Community Health Centers in Florida

A Guide to Understanding Florida’s Federally Qualified Health Centers and 330 Expansion Opportunities

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Sponsored by the Florida Association of Community Health Centers and the State of Florida, Department of Health

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Dear Reader:

Federally Qualified Health Centers (FQHCs), commonly known as Community Health Centers (CHCs), have been the backbone of the healthcare safety net provider system in the U.S. for over 40 years. Last year community health centers served more than 16 million patients across the country. In Florida CHCs served over 588,000 patients with 2.3 million visits at 172 service centers throughout the state. Our patients live in medically underserved areas and represent some of the most economically disadvantaged and health challenged people in Florida.

It has been said that all healthcare is local and no model better exemplifies those words than CHCs. Community Health Centers are just that - community based. Their dedicated operational and clinical staff holds fast to the mission shared by all FQHCs “Serve all patients regardless of their ability to pay.” For CHCs, it has always been about putting the patient first.

The Guide to Understanding Florida’s FQHCs and 330 Expansion Opportunities, as well as our larger community and health center development efforts, are carried out in partnership with the Florida Department of Health. We are grateful for the opportunity to work closely with the Office of Health Professional Recruitment on our mutual goal of increasing access to affordable, quality healthcare for all Floridians.

The guide is intended to provide insight into Florida’s FQHCs and efforts to expand them. It is with pride that we present it to Florida’s communities, especially those that may be considering the development of an FQHC. As you will learn from the guide, it requires a great deal of dedication and hard work. But you are not alone in your quest. The Florida Association of Community Health Centers and the Florida Department of Health are here to assist you in your efforts.

Sincerely,

Andrew R. Behrman
President and CEO
Community Health Centers in Florida

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Introduction

This guide is intended for those who want to understand more about Florida’s Federally Qualified Health Centers (FQHCs), how they work, who they serve and why they are such an important part of Florida’s healthcare safety net. FQHCs are complex organizations that must adhere to strict federal guidelines which can be confusing to those who are unfamiliar with the program. It is our intention to clarify the most important elements of this successful model for delivering high quality, affordable healthcare to those who need it most.

Section one focuses on FQHC patients and staff, describing the types of services they provide, how they run, and how they measure quality. This includes a discussion about Healthy People 2010 and the Health Disparities Collaboratives, two federal initiatives of which FQHCs are an integral part. Section one also includes a discussion of the important role of Florida’s two integrated service delivery networks (ISDNs) which play a vital role in helping Florida’s FQHCs operate more effectively and efficiently.

Section two provides contextual information highlighting the need for affordable healthcare in our complex state. This section includes demographic, economic and political trends in Florida and their impact on the need for healthcare services. Section two includes a summary of Florida’s Medicaid reform plans and the potential impact on FQHCs in Florida.

Section three describes FACHC’s statewide strategic planning process and efforts to pinpoint areas of the state in need of additional primary healthcare services. Strategies for expanding FQHCs are discussed as well as progress made in this area to date. Section three also touches upon some of the on-going challenges related to the expansion of FQHCs in Florida.

Section four outlines the federal funding guidelines and criteria used by the Health Resources and Services Administration (HRSA) to determine where new FQHC resources will go.

The Guide to Understanding Florida’s Federally Qualified Health Centers (FQHCs) and 330 Expansion Opportunities provides the most relevant information for understanding Florida’s Federally Qualified Health Centers and the statewide healthcare environment in which they operate. We encourage you to visit the “Community and health center development” section of our web page at www.fachc.org where you can download other useful resources including So You Want to Start A Health Center?, another practical guide to understanding FQHCs. Please contact us with your comments and questions.
Section One

Overview of Florida’s Federally Qualified Health Centers (FQHCs)

What is an FQHC?

Federally Qualified Health Centers (FQHCs) are authorized under section 330 of the Public Health Service Act and are sometimes referred to as “330 grantees” or more commonly called, “Community Health Centers (CHCs)”. These terms, Federally Qualified Health Centers, Section 330 Grantees and Community Health Centers, are used interchangeably. Community Health Centers are funded by the Health Resources Services Administration (HRSA) to provide quality primary healthcare services to medically underserved populations or people with limited access to healthcare services. Federally Qualified Community Health Centers must serve a federally designated Medically Underserved Area (MUA) or Medically Underserved Population (MUP). A high percentage of Community Health Center patients are uninsured and live at or near the federal poverty level (FPL). Many are recipients of Medicaid. Fifty-six percent (56%) of Florida FQHC patients live at or below 100% of the FPL ($20,000 for a family of four). Another 20% of Florida FQHC patients live between 100% and 200% of the FPL ($40,000 for a family of four). Table 1 provides an analysis of Florida FQHC patient insurance status.

Table 1: Source of Insurance for Florida FQHC Patients

<table>
<thead>
<tr>
<th>Type of Insurance</th>
<th>Percentage of Florida CHC Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured</td>
<td>56.8%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>25%</td>
</tr>
<tr>
<td>Medicare</td>
<td>5.9%</td>
</tr>
<tr>
<td>Other Public</td>
<td>2.9%</td>
</tr>
<tr>
<td>Private insurance</td>
<td>9.5%</td>
</tr>
</tbody>
</table>

Percents may not sum to 100% due to rounding

Source: BPHC Section 330 Grantees Uniform Data System (UDS) 2004

Federally funded Community Health Centers are independent, non-profit, community-based organizations run by a Board of Directors that is responsible for setting organizational policies. All federally funded Community Health Centers must comply with federal Program Expectations outlined in HRSA’s Policy Information Notice (PIN) 98-23 that states that basic primary care services must be available to all, without regard for ability to pay. Community Health Centers must have a Board approved sliding fee schedule that is tied to the FPL, making services affordable for low income people and for the uninsured. The minimum charge for a visit at most Florida Community Health Centers is around $15-$20 however, if a patient is unable to pay the requested amount, they cannot be denied services. Community Health Centers are required to accept patients with Medicaid and Medicare coverage and also accept private insurance. Federally Qualified Health Centers benefit from enhanced reimbursement under the Prospective Payment System (PPS) that helps an organization recover some of the cost incurred in providing uncompensated care to the uninsured. In 2004, Florida Federally Qualified Health Centers provided $100 million in uncompensated care.
What is an FQHC “Look Alike”?

An FQHC “Look Alike” (FQHC-LA) adheres to all the rules and regulations of a federally funded Section 330 Community Health Center. FQHC-LA organizations do not, however, receive federal grant funding. An FQHC-LA does receive enhanced reimbursement through the Prospective Payment System (PPS) and participation in cost saving federal programs like the 340B drug pricing program and the National Health Services Corps (NHSC), that matches communities in need with clinicians who agree to work for a period of time in exchange for educational loan repayment. Currently, HRSA is considering plans to include Federal Tort Claims Act (FTCA) coverage for FQHC-LA organizations. FTCA is no-cost federal malpractice liability insurance. See page 65 for a chart comparing FQHCs and FQHC-LAs.

For the purposes of this guidebook, references to “FQHCs” include “Look Alike” organizations unless otherwise noted. There are currently no FQHC Look Alikes in Florida. However, several communities are planning to submit FQHC-LA applications.

How Many FQHCs Are There In Florida?

There are a total of thirty-seven (37) FQHCs in Florida of varying sizes and levels of complexity. Several FQHCs are large with multiple service delivery sites serving numerous communities/counties. There are several small or large single site FQHCs with simple organizational structures. Thirty-three (33) of Florida’s thirty-seven (37) FQHC organizations are members of the Florida Association of Community Health Centers (FACHC), the state’s Primary Care Association (PCA) that supports CHCs in their efforts to expand access to affordable healthcare. Table 2 illustrates the size of FACHC member organizations based on their number of sites and patients served annually.

<table>
<thead>
<tr>
<th>Number of Sites</th>
<th>Number of FACHC Members</th>
<th>Number of Patients</th>
<th>Number of FACHC Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>8</td>
<td>Less than 5000</td>
<td>6</td>
</tr>
<tr>
<td>2-5</td>
<td>12</td>
<td>5000-14,999</td>
<td>9</td>
</tr>
<tr>
<td>6-9</td>
<td>7</td>
<td>15,000-25,000</td>
<td>9</td>
</tr>
<tr>
<td>10-15</td>
<td>5</td>
<td>25,000-50,000</td>
<td>8</td>
</tr>
<tr>
<td>15&lt;</td>
<td>1</td>
<td>More than 50,000</td>
<td>1</td>
</tr>
</tbody>
</table>

What Healthcare Services Are Provided At FQHCs?

Federally Qualified Community Health Centers must offer comprehensive primary healthcare services across all life cycles including primary medical care, health screenings, prenatal care, family planning, pediatrics, immunizations, emergency medical services, vision services, diagnostic X-ray and laboratory services. New applicants seeking FQHC funding must offer dental and mental health/substance abuse counseling services. Established FQHC organizations must plan to begin offering oral health and mental health/substance abuse counseling if they do not already do so. FQHCs work with a variety of community organizations to ensure that all required services are covered either in-house or under contract with other providers. They also offer a comprehensive
array of “*Enabling Services*” designed to reduce the barriers to healthcare that are experienced by many CHC patients. Language services, transportation, outreach, case management, education and other support services make healthcare more accessible for those who need them most. Unlike many healthcare providers, FQHCs cannot be selective about who they serve. They are required to serve everyone - women, men, children, young, old, black, white, Hispanic - everyone.

In 2004, Florida’s FQHCs saw **588,288 patients** with almost **2.4 million medical, dental and mental health encounters** at **172 sites** across the state in some of Florida’s most rural and inner city communities. Florida FQHCs employ 3,568 people including physicians, dentists, nurse practitioners, physician assistants, nurses, medical assistants, pharmacists, case managers, outreach workers and other support staff. Table 3 illustrates the total number of patient encounters delivered by Florida FQHCs by category and number of visits (encounters) per patient.

### Table 3: Florida FQHC Patient Encounters by Type, Number and Ratio

<table>
<thead>
<tr>
<th>Type of Patient Encounter</th>
<th># of Encounters</th>
<th>Average # of Encounters per Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>1,845,136</td>
<td>3.28</td>
</tr>
<tr>
<td>Dental</td>
<td>205,355</td>
<td>2.37</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse</td>
<td>90,334</td>
<td>5.09</td>
</tr>
<tr>
<td>Enabling</td>
<td>190,921</td>
<td>2.27</td>
</tr>
<tr>
<td>Total Encounters</td>
<td>2,351,108</td>
<td></td>
</tr>
</tbody>
</table>

Source: Florida Uniform Data System (UDS) 2004

### Who Are FQHC Patients?

Many FQHC patients are economically disadvantaged, uninsured and face substantial social challenges and barriers to affordable healthcare. The lack of financial resources and health insurance places major limitations on the availability of healthcare services for many people. FQHCs are required by federal regulations to serve **medically underserved areas or populations (MUAs/MUPs)** where access to healthcare is particularly difficult for residents. Many CHC patients work in low paying jobs with few, if any, benefits and cannot afford to miss an afternoon of work to see a clinician. Barriers to healthcare access are frequently compounded by a lack of reliable transportation. Many Florida CHCs make arrangements for transportation to and from health center sites, and to other providers who agree to provide additional services. Most physicians’ offices are open between the hours of nine and five. When working people (particularly low paid hourly workers) are sick, they often have to choose between risking the loss of needed employment, forgoing care for themselves and their loved ones or turning up at the emergency room after work hours. None of these options are good ones. Many Florida Community Health Centers offer evening and weekend hours making services more accessible to the populations they serve.

Nearly 10% of Florida FQHC patients are privately insured and have options about where to go for healthcare. They choose to use FQHCs because of the number and scope of services they offer, the quality of care and the enabling services that make healthcare more accessible to them. Table 4 illustrates selected demographics for Florida FQHC patients.
Table 4: Florida FQHC Patients by Age, Ethnicity, Language And Special Population Category

<table>
<thead>
<tr>
<th>Patient Demographics</th>
<th>Percent of all CHC Patients</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients &lt;15</td>
<td>31%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Patients 15-64</td>
<td>N/A</td>
<td>64%</td>
<td>36%</td>
</tr>
<tr>
<td>Patients 65&lt;</td>
<td>6%</td>
<td>61%</td>
<td>39%</td>
</tr>
<tr>
<td>Women 15-44</td>
<td>28%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Black</td>
<td>26%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>White</td>
<td>35%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Latino</td>
<td>37%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Best Served in a Language Other than English</td>
<td>28%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Migrant and Seasonal Farmworker</td>
<td>10.5%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Homeless</td>
<td>10.5%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Source: Florida Uniform Data System (UDS) 2004

Florida FQHCs are experienced at providing high quality, linguistically and culturally competent healthcare to a very diverse clientele. Twenty-eight percent (28%) of Florida CHC patients self-identify as best being served in a language other than English. FQHCs must comply with federal regulations ensuring services are available in the languages of their “Target Populations.” FQHCs value diversity and actively recruit providers, staff, board members and volunteers who reflect their community’s racial and ethnic populations. The result is better communication, higher quality and improved health outcomes.

Many immigrants to the U.S. are served at Florida FQHCs, some of whom are undocumented, meaning they are in the country illegally. Fear of arrest and possible deportation is an additional barrier to seeking needed healthcare services. More than 80% of Florida’s estimated 250,000 farmworkers are immigrants, many of them undocumented. Geographic isolation, anti-immigration sentiments and an over-reliance on their “Crew Chief” for all aspects of daily life contribute to the physical and social isolation and depression that many farmworkers experience. Active and effective “Outreach” is a key to making preventative and primary healthcare services accessible to farmworkers, immigrants and other hard to reach populations, including the homeless. In 2004, Florida FQHCs employed 78 full-time outreach workers whose successful efforts to reach these populations may have saved Florida millions of dollars in acute and critical care that would have been provided in hospital emergency rooms.

“Special Populations”

Some FQHCs receive Section 330 funding to serve “Special Populations” that include the following HRSA categories: migrant and seasonal farmworkers (MSFW), the homeless, school children and their families and residents of public housing. These FQHCs are required to meet the same program expectations as all other 330 organizations with the added expectation that they will
make the extra effort required to make their healthcare services available to these challenging populations. Federal Program Expectations are outlined in Policy Information Notice (PIN) 98-23 available at http://www.fachc.org/cd_community%20development%20.htm. Special populations are generally uninsured at a higher rate than regular CHC patients and cost more to serve as they often have multiple serious health conditions associated with their lifestyle and lack of access to regular care. To compensate, HRSA provides additional funding for members of special populations ($200 federal grant dollars for each special population patient compared to $150 for a “Community” patient).

Individuals representative of the special populations served must be represented on the FQHC board of directors. Maintaining board representation can be a challenge, particularly with mobile populations like migrant farmworkers and the homeless. Health centers may be granted a waiver of the board requirement but they must still demonstrate active input from members of the target populations through advisory boards, focus groups or other ongoing and effective measures. Table 5 illustrates the number of Florida FQHC organizations by 330 funding category.

Table 5: Florida FQHCs by 330 Funding Category

<table>
<thead>
<tr>
<th>Type of Funding Received</th>
<th>Number of FQHCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Center (330e) Only</td>
<td>19</td>
</tr>
<tr>
<td>Only Migrant Health Center (330g) Only</td>
<td>0</td>
</tr>
<tr>
<td>Homeless Health Center (330h) Only</td>
<td>5</td>
</tr>
<tr>
<td>Community and Migrant Health Center</td>
<td>10</td>
</tr>
<tr>
<td>Community, Migrant and Homeless</td>
<td>2</td>
</tr>
<tr>
<td>School Based Health Center (SBHC)</td>
<td>1</td>
</tr>
<tr>
<td>Public Housing Primary Care (330i)</td>
<td>0</td>
</tr>
</tbody>
</table>

In 2004 Florida CHCs served 61,819 homeless individuals and 61,992 migrant and seasonal farmworkers. Each of these populations has unique challenges related to their work and lifestyle. Their mobility makes providing continuity of care difficult. Likewise both populations may be untrusting of large institutions and the people who work in them. Aggressive outreach is a pivotal part of making healthcare services accessible to both farmworkers and homeless individuals and families. Table 6 illustrates selected patient demographics for different categories of special populations served at Florida FQHCs.
Table 6: Demographic Characteristics of “Special Populations” Served by Florida FQHCs

<table>
<thead>
<tr>
<th></th>
<th>Homeless</th>
<th>Migrant</th>
<th>School Based</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of 330 Grantees</td>
<td>7</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>Total Patients</td>
<td>61,819</td>
<td>61,992</td>
<td>8,598</td>
</tr>
<tr>
<td>Male</td>
<td>62.5%</td>
<td>43.6%</td>
<td>43.9%</td>
</tr>
<tr>
<td>Female</td>
<td>37.5%</td>
<td>56.4%</td>
<td>56.1%</td>
</tr>
<tr>
<td>Black</td>
<td>39.1%</td>
<td>9.2%</td>
<td>5.4%</td>
</tr>
<tr>
<td>White</td>
<td>41.8%</td>
<td>3.9%</td>
<td>7.8%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>15.8%</td>
<td>84.8%</td>
<td>81%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>96%</td>
<td>60.3%</td>
<td>89%</td>
</tr>
</tbody>
</table>

Percent may not sum to 100% due to rounding

Source: BPHC Section 330 Grantees Uniform Data System (UDS) 2004

A number of national, regional and state organizations funded through HRSA and coordinated through the Office of Special Populations support the important work of migrant and homeless health centers. Some of them are illustrated in Table 7.

Table 7: National Organizations Supporting FQHC Special Populations

<table>
<thead>
<tr>
<th>Organization</th>
<th>Services and Support Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Healthcare for the Homeless Council (NHHC)</td>
<td>Advocacy; Research; Training; Materials</td>
</tr>
<tr>
<td>Farmworker Health Services (FSHI)</td>
<td>Training, materials and resources to strengthen outreach programs and networks</td>
</tr>
<tr>
<td>Migrant Health Promotion (MHP)</td>
<td>Training, materials and resources to build effective “Promotora” or lay health promotion programs</td>
</tr>
<tr>
<td>The Migrant Clinicians Network (MCN)</td>
<td>Training, materials and resources for clinicians</td>
</tr>
<tr>
<td>The National Center for Farmworker Health (NCFH)</td>
<td>Leadership development, including governance; Call for Health national referral program</td>
</tr>
<tr>
<td>The Farmworker Justice Fund (FJF)</td>
<td>Legislative advocacy and public education around issues such as pesticides</td>
</tr>
<tr>
<td>The National Association of Community Health Centers (NACHC)</td>
<td>Health center growth and expansion; advocacy and legislative issues</td>
</tr>
<tr>
<td>*Regional Migrant Health Coordinators (Migrant Coordinators)</td>
<td>Local and regional needs assessments and strategic planning; training and partnership development</td>
</tr>
<tr>
<td>State Primary Care Associations (PCAs) and Primary Care Offices (PCOs)</td>
<td>Training, technical assistance, legislative advocacy</td>
</tr>
</tbody>
</table>

*The Southeast Migrant Health Coordinator serves FL, GA, AL and MS and is housed at FACHC.
In 2005, the Florida Legislature, in recognition of the important economic contributions of farmworkers revived the Joint Commission on Migrant and Seasonal Labor to better understand and address some of the many challenges faced by farmworkers in Florida including lack of affordable housing, barriers to healthcare and human rights abuses under the contract labor system. The Florida Homeless Coalition and 15 regional “Continuums of Care” in cooperation with Florida Department of Children and Families, State Office of Homelessness work with homeless advocates and service providers to prevent further homelessness and alleviate suffering by sharing information, resources and strategies; supporting local legislative initiatives; monitoring public policies; and promoting leadership in the development of a statewide agenda to end homelessness.

