# Health Center Program Site Visit Guide

## For HRSA Health Center Program Grantees and Look-Alikes

NOVEMBER 2014/FISCAL YEAR 2015

## OVERVIEW: HEALTH CENTER PROGRAM SITE VISITS AND SITE VISIT GUIDE

***Purpose of Health Center Program Site Visits***: Site visits support the Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care's (BPHC) program oversight role and responsibilities. The most common types of site visits are Operational Site Visits (OSVs). OSVs provide an objective assessment and verification on the status of each Health Center Program grantee and look-alike's compliance with the statutory and regulatory requirements (see: http://www.bphc.hrsa.gov/about/requirements/index.html) of the Health Center Program, as well as a review of progress on clinical and financial performance and if applicable, capital grants. When appropriate, other types of site visits may also be conducted and utilized to provide assistance to health centers in addressing areas of non-compliance, to focus on specific areas of clinical, financial, or other areas of performance improvement, and/or to assist with the identification and implementation of best practices.

Health centers are individually responsible for ensuring they operate in accordance with all applicable Federal, State, and local laws and regulations. Specifically, the governing board of a health center provides leadership and guidance in support of the health center's mission and is legally responsible for ensuring that the health center is operating in accordance with applicable Federal, State, and local laws and regulations. Therefore, though the purpose and focus of OSVs and other sites visits conducted by BPHC are to assess compliance with Health Center Program requirements, the governing board and key management staff of the health center retain responsibility for assessing and maintaining compliance with all applicable Federal, State, and local laws and regulations, including those not assessed or addressed through the OSV process.

***Authority***: U.S. Department of Health and Human Services (HHS) grant regulations (45 CFR Part 74.51,see: http://go.usa.gov/B3hd) permit HRSA to "make site visits, as needed." In addition, 45 CFR part 74.53 states that "HHS awarding agencies, the HHS Inspector General, the U.S. Comptroller General, or any of their duly authorized representatives, have the right of timely and unrestricted access to any books, documents, papers, or other records of recipients that are pertinent to the awards, in order to make audits, examinations, excerpts, transcripts and copies of such documents. This right also includes timely and reasonable access to a recipient's personnel for the purpose of interview and discussion related to such documents." Therefore, if appropriate as part of the site visit process, HRSA staff and/or consultants conducting site visits as HRSA's duly authorized representatives, may review a health center's policies and procedures, financial or clinical records, and other relevant documents, in order to assess and verify compliance with Health Center Program requirements. If health centers wish to have HRSA staff and/or consultants sign confidentiality statements or related documents, this is permissible, but should be communicated to the site visit team at the beginning of the visit to avoid any disruption or delay in the site visit process.

***Site Visit Frequency and Timing***: HRSA routinely conducts Operational Site Visits during the first 10 to 14 months of a Newly Funded/Designated health center's project/designation period and subsequently, *at least once per project/designation period or at least once every 3 years*. Therefore, generally OSVs will take place 18 months into a typical 3-year project/designation period for most health centers. The timing and type of any additional site visits will depend on the needs of BPHC, the needs of the health center, and the availability of BPHC site visit resources.

***Site Visit Format and Outcomes***: The outcome of all site visits is an objective, in-depth assessment of the health center's compliance and/or performance status. Specifically:

- The site visit is conducted utilizing the questions and resources provided in this Health Center Program Site Visit Guide and in accordance with the corresponding guidance provided by BPHC's Technical Assistance Contractor.
- For Operational Site Visits, there are multiple members of the site visit team; each member of the consultant team will be assigned a particular area of the review (administration/governance, fiscal, and clinical) based on their program expertise.
- When possible, the health center's Project Officer and/or other BPHC staff will attend the site visit. In all cases the BPHC Project Officer will work and communicate with the consultant site visit team, and serve as *the health center's ongoing primary point of contact for all questions and areas related to the Health Center Program*.
- Site visits will result in a standardized site visit report that provides a comprehensive assessment of the health center's compliance and/or performance status (as applicable based on site visit type).
- The health center's BPHC Project Officer will transmit this final site visit report to the health center in a timely manner, after the site visit is completed.

***Overview of the Health Center Program Site Visit Guide and Related Resources***: The Health Center Program Site Visit Guide is BPHC's standardized review instrument used to conduct Operational Site Visits and, when appropriate, other types of site visits at health centers. It includes review questions used by the team conducting the site visit to assess compliance with each program requirement, to review progress on clinical and financial performance and capital grants (if applicable), and, when possible, to identify any best practices established by the health center. Health centers may also use this guide to assess compliance with program requirements, and to identify clinical and financial performance improvement areas. **NOTE**: The Health Center Program Site Visit Guide is updated annually; use only the most current version available on the BPHC website at http://www.bphc.hrsa.gov/policiesregulations/centerguide.html.

