National Association of Community Health Centers, Inc. ®

SO YOU WANT TO START A HEALTH CENTER...?

A Practical Guide for Starting a Federally Qualified Health Center

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CHAPTER III

NEEDS ASSESSMENT AND PLANNING

At this point, there may be general consensus about a lack of access to primary care in the community or for certain populations such as the uninsured or Medicaid patients, but that most likely does not provide the information needed to actually plan and implement a health center. Good program planning requires good needs assessment.

Needs assessments involve answering two questions as accurately as possible: (1) what are the target population(s) and service area for the health center? (2) Given the target population(s), what are the service needs that the health center should be prepared to meet?

Once these questions have been answered the planning process involves prioritizing the identified health needs, developing specific growth and resource plans for how the health center will meet those needs and undertaking implementation.

This chapter will provide an overview of needs assessment and planning at the community level, as well as state-level planning activities that can support communities. Also discussed is information on the various federal shortage designations and how to obtain them.

A. Participating in Statewide Planning Activities

Three important resources for developing a new health center and for identifying what information is available and how to locate it are the state PCA, the National Association of Community Health Centers, and the federal Bureau of Primary Health Care.

Through several initiatives and programs, the PCA has a myriad of resources and expertise to assist interested communities and organizations with planning, developing and implementing a new health center.

Community Development — The PCA (and in some instances the PCO) has resources to assist with community organizing and building citizen support. The National Health Service Corps also conducts a Community Development program for communities that are interested in FQHCs, RHCs and NHSC site approval. Under the President's Initiative, many PCAs are receiving supplemental funding specifically to assist communities in developing new health center*s*.

Market Place Analysis (MPA) — The MPA is a collaborative planning process of PCAs and NACHC, supported by the BPHC-- is a process to gather information about the state, as well as broad healthcare markets within the state. The data collected through the MPA is valuable for planning activities. Despite the wealth of information available from a variety of sources including the Internet, gathering, managing and analyzing

appropriate and current information can be a challenging and time consuming endeavor. The elements of the MPA include assessing:

- The state's legislative and regulatory environment;
- Competition/collaboration among providers;
- Demographic and socio-economic trends;
- Managed care trends;
- Provider trends;
- Health Insurance coverage.

Statewide Strategic Planning — Statewide Strategic Planning (SSP) is a NACHC process that PCAs, existing Section 330 grantees and potential new grantees undertake to identify needs in the state, and potential 330-funded initiatives for serving new populations and existing health center patients with an expanded array of services. It is critically important that communities expecting to implement a new health center participate in the SSP process. This SSP process will support long range and operational planning activities and implementation. As part of the SSP process:

1) Determine a methodology for identifying unmet need.

2) Estimate the number of new patients who could be served with new or expanded primary care access and services.

3) Estimate the related staffing, capital and operating costs for new sites/expanded services.

4) Investigate whether your state PCA provides assistance for planning and implementation activities including detailed planning activities, governance considerations, grant assistance or recommendations for assistance resources, and recruitment and retention assistance.

Other Technical Assistance — These following organizations can provide assistance with conducting a needs assessment planning. Contact the National Association of Community Health Centers at www.nachc.com or (301) 347-0400.

1) NACHC has implemented the Managed Growth Assistance Program that targets assistance to communities interested in developing new health centers, newly funded Section 330 centers, and FQHCs looking to expand services and capacity. Technical support and training materials are available in all areas of health center clinical, administrative, finance and governance functions. Additionally, NACHC is a source of expertise on affiliations, structuring health center organizations, and understanding regulations and guidelines.

2) Determine whether there is a network of health centers in your state or region.

- Administrative: several states also have established administrative networks, which may provide cost savings for MIS and/or key staff such as a CFOs and can also provide technical assistance;

- Clinical networks are also available and may be a resource for clinical support, health care protocols and long-term retention considerations

3) Seek HRSA/BPHC Assistance:

- HRSA and BPHC are also sources of information. Check out the HRSA and BPHC websites at http://www.hrsa.gov and http://www.bphc.hrsa.gov.

B. Identifying the Target Population(s)

Target Population — *Unlike* the expansive view of community used in Chapter II when talking about ensuring community investment, a much more narrowly defined *target population* is used for program planning purposes. The target population consists of a group of people, within your defined service area, who are unserved or underserved, i.e. not receiving or not having access to adequate, quality primary and preventive health care.[6] To identify the target population you need to obtain information on demographics and health status of the community, the amount of accessible health care for that population, and the barriers that people in the target population may encounter in trying to access health care services.