Measures of Quality

How Do FQHCs Measure Quality?

FQHCs are required to have a performance improvement plan to ensure the delivery of high quality, linguistically and culturally appropriate healthcare. HRSA regularly monitors their progress in achieving quality standards through a Performance Review Protocol. CHCs have quality assurance teams, generally led by the Medical Director, that meet regularly and conduct ongoing activities including periodic patient satisfaction surveys, to ensure that the highest standards of care are maintained. FQHC board members, 51% of whom are required to be patients of the health center, actively monitor the quality of care, providing direction on how to design and provide user friendly services. The majority of Florida FQHC organizations are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), considered by many to be the “gold standard” in healthcare quality. The Federal Office of Management and Budget (OMB) rates FQHCs as one of the top 10 most effective federal programs in the U.S.

How Can FQHCs Run So Efficiently?

Achieving the highest level of quality and efficiency while serving patients that are least able to pay for services requires strong organizational leadership, a clear understanding of the healthcare environment and a high level of business acumen. Florida FQHCs are generally led by a management team that includes the Chief Executive Officer (CEO), Chief Financial Officer (CFO) and Chief Medical Officer (CMO), who together with the Board of Directors and other members of the management team make key organizational decisions. A sample FQHC organizational chart can be viewed at www.fachc.org/cd_presidents%20initiative.htm. Management Information Systems (MIS) enable FQHCs to analyze a wide variety of data that helps leadership make sound decisions. The Uniform Data Reporting System (UDS) required of all FQHCs helps the Board and management analyze current information on provider productivity, patient demographics, key diagnoses, service utilization and fiscal issues.

FQHCs benefit from participation in a number of federal programs including the 340B Drug Program that allows them to offer pharmaceuticals to patients at greatly reduced cost, either on site or through contracts with local pharmacies. Florida FQHCs currently employ 32 National Health Service Corps (NHSC) clinicians who practice at CHCs in exchange for federal repayment of educational loans or scholarship obligations. Services provided at FQHCs are covered under the Federal Tort Claims Act (FTCA) saving Florida 330 organizations millions of dollars in malpractice insurance costs every year.
To remain competitive in the current healthcare marketplace FQHCs must operate with sound business practices. Health center leaders are continually looking for and creating opportunities to increase revenues and reduce costs so that they can provide more and better services for their target populations. The federal 330 grant revenue received by Florida FQHCs represents less than 30% of their overall budgets. Table 8 illustrates the various revenue streams that allow Florida CHCs to keep their doors open and highlights the significance of Medicaid as an important revenue source.

Table 8: Florida FQHC Revenue Sources

<table>
<thead>
<tr>
<th>Source of Revenue</th>
<th>Percent of Budget</th>
<th>Source of Revenue</th>
<th>Percent of Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>330 grant</td>
<td>27.1%</td>
<td>Medicaid</td>
<td>27.5%</td>
</tr>
<tr>
<td>Other Federal Grants</td>
<td>3.2%</td>
<td>Medicare</td>
<td>4.2%</td>
</tr>
<tr>
<td>State and Local Grants and Contracts</td>
<td>13.6%</td>
<td>Other Public Insurance</td>
<td>1.1%</td>
</tr>
<tr>
<td>Foundation or Private Grants</td>
<td>1.6%</td>
<td>Private Insurance</td>
<td>4.6%</td>
</tr>
<tr>
<td>Patient Self Pay Revenue</td>
<td>12.4%</td>
<td>Public Indigent Care Programs</td>
<td>3.4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other Revenue</td>
<td>1.2%</td>
</tr>
</tbody>
</table>

Percents may not sum to 100% due to rounding

Source: BPHC Section 330 Grantees Uniform Data System (UDS) 2004

Integrated Service Delivery Networks (ISDN)

The majority of Florida’s thirty-seven (37) CHCs belong to one of two “Integrated Service Delivery Networks” (ISDNs), Health Choice Network (HCH) or Community Health Centers Alliance (CHC Alliance). FQHCs who belong to a “Network” delegate business services that can be operated more efficiently when organized collectively rather than individually. The Networks create economies of scale that allow CHCs to operate at a higher level of effectiveness and efficiency, in part because it provides them with technologies they might not otherwise be able to afford. As a result, the health centers serve more patients, offer more services and enhance the level of care they provide which results in improved health outcomes. Business and clinical systems provided by the networks include information technology, financial leadership, centralized billing, contract management and electronic health records. Network leaders play an important role in ensuring the success of Florida’s FQHCs.

Who Are The FQHC Healthcare Providers?

FQHC clinicians include family practitioners, general practitioners, internists, pediatricians, OB/GYNs, nurse practitioners, physician assistants, nurses, nurse midwives, dentists and mental health professionals that are experts at providing the highest quality of healthcare to some of Florida’s least healthy residents. In order to maintain malpractice liability insurance under the Federal Tort Claims ACT (FTCA), CHC providers must meet strict requirements and ensure that all their clinicians have the proper qualifications, licenses and educational credentials to fulfill their role in the health center. FQHC clinicians are some of the most productive healthcare providers in the public or private sector. Table 9 illustrates the number of selected Full Time Equivalent (FTE) providers employed at Florida FQHCs and their average number of patient visits per year.
Table 9: Florida FQHC Provider Productivity

<table>
<thead>
<tr>
<th>Type of Provider</th>
<th>FTE</th>
<th>Yearly Patient Encounters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Practitioners</td>
<td>108.71</td>
<td>4761</td>
</tr>
<tr>
<td>General Practitioners</td>
<td>15.86</td>
<td>4204</td>
</tr>
<tr>
<td>Internists</td>
<td>43.47</td>
<td>4099</td>
</tr>
<tr>
<td>OB GYN</td>
<td>31.93</td>
<td>3806</td>
</tr>
<tr>
<td>Pediatricians</td>
<td>80.76</td>
<td>4501</td>
</tr>
<tr>
<td>Other Specialists</td>
<td>1.31</td>
<td>4043</td>
</tr>
<tr>
<td>Nurse Practitioners</td>
<td>87.83</td>
<td>3083</td>
</tr>
<tr>
<td>Physicians Assistants</td>
<td>25.22</td>
<td>3342</td>
</tr>
<tr>
<td>Certified Nurse Midwives</td>
<td>26.66</td>
<td>2613</td>
</tr>
<tr>
<td>Nurses</td>
<td>360.97</td>
<td>463.9</td>
</tr>
<tr>
<td>Dentists</td>
<td>59.43</td>
<td>2856</td>
</tr>
<tr>
<td>Dental Hygienist</td>
<td>26.38</td>
<td>1349</td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>7.36</td>
<td>4041</td>
</tr>
<tr>
<td>Other Licensed Mental Health Providers</td>
<td>16</td>
<td>1339</td>
</tr>
</tbody>
</table>

Source: BPHC Section 330 Grantees Uniform Data System (UDS) 2004

Recruiting physicians and other clinicians is an on-going challenge for healthcare agencies throughout Florida. To remain competitive FQHCs must offer attractive salary and benefits packages while choosing compassionate providers who want to be a part of the CHC mission.

What Is The Difference Between A Community Health Center (CHC) And A County Health Department (CHD)?

Community Health Centers are sometimes confused with County Health Departments (CHDs) that are located in each of Florida’s 67 counties. CHDs are funded by the State of Florida to maintain public health and safety by promoting healthy lifestyles and monitoring and preventing health risks including the spread of disease. Many Florida CHDs offer primary healthcare services in addition to their “public” health role. The provision of primary health care does not mean CHDs are CHCs, a designation that can only be granted by the federal government. There are however, five FQHCs in Florida that are part of a CHD. These “hybrid” organizations must comply with the same federal expectations as all other FQHCs, including the governance requirement stipulating that the health center must be run by a community Board of Directors, 51% of whom must be patients of the health center’s services. CHDs must also comply with state requirements for CHDs. Table 10 lists the FQHCs in Florida that are part of CHDs.
Table 10: Florida FQHCs Functioning As Part of County Health Departments

<table>
<thead>
<tr>
<th>Community Health Center (FQHC)</th>
<th>County Health Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agape</td>
<td>Duval CHD</td>
</tr>
<tr>
<td>C. L Brumback</td>
<td>Palm Beach CHD</td>
</tr>
<tr>
<td>Nature Coast</td>
<td>Hernando CHD</td>
</tr>
<tr>
<td>Poinciana Primary Healthcare</td>
<td>Osceola CHD</td>
</tr>
<tr>
<td>St Joseph’s Healthcare</td>
<td>Gulf CHD</td>
</tr>
</tbody>
</table>

What is a Health Disparities Collaborative (HDC)?

Twenty-five (25) of Florida’s 37 FQHCs participate in at least one Health Disparities Collaborative (HDC) aimed at eliminating health disparities for the underserved who suffer disproportionately from chronic diseases including diabetes, hypertension, asthma, cancer and depression. Participating health centers adopt shared national and local measures aligned with expert guidelines, external reporting requirements and other community standards of care. Patient self-management is an important shared national measure and CHC patients receive intense education about managing their illness and preventing other health problems. Incorporation of these standards into the healthcare practice has led to measurably improved health outcomes, and increased patient self-management in health centers across the state and the nation. The success of the HDC Model has led to a recent partnership with the Florida Department of Health’s Heart Disease and Stroke Prevention Program to spread the HDC concept throughout local healthcare delivery systems.

Conclusion of Section One

Florida’s FQHCs are a vital part of Florida’s healthcare safety net, providing high quality, linguistically and culturally competent healthcare to a diverse clientele that face many healthcare challenges. FQHC clinicians are among the most productive in the state and FQHC leaders are adept at managing change in a rapidly shifting healthcare marketplace, ensuring that Florida’s neediest residents continue to receive the primary and preventative care services they need.
Section Two

Significant Florida Trends and their Implications for Healthcare

Rising uninsurance rates and population growth combined with other demographic, political and economic factors indicate a growing need for affordable healthcare in Florida.

Rising Rates of Uninsured

According to the Florida Agency for Healthcare Administration (AHCA) 2005 Report Comparative Findings from the 1999 and 2004 Florida Health Insurance Study, between 1999 and 2004 the percentage of Floridians under age 65 that are uninsured increased from 16.8% to 19.2%. Rates of uninsurance increased slightly or were stable for people at either end of the income spectrum, but increased markedly for middle-income families, especially working families with annual incomes between $15,000 and $45,000. The majority of uninsured Floridians have jobs but do not have the option of purchasing employer sponsored health insurance or cannot afford the premiums. Florida’s economy is based on tourism, the service sector and agriculture, all of which are dominated by low paying jobs that offer few if any health insurance benefits. Lack of affordability was listed as the main reason for not having health insurance for 63.1% of survey respondents in 2004. Forty-two percent (42%) of the uninsured people surveyed indicated they had delayed or not obtained needed medical care within the past 12 months because they could not afford it. Table 11 illustrates key characteristics of Florida’s uninsured population. Table 12 illustrates the rising uninsurance rates for employed adults as well as for all racial and ethnic groups.

Table 11: Key Characteristics of Florida’s Uninsured Population

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Floridians with no health insurance coverage</td>
<td>19%</td>
</tr>
<tr>
<td>Counties that have a rate of uninsured exceeding 20%</td>
<td>37%</td>
</tr>
<tr>
<td>Uninsured individuals between 100% and 200% of the federal poverty level</td>
<td>39%</td>
</tr>
<tr>
<td>Uninsured individuals employed in the hospitality, retail or construction sectors</td>
<td>43%</td>
</tr>
<tr>
<td>Uninsured individuals who are working age adults</td>
<td>82%</td>
</tr>
<tr>
<td>Uninsured individuals who have a paying job</td>
<td>63%</td>
</tr>
</tbody>
</table>

Source: AHCA Florida Health Insurance Study 2004 (note percents have been rounded).
Table 12: Uninsurance Rates for Specific Groups of Floridians 1999-2004

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>2004</th>
<th>1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed Floridians 18 to 64 reporting that their employers do not offer</td>
<td>69.2%</td>
<td>65.2%</td>
</tr>
<tr>
<td>health insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of Hispanics who are uninsured</td>
<td>31.8%</td>
<td>28.6%</td>
</tr>
<tr>
<td>Percentage of blacks who are uninsured</td>
<td>22.6%</td>
<td>19.6%</td>
</tr>
<tr>
<td>Percentage of white non-Hispanics who are uninsured</td>
<td>14.3%</td>
<td>13.2%</td>
</tr>
</tbody>
</table>

Source: AHCA Comparative Findings from the 1999 and 2004, (note, percents have been rounded).

Table 12 highlights significant disparities in insurance rates between whites, non-whites and Hispanics, with the latter, consistently having the highest rates of uninsurance.

Between 1999 and 2004, 14 of 17 Florida health insurance districts recorded an increase in the percentage of full-time workers who are uninsured. The highest uninsured rates in both 1999 and 2004 were in health insurance districts 17 (Dade), 12 (Southern Interior) and 14 (SW Florida) followed by District 2 that includes 25 counties in North Central Florida and the Panhandle. Table 13 illustrates the three (3) health insurance districts with the highest uninsured rates in 1999 and 2004.

Table 13: Florida Health Insurance Districts with the Highest Rates of Uninsured

<table>
<thead>
<tr>
<th>District</th>
<th>Counties</th>
<th>1999 Rate of Uninsured</th>
<th>2004 Rate of Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>Dade County,</td>
<td>24.6%</td>
<td>28.7%</td>
</tr>
<tr>
<td>12</td>
<td>DeSoto, Glades, Hardee, Hendry, Highlands, Monroe and Okeechobee</td>
<td>25.5%</td>
<td>24.4%</td>
</tr>
<tr>
<td>14</td>
<td>Charlotte, Collier and Lee</td>
<td>24.4%</td>
<td>19.8%</td>
</tr>
</tbody>
</table>

Population Growth

Florida is one of the most populated and fastest growing states in the nation, with an estimated 17.4 million residents and 6000 new residents arriving daily. Between 1990 and 2000, the population of Florida increased by over three million people for the third consecutive decade. Almost every Florida County experienced growth. More than half or Florida’s 67 counties grew by more than 25 percent.

This high rate of growth is expected to continue for all parts of the state but may be most dramatic in the panhandle which is still very rural. The large scale sale of St. Joe Paper Company land portends rapid development and population growth with the service, tourism and construction sectors gaining in importance. These industries traditionally do not offer health insurance to the majority of their workers. Landscaping and related industries will increase in importance, including niche markets like the pine straw industry which employs increasing numbers of immigrants in
North Florida. The rapid spread of urban areas will continue in the South and Central portions of the state where farmland for urban development is being sold at staggering rates, leaving the future of agriculture in our state in question. A shortage of affordable housing will continue to negatively impact the economy unless the issue is proactively addressed. The availability of housing will be an important component of Florida’s efforts to recruit more healthcare providers and the staff needed to support them.

According to a U.S. Census Population Report released in April 2005, three states — Florida, California and Texas will account for nearly one-half (46 percent) of total U.S. population growth between 2000 and 2030. It is estimated that Florida, now the fourth most populous state, will edge past New York into third place by the year 2011. Eighty-five percent (85.3%) of Florida’s growth is due to net migration.

**Poverty**

Over two million Floridians live at or below 100% of the federal poverty level (FPL), (currently $20,000 for a family of four). Sixteen (16) Florida counties are in the fourth quartile for the percentage of residents that live at or below the FPL. Thirteen (13) of these 16 counties are located in the rural counties of *North Florida* and the *Panhandle*. The other three are located in the rural *Southern interior. Miami-Dade County* the most populous county in Florida is not in the fourth quartile, however according to the U.S. Census Bureau; in 2000, there were 439,000 Dade county residents who lived at or below the FPL. All of Florida’s metropolitan areas have large pockets of economically disadvantaged people. Some Florida counties are characterized by dramatic regional and economic contrasts. Such is the case in Palm Beach and Collier counties, which are both characterized by very affluent coastal areas (Palm Beach and Naples), contrasted with interior towns (Belle Glade and Immokalee) where large numbers of people live in grinding poverty. Table 15 illustrates selected poverty indicators for Florida.

**Table 15: Florida Poverty Indicators**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Floridians at or below the FPL</td>
<td>12.5%</td>
</tr>
<tr>
<td>Florida children at or below the FPL</td>
<td>24.5%</td>
</tr>
<tr>
<td>Florida families at or below the FPL</td>
<td>9%</td>
</tr>
<tr>
<td>Female-headed households at or below the FPL</td>
<td>44.6%</td>
</tr>
<tr>
<td>Counties where more than a third of the population lives at or below 200%</td>
<td>49%</td>
</tr>
<tr>
<td>of the FPL ($40,000 for a family of four)</td>
<td></td>
</tr>
<tr>
<td>Increase in the number of Floridians living in poverty between 1990 and</td>
<td>22%</td>
</tr>
<tr>
<td>2000</td>
<td></td>
</tr>
</tbody>
</table>

Source: U.S. Census, 2000
Lack of Access to Affordable Healthcare

Medically Underserved Areas or Populations (MUAs/MUPs) are a measure of medical underservice as defined by the U.S. Department of Health and Human Services (HHS). These designations determine the level of need using the following criteria: (1) percentage of the population below 100% of the FPL, (2) percentage of the population over age 65, (3) infant mortality rate, and (4) population-to-physician ratio. There are three different types of MUA/MUP designations. A designation for the “Whole County” indicates there is a shortage of providers for everyone living in the county, regardless of their ability to pay for services. A “Geographic” designation within a county indicates there is a shortage of health care providers for everyone living in a particular section of the county. A designation of “Special Population” indicates there is a shortage of providers to meet the needs of certain populations (such as low income people or migrant farmworkers) who, because of poverty, insurance status, cultural barriers and other factors, have difficulty accessing healthcare services. There are an estimated 982,544 individuals in Florida who live in areas designated as an MUA or MUP. There are many others in the state who do not live in a federally designated MUA or MUP but have the same degree of difficulty accessing healthcare services. Such individuals may live in an affluent area with many physicians and healthcare resources but cannot access services because they are poor or uninsured.

All of Florida’s 67 counties have some type of federal designation as an MUA or MUP with 20 counties having a “Whole County” designation. The Whole County MUAs/MUPs are located primarily in North Florida and the Panhandle with a few located in the rural southern interior. Thirty (30) counties have “Whole County” designations for Special Populations. The remainder have “Partial County” designations for specific geographic areas or special populations. A current list of Florida designations and further information is available at http://www.doh.state.fl.us/Workforce/recruit1/index.html

A High Percentage of Immigrants

Meeting the healthcare needs of Florida’s growing number of poor, uninsured, and medically underserved is a challenge compounded by the cultural diversity of our state – a diversity that includes a number of “Special Populations” that face unique challenges in accessing affordable healthcare. Table 16 compares Florida’s cultural diversity with that of the U.S. as a whole.

