2021

National Health Center Training and Technical Assistance Needs Assessment:

SUMMARY ANALYSIS OF RESULTS

This report is a collaborative effort coordinated by the National Association of Community Health Centers (NACHC) on behalf of the 21 National Training and Technical Assistance Partners (NTTAPs) funded by the Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care (BPHC).

Association of Asian Pacific Community Health Organizations (AAPCHO)
Association of Clinicians for the Underserved (ACU) STAR2 Center
Capital Link
Community Health Center, Inc. (CHCI)
Corporation for Supportive Housing (CSH)
Farmworker Justice (FJ)
Health Partner on IPV + Exploitation
HITEQ Center
Health Outreach Partners (HOP)
Migrant Clinicians Network (MCN)
MHP Salud
National Association of Community Health Centers (NACHC)
National LGBTQIA+ Health Education Center
National Center for Equitable Care for Elders (NCECE)
National Center for Farmworker Health (NCFH)
National Center for Health in Public Housing (NCHPH)
National Center for Medical-Legal Partnership (NCMLP)
National Health Care for the Homeless Council (NHCHC)
National Nurse-Led Care Consortium (NNCC)
National Network for Oral Health Access (NNOHA)
School-Based Health Alliance

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TABLE OF CONTENTS

PURPOSE OF REPORT

This report summarizes the assessment process and highlights key findings associated with the National Health Center Training and Technical Assistance Needs Assessment. The assessment findings will inform future training and technical assistance (TTA) planning, development, dissemination, and evaluation to best support health center operational needs. The ultimate goal of the assessment is to help health centers advance access, quality, impact, and rebuild after the novel coronavirus disease outbreak (COVID-19). The use of these findings will assist health centers as they adapt and thrive in a rapidly evolving health system with support from coordinated, accessible and relevant TTA resources.

BACKGROUND ON ASSESSMENT

The Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care (BPHC) tasked NACHC with developing, implementing, and analyzing a nationally coordinated TTA needs assessment in collaboration with 21 National Training and Technical Assistance Partners (NTTAPs) who support health centers in increasing access to primary care, increasing equity and improving quality. The needs assessment was designed to reduce the burden of multiple assessments on health center staff (leadership/executive team, front line and operations staff). The purpose of this effort is to inform and coordinate the resources and efforts of HRSA/BPHC, NTTAPs, Primary Care Associations (PCAs), Health Center Controlled Networks (HCCNs) and to facilitate the provision of coordinated, collaborative TTA. Utilizing the 2018 needs assessment as a starting point, the 2021 needs assessment tool went through various revisions to incorporate feedback from NTTAPs, BPHC, the Needs Assessment Working Group (NAWG), and representative PCAs and HCCNs. John Snow, Inc. (JSI) served as NACHC's contracted evaluation and assessment subject matter experts (SMEs). The 2021 TTA needs assessment was distributed during Fall 2021 to health centers throughout the country.

ASSESSMENT DEVELOPMENT AND PILOTING

Various stakeholders were engaged in the development of the 2021 TTA needs assessment. This involved input from SMEs to address specific topics in the tool (e.g., telehealth policy/practices, COVID-19, and health equity) and ensure alignment with BPHC's Advancing Health Center Excellence seven key domains. NACHC engaged with their contracted consultant, JSI, to revise the tool. Specific revisions of the tool considered:

- **2018 lessons learned:** Some topics are covered within various domains. The tool was revised to remove duplicative questions, and it was reorganized to ensure topics within domains are in the most relevant sections. Through reorganization, several questions were removed to shorten the length of the tool while maintaining the integrity of NTTAPs- desired topics. To maintain the assessment's duration, questions were added only when accompanied by the deletion of another question.

- **BPHC Advance Health Center Excellence domain alignment:** Domains drive how the assessment is organized. Domain categories were reorganized from alignment with the National Resource Center Clearinghouse topic areas to BPHC's Advance Health Center Excellence domain-based maturity model to characterize overall health center performance: 1. Access and Affordability; 2. Patient Experience; 3. Quality, Patient Care, and Safety; 4. Population Health and Social Determinants of Health; 5. Financial Sustainability; 6. Workforce; 7. Governance and Management.

- **Emergency Preparedness:** One additional domain was added to reflect the ongoing COVID-19 pandemic: Emergency Preparedness. Alignment with BPHC's maturity model allows for further advancement of BPHC's TTA efforts, of which NTTAPs are a significant component.
- **Needs Assessment Work Group (NAWG) top 10 recommendations:** Working group members, comprised of NTTAP representatives, provided comprehensive feedback about the process and content included in the 2018 needs assessment. Recommendations were prioritized, and the top 10 recommendations were put forward for inclusion in the 2021 version of the tool.
- **JSI SME feedback:** The JSI team, comprising technical advisors and assessment methodology and design SMEs, provided review and recommendations to address specific topics for inclusion in the tool—for example, new or updated questions on telehealth policy/practices, infectious disease/immunizations, workforce wellness, unique needs of special populations, anti-racism and diversity efforts, and financial sustainability.
- **BPHC feedback:** BPHC review strengthened the tool and confirmed the intent to align with BPHC's strategic priorities and standards. Specific recommendations included alignment with special populations terminology, the addition of refugees and those at risk of HIV, and the inclusion of a question about where health centers would like to be in five years with relation to the maturity model.
- **NACHC internal feedback:** JSI engaged NACHC staff for feedback and input throughout the revision process. NACHC provided valuable input on BPHC priority areas and contributed suggestions for consolidating responses to ensure the duration of the tool was maintained or reduced.

NACHC secured approval from BPHC to pilot the tool with 13 health center participants from May 4, 2021, to June 4, 2021. NACHC, NAWG, and JSI's technical advisors identified pilot participants that represented diversity in rural/urban status, large/small health centers, geographic location, funding streams, and health center staff positions. In general, respondents answered positively concerning the length, clarity, and usefulness of the needs assessment questions. No major changes were identified through the pilot process, but several formatting changes were included (e.g., adding a progress bar and changing the format of the health center organization field).

FIELDING STRATEGY

The NTTAPs used a collective strategy for fielding the assessment to all health center organizations across the country to ensure a broad outreach. The fielding strategy objectives were to ensure a sufficient response rate and respondent composition to provide meaningful, actionable results. Based on feedback regarding health center survey fatigue and substantial strain on the time of health center staff due to the ongoing COVID-19 pandemic/emergency operations, the assessment was delayed until August 2021 from Spring 2021. The NTTAPs used a multi-pronged approach to field the assessment in an effort to gain input from a variety of health center staff types/roles and to engage staff who remained busy responding to the COVID-19 pandemic in their communities and patient population. The approach included the following:

- ☑ Emails to all health center leadership, specifically chief executive officers and chief medical officers, requesting their input and their encouragement of their staff to respond;
- ☑ Broad marketing to health center program staff across the country through multiple BPHC communication streams, including the Digest and special Bulletin;
- ☑ Promotion through 21 NTTAPs, including promoting the needs assessment link on organizational websites and through webinars, emails, conference events, and social media accounts; and
- ☑ Promotion through Primary Care Associations, who partnered with the NTTAPs to follow-up with health centers in their respective states to ensure a robust state-wide response to the assessment.

METHODOLOGY

The national needs assessment was administered using Qualtrics, an online platform for survey design. Inclusion criteria required that participants were employed at a Federally Qualified Health Center (FQHC) or a Health Center Program Look Alike (LAL) and had completed all questions within the eight TTA domains, which is how the needs assessment tool was organized (7 domains from the BPHC Advance Health Center Excellence framework plus the domain of Emergency Preparedness).

Measures

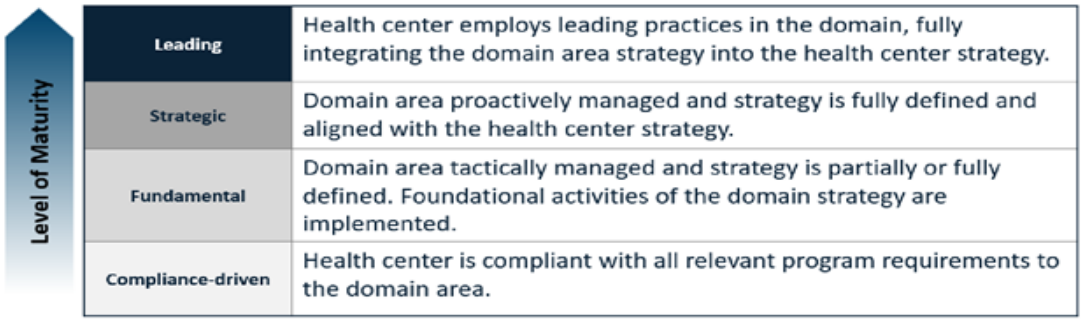
In order to quantify TTA needs by organizational size, health centers were divided into two groups based on the total number of patients. Small health centers were defined as serving 10,000 or fewer patients. Large health centers were defined as serving 10,000 or more patients.

Geographical Location. Rural or urban classification of health centers was derived from the 2020 UDS dataset, though there is a limitation to using this designation. Because UDS data is self-reported, it may not accurately depict the true number of rural and urban health centers.

Vulnerable Populations. Vulnerable populations included those with a high proportion of 1) uninsured patients, 2) elderly patients (ages 65+), 3) patients who identify as Asian, Hawaiian, or Other Pacific Islander (AHOPI), and 4) veteran patients. A health center was classified as having a high proportion if the percentage of the population served by that organization was greater than one standard deviation from the mean of all UDS health centers that reported data.

Special Population Funding Type. Responses were also analyzed by Section 330 Special Population grantee type in order to determine TTA needs of various special populations: 1) migrant and seasonal agricultural worker patients, 2) homeless patients or those at risk of homelessness, and 3) residents of public housing.

Maturity Model. Health center executive team respondents were asked to rate their health center's maturity level on each TTA domain. Maturity levels were developed by the U.S. Health Resources and Services Administration (HRSA) Bureau of Primary Health Care (BPHC) as part of the Advancing Health Center Excellence framework. A health center may rate themselves as 1) compliance-driven, 2) fundamental, 3) strategic, or 4) leading.



Analysis

The analysis utilized two data sources: 1) 2021 National Health Center Needs Assessment data and 2) 2020 HRSA Uniform Data System (UDS) data. The assessment's raw dataset initially included 2,063 responses. By applying exclusion criteria, 957 responses were dropped. Responses were excluded if respondents did not complete any TTA domains (597), if they did not complete all questions concerning the eight TTA domains (303), if they were not a 2020 FQHC or LAL (4), or if they provided duplicate responses (53). The final analytic dataset consisted of 1,106 responses.

Health Center—Level versus Individual-Level Analysis

Assessment responses were aggregated at the health center level in order to capture one representative response for each FQHC and LAL. Responses from the same health center organization were identified and aggregated and put into UDS groups based upon shared UDS number and city. For organizations with multiple respondents, a TTA domain was attributed to an organization if any respondent from that organization identified that domain as a need. After responses were aggregated at the health center level, we examined TTA differences within UDS groups. Meaningful differences in TTA domains within UDS groups were identified by large absolute differences in percentage relative to other TTA domains. Assessment responses were also examined at the individual level in order to capture TTA needs that did not appear at the health center level. Individual-level responses were analyzed as independent of one another.

Drop-Out Analysis

Respondents who dropped out of the survey before completing all eight TTA domains were excluded from the final analytic dataset due to potential bias towards TTA domain presented earlier in the survey. A separate, supplementary analysis was conducted on dropouts in order to further explore TTA needs of respondents who did not complete the entire survey. Demographic characteristics and TTA needs among these 303 dropout respondents were similar to the overall analysis and are summarized in Appendix 1.

RESULTS

Response Rate

The 2021 needs assessment generated responses from 1,106 participants, representing 36.0% of health centers across the United States (Appendix 3). Of all health center staff respondents, 76.0% identified as female, 22.0% as male, 0.4% as other, and 1.6% preferring not to answer. More than half of the respondents were between the ages of 45 and 64 (55.3%). The majority of respondents identified as White (66.9%), followed by Black or African American (15.6%), Hispanic or Latino (11.6%), Asian, Hawaiian, or Other Pacific Islander (5.9%), and American Indian or Alaska Native (2.3%). When looking at staff type, 36.6% were executive team members, and 63.4% belonged to the health center front line and operations staff. Nearly 47% of the front line and operations staff worked in management or administration and almost 26.3% worked in direct patient care (18.7% clinical and 7.6% non-clinical). These descriptive statistics are summarized in Appendix 4.

The assessment was fielded to all

1,375

Federally Qualified Health Center Programs (FQHCs), as well as

107

Health Center Program Look-Alikes (LALs).

Characteristics of Health Centers

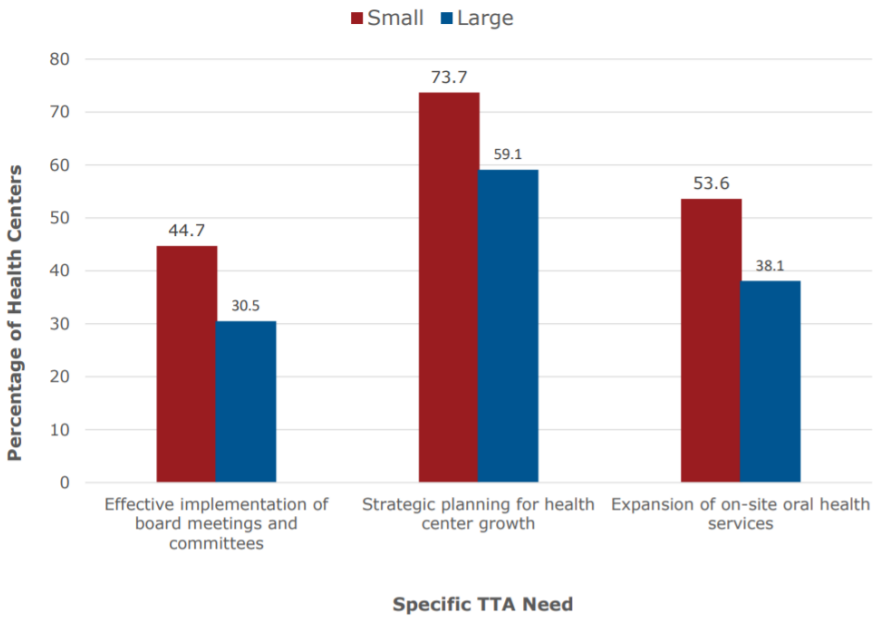
Of the 1,375 FQHCs, 507 (36.9%) had at least one respondent. Of the 107 LALs, 26 (24.3%) had at least one respondent. UDS characteristics were generally consistent between responding FQHCs and non-responding FQHCs, indicating that assessment results are likely representative of federally-funded health centers (Appendix 5).

Health Center—Level Analysis

Top Three TTA Needs. Overall rankings of health centers' TTA needs revealed three top TTA domains: 1) Quality, Patient Care, and Safety (69.4%); 2) Workforce Experience and Development (60.0%); and 3) Access and Affordability (52.9%). These TTA categories were consistently ranked as the top three TTA needs across UDS characteristics, though there were notable differences within UDS characteristics across all eight TTA domains:

TTA Needs by Size. Small health centers more often reported governance as a TTA need (Figure 1), while large health centers more often reported workforce experience and development, patient experience, and population health and social determinants as TTA needs.

Figure 1. Small health centers more often reported governance and management as a TTA need



TTA Needs by Geographical Location. TTA needs were mostly comparable across rural and urban health centers. Urban health centers more often reported patient experience as a need, while rural health centers more often reported emergency preparedness as a TTA need (Table 1).

Table 1. TTA Differences between Rural and Urban Health Centers

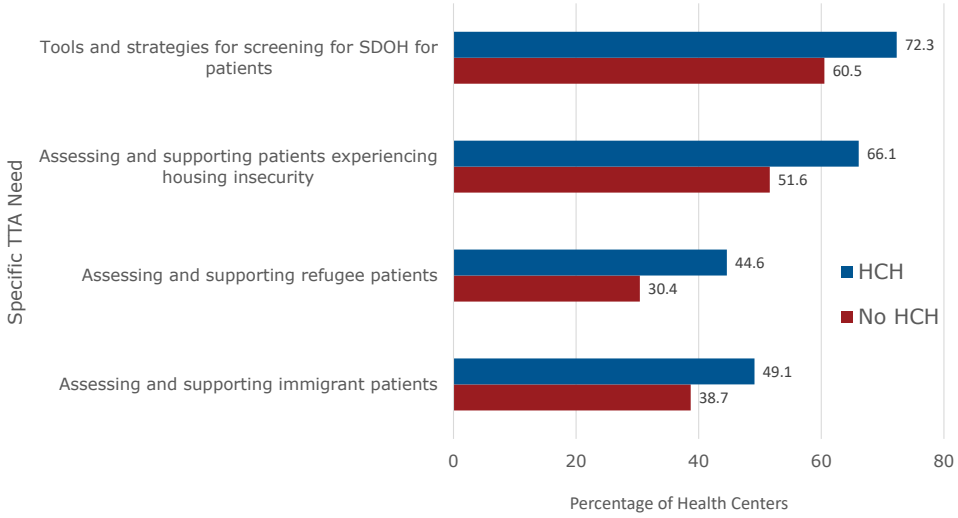
Patient Experience	**Rural (*n*=216)**		**Urban (*n*=291)**	
Specific TTA Need	***n***	**%**	***n***	**%**
Culturally responsive staff equipped to serve special and vulnerable populations	101	46.8	172	59.1
Emergency Preparedness	**Rural (*n*=216)**		**Urban (*n*=291)**	
Specific TTA Need	***n***	**%**	***n***	**%**
Cybersecurity protection, risk mitigation, and crisis response	136	63.0	170	58.4
Contingency planning (e.g., quick leadership transfer)	123	56.9	149	51.2

TTA Needs by Vulnerable Population. Health centers with a high proportion of elderly patients less often reported patient experience as a TTA need, compared to those with a lower proportion of elderly patients (30.3% vs. 51.7%). Health centers with a high proportion of veterans less often reported patient experience (33.3% vs. 50.3%) and quality, patient care, and safety (65.0% vs. 75.0%) as TTA needs. Health centers with at least one school-based service site more often reported workforce experience and development as a TTA need, compared to health centers without a school-based service site (64.0% vs. 54.4%).