Demographic information describes the population:

- Age and sex breakdowns: What are the percents of children, childbearing age women, and elderly?

- Is there a large number of poor[7]? Low-income[8]?

- Is unemployment at a high rate or are there a large number of people employed at low wages and/or without health insurance?

- What is the rate of health insurance coverage? Is underinsurance (prohibitively high premiums or co-pays) a consideration in the community?

- What is the ethnic/racial make-up?

- Are there Special Populations?[9]:

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[6] Unserved: Individuals living in areas designated as Health Professional Shortage Area (HPSAs) who do not have access to primary care physician. Underserved: Individuals living in areas designated as Medically Underserved Areas/Populations (MUA/MUP).

[7] At or below 100% of the Federal Poverty Level (FPL).

[8] Between 100% and 200% of the FPL.

— Homeless people
— Migrant or seasonal agricultural workers
— At-risk children and youths
— Residents of public housing
— Isolated elderly
— Recent immigrants
— Single parents
— Specific ethnic or minority groups
— Working poor and uninsured
— Displaced farmers

Health status information indicates the health problems of the population:

- Inadequate or late entry to prenatal care;
- Incidence of teenage pregnancy, low birth weight and infant mortality;
- Rates of communicable disease incidence and/or deaths;
- Incidence of chronic illness such as diabetes, hypertension and heart disease;
- Incidence and mortality from cancer (overall, breast, colon, prostate);
- Rates of avoidable hospitalizations;
- Incidence of exposure to pesticides or lead poisoning;
- Incidence of dental caries and other oral diseases;
- Incidence of substance abuse and addictive behaviors;
- Incidence of depression and other mental health problems;
- Use of hospital emergency rooms for primary health care;
- Incidence of asthma in children and adults;
- Other health status indicators and risk factors specific to the target population.

Tables 2 and 3 provide more detail about each type of data and possible sources of information. Using this as a guide, prepare a description of the target population that is as detailed and accurate as possible.

[9] The special populations identified are from the BPHC list of official "special populations." It should be noted that depending upon the geographic location, there may be additional/different population groups that also experience poor health status and problems accessing health care such as: Native Americans; Alaskan Natives; Latino Americans; gay, lesbian, bisexual, and transsexual populations; people living with HIV/AIDS; residents of the Mississippi Delta; residents living along the U.S.-Mexico border, to name a few.

TABLE 2
***Sources of Demographic and Health Status Information*[10]**

Indices	Sources of Information
Demographic indicators	
Age, sex, ethnic and linguistic distribution of the population	U.S. Census PCA, PCO
Percentage of the population that is: ▪ Below 100% of poverty ▪ Between 100-149% of poverty ▪ Between 150% and 200% of poverty ▪ Over 200% of poverty	▪ PCA, PCO ▪ U.S. Census for income distribution DHHS federal poverty guidelines, published annually ▪ PCA ▪ NACHC's REACH data ▪ BPHC Community Health Indicators HRSA, BHPr, DSD Population Estimates
Estimates of migrant population	▪ Office of Migrant Health ▪ State Migrant Education or Legal Services Offices ▪ PCA ▪ Atlas of State Profiles ▪ BPHC Community Health Indicators
Insurance coverage of different population groups	▪ State Medicaid agency ▪ PCA Surveys by market research firms, health care providers, and state/local governments on uninsured populations
Housing and employment trends	▪ PCA ▪ U.S. Census ▪ State Employment Security Office ▪ County/city planning agencies ▪ State Departments of Labor and Economic Development

[10] A summary of websites that provide various types of health and demographic data is located in Attachment Q.

TABLE 2 – continued
***Sources of Demographic and Health Status Information*[11]**

Indices	Sources of Information
Health Status Indicators	
Infant mortality and morbidity Low birth weight, entry to prenatal care Death rates	▪ State and local vital statistics report (all states and localities are required by law to compile and publish vital statistics) ▪ PCA, PCO ▪ State health Department records on transmittable diseases mandated by the Centers for Disease Control) ▪ PCA
Incidence of communicable disease: sexually transmitted diseases, TB, HIV, vaccine- preventable diseases	▪ State health department records on transmittable diseases (mandated by Centers for Disease Control) ▪ PCA
Incidence of other health diseases	Cancer registries: ▪ Nonprofit organizations or foundations dedicated to certain diseases or condition (e.g., SIDS Foundation, Lung Associations, etc.) ▪ BPHC Community Health Indicators
Birth defect information	▪ State vital statistics reports
Environmentally-influenced conditions (such as pesticide exposure, lead poisoning)	▪ Local or state health department
Health indicators specific to the community	▪ State vital statistics reports ▪ Hospital discharge data ▪ State/county health department records

[11] A summary of websites that provide various types of health and demographic data is located in Attachment Q.

