-house, or contract with many different kinds of vendors to operate it with them. HRSA/BPHC-supported Health Center Controlled Networks (HCCN) offer an excellent opportunity to work with other health centers, sometimes from around the nation, to provide electronic records systems. Information about HCCN can be found at <http://www.hrsa.gov/healthit/toolbox/healthitadoptiontoolbox/opportunitiescollaboration/abouthccns.html>. You must have a thorough process for selecting the right system for your health center. Many people will need to be part of the decision – providers, finance, and the IT team to name a few. Your operational workflows will need to change to accommodate the system. And the system will cause a radical change in the way providers deliver care to their patients.

Whether or not you have an electronic health record in place, the health center must comply with HITECH. The moment you send a bill electronically to Medicaid or Medicare, you have PHI stored in an electronic format. Conduct a planning audit of your networks and other systems to make sure they are compliant. Fines for violations can be hefty.

Once you have an EHR, one of the key things to test is its ability to generate reports. The UDS report is crucial. You need to know how your EHR generates the UDS report, so providers and support staff can get the right training to populate the database in a way that will produce a correct (and complete) report.

One operational tool the health center needs is secure messaging, so you can share PHI electronically without worry. Also, especially if you are using a contracted or hosted EHR, you will need to have redundant Internet connectivity. The specter of having to provide health care without even being able to see a note from the last visit will be enough to ensure you obtain enough redundant capacity at least to be able to print visit summaries for providers to use in case of a protracted shut-down of internet access. That loss of Internet connectivity will happen at some point. In addition to redundancy, the health center also needs a comprehensive action plan to put into place when the connectivity is severed.

IT is the keeper of all electronic systems and plays a key role in decision-support. This relates to the ability of all the health center's electronic data systems to produce reports. Work especially closely with the CMO and the QI team to make sure you can produce what they need.

Staff members need different access to systems, files and folders. Access is typically determined by function. The IT team will create a system to assign appropriate access levels by employee type. This access goes not only for the EHR, but also for financial information, correspondence files, etc.

Legacy technologies, like faxing, often still play a major role in the delivery of health care. Reports from emergency departments, referral reports from specialists, lists from managed care providers often arrive in the health center via fax. Because these can contain sensitive information (and even PHI), the health center should have a secure faxing system in place. Fortunately, these systems often integrate directly with EHRs, and therefore faxed documents from referral sources often tie directly and automatically to a patient record.

Telephones today are really IT systems. Costly yet feature-laden, today's telephone systems are really access management tools that will help the health center put its best foot forward. The technology changes rapidly, with ever more sophisticated call routing, hold messaging and data reporting available. Choose a system wisely to allow you to grow.

One development underway is the Health Information Exchange (HIE). These exchanges will permit health providers to communicate electronically with one another, sharing details of patient records, care outcomes and lab reports, to name just a few things. In some parts of the country they are highly developed; elsewhere they remain a dream for the future. It is recommended to start working with any HIEs in your area right away, to make sure your systems can communicate with these important networks.



Checklist #8: Facility Management

Promising Practices

1. *Implement hazardous materials handling procedure*
2. *Contact for trash/biomedical waste handler*
3. *Establish standards and systems for regular maintenance*
4. *Establish building access systems*
5. *Establish calendar for fire, flood, earthquake, tornado, disaster drills (as appropriate)*
6. *Ensure Material Safety Data Sheets (MSDS) in proper locations*
7. *Determine Americans with Disabilities Act (ADA) compliance for building*
8. *Assure compliance with local building/occupancy codes*
9. *Review Occupational Safety and Health Administration (OSHA) compliance*
10. *Determine need for state or local licensure for equipment and building systems*

Your facility will help you succeed if it is optimized for your patients. It is one of the first ambassadors of your brand your patients see, and it plays a major role in patient and staff satisfaction. These tips are designed to help you make sure your facility is help, not hindrance.

The health center will generate hazardous waste. A competent handler of these materials should be one of the first agreements you sign, as liability is high for the inappropriate disposal of hazardous materials.

Planning for regular maintenance and repairs will help you avoid crisis situations when they inevitably arise. No one wants to face a burst pipe, especially when the health center has no relationship with a plumber. It is recommended to establish regular maintenance schedules for major building systems and also be sure a proper housekeeping protocol is developed and maintained. Consider the housekeeping protocol from the perspective of patients and staff. A list of systems is in the appendix.

Access to the facility must also be controlled. Patients have a right to privacy in their seeking of medical care, and everyone who works in or visits the health center has a reasonable expectation of security while in the premises. A single point of visitor access is recommended to control access to the building. Other employee ingresses may be provided though it is recommended that there be a system in place (key cards or something similar) to track who is in the building at any one time. Especially in case of an emergency, knowing who is on the premises will help ensure safe evacuation.

