

# So You Want to Start a Health Center?

September 2019



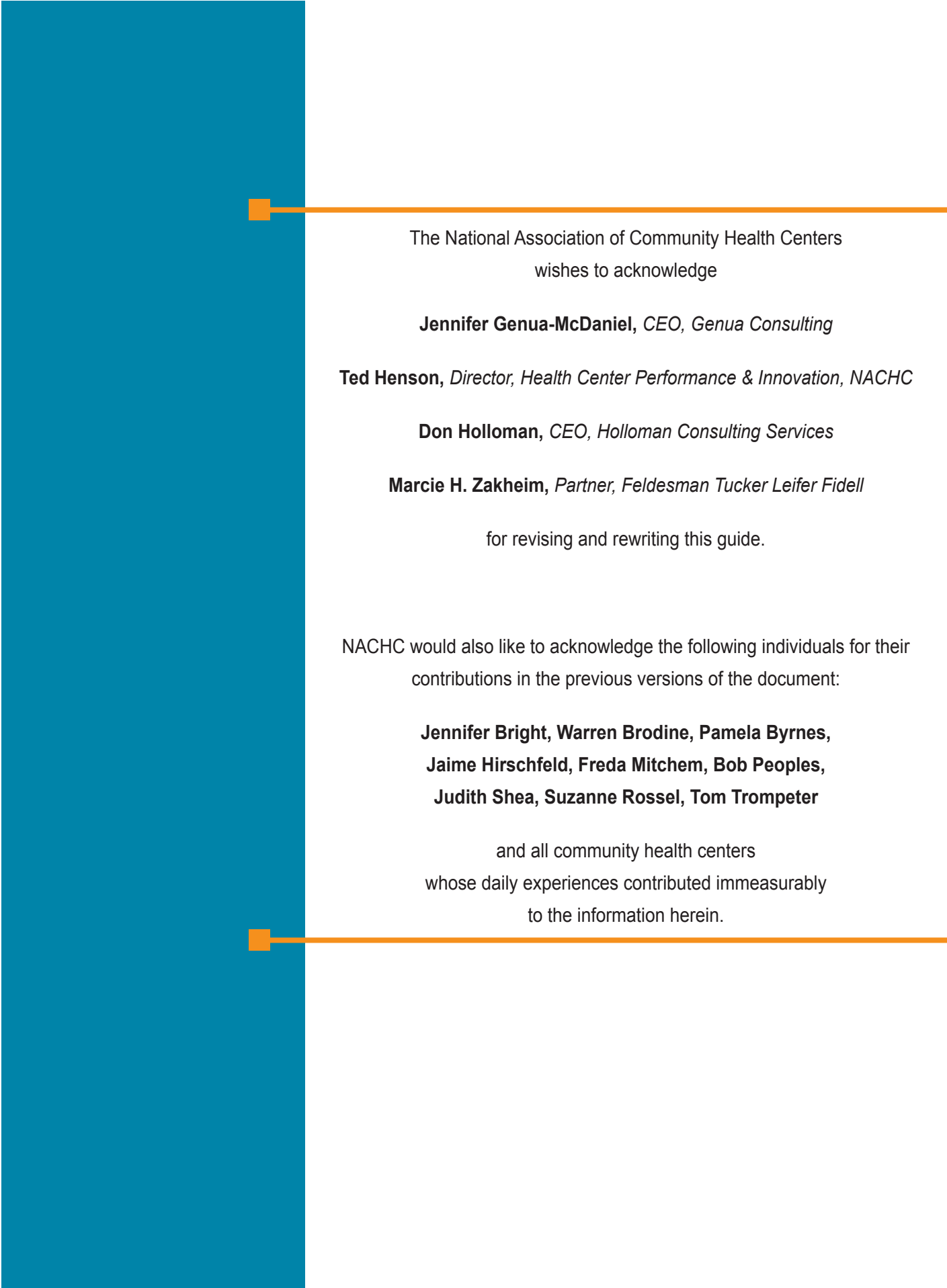
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*This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under cooperative agreement number U30CS16089, Technical Assistance to Community and Migrant Health Centers and Homeless for \$6,375,000.00. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.*



The National Association of Community Health Centers  
wishes to acknowledge

**Jennifer Genua-McDaniel**, *CEO, Genua Consulting*

**Ted Henson**, *Director, Health Center Performance & Innovation, NACHC*

**Don Holloman**, *CEO, Holloman Consulting Services*

**Marcie H. Zakheim**, *Partner, Feldesman Tucker Leifer Fidell*

for revising and rewriting this guide.

NACHC would also like to acknowledge the following individuals for their  
contributions in the previous versions of the document:

**Jennifer Bright, Warren Brodine, Pamela Byrnes,  
Jaime Hirschfeld, Freda Mitchem, Bob Peoples,  
Judith Shea, Suzanne Rossel, Tom Trompeter**

and all community health centers  
whose daily experiences contributed immeasurably  
to the information herein.



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## Foreword

This publication is a guide for health care providers and organizations, public agencies, or community-based organizations and individuals interested in becoming part of the Health Center Program.

This guide outlines the many considerations and recommended steps a community must consider for assessing readiness to apply to become a community health center. This guide provides links to resources and toolkits that support each step of the process.

There is no single way to start a community health center.<sup>1</sup> There is no one-size-fits-all model.

The decision to embark on the long path of becoming a community health center is not an individual or organizational decision. It is a community decision. The very essence of a health center is that it grows from, responds to, and is governed by the community it services.

Pursuing a health center and choosing the right option depends on many things:

- Community needs (health status, barriers to health care access, special populations, etc.)
- Qualifying health professional shortage designations
- Community support and participation in building, sustaining, and utilizing the health center
- Ability to create and sustain consumer-majority governance
- Current or potential collaborative partnerships

In addition to these conditions, every health center must meet the statutory, regulatory, and policy requirements set forth in Section 330 of the Public Health Service Act (42 U.S.C 254b) – the authorizing statute of the Health Center Program – and the requirements set forth in the Health Resources & Services Administration’s (HRSA) Health Center Program Compliance Manual.<sup>2</sup> The requirements set forth in the Compliance Manual apply to all health centers that apply for and/or receive Federal Health Center Program award funds as well as subrecipient organizations and Health Center Program look-alikes (which do not receive Federal funding under section 330).

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1 Throughout this document, the term “health center” is used to denote community health centers, migrant health centers, healthcare for the homeless health centers, public housing primary care centers, and health center Look-Alikes, and is used interchangeably, unless noted otherwise.

2 Throughout this document, HRSA’s Health Center Program Compliance Manual will be referred to as “Compliance Manual.” <https://bphc.hrsa.gov/programrequirements/compliancemanual/index.html>

## Section 1

# Background & Overview

Health centers are a vital part of health care delivery in the United States today.

In 2018, nearly 1,400 health center organizations delivered care to over 28 million people at over 11,000 sites in every state, territory, and the District of Columbia.<sup>3</sup> Health centers serve one in twelve people in the United States, including one in three people living in poverty, one in five people in rural areas, one in six Medicaid beneficiaries, and one in nine children.<sup>4</sup> Over 90% of health center patients are low-income, over 80% are uninsured or publicly insured (i.e. Medicaid, Medicare, CHIP, etc.), nearly 1.4 million patients served by health centers are homeless, and more than 385,000 patients are veterans.<sup>5</sup>

By mission and statute, the health center model requires that health centers locate in areas of greatest need, provide services regardless of patients' ability to pay, and are led by representatives of the population they serve. Despite addressing higher levels of need and patient complexity, health centers consistently demonstrate quality health outcomes at costs well below national averages.

Health centers are estimated to save the entire health care system more than \$24 billion annually.<sup>6</sup> Every \$1.00 of federal Health Center Program funding is estimated to generate \$5.73 of economic activity for low-income and underserved communities.<sup>7</sup> In total health centers generate an estimated \$54.6 billion in economic activity.<sup>8</sup>

## Section 330 of the Public Health Service Act (42 U.S.C 254b)

The authorizing Statute for the Health Center Program is Section 330 of the Public Health Service Act (42 U.S.C 254b).

Section 330 funding is subject to Congressional appropriation and may or may not be available every year. Historically, support for health centers has been high and bipartisan. However, budget constraints at the federal level can affect availability of funds for new organizations.

In general, health centers are required by Statute to provide of primary and preventive health care to medically underserved populations. In addition to medical care, health centers must provide or arrange for preventive dental care, certain basic behavioral health services, and “enabling” services – wraparound care, like case management, interpretation and transportation – that help patients get the care they need.

Some health centers also provide additional specialty medical dental and behavioral health services. Health centers focus not only on the health of individual patients, but also on the health of the entire community. Needs assessment, program development, evaluation and the very definition of “community” are all framed in terms of each community’s unique assets and needs.