TABLE 3. *Sources of Information on Access to Health Care*	
Information	**Sources of Information**
Insurance coverage of different population groups	▪ State Medicaid agency; ▪ State provider licensing agency; ▪ Surveys by market research firms, health care providers, and state/local governments on uninsured populations; ▪ Insurance status of patients of providers; currently serving the target population.
Access to care for Medicaid patients	▪ State Medicaid agency; ▪ State provider licensing agency; ▪ Survey of primary care providers: what percentage of their practice is Medicaid? ▪ Hospital Emergency room usage?
Access to care for uninsured patients	▪ Survey of primary care providers: do they have a sliding fee scale based on patient income? ▪ What percentage of their practice is sliding fee? ▪ Hospital emergency room usage?
Standards for health care utilization	▪ National Center for Health Statistics; ▪ BPHC

C. **Access to Care**

Once the service area and target population are described, access to health care and unmet need for services must be assessed. This is often as much an art as a science, but the following strategies can provide a good estimate. Table 3 provides some suggestions for obtaining information useful in estimating unmet need.

The initial step in identifying unmet need should be to contact the state PCA to ascertain what methodologies may have been established as part of the SSP for identifying unmet need. If the service area and/or population have already been designated as an MUA/P and/or HPSA some quantified need estimates may be available. This information is available from the state PCA and PCO.

Estimating Need — Assessing the target population should provide some information helpful in estimating the need for services. Using this information, an estimate of the

demand for primary care services can be made using either a quick-and-easy method or a more involved one.

The quick-and-easy method: A good rule of thumb is that there should be about one primary care physician for every 1200 to 1500 patients.[12] This range provides a quick estimate of the number of full-time physicians needed for the target population. According to BPHC data, one dentist (and one dental hygienist) is required for every 1000 patients, and a mental health provider is needed for every 200-300 patients.

The more involved method:

1) Using the information gathered on the target population, **quantify the population** as accurately as possible in terms of size and demographic characteristics.

2) **Estimate the number of primary care encounters** needed by this population. Start with the fact that, on average, an individual generates 3.5 primary medical care visits per year.[13] As appropriate, adjust the estimates based on:

- The age and gender distribution of the population (elderly and female patients generate more visits per year);
- The incidence of diseases such as HIV, TB or chronic care that will increase the need for care and more visits;
- Maternity rates;
- Environmental conditions affecting health.

3) **Compare these estimates** against actual service usage and adjust the estimates as appropriate.

- If there is already a health care provider in the community that is serving the target population, try to examine service utilization and diagnosis data from that provider for patients in the target population.
- If there is not a provider serving the target population, try to obtain information from other providers on service utilization and hospital discharges for the target population.
- Try to obtain information on service utilization for similar communities or target populations, particularly from health centers serving those communities or populations.

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[12] Based upon the BPHC's assumption that primary care physicians should have between 4,200 and 6,000 encounters per year. BPHC's Uniform Data System (UDS) for the year 2000 reports that a health center patient on average generates 3.1 visits per year; an individual dental patient on average generates 2.3 visits per year; a mental health patient on average generates 5.3 visits per year, and; a substance abuse patient on average generates 9.6 visits per year.

[13] Ibid.

Table 4 provides information on national figures concerning physician office visits by specialty that may be useful.[14]

TABLE 4
Select National Averages: Health Resource Utilization

4A. Annual number of office visits per 100 persons, 1999

Physician Practice Characteristic	General & Family Practice	Internal Medicine	Pediatrics	Obstetrics & Gynecology
Number of Visits/100 Persons	62.8	49.9	27.2	21.9[15]

4B. Annual number of office visits per 100 persons, 1999 By gender and age

Age	All	Female	Male
All Ages	678.7	319.9	234.9
Under 15	194.2	187.9	200.3
15 to 24	157.3	204.4	110.9
25 to 44	225.5	283.3	165.4
45 to 64	344.3	394.3	290.9
65 to 74	520.6	529.6	509.7
75 years and older	678.7	688.8	662.9

Source: *National Ambulatory Medical Care Survey 1999 Summary* Vital and Health Statistics, No. 322, National Center for Health Statistics, Centers for Disease Control, - July 2001.