Plan for your annual disaster drills early. A calendar established by the senior management staff to make sure all of the required drills occur each year is easy, and will help you make sure you do not forget these required exercises. Don't forget that evacuation may be caused by more than fire – think about how evacuation may be different in case of tornado, or flash flood.

Chemicals used in cleaning, provision of health care and other activities that occur in the health center every day may be dangerous, especially if they are inadvertently mixed with other substances. Material Safety Data Sheets must be available to staff who use chemicals in their work so they can handle spills, accidental exposure and have access to warning information about potentially lethal mixtures.

Compliance with various building codes – from access standards under the Americans with Disabilities Act to local building requirements for sprinklers, number of electrical outlets, toilet availability and other areas must be complied with. OSHA compliance is another requirement, and may relate to air quality, water standards, etc. Further, some jurisdictions require certain licensure. A list is in the appendix.

Checklist #9: Risk Management

Promising Practices

1. *Establish conflict of interest policies and procedures immediately*
2. *Review insurance coverage:*
 - a. *Malpractice (Medical, Dental, Behavioral Health) pending FTCA*
 - b. *General Liability*
 - c. *Property and Casualty*
 - d. *Workers' Compensation*
 - e. *Directors' and Officers' (D&O) Liability*
 - f. *Employee Benefits Coverage*
 - g. *Employment Retirement Income Security Act (ERISA) Rider for offering Employee Benefits*
 - h. *Employment Practices Liability Insurance (EPLI)*
 - i. *HIPAA Cyber Liability*
3. *Begin Emergency Preparedness Plan*
4. *Establish emergency communications systems*
5. *Inform health departments and other first responder agencies of the health center's ability to assist in emergencies*
6. *Begin establishing corporate compliance systems*

As a newly funded health center, the organization has assumed certain risk that may exceed the risk level it had before. The critical component of managing risk is first to know what the risk is, and then begin to find ways to manage and mitigate it.

The very first thing you should do in the area of risk management as a newly-funded health center is establish a conflict of interest policy for each board member, and typically senior-level leaders. Usually, they make an annual conflict of interest disclosure. HRSA/BPHC has a document to help in this area: <http://bphc.hrsa.gov/technicalassistance/newguide/5cconflictinterest.pdf>. A health center should also review this policy and its related disclosure statement with local counsel to be sure it meets any state or local requirements.

Adequate insurance coverage is a must. There are many coverage options available, and a qualified broker will be able to help you determine your health center's risk appetite, the likelihood of exposure and the value proposition of certain coverage. Above, in the checklist itself, we have listed some of the most common coverage obtained by health centers. You should also inquire with your broker about umbrella coverage, also known as excess liability coverage, to preserve the center's assets in the event of a loss. The broker will be able to advise you on the need for flood coverage, which may be a requirement in your area.

An emergency preparedness plan is something the health center must have. On September 11, 2001, health care organizations realized just how fragile the system is for handling major disasters. Local authorities from coast to coast began establishing emergency preparedness plans for their communities, and health centers are a core part of those plans. Confer with your local health departments and first responder agencies about how the health center can fit into those plans. You will also need a disaster plan for the health center's operations – knowing where to go, whom to call, and where operations will centralize in the event of a disaster is something you must know. Your emergency communications system is also a major part of this plan, though it is the facet of the plan you will use the most, especially if your community faces challenging weather (severe winter storms, tornadoes, hurricanes, etc.).

Corporate compliance systems are the best way to make sure you proactively manage and address risk in the health center. The Office of Inspector General (OIG) at the Department of Health and Human Services offers guidance free of charge on establishing a corporate compliance program. These resources can be found at <https://oig.hhs.gov/compliance/101/>.



SECTION II – The Rest of Year 1

Congratulations! Your health center has passed its first hurdle – the first 120 days of operations. In this time, you and your team have positioned the health center for success, and begun thinking, looking, and feeling like a fully-operational health center. You have worked hard, expended a considerable amount of energy, and are ready for more advanced topics.

There is a saying in the health center movement: “When you’ve seen one health center, you’ve seen one health center.” There is a lot of truth to this. Every health center will look and feel just a little bit different from its peers – you will serve patients in different languages according to your community need, you will offer a slightly different set of services (but everyone will provide the required services), and you will use different techniques of outreach and communication with your patient base. At the core, however, most health centers will perform most of the same tasks, and will have very similar things to review, perfect, and operationalize.

In this section, we will give you some suggestions how to approach the next eight months of your development. Some may think that the heavy lifting has passed, but this is no time to rest on your laurels. The systems you develop during this period will be the enduring way the health center approaches its compliance and operations for many years to come. Building it right the first time will save the health center from having to recreate systems in the future.