Table 15: Florida’s Cultural Diversity Compared With the U.S.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Florida</th>
<th>U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of population that is black</td>
<td>14.6%</td>
<td>12.3%</td>
</tr>
<tr>
<td>Percentage of population that is foreign born</td>
<td>16.7%</td>
<td>11.1%</td>
</tr>
<tr>
<td>Percentage of population that speaks a language other than English at home</td>
<td>23.1%</td>
<td>16.7%</td>
</tr>
<tr>
<td>Hispanics as a percentage of total population</td>
<td>19%</td>
<td>14%</td>
</tr>
<tr>
<td>Haitians in Florida as a percentage of all Haitians in the U.S.</td>
<td>43.5%</td>
<td></td>
</tr>
</tbody>
</table>

Source: U.S. Census, 2000
Linguistic and cultural differences and unfamiliarity with the U.S. healthcare system create high levels of stress and significant barriers to healthcare for many immigrants, particularly those that are less educated. Immigrants are more likely to live in poverty and work in dangerous occupations than the general population and are less likely to benefit from Social Security, workers compensation, disability insurance and other safety net programs, including public and private insurance. Undocumented immigrants live in fear of deportation which may deter them from seeking needed healthcare services. Their inability to legally obtain a driver’s license makes transportation to and from health centers and other needed services a challenge. Florida has a growing number of indigenous language speakers who cannot even speak Spanish, much less English. This makes the delivery of linguistically appropriate services an increasing challenge.

A High Percentage of Farmworkers

There are an estimated 200,000 to 250,000 farmworkers and their dependants living in Florida due to the fact that the state has one of the longest growing seasons in the country (9 months). An analysis of the 2000 Larson’s Enumeration Study commissioned by HRSA indicates that 60% of Florida’s farmworkers are concentrated in 11 counties in the South and Central regions of the state; however, 31 counties have at least 1500 farmworkers. County-by-county estimates of the number of farmworkers in Florida can be found at www.fachc.org/state_specific_resources.htm. It is estimated that two-thirds of Florida’s farmworkers migrate north each year following the agricultural season up the east coast or into the Midwest, returning to Florida in late September or early October. Farmworker livelihoods are tied to the seasons and are subject to many unpredictable variables, including hurricanes. As a result, farmworkers’ income fluctuates significantly from month-to-month and year-to-year. According to the National Agricultural Workers Survey (NAWS), a random survey of the demographic and employment characteristics of the U.S. crop labor force, the average income for a farmworker family of four is around $10,000.

Farm work demands grueling physical labor, long work hours, and frequent contact with harmful pesticides that have been linked to a host of health problems including asthma, cancer and birth defects. Florida has a rapidly growing nursery and greenhouse industry where workers are at high risk for pesticide exposure because workers toil in enclosed spaces with limited ventilation. A high percentage of greenhouse workers are women, perhaps due to their smaller hands and manual dexterity. This trend is troublesome since children, including the unborn, are particularly vulnerable to the effects of pesticide poisoning. Yet, pesticide poisoning is only one of the many health conditions that farmworkers suffer from disproportionately. For more on farmworkers visit http://www.fachc.org/mig_index.htm

A High Percentage of Homeless

According to the Florida Department of Children and Families Annual Report on Homeless Conditions in Florida, there were an estimated 83,391 homeless individuals in Florida in 2005, up from 76,675 in 2003. Part of the increase in homelessness may be attributed to the damage inflicted by the hurricanes of 2004 that destroyed 20,000 homes and damaged another 45,000. Some areas of the state saw a dramatic rise in the number of homeless individuals. For example, Escambia, Santa Rosa and Okaloosa counties in the western Panhandle reported an increase of nearly 15,000 homeless persons and Charlotte County, the epicenter of hurricane Charlie, reported 2,800 new
homeless individuals in 2005. Thirty-eight percent (38%) of Florida’s homeless population is made up of families with minor children.

Poor health is closely associated with homelessness. For struggling families, serious injury or disability can initiate the downward spiral into homelessness. According to the National Coalition for the Homeless, the problem of homelessness has been increasing as the number of uninsured individuals continues to rise. Rates of both chronic and acute health problems are extremely high among the homeless population and many homeless people have multiple health problems. Lack of proper nutrition and difficulty taking care of personal hygiene and basic first aid contributes to the poor health status of the homeless population. For more information on healthcare for the homeless visit http://www.nhchc.org/

A High Percentage of Elderly

Florida has a higher proportion of elderly people than any other state with 17.6% of our residents aged 65 and older compared with 12.5% for the U.S. Fifteen percent (15%) of Florida’s elderly population live below the FPL and minority elders are more likely to live in poverty than the white elderly. Florida ranks second in the country for the percentage of people on Medicare with almost three million Floridians currently enrolled in the Medicare program. Hispanic elders are less likely to receive Social Security and Medicare than whites and blacks, as many Hispanic elders are ineligible for the programs because of their residency status.

The rising cost of prescription drugs is perhaps one of the greatest concerns for many lower income Florida seniors who are often forced to choose between everyday necessities and the medications they need to stay healthy. Seniors are particularly vulnerable to sweeping changes in federal programs such as those recently implemented in Medicare (Part D) and the planned overhaul of Florida’s Medicaid program that many seniors depend on to cover their medical costs. Changes in eligibility standards, enrollment policies or covered services, if not considered thoughtfully, have the potential to put seniors at greater risk of being uninsured.

Florida’s special populations including migrant and seasonal farmworkers, immigrants, the homeless and the elderly face significant barriers to affordable quality healthcare. Lack of insurance, transportation, access to prescription medications and challenges in understanding how to use the healthcare system are a few of the barriers they face. These populations are particularly vulnerable during times of disaster like the many hurricanes Florida has endured in recent years.

Health Disparities in Florida

What Is Healthy People 2010 And What Is A “Health Disparity”?  
Healthy People 2010 is a Federal initiative focused on a comprehensive set of health objectives that serve as a roadmap for improving the health of people in the U.S. Healthy People 2010 serves as the overarching guideline for the nation’s health initiatives. The goals of Healthy People 2010 are to increase the quality and years of healthy life for all Americans and to eliminate disparities in health status between different groups of people.
Florida, like other states, has room for progress in reducing and ultimately eliminating health disparities between whites and non-whites. Poverty, limited access to health care services as well as language and cultural barriers are primary reasons for low rates of screening and treatment that result in higher rates of morbidity and mortality among non-white Floridians. Table 17 illustrates disparities (or differences) in poverty and insurance rates among different groups of Floridians showing that blacks and Hispanics are more likely to be poor and uninsured than whites.

**Table 17: Disparities in Poverty and Insurance Rates between Whites, Blacks and Hispanics in Florida**

<table>
<thead>
<tr>
<th></th>
<th>White</th>
<th>Black</th>
<th>Hispanic</th>
<th>Foreign Born</th>
</tr>
</thead>
<tbody>
<tr>
<td>Floridians in poverty</td>
<td>11%</td>
<td>33%</td>
<td>25%</td>
<td>N/A</td>
</tr>
<tr>
<td>Percentage of group that is uninsured</td>
<td>15%</td>
<td>20%</td>
<td>33%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Source: AHCA Florida Health Uninsurance Study, 2004*

The measurement of *years of potential life* lost before age 75 (YPLL) is one of the *Health Outcome Indicators* defined by the state of Florida to measure progress toward Healthy People 2010 objectives. Table 18 illustrates the years of potential life lost for non-whites as compared to whites in the three-year period 2002-2004, as well as disparities in the early detection of breast cancer between the two groups.

**Table 18: Disparities between White and Non-White Floridians in YPLL and Early Detection of Breast Cancer**

<table>
<thead>
<tr>
<th></th>
<th>White</th>
<th>Non-Whites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years of Potential Life Lost (YPLL) under 75</td>
<td>7637.2</td>
<td>11,055</td>
</tr>
<tr>
<td>Breast cancers detected at an early stage</td>
<td>77%</td>
<td>52%</td>
</tr>
</tbody>
</table>

*Source: Florida Department of Health*

Table 19 illustrates Florida’s leading causes of death highlighting disparities in the rate of death from these diseases between whites and non-whites. Unfortunately reporting on Hispanics is sketchy so they were excluded from this comparison. However, findings from the 2005 *Healthcare Disparities Report* from the *Agency for Healthcare Research and Quality (AHRQ)* report that overall, “more racial disparities in quality of care were narrowing than were widening health disparities for Hispanics were growing wider.” Considering the large number of Hispanics in Florida, we can reasonably extrapolate that Hispanics suffer disproportionately from the major causes of death in Florida. If we are to have an accurate picture of Hispanic health in Florida, a concerted effort to capture this data must be made. County level comparisons of death rates from heart disease, stroke, diabetes, cancer and HIV/AIDS for whites and non-whites are available from FACHC.
Table 18: Florida’s White and Non-White Health Disparities as Leading Causes of Death

<table>
<thead>
<tr>
<th>Age Adjusted Death Rate 2002-2004</th>
<th>White Non Hispanic</th>
<th>Non White Non Hispanic</th>
<th>Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart disease</td>
<td>199.2</td>
<td>241.6</td>
<td>N/A</td>
</tr>
<tr>
<td>Cancer</td>
<td>173.0</td>
<td>188</td>
<td>N/A</td>
</tr>
<tr>
<td>Stroke</td>
<td>39.0</td>
<td>69.0</td>
<td>N/A</td>
</tr>
<tr>
<td>Diabetes</td>
<td>18.4</td>
<td>45.3</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Source: Florida Department of Health

The data in the previous tables underscores the need for health disparities collaboratives and other coordinated state and federal initiatives that address disparities in healthcare for different populations.

In addition to racial and economic considerations, there are significant geographic disparities across Florida. Disparities are most evident in the rural, northern third of the state and the rural southern interior (areas that suffer from a disproportionate share of age adjusted deaths from all the leading causes of death). For example, all 16 counties in the fourth quartile for deaths from cancer are in north Florida. All but one of 16 counties in the fourth quartile for stroke are in north Florida. Fourteen (14) of 16 counties in the fourth quartile for deaths from heart disease are in north Florida, the other two are in the southern interior. Fourteen of 16 counties in the fourth quartile for deaths from diabetes are in north Florida; the other two counties are in the southern interior. This data indicates a need for more healthcare services particularly in North Florida and the Panhandle, where there are currently a limited number of FQHCs.

Marketplace and Policy Issues Affecting Healthcare in Florida

Medicaid is a key safety net program for over two million of Florida’s most vulnerable citizens including children, the low income, pregnant women, seniors and the disabled who rely on the public health insurance program to meet their medical needs. In an effort to reduce the growth of Medicaid spending in Florida, a cost that represents 25% of the state’s budget, the Florida Legislature initiated a major Medicaid Reform effort to restructure how Florida’s Medicaid program will work. The Legislature, in the 2005 session, authorized the Agency for Healthcare Administration (AHCA) to submit an 1115 Waiver to the Center for Medicare and Medicaid Services (CMS). The 1115 Waiver allows Medicaid Reform efforts to begin in two counties, Duval and Broward, in July of 2006. The Florida Legislature and the Centers for Medicare and Medicaid at the federal level must approve the final version before Medicaid reform can begin statewide. Changes to the structure, reimbursement mechanism and coverage policies could potentially have a huge impact on FQHCs and other Medicaid providers in our state.

The goal of Florida’s Medicaid reform plan is to increase the number of individuals in a capitated or premium-based managed care program and to reduce the number of individuals in a fee for services program thus controlling costs. The plan is modeled on private insurance with an overall limit on state expenditures and a cap on the amount of money a beneficiary is allotted for medical services. Under the proposal, the state will pay a risk adjusted premium for each enrollee using multiple vendors or care networks to provide services. Vendors may include managed care organizations (MCOs), health maintenance organizations (HMOs), preferred provider organizations (PPOs), and other health care delivery methods.
organizations (PPO,) provider sponsored networks (PSN), minority physicians networks and rural healthcare networks. Vendors will develop a variety of healthcare plans with unique sets of covered services to compete for enrollment. Florida proposes that Medicaid recipients, with the help of counselors, will use their state supplied premium to purchase a healthcare plan or “opt out” of Medicaid and use their premium to purchase private insurance, and enroll in a flexible spending account.

Another important element in Florida’s Medicaid reform proposal is replacing the state’s current upper payment limit financing (UPL) with a $1 billion annual Low income pool” (LIP) fund to pay for care provided to the uninsured. Prior to the development of the low income pool, only hospitals could participate in the UPL program, restricting any efforts to reduce the inappropriate use of emergency rooms. The new low income pool allows other providers of primary and preventative care to benefit from the federal LIP funding. FQHCs will participate in the low income pool, along with an additional 80 hospitals that previously did not benefit from the UPL financing. The FQHC UPL funds will help divert the inappropriate use of emergency rooms by increasing the capacity of health centers to provide services for the uninsured, including increasing the number of hours that services are available, aiding the state in reducing access barriers to primary care for the uninsured.

A quarter of the revenue that allows Florida’s FQHCs to keep their doors open comes from Medicaid. Changes to the program have serious implications for the survival of FQHCs and other safety net providers. If the state fails to provide recipients with sufficient funds to purchase adequate low-deductible insurance coverage, patients are likely to go to FQHCs when they have exhausted their coverage elsewhere or if they are unable to meet the cost sharing requirements of their plans. Under the new system FQHCs could potentially lose their current Medicaid patients to other plans and receive them back as uninsured patients, losing a significant source of revenue and jeopardizing their financial viability. Florida’s Medicaid reform proposal requires local plans to make a “good faith effort” to include FQHCs, rural health clinics, and county health departments in their network. However, if a plan can demonstrate to the state and CMS that adequate capacity and an appropriate range of services is available for vulnerable populations without contracting with FQHCs, rural health clinics and CHDs then the plan can be relieved of this requirement.

**Conclusion of Section Two**

Florida is a large and complex state that is home to a diverse population, including a number of “Special Populations” that face unique healthcare challenges. Our population is growing at a rapid pace. Increases in poverty and uninsurance rates exacerbate the need for affordable healthcare. Like other states, Florida needs to address disparities in healthcare based on race, ethnicity and geographic factors. Florida FQHCs can serve as a stable source of quality healthcare for low income Floridians. It is critical to the health of our state that the FQHC role as safety net providers be recognized and preserved under any new and evolving system.
Section Three
Strategic Planning for the Expansion of FQHCs in Florida

Barriers to Healthcare

What Is Meant By “Lack Of Access” To Healthcare?

Lack of affordable insurance and the resulting lack of access to healthcare providers and services is perhaps the biggest barrier to affordable, quality healthcare for many Floridians. Most healthcare providers do not have a sliding fee schedule and do not accept uninsured patients, leaving uninsured patients with few options of where to go for healthcare. Those Floridians who have Medicaid, a public form of health insurance, also encounter obstacles to accessing healthcare. Many providers will not accept Medicaid patients because Medicaid does not pay as high a rate for their services as private insurance companies. Those providers that choose to accept Medicaid generally put tight restrictions on the number of Medicaid patients they will accept at any given time. If a Medicaid recipient is successful in finding a provider in their area who will accept their insurance (which can be very time consuming) it may take months before they actually receive an appointment to see a clinician. If they are sick, the wait is unacceptable causing many Medicaid and uninsured individuals to seek services at local emergency departments.

Emergency departments are an essential element of our healthcare system. But they are designed to offer immediate care for emergency and acute conditions and are not a substitute for ongoing primary preventative healthcare or for the management of chronic diseases.

What is a Health Professional Shortage Area (HPSA)?

Similar to MUA/MUP designations, federal designation as a Health Professional Shortage Area (HPSA) indicates a shortage of health care providers and the existence of barriers to healthcare including poverty, lack of public transportation, travel time and distance to the next source of undesignated care. To be eligible for designation, a geographic area or a population group (such as low income people or migrant and seasonal farmworkers) must have a population-to-physician ratio greater than 3,000:1. There are three types of HPSA designations.

- A geographic designation for a whole county means there is a shortage of providers for everyone living in the county, regardless of ability to pay for services through insurance or other means.
- A geographic area within the county means there is a shortage of health care providers for everyone living in that area of the county.
- A special population designation for the whole county (or parts of counties) means there is a shortage of providers to meet the needs of low income people, migrant farmworkers or other special populations because the existing providers do not serve these populations.

All of Florida’s 67 counties have some type of HPSA designation indicating shortages of providers of primary care, dental or mental health services, particularly in the northern part of the state and the rural southern interior. Table 20 illustrates shortage designations in more detail.
Table 20: Florida HPSA Designations by Type and Number of Counties

<table>
<thead>
<tr>
<th>HPSA Designation</th>
<th>Designation Type</th>
<th># of Counties</th>
<th>Geographic Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whole county - geographic</td>
<td>Primary Care</td>
<td>13</td>
<td>Panhandle with a few in the rural southern interior</td>
</tr>
<tr>
<td>Whole county - special population</td>
<td>Primary Care</td>
<td>37</td>
<td>North, Central and South</td>
</tr>
<tr>
<td>Partial county - special population</td>
<td>Primary Care</td>
<td>15</td>
<td>Varied</td>
</tr>
<tr>
<td>Partial county - geographic and/or special populations</td>
<td>Primary Care</td>
<td>5</td>
<td>Varied</td>
</tr>
<tr>
<td>Partial county - special population</td>
<td>Dental</td>
<td>10</td>
<td>Varied, mostly urban</td>
</tr>
<tr>
<td>Whole county - special populations</td>
<td>Dental</td>
<td>50</td>
<td>Varied</td>
</tr>
<tr>
<td>Whole county - geographic</td>
<td>Mental Health</td>
<td>16</td>
<td>North and Panhandle</td>
</tr>
<tr>
<td>Whole county - special population</td>
<td>Mental Health</td>
<td>22</td>
<td>Big Bend, Panhandle, Central and Southern Interior</td>
</tr>
<tr>
<td>Partial county - geographic</td>
<td>Mental Health</td>
<td>2</td>
<td>Hillsborough and Martin</td>
</tr>
<tr>
<td>Partial county - special population</td>
<td>Mental Health</td>
<td>4</td>
<td>Indian River, Palm Beach, Pasco and Manatee</td>
</tr>
</tbody>
</table>

Source: Florida DOH Office of Health Professional Recruitment

The Office of Health Professional Recruitment (HPR) at the Florida Department of Health is the agency responsible for reviewing areas of the state and making recommendations for federal designation as a HPSA and/or MUA/MUP. These designations are important for communities that want to access federal resources that are specifically intended for high need areas. HPR also recommends health professionals for placement in underserved areas under federal health professional recruitment programs. The National Health Service Corps (NHSC) is a federal program that provides scholarships or repays the educational loans of primary care physicians and other health care providers (nurse practitioners, physician assistants, dentists and hygienists, mental health professionals and certified nurse midwives) who agree to serve a minimum of two years in a HPSA. The J-1 Visa Waiver Program allows foreign medical graduates to obtain a waiver of the two-year home residence requirement provided they agree to work for three years in a designated shortage area (HPSA or MUA/MUP.) These programs are an important part of alleviating the shortage of medical providers in Florida but there is still a great need for more physicians and other clinicians.