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3 National Association of Community Health Centers. Community Health Center Chartbook. January 2019. <http://www.nachc.org/wp-content/uploads/2019/01/Community-Health-Center-Chartbook-FINAL-1.28.19.pdf>

4 Ibid.

5 “2017 Health Center Data,” HRSA’s Uniform Data System (UDS) National Data.

6 Ku et al. Using Primary Care to Bend the Curve: Estimating the Impact of a Health Center Expansion on Health Care Costs. GWU Department of Health Policy. Policy Research Brief No. 14. September 2009.

7 Leavitt Partners in collaboration with NACHC. Based on Bureau of Economic Analysis RIMS II Industry-Specific Multipliers for Ambulatory Health Care Services. December 2018.

8 Ibid.

## Health Center Program Compliance Manual

The Health Resources and Services Administration (HRSA) / Bureau of Primary Health Care (BPHC) monitors and helps support a health center's compliance with all requirements outlined in the [Health Center Program Compliance Manual](#), which was released in 2017.

HRSA updated the Compliance Manual in 2018 to reflect amendments to Section 330 that resulted from the Bipartisan Budget Act of 2018. The Compliance Manual outlines the Health Center Program Requirements – which form the foundation of the Health Center Program – and describes how health centers demonstrate compliance with these requirements.

## Health Center Program Site Visit Protocol

One of the mechanisms by which HRSA assesses compliance with the Health Center Program requirements is through conducting Operational Site Visits (OSV).

During the OSV, a team of three independent consultants utilizes the [Health Center Program Site Visit Protocol](#) (SVP), which is HRSA's tool for assessing compliance. Nearly all the elements within the Health Center Program Compliance Manual are assessed during an OSV, and the SVP serves as an “open-book” test for health centers and reviewers.

Health centers – current awardees and look-alikes – in addition to applicants applying to receive initial look-alike designation must review methodologies and questions in the SVP. In circumstances where HRSA has determined that a health center has failed to demonstrate compliance with one or more of the Health Center Program requirements, a condition(s) will be placed on the award/designation, which will follow the Progressive Action policy and process. A condition placed on the award/designation may mean the following:

- Requiring payments as reimbursements rather than advance payments;
- Withholding authority to proceed to the next phase of the project until receipt of evidence of acceptable performance within a given period of performance; or
- Requiring additional, more detailed financial reports.

If it is determined that noncompliance cannot be remedied by imposing such additional conditions, one or more of the following actions may be taken as appropriate in the circumstances:

- Temporarily withhold cash payments pending further action;
- Disallow all or part of the cost of the activity or action not in compliance;
- Wholly or partly suspend award activities or terminate the Federal award
- Initiate suspension or debarment proceedings
- Withhold further Federal awards for the project or program; or
- Take other remedies that may be legally available.

More information is available in “[Chapter 2: Health Center Program Oversight](#),” of the Compliance Manual.

## Options for Becoming a Health Center

### Applying for Health Center Program Funding

Eligible organizations may apply for Health Center Program funding by applying in response to a competitive open funding opportunity announcement.

HRSA's two most common competitive funding opportunity types are 1) New Access Point (NAP) funding; and 2) Service Area Competition (SAC) funding. HRSA maintains a list of open and previously funded opportunities on their website (see [HRSA Program Funding Opportunities](#)).

### New Access Point (NAP) Funding

- HRSA releases a notice of funding opportunity (NOFO) when Congress appropriate funds for new access points (NAPs). These funds may not be available every year.
- Recent NAP NOFOs have required that proposals be submitted by 1) new organizations (new applicants) not currently directly receiving Health Center Program funding or 2) health centers currently receiving Health Center Program operational funding (satellite applicants).
- New applicants include Health Center Program look-alikes, an organization that is operational at the time of application, or an organization that proposes to become operational within 120 days of the Notice of Award.
- NAP applications must include a proposal for at least one full-time, permanent service delivery site for the provision of comprehensive primary health care services to underserved populations. Applicants may propose multiple access points in a single NAP application with the understanding that all proposed sites must be open and operational within 120 days of the Notice of Award.
- All applications are scored through an objective review process. HRSA uses this score and other factors to make the final funding determinations.
- Selected applicants receive a Notice of Award (NOA), which is the legal document issued to notify the recipient of the award.
- In the 2019 NAP funding competition, the maximum amount of the award was \$650,000 total costs (includes both direct and indirect costs) per year. Up to \$150,000 of those funds were able to be used in Year 1 for one-time only minor capital costs for equipment and/or minor alteration/renovation.

### Service Area Competition (SAC) Funding

Service Area Competition (SAC) funding ensures continued access to affordable, quality primary health care services for communities and vulnerable populations currently served by the Health Center Program award recipients.

Organizations that have historically been eligible to compete for SAC funds include domestic public or nonprofit private entities, such as tribal, faith-based, or community-based organizations, that propose to serve an announced service area and its associated population(s) to ensure continued access to affordable, quality primary health care services.

HRSA maintains a Service Area Announcement Table (SAAT) on its website which lists all services areas currently announced for competition through the SAC NOFO. The table includes the patient target for each service area (see [HRSA's Service Area Competition Technical Assistance webpage](#)).

### Applying for Look-Alike Designation

Look-Alikes are organizations that do not receive a Health Center Program Federal award but are designated by HRSA as meeting all Health Center Program requirements. (Section 1861(aa)(4)(B) and section 1905(l)(2)(B) of the

SSA.)<sup>9</sup> Look-Alikes were created to maximize access to care for medically underserved populations and communities by allowing organizations that don't receive 330-funding to be a part of the Health Center Program.<sup>10</sup>

Applying for Look-Alike status is an option for organizations seeking to become part of the Health Center Program. Applying for Look-Alike status is an option even when there are no funding opportunities for new access points. HRSA accepts applications for Look-Alike (LAL) initial designation from private, non-profit entities or public agencies on an ongoing basis.

Organizations seeking LAL-status must meet the additional requirements:

1. Deliver comprehensive primary health care services to patients within the proposed service area;
2. Operates the Health Center Program project and that it owns and controls its assets and liabilities; and
3. Not currently receiving funding as a Health Center Program Federal award recipient.

For more information on becoming a Look-Alike, refer to [HRSA's Look-Alike Initial Designation Technical Assistance webpage](#).

## Health Center Program Benefits

Health centers participating in the Health Center Program that demonstrate compliance with program requirements are eligible for multiple benefits. The benefits below are specifically for health center that receive 330-funding:

- **Section 330-Funding Awards:** In 2017, 1,367 health centers received funding to provide comprehensive primary care services to underserved populations and communities.
- **Health Center Federal Tort Claims Act (FTCA) Medical Malpractice Program Coverage:** Through the Federal Tort Claims Act (FTCA), eligible HRSA-supported health centers may be granted medical malpractice liability protection. To obtain deemed status, health centers that receive funding under section 330 of the PHS Act must submit an initial deeming application to HRSA/BPHC and meet certain statutory deeming requirements. Renewal applications for redeeming must be submitted on an annual basis.

Health centers receiving 330-funds and health centers that do not receive funding (i.e. Look-Alikes) are eligible for a range of program benefits:

- **340B Drug Pricing Program:** Ability to Participate in Public Health Service Act (PHS) 340B drug pricing program to purchase prescription drugs at discount, subject to application and approval.  
<http://www.hrsa.gov/opa>
- **National Health Service Corps (NHSC):** Health Center Program awardees and designees have access to NHSC providers and resources.  
<http://nhsc.hrsa.gov>
- **Medicaid and Medicare Prospective Payment Systems (PPS):** A Prospective Payment System (PPS) is a method of reimbursement in which Medicare and Medicaid payment is made on a predetermined, fixed amount. Health centers designated by CMS as a Federally Qualified Health Center (FQHC) are eligible for the FQHC PPS rate of reimbursement for services to Medicare and Medicaid beneficiaries.<sup>11</sup>
- **Vaccine for Children (VFC) Program:** This program through the Centers for Disease Control & Prevention (CDC) provides free vaccines for uninsured and underinsured children.  
<https://www.cdc.gov/vaccines/programs/vfc/index.html>
- **Access to other potential federal, regional, and state funding programs**

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9 "Health Center Program Compliance Manual," *Health Resources & Services Administration*, August 18, 2018.

10 "Health Center Program Look-Alikes," *Health Resources & Services Administration*, May 29, 2019.

11 "Federally Qualified Health Center," *Centers for Medicare and Medicaid Services*, January 2018.



## Health Center Program Eligibility

Decisions will need to be made about the type of organization the health center will be. Establishing a new corporate entity, filing with the Internal Revenue Service and state officials, and establishing a board and staff can be major undertakings. Likewise, to convert an existing corporation to a health center will almost certainly require changes to the board and by-laws, and maybe even articles of incorporation. Review with legal counsel to help determine the best path.

