Iowa Primary Care Association
&
INConcertCare, Inc.

Membership Manual
July 2011

This manual is designed to provide information to association members and senior staff about the organizations' available resources and services.

Iowa PRIMARY CARE ASSOCIATION

INConcertCare
expanding our capacity to care

Table of Contents

Office Information 3

Iowa Primary Care Association (Iowa PCA)

Staff Guide 6
Overview 8
Membership Services and Benefits 9
Training & Technical Assistance 11
Member Email List Serves 14
Board of Directors & Committees 15
- Advocacy Committee Charter 17
- Clinical Committee Charter 20
- Finance Committee Charter 23
- Marketing Committee Charter 25
- Statewide Strategic Growth 27
- Workforce Committee Charter 29

Membership 32
2011-2013 Strategic Plan 37
Bylaws 44

INConcertCare, Inc. (INCC)

Staff Guide 51
Overview 52
Network Services 53
Board of Directors 54
Network Partners 55
Bylaws 58

Acronyms & Glossary of Terms and Concepts 64

Iowa PCA & INCC Office Information

9943 Hickman Road, Suite 103
Urbandale, Iowa 50322
Phone: (515)244-9610
Fax: (515)243-3566
Toll-free: 800-244-9612

E-mail: info@iowapca.org
Web address: www.iowapca.org
Office hours: Monday through Friday 8:00 a.m. – 5:00 p.m. (CDT)

Directions to Iowa PCA & INCC Office

9943 Hickman Road, Suite 103
Urbandale, Iowa 50322

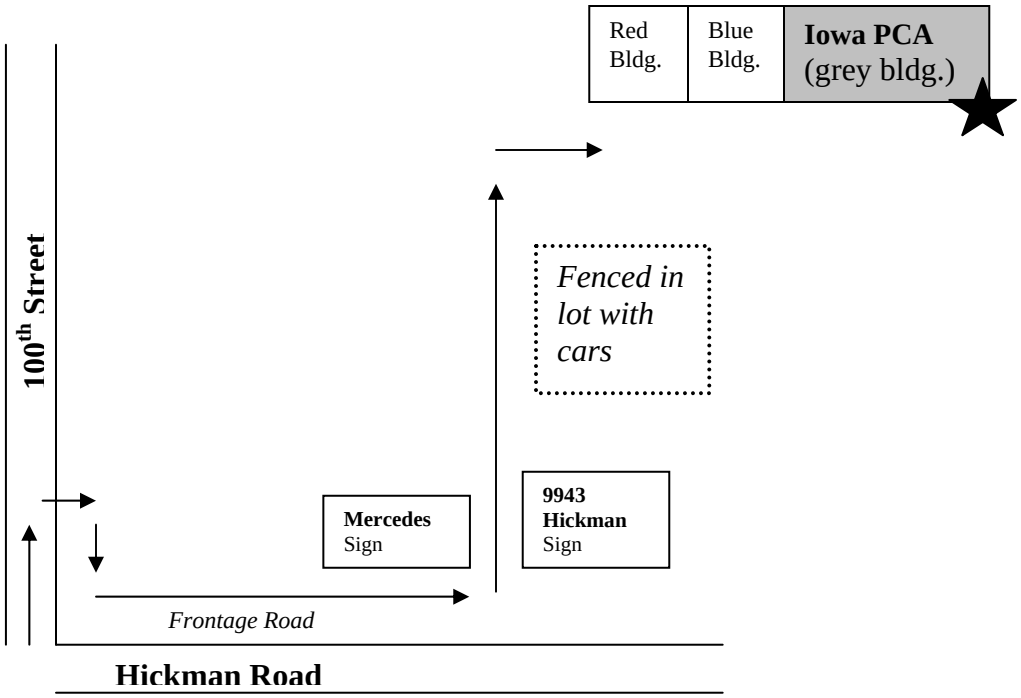
Traveling I-35 from North/South or I-80 from East/West

1. Continue on I-35/I-80 to the Hickman Road exit.
2. Turn east onto Hickman
   - From the **north** this will be a left-hand turn onto Hickman
   - From the **south** this will be a right-hand turn onto Hickman)
3. Travel on Hickman to 100th Street.
4. Turn left (north) onto 100th Street and take the first right onto the frontage road.
5. Take frontage road east and make a left turn (north) on the road between the signs for **Mercedes** and **9943 Hickman**.
6. Travel past the car lots. There will be a chain-link fence on your right – once you get past the fence, turn right.
7. The Iowa PCA & INCC Office is at the far end of the multi-colored (red, blue, grey) building. **The Iowa PCA & INCC office is grey.**

Traveling I-235 from East/West

1. Exit on 100th Street/Valley West Drive
2. Turn north onto 100th Street/Valley West Drive
   - From the **west** this will be a left-hand turn onto 100th/Valley West Drive.
   - From the **east** this will be a right-hand turn onto 100th/Valley West Drive.
3. Cross Hickman and take the first right onto the frontage road.
4. Take frontage road east and make a left turn (north) on the road between the signs for **Mercedes** and **9943 Hickman**.
5. Travel past the car lots. There will be a chain-link fence on your right – once you get past the fence, turn right.
6. The Iowa PCA & INCC Office is at the far end of the multi-colored (red, blue, grey) building. **The Iowa PCA and INCC office is grey.**

See next page for map.


Red Bldg.
Blue Bldg.
Iowa PCA (grey bldg.)
100th Street
Fenced in lot with cars
Mercedes Sign
9943 Hickman Sign
Frontage Road
Hickman Road

Staff Guide

The Iowa PCA staff provides services to federally-funded health centers, FQHC Look-alike, and additional safety net provider organizations.

Theodore J. Boesen, Jr., *Executive Director*
tboesen@iowapca.org
515-333-5010
515-778-7063 (cell)

Administration

Jennifer Conner-Mennenga, *Office Manager*
jconner@iowapca.org
515-333-5019

Health Center Development & Expansion/Communication/Advocacy & Policy

Tori Squires, *Senior Program Director*
tsquires@iowapca.org
515-333-5012

Katie Mahnke, *Communications Program Manager*
kmahnke@iowapca.org
515-333-5015

Amy Campbell and Craig Patterson, *Government Affairs*
Campbell-Patterson Consulting
1011 Locust Street, Suite 200, Des Moines, Iowa 50309
amy@campbell-patterson.com
515-554-5838

Quality & Performance Improvement

Deb Kazmerzak, *Senior Program Director*
dkazmerzak@iowapca.org
515-333-5013

Dawn Gentsch, MPH, CHES, *Network Performance Improvement Manager*
dgentsch@iowapca.org
515-333-5014

Pamela Lester, RN, BSN, *Clinical Program Manager*
plester@iowapca.org
515-333-5029

Nancy Adrianse, *Oral Health Manager*
adriansen@iowapca.org

Bery Engebretsen, MD, *Clinical Consultant*
bengebretsen@iowapca.org
515-244-9610

Linda Ruble, PA, NP, *Clinical Consultant*
2emma@mchsi.com
515-244-9610

The Recruitment Center & Workforce Development

Julie Blum, MAPA, *Workforce Development and Recruitment Director*
julieblum@aol.com
515-244-9610

Mary Klein, *Recruitment Manager*
mklein@iowapca.org
515-333-5011

Special Projects

Sarah Dixon Gale, MPA, *Lead Contract Manager*
sdixongale@iowapca.org
515-333-5016

Virginia Tonelli, *Program Manager*
vtonellir@iowapca.org
515-333-5025

Overview

The Iowa Primary Care Association (PCA) is a non-profit membership association comprised of health centers and other safety net providers in Iowa. Established in 1988, **Iowa PCA's mission is to promote, advocate, support and strengthen a quality system of health care while improving access primarily for the underserved in Iowa.** The Iowa PCA fulfills its mission by providing technical assistance and training to our members.

Our members provide comprehensive, one-stop primary health care. Members focus on prevention and chronic disease management designed to ensure effectiveness of medical care.

Iowa PCA works closely with Iowa Department of Public Health and Iowa Primary Care Office.

Support for Iowa PCA comes from its membership, the federal government and other grants and contracts.

Membership Services and Benefits

Iowa PCA offers its members opportunities to network and work cooperatively with other agencies and associations to develop strategies, polices and programs that lead to the efficient and effective delivery of primary health care to the underserved.

The association provides technical assistance and training to its members in several areas, including advocacy/policy, workforce, quality and performance improvement, health center development and expansion, and marketing and fundraising.

Iowa PCA also undertakes special projects with an emphasis on creating opportunities for growth and developing solutions to address its members' challenges.

Advocacy/Policy

- Grassroots advocacy network
- State and federal legislative efforts
- State and federal policy

Quality/Performance Improvement

- UDS and clinical content standardization
- Meaningful use
- IowaCare data requirements & implementation
- FTCA and HRSA quality requirements
- Operations, informational technical assistance
- Oral and behavioral health
- Pharmacy and 340B

Workforce

- Recruitment center
- Workforce development

Marketing & Fundraising

- Communications
- PCA marketing
- Health center marketing

Contracting

- Major contracts management
- Contract performance measures and outcomes

Health Center Development & Expansion

- Planning
- Site and services
- New Start support

Be Involved in Your Association!

- Make your organization part of the effort to gain access to needed primary care for Iowa's most vulnerable populations.
- Stay informed of the changing safety net health care environment through current information.
- Add strength to the community health and health center advocacy efforts.
- Receive needed resources and support to better serve your patient population and help your staff stay current in their field of endeavor.
- Network with other health care providers, federal and state policy makers, and agency personnel.

Training and Technical Assistance

Training and technical assistance are the core of the Iowa PCA mission. While the topic and content of these services vary widely, they can be grouped into the following foundational areas:

- Administrative (Human Resources, Finance, Board and Committees)
- Advocacy (local, state and national)
- Quality and performance improvement (Medical, Dental, Pharmacy, Behavioral Health, Meaningful Use, and Patient Centered Medical Home)
- Marketing and Fundraising
- Health Center Development and Expansion
- Recruitment/Workforce development

Training

Iowa PCA hosts an annual conference, which is typically attended by member health center executive, administrative, and clinical leadership as well as health center board members. Training is provided on a variety of topics targeted to needs identified throughout the year as determined by input from membership and staff.

Additional training is provided throughout the year through various means (e.g. conference call, webinar, onsite). The National Association of Community Health Centers (NACHC) and the HRSA Bureau of Primary Health Care periodically partner with Iowa PCA and the other state Primary Care Associations to provide training on topics of interest and new regulatory requirements as needed. Other training content is developed and provided based on member need/request.

Continuing education credits are made available for relevant disciplines.

Technical Assistance

The types and content of technical assistance (TA) is delivered in numerous ways and requires varying levels of effort by Iowa PCA staff. Types of TA, both formal to informal, include:

- development of tools for member use;
- convening conference calls on specific topics of interest;
- conducting background research on an issue or topic; and
- sharing sample forms collected by staff from various sources.

The following table provides examples of the types of technical assistance often provided to member health centers. ***This is not intended as an exhaustive list of technical assistance provided by Iowa PCA,*** but to illustrate the types of TA provided. We encourage you to contact Iowa PCA staff if you have questions regarding available TA.

Examples of Technical Assistance Provided by Iowa PCA

Foundational Area	TA Requested	TA Provided by Iowa PCA
Administrative	Sample policies and procedures for pre-employment screenings	Materials collected from various sources and request on Iowa PCA HR listserv
Administrative	Questions about annual cost report	Request for members to share practices or experiences on CFO listserv
Administrative	Establish clinical contract/program for tobacco cessation services	Serve as liaison between health center clinicians and leadership and state to design, negotiate and facilitate establishment of tobacco cessation program
Administrative	Questions regarding HRSA requirements on board composition	Conduct research and clarify HRSA requirements
Administrative	Information about accounting systems	Query finance staff on listserv, compile and send responses
Administrative	Networking, exchange of information	Staff and facilitate workgroup of finance staff at member health centers
Advocacy	Coordinate national advocacy strategy	Identify grassroots advocates and ensure ongoing communications
Quality and Performance Improvement	Contact with another lab manager for advice on setting up lab services	Facilitate networking/connection between experienced lab director and member working to establish lab services
Quality and Performance Improvement	Questions about state based program and impact on UDS clinical measures	Submit question to UDS helpline and share response with health centers impacted by the program
Quality and Performance Improvement	Assistance in establishing clinical programs, services, protocols for new start health center	Site visit with review of regulatory guidance and expectations, resources and networking sources available
Quality and Performance Improvement	Job descriptions for hygienist	Search resources available and post on Iowa PCA oral health listserv
Quality and Performance Improvement	Assistance with management of 340B drug program	Develop formulary template that considers therapeutic classes as well as 340B pricing
Quality and Performance Improvement	Orientation for clinic manager	Site visit to orient clinical leadership on expectations and resources
Marketing	Assistance communicating significant accomplishment of health center	Write press release for distribution to local media
Health Center Development and Expansion	Assistance with HRSA Expanded Services grant applications	Iowa PCA staff respond to questions about the grant guidance and review and provide comments on draft application

		prior to submission
Health Center Development and Expansion	Grant writing	Identify and provide contact information for possible grant writers with good success rates for FQHC applications
Health Center Development and Expansion	Assistance with local medical society expressing public opposition to new start	Contacts with local hospital, provider groups to educate, ascertain concerns and assist health center with strategy development
Health Center Development and Expansion	Local coalition building in community	Input on suggested organizations, facilitate meetings to establish partnerships
Recruiting and Workforce Development	Assistance with recruiting physician assistant	Post job opening on Iowa PCA, 3RNet, NACHC, college and university job boards
Recruiting and Workforce Development	Access to health science program graduates	Develop relationships with health science programs at colleges and universities to increase awareness of CHCs as a career choice
Recruiting and Workforce Development	Salary information	Conduct a semi-annual compensation and benefits survey of member health centers, compile, analyze and report results

Member Email List Serves

Iowa PCA has established several email list serves to facilitate communication among association members. If you would like to join a list, email Tori Squires at tsquires@iowapca.org.

List Serve Instructions

To send a message to the list serve, type the appropriate address below into the "To" section of your email message. Note that you must be a member of the list serve to send emails to the list.

CEOs: CEO@list.iowapca.org

CFOs: cfo@list.iowapca.org

Clinical: clinical@list.iowapca.org

Iowa Care: IowaCare@list.iowapca.org

Marketing: Marketing@list.iowapca.org

Medical Directors: Medical_Directors@list.iowapca.org

Oral Health: Oral_Health@list.iowapca.org

Pharmacy: Pharmacy@list.iowapca.org

Quality: Quality@list.iowapca.org

Workforce: Workforce@list.iowapca.org

2010-2012 Board of Directors

Iowa PCA is governed by a board of directors comprised of the Directing Members of the Association including the federally-funded health centers, State-funded health centers, and FQHC Look-alikes in Iowa.

Officers

Chair: Michelle Stephan – CEO, Siouxland Community Health Center, Sioux City
Vice-Chair: Kelly Huntsman – Executive Director, Primary Health Care, Inc., Des Moines
Secretary: Julie Woodyard – Executive Director, Crescent Community Health Center, Dubuque
Treasurer: Tom Bowman – CEO, Community Health Care, Davenport
Immediate Past Chair: Cecelia Creighton – Executive Director, Council Bluffs Community Health Center, Council Bluffs

Directing Members

- **Jennifer Genua-McDaniel** – Executive Director, Community Health Center of Fort Dodge, Fort Dodge
- **Ron Kemp** – CEO, Community Health Centers of Southeastern Iowa, Inc., West Burlington
- **Doug Jaeger** –CEO, Community Health Centers of Southern Iowa, Inc., Lamoni/Leon
- **Nancy Dykstra** –Executive Director, Greater Sioux Community Health Center, Sioux County
- **Tim Olson** – Interim CEO, Linn County Care, Cedar Rapids
- **Jennifer Lightbody –** Executive Director, Peoples Community Health Clinic, Waterloo
- **Jesus Soto** – Executive Director, Proteus Migrant Health Project, Des Moines
- **Rick Johnson** – Executive Director, River Hills Community Health Center, Inc., Ottumwa
- **Brad Meyer** – Executive Director, United Community Health Center, Storm Lake

Iowa PCA Committees

The purpose of the Iowa PCA board committees is to make board operations more efficient and comprehensive. All association members have the opportunity to participate on committees. Committees meet on a quarterly basis. Committees include a combination of standing and ad hoc groups required to operate and guide the business.

Ad hoc committees: Committees established by the membership on an as needed basis to consider topics critical to the membership, such as Nominating Committee and By-laws Committee.

Advocacy/Legislative Committee: Recommends content and execution of the association's legislative strategy.

Clinical Committee: Represents the clinical leadership of the membership in all matters related to direct patient care.

Executive Committee: Works with the executive staff to guide the operation of the business. The committee includes the Iowa PCA Officers.

