



***Strengthening Oklahoma's  
Safety Net Through  
CHC Board Development***

***Board Bulletins  
Volume 6 • 2008***

**Oklahoma Primary Care Association  
4300 N. Lincoln Blvd., Ste 203, OKC, OK 73105  
(405) 424-2282 • Fax (405) 424-1111 • [www.okpca.org](http://www.okpca.org)**



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

## Board Bulletin

### Volume 6 • 2008

#### *Inside Volume 6...*

- ◆ ***Understanding Financial Reports***  
Number 1 - January 2008
- ◆ ***Breaking Down the Balance Sheet: Part 1***  
Number 2 - February 2008
- ◆ ***Breaking Down the Balance Sheet: Part 2***  
Number 3 - March 2008
- ◆ ***Analyzing the Statement of Activity***  
Number 4 - April 2008
- ◆ ***Financial Management Using Cash Flow and Key Ratios***  
Number 5 - May 2008
- ◆ ***Required Financial Performance Measures***  
Number 6 - June 2008
- ◆ ***Required Clinical Performance Measures***  
Number 7 - July 2008
- ◆ ***Effective Tools for Monitoring Progress***  
Number 8 - August 2008
- ◆ ***The Importance of Internal Controls to CHC Health***  
Number 9 - September 2008
- ◆ ***A Closer Look at Control Activities***  
Number 10 - October 2008
- ◆ ***New Look to Reach New Heights***  
Number 11 - November 2008
- ◆ ***Calling All Leaders! Calling All Advocates!***  
Number 12 - December 2008



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

## **Board Bulletin**

*Volume 6, Number 1 • January 2008*

### **Understanding Financial Reports**

As stewards of community health centers (CHCs), board members must understand how to read financial statements to exercise prudent fiscal oversight. All board members, not just those serving on the Finance Committee, are held accountable for reviewing and approving financial reports. The fiscal soundness of the CHC must be determined and carefully monitored by the board, including appropriate questioning of reported financial information. Unfortunately, many board members feel inadequate when it comes to reading financial reports. A thorough review of standard financial reports and their components should enable board members to ask sensible questions and prevent board paralysis when it comes to fiscal matters.

#### **Guidelines for Reviewing Reports**

- ◆ **Never Lose Sight of the Mission** – When exercising the duty of care in reviewing financial reports, do not forget the CHC's mission. The for-profit world mantra of "No margin, no mission" is applicable to nonprofits in the sense that the mission cannot be accomplished if sound fiscal oversight is not exercised.
- ◆ **Foster Trust and Transparency** – Boards must trust their one employee, the CHC chief executive officer (CEO), to secure trustworthy senior management staff – this includes the chief financial officer (CFO). It is counterproductive to the CHC to have a micromanaging board. A delicate balance must be achieved that enables the board to have all of the information necessary for prudent financial oversight while allowing the CEO and CFO to do their jobs. However, if the board does not trust the CEO to ensure full disclosure of health center financial status, corrective action must be taken.
- ◆ **Report Formats May Vary** – While CHCs are directed to use recognized "Generally Accepted Accounting Principles" (GAAP), reporting formats will vary from health center to health center. The review used in this series will focus on report components rather than the format in which they appear.
- ◆ **Recognize Reporting Limitations** – Financial statements are limited in that they report information for a period of time. It is dangerous to isolate one report. Boards should carefully review each report but understand that the real picture of CHC financial health can only be seen by comparing previous reports to the current one.

#### **Standard Financial Reports**

- ◆ **Statement of Financial Position** – Known for years as the "Balance Sheet", the Statement of Financial Position does just as the name implies – offers a snapshot of the health center's financial position for a given period of time. The formula is as follows:  $Assets = Liabilities + Equity$ .
- ◆ **Statement of Activity** – This report has been historically called the "Income Statement" or "Profit and Loss Statement." Because it shows the costs and expenses associated with earning revenue, the "bottom line" of the statement indicates how much the health center earned or lost during the reporting period.
- ◆ **Cash Flow Statements** – "Cash on hand" is becoming of greater interest to funders because it indicates the ability to pay expenses and purchase assets necessary for health center operations. The purpose of this report is to capture the inflows and outflows of cash over time. Cash flow is reviewed according to the following categories: 1) operating activities, 2) investing activities, and 3) financing activities.
- ◆ **Dashboard Reports** – Boards should work with the CEO, receiving input from the CFO, to develop reports for items of most interest. Just as car gauges assist drivers in knowing the operational status of the vehicle, health centers should employ a dashboard approach for key items such as the asset to liability ratio.

*Bottom line:* CHC boards must be confident they are receiving the financial information necessary for prudent fiscal oversight. Boards must work in concert with the CEO to ensure accurate and timely information that truly reflects health center financial status. The board must document receipt of reports to validate their duty of care.

To review OPCA's entire *Board Bulletin* series, visit the 'CHC Boards' section of [www.okpca.org](http://www.okpca.org).

**Oklahoma Primary Care Association**  
**4300 N. Lincoln Blvd., Ste 203, OKC, OK 73105**  
**(405) 424-2282, Ext. 104 • Fax (405) 424-1111 • [www.okpca.org](http://www.okpca.org)**



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

## **Board Bulletin**

*Volume 6, Number 2 • February 2008*

### **Breaking Down the Balance Sheet: Part 1**

Community health center (CHC) board members, as stewards of the health center, are accountable for the fiscal oversight. As part of the series dedicated to improving understanding of financial reports, this issue will focus on the Balance Sheet, more properly known as the Statement of Financial Position.