This section is deliberately “lighter” in terms of suggested activities – it is understood that you have done a lot of work getting through the first 120 days, and the health center must now concentrate on establishing sustainable processes that will work for years to come. It is time to start thinking about the future and positioning the organization for long-term success.

Rest of year one: Governance checklist

1. *Conduct board training to solidify board's role and its long-term plan*
2. *Make a long-term board recruitment plan*
3. *Solidify and finalize committee structures*
4. *Discuss the board's role in areas like quality oversight, financial oversight, and fundraising*
5. *Perform board self-assessment toward the end of the year*

Conduct board training

Board training can happen at any time, but we recommend completing it after the first 120 days are complete but still in the first year of operations.

One trap some health centers have fallen into is blurring the lines between the role of governance and management – and board training can help you make sure that everyone knows the roles to play. Boards must understand their obligations under state and federal law, and their duty to advance the mission and vision of the organization. Scheduling a board retreat during this time, in which you will revisit the obligations of a board of directors, is highly recommended. These obligations should take into account not only corporate governance requirements, but also the requirements of health center boards under Program Requirements.

Long term board recruitment plan

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

HRSA/BPHC publishes periodic recommendations on governance issues. The general link to those resources is at: <http://bphc.hrsa.gov/programrequirements/resourcecenter/governance/index.html>

These tools can help evaluate the board's current composition, the ideal composition, and what positions you need to recruit to meet an ideal board composition. Don't totally eliminate potential recruits who may not fall into a matrix category. Some people have such interest, passion, or potential that they should be asked to join the board even if they don't fit neatly into the matrix.

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

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

Keep a listing of desired skills and abilities you would like to have on the board, so all board members and interested parties can be on the lookout for candidates. Share the list at least quarterly, and review it on that schedule with the board development and executive committees so that it remains always fresh in everyone's mind.

Solidify and finalize board committee structure

Chances are the health center has been so focused on meeting HRSA's requirements within the first 120 days (and making sure the health center is operational) that neither staff nor board leadership has had the opportunity to focus on how the board will do its work for the long term. Now is the opportunity to think through the committee structure that is envisioned in the health center's bylaws and compare it to some best practices for governance. Think carefully about establishing standing committees in the bylaws, as they must be sustained long-term. It is often recommended that an executive committee, a quality committee and a finance committee form the backbone of the committee structure. Earlier, we suggested a board development committee, also to have responsibility for nominations; we think this is a promising practice for health centers. You may wish to consider having an audit committee separate from your finance committee, and we recommend conferring with local counsel and your auditor on this point. Some boards of directors rely on ad hoc task forces, charged with a single deliverable, that you can rely upon for issues like strategic planning and other shorter-term, time-limited, work.

The board's role in fundraising

Fundraising is an area that many boards will become involved in over the course of their tenure. Who better to tell the story of the health center, than a patient-majority board of directors? Boardsource.org has free materials available to help the health center with this and other topics, and there is more information on fundraising later in this document.

Board Self-Evaluation

Every board of directors should undertake a self-evaluation of its own performance. Boards can rate themselves on various topics, such as attendance, participation, involvement in committee work, and other topics. The Council of Nonprofits has self-evaluation information available free of charge at councilofnonprofits.org. Boardsource.org, mentioned above, also has free board self-evaluation tools. Like any kind of long-term evaluation, it is recommended that the organization select or develop a tool, and plan to stick with it for a few years, to track and trend its performance over time.



Rest of year one: Administration checklist

1. *Revisit days and hours of operations*
2. *Establish or refine care management processes*
3. *Create your focus on outreach and marketing*
4. *Review contracting options for needed services*
5. *Interact with payers*

As the health center goes through the rest of its first year, it will face the opportunity to look at systems, processes and plans. What you put in place administratively today will make a big difference towards the outcome.

In the rest of the first year, the health center should focus on being responsive to patients and community stakeholders. This means that you will be focused on how the health center holds itself out to the community both in terms of marketing and in linking up with other health care providers.

Revisit Days/Hours of Operation

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

Care management processes

The future of healthcare is in care coordination and management. Using a comprehensive care management protocol and function the health center can drive evidence-based medical care into the community, and also deliver the revenues needed to thrive and grow. Furthermore, as the health center looks down the road toward accreditation and certification as a Primary Care Medical Home (PCMH), it is important to know that both have deep roots in care management/coordination.

During this rest of year 1, the health center is in the perfect position to refine processes for making referrals and receiving reports from other health care providers. A big part of this process is understanding what services the health center needs to refer out and how the patient care team is going to make sure that care is delivered effectively.