The shortage of providers includes not only physicians but also nurses and other healthcare providers. According to HRSA, Florida providers are experiencing a seven percent vacancy rate in nursing positions expected to rise to 33 percent (more than 61,000 nurse vacancies) by 2020. According to the Florida statistical abstract there was a 10% decline in the number of licensed registered nurses between 1995 and 2001. Florida ranks 31rst in the number of RNs per 100,000, far below other large states with younger and less complex populations. Recruiting and retaining qualified physicians and other clinicians is an ongoing challenge in Florida, particularly in rural areas.
Exacerbating the shortage of available healthcare services is the fact that many physicians in Florida are reducing or eliminating needed services due to high liability insurance costs. A November 2004 study published in the *Archives of Internal Medicine* examining the impact of the medical professional liability insurance crisis on access to care in Florida concluded that the current professional liability insurance crisis is having a major affect on the availability and delivery of healthcare services in rural areas of Florida. Premiums for Professional Liability Insurance had a mean increase of 93.5%. Nearly fifty-three percent (52.6%) of 781 physicians surveyed for the study had decreased or eliminated services during the past year. Most dramatic was the reduction in OB/GYN services. Seventy percent (70.2%) of OB/GYN practitioners had reduced or eliminated services and 61.3% (73 of 119) had decreased or eliminated vaginal deliveries. These facts are troubling; especially in light of the fact that there are 33 counties in the state that lack even one OB/GYN. Likewise, 14 counties lack even one pediatrician. Florida will need to address the critical shortage of healthcare providers and the high cost of liability insurance in its efforts to make healthcare more accessible to the residents of the state.

Access to specialty care that goes beyond the primary healthcare level is a particular challenge for low income Floridians. FQHC doctors, nurses and case workers constantly strive to find specialists to whom they can refer their patients. Many specialists are not willing to see uninsured patients on a sliding fee scale and those that are, usually have strict limits on the number they will accept. Fewer and fewer numbers of specialists accept Medicaid for a variety of reasons, which include relatively low reimbursements rates. Some counties have attempted to address this problem through the creation of specialty care networks in which specialists agree to take a certain number of non-paying patients per year. Doctors in Florida who provide their services voluntarily (at no cost) can be covered by liability insurance under the state’s Sovereign Immunity program. This has helped alleviate the problem in some areas but almost all of these programs are limited to county or city residents leaving those outside the defined geographic area without access to their benefits. It remains to be seen whether Florida’s Medicaid reform initiative will alleviate or exacerbate the lack of access to specialty care for Florida’s Medicaid and uninsured patients.

**FACHC’s Statewide Strategic Planning**

As the state’s primary care association (PCA), the Florida Association of Community Health Center’s (FACHC) role is to support Florida FQHCs in their efforts to increase access to primary and preventative healthcare services. This requires ongoing cooperation with other statewide and regional organizations with similar goals. Key partners include the Florida Department of Health, Rural Health Networks, County Health Departments (CHD), Area Health Education Centers (AHEC), The Agency for Healthcare Administration (AHCA) and others. FACHC also works with the National Association of Community Health Centers (NACHC) and National Office of Rural Health as well as other PCAs in our region.

Resources in our state are diminishing, competition is growing and the pace of change is accelerating. Public safety net programs like Medicare and Medicaid continue undergoing reforms, the outcomes of which are yet to be determined. FACHC and its partners must be ready to respond to changes and challenges as well as new threats to the public’s health and safety. Change can bring new opportunities when careful planning results in appropriate strategies designed to respond to a constantly shifting healthcare environment.
What is FACHC’s Statewide Strategic Plan (SSP)?

In early 2003, FACHC, in conjunction with Florida’s FQHCs, initiated the first phase of a Statewide Strategic Planning (SSP) process with the goal of planning for the provision of primary healthcare services to more underserved Floridians. Phase I addressed the expansion plans of existing 330-funded grantees. Phase II, initiated in 2004, focused on expanding care into new areas where there were currently no existing FQHC. Almost 90% of the state’s FQHCs in 2003, including FACHC members as well as non-members, participated in the planning process that was guided by a national consultant in partnership with HRSA. Each participating FQHC took part in three face-to-face meetings designed to increase FACHC’s understanding of anticipated growth activities planned by Florida FQHCs as well as their concerns for the future and strategies being employed to address emerging issues. The data gathered through the statewide strategic planning process was compiled into a draft report that was then reviewed by FQHCS, edited based on their feedback and re-edited, resulting finally in a blueprint for the strategic growth of FQHCs in Florida.

What Are the Strategies for Growing Florida’s FQHCs?

The Three main methods for achieving access to primary healthcare were identified through FACHC’s SSP are:

1. *Existing FQHCs* opening new sites in previously unserved or underserved areas,
2. *Existing FQHCs* increasing medical capacity at existing sites by extending hours, increasing clinical staff or expanding the types of services offered, and
3. *New organizations* in unserved or underserved areas opening new FQHCs.

There are significant costs involved with starting a new FQHC as opposed to expanding existing organizations that have key staff, expertise and systems in place that can be spread to cover new sites relatively easily. For this reason, HRSA encourages existing FQHCs to expand into new areas whenever feasible and when expansion can be accomplished without compromising the community-based orientation that is the hallmark of FQHCS. One factor an organization considers is whether the proposed new site is within a reasonable distance of the existing organization. HRSA wants to maximize their investment, so the agency is careful to fund strategic new sites in high need areas that are not being served (or potentially could be served) by an existing FQHC. Competitive applications for new 330 funding must include letters of support from the nearest FQHC and from the state PCA. These requirements apply to “Look Alikes” as well as federally funded FQHCs. Table 21 provides a summary of expansion efforts that were planned by Florida FQHCs in 2003 as well as projected expansions for new communities and the resources required to accomplish them.
Table 20: FACHC Five Year Growth and Expansion Plan Summary

<table>
<thead>
<tr>
<th>PROJECTED RESULT</th>
<th>REQUIRED RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>New Sites</td>
</tr>
<tr>
<td>New FQHC</td>
<td>1</td>
</tr>
<tr>
<td>Existing FQHC</td>
<td>28</td>
</tr>
<tr>
<td>Expanded Capacity</td>
<td>10</td>
</tr>
<tr>
<td>(Existing FQHC - more hours, providers)</td>
<td></td>
</tr>
<tr>
<td>Expanded Services</td>
<td>11</td>
</tr>
<tr>
<td>(Existing FQHC) - new oral health services</td>
<td></td>
</tr>
<tr>
<td>Expanded Services</td>
<td>5</td>
</tr>
<tr>
<td>(Existing FQHC) - mental health services</td>
<td></td>
</tr>
</tbody>
</table>

Source: FACHC Statewide Strategic Plan, 2003 and 2004

What Are The Challenges To Achieving Expansion Goals And How Are They Being Addressed?

Capital financing and physician shortages challenge health centers in their efforts to expand and are likely to continue throughout the next decade. To assist CHCs in meeting their need for capital HRSA introduced two programs to connect FQHCs with loan guarantee programs. Additionally, the 2002 Florida Legislature approved a Bill, The Community Health Center Expansion Grant Program, whereby FQHCs in Florida could apply, through the Department of Health and the Agency for Health Care Administration, for funds to expand access to health care services in their area. Applicants are required to provide allowable local matching dollars in order to participate and compete for funds on a yearly basis. The total amount appropriated by the Legislature in the program’s first year was $2.1 million which over time has been increased to a budget of $7.3 million in 2006.

To meet the need for healthcare providers FACHC and its members work closely with Area Health Education Centers (AHECs) and Florida Medical Schools to provide opportunities for students to do rotations in CHCs. These assignments provide students with valuable learning experiences that can lead to life changing career decisions and fruitful partnerships for FQHCs. FACHC and its members also work closely with the Florida DOH Office HPR to place National Health Service Corps (NHSC) scholars, loan repayors, and Foreign (J-1) Visa physicians in high need areas.

What Progress Has Been Made In Increasing Access To Healthcare?

In spite of ongoing challenges, significant progress has been made in increasing access to affordable healthcare in Florida. Through state and federal funding initiatives, FQHCs have been able to open new sites, expand capacity (hours, providers, space) at existing sites and add new services (dental and mental health) that were not previously available. Since 2001, eight completely new...
organizations have received 330 funding to serve previously unserved or underserved areas in Gulf, Bay, Hernando, Osceola, Volusia and Miami-Dade counties. Table 21 illustrates some of the health centers that have been awarded expansion funds through the state’s *Federally Qualified Community Health Center Access Program* and how many people are benefiting.

**Table 21: Florida FQHC State Expansion Projects with Expected Results**

<table>
<thead>
<tr>
<th>Organization</th>
<th>Services Provided</th>
<th># Of New Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tampa Community Health Center</td>
<td>Increase services to homeless population through use of mobile medical unit</td>
<td>6,819</td>
</tr>
<tr>
<td>Community Health of S. Dade</td>
<td>Increase dental services at Doris Ison Health Center and established dental services at Naranja Health in Homestead and Everglades Health Center in Florida City</td>
<td>19,188</td>
</tr>
<tr>
<td>Suncoast Community Health Center</td>
<td>Add increased children's services in Plant City</td>
<td>22,439</td>
</tr>
<tr>
<td>Manatee County Rural Health Services</td>
<td>Establish CHC in Sarasota County</td>
<td>23,578</td>
</tr>
<tr>
<td>Miami Beach Community Health Center</td>
<td>Expand available exam rooms at Beverly Press Center, expand hours of operation and add staffing</td>
<td>21,450</td>
</tr>
<tr>
<td>Collier Health Services</td>
<td>Establish CHC in East Naples to provide comprehensive adult care and prenatal/gynecological services to the uninsured</td>
<td>7,842</td>
</tr>
<tr>
<td>C.L. Brumback Community Health Center</td>
<td>Add increased staffing to provide additional services and to expand hours of operation</td>
<td>39,241</td>
</tr>
<tr>
<td>Treasure Coast Community Health Center</td>
<td>Expand dental services available for adults and increase preventive dental care for all patients.</td>
<td>8,055</td>
</tr>
<tr>
<td>Bond Community Health Center</td>
<td>Expand primary care services with a focus on children.</td>
<td>2,649</td>
</tr>
<tr>
<td>Treasure Coast Community Health Center</td>
<td>Expand primary care services at Fellsmere and Vero Beach with a focus on children and adolescents of Migrant and Seasonal Farmworkers</td>
<td>693</td>
</tr>
<tr>
<td>Manatee County Rural Health Services</td>
<td>Emergency room diversion project; extend hours of operation at the East Manatee Family Healthcare Center and Lawton Chiles Family Healthcare Center</td>
<td>6,114</td>
</tr>
<tr>
<td>Community Health Centers of Pinellas</td>
<td>Expand primary care services at Clearwater and Pinellas Park</td>
<td>5,537</td>
</tr>
<tr>
<td>Health Care Center for the Homeless</td>
<td>Renovate administrative facility to consolidate services. Allow for extended hours</td>
<td>2,413</td>
</tr>
<tr>
<td>Central Florida Health Care</td>
<td>Renovation project and upgrade technology</td>
<td>5,070</td>
</tr>
<tr>
<td>Premiere Community Health Care Group</td>
<td>Renovate/expand Dade City facility to add additional medical staff</td>
<td>6,500</td>
</tr>
<tr>
<td>Suncoast Community Health Center</td>
<td>New Dover Health Center</td>
<td>3,100</td>
</tr>
<tr>
<td>Community Health Centers, Inc.</td>
<td>Relocate the Pine Hills Family Health Center to more adequate facility and add dental services</td>
<td>7,300</td>
</tr>
</tbody>
</table>
Table 21: Florida FQHC State Expansion Projects with Expected Results (Continued)

<table>
<thead>
<tr>
<th>Organization</th>
<th>Services Provided</th>
<th># Of New Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Florida Health Care</td>
<td>Renovate Wauchula Health Center to add dental services</td>
<td>1,500</td>
</tr>
<tr>
<td>Poinciana Primary Health Care</td>
<td>Expansion of Poinciana facility</td>
<td>4,500</td>
</tr>
<tr>
<td>Tampa Community Health Center</td>
<td>Construction of new facility - West Waters in Tampa</td>
<td>6,527</td>
</tr>
<tr>
<td>Premiere Community Health Care</td>
<td>Expand primary care services in Dade City</td>
<td>900</td>
</tr>
<tr>
<td>Collier Health Services</td>
<td>Increase access for primary care</td>
<td>400</td>
</tr>
<tr>
<td>Community Health of S. Dade</td>
<td>Expand dental services, increase patients</td>
<td>3,025</td>
</tr>
<tr>
<td>Miami Beach Community Health Center</td>
<td>Increase access for primary care</td>
<td>1,500</td>
</tr>
<tr>
<td>Manatee Rural Health Services</td>
<td>Perinatal Services in Manatee &amp; DeSoto Counties</td>
<td>400</td>
</tr>
</tbody>
</table>

Source: Florida Department of Health

Since 2001, Florida has benefited from federal funding to expand access to healthcare at FQHCs through the creation of FQHC “New Access Point” (NAPS), “Expanded medical capacity” (EMC) and the addition of new healthcare services. In the five year period between 2001-2005 fifteen new FQHC sites were funded in Florida, benefiting from what is commonly referred to as “The President’s Initiative to Expand Health Centers”. Federal funding for 330 expansions also increased medical capacity (hours or providers) at ten existing FQHCs and enabled fourteen FQHCs to add new types of services including oral health, mental health, substance abuse and pharmacy. Tables 22 to 24 provide a breakdown of federal 330 expansion funds awarded to Florida FQHC organizations between 2001 and 2005 according to the type of 330 funding they received.

Table 22: Florida FQHC New Access Points (NAPS) Funded 2001-2005

<table>
<thead>
<tr>
<th>Organization</th>
<th>County</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brevard Health Alliance *</td>
<td>Brevard</td>
<td>2004</td>
</tr>
<tr>
<td>Camillus Health Concern *</td>
<td>Dade</td>
<td>2001</td>
</tr>
<tr>
<td>Central Florida Family Health Care</td>
<td>Seminole</td>
<td>2002</td>
</tr>
<tr>
<td>Citrus Health Network *</td>
<td>Miami-Dade</td>
<td>2004</td>
</tr>
<tr>
<td>Economic Opportunity Family Health Center</td>
<td>Miami-Dade</td>
<td>2002</td>
</tr>
<tr>
<td>Family Health Center of Southwest Florida</td>
<td>Lee</td>
<td>2001</td>
</tr>
<tr>
<td>Family Health Center of Southwest Florida</td>
<td>Lee</td>
<td>2002</td>
</tr>
<tr>
<td>Health Care Center for the Homeless of Orlando</td>
<td>Orange</td>
<td>2002</td>
</tr>
<tr>
<td>St. Joseph Healthcare *</td>
<td>Gulf</td>
<td>2003</td>
</tr>
<tr>
<td>North Florida Medical Centers</td>
<td>Leon</td>
<td>2003</td>
</tr>
<tr>
<td>Northeast Florida Health Services *</td>
<td>Volusia</td>
<td>2003</td>
</tr>
<tr>
<td>Nature Coast Community Health Center*</td>
<td>Hernando</td>
<td>2005</td>
</tr>
<tr>
<td>Pancare *</td>
<td>Bay</td>
<td>2005</td>
</tr>
<tr>
<td>Poinciana Primary Healthcare *</td>
<td>Osceola</td>
<td>2005</td>
</tr>
<tr>
<td>Treasure Coast Community Health Center</td>
<td>Indian River</td>
<td>2005</td>
</tr>
</tbody>
</table>

Source: HRSA, Note: * Indicates a new FQHC vs. an existing FQHC organization; County indicates administrative office, not necessarily expansion site
### Table 23: Florida FQHC Expanded Medical Capacity Funded 2001-2005

<table>
<thead>
<tr>
<th>Organization</th>
<th>County</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Camillus Health Concern</td>
<td>Miami-Dade</td>
<td>2002</td>
</tr>
<tr>
<td>Florida Community Health Centers Inc.</td>
<td>W. Palm Beach</td>
<td>2002</td>
</tr>
<tr>
<td>Family Health Centers of Southwest Florida</td>
<td>Lee</td>
<td>2002</td>
</tr>
<tr>
<td>Manatee County Rural Health Services</td>
<td>Manatee</td>
<td>2002</td>
</tr>
<tr>
<td>Family Medical and Dental Centers</td>
<td>Putnam</td>
<td>2002</td>
</tr>
<tr>
<td>Community Health Centers, Inc.</td>
<td>Orange</td>
<td>2003</td>
</tr>
<tr>
<td>Manatee County Rural Health Services</td>
<td>Manatee</td>
<td>2003</td>
</tr>
<tr>
<td>Camillus Health Concern</td>
<td>Miami-Dade</td>
<td>2004</td>
</tr>
<tr>
<td>Community Health of South Dade</td>
<td>Miami-Dade</td>
<td>2004</td>
</tr>
<tr>
<td>Tampa Community Health Center</td>
<td>Hillsborough</td>
<td>2004</td>
</tr>
<tr>
<td>C.L. Brumback Community Health Center</td>
<td>Palm Beach</td>
<td>2005</td>
</tr>
</tbody>
</table>

Source: HRSA, Note: County indicates administrative office, not necessarily expansion site

### Table 24: Florida FQHC Service Expansions Funded 2001-2005

<table>
<thead>
<tr>
<th>Organization</th>
<th>County</th>
<th>Service Type</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bond Community Health Center</td>
<td>Leon</td>
<td>Pharmacy</td>
<td>2001</td>
</tr>
<tr>
<td>Borinquen Health Care Center</td>
<td>Miami-Dade</td>
<td>Oral</td>
<td>2001</td>
</tr>
<tr>
<td>Camillus Health Concern</td>
<td>Miami-Dade</td>
<td>Oral</td>
<td>2001</td>
</tr>
<tr>
<td>Camillus Health Concern</td>
<td>Miami-Dade</td>
<td>Oral</td>
<td>2003</td>
</tr>
<tr>
<td>C.L. Brumback Community Health Center</td>
<td>Palm Beach</td>
<td>Oral</td>
<td>2004</td>
</tr>
<tr>
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<td>Collier</td>
<td>Oral</td>
<td>2001</td>
</tr>
<tr>
<td>Community Health Centers Inc.</td>
<td>Orange</td>
<td>Pharmacy</td>
<td>2002</td>
</tr>
<tr>
<td>Community Health Centers Inc.</td>
<td>Orange</td>
<td>Oral</td>
<td>2002</td>
</tr>
<tr>
<td>Community Health Of South Dade</td>
<td>Miami-Dade</td>
<td>Oral</td>
<td>2001</td>
</tr>
<tr>
<td>Community Health Of South Dade</td>
<td>Miami-Dade</td>
<td>MH/SA</td>
<td>2001</td>
</tr>
<tr>
<td>Economic Opportunity Family Health Center</td>
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<td>Oral</td>
<td>2001</td>
</tr>
<tr>
<td>Economic Opportunity Family Health Center</td>
<td>Miami-Dade</td>
<td>MH/SA</td>
<td>2002</td>
</tr>
<tr>
<td>Family Health Centers of Southwest Florida</td>
<td>Lee</td>
<td>Oral</td>
<td>2002</td>
</tr>
<tr>
<td>Premiere Community Health Care Group</td>
<td>Pasco</td>
<td>Pharmacy</td>
<td>2001</td>
</tr>
<tr>
<td>Helen B. Bentley Family Health Center</td>
<td>Dade</td>
<td>MH/SA</td>
<td>2001</td>
</tr>
<tr>
<td>Manatee County Rural Health Services</td>
<td>Manatee</td>
<td>Oral</td>
<td>2001</td>
</tr>
<tr>
<td>North Florida Medical Centers</td>
<td>Leon</td>
<td>Oral</td>
<td>2002</td>
</tr>
<tr>
<td>Thomas Langley Medical Center</td>
<td>Sumter</td>
<td>MH/SA</td>
<td>2002</td>
</tr>
<tr>
<td>Treasure Coast Community Health Center</td>
<td>Indian River</td>
<td>MH/SA</td>
<td>2001</td>
</tr>
</tbody>
</table>

Source: HRSA, Note: County indicates administrative office, not necessarily expansion site; MH/SA = Mental Health and/or Substance Abuse

While Florida has clearly benefited from the federal initiative to expand FQHCs we lag behind other states in the proportion of new 330 funds received in relation to state size, population, and documented need.
According to HRSA \textit{Phase II} of the \textit{“President’s Initiative”}, scheduled to begin in 2007, will focus on creating new FQHCs in “Needy” counties where none currently exist. To date, the criteria that will be used to determine the neediest counties has not been defined and no list of targeted counties has been published. There are currently 20 counties in Florida without an FQHC that are illustrated in Table 25 and the map that follows.