Finance Committee: Represents the financial leadership of the membership in matters related to financial performance, monitoring, alternative sources of funds and associated matters.

Marketing Committee: Recommends content and execution of marketing and development activities of the Association.

Statewide Strategic Growth Committee: Monitor Association activities related to health center growth and development and advise the Association on growth strategies.

Workforce Development Committee: Recommends content and execution of work force development activities including training, recruitment and retention initiatives.

Advocacy Committee Charter

Purpose

To monitor and advocate for Iowa legislation and policies that further the objectives of Iowa PCA and the Community Health Center movement.

Scope of Duties

- Make recommendations on the content of Iowa PCA's legislative agenda
- Keep lines of communication open and exchange information with state agencies whose activities and policies impact health centers
- Communicate legislative activities to Iowa PCA and health centers and make recommendations for action as appropriate
- Work with Iowa PCA staff and contracted legislative consultants to prioritize where Iowa PCA and health centers want to focus advocacy efforts
- Educate legislature before and during deliberation and implementation of laws as to their impact on health centers and constituents
- Stay informed on state issues and trends to proactively address potential legislation that may impact health centers
- Support and guide grassroots advocacy work by educating health centers on issues, providing talking points to policymakers, and encouraging activities that positively influence legislation
- Stay informed on national issues and legislation, and communicate outcome and impact at the state, regional and local levels
- Advise Iowa PCA regarding state appropriations as necessary

Member Composition

The Advocacy/Legislative Committee is comprised of representatives from health centers belonging to Iowa PCA. All committee membership is voluntary, with emphasis on soliciting adequate geographic representation from health centers across Iowa. Committee members have experience and interest in policy development and advocacy concerning their health center.

The committee has one Committee Chair, as well as an Iowa PCA staff member who serves as committee liaison to the Iowa PCA Board. In addition, the Iowa PCA Executive Director provides direction, feedback, and approval to the committee as appropriate to ensure alignment with Iowa PCA objectives, and facilitates open communication between the committee and the Iowa PCA Board of Directors.

The Iowa PCA Board Chair appoints an individual to serve as the Committee Chair. Terms for the Committee Chair will be one year. Chairs may serve more than one term. Committee composition will be reviewed annually to ensure appropriate representation of the membership.

Member Roles & Responsibilities

<u>All Members</u>

All committee members are responsible for:

- Regularly attending committee meetings
- Being familiar with the committee's purpose, history, current agenda, past meeting minutes, and other committee members
- Having awareness of the legislative landscape at national, state and local levels
- Actively contributing to discussions and decision-making
- Having the authority to both provide input and make recommendations for decisions on behalf of their organization
- Cultivating and maintaining relationships with legislative representatives (state/national) in the interest of the health centers
- Taking action between meetings as needed to make progress on committee issues and projects

Committee Chair

In addition to "All Member" responsibilities, the Committee Chair:

- Schedules and initiates meetings throughout the year
- Monitors legislative initiatives and recommends relevant committee action
- Gives final approval on meeting agenda
- Runs meetings between legislative sessions
- Aids legislative consultant in running meetings during legislative session
- Supports Executive Director in communicating committee activities and recommendations to the Iowa PCA Board

PCA Staff Liaison

In addition to "All Member" responsibilities, the PCA Staff Liaison:

- Keeps committee chair updated on significant needs, updates, and activities related to legislation and advocacy
- Writes and distributes meeting minutes to all members
- Works with the committee chair to establish meeting agendas
- Manages meeting logistics – meeting reminders, call-in information, etc.
- Helps facilitate meetings with the Committee Chair as needed
- Prepares meeting summaries and takes care of any follow up items
- Recruits committee members
- Supports Executive Director in communicating committee activities and recommendations to the Iowa PCA Board

Meetings and Communication

The committee members meet at least quarterly via conference call or in person. During these meetings, members discuss updates, progress and issues; and make decisions and/or recommendations to Iowa PCA relevant to the committee's scope of duties.

Committee members provide potential items to the Committee Chair or PCA Staff Liaison prior to upcoming meeting. The PCA staff liaison prepares and distributes agenda to all committee members before the upcoming meeting. The PCA staff liaison writes the meeting minutes and sends them to all members after the meeting.

In addition, committee members will communicate with one another and with Iowa PCA staff between meetings as needed to make progress on committee issues and projects. Also, the legislative consultant keeps committee members apprised on relevant activities via email between meetings.

Reporting/Accountability

The Committee reports directly to the Iowa PCA Board on all matters. The PCA Staff Liaison sends meeting summaries to the Iowa PCA Executive Director on a quarterly basis. The Committee Chair, with the support of the Iowa PCA Staff Liaison, reports to the Iowa PCA Board of Directors on the committee's activity. The Committee Chair and/or Staff Liaison may also raise issues of concern that need immediate attention to the PCA Executive Director, who will assist in determining the most appropriate course of action.

Charter Review

The Committee reviews its charter annually and makes updates and revisions as necessary.

Clinical Committee Charter

Purpose of the Committee

To advise the Iowa PCA Board on issues affecting clinical operations and quality, and engage in initiatives that improve patient health outcomes across all member health centers.

Scope of Duties

- **Annual planning**. Meet annually to identify, prioritize, and plan clinical issues and initiatives for the committee to address in the coming year. Examples include focus on specific UDS measures; educational needs; emergency preparedness activities; patient-centered medical home programs; network-wide funding opportunities; joint commission standards implementation; and other member-wide quality improvement efforts.
- **Clinical Data**. Review, evaluate, share best practices and make recommendations on defining and standardizing clinical data collection, analysis and reporting to drive clinical quality improvement across all health centers in Iowa PCA network.
- **Health improvement initiatives**. Identify and evaluate opportunities for health centers to collaborate on health improvement initiatives and grants. Help share processes and practices developed through specific grants and programs with all members.
- **Emerging clinical issues**. Provide ongoing clinical input and guidance to the Iowa PCA board on important clinical issues emerging from health centers. Make recommendations to the board on how best to support members in addressing these issues.

Member Composition

The Clinical Committee is comprised of representatives from health centers belonging to Iowa PCA. All committee membership is voluntary, with emphasis on soliciting representation from health centers. Committee members have working knowledge of and/or responsibility for clinical process and flow at their health center. Examples of members include medical directors, clinical directors, quality directors, and clinicians.

The Clinical Committee also includes one Committee Chair and an Iowa PCA staff member who serves as committee liaison to the Iowa PCA Board. In addition, the Iowa PCA Executive Director provides direction, feedback, and approval to the committee as appropriate to ensure alignment with Iowa PCA objectives, and facilitates open communication between the committee and the Iowa PCA Board of Directors.

The clinical representative on the Iowa PCA Board of Directors serves as the Committee Chair and the Iowa PCA Board of Directors votes on the nomination. Terms for the Committee Chair will be two years. Chairs may serve more than one term. Committee composition will be reviewed annually to ensure appropriate representation of the membership.

Member Roles & Responsibilities

<u>All Members</u>

All committee members are responsible for:

- Regularly attending committee meetings
- Being familiar with the committee's purpose, history, current agenda, past meeting minutes, and other committee members
- Actively contributing to discussions and decision-making processes

- Having the authority to both provide input and make recommendations for decisions on behalf of their organization
- Taking action between meetings as needed to make progress on committee issues and projects

Committee Chair

In addition to "All Member" responsibilities, the Committee Chair:

- Solicits agenda topic ideas from committee members for upcoming meetings (shared responsibility with PCA Staff Liaison)
- Gives final approval on committee meeting agendas
- Facilitates committee meetings and keeps proceedings on agenda
- Approves committee meeting minutes before distribution
- Reports to the committee on Iowa PCA Board decisions that affect the committee's work
- Where appropriate, guides the committee in proposing new activities and service that further the mission and goals of the committee and Iowa PCA
- Where appropriate, proposes policy recommendations to the Iowa PCA Board
- Supports Executive Director in communicating committee activities and recommendations to the Iowa PCA Board

PCA Staff Liaison

In addition to "All Member" responsibilities, the PCA Staff Liaison:

- Recruits committee members and manages meeting logistics
- Solicits agenda topic ideas from committee members for upcoming meetings (shared responsibility with PCA Staff Liaison)
- Works with the Committee chair to establish agendas and facilitate meetings
- Writes and distributes meeting minutes and handles any follow up items
- Keeps Chair updated on significant needs, updates, and clinical staff activity
- With input from the clinical committee, works with Iowa PCA staff to share clinical-related resources, training, and technical assistance to health centers
- Supports Executive Director in communicating committee activities and recommendations to the Iowa PCA Board

Meetings and Communication

Committee members meet at least quarterly via conference call or in person, and annually face-to-face in conjunction with the Iowa PCA Board meeting. During these meetings, members discuss updates, progress and issues; and make decisions and/or recommendations to Iowa PCA relevant to the committee's scope of duties.

To address issues or initiatives pertaining to a specific state or group of health centers, select members of committee may meet as subcommittees outside of regularly scheduled clinical committee meetings.

Committee members provide potential items to the Committee Chair or PCA Staff Liaison prior to an upcoming meeting. The PCA Staff liaison prepares and distributes agenda to all committee members before the upcoming meeting. After the meeting, the PCA Staff Liaison prepares and distributes minutes to all members.

In addition, committee members will communicate with one another and with Iowa PCA staff between meetings as needed to make progress on committee issues and projects.

Reporting/Accountability

The Committee reports directly to the Iowa PCA Board on all matters. The PCA Staff Liaison sends meeting summaries to the Iowa PCA Executive Director on a quarterly basis. The Committee Chair, with the support of the Iowa PCA Staff Liaison, reports to the Iowa PCA Board of Directors on the committee's activity. The Committee Chair and/or Staff Liaison may also raise issues of concern that need immediate attention to the PCA Executive Director, who will assist in determining the most appropriate course of action.

Charter Review

The Clinical Committee reviews its charter annually and makes updates and revisions as necessary.

Finance Committee Charter

Purpose

To plan, monitor, and report on the financial operations of Iowa PCA and INConcertCare to effectively support their members.

Scope of Duties

- Assist in developing the annual budget for Iowa PCA and INConcertCare for Board approval prior to the beginning of the fiscal year
- Review association finances and create appropriate financial reports to the Iowa PCA Board at least quarterly during the fiscal year
- Determine and make recommendations to the Board on policy related to internal controls and approval authority
- Review and provide guidance on unbudgeted association expenses
- Provide for and oversee annual audit of the organizations
- Review funding sources and recommend funding guidelines
- Recommend appropriate level of membership dues
- Engage in long-range fiscal planning

Member Composition

The Finance Committee is comprised of representatives from health centers belonging to Iowa PCA and INConcertCare. All committee membership is voluntary, with emphasis on soliciting balanced member representation. Committee members are expected to have experience and interest in financial issues concerning both Iowa PCA and INConcertCare.

The committee comprises the Committee Chair, three to five committee members, the PCA Staff Liaison, and the Iowa PCA Executive Director as ex-officio member. The Executive Director provides direction, feedback, and approval to the committee as appropriate to ensure alignment with Iowa PCA objectives, and facilitates open communication between the committee and the Iowa PCA Board of Directors.

The Iowa PCA Board Chair appoints an individual to serve as the Committee Chair. Terms for the Committee Chair will be one year. Chairs may serve more than one term. Committee composition will be reviewed annually to ensure appropriate representation of the membership.

Member Roles & Responsibilities

<u>All Members</u>

All committee members are responsible for:

- Regularly attending committee meetings
- Being familiar with the committee's purpose, history, current agenda, past meeting minutes, and other committee members
- Actively contributing to discussions and making recommendations with respect to Association finances
- Making recommendations to recruit other committee members (with support from Iowa PCA staff and Executive Director)

- Taking action between meetings as needed to make progress on committee issues and projects

Committee Chair

In addition to "All Member" responsibilities, the Committee Chair:

- Provides input on meeting agendas as appropriate
- Brings meeting to order, ensures a quorum, and conducts meetings, with support from Executive Director and PCA Staff Liaison
- Facilitates motions on specific committee actions
- With the Iowa PCA Executive Director, co-sign checks in excess of $10,000
- Supports Executive Director in communicating committee activities and recommendations to the Iowa PCA Board

PCA Staff Liaison

In addition to "All Member" responsibilities, the PCA Staff Liaison:

- Manages meeting logistics—meeting reminders, call-in information, etc.
- Works with Executive Director and Committee Chair to set meeting agendas
- Prepares meeting minutes, distributes to all members, and handles any follow-up items
- Helps facilitate committee meetings as needed
- Supports Executive Director in communicating committee activities and recommendations to the Iowa PCA Board

Meetings and Communication

The committee meets at least quarterly via conference call or in person. During these meetings, members discuss updates, progress and issues; and make decisions and/or recommendations to Iowa PCA relevant to the committee's scope of duties.

Committee members may provide potential agenda items to the Committee Chair, Executive Director or PCA Staff Liaison prior to an upcoming meeting. The PCA Staff Liaison prepares and distributes agenda to all committee members before the upcoming meeting. The PCA Staff Liaison writes the meeting minutes and sends them to all committee members after the meeting.

In addition, committee members will communicate with one another and with Iowa PCA staff between meetings as needed to make progress on committee issues and projects.

Reporting/Accountability

The Committee reports directly to the Iowa PCA Board on all matters. The PCA Staff Liaison sends meeting summaries to the Iowa PCA Executive Director on a quarterly basis. The Committee Chair, with the support of the Iowa PCA Staff Liaison, reports to the Iowa PCA Board of Directors on the committee's activity. The Committee Chair and/or Staff Liaison may also raise issues of concern that need immediate attention to the PCA Executive Director, who will assist in determining the most appropriate course of action.

Charter Review

The Committee reviews its charter annually and makes updates and revisions as necessary.

Marketing Committee Charter

Purpose
To advise on Iowa PCA initiatives and execute projects in support of the member health centers' marketing, development, and communications efforts.

Scope of Duties

- Advise and support Iowa PCA staff in development of communications tools to assist health centers in their marketing efforts.
- Gather and analyze input from member health centers on marketing assistance needs. Make recommendations to Iowa PCA board on strategies to meet those needs.
- Gather and analyze input from member health centers on development assistance needs. Make recommendations to Iowa PCA board on strategies to meet those needs.

Member Composition

The Marketing Committee is comprised of representatives of member health centers belonging to Iowa PCA. All committee membership is voluntary. Committee members have experience and interest in marketing, development, and communications.

The committee has one Committee Chair, as well as an Iowa PCA staff member who serves as committee liaison to the Iowa PCA Board. In addition, the Iowa PCA Executive Director provides direction, feedback, and approval to the committee as appropriate to ensure alignment with Iowa PCA objectives, and facilitates open communication between the committee and the Iowa PCA Board of Directors.

The Iowa PCA Board Chair appoints an individual to serve as the Committee Chair. Terms for the Committee Chair will be one year. Chairs may serve more than one term. Committee composition will be reviewed annually to ensure appropriate representation of the membership.

Member Roles & Responsibilities

<u>All Members</u>
All committee members are responsible for:

- Regularly attending committee meetings
- Being familiar with the committee's purpose, history, current agenda, past meeting minutes, and other committee members
- Actively contributing to discussions and decision-making
- Having the authority to both provide input and make recommendations for decisions on behalf of their organization
- Taking action between meetings as needed to make progress on committee issues and projects

<u>Committee Chair</u>
In addition to "All Member" responsibilities, the Committee Chair:

- Schedules and initiates meetings throughout the year
- Gives final approval on meeting agenda
- Supports Executive Director in communicating committee activities and recommendations to the Iowa PCA Board

PCA Staff Liaison

In addition to "All Member" responsibilities, the PCA Staff Liaison:

- Keeps committee chair updated on significant needs, updates, and activities related to marketing, development, and communications
- Writes and distributes meeting minutes to all members
- Works with the committee chair to establish meeting agendas
- Manages meeting logistics – meeting reminders, call-in information, etc.
- Helps facilitate meetings with the Committee Chair as needed
- Prepares meeting summaries and takes care of any follow up items
- Recruits committee members
- Supports Executive Director in communicating committee activities and recommendations to the Iowa PCA Board

Meetings and Communication

The committee members meet at least quarterly via conference call or in person. During these meetings members discuss updates, progress and issues, and make decisions and/or recommendations to Iowa PCA relevant to the committee's scope of duties.

Committee members provide potential items to the Committee Chair or PCA Staff Liaison prior to upcoming meeting. The PCA staff liaison prepares and distributes agenda to all committee members before the upcoming meeting. The PCA staff liaison writes the meeting minutes and sends them to all members after the meeting.

In addition, committee members will communicate with one another and with Iowa PCA staff between meetings as needed to make progress on committee issues and projects.