TTA Needs by Special Population Funding Type. The top three TTA needs across all special population funding types aligned with the top three TTA rankings overall: 1) quality, patient care, and safety; 2) workforce experience and development; and 3) access and affordability.

» *Healthcare for the Homeless (HCH) programs* more often reported population health and social determinants as a TTA need (Figure 2), compared to health centers without HCH programs (55.4%vs. 43.0%). Only 15.2% of health centers with HCH programs reported emergency preparedness as a TTA need, compared to 22.5% of health centers without HCH programs.

Figure 2. Health center with Healthcare for the Homeless (HCH) programs more often reported population health and social determinants as a TTA need



» *Public Housing Primary Care (PHPC) programs* more often reported population health and social determinants (60.5% vs. 44.4%) and quality, patient care, and safety (79.1% vs. 68.5%) as TTA needs, compared to non-public housing primary care programs (Table 2).

Table 2. TTA Differences between Health Centers with Public Housing Primary Care Programs and Health Centers without Public Housing Primary Care Programs

Population Health and Social Determinants	**Public Housing (*n*=43)**		**No Public Housing (*n*=464)**	
Specific TTA Need	***n***	**%**	***n***	**%**
Establishing HIT capabilities for data collection specific to survivors of intimate-partner violence/human trafficking	23	53.5	200	43.1
Assessing and supporting patients lacking transportation/ access to public transportation, including information for state/local resources	25	58.1	229	49.4
Assessing and supporting patients experiencing social isolation, including community-dwelling older adults, through support groups, community activities, and volunteer services	26	60.5	243	52.4
Techniques for assessing community-level barriers to health equity	33	76.7	309	66.6
Strategies and tactics for addressing community-level barriers to health equities	35	81.4	322	69.4
Quality, Patient Care, and Safety	**Public Housing (*n*=43)**		**No Public Housing (*n*=464)**	
Specific TTA Need	***n***	**%**	***n***	**%**
Accessibility training for clinical providers working with patients with disabilities (e.g., visual and hearing impairment, as well as physical, invisible, emotional, and cognitive disabilities)	23	53.5	165	35.6
Integrating behavioral health into primary care	24	55.8	216	46.6

Individual-Level Analysis

Overall, individual respondent-level findings were largely consistent with those found at the health center level. However, there was considerable variability in TTA needs among individual respondents, which differed from the variability in health center needs described above:

TTA Needs by Size. In contrast to the health center-level analysis, the individual-level analysis found that respondents from small health centers more often reported access and affordability as TTA needs, compared to large health centers (54.7% vs. 44.9%). Notably, there was no variation between small and large health centers in population health and social determinants TTA, even though this variation was present at the health center level.

TTA Needs by Geographical Location. At the individual level, respondents from urban health centers more often reported population health and social determinants as a TTA need, compared to respondents from rural health centers (35.3% vs. 28.7%). There was no variation between rural and urban health centers in patient experience TTA, even though this variation was present at the health center level.

TTA Needs by Vulnerable Populations. In contrast to the health center-level analysis, the individual-level analysis showed that respondents from health centers with a high proportion of veteran patients more often reported workforce as a TTA need, compared to respondents from health centers without a high proportion of veterans (56.4% vs. 44.2%).

TTA Needs by Special Populations Funding Type. Overall, variability within funding types was similar to health center-level findings. There were no marked differences between health centers with at least one school-based site and those without, even though this variation was present at the health center level.

Top TTA Sub-domains. Table 3 summarizes top-level findings for the top three TTA domains selected by respondents. See Appendices 8-15 for full results of these TTA needs by sub-domain.

Table 3. Top TTA Needs by Subdomain (*n*=1,106)

Workforce Experience and Development			
TTA Subdomain	**Specific TTA Need**	***n***	**%**
Leadership	Empowerment of health center staff (e.g., coaching and mentoring)	695	62.8
Recruitment and Retention	Improving job satisfaction and well-being of staff	690	62.4
	Developing a comprehensive staff retention plan	684	61.8
Access and Affordability			
TTA Subdomain	**Specific TTA Need**	***n***	**%**
Outreach and Enabling Services	Development and implementation of outreach programs and/or partnerships to respond to and address community-identified health disparities	609	55.1
	Development of outreach services, such as community health workers, to address chronic diseases or conditions (e.g., diabetes, hypertension, cancer, substance use and behavioral health)	653	59.0
	Evaluation of outreach programs (e.g., effectiveness at engaging special and vulnerable populations, and sustainability)	605	54.7

Quality, Patient Care, and Safety			
TTA Subdomain	**Specific TTA Need**	***n***	**%**
Data Collection and Use	Leveraging use of data to guide/inform clinical quality and operational and financial improvement (e.g., at the individual and population level, and patient experience data)	594	53.7
	Collecting and optimizing use of enabling (non-clinical) services data and patient-level data on social determinants of health to enhance patient outcomes and health equity	604	54.6
General Patient Care and Safety	Expansion of telehealth care provision to improve continuity of care	509	46.0

Executive team respondents more often reported **workforce** and **finance** as their other top TTA needs, while front line and operations staff respondents more often reported **access and affordability** and **patient experience**.

Respondents in both direct patient clinical and non-clinical care reported **access and affordability and quality**, **patient care, and safety** as their top two TTA needs.

Health Center Roles

Top TTA Needs of executive team versus front line and operations staff. Both executive team and front line and operations staff respondents reported **quality, patient care, and safety** as a top TTA need.

Top TTA Needs among front line and operations staff. However, respondents in direct patient clinical care more often reported **patient experience** as their number three TTA need, while respondents in direct patient non-clinical care more often reported **population health** as their number three TTA need. Respondents working in management/administration roles most often reported **workforce, access and affordability** and **quality, patient care,** and **safety** as their top two TTA needs. Interestingly, facility/non-clinical support staff more often reported emergency preparedness as a TTA need than any other staff type in the front line and operations staff.

Maturity Levels

Most executive team respondents rated themselves as either fundamental or strategic in all domains. When examining compliance-driven responses, the TTA domains most often reported were population health and social determinants (23.9%) and emergency preparedness (23.4%). When examining leading responses, the TTA domains most often reported were finance (20.8%) and governance (16.2%).

Emerging Issues or Trends

Health center leadership identified additional TTA needs around emerging issues and trends they anticipated needing support for (Appendix 20). The top three areas related to workforce, emergency preparedness, and funding. New topics identified in workforce included securing competitive benefit packages, satisfaction surveys, burnout and joy in the workplace, change management for new leadership, and intergenerational discord. Respondents identified emergency preparedness topics

concerning natural disaster preparation and response, financial planning for emergencies, hazard assessment and security, violent patients, and active shooter scenarios. Financial topics included mergers and acquisitions, partnership with hospitals, and increasing reimbursement for enabling and social services. Additional unique topics raised were engagement in climate change efforts; maintaining OSHA compliance; reconnecting with patients post-pandemic; operating in non-traditional locations; leadership training on diversity, equity, and inclusion; handling service area overlap; scaling growth/growth management; and primary care in the future, such as remote patient monitoring, artificial intelligence, and data-driven decision-making.

Where Health Centers See Themselves in Five years

Health center leaders were asked what TTA is needed to help their health center achieve their five-year visions (Appendix 21). Three distinct areas rose to the top: workforce, financing, and clinical care/quality, which mirrors the top, near-term TTA needs identified by health center leaders. More than half of the respondents mentioned health center workforce, including improving employee experience and satisfaction. Nearly half of the respondents noted the need for TTA around financing, including understanding and participating in value- based payment and becoming financially sustainable. Clinical care and quality were noted by nearly a third of the respondents, with mention of improving the patient experience and improving quality outcomes.

Health Center Feedback on TTA Accessed in the Past Year

TTA Utilization. In total, 891 (82.7%) of health centers accessed TTA in the past year, and 187 (17.3%) indicated that they had not utilized any TTA in the past year. When asked which sources of TTA were accessed in the past year, 50.4% of the respondents reported a Primary Care Association (PCA), 31.4% reported a Health Center Controlled Network (HCCN), 29.6% reported Other HRSA-Funded TTA Provider, and 21.1% reported a National Training and Technical Assistance Partner (NTTAP).

Reasons for Not Accessing TTA in the Past Year. While 28.3% reported that their health center organization plans to access TTA sources within the next year, but that they had not accessed any at the time of the assessment, a majority of respondents reported "Other" (45.7%). Respondents providing "Other" responses were prompted to provide a qualitative response. Most responses were nonspecific, but one clear theme emerged, relating to the COVID-19 pandemic: 14 (16.7%) respondents reported they had not utilized TTA in the past year, due to lack of capacity and system overwhelm.

TTA Source Accessibility. Finally, 111 (15%) of the respondents reported a need for which they were unable to find an appropriate TTA source. These respondents were prompted to provide a qualitative response describing what type of TTA their health center had difficulty locating. Based on a review of the responses, the most prominent categorical themes were related to billing and management, staff recruitment/retention and organizational needs, and training for clinical providers

SUMMARY CONCLUSION

The 2021 National Health Center Needs Assessment found common TTA needs among health centers across the nation, including workforce, access and affordability and quality patient care, and

elevated distinct TTA needs of health centers by size, geography, funding type, and staff role. Assessment data can be used to further understand similarities and differences in specific TTA topics by health center characteristics and staff roles. Future research could include health center staff focus groups to gain more context on these identified TTA needs. Health center staff could provide detail on how identified TTA needs relate to health centers, current and near-term realities, and in relation to their strategic priorities and available resources. Finally, TTA needs are identified by NTTAPs and BPHC throughout the year through annual analysis of the Uniform Data System (UDS), learning collaboratives, TTA evaluations, and website analytics, among other methods. The findings from the 2021 needs assessment provide a robust method to complement this continuous data analysis and feedback that NTTAPs and BPHC collect.

APPENDICES

Appendix 1

Drop-out Response Analysis

Drop-out Response Analysis

Drop-out responses: descriptive characteristics of drop-out respondents (N=303)

Characteristic	N	%
Age		
Under 21	0	0.0
21-24	7	2.3
25-34	52	17.2
35-44	68	22.4
45-54	81	26.7
55-64	62	20.5
65-74	22	7.3
75+	2	0.7
Prefer not to answer	9	3.0
Sex		
Female	245	80.9
Male	50	16.5
Other	0	0.0
Prefer not to answer	8	2.6
Race/Ethnicity		
American Native or Alaskan Native	1	0.3
Asian	19	6.3
Black or African-American	39	12.9
Hispanic or Latino or Spanish Origin	58	19.1
Native Hawaiian or Other Pacific Islander	1	0.3
White	184	60.7
Other	2	0.7
Prefer not to answer	14	4.6
Staff Type		
Executive team	65	21.5
Community health center workforce	238	78.5
Direct patient clinical care	45	18.9
Direct patient non-clinical care	22	9.2
Facility/non-clinical support	17	7.1
Management staff/administration	96	40.3
Quality improvement	14	5.9
Other	44	18.5

Drop-out responses: over the next two years, I anticipate my health center organization will need ACCESS AND AFFORDABILITY TTA in the areas of: (N=303)

Sub-Domain	N	%
Outreach and Enabling Services:		
Implementation of case management services	64	21.1
Implementation of patient-centered transportation strategies	75	24.8
Development and implementation of outreach programs and/or partnerships to respond and address community identified health disparities	96	31.7
Development of outreach services, such as community health workers, to address chronic diseases or conditions (e.g., diabetes, hypertension, cancer, behavioral health)	97	32.0
Evaluation of outreach programs (e.g., effectiveness at engaging special and vulnerable populations, sustainability)	87	28.7
Housing services:		
Care coordination with housing providers	60	19.8
Care coordination with temporary housing and/or shelter provisions	64	21.1
Assisting with housing applications for patients seeking public housing or other housing assistance (e.g. Housing Choice Voucher, Section 8)	63	20.8
Coordinating with Community Programs/Partners:		
Partnering with caregiver support services (i.e., spousal support groups)	67	22.1
Partnering with family support services (i.e., parenting classes)	74	24.4
Assess and support connection to educational resources for patients (e.g., navigation towards getting a general educational diploma (GED))	52	17.2
Assess and support connection to employment resource	57	18.8
Language and/or Translation Services:		
Implementation of culturally and linguistically appropriate services (CLAS) Standards	69	22.8
Developing, monitoring implementation of a Limited English Proficiency (LEP) Plan	53	17.5
Provision of oral interpretation services	72	23.8
Provision of written translation services	59	19.5
Health Insurance Eligibility and Enrollment:		
Development of healthcare navigator services	73	24.1
Improving coordination with Military and Veterans Benefits and Services	55	18.2
Medical - Legal Partnerships:		
Understanding the core components of medical-legal partnerships	55	18.2
Identifying and engaging a legal partner	38	12.5
Using medical-legal partnerships to affect policy changes that benefit patients and communities	57	18.8
Evidence-based or promising practices for developing workflows for medical-legal partnership referrals, sharing information, integrating, and medical-legal partnerships	65	21.5
Screening for legal needs; aligning with social determinants of health screen	57	18.8
Other:		
Other, please specify	5	1.7

Drop-out responses: over the next two years, I anticipate my health center organization and/or Board will need GOVERNANCE AND MANAGEMENT TTA in the areas of: (N=144)

Sub-Domain	N	%
Governance:		
Effective board governance practices/approaches	41	28.5
Board culture and dynamics	37	25.7
Board's role in strategic planning	36	25.0
Board's role in financial oversight	35	24.3
Board's role in clinical quality oversight	39	27.1
Succession planning	37	25.7
Board recruitment and retention (i.e., members that represent special and vulnerable populations, with an emphasis on racial and ethnic diversity)	45	31.3
Effective implementation of board meetings and committees	26	18.1
Board education materials in non-English (Specify what language(s))	8	5.6
Strategic Direction/Priority Setting:		
Design and implementation of needs assessments	42	29.2
Data analysis and interpretation to inform and improve service delivery	39	27.1
Quality improvement and quality assurance methods and approaches	45	31.3
Training health center leadership and boards about health care transformation and navigating value-based payment	47	32.6
Developing a vision and strategy around payment and delivery reform	38	26.4
Health Information Technology		
Electronic Health Record (EHR) optimization	50	34.7
EHR interoperability, ability to exchange data with others (e.g., to support care coordination and services integration)	38	26.4
Transitioning/switching to a new EHR system from an old EHR system (e.g., planning, implementation)	27	18.8
Telehealth integration with EHR/HIT systems	37	25.7
Deploying decision support systems (e.g., implementation, use, restructuring work- flows) and developing effective data dashboards	33	22.9
Expansion Planning:		
Strategic planning for health center growth	56	38.9
Workforce expansion	53	36.8
Partnership development to support health center capital planning and development, including co-location with housing and/or other services	30	20.8
Behavioral health services expansion and partnering with local providers	47	32.6
Expanding capacity to meet the behavioral health needs of special and vulnerable populations	49	34.0
Expansion of on-site oral health care services	38	26.4
Development and implementation (e.g., financial models, sustainability, and utilization) for special populations	34	23.6
Other:		
Other, please specify	3	2.1

Drop-out responses: over the next two years, I anticipate my health center organization will need QUALITY, PATIENT CARE, AND SAFETY TTA in the areas of: (N=111)

Sub-Domain	N	%
Data collection and use:		
Leveraging use of data to guide/inform clinical quality, operational and financial improvement (e.g., at the individual and population-level and patient experience)	37	33.3
Collection and optimizing use of enabling (non-clinical) services data and patient-level data on social determinants of health to enhance patient outcomes and health equity	37	33.3
Collection and use of reporting measures (e.g., Uniform Data System (UDS), Healthcare Effectiveness Data and Information Set (HEDIS))	31	27.9
Performance improvement on clinical outcome measures (such as preventive care and screening, chronic disease management, maternal care and children's health, and mental health and substance use). Please specify what measure(s)	19	17.1
General Patient Care and Safety		
Development, implementation, optimization of interdisciplinary care teams	36	32.4
Development and implementation of a healthcare risk management program	32	28.8
Patient Centered Medical Home accreditation	24	21.6
Expansion of telehealth care provision to improve continuity of care	35	31.5
Accessibility training for clinical providers working with patients with disabilities (i.e., visual, hearing impairment, physical, invisible, emotional, and cognitive disabilities)	25	22.5
Practices to increase prevention or early intervention visits (e.g., well-child visits, pre- natal visits, annual physicals, vision screening, hearing screening)	27	24.3
Prescribing Pre-Exposure Prophylaxis (PrEP) to prevent Human Immunodeficiency Virus (HIV) infection (11)	21	18.9
Trauma-informed care and healing-centered engagement (strength-based approach to address trauma focused on well-being)	27	24.3
Best practices for patient and provider safety during public health emergencies (e.g., COVID-19)	31	27.9
Behavioral Health (Mental Health and Substance Use Disorder) Services:		
Integrating behavioral health into primary care	32	28.8
Follow-up after behavioral health referrals	31	27.9
Integration of therapy for opioid use disorder including application of screening, intervention, referral (SBIRT model), harm reduction, access to medication assisted treatment (MAT)	27	24.3
Using peer specialists/ peer support specialists to address patients' behavioral health care needs	23	20.7
Telehealth delivery model for behavioral health services	27	24.3
Oral Health Services:		
Integrating oral health into primary care	32	28.8
Development and implementation of innovative dental health delivery methods (e.g., dental therapists, hygienists, community dental health coordinators)	27	24.3
Using tele-dentistry to expand access to oral health care	29	26.1
Evidence-based, promising practices for use of dental sealant	24	21.6
Other:		
Other, please specify:	1	0.9

Drop-out responses: over the next two years, I anticipate my health center organization will need PATIENT EXPERIENCE TTA in the areas of: (N=69)