BPHC's Technical Assistance (TA) Web page (see http://www.bphc.hrsa.gov/technicalassistance/index.html) also provides a variety of resources that support the program requirements and clinical and financial performance improvement areas outlined within this site visit guide. Resources include a Samples and Templates Resource Center,[1] training opportunities (e.g., webinars, meetings, and conference calls), and links to the websites of BPHC Cooperative Agreement partners that provide training and TA for all health centers, as well as assistance to health centers serving special populations (e.g., migratory and seasonal agricultural workers, homeless individuals, and residents of public housing), other populations, or specific service needs.

[1] This is a repository of vetted documents shared by BPHC consultants, health centers, and BPHC Cooperative Agreement partners. Documents are arranged categorically within the Samples and Templates Resource Center (Resource Center). Please note that all documents that are not HRSA/BPHC publications posted in the Resource Center were made possible by contract number HHSH232200864001C from the Health Resources and Services Administration (HRSA), Bureau of Primary Health Care, and the contents of such documents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA.

# TABLE OF CONTENTS


| SECTION I: NEED | | | |
|---|---|---|---|
| No. | Title | Program Requirement Compliance Review | Page |
| 1 | Needs Assessment | Health center demonstrates and documents the needs of its target population, updating its service area, when appropriate. | 2 |

| SECTION II: SERVICES | | | |
|---|---|---|---|
| No. | Title | Program Requirement Compliance Review | Page |
| 2 | Required and Additional Services | Health center provides all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established written arrangements and referrals.<br><br>Note: Health centers requesting funding to serve homeless individuals and their families must provide substance abuse services among their required services. | 3 |
| 3 | Staffing | Health center maintains a core staff as necessary to carry out all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established arrangements and referrals. Staff must be appropriately licensed, credentialed and privileged. | 6 |
| 4 | Accessible Hours of Operation / Locations | Health center provides services at times and locations that assure accessibility and meet the needs of the population to be served. | 9 |
| 5 | After Hours Coverage | Health center provides professional coverage for medical emergencies during hours when the center is closed. | 10 |
| 6 | Hospital Admitting Privileges and Continuum of Care | Health center physicians have admitting privileges at one or more referral hospitals, or other such arrangement to ensure continuity of care. In cases where hospital arrangements (including admitting privileges and membership) are not possible, health center must firmly establish arrangements for hospitalization, discharge planning, and patient tracking. | 11 |

<table>
<tr><th colspan="4">SECTION II: SERVICES</th></tr>
<tr><th>No.</th><th>Title</th><th>Program Requirement Compliance Review</th><th>Page</th></tr>
<tr><td>7</td><td>Sliding Fee Discounts</td><td>Health center has a system in place to determine eligibility for patient discounts adjusted on the basis of the patient’s ability to pay.<br><br>• This system must provide a full discount to individuals and families with annual incomes at or below 100% of the Federal poverty guidelines (only nominal fees may be charged) and for those with incomes between 100% and 200% of poverty, fees must be charged in accordance with a sliding discount policy based on family size and income.<br>• No discounts may be provided to patients with incomes over 200 % of the Federal poverty guidelines.<br>• No patient will be denied health care services due to an individual’s inability to pay for such services by the health center, assuring that any fees or payments required by the center for such services will be reduced or waived.</td><td>12</td></tr>
<tr><td>8</td><td>Quality Improvement / Assurance Plan</td><td>Health center has an ongoing Quality Improvement/Quality Assurance (QI/QA) program that includes clinical services and management, and that maintains the confidentiality of patient records. The QI/QA program must include:<br>• a clinical director whose focus of responsibility is to support the quality improvement/assurance program and the provision of high quality patient care;*<br>• periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the health center; and such assessments shall: *<br>    o be conducted by physicians or by other licensed health professionals under the supervision of physicians;*<br>    o be based on the systematic collection and evaluation of patient records;* and<br>    o identify and document the necessity for change in the provision of services by the health center and result in the institution of such change, where indicated.*</td><td>15</td></tr>
</table>