#### ***How Do Balance Sheets Balance?***

The Statement of Financial Position (Balance Sheet) offers a snapshot of the health center's financial position for a given period of time. The Balance Sheet formula is as follows:  $Assets = Liabilities + Equity$ . The balance sheet shows what a company owns and what it owes at a fixed point in time. If the sum of what a company owns (Assets) is more than the sum of what it owes (Liabilities), the remainder is equity – that is how the balance sheet balances. While multi-million dollar budgets may be intimidating, the basic finance principles are the same used at home - you must have more money coming in than you spend to stay solvent.

#### ***Know Your Assets***

Assets have positive monetary value worthy of being exchanged – real estate, automobiles, equipment, cash, etc. Because there are different kinds of assets with fluctuating value, it is important to know what makes up each category listed in the Asset section of the Balance Sheet. Some examples are:

◆ **Current Assets** – The first major Balance sheet component, Current Assets, includes items of value that can easily be converted into cash and are at the disposal of the organization to fund day-to-day operations. Different types of current assets listed on a health center Balance Sheet may include the following:

Cash – As the name implies, it is literally cold, hard cash considered a liquid asset that could be used immediately. Because health centers are in the business of providing a service to a growing number of uninsured with limited resources, cash on hand has historically been minimal. This creates solvency issues and threatens sustainability of the health center. In recent years, the Health Resources and Services Administration (HRSA) Bureau of Primary Health Care (BPHC) has shown greater interest in CHCs improving their 'cash on hand' status. Be mindful that this number fluctuates with reporting period as cash flows in and out of an organization. The information must be trended to see if there is a real issue or just a reporting period anomaly.

Accounts Receivable – This figure, commonly abbreviated as A/R, represents the money owed to the health center by its users for services already rendered. While it is important for health centers to capture all charges and aggressively bill patients for services, boards must institute a policy designed to clear out projected revenue from A/R that is not collectible and needs to be written off. "Allowance for bad debt" should be included in parentheses beside the A/R number that reflects this activity. If bad debts are not written off, A/R will be overstated and present a financial position that looks more favorable than it actually is. Conversely, if the bad debt write-offs escalate, boards should review their collection policies, direct the CEO to investigate patient fee collection issues and then report to the board regarding improvement measures.

Prepaid Expenses - This category represents amounts that have been set aside for payment to keep from incurring the entire expense in one reporting period.

◆ **Property and Equipment** – Also known as long-term or fixed assets since they are not expected to be converted into cash within the current year. The loss of value of an asset, known as depreciation, should also be reported to provide board members with a reasonable estimate of its current value.

◆ **Other Assets** – A category like "Available Grant Funds" should be included on the Balance Sheet to track use of grant funds. As mentioned previously, health centers have varying formats for reporting this information. Boards should check with the CEO to ensure that measures have been implemented to distribute grant funds over the entire year. CHCs must also guard against having a budget issue that results in unobligated funds – a situation that would require the health center to return grant dollars to HRSA/BPHC.

To review OPCA's entire *Board Bulletin* series, visit the 'CHC Boards' section of [www.okpca.org](http://www.okpca.org).

**Oklahoma Primary Care Association**  
**4300 N. Lincoln Blvd., Ste 203, OKC, OK 73105**  
**(405) 424-2282, Ext. 104 • Fax (405) 424-1111 • [www.okpca.org](http://www.okpca.org)**



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

## **Board Bulletin**

*Volume 6, Number 3 • March 2008*

### **Breaking Down the Balance Sheet: Part 2**

Because community health center (CHC) boards are held accountable for fiscal oversight, each member must enhance their understanding of financial statements by studying report components and how each one relates to health center operations. As discussed previously, the Balance Sheet offers a snapshot of the health center's financial position for a given period of time. The Balance Sheet formula is as follows:  $Assets = Liabilities + Equity$ . This issue will focus on the second part of the equation – liabilities and capital.

#### **Liabilities Language**

◆ **Current Liabilities** – This portion of the balance sheet reveals the CHC's short-term debt (less than a year) and how much will be needed to pay the bills. CHCs have varying reporting formats and required items will be listed by different titles. Some commonly entitled categories of Current Liabilities include:

- **Accounts Payable** – This grouping represents the payments due to suppliers, partners and employees. It is basically the cost of doing business that has not yet been paid. Board members will want to heed particular attention to types of expenses incurred to ensure appropriate spending and that grant funding is being used in accordance with federal regulations. It is also important to 'age' Accounts Payable to determine how many days the bill has been unpaid. If there are bills that have not been paid in a timely manner, boards should ask questions as this may be an indicator of financial distress. CHCs must be careful to pay bills responsibly so community trust is not compromised.

- **Accrued Expenses** – Accrue means to accumulate. Bills owed by the CHC that are accumulating on a set schedule but have not yet come due would fall into this category. Vacation payable is an example of an accrued expense. Annual leave is owed by the employer according to the CHC's policy but is not paid until the vacation is actually taken.