Three models will be discussed here, as they represent the most common models for starting new health centers: non-profit models, public entity models, and tribal or urban Indian organizations. More detailed information is included in HRSA's Health Center Program Compliance Manual.

- Non-profit Organization
- Public Agency Organization/Public Entity Models
- Tribal or Urban Indian Organization

### Non-profit Organization

Non-profit entities are eligible to apply to be health centers. For-profit entities are not eligible to be health centers.

If there is an existing non-profit organization in the community that could serve as the corporate vehicle (or for conversion of a community provider, like a community action program or free clinic), it can save a lot of effort. Otherwise, the health center could form a new non-profit organization.

This approach requires forming a nonprofit corporate entity under State law and filing for tax-exempt status under the US Internal Revenue Code, both of which can be completed with the help of legal counsel.

- A designated 501(c)(3) tax-exempt organization does not pay income tax on net revenue or donations. Donations given to the entity are tax deductible by the donor. These organizations have limitations on lobbying and must have an appropriate tax-exempt purpose (providing health care services to the underserved is one of them).
- A designated 501(c)(4) tax-exempt organization is primarily an education-based organization and can conduct unlimited lobbying. Donations are not tax deductible to the donor.

The organization will need to meet compliance requirements for health centers as outlined in the Health Center Program Compliance Manual. To do this, health centers must establish a governing board that has specific responsibility for oversight of the Health Center Program project.

Health center governance is one of the most fundamental and important parts of the Health Center Program's success (see **Section 6: Developing Community Governance**). Unlike other non-profits or health care providers, health center boards must be composed of a majority (at least 51%) of patients served by the health center and the patients must represent the individuals who are served by the health center. The health center's governing board must consist of at least 9 and no more than 25 members. For non-profits seeking health center status, they might have to replace existing board members or limit the size of their board. For more information on the governance requirements for health centers, the Compliance Manual contains two chapters specifically on governance: [Chapter 19: Board Authority](#); and [Chapter 20: Board Composition](#).

To become a health center, the types of programs or services may need to be modified. For instance, an independent women's health center providing mostly family planning would need to broaden its services to include comprehensive primary and preventive care and to accept males, children and the elderly, or at the very least make arrangements for their care following HRSA/BPHC program requirements, which can be stringent. For example, under Chapter 9 of the Compliance Manual, no patient shall be denied service due to an inability to pay. As a result, all health centers must prepare a fee schedule or payments for the provision of its services "consistent with locally prevailing rate or charges."

## Public Agency Organizations (Public Agency Health Centers)

An organization that is organized at the State, territorial, county, city, or municipal government level is eligible to apply to the Health Center Program. This can include public health departments, public universities, and other public institutions.

Public agency health centers may find it difficult to comply with Health Center Program requirements. One reason for this is that the governmental entity's leadership may be elected or appointed. Public agencies are permitted to utilize a co-applicant governance structure for the purposes of meeting Health Center Program governance requirements.

Public agency health centers may be structured in one of two ways to meet the program requirements: 1) the public agency independently meets all the Health Center Program governance requirements based on the existing structure and vested authorities of the public agency's governing board; or 2) together, the public agency and the co-applicant meet all Health Center Program requirements. Public agencies with a co-applicant board must have a co-applicant agreement that delegates the required authorities and functions to the co-applicant board and delineates the roles and responsibilities of the public agency and the co-applicant in carrying out the Health Center Program project.<sup>12</sup>

HRSA's requirements for public agency health centers (including the definition of public agencies eligible to apply for this model) are found in the Health Center Program Compliance Manual and are subject to the same Health Center requirements. Also, NACHC has a free publication on public centers, "Public Agency Centers: A Discussion Monograph."

## Tribal or Urban Indian Organization

Native American tribal organizations, including those defined under the Indian Self-Determination Act or the Indian Health Care Improvement Act, are eligible to apply for Health Center Program funding or designation.<sup>13</sup> These organizations would have to meet the necessary criteria for demonstrating that they are either non-profits or public agencies.

## Other Programs that Support Health Centers

Primary Care Associations (PCA) are nonprofit associations representing health centers and other primary care safety net providers at state and regional levels. PCAs provide a wide array of services to their members and to the primary care community. Some services include centralized clinician recruitment support, technical assistance on clinical, management, finance and governance matters, training, conferences, and more. PCAs are actively involved in health policy at the state and national levels as well. PCAs vary in the services they provide. HRSA has a [Primary Care Association webpage](#) where you can find your state PCA.

Primary Care Offices (PCO) are usually part of state government (often housed in the State Health Department). They receive funding through the Bureau of Health Workforce (BHW) to provide planning and other services in support of community based primary care providers. PCOs work in partnership with PCAs in areas including analyzing and prioritizing need for primary care services, submitting requests for MUA, MUP and HPSA designations, helping recruit and retain physicians and other clinicians in the state, and advocating for health centers within the State Government. HRSA has a [Primary Care Office webpage](#) where you can find your state PCO.

National Association of Community Health Centers (NACHC) is the primary national, nonprofit, professional membership and advocacy organization that represents health centers. NACHC promotes the provision of high quality, comprehensive health care that is accessible, coordinated, culturally and linguistically appropriate and community

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<sup>12</sup> "Chapter 19: Board Authority," Health Center Program Compliance Manual, p.75, HRSA, August 2018.

<sup>13</sup> "Chapter 1: Health Center Program Compliance Manual," *Health Resources & Services Administration*, August 18, 2018.

directed for all underserved populations. In addition to advocacy on issues that affect the delivery of health care for the medically underserved and uninsured, NACHC:

- Provides education, training and technical assistance to community-based health care providers and patient-majority boards of directors in support of their missions and responsibilities;
- Develops and implements programs that stimulate public and private sector investment in the delivery of quality health care;
- Provides benefits and services to those centers that participate in NACHC as members, sometimes in conjunction with affiliated PCAs.

For additional training and technical assistance regarding starting a health center, refer to **Section 10: Additional Resources**.

## Section 2

# Defining Community

The core concept of a community health center is that it serves the community in which it is located.

As previously discussed, the requirements of health center status also preserve the community focus, by requiring the governance of the organization to reflect the community, as well as be made up of a majority of actual, active patients of the health center. In addition, a new health center will want to serve a broad spectrum of community members with a variety of payment sources (commercial insurance, Medicare, Medicaid, etc.) to ensure a stable and predictable revenue stream while providing care regardless of ability to pay, insurance status, immigration status, or any other reason.

Health centers also respond to their community by keeping abreast of changing demographics, emerging health trends, and population shifts – and then planning and executing strategies to serve all. This would include providing care in languages other than English, monitoring disease hotspots (like influenza outbreaks or sexually transmitted infection spikes) and working in conjunction with other local providers, local social service organizations, and the faith community so the health center can be an integral part of a whole community's service offerings – in a way that makes care affordable and accessible.

In addition to these market conditions, health centers are required to provide services in areas of the greatest needs. HRSA defines these communities in specific ways, which are highlighted below.

## Medically Underserved Area/Medically Underserved Population

Each health center must serve at least one Medically Underserved Area (MUA) or Medically Underserved Population (MUP). MUAs and MUPs are designations used by the federal government to designate areas and populations with a shortage of primary care services. Later in this guide there will be information about how to apply for such designation, but a background on MUAs/MUPs is relevant now.

MUAs have a shortage of primary care health services for residents within a geographic area, such as a whole county, a group of neighboring counties, a group of urban census tracts, or a group of civil divisions. MUPs are specific sub-groups of people living in a defined geographic area with a shortage of primary care health services.

MUA and MUP designations are based on the Index of Medical Underservice (IMU). The IMU is calculated based on four criteria:<sup>14</sup>

1. The population-to-provider ratio
2. The percent of the population living below the federal poverty level
3. The percent of the population over age 65
4. The infant mortality rate

While MUAs are designated for geographic areas, MUPs are designated for population subsets within a geographic area, for instance low-income individuals. This designation option recognizes that some groups within the broader service area may experience exceptional difficulty accessing health care or have extraordinary health status challenges, even though the broader population within a geographic area may not.

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<sup>14</sup> "Medically Underserved Areas and Populations (MUA/Ps), HRSA Health Workforce, May 30, 2019.

It is important to note that the health center must serve individuals who live in an MUA or are part of an MUP, but the center doesn't have to be physically located in the MUA. Moreover, this is an organizational requirement, not a site-based one: only one site of a multi-site health center must serve an MUA/MUP.

Each state has a Primary Care Office (PCO) that assists with MUA/MUP designation, along with four PCOs that serve U.S. territories, and state PCAs, and HRSA/BPHC also can provide assistance. Your target community or population may already have a designation. Current designations, and updates on designation criteria can be seen at <https://bhw.hrsa.gov/shortage-designation/nuap>. If there is no MUA/MUP designated for the health center to serve, one will need to be applied for, and the state PCA and PCO can assist with that process.