<table>
<tr><th colspan="4">SECTION III: MANAGEMENT AND FINANCE</th></tr>
<tr><th>No.</th><th>Title</th><th>Program Requirement Compliance Review</th><th>Page</th></tr>
<tr><td>9</td><td>Key Management Staff</td><td>Health center maintains a fully staffed health center management team as appropriate for the size and needs of the center. Prior approval by HRSA of a change in the Project Director/Executive Director/CEO position is required.</td><td>18</td></tr>
</table>

| SECTION III: MANAGEMENT AND FINANCE | | | |
|---|---|---|---|
| No. | Title | Program Requirement Compliance Review | Page |
| 10 | Contractual/Affiliation Agreements | Health center exercises appropriate oversight and authority over all contracted services, including assuring that any subrecipient(s) meets Health Center Program requirements. | 19 |
| 11 | Collaborative Relationships | Health center makes effort to establish and maintain collaborative relationships with other health care providers, including other health centers, in the service area of the center. The health center secures letter(s) of support from existing health centers (section 330 grantees and FQHC Look-Alikes) in the service area or provides an explanation for why such letter(s) of support cannot be obtained. | 20 |
| 12 | Financial Management and Control Policies | Health center maintains accounting and internal control systems appropriate to the size and complexity of the organization reflecting Generally Accepted Accounting Principles (GAAP) and separates functions appropriate to organizational size to safeguard assets and maintain financial stability. Health center assures an annual independent financial audit is performed in accordance with Federal audit requirements, including submission of a corrective action plan addressing all findings, questioned costs, reportable conditions, and material weaknesses cited in the Audit Report. | 21 |
| 13 | Billing and Collections | Health center has systems in place to maximize collections and reimbursement for its costs in providing health services, including written billing, credit and collection policies and procedures. | 23 |
| 14 | Budget | Health center has developed a budget that reflects the costs of operations, expenses, and revenues (including the Federal grant) necessary to accomplish the service delivery plan, including the number of patients to be served. | 25 |
| 15 | Program Data Reporting Systems | Health center has systems which accurately collect and organize data for program reporting and which support management decision-making. | 26 |
| 16 | Scope of Project | Health center maintains its funded scope of project (sites, services, service area, target population, and providers), including any increases based on recent grant awards. | 27 |

| SECTION IV: GOVERNANCE | | | |
|---|---|---|---|
| No. | Title | Program Requirement Compliance Review | Page |
| 17 | Board Authority | Health center governing board maintains appropriate authority to oversee the operations of the center, including:<br>• holding monthly meetings;<br>• approval of the health center grant application and budget;<br>• selection/dismissal and performance evaluation of the health center CEO;<br>• selection of services to be provided and the health center hours of operations;<br>• measuring and evaluating the organization's progress in meeting its annual and long-term programmatic and financial goals and developing plans for the long-range viability of the organization by engaging in strategic planning, ongoing review of the organization's mission and bylaws, evaluating patient satisfaction, and monitoring organizational assets and performance;* and<br>• establishment of general policies for the health center.<br>Note: In the case of public centers (also referred to as public entities or agencies) with co-applicant governing boards, the public center is permitted to retain authority for establishing general policies (fiscal and personnel policies) for the health center. | 29 |
| 18 | Board Composition | The health center governing board is composed of individuals, a majority of whom are being served by the center and, this majority as a group, represent the individuals being served by the center in terms of demographic factors such as race, ethnicity, and sex. Specifically:<br>• Governing board has at least 9 but no more than 25 members, as appropriate for the complexity of the organization.*<br>• The remaining non-consumer members of the board shall be representative of the community in which the center's service area is located and shall be selected for their expertise in community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social service agencies within the community. *<br>• No more than one half (50%) of the non-consumer board members may derive more than 10% of their annual income from the health care industry. *<br>Note: Upon a showing of good cause the Secretary may waive, for the length of the project period, the patient majority requirement in the case of a health center that receives a grant pursuant to subsection (g), (h), (i), or (p). | 33 |
| 19 | Conflict of Interest Policy | Health center bylaws or written corporate board approved policy include provisions that prohibit conflict of interest by board members, employees, consultants, and those who furnish goods or services to the health center.<br>No board member shall be an employee of the health center or an immediate family member of an employee. The Chief Executive Officer may serve only as a non-voting ex-officio member of the board.* | 36 |

**NOTE:** Portions of program requirements notated by an asterisk "*" indicate regulatory requirements that are recommended ***but not required*** for health centers that receive funds/designation solely for Health Care for the Homeless (section 330(h)) and/or the Public Housing Primary Care (section 330(i)) Programs.