Sub-Domain	N	%
Assess and support patient engagement in telehealth (e.g., portals, mobile health technology)	22	31.9
Collection and optimizing use of patient experience/satisfaction data	19	27.5
Patient engagement in oral health care services	13	18.8
Culturally-responsive staff equipped to serve special and vulnerable populations	17	24.6
Strategies to improve reporting on special and vulnerable populations in the UDS	17	24.6
Developing clinical competencies to treat special and vulnerable populations including but not limited to any of the following: - Children and youth (aged 0-17) - Individuals and families experiencing homelessness (and persons at-risk for homelessness) – Immigrants -LGBTQ+ patients - Migratory and Seasonal Agricultural patients - Military Veterans and their families - Older adults - People with disabilities - Pregnant people - Residents of Public Housing - Racial and ethnic minorities - Refugees - Persons at risk of HIV - Other	12	17.4
Patient education materials that are targeted to the needs of special and vulnerable populations including but not limited to any of the following: - Children and youth (aged 0-17) - Individuals and families experiencing homelessness (and persons at-risk for homelessness) Immigrants - LGBTQ+ patients - Migratory and Seasonal Agricultural patients - Military Veterans and their families - Older adults - People with disabilities - Pregnant people - Res- idents of Public Housing - Racial and ethnic minorities (please specify which in the textbox)- Refugees - Persons at risk of HIV - Other	12	17.4
Revisions of procedures, policies, and forms to promote an inclusive and affirming environment for: - Children and youth (aged 0-17) - Individuals and families experiencing homelessness (and persons at-risk for homelessness) - Immigrants - LGBTQ+ patients - Migratory and Seasonal Agricultural patients - Military Veterans and their families - Older adults- - People with disabilities - Pregnant people - Residents of Public Housing - Racial and ethnic minorities - Refugees - Persons at risk of HIV - Other	12	17.4
Other, please specify:	1	1.4

Drop-out responses: 0ver the next two years, I anticipate my health center organization will need POPULATION HEALTH AND SOCIAL DETERMINANTS TTA in the areas of: (N=47)

Sub-Domain	N	%
Assessing and Addressing Patient's Needs		
Tools and strategies for screening for social determinants of health for patients, including specific populations of focus	28	59.6
Establishing Health Information Technology (HIT) capabilities for data collection specific to special and vulnerable populations (e.g., sexual orientation, gender identity, housing status)	23	48.9
Establishing HIT capabilities for data collection specific to intimate partner violence/ human trafficking survivors	16	34.0
Techniques to inform design of programs, interventions, or partnerships necessary to assess and address the social and non- clinical needs of health center patients (e.g., using data or asset mapping to determine the kinds of programs needed to address social determinants and build enabling service)	21	44.7
Assessing and supporting patients experiencing food insecurity	25	53.2
Assessing and supporting patients experiencing housing insecurity	25	53.2
Assessing and supporting patients experiencing financial strain	27	57.4
Assessing and supporting migrant and seasonal agricultural patients	15	31.9
Assessing and supporting patients experiencing lack of transportation/access to public transportation including information for state/local resources	18	38.3
Assessing and supporting refugee patients	19	40.4
Assessing and supporting immigrant patients	21	44.7
Assessing and supporting patients experiencing social isolation, including community-dwelling older adults, through support groups, community activities, and volunteer services	20	42.6
Assessing and supporting patients in need of employment opportunities	19	40.4
Improving health equity:		
Techniques for assessing community-level barriers to health equity	28	59.6
Strategies and tactics for addressing community-level barriers to health equities	29	61.7
Other:		
Other, please specify:	2	4.3

Drop-out responses: over the next two years, I anticipate my health center organization will need WORK- FORCE EXPERIENCE/DEVELOPMENT TTA in the areas of: (N=27)

Sub-Domain	N	%
Leadership:		
Clinical, operational, and financial improvement	7	25.9
Workforce strategies and planning	9	33.3
Innovations in health centers	7	25.9
Community–minded leadership and strategic partnerships that benefit health center patients and the community	8	29.6
Empowerment of health center staff (e.g., coaching, mentoring)	10	37.0
Orientation and onboarding to health center operations, environment, and culture	8	29.6
Strengthen financial management	6	22.2
Leadership succession planning	8	29.6
Creating a mission-driven workforce culture	8	29.6
Management:		
Supporting young professional and early to mid-career staff (non-clinical)	7	25.9
Supporting advance practice providers' development (i.e., NPs, PAs)	7	25.9
Project management (e.g., workplan development, implementation)	8	29.6
Change management	5	18.5
Communication and presentation skills	6	22.2
Managing staff (e.g., performance evaluation, staff management, integrated approaches, meeting facilitation skills, conflict resolution skills, team care, managing virtual staff)	7	25.9
Recruitment and Retention:		
Building effective processes for recruiting clinical staff into an integrated care model	7	25.9
Building effective processes for recruiting enabling services staff and community health workers into an integrated care model	7	25.9
Building effective processes for recruiting non-clinicians	6	22.2
Building effective processes for recruiting executive level leadership (e.g., Chief Work- force Officer, Chief Medical Officer, Chief Executive Officer, Chief Financial Officer, Chief Operating Officer, Chief Information Officer, Chief Behavioral Health Office, etc.)	3	11.1
Development and implementation of postgraduate training programs (e.g., organizational support, evaluation of training programs, residency program accreditation)	5	18.5
Development and implementation of student training programs	6	22.2
Developing streamlined processes for provider credentialing and privileging	5	18.5
Building a diverse and inclusive workforce including people with lived experience and/or reflect the patient population	5	18.5
Developing a comprehensive staff retention plan	7	25.9
Developing organizational strategies to reduce clinician burnout	8	29.6
Identification and analysis of workforce data	4	14.8
Creating equitable and sustainable compensation packages for clinicians and other staff	5	18.5
Improving job satisfaction and well-being of staff	7	25.9
Developing a data-driven approach to understanding and addressing staffing needs	6	22.2
Other		
Other, please specify:	0	0.0

Drop-out response: over the next two years, I anticipate my health center organization will need FINANCE TTA in the areas of: (N=16)

Sub-Domain	N	%
Finance (general):		
Medicaid Prospective Payment System (PPS) reimbursement	3	18.8
Medicare PPS reimbursement	2	12.5
Other health center reimbursement	4	25.0
Payment under managed care	3	18.8
Becoming a provider under managed care	2	12.5
Telehealth reimbursement	4	25.0
Medicare cost reports	3	18.8
Understanding your costs in an evolving payment environment	2	12.5
Accounting systems and processes	3	18.8
Developing or operating under rolling budgets (known as continuous budgets)	1	6.3
Internal controls for cash management	1	6.3
Forecasting and financial projections	2	12.5
Federal grants management	4	25.0
Setting fee schedules	3	18.8
Federal procurement rules	1	6.3
Long-term financial planning	2	12.5
Allocating sustainable funding to implement or expand Community Health Worker or outreach programs	2	12.5
Financial resilience planning	2	12.5
Capital Financing:		
Integrating capital planning in health center strategic plans	2	12.5
Assessing readiness for capital expansion	3	18.8
Evaluating community partnerships and capital expansion	3	18.8
Assessing funding needs (e.g., assessing project size, funding availability, and obstacles to obtaining resources)	3	18.8
Assistance in understanding traditional and non-traditional forms of financing including the Health Resources and Services Administration (HRSA) Loan Guarantee Program	2	12.5
Securing funding/financing for health center capital development including through the use of the HRSA Loan Guarantee Program	2	12.5
Value Based Payment:		
Best practices on strategies for accelerating payment reform readiness	2	12.5
Opportunities to integrate dentistry and behavioral health services in value-based payment reform	2	12.5
Organizational preparation to engage in value-based payment environments	2	12.5
Financial modeling and other strategies for risk-based contracting	1	6.3
Risk stratification encompassing social determinants of health	3	18.8
Other:		
Other, please specify	0	0.0

Drop-out responses: over the next two years, I anticipate my health center organization will need EMERGENCY PREPAREDNESS TTA in the areas of:

(N=9)

Sub-Domain	N	%
Cybersecurity protection, risk mitigation, and crisis response	0	0.0
Novel Coronavirus Disease (COVID-19) response and recovery	0	0.0
Infectious Disease response and recovery	0	0.0
Contingency planning (i.e., quick leadership transfer)	0	0.0
Planning for special and vulnerable populations during an emergency	0	0.0
Creating an emergency response plan that is compliant with local, state, and federal regulations focused on natural hazards (such as flood, earthquake, tornado, hurricane, blizzard)	0	0.0
Creating an emergency response plan that is compliant with local, state, and federal regulations focused on industrial hazards (such as fire, blackout, loss of water, gas failure)	0	0.0
Creating an emergency response plan that is compliant with local, state, and federal regulations focused on human-made hazards	0	0.0
Exercising an emergency response plan	0	0.0
Planning for staffing and personnel (i.e., staff available in an emergency, volunteers available, staff training)	0	0.0
Equipment inventory including communications equipment, first aid kits, emergency power equipment, personal protective equipment	0	0.0
Backup systems planning including patient services, emergency power, information systems support	0	0.0
Strengthening partnerships with state and local public health	0	0.0
Other, please specify	0	0.0

Appendix 2

2021 Health Center Needs Assessment Tool

National Health Center Needs Assessment: Identifying Assistance Needed to Help Health Centers Thrive

2021 National Needs Assessment

About this Assessment: The Health Resources and Services Administration's Bureau of Primary Health Care (HRSA/BPHC) is requesting that the National Association of Community Health Centers (NACHC) conduct a national health center needs assessment to inform the development of operational training and technical assistance (T/TA) necessary to help health centers improve access to primary health care as well as to advance health center quality and impact. To deliver this training and assistance, HRSA/BPHC supports 21 National Training & Technical Assistance Partners (NTTAPs), including NACHC. **The ultimate goal of this assessment is to help health centers rebuild after the Novel Coronavirus disease outbreak (COVID-19) and ensure they are able to adapt and thrive in a rapidly evolving health system.** NACHC is conducting this assessment, in partnership with the other NTTAPs, in order to understand and address current health center needs, challenges, and priorities. This needs assessment is structured to allow the respondent to quickly identify and select needs across a variety of T/TA topics. **Your response is critical** and may take 20-30 minutes to complete. Complete the assessment from your perspective of what T/TA your health center organization needs. Your feedback will be used to design and deliver T/TA most desired by health centers to improve the health of the patients and populations they serve.

Confidentiality: NACHC and its needs assessment partners will maintain the confidentiality of responses. Results from this assessment will be published or disseminated in such a way that you or your health center cannot be individually identified. Needs assessment partners include the 21 NTTAPs and NACHC's contracted consultant, John Snow, Inc. These organizations will maintain the confidentiality of responses under a signed Data Use Agreement with NACHC, and will use identifiable data only for the purpose of designing T/TA through their HRSA/BPHC supported NTTAP. NACHC will not share individual identifiers with HRSA/BPHC, and therefore HRSA/BPHC will not know who completed or did not complete this assessment or identify any individual respondent.

FIRST NAME:
LAST NAME:
TITLE:
HEALTH CENTER/ORGANIZATION STATE/TERRITORY:
HEALTH CENTER/ORGANIZATION (listed by state/territory abbreviation):
If you did not see your health center listed, please enter your Grant # (leave blank otherwise):
EMAIL:
PHONE:
What is your age?

- **Under 21**
- **21-24**
- **25-34**
- **35-44**

- **45-54**
- **55-64**
- **65-74**
- **75+**
- **Prefer not to answer**

What gender do you identify as?

- **Male**
- **Female**
- **Other: _____**
- **Prefer not to answer**

Please specify your race and ethnicity:

- **White**
- **Black or African-American**
- **American Native or Alaskan Native**
- **Asian**
- **Native Hawaiian or Other Pacific Islander**
- **Hispanic or Latino or Spanish Origin**
- **Other, please specify:_____**
- **Prefer not to answer**

Q1: Please identify your job role/function at your health center. Please select the one that is most reflective of your primary role/function:

- C-suite health center leadership (e.g. Chief Executive Officer, Chief Medical Officer, Chief Financial Officer)
- Management staff/Administration (e.g. human resources, administrative professional, medical director)
- Facility/non-clinical support (e.g. billing, information technology)
- Direct patient clinical care (e.g., primary care providers, mental health providers, dental)
- Direct patient non-clinical care (e.g. outreach, enabling services)
- Quality improvement (e.g. data specialists, statisticians, staff dedicated to HIT/EHR informatics)
- Other (specify): _____

Section I: Your Health Center Organization's Training and Technical Assistance Needs

This section includes questions to help us understand your health center's immediate and short term training and technical assistance (T/TA) needs between NOW and the NEXT TWO YEARS.

Please answer the questions in this section from *your individual perspective* of what T/TA your health center organization needs based on your understanding and awareness.

- The Bureau of Primary Health Care (BPHC) defines **special populations** as individuals and families experiencing homelessness, migratory and seasonal agricultural workers, and residents of public housing.

- For the purpose of this needs assessment**, vulnerable populations** include school children, the elderly, pregnant women and infants, immigrants, minority populations, the lesbian, gay, bisexual, transgender and queer (LGBTQ+) community, people with disabilities, and military veterans.

Q2: Over the next two years, I anticipate my health center organization will need ACCESS AND AFFORDABILITY T/TA (including barriers to accessing care).

☐Yes [Continue to **Q3**]

☐No [Continue to **Q4**]

Q3: Over the next two years, I anticipate my health center organization will need ACCESS AND AFFORDABILITY T/TA (including barriers to accessing care) in the areas of (select all that apply):

Outreach and Enabling Services:

☐ Implementing case management services
☐ Implementing patient-centered transportation strategies
☐ Development and implementation of outreach programs and/or partnerships to respond and address community identified health disparities
☐ Development of outreach services, such as community health workers, to address chronic diseases or conditions (e.g., diabetes, hypertension, cancer, substance use, behavioral health)
☐ Evaluation of outreach programs (e.g., effectiveness at engaging special and vulnerable populations, sustainability)

Housing services:

☐ Care coordination with housing providers
☐ Care coordination with temporary housing and/or shelter provisions
☐ Assisting with housing applications for patients seeking public housing or other housing assistance (e.g. Housing Choice Voucher, Section 8)

Coordinating with Community Programs/Partners:

☐Partnering with caregiver support services (i.e., spousal support groups, peer support groups)
☐Partnering with family support services (i.e., parenting classes)
☐Assess and support connection to educational resources for patients (e.g., navigation towards getting a general educational diploma (GED))
☐Assess and support connection to employment resources for patients (e.g., partnering for job training, vocational training, etc.)

Language and/or Translation Services:

☐Implementation of culturally and linguistically appropriate services (CLAS) Standards
☐Developing, monitoring implementation of a Limited English Proficiency (LEP) Plan
☐Provision of oral interpretation services

☐Provision of written translation services

Health Insurance Eligibility and Enrollment:
☐Development of healthcare navigator services
☐Improving coordination with Military and Veterans Benefits and Services

Medical - Legal Partnerships:
☐ Understanding the core components of medical-legal partnerships
☐ Identifying and engaging a legal partner
☐ Using medical-legal partnerships to affect policy changes that benefit patients and communities
☐ Evidence-based or promising practices for developing workflows for medical-legal partnership referrals, sharing information, integrating, and expanding medical-legal partnerships
☐ Screening for legal needs and aligning with other social determinants of health screening

N/A or Other:
☐ N/A – my health center does not have T/TA needs specific to this area.

☐ Other, please specify: _____

Q4. Over the next two years, I anticipate my health center organization and/or Board will need GOVERNANCE AND MANAGEMENT T/TA (including strategic planning, quality improvement, information technology, and governance).

☐Yes [Continue to **Q5**]

☐No [Continue to **Q6**]

Q5. Over the next two years, I anticipate my health center organization and/or Board will need GOVERNANCE AND MANAGEMENT T/TA (including strategic planning, quality improvement, information technology, and governance) in the areas of:...

Governance:
☐ Effective board governance practices/approaches
☐ Board culture and dynamics
☐ Board's role in strategic planning
☐ Board's role in financial oversight
☐ Board's role in clinical quality oversight
☐ Succession planning
☐ Board recruitment and retention (i.e., members that represent special and vulnerable populations, with an emphasis on racial and ethnic diversity)
☐ Effective implementation of board meetings and committees
☐ Board education materials in non-English
Specify what language(s): _____

Strategic Direction/Priority Setting:

☐ Design and implementation of needs assessments
☐ Data analysis and interpretation to inform and improve service delivery
☐ Quality improvement and quality assurance methods and approaches
☐ Training health center leadership and boards around the health care transformation landscape and navigating value-based payment opportunities
☐ Developing a vision and strategy around payment and delivery reform

Health Information Technology

☐ Electronic Health Record (EHR) optimization
☐ EHR interoperability, ability to exchange data with others (e.g., to support care coordination and services integration)
☐ Transitioning/switching to a new EHR system from an old EHR system (e.g., planning, implementation)
☐ Telehealth integration with EHR/HIT systems
☐ Deploying decision support systems (e.g., implementation, use, restructuring workflows) and developing effective data dashboards

Expansion Planning:

☐ Strategic planning for health center growth
☐ Workforce expansion
☐ Partnership development to support health center capital planning and development, including co-location with housing and/or other services
☐ Behavioral health services expansion and partnering with local providers
☐ Expanding capacity to meet the behavioral health needs of special and vulnerable populations
☐ Expansion of on-site oral health care services
☐ Development and implementation (e.g., financial models, sustainability, and utilization) for special populations

N/A or Other:

☐ N/A – my health center does not have T/TA needs specific to this area.

☐ Other, please specify: _____

Q6. Over the next two years, I anticipate my health center organization will need QUALITY, PATIENT CARE, AND SAFETY T/TA (including physical, behavioral, and dental health care outcomes).

☐Yes [Continue to **Q7**]

☐No [Continue to **Q8**]

Q7. Over the next two years, I anticipate my health center organization will need QUALITY, PATIENT CARE, AND SAFETY T/TA (including physical, behavioral, and dental health care

outcomes) in the areas of:….

Data collection and use:

☐ Leveraging use of data to guide/inform clinical quality, operational and financial improvement (e.g., at the individual and population-level and patient experience data)

☐ Collection and optimizing use of enabling (non-clinical) services data and patient-level data on social determinants of health to enhance patient outcomes and health equity

☐ Collection and use of reporting measures (e.g., Uniform Data System (UDS), Healthcare Effectiveness Data and Information Set (HEDIS))

☐ Performance improvement on clinical outcome measures (such as preventive care and screening, chronic disease management, maternal care and children's health, and mental health and substance use).