\textbf{Table 25: Florida Counties without FQHC}

<table>
<thead>
<tr>
<th>Baker</th>
<th>Hamilton</th>
<th>Nassau</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calhoun</td>
<td>Holmes</td>
<td>Okaloosa</td>
</tr>
<tr>
<td>Citrus</td>
<td>Jackson</td>
<td>Saint Johns</td>
</tr>
<tr>
<td>Clay</td>
<td>Levy</td>
<td>Santa Rosa</td>
</tr>
<tr>
<td>Escambia</td>
<td>Liberty</td>
<td>Sarasota</td>
</tr>
<tr>
<td>Flagler</td>
<td>Marion</td>
<td>Washington</td>
</tr>
</tbody>
</table>

| Glades  | Monroe     |

Unrepresented counties are shaded in grey.

The map above indicates that most of the counties without an FQHC are located in the northern part of the state. Some of the counties are served by other safety net providers including county health departments, hospitals and rural health clinics. FACHC is working with many individuals and organizations to help them determine level of interest, competitiveness and readiness to become an FQHC and providing technical assistance to those who want to move forward with the process. We are also helping those that do not want an FQHC find alternative strategies for increasing access to care. FACHC is also working with existing FQHCs in their efforts to open new sites, add services or expand medical capacity.
Where Are The Greatest Needs For Healthcare Services?

In 2004, FACHC and the Florida DOH Office of Health Professional Recruitment (HPR) worked on an assessment of the need for primary healthcare in Florida’s 67 counties. As a framework, we used the criteria on the 330 Need for Assistance Worksheet (NFA) that is required of all applicants for 330 New Access Point (NAP) funding. The results of Florida’s needs assessment projected an NFA score for each of Florida’s counties. The needs document is available on HPR’s web site at http://www.doh.state.fl.us/workforce/recruit1/index.html. In 2005, HRSA changed the NFA format, criteria and scoring mechanism seeking public comment on the proposed new NFA in the February 4th issue of the Federal Register (Vol. 70. No.23). HRSA's web site has since posted a new version of the NFA worksheet at http://bphc.hrsa.gov/chi/needforassistance.htm.

While useful in providing a snapshot of need, county level data has limitations when trying to pinpoint and establish priority areas in the state that lack adequate access to primary health care. Zip code or census level information is more useful. In 2004, FACHC in conjunction with the Florida DOH conducted an analysis of primary care needs in Florida using two of the three required major access barriers on the proposed new NFA worksheet. These factors were the population to physician ratio and the percent of the population living at or below 200% of the FPL. Each community on the resulting List of Florida Communities in Need of Primary Health Care met the following criteria: they were (1) within 15 miles of a population of at least 5,000 individuals that (2) has a population to physician ration of 3000:1 or greater and (3) where at least 44% of the population lives at or below 200% of the FPL and (4) are not currently served by an existing FQHC or actively working with an FQHC on the creation of a New Access Point. The List of Florida Communities in Need of Primary Health Care can be found at www.fachc.org/cd_community%20development%20.htm and is used to help guide FACHC’s community development (CD) efforts.

“Community Development” is the process of helping communities and their stakeholders objectively assess their need for healthcare services and develop strategies to address their identified needs. FACHC’s priorities are focused on areas with the highest level of need in terms of the number of unserved or underserved people, the level of poverty, relative health outcomes, and the degree of health disparities. We understand that communities have competing priorities and are in different places in terms of their readiness to focus on healthcare access and the challenges associated with becoming an FQHC. It is relatively easy to initiate community development activities with some communities if there are leaders committed to addressing healthcare access issues while efforts to initiate community development activities elsewhere can be more difficult. To be successful there needs to be an infrastructure with resources, people and networks to sustain long term community work. It is important that leaders are enthusiastic and supportive, and that the community as a whole perceives the need to increase health care access and reduce health disparities. FACHC considers all of these factors when determining where to focus our community development efforts.
Activities FACHC undertakes to accomplish community development goals include working with FQHCs and communities to help them:

- Understand FQHC funding, “Look Alike” and related opportunities
- Understand federal expectations and requirements of FQHC programs
- Locate data to help determine or demonstrate levels of need
- Achieve the highest possible score on the Need for Assistance (NFA) worksheet
- Establish the necessary foundations for becoming an FQHC including building community support and establishing a community led Board of Directors.
- Develop or strengthen partnerships between FQHCs and other organizations
- Link communities and FQHCs with 330 grant writers and other consultants

FACHC accomplishes these goals through:

- Statewide, regional and local trainings, meetings and events
- Conference calls
- On-going email and telephone technical assistance
- Written materials
- FACHC’s web site

Since 2004, FACHC has provided community development assistance to the following counties:

<table>
<thead>
<tr>
<th>Alachua</th>
<th>Hernando</th>
<th>Pasco</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baker</td>
<td>Highlands</td>
<td>Pinellas</td>
</tr>
<tr>
<td>Bay</td>
<td>Levy</td>
<td>Polk</td>
</tr>
<tr>
<td>Brevard</td>
<td>Jackson</td>
<td>Sarasota</td>
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<tr>
<td>Broward</td>
<td>Marion</td>
<td>Seminole</td>
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<tr>
<td>Dade</td>
<td>Orange</td>
<td>Suwannee</td>
</tr>
<tr>
<td>Duval</td>
<td>Osceola</td>
<td>Volusia</td>
</tr>
<tr>
<td>Escambia</td>
<td>Palm Beach</td>
<td>Walton</td>
</tr>
</tbody>
</table>

**Conclusion of Section Three**

There is a great deal of unmet need for healthcare services in Florida, particularly for low income people and the uninsured. As the state’s primary care association FACHC works with FQHCs and other safety net providers to increase access to quality healthcare services. FACHC’s strategic planning, needs assessment and community development activities help set priorities and guide our efforts to increase access to care. FACHC, in partnership with the Florida Department of Health, is actively working with communities and FQHCs throughout the state on the expansion of affordable quality healthcare services. Significant progress has been made but there is still much left to do.
Section Four
Understanding Federal 330 Funding Opportunities

_Federally Qualified Health Centers (FQHCs)_ were created under section 330 of the Public Health Service Act and are therefore sometimes referred to as “330 grantees” but are more commonly known as “Community Health Centers (CHCs)”. The first CHC was opened in 1965. Since that time the program has grown to include 914 FQHCs in the U.S. including 37 FQHC organizations in Florida with a total of 180 service delivery sites.

Recognizing the important role of FQHCs in our healthcare safety net, in 2001 President Bush unveiled an initiative to double the number of patients served at FQHCs by 1) Increasing the number of new sites or “New access points” (NAPs) 2) Expanding the medical capacity (EMC) of existing FQHC sites unable to meet their current need and 3) Adding new services (Service Expansion) including oral health, substance abuse and mental health services. Between 1997 and 2004 the number of FQHC sites increased by 58% and the number of patients increased by 90%, Today FQHCs in the U.S. provide care to _13 million patients_ at more than _5,500 sites_, including _650 newly established delivery sites_.

As a result of the “President’s Initiative” FQHCs have gained deserved recognition for their important work providing quality comprehensive healthcare to our country’s most underserved populations. While significant progress has been achieved the need is still great, as poverty and uninsurance rates continue to rise. Unfortunately, there are many people who still have little or no access to primary healthcare services. FACHC and our partners around the state and nation will continue to advocate for increased health center funding to meet the need for new and expanded FQHC sites and services.

Section four of this guide provides insight into the _330 funding process_. Potential applicants are encouraged to be proactive in laying the foundation for becoming an FQHC. Competition for new 330 funding has increased and today, only the very best proposals are ultimately funded. These applications reflect the many months and years of work involved in getting a successful FQHC off the ground. This section will familiarize readers with the most important elements of the _330 application guidance_ and clarify its relationship with the _330 program expectations_ which guide the community health center program.

Potential FQHC applicants should be aware of the opportunity to apply for _FQHC “Look Alike”_ designation. While there is no 330 funding associated with being a “Look Alike” there are other substantial benefits including enhanced Medicaid reimbursement under the _Prospective Payment System (PPS)_ , participation in the federal _340B Drug Pricing Program_ and eligibility for _National Health Service Corps (NHSC)_ doctors and other clinicians. “Look Alikes” must meet all the same requirements as funded FQHCs however the application process is on-going and is not a competitive process.

Apart from this guide, another valuable resource for understanding FQHCs is called _So You Want to Start a Health Center?_ It is available at [http://www.fachc.org/cd_presidents%20initiative.htm](http://www.fachc.org/cd_presidents%20initiative.htm) or a hard copy can be requested from FACHC. Chapters include: (1) Health Center Basics, (2) Ensuring Broad Community Support and Investment, (3) Needs Assessment and Planning, (4)
Developing Community Governance, (5) Looking for an Organizational and Physical Home, (6) Human Resources, (7) Business Planning, (8) Insurance, (9) MIS and Data. Section four of this guide will refer readers to specific chapters in *So You Want to Start a Health Center?* where they can find additional information about specific topics being discussed.

**Disclaimer:** The information provided in section four is from the most recent HRSA application guidance for each particular funding category (NAP, EMC). It is intended as a *general overview* of 330 requirements and expectations. The 330 application guidance and review criteria are likely to *change* when a new competition is announced.
Overview of New Access Point Funding

There Are Three Types Of 330 Funding.

1. New Access Point (NAP)
2. Expanded Medical Capacity (EMC)
3. Service Expansion (SE)

80% of new 330 funds appropriated during the past five years have been for NAP or EMC therefore, this guide will address only these two categories.

What is a New Access Point (NAP)?

A new access point (NAP) is a new delivery site for the provision of comprehensive primary and preventive health care services. There are two types of NAPS (1) New starts and (2) Satellites. A new start applicant is an organization that currently doesn’t receive federal 330 grant support. A satellite applicant is an existing FQHC that currently receives 330 grant support.

Who Can Apply for 330 New Access Point (NAP) Funding?

Public or private nonprofit entities, including tribal, faith-based and community-based organizations, may apply for 330 funding.

What Are The Eligibility Requirements to Apply for a New Access Point (NAP)?

The application must have a clear plan for providing comprehensive primary and preventive health care services including: Primary Medical Care; Diagnostic Laboratory and radiological services; Prenatal and Perinatal, Cancer and other disease screenings; Well child services; Immunizations; Screening for elevated blood levels, communicable diseases and cholesterol; Eye, ear, and dental screenings for children; Family planning services; Emergency medical and dental services; Pharmaceutical services; Substance abuse services; Dental Care; Mental Health Care; Appropriate enabling services such as: Case management, Referrals, Outreach, Transportation, Interpreters and Patient Education. Some services may be provided under contact with other providers.

Applicants must serve a federally-designated Medically Underserved Area (MUA) or a Medically Underserved Population (MUP). However proposals for migrant health centers (MHC), Health Centers for the Homeless (HCH) and Public Housing Primary Care (PHPC) do not need to have an MUA/MUP designation.

Applicants must clearly show how they will meet all the requirements in HRSA’s Policy Information Notice (PIN) 98-23 which outlines the federal expectations of 330 programs. In addition to having a good understanding of this document, HRSA also recommends that 330 applicants read the following reference documents which are available on their web site at http://bphc.hrsa.gov/pinspals/pins.htm and also on FACHC’s web site (www.fachc.org) under the “Community and Health Center Development” link.
• Section 330 of the PHS Act as amended (Health Care Safety Net Amendments of 2002, Public Law 107-251)
• PIN 98-12, “Implementation of the Section 330 Governance Requirements”
• PIN 98-24, “Amendment to PIN 97-27 Regarding Affiliation Agreements of Community and Migrant Health Centers”
• PIN 97-27, “Affiliation Agreements of Community and Migrant Health Centers”
• PIN 2001-13, “Clarification of Program Requirements and Benefits for Bureau of Primary Health Care Supported School-Based Health Centers”
• PAL 2002-09, “President’s Initiative to Expand Health Centers”

Applicants must have a community led Board of Directors that independently exercises key decisions including hiring the Chief Executive Officer (CEO), adopting policies and procedures, establishing services, hours of operations, fee schedules and the annual budget. The board must be representative of the communities being served and at least 51% of board members must be regular consumers of the health center.

Applicants must have a schedule of fee discounts based on the patient’s ability to pay. The “Sliding fee” schedule must be based on current federal poverty guidelines.

What Factors Should We Consider Before Deciding Whether to Apply for a NAP?

To be competitive, NAP applications must demonstrate:

• That all persons will have ready access to the full range of required primary, preventive, enabling and supplemental health services, including oral health care, mental health care and substance abuse services, either directly on-site or through established arrangements without regard to ability to pay.
• How section 330 funds will expand services and increase the number of people served through the establishment of a new service delivery site(s) and/or at an existing site(s) not currently within a BPHC funded scope of project.
• That the site(s) will be operational and services will be initiated within 120 days of a grant award.
• How section 330 funds will augment already available funds and in-kind resources to expand existing primary health care service capacity to underserved populations.

What Types of NAP Proposals Will Not be Accepted?

The following types of proposals will not be accepted:

• Proposals to provide a single service, such as dental, mental health or prenatal services.
• Proposals to serve a single age group (i.e., children) or lifecycle (i.e., geriatric only) except in the case of organizations applying under section 330(h) to target services for homeless children or adolescents and/or children and youth at risk of homelessness.
• Applications from existing CHCs designated as an exceptional/high risk grantee at the time of the application.
• Proposals to support the relocation of sites already in the approved scope of project of existing FQHCs.
• Proposals to support the expansion of capacity (additional providers, new services, etc.) at a site already in the approved scope of project of an existing FQHC.

How Many Sites and Funding Programs Can Be Requested in a NAP Application?

New start and satellite applicants may submit an application for federal support to establish a single new access point or multiple access points and may request funding to support one or multiple types of health centers based on the population(s) to be served.

How Much Support is Available to Serve “Special Populations”?

Approximately 9% of new 330 funding is allocated for “Special populations”. NAP applicants may apply for funding from various categories (listed below), based on the needs of their service area and target populations.

- Community Health Centers (CHC) - section 330(e)
- Migrant Health Centers (MHC) - section 330(g)
- Health Care for the Homeless (HCH) - section 330(h)
- Public Housing Primary Care (PHPC) - section 330(i)
- Schools Based Health Centers (SBHC) – section 330

What is the Maximum Level of Support?

The BPHC established a cap of $650,000 per year for NAP applications, which cover a three year period. Applicants may request support up to $150,000 in Year 1 only for one-time minor capital costs for equipment and/or alteration/renovation; however, the total request for section 330 support must not exceed the established cap of $650,000 for each of the three years. Once the organizations proves itself capable of effectively meeting the needs in their community, this amount permanently becomes their base of funding.

The following is provided as a guideline in developing the Federal budget request: $150 Federal grant dollars per general community health center (CHC) user and $200 Federal grant dollars per migrant/seasonal farmworker (MSFW) user, homeless user, public housing (PHPC) user; and school-based health center user.

What Additional Requirements are Associated with Serving “Special Populations”?

In addition to the general 330 requirements, there are specific requirements and expectations for applicants requesting funding for special populations. Applicants requesting funding to support one or more health center types are expected to demonstrate compliance with guidelines, expectations and requirements, as applicable.

Migrant Health Center (MHC) Applicants (section 330(g)) will:

• Address how the special needs of MSFW and their families will be met
• Describe how they will ensure that farmworkers will have access to services through
mechanisms such as: *outreach* that is integrated into the primary health care delivery system; use of *mobile vans* or *health teams* that travel to *migrant camps; transportation; extended clinic hours*; etc.

- Describe how they will address the special *environmental health concerns* that are associated with MSFWs.
- Describe how the health center *governance requirements* will be addressed

*Migrant voucher programs* may propose to arrange for the delivery of required services with existing providers through contractual arrangements.

**Health Center for the Homeless (HCH) Applicants (section 330(h)) will:**

- Indicate the mechanism for delivering *substance abuse services* to homeless patients
- Describe the manner in which *comprehensive outreach* is to be conducted, and how *transportation* and other *enabling services* will be provided.
- Describe the manner in which *case management, eligibility assistance, and access to housing services* will be made available to homeless patients.
- Include information about how the health center *governance requirements* will be addressed.

**Public Housing Primary Care (PHPC) Applicants section 330(i) will:**

- Increase access to care and improve the health status of underserved *public housing residents*
- Include information about how the health center *governance requirements* will be addressed.

**School Based Health Center (SBHC) Applicants (section 330) will:**

- Demonstrate how the SBHC will *serve other community members* in addition to the students attending the school(s) where the SBHC is located.
- Demonstrate how community members may be served in *other locations* operated by the applicant organization.
- Describe arrangements to serve *non-students* at the SBHC (e.g. teachers).
- Operate at least *30 hours per week* at each school-based health center, except in sparsely populated and rural areas utilizing mobile vans.
- Provide a *signed agreement* with the school that is hosting the SBHC.

**How Can We Ensure That our NAP Application is Competitive?**

**Competitive NAPS Will Clearly Demonstrate:**

- A *high level of need* in their community.
- That the proposed NAP will serve populations in *areas with the greatest need* for services.
- That the proposed project will *increase access* to primary health care services and *reduce health disparities* in the community/population to be served.
- The extent to which funding will increase access to care in terms of the *number of people to be served* and the *number of primary care providers* to be made available to the population.
- Efforts to achieve the goals of *Healthy People 2010* as part of their efforts to increase access
and reduce health disparities.

- Responsiveness to their health care environment.
- Established collaborative and coordinated delivery systems for the provision of health care to the underserved in their communities.
- That within 120-days of a grant award a facility will be available, ready for occupancy and adequate to serve the proposed population/community.
- That within 120-days of a grant award providers will be available to serve at the NAP
- A reasonable and accurate 3-year budget consistent with the health care and business plans presented in the application.
- A thorough and complete response to the application review criteria.

How are NAP Applications Reviewed?

Each 330 application is reviewed initially for eligibility, completeness and responsiveness to the application guidelines. Those applications that are determined to be ineligible, incomplete or non-responsive to the grant application guidance and/or section 330 program requirements are discarded without further consideration.

