



*Strengthening Oklahoma's Safety Net,
One Community At A Time*

Board Bulletin

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Required Financial Performance Measures

Section 330 community health centers (CHCs) operate within a project period determined by the Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care (BPHC). CHCs typically have a three-year project period when initially funded with a five-year project period in subsequent cycles. During the project period, CHCs are required to submit a Budget Period Renewal (BPR) annually. At the end of the project period, CHCs must submit a Service Area Competition (SAC) grant application to renew the funding. The FY2009 SAC guidance, released by HRSA/BPHC in February 2008, included revised performance requirements for clinical and financial operations. With the revised SAC, CHCs must use baseline data to develop benchmarks for the required measures, establish performance goals and track performance against these goals throughout the entire approved project period. Interim progress will be reported in the BPR. By aligning the SAC and BPR performance measures with those added to the 2008 Uniform Data System (UDS), CHC performance can be guided by data which will ultimately improve patient outcomes. Since CHC boards are responsible for grant applications, board members must review the performance measures with related benchmarks to monitor progress, plan strategically, and protect federal funding.

Financial Performance Measures

There are five required measurements in two focus areas: 1) Costs; and 2) Financial Solvency. CHC grantees select two additional measures to address self-identified needs, which complete the application's seven Business Plan measures. Baseline data for the five required measures is obtained from the grantee's most recent UDS report or annual audit. Required financial performance measures are as follows:

- ◆ **Total Cost Per Patient** (Focus Area – Cost; Data Source - UDS) – Reflects the total accrued (accumulated) cost before donations and after allocation (assignment) of overhead divided by total patients. This captures UDS-reported financial costs for: 1) Medical Care (medical staff, lab and x-ray); 2) Other Clinical Services (dental, mental health, substance abuse, pharmacy); 3) Enabling and Program-Related Services (case management, transportation, outreach, etc.); and 4) Overhead (facility and administration). How efficiently does the health center deliver patient care? Is it cost-effective for the number of patients served?
- ◆ **Medical Cost per Medical Encounter** (Focus Area – Cost; Data Source - UDS) – The description for this is total accrued medical staff and other medical cost after allocation of overhead (excludes lab and x-ray cost) divided by non-nursing medical encounters (excludes nursing and psychiatrist encounters). Is the health center generating physician and advance practice provider encounters appropriate for medical costs expended?
- ◆ **Change in Net Assets to Expense Ratio** (Focus Area - Financial Solvency; Data Source - Audit) – Calculated by taking the change in net assets (Ending Net Assets – Beginning Net Assets) and dividing it by the Total Expenses. Does the health center have assets that equal, if not exceed, health center expenses?
- ◆ **Working Capital to Monthly Expense Ratio** (Focus Area - Financial Solvency; Data Source - Audit) – The formula for this is Current Assets minus Current Liabilities divided by Average Monthly Expenses (Total Expenses/Number of Months in Audit). How much working capital does the health center have to stay operational if the revenue stream is interrupted (e.g., loss of a provider)?
- ◆ **Long Term Debt to Equity Ratio** (Focus Area - Financial Solvency; Data Source - Audit) – To calculate this ratio, divide Long Term Debt by Net Assets. Is the health center financially stable – owning more than it owes? Would it be able to borrow money if necessary?

The HRSA/BPHC SAC guidance also makes it clear that CHC grantees are “expected to sustain and/or increase users/encounters” throughout their project period. Only CHCs that are cost-effective and financially solvent can meet this expectation. To review OPCA's entire *Board Bulletin* series, visit the ‘CHC Boards’ section of www.okpca.org.

* **Revision Note:** Minimal expectations have been removed from original text. Measures should be specific to each individual CHC based on their current circumstances and the realistic assessment of how they can improve their performance.

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