Care management/coordination can take many forms. Usually led by registered nurses, these personnel have the clinical skills and knowledge to interact with patients on health related issues and intimate knowledge of the health care delivery system to help patients get the care they need. Review the NCQA's sections on PCMH to learn more about care management, <http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx>.

Outreach to the Community

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

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

Create a process for evaluation

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

Make sure to connect early with your local schools. Contact the Parent-Teacher Organizations to educate them on your services. Come up with creative ways to get kids and their families into the health center and to make the health center their medical home.

Outreach/marketing and care coordination intersect when the health center is locating patients to bring them in for needed care. Following evidence-based medicine, the health center will be contacting patients to bring them in for needed care. In today's marketplace, health centers must be able to use proven marketing strategies to do so. This is the time to learn about market segmentation and how to parse the patient population to conduct micro-targeted outreach to patients for the care they need.

Also during this period the health center will be making a lot of decisions about what things to do in-house and what to contract for in the marketplace. Contracting (for everything from housekeeping service to temporary personnel to provider staff to augment salaried staff) can be a good idea for the health center, but it is a relationship that must be entered into carefully. Remember that all contracts must be entered into under the requirements of 45 CFR Part 75.

To Contract or Not To Contract

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

It is always wise to have your legal counsel involved in contract development and execution, because all contracts with the health center must adhere to the provisions of 45 CFR Part 75. Specifically, 45 CFR 75.327 relates to procurements, which governs contracted health services. Contracts involving billing should address patient protec-

tions such as how patients with the inability to pay are addressed with and who retains the right to proceed to bill for overdue accounts. PIN 2014-02 can help provide guidance on the requirements that health centers must follow, even when services are rendered by contracted entities. Also, make sure the health center's board-approved policies address collections efforts by contracted entities.

Interact with payers

In the first 120 days you ensured Medicare and Medicaid applications were filed and began looking at managed care plans, ACA marketplace plans and other health plans for your patient population. The rest of this year will see you working with the many plans at work in your community to make sure you can serve those who want your care. Here we discuss a couple of types of arrangements – Managed Care Organizations (MCO) and Accountable Care Organizations (ACO), to help you get started. More information on MCOs and ACOs is in the appendix.



Rest of year one: Human Resources checklist

1. *Establish competency assessment system for support staff*
2. *Build an on-boarding process*
3. *Establish recruitment relationships*
4. *Make and execute a staffing-up plan*

During the rest of year 1, the health center will likely devote energy in developing the staff. You will be establishing competency assessments for ancillary staff, beefing up your on-boarding, and perhaps most importantly, recruiting considerable numbers of people to your team. What's more, you will be establishing the relationships for staffing that will carry the health center forward for years to come.

Competency assessments are critical. When you employ nurses, medical assistants, dental assistants and other staff, the health center must know that the staff employed has the skills needed to perform the duties they must to care for the patients. Typically, this is completed through the direct observation of the proper implementation of protocols that reflect professionalism of the team in place, and should be done at the time of hire and annually thereafter. Developing a system of competency assessments is time consuming, and while it is vitally important, it was deferred to this time frame to allow for focus in the first 120 days of making sure the health center is operational.

Develop a Strategy for “Staffing up”

In the first 120 days, the health center took a look at its organizational chart. Now, it is time to fill in the chart in a thoughtful way with the staff you need to deliver care to your community. Remember, according to the health center statute and HRSA regulations, **the CEO/Executive Director must be selected, evaluated, and removed (if needed) by the health center board**. The board of directors is responsible for ensuring that the health center has a core staff sufficient to provide services as outlined in its initial grant application and implementation plan. It is recommended that most of the health center staff be employed by the health center directly, to help ensure that the line of accountability to the board's policies for care delivery are followed.

In the appendix is a wide-ranging, but not inclusive, list of positions that a health center may choose to employ. Although these are grouped clearly by major functional area (Administrative, Financial and Clinical), there will most likely be crossover into multiple departments; crossover should be reflected on the organizational chart.



Rest of year one: Finance checklist

1. *Ensure items from first 120 days' checklist are fully implemented*
2. *Create regular monthly financial closure procedures*
3. *Prepare for annual audit*
4. *Consider securing a line of credit*

The rest of year 1 is a time for the finance department to focus on implementing its processes. In the first 120 days, the finance team focused on developing compliant charts of accounts, helped the board secure the services of an auditor, began providing financial statements and established procedures for the receipt of federal funds. It also made sure that tracking could occur of federal dollar expenditures.

You have no doubt noticed the reference back to the first 120 days' checklist here. It is understood and recognized that the organization of a finance department may be a herculean effort. Your finance team will be tired, and they will have invested countless hours in making sure that the health center is prepared to operate effectively from a financial standpoint. They may not have gotten everything done, and they need time to complete the tasks before them.