- **Payroll Deductions Payable** – Board members need to be watchful to ensure that all required taxes and withholding is paid in a compliant manner. Also included in this category would be retirement payable if the CHC offers retirement plans. Two areas that board members can be held individually liable are 1) failure to pay taxes and 2) inappropriate accounting of retirement funds. By documenting receipt of financial reports that reflect proper payment of taxes and retirement, board members demonstrate 'duty of care' was exercised.

- **Short-Term Notes Payable** – This includes amounts drawn from a financial institution line of credit that must be repaid within 12 months. If a portion of a long-term debt becomes due within the year, it will be counted as a current liability.

- **Unapplied Grant Funds** – Grant funds not yet drawn down are recorded as an asset reflecting dollars available for use. As grant dollars are expended, there should also be a liability entry that shows obligated grant funds. It most likely will never equal the asset amount because of expenses in accounts payable that have been charged to the grant but not yet paid. Again, the reporting format of unapplied grant funding varies. It is important to track grant draw downs to ensure that funds are available for use throughout the funding period. Also, be aware of the "order of dollars spent" that requires federal dollars be spent last. Proper budgeting of program income is necessary to prevent an 'unobligated balance' situation that may require return of federal funds.

#### **Equity**

The remaining component of the balance sheet equation is equity, also known as capital or fund balance. **Excess program income** - the desired effect of proper budgeting of program income and management of expenses that result in excess revenue over outlays – would be included in this category. If the board has an established policy requiring a designated reserve fund, that amount would be contained within the equity section.

In essence, the balance sheet shows how much a CHC has to pay for the things it owns (assets) by either borrowing money (liabilities) or using reserves (equity). To review OPCA's entire *Board Bulletin* series, visit the 'CHC Boards' section of [www.okpca.org](http://www.okpca.org).

**Oklahoma Primary Care Association**  
**4300 N. Lincoln Blvd., Ste 203, OKC, OK 73105**  
**(405) 424-2282, Ext. 104 • Fax (405) 424-1111 • [www.okpca.org](http://www.okpca.org)**



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

## **Board Bulletin**

*Volume 6, Number 4 • April 2008*

### **Analyzing the Statement of Activity**

This report is historically called the “Income Statement” or “Profit and Loss Statement.” It is also referred to as the “Statement of Operations.” Because it shows the income or revenue and expenses associated with providing services, the “bottom line” of the statement indicates how much the health center earned or lost during the reporting period. Community health center (CHC) board members should carefully review the Statement of Activity report to ensure that the health center is operationally sound with revenue greater than expenses.

#### **Trends & Relationships**

As a trending tool, the Statement of Activity will most likely have four columns that list *Current Month, Year-to-Date, Budget* and *Variance*. This allows boards to compare the actual activity to the operating budget and analyze the variance – either (over) or under. Because the budget reflects the mission and programmatic goals for the current year, this format allows boards to determine if the health center is meeting established goals in financial terms. Boards may use a second “Statement of Activity” format to compare current operations with the previous year, trending the current activity with what happened a year ago. The columns for that report would reflect *Current Year, Prior Year, Variance* and *% Change*. Effective review of the Statement of Activity requires board members to be educated on which variances are significant. An ‘under’ amount in income needs to be investigated while an (over) in expenses would indicate that more money is being spent than budgeted. Board members must feel free to ask questions and those reporting must be prepared to explain variances.

#### **Patient Visits**

Because productivity factors greatly on revenue and the health center’s bottom line, health centers should track “Visit” numbers on the Statement of Activity. Patient volume (i.e., visits) should be tracked by users (to determine patient utilization trends) and by providers (to identify provider productivity trends).

#### **Revenue**

330-funded health center revenue sources - the amount of money an organization brings in - would include, but not be limited to, the following:

**Grant Funding** – Because federal funding is typically a significant portion of the overall CHC budget, it will most likely be listed as a line item. By listing the amount of federal funding recognized as revenue for the month, boards can easily compare that to the overall budget to ensure reasonable ‘draw down’ of grant dollars.

**Patient Revenue** – Boards must compare changes in patient revenue to changes in patient volume (i.e., visits) by looking at ‘current activity to budget’ and ‘current year to prior year.’ Unusual trends, such as a change in reimbursement rates or shifts in payor mix, need to be analyzed further.

#### **Expenses**

CHCs cannot deliver health care without spending money. Boards, as health center stewards, must review expenses to ensure money is spent prudently and in accordance with the budget. Statement of Activity reports will include numerous expense line items which require monitoring, including the following:

**Salaries & Wages** and **Fringe Benefits** – As the largest expense categories for health centers, they deserve full board attention to ensure budget compliance. **Consultant and Professional Fees** must also be monitored.

**Supplies, Laboratory** and **Pharmaceuticals** - Three expense categories required for health care delivery. If notable spending increases occur, boards should ask questions and expect reasonable explanations.

**Travel and Conferences** – The CHC world requires numerous trainings and conferences. However, excessive expenses in this category should be researched further to ensure proper and effective use of health center funds.

**Bad Debt Provision** – If ‘bad debt’ increases significantly, this may be a sign of poor collection procedures.

In summary, monitoring variances from actual activity to budget and from current year to prior year is key to the bottom line. To review OPCA’s entire *Board Bulletin* series, visit the ‘CHC Boards’ section of [www.okpca.org](http://www.okpca.org).