Reporting/Accountability

The committee reports directly to the Iowa PCA Board on all matters. The PCA Staff Liaison sends meeting summaries to the Iowa PCA Executive Director on a quarterly basis. The Committee Chair, with the support of the Iowa PCA Staff Liaison, reports to the Iowa PCA Board of Directors on the committee's activity. The Committee Chair and/or Staff Liaison may also raise issues of concern that need immediate attention to the PCA Executive Director, who will assist in determining the most appropriate course of action.

Charter Review

The Committee reviews its charter annually and makes updates and revisions as necessary.

Statewide Strategic Growth Committee Charter

Purpose
To advise on Iowa PCA initiatives and execute projects in support of the member health centers' growth and expansion efforts.

Scope of Duties

- Provide oversight and direction to Iowa PCA staff on updating the annual Statewide Strategic Growth Plan.
- Recommends to the Iowa PCA Board policies on expansion and growth strategies.
- Makes recommendations to Iowa PCA Board regarding issues of potential service area overlap.

Member Composition

The Strategic Growth Committee is comprised of representatives of member health centers belonging to Iowa PCA. All committee membership is voluntary. Committee members have experience and interest in expansion and growth of health centers in Iowa.

The committee has one Committee Chair, as well as an Iowa PCA staff member who serves as committee liaison to the Iowa PCA Board. In addition, the Iowa PCA Executive Director provides direction, feedback, and approval to the committee as appropriate to ensure alignment with Iowa PCA objectives, and facilitates open communication between the committee and the Iowa PCA Board of Directors.

The Iowa PCA Board Chair appoints an individual to serve as the Committee Chair. Terms for the Committee Chair will be one year. Chairs may serve more than one term. Committee composition will be reviewed annually to ensure appropriate representation of the membership.

Member Roles & Responsibilities

<u>All Members</u>

All committee members are responsible for:

- Regularly attending committee meetings
- Being familiar with the committee's purpose, history, current agenda, past meeting minutes, and other committee members
- Actively contributing to discussions and decision-making
- Having the authority to both provide input and make recommendations for decisions on behalf of their organization
- Taking action between meetings as needed to make progress on committee issues and projects

<u>Committee Chair</u>

In addition to "All Member" responsibilities, the Committee Chair:

- Schedules and initiates meetings throughout the year
- Gives final approval on meeting agenda
- Supports Executive Director in communicating committee activities and recommendations to the Iowa PCA Board

PCA Staff Liaison

In addition to "All Member" responsibilities, the PCA Staff Liaison:

- Keeps committee chair updated on significant needs, updates, and activities related to strategic growth and expansion
- Writes and distributes meeting minutes to all members
- Works with the committee chair to establish meeting agendas
- Manages meeting logistics – meeting reminders, call-in information, etc.
- Helps facilitate meetings with the Committee Chair as needed
- Prepares meeting summaries and takes care of any follow up items
- Recruits committee members
- Supports Executive Director in communicating committee activities and recommendations to the Iowa PCA Board

Meetings and Communication

The committee members meet at least quarterly via conference call or in person. During these meetings members discuss updates, progress and issues, and make decisions and/or recommendations to Iowa PCA relevant to the committee's scope of duties.

Committee members provide potential items to the Committee Chair or PCA Staff Liaison prior to upcoming meeting. The PCA staff liaison prepares and distributes agenda to all committee members before the upcoming meeting. The PCA staff liaison writes the meeting minutes and sends them to all members after the meeting.

In addition, committee members will communicate with one another and with Iowa PCA staff between meetings as needed to make progress on committee issues and projects.

Reporting/Accountability

The Committee reports directly to the Iowa PCA Board on all matters. The PCA Staff Liaison sends meeting summaries to the Iowa PCA Executive Director on a quarterly basis. The Committee Chair, with the support of the Iowa PCA Staff Liaison, reports to the Iowa PCA Board of Directors on the committee's activity. The Committee Chair and/or Staff Liaison may also raise issues of concern that need immediate attention to the PCA Executive Director, who will assist in determining the most appropriate course of action.

Charter Review

The Committee reviews its charter annually and makes updates and revisions as necessary.

Workforce Committee Charter

Purpose of the Committee

To advise on Iowa PCA workforce development initiatives and execute projects in support of the development and expansion of a strong workforce at member health centers.

Scope of Duties

- *Annual PCA conference*. Support Iowa PCA in planning the PCA annual conference. Advises the association on content and logistics.
- *Compensation and benefits*. Review, revise and make recommendations on surveys and reporting of health center compensation and benefits packages at least every other year.
- *Provider recruitment*. Provide oversight and direction to the Recruitment Center staff as they assist health centers recruit and retain healthcare professionals.
- *Resource Training Center* Support health center staff in ongoing professional development, including management competency assessment and training. Offer formal in-person and on-line training and technical assistance at least once a quarter to new health center management staff joining the Association.
- *Human resources.* Provide information and guidance to health centers on human resources issues including policies, regulations, job descriptions, performance evaluations, and contacts.

Member Composition

The Workforce Development Committee is comprised of representatives from health centers belonging to Iowa PCA. All committee membership is voluntary, with emphasis on soliciting representation from health centers in both Iowa and Nebraska. Committee members have working knowledge of and/or responsibility for workforce development activities at their health center. Examples of members include executive directors and human resources directors.

The committee also includes one Committee Chair and an Iowa PCA staff member who serves as committee liaison to the Iowa PCA Board. In addition, the Iowa PCA Executive Director provides direction, feedback, and approval to the committee as appropriate to ensure alignment with Iowa PCA objectives, and facilitates open communication between the committee and the Iowa PCA Board of Directors.

The Iowa PCA Board Chair appoints an individual to serve as the Committee Chair. Terms for the Committee Chair will be one year. Chairs may serve more than one term. Committee composition will be reviewed annually to ensure appropriate representation of the membership.

Member Roles & Responsibilities

<u>All Members</u>

All committee members are responsible for:

- Regularly attending committee meetings
- Being familiar with the committee's purpose, history, current agenda, past meeting summaries, and other committee members

- Actively contributing to discussions and decision-making processes
- Having the authority to both provide input and make recommendations for decisions on behalf of their organization
- Taking action between meetings as needed to make progress on committee issues and projects

Committee Chair

In addition to "All Member" responsibilities, the Committee Chair:

- Solicits agenda topic ideas from committee members for upcoming meetings (shared responsibility with PCA Staff Liaison)
- Gives final approval on committee meeting agendas
- Facilitates committee meetings and keeps proceedings on agenda
- Approves committee meeting summary before distribution
- Where appropriate, guides the committee in proposing and executing new activities that further the workforce development goals of Iowa PCA
- Supports Executive Director in communicating committee activities and recommendations to the Iowa PCA Board

PCA Staff Liaison

In addition to "All Member" responsibilities, the PCA Staff Liaison:

- Manages all meeting logistics
- Prepares and sends materials for committee members to review prior to the meeting
- Solicits agenda topic ideas from committee members for upcoming meetings (shared responsibility with Committee Chair)
- Works with the Committee Chair to establish agendas and facilitate meetings
- Writes and distributes meeting summary and handles any follow up items
- Keeps Committee Chair updated on significant workforce activities and needs
- Supports Executive Director in communicating committee activities and recommendations to the Iowa PCA Board

Meetings and Communication

Committee members meet at least quarterly, face-to-face or by teleconference as appropriate. During these meetings, members discuss updates, progress and issues; and make decisions and/or recommendations to Iowa PCA relevant to the committee's scope of duties.

Committee members provide potential items to the Committee Chair or PCA Staff Liaison prior to an upcoming meeting. The PCA Staff liaison prepares and distributes the agenda to all committee members before the meeting. After the meeting, the PCA Staff Liaison prepares and distributes the meeting summary to all members.

In addition, committee members will communicate with one another and with Iowa PCA staff between meetings as needed to make progress on committee issues and projects.

Reporting/Accountability

The Committee reports directly to the Iowa PCA Board on all matters. The PCA Staff Liaison sends meeting summaries to the Iowa PCA Executive Director on a quarterly basis. The Committee Chair, with the support of the Iowa PCA Staff Liaison, reports to the Iowa PCA Board of Directors on the committee's activity. The Committee Chair and/or Staff Liaison may also raise issues of concern that need immediate attention to the PCA Executive Director, who will assist in determining the most appropriate course of action.

Charter Review

The Workforce Development Committee reviews its charter annually and makes updates and revisions as necessary.

Membership

Below are the Iowa PCA Directing Members, which include federally-funded community health centers located in the states of Iowa or Nebraska, State-funded community health centers, and FQHC Look-alikes.

Directing Members

Federally-funded community health centers located in the state of Iowa, State-funded community health centers, and FQHC Look-alikes. Directing members have voting privileges.

Community Health Care, Inc.

500 West River Drive
Davenport, Iowa 52801
Medical Clinic Phone: (563)336-3000
Dental Clinic Phone: (563)336-3230
Fax: (563)336-3044
www.davchc.com

Clinics located in:

- Davenport, Iowa
- Moline, Illinois
- Rock Island, Illinois

Community Health Center of Fort Dodge

126 N 10th Street
Fort Dodge, Iowa 50501
Medical Clinic Phone: (515)576-6500
Dental Clinic Phone: (515)571-8667
Fax: (515)576-1951
www.chcfd.com

Community Health Centers of Southeastern Iowa, Inc.

1706 West Agency Road
West Burlington, Iowa 52655
Medical Clinic Phone: (319)768-5858
Dental Clinic Phone: (319)752-5540
Fax: (319)753-2301
www.chcseia.com

Clinics located in:

- West Burlington, Iowa
- Keokuk, Iowa
- Columbus City, Iowa
- Hamilton, Illinois
- Warsaw, Illinois

Community Health Centers of Southern Iowa, Inc.

302 NE 14th Street
Leon, Iowa 50144
Phone: (641)446-2383
Fax: (641)446-2382
www.chcsi.org

Clinics located in:

- Leon, Iowa
- Lamoni, Iowa

Council Bluffs Community Health Center, Inc.

Omni Centre Business Park
300 West Broadway, Suite 6
Council Bluffs, Iowa 51503
Medical Clinic Phone: (712)325-1990
Dental Clinic Phone: (712)256-9151
Fax: (712)325-0288
www.cbchc.com

Crescent Community Health Center

1789 Elm Street, Suite A
Dubuque, Iowa 52001
Phone: (563)690-2850
Fax: (563)557-8488
www.crescentchc.org

Greater Sioux Community Health Center

3381 1st Avenue, NW
Sioux Center, Iowa 51250
Phone: (712) 722-1700
Fax: (712)722-1770
www.greatersiouxchc.org

Linn Community Care

Linn Community Care
1201 3rd Avenue, SE
P.O. Box 2205
Cedar Rapids, IA 52403
Phone: (319)730-7300
Fax: (319)730-7368
www.linncommunitycare.org

Peoples Community Health Clinic, Inc.

905 Franklin Street
Waterloo, Iowa 50703-4407
Phone: (319)272-4300
Fax: (319)272-4321
www.peoples-clinic.com

Clinics located in:

- Waterloo, Iowa
- Clarksville, Iowa

Primary Health Care, Inc.

Administrative Office
9943 Hickman Road, Suite 105
Urbandale, Iowa 50322
Phone: (515)248-1447
Fax: (515)248-1440
www.phcinc.net

Clinics located in:

- Des Moines, Iowa
  Engebretsen Clinic
  East Side Center
  Grand View Health Center
  Outreach Project Office
  Healthcare for the Homeless:
    - New Directions
    - Family Violence Center
    - YMCA
    - YWCA
    - Family Futures
    - Door of Faith Mission
    - Youth Emergency Shelter
    - Bethel Rescue Mission
    - Salvation Army
    - Churches United Shelter
    - Iowa Homeless Youth
- Marshalltown, Iowa

Proteus Migrant Health Project

Merle Hay Tower
3850 Merle Hay Road, Ste. 500
Des Moines, Iowa 50310-1322
Phone: (515)271-5303
Fax: (515)571-5309
www.proteusinc.net

Offices located in:

- Des Moines, Iowa
- Fort Dodge, Iowa
- Iowa City, Iowa

River Hills Community Health Center, Inc.

201 South Market Street
P.O. Box 458
Ottumwa, Iowa 52501
Phone: (641)683-5773
Fax: (641)682-5584
www.riverhillshealth.org

Clinics located in:

- Ottumwa, Iowa
- Richland, Iowa
- Centerville, Iowa

Siouxland Community Health Center, Inc.

1021 Nebraska Street
P.O. Box 5410
Sioux City, Iowa 51102
Medical Clinic Phone: (712)252-2477
Dental Clinic Phone: (712)202-1006
Pharmacy Phone: (712)255-4204
Fax: (712)252-5516
www.slandchc.com

United Community Health Center

715 West Milwaukee
Storm Lake, Iowa 50588
Medical Clinic Phone: (712)213-0109
Dental Clinic Phone: (712)213-0179
www.uchcsl.com

Affiliate Members

One representative from the Clinical Component of the Association and any association or state department interested in primary care. Affiliate Members or representatives of these organizations are invited to attend and participate in all meetings of the Association. Affiliate members do not have voting privileges.

Clinical Representative

Dr. Sharon Duclos
Peoples Community Health Clinic, Inc.
905 Franklin Street
Waterloo, Iowa 50703-4407
Phone: (319)272-4300

Iowa Primary Care Offices

Bobbi Buckner-Bentz
Lucas State Office Building
321 E. 12th Street
Des Moines, Iowa 50319
Phone: 515-281-8517
Fax: 515-242-6384
bbuckner@idph.state.ia.us

Associate Members

Health clinics or individual professionals engaged or interested in primary health care. Associate Members or representatives of these organizations are invited to attend and participate in all meetings of the Association. These representatives shall not have voting privileges on matters brought before the Association.

Des Moines Health Center

1111 9th Street, Suite 190
United Way Human Services Campus
Des Moines, Iowa 50314
Phone: (515)244-9136
Fax: (515)244-9153

La Clinica de la Esperanza

2679 Maury Street
Des Moines, Iowa 50317
Phone: (515)244-6162
Fax: (515)266-3105

Iowa PCA 2011-2013 Strategic Plan

Participants

Iowa PCA Board Members:
Tom Bowman, CEO, Community Health Care, Inc.
Cecelia Creighton, Executive Director, Council Bluffs Community Health Center
Dr. Sharon Duclos, Co-Medical Director, Peoples Community Health Clinic
Nancy Dykstra, Executive Director, Greater Sioux Community Health Center
Kelly Huntsman, Executive Director, Primary Health Care, Inc.
Doug Jaeger, CEO, Community Health Centers of Southern Iowa
Rick Johnson, CEO, River Hills Community Health Center
Ron Kemp, CEO, Community Health Centers of Southeast Iowa
Jennifer Lightbody, Executive Director, Peoples Community Health Clinic
Jesus Soto, Executive Director, Proteus Migrant Health Project
Michelle Stephan, CEO, Siouxland Community Health Center
Julie Woodyard, Executive Director, Crescent Community Health Center

Iowa PCA Staff Members:
Ted Boesen, CEO
Dr. Bery Engebretsen, Clinical Consultant
Deb Kazmerzak, Senior Program Director (Clinical)
Tori Squires, Senior Program Director (Community Development)

Facilitation and Consulting Assistance:
Integrated Work Strategies, LLC

Introduction

Iowa/Nebraska Primary Care Association (IA/NEPCA) has historically been a bi-state non-profit membership association comprised of community health centers and other safety net providers in Iowa and Nebraska. IA/NEPCA's mission has been to provide leadership by promoting, supporting, and developing quality health care for underserved populations in Iowa and Nebraska.

On December 13-14, 2010, 12 IA/NEPCA board members and four IA/NEPCA staff members convened in Perry, Iowa to conduct strategic planning relative to transitioning the organization to a single-state association for Iowa community health centers and safety net providers under a new name: the Iowa Primary Care Association (Iowa PCA).

Strategic Planning Process

Prior to the meeting, association staff members prepared accomplishments, draft objectives, and questions for the board to address under eight general work domains (see page 4). During the planning session, board members and staff 1) refined Iowa PCA's new mission and vision; 2) identified key issues and priorities for the new association; and 3) prioritized key objectives for each work domain along with some preliminary action steps.

1. Iowa PCA Mission and Vision

Iowa PCA's new mission and vision are:

MISSION:	*To promote, advocate, support and strengthen a quality system of health care while improving access primarily for the underserved in Iowa.*
VISION:	*Support a strong system of care so that all people in Iowa have access to a quality health home.*

2. Iowa PCA Priorities and Issues

Key staff priorities for transitioning to Iowa PCA include:

- Conduct strategic planning for the new association
- Communicate transition to stakeholders
- Note transition in legislative objectives book
- Roll out new branding, including publications, website, and emails
- Address legal, financial, contractual, tax and grants issues concerning the new organization
- Update bylaws (Iowa and INCC) to reflect new organization.