| SECTION V: CLINICAL AND FINANCIAL PERFORMANCE | |
|---|---|
| | Page |
| Clinical and Financial Performance Review | 38 |

| SECTION VI: CAPITAL AND OTHER GRANT PROGRESS | |
|---|---|
| | Page |
| Capital and Other Grant Progress Review | 40 |

| SECTION VII: INNOVATIVE/BEST PRACTICES | |
|---|---|
| | Page |
| Innovative/Best Practices Documentation | 42 |

| APPENDICES | | |
|---|---|---|
| | | Page |
| A | Cross-Cutting Reference Documents and Websites | 43 |

| SUMMARY OF UPDATES TO HEALTH CENTER PROGRAM SITE VISIT GUIDE: NOVEMBER 2014 | |
|---|---|
| **The following changes have been made to the Health Center Program Site Visit Guide in accordance with updates and clarifications of the Health Center Program requirements and HRSA/BPHC policy. Users of the Health Center Program Site Visit Guide can ensure that they are using the most current version of the guide by visiting http://www.bphc.hrsa.gov/policiesregulations/centerguide.html.** | |
| Section | Updates |
| II. Services | • Questions for assessing and documenting compliance with the Required and Additional Services program requirement have been modified. Assessments of compliance specific to the application of sliding fee discounts to required and additional services will now be documented under the Sliding Fee Discount program requirement.<br>• Questions for assessing and documenting compliance with the Sliding Fee Discounts program requirement have been updated to align with the 2014 Sliding Fee Discount and Related Billing and Collections Program Requirements policy (PIN 2014-02). |
| III. Management and Finance | • Questions for assessing and documenting compliance with the Billing and Collections program requirement have been updated to align with the 2014 Sliding Fee Discount and Related Billing and Collections Program Requirements policy (PIN 2014-02).<br>• All references to Financial Recovery Plans have been removed as HRSA/BPHC is no longer requiring or utilizing these plans. |
| IV. Governance | • The question for assessing whether the board meets monthly under the Board Authority program requirements has been clarified as all organizations, including those that were developing plans to meet monthly due to being waived out of this requirement previously, are now required to implement these actions. These organizations are to be assessed for compliance regardless of previous waiver status for monthly meetings in accordance with the Health Center Program Governance policy (PIN 2014-01). |
| Appendix A | Appendix A: Has been updated to include the most recent policies. |

# SECTION I: NEED

## Program Requirement 1: NEEDS ASSESSMENT

*Authority:* Section 330(k)(2) and (k)(3)(J) of the PHS Act

*Documents to Review Onsite or in Advance:* 1) Most recent needs assessment(s) 2) Service area map 3) UDS patient origin data 4) Health center's list of sites with service area zip codes (Form 5B)

*Related HRSA Resources:* 1) UDS Mapper tool: http://www.udsmapper.org ( http://bphc.hrsa.gov/exitdisclaimer/hrsaexitdisclaimer.html ) 2) Service Area Overlap: Policy & Process (PIN: 2007-09): http://bphc.hrsa.gov/policiesregulations/policies/pin200709.html 3) HRSA Geospatial Data Warehouse: http://datawarehouse.hrsa.gov/

| Requirements | Questions | Response |
|---|---|---|
| Health center has a documented assessment of the needs of its target population, and has updated its service area when appropriate. | Does the health center have a written needs assessment? | |
| | Does the health center have a defined service area? Is this defined service area consistent with its patient origin data in UDS? | |

# SECTION II: SERVICES

## Program Requirement 2: REQUIRED AND ADDITIONAL SERVICES

*Authority:* Section 330(a) and (h)(2) of the PHS Act

*Documents to Review Onsite or in Advance:* 1) Health center's official scope of project for services (Form 5A) 2) Clinical practice protocols and/or related policies and/or procedures that support the delivery of health center services 3) Contracts, MOAs, MOUs, etc., for services provided via formal written agreements and/or formal written referral arrangements, including general tracking and referral policies and/or procedures

*Related HRSA Resources:* 1) Scope of Project Information and Policies: http://bphc.hrsa.gov/about/requirements/scope/ including, Form 5A Service Descriptors: http://bphc.hrsa.gov/about/requirements/scope/form5aservicedescriptors.pdf and: Form 5A Column Descriptors: http://bphc.hrsa.gov/about/requirements/scope/form5acolumndescriptors.pdf 2) HIV/AIDS Testing, Care and Treatment Program Assistance Letters: http://www.bphc.hrsa.gov/policiesregulations/policies/services.html 3) HRSA Culture, Language and Health Literacy Resources: http://www.hrsa.gov/culturalcompetence/index.html