Assessing Available Resources — Estimating the availability of resources can be more or less difficult depending on the attitude of other health care providers toward the idea of a health center within their community. If providers and professional associations are supportive of a health center and forthcoming with information about their services and practices, the job will clearly be easier than if they are suspicious, uncooperative, or feel threatened. An important resource for assessing available provider resources is the state PCO.

[14] Annual updates are available on the Centers for Disease Control website usually in June or July (www.cdc.gov/nchs/data).

[15] The visit rate is 42.7 per 100 females.

When estimating the availability of primary care physicians, count doctors of allopathic and osteopathic medicine that practice in general/family practice, pediatrics, general internal medicine, and obstetrics/gynecology. For dentistry include primary care dentists and not specialists; for mental health professionals include "core" providers including psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists and licensed marriage and family therapists (these latter categories may vary by state). In the discussion that follows, dentist and mental health professional may be substituted for the term "physician."

1) Contact physicians' professional associations and find out whether they have a listing of providers in the community with the providers' specialties. If necessary conduct a survey to determine the number of primary care physicians and their accessibility to the target population[16]. Important information includes:

- What is the total number of hours a week they spend in direct ambulatory patient care (not including administrative, hospital visits and lunch times)?
- D they accept regularly accept Medicaid patients?
- Do they have a regular and published sliding fee schedule of discounts based on income applicable to all patients?
- What percentage of their practice is Medicaid; discounted fees?
- How long do new and established patients have to wait for an appointment?
- Are they accessible by public transportation?
- Can they take patients with limited English proficiency?

2) Estimate provider accessibility for the Medicaid and uninsured populations by totaling the percentage of each physician's practice that is reported as Medicaid, sliding-fee, or "charity" care. Do not rely on counting the number of physicians listed by the state Medicaid agency for estimating access to care. Many registered providers serve limited numbers of Medicaid patients, may have closed their practices to new patients, or may even be on the list for having served at least one patient at some point although they no longer do.

3) Do not include hospital physicians who work exclusively in inpatient settings; do not include time spent in administrative activities or in research.

4) Among the primary care providers exclude the proportion of their practice spent on specialty care. For example, gynecologists and pediatricians may spend some of their time doing surgery, which would be considered specialty care.

5) Obtain information on providers' availability in terms of *direct patient care hours* or *full time equivalencies (FTEs),* rather than office hours. See Table 5 for guidance on converting physician office hours to FTEs.

6) <u>As appropriate</u> include other primary care providers such as nurse practitioners, nurse midwives and physician assistants. In some communities these practitioners are an important source of care. However, the scope of services

[16] This is most often done by telephone using a brief interview form. An office manager is frequently the most accessible and knowledgeable source.

provided by such professionals is dependent on state law and can vary considerably.

Physician FTE Conversions — If a physician follows his or her patient's progress in the hospital, the number of *direct patient care hours* that the physician works will be greater than the number of office hours. When estimating total health care resources, the number of hours spent in direct patient care is important data. When conducting a provider survey, ask the physician:

- Do you follow your patients in the hospital?
- If so, how many hours do you spend altogether on direct patient care?

If information about office hours is available, or if conversion of direct patient hours into FTEs is necessary, use the following table to estimate FTEs for the different primary care physician specialties.

Never include a physician as more than one FTE.

Table 5.
Physician FTE Conversions

	Average Office Hours/ Week (Patient care)	Average Direct Patient Care Hours/Week (I.0 FTE)	Conversion Factor: Office Hours x Factor Direct Patient Hours
All primary care	30.8	50.1	1.6
General and family practice	35.1	49.9	1.4
Internal medicine	27.1	49.5	1.8
Pediatrics	31.9	46.0	1.4
Obstetrics and gynecology	29.2	55.5	1.9

Source: U.S. Bureau of Primary Health Care, "Guidance for Calculating Primary Care Physician Full-Time Equivalency," July 1993

Example #1: If a pediatrician reports that s/he works 35 office hours per week (actually seeing patients), and that s/he follows patients in the hospital, the total direct patient care hours would be:

35 office hours X 1.4 = 49 direct patient care hours

Since 1 FTE for a pediatrician is 46 hours, this provider would be 1.0 FTE

Example #2: If the only information available is that primary care providers in the community work 45 direct patient care hours per week on average, use the "all primary care" figure to calculate FTEs:

$$\frac{\text{45 direct care hours}}{\text{50.1 hours/FTE}} = \text{0.9 FTE}$$

Thus, each provider should be counted as 0.9 FTE. Time spent away from the office for continuing education, vacation, military leave, etc., can and should be deducted from the average direct patient care hours per week.