## Health Professional Shortage Areas

A Health Professional Shortage Area (HPSA) is a federal designation that refers to a geographic area, population, or facility with a shortage of primary care, dental, or mental health providers and services.

HPSA designations are used to allocate resources for several federal programs, including programs for health care professionals who receive educational loan repayment or scholarships through the National Health Service Corps (NHSC), in return for working in underserved communities at eligible organizations (see **Section 8: Human Resources** for more information). PCOs submit designation applications to HRSA, which then evaluates applications based on established criteria. If a submitted application meets the criteria, HRSA designates the area, population, or facility in question as a HPSA.

HPSAs are designated in three health disciplines:

- Primary Care – indicating few primary care clinicians available to population
- Dental Health – indicating a shortage of primary care dentists
- Mental Health – indicating a lack of psychiatrists and/or core mental health providers

These shortages may be:

- Geographically-based: There is a shortage of providers for an entire population within a defined geographic area.
- Population-based: There is a shortage of providers for a specific population group within a defined geographic area (i.e. low income, migrant farmworkers, Native Americans, non-English speaking population, etc.).
- Facility-based: HPSA-designation automatically applies to some types of facilities such as 330-funded FQHCs, FQHC Look-Alikes, Indian Health Facilities, and Rural Health Clinics that meet NHSC site requirements. Other facilities which are not automatically designated by statute, such as correctional facilities and state mental hospitals, may also be designated if qualifying applications are submitted to HRSA.

For more information, refer to HRSA's "[Shortage Designation Application and Review Process](#)" webpage. To see if your community is already designated as a HPSA, visit: <http://hpsafind.hrsa.gov>.

## Special Populations

Many health centers choose to focus on special populations or certain subsets of the community at large.

Three of these populations have specific funding streams within Section 330 of the Public Health Service Act to support care to them (HRSA defines each population in detail in the Compliance Manual glossary)<sup>15</sup>:

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<sup>15</sup> "Glossary," Health Center Program Compliance Manual, p.89, HRSA, August 2018.

- 330(g) Migratory and Seasonal Agricultural Worker (MSAW)
- 330(h) Homeless Populations
- 330(i) Residents of Public Housing

Health centers should consider working closely with one of these populations if there is significant need in your community, as these individuals typically experience some of the greatest barriers to access to health care anywhere. There are other underserved populations in communities that can experience barriers – communities of color, the LGBTQ+<sup>16</sup> population, Asian/ Pacific Islanders, and veterans, to name a few. HRSA/BPHC has awarded funding through National Cooperative Agreements (NCAs) to organizations that can provide technical assistance on reaching certain populations. A list of current NCA partners and their target populations is available on the Health Center Resource Clearinghouse (which is a project of the 20-NCAs): <https://www.healthcenterinfo.org/our-partners/>

## Defining Services Area

Now that the federal definitions of MUAs, MUPs, HPSAs, and special populations have been explained, it's important to consider what your health center will propose for its service area.

Because of the unique traits of health centers – especially community responsiveness – the health center must propose to serve a geographic area (sometimes called a “service” area). There must be at least one MUA or MUP contained within the service area of the health center and targeted by the health center for care. A health center should be available to serve other patients as well. If a health center chooses to target care to migrant, homeless, and public housing programs the health center should be physically located so as to be convenient, and the health center should expect to target a significant portion of its resources and efforts to serving them.

Currently, as part of Service Area Competition NOFOs, HRSA requires that at least 75% of the health center's patients come from the service area as defined by the health center. Beyond the requirements, however, the service area should be a rational and logical geographic area for the delivery of services, taking into consideration, among other factors, the ability to ensure the health center's services are available and accessible to all residents of the area and the elimination of barriers to care. This can vary based on the population and the nature of the geography. Some programs serving migrant or seasonal agricultural workers, for instance, serve the entire state, while an urban program in a major city may be made up of just a few census tracts, ZIP codes, or even city blocks. In general, a service area is defined by:

- Minor civil division
- Census county division
- Census tract (in metropolitan areas)
- A group of the above that constitute a “natural neighborhood”

A service area can also be defined by:

- A lack of transportation (particularly public transportation)
- Geographic barriers, such as a river, mountain range or highway
- Location in relationship to other service providers
- Travel time to other providers
- Cultural, ethnic or linguistic variables

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<sup>16</sup> LGBTQ is defined as Lesbian, Gay, Bisexual, Transgendered and Queer+

## Section 3

# Developing a Needs Assessment

Successful program planning requires an excellent needs assessment. HRSA requires every health center to conduct a comprehensive needs assessment for the current or proposed patient population utilizing the most recent available data for the service area (and any special populations within the area). More information is provided at Chapter: Needs Assessment in the HRSA Compliance Manual.

The needs assessment must address, at a minimum:

- Factors associated with access to care and service utilization;
- Significant causes of morbidity, mortality, as well as any associated health disparities (per Compliance Manual); and
- Other unique health care needs or characteristics that impact health status, access and/or utilization.

The manner by which the needs assessment is completed and the extent to which additional indicators or a focus on specific population subset(s) are included, however, is within the discretion of each health center to decide. In the 2019 NAP NOFO, HRSA awarded additional priority points to applicants that proposed “NAP full-time service sites” that were located in “hot spot zip codes” – HRSA provided a list of hot spots – in addition to “NAP service sites” operating at least 20 hours a week.”

## State and Community Planning Efforts

Certain states and communities undertake robust health planning efforts. Many state PCAs have significant needs assessment data already compiled for a community planning effort and may also be able to dedicate resources to your effort. These efforts may also link the potential health center with existing operational resources, like statewide information technology networks, that can inform the planning process.

Similarly, some major urban areas also maintain priority lists of communities that need primary care resources. If your area has a large public hospital or health department, for instance, those institutions would be well aware of areas that need primary care resources. Indeed, presently, every non-profit hospital is required to complete a community needs assessment, and usually will make those findings available to other community groups. Information on these needs assessments can be found on the Centers for Disease Control and Prevention’s website: <http://www.cdc.gov/chinav/index.html>

Another key tool to leverage in planning efforts is the UDS mapper. UDS, short for Uniform Data Systems, is the report that all health centers must file annually with HRSA/BPHC. One key data point of this report is patient origin data by ZIP code, which the UDS mapper aggregates into map form. The UDS Mapper is a tool will help you pinpoint the estimated number of individuals at or below 200% of the federal poverty level and tie those individuals to existing health centers that serve them. It will also provide information on geographic reach, penetration rate, and growth of Section 330-funded and look alike health centers, so you can have an idea where the residents of your community are seeking care today. Visit [www.udsmapper.org](http://www.udsmapper.org) to register (free of charge) and gain access to the wealth of information at that site.

## Setting Priorities and Planning

Setting priorities is the first step in needs assessment planning. It is important to remember that it is unlikely that a new health center will be able to address all of the unmet need for primary care in any community, so available resources and programmatic aims will need to be prioritized. The quantitative data is the start, and qualitative feedback from the group about what the health care priorities are will help target resources and interventions. Perceptions about these priorities will likely differ among respondents, but that does not make any perception “wrong.” Diversity of opinion among community leaders and planning group members make the process strong. Likewise, members of the planning group will need to compromise on their areas of focus to develop a good health center.

## Community Analysis

Understanding the assets and needs of a community is the basis for establishing support for a health center. This is more than just a quantifiable analysis of demographics, health status and care utilization. It is a broader analysis that paints a picture of how the community is structured and where facilitators and barriers to community health care are likely to emerge.

Here are some steps for conducting this analysis:

- Identify the sectors of a community. These can include business, labor, government, faith community, health care, civic organization, educational institutions as well as others.
- Identify the key populations, subpopulations, and key constituencies that make the community unique (i.e. immigrant populations, elderly community, children and youth, etc.).
- List the organizations that represent the identified sectors and populations/constituencies in the community.
- Identify the influencers of that sector – the key individuals as well as the key trends.
- Identify potential organizations/individuals that may pose barriers to starting a health center.

Remember that in the case of individuals, today’s naysayer may be tomorrow’s cheerleader, so remember to think of them as opportunities rather than brick walls.

## Community Participation

Once you have a list of influencers – individuals, organizations, and sectors – from the community analysis, the next step is to start bringing people together to involve them in the effort. **Tip:** One of the great keys to doing community-based work is that people like to be asked to participate and provide their opinion.

There are three main components to this process: getting the word out, holding public forums, and keeping people involved and motivated to do the work.