NOTES:

**Any findings regarding the ACCURACY of a health center's scope of project in terms of the SERVICES listed on Form 5A (e.g., health center is providing a service in scope, but the service is NOT listed on Form 5A) must be documented under PROGRAM REQUIREMENT 16: SCOPE OF PROJECT.**

**Any findings regarding the structure or availability of a health center's SLIDING FEE DISCOUNT PROGRAM as it relates to the SERVICES listed on Form 5A (e.g., health center is providing an additional service directly, but the service is NOT discounted through the health center's sliding fee discount program) must be documented under PROGRAM REQUIREMENT 7: SLIDING FEE DISCOUNTS.**

| Requirements | Questions | Response |
|---|---|---|
| Health center provides all required primary, preventive, and enabling health services (defined in section 330(b)(1)(A) of the PHS Act) and provides additional health services (defined in section 330(b)(2)) as appropriate and necessary, either directly or through established written arrangements and referrals. | For all required services currently listed on the health center's Form 5A, in Column I as being provided *directly* by the health center, are these services available across the various health center site(s)?<br><br>***Note:*** *Not all services must be available at all sites* | |

| Requirements | Questions | Response |
|---|---|---|
| ***Note:*** Health centers that receive (section 330(h)) funding/designation to serve homeless individuals and their families must provide substance abuse services among their required services. | ***If the health center receives (section 330(h)) funding/designation to serve homeless individuals and their families***: Is the health center providing substance abuse services either directly and/or through formal written agreements or formal written referral arrangements? | |
| | If the health center provides any required services (per the health center's Form 5A) through an outside organization/provider, either through a *formal written agreement (Form 5A, Column II)* or a *formal written referral arrangement (Form 5A, Column III)* the following two questions must be addressed.<br><br>***Note:*** *Reviewing a sample of these agreements/arrangements may be acceptable in cases where the health center offers numerous services via these service delivery methods.* | |
| | **For required services provided via formal written agreement(s)/contract(s) (Form 5A, Column II):** Is there a written agreement (e.g., MOA, contract) in place between the health center and outside organization/provider that addresses<br>• How the service will be documented in the health center's patient record;<br>• How the health center will pay and/or bill for the service; and<br>• How the health center's policies and/or procedures will apply? | |
| | **For required services provided via formal written referral arrangements (Form 5A, Column III):**<br>• Is an MOU, MOA, or other formal agreement in place between the health center and outside organization/provider that, at minimum, describes the manner by which the referral will be made and managed, and the process for referring patients back to the center for appropriate follow-up care?<br>• Is the referred service available equally to all health center patients? ***Note:*** *The referred service must be available equally, but not necessarily via the same referral provider.*<br>• Is tracking and follow-up care for referred patients provided by the health center? | |

| Requirements | Questions | Response |
|---|---|---|
| | If the health center serves patients with limited English proficiency (LEP)[2] or with disabilities, has the health center taken reasonable steps to provide meaningful access to their services (Required and Additional) for such patients? Specifically:<br>• Are interpretation/translation service(s) provided that are appropriate and timely for the size/needs of the LEP health center patient population (e.g., bilingual providers, onsite interpreter, language telephone line)?<br>• Are auxiliary aids and services readily available and responsive to the needs of patients with disabilities (e.g., sign language interpreters, TTY lines)?<br>• Are documents or messages vital to a patient's ability to access health center services (e.g., registration forms, sliding fee discount schedule, after hours coverage instructions, signage) provided to patients in the appropriate languages, literacy levels, and/or alternative formats (for patients with disabilities), and in a timely manner?<br>• Are patients made aware of these resources? | |

[2] LEP includes individuals who do not speak English as their primary language and/or who have a limited ability to read, write, speak, or understand English, and who may be eligible to receive language assistance with respect to the particular service, benefit, or encounter.