One thing that is recommended is that there be an unbending process for the closure of month end financial transactions. This ultimately requires the assistance of everyone in the health center. All transactions for the month should be in and posted at a given time, and the finance team ready to convert the raw data into a regular financial report. We advise health centers to make and stick to a calendar of financial closing that supports this aim. The entire health center staff should be aware of these closing deadlines so that your process is smooth.

As the end of the first year approaches, it will be time to consider the annual audit. With luck, the board of directors had chosen an audit firm during the first 120 days. The Chief Financial Officer (CFO) and Chief Executive Officer (CEO) should meet with the audit partner every couple of months during the first year to help identify issues that could arise. While the actual audit cannot occur until the entire year has been closed, there is much that can be done early.

A line of credit is an excellent idea for any health center organization. There's a saying among finance professionals: when you need a line of credit, you can't get one, and when you don't need one, you can. Remember this. Work closely with your bank and be prepared to be able to secure a line of credit for the organization as quickly as you possibly can.



Rest of year one: Clinical checklist

- 1. Increase and maximize clinical productivity*
- 2. Recruit patients to fill out patient panels*
- 3. Identify where contracts with payers have quality incentive bonuses to the organization and make sure they are being met*
- 4. Plan for and begin recruitment efforts for new providers*
- 5. Revisit and solidify clinical referral patterns*
- 6. Start doing performance improvement based on QI plan data*

In the first 120 days, clinical staff focused on startup procedures that it needed to complete. QI committees have been formed, and that team has started collecting and analyzing data. The CMO working with the board obtained privileges for practicing providers, and providers became ready to go through credentialing processes for hospitals and payers.

Now, attention turns to maximizing productivity, building patient panels, planning for recruitment of new providers, solidifying clinical referral processes, and beginning performance improvement activities as part of the QI plan.

The secret to success of a health center is production. Reality is that when health care services are delivered, the health center fulfills its mission and generates revenues. Providers must have adequate numbers of patients to see, and some providers will be more popular than others. It is the task of the clinical function to see to it that panel sizes are set, and that patients have the opportunity to bond with a provider at the health center. That means that providers have a limited number of unique patients for whom they can be responsible. Typically, patient panel size ranges between 1,500 and 3,000, depending on the type of provider, with midlevel providers and internal medicine physicians being at the lower end of the scale, family practice providers in the middle, and pediatricians at the higher end. With family practice, ensure that the physicians have a reasonable mix of adult and pediatric patients, or be willing to adjust the panel size accordingly, especially if the physician is essentially acting as an internal medicine specialist.

Historically, health care providers have been paid based on the amount of care they render. In the future, however, most health care payments will be made on a global, capitated, or outcomes basis. While there will always be some reimbursement models that contain payments for visits, the trend is toward paying for health outcomes wherever possible. Those outcomes are measured in many ways – last (or average) blood pressure, percent of patients in the plan under management who

have received annual women's health exams, average Hemoglobin A1C⁸. Most MCOs offer incentive payments to providers (including health centers) for attaining certain goals. In addition, some plans offer bonus incentives for providing flu shots, doing clinical breast exams, and other proven preventive measures that result in good health outcomes. Working closely with finance, administration and operations, Clinical should lead the charge in making sure that the health center achieves the maximum compensation from these systems as possible. This means not only providing the care, but also properly coding and documenting the incentivized services to be able to prove the care occurred. Everyone will have to be involved, and this is an excellent use of time and resources. Some health centers see their bonus payments exceed capitation or fee for service payments by multiples.

Recruitment and retention of providers is a never-ending process. July 1st is a date to keep in mind, as that date traditionally marks the beginning of residency for physicians, and is an annual rite of passage that sees physicians joining new practices. New graduates from residency programs will start seeking a permanent position in the autumn of the prior year – the cycle can take 6-9 months. The health center will need a recruitment plan that can accommodate these cycles and should start planning immediately for recruitment. Also, do not forget that many state PCAs also offer recruitment help. And it never hurts to develop a relationship with local residency programs in your area. Finally, do not forget provider retention. The CMO should be meeting regularly with clinicians to assess their satisfaction and to seek input that is really used to create an environment that is attractive to clinicians to work in.

As the patient load builds, so too will the number of referrals made by clinicians to other providers. These can include specialist physicians, physical and occupational therapists, and others. What they all need are processes to ensure that your referral information is getting to the other provider, and that your health center is getting reports from that provider on the care that was delivered.