Note: There are no comparable conversion factors for dentists or mental health professionals.

Again, the important thing to consider is accessibility to services in terms of cost, transportation and language and not just numbers of providers.

Unmet need is the difference between the amount of primary care required by the population and the amount that is actually available.

D. Setting Priorities and Planning

Armed with accurate and comprehensive information, the health center planning process can begin in earnest.

The first step in planning is setting priorities. Although an estimate of unmet need for health services in the community has been accomplished, the needs assessment does not provide the whole picture. Chances are that a new health center is not going to be able to address all unmet need for primary care so available resources and programmatic energy will have to be prioritized. This should be done using not only *quantitative* data about health problems, but also *qualitative* feedback from community leaders and members about what the health care priorities are in the community and among high need populations. Perceptions about health priorities may differ from the picture emerging from the demographic and epidemiological data, but this does not make perceived priorities "wrong." **Differing priorities will result in part because differences in culture, values and beliefs produce diverse definitions of *"health."*** For example, different values and beliefs about family planning will affect views about health status and needs. When it comes to setting priorities, an inclusive, community-oriented approach to health must take this diversity into account, along with a solid needs assessment.

The planning process itself goes from the "broad brush" of long range strategic planning to the real "nitty gritty" of operational and financial planning.

Long Range Strategic Planning — allows a health center to look to the future and develop a vision of its role in a particular environment. This type of planning generally covers a period of three-to-five years. The vision developed during strategic planning is used as a blueprint for program development activities. There are many different approaches to strategic planning but all have in common linking mission, analyzing important external and internal factors, and developing broad goals and objectives in an *iterative* way that requires regular feedback on progress.

Operational and Financial Planning — provides for developing the overall structure of programs and finances of the organization. Once a health center is operational, Board involvement in this kind of planning is generally limited to review and approval of proposed plans and budgets. It is the responsibility of key staff to prepare and propose for Board approval the operational plans along with operating, capital and staffing budgets.

Program and Project Planning — sets the framework for implementing specific activities. In smaller organizations there may be little difference between this type of planning and Operational and Financial planning. Again, the actual work to prepare plans and budgets should be the responsibility of staff with approval by the Board.

E. Securing the Appropriate Federal Designations[17]

Once the initial needs assessment is completed and the planning process is being undertaken, you should identify federal programs and designations that your community is eligible for. Even if a health center does not receive federal Section 330 funding, federal designations can be extremely beneficial because they may provide the health center with a more advantageous method of reimbursement for Medicaid and Medicare patients and access to National Health Service Corps resources. Knowing which designations the health center and its community are eligible for are fundamental to moving forward with the priority setting and planning process. Following is a brief summary of where and how to apply for several federal designations. *Many of these programs are currently changing; for current information contact your state PCA and PCO or NACHC.*

Medically Underserved Area or Population — It is required that the service area of an organization that wishes to apply for FQHC status or federal health center Section 330 funding includes an MUA or MUP. HPSA designation may be used in lieu of MUA status for obtaining Rural Health Clinic status (see HPSA below). Contact information regarding the federal agencies cited below is located in Attachment A..

[17] The HRSA website includes contact information for all of the listed programs and designations. Start at www.hrsa.gov.

- *Apply to:* Division of Shortage Designation, Bureau of Health Professions, HRSA, usually in cooperation with the state PCO.

- *Requirements:* MUA/P designation is based on a composite score (the Index of Medical Underservice - IMU) compiled from four indicators: physician-to-population ratio, infant mortality rate, percentage of the population below the federal poverty level and percentage of the population over 65 years of age. MUP designation also uses the IMU, but substitutes the characteristics of the target population (minimum of 30 percent of the overall population in a service area for the percent of population below the FPL), as well as supporting documentation about special health needs within the target population. Please note new formulas are being developed for both MUA/P and HPSA designations.

- *For more information:* Guidance is available through the Division of Shortage Designation, and the state PCO or PCA. Listings of presently designated MUA/Ps are located on the BPHC website (www.bphc.hrsa.gov) under Databases.

Health Professionals Shortage Area — Required for organizations that wish to employ NHSC providers; can also be used for obtaining Rural Health Clinic status. HPSA designation is an important factor in the Section 330 funding criteria.