## Program Requirement 3: STAFFING

*Authority:* Section 330(a)(1), (b)(1)-(2), (k)(3)(C), and (k)(3)(I) of the PHS Act

*Documents to Review Onsite or in Advance:* 1) Staffing Profile 2*)* Provider contracts, agreements, and any subrecipient arrangements related to staffing (as applicable) 3) Credentialing and privileging policies and/or procedures 4) Documentation of provider licensure or certification for all licensed or certified health center practitioners 5) Privileging lists

*Related HRSA Resources:* Credentialing and Privileging Policies (PINs 2002-22 & 2001-16): http://www.bphc.hrsa.gov/policiesregulations/policies/qualityrisk.html

| Requirements | Questions | Response |
|---|---|---|
| Health center maintains a core staff as necessary to carry out all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established arrangements and referrals. Staff must be appropriately licensed, credentialed and privileged. | Is the core staff (those responsible for carrying out both clinical and non-clinical services) appropriate for serving the patient population in terms of size and composition and adequate for carrying out the approved scope of project (e.g., staffing for services included on Form 5A (Column I) and for the sites documented on Form 5B)?<br><br>***Note:*** *There is no required national health center staffing number/ratio or threshold.* | |
| | Are all health center providers appropriately licensed or certified to perform the activities and procedures detailed within the health center's approved scope of project? ***Note:*** *Appropriate documentation (as outlined in the chart below) must include written confirmation of credentialing licensure or certification (i.e., primary source verification of provider licensure, registration, or certification) for all licensed or certified health center practitioners, employed or contracted, volunteers, and locum tenens, currently providing services at any health center sites or locations.* | |
| | Do the health center's written, board-approved *credentialing and privileging policies and/or supporting operating procedures* meet or address all of the requirements outlined in the chart below, including addressing credentialing and privileging for all licensed or certified health center practitioners, employed or contracted, volunteers, and locum tenens, currently providing services at the health center sites or locations? | |

| Requirements for Credentialing and Privileging "Licensed or Certified Health Care Practitioners"<br>Notes:<br>o Ultimate approval authority for credentialing and privileging of licensed independent practitioners (LIPs) is vested in the governing board which may review recommendations from either the Clinical Director or a joint recommendation of the medical staff (including the Clinical Director) and the Chief Executive Officer. Alternatively, the governing board may delegate this responsibility (via resolution or bylaws) to an appropriate individual to be implemented based on board-approved policies and/or related operating procedures (including methods to assess compliance with these policies and/or procedures).<br>o Health centers may choose to have additional standards and/or processes as part of their credentialing and privileging policies and/or procedures that go above and beyond these minimum requirements. | | |
|---|---|---|
| Credentialing or Privileging Activity | "Licensed or Certified Health Care Practitioner" | |
| | Licensed independent practitioner (LIP)<br>*Examples: Physician, Dentist, Physician Assistant, Nurse Practitioner* | Other licensed or certified practitioner<br>*Examples: Registered nurse, Licensed practical nurse, Certified medical assistant, Registered dietician* |
| A. CREDENTIALING | METHOD | |
| 1. Verification of licensure, registration, or certification | Primary source | Primary source |
| 2. Verification of education | Primary source | Secondary source |
| 3. Verification of training | Primary source | Secondary source |
| 4. Verification of current competence | Primary source, written | Supervisory evaluation per job description |
| 5. Health fitness (ability to perform the requested privileges) | Confirmed statement | Supervisory evaluation per job description |
| 6. Approval authority | Governing body or other appropriate individual (usually concurrent with privileging) | Supervisory function per job description |
| 7. Government issued picture identification | Secondary source | Secondary source |

| A. CREDENTIALING | METHOD | |
|---|---|---|
| 8. Immunization and PPD status | Secondary source | Secondary source |
| 9. Life support training (if applicable) | Secondary source | Secondary source |
| 10. Drug Enforcement Administration (DEA) registration | Secondary source, if applicable | Secondary source, if applicable |
| 11. Hospital admitting privileges | Secondary source, if applicable | Secondary source, if applicable |
| B. INITIAL GRANTING OF PRIVILEGES | METHOD | |
| 1. Verification of current competence to provide services specific to each of the organization's care delivery settings | Primary source, based on peer review and/or performance improvement data | Supervisory evaluation per job description |
| 2. Approval authority | Governing body or other appropriate individual (usually concurrent with credentialing) | Supervisory evaluation per job description |
| C. RENEWAL OR REVISION OF PRIVILEGES | METHOD | |
| 1. Frequency | At least every 2 years | At least every 2 years |
| 2. Verification of current licensure, registration, or certification | Primary source | Primary source |
| 3. Verification of current competence | Primary source based on peer review and/or performance improvement data | Supervisory evaluation per job description |
| 4. Approval authority | Governing body or other appropriate individual | Supervisory function per job description |
| 5. Appeal to discontinue appointment or deny clinical privileges | Process required | Organization option |
| Source: Health Resources and Services Administration (HRSA) Bureau of Primary Health Care (BPHC). Clarification of Bureau of Primary Health Care credentialing and privileging policy outlined in Policy Information Notice 2001-16 and Policy Information Notice 2002-22. | | |