1. Getting the word out. Use contacts, social media and people already familiar with the planning of a health center to speak to key individuals across sectors of the community. Decide who is going to speak to whom, and have a process for feedback and evaluation.
  - Train those who are going to speak about the health center project on not only the details of the project, but also tips on public speaking, and how to report questions back, especially if the question is a new one.
  - It’s always a good idea to use an approved presentation template – so that the audiences are getting the same message every time no matter who is giving the presentation.
2. Holding public forums. Personal invitations to public meetings are always better than relying on posters or other kinds of communication. Tips for a public forum include:



- Be sure the sponsor is a trusted member of the community.
  - Hold the meeting at an accessible and convenient time and location.
  - Invite the media, if appropriate.
  - Offer assistance in attending the meeting: transportation, child-care, translation, etc.
  - Document attendance with a sign-in sheet that includes follow up contact information.
3. Keeping people involved and motivated. Helping people know their efforts are worthwhile and making a difference is important.
- Assign clear and manageable roles and tasks.
  - Build on success to maintain momentum.
  - Build a feedback loop into every action or task. People must see that there are outcomes to their efforts.
  - Use technology to maintain connection and to drive additional interest – platforms like LinkedIn, Facebook, Twitter and Instagram, as well as traditional telephone, email and text messaging techniques (i.e. WhatsApp) – can be valuable communication tools.

## Thinking About Partnerships

The support of the health care provider community is very important when starting a health center.

Perhaps the first step of involving the health care community is to get a full picture of other health centers in the area. The *HRSA Data Warehouse* has a “[Find a Health Center](#)” function on their website.<sup>17</sup> Enter in the potential site location or community to get a list of nearby health centers. Contact these health centers and enlist their help. It will be vital that you demonstrate that there is not a potential service area overlap and that the need is great enough in your service area to justify new health centers or sites.

Initial reactions to the effort can range from full support to opposition – some providers will see the effort as creating competition. Aside from other health centers, hospital systems are increasingly building referral networks, purchasing and establishing practices in their communities both to ensure a steady flow of patients for diagnostic and surgical procedures and to establish systems for referral to prevent readmissions after hospitalization.

Support from local providers will help the health center’s effort in the eyes of the public at large and could be a good recruitment strategy for board members. Although the number of non-patient health care professionals on the board is limited by federal statute, they can serve on committees and serve as liaisons to other professionals in the community. Contact other local health care providers, medical and dental societies, health departments, hospitals and private primary care providers to enlist their help.

As a health center expands into a community or is already established, community relationships are important. Coordination and integration of activities are key factors in starting a health center. An organization must think about collaborating with other providers or programs in the service area, including local hospitals specialty providers, and social service organizations to provide access to services not available through the health center in order to support:

- Reductions in the non-urgent use of hospital emergency department;
- Continuity of care across community providers; and
- Access to other health or community services that impact the patient.

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<sup>17</sup> “Find A Health Center,” *HRSA Data Warehouse*. May 30, 2019. <https://findahealthcenter.hrsa.gov/>

As you start to think about these areas, make a list of agencies, organizations, or individual health care providers (or non-health care providers) that could help serve your population. Once you've made a list, think in a broader sense, and ask:

- Are there any other community health centers I can partner with?
- What other state agencies can I work with?
- Are there any federal programs that can help me take care of the population we are serving?

Your health center is just one component of your patient's, and your community's, well-being. Strong partnerships with other providers, community-based organizations, public agencies, and social institutions isn't something that's just nice-to-have, it's a critical ingredient for your long-term success.

## Section 4

# Physical Space Considerations

A health center must consider both the size and location of their health in order to provide access to its community and to help attract and retain patients.

## Access and Location

In practice, the health center must be easy to reach and convenient for the patients the health center wishes to serve. Depending on the target population, it may make sense to locate near where people live, where they work, or where they access social networks, like churches, community centers, and the like. Usually, a major street, located among other businesses that serve the population, is a good idea. Public transportation access and parking are major considerations. A beautiful facility that is several blocks away from public transit routes or that has no available parking may not be easily accessible to patients. The HRSA Compliance Manual, [Chapter 6: Accessible Locations and Hours of Operations](#)<sup>18</sup> outlines the requirements associated with ensuring that locations and hours of operations do not pose a barrier to care.

## Space or Building Considerations

When looking for space, plan for growth as successful start-up operations may outgrow their space quickly. While services can be provided directly, through contract or referral arrangements, a health center may need to plan for expansion of:

- Provider offices, exam and treatment rooms, dental suites, and private spaces for behavioral health counseling
- Areas devoted to other health services, like reception, patient waiting and counseling, social work, laboratory and x-ray services, and pharmacy
- Administrative and clinical and information systems functions

Because each new health center will have its own circumstances related to physical space (including cost and availability), there is no one standard approach that all new health centers should adopt. Most health centers do plan for the following:

- Two to three exam rooms per medical provider (physician, nurse practitioner, physician assistant, nurse midwife). This should allow for sufficient patient flow. Being on the ground floor (or in a building with adequate, and redundant, elevator service) is usually a good idea for those with mobility challenges
- Two to three dental suites for each dental care team (which may consist of a dentist, dental hygienist, and/or dental assistant)
- One private space for each behavioral health provider, and a room for group sessions (if this is in your plan)

It may make long-term sense to secure professional assistance from functional space planners to identify space and equipment required by health center operations and local licensing (if applicable). Space planners help both ensure adequate space is available and prevent overbuilding.

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<sup>18</sup> Chapter 6: Accessible Locations and Hours of Operations can be found at <https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-6.html#titletop>

One resource to help with space considerations is Capital Link ([www.caplink.org](http://www.caplink.org)), which is an NCA funded by HRSA/ BPHC to help health centers in accessing capital financing for buildings and equipment. They can also provide extensive technical assistance with financial and market analyses, business plans, and proposal development for capital projects, space design, project planning, debt financing, and fundraising. Many of their services are free of charge to health centers.

## Section 5

# Business Planning

The health center planning group has considered community, service area, target population, locations, and matters of organizational governance. Now it turns to business planning to determine the viability of a health center organization. This business plan will be the critical tool in determining a health center's future. To make a business plan, it is necessary to translate services into volume, revenues and expenses, and plan for financial viability.

Note that business planning is more than just making a budget. This kind of planning, which projects volumes and utilization, as well as forecasts revenues and costs, is really a must for any organization considering health center development. Much of the information needed for the business plan should have been obtained during the needs assessment phase, though it may need to be supplemented at this point. Please refer to **Section 3: Developing a Needs Assessment** for additional information.

## Market Share

Perhaps the most important estimate that will be made during business planning is just how many people will seek services at the center. During the planning phase it can be easy to assume a “build it and they will come” mentality – but does the planning group really understand the competitive environment in which it plans to operate? A potential health center would undertake primary market research – surveying people and organizations within the target service area (and population) to ensure the validity of key assumptions that influence later components of the plan. The potential volumes will drive financial projections that will determine whether the health center is a viable entity.

This research seeks information about the location, range of services, charges and best communication methods to drive utilization of the health center. It is also important to understand how this potential health center can distinguish itself from the competition – what would cause a potential patient to disrupt her existing provider relationship and choose this center? This is an inexact science but err on the side of conservatism – if it seems that 10,000 people will choose to use the health center, work from an assumption that 5,000 or 6,000 actually will do so.

This estimate becomes the health center's “market share.” Tools for calculating market share are in the business planning section of the appendix.

## Business Strategy

Once the potential market share is understood, the business planner turns next to how patients will be served. This is where the planning group documents how the health center will differentiate itself from its competition. This differentiation discussion should be completed before a physical location is chosen – because often times, location is the single most important differentiator possible.

This is also where qualitative research comes into play. In learning about the community's needs and wants in a health care provider, the planning group possibly heard commentary about availability during non-traditional hours, care in other languages, and other kinds of suggestions. This is where the planning group would cement their decisions about what kind of health center the organization will be at least initially. Remember that it will be the responsibility of the board to understand changes in the community, so that in the future, these assumptions may change. That kind of change is good – it is a sign that the health center organization is healthy and truly responsive to the community it serves.

Collaborations should also be determined during this phase. Deciding to collaborate for certain services – like dental care, for instance – will have a major impact on the rest of the planning process.

## Management and Organization of the Health Center

During the business planning phase of health center development, it will be time to make some decisions about who is going to govern the health center, who will operate the health center, and the need for external assistance or support for getting started. While all the decisions may not be ready to be made, knowing what decisions will be on the horizon will be helpful for the health center's first board of directors.