In addition, members identified overall association priorities, such as:

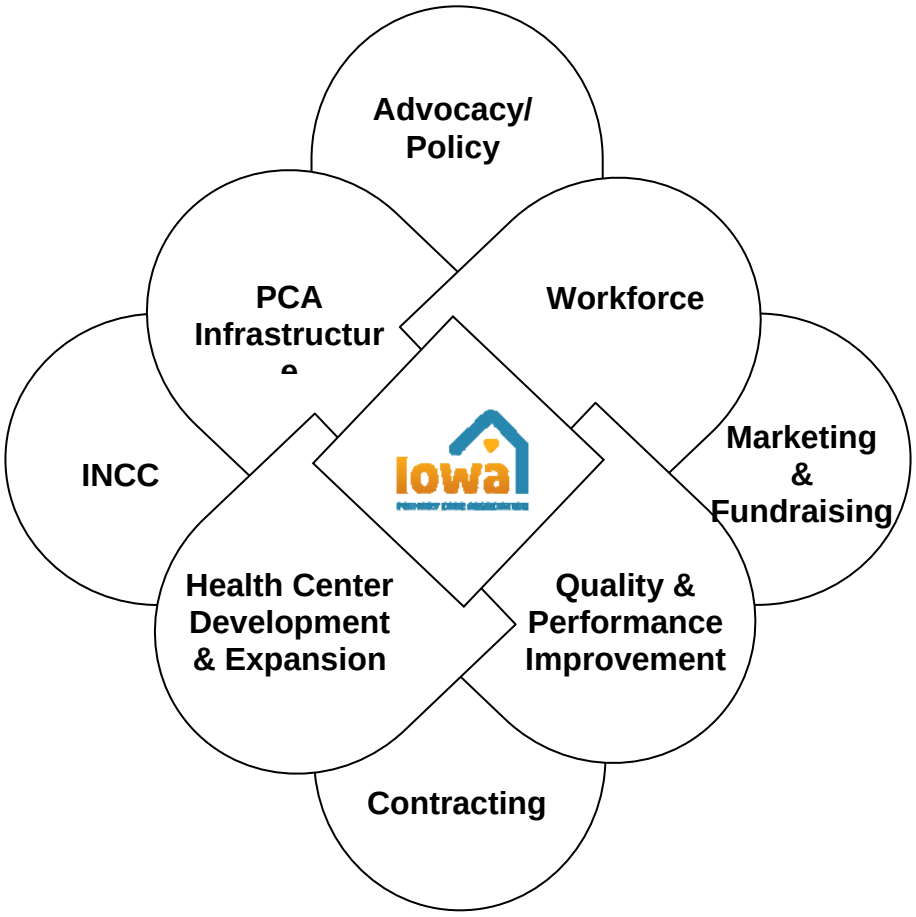
- Help health centers be the premier provider of healthcare in Iowa

- Support EHR implementation at all member health centers
- Cultivate key partnerships that help the association sustainably respond to the health center growth imperative
- Prioritize activities within and across work domains
- Preserve and build on existing competencies
- Improve overall efficiency as an organization
- Grow selectively
- Ask for help and support one another
- Make time for face-to-face relationship-building
- Review board committee charters and composition based on strategic plan; identify and implement any changes in scope and priorities, and develop customized recruitment strategies for each committee.

3. Iowa PCA Work Domains, Objectives, and Action Plan

The following pages outline Iowa PCA's eight main work domains, prioritized key objectives for each domain, and worksheets to further develop action plans for each objective.

Iowa PCA Work Domains



Advocacy/Policy
- Grassroots advocacy network
- State and federal legislative efforts
- State and federal policy

Quality/Performance Improvement
- UDS and clinical content standardization
- Meaningful use
- IowaCare data requirements & implementation
- FTCA and HRSA quality requirements
- Operations, informal technical assistance
- Oral and behavioral health
- Pharmacy and 340B

Workforce
- Recruitment center
- Workforce development

Marketing & Fundraising
- Communications
- PCA marketing
- Health center marketing

Contracting
- Major contracts management
- Contract performance measures and outcomes

Health Center Development & Expansion
- Planning
- Sites and services
- New Start support

Iowa PCA Objectives

Work domain	Advocacy / Policy
OBJECTIVE #1	Ensure the IowaCare expansion is communicated effectively to policy makers.
OBJECTIVE #2	Educate new legislators and state department heads on health centers and identify opportunities for collaborations; assess threats & opportunities in structuring/restructuring at state level.
OBJECTIVE #3	Keep health centers informed about state and national legislative and policy issues; monitor and promote Iowa PCA to the Iowa General Assembly and NACHC legislative agenda to the Iowa congressional delegation.
OBJECTIVE #4	Monitor Affordable Care Act provisions and ensure that health center interests are addressed through state implementation of ACA.
OBJECTIVE #5	Support CHC CEOs with data and tools and encourage accountability on grassroots efforts.
OBJECTIVE #6	Develop system to cultivate healthcare access in Iowa by 2014.

Work domain	Workforce
OBJECTIVE #1	Recruit and fill 22% percent of available openings at member centers for physicians, dentists, nurse practitioners and physician assistants.
OBJECTIVE #2	Continue to populate Resource and Training Center with as many trainings and resources as possible for all 16 competency domains by August 2011.
OBJECTIVE #3	Develop an orientation and mentoring program for new CEOs (and for CEOs, CFOs, CMOs, and other senior level staff new to existing health centers).
OBJECTIVE #4	Determine member centers' needs for board training and development and evaluate alternatives to meeting said needs.
OBJECTIVE #5	Provide succession plan policy and recruitment/retention plan templates for customization by member centers.
OBJECTIVE #6	Identify and cultivate long-term relationships for pipeline development.

Work domain	Marketing & Fundraising
OBJECTIVE #1	Engage consultant for earned media placement strategy and intentional messaging for all IA centers.
OBJECTIVE #2	Develop and implement a proactive marketing strategy for member centers, building on the "Your Health Home" brand (incorporate contemporary tools and rethink older tools) to educate external audiences on the value of health centers.
OBJECTIVE #3	Assist health centers in identifying and cultivating relationships for successful fundraising efforts.

Work domain	Quality & Performance Improvement
OBJECTIVE #1	Provide member health centers with necessary support and assistance with preparation for and implementation of IowaCare by 2012, including NCQA Recognition for patient-centered medical home; which will be accomplished through a collaborative coaching model, including on-site assistance when needed, facilitating health center teams to address workflow, data collection/documentation and practice changes necessary to achieve, at a minimum, Tier 1 Recognition.
OBJECTIVE #2	Provide necessary support and assistance for member health center providers to reach capacity to successfully report Meaningful Use measures in order to access incentive funding to support INCC infrastructure and health center HIT.
OBJECTIVE #3	Provide necessary support and assistance to member health centers to build capacity to enable reliable, validated reporting of UDS and other required measures by 2012.
OBJECTIVE #4	Assist member health centers in their efforts to provide or enhance existing integrated behavioral health services, including partnership development with community mental health centers and Megallan of Iowa, exploration of models, and addressing barriers such as billing, access, and recruitment.
OBJECTIVE #5	Establish quality initiatives for member health center oral health programs and assist member health centers with oral health program start up, expansion, workflow and quality. Conduct outreach to the broader general public, policymakers and dental community to facilitate improved awareness and support for FQHC dental programs by 2013.
OBJECTIVE #6	Continue to explore ways to collaborate among CHCs for specialty services.

Work domain	Contracting
OBJECTIVE #1	Continue to meet contractual objectives and obligations specific to each contract.
OBJECTIVE #2	Discuss/pursue potential partnerships that align with 2010 Strategic Planning objectives, with Board approval.

Work domain	Health Center Development & Expansion
OBJECTIVE #1	Support health centers and communities in meeting the goals outlined in the 2010 State-wide Strategic Growth Plan.
OBJECTIVE #2	Access workgroup gathers/shares best practices for implementation of behavioral health, oral health, pharmacy, vision, and enabling services.
OBJECTIVE #3	Support New Access Point grantees as they prepare to open their doors within 120 days of Notice of Grant Award.

Work domain	PCA Infrastructure
OBJECTIVE #1	Strengthen overall PCA infrastructure to support overall growth.
OBJECTIVE #2	Develop PCA corporate compliance plan and explore corporate compliance support for members.
OBJECTIVE #3	Develop resources through grant applications and other funding opportunities.
OBJECTIVE #4	Evaluate network-wide benefit plan possibilities.

By-Laws

IOWA PRIMARY CARE ASSOCIATION

ARTICLE I

NAME, LOCATION, PURPOSE, AND POWERS

Section 1. The name of the Organization shall be the Iowa Primary Care Association.

Section 2. The principal office of the Association shall be located at a site designated by the Board of Directors.

Section 3. The Association is constituted for the purpose of improving the quality, access, and delivery of health care to the underserved in the state of Iowa. The goals included in this purpose are the following:

A. To serve as advocates for and further the unique missions of health centers located in Iowa.

B. To provide technical assistance concerning the establishment and operation of health centers.

C. To act as a central information source for health centers and community groups interested in health care delivery.

D. To assure that high quality primary health care is available to all individuals in Iowa regardless of ability to pay:

i. By providing a forum for the exchange of information between primary health care providers in the state of Iowa.

ii. By forming and operating a communication network to gather, compile, and disseminate pertinent information to members of the association and their associates.

iii. By actively participating in state level policy analysis, development, and evaluation regarding delivery of primary health care in Iowa.

iv. By actively recruiting providers of primary health care as participants in the association whose focus is on delivery of health care to the uninsured and underserved in Iowa.

Section 4. The purpose and activities of the Association shall be exclusively charitable and educational. No property belonging to the Association shall inure to the benefit of any member, officer, employee, or other individual associated with the organization. The Association shall not participate or engage in any activity or practice which is

prohibited to an exempt organization under Section 501 (c) (3) of the Internal Revenue Code or successor provisions thereof.

Section 5. The Association, within the limits of the corporate entity, shall have all the powers and privileges granted to similar corporations under the applicable laws of the State of Iowa.

ARTICLE II

MEMBERSHIP AND MEETINGS

Section 1. There are three categories of members within the Association: Directing Members, Affiliate Members, and Associate Members.

A. Directing Members:

Directing Members are federally-funded community health centers located in the state of Iowa, State-funded community health centers, and FQHC Look-alikes. As Directing Members, these organizations shall be entitled to all the rights and privileges as defined in Article III.

A current membership roster is appended to this document.

B. Affiliate Members:

Affiliate Members include one representative from the Clinical Component of the Association and any association or state department interested in primary care. Affiliate Members or representatives of these organizations are invited to attend and participate in all meetings of the Association. These representatives shall not have voting privileges on matters brought before the Association.

C. Associate Members:

Associate Members include health clinics or individual professionals engaged or interested in primary health care. Associate Members or representatives of these organizations are invited to attend and participate in all meetings of the Association. These representatives shall not have voting privileges on matters brought before the Association.

Section 2. Each member shall be entitled to be represented by one individual at all Board meetings of the Association. Each member shall be represented by its Chief Executive Officer or Executive Director. Each member shall submit to the Secretary the name and mailing address of the representative on or before December 31 of each year. The Clinical Representative shall be a clinician from a Directing Member organization. The Clinical Representative shall represent the interests of the Association's clinicians and not exclusively the interests of her/his own health center. The Clinical Representative shall be selected by the members of the Association's Clinical Committee for a four-year term and may serve more than one term.

Section 3. After the initial year of operation, the annual meeting of the Association shall take place at the close of the grant year. The business of this meeting shall consist of election of officers, appointment of committee members, an annual report by the Chair and Treasurer for the preceding year and the transaction of any general business, which may come before the membership.

Section 4. Special meetings of the Association may be called by the Chair or by a petition presented to the Secretary and signed by the representatives of at least three Directing Members.

Section 5. Written notice of each annual or special meeting of the Association stating the place, day, hour, and order of business shall be mailed by the Secretary to each representative at least five (5) working days before the date of the meeting.

Section 6. Attendance by fifty-one percent (51%) of the Directing Members shall be necessary to constitute a quorum at any meeting.

ARTICLE III

BOARD OF DIRECTORS, MEETINGS, POWERS

Section 1. The Board of Directors of the Association shall be composed of all the Directing Members identified under Article II Section 1. Each Director shall have one vote on all matters brought before the Board.

Section 2. Meetings. The Executive Committee shall meet at least once each quarter. The Board of Directors shall meet at least once each quarter. Special meetings of the Executive Committee may be called as necessary by the Chair.

Section 3. The requirements of Article II Section 4, 5, and 6 dealing with special meetings, notice, quorum, and voting shall be applicable to the meetings of the Board of Directors.

Section 4. The powers of the Board of Directors shall include:

A. Employment of an Executive Director who carries out the management functions of planning, organization, staffing, and directing and controlling the operations of the Association.

B. Approval of annual budgets, organizational structure, and contracts with federal and state agencies, consultants, and corporations, public and private.

C. Make operational decisions for the Association if those decisions:

i. Require resource allocations beyond existing, approved budgets after review by the Finance Committee;

ii. Bind the Association to a contract in addition to what has been approved by the board in the annual budget or a funding application; or

iii. Changes the strategic direction of the Association.

D. Approval of operation and management policies.

E. Approval of annual audit and strategic plan.

F. Assurance of compliance with applicable laws and regulations.

G. Establish a membership dues structure for each membership category based on a set of criteria approved by the Board. Annual dues will be calculated based on that structure and communicated by Association staff to members by March 1 of each year. Members that do not pay their dues within 90 days shall forfeit their voting rights, shall not participate on Board committees, and shall not have access to Association services and resources until dues have been paid. The membership year of the Association shall be April 1 to March 31. Dues for new members shall be pro-rated based on when the membership application is approved.

ARTICLE IV

OFFICERS, DUTIES, ELECTIONS, VACANCIES

Section 1. The officers of the Association shall be the Chair, Vice Chair, Secretary, Treasurer, and the Immediate Past Chair. These officers shall constitute the Executive Committee. The Board of Directors shall elect a Chair, Vice-Chair, Secretary, and Treasurer from the Board membership. These officers shall be elected at the annual membership meeting specified in Article II, Section 3. All officers will be elected to a two-year term. The Vice Chair shall succeed to the office of Chair upon completion of their terms.

Section 2. The Chair shall preside over the Board of Directors of the Association. The Chair shall preside at all meetings of the Members and of the Board. The Chair shall also have the discretionary power to appoint any ad hoc committees. The Chair shall be a member of the committees, but shall not vote except in the case of a tie.

Section 3. The Vice Chair, in the absence of the Chair, shall perform the duties and exercise the power of the Chair.

Section 4. The Secretary shall be responsible for keeping a record of all meetings of the membership and Board of Directors as well as for keeping all maintained by others. These records shall be available to all designated members and Directors at any

reasonable time. The Secretary shall be responsible for all correspondence of the Board and shall cause to keep in safe custody the seal of the Association and when authorized, to affix the same to any instrument requiring the same.

Section 5. The Treasurer shall have custody of the corporate funds and shall keep or cause to be kept, full and accurate records of the payment of all bills and collection of all monies due the Association. Such records shall be property of the Association and shall be available to all designated members and Directors at any reasonable time.

Section 6. The Chair and the Treasurer shall present reports indicating the full and true statement of the affairs of the Association, which shall be presented at the annual meeting of the members.

Section 7. The officers of the Association may be removed from office with or without cause, by a vote of three quarters of the Association, which shall present at any meeting called for that purpose.

Section 8. Any vacancies among the officers may be filled by majority vote of the Directing Members.

Section 9. The Board of Directors will ensure the officers of the Association are representative of the geographic diversity of the membership.

ARTICLE V
COMMITTEES

Section 1. Standing Committees of the Board shall be as follows: Executive Committee, Finance Committee, Clinical Committee, Advocacy/Legislative Committee, Marketing Committee, Statewide Strategic Growth Committee, and Workforce Development Committee. Committee members of the board will be appointed by the Chair of the Board in conjunction with the designated chair of each committee at the annual meeting. Committee members do not have to be Board members, but must be employed by member organizations. It is expected that Directing Members serve on at least one committee.

Section 2. Each standing committee will be chaired by a member of the Board. Each standing committee shall have the authority to appoint any members it deems necessary to accomplish the tasks assigned to it by the Board of Directors.

Section 3. Meetings of committees may be held without Board notice at such time and place to be determined by each committee. Committees shall meet on a quarterly basis.

Section 4. Standing committees shall keep regular meeting minutes of their proceedings and shall provide written reports to the Board of Directors.

Section 5. Ad Hoc Committees may be appointed as needed.

Section 6. The Chair of each committee will ensure committee membership is representative of the geographic diversity of the Association.

Section 7. Functions and Duties

Charters specifying the functions and duties of each committee shall be developed.