During this time, your QI program will also mature. Just measuring outcomes is not sufficient. The health center will now start to make improvements based on the data – and the clinical team will need to spearhead it. The data will show whether or not the patients are getting the care they need. Visits will need to be redesigned, patient flow reexamined and clinical decision making supports put into place to ensure that patients are cared for properly. Performance Improvement (PI) is a discipline unto itself. PI professionals know how to examine processes and outcomes, and are experts in how the processes support the desired outcomes. You should have added a PI professional to your team by now, though if you have not, it is now the time.

8 A measure of blood sugar used to diagnose and manage diabetes.



Rest of year one: Operations checklist

- 1. Refine your clinical schedule – consider open access scheduling*
- 2. Review front desk operations*
- 3. Consult on performance improvement*

The clinical schedule drives organizational performance. Throughout this guide, it is made clear that providing direct care is the critical item of performance that health centers must do. Once HRSA/BPHC signs off on the health center's first 120 days, the first thing to do operationally is to review the health center schedule. Observe, collect data and monitor the implementation of the schedule. A key metric to review is known as third next available appointment. This metric is considered better than next available appointment, as the latter can be subject to last minute cancellations and skew actual provider availability. Third next available appointment, by specialty and by provider, will serve as a key access to care measure for the health center, and Open Access scheduling can help you manage appointment availability. More information is in the appendix.

Review the front desk. That team not only controls access to the facility, it is also gathers proper data for billing and assesses patients for the Sliding Fee Discount Program. These staff people literally have the success of the health center in their hands. During this time, establish performance metrics and begin to collect and measure data. Involve the staff members themselves in the planning and execution of these reviews, because they need to understand why they are doing what they do, not just that they need to do it. These staff people really understand the work they do, and will be able to offer leadership their insights so improvements can be made.

Where the front desk is concerned, measure everything that can be measured. Understand how long it takes to complete a new patient registration as well as to update information. Realize that patients may not always have everything they need with them to complete a registration – how does that impact operations? It is also essential that the front desk staff not view this as a punitive exercise. The front desk is the first foot forward – if the team is not bought into the health center's vision, patients will feel the effects.

Performance Improvement was covered in the previous section. Operations play a major role in making performance improvement come to fruition. Whether it's patient flow, the availability of supplies and equipment, or trained staff ready to perform the needed functions, Operations will play an important role. Also, as process-oriented thinkers, operations leaders have a unique set of skills and abilities that can examine how the work of the center is accomplished and find efficiencies and improvements in its delivery. Help the PI team complete their work.



Rest of year one: Information Technology checklist

1. *Complete items from first 120 days*
2. *Conduct HIPAA security audit*
3. *Conduct disaster drill*
4. *Test backup procedures and failovers*
5. *Begin an IT strategic plan*

The work of IT in the first 120 days was just a kick-off. IT projects take months and years, not days and weeks. From the procurement of equipment, to extensive testing, to implementations and go-lives, most of the work from the period right after funding approval will be just getting off the ground at the end of the first 120 days, beyond those items that must be done quickly in order to be operational.

One item for risk management that also tests systems is a HIPAA security audit. This should be conducted at least annually. It is likely that a contractor will be required in order to do this, as systems that include Internet connectivity need to be assessed, and it's unlikely that the health center will have the expertise to do that testing. Also, all IT vendors will need to complete a questionnaire for the annual financial audit. The IT function typically is charged with preparing vendors for that reporting.

IT should periodically test disaster scenarios. If the health center is using an electronic health records system, how does the system function during an outage? Those systems should be as robust as possible, and providers as well as support staff need to know how to operate in the event of an outage. Providers may not have access to prior records, the front desk cannot access patient financial information, and the billing team cannot issue bills, work denials, or communicate with patients about their outstanding bills. Because it is not the intention to provide less than stellar service, these drills should be done during slower periods, and without any actual impact on patients. But they must be completed, because your system will be unavailable at some time, and staff must be prepared to operate without their usual tools.

All IT systems – especially those that communicate externally to the organization -- should have redundancy built into them. A redundant system has no value if it is not understood how it works. While theoretically “failover” is an automatic process – i.e., if the primary internet connection is lost, a backup system automatically kicks in and should be nearly seamless to most users, IT should test this failover regularly to ensure that if the health center ever needs it, it is operating effectively and is reliable.

IT costs can be very high, a significant percentage of an organization's budget. Every health center should manage this cost in the context of an IT strategic plan. While this plan would be part of the organization's overall plan, it is recommended that a special effort be given to such a large cost item in the health center's budget. Consider operational needs, equipment refresh schedules, financing of IT projects, and developing technologies when thinking strategically about information technology.



Rest of year one: Facilities Management checklist

1. *Complete first 120 days checklist*
2. *Review all contractors for performance*
3. *Perform preventive maintenance*

We expect that there will be outstanding items from the first 120 days that must still be completed throughout the rest of year 1. These should take primary priority during this period. If the health center is operating in a temporary location, the facilities team may be focused on a construction project in addition to regular maintenance. This work will go on until the project is complete, and when it is, the team will truly get to work learning to operate new systems, understanding the maintenance requirements and methods those systems have, and activating the new facility to have it ready for patient care.