**Oklahoma Primary Care Association**  
**4300 N. Lincoln Blvd., Ste 203, OKC, OK 73105**  
**(405) 424-2282, Ext. 104 • Fax (405) 424-1111 • [www.okpca.org](http://www.okpca.org)**



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

## **Board Bulletin**

*Volume 6, Number 5 • May 2008*

# **Financial Management Using Cash Flow and Key Ratios**

To exercise proper financial stewardship, community health center (CHC) board members must know if their health center has sufficient cash to meet both short-term and long-term obligations. While the Balance Sheet and the Statement of Activity are excellent financial reporting tools, they do not reflect the inflows and outflows of cash. CHC boards should also monitor key ratios to determine the health center's financial status. Cash flow statements and ratio reviews are important components of the board's monthly financial reporting package.

### **Cash Flow Statements**

A cash flow statement is necessary for boards to determine if enough cash is on hand to pay expenses and purchase assets. Cash flow statements, using information from both the Balance Sheet and Statement of Activity, reflect changes over time rather than the exact dollar amount for a point in time. Review of a cash flow statement will tell the board if the health center generated cash with the bottom line showing whether there was a net increase or decrease in cash. Cash flow statements compare current year balances with the previous year and are generally divided into three categories: 1) operating activities; 2) investing activities; and 3) financing activities. Under the operating activities section, the board will see the health center's cash flow from net income or losses. The net income as shown on the Statement of Activity will be reconciled to the actual cash received from health center operations by adjusting non-cash items and cash that was used or provided by other operating assets and liabilities. For example, depreciation expenses (a non-cash item) are added back to net income to reflect actual cash. Healthy organizations have a positive cash flow from operating activities. Investing activities, the second part of a cash flow statement, includes purchases or sales of long-term assets (e.g., property and equipment) and investment securities. If the health center invested in dental equipment, this will be reflected as a cash outflow from investing activities on the cash flow statement. Proceeds from sales of equipment or investments would be posted as a cash inflow in this category. The financing activities section of the cash flow statement includes cash borrowed (inflow) or cash used to make loan payments (outflow).

### **Key Ratios and Financial Indicators**

Specific ratios, designed to monitor and trend health center performance, plus other financial indicators are used by the Health Resources and Services Administration (HRSA) to determine health center viability and sustainability. Boards should establish a benchmark (from a prior reporting period) by which to compare the current period to make sure the health center is moving in a fiscally sound direction – and take corrective action before a CHC gets in trouble. Key ratios and financial indicators include, but are not limited to, the following:

**Current ratio** (current assets/current liabilities) – monitors health center liquidity and is looked at closely during performance reviews. Does the health center have the ability to pay obligations as they become due? Health centers should, at a minimum, strive for 1.5:1, always having more assets than liabilities.

**Days in Patient A/R** – This reflects the length of time the net patient revenues remain uncollected in net patient receivables. An increase in the number of days patient revenues are outstanding is an indicator that problems exist with collections. It could be failure to collect patient payments, incorrect filing of claims, or payor reimbursement issues. Whatever the reason, it must be resolved immediately for financial viability.

**Working Capital** (current assets – current liabilities) – Health centers should strive for working capital that ranges between 1 – 2 months of expenses. Is there working capital available to accomplish health center goals?

**Days Cash on Hand** - This number reflects how many days the health center could be operable (e.g., make payroll, pay bills, etc.). HRSA is paying close attention to this indicator as it reflects health center sustainability. If there is a decreasing trend in days of cash on hand, the board must find out why.

**Days in A/P** – indicates how long it is taking the health center to pay its bills. If there is an increase in the number of days it takes to meet obligations, the board needs to ask why there is a delay in paying bills. Is it because funds are not available or staff negligence? Health center credibility within the community is at stake.

To review OPCA's entire *Board Bulletin* series, visit the 'CHC Boards' section of [www.okpca.org](http://www.okpca.org).

**Oklahoma Primary Care Association**  
**4300 N. Lincoln Blvd., Ste 203, OKC, OK 73105**  
**(405) 424-2282, Ext. 104 • Fax (405) 424-1111 • [www.okpca.org](http://www.okpca.org)**



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

## **Board Bulletin**

*Volume 6, Number 6 • June 2008*

### **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. The minimal expectation for this measure is Change (or Ratio) > or = to 0. 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). Working Capital is, at a minimum, expected to be equal to if not greater than One Month of Expense. The ratio would be > or = 1.0. 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. The minimal expectation for this measure is that Long Term Debt is less than or equal to Half Net Assets – meaning the ratio should be < than or = to 0.5. 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](http://www.okpca.org).

**Oklahoma Primary Care Association**  
**4300 N. Lincoln Blvd., Ste 203, OKC, OK 73105**  
**(405) 424-2282, Ext. 104 • Fax (405) 424-1111 • [www.okpca.org](http://www.okpca.org)**



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

## **Board Bulletin**

*Volume 6, Number 6 (Revised\*) • June 2008*

### **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](http://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.

**Oklahoma Primary Care Association**  
**4300 N. Lincoln Blvd., Ste 203, OKC, OK 73105**  
**(405) 424-2282, Ext. 104 • Fax (405) 424-1111 • [www.okpca.org](http://www.okpca.org)**



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

## **Board Bulletin**

*Volume 6, Number 7 • July 2008*

### **Required Clinical Performance Measures**

The FY2009 Service Area Competition (SAC) guidance, released by HRSA/BPHC in February 2008, included revised performance requirements for clinical operations. Using baseline data, CHCs must develop benchmarks for the required measures, establish performance goals and track performance against these goals throughout the approved project period. Alignment of the SAC, the Budget Period Renewal (BPR) and the Uniform Data System (UDS) should help CHCs clarify performance improvement goals and design health services that improve patient outcomes. CHCs will also benefit as high quality health care delivered in a cost-effective manner results in viability and sustainability. As stewards of the CHC, board members must monitor progress, plan strategically, and protect Section 330 funding and associated benefits.