Specify for what measure(s): _____

General Patient Care and Safety

☐ Development, implementation, optimization of interdisciplinary care teams

☐ Development and implementation of a healthcare risk management program

☐ Patient Centered Medical Home accreditation

☐ Assessing patient barriers to virtual service engagement

☐ Expansion of telehealth care provision to improve continuity of care

☐ Accessibility training for clinical providers working with patients with disabilities (i.e., visual, hearing impairment, physical, invisible, emotional, and cognitive disabilities)

☐ Practices to increase prevention or early intervention visits (e.g., well-child visits, prenatal visits, annual physicals, vision screening, hearing screening)

☐ Prescribing Pre-Exposure Prophylaxis (PrEP) to prevent human immunodeficiency virus (HIV) infection

☐ Trauma-informed care and healing-centered engagement (strength-based approach to address trauma focused on well-being)

☐ Best practices for patient and provider safety measure during public health emergencies (e.g., COVID-19)

Behavioral Health (Mental Health and Substance Use Disorder) Services:

☐ Integrating behavioral health into primary care

☐ Follow-up after behavioral health referrals

☐ Integration of therapy for opioid use disorder including application of screening, intervention, referral (SBIRT models), harm reduction, access to medication assisted treatment (MAT)

☐ Using peer specialists/ peer support specialists to address patients' behavioral health care needs

☐ Telehealth delivery model for behavioral health services

Oral Health Services:

☐ Integrating oral health into primary care

☐ Development and implementation of innovative dental health delivery methods (e.g., dental therapists, hygienists, community dental health coordinators)
☐ Using tele-dentistry to expand access to oral health care
☐ Evidence-based, promising practices for use of dental sealant

N/A or Other:
☐ N/A – my health center does not have T/TA needs specific to this area.

☐ Other, please specify: _____

Q8. Over the next two years, I anticipate my health center organization will need POPULATION HEALTH AND SOCIAL DETERMINANTS T/TA (including health related social needs and social risk factors).

☐Yes [Continue to **Q9**]

☐No [Continue to **Q10**]

Q9. Over the next two years, I anticipate my health center organization will need POPULATION HEALTH AND SOCIAL DETERMINANTS T/TA (including health related social needs and social risk factors) in the areas of: …..

Assessing and Addressing Patient's Needs
☐ Tools and strategies for screening for social determinants of health for patients, including specific populations of focus
☐ Establishing Health Information Technology (HIT) capabilities for data collection specific to special and vulnerable populations (e.g., sexual orientation, gender identity, housing status)
☐ Establishing HIT capabilities for data collection specific to intimate partner violence/human trafficking survivors
☐ Techniques to inform design of programs, interventions, or partnerships necessary to assess and address the social and non- clinical needs of health center patients (e.g., using data or asset mapping to determine the kinds of programs needed to address social determinants and build enabling service)
☐ Assessing and supporting patients experiencing food insecurity
☐ Assessing and supporting patients experiencing housing insecurity
☐ Assessing and supporting patients experiencing financial strain
☐ Assessing and supporting migrant and seasonal agricultural patients
☐ Assessing and supporting patients experiencing lack of transportation/access to public transportation including information for state/local resources
☐ Assessing and supporting refugee patients
☐ Assessing and supporting immigrant patients
☐ Assessing and supporting patients experiencing social isolation, including community-dwelling older adults, through support groups, community activities, and volunteer services
☐ Assessing and supporting patients in need of employment opportunities

Improving health equity:

☐ Techniques for assessing community-level barriers to health equity

☐ Strategies and tactics for addressing community-level barriers to health equities

N/A or Other:

☐ N/A – my health center does not have T/TA needs specific to this area.

☐ Other, please specify: _____

Q10. Over the next two years, I anticipate my health center organization will need PATIENT EXPERIENCE T/TA (including special and vulnerable populations, patient engagement in telehealth).

☐Yes [Continue to **Q11**]

☐No [Continue to **Q12**]

Q11. Over the next two years, I anticipate my health center organization will need PATIENT EXPERIENCE T/TA (including special and vulnerable populations, patient engagement in telehealth) in the areas of:...

☐ Patient engagement in telehealth (e.g., portals, mobile health technology)

☐ Collection and optimizing use of patient experience/satisfaction data

☐ Patient engagement in oral health care services

☐ Culturally-responsive staff equipped to serve special and vulnerable populations

☐ Strategies to improve reporting on special and vulnerable populations in the UDS

☐ Developing clinical competencies to treat special and vulnerable populations including but not limited to any of the following (please specify the population(s) in the textbox:

- Children and Youth (aged 0-17)
- Individuals and families experiencing homelessness (and persons at-risk for homelessness)
- Immigrants
- LGBTQ+ patients
- Migratory and Seasonal Agricultural patients
- Military Veterans and their families
- Older adults
- People with disabilities
- Pregnant women
- Residents of Public Housing
- Racial and ethnic minorities (please specify which in the textbox)
- Refugees
- Persons at risk of HIV
- Other

  _____

☐ Patient education materials that are targeted to the needs of special and vulnerable populations including but not limited to any of the following (please specify the population(s) in the textbox:

- Children and Youth (aged 0-17)

- Individuals and families experiencing homelessness (and persons at-risk for homelessness)
- Immigrants
- LGBTQ+ patients
- Migratory and Seasonal Agricultural patients
- Military Veterans and their families
- Older adults
- People with disabilities
- Pregnant women
- Residents of Public Housing
- Racial and ethnic minorities (please specify which in the textbox)
- Refugees
- Persons at risk of HIV
- Other (specify)

_____

☐Revisions of procedures, policies, and forms to promote an inclusive and affirming environment for (please specify the population(s) in the textbox:

- Children and Youth (aged 0-17)
- Individuals and families experiencing homelessness (and persons at-risk for homelessness)
- Immigrants
- LGBTQ+ patients
- Migratory and Seasonal Agricultural patients
- Military Veterans and their families
- Older adults
- People with disabilities
- Pregnant women
- Residents of Public Housing
- Racial and ethnic minorities (please specify which in the textbox)
- Refugees
- Persons at risk of HIV
- Other

_____

☐ N/A – my health center does not have T/TA needs specific to this area.

☐ Other, please specify: _____

Q12. Over the next two years, I anticipate my health center organization will need WORKFORCE EXPERIENCE/DEVELOPMENT T/TA (including clinical training programs, leadership and management, and recruitment and retention).

☐Yes [Continue to **Q13**]

☐No [Continue to **Q14**]

Q13. Over the next two years, I anticipate my health center organization will need WORKFORCE EXPERIENCE/DEVELOPMENT T/TA (including clinical training programs, leadership and management, and recruitment and retention) in the areas of:….

Leadership:

☐Clinical, operational, and financial improvement

☐Workforce strategies and planning

☐Innovations in health centers

☐ Community–minded leadership and strategic partnerships that benefit health center patients and the community
☐ Empowerment of health center staff (e.g., coaching, mentoring)
☐ Orientation and onboarding to health center operations, environment, and culture
☐ Strengthen financial management
☐ Leadership succession planning

Management:
☐ Supporting young professional and early to mid-career staff (non-clinical)
☐ Supporting advance practice providers' development (i.e., NPs, PAs)
☐ Project management (e.g., workplan development, implementation)
☐ Change management
☐ Communication and presentation skills
☐ Managing staff (e.g., performance evaluation, staff management, integrated approaches, meeting facilitation skills, conflict resolution skills, team care approach, managing virtual staff)
☐ Creating a mission-driven workforce culture

Recruitment and Retention:
☐ Building effective processes for recruiting clinical staff into an integrated care model
☐ Building effective processes for recruiting enabling services staff and community health workers into an integrated care model
☐ Building effective processes for recruiting non-clinicians (e.g., finance, HIT, administrative staff, outreach staff)
☐ Building effective processes for recruiting executive level leadership (e.g., Chief Workforce Officer, Chief Medical Officer, Chief Executive Officer, Chief Financial Officer, Chief Operating Officer, Chief Information Officer, Chief Behavioral Health Office, etc.)
☐ Development and implementation of postgraduate training programs (e.g., cultivating organizational support, evaluation of postgraduate training programs, accreditation of postgraduate residency programs)
☐ Development and implementation of student training programs
☐ Developing streamlined processes for provider credentialing and privileging
☐ Building a diverse and inclusive workforce including people with lived experience and/or reflect the patient population
☐ Developing a comprehensive staff retention plan
☐ Developing organizational strategies to reduce clinician burnout
☐ Identification and analysis of workforce data
☐ Creating equitable and sustainable compensation packages for clinicians and other staff
☐ Improving job satisfaction and mental health needs of staff
☐ Developing a data-driven approach to understanding and addressing organizational staffing needs

N/A or Other
☐ N/A – my health center does not have T/TA needs specific to this area.

☐ Other, please specify: _____

Q14. Over the next two years, I anticipate my health center organization will need FINANCE T/TA (including general, alternative payments, capital finance, or value based care topics).

☐Yes [Continue to **Q15**]

☐No [Continue to **Q16**]

Q15. Over the next two years, I anticipate my health center organization will need FINANCE T/TA (including general, alternative payments, capital finance, or value based care topics) in the areas of: …..

Finance (general):

☐ Medicaid Prospective Payment System (PPS) reimbursement
☐ Medicare PPS reimbursement
☐ Other health center reimbursement
☐ Payment under managed care
☐ Becoming a provider under managed care
☐ Telehealth reimbursement
☐ Medicare cost reports
☐ Understanding your costs in an evolving payment environment
☐ Accounting systems and processes
☐ Developing or operating under rolling budgets (also often known as continuous budgets)
☐ Internal controls for cash management
☐ Forecasting and financial projections
☐ Federal grants management
☐ Setting fee schedules
☐ Federal procurement rules
☐ Long-term financial planning
☐ Allocating sustainable funding to implement or expand Community Health Worker or outreach programs
☐ Financial resilience planning

Capital Financing:

☐ Integrating capital planning in health center strategic plans
☐ Assessing readiness for capital expansion
☐ Evaluating community partnerships and capital expansion
☐ Assessing funding needs (e.g., assessing project size, funding availability, and obstacles to obtaining resources)
☐ Assistance in understanding traditional and non-traditional forms of financing including the Health Resources and Services Administration (HRSA) Loan Guarantee Program
☐ Securing funding/financing for health center capital development including through the use of the HRSA Loan Guarantee Program

Value Based Payment:

☐ Best practices on health center strategies for accelerating transformation and payment reform readiness
☐ Opportunities to integrate dentistry and behavioral health services in value-based payment reform
☐ Organizational preparation to engage in value-based payment environments (e.g., Accountable Care Organizations, Independent Provider Associations, Federally Qualified Health Center (FQHC) Alternative Payment Methodologies, and value- based contracts with Managed Care Organizations)
☐ Financial modeling and other strategies for risk-based contracting
☐ Risk stratification encompassing social determinants of health

N/A or Other:

☐ N/A – my health center does not have T/TA needs specific to this area.

☐ Other, please specify: _____

Q16. Over the next two years, I anticipate my health center organization will need EMERGENCY PREPAREDNESS T/TA (including mitigation, preparedness, response, and recovery).

☐Yes [Continue to **Q17**]

☐No [Continue to **Q18**]

Q17. Over the next two years, I anticipate my health center organization will need EMERGENCY PREPAREDNESS T/TA (including mitigation, preparedness, response, and recovery) in the areas of: …

☐ Cybersecurity protection, risk mitigation, and crisis response
☐ Novel Coronavirus Disease (COVID-19) response and recovery
☐ Infectious Disease response and recovery
☐ Contingency planning (i.e., quick leadership transfer)
☐ Planning for special and vulnerable populations during an emergency
☐ Creating an emergency response plan that is compliant with local, state, and federal regulations focused on natural hazards (such as flood, earthquake, tornado, hurricane, blizzard)
☐ Creating an emergency response plan that is compliant with local, state, and federal regulations focused on industrial hazards (such as fire, blackout, loss of water, gas failure)
☐ Creating an emergency response plan that is compliant with local, state, and federal regulations focused on human-made hazards (such as transportation events, chemical leaks, bomb threats, intruders)
☐ Exercising an emergency response plan
☐ Planning for staffing and personnel (i.e., staff available in an emergency, volunteers available, staff training)

☐ Equipment inventory including communications equipment, first aid kits, emergency power equipment, personal protective equipment
☐ Backup systems planning including patient services, emergency power, information systems support
☐ Strengthening partnerships with state and local public health

☐ N/A – my health center does not have T/TA needs specific to this area.

☐ Other, please specify: _____

Q.18. Over the next two years, are there other T/TA needs around emerging issues or trends you anticipate your health center may need? (open ended) _____

Q19: Please click and drag the top three T/TA category options to the top of the list below to rank them in order of need to your health center organization between NOW and the NEXT TWO YEARS. Note: Please answer this question from your individual perspective of what you believe are the T/TA needs of your health center organization from your own understanding and awareness.

Training and Technical Assistance Categories:
Access and Affordability
Governance and Management
Quality, Patient Care and Safety
Patient Experience
Population Health and Social Determinants of Health
Workforce Experience
Financial Sustainability
Emergency Preparedness

Q20. [*Only for C-Suite link] Please move the slider to indicate the health center's maturity level on each of the training and technical assistance categories below.
Note: Maturity levels were developed by HRSA as part of the advancing health center excellence framework to assess current state of performance, a desired future state of performance, and identify data-driven and evidence-based capabilities, activities, behaviors, and resources needed to reach and sustain a higher level of domain performance.

Training and Technical Assistance Categories:	Compliance Driven	Fundamental	Strategic	Leading
Access and Affordability				
Governance and Management				
Quality, Patient Care and Safety				
Patient Experience				
Population Health and Social Determinants of Health				
Workforce Experience				
Financial Sustainability				
Emergency Preparedness				

Definitions (embedded in hover-over descriptions in online version):

- **Compliance Driven: Health center is compliant with all relevant program requirements.**
- **Fundamental: Health center tactically manages and the strategy is partially or fully defined. Foundation strategies are implemented.**
- **Strategic: Domain area is proactively managed and fully defined. Domain area strategy aligns with overall health center strategic areas.**
- **Leading: Health center employs leading practices and the strategy is fully implemented into the health center's organizational strategy.**
- Access and affordability: The health center ensures the availability of comprehensive, affordable, and culturally and linguistically appropriate health services in a timely manner.
- Governance and Management: The health center implements effective governance, leadership, and management that continuously promotes operational excellence to support delivery of high-quality, cost-efficient, patient-centered care to the community. Leadership and management of a health center is a shared responsibility carried out by the health center board and key management staff.
- Quality, Patient Care and Safety:The health center provides safe, effective, appropriate, timely, and equitable health care services to patients to increase the likelihood of desired health outcomes.
- Patient Experience: The health center provides care that is respectful of, and responsive to, individual patient preferences, culture, needs and values, and ensures that patient values guide all clinical decisions. The health center coordinates equity-oriented, patient-centered care and provides information and education to encourage patients, families, and caregivers to actively engage in their care.
- Population Health and Social Determinants of Health: The health center provides comprehensive services to address patients' needs and those of the community it serves. It achieves this by understanding the social risk factors and social needs in the community and by collaborating with diverse partners to achieve health equity by addressing key drivers of poor health.
- Workforce Experience: The health center recruits, develops, engages, and retains the appropriate staffing mix of qualified providers and staff needed to provide safe and culturally affirming care to its patient population.
- Financial Sustainability:The health center has fiscally sound accounting, revenue cycle, and financial management and planning policies and practices. It seeks to optimally manage revenue diversity and financial viability while advancing patient outcomes.
- Emergency Preparedness: The health center develops, reviews, and is positioned to implement emergency response plans.

Q21. [*Only for C-Suite link] Think about where you would like to see your health center in 5 years. Identify 2 specific areas of T/TA you would need to get there. (open-ended) _____

Q22. Does your health center want to receive targeted outreach from the NTTAPs for T/TA needs you have identified in this assessment?

☐ Yes
☐ No

Q23. Please select opt-out below if you do not want NACHC to share anonymous data by state with the state PCAs.

☐ Opt-out

Section II: Training and Technical Assistance Your Health Center Organization Accessed This Past Year: The next set of questions in this section will inquire about T/TA your health center organization has accessed this **PAST YEAR**.

Q.1a In the PAST YEAR, has your organization accessed T/TA, inclusive of webinars, trainings, outside coaching/consulting, publications, toolkits, and other resources?

☐Yes [Continue to **Q.12b**]

☐No [Continue to **Q.12c**]

Q.1b In the PAST YEAR, which sources of T/TA has your organization accessed? (Check all that apply)

☐National Training & Technical Assistance Partner (NTTAP)

☐Primary Care Association (PCA)

☐Health Center Controlled Network (HCCN)

☐Other HRSA Funded TTA Provider (please specify in the textbox)
- Healthcare Systems (HSB)
- HIV/AIDS (HAB)
- Maternal and Child Health (MCHB)
- Primary Health Care (BPHC)
- Rural Health Policy (FORHP)

_____

☐ Don't know
☐ Other (i.e. private consultant, state-funded T/TA, foundation-funded T/TA), please specify: _____

Q.1c Please indicate why your health center organization has NOT accessed T/TA this PAST YEAR? (Check one)

☐As of today, my health center organization has NOT identified any T/TA needs where we need assistance.
☐My health center organization cannot afford any training and technical assistance.

☐My health center organizations has been unable to identify sources of T/TA specific to our T/TA need(s) [Continue to **Q3**]

☐My health center organization plans to access T/TA sources within the next year; we just have not accessed any (as of today).

☐Other (Briefly explain):_____
__
_____
_____
_____

Q.2: During this PAST YEAR, even if your health center staff have utilized T/TA, has your health center organization experienced a need for T/TA for which staff could not find a T/TA resource? (Check one}

☐Yes [Continue to **Q3**]

☐No [Continue to **end of survey**]

Q.3: Briefly describe what type of T/TA your health center organization has had a difficult time locating?

_____
_____
_____
_____
_____

THANK YOU!