Much of the work of facilities occurs on a day-to-day basis, rather than on any kind of schedule. The facilities team will be constantly responding to acute situations, like spills, emergent repairs, etc., and they must have the availability to do that essential work.

Usually, health centers have contracted for certain facilities-related services. In the rest of the first year, Facilities should be reviewing the performance of all contractors to make sure the organization's expectations are being met. This review can include walk-throughs with representatives of the contractor, surveys given to staff and patients about the facility, discussions with consumer and non-consumer board members, and discussions with representatives of the general community. During this time, the health center may be renewing licenses, hosting facilities review panels from state and local agencies, and completing major projects like repairing roofs, winterizing building systems, and ensuring that all preventive maintenance has been completed.



Rest of year one: Risk Management checklist

1. *Renew insurance coverage*
2. *Convert to FTCA if deemed*
3. *Complete provider peer review*
4. *Review trends in incident reporting*
5. *Finish emergency preparedness plan and emergency communications systems*
6. *Activate corporate compliance plan*

It seems hard to believe – the health center just obtained insurance coverage! However, 90 days out from renewal, the health center will begin the renewal process. This will include a review of projected revenues and expenses, growth in personnel, major additions to equipment and supply stores, and a review of any workers' compensation claims that occurred. Your insurance broker will be guiding the health center through this process, and it helps to start it early. Work closely to be prepared for the renewal season, so that it doesn't interfere with end of year financial closing and other federal, state, local or foundation reporting periods that can tax the health center's systems.

With good planning and systems the health center will receive deeming under the Federal Tort Claims Act during this period of time. Converting to FTCA coverage has implications for risk management. The prior malpractice carrier may require the purchase of "tail" coverage that essentially extends insurance of prior acts once FTCA is in effect. More information is in the appendix. Work closely with HRSA/BPHC (especially the Office of Quality Improvement), insurance carrier and insurance broker to make sure the health center and its providers are properly protected.

Provider peer review is something that should occur regularly. It consists of the analysis of randomly-selected patient charts for another provider of the same type or specialty to review the care delivered and express a professional opinion on that care. Reviewers will opine on the comprehensiveness of the plan of care developed for each patient. Note: only clinicians can see the actual commentary on peer review documents. This is often limited to physicians, and perhaps a nurse who coordinates the peer review process. The actual commentary should be sealed, and only aggregate data per provider reported to non-clinical management, including the board.

Every health center has incidents. These can be as serious as a needle stick, or as minor as a slight slip on a carpet. Every incident, no matter how small, should be documented. Data should be kept on all incidents and tracked and trended regularly. These should be reported to senior management (individually and in the aggregate) and to the board of directors (in the aggregate only). Trends should be identified early and remedial action put into place to minimize exposure to the health center.

During the first 120 days, the health center started emergency preparedness work. This should be completed during year 1. As part of this, the health center should complete an emergency preparedness self-assessment, which can then be updated every year. These systems will include emergency communications systems, which should be tested periodically.

The health center also should have instituted a corporate compliance program. As with any comprehensive system, instituting the program is not enough – it must be activated. Activation of the system includes ongoing training and education, as well as prospective audits of at-risk functions to be sure the health center is operating within proper parameters.



ADVANCED CONCEPTS – years 2 and beyond

The health center has celebrated its first anniversary and has become a vital part of the community. Through your hard work, planning and determination the health center is positively impacting countless individuals. In the coming years, the health center needs to move from the implementation phase to the next level in operations and planning. This next section will merely highlight the areas you should think about in years 2 and beyond.

Accreditation/Recognition Initiative

Accreditation is an area of consideration for health centers that must be carefully reviewed. HRSA recognizes two accrediting bodies: The Joint Commission (TJC) and the Accreditation Association of Ambulatory Health Care, Inc. (AAAHC). Many factors come into play as a health center considers accreditation.

Accreditation and/or certification are the processes of requesting an independent review of your organization's performance against national quality and safety requirements. In October 1996, BPHC began an initiative to promote accreditation of health centers. More information on this initiative is in the appendix.

Meaningful Use (MU)

CMS and the Department of Health and Human Services have established incentives for health care providers using electronic health records to demonstrate that the investment in such systems conveys value to the organizations. In addition, there is a desire to incentivize the use of such systems in ways that are proven to have positive impacts on patient care and health outcomes. This system is called "Meaningful Use."