#### ***Clinical Performance Measures***

Health center clinical measures are divided into two focus areas: 1) Quality/Risk Management; and 2) Health Outcomes/Disparities. Six required performance measures (three in each focus area) were selected by BPHC because they provided a “balanced and comprehensive representation of health center services, clinically prevalent conditions amongst underserved communities, and the population across life cycles.” BPHC also felt that CHCs had extensive experience working with target populations to improve care in diabetes, hypertension, cancer prevention and childhood immunizations. Additionally, the measures are commonly used by Medicare and Medicaid plus other health care insurance/managed care organizations to assess quality and performance. The six required performance measures for which CHCs will be held accountable are as follows:

#### ***Quality/Risk Management Measures***

- ◆ **First Trimester Prenatal Care** – Percentage of pregnant women beginning prenatal care in the first trimester
- ◆ **Child Immunizations** – Percentage of two-year olds having appropriate immunizations (shots)
- ◆ **Pap Tests** – Percentage of women 21-65 years of age who received one or more Pap tests during the measurement year or during the two years prior to the measurement year

#### ***Health Outcomes/Disparities Measures***

- ◆ **Diabetes** – Percentage of diabetic patients whose HbA1c levels are less than or equal to 9 percent
- ◆ **Hypertension** – Percentage of adult patients 18 years or older with diagnosed hypertension whose most recent blood pressure was less than 140/90
- ◆ **Low Birthweight Rates** - Percentage of births less than 2,500 grams (about 5 pounds, 8 ounces)

#### ***Mandatory Measures***

There are two additional mandatory measures chosen by the grantee – one for **Oral Health** and one for **Behavioral Health**. CHC Health Plans must include all 8 performance measures that outline action steps for improving patient outcomes. If a CHC identifies specific needs for its target population (e.g., geriatric care), the grantee is encouraged to include additional measures as appropriate.

#### ***What Purpose Will The Measures Serve?***

As Health Center Program growth continues, public scrutiny also increases. Performance measures that demonstrate quality improvement will help document the overall value of the CHC program. As discussed, health centers will be able to track performance against established goals and make necessary adjustments to improve patient outcomes. HRSA/BPHC will monitor progress annually using health centers' BPR application. Because CHCs are expected to “sustain and/or increase users/encounters” as outlined in the SAC guidance, boards and senior management must carefully monitor the potential impact new patients will have on performance measures. Understanding your environment and target population (e.g., an influx of new patients with intense health issues) will be critical in tracking performance measures, documenting challenges, and making adjustments to meet established goals.

To review OPCA's entire *Board Bulletin* series, visit the 'CHC Boards' section of [www.okpca.org](http://www.okpca.org).

**Oklahoma Primary Care Association**  
**4300 N. Lincoln Blvd., Ste 203, OKC, OK 73105**  
**(405) 424-2282, Ext. 104 • Fax (405) 424-1111 • [www.okpca.org](http://www.okpca.org)**



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

## **Board Bulletin**

*Volume 6, Number 8 • August 2008*

### **Effective Tools for Monitoring Progress**

In February 2008, the Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care (BPHC) outlined required performance measures in the FY2009 Service Area Competition (SAC) guidance. With the new financial and clinical performance measures comes a heightened responsibility for the board to monitor progress and ensure performance goals are achieved. Never forget that the day-to-day operations are under the purview of the board's one employee - the chief executive officer. However, the board must monitor health center performance, and if necessary, intervene with corrective action to fulfill stewardship duties.

#### **Benchmarks**

Benchmarks are necessary to understand the health center's starting point, its current status and what it will take to reach future expectations. Senior management will review criteria and baseline data for each measure based upon the current patient population, identify benchmarks and establish reasonable improvement goals. Avoid the tendency to use benchmarks to justify current status but rather always strive for improvement. While the HRSA-required performance measures focus on internal improvement, health centers can use external data such as the Uniform Data System (UDS) reports to see how they compare to other health centers statewide and nationally. By using benchmarks, boards can trend information to gauge performance over a specified period of time to determine if health center operations are headed in the right direction. Health centers submitting SAC grants for FY 2009 and beyond are required to establish benchmarks as part of the application's Health Care Plan and Business Plan. Because the board chair signs grant applications on behalf of the entire board, it is imperative that each member understand their health center's benchmarks and associated improvement goals.

#### **Dashboards**

To fully exercise 'duty of care' and demonstrate prudent oversight, boards should review full financial reports monthly. However, drilling down to those measures that bear a closer review will be crucial for adequately monitoring performance progress. Just as a driver scans a vehicle dashboard to check operational status (e.g., fuel level, oil pressure, temperature, etc.), boards should develop their own dashboard that allows members to focus on select performance measures, quickly identify issues and take corrective action if necessary. Financial and clinical performance measures, with related goals, can easily be presented on a one-page 'dashboard' report. HRSA-required financial measures include 1) Total Cost per Patient; 2) Medical Cost per Medical Encounter; 3) Change in Net Assets to Expense Ratio; 4) Working Capital to Monthly Expense Ratio; and 5) Long Term Debt to Equity Ratio. The required clinical performance measures reflect rates for the following: 1) First Trimester Prenatal Care entry; 2) Child Immunizations; 3) Pap Tests; 4) Diabetes; 5) Hypertension; and 6) Low Birthweight plus two additional measures – one for Oral Health and one for Behavioral Health. (See June and July 2008 issues of *Board Bulletin* for performance measure explanations).