Those applications that are determined to be eligible will have the need for assistance and merits of the application evaluated by an Independent Review Committee (IRC) comprised of approximately 15 Federal and non-Federal healthcare and community health center experts. Each IRC member is mailed approximately five applications to read and review on their own in advance of an “On site” review. Using the review criteria they assign each application a score and outline its strengths and weaknesses. Each application has a “Primary reviewer” who is responsible for thoroughly understanding the proposal and clearly presenting this information to the other reviewers on their committee. Committee members are encouraged to ask detailed questions to learn more about the proposed project. Two “Secondary reviewers” are responsible for helping the primary reviewer address all the questions about the application. Once each member of the review committee has reached a thorough understanding of the proposed project, each person assigns the application a score. The final score reflects the average of all the reviewer’s scores. A scribe notes all the strengths and weaknesses, which are edited and revised by the review committee, and eventually shared with the applicant regardless of whether or not the proposal is funded.

Typically each application is actually read by only a third of the reviewers on a committee. Those reviewers who have not had the benefit of reading an application depend upon the primary and secondary reviewers to clearly articulate its merits. The level of enthusiasm expressed for the proposed project by the primary and secondary reviewers will greatly influence the final score. It is incumbent upon the applicant to ensure that the primary and secondary reviewers have a clear understanding of the populations being targeted, their healthcare needs and the organization’s ability to effectively meet those needs. If the primary and secondary reviewers do not clearly understand the application, they will have difficulty explaining its merits to the other reviewers. If they do believe in the project, however, most reviewers will go to great lengths to ensure that their colleagues on the IRC fully appreciate the strengths of a worthwhile application.

HRSA reserves the right to review fundable applicants for compliance with BPHC program expectations through a review of site visits, audit data, Uniform Data System (UDS) or similar reports,
What Criteria Are Used to Review the NAP Application?

NAP application guidelines include a set of eight criteria reviewers use to score each proposal and evaluate its strengths and weaknesses. Criteria are divided into the following categories and are assigned the corresponding maximum number of points:

1. Description of The Service Area/Community And Target Population (Maximum 10 Points) (3-4 Pages)
2. Strategic Planning (Maximum 10 Points) (2-3 Pages)
3. Service Delivery Strategy And Model (Maximum 20 Points) (4-5 Pages)
4. Health Care Services (Maximum 15 Points) (5-6 Pages)
5. Organizational Capabilities And Expertise (Maximum 15 Points) (3-4 Pages)
6. Budget (Maximum 10 Points) (2-3 Pages)
7. Governance (Maximum 10 Points) (2-3 Pages)
8. Readiness (Maximum 10 Points) (1-2 Pages)

What Criteria Are Used To Score And Evaluate The “Description Of The Service Area, Community And Target Population” (Criteria #1) (Maximum 10 Points)?

1. Applicant describes the service area(s)/community(ies) to be served by the NAP(s):
   (a) Identify the counties, census tracts, minor civil divisions, schools/school districts, etc., (as appropriate) in the service area.
   (b) Discuss any geographic factors and/or culturally specific characteristics that impact access to and the delivery of health care services.
   (c) Describe any relevant geographic barriers to care and other factors impacting access to care.
   (d) Describe any significant changes over the past year in the service area or population being served (i.e., influx of refugee population, or closing of local hospital, etc.)

2. Applicant describes the target population(s) (e.g., general community members, migrant/seasonal agricultural workers, residents of public housing, homeless persons, low-income school children, etc.) within the service area/community:
   (a) Identify the unserved and underserved populations in the community.
   (b) Describe the unique demographic characteristics of the target population (e.g., age, gender, insurance status, unemployment, poverty level, ethnicity/culture, education, etc.).
   (c) Define any special health care needs of the target population(s).
   (d) Identify any other populations that are in need of access to primary health care (e.g., migrant/seasonal farmworkers, homeless populations, residents of public housing, low-income school children/adolescents and their families).
   (e) Describe relevant access to care and health status indicators of the target population/community. These should be indicated in the Need for Assistance Worksheet and addressed in the Health Care Plan.
   (g) Describe the unique characteristics and other factors of the target population.
3. Applicant identifies how many people will be served and the number of projected encounters that will be generated after the first year of operation and at full operational capacity (within two years at the proposed funding level) at the proposed new access point(s).

4. Applicant identifies and describes the most significant barriers to care, gaps in services, significant health disparities and the major health care problems in the community that will be addressed by the new access point. (The Health Care Plan should present goals and measurable, time-framed objectives to address these identified needs.)

5. Applicant identifies any health care providers of care, resources and/or services of other public and private organizations within the proposed service area that are providing care to the target population(s) including all other federally qualified health centers and section 330 grantees.

6. Applicant identifies any section 330 funding received, including any special initiatives (e.g., integrated service network, dental pilot, etc.) and urgent supplemental funds and/or funds received from other related Federal programs such as Healthy Start, Housing and Urban Development Homeless resources, etc.

In addition to the above criteria, applicants requesting funding for a new access point(s) must also respond to the following criteria:

(a) In areas where there is one or more existing section 330(h) grantee, new start applicants demonstrate collaboration and coordination of services with other providers including the existing section 330 grantees (e.g., contracts, MOUs, letters of support from the current grantee(s), etc.).

What is the Need for Assistance Worksheet (NFA)?

Each applicant for NAP funds must submit a Need for Assistance Worksheet (NFA) demonstrating a need for the services the applicant is proposing to address. Need is based on data related to both the proposed service area and the target population. New start applicants (new FQHC organizations) are expected to provide data for the proposed scope of project while satellite applicants (existing FQHC organizations) are expected to provide data for the proposed new service delivery site only.

The following guidelines are provided for completing the NFA Worksheet:

- All responses must be given in the format requested (i.e., if a percentage is requested, the response must be a percentage; if a rate is requested, the response must be a rate).
- Documentation of the source of the data is required.
- Data cited must be the most recent data available.
- Data must be from a reliable and independent source including: Census data; Service area data; Local or State-level data; and/or National data, where no other data is available.
- Applicants should use the most geographically focused data available.
- Applicants may not use data generated by their own internal data systems.
- Each response must clearly address the target population(s) to be served.
- If an applicant proposes to serve multiple sites or service areas, the NFA should include...
responses that represent the total **targeted populations/areas**.

- No more than **one response** should be submitted for each question.
- All responses must be **finite numbers** (i.e., 212) and cannot be presented as ranges (i.e., 31-35).
- In completing the Health Disparities section, a response must be presented for the target population as well as for the **benchmark area**. A benchmark response, such as County, State, National or other established reporting area, must be used as a **point of comparison** for the target population.

See [http://bphc.hrsa.gov/] for a copy of the NFA worksheet and scoring criteria that will be used in Phase II of the President’s Health Center Initiative which will focus on the 200 highest poverty counties in the U.S.

**Where Can I Find More Information About Describing Our Service Area, Community And Target Population?**

See the guide *So You Want To Start A Health Center?*, Chapters 2 and 3 for more information on how to describe your service area and target populations. This guide is available at [http://www.fachc.org/cd_presidents%20initiative.htm](http://www.fachc.org/cd_presidents%20initiative.htm)

**What Criteria Are Used To Score And Evaluate The “Strategic Planning” Section (Criteria #2) (Maximum 10 Points)?**

1. Applicant demonstrates a thorough understanding of the **health care environment** including:
   (a) the impact in the *State of the implementation of SCHIP, 1115 and 1915(b) waivers*, State Medicaid **prospective payment system**; Medicaid managed care, *State laws, current and proposed welfare reform initiatives*, etc.
   (b) the impact that these changes have had on the **access to services or demand for services** among the target population(s)
   (c) the organization’s **strategic response** to these issues.

2. Applicant demonstrates whether/how the proposed new access point is a **priority in the State** for increasing access to care for the underserved. [Contact the State PCA and/or State PCO for more information on the marketplace and unmet needs priorities.

3. Applicant describes the organization’s role and **relationships within the community** including:
   (a) how the organization fits into the community and its **service delivery network**
   (b) the **role of clients, community, staff and Board of Directors** in establishing and developing the proposed new access point.

4. Applicant demonstrates and provides evidence of the **community’s support** for the organization and the proposed new access point (e.g., letters of commitment, Memoranda of Understanding, etc.). Applicants may include letters of support and MOUs as appropriate, and/or may include a list of additional letters of commitment, MOUs, etc on file at the health center.

5. Applicant describes the **strategic planning process** for the development of the new access point including any community input and Board involvement in the development of the
proposed project and any collaboration and support from other federally qualified health centers in the area.

In addition to the above criteria, applicants requesting funding for a new access point(s) for the following types(s) of health center must also respond to the following criteria:

**FOR MHC APPLICANTS:**

(a) Applicant demonstrates that there has been an increase in the MSFWs in the service area(s) over the past 3 years.

(b) Applicant discusses the agricultural area, the impact of agriculture, and relationship between the crops, growing seasons and their impact on the influx of MSFWs (e.g., the need for hand labor or the number of temporary workers).

(c) Applicant discusses any network of care for migrant health. Discuss linkages (e.g., MOAs, MOUs, contracts, etc.) with other migrant health organizations such as Migrant Education, Migrant Head Start, and Migrant WIC programs. Submit copies of all signed agreements, contracts, etc.

**FOR PHPC APPLICANTS:**

(a) Applicant documents a formal relationship with the local Public Housing Authority and Public Housing resident groups within the community.

Where Can I Find More Information About Strategic Planning for Becoming an FQHC?

See *So You Want To Start A Health Center?* Chapter 3 for more information on strategic planning for FQHCs. This guide is available at [http://www.fachc.org/cd_presidents%20initiative.htm](http://www.fachc.org/cd_presidents%20initiative.htm)

What Criteria Are Used To Score And Evaluate The “Service Delivery Strategy And Model (Criteria #3) (Maximum 20 Points)?

1. Applicant describes the proposed service delivery model (e.g., freestanding, single or multi-site, migrant voucher, or combination) including a discussion of comprehensiveness and continuity of care, services provided via contract, the referral system process and access problems the model would address and resolve.

2. Applicant describes how the proposed model is most appropriate and responsive to the identified community health care needs (i.e., the applicant provides a service delivery plan of services and staffing that addresses the priority health and social problems of the target population for all the major life cycles). In particular, the service delivery plan should address the special health care needs documented in the application, the Health Care Plan and the Need for Assistance Worksheet.

3. Applicant discusses the extent to which project activities are coordinated and integrated with the activities of other federally qualified health centers and section 330 grantees, State and local health services delivery projects and programs serving the same population(s) including any actual or proposed partnerships and collaborative activities. Provide copies of all relevant contracts, memorandum of understanding, letters of
4. Applicant discusses the extent to which the proposed service delivery model will *increase access* to primary health care services for the *medically underserved in the community/target population*.

5. Applicant discusses the extent to which the proposed service delivery model will, and demonstrates a clear plan to, *reduce or eliminate disparities* identified in the population or community to be served.

6. Applicant describes how the proposed new access point(s) is a *cost-effective* approach to meeting the primary care needs of the target population given the health care needs of the target population and the level of health care resources currently available in the community.

7. Applicant demonstrates, in cases where the site(s) are already operational, how section 330 funds will *augment/supplement existing services, resources and providers* to expand accessibility and availability of primary health care services to underserved populations.

In addition to the above criteria, applicants requesting funding for a new access point(s) for the following types(s) of health center must also respond to the following criteria:

**FOR MHC APPLICANTS:**
(a) Applicant describes an *outreach program* that will increase access to primary and preventive health care services and how the outreach program is integrated into the primary care delivery system.

**FOR SBHC APPLICANTS:**
(a) Applicant provides documentation of *access to health care during the summer*.

**FOR PHPC APPLICANTS:**
(a) Applicant documents a *formal agreement with the local Public Housing Authority* that demonstrates the sufficient provision of comprehensive services.

**FOR HCH APPLICANTS:**
(a) Applicant describes, for each service offered, the *service setting* (e.g. permanent site, mobile van, shelter site, etc.)

**Where Can I Learn More About Considerations Related to the Service Delivery Strategy And Model?**

See the guide *So You Want To Start A Health Center?*, Chapters 5-6 for guidance on human resources and choosing an organizational home. This guide is available at [http://www.fachc.org/ed_presidents%20initiative.htm](http://www.fachc.org/ed_presidents%20initiative.htm)
What Criteria Are Used To Score And Evaluate The “Healthcare Services” Section (Criteria #4) (Maximum 15 Points)?

1. Applicant demonstrates how the required primary, preventive and supplemental health services (e.g., enabling services, eligibility assistance, outreach, and transportation) will be available and accessible to all lifecycles of the target population either directly on-site or through established arrangements.

2. Applicant demonstrates a clear and defined plan for providing oral health care that assures availability and accessibility to the target population either directly on-site or through established arrangements (contract, referral, etc.).

3. Applicant demonstrates a clear and defined plan for providing mental health care and substance abuse services that assures availability and accessibility to the target population either directly on-site or through established arrangements (contract, referral, etc.).

4. Applicant demonstrates that the proposed clinical staffing pattern (e.g., number and mix of primary care physicians and other providers and clinical support staff, language and cultural appropriateness, etc.) at the new access point is appropriate for the level and mix of services to be provided.

5. Applicant demonstrates that the services will be culturally and linguistically appropriate.

6. Applicant demonstrates through the Health Care Plan that priority health care needs of the target population will be addressed and health disparities will be reduced.

7. Applicant demonstrates a detailed plan for recruiting and retaining appropriate health care providers as appropriate for achieving the proposed staffing pattern.

8. Applicant demonstrates an understanding of the most common causes of mortality, and the incidence and prevalence of chronic and infectious diseases in the target population, and discusses activities to address these issues including participation in or plans for participating in a formal disease/care management and system improvement program, such as the BPHC-supported or sponsored Health Disparities Collaborative.

9. Applicant demonstrates their efforts or plans to achieve the goals of Healthy People 2010 as part of their efforts to increase access and reduce health disparities. (Information on Healthy People 2010 is available at: www.health.gov/healthypeople/.)

10. Applicant discusses comprehensiveness, coordination and continuity of care, including:

    (a) Hours of operation to assure services are available and accessible at times required for meeting the needs of the population including evenings and weekends as appropriate

    (b) Mechanism to assure professional coverage during the hours when the health center is closed

    (c) Case management system that demonstrates care coordination at all levels of
health care, including arrangements for referrals, hospital admissions discharge planning and patient tracking.
(d) Means to obtain patient feedback including conducting patient satisfaction surveys.

In addition to the above criteria, applicants requesting funding for a new access point(s) for the following types(s) of health center must also respond to the following criteria:

**FOR MHC APPLICANTS:**
(a) Applicant describes how the health care needs associated with the environmental hazards to which farmworkers and their families are exposed will be met.
(b) Applicant describes the setting(s) in which health and enabling services will be provided, i.e., are there special arrangements to provide services at camps and/or farms; use of mobile teams and or vans; extended hours/weekend services, etc.

**FOR SBHC APPLICANTS:**
(a) Applicant provides evidence of on site care through established arrangements with the school staff and providers (e.g. school nurse, school psychologist, etc.) when applicable.

**FOR HCH APPLICANTS:**
(a) Applicant describes the mechanism for informing homeless people of the availability of services and the features of its outreach program.
(b) Applicant discusses coordination of services with providers of housing, job training, and other essential support for persons who are homeless. The applicant must also describe its relationship with homeless coalitions, advocacy groups, and “Continuum of Care” in their community.

What Is A Healthcare Plan?

The Healthcare Plan (HP) outlines how the identified community health needs and issues will be addressed. It is broken down into major health related goals and objectives for each of the life cycles. The HP should include quality improvement plans and activities as well as clinical outcome measures. One of HRSA’s major goals is to achieve the objectives outlined in Healthy People 2010; therefore, a strong healthcare plan will clearly be tied to these HP2010 measures and will also address plans to participate in health disparities collaboratives (HDCs) and/or other programs aimed at achieving national standards. The HP should outline planned activities to eliminate health disparities as appropriate for the target community. Retention and recruitment of qualified staff and risk management plans should also be addressed.

If special populations are included in the target population for the NAP, the health care plan must describe how the special access problems and the unique health care needs of these populations are being met. Satellite applicants must demonstrate the extent to which the satellite site will be integrated into the applicant’s existing clinical, administrative and financial systems already in use in the existing program. For sample pages from a healthcare plan, see www.fachc.org/cd_presidents%20initiative.htm
What Criteria Are Used To Score And Evaluate The “Organizational Capabilities And Expertise” Section (Criteria #5) (Maximum 10 Points)?

1. Applicant demonstrates why it is the **appropriate entity** to establish the new access point(s) and why these funds are needed (e.g., staff skills, capacity, clinical outcomes, cultural and linguistic competence, evaluation capabilities, etc.).

2. Applicant describes its **experience and expertise** in working with the target population(s), in addressing the identified health care needs and in developing and implementing appropriate administrative, clinical, and financial management systems.

3. Applicant demonstrates that its **structure, management system and lines of authority** are appropriate and adequate for the size and scope of the proposed project.

4. Applicant demonstrates that the **key management staff of the health center is appropriate** and that the process for hiring key management staff is in accordance with Health Center Program Expectations and BPHC guidelines.

5. Applicant demonstrates **financial viability and accounting and internal controls** in accord with sound financial management procedures that are appropriate to the size of the organization, funding requirements, and staff skills available.

6. Applicant demonstrates the ability to **monitor the quality and outcomes** of the services provided (e.g., adequate management information systems, established quality assurance program, patient feedback, etc.).

7. Applicant demonstrates the ability to evaluate the quality and outcomes of the services provided including an **evaluation plan that includes specific time framed, measurable outcomes and clear methods/action steps.**

8. Applicant demonstrates through the **Business Plan** that **operational issues and administrative, financial and clinical systems** for the establishment of the new access point will be addressed.

9. Applicant demonstrates the ability or a plan `to enhance the quality of care, increase the efficiency and effectiveness` of operations, and reduce costs through the use of **technological improvements** such as the use of telehealth, distance learning, remote patient monitoring, personal data assistants (PDAs), interactive video, satellite broadcasting and store-and-forward technology.

10. Applicant demonstrates a **performance improvement system** that includes eliminating disparities in health outcomes, reducing patient risk, improving patient satisfaction, credentialing and privileging, incident reporting, etc., that integrates planning, management, leadership and governance into the evaluation processes of program effectiveness.
What is a Business Plan?

The *Business Plan (BP)* outlines how the goals and objectives of the NAP are tied into the overall operational business goals of the organization. It should be divided into the following categories: *Administrative, Governance, Fiscal, and MIS* and address:

- **Financial implications** to the organization related to the NAP
- **Cost-savings activities** such as joint purchasing or network development
- **Continuous quality improvement** relative to administrative/fiscal activities
- Plans for attaining and maintaining *long-term viability*
- **Audit conditions** or exceptions as identified in the most recent report
- **Managed care arrangements** and their impact on the organization.
- Factors that may have affected, or are expected to affect, progress for the NAP in either a positive or negative way.
- Current grantees should also address outstanding *business/management issues* identified in a previous notice of grant award, pre-application guidance letter, and/or performance review.

For sample pages from a business plan, see [www.fachc.org/cd_presidents%20initiative.htm](http://www.fachc.org/cd_presidents%20initiative.htm).

Where Can I Learn More About Business Planning?