Health centers that have implemented EHR systems should review the MU criteria and plan to organize their use of the system to achieve MU. The incentive payments to health centers can be significant, and will help offset the high cost of purchasing and maintaining the EHR systems. More information about Meaningful Use can be found at: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html.

Long-range strategic planning

Strategic planning determines an organization's direction for the future (usually three years), how the organization is going to get there, and how it will know if it got there or not. The focus of a strategic plan is usually on the entire organization, while the focus of a business plan is usually on a particular product, service or program. We recommend a three-year strategic planning cycle. Health centers should also do annual operational planning that focuses on short-term objectives within the context of the broad strategic plan.

Strategic planning should be based on collecting and analyzing data, as well as on input from diverse stakeholders: health center governing board members, staff at all levels, community members, clients and organizations involved in providing or paying for health care in the marketplace. When considering input from community stakeholders, do not overlook health planning agencies, local health departments, your state primary care association, and elected officials. All of these can provide insight to your planning process that will inform and improve the final product. If you receive funding under special populations (migrant and seasonal farmworker, homeless and public housing) do not forget to confer with representatives of these populations either in crafting your strategic plan. Finally, excellent strategic plans include financial modeling that demonstrates the likely impacts of implementing the strategies identified in the planning process.

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

As a new organization, it is essential that you look towards the future and develop a plan for the entire organization. This plan should have a clear statement of where the health center is today and where it will go in the future.

The board should be involved in the process from the beginning, not just review a plan proposal from the management team. Board members should sit on the strategic planning committee and progress on the development of the strategic plan should be reported monthly at board meetings. Ultimately it is the board that must approve the strategic plan. Once the plan is approved, the board should receive periodic updates on the plan's progress. It is recommended that this occur no less than quarterly.

Revisiting the needs assessment

In your preparations for annual budget period renewal application and Service Area Competition application – you must revisit the needs assessment. Everyone knows that the health care marketplace changes rapidly. Part of why your health center was established is that your organization demonstrated that you understand and can respond to these rapid changes in the market. Links to resources are in the appendix.

Fundraising

As a non-profit, charitable entity in your community, you should conduct fundraising among local, state and national foundations, individuals, and the corporate sector. As the health center grows more and more sophisticated, it is recommended that you have a robust fundraising function to help you provide support to your patients when insurance or public financing is not sufficient or simply does not pay for the services your patients need. Furthermore, fundraising can be an effective strategy for capital needs.

Most major cities have a foundation resource center with teams that can help you research the philanthropic community in your area. <http://foundationcenter.org> is a resource that catalogues foundation giving nationally and can be a starting point.

Project Period Renewal application

About 4 months before the end of your project period you will need to submit a comprehensive reapplication for your health center grant. This Service Area Competition (SAC) application will essentially mirror the initial New Access Point application your organization submitted. Each year, HRSA/BPHC issues a new Funding Opportunity Announcement (FOA) for these applications. They are updated every year, so details will change.

For this application, you will need to complete a comprehensive needs assessment, staffing plan, and budget – everything you did to submit your original application. Be sure you have accounted for the time and effort this application will require. This effort should be considered in the strategic plan – during this time, you will need to be focused on the reapplication.

Ideally, you will have completed the health center's strategic plan to start in the third year of funding. That way the health center will have its road map in place for most of the future funding period, with the understanding that completing the new strategic plan will be a key function in the new operating plan.

For this submission (just like the health center's initial application) the health center will have to document broad-based support. It is never too soon to begin obtaining letters of support and commitment, as well as updating any memoranda of understanding and contracts for services. Each of these should be documented well and available to submit as required.

This section has focused quite a bit on revisiting the needs assessment. It cannot be overstressed. The health center should also undertake a competitor analysis during this time, so that the application can discuss clearly the operating environment in which you provide care. Any new populations that have moved into the marketplace should be outlined – and the application provides a way for you to discuss and demonstrate how the health center has been responsive to these changes.

Another area to consider is a discussion of the performance of the board itself. Every year you will conduct a self-evaluation of the board's performance, recruitment, and other factors. This was completed in the first year, and is an annual exercise. Take this evaluation seriously.

The takeaway message is to plan effectively and put as much effort into the SAC application as for the initial application.



CONCLUSION

Obtaining the initial funding represents a major victory for your community – and represents a starting point, not an ending. No startup guide can cover every possible set of circumstances that face a new health center. This monograph has provided the newly-funded health center with a set of suggestions that guide toward compliance with Health Center Program Requirements and provided some tips from the industry that we hope will guide the new center to success.

Remember to make use of the many resources available to you. From your project officer, to your state or regional Primary Care Association, to the holders of cooperative agreements for special populations, to NACHC, to your fellow grantees around the country, there are many people willing to help you be successful. You have joined much more than an industry. The health center movement really is a family.