- *Apply to:* Division of Shortage Designation, Bureau of Health Professions, HRSA, usually in cooperation with the state PCO[18].

- *Requirement:* A geographic Primary Care *HPSA* is an area with a physician-to-population ratio of 1:3500 or greater. A 1:3000 ratio is acceptable in areas with an unusually high need for primary health care, as illustrated by a high birth, infant mortality or poverty rate. Health care providers must be considered to have insufficient capacity (based on office visit rates, waiting times for appointments, or excessive emergency room use), or to be excessively distant or inaccessible. A population *HPSA* is a sub-population with a ratio of 1:3000 or greater.

- *Requirement:* A geographic Dental Health *HPSA* is an area with a dentist-to-population ratio of 1:4500 or greater. A 1:4000 ratio is acceptable in areas with unusually high need and for a population *HPSA*.

- *Requirement:* There are three options by which to calculate a geographic or unusually high need Mental Health *HPSA*. The methods vary based on the inclusion of "core" mental health professionals (i.e., psychiatrist, clinical psychologist, clinical social worker, psychiatric nurse specialist and licensed marriage and family therapist) in the calculation of the ratio. Organizations should contact the state PCO, or the Division of Shortage Designation.

[18] State PCOs are vested with the responsibility for monitoring new applications and reapplications for designated areas. Under the proposed new rules they will be even more focal in the process so it is important to check with them first regarding MUA/P and HPSA designations.

Please note new formulas are being developed for both MUA/P and HPSA designations.

- *For more information:* Guidance is available from the Division of Shortage Designation, and the state PCO and PCA. Listings of presently designated HPSAs are located on the BPHC website (www.bphc.hrsa.gov) under Databases.

In addition to the above HPSA categories, there are special exception and Governor request vehicles for obtaining designation. Check with the state PCO and the Division of Shortage Designation for information about these approaches.

Federally Qualified Health Center (FQHC) — Allows an organization to receive prospective (PPS) Medicaid payments and cost-based Medicare reimbursement. FQHC's also are eligible for the Section 340B PHS Drug Pricing Program.

- *Apply through:* BPHC. Guidance for the application is available on the BPHC website (www.bphc.hrsa.gov) under Documents/PINS and PALS.[19].

- *Requirement:* Federally Section 330 funded health center*s* are automatically eligible for FQHC designation. An entity not receiving Section 330 funding must demonstrate that it meets the statutory and regulatory requirements and program expectations governing community health centers to become designated as a FQHC "look-alike".

- *For more information:* Contact the BPHC Division of Health Center Development, the state PCA or NACHC.

National Health Service Corps (NHSC) — Site approval allows organizations to employ health care professionals who seek assistance with educational expenses (through either a scholarship or loan forgiveness through the federal government and many state programs).

- *Apply to:* BHPr/NHSC, Rockville, MD.

- *Requirement:* The organization must be in a *HPSA,* must agree to serve Medicaid patients and to serve Medicare patients without billing those patients in excess of what Medicare pays, and must have a sliding-fee schedule of discounts for people who are living below 200% of the FPL and without insurance. Organizations are placed on a priority list according to their HPSA priority score that is determined by the NHSC.

- *Requirement:* Many states also have adopted supplemental state loan repayment programs that apply to primary care providers (physicians and

[19] If a health center is applying directly for federal Section 330 funding the guidance issued by BPHC as to when, where and how to submit the application should be followed. These applications are available on the BPHC website (www.bphc.hrsa.gov) under Documents/PINs and PALs.

non-physician providers such as Nurse Practitioners, Physician Assistants and Nurse Midwives), while some include dental and mental health professionals as well. Eligibility criteria vary by state. Interested organizations should contact the state PCO or PCA.

- *For more information:* Request a site application from BHPR/Division of NHSC.

Rural Health Clinic — Designation allows public and private, non-profit and for-profit providers to receive cost-based reimbursement for services provided Medicare beneficiaries and prospective Medicaid payment rates for services provided Medicaid recipients.

- *Apply through:* State health department.

- *Requirements:* The organization must be located in a rural, non-urbanized area that is currently designated as a MUA or HPSA, and have a nurse practitioner/midwife or physician assistant onsite at least 50 percent of the time the RHC is open and providing RHC services.

- *For more information:* Contact the State Health Licensing Department, State Office of Rural Health, the Field CMS Office, or the DHHS Office of Rural Health Policy.

The chapters that follow take you through the specific requirements of and approaches to planning and implementing your health center.