A. The Executive Committee shall be chaired by the Chair of the Board of Directors and shall act on behalf of the Board of Directors. Members of the committee shall include the officers of the Association specified in Article IV, Section 1. All action taken by the Executive Committee shall be taken to the Board and ratified. Duties of the committee shall include:

i. Making decisions on behalf of the Board when a decision must be made between Board meetings.

ii. Managing the work of committees and regularly reviewing committee assignments and activities.

iii. Providing guidance for how and where key issues are decided.

iv. Providing input and feedback on ideas the Executive Director presents.

v. Managing the employment/contractual relationship and providing a performance review for the Executive Director.

vi. Providing leadership by mentoring new Board members.

B. The Finance Committee shall be chaired by the Treasurer and shall consist of at least four other Board members. The committee shall meet monthly. The committee shall assist the Executive Director in preparation of the annual budget and related matters, review monthly financial reports, monitor the overall financial welfare of the Association, review independent contractor agreements, review all contracts entered into by the Association, and direct and review an annual independent audit.

C. The Clinical Committee shall be chaired by the clinical representative on Board of Directors. The committee's duties are to advise the Board on issues affecting the clinical operations of the members and in all matters related to patient care.

D. The Advocacy/Legislative Committee shall be chaired by a Board member appointed by the Chair. The committee's duties are to recommend content and execution of the Association's state legislative agenda, promote legislation on both the state and national levels, review pending legislation and its impact on health centers, and to seek state appropriations when deemed necessary.

E. The Workforce Development Committee shall be chaired by a Board member appointed by the Chair. The committee's duties are to recommend content and execution of workforce development activities of the Association including the Association annual conference, other training sessions and recruitment activities.

F. The Marketing and Fundraising Committee shall be chaired by a Board member appointed by the Chair. The committee's duties are to recommend content and execution of marketing and fundraising activities of the Association.

G. The Statewide Strategic Growth Committee shall be chaired by a Board member appointed by the Chair. The committee's duties are to monitor Association activities related to health center growth and development and advise the Association on growth strategies.

ARTICLE VI
PARLIMENTARY AUTHORITY

The rules contained in the current edition of Robert's Rules of Order Newly Revised shall govern the Association in all cases to which they are applicable and in which they are not inconsistent with these By-Laws and any special rules of order the Association may adopt.

ARTICLE VII
AMENDMENT OF BY-LAWS

These By-Laws may be amended at any regular or special meeting of the membership or Board by a two-thirds vote of those present and voting provided that a quorum is present and further provided that written notice of an intent to so amend, together with a statement of the proposed amendment is served on each member or Director at least seven days prior to such meeting.

Adopted as revised this twentieth day of December, 1996
Directors updated as of November 1998
Directors updated as of January 2005
Directors updated as of August 2007
Directors updated as of September 2009
Directors updated as of March 2011

Michelle Stephan
Board Chair

Date

INConcertCare, Inc.

Expanding Our Capacity to Care

Staff Guide

Theodore J. Boesen, Jr., *Chief Executive Officer*
tboesen@iowapca.org
515-333-5010
515-778-7063 (cell)

Brad Peterson, *IT Director*
bpeterson@iowapca.org
563-343-7927

David Rowatt, *Regional IT Manager*
drowat@inconcertcare.com
563-336-3197

Kyle Haindfield, *Lead Clinical Implementation Specialist*
khaindfield@iowapca.org
515-333-5018

Jennifer Cox, *Clinical Implementation Specialist*
jcox@iowapca.org
515-333-5030

Kyle Pedersen, *Clinical Implementation Specialist*
kpedersen@iowapca.org
515-333-5027

Overview

Network Vision

A comprehensive integrated bi-state health care delivery network to ensure access for the medically underserved.

Network Mission

To improve the delivery of accessible, efficient, coordinated, quality and appropriate health care services that meets the needs and improves the health status of the medically needy through the creation of a comprehensive, community-based integrated health care delivery network. INCC members (partners) continue to fulfill their individual and collective missions providing primary care services to underserved and indigent populations.

Who We Are

In 1997, due to adverse changes in the bi-state health care delivery system, several Iowa and Nebraska community health centers joined together to form an integrated service delivery network to strengthen their position in their respective marketplaces and statewide. In coming together the centers founded INConcertCare, Inc. (INCC), a nonprofit network to assist member centers to improve access to health care, maximize the quality of their services, and achieve cost savings – all vital to the ability of these centers to thrive in the health care arena where partnerships are the key to successful participation in the health care market.

INConcertCare, Inc., as a 501(c)(4), was formed and is capitalized and sustained through individual member organizations' annual investment for services and additional network and technology grants. Today, INCC is recognized by the Health Resources and Services Administration as a health center controlled network.

INConcertCare, Inc. has been designed to adjust to the changing environment with its primary focus on providing primary care for the underserved. It is becoming clearer as the large networks open and subsequently close primary care clinics that providing health care to the poor and underserved is difficult for those entities that demand a greater return on their investment. INConcertCare, Inc. builds upon principles of the community health care model and expects the margins gained, and the cost-benefit provided to the members, will be adequate and ensure the sustainability of the corporation of the centers.

Network Services

Working on behalf of the member centers, INConcertCare supports and facilitates the development of a shared information infrastructure, streamlining operational services, coordination of training and educational programs, implementation of best practices, and providing opportunities for member centers to learn from each other's expertise.

INCC has been in existence for 14 years and has successfully implemented several network projects, including a centralized information system using HealthPro as the practice management software, as well as Internet access, e-mail and Microsoft Office services. In 2009, the network began implementation of an electronic medical record system in eight health centers. The network also offers training programs for member organization staff, a clinical initiative related to self-management of patients with diabetes, several work groups of senior management staff of the partner organizations, and conducts bi-state marketplace analysis and strategic planning.

Electronic Medical Record System

In fall 2009, began implementation of an EMR system in eight health centers in Iowa and Nebraska.

Patient Management Information System

Twelve sites with 300 users are using Sage's HealthPro software hosted in INCC's Davenport Network Operations Center (NOC).

Patient Registry

i2iTracks – INCC recently implemented i2iTracks, a chronic disease and preventive health management system at 14 sites in Iowa and Nebraska. i2iTracks allows centers to track and report on chronic disease, as well as monitor preventive efforts.

Dentrix Software

Dentrix Enterprise software is a comprehensive dental practice management software which has been implemented at 10 sites in the two states. This system serves as an electronic dental record and has improved systems in members' dental clinics. Data is stored on the INCC server.

Help Desk

The Help Desk responds to GE Centricity, Health Pro, Dentrix, i2iTracks, and network management issues from member system users.

Clinical Initiatives

Working with the Iowa PCA clinical committee and medical director, oral health and pharmacy networks, the network centers are pursuing various innovative clinical strategies focusing on quality.

Transcription Services

Seven members currently participate in a network wide transcription contract with MediGrafix. Since 2005, MediGrafix has been providing transcription services to INCC members.

2011-2013 Board of Directors

INCC is governed by a board of directors comprised of one director from each organizational member of the corporation.

Officers

President: Jennifer Lightbody – Executive Director, Peoples Community Health Clinic, Inc., Waterloo, Iowa
Vice President: Jeff Tracy – Executive Director, Panhandle Community Health Center, Gering, Nebraska
Secretary/Treasurer: Rick Johnson – Executive Director, River Hills Community Health Center, Ottumwa, Iowa

Partner Member Facilities

- **Richard Brown, Ph.D., FACHE** – CEO, Charles Drew Health Center, Inc., Omaha, Nebraska
- **Tom Bowman** – CEO, Community Health Care, Davenport, Iowa
- **Jennifer Genua McDaniel** – Executive Director, Community Health Centers of Fort Dodge, Fort Dodge, Iowa
- **Ron Kemp** – CEO, Community Health Centers of Southeastern Iowa, West Burlington, Iowa
- **Cecelia Creighton** – Executive Director, Council Bluffs Community Health Center, Council Bluffs, Iowa
- **Julie Woodyard** – Executive Director, Crescent Community Health Center, Dubuque, Iowa
- **Kelly Huntsman** – Executive Director, Primary Health Care, Inc., Des Moines, Iowa
- **Jesus Soto** – Executive Director, Proteus Migrant Health Project, Des Moines, Iowa
- **Michelle Stephan** – CEO, Siouxland Community Health Center, Inc., Sioux City, Iowa

Network Partners

There is a unique culture and trust among INCC members that has allowed this effort in sharing and integrating services to occur. The strategic vision of INCC is to be the corporate entity which provides the vehicle for further integrating services in the future.

Partner Member Facilities

Health Resources and Services Administration Community Health Center (Section 330) grantees in Iowa or Nebraska that purchase their Electronic Health Record (EHR) system (medical and/or dental) through the Corporation.

Charles Drew Health Center
2915 Grant Street
Omaha, Nebraska 68111
Phone: (402)453-1433

Community Action Partnership of Western Nebraska
975 Crescent Dr.
Gering, Nebraska 69341
Phone: (308)632-2752

Community Health Care, Inc.
500 West River Dr.
Davenport, Iowa 52801
Phone: (563)336-3000

Community Health Center of Fort Dodge
126 North 10th Street
Fort Dodge, Iowa 50501
Phone: (515)576-6500

Community Health Centers of Southeastern Iowa, Inc.
1706 West Agency Road
West Burlington, Iowa 52655
Phone: (319)753-2301

Council Bluffs Community Health Center
300 West Broadway, Suite 6
Council Bluffs, Iowa 52503
Phone: (712)325-1990

Crescent Community Health Center
1789 Elm Street, Suite A
Dubuque, Iowa 52001
Phone: (563)690-2850

Peoples Community Health Clinic, Inc.
905 Franklin St.
Waterloo, Iowa 50703
Phone: (319)272-4321

Primary Health Care, Inc.
9943 Hickman Road, Suite 105
Urbandale, Iowa 50322
Phone : (515)333-5024

Proteus Migrant Health Project
3115 Douglas Avenue
Des Moines, Iowa 50310
Phone: (515)271.5303

River Hills Community Health Center
201 S. Market St
Ottumwa, Iowa 52501
Phone: (641)683-5773

Siouxland Community Health Center
1021 Nebraska Street
Sioux City, Iowa 51102
Phone: (712)252-2477

Participating Member Facilities

Health Resources and Services Administration Community Health Center (Section 330) grantees in Iowa or Nebraska that purchase other, non-EHR services through the Corporation.

Community Health Centers of Southern Iowa, Inc.
302 NE 14th Street
Leon, Iowa 50144
Phone: (641)446-2383

Good Neighbor Community Health Center
2282 East 32nd Avenue
Columbus, Nebraska 68601
Phone: (402)563-9224

Greater Sioux Community Health Center
338 1st Avenue, NW
Sioux Center, Iowa 51250
Phone: (712)722-1700

United Community Health Center
630 Ontario Street
Storm Lake, Iowa 50588
Phone: (712)213-0109

Clinical Representative

The same individual provider of health care services who is the designee for the Iowa Primary Care Association clinical component board representative.

Clinical Representative

Dr. Sharon Duclos
Peoples Community Health Clinic, Inc.
905 Franklin St.
Waterloo, Iowa 50703
Phone: (319)272-4321

By-Laws
INCONCERTCARE, INC.

ARTICLE I
NAME

The name of this corporation shall be known as INCONCERTCARE, INC.

ARTICLE II
THE CORPORATION

Section 1: Legal Status
INConcertCare, Inc. (hereinafter, the "Corporation") is a not-for-profit corporation organized under Chapter 504A, Code of Iowa. No part of the net earnings of the Corporation shall inure to the benefit of any director or officer of the corporation, or any private individual (except that reasonable compensation may be paid for services rendered to or for the corporation). No substantial part of the activities of the Corporation shall consist of carrying out propaganda, or otherwise attempting to influence legislation, and the Corporation shall never, directly or indirectly, participate in, or intervene in, any political campaign on behalf of any candidate for public office. This Corporation shall also have the power and authority to enter into contracts with, and to receive grants from other foundations, corporations, agencies, and institutions, governmental or private, in furtherance of its purpose.

Section 2: Administrative Functions/Locations
The principal location of the Corporation shall be in Des Moines, Iowa, or at such other location as designated by resolution of the Board of Directors.

Section 3: Funding and Operational Costs
The Corporation is self-supported through contributions, grants, and endowments, and gifts. From time to time, by a vote of approval of the Board of Directors, the Member Facilities (as defined in Article IV, Section 1) may be required to provide funding to the Corporation. An affirmative vote of three-fourths of the Partner Members (as defined in Article IV, Section 1) shall be required for the approval of any funding from the Member Facilities.

ARTICLE III
PURPOSE

The general purposes of the Corporation are to:

A. Improve the delivery of accessible, efficient, coordinated, quality and appropriate health-care services that meet the needs of and improve the health status of the medically underserved; and

B. Integrate and re-engineer administrative and delivery systems that will result in a comprehensive, community health integrated delivery network that achieves cost efficiencies and cost reductions; and

C. Preserve and promote the health center model of care while providing a solid base for managed competition in the changing health marketplace; and

D. To promote and conduct activities designed to improve the social, physical and mental welfare in underserved, low-income or otherwise needy areas in Iowa and Nebraska.

The specific purposes of the Corporation shall be as follows:

1. To support collective infrastructure and operational system development in order to compete in managed care settings.

2. To support coordination, information sharing and information dissemination, including, but not limited to, coordinating and operating shared management information systems, between and about community-based, community-controlled health centers who serve the medically underserved regardless of their ability to pay.

3. To provide, direct and support shared clinical, administrative and management services efforts, which result in more efficient and more effective health care services delivery.

4. To identify, investigate, obtain, administer and disburse financial resources to improve both the quality of services provided by or through the Corporation.

5. To exercise all the rights, power and duties, which are now or may hereafter be conferred on non-profit corporations organized under the Iowa Not-for-Profit Corporation Law.

ARTICLE IV
MEMBERSHIP

Section 1: Composition
Corporation membership shall consist of the following:

1. Partner Member Facilities
   Partner Member Facilities are Health Resources and Services Administration Community Health Center (Section 330) grantees in Iowa or Nebraska that purchase their Electronic Health Record (EHR) system (medical and/or dental) through the Corporation.

2. Participating Member Facilities
   Participating Member Facilities are Health Resources and Services Administration Community Health Center (Section 330) grantees in Iowa or Nebraska that purchase other, non-EHR services through the Corporation.

3. Clinical Representative
   The Clinical Representative shall be the same individual provider of health care services who is the designee for the Iowa Primary Care Association clinical component board representative.

ARTICLE V
BOARD OF DIRECTORS

Section 1: Powers and Authority
The Board of Directors shall supervise, control and direct the affairs of the Corporation and shall determine its policies or changes therein within the limits established by the Articles of Incorporation and herein. The Board of Directors may adopt such rules and regulations for the conduct of the Corporation's business as shall be deemed advisable. The Board of Directors may delegate the management of the activities of the Corporation to any person or persons, management company, or committee however composed, provided that the activities and affairs of the Corporation shall be managed and all corporate powers shall be exercised under the ultimate direction of the Board of Directors.

The Board of Directors shall have, including, without limitation, the power to:

1. Hire employees as deemed necessary.

2. Conduct, manage, and control the affairs and business of the Corporation, and to make rules and regulations not inconsistent with law, the Articles of Incorporation and these By-Laws.

3. Borrow money and incur indebtedness for the purpose of the Corporation, and for those purposes to cause to be executed and delivered, in the Corporation's name, promissory notes, bonds, debentures, deeds of trust, mortgages, pledges, or any other evidence of debt or security.

Section 2: Number, Tenure
The Board of Directors shall consist of one Director from each Partner and Participating Facility and one Clinical Representative (as defined in Article IV, Section 1 hereof). Each of the Partner and Participating Facilities shall have the right, but not the obligation, to annually appoint a single director to serve on the Board of Directors, which shall occur at the annual meeting of the Board of Directors. Each Director's term shall be as determined by his or her respective facility. The Clinical Representative shall be approved by the Board of Directors, and shall serve a four-year term and may serve more than one term. The Clinical Representative shall represent the interests of the Corporation's clinicians and not exclusively the interests of her/his own facility.

Section 3: Voting
Partner Members shall have full voting privileges. Participating Members and the Clinical Representative shall not have voting privileges, but are encouraged to attend Board meetings and contribute to Board deliberations.

Section 4: Quorum and Manner of Acting
The majority of the number of Directors representing Partner Members then holding office shall constitute a quorum; but if at any meeting of the Board of Directors there is less than a quorum present, a majority of the Directors then present may adjourn the meeting. At all meetings of Directors where a quorum is present, the act of a majority of the directors present, unless otherwise stated herein, shall be the act of the Board of Directors.

Section 5: Removal of Director
Any Director may be removed, with or without cause, by the Partner or Participating Facility (as defined in Article IV, Section 1 hereof), which appointed such Director.