Appendix 3

Number and Percent of Respondents by State and U.S. Territory

Number and Rate of Health Center (HC) Responses by State or U.S. Territory

State or Territory	*Number of FQHCs*	*Number of LALs*	*Total Number of HC Program Grantees, 2021*	Number of Individual Responses	Number of Unique HC Responses (FQHC + LAL)	Rate Response (percentage of unique HC responses)
Alabama	*17*	*2*	*19*	5	3	15.8%
Alaska	*27*	*2*	*29*	26	14	48.3%
American Samoa	*1*	*0*	*1*	0	0	0.0%
Arizona	*23*	*0*	*23*	35	14	60.9%
Arkansas	*12*	*0*	*12*	40	9	75.0%
California	*175*	*30*	*205*	74	49	23.9%
Colorado	*19*	*1*	*20*	12	6	30.0%
Connecticut	*16*	*1*	*17*	15	8	47.1%
Delaware	*3*	*0*	*3*	0	0	0.0%
District of Columbia	*8*	*1*	*9*	2	1	11.1%
Florida	*47*	*5*	*52*	52	24	46.2%
Federated States of Micronesia	*4*	*0*	*4*	3	2	50.0%
Georgia	*35*	*1*	*36*	17	12	33.3%
Guam	*1*	*0*	*1*	0	0	0.0%
Hawaii	*14*	*1*	*15*	16	5	33.3%
Idaho	*14*	*0*	*14*	6	4	28.6%
Illinois	*45*	*4*	*49*	31	17	34.7%
Indiana	*27*	*11*	*38*	15	11	28.9%
Iowa	*14*	*0*	*14*	17	7	50.0%
Kansas	*19*	*2*	*21*	48	13	61.9%
Kentucky	*25*	*3*	*28*	20	12	42.9%
Louisiana	*36*	*3*	*39*	10	5	12.8%
Maine	*18*	*1*	*19*	9	7	36.8%
Maryland	*17*	*0*	*17*	20	6	35.3%
Marshall Islands	*1*	*0*	*1*	1	1	100.0%
Massachusetts	*37*	*0*	*37*	38	21	56.8%
Michigan	*39*	*1*	*40*	20	10	25.0%
Minnesota	*16*	*1*	*17*	8	5	29.4%
Mississippi	*20*	*0*	*20*	7	7	35.0%
Missouri	*28*	*1*	*29*	21	13	44.8%
Montana	*14*	*1*	*15*	3	2	13.3%
Nebraska	*7*	*0*	*7*	4	4	57.1%
Nevada	*8*	*0*	*8*	16	3	37.5%

Continued:

State or Territory	*Number of FQHCs*	*Number of LALs*	*Total Number of HC Program Grantees, 2021*	Number of Individual Responses	Number of Unique HC Responses (FQHC + LAL)	Rate Response (percentage of unique HC responses)
New Hampshire	*10*	*1*	*11*	26	7	63.6%
New Jersey	*23*	*0*	*23*	18	8	34.8%
New Mexico	*16*	*3*	*19*	7	5	26.3%
New York	*63*	*6*	*69*	61	27	39.1%
North Carolina	*39*	*3*	*42*	68	26	61.9%
North Dakota	*4*	*0*	*4*	1	0	0.0%
Northern Mariana Islands	*1*	*0*	*1*	2	1	100.0%
Ohio	*51*	*6*	*57*	22	18	31.6%
Oklahoma	*21*	*0*	*21*	11	5	23.8%
Oregon	*30*	*2*	*32*	9	8	25.0%
Pennsylvania	*42*	*7*	*49*	42	18	36.7%
Puerto Rico	*22*	*0*	*22*	32	16	72.7%
Republic of Palau	*1*	*0*	*1*	1	1	100.0%
Rhode Island	*8*	*0*	*8*	20	5	62.5%
South Carolina	*23*	*1*	*24*	60	14	58.3%
South Dakota	*4*	*0*	*4*	2	2	50.0%
Tennessee	*29*	*1*	*30*	25	11	36.7%
Texas	*72*	*1*	*73*	37	29	39.7%
Utah	*13*	*0*	*13*	1	1	7.7%
Vermont	*11*	*1*	*12*	3	3	25.0%
Virginia	*26*	*0*	*26*	17	5	19.2%
Virgin Islands	*2*	*0*	*2*	0	0	0.0%
Washington	*27*	*0*	*27*	19	12	44.4%
West Virginia	*28*	*3*	*31*	17	8	25.8%
Wisconsin	*16*	*0*	*16*	13	7	43.8%
Wyoming	*6*	*0*	*6*	1	1	16.7%
Total	*1,375*	*107*	*1,482*	**1,106**	**533**	**36.0%**

Notes: Total number and rate of unique health center responses includes both Federally Qualified Health Centers and Health Center Program Look-Alikes.

Appendix 4

Descriptive Characteristics of Assessment Respondents

Descriptive Characteristics of Assessment Respondents (N=1,106)

Characteristic	N	%
Age		
Under 21	1	0.1
21-24	16	1.4
25-34	112	10.1
35-44	240	21.7
45-54	317	28.7
55-64	295	26.7
65-74	98	8.9
75+	5	0.5
Prefer not to answer	22	2.0
Sex		
Female	841	76.0
Male	243	22.0
Other	4	0.4
Prefer not to answer	18	1.6
Race/Ethnicity		
American Native or Alaskan Native	25	2.3
Asian	47	4.2
Black or African-American	173	15.6
Hispanic or Latino or Spanish Origin	128	11.6
Native Hawaiian or Other Pacific Islander	18	1.6
White	740	66.9
Other	12	1.1
Prefer not to answer	30	2.7
Staff Type		
Executive team	405	36.6
Community health center workforce	701	63.4
Direct patient clinical care	131	18.7
Direct patient non-clinical care	53	7.6
Facility/non-clinical support	31	4.4
Management staff/administration	329	46.9
Quality improvement	72	10.3
Other	85	12.1

Appendix 5

UDS Characteristics of Responding vs. Non-Responding Federally Qualified Health Centers

UDS Characteristics of Responding vs. Non-Responding Federally Qualified Health Centers (FQHCs)

	Responding FQHCs		Non-Responding FQHCs	
	N	%	N	%
Overall Response Rate (N=1,375 - UDS 2020)	**507**	**36.9**	**868**	**63.1**
UDS Characteristic				
Health Center Organization Size				
Small	179	35.3	383	44.1
Large	328	64.7	485	55.9
Location				
Rural	216	42.6	362	41.7
Urban	291	57.4	506	58.3
Vulnerable Populations				
High proportion uninsured	**83**	**16.4**	**114**	**13.1**
Not high proportion uninsured	424	83.6	753	86.8
High proportion elderly	**76**	**15.0**	**139**	**16.0**
Not high proportion elderly	431	85.0	729	84.0
High proportion AHOPI	**25**	**4.9**	**40**	**4.6**
Not high proportion AHOPI	481	94.9	827	95.3
High proportion veterans	**60**	**11.8**	**110**	**12.7**
Not high proportion veterans	446	88.0	753	86.8
Funding Type				
Community Health Center Funding only	**484**	**95.5**	**820**	**94.5**
Migrant Health Center Grantee	**75**	**14.8**	**100**	**11.5**
Not Migrant Health Center Grantee	432	85.2	768	88.5
Homeless Health Center Grantee	**112**	**22.1**	**187**	**21.5**
Not Homeless Health Center Grantee	395	77.9	681	78.5
Public Housing Health Center Grantee	**43**	**8.5**	**64**	**7.4**
Not Public Housing Health Center Grantee	464	91.5	804	92.6
School Based Health Center	**200**	**39.4**	**294**	**33.9**
Not School Based Health Center	297	58.6	558	64.3

Notes: Small health centers defined as serving 10,000 patients or fewer.

High proportion defined as 1 standard deviation (SD) above the mean.

Elderly includes all patients 65+.

AHOPI refers to patients who identify as Asian, Hawaiian or Other Pacific Islander, and includes Asian, Hispanic, Asian Non-Hispanic, Hawaiian/Other Pacific Islander Hispanic, and Hawaiian/Other Pacific Islander Non-Hispanic patients.

Appendix 6

Number and Percent of Unique Health Centers Reporting Each TTA Domain as one of their Top 3 Needs, by UDS Characteristic

Number and Percent of Unique Health Centers Reporting Each TTA Domain as one of their Top 3 Needs, by UDS Characteristic

	Access/ Affordability		Governance		QPCS		Patient Experience	
	N	%	N	%	N	%	N	%
Overall	**268**	**52.9**	**197**	**38.9**	**352**	**69.4**	**246**	**48.5**
UDS Characteristic								
Health Center Organization Size								
Small	97	54.2	84	46.9	124	69.3	75	41.9
Large	171	52.1	113	34.5	228	69.5	171	52.1
Location								
Rural	121	56.0	88	40.7	147	68.1	95	44.0
Urban	147	50.5	109	37.5	205	70.4	151	51.9
Vulnerable Populations								
High proportion uninsured	**49**	**59.0**	**28**	**33.7**	**60**	**72.3**	**41**	**49.4**
Not high proportion uninsured	219	51.7	169	39.9	292	68.9	205	48.3
High proportion elderly	**44**	**57.9**	**34**	**44.7**	**54**	**71.1**	**23**	**30.3**
Not high proportion elderly	224	52.0	163	37.8	298	69.1	223	51.7
High proportion AHOPI	**12**	**48.0**	**11**	**44.0**	**18**	**72.0**	**11**	**44.0**
Not high proportion AHOPI	256	53.1	185	38.4	333	69.1	235	48.8
High proportion veteran	**26**	**43.3**	**27**	**45.0**	**39**	**65.0**	**20**	**33.3**
Not high proportion veteran	242	54.1	169	37.8	313	70.0	225	50.3
Funding Type								
Community Health Center Funding only	**255**	**52.7**	**184**	**38.0**	**336**	**69.4**	**235**	**48.6**
Migrant Health Center Grantee	**42**	**56.0**	**25**	**33.3**	**58**	**77.3**	**40**	**53.3**
Not Migrant Health Center Grantee	226	52.3	172	39.8	294	68.1	206	47.7
Homeless Health Center Grantee	**65**	**58.0**	**39**	**34.8**	**78**	**69.6**	**60**	**53.6**
Not Homeless Health Center Grantee	203	51.4	158	40.0	274	69.4	186	47.1
Public Housing Health Center Grantee	**22**	**51.2**	**16**	**37.2**	**34**	**79.1**	**20**	**46.5**
Not Public Housing Health Center Grantee	246	53.0	181	39.0	318	68.5	226	48.7
School Based Health Center	**112**	**56.0**	**70**	**35.0**	**143**	**71.5**	**99**	**49.5**
Not School Based Health Center	151	49.2	122	39.7	203	66.1	140	45.6

Notes: Small health centers defined as serving 10,000 patients or fewer.
High proportion defined as 1 standard deviation (SD) above the mean.
Elderly includes all patients 65+.
AHOPI refers to patients who identify as Asian, Hawaiian or Other Pacific Islander, and includes Asian, Hispanic, Asian Non-Hispanic, Hawaiian/Other Pacific Islander Hispanic, and Hawaiian/Other Pacific Islander Non-Hispanic patients.

Continued:

	Pop. Health		Workforce		Finance		Emergency Preparedness	
	N	%	N	%	N	%	N	%
Overall	**232**	**45.8**	**304**	**60.0**	**232**	**45.8**	**106**	**20.9**
UDS Characteristic								
Health Center Organization Size								
Small	69	38.5	99	55.3	88	49.2	38	21.2
Large	163	49.7	205	62.5	144	43.9	68	20.7
Location								
Rural	101	46.8	126	58.3	100	46.3	55	25.5
Urban	131	45.0	178	61.2	132	45.4	51	17.5
Vulnerable Populations								
High proportion uninsured	**33**	**39.8**	**45**	**54.2**	**40**	**48.2**	**15**	**18.1**
Not high proportion uninsured	199	46.9	259	61.1	192	45.3	91	21.5
High proportion elderly	**33**	**43.4**	**48**	**63.2**	**35**	**46.1**	**18**	**23.7**
Not high proportion elderly	199	46.2	256	59.4	197	45.7	88	20.4
High proportion AHOPI	**8**	**32.0**	**15**	**60.0**	**15**	**60.0**	**4**	**16.0**
Not high proportion AHOPI	223	46.3	289	60.0	217	45.0	102	21.2
High proportion veteran	**27**	**45.0**	**37**	**61.7**	**26**	**43.3**	**11**	**18.3**
Not high proportion veteran	205	45.9	266	59.5	206	46.1	95	21.3
Funding Type								
Community Health Center Funding only	**221**	**45.7**	**295**	**61.0**	**226**	**46.7**	**103**	**21.3**
Migrant Health Center Grantee	**38**	**50.7**	**44**	**58.7**	**33**	**44.0**	**14**	**18.7**
Not Migrant Health Center Grantee	194	44.9	260	60.2	199	46.1	92	21.3
Homeless Health Center Grantee	**62**	**55.4**	**70**	**62.5**	**46**	**41.1**	**17**	**15.2**
Not Homeless Health Center Grantee	170	43.0	234	59.2	186	47.1	89	22.5
Public Housing Health Center Grantee	**26**	**60.5**	**24**	**55.8**	**13**	**30.2**	**9**	**20.9**
Not Public Housing Health Center Grantee	206	44.4	280	60.3	219	47.2	97	20.9
School Based Health Center	**98**	**49.0**	**128**	**64.0**	**89**	**44.5**	**46**	**23.0**
Not School Based Health Center	130	42.3	167	54.4	139	45.3	58	18.9

Notes: Small health centers defined as serving 10,000 patients or fewer.
High proportion defined as 1 standard deviation (SD) above the mean.
Elderly includes all patients 65+.
AHOPI refers to patients who identify as Asian, Hawaiian or Other Pacific Islander, and includes Asian, Hispanic, Asian Non-Hispanic, Hawaiian/Other Pacific Islander Hispanic, and Hawaiian/Other Pacific Islander Non-Hispanic patients.

Appendix 7

Number and Percent of Respondents Reporting Each TTA Domain as one of their Top 3 Needs, by UDS Characteristic

Number and Percent of Respondents Reporting Each TTA Domain as one of their Top 3 Needs, by UDS Characteristic

	Access/ Affordability		Governance		QPCS		Patient Experience	
	N	%	N	%	N	%	N	%
Overall	**541**	**48.9**	**328**	**29.7**	**668**	**60.4**	**438**	**39.6**
UDS Characteristic								
Health Center Organization Size								
Small	251	54.7	152	33.1	287	62.5	147	32.0
Large	291	44.9	176	27.2	382	59.0	291	44.9
Location								
Rural	225	50.1	138	30.7	276	61.5	174	38.8
Urban	260	45.6	164	28.8	341	59.8	240	42.1
Vulnerable Populations								
High proportion uninsured	**75**	**50.7**	**37**	**25.0**	**92**	**62.2**	**58**	**39.2**
Not high proportion uninsured	410	47.1	265	30.4	525	60.3	356	40.9
High proportion elderly	**83**	**53.2**	**49**	**31.4**	**100**	**64.1**	**48**	**30.8**
Not high proportion elderly	402	46.6	253	29.3	517	59.9	366	42.4
High proportion AHOPI	**21**	**48.8**	**15**	**34.9**	**29**	**67.4**	**13**	**30.2**
Not high proportion AHOPI	464	47.6	286	29.3	587	60.2	401	41.1
High proportion veteran	**34**	**37.0**	**33**	**35.9**	**52**	**56.5**	**28**	**30.4**
Not high proportion veteran	451	48.7	268	28.9	565	61.0	385	41.6
Funding Type								
Community Health Center Funding only	**468**	**47.5**	**286**	**29.0**	**596**	**60.5**	**400**	**40.6**
Migrant Health Center Grantee	**67**	**43.5**	**41**	**26.6**	**103**	**66.9**	**68**	**44.2**
Not Migrant Health Center Grantee	418	48.3	261	30.2	514	59.4	346	40.0
Homeless Health Center Grantee	**120**	**48.2**	**67**	**26.9**	**144**	**57.8**	**110**	**44.2**
Not Homeless Health Center Grantee	365	47.4	235	30.5	473	61.4	304	39.5
Public Housing Health Center Grantee	**39**	**43.8**	**23**	**25.8**	**54**	**60.7**	**37**	**41.6**
Not Public Housing Health Center Grantee	446	48.0	279	30.0	563	60.5	377	40.5
School Based Health Center	**202**	**48.6**	**118**	**28.4**	**253**	**60.8**	**164**	**39.4**
Not School Based Health Center	275	47.3	177	30.4	353	60.7	238	40.9

Notes: Small health centers defined as serving 10,000 patients or fewer.
High proportion defined as 1 standard deviation (SD) above the mean.
Elderly includes all patients 65+.
AHOPI refers to patients who identify as Asian, Hawaiian or Other Pacific Islander, and includes Asian, Hispanic, Asian Non-Hispanic, Hawaiian/Other Pacific Islander Hispanic, and Hawaiian/Other Pacific Islander Non-Hispanic patients.

Continued:

	Pop. Health		Workforce		Finance		Emergency Preparedness	
	N	%	N	%	N	%	N	%
Overall	**363**	**32.8**	**494**	**44.7**	**341**	**30.8**	**145**	**13.1**
UDS Characteristic								
Health Center Organization Size								
Small	139	30.3	185	40.3	154	33.6	62	13.5
Large	224	34.6	310	47.8	187	28.9	83	12.8
Location								
Rural	129	28.7	192	42.8	137	30.5	76	16.9
Urban	201	35.3	270	47.4	174	30.5	60	10.5
Vulnerable Populations								
High proportion uninsured	**50**	**33.8**	**59**	**39.9**	**54**	**36.5**	**19**	**12.8**
Not high proportion uninsured	280	32.1	403	46.3	257	29.5	117	13.4
High proportion elderly	**41**	**26.3**	**69**	**44.2**	**53**	**34.0**	**25**	**16.0**
Not high proportion elderly	289	33.5	393	45.5	258	29.9	111	12.9
High proportion AHOPI	**10**	**23.3**	**20**	**46.5**	**17**	**39.5**	**4**	**9.3**
Not high proportion AHOPI	319	32.7	442	45.3	294	30.2	132	13.5
High proportion veteran	**31**	**33.7**	**52**	**56.5**	**34**	**37.0**	**12**	**13.0**
Not high proportion veteran	299	32.3	409	44.2	277	29.9	124	13.4
Funding Type								
Community Health Center Funding only	**316**	**32.1**	**451**	**45.8**	**305**	**31.0**	**133**	**13.5**
Migrant Health Center Grantee	**52**	**33.8**	**68**	**44.2**	**43**	**27.9**	**20**	**13.0**
Not Migrant Health Center Grantee	278	32.1	394	45.5	268	31.0	116	13.4
Homeless Health Center Grantee	**106**	**42.6**	**112**	**45.0**	**67**	**26.9**	**21**	**8.4**
Not Homeless Health Center Grantee	224	29.1	350	45.5	244	31.7	115	14.9
Public Housing Health Center Grantee	**43**	**48.3**	**38**	**42.7**	**21**	**23.6**	**12**	**13.5**
Not Public Housing Health Center Grantee	287	30.9	424	45.6	290	31.2	124	13.3
School Based Health Center	**137**	**32.9**	**200**	**48.1**	**116**	**27.9**	**58**	**13.9**
Not School Based Health Center	187	32.1	251	43.1	189	32.5	76	13.1

Notes: Small health centers defined as serving 10,000 patients or fewer.
High proportion defined as 1 standard deviation (SD) above the mean.
Elderly includes all patients 65+.
AHOPI refers to patients who identify as Asian, Hawaiian or Other Pacific Islander, and includes Asian, Hispanic, Asian Non-Hispanic, Hawaiian/Other Pacific Islander Hispanic, and Hawaiian/Other Pacific Islander Non-Hispanic patients.