#### **Board-Specific Work Plans**

Another tool used by boards to build member accountability and ensure compliance is a short-range board-specific work plan (1 year) designed to support the longer-range organizational strategic plan (3-5 years). A board work plan ensures that all governance obligations are given proper attention so that the organization can be successful. The board should appoint a point person or committee to work in concert with the CEO to draft a plan that can be presented to the full board for approval. This can be done as part of the strategic planning retreat or through a free-standing session. If a health center's program year differs from the fiscal year, the board has to determine which year it will track. By having a work plan that is routinely monitored throughout the year, crises are minimized and the board's efficiency is maximized. A board work plan covers fiduciary responsibilities such as review of policies and procedures, budget approvals, grant submission approvals – items that need full board engagement to accomplish. The board work plan should be kept simple yet able to yield desired results. It can also be used as a tool to assist in the annual board evaluation. To review OPCA's entire *Board Bulletin* series, visit the 'CHC Boards' section of [www.okpca.org](http://www.okpca.org).

**Oklahoma Primary Care Association**  
**4300 N. Lincoln Blvd., Ste 203, OKC, OK 73105**  
**(405) 424-2282, Ext. 104 • Fax (405) 424-1111 • [www.okpca.org](http://www.okpca.org)**



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

## **Board Bulletin**

*Volume 6, Number 9 • September 2008*

### **The Importance of Internal Controls to CHC Health**

Often viewed as oppressive, rules are necessary to transform chaos into order and to guide human behavior towards positive results. Traffic signs lived by today are responses to adverse events of the past. While it is impossible to eliminate human error or misconduct altogether, rules are implemented to mitigate risks and prevent accidents. Internal controls include rules designed to: 1) improve operational effectiveness and efficiency; 2) ensure reliability of financial reporting; and 3) enforce compliance with laws and regulations. Internal control consists of five components working in tandem. The critical role internal controls have relative to a community health center's (CHC) organizational health justifies further review of each component.

#### **Control Environment**

Governing boards set the tone "from the top" by establishing policies that include standards of conduct for the organization. This only works if the governing board lives by those same rules and conducts business in an ethical manner. Using the discipline and structure of the control environment, management must foster a corporate culture that promotes professionalism and integrity. Individuals must recognize that all will be held accountable to uphold outlined standards – and that disciplinary action will be taken when necessary.

#### **Risk Assessment**

Setting performance goals for financial and operations management that support strategic planning are first steps in risk assessment. After goals are determined, an analysis that includes reviewing responsible party actions and identifying risks by transaction types must be conducted – examining both internal and external sources. High-risk transactions include travel expenditures, confidential information, payroll and equipment. There are: 1) quantitative costs – those associated with a specific dollar amount; and 2) qualitative costs – loss of public trust, future grants, etc. Both can be devastating. Through risk assessment, governing boards and management can prioritize risk management efforts, estimate potential impact, and effectively manage risks when they occur.

#### **Control Activities**

Supported by policies and procedures, control activities ensure management directives are fulfilled. *Preventive controls* include approvals, authorizations, and verifications that validate policy adherence; and segregation of duties separating responsibilities to reduce risks. Reconciliations of data sets (e.g., bank accounts) are *detective controls* as are performance reviews. Security of assets (e.g., equipment, inventories, and cash) involves restricting access (preventive) and comparing inventories to control records (detective). Information systems require: 1) general controls that cover data center operations, software acquisition and system maintenance; and 2) application controls such as edit checks to ensure processing accuracy.

#### **Information and Communication**

For people to be fully engaged in the internal control process, they must have information that is relevant in a useful form and timeframe. Information regarding the organization's plans, control environment, identified risks, control activities and performance must be communicated up, down and across the CHC spectrum.

#### **Monitoring**

By reviewing internal controls over a period of time using ongoing monitoring activities, self-assessments, peer reviews and internal audits, the system's performance can be assessed to determine if all five components are being properly executed to minimize risks. Serious internal control deficiencies should be reported to top management and the board so corrective action can be taken to prevent further damage and minimize impact. While it is impossible to eliminate all risks, boards exercising 'duty of care' will make every effort to curtail adverse events that hinder organizational health. When making policy, boards must incorporate internal controls that reduce risks and assist with the successful achievement of CHC goals. To review OPCA's entire *Board Bulletin* series, visit the 'CHC Boards' section of [www.okpca.org](http://www.okpca.org).

**Oklahoma Primary Care Association**  
**4300 N. Lincoln Blvd., Ste 203, OKC, OK 73105**  
**(405) 424-2282, Ext. 104 • Fax (405) 424-1111 • [www.okpca.org](http://www.okpca.org)**



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

## **Board Bulletin**

*Volume 6, Number 10 • October 2008*

### **A Closer Look at Control Activities**

Community health center (CHC) boards must closely examine the organization's control activities, particularly as an organization grows in size, budget, technology and services. Systems can also become stale and mechanical with procedures being 'rubber stamped' - causing a loss of focus on the desired goal of protecting CHC resources from human error or misconduct. Strong governing boards, working with the chief executive officer, will routinely examine and monitor implementation of the following areas of control activities.