Section 6: Officers
The Board of Directors shall elect a President, Vice President, Secretary, and Treasurer, who shall be elected, a quorum being present, by a majority vote of the Directors representing Partner Members. One person may hold the offices and perform the duties of two or more of said officers. All officers will be elected to a two-year term. The Vice President shall succeed to the office of Chair upon completion of their terms. Elections shall be held at a designated meeting of the Board of Directors of the Corporation in even numbered years.

Section 7: Duties of Officers
President
Subject to the control of the Board of Directors, the President shall preside over all meetings of the Corporation, discharge the usual duties of a presiding officer, and be an ex-officio member of all committees.

Vice President
The Vice President shall assist the President in the discharge of duties and shall, subject to the restrictions on the President, assume such duties in the absence, death or disability of the President. The Vice President shall perform such duties as may be assigned, from time to time, by the President.

Secretary
The Secretary shall:
1. Keep the minutes of the proceedings of all meetings, all corporate resolutions, and contracts of the Corporation.
2. Keep a current list of Participating Facilities and directors elected thereby.
3. Perform other duties as assigned by the President.
4. Be custodian of all books and records of the Corporation.

Treasurer
The Treasurer shall:
1. Keep the financial accounts of the Corporation.
2. Perform other duties as assigned by the President.

Section 8: Vacancies and Removal of Officers
Vacancies in any office shall be filled by the Board of Directors without delay at its next regular meeting or at a special meeting called for that purpose. Any officer may be removed by the

Board of Directors, whenever in its judgment the best interests of the Corporation will be served thereby.

ARTICLE VI
MEETINGS

An annual meeting shall be held with the date set by the President of the Corporation. Special meetings shall be held as needed and may be called by the President or any one (1) director at that time. Regular meetings shall be called as needed. Written notice of all meetings, whether annual, regular, or special, shall be given to each Participating Facility of its appointed director not less than five (5) days prior to such meetings.

ARTICLE VII
WRITTEN INSTRUMENTS, LOANS, CHECKS AND DEPOSITS

Section 1: Written Instruments
All Deeds and mortgages made by the Corporation and all other written contracts and agreements to which the Corporation shall be a party shall be executed in its name by the President.

Section 2: Loans
No loans shall be contracted on behalf of the Corporation, and no evidences of indebtedness shall be issued in its name unless authorized by a resolution of the Board of Directors. Such authority may be general or confined to specific instances.

Section 3: Checks, Drafts, Etc.
All checks, drafts or other orders for payment of money, notes or other evidences of indebtedness issued in the name of the Corporation, shall be signed by such officer or officers, agent or agents of Corporation and in such manner as shall from time to time be determined by resolution of the Board of Directors.

Section 4: Deposits
All funds of the Corporation not otherwise employed shall be deposited from time to time to the credit of the Corporation in such bands, trust companies or their depositories as the Board of Directors may select.

ARTICLE VIII
INDEMNIFICATION

As more fully set forth in the Articles of Incorporation, the Corporation shall have the power to indemnify any person who is or was an officer, director, employee or agent of the Corporation who is or was serving at the request of the Corporation as an officer, director, employee, or

agent of the Corporation, against any liability asserted against him or her and incurred by such person in such capacity, or arising out of such person's status as such.

ARTICLE IX
AMENDMENT

These By-Laws may be made, amended or repeated, in whole or in part, by two-thirds vote of the Board of Directors present at any meeting of the Board of Directors duly called and organized; provided, however, that notice of intention to make, amend or repeal the By-Laws shall have been given in the notice of such meeting.

ARTICLE X
FISCAL YEAR, NO SEAL, DISSOLUTION

Section 1: Fiscal Year
The fiscal year shall end at the close of business on the 31st day of March of each year.

Section 2: No Seal
The Corporation shall have no corporate seal.

Section 3: Dissolution
A resolution to dissolve the Corporation and conclude its affairs shall be approved by resolution of a three-fourths majority of the Board. Upon adoption of such resolution by the Board, the Corporation shall cease to conduct its affairs except as may be necessary for ceasing operation of the Corporation. It shall immediately cause a notice of the proposed dissolution to be mailed to each of its known creditors, and shall proceed to collect its assets and distribute them as provided in the Articles of Incorporation and under the laws of the State of Iowa. The method for distribution of assets prescribed in corporate policies and procedures shall be followed.

ARTICLE XI
RATIFICATION

All prior acts of the Corporation are hereby ratified and approved by the Board of Directors upon the approval of these By-Laws.

Adopted as revised this twelfth day of January 2011.

_____
President

Acronyms

-#-

340B	Discount Drug Purchasing Program
1115 Waiver	Medicaid Waiver, often statewide and related to managed care
1915(b)Waiver	Medicaid freedom of choice/managed care waiver

-A-

AAAHC	Accreditation Association for Ambulatory Health Care
AAP	American Academy of Pediatrics
AAPCC	Adjusted Average Per-Capita Cost
ADA	Americans with Disability Act
ADAP	AIDS Drug Assistance Program
AETC	AIDS Education and Training Center
AHA	American Hospital Association
AHEC	Area Health Education Center
AIDS	Acquired Immunodeficiency Syndrome
AMA	American Medical Association

-B-

BHPR	Bureau of Health Professions
BIPA	Benefits Improvement and Protection Act of 2000 (PPS was a part of this legislation)
BLCP	Black Lung Program
BPHC	Bureau of Primary Health Care

-C-

CARE	Comprehensive AIDS Resources Emergency Act
CBO	Congressional Budget Office

CBR	Cost Based Reimbursement
CDC	Centers for Disease Control and Prevention
CFR	Code of Federal Regulations
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHC	Community Health Center
CHIP	Child Health Insurance Program
CLIA	Clinical Laboratory Improvement Act
CME	Continuing Medical Education
C/MHC	Community and Migrant Health Center
CMS	Center for Medicare and Medicaid Services
CPT	Current Procedural Terminology
CQI	Continuous Quality Improvement
CSHCN	Children with Special Health Care Needs
CY	Calendar Year

-D-

DHHS	Department of Health and Human Services
DME	Durable Medical Equipment
DOJ	Department of Justice
DSH	Disproportionate Share Hospital

-E-

ED	Emergency Department
EIS	Early Intervention Services
EPA	Environmental Protection Agency
EPI	Excess Program Income
EPSDT	Early Periodic Screening Diagnosis and Treatment
ER	Emergency Room

-F-

FDA	Food and Drug Administration
FEHBP	Federal Employees Health Benefits Program
FFS	Fee for Service
FIP	Family Investment Program
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FQHC-LA	Federally Qualified Health Center Look-a-Like
FRN	Federal Register Notice
FSR	Financial Status Report
FTCA	Federal Tort Claims Act
FTE	Full Time Equivalent
FY	Fiscal Year

-G-

GA	General Assistance
GAAP	Generally Accepted Accounting Principles
GAO	General Accounting Office
GME	Graduate Medical Education

-H-

HAB	HIV/AIDS Bureau
HCH	Health Care for the Homeless
HEDIS	Health Plan Employer Data and Information Set
HIFA	Health Insurance Flexibility and Accountability
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization

HPSA	Health Professions Shortage Area
HRSA	Health Resources Services Administration

-I-

Iowa PCA	Iowa Primary Care Association
IBNR	Incurred But Not Reported
ICD-9	International Classification of Diseases, 9th Revision
ICDA	International Classification of Diseases, Adapted
IDS	Integrated Delivery System
IHS	Indian Health Service
IMU	Index of Medical Underservice
INCC	INConcertCare, Inc.
INS	Immigration and Naturalization Service
ISD	Integrated Service Delivery
IDPH	Iowa Department of Public Health

-J-

JCAHO	Joint Commission on Accreditation of Health care Organizations (Now *The Joint Commission*)

-M-

MA	Medical Assistance/Medicaid
MCH	Maternal and Child Health
MCHB	Maternal and Child Health Bureau
MCN	Migrant Clinician Network
MCO	Managed Care Organization
MEI	Medicare Economic Index
MHC	Migrant Health Center

MIS	Management Information System
MOU	Memorandum of Understanding
MS0	Management Service Organization
MUA	Medically Underserved Area
MUP	Medically Underserved Population

-N-

NACHC	National Association of Community Health Centers
NCFH	National Center for Farmworkers Health
NCQA	National Center for Quality Assurance
NGA	Notice of Grant Award
NHSC	National Health Service Corps
NIH	National Institute of Health
NIMH	National Institute of Mental Health
NPRM	Notice of Proposed Rulemaking
NHRA	National Rural Health Association
NHHSS	Nebraska Health and Human services System

-O-

OB/GYN	Obstetrics/Gynecology
OGC	Office of General Counsel
OGM	Office of Grants Management
OIG	Office of the Inspector General
OMB	Office of Management and Budget
OPD	Outpatient Department
ORHP	Office of Rural Health Policy

-P-

PACE	Program of All-Inclusive Care for the Elderly

PAL	Program Assistance Letter
Part A	Hospital Insurance Program of Medicare
Part B	Supplementary Medical Insurance Program of Medicare
PCA	Primary Care Association
PCCM Waiver	Primary Care Case Management Medicaid Waiver
PCO	Primary Care Office
PCP	Primary Care Physician
PDPA	Prescription Drug Purchase Assistance Program
PEERS	Patient Experience Evaluation Report System
PHO	Physician Hospital Organization
PHP	Prepaid Health Plan
PHPC	Public Housing Primary Care
PHS	Public Health Service
PHS Act	Public Health Service Act
PIN	Policy Information Notice
PMPM	Per Member Per Month
POMR	Patient Oriented Medical Record
PPIR	Prevention, Problem Identification and Resolution
PPO	Preferred Provider Organization (or Private Practice Option)
PPS	Prospective Payment System
PSO	Provider Sponsored Organization

-Q-

QA	Quality Assurance
QIL	Quality Improvement Letter
QMB	Qualified Medicare Beneficiaries

-R-

RBRVS	Resource Based Relative Value Scale
RFP	Requests for Proposals
RHA	Regional Health Administrator
RHC	Rural Health Clinic
ROR	Reach Out and Read
RVU	Relative Value Unit

-S-

SAMHSA	Substance Abuse and Mental Health Service Administration
SCHIP	State Child Health Insurance Program
SIDS	Sudden Infant Death Syndrome
SIMIS	Shared Integrated Management Information System
SNP	Safety Net Provider
SOS	Scope of Services
SPA	State Plan Amendment
S/RPCA	State/Regional Primary Care Association
SSA	Social Security Administration
SSI	Supplemental Security Income

-T-

TA	Technical Assistance
TANF	Temporary Assistance for Needy Families
Title V	Maternal and Child Health Service Block Grant Statute
Title X	Family Planning Statute
Title XVIII	Medicare Statute
Title XIX	Medicaid Statute
TPL	Third Party Liability

-U-

UCR	Usual, Customary and Reasonable
UDS	Uniform Data System
UM	Utilization Management
UR	Utilization Review
USC	United State Code

-V-

VFC	Vaccines for Children Program
VHA	Veterans Health Administration
VICP	Vaccine Injury Compensation Program

-W-

WIC	Women, Infants, and Children Supplemental Food Program

Glossary of Terms and Concepts

340B: the 340B Drug Pricing Program limits the cost of drugs to federal purchasers and to certain grantees of federal agencies. Significant savings on pharmaceuticals may be seen by those entities that participate in this program.

1115 waiver: a Medicaid waiver that grants the Secretary of Health and Human Services broad authority to waive certain laws relating to Medicaid for the purposes of conducting pilot, experimental or demonstration projects which are "likely to promote the objectives" of the program. These demonstration waivers allow states to change provisions of their Medicaid programs, including: eligibility requirements, the scope of services available, the freedom to choose a provider, a provider's choice to participate in a plan, the method of reimbursing providers, and the statewide application of the program.

1915(b) waiver: allows states to require Medicaid recipients to enroll in HMOs or other managed care plan in an effort to control costs. The waivers allow states to: implement a primary care case management system; require Medicaid recipients to choose from a number of competing health plans; provide additional benefits in exchange for savings resulting from recipients' use of cost-effective providers; and limit the providers from which beneficiaries can receive non-emergency treatment. The waivers are granted for two years, with two-year renewals. Often referred to as "freedom-of-choice waiver."

-A-

actual charge: the amount a physician or other practitioner actually bills a patient for a particular medical service or procedure. The actual charge may differ from the customary, prevailing, and/or reasonable charges under Medicare and other insurance programs.

actuary: in insurance, a person trained in statistics, accounting, and mathematics who determines policy rates, reserves, and dividends by deciding what assumptions should be made with respect to each of the risk factors involved (such as the frequency of occurrence of the peril, the average benefit that will be payable, the rate of investment earnings, if any, expenses, and persistency rates), and who endeavors to secure as valid statistics as possible on which to base his assumptions.

ambulatory care: all types of health services which are provided on an outpatient basis, in contrast to services provided in the home or to persons who are inpatients. While many inpatients may be ambulatory, the term ambulatory care usually implies that the patient has come to a location other than his home to receive services and has departed the same day.

amortization: the act or process of extinguishing a debt, usually by equal payments at regular intervals over a specific period of time.

ancillary services: hospital or other inpatient health program services other than room and board, and professional services. They may include X-ray, drug, laboratory or other services not separately itemized, but the specific content is quite variable.

appropriation: an act of Congress that permits Federal agencies to incur obligations and to make payments out of the Treasury for specific purposes. An appropriation usually follows enactment of authorizing legislation. An appropriation is the most common form of budget authority, but in some cases the authorizing legislation provides the budget authority.

assigned risk: a risk which underwriters do not care to insure (such as a person with hypertension seeking health insurance) but which, because of State law or otherwise, must be insured. Insuring assigned risks is usually handled through a group of insurers (such as all companies licensed to issue health insurance in the State) and individual assigned risks are assigned to the companies in turn or in proportion to their share of the State's total health insurance business. Assignment of risks is common in casualty insurance and less common in health insurance. As an approach to providing insurance to such risks, it can be contrasted with pooling of such risks in which the losses rather than the risks are distributed among the group of insurers.

at risk: the state of being subject to some uncertain event occurring which connotes loss or difficulty. In the financial sense, this refers to an individual, organization (e.g., HMO) or insurance company assuming the chance of loss - through running the risk of having to provide or pay for more services than paid for through premiums or per capita payments. If payments are adjusted after the fact so that no loss can occur, then there is no risk. In fact, of course, losses incurred in one year may be made up by increases in premiums or per capita payments in the next year, so the "risk" is somewhat tempered. A firm that is at risk for losses also stands to gain from profits if costs are less than premiums collected. For a consumer being financially at risk usually means being without insurance or at risk for substantial out-of-pocket expenses. A second use of the term relates to the special vulnerability of certain populations to certain diseases or conditions; ghetto children are at risk for lead poisoning or rat bite; workers in coal mines are at risk for black lung disease.

authorization or authorizing legislation: in the Federal budget, legislation enacted by Congress which sets up or continues the legal operation of a Federal program or agency indefinitely or for a specific period of time, often three years in the health area. Such legislation is normally a prerequisite for subsequent appropriations, or other kinds of budget authority to be contained in appropriation acts. It may limit the amount of budget authority to be provided subsequently or may authorize the appropriation of "such sums as may be necessary"; in a few instances budget authority may be provided in the authorization. The term is often used more narrowly to refer to annual dollar limits specified in authorizing legislation or amounts which may be appropriated for the authorized program.

-B-

bad debts: the amount of income lost to a provider because of failure of patients to pay amounts owed. The impact of the loss of revenue from bad debts may be partially offset for proprietary institutions by the fact that income tax is not payable on income not received. They may also be recovered by increasing charges to paying patients by a proportional amount. Some cost-base reimbursement programs reimburse certain bad debts

beneficiary: a person who is eligible to receive, or is receiving, benefits from an insurance policy (usually) or health maintenance organization (occasionally) - usually include both people who have themselves contracted for benefits and their eligible dependents.

benefit package: a contractually defined set of health services, the cost of which is borne in full or in part by a health insurance plan.

Bureau of Primary Health Care (BPHC): the Bureau of Primary Health Care helps ensure that the people of our Nation receive adequate health care. BPHC programs include Black Lung Clinics, Community Health Centers, Federally Qualified Health Center Look-Alikes, Health Care for the Homeless, Healthy Schools Healthy Communities, Migrant Health Centers, Outreach and Primary Health Services for Homeless Children, and Public Housing Primary Care. It falls under the Health Resources and Services Administration of the U.S. Department of Health and Human Services.