Appendix 8

TTA Domain: Access and Affordability

Over the next two years, I anticipate my health center organization will need ACCESS AND AFFORDABILITY TTA in the areas of: (N=1,106)

Sub-Domain	N	%
Outreach and Enabling Services:		
Implementation of case management services	489	44.2
Implementation of patient-centered transportation strategies	516	46.7
Development and implementation of outreach programs and/or partnerships to respond and address community identified health disparities	609	55.1
Development of outreach services, such as community health workers, to address chronic diseases or conditions (e.g., diabetes, hypertension, cancer, substance use, behavioral health)	653	59.0
Evaluation of outreach programs (e.g., effectiveness at engaging special and vulnerable populations, sustainability)	605	54.7
Housing services:		
Care coordination with housing providers	416	37.6
Care coordination with temporary housing and/or shelter provisions	406	36.7
Assisting with housing applications for patients seeking public housing or other housing assistance (e.g. Housing Choice Voucher, Section 8)	384	34.7
Coordinating with Community Programs/Partners:		
Partnering with caregiver support services (i.e., spousal support groups, peer support groups)	436	39.4
Partnering with family support services (i.e., parenting classes)	427	38.6
Assess and support connection to educational resources for patients (e.g., navigation towards getting a general educational diploma (GED))	311	28.1
Assess and support connection to employment resources for patients (e.g., partnering for job training, vocational training, etc.)	396	35.8
Language and/or Translation Services:		
Implementation of culturally and linguistically appropriate services (CLAS) Standards	413	37.3
Developing, monitoring implementation of a Limited English Proficiency (LEP) Plan	284	25.7
Provision of oral interpretation services	336	30.4
Provision of written translation services	311	28.1
Health Insurance Eligibility and Enrollment:		
Development of healthcare navigator services	465	42.0
Improving coordination with Military and Veterans Benefits and Services	370	33.5
Medical - Legal Partnerships:		
Understanding the core components of medical-legal partnerships	345	31.2
Identifying and engaging a legal partner	223	20.2
Using medical-legal partnerships to affect policy changes that benefit patients and communities	327	29.6
Evidence-based or promising practices for developing workflows for medical-legal partnership referrals, sharing information, integrating, and expanding medical-legal partnerships	409	37.0
Screening for legal needs and aligning with other social determinants of health screening	399	36.1
Other:		
Other, please specify	29	2.6

Appendix 9

TTA Domain: Governance and Management

Over the next two years, I anticipate my health center organization and/or Board will need GOVERNANCE AND MANAGEMENT TTA in the areas of: (N=1,106)

Sub-Domain	N	%
Governance:		
Effective board governance practices/approaches	477	43.1
Board culture and dynamics	377	34.1
Board's role in strategic planning	483	43.7
Board's role in financial oversight	381	34.4
Board's role in clinical quality oversight	436	39.4
Succession planning	450	40.7
Board recruitment and retention (i.e., members that represent special and vulnerable populations, with an emphasis on racial and ethnic diversity)	478	43.2
Effective implementation of board meetings and committees	295	26.7
Board education materials in non-English (Specify what language(s))	117	10.6
Strategic Direction/Priority Setting:		
Design and implementation of needs assessments	417	37.7
Data analysis and interpretation to inform and improve service delivery	460	41.6
Quality improvement and quality assurance methods and approaches	447	40.4
Training health center leadership and boards about health care transformation and navigating value-based payment	532	48.1
Developing a vision and strategy around payment and delivery reform	430	38.9
Health Information Technology		
Electronic Health Record (EHR) optimization	404	36.5
EHR interoperability, ability to exchange data with others (e.g., to support care coordination and services integration)	431	39.0
Transitioning/switching to a new EHR system from an old EHR system (e.g., planning, implementation)	246	22.2
Telehealth integration with EHR/HIT systems	385	34.8
Deploying decision support systems (e.g., implementation, use, restructuring workflows) and developing effective data dashboards	435	39.3
Expansion Planning:		
Strategic planning for health center growth	598	54.1
Workforce expansion	566	51.2
Partnership development to support health center capital planning and development, including co-location with housing and/or other services	375	33.9
Behavioral health services expansion and partnering with local providers	438	39.6
Expanding capacity to meet the behavioral health needs of special and vulnerable populations	463	41.9
Expansion of on-site oral health care services	392	35.4
Development and implementation (e.g., financial models, sustainability, and utilization) for special populations	355	32.1
Other:		
Other, please specify	19	1.7

Appendix 10

TTA Domain: Quality, Patient Care and Safety

Over the next two years, I anticipate my health center organization will need QUALITY, PATIENT CARE, AND SAFETY TTA in the areas of: (N=1,106)

Sub-Domain	N	%
Data collection and use:		
Leveraging use of data to guide/inform clinical quality, operational and financial improvement (e.g., at the individual and population-level and patient experience data)	594	53.7
Collection and optimizing use of enabling (non-clinical) services data and patient-level data on social determinants of health to enhance patient outcomes and health equity	604	54.6
Collection and use of reporting measures (e.g., Uniform Data System (UDS), Healthcare Effectiveness Data and Information Set (HEDIS))	501	45.3
Performance improvement on clinical outcome measures (such as preventive care and screening, chronic disease management, maternal care and children's health, and mental health and substance use). Please specify what measure(s)	240	21.7
General Patient Care and Safety		
Development, implementation, optimization of interdisciplinary care teams	458	41.4
Development and implementation of a healthcare risk management program	418	37.8
Patient Centered Medical Home accreditation	275	24.9
Expansion of telehealth care provision to improve continuity of care	509	46.0
Accessibility training for clinical providers working with patients with disabilities (i.e., visual, hearing impairment, physical, invisible, emotional, and cognitive disabilities)	338	30.6
Practices to increase prevention or early intervention visits (e.g., well-child visits, prenatal visits, annual physicals, vision screening, hearing screening)	460	41.6
Prescribing Pre-Exposure Prophylaxis (PrEP) to prevent Human Immunodeficiency Virus (HIV) infection (11)	296	26.8
Trauma-informed care and healing-centered engagement (strength-based approach to address trauma focused on well-being)	406	36.7
Best practices for patient and provider safety during public health emergencies (e.g., COVID-19)	491	44.4
Behavioral Health (Mental Health and Substance Use Disorder) Services:		
Integrating behavioral health into primary care	453	41.0
Follow-up after behavioral health referrals	435	39.3
Integration of therapy for opioid use disorder including application of screening, intervention, referral (SBIRT model), harm reduction, access to medication assisted treat-ment (MAT)	382	34.5
Using peer specialists/ peer support specialists to address patients' behavioral health care needs	394	35.6
Telehealth delivery model for behavioral health services	416	37.6
Oral Health Services:		
Integrating oral health into primary care	469	42.4
Development and implementation of innovative dental health delivery methods (e.g., dental therapists, hygienists, community dental health coordinators)	465	42.0
Using tele-dentistry to expand access to oral health care	451	40.8
Evidence-based, promising practices for use of dental sealant	345	31.2
Other:		
Other, please specify:	19	1.7

Appendix 11

TTA Domain: Patient Experience

Over the next two years, I anticipate my health center organization will need PATIENT EXPERIENCE TTA in the areas of: (N=1,106)

Sub-Domain	N	%
Assess and support patient engagement in telehealth (e.g., portals, mobile health technology)	658	59.5
Collection and optimizing use of patient experience/satisfaction data	576	52.1
Patient engagement in oral health care services	435	39.3
Culturally-responsive staff equipped to serve special and vulnerable populations	504	45.6
Strategies to improve reporting on special and vulnerable populations in the UDS	422	38.2
Developing clinical competencies to treat special and vulnerable populations including but not limited to any of the following: - Children and youth (aged 0-17) - Individuals and families experiencing homelessness (and persons at-risk for homelessness) - Immigrants - LGBTQ+ patients - Migratory and Seasonal Agricultural patients - Military Veterans and their families - Older adults - People with disabilities - Pregnant people - Residents of Public Housing - Racial and ethnic minorities (please specify which in the textbox) - Refugees - Persons at risk of HIV - Other	401	36.3
Patient education materials that are targeted to the needs of special and vulnerable populations including but not limited to any of the following: - Children and youth (aged 0-17) - Individuals and families experiencing homelessness (and persons at-risk for homelessness) - Immigrants - LGBTQ+ patients - Migratory and Seasonal Agricultural patients - Military Veterans and their families - Older adults - People with disabilities - Pregnant people - Residents of Public Housing - Racial and ethnic minorities (please specify which in the textbox) - Refugees - Persons at risk of HIV - Other	404	36.5
Revisions of procedures, policies, and forms to promote an inclusive and affirming environment for: - Children and youth (aged 0-17) - Individuals and families experiencing homelessness (and persons at-risk for homelessness) - Immigrants - LGBTQ+ patients - Migratory and Seasonal Agricultural patients - Military Veterans and their families - Older adults - People with disabilities - Pregnant people - Residents of Public Housing - Racial and ethnic minorities (please specify which in the textbox) - Refugees - Persons at risk of HIV - Other	400	36.2
Other, please specify:	14	1.3

Appendix 12

TTA Domain: Population Health and Social Determinants

Over the next two years, I anticipate my health center organization will need POPULATION HEALTH AND SOCIAL DETERMINANTS TTA in the areas of: (N=1,106)

Sub-Domain	N	%
Assessing and Addressing Patient's Needs		
Tools and strategies for screening for social determinants of health for patients, including specific populations of focus	564	51.0
Establishing Health Information Technology (HIT) capabilities for data collection specific to special and vulnerable populations (e.g., sexual orientation, gender identity, housing status)	462	41.8
Establishing HIT capabilities for data collection specific to intimate partner violence/ human trafficking survivors	384	34.7
Techniques to inform design of programs, interventions, or partnerships necessary to assess and address the social and non- clinical needs of health center patients (e.g., using data or asset mapping to determine the kinds of programs needed to address social determinants and build enabling service)	489	44.2
Assessing and supporting patients experiencing food insecurity	475	42.9
Assessing and supporting patients experiencing housing insecurity	494	44.7
Assessing and supporting patients experiencing financial strain	492	44.5
Assessing and supporting migrant and seasonal agricultural patients	311	28.1
Assessing and supporting patients experiencing lack of transportation/access to public transportation including information for state/local resources	449	40.6
Assessing and supporting refugee patients	324	29.3
Assessing and supporting immigrant patients	393	35.5
Assessing and supporting patients experiencing social isolation, including community-dwelling older adults, through support groups, community activities, and volunteer services	466	42.1
Assessing and supporting patients in need of employment opportunities	376	34.0
Improving health equity:		
Techniques for assessing community-level barriers to health equity	627	56.7
Strategies and tactics for addressing community-level barriers to health equities	655	59.2
Other:		
Other, please specify:	17	1.5

Appendix 13

TTA Domain: Workforce Experience/Development

Over the next two years, I anticipate my health center organization will need WORK-FORCE EXPERIENCE/DEVELOPMENT TTA in the areas of: (N=1,106)

Sub-Domain	N	%
Leadership:		
Clinical, operational, and financial improvement	551	49.8
Workforce strategies and planning	630	57.0
Innovations in health centers	557	50.4
Community–minded leadership and strategic partnerships that benefit health center patients and the community	472	42.7
Empowerment of health center staff (e.g., coaching, mentoring)	695	62.8
Orientation and onboarding to health center operations, environment, and culture	506	45.8
Strengthen financial management	333	30.1
Leadership succession planning	510	46.1
Creating a mission-driven workforce culture	475	42.9
Management:		
Supporting young professional and early to mid-career staff (non-clinical)	599	54.2
Supporting advance practice providers' development (i.e., NPs, PAs)	467	42.2
Project management (e.g., workplan development, implementation)	474	42.9
Change management	466	42.1
Communication and presentation skills	463	41.9
Managing staff (e.g., performance evaluation, staff management, integrated approaches, meeting facilitation skills, conflict resolution skills, team care approach, managing virtual staff)	609	55.1
Recruitment and Retention:		
Building effective processes for recruiting clinical staff into an integrated care model	609	55.1
Building effective processes for recruiting enabling services staff and community health workers into an integrated care model	513	46.4
Building effective processes for recruiting non-clinicians (e.g., finance, HIT, administrative staff, outreach staff)	459	41.5
Building effective processes for recruiting executive level leadership (e.g., Chief Work-force Officer, Chief Medical Officer, Chief Executive Officer, Chief Financial Officer, Chief Operating Officer, Chief Information Officer, Chief Behavioral Health Office, etc.)	389	35.2
Development and implementation of postgraduate training programs (e.g., cultivating organizational support, evaluation of postgraduate training programs, accreditation of postgraduate residency programs)	338	30.6
Development and implementation of student training programs	390	35.3
Developing streamlined processes for provider credentialing and privileging	415	37.5
Building a diverse and inclusive workforce including people with lived experience and/or reflect the patient population	404	36.5
Developing a comprehensive staff retention plan	684	61.8
Developing organizational strategies to reduce clinician burnout	633	57.2
Identification and analysis of workforce data	396	35.8
Creating equitable and sustainable compensation packages for clinicians and other staff	501	45.3
Improving job satisfaction and well-being of staff	690	62.4
Developing a data-driven approach to understanding and addressing organizational staffing needs	533	48.2
Other		
Other, please specify:	16	1.4

Appendix 14

TTA Domain: Finance

Over the next two years, I anticipate my health center organization will need FINANCE TTA in the areas of: (N=1,106)

Sub-Domain	N	%
Finance (general):		
Medicaid Prospective Payment System (PPS) reimbursement	365	33.0
Medicare PPS reimbursement	329	29.7
Other health center reimbursement	275	24.9
Payment under managed care	291	26.3
Becoming a provider under managed care	162	14.6
Telehealth reimbursement	429	38.8
Medicare cost reports	252	22.8
Understanding your costs in an evolving payment environment	333	30.1
Accounting systems and processes	212	19.2
Developing or operating under rolling budgets (also often known as continuous budgets)	209	18.9
Internal controls for cash management	188	17.0
Forecasting and financial projections	276	25.0
Federal grants management	314	28.4
Setting fee schedules	280	25.3
Federal procurement rules	213	19.3
Long-term financial planning	301	27.2
Allocating sustainable funding to implement or expand Community Health Worker or outreach programs	289	26.1
Financial resilience planning	269	24.3
Capital Financing:		
Integrating capital planning in health center strategic plans	328	29.7
Assessing readiness for capital expansion	300	27.1
Evaluating community partnerships and capital expansion	290	26.2
Assessing funding needs (e.g., assessing project size, funding availability, and obstacles to obtaining resources)	313	28.3
Assistance in understanding traditional and non-traditional forms of financing including the Health Resources and Services Administration (HRSA) Loan Guarantee Program	257	23.2
Securing funding/financing for health center capital development including through the use of the HRSA Loan Guarantee Program	263	23.8

Value Based Payment:		
Best practices on health center strategies for accelerating payment reform readiness	439	39.7
Opportunities to integrate dentistry and behavioral health services in value-based payment reform	417	37.7
Organizational preparation to engage in value-based payment environments (e.g., Accountable Care Organizations, Independent Provider Associations, Federally Qualified Health Center (FQHC) Alternative Payment Methodologies, and value- based contracts with Managed Care Organizations)	400	36.2
Financial modeling and other strategies for risk-based contracting	331	29.9
Risk stratification encompassing social determinants of health	399	36.1
Other:		
Other, please specify	12	1.1

Appendix 15

TTA Domain: Emergency Preparedness

Over the next two years, I anticipate my health center organization will need EMERGENCY PREPAREDNESS TTA in the areas of:
(N=1,106)

Sub-Domain	N	%
Cybersecurity protection, risk mitigation, and crisis response	535	48.4
Novel Coronavirus Disease (COVID-19) response and recovery	437	39.5
Infectious Disease response and recovery	368	33.3
Contingency planning (i.e., quick leadership transfer)	456	41.2
Planning for special and vulnerable populations during an emergency	398	36.0
Creating an emergency response plan that is compliant with local, state, and federal regulations focused on natural hazards (such as flood, earthquake, tornado, hurricane, blizzard)	385	34.8
Creating an emergency response plan that is compliant with local, state, and federal regulations focused on industrial hazards (such as fire, blackout, loss of water, gas failure)	340	30.7
Creating an emergency response plan that is compliant with local, state, and federal regulations focused on human-made hazards	312	28.2
Exercising an emergency response plan	387	35.0
Planning for staffing and personnel (i.e., staff available in an emergency, volunteers available, staff training)	426	38.5
Equipment inventory including communications equipment, first aid kits, emergency power equipment, personal protective equipment	327	29.6
Backup systems planning including patient services, emergency power, information systems support	401	36.3
Strengthening partnerships with state and local public health	375	33.9
Other, please specify	13	1.2

Appendix 16

Number and Percent of Respondents Reporting Each TTA Domain as one of their Top 3 Needs, by Health Center Role

Number and Percent of Respondents Reporting Each TTA Domain as one of their Top 3 Needs, by Health Center Role