See the guide *So You Want To Start A Health Center?*, Chapter 7 for more information on business planning. This guide is available at [http://www.fachc.org/cd_presidents%20initiative.htm](http://www.fachc.org/cd_presidents%20initiative.htm)

Where Can I Learn More About MIS and Data Systems?

See the guide *So You Want To Start A Health Center?*, Chapter 9 for more information on MIS and Data systems. This guide is available at [http://www.fachc.org/cd_presidents%20initiative.htm](http://www.fachc.org/cd_presidents%20initiative.htm)

What Criteria Are Used To Score And Evaluate The “Budget” Section (Criteria #6) (Maximum 10 Points)?

1. Applicant provides an annualized *12-month budget and narrative* for each of the years for which support is requested (i.e., *for year 1, year 2 and year 3*). The budget should be appropriate and reasonable in terms of:
   (a) The *level of requested Federal grant funds* for year 1, year 2 and year 3 *versus total budget*;
   (b) The *total resources required* to achieve the goals and objectives (i.e., to achieve the applicant’s proposed service delivery plan) of the new access point(s);
   (c) The *maximization of non-grant revenue* relative to the proposed plan and leveraging of other resources.
   (d) The *projected patient income* for each year of support requested (i.e., year 1, year 2 and year 3) is reasonable based on the patient mix and number of projected users and encounters.
   (e) The number of *proposed users and encounters* at full operational capacity.
   (f) The *total cost per user and encounter*.
   (g) The *total grant dollars* per user.
2. Applicant describes the extent to which Federal section 330 funds will be used to expand services and capacity to provide services. If the applicant is purchasing/taking over/assuming a clinic(s) operation as part of the proposal, the applicant must demonstrate the level of continued commitment and collaboration of the other organization to assure the viability of the clinic operation.

3. Applicant demonstrates that the Federal grant funds requested are being used to leverage other sources of funding and that alternative sources of revenue (i.e., Medicaid, SCHIP, and other third party resources) are being maximized to support the operation of the new access point(s).

4. Applicant demonstrates that the Business Plan goals and objectives are targeted to activities related to the new access point and demonstrate appropriate financial planning in the development of the proposal and for the long-term success of the project.

In addition to the above criteria, applicants requesting funding for a new access point(s) for the following types(s) of health center must also respond to the following criteria:

FOR SBHC APPLICANTS:
(a) Applicant itemizes the estimated value of in-kind resources (including equipment, rent, personnel, renovations and alterations).

FOR PHPC APPLICANTS:
(a) Applicant demonstrates no more than 20 percent of the grant funds will be used for outreach activities.

Are There Any Specific Guidelines For Developing The Budget?

The following is provided as a guideline in developing the Federal budget request: $150 Federal grant dollars per general community user, $200 Federal grant dollars per migrant/seasonal farmworker user, homeless user, public housing user and school-based health center user.

The budget should be consistent with the health care and business plans presented in the application. Form 424A is the basis for the budget presentation that will enable reviewers to make judgments as to the appropriateness and reasonableness of the proposed costs as they relate to the Project Description, Health Care Plan and Business Plan. Each budget should be accompanied by a complete and comprehensive Budget Narrative that provides an explanation for each budget line item. Applicants must present three complete 12-month budgets (For years 1, 2 and 3).

See www.fachc.org/cd_presidents%20initiative.htm for a sample Form 424A and budget narrative.

The BPHC recognizes that budgeted operational costs and income may be lower in year 1 due to gradual ascent to full capacity; and it is also anticipated that year 1 may appropriately include some unique one-time costs such as equipment and alterations/renovations. It is expected that the year 2 and year 3 budgets, will represent the organization at full operational capacity.
The total request for section 330 support (inclusive of any request for one-time minor capital costs in Year 1) **MUST NOT exceed the established cap of $650,000 in Year 1, Year 2 or Year 3.** As part of the year 1 budget, applicants may include **one-time minor capital costs up to $150,000**, associated with equipment and/or capital alteration/renovation.

**Should We Include the Cost of Liability Malpractice Insurance in our Budget?**

New start applicants should include the costs associated with the purchase of appropriate **malpractice insurance** in the proposed budget, and may later request to be deemed eligible under the **Federal Tort Claims Act (FTCA)**. If currently deemed, applicants seeking a new access point grant need not submit a new FTCA deeming application. If their new access point application is approved and funded the new access point will be part of their approved **scope of project** and covered by their existing deemed status. If not currently deemed new and existing grantees may submit a separate deeming application found in PIN 99-08 to:

HRSA
FTCA Program: Deeming Application
150 S. Independence Mall West
Suite 1172
Philadelphia, PA  19106-3499

For assistance in completing a deeming application contact Susan Lewis, HRSA/BPHC/Division of Clinical Quality at 215-861-4373 or slewis@hrsa.gov. For general information on this malpractice program please review PIN 99-08, and contact our toll free hotline 866-FTCA-HELP (866-382-2435).

**Where Can I Learn More About FQHC Insurance Considerations?**

See the guide *So You Want To Start A Health Center?*, Chapter 8 for more information on business planning. This guide is available at [http://www.fachc.org/cd_presidents%20initiative.htm](http://www.fachc.org/cd_presidents%20initiative.htm)

**Where Can I Learn More About FQHC Budgeting?**

See the guide *So You Want To Start A Health Center?*, Chapter 7 for more information on budgeting. This guide is available at [http://www.fachc.org/cd_presidents%20initiative.htm](http://www.fachc.org/cd_presidents%20initiative.htm)

**What Criteria Are Used To Score And Evaluate The “Governance” Section (Criteria #7) (Maximum 10 Points)?**

1. Applicant describes the structure of the Board in terms of **size, expertise, and representativeness of the populations served.**

2. Applicant demonstrates its plan for assuring that the Board appropriately **represents the community/target population to be served** by the new access point(s).

3. Applicant demonstrates that the Governing Board is representative of (for new start applicants) or will include (for satellite applicants) **representation from the proposed service area.**
4. Applicant discusses the mechanism to train the governing board and new governing board members in appropriate responsibilities and requirements of the Federal grant program.

In addition to the above criteria, applicants requesting funding for a new access point(s) for the following types(s) of health center must also respond to the following criteria:

**FOR CHC, MHC and SBHC APPLICANTS ONLY:**
(a) Applicant demonstrates through completion of Form 8, Affiliation Checklist that any potential affiliations related to the operation and management of the new access point comply with the requirements and guidelines set forth in the BPHC Program Expectations and Policy Information Notices (PIN) 97-27 “Affiliation Agreements of Community and Migrant Health Centers” and PIN 98-24 “Amendment to PIN 97-27 Regarding Affiliation Agreements of Community and Migrant Health Centers”.

See www.fachc.org/cd_presidents%20initiative.htm for a copy of Form 8 - Affiliation Checklist.

**FOR HCH, PHPC AND MHC APPLICANTS ONLY:**
(a) Where applicable, applicant clearly requests a waiver of governance requirements. Only PHPC, HCH and MHC applicants that receive or are only requesting funding under for one of these types of health centers may request a waiver. Applicants that receive/are requesting funding for a CHC and/or SBHC are not eligible to request a waiver.

**FOR MIGRANT VOUCHER PROGRAMS:**
(a) Where applicable, migrant voucher programs that are not CHC-based, clearly requests a waiver from the governing board requirements. Applicant identifies plans to utilize migrant and seasonal farmworker representation on advisory councils to meet the requirements for consumer input. New start voucher programs that do not meet the governance requirements of section 330, must request a waiver.

Where Can I Find More Information About Community Governance at FQHCs?

See the guide So You Want To Start A Health Center Chapter 4 for more information on developing community governance. This guide is available at http://www.fachc.org/cd_presidents%20initiative.htm

**What Criteria Are Used To Score And Evaluate The “Readiness” Section (Criteria #8) (Maximum 10 Points)?**

1. Applicant demonstrates that the proposed facility(ies) is the most appropriate for serving the target population based on issues of transportation, population density, and available providers.

2. Applicant demonstrates that the new access point facility(ies) is appropriate and reasonable in terms of the proposed number of new users, the size and number of exam rooms based on the proposed level of staffing and scope of services to be provided. Provide floor plans.
3. Applicant demonstrates that the proposed **timeline for initiating services is reasonable**.

4. Applicant provides evidence that the **facility will be available and operational within 120-days** of a grant award as expected. Provide appropriate documentation (e.g., lease agreement, intent to lease, renovation plans, etc., as appropriate).

5. Applicant provides evidence that the **appropriate staff and providers will be available and operational within 120-days** of a grant award as expected. Provide appropriate documentation (e.g., provider contracts, commitment letters, etc.).

In addition to the above criteria, applicants requesting funding for a new access point(s) for the following types(s) of health center must also respond to the following criteria:

**FOR HCH, SBHC, PHPC APPLICANTS:**
(a) Applicant includes, where appropriate, an **agreement from site sponsor** to allow applicant organization to provide services at specified location.

**FOR SBHC APPLICANTS:**
(a) Applicant provides the plan for compliance to the **certification and/or licensure** processes, if the applicant is in a state with certification and/or where licensure is required for SBHCs.

Are There Any 330 Checklists We Can Refer to When Developing Our 330 Application?

See [www.fachc.org/cd_presidents%20initiative.htm](http://www.fachc.org/cd_presidents%20initiative.htm) for checklists to help ensure compliance with HRSA 330 program expectations.

How Do We Apply to Become and FQHC Look Alike?

An **FQHC “Look Alike”** must meet all the same program requirements and expectations as a regular FQHC but they do not receive 330 funding. They do however benefit from enhanced reimbursement through the **Prospective Payment System (PPS)** and participation in cost savings federal programs like the **340B drug pricing program** and the **National Health Services Corps (NHSC)**, program which matches doctors and other clinicians to **MUAs/MUPs** where they agree to work for a period of time in exchange for repayment of their educational loans. HRSA is considering plans to include **Federal Tort Claims Act (FTCA)** coverage as a benefit to FQHC Look Alikes. The deadline for FQHC “Look Alike” Applications is ongoing. Application Guidelines can be downloaded at [http://bphc.hrsa.gov/chc/lookalikes.htm](http://bphc.hrsa.gov/chc/lookalikes.htm)
Overview of 330 “Expanded Medical Capacity” Funding

Who is Eligible to Apply for Expanded Medical Capacity (EMC) Funding?

EMC sites are defined as service delivery sites within an existing health center’s current approved scope of project which are being expanded to significantly increase access to primary health care services to underserved populations in communities where the health center’s ability to provide care falls short of meeting the need for services. The sites proposed for a medical expansion must be listed on the existing 330 applicant’s most recently approved Form 5-Part B/Exhibit B from a service area competition, change in scope, or non-competing continuation application.

What Can EMC Funds Be Used For?

Strategies for expanded medical capacity may include but are not limited to expanding existing primary care medical services, adding new medical providers where excess facility capacity exists, expanding hours of operations, or providing additional medical services through contractual relationships (e.g., obstetrics and gynecology services) at an existing health center site.

A portion of the funds may be used to: (1) hire outreach workers and other enabling services staff to increase penetration in support of the capacity expansion; (2) hire administrative, nursing, and other support staff (e.g., translators, data analysts, etc.) necessary to support services provided through this expansion and achieve the goals and objectives of the proposal; and (3) support one-time minor capital costs in Year 1 only (up to $150,000) for renovating and expanding existing sites or replacing and expanding existing sites to a location proximate to the current health center(s).

What Can EMC Funds Not Be Used For?

EMC funds may not be used to expand capacity at sites operated outside of a grantee’s current approved scope of project. EMC funds may not be used to establish new sites, or to expand non-medical services.

What Constitutes a “Significant Increase in New Users”?

All EMC applicants must ensure that proposed strategies will result in a significant increase in the number of health center users served by existing delivery sites as defined below.

- Health centers that propose to expand medical capacity of an existing CHC program, regardless of whether EMC funding is also requested to serve a special population must demonstrate an increase in users of 25 percent of the total number of users the organization reported in the last year’s UDS, or 3000 new users – whichever is less.

- MHC (migrant health centers), HCH (health centers for the homeless) and/or PHPC (public housing primary care) only health centers (that do not receive 330e “community health center” funding) proposing to expand medical capacity by initiating a CHC program for the first time must demonstrate a minimum increase of 3000 new users.
• Health centers that propose to expand medical capacity by initiating or expanding only a MHC, HCH, and/or PHPC program, and do not also include a request for new or additional CHC funding, must demonstrate a minimum increase in users of 10 percent of the total number of users for the last calendar year UDS, or 1000 new users – whichever is less.

What Are HRSA’s Expectations of EMC Applicants?

Applicants are expected to:
• Present a sound and complete plan for the successful expansion of their medical capacity that demonstrates responsiveness to the identified needs of the target population within the existing service area.
• Demonstrate a significant increase in penetration into underserved communities or populations.
• Demonstrate readiness to initiate the proposed project, i.e., proposed staff recruited and services provided to the community within 120 days of receiving the grant award.
• Present a reasonable and appropriate budget based on the activities proposed in the project plan and business plan. The proposed budget should be based on an appropriate increase in medical users.
• Describe systems that ensure participation of the diverse cultures in their communities, including participation of persons with limited English-speaking ability
• Demonstrate that the proposed clinical staffing pattern (e.g., number and mix of primary care physicians and other providers and clinical support staff, linguistic and cultural competency, etc.) is appropriate for the level and mix of services to be provided.
• Demonstrate continued compliance with the Health Center Program Expectations (Program Information Notice 98-23).

Can EMC Funds Be Used To Expand Mental Health And Substance Abuse Services?

Mental Health and Substance Abuse providers can be included in the EMC only where necessary to support medical providers when mental health and substance abuse problems are prevalent in the new populations being served. All other proposals to add new services should be submitted through a 330 Service Expansion application, which is a separate competition.

Are There Any Special Considerations for Applicants Proposing to Serve Special Populations?

Migrant Health Center (MHC) (330g) applicants must address how the special needs of migratory and seasonal farmworkers (MSFW) and their families will be met and how services will be made available through mechanisms such as outreach that is integrated into the primary health care delivery system; use of existing mobile vans or health teams that travel to migrant camps; transportation; extended clinic hours; etc. Migrant EMCs must also demonstrate how the special environmental health concerns that are associated with MSFWs will be addressed and how all applicable BPHC regulations and guidelines, including the governance requirement, will be met.

Health Center for the Homeless (HCH) (330h) applicants must indicate the mechanism for delivering substance abuse services to homeless patients and describe the manner in which comprehensive outreach is to be conducted, and how transportation and other enabling services
will be provided. They must also describe the manner in which case management, eligibility assistance, and access to housing services will be made available to homeless patients. Public Housing Primary Care (PHPC) (330i) applicants must demonstrate consultation with the residents in the development of the application.

Can EMC Funds Be Used to Move to a New “Replacement” Site?

Applicants proposing to expand medical capacity by completely replacing a current site(s) by moving all clinical operations to a larger facility should do so only if the proposed location for the replacement site(s) allows the organization to continue to provide access to the same community/target population within the applicant organization’s currently approved scope of project. Organizations proposing to replace a current site(s) must move ALL clinical services from the site(s) being replaced to the new site and must ensure that the new site(s) will result in a significant increase in new users. The proposal to replace a site(s) must also address proximity of the relocated site to other health center delivery sites in the service area and should assure that providers (including other section 330 grantees, Federally Qualified Health Center (FQHC) Look-Alikes, and other primary care providers) serving the same target population in the same service area have been consulted regarding the proposed relocation of the site(s). Applicants should include letters or some other indication of support for the proposed expansion from the other area providers. All replacement sites must be operational within 120 days of receiving an EMC award. EMC funds may not be used to pay for construction costs for a replacement site.

Can EMC Funds Be Used to Purchase Mobile Vans?

EMC proposals may include an expansion of the medical capacity of an existing mobile van within the organization’s currently approved scope of project for the delivery of primary care services in any of the following ways:

- Renovation or replacement of an existing mobile van currently used by the health center
- Increase in medical provider FTEs dedicated to the mobile van
- Increase in the mobile van’s hours of operation
- Addition of primary care medical services provided through the mobile van.

The existing van must serve one or more locations, operate on a regular, fixed schedule, and provide primary care services through the use of clinicians who exercise independent judgment and generate clinical encounters. Proposals to add a new mobile van would be considered new access points and would not be eligible for consideration under EMC funding.

What is the Maximum Level of EMC Support?

The BPHC has established an annual cap of $600,000 for section 330 support of EMC grants. The cap is the maximum amount of section 330 funding that can be requested annually in an EMC grant application regardless of the number and/or type of EMC sites to be supported and/or populations to be served through the application.

Applicants may request support up to $150,000 in Year 1 only for one-time minor capital costs for equipment and/or alteration/renovation. Minor alteration and renovation is defined as work
required to change the interior arrangements or other physical characteristics of an existing facility or installed equipment so that it may be more effectively utilized for its currently designated purpose or adapted to an alternative use to meet a programmatic requirement. Federal funds may not be used to support new construction costs for activities proposed under this announcement.

How are EMC Applications Reviewed? See, “How are NAP Applications Reviewed?” in the previous section for details about the Independent Review Process.

What Criteria Are Used to Evaluate EMC Applications?
EMC application guidelines include a set of six criteria reviewers use to score each proposal and evaluate its strengths and weaknesses. Criteria are divided into the following categories and are assigned the corresponding maximum number of points: The following review criteria are used to evaluate EMC applications:

- Need (20 points maximum)
- Response (35 points maximum)
- Evaluative Measures (10 points maximum)
- Impact (5 points maximum)
- Resources and Capabilities (20 points maximum)
- Support Requested (10 points maximum)

What Criteria Are Used To Score And Evaluate The “Need” Section (Criteria #1) (Maximum 20 Points)?

1. Applicant clearly describes the service area(s)/community(ies) to be impacted by the EMC project, including:
   (a) The service area population and the area to be served (i.e., urban, rural).
   (b) If the applicant is requesting a funding preference as a sparsely populated rural frontier area (i.e., the entire proposed service area has 7 or fewer people per square mile).
   (c) The counties, census tracts, minor civil divisions, schools/school districts, etc., (as appropriate) in the service area.
   (d) Any Medically Underserved Areas (MUAs), Medically Underserved Populations (MUPS), High Impact Areas, and Health Professional Shortage Areas (HPSAs), as applicable.

2. Applicant clearly describes the target population(s) for the EMC project including:
   (a) The unserved and underserved populations in the community, including migrant/seasonal farmworkers (MSFWs), homeless people, public housing residents, and any other populations in need of access to primary health care (e.g., low-income school children/adolescents and their families, elderly people, recent immigrants).
   (b) The unique demographic characteristics of the target population (e.g., age, gender, insurance status, unemployment, poverty level, ethnicity/culture, education, etc.).
   (c) The relevant access to care and health status indicators of the target population/community including the most common causes of mortality and the incidence and prevalence of chronic and infectious diseases.
3. Applicant clearly identifies and describes the most significant barriers to care, gaps in services, significant health disparities and the major health care problems in the community that will be addressed by the EMC project. This should include a description of:

(a) Any culturally specific characteristics that impact access to and the delivery of health care services.
(b) Any relevant geographic barriers to care and other factors impacting access to care.
(c) Any major and/or unique health care needs of the target population(s).

4. For those organizations proposing to serve a new population (i.e., MSFWs, homeless people, public housing residents) for which they do not currently receive Federal support, the applicant clearly identifies the specific health care needs and barriers to care for this population to be addressed by the EMC project and justifies the need to expand its focus to new populations.