The following tips will help with planning:

1. **Members of the board of directors:** These should be identified by name, with care taken to make sure that the patient majority requirement as well as other board requirements will be met. It may also be helpful to determine who will serve in positions of board leadership at the outset. Guidance for HRSA compliance of program requirements should be taken from the HRSA Compliance Manual, [Chapter 20: Board Composition](#).
2. **The Proposed Management Team:** Who will serve as the CEO, or will a search need to be conducted? A Chief Medical Officer (CMO) and Chief Financial Officer (CFO)<sup>19</sup> should also be identified, as both will be critical staffing positions necessary to get operations going quickly. If these individuals are unknown, the planning group should craft job descriptions, or at a minimum, a statement of desired characteristics to guide selection. This is also an opportunity to propose an organizational structure for inside the health center, including an organizational chart. [Chapter 11: Key Management Staff](#) from the HRSA Compliance Manual is an excellent place to start ensuring compliance with Program Requirements.
3. **Need for Outside Assistance:** It is common for a newly formed health center to need consulting services to help get started, or even to help design parts of the program for approval. While not a HRSA requirement, it is not uncommon for health centers to expend 2% or more of their initial funding on external consultants to help create policies and procedures, think through operational plans, or just to complete start up tasks that the staff does not have time to do. There are many consultants that have experienced operating and assisting new and established health centers, health centers with special population-funding, and health centers with unique operational models (i.e. public agency health centers).

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<sup>19</sup> While CMO and CFO is used, Medical Director and Finance Director can be used interchangeably

## Section 6

# Developing Community Governance

One of the most important and distinguishing features of the health center model is the community-based, patient-majority governance structure, which is mandated by federal Statute.

Health Center Program Requirements, referenced extensively earlier in this document, spell out the standards health centers must meet. In particular, in the Compliance Manual, Chapters 19 and 20 – on Board Authority and Board Composition respectively – include a comprehensive review of governance requirements regarding size, composition and authorities.<sup>20</sup>

The board of a health center is the ultimate authority and cannot be limited in exercising its authorities. “The organizational structure and documents do not allow for any other individual, entity or committee (including, but not limited to, an executive committee authorized by the board) to reserve approval authority or have veto power over the health center board with regard to the required authorities and functions.” And/or the health center board exercises, without restriction, its required authorities and functions.

To ensure appropriate board composition, the HRSA Compliance Manual, [Chapter 20: Board Composition](#) outlines not only requirements needed within board approved health center bylaws but composition requirements for board members. The number of board members must be specified in the bylaws of the organization. This can be either a specific number or a limited range. HRSA Program Requirements require that boards have between nine (9) and twenty-five (25) members who are representative of the population served. The size should relate to the complexity of the organization and the diversity of the community served. Please note, as a best practice, while not a program requirement, it is encouraged that the bylaws stipulate a range of members so that additions and deletions do not require bylaw changes and be sure to compare the desired range with any state law applicable to board membership ranges. Another best practice, while not a program requirement, it is best to have more than nine members so that if one person has to drop off the health center does not fall out of compliance with the HRSA Program Requirements in [Chapter 20: Board Composition](#).

In addition, the Health Center board must meet the following requirements:

- A majority (at least 51%) of the board members must be individuals who use the health center as their regular source of health care. The Health Center Program Compliance Manual defines “patient” for board representation purposes as an individual who has received at least one service in the past 24 months that generated a health center visit, where both the service and the site at which the service was provided are included within the HRSA-approved scope of project.
- A parent, foster parent, court appointed guardian or caretaker of a dependent child or adult, a legal sponsor of a legal immigrant who is a patient or a person with legal authority to make health care decisions on behalf of a patient also may qualify as a patient board member.
- No more than one half of the non-patient board members may be individuals who derive more than 10% of their annual income from the health care industry. It is in the discretion of the health center and its board to define the term “health care industry,” provided that it is applied uniformly.

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<sup>20</sup> The governing board of a health center operated by Indian tribes, tribal groups, or Indian organizations under the Indian Self-Determination Act or Urban Indian Organizations under the Indian Health Care Improvement Act is exempt from the specific board authority requirements discussed in this chapter. Section 330(k)(3)(H) of the PHS Act.

- The remaining non-patient board members should be broadly representative of the community served by the health center, and should be experts in community affairs, local government, finance, legal affairs, marketing or public relations, or other areas of expertise relevant to the health center.
- It is important to note that no board member may be an employee of the health center<sup>21</sup> or the spouse, child, parent, brother or sister of a health center employee by blood, marriage, or adoption. By including marriage, this includes in-laws, and extends to same- and opposite-sex marriages.

Organizations that serve exclusively migrant or seasonal agricultural workers, persons experiencing homelessness, or public housing residents may be able to apply for a waiver of the patient majority governance requirement, but that waiver may not supplant the intent that patients of the health center's services guide and direct the care that is offered. Health centers integrate into the communities they serve and processes to monitor the needs of a community must be woven into any request for waiver from governance requirements.

## Roles and Responsibilities of the Board

The Board of Directors (or Governing Board) is the principal policymaking body of the health center. The Board of Directors is required to hold monthly meetings. It is autonomous, bound only by its legal responsibilities under its charter and bylaws, and state and federal statutes. The Board of Directors of a health center is charged with the responsibility of assuring that the mission of the center is carried out through its strategic plan and services. This is an implied and extremely important obligation to the broader community in which the health center is located – an obligation to accomplish the objectives of the health center.

As the health center's policymaking body, the Board of Directors (board) should distinguish its policymaking authority and responsibility from the authority and responsibility of the health center's executive director and staff. The executive director and staff implement and execute the policies set by the board. The board delegates the day-to-day operational responsibilities to the Executive Director/CEO. This means that the board must observe, question, and monitor the operational functions of the health center, but it should refrain as much as possible from direct participation in those functions or risk becoming micro-managers.

There are various primary areas in which a board has responsibilities:<sup>22</sup>

### 1. Finance

The board adopts financial management practices including a system to ensure accountability for health center assets and resources; approves the annual budget (including the use of grant and non-grant funds and resources); monitors the financial status of the health center; selects the independent auditor, accepts the annual audit, and ensures that appropriate follow-up actions are taken; approves payment and eligibility for services including the Sliding Fee Discount Program for individuals with incomes at or below 200% of the federal poverty level, the fee schedule, adopts billing and collection policies related to waiver / reduction of fees and limiting/denying services due to an unwillingness to pay;

### 2. Legal

The board ensures that the health center is operated in compliance with applicable federal, state and local laws and regulations. The board protects the corporation from unnecessary liability and ensures compliance in accordance with the priority areas of the Office of Inspector General of the Department of Health and Human Services. The board also approves the applications related to the Health Center Program project, including approving the annual budget, which outlines the proposed uses of both Health Center Program award and non-Federal resources and revenue. For more information on the board's oversight role, see [Health Center Program Site Visit Protocol: Board Authority](#). For information on the Office of Inspector General, visit <https://oig.hhs.gov>.

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<sup>21</sup> The executive director or CEO may be considered an ex-officio member of the board, though does not count in determining patient majority or in meeting any other requirement of governance.

<sup>22</sup> Board duties and responsibilities are outlined in the HRSA Compliance Manual, Chapter 19-Board Authority, Element C, D,E, F.



### **3. Human Resources**

The board establishes general personnel policies including CEO selection/hiring and periodic CEO evaluation, compensation of the CEO and wage and benefit schedules for other personnel, continuing education, employee grievance policies, equal employment opportunity practices and Department of Labor requirements (Federal and State), as well as any local hiring requirements. The board's responsibility is to establish policy, not to engage in implementing these policies.

### **4. Evaluation**

The board evaluates the performance of the health center and ensures appropriate follow-up actions are taken regarding quality of care, service utilization patterns, and productivity (efficiency and effectiveness).

### **5. Planning**

The board engages in strategic planning at least once every three years, which at a minimum addresses financial management and capital expenditure needs. The board also approves the health center's purpose, mission, vision, and values.

### **6. Resource Development**

The board is responsible for fundraising and approving programmatic improvements through grants from federal, state, foundation and other sources.

The goal of this involvement is to make sure the board of directors is active and abreast of developments and challenges the organization is facing and is prepared to make policy recommendations to ensure the mission of the organization – providing health care services to target populations – is achieved.

## **Organization of the Board's Work**

While not a HRSA program requirement, as a best practice, most health centers find it valuable to organize themselves into certain committees, so that a subset of board members becomes intimately familiar with certain areas of operation, sharing their in-depth review with the full board. These committees may be standing committees – they are always constituted and have specific areas of focus identified in the bylaws, or can be ad hoc committees, charged with undertaking a specific, time-limited task (like bi-annual strategic planning). A health center may also have advisory committees, composed of other community members, or non-governing board member patients, to provide additional insight into health center operations.

## **Legal Issues**

One of the major responsibilities, briefly mentioned above, is compliance. Corporate compliance should start with the adoption of a resolution establishing a formal Corporate Compliance Program. Focus areas covered by the Corporate Compliance Program may include:

- Written Policies, Procedures, and Practice Standards
- Designation of a Compliance Officer
- Staff Education and Training
- Communication
- Internal Auditing and Monitoring
- Discipline and Enforcement
- Corrective Action Planning

Furthermore, as part of the Corporate Compliance Program, the health center should demonstrate the board's approval of a Program's framework which recognizes that board members have specific obligations in dedicating

resources to assure compliance. Regularly, the board must monitor the implementation and operation of the compliance program to ensure its effectiveness.