## Program Requirement 4: ACCESSIBLE HOURS OF OPERATION / LOCATIONS

*Authority:* Section 330(k)(3)(A) of the PHS Act

*Documents to Review Onsite or in Advance:* 1) Hours of operation for health center sites 2) Most recent Form 5B: Service Sites (*Note that the form lists only the TOTAL number of hours per week each site is open, not the specific schedule)* 3) Form 5C: Other Activities/Locations 4) Service area map with site locations noted

*Related HRSA Resources:* 1) Scope of Project Information and Policies: http://bphc.hrsa.gov/about/requirements/scope/ 2) UDS Mapper tool: http://www.udsmapper.org ( http://bphc.hrsa.gov/exitdisclaimer/hrsaexitdisclaimer.html )

NOTE: Any findings regarding the ACCURACY of a health center's scope of project in terms of the SITES listed on Form 5B (e.g., health center has closed a site, but it is still listed on Form 5B) must be documented under PROGRAM REQUIREMENT 16: SCOPE OF PROJECT.

| Requirements | Questions | Response |
|---|---|---|
| Health center provides services at *times* that assure accessibility and meet the needs of the population to be served. | Are the *times* that services are provided at sites reasonably appropriate to ensure access for the population to be served? | |
| Health center provides services at *locations* that assure accessibility and meet the needs of the population to be served. | Is the *location(s)* (as documented on Form 5B) at which services are provided accessible to the population to be served?<br><br>**For health centers that receive targeted funding/designation to serve public housing residents**: Has the health center made services available in areas immediately accessible to the targeted public housing communities? | |

## Program Requirement 5: AFTER HOURS COVERAGE

*Authority:* Section 330(k)(3)(A) of the PHS Act and 42 CFR Part 51c.102(h)(4)

*Documents to Review Onsite or in Advance:* 1) Health center's after hours coverage policies and/or procedures 2) Agreements, systems and/or contracts that support after hours coverage, if applicable 3) Most recent Form 5A: Services Provided, see "Coverage for Emergencies During and After Hours"

*Related HRSA Resources:* 1) Form 5A Service Descriptors: http://bphc.hrsa.gov/about/requirements/scope/form5aservicedescriptors.pdf 2) Health Center Collaboration (PAL 2011-02): http://bphc.hrsa.gov/policiesregulations/policies/pal201102.html

| Requirements | Questions | Response |
| --- | --- | --- |
| Health center provides professional coverage for medical emergencies during hours when the center is closed. | Is professional coverage for medical emergencies available to health center patients after the center's regularly scheduled hours through clearly defined arrangements? | |
| | Are patients made aware of the availability of, and procedures for, accessing professional coverage after hours, including patients with LEP or disabilities (e.g., health center provides information/instructions on how to access after hours coverage in the appropriate language(s)/literacy levels for the health center's patient population)? | |

## Program Requirement 6: HOSPITAL ADMITTING PRIVILEGES AND CONTINUUM OF CARE

*Authority:* Section 330(k)(3)(L) of the PHS Act

*Documents to Review Onsite or in Advance:* 1) Hospital admitting privileges agreements/documentation 2) Most recent Form 5C: Other Activities/Locations (if applicable, hospitals where health center providers have admitting privileges should be noted on the form)

*Related HRSA Resources:* Health Center Collaboration (PAL 2011-02): http://bphc.hrsa.gov/policiesregulations/policies/pal201102.html

| Requirements | Questions | Response |
|---|---|---|
| Health center physicians have admitting privileges at one or more referral hospitals, or other such arrangement to ensure continuity of care. In cases where hospital arrangements (including admitting privileges and membership) are not possible, the health center must firmly establish arrangements for hospitalization, discharge planning, and patient tracking. | Does the health center have arrangements for the hospitalization of all health center patients as needed (e.g., labor and delivery, emergencies, children, adults)? ***Note:*** *Hospital arrangements may be accomplished either by the health center's own providers having admitting privileges at one or more hospitals, and/or by the health center having hospital admitting arrangements with non-health center providers (e.g., hospital, hospitalists, group practices).* | |
| | Does the health center have internal policies, systems, or procedures addressing hospitalization/emergency department referrals, discharge follow-up, and patient tracking (e.g., tracking laboratory and radiology results not available at the time of discharge) to assure continuity of care for hospitalized health center patients? | |
| | If non-health center providers care for health center patients during hospitalization, does the health center have firmly established arrangements that address hospitalization, discharge planning, and patient tracking in order to assure appropriate communication and continuity of care between the health center and non-health center providers? | |