	Access/ Affordability		Governance		QPCS		Patient Experience	
Role	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Executive team	149	36.8	124	30.6	212	52.3	147	36.3
Community health center workforce	392	55.9	204	29.1	456	65.0	291	41.5
Direct patient clinical care	95	72.5	45	34.4	91	69.5	49	37.4
Direct patient non-clinical care	38	71.7	13	24.5	32	60.4	19	35.8
Facility/non-clinical support	20	64.5	9	29.0	20	64.5	10	32.3
Management staff/administration	155	47.1	90	27.4	201	61.1	146	44.4
Quality improvement	29	40.3	23	31.9	49	68.1	26	36.1
Other	55	64.7	24	28.2	63	74.1	41	48.2

	Pop. Health		Workforce		Finance		Emergency Preparedness	
Role	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Executive team	139	34.3	217	53.6	178	44.0	49	12.1
Community health center work-force	224	32.0	277	39.5	163	23.3	96	13.7
Direct patient clinical care	36	27.5	43	32.8	23	17.6	11	8.4
Direct patient non-clinical care	25	47.2	13	24.5	10	18.9	9	17.0
Facility/non-clinical support	6	19.4	13	41.9	8	25.8	7	22.6
Management staff/administration	108	32.8	155	47.1	91	27.7	41	12.5
Quality improvement	28	38.9	33	45.8	15	20.8	13	18.1
Other	21	24.7	20	23.5	16	18.8	15	17.6

Appendix 17

Number and Percent of C-Suite Respondents Reporting their Health Center's Maturity Level on Each TTA Domain

Number and Percent of C-Suite Respondents Reporting their Health Center's Maturity Level on Each TTA Domain (N=394)

	Access/ Affordability		Governance		QPCS		Patient Experience	
Role	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Compliance-driven	33	8.4	50	12.7	28	7.1	50	12.7
Fundamental	112	28.4	124	31.5	112	28.4	169	42.9
Strategic	207	52.5	155	39.3	195	49.5	150	38.1
Leading	42	10.7	64	16.2	59	15.0	24	6.1

Continued:

	Pop. Health		Workforce		Finance		Emergency Preparedness	
Role	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Compliance-driven	94	23.9	86	21.8	33	8.4	92	23.4
Fundamental	165	41.9	185	47.0	110	27.9	139	35.3
Strategic	109	27.7	96	24.4	169	42.9	110	27.9
Leading	24	6.1	23	5.8	82	20.8	53	13.5

Appendix 18

Past Use of TTA

In the PAST YEAR, has your organization accessed TTA, inclusive of webinars, trainings, outside coaching/consulting, publications, toolkits, and other resources?		
	N	%
Yes	891	82.7
No	187	17.3

In the PAST YEAR, which sources of TTA has your organization accessed?		
	N	%
National Training & Technical Assistance Partner (NTTAP)	233	21.1
Primary Care Association (PCA)	557	50.4
Health Center Controlled Network (HCCN)	347	31.4
Other HRSA Funded TTA Provider (please specify in the textbox): - Health Workforce (BHW) - Healthcare Systems (HSB) - HIV/AIDS (HAB) - Maternal and Child Health (MCHB) - Primary Health Care (BPHC) - Rural Health Policy (FORHP)	327	29.6
Other (i.e. private consultant, state-funded TTA, foundation-funded TTA), please specify:	170	15.4
Don't know	239	21.6

Please indicate why your health center organization has NOT accessed TTA this PAST YEAR?		
	N	%
As of today, my health center organization has NOT identified any TTA needs where we need assistance.	22	12.0
My health center organization cannot afford any training and technical assistance.	12	6.5
My health center organization has been unable to identify sources of TTA specific to our TTA need(s)	14	7.6
My health center organization plans to access TTA sources within the next year; we just have not accessed any (as of today).	52	28.3
Other	84	45.7

Briefly describe what type of TTA your health center organization has had a difficult time locating?		
	N	%
Our health center is complex with sophisticated systems, and very large (3500 employees). This makes it hard to implement any changes unless proposed and backed by C-Suite. C-Suite does not attend TTA. Also, anything presented to C-Suite from TTA, takes staff time to tailor for the health center environment - and none of us have time to spare.	1	1.2
Asked but didn't receive	1	1.2
Communication here is poor.	1	1.2
COVID (lack of capacity)	14	16.7
Have not had good structure in place to access these resources	1	1.2
I am a new employee/new to my position and am unsure.	4	4.8
I am not aware of any training in the last year/I do not know	47	56.0
It has been difficult to afford in the past.	1	1.2
Too busy/too overwhelmed	2	2.4
Not clear how the TTA can help with things like primary care supply shortages.	1	1.2
The CEO operates independently of any data and has been given carte blanche by the Chairwoman of the Board (a good friend of hers) to do whatever she likes. Even though she holds a RN degree her decisions do not reflect basic understanding of health care contagion or respectfulness to clinicians.	1	1.2
There have been positive changes in the Quality Department -- we have added a Clinical Nursing component which will focus not just on the quality -- but the why and benefits of patient outcomes-- on the quality of nursing /clinical /medical and we are excited to learn and educate.	1	1.2
These options have not been identified by management for the use by Enrollment Counselors	1	1.2
They may have done- I just have not associated all the things we are using as resources with TTA	1	1.2
we have other sources of assistance, coaching and mentoring	1	1.2

Appendix 19

Number and Percent Anticipating TTA Needs by Domain

Number and Percent of Reporting That They Anticipate their Health Center Will Have *Any* Needs in each TTA Domain:

TTA Domain	Access/ Affordability		Governance		QPCS		Patient Experience	
	N	%	N	%	N	%	N	%
	933	84.4	887	80.2	911	82.4	879	79.5

Continued:

TTA Domain	Pop. Health		Workforce		Finance		Emergency Preparedness	
	N	%	N	%	N	%	N	%
	896	81.0	964	87.2	733	66.3	736	66.5

Appendix 20

Emerging TTA Needs


compliance
integration
disease
supply
FTCA
OSHA
competitive
leading
sustaining
pandemic
Recruiting
health
populations
staff
change
planning
patient
time
diabetes
management
climate
mergers
market
emergency
crises
COVID
clinical
physicians
training
dental
merging
services
inclusion
sites
community
growth

Over the next two years, are there other TTA needs around emerging issues or trends you anticipate your health center may need?
I have assembled an excellent team with the technical knowledge to cover all my needs; I gave up waiting for the PCA to assemble the resources. We are, in fact, spending a large portion of our time assisting other health centers with their needs.
How GQHCs manage in an increasingly competitive market and amongst large health system mergers; also mergers and acquisitions for FQHCs and private practices
What happens when our democratic institutions shift to non-democratic; how can we meet our mission in this context?
This list was pretty comprehensive
I think that we should be able to merge with another FQHC rather than be taken over by an outside entity and we will lose our FQHC status which is much needed here.
No
no
No
I think the check list covers anything I can think of.
Not that I can think of that is not included in this survey
No
growth management, scaling growth.
we will be moving into a new facility and all the training around setting that up correctly will be MOST helpful
No
no
Development and implementation of HIV program and value based care integration.
no
No
No
Christianity. Fear of God.
affordability of health care benefits - we are struggling to compete with big health systems for quality staff because we cannot offer the same benefits (group benefit planning in states maybe?); staffing during a pandemic - creative strategies when we have staff sick or home with sick children and do not have the structure to cover or meet the patient demand; school-based health center model - how to build relationships and expand into schools or other accessible locations for vulnerable populations.
no
We need dental services, eye services in our building, transportation for our homeless and Older adults and disabled population.
As Clinical personnel I have very little contact with administration and really am not aware of community health Processes.
Impact of climate change and what to anticipate.
NA
Development of early and mid-career physicians. Recruiting strategies for family medicine and ob physicians.
N/a
Continued supply of PPE, air filtration systems for dental sites as COVID continues through emerging variants.

(Continued) Over the next two years, are there other TTA needs around emerging issues or trends you anticipate your health center may need?
Decreasing waiting time by improving our slow antiquated internet system. Incorporating meaningful use system which decreases the number of times one has to click and allows for better patient care and time with patients
No
Staff lack of computer literacy in general
No
We are already overloaded with the TTA requirements already specified in this survey.
Natural Disaster - Hurricane1
Forward movement
No.
No
Not for now
Financial planning for emergencies
emergency response plan
none
efficient way to constantly check Center compliance with rapidly changing safety mandates (OSHA)
a lot of assisting in different areas too many to explain
ALL of the above
Dietician for chronic diseases
no
Addressing and sustaining "Realizing Joy in the Workplace".
Emergency Planning in general
remote patient monitoring,
NO
managing service area overlap
Influx of refugees
Operationalizing revenue opportunities; encouraging provider productivity
no
educational classes designed to address chronic illnesses, such as diabetes management, chronic kidney disease, hypertension, etc.
NA
not sure
COVID 19 funding and guidance
No.
N/A
COnsideration of acquiring smaller practices-- merging sub-recipient sites
Role of the health center in the community around issues of social justice, diversity, and inclusion.
not that I can think of
I can't think of anything that this survey did not cover.
Shelter for the employees and cots. We need the supply and medical equipment at least one month after the emergency.
N/A

(Continued) Over the next two years, are there other TTA needs around emerging issues or trends you anticipate your health center may need?
N/A
Yes
no
OSHA compliance
STAFFING AND RECRUITMENT COMPETITIVE WAGES
N/A
Yes
None that I can think of
The health centers need to have a plan to deal with any emerging global pandemic like the COVID 19.
n/a
none come to mind
na
NO
FTCA and risk management training.
Project management, Use of data for accountability.
Chronic disease management
Rural need vs urban/suburban needs
Addressing climate change on a sustained, on-going basis, not just during emergencies. I think we also have a responsibility to lead in training health centers and staff to do everything within our power to contribute reducing global warming through environmental, personal, and corporate action. We could be a galvanizing force, and we know that our patients are, as always, disproportionately adversely affected.
NA
N/a
none
How to look 10 years out and be prepared How to be engaged in the climate crises The talent pipeline How to move staff and patients toward care at home--house calls AI in primary care Expansion of primary care - what is the next definition The baby boomers are seniors - how to get them in the clinic Bring to health centers - leading authors and leaders about now and the future Cashless health systems Primary Care in 10 years - can I get it in a vending machine or robot or on line
clinical leadership training
FTCA deeming
no
Assistance with competency assessment, drills, and exercises for emergency preparedness Hazard Assessment
Staff burnout, specific to pandemic impacts. Understanding and responding to "the great resignation" related to pandemic impacts.
none
NO
how to fully integrate BH in a primary care Integrated health model.
Not sure
n/a

(Continued) Over the next two years, are there other TTA needs around emerging issues or trends you anticipate your health center may need?
Maintaining adequate staffing in general and being able to be somewhat competitive in te market on C&B.
-best practices for sustainable/eco-friendly/reduced carbon footprint health care/environmental health -finding grants that invest in people/training/wages versus capital costs (buildings, equipment) only
funding
No.
Not able to assess.
N/A
No1
integration of DEI principles,
No
None
Security in health centers. People seem to be stressed and more violent and combative.
N/A
creating dental residency
value based payments
Health Center funding post 330b state management
N/A
Auditing / Monitoring of Electronic Medical Records, including Telehealth visits Auditing / Monitoring of external Contracted 340B pharmacies
automated data transfer of patient remote monitoring device
340b and pharmacy expansion; building a clinical pharmacy program
NA
n/a
capacity for more services
Active Shooter, violent patient/group within clinic building and in community outreach settings
Not at this time
n/a
n/a
As a new FQHC Look Alike, we are open to learning and bettering our health center and staff. I believe that continual learning for our directors as well as training for our staff should help us in improving all the way around.
no
LGBTQIA+
No
Implementation of the information blocking rule, UDS+, data driven care and analytics
Resiliency, Change Management, New Leaders
No
climate change, gun violence, expand use of school facilities so they are community focal points and service access centers, not just for youth
no
need to find reputable EHR
Awaiting promised investments in infrastructure, expanding social services and addressing climate change via legislation from the US Congress which should be implemented with accountability and transparency at the state and local level.

(Continued) Over the next two years, are there other TTA needs around emerging issues or trends you anticipate your health center may need?
no
NO
none that I am aware of
Anti racist and anti immigrant/refugee trainings for staff and board
NA
N/A
Merging of health centers to maximize efficiencies.
IN PERSON SUBSTANTIALBILITIES MORE OFTEN
balancing workforce shortages alongside federal mandates along with increased wages to offset unemployment benefits
No
Developing a Compliance Budget
N/A
None.
Health Center and Hospital service partnerships
Strategies for reconnecting with patients that have not been in for care due to pandemic and afraid to do so but don't have the technology to connect via telehealth.
Not sure
N/A
yes
develop a plan for staff safety such as a active shooter.
pandemic, civil disturbance
None
maintaining clinicians and staff in a financially competitive environment of other practices (hospitals, competitor clinics)
security in the builling
Natural Disaster planning particularly around technology infrastructure collapses
No
intergenerational staff discord, hours of operation, participant engagement
none
No
No.
Physician engagement and ability to meet productivity needs.
no
No
Recruitment, Retention specifically of Medical Assistants, Nurses and Radiology Techs
Industry shifts to diverse location and care delivery impacts on primary care programs.
Compliance and risk management advance training.
California wild fire
I think a focus on grants management best practices is especially important over the next year. Perhaps creating a standard tool (in excel) that can help health center's illustrate multiple grant allocations across all cost categories for a specific date range. Or being able to allocate multiple grants to 1 FTE and be able to show for what period each respective grant was classed to that FTE. Or some sort of grants audit tool would be nice.

(Continued) Over the next two years, are there other TTA needs around emerging issues or trends you anticipate your health center may need?
Promoting reimbursement rates for social services and the total cost of care including comprehensive case management, improving access to care and restarting and re-establishing care for patients in light of COVID-19, improving integration of primary care and behavioral health care.
Not at this time.
no
N/A
value based care, expanded models of psychiatry (aims model)
no
EHR use ability to allow patients to contact providers via messaging for medical requests
None
No
Facing any or health emergency and Pandemic
no
Compliance with HRSA 330 grant requirements and OSV preparation and success
Closing the loop on SDOH referrals.
developing employee and patient engagement parameters, a better way to assess employee satisfaction and patient satisfaction
Employee health insurance benefits are drastically increasing. Many years ago provider liability insurance coverage was a tremendous financial drain on the CHC budget and and HRSA established the FTCA to assist with this which was and still is a great help. At this time a critical need now is for assistance with employee premiums for their single and family health insurance . It is so sad..that the CHC is helping so many others with their health services and yet the CHC is struggling to get fair insurance rates for their own employees. This is a major issue that must be addressed.
No
NO
No
No
none
No
No.
Recruiting and retention of staff.
Staff lack of computer literacy in general

Appendix 21

5-Year Future TTA Needs


physician
Quality
Affordability
retention
Care
Patient
Safety
recruitment
Stability
Financial

Think about where you would like to see your health center in 5 years. Identify 2 specific areas of TTA you would need to get there:
Address physician recruitment and retention
Financial Stability
(1) Quality, Patient Care, Safety (2) Affordability & Access
Expansion - Improvement in Quality Measures
Become a full professional risk provider -Identify other revenue sources outside of HRSA and state funding
1) Capital growth and management 2) Patient engagement and access--marketing
1) Financial Sustainability, and 2) Quality and Patient Care
1) Operational funding for expansion 2) Recruitment of providers in rural areas
1) Planning and implementing value-based care, different payment models. 2) Workforce Wellbeing, burnout, sustainability.
1) Social determinants of health 2) Workforce experience
1. Positioning ourselves in the community as defined by our strategic plan and identified needs. 2. Develop the appropriate infrastructure to accomplish our goals.
1. recruitment of clinical staff 2. staff burn out
1. Developing an effective workforce from unskilled worker pool 2. Attracting providers into a rural area that is not located within walking distance of the latest shopping malls and boutiques, bistros, theater districts and other avant garde attractions
1. Financial sustainability 2. Access and affordability
1. Population health. 2. Workforce experience.
1. Stabilized work force. No one wants to work, or they want to work from home, or they don't want to work full time. 2. Mission-focused work. Getting staff to commit to the mission and show up for work.
1. Staffing capacity at 100% 2. Dependence on HRSA grant
1.Transitioning to Value Based care 2. Improving Patient Engagement
A strong and viably entity. Growing with and towards the needs of our community.
Access - Scheduling & Empanelment
Access and Workforce Well-Being
Access and patient care and safety
Achieve Patient Center Medical Home, Joint Commission and others
Adding additional locations Teaching Health Center status
An additional site, and becoming a leader in all areas of care, including Behavioral Health Integration and Population Health Intregration
As listed above
As we are a PCA, I'd like to see our range of services to our members increase. I'd like to see some board-to-PCA growth in interaction and governance. Succession planning
Attracting male population to primary care Addressing SDOH
Best practices for patient data collection for income. Best practices for governance.
Billing and Collections Management Workforce
Board / Governance Training Workforce Development

(Continued) Think about where you would like to see your health center in 5 years. Identify 2 specific areas of TTA you would need to get there:
Board Training and continued Workforce Development
Board governance Competitive telehealth billing and practice
Board governance, primary care provider expansion
Building management systems is probably the most important. We are a fast growing organization, and some of the leaders as well as systems that have served us well as a small organization no longer work as well as we become larger. We need to work on sk
Building the new leaders for the health center
Business continuity within context of environmental hazards fire, smoke, whatever else and political upheavals at national level
Capital Planning, Workforce cross-training and succession planning
Capital and expansions/acquisitions; workforce/management/organizational structure
Capital campaigns, workforce sustainability
Capital for a new site Workforce development for recruitment and retention
Capital funding for a new facility; continued refinement of recruitment and retention plan.
Capital funding of a new building project
Capitol projects and Recruitment of specialty providers
Considerations for market expansion
Continued expansion of services to meet needs of our population, with fully integrated telehealth strategy that supports continuity and PCMH model, and more robust assessment of SDOH
Continuing to increase financial stability
Contracting in risk based environments. Health analytics and planning for population health care.
Culture enhancement; risk management
DATA ANALYSIS ON PHYSICIAN PERFORMANCE EVALUATION AND UDS MEASURES COMPLIANCE ON AN INDIVIDUAL PROVIDER BASIS
Data Analytics & Change
Data analytics and the incorporation of patient facing smartphone apps to enable care. Value based care sustainability.
Data management - analysis including billing complexity reduction Provider recruitment and retention
Dealing with staff burnout due to COVID 19 Better integrating dental and mental health with primary care
Developing Value Based payment plans, Improving Quality Performance Measures
Do a better job assessing then addressing SDOH issues; create a stronger referral system. Must improve internal operations to improve the patient experience, specifically front desk.
EHR Financial
Effective value based payment contracts and new models of reimbursement.
Emergency & Financial Sustainability
Emergency Preparedness & Workforce Security
Emergency Preparedness, Governance and Management