-C-

capital: fixed or durable non-labor inputs or factors used in the production of goods and services, the value of such factors, or money specifically available for their acquisition or development. This includes, for example, the buildings, beds, and equipment used in the provision of hospital services. Capital goods are usually thought of as permanent and durable (in cases of doubt, those lasting over a year) and should be distinguished from such things as supplies. Refers also to investment in self (human capital, for example where preventive care is purchased because of the positive effect such care may have on one's ability to sustain future earning capacity).

capitation: a method of payment for health services in which an individual or institutional provider is paid a fixed, per capita amount for each person served without regard to the actual number or nature of services provided to each person. Capitation is characteristic of health maintenance organizations but unusual for physicians. Also, a method of Federal support of health professional schools authorized by the Comprehensive Health Manpower Training Act of 1971, P.L. 92-157, and the Nurse Training Act of 1971, P.L. 92-158 (sections 770 and 810 of the PHS Act), in which each eligible school receives a fixed capitation payment from the Federal government for each student enrolled, called a capitation grant.

categorically needy: persons who are both members of certain categories of groups eligible to receive public assistance, and economically needy. As used in Medicaid, this means a person who is aged, blind, disabled, or a member of a family with children under 18 (or 21, if in school) where one parent is absent, incapacitated or unemployed and, in addition, meets specified income and resources requirements which vary by State. In general, categorically needy individuals are persons receiving cash assistance under the AFW or SSI programs. A State must cover all recipients of AFDC payments under Medicaid; however, it is provided certain options (based, in large measure, on its coverage levels under the old Federal/State welfare programs) in determining the extent of coverage for persons receiving Federal SSI and/or State supplementary SSI payments. In addition, a State may cover additional specified groups, such as foster children, as categorically needy. A State may restrict its Medicaid coverage to this group or may cover additional persons who meet the categorical requirements as medically needy.

Centers for Medicare and Medicaid Services (CMS): the Centers for Medicare & Medicaid Services (CMS) is a federal agency within the U.S. Department of Health and Human Services. CMS is responsible for running the Medicare and Medicaid programs. With the Health Resources and Services Administration, CMS runs the State Children's Health Insurance Program (SCHIP), a program that is expected to cover many of the approximately 10 million uninsured children in the United States.

claims made policy: a form of malpractice insurance gaining increasing popularity among insurers because it increases the accuracy of ratemaking. In this type of policy the insured is covered for any claim made, rather than any injury occurring, while the policy is in force. Claims made after the insurance lapses are not covered as they are by a claims incurred policy. This type of policy was initially resisted by providers because of the nature of medical malpractice claims, which may arise several years after an injury occurs. A retired physician, for example, could be sued and not covered, unless special provisions are made to continue his coverage beyond his years of practice. There are also retrospective problems for providers who switch from a conventional policy to a claim made policy, since the latter policy would not cover claims arising from events occurring during the years when the conventional policy was in effect. Insurers marketing such policies are now offering providers the opportunity to purchase insurance for both contingencies.

Clinical Laboratory Improvement Amendments (CLIA): the Clinical Laboratory Improvement Amendments establish quality standards for all laboratory testing to ensure the accuracy, reliability and timeliness of patient test results regardless of where the test was performed. A laboratory is defined as any facility which performs laboratory testing on specimens derived from humans for the purpose of providing information for the diagnosis, prevention, treatment of disease, impairment of, or assessment of health. CLIA is user fee funded; therefore, all costs of administering the program must be covered by the regulated facilities, including certificate and survey costs.

coinsurance: a cost-sharing requirement under a health insurance policy which provides that the insured will assume a portion or percentage of the costs of covered services. The health insurance policy provides that the insurer will reimburse a specified percentage (usually 80 percent) of all, or certain specified covered medical expenses in excess of any deductible amounts payable by the insured. The insured is then liable for the remaining percentage of the costs, until the maximum amount payable under the insurance policy, if any, is reached.

community health center: an ambulatory health care program that serves an area with scarce or non-existent health services or a population with special health needs. Grant support for such centers was originally provided on a research and demonstration basis from the Community Action Program of the Office of Economic Opportunity. Subsequently, the funding authority for these projects shifted to section 314(e) of the Public Health Service Act. In 1975 legislation was approved, authorizing the Community Health Centers program under section 330 of the PHS Act. Community health centers coordinate Federal, State and local resources in a single organization capable of delivering both health care and related social services to a defined population. While such centers may not directly provide all types of health care, they usually take responsibility for arranging for all medical services needed by their patients.

community rating: a method of establishing premiums for health insurance in which the premium is based on the average cost of actual or anticipated health care used by all subscribers in a specific geographic area or industry and does not vary for different groups or subgroups of subscribers or with such variables as the group's claims experience, age, sex, or health status. the BMD Act(section 1302(8) of the PHS Act) defines community rating as a system of fixing rates of payments for health services which may be determined on a per person or per family basis "and may vary with the number of persons in a family, but mist be equivalent for all individuals and for all families with similar composition.,, The intent of community rating is to spread the cost of illness evenly over all subscribers (the whole community) rather than charging the sick more than the healthy for health insurance. Community rating is the exceptional means of establishing health insurance premiums in the United States today. The Federal Employee's Health Benefits Program for example is experience rated, not community rated.

consortium: generally, a formal arrangement between or among two or more entities, functioning under a set of written rules to which each entity (member) agrees to abide, for purposes of conducting joint actions to benefit each member. Consortiums may involve like entities (horizontal), or different entities (vertical), and may be formed for such purposes as shared staffing or system, joint purchasing of supplies or products, access to capital financing, revenue enhancement, new ventures (service or product lines), or to ward off destructive competition. (See also ‘shared services.’)

consultation: requesting advice from another provider, usually a specialist, regarding the diagnosis and/or treatment of a patient.

contingency reserves: reserves set aside by an insurance company for unforeseen or un-planned circumstances and expenses other than the normal losses incurred by the risks insured.

co-payment: a type of cost sharing whereby insured or covered persons pay a specified flat amount per unit of service or unit to time (e.g., $2 per visit, $10 per inpatient hospital day), their insurer paying the rest of the cost. The co-payment is incurred at the time the service is used. The amount paid does not vary with the cost of the service (unlike coinsurance, which is payment of some percentage of the cost).

cost-related or cost-based reimbursement: one method of payment of medical care programs by Medicare for health centers and, typically Blue Cross plans or government agencies, for services delivered to patients. In cost-related systems, the amount of the payment is based on the costs to the provider of delivering the service. The actual payment may be based on any one of several different formulae, such as full cost, full cost plus an additional percentage, allowable costs, or a fraction of costs. Other reimbursement schemes are based on the charges for the services delivered or on budgeted or anticipated costs for a future time period (prospective reimbursement).

cost sharing: provisions of a health insurance policy which require the insured or otherwise covered individual to pay some portion of his covered medical expenses. Several forms of cost-sharing are employed, particularly deductibles, coinsurance and co-payments. A deductible is a set amount which a person must pay before any payment of benefits occurs. A co-payment is usually a fixed amount to be paid with each service. Coinsurance is payment of a set portion of

the cost of each service. Cost-sharing does not refer to or include the amounts paid in premiums for the coverage. The amount of the premium is directly related to the benefits provided and hence reflects the amount of cost-sharing required. For a given set of benefits, premiums increase as cost-sharing requirements decrease. In addition to being used to reduce premiums, cost sharing is used to control utilization of covered services, for example, by requiring a large co-payment for a service that is likely to be overused.

-D-

deductible: the amount of loss or expense that must be incurred by an insured or otherwise covered individual before an insurer will assume any liability for all or part of the remaining cost of covered services. Deductibles may be either fixed dollar amounts or the value of specified services (such as two days of hospital care or one physician visit). Deductibles are usually tied to some reference period over which they must be incurred, e.g., $100 per calendar year, benefit period, or spell of illness. Deductibles in existing policies are generally of two types: 1) static deductibles which are fixed dollar amounts, and 2) dynamic deductibles which are adjusted from time to time to reflect increasing medical prices. A third type of deductible is proposed in some national health insurance plans: a sliding scale deductible, in which the deductible is related to income and increases as income increases.

dual choice: the practice of giving people a choice of more than one health insurance or health program to pay for or provide their health services. Usually done by employers who offer employees more than one group health insurance program, or a health insurance program and a prepaid group practice to choose from as a benefit of their employment. Characteristic of the Federal Employees Health Benefit Program. Required by the HM Act, of employers with respect to qualified HMOs.

-E-

effectiveness: the degree to which diagnostic, preventive, therapeutic or other action or actions achieves the intended result. Effectiveness requires a consideration of outcomes to measure. It does not require consideration of the cost of the action, although one way of comparing the effectiveness of actions with the same or similar intended results is to compare the ratios of their effectiveness to their costs. Usually synonymous with efficacy in common use.

efficiency: the relationship between the quantity of inputs or resources used in the production of medical services and the quantity of outputs produced. Efficiency has three components: input productivity (technical efficiency), input mix (economic efficiency), and the scale of operation. Efficiency is usually measured by indicators such as output per person-hour or cost per unit of output. However, such indicators fail to account for the numerous relevant dimensions (such as quality) of both inputs and outputs and are, therefore, only partial measures. Colloquially, efficiency measures the "bang for the buck" but, as the above suggests, it is a difficult concept to define and quantify. Ultimately, efficiency should probably be measured in terms of the costs of achieving various health outcomes defining it in terms of productivity assumes that what is produced is efficacious and used in an effective manner.

encounter: a face-to-face contact between a patient and a health care provider during which health care services are provided.

enrollee: one who enrolls in a pre-paid health program for health services.

expanded medical capacity: increased and expanded access to primary health care services by increasing penetration into a health center's current service area to improve the health status of the people in those areas.

experience rating: a method of establishing premiums for health insurance in which the premium is based on the average cost of actual or anticipated health care used by various groups and subgroups of subscribers and thus varies with the health experience of groups and subgroups or with such variables as age, sex, or health status. It is the most common method of establishing premiums for health insurance in private programs.

-F-

Federal Tort Claims Act (FTCA): the FTCA program allows 330 grantees to apply for coverage under the law that provides their Centers (and thereby employees and certain contractors) with immunity from medical malpractice suits for actions that fall within the scope of their employment. Potential plaintiffs must follow the requirements of the FTCA for relief, which would apply to acts, or omissions of covered entities in the performance of covered activities.

Federal Register: an official, daily publication of the Federal Government which publishes proposed rulemaking, final rules and regulations, and legal notices.
Federally Qualified Health Center: a facility located in a medically underserved area that provides preventive primary medical care under the general supervision of a physician. FQHCs must be a public or a private nonprofit entity, serve, in whole or in part, a Federally designated Medically Underserved Area (MUA) or Medically Underserved Population (MUP), and meet the statutory, regulatory and policy requirements for grantees supported under section 330 of the Public Health Service Act. FQHC status entitles them to receive reasonable cost reimbursement for Medicaid and Medicare services they provide in accordance with Section 1905 (1)(2)(B) of the Social Security Act. FQHCs may or may not receive section 330 funding.

Federally Qualified Health Center Look Alike (FQHC LA): a distinct class of Federally Qualified Health Centers under the law. Look Alikes are distinguished from other organizations that are recognized as FQHCs because Look Alikes receive no grant funding. Look Alikes, by definition, must meet the requirements for health centers (section 330 grantees) and are governed by the same expectations as grant funded health centers, i.e., be a public or a private nonprofit entity, serve, in whole or in part, a Federally designated Medically Underserved Area (MUA) or Medically Underserved Population (MUP), meet the statutory, regulatory and policy requirements for grantees supported under section 330 of the PHS Act, comply with the policy implementation documents for the Balanced Budget Act of 1997 amendment which added the requirement that an FQHC Look-Alike entity may not be owned, controlled or operated by another entity. By virtue of their FQHC status, they are entitled to receive reasonable cost reimbursement for Medicaid and Medicare services they provide in accordance with Section 1905 (1)(2)(B) of the Social Security Act.

fee for service: method of charging whereby a physician or other practitioner bills for each encounter or service rendered. This is the usual method of billing by the majority of the country's physicians. Under a fee for service payment system, expenditures increase only if the fees themselves increase but also if more units of service are charged for, or more expensive services are substituted for less expensive ones. This system contrasts with salary, per capita or prepayment systems, where the payment is not changed with the number of services actually used or if none are used. While the fee for service system is now generally limited to physicians, dentists, podiatrists and optometrists, a number of other practitioners, such as physician assistants, have sought reimbursement on a fee for service basis.

fee schedule: a list of charges for specific health care services.

fiduciary: relating to or founded upon a trust or confidence. A fiduciary relationship exists where an individual or organization has an explicit or implicit obligation to act in behalf of another person's or organization's interests in matters which affect the other person or organization. A physician has such a relationship with his/her patient and a hospital trustee with a hospital.

fiscal agent or intermediary: a contractor that processes and pays provider claims on behalf of a payer (such as Medicare or State Medicaid agency). Fiscal agents are rarely at risk, but rather serve as an administrative unit for the payer, handling the payment of bills. Fiscal agents may be insurance companies, management firms, or other private contractors.

free standing: an ambulatory care facility that has no physical connection with a hospital or other health care unit.

-G-

Generally Accepted Accounting Principles (GAAP): this body of uniform accounting standards is promulgated by the Governmental Accounting Standards Board, and allows for comparability between jurisdictions.

-H-

Health Insurance Portability and Accountability Act of 1996 (HIPAA): protects health insurance coverage for workers and their families when they change or lose their jobs. The Administrative Simplification provisions of the HIPAA require the Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data.

health maintenance organization (HMO): an entity with four essential attributes: 1) an organized system for providing health care in a geographic area, which entity accepts the responsibility to provide or otherwise assure the delivery of 2) an agreed upon set of basic and supplemental health maintenance and treatment services to 3) a voluntarily enrolled group of persons, and 4) for which services the HMO is reimbursed through a predetermined, fixed, periodic prepayment made by or on behalf of each person or family unit enrolled in the HMO without regard to the amounts of actual services provided. The HMO is responsible for providing most health and medical care services required by enrolled individuals or families. These

services are specified in the contract between the HMO and the enrollees. The HMO must employ or contract with health care providers who undertake a continuing responsibility to provide services to its enrollees. HMOs are of public policy interest because the Prototypes appear to have demonstrated the potential for providing high quality medical services for less money than the rest of the medical system.

health professional(s) shortage area (HPSA): any of the following which the Secretary determines has a shortage of health professional(s): (1) An urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services); (2) a population group; or (3) a public or nonprofit private medical facility.

hold harmless provision: a provision of law that prevents a governmental entity, institution or other party from suffering additional expenses or loss of benefits as a result of a change in a statute or regulations. Without such a provision such an entity or institution would be responsible for expenses not previously anticipated due to an expanded caseload, more generous coverage provisions, or both. On the other hand ' the use of hold harmless provisions often creates substantial confusion, heterogeneity and inequity in eligibility, coverage and responsibilities under a statute. In insurance, a provision offering the insured protection in disputes between the insurer and the provider of a covered service.

home health agency: an agency which provides nursing services and at least one additional therapeutic service in the home.

-I-

income poverty guidelines: income guidelines determined annually by the Community Service Administration which specify the level of income that is used to determine program eligibility, for numerous federal programs (e.g., food stamps), WIC, Hill-Burton and "zero par" categories at CHCs and MHCS).

incur: in insurance, to become liable for a loss, claim or expense. Cases or losses incurred are those occurring within a fixed period for which an insurance plan becomes liable whether or not reported, adjusted and paid.

individual practice association (IPA): a partnership, corporation, association, or other legal entity which has entered into an arrangement for provision of their service with persons who are licensed to practice medicine, osteopathy, dentistry, or with other health providers (a majority of whom are licensed to practice medicine or osteopathy), which arrangement provides that such persons provide their professional services in accordance with a compensation arrangement established by the entity; and to the extent feasible (I) that such persons use such additional professional personnel, allied health professions personnel, and other health personnel as are available and appropriate for the effective and efficient delivery of the services; (II) for the sharing by such persons of medical and other records, equipment, and professional, technical and administrative staff; and (III) for the arrangement and encouragement of the continuing education of such persons in the field of clinical medicine and related areas. IPAs are a source of professional services for HMOs and are modeled after medical foundations.

intensity of service: the quantities of services provided to patients in a hospital or same other identifiable setting. Intensity can be expressed in terms of a weighted index of services provided, or in terms of a set of statistics indicating the average number of laboratory tests, surgical procedures, X-rays, etc., provided per patient or per patient day. Intensity is a function of the type of program and its case-mix.

-J-

Joint Committee on Accreditation of Health Care Organizations (Accreditation): the Joint Commission evaluates and accredits nearly 18,000 health care organizations and programs in the United States. Previously known as JCAHO, this is now know as simply the Joint Commission.

-M-

malpractice: professional misconduct or lack of ordinary skill in the performance of a professional act. A practitioner is liable for damage or injuries caused by malpractice. Such liability, for same professions like medicine, can be covered by malpractice insurance against the costs of defending suits instituted against the professional and/or any damages assessed by the court, usually up to a maximum limit. Malpractice requires that the patient demonstrate some injury and that the injury be negligently caused.

managed care: a concept which assumes that each person who enters into the health care system has a provider who coordinates and manages his or her care, assures access to primary, secondary and tertiary care and coordinates efforts at all levels for effectiveness, cost efficiency, quality of care and avoidance of duplicate effort.

management information system: a system which provides management with information necessary for decision making.