#### **Segregation of Duties**

Always have at least 'two sets of eyes' review transactions, reports and reconciliations. No one person should ever initiate, approve, record, inventory, reconcile and report transactions. Proper segregation of duties is critical to minimize human error and detect erroneous activity. When it is difficult to completely segregate duties in small organizations, a detailed supervisory review of activities should be required. Duty segregation is critical to purchasing approvals, reconciliations, payment handling, and financial reporting.

#### **Approvals**

Written policies and procedures must be in place to specify approval authorization activities for transactions - those usually linked to specific dollar amounts or confidentiality issues. To ensure that the action is appropriate and compliant with laws, regulations and policies, careful review of transactions and supporting documentation must happen before authorized approval is given. Authorized approvers should never allow others to sign for them or share passwords associated with restricted transactions. Limits to authority must also be instituted.

#### **Reconciliations**

Reconciliation is the process of comparing different sets of data to identify and investigate differences followed by corrective action. Examples of reconciliations - comparing reports to actual amounts - include bank statements, financial and departmental accounting records, vacation and sick leave balances, and inventory listings. The reconciliation process is not complete until identified differences have been resolved.

#### **Reviews**

In the same way metal detectors are used for airport security, report reviews are designed to detect problems within an organization. Policy must require routine management review of reports such as budgets, health care plans, and performance benchmarks to ensure consistency and reasonableness of CHC activities. Boards must monitor financial and performance reports monthly to determine if goals and objectives are being met.

#### **Asset Security**

With this control activity, access to assets must be controlled. Assets include not only cash and equipment but also intellectual assets such as medical records that need to be protected against unauthorized use. Access controls include systems that incorporate locks, key pads, card keys, badges, computer passwords and remote access mechanisms. Certainly, security guards and locked file cabinets would fall into this category. Assets should be periodically counted and matched to an inventory to detect losses.

#### **Information Systems**

As CHCs embrace technology to improve operations, policies must be updated to protect the health center from harm caused by inappropriate or criminal use of data. If data is critical to the operation (e.g., billing systems, UDS reporting) or requires complete confidentiality (e.g., medical records), general controls must be in place to protect against vandalism, sabotage, network destruction, power surges or other environmental hazards. Application controls must address processing accuracy and use authorization.

No system is perfect and humans make mistakes. If no errors are ever detected, that may be indicative of internal controls failure. To review OPCA's entire *Board Bulletin* series, visit the 'CHC Boards' section of [www.okpca.org](http://www.okpca.org).

**Oklahoma Primary Care Association**  
**4300 N. Lincoln Blvd., Ste 203, OKC, OK 73105**  
**(405) 424-2282, Ext. 104 • Fax (405) 424-1111 • [www.okpca.org](http://www.okpca.org)**



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

## **Board Bulletin**

*Volume 6, Number 11 • November 2008*

### **New Look to Reach New Heights**

2008 marks the fifteenth anniversary for Oklahoma Primary Care Association (OKPCA). Celebration was the theme of this year's annual conference – honoring the past, appreciating today and embracing tomorrow. As author Pauline R. Kezer so aptly states, “Continuity gives us roots; change gives us branches, letting us stretch and grow and reach new heights.” The observant have already noticed a changed logo and the addition of ‘K’ in the association’s acronym. These two changes, accompanied by a revamped website by 2009 and ‘affordable’ added to the mission, were strategic moves to enable OKPCA to best accomplish the mission of strengthening access to *affordable* community-based health care for Oklahomans. While it is sometimes difficult to leave the comfortable, change is necessary to move forward and reach new heights. Another author’s quote worth review comes from Irene Peter “Just because everything is different doesn't mean anything has changed.” It is not enough to update the website or change the logo, mission and acronym. Change for the sake of change accomplishes little unless a sound strategic plan is developed in tandem that outlines a clear vision. Community health center (CHC) board members will be instrumental in making these changes result in forward movement.

#### ***OKPCA Strategic Plan: April 1, 2009 – March 31, 2012***

In June 2008, eleven Oklahoma CHC grantees participated in the two-day retreat that included an intensive SWOT (strengths, weaknesses, opportunities and threats) analysis. Technology, growth, resource development and education were identified as strategic priorities. Four goals with associated objectives were established:

- *Growth Strategies to Increase Membership and Visibility* – includes development of a statewide expansion plan, strengthening advocacy efforts and increasing local support of CHCs through statewide education
- *Strengthen Health Centers and Improve Performance* – includes enhancing OKPCA training and technical assistance offerings using online technology and updated guidance books, strengthening quality improvement activities to improve health outcomes and demonstrate CHC effectiveness, leveraging resources to build capacity and workforce development
- *Develop Shared Resources Program* – includes development of a “Health Educators” program for all CHCs, exploration of an ‘After Hours’ call service for all CHCs, and development of group purchasing programs that allow CHCs to share and lower costs
- *Build Networks to Support Systems of Care* – includes coordination of an OKPCA-driven Health Information Technology (HIT) program that promotes CHC interoperability and assessment of local health care systems to aid CHCs in network development that will increase access and address emergency preparedness

One of the objectives associated with growth and visibility is to increase advocacy contacts to 3,000. In the coming months, CHC board members will be asked to take a more active role in grassroots advocacy efforts. CHC success depends on having a strong, unified voice at the state and national level.