5. Applicant clearly describes any significant changes over the past year in the health care environment, service area or population being served (e.g., influx of refugee population, closing of local factory) impacting on the need for services. This should include a description of any significant changes for each target population type served (i.e., MSFWs, homeless people, public housing residents, low-income school children/adolescents and their families).

6. Applicant clearly identifies any health care providers (including all other FQHC Look Alikes and section 330 grantees), resources and/or services of other public and private organizations within the proposed service area that are providing care to the target population(s). Appropriate justification is provided as to why existing health center resources and other local resources (e.g., other HRSA supported programs, rural health clinics, etc.) are unable to meet the need for increased access to primary care.

What Criteria Are Used To Score And Evaluate The “Response” Section (Criteria #2) (Maximum 35 Points)?

1. Applicant provides a detailed description of the proposed project that is appropriate and responsive to the identified community and target population health care needs. Included should be the number and location of targeted EMC sites, the number of new patients to be served, the number of new encounters projected, the types of services impacted, the increase in providers and support staff, and any increase or modification to hours of operation. Applicant must include the number of users and encounters for each special population, (i.e., MSFWs, homeless, public housing residents) if funds are requested for one or more of these populations.

2. Applicant describes reasonable and appropriate strategies/methods that will attract new users, expand access to primary care services for the target population and increase primary care medical capacity. Strategies may include but are not limited to providing additional services, additional providers where excess facility capacity exists, expanded hours of operation, or providing additional services through contractual relationships (e.g., OB/GYN) at existing sites. If the proposal includes completely relocating an existing site(s) to a more appropriate facility, the applicant clearly demonstrates how the project will
continue to maximize access to health care for the community currently being served by the existing site.

3. Applicant provides a Service Delivery Plan that is appropriate and realistic for the proposed EMC project, and responsive to the identified needs of the community, including any targeted health disparities. The plan includes adequate medical and other providers (e.g., outreach workers, case managers) and support staff associated with the expansion. The Service Delivery Plan addresses its impact on the current Health Care Plan for the organization, and any significant changes (e.g., serving a new population or age group, or expanding into new services) are noted in an addendum to the existing Health Care Plan.

4. Applicant provides a Business Plan that is appropriate and realistic for the proposed EMC project. Each relevant component of the Heath Center (e.g., Administration, Fiscal, Clinical, MIS, Governance, etc.) is sufficiently addressed, and the goals and activities are appropriate for the proposed project.

5. Applicant proposes appropriate plans for incorporating or improving the use of outreach and other enabling services to bring new users in to the health centers and/or medical services, both for traditional health center users and, where applicable, for special populations (e.g., MSFWs, homeless individuals and families, residents of public housing).

6. Applicant demonstrates that the new or expanded services being proposed are culturally and linguistically appropriate for the populations to be served.

7. For organizations proposing an expansion to serve a population for which they do not currently receive Federal support, the applicant:
   (a) Demonstrates awareness of the appropriate organizational changes to be made (per statutory and other requirements and expectations of health centers). Areas of consideration include representation in governance, and modifications to clinical and business systems, enabling services and overall cultural competency.
   (b) Presents a sound plan to assure compliance upon receipt of funding.
   (c) Assures the organization’s ability to implement the necessary changes.

8. Applicant provides a feasible and credible timeline for implementation of the project. The applicant demonstrates operational readiness within 120 days of award (i.e., proposed staff recruited and services provided), including those applicants proposing to open a replacement site.

What Criteria Are Used To Score And Evaluate The “Evaluative Measures” Section (Criteria #3) (Maximum 10 Points)?

1. Applicant demonstrates the ability to evaluate the effectiveness of the EMC project, including the quality and outcomes of the services provided (e.g., adequate management information systems, patient satisfaction). Applicant provides an evaluation plan that is appropriate for the EMC project goals and projected outcomes.
2. If applicable, the applicant describes the health center’s successful progress in meeting the initial goals and objectives under a time-limited *State funded program* (i.e., incubator program), and how these goals/objectives will align with the proposed EMC project.

3. Applicant demonstrates an appropriate *quality improvement program* that includes *eliminating disparities* in health outcomes, reducing patient risk, *credentialing and privileging, incident reporting*, etc.

4. Applicant describes the mechanism(s) by which the organization identifies and *responds to the community and its needs* (e.g., patient surveys, needs assessments, statewide data, census data).

**What Criteria Are Used To Score And Evaluate The “Impact” Section** (Criteria #4) (Maximum 5 Points)?

1. Applicant demonstrates the extent to which the proposed EMC project will *increase access to care and eliminate major barriers to care* for the medically underserved in the community/target population(s) to be served.

2. Applicant demonstrates the extent to which the proposed EMC project will *address the major health care needs and reduce health disparities* for the medically underserved in the community/target population(s) to be served.

**What Criteria Are Used To Score And Evaluate The “Response” Section** (Criteria #5) (Maximum 20 Points)?

1. Applicant clearly describes its *mission and structure, scope of current activities* (including participation in a state-funded incubator program if applicable) and systems, and includes an organizational chart depicting the EMC project within the organizational structure. The applicant also demonstrates the organization’s *ability to successfully implement the proposed medical expansion* project and meet program expectations.

2. Applicant demonstrates *experience with similar projects* and sufficient knowledge, skills and abilities within the organization to successfully implement the EMC project. (e.g., previous successful expansion projects, etc.)

3. Applicant demonstrates and *documents that it is operating at full capacity* for the providers currently in place and the resources currently available.

4. Applicant discusses the ability and experience of the proposed management team in *leading and managing internal administrative, human resources, financial systems, information systems, and clinical disciplines*.

5. Applicant demonstrates that the *facilities proposed for the EMC project are adequate and appropriate* for the projected increase in the provision of services. The applicant also provides an *appropriate plan for any necessary facility modifications/renovations*. 
6. Applicant demonstrates appropriate **collaboration with other area providers** (including other section 330 funded programs), to minimize duplication of services and assure an effective continuum of care. MOAs, MOUs, and/or a list of additional letters of commitment, on file at the health center, should be included as appropriate.

7. Applicant demonstrates and provides **evidence of the community’s support** for the proposed EMC project. Letters of support should be included as appropriate.

8. For applicants proposing to expand into **new target populations**, the applicant demonstrates an awareness of all appropriate **organizational changes** necessary for a successful project, a **plan for compliance** and the ability to implement the necessary organizational changes for serving new populations. The applicant must discuss the changes necessary to comply with all relevant program requirements to receive grant funds for services targeted to the proposed populations. The application certifies that the organization will be brought into compliance upon receipt of grant funding, and include information exhibiting the applicants ability to do so.

9. Applicant demonstrates that the organization’s **existing operations will not be jeopardized** if the expansion budget projections are not realized, and that the addition of new providers and staff **will not adversely affect the efficiency of current providers**.

**What Criteria Are Used To Score And Evaluate The “Support Requested” Section (Criteria #6) (Maximum 10 Points)?**

1. Applicant demonstrates in the budget presentation, **two 12-month annualized budgets** which are appropriate and reasonable in terms of:
   - (a) The level of **requested Federal grant funds versus total budget** for each year
   - (b) The total **resources required** to achieve the goals and objectives of the proposed EMC project (i.e., total project budget) and Business Plan provided as part of the RESPONSE section of the Program Narrative
   - (c) The **maximization of non-grant revenue** relative to the proposed plan and other Federal/State/local/in-kind resources applied to the project
   - (d) The **projected patient income** for each year is reasonable based on the patient mix and number of projected users and encounters
   - (e) The **number of proposed users and encounters**, after the first year of finding, and at full capacity after two years of funding
   - (f) The **total cost per user and encounter**
   - (g) The **total Federal section 330 grant dollars per user**
   - (h) The **one-time minor capital costs**.

2. Applicant demonstrates how **all sources of revenue, including non-Federal, will be maximized**.

3. Applicant presents a **budget narrative that is complete**, comprehensive and provides an explanation for each budget line item.

4. Applicant describes how the proposed expansion project is a **cost-effective** approach to meeting the primary care needs of the target population given the health care needs of the
target population and the level of health care resources currently available in the community.

Where Can I Find Further Guidance and Q&A related to EMC Funding?
Further Guidance can be found at http://www.fachc.org/cd_community%20development%20.htm
General 330 and FQHC-LA Funding Questions

When Can We Apply for 330 Funds?

Funding for new and expanded 330 programs depends upon annual congressional appropriations. Funding cycles can vary, however, historically, there have been two NAP and EMC funding cycles each year, one in May and one in December.

How Can I Stay Abreast Of 330 Funding Opportunities?

Each year HRSA releases a preview of anticipated funding opportunities which can be viewed and downloaded at [http://www.hrsa.gov/grants/preview/](http://www.hrsa.gov/grants/preview/). You can sign up to receive an electronic copy of the preview each time it is released. You can search for federal funding opportunities at [http://grants.gov/search/searchHome.do](http://grants.gov/search/searchHome.do). New 330 funding opportunities will be posted to FACHC’s web site, [www.fachc.org](http://www.fachc.org).

What Steps Should We Take in Preparations for Submitting an Application for 330 Funding?

All new HRSA applicants are required to be submitted electronically through [grants.gov](http://grants.gov). The process of registering and receiving approval may take up to four weeks. In order to register with Grants.gov, your organization will need a Data Universal Number System (DUNS) Number. A DUNS number is a unique nine-character identification number provided by the commercial company Dun & Bradstreet (D&B). If your organization is located in the United States, you can request and register for a DUNS number by calling 1-866-705-5711. If your organization is located outside of the United States, you can request and register for a DUNS number online at [http://ccr.dnb.com/ccr/pages/CCRSearch.jsp](http://ccr.dnb.com/ccr/pages/CCRSearch.jsp).

Where Can I find Sample 330 Applications?

You can view examples of past 330 grant application guidance at [http://www.fachc.org/mig_funding_archives1.htm](http://www.fachc.org/mig_funding_archives1.htm). 330 application guidance is subject to change; therefore these examples should serve only to provide insight into the 330 requirements and criteria, which will change when a new competition is announced.

Can We Apply for Both 330 Funding and FQHC-LA designation?

Yes, organizations may apply for FQHC-LA designation and 330 funding simultaneously.

What Factors Should be Considered When Deciding Whether to Apply for FQHC -LA Designation or 330 Funding?

FQHC-LAs must be fully operational and meet all the FQHC program expectations at the time they submit their application. This includes having all staff, MIS, billing and other systems in place when they apply. Applicants for 330 funding do not necessarily have to have all of these systems in place at the time of their application; however they must have a clear and convincing plan for how they will be fully operational within 120 days of receiving their grant.
Some experts believe that 330 applications are more competitive if the applicant organization is already an FQHC-LA, since they are already fulfilling all the requirements for 330 funding.

**Comparison of FQHCs and “Look Alikes”**

<table>
<thead>
<tr>
<th>Benefit or Requirement</th>
<th>FQHC</th>
<th>FQHC - LA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Application Process</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Competing grant applications with continuation applications</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Annual Certification</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Specific application cycles (FY deadlines)</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Fully operational at time of application</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td><strong>Eligibility Requirements</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Be a public or private non-profit entity</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Serve an MUA/MUP</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Meet all 330 statutory, regulatory and policy requirements</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td><strong>Benefits</strong></td>
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<td></td>
</tr>
<tr>
<td>Grant funding</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Federal Tort Claims Act (FTCA) coverage</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Enhanced Medicare reimbursement</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Enhanced Medicaid reimbursement</td>
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<td>YES</td>
</tr>
<tr>
<td>Eligible for federal 340B Drug Pricing Program</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Safe Harbor Act protection</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Automatic HPSA designation</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td><strong>Reporting Requirements &amp; BPHC Oversight</strong></td>
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<td></td>
</tr>
<tr>
<td>Uniform Data System (UDS)</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Annual Audits</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Office of Performance Review (OPR) Site Visits</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>
Glossary

340B A federal program that limits the cost of covered outpatient drugs providing significant savings for FQHCs and their patients

BPHC - Bureau of Primary Health Care, one of four bureaus at the Health Services Resources Administration (HRSA) which has responsibility for assuring that underserved and vulnerable people get the health care they need.

Capitated Payment - A predetermined payment amount made on a per capita (per patient) basis regardless of the amount of services used during any given period of time, unlike “fee for service” payments structures which pay for services provided to each individual patient based on the type and amount of service provided at each visit.

CHC - Community Health Center, also known as Federally Qualified Health Centers (FQHCs) or 330 Grantees.

CHD - County Health Department is a public agency funded by the Florida legislature to promote healthy lifestyles and monitor and prevent health risks including the spread of disease. Some CHDs provide primary healthcare services in addition to their “public” health role.

Continuum of Care - A local or regional system for helping people who are homeless or at imminent risk of homelessness by providing housing and services appropriate to their needs from homeless prevention to emergency shelter to permanent housing.

Enabling Services - Support services provided at FQHCs including transportation, translation and interpretation, case management, outreach, patient education which make primary and preventative healthcare services more accessible to the target populations served by an FQHC.

Expanded Medical Capacity (EMC) - A category of 330 expansion funding aimed at increasing the number of hours, space or providers at an existing FQHC.

Federal Tort Claim Act (FTCA) - Grants medical malpractice liability protection to HRSA-supported health centers. Under the Act, health centers, their employees, and eligible contractors are considered Federal employees immune from suit with the Federal government acting as their primary insurer.

Fee for Service - Payment based on the specific type and amount of services provided to each individual patient unlike “capitated” payment structures which pay a predetermined amount on a per capita (per patient) basis regardless of the amount of services used during any given period of time.

FQHC - Federally Qualified Health Centers, also known as Community Health Centers (CHCs) or 330 Grantees.

FQHC “Look Alike” - A federal designation indicating that a health center meets all the same requirements as an FQHC without the 330 funding.
Health Disparities Collaboratives (HDC) - A federal initiative aimed at eliminating health disparities for underserved Americans who suffer disproportionally from chronic diseases including diabetes, hypertension, asthma, cancer and depression.

Health Professional Shortage Area (HPSA) - A federal designation documenting a shortage of health care providers (a minimum population to provider ratio of at least 3000:1) and the existence of barriers to accessing care.

Healthy People 2010 (HP 2010)- A Federal initiative focused on a comprehensive set of health objectives that serve as a roadmap for increasing the quality and years of healthy life for all Americans and eliminating disparities in health status between different groups of people.

Homeless - an individual who lacks housing including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing.

HRSA - Health Resources Services Administration, the federal agency that funds the 330 program.

Integrated Service Delivery Network (ISDN) - A network of FQHCs that shares business services creating economies of scale resulting in higher levels of efficiency.

J-1 Visa Waiver Program - Allows foreign medical graduates to obtain a waiver of the two-year home residence requirement provided they agree to work for three years in a designated medically underserved or health professional shortage area (MUA/MUP or HPSA)

JCAHO - Joint Commission on Accreditation of Health Care Organizations provides health care accreditation that support performance improvement in health care organizations

Language Access - Ability of non speaking people to access healthcare services in a language they understand.

Medically Underserved Area (MUA) / Medically Underserved Population (MUP) - A federal designation indicating that a geographic area or population is medically underserved based on (1) percent of the population below 100 percent of the Federal Poverty Level, (2) percent of the population over age 65, (3) infant mortality rate (5 year average) and (4) population-to-physician ratio. All FQHCs are required to serve an MUA or MUP.

Migrant and Seasonal Farmworker (MSFW) - A person or their dependents who earns at least 51% of their income from agricultural work.

National Health Service Corps (NHSC) - A federal program that matches physicians and other clinicians with communities designated at Health Professional Shortage Areas (HPSA)

Need for Assistance Worksheet (NFA) - Part of the 330 application process which assists communities in identifying the unique health issues and disparities as well as other factors impacting access to care for their communities.
**New Access Point (NAP)** - a new FQHC delivery site which may either be a “Satellite” of an existing FQHC or a “New start” which is a completely new FQHC organization.

**Outreach** - Coordinated effort by an FQHC to “Reach out” to populations in need of healthcare services.

**Policy Information Notice (PIN)** - An official federal guidance. HRSA PINS can be found at [http://bphc.hrsa.gov/pinspals/pins.htm](http://bphc.hrsa.gov/pinspals/pins.htm).

**Program Expectations** - Federal expectations and minimum requirements for FQHCs outlined in PIN 98-23.

**Prospective Payment System (PPS)** - A payment system established by congress which allows states to set Medicaid reimbursement rates to ensure adequate Medicaid reimbursement at CHCs.

**Performance Review Protocol** - A process to improve performance of HRSA funded programs by working collaboratively to measure program performance, analyze the factors impacting performance, and identify effective strategies and partnerships to improve performance, with a particular focus on outcomes.

**Primary and Preventative Healthcare** - Includes basic medical care, health screenings, prenatal care, family planning, pediatrics, immunizations, emergency medical services, vision services, diagnostic X-ray and laboratory services.

**Service Area** - The geographic or “catchment” area served by an FQHC.

**Scope of Service** - Officially defines the range of services and geographic area served by an FQHC.

**Special Population** - Populations with special barriers to healthcare access. Categories of 330 funding for special populations include homeless, migrant and seasonal farmworkers, public housing residents and school children and their families.

**Target population** - A high need population targeted for services by an FQHC. This may include low income people, the uninsured, the elderly, school children, the unemployed, farmworkers, homeless etc.

**Uniform Data System (UDS)** - A core set of information reported by every FQHC allowing monitoring and evaluation of health center performance and trends including provider productivity, patient demographics, key diagnoses, service utilization and fiscal issues.
Directory of Florida FQHCs

1. Agape Community Health Center
2. Bond Community Health Center
3. Borinquen Health Care Center
4. Brevard Health Alliance
5. Broward Community and Family Health Center
6. Camillus Health Concern (Homeless)
7. Central Florida Family Health Centers
8. Central Florida Health Care (Migrant)
9. Citrus Health Network
10. C.L. Brumback Community Health Center (Migrant/Homeless)
11. Collier Health Services (Migrant)
12. Community Health Centers, Inc. (Migrant)
13. Community Health Centers of Pinellas
14. Community Health of South Dade (Migrant/Homeless)
15. Economic Opportunity Family Health Center
16. Family Health of Columbia County
17. Family Health Center of SW Florida (Migrant/Homeless)
18. Family Medical and Dental Centers (Migrant)
19. Florida Community Health Centers (Migrant)
20. Health Care Center for the Homeless
21. Helen B. Bentley Family Health Centers
22. I.M. Sulzbacher Center (Homeless)
23. Manatee County Rural Health Services (Migrant)
24. Miami Beach Community Health Center
25. Nature Coast Community Health Center
26. North Florida Medical Centers
27. Pancare Community Health Center
28. Pierson Medical Center
29. Pinellas Healthcare for the Homeless
30. Poinciana Primary Health Care
31. Premiere Community Health Care Group (Migrant)
32. St. Joseph's Health Care
33. Suncoast Community Health Centers (Migrant)
34. Tampa Community Health Centers (Homeless)
35. Thomas E. Langley Medical Center
36. Treasure Coast Community Health, Inc. (Migrant)
37. Trenton Medical Center
Map of Florida FQHCs

For detailed information about Florida FQHCs including satellite locations visit http://www.fachc.org/map_member_locations.htm