(Continued) Think about where you would like to see your health center in 5 years. Identify 2 specific areas of TTA you would need to get there:
Emergency planning and financial sustainability
Emergency preparedness, Pop health Social determinants
Emergency preparedness, creating an equitable environment for staff and patients
Employee Burnout Provider Recruitment
Employee and Patient Experience Improvement
Employee engagement, building basic skills of front line staff in a way that makes them feel invested in FQHCs.
Employee retention and patient experience
Employee retention and patient experience.
Establishment of a permanent home with full ownership and a fully operational care coordination program for all services.
Excellence in onboarding. Staff ongoing training & education
Excellent patient experience and Wonderful workforce experience
Expand from 3 sites to 5 Sites
Expand medical, mental and dental services and add vision services Become the provider of choice, employer of choice
Expanded access to dental services Succession planning
Expanded services to other areas. Financial stability
Expansion and growth of health centers through workforce development and sustainable growth strategies.
Expansion and quality management
Expansion in service area and unrestricted and reimbursable revenue to reach out to more patients in need
Expansion of care management and outreach functions
Expansion of service in to surrounding communities, as well as adding vision services.
Expansion planning and assistance Workforce recruitment & retention
Expansion, patient population grown to 10K patients and a stand alone building.
Expansion-property development, low-income housing, etc. Competitive recruitment.
Experienced, culturally competent and strategic consultants Regional expertise
Exploring the feasibility of new service lines. Capital expansion planning
FQHC billing resources and training. Data driven operational management strategies.
Finance and patient experience
Financial Stability - workforce development recruitment and retention
Financial Stability and Growth
Financial Stability, Patient Experience
Financial Strategic Planning
Financial Sustainability Workforce Development
Financial Sustainability
Financial Sustainability (Capital Expansion) and Workforce Experience (Recruitment and Retention)
Financial Sustainability and Board Governance

(Continued) Think about where you would like to see your health center in 5 years. Identify 2 specific areas of TTA you would need to get there:
Financial Sustainability and Governance and Management
Financial Sustainability and Quality, Patient Care, and Safety.
Financial Sustainability and Quality, Patient Experience and Safety
Financial Sustainability and Workforce Experience
Financial Sustainability, Access and affordable
Financial Sustainability, Marketing
Financial Sustainability, Patient Experience
Financial Sustainability; Governance and Management
Financial Sustainability; Patient Experience
Financial forecasting Quality Programs and Improvements
Financial management, MLP
Financial management, forecasting, and sustainability planning; workforce recruitment and retention/ benefits planning
Financial readiness and population health management
Financial stability Leading with excellence
Financial stability & recruitment/ retention of staff
Financial stability and Workforce Recruitment/retention
Financial stability and workforce experience
Financial stable with strategized growth.
Financial sustainability in the changing healthcare environment & use of technology in the future
Financial sustainability with expansion project, clear workflows and processes around operations, compliance, onboarding, and clinical.
Financial sustainability, governance and management
Financial sustainability/ IT Department improvement
Financial sustainablity and Quality management
Financial viability in the value based world. Strategic expansion to address community needs.
Financial/Revenue Cycle Management Quality of Care
Financially sustainable
Fiscal Sustainability, workforce experience
Flourishing financials and population health management
Fully retained provider staff Understanding payment reform
Fully staffed with trained professionals and able to access the data we need easily in order to make decisions.
Funding sources traditional and non-traditional
Funding, site and program expansions to meet ever increasing needs of the communities we serve
GOVERNANCE, QUALITY
Goal: add a new site. TTA related to financial stability and employee retention
Governance (BOD TTA). Financial Sustainability beyond a balanced budget.
Governance Responsabylities
Governance and Management; Financial Sustainability

(Continued) Think about where you would like to see your health center in 5 years. Identify 2 specific areas of TTA you would need to get there:
Governance and workforce
Governance/Management and Strategic Planning.
Governance/Management education and development Finance staff continued development
Grants management and advanced integrated behavioral/primary care
Growing our own workforce, capital funding for expansion
Growing unduplicated patients Workforce development and hiring issues
Growth Planning Improving Operations
Growth in Accessibility to Centers, Quality Measures
Heath Center expansion Workforce development
High outcomes scores and transparency.
Higher more strategic data analysis.
Highly diverse workforce to meet community needs; Excelling in patient health outcomes
How to assess potential areas to expand
How to grow and expand sustainably; innovative financial models (diversifying revenue; preparing for VBP_
I think being the leader in quality care. Expand our service area to those without primary care.
I would like our health center to achieve an operational margin of 3% to ensure that we have the financial resources to achieve our goals for high quality care, a well-trained and fully staff workforce, and strategic partnerships that focus on prevention.
I would like to see the my health center be recognized as a national example of health center excellence. I would like to see our health center be a leader in implementing innovative strategies that help further the FQHC movement.
I would like to see the organization as self-sustainable and in an increasingly financially stable position
I would like to see us more data driven and outcomes based in measuring and tracking and addressing Social Determinants of health, with better success recruiting and retaining physicians, behavioral health providers, and Medical Assistants, and having rev
IT
Identified this in prior TA needs section. 1-Grow a talented, flexible, workforce 2-Fiscal stability as the pandemic winds down
If I had to choose two it would be Quality and Population Health
Improve Financial Sustainability and Improve Access and Affordability
Improve of clinical measures Increase the Number of patients
Improve our patient and employee satisfaction and increase our total unduplicated users reported in our UDS.
Improve staffing and better patient and staff experience
Improve workforce retention; Improved SDOH
Improved Board Governance, Financing to insure our FQHC is considered a great place to work.
Improved patient and staff experience through building efficiency and data driven.
Improving our quality measure scores and patient experience scores

(Continued) Think about where you would like to see your health center in 5 years. Identify 2 specific areas of TTA you would need to get there:
Improving patient surveys and co-designing of programs with patients. Improving work flows, program and department budgeting and bringing more transparency and collaboration among all health center staff and CHC sites.
Increase access to specialty care Further development of chronic care services, particularly diabetes management
Increase in Federal funding.
Increase our Quality of Care and SDOH, and strengthen our Board Leadership
Increased patient access to services around social determinants of health.
Increased workforce and patients
Insurance access
Integrating Work into Strategy; Comprehensive strategic planning
Integration of SDoH and the workforce experience.
Integration of healthcare services that are within or at the boundaries of primary healthcare services
Just implementing Epic and would like to exploit all the functionality for improved efficiency, Quality and patient experience. Need to have mid-level managers trained on:: * How to best view, Explore, utilize data for management and decision making inc
Larger, more stable, better customer service, better retention, better facilities
Leaders in quality and patient safety by strengthening our program and increasing our quality numbers. Patient experience by employing a director and specifically targeting areas of need for improvement.
Leadership Development Workforce - Recruitment and Retention
Leadership change. marketing
Leading in Financial Sustainability and Workforce Experience
Long term financial sustainability & Innovation
Managing wage pressure with productivity and shift from volume to value
Money for LALs More flexibility to respond to disasters
More workforce
Multi-tenant non profit campus
Multiple permanent outreach sites; training MAs and/or medical students/residents.
NA
Need a streamlined recruitment of qualified individuals with a parallel retention strategy
New access points and capital expansion grants, value based care for large uninsured patient case load
New payment structures, quality and integrated care.
No comment
None
Operating with additional mental health providers and exploring PCMH.
Optimizing virtual care Leadership and Governance

(Continued) Think about where you would like to see your health center in 5 years. Identify 2 specific areas of TTA you would need to get there:
Organizational understanding of new P4P and PC Cap funding. Staff retention including the identification/ mitigation of burn out.
Outreach to under-served populations. Forever-increased patient experience.
PCMH + Provider accountability and retension
PHSC
PPS Rate Adjustment and Increased Cluster Grant Funding to keep up with patient growth
Pandemic preparedness and training
Patent experience and Workforce experience
Patient Care and Finance
Patient Experience Access and Affordability
Patient Experience, Financial Sustainability (specifically preparing for APM)
Patient Experience, Workforce Experience (Retention and Recruitment)
Patient Experience; Workforce Retention
Patient access; social determinants
Patient and workforce experience
Patient and workforce experience.
Patient engagement with technology and telehealth Expanding services to meet patient population needs
Patient experience Employee Engagement
Patient experience Workforce experience
Patient experience and engagement; community needs assessment; financial security
Patient experience, workforce recruitment/retention w/ housing struggles
Patient satisfaction Quality
Payment Reform and Value Based Care
Pharmacy beyond 340B - fully utilizing pharmacists as a member of clinical care team.
Playing a leadership role in addressing climate change from a prevention, mitigation, and emergency response perspective in the communities we serve and of course at a national/global level
Pop health, Achieving a 330 Grantee status
Population Health & Access and Affordability
Population Health & Social Determinants of Health; Financial Sustainability
Population Health & Workforce devel
Population Health and Quality
Population Health and SDOH
Population Health and Social Determinants of Health Access and Affordability
Population Health is an area where I would like to see growth so that we are more visible in the community. Financial stability will come once we are more familiar with grants. Hopefully within 5 years there might be an opportunity to become a 330 Grant

(Continued) Think about where you would like to see your health center in 5 years. Identify 2 specific areas of TTA you would need to get there:
Population health and financial stability.
Population health and social determinants of health Workforce development - recruitment and retension
Population health management; oral health integration
Population health programming Advancement in payment models
Population health/quality and Employee satisfaction/retention
Preparation for NAP Grant for Look-Alikes Financial sustainability
Providing high quality care with happy patients and an engaged workforce in a financially sustainable way to over 200,000 unique patients. 1. Pop Health & SDOH. 2. Workforce experience.
Providing more direct services. Adding more locations.
Quality SDOH
Quality and Patient Experience
Quality, Patient Care & Safety and Emergency Preparedness
Quality-based payment, business planning
Realizing that health equity begins with access equity, and 'an open schedule' is not automatically equitable to those with SDoH needs.
Recruitment
Recruitment & Retention Better reimbursement for financial stability
Recruitment, retention,
Reduced turnover and mature in Emergency Response
Residency training program for dentistry Development/recruitment of clinical support staff
Resources for sustainable funding for Chronic Disease prevention and and lifestyle medicine. Opportunities for LAL to become FQHCs.
Revenue Enhancement and RCM; New Access Point and fill FQHC status
School based dental program; operationalizing a satellite.
See results of survey questions.
Social Determinants and Quality
Social Determinants of health Care Teams
Social determinants of health and creating pipeline for medical professionals
Stability of the workforce and also capital project completion leading to growth
Stable workforce - low turnover, low vacancy rate; Quality Leader - CQMs in 1st Quartile
Stable workforce, better leadership
Staff Customer Service, Emergency Preparedness
Staff and management training (building a sustainable, replicable program to train at onboarding as well as provide ongoing training and education); prioritization of DEI/SDH at the forefront of all that we do.
Staff development and retention; Financial growth
Staff recruitment and retention. Achieving quality measure targets
Staff satisfaction and retention which leads to quality patient care
Staffing Models, Providers Access Goals
Staffing and Retention Quality

(Continued) Think about where you would like to see your health center in 5 years. Identify 2 specific areas of TTA you would need to get there:
Strategic Planning Financial Planning
Strategic Planning, Workforce Development
Strategic financing; sustainable innovation in SDOH care and support
Strategic growth and workforce sustainability
Strategic planning for and strategic management of growth. Further development of mid-level managers.
Strategic with patient access and well defined population health implementation
Strategies for hard to reach special population; migrant seasonal farmworkers Improving access to care during COVID
Strengthening our workforce is are biggest pain point at the moment. Education on how staff play a key role in contributing to the patient's overall experience during their visit.
Succession planning Board growth
Succession planning Logical fee schedule
Succession planning for CEO departure, increased planning/strategy around value based care models of payment
Succession planning, improved workforce retention
Support for developing leading Healthcare for the Homeless services. Support to enhance the workforce experience.
Supporting workforce and patient flow (from first call to check out)
Sustainability and Customer Service
Sustainability of behavioral health and dental services in value-based environment providing team-based care. Effective recruitment and retention of clinical support staff.
Sustainable oral health services operations that provide meaningful access to care; robust model of mobile delivery services for agricultural workers, homeless, uninsured, and very low income populations
TTA for Capital Expansion and VBC Reimbursement
TA - building ownership vs. lease due to market growth and rising lease prices, TA to increase program income and less reliant on applying for private grant funding
TeleHealth, Emergency Preparedness
Telehealth billing support and financial sustainability
Telemedicine, Remote monitoring devices, UDS modernization, how to create better health outcomes through social determinants of health.
Training around addressing SDOH beyond food and housing insecurity, as well as training and assistance regarding the LGBTQ+ population including testing for at risk populations for HIV and prescribing of PrEP
Training in Value Based Care Models and Outreach to achieve Fiscal Sustainability in our Market
Use of dashboards and data integration Using screening tools (CAGE, SDOH screeners) prior to the patient visit
VBP Success Clinician retention
Value Base leader; GME leader and Upstream patient management leader
Value Based Care True Population Management

(Continued) Think about where you would like to see your health center in 5 years. Identify 2 specific areas of TTA you would need to get there:
Value Based Reimbursement with alignment of staff and provider compensation Succession Planning
Value Based Reimbursement, workforce sustainibility
Value based Reimbursement
Value based care Taking on risk
Value based payments will still be driving and 340B pharmacy and it is impact on FQHC's
Value-Based Care, SDOH
Values Based Care/Reimbursement Access and Affordability
Viable with security well managed.
We need Medicaid expansion in Kansas....not sure you can help with that.
We need population health management and/or predictive analysis related to health disparities. We need to fully integrate all services line and community mental into a seamless whole
We would need the NAP to drop and be designated full FQHC (we are LAL); then successfully navigate the deeming process for FTCA coverage.
Work force after pandemic. retain reimbursement
Work force recruitment and EMR updating
Workforce Experience and Financial Sustainability
Workforce Development Integration of Behavioral Health Services
Workforce Development and Governance and Management topics. Specifically how to partner and/or develop a pipeline of people for workforce. Help a small rural health center understand the basics of governance and management best practices.
Workforce Development. Capital/Facilities Development.
Workforce Experience and Patient Experience
Workforce Experience and Value-Based Pay related work.
Workforce Experience, specifically around Leadership Development for mid-level Leaders and Quality driven programs that positively impact patient outcomes
Workforce Experience; Access and Affordability
Workforce Management & Sustainability Leadership training for management and supervisors
Workforce and Patient Experience
Workforce and Patient experience
Workforce and reimbursement
Workforce development and experience and caring for patients in a post COVID world
Workforce development and financial
Workforce development and financial stability
Workforce development especially in recruiting competent staff Behavioral Health Integration
Workforce development, financial sustainability
Workforce development. Adequate compensation for entry level staff.

(Continued) Think about where you would like to see your health center in 5 years. Identify 2 specific areas of TTA you would need to get there:
Workforce development/addressing burn out and the further strain generated from the pandemic & infrastructure needs for growth consisting of facilities, funding opportunities and expansion needs of our community
Workforce experience Patient experience
Workforce experience and patient experience
Workforce experience, Government and Management
Workforce improvement Reduction of provider burnout
Workforce recruitment and retention, Access and affordability for patients
Workforce retention and development. Quality with virtual care.
Workforce retention and improvement and growth of the health center
Workforce retention and stability Capital to expand sites and services
Workforce retention and training
Workforce stability and effective mission pervasiveness to staff Access and disparity in cyberconnectivity overcome
Workforce sustainability and experience expansion of IT
Workford Experience and Population Health and Social Determinants of Health
Would always like to see more users. That patients truly understand how to access patient centered medical care and understand their role in their healthcare. TTA - increasing outreach and awareness, promotion of PCMH model.
Would like TTA on forming a partnership for legal services for our low income patients.
access and work force
access to services (population health); becoming national quality leader
alternate payment models, provider burnout prevention
alternative models of care alternative payment models
behavioral health, MAT
better use of EHR
billing, value based care
buidling community health worker program into part of care team, making it sustainable. documenting the financial impact and getting local hospital system to support it
capital expenditures, simplified compliance
dental residency
effective care teams managing patient's pop health and SDOH; patient experience
emergency preparedness and social determinants of health
expansion into public housing clinics
finance & productivity
finance, capital planning and expansion; strategic partnerships with community agencies,
financial sustainability and provider retention
financial sustainability, patient experience
financially sustainable, located in new bldg.

(Continued) Think about where you would like to see your health center in 5 years. Identify 2 specific areas of TTA you would need to get there:
healthcare of Excellence
i would like to see quality patient care and safety move up to strategic
improve accessibility and continued financial sustainability
improve quality and staffing needs addressed
improvement strategies to move from good to great in SDoH patient driven population health and workforce
in a new value based payment model
leadership follow thru on implementation of ideas
management training capital planning and development
management; workforce experience
middle management training, clinical team integration at the higher level,
modernization in facilities, number one employer and outstanding patient experience
more patients
partnership with community mental health centers/ alignment with CCBHC
patient experience and growth/ financial sustainability
patient increase, resource increase
pediatric GME
population health and quality patient care
recruitment of primary care physicians to full staff. stability of clinical staff.
stable clinical and non-clinical workforce, outreach for patients to access care
strategic planning and needs assessment template developed
strong leadership new buildings and financial stability
uncertain
understanding our data - we have so much, and knowing the most important data that will improve our quality scores and patient satisfaction; how to improve both the quality and patient satisfaction scores based on what the data tells us.
value based care, expansion
worforce development sustainability
workforce and patient experience
workforce development, quality of care
workforce experience and access and affordability
workforce management; provider recruitment
workforce recruitment strategies, change management
workforce stabilization and financial sustainability
workforce, quality & patient care
would like to see our health center be financially self-sustainable and offering the best quality care to our patients