#### ***Access for All Oklahomans***

The National Association of Community Health Centers (NACHC) issued its *Access for All America* plan in February 2008 that includes CHCs reaching 30 million patients by 2015. NACHC challenged each PCA to follow suit with respective state-specific plans. *Access for All Oklahomans*, to be released in December 2008, reflects OKPCA strategic goals and will be used to leverage resources for CHCs to increase access and reduce health disparities. As board members, you will be asked to take the state access plan message to legislators, foundations, and other stakeholders to encourage investment into Oklahoma’s CHC program.

According to politician Harold Wilson, “He who rejects change is the architect of decay. The only human institution which rejects progress is the cemetery.” Help make these changes mean something to not only the health centers you govern but for all Oklahomans! To review OKPCA’s entire *Board Bulletin* series, visit the ‘CHC Boards’ section of [www.okpca.org](http://www.okpca.org).

**Oklahoma Primary Care Association**  
**4300 N. Lincoln Blvd., Ste 203, OKC, OK 73105**  
**(405) 424-2282, Ext. 104 • Fax (405) 424-1111 • [www.okpca.org](http://www.okpca.org)**



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

## **Board Bulletin**

*Volume 6, Number 12 • December 2008*

### **Calling All Leaders! Calling All Advocates!**

News reports have made it official – 2008 will end in a recession. For the past several months, Americans have witnessed a declining economy with corporate giants falling and unprecedented bailouts sought from Congress. What does all of this mean to community health centers (CHCs) as a new year begins? One thing is for certain, hard times call for exceptional leadership. Priorities must be clear and well-articulated. CHC board members, as organizational leaders, will be increasingly important in ensuring that Oklahoma health centers succeed in spite of economic woes. Board members, as consumers and civic leaders, are the most powerful advocates in taking the CHC message to both state and federal legislators.

#### **Top 4 Leadership Characteristics**

Authors Kouzes and Posner began research over twenty-five years ago to determine what characteristics are expected from leaders and report their findings in the acclaimed book, *The Leadership Challenge*, now in its 4<sup>th</sup> edition. Over 75,000 people from around the globe have completed the leadership traits questionnaire with top responses remaining constant over time. Kouzes and Posner report, “For people to follow someone willingly, the majority of constituents believe the leader must be honest, forward-looking, inspiring, and competent.”

- *Honest* – Also viewed as having impeccable character and integrity. Corporate debacles of the past decade (e.g., Enron, Tyco, etc.) painfully demonstrate what happens when dishonesty abounds. The need for honest leaders is paramount as the public demands increased transparency.
- *Forward-looking* – People want to follow someone who is going “somewhere.” Providing direction that will move the health center forward must be a board priority, requiring purposeful strategic planning.
- *Inspiring* – Leaders must ignite others to fulfill the mission with more than just talk. Enthusiasm and energy must be channeled into something real that motivates action and sustains efforts to achieve goals.
- *Competent* – There must be a level of confidence in the leaders’ ability before others are willing to follow. The board must also have the community’s trust and respect to be effective health center stewards.

#### **CHC Talking Points for 2009 and Beyond**

CHCs offer a great return on investment – particularly during economic difficulties. The following talking points must be woven into the CHC message board members take to legislators and local leaders.

- *Primary care* – CHCs focus on prevention and wellness; saving dollars and improving health outcomes.
- *‘Medical Home’ and ‘Health Care Home’* – Buzz words of the day. The truth is that CHCs have always provided patient-centered medical homes, offering an array of support services to enhance health care access.
- *Eliminating disparities* – One of the core CHC tenets is that they serve all people regardless of ability to pay, race/ethnicity, socio-economic status, gender, or age – improving health outcomes for all people.
- *Cost-effective* – According to 2007 Uniform Data System (UDS) reports, total annual cost per patient for medical services in Oklahoma CHCs was \$270 – much less than one visit to the emergency room.
- *Quality health care* – CHCs must adhere to clinical performance measures, embracing stringent quality assurance programs designed to improve patient outcomes and required for Federal Tort Claims Act coverage.
- *Economic engines* – In March 2008, the National Center for Rural Health Works at Oklahoma State University reported that Oklahoma CHCs, with indirect and induced spending included, had a total employment impact of 1,063 jobs and a total income impact of \$39,379,174 in the state of Oklahoma.
- *COMMUNITY health center* – Since inception as health centers of, by and for the people, CHCs have been governed by a patient-majority board that offers services to meet demonstrated community need.

As U.S. Senate Finance Committee Chairman Max Baucus (D-MT) so aptly stated, “...money will be spent on health care anyway. We simply have to choose whether to spend it to get healthier, more financially secure citizens, or whether to spend it on the status quo for the same ineffective results.”

To review OKPCA’s entire *Board Bulletin* series, visit the ‘CHC Boards’ section of [www.okpca.org](http://www.okpca.org).

**Oklahoma Primary Care Association**  
**4300 N. Lincoln Blvd., Ste 203, OKC, OK 73105**  
**(405) 424-2282, Ext. 104 • Fax (405) 424-1111 • [www.okpca.org](http://www.okpca.org)**