Nonprofit organizations usually can indemnify their board members against losses incurred as a result of service as a board member. This means that the organization will bear any cost associated with defending a legal action against a board member, including judgment or settlement. The circumstances in which a board member can be indemnified are a matter of state law and are usually specified in the by-laws. Legal counsel should be consulted on this matter.

## Section 7

# Planning to Meet Health Care Standards

A health center must provide high quality care to the patients and communities it serves. The planning process is the right time to start considering standards of care that the health center will meet. Fortunately, there are many sources to help with this planning. One of the best resources a planning group will have is a clinical leader who is well versed in evidence-based medicine. This individual will be able to help interpret health care standards to the planning group in a way that makes them easy to adopt and implement.

Health centers focus on primary health care services and outcomes. That means focusing on periodic physician care, chronic disease care, and wellness care. These are reflected in the listings of required services available in Program Requirements, found in [Chapter 4: Required and Additional Health Services](#) and can always be expanded upon with approval.

HRSA requires health centers to establish and maintain ongoing quality improvement and quality assurance programs and systems that include both clinical services and clinical management. The specific requirements for such programs are addressed in [Chapter 10: Quality Improvement and Assurance](#) of the Health Center Program Compliance Manual.

The Primary Care Medical Home (PCMH) standards are an excellent basis for the kinds of care a health center will provide. Included in these standards are recommendations for care coordination, regular reminders and follow up plans for patients, and ideas for how to ensure patients receive all the care they need.

In addition to the Program Requirements and PCMH standards, the following are some guidelines a new health center may wish to consider in planning its care:

- Medicaid Health Plan Employer Data and Information Set (HEDIS) are a standardized set of measures to assess the performance of Medicaid managed care plans (and are often also used by commercial plans). They were developed by the National Committee for Quality Assurance (NCQA), and can be found here: <https://www.ncqa.org/hedis/>
- Quality Family Planning (QFP) Guideline were issued by the Centers for Disease Control and Prevention (CDC) in 2014. These recommendations for family planning apply to both women and men. For more information, visit <https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf>
- The Joint Commission's ambulatory care accreditation is a process that can promote high quality and improve both patient safety and healthcare outcomes for your community health center. Successful community health centers embark on and complete the accreditation journey as a team. For more information, visit: [https://www.jointcommission.org/accreditation/ambulatory\\_healthcare.aspx](https://www.jointcommission.org/accreditation/ambulatory_healthcare.aspx)
- Prenatal care standards are available from the Office of Women's Health within the U.S. Department of Health and Human Services: <https://www.womenshealth.gov/pregnancy/youre-pregnant-now-what/prenatal-care-and-tests>
- Pediatric care standards, following the American Academy of Pediatrics Bright Futures guidelines are available at: <https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/Pages/default.aspx>

While this list is not exhaustive, it can provide a starting point for some of the most common health care standards a new health center will want to follow.

## Section 8

# Human Resources

Earlier in this document the specific role of the board of directors as related to human resources was discussed. That role is but the beginning of the human resources function of a health center. In most other organizations, aside from selecting a CEO, human resources functions are completely delegated to management.

Every health center is required to have a CEO and strongly recommended to have a CMO and CFO. As health centers grow, they may have chief operations officers, human resources directors, a chief information officer, a head of quality improvement, and other leaders. Under [Chapter 11: Key Management Staff](#), only the CEO must be directly employed by and reports to the board.

## Staffing Needs and Clinician Recruitment and Retention

Each health center will have its own staffing needs. HRSA recognizes the need for this flexibility in [Chapter 5: Clinical Staffing](#) of the Health Center Program Compliance Manual, which requires health centers to have sufficient staff to ensure that services are available and accessible promptly, as appropriate and in a manner to ensure continuity of care, taking into consideration the size, demographics and health needs of the patients.

While health centers rely on licensed independent practitioners (LIPs<sup>23</sup>) in order to provide patient care, the rest of the staffing model of the health center will be up to the project plan the health center creates. The types of practitioners that a new health center plans to employ will depend on the quantity and specific service needs of the population to serve.

In any event, the new health center should plan for appropriate clinical support staff (nurses, medical assistants, registration/check in, referral processing staff, dental assistants, behavioral health intake clerks, clinic secretary, health educators, to name a few) in order to deliver the care the community wants and needs.

When hiring new providers, health centers can refer to the National Practitioner Data Bank (NPDB). NPDB was established by Congress in 1986 and is a web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to health care practitioners, providers, and suppliers. This tool was designed to prevent practitioners from moving state to state without disclosure or discovery of previous damaging performance. The NPDB contains more than 1.4 million reports and interacts with more than 23,000 entities. For more information, refer to <https://www.npdb.hrsa.gov/index.jsp>.

Recruiting and retaining clinicians is as much art as science. The first step is understanding where help is available. One of the best sources for clinical recruitment and retention for a health center is the National Health Service Corps (NHSC). NHSC can be a significant help in recruiting providers and helping in placing primary, dental, and mental health clinicians and repaying professional education loans. There are stringent eligibility rules for both providers and health center. It is recommended that health centers interested in NHSC recruitment contact the National Health Service Corps ([www.nhsc.hrsa.gov](http://www.nhsc.hrsa.gov)) as well as their state PCA.

The PCA can help with more than just connection to the NHSC. Many state PCAs maintain databases of vacancies in their states and can help health centers create recruitment plans.

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<sup>23</sup> Licensed independent practitioners (physicians – both MD and DO, Advance Practice Nurses, Dentists, Clinical Psychologists, and sometimes Physician Assistants, Dental Hygienists and Clinical Social Workers, depending on the state) are individuals who because of their licensure may exercise independent clinical judgment and provide health care services without supervision.

Another area not to overlook for clinician recruitment is the local hospital community and medical schools and residency programs, dental schools and schools of psychology. Hospitals may be seeking outpatient practice opportunities for clinicians they wish to recruit to the community, and training programs are always looking for rotation sites or shadowing locations for students, residents and interns. If there is a medical or dental residency program in your area, linking with that program right away can help the health center form a long-term pipeline for candidates.

In addition, some National Cooperative Agreement partners (some mentioned earlier in this document with links to their sites) assist in clinician recruitment. Visit the Health Center Resource Clearinghouse for more information on NCA partner resources: [www.healthcenterinfo.org](http://www.healthcenterinfo.org).

## Staffing Ramp Up

Another area that health centers need to consider is the ramp up, or phase in period. Looking at the business plan, the health center will undoubtedly have a period of time over the first few years of operation that patient volumes are growing. The health center should have a ramp up plan that takes this growth into account. Do not overcommit the resources of the health center by staffing for full production at day one.

Recruitment of provider staff is a key area that a planning group should consider.

- Will the health center be located in an area that is easy to attract providers to?
- Or will recruitment and retention be an ongoing challenge?

In the ramp up plan, the health center should think about employing a slight excess of provider staff if recruitment is expected to be challenging. The clinician recruitment cycle follows the academic cycle in many cases, so expect that clinicians seeking a position directly from training will start their searches around September or October, with an expectation of executing contracts around April or May of the following year, and then starting a position in July or August.

Adequate provider staffing is a key area of focus for new health centers (and for existing centers). Some health center experts recommend staffing for about 115% of expected provider productivity (as it relates to patient volume). Additional provider and provider support staffing (i.e. medical assistants) should be planned for when the health center is consistently outperforming volume expectations by 10% (e.g. every week for six weeks).

## Creating a Competitive Staffing Environment

For clinicians, as well as for all positions in the health center, offering a competitive employment package is no longer a luxury. It is essential in the marketplace if the new center wishes to attract and retain a high caliber workforce. Here are some tips for recruitment and retention of the entire staff of the health center:

- **Market competitive wage/salary:** The successful health center will study local prevailing rates and propose to the board of directors a salary band that allows recruitment of the best candidates.<sup>24</sup> In the past some have maintained that health centers cannot and should not attempt to meet prevailing rates, but in today's competitive environment, this is no longer a viable strategy.
- **Market the health center:** A newly forming health center can offer lots of advantages to staff members. The opportunity to be in "on the ground floor" of setting up the practices and growing along with the patient population can be most satisfying. Developing recruitment materials can help a whole team of health center supporters be recruitment advocates.

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<sup>24</sup> The board of directors must approve salary bands, but the CEO (or designate) determines the actual rate within the band.