Medicaid (Title XIX): a Federally-aided, State operated and administered program which provides medical benefits for certain low-income persons in need of health and medical care. The program, authorized by title XIX of the Social Security Act, is basically for the poor. It does not cover all of the poor, however, but only persons who are members of one of the categories of people who can be covered under the welfare cash payment programs - the aged, the blind, the disabled, and members of families with dependent children where one parent is absent, incapacitated or unemployed. Under certain circumstances states may provide Medicaid coverage for individuals who are not categorically related. Subject to broad Federal guidelines, States determine the benefits covered, program eligibility, rates of payment for providers, and methods of administering the program. Medicaid is estimated to provide services to some 25 million people, with Federal-State expenditures of approximately $40 billion in fiscal year 1985.

medically indigent: a person who is too impoverished to meet his/her medical expenses. It may refer to either persons whose income is low enough that they can pay for their basic living costs but not their routine medical care or, alternately, to persons with generally adequate income who suddenly face catastrophically large medical bills.

medically needy: in the Medicaid program, persons who have enough income and resources to pay for their basic living expenses (and so do not need welfare), but not enough to pay for their medical care. Medicaid law requires that the standard for income used by a State to determine if someone is medically needy cannot exceed 133 percent of the maximum amount paid to a family of similar size under the welfare program for the Family Investment Program (FIP). In order to be eligible as a medically needy, people must fall into one of the categories of people who are covered under the regular Medicaid program. They receive benefits if their income after deducting medical expenses is low enough to meet the eligibility standard. Forty States now provide Medicaid coverage to medically needy.

medically underserved area (MUA): a geographic location (i.e., an urban or rural area) which has insufficient health resources (manpower and/or facilities) to meet the medical needs of the resident population. Such areas are also defined by measuring the health status of the resident population, an area with an unhealthy population being considered underserved. The

term is defined and used several places in the PHS Act in order to give priority to such areas for Federal assistance.

medically underserved population (MUP): Population groups with economic barriers (low-income or Medicaid-eligible populations), or cultural and/or linguistic access barriers to primary medical care services. The term is defined and used several places in the PHS Act in order to give priority to such areas for Federal assistance.

Medicare (Title XVIII): a nationwide health insurance program for people aged 65 and over, for persons eligible for social security disability payments for over two years, and for certain workers and their dependents who need kidney transplantation or dialysis. Health insurance protection is available to insured persons without regard to income. Monies from payroll taxes and premiums from beneficiaries are deposited in special trust funds for use in meeting the expenses incurred by the insured. It consists of two separate but coordinated programs: hospital insurance (Part A) and supplementary medical insurance (Part B).

medigap policy: a supplemental health insurance policy designed to supplement Medicare.

mid-level practitioners: nurse practitioners and physician assistants.

-N-

National Health Service Corps (NHSC): a program which places U.S. health personnel in Health Professional Shortage Areas (HPSAs) for the purpose of improving the delivery of health care and services to persons residing in such areas. The Corps was established by the Emergency Health Personnel Act of 1970. The first Corps members were assigned in January, 1972.

new access point: a new delivery site for the provision of comprehensive primary and preventive health care services. New access points include new starts, which are organizations that do not currently receive funds under the section 330 program for which they are applying, and expansions, which are organizations that currently receive funds under a section 330 program, that propose to expand their capacity under that program to serve a new patient population through the establishment of one or more new primary health care service delivery sites.

notice of grant award (NGA): the unified notice of grant award is the document utilized by the Bureau of Primary Health Care to award funds to private non-profit and public organizations based on the approval of a grant application. The unified notice of grant award provides a description of funding awarded for community and migrant health centers, health care for the homeless, public housing primary care, and healthy schools health communities approved projects. The notice reflects acceptance of the budget breakdown by object class category as reflected on the Standard Form 424A submitted as part of the application or as revised.

notch: a sudden and sharp discontinuity in health or financial benefits for individuals with slightly different income. In certain public and medical assistance programs, an additional dollar of income can mean a total loss of benefits. For example, in Medicaid, families just below the income eligibility standard receive fully subsidized coverage while families with only slightly

more income and just above eligibility standards receive no benefits. Substantial incentives for families to restrict their incomes in order to remain eligible may result. Spend down provisions are used to compensate for notches. A notch may also occur when, without change in eligibility, cost-sharing requirements increase suddenly with a small change in income.

-O-

Office of Rural Health Policy (ORHP): the Office of Rural Health Policy promotes better health care service in rural America. The programs are established under titles XVIII and XIX on the financial viability of small rural hospitals, the ability of rural areas (and rural hospitals in particular) to attract and retain physicians and other health professionals, and access to (and the quality of) health care in rural areas. It falls under the Health Resources and Services Administration of the U.S. Department of Health and Human Services.

-P-

Policy Information Notices (PIN): provide official BPHC guidance to grantee organizations regarding a broad range of areas affecting BPHC grantees.

Point-of-Service Health Plan (POS): also identified as open-ended HMO. A plan combining the features of an HMO with an indemnity insurance option. The member uses the plan like an HMO and receives HMO coverage; but the member may exercise "freedom of choice" and seek care outside the HMO system with additional charges (higher copayments and deductibles, and submission of claims forms). Members choose how and from whom to receive services at the time they need them.

Pre-Application Guidance Letter (PAGL): the PAGL, which is sent to all grantees and is issued six months prior to the start of the budget period, provides information on the due date of a renewal application, general instructions regarding submission of the application, significant changes in the application instructions, and sometimes highlights new priorities for the fiscal year. It also provides information on the mid-year assessment of the grantee.

Preferred Provider Organization (PPO): an arrangement in which the health plan contracts with independent physicians, hospitals and other health care providers who become the "preferred" or "participating" providers. Providers typically accept reduced, "discounted fee-for-service" rates of reimbursement from the health plan in exchange for access to the PPO's enrollees. PPOs have fewer restrictions than HMOs (e.g., patients are not required to select a primary care physician or seek prior authorization for services). Patients may choose to receive care from providers who do not participate in the PPO, with higher co-payments and deductibles attached to services provided by non-participating providers.

prepaid health plan (PHP): generically, a contract between an insurer and a subscriber or group of subscribers whereby the PHP provides a specified set of health benefits in return for a periodic premium. In Medicaid, the term refers to organizational entities other than federally-qualified or state qualified HMOs (including most CHCs and NHCs) which are eligible for risk based contracting with State Medicaid agencies.

prepayment: inconsistently used, sometimes synonymous with insurance, sometimes refers to any payment ahead of time to a provider for anticipated services (such as an expectant mother paying in advance for maternity care), sometimes distinguished from insurance as referring to payment to organizations (such as HMOs, prepaid group practices and medical foundations) which, unlike an insurance company, take responsibility for arranging for and providing needed services as well as paying for them.

prevailing: a charge which falls within the range of charges most frequently used in a locality for a particular medical service or procedure. The top of this range establishes an over-all limitation on the charges that a carrier, which considers prevailing charges in reimbursement, will accept as reasonable for a given service, without adequate special justification. Current Medicare rules state that the limit of an area's prevailing charge is to be the 75th percentile of the customary charges for a given service by the physicians in a given area. For example, if customary charges for an appendectomy in a locality were distributed so that 10 percent of the services were rendered by physicians whose customary charge was $150, 40 percent by physicians who charged $200, 40 percent who charged $250, and 10 percent who charged $300 or more, then the prevailing charge would be $250, since this is the level that, under Medicare regulations, would cover at least 75 percent of the cases.

preventive medicine: care designed to prevent disease and or its consequences. a) Primary, such as immunization, aimed at preventing disease; b) Secondary, such as disease screening programs, aimed at early detection of disease; and c) Tertiary, such as physical therapy, aimed at restoring function after disease has occurred.

primary care: basic or general health care which emphasizes the point when the patient first seeks assistance from the medical care system and the care of the simpler and more common illnesses. The primary care provider usually also assumes ongoing responsibility for the patient in both health maintenance and therapy of illness. It is comprehensive in the sense that it takes responsibility for the overall coordination of the care of the patient's health problems, be they biological, behavioral or social. The appropriate use of consultants and community resources is an important part of effective primary care. Such care is generally provided by physicians, but is increasingly provided by other personnel such as nurse practitioners, physician assistants and nurse midwives.

Primary Care Associations (PCA): represent safety net providers throughout the state. They are uniquely positioned to work with providers, policy makers, program administrators, and communities to advance the goals of increasing access and reducing disparities. The Bureau of Primary Health Care provides grants to these organizations.

Primary Care Offices (PCO): located within State government. They are uniquely positioned to work with policy makers, program administrators, communities, and providers to advance the goals of increasing access and reducing disparities. The Bureau of Primary Health Care has cooperative agreements with primary care offices in each State.

primary care physician (PCP): a physician, usually an internist, pediatrician or family physician, devoted to general medical care of patients. Most HMOs require members to choose a primary care physician, who is then expected to provide or authorize all care for that patient.

Program Assistance Letter (PAL): a mechanism used by the Bureau of Primary Health Care to provide information to grantee organizations regarding a broad range of areas affecting grantees. A PAL does not establish an official requirement; rather it describes an issue and suggests some action that will benefit health centers.

Prospective Payment System (PPS): a payment method in which the amount of payment is set in advance, and the hospital is at least partially at risk for either the losses or gains made in treating the patient.

-Q-

quality assurance: activities and programs intended to assure the quality of care in a medical program, to remedy identified deficiencies in quality and to assess the programs own effectiveness.

-R-

reasonable cost: generally the amount which a third party using cost-related reimbursement will actually reimburse. Under Medicare, reasonable costs are costs actually incurred in delivering health services excluding any part of such incurred costs found to be unnecessary for the efficient delivery of needed health services. The law stipulates that, except for certain deductible and coinsurance amounts that must be paid by beneficiaries, payments to institutional providers (except hospitals) shall be made on the basis of the reasonable cost of providing the covered services. Medicare has prescribed rules setting forth the method or methods to be used and the items to be included in determining the reasonable cost of covered care. The regulations require that costs be apportioned between Medicare beneficiaries and other hospital patients so that neither group subsidizes the costs of the other. The items or elements of cost, both direct and indirect, which the regulations specify as reimbursable are known as allowable costs. Such costs are reimbursable on the basis of a hospital's actual costs to the extent that they are reasonable and are related to patient care. Under certain conditions the following items maybe included as allowable costs: capital depreciation; interest expenses; educational activities; research costs related to patient care; unrestricted grants, gifts and income from endowments; value of services of non-paid workers, compensation of owners; payments to related organizations; and return on equity capital of proprietary providers. Bad debts may only be included to the extent institutions fail in good faith efforts to collect the debts.

relative value unit (RVU): the unit of measure for a relative value scale. RVUs must be multiplied by a dollar conversion factor to become payment amounts. This is a common term in economics.

reserves: balance sheet accounts set up to report the liabilities faced by an insurance company under outstanding insurance policies. Their purpose is to secure as true a picture as possible of the financial condition of the organization (by permitting conversion of disbursements from a paid to an accrual basis). The company sets the amount of reserves in accord with its own estimates, State laws, and recommendations of supervisory officials and national organizations. Regulatory agencies can accept the reserves or refuse them as inadequate or excessive. For Blue Cross plans, for example reserves are set aside to cover average monthly claims and

operating expenses for some period of time. Reserves, while estimated, all are obligated amounts and have four principal components; reserves for known liabilities not yet paid; reserves for losses incurred but unreported; reserves for future benefits; and other reserves for various special purposes, including contingency reserves for unforeseen circumstances.

rural health clinics (RHCs): provider organizations in rural medically underserved areas or in designated health professional shortage areas. Unlike community/migrant health centers, RHCs may be for-profit organizations and are not required to have a governing board with a majority of clinic users. RHCs provide primary medical care, including pediatric and dental care (dependent on provider availability), and may deliver some primary, mental health care services. RHCs must have a nurse practitioner or physician assistant available at least 60 percent of the time. RHCs do not necessarily receive federal community health center grants, but they are eligible for Medicaid and Medicare following the same reimbursement policies that apply to community/migrant health centers.

Ryan White Comprehensive AIDS Resources Emergency (CARE) Act: the CARE Act was signed into law on August 15, 1990 to improve the quality and availability of care for people with HIV/AIDS and their families. The CARE Act funds primary care and support services for individuals living with HIV disease who lack health insurance and financial resources for their care. CARE Act programs reach more than 500,000 individuals each year. While ambulatory health care and support services are the primary focus of the legislation, training, technical assistance, and demonstration projects are also funded.

-S-

safety net: the health care system of each state that provides care to people, even if they do not have health insurance or money to pay for care. The safety net is comprised of doctors, dentists, nurses, and others who work in public hospitals, non-profit community hospitals, community-based and school-based health centers, public health clinics, and private practices, often in isolated rural and poor urban areas where most other providers choose not to practice.

scope of project: a description of a health center's project, categorized by five core elements: services, sites, providers, target population, and service area(s).
Shared Integrated Management Information System (SIMIS): The Shared Integrated Management Information System (SIMIS) Initiative was developed to significantly improve the health center's ability to collect, manage, and use information, in order to improve its ability to be more cost-competitive. The focus of the SIMIS Initiative is to strategically align health center information systems with business objectives in an effort to meet demands driven by competition in the marketplace.

shared services: the coordinated, or otherwise explicitly agreed upon, sharing of responsibility for provision of medical or non-medical services on the part of two or more otherwise independent hospitals or other health programs. The sharing of medical services might include, for example, an agreement that one hospital provide all pediatric care needed in a community and no obstetrical services while another undertook the reverse. Examples of shared non-medical services would include joint laundry or dietary services for two or more nursing homes. Common laundry services purchased by two or more health programs from one independent

retailer of laundry services are not usually thought of as shared services unless the health programs own or otherwise control the retailer.

spend down: a method by which an individual establishes eligibility for a medical care program by reducing gross income through incurring medical expenses until net income (after medical expenses) becomes low enough to make him eligible for the program. The individual in effect, spends income down to a specified eligibility standard by paying for medical care until his bills become high enough in relation to income to allow him to qualify under the program's standard of need, at which point the program benefits begin. The spend-down is the same as a sliding scale deductible related to the over-all income level of the individual. For example, if persons are eligible for program benefits because their income is $200/month or less, a person with a $300/month income would be covered after spending $100 out-of-pocket on medical care; a person with an income of $350 would not be eligible until he incurred medical expenses of $150. The term spend-down originated in the Medicaid program. An individual whose income makes him ineligible for welfare but is insufficient to pay for medical care, can become Medicaid-eligible as a medically needy individual by spending some income on medical care.

State Children's Health Insurance Program (SCHIP): a State and Federal partnership designed to help children without health insurance, many of whom come from working families with incomes too high to qualify for Medicaid but too low to afford private health insurance. The SCHIP law appropriated $40 billion in federal funds over 10 years to improve children's access to health coverage.

-T-

technical assistance (TA): technical assistance is a professional/client relationship designed to assess need, identify gaps, set goals and apply resources, help, know-how and/or coaching. It is designed to move the client organization toward change.

Title V: part of the Social Security Act, enacted in 1935, which authorized the creation of the Maternal and Child Health Services programs, providing a foundation and structure for ensuring the health of mothers and children. Title V is a Federal/State partnership to provide and assure mothers and children access to quality services; to reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children; to provide rehabilitation services to children under the age of 16; and to provide and promote family-centered, community-based, coordinated care for children with special health care needs; and to facilitate the development of community based systems of services for these children. Title V is administered by the Maternal and Child Health Bureau (MCHB) as part of the Health Resources and Services Administration, U.S. Department of Health and Human Services.

Title X: part of the Public Health Services Act of 1970, which was the first program devoted completely to family planning services. It provides Federal grants to provide money to subsidize family planning care to poor women. Grants are given to clinics, public agencies, private nonprofit organizations for training, technical assistance and other services.

-U-

Uniform Data System (UDS): a uniform set of tables, data elements and definitions pertaining to the operational, financial and administrative management of the program, which BPHC grantees are required to file on a semi-annual basis.

underwriting: in insurance, the process of selecting, classifying, evaluating and assuming risks according to their insurability. Its fundamental purpose is to make sure that the group insured has the same probability of loss and probable amount of loss, within reasonable limits, as the universe on which premium rates were based. Since premium rates are based on an expectation of loss, the underwriting process must classify risks into classes with about the same expectation of loss.

utilization review (UR): evaluation of the necessity, appropriateness and efficiency of the use of medical services, procedures and facilities. In a hospital this includes review of the appropriateness of admissions, services ordered and provided, length of stay, and discharge practices, both on a concurrent and retrospective basis. Utilization review can be done by a utilization review committee, peer review group, or public agency.