- **Act fast when identifying a candidate for a position:** Assuming the health center can afford the addition and the position is necessary for the operation and growth of the enterprise, do not hesitate. In a world of instant communication, the organization that contacts a candidate first, consistently and effectively will win the candidate.
- **Fit is everything** Candidates must share the values of the organization and have a commitment to serving the underserved. It is far preferable to have a vacancy in a position than it is to have a poor hire. Plus, the rest of the team will appreciate the commitment to the mission. One way to do so is to have teams of health center staff interview potential candidates, so they can get a sense of what it would mean to work with them each day.
- **Credentialing and Privileging:** All health center staff must meet the Credentialing and Privileging Requirements as described in [Chapter 5: Clinical Staffing](#).

**All employees and contractors of the health center must be checked against the OIG's exclusions list:** Any health care entity that receives reimbursement under Medicare and Medicaid must ensure they are not employing or contracting with anyone on the exclusions database, or risk heavy sanction. Indeed, this verification occurs not only at the point of hire or contract but must be reviewed periodically as well. Some organizations review the database monthly. The database is available at <http://exclusions.oig.hhs.gov>.

Retention is a major factor for health centers as well, not only for clinicians but for all staff. Health centers must consider carefully their competitive environment. Note that salary level is but one factor – though the lower the wage or salary, the bigger a factor it is. Benefits, retirement savings vehicles and staff bonus programs, as well as a voice in the workplace are all key factors that can help good employees stay.

## Section 9

# Information Technology

The health center's information technology system (IT) serves many purposes – from patient appointment scheduling and billing to ongoing needs assessments and quality improvement and performance improvement. IT systems are increasingly complex, and there are several systems that are specialized for health center operations.

IT systems are generally categorized into two areas: operations functions and management functions.

**Operations functions** are those aspects of data and information processing that allow health center staff to work efficiently every day. This includes patient registration and scheduling, visit documentation, billing systems, and telephone systems.

**Management functions** include reporting of data and outcomes that allow the health center leadership (board and staff) to evaluate the health center's activities and make any changes necessary. Patient utilization information, health status outcomes on an aggregated basis and provider productivity are examples of management functions.

## Electronic Health Records

Data warehouses and centralized software sharing systems (sometimes known as an ASP model – ASP standing for “application service provider”) are becoming the norm. HRSA/BPHC supports Health Center Controlled Networks (HCCN), many of which offer shared IT system support. An HCCN serving your area may be able to help plan for IT development.

It likely goes without saying that a newly forming health center should plan to launch an electronic health record (EHR) from the very beginning. Avoiding a conversion to electronic systems later will save a major organizational transformation. What's more, in planning for space needs, starting out with an electronic health record means not building space for traditional paper medical records, and means dedicating adequate resources to computer equipment, cabling, wireless capacity, and low voltage service throughout the health center.

HRSA requires health centers to establish systems for monitoring program performance. However, HRSA stops short of requiring formal IT systems. Regardless of the type of system a health center establishes, it must ensure 1) Oversight of operations of the Federal award-supported activities; 2) Performance expectations (as described in the Notice of Award); and 3) Areas of improvement in program outcome and activity. See [Chapter 18: Program Monitoring and Data Reporting Systems](#) for more information.

When selecting an IT system for the new health center, make sure the system can collect and organize all the required data elements that a health center need. Most importantly among these is the UDS Report – Uniform Data System – that all health centers file annually with HRSA/BPHC. It is recommended when considering an IT system that a health center interview many customers about their experiences with the system, and specifically ask about UDS preparation. If the IT system is not configured properly, completing this voluminous report will be a herculean effort.

Remember as well to consider future scalability of an IT system. The small physician practice system that is very simple for providers to use may not be able to keep pace with planned growth in the health center, nor produce the detailed reports required under PCMH, UDS and other funder programs.

For tips on selecting an IT system, contact the PCA, NACHC, and visit [www.healthit.gov](http://www.healthit.gov), specifically the page dedicated to selecting the right IT vendor, <https://www.healthit.gov/faq/how-do-i-select-vendor>.

## Other IT Systems in the Health Center

There's more to IT systems than EHRs and telephone systems, of course. A health center will need standard office processing suites (word processing, spreadsheet and perhaps statistical modeling programs), finance systems and perhaps HR systems. This document will not consider standard office suites but will touch on finance systems and HR IT systems.

## Finance Systems

A new health center will need to establish good financial controls, and one of the ways this is accomplished is through the general ledger and accounting system. It is recommended that a new health center contact other health center chief financial officers for advice on selecting a finance system that works, all the while considering integration with the EHR system for patient accounting.

A financial system will need to have accounting, treasury and inventory control functions, and be able to be adjustable in terms of the chart of accounts. Additional information on the requirements for financial management systems can be found in 45 C.F.R. Part 75, which is applicable to all federal grantees receiving funds from HHS, as well as the Health Center Program Compliance Manual.

## HR Systems

A robust HR system may be an excellent investment for a new health center. These systems can help with time-keeping, salary history, tracking of benefit time, and eligibility to work in the United States. Some payroll vendors offer ASP model HR systems that can be easily configured and come at low cost, compared with implementing a full-scale system.



## Section 10

# Additional Resources

Many resources have been listed and presented throughout this document.

HRSA/BPHC maintains many free sources of technical assistance for health centers and organizations that wish to become health centers. Below is additional information about key HRSA-funded resources:

- **Primary Care Associations (PCAs):** PCAs are nonprofit associations representing health centers and other primary care safety net providers at state and regional levels. PCAs provide a wide array of services to their members and to the primary care community. Some services include centralized clinician recruitment support, technical assistance on clinical, management, finance and governance matters, training, conferences, and more. PCAs are actively involved in health policy at the state and national levels as well. PCAs vary in the services they provide. Your state and regional PCA can be found at: <https://bphc.hrsa.gov/qualityimprovement/strategicpartnerships/ncapca/associations.html>
- **Primary Care Offices (PCOs):** PCOs are usually part of state government (often housed in the State or Territorial Health Department). They receive funding through the Bureau of Health Workforce (BHW) to improve primary care service delivery, conduct health provider needs assessments, manage health professional shortage designation, and address workforce availability in the various states and/or territories to meet the needs of underserved populations. PCOs work in partnership with PCAs in areas including analyzing and prioritizing need for primary care services, submitting requests for MUA, MUP and HPSA designations, helping recruit and retain physicians and other clinicians in the state, and advocating for health centers within the State Government. Find your PCO here: <https://bhw.hrsa.gov/shortage-designation/hpsa/primary-care-offices>
- **National Cooperative Agreements (NCAs):** As of 2019, twenty (20) organizations have a national cooperative agreement (NCA) with HRSA to provide free training and technical assistance (T/TA) to support existing and potential health center awardees and FQHC look-alikes. The NCA partners possess subject matter expertise in functional areas, and support health center's ability to maintain fiscal and operational excellence, engage in effective workforce development activities, utilize cutting-edge health information technology and structure health care services in a manner culturally and linguistically appropriate to the patient population served. These organizations are funded to provide T/TA to health centers in a manner that increases patient safety and health outcomes, effectively serves diverse special, vulnerable, and underserved rural, frontier, and urban populations. This T/TA often takes the form of learning collaboratives, state/regional/national trainings, webinars, newsletters, toolkits, and fact sheets. A list of organizations can be found at: <https://bphc.hrsa.gov/qualityimprovement/strategicpartnerships/ncapca/natlagreement.html>
- **Health Center Resource Clearinghouse:** In 2018, the twenty NCAs – collaborating through the National Resource Center on Training and Technical Assistance – launch the National Health Center Resource Clearinghouse: <https://www.healthcenterinfo.org/>. As of 2019, over 500 resources on diabetes, social determinants of health, workforce, finance, emergency management, special and vulnerable populations, quality improvement, capital development, and other topics, are available for free in the Clearinghouse.



## Conclusion

This guide has offered advice and insight on key considerations for starting a health center.

As stated in the beginning – there is no one right way to complete this task. Every community is different, and every person has different priorities. The goal in a health center planning process is to design a community-based health care intervention that will address the needs of the population. A well-functioning planning group will succeed in this effort.

As discussed throughout this guidance, the [Health Center Program Compliance Manual](#) can be particularly helpful in understanding the federal requirements for many of the areas addressed in this guide. The HRSA Compliance Manual is the principal resource to assist health centers in understanding and demonstrating compliance with Health Center Program Requirements. Before deciding to begin the effort to establish a health center, you must understand the federal requirements on health center governance, clinical operations, quality of care, services provided, and management and finance systems. The Health Center Resource Clearinghouse – [www.healthcenterinfo.org](http://www.healthcenterinfo.org) – contains hundreds of training and technical resources for Health Centers and organizations seeking Health Center status.

**Some final advice:** Do not be afraid to ask for help.

- Tap the network of more than 1,400 health center organizations around the country that have gone down the path of becoming a health center.
- Contact your state PCA.
- Contact your state PCO.
- Contact NCA-organizations for technical assistance.
- Contact HRSA/BPHC for guidance.

And most importantly, make your presence active and known within your community. Your community partners are the keys to your success.

Good luck!