## Program Requirement 7: SLIDING FEE DISCOUNTS

*Authority:* Section 330(k)(3)(G) of the PHS Act and 42 CFR Part 51c.303(f) and (u)

*Documents to Review Onsite or in Advance:* 1) Schedule of fees/charges for all services in scope 2) Sliding fee discount schedule/schedule of discounts (often referred to as the "sliding fee scale") 3) Policies for the sliding fee discount program 4) Supporting operating procedures for the sliding fee discount program 5) Sliding fee signage and/or notification methods 6) Documents/forms that support the eligibility process for the sliding fee discount program 7) Any other supporting documents such as evaluations of the sliding fee discount program or basis for setting nominal charges 8) Health center's official scope of project for services (Form 5A)

*Related HRSA Resources:* 1) Sliding Fee Discount and Related Billing and Collections Program Requirements (PIN 2014-02): http://bphc.hrsa.gov/policiesregulations/policies/pin201402.html 2) Most recent Federal Poverty Guidelines: http://aspe.hhs.gov/poverty/index.cfm 3) Scope of Project Information and Policies: http://bphc.hrsa.gov/about/requirements/scope/

| Requirements | Questions | Response |
|---|---|---|
| The health center has written policies and supporting operating procedures for its sliding fee discount program. | At a minimum, are the following areas of the sliding fee discount program addressed in written board-approved policies and/or supporting operating procedures? | |
| | • Definitions of income and family size | |
| | • Eligibility for sliding fee discounts based on income and family size for all patients and no other factors | |
| | • Methods for making patients aware of the availability of sliding fee discounts that are effective and appropriate for the language and literacy levels of the patient population | |
| | • Documentation and verification requirements used to determine patient eligibility for sliding fee discounts and frequency of re-evaluation of patient eligibility | |
| | • Specific structure of all sliding fee discount schedule(s) (SFDS) *(Please assess structural requirements based on the criteria below.)* | |
| | Has the sliding fee discount program been evaluated, or is there a plan to ensure it will be evaluated, at least once every 3 years from the perspective of reducing patient financial barriers to care? | |

| Requirements | Questions | Response |
|---|---|---|
| The health center has a system in place to adjust fees on the basis of the patient's ability to pay. | Do the SFDS's income/family size figures reflect the current Federal Poverty Guidelines (FPG)?<br><br>***Note:*** *The Federal Poverty Guidelines are a version of the income thresholds used by the U.S. Census Bureau to estimate the number of people living in poverty. The thresholds are annual income levels below which a person or family is considered to be living in poverty. The income threshold increases by a constant amount for each additional family member.* | |
| | Do all SFDS adjust fees for individuals and families with incomes above 100 percent of the Federal Poverty Guidelines (FPG) and at or below 200 percent of the FPG, *using at least three (3) discount pay classes*? | |
| | Is a full discount provided for individuals and families with annual incomes at or below 100 percent of the FPG, unless the health center has elected to have a nominal charge? | |
| | If the health center has a nominal charge, is the nominal charge | |
| | • Nominal from the perspective of the patient (e.g., based input from patient focus groups, patient surveys)? | |
| | • A fixed fee (not a percentage of the actual charge/cost) that does not reflect the true cost of the service(s) being provided? | |
| | • Not more than the fee paid by a patient in the first SFDS pay class above 100 percent of the FPG? | |
| All required and additional services within a health center's approved scope of project are available to health center patients regardless of ability to pay through a sliding fee discount program. | Are sliding fee discounts applied to all services within a health center's approved scope of project for which there is an established charge, regardless of the service type (required or additional) or mode of delivery (direct, by contract, or by formal referral agreement, as indicated on Form 5A: Services Provided, Columns I, II, or III)?<br><br>***Note:*** *Reviewing a sample of the SFDS(s) for Column II and/or III services is acceptable in cases where the health center offers numerous services via these service delivery methods.*<br><br>Specifically: | |

| Requirements | Questions | Response |
|---|---|---|
| | **For services provided directly by the health center (Form 5A, Column I):** Are all of these services for which there is an established charge, discounted in accordance with the health center's SFDS? | |
| | **For services provided via formal written agreement(s)/contract(s) (Form 5A, Column II):** Does the written agreement (e.g., MOA, contract) in place between the health center and outside organization/provider describe how contracted services provided to health center patients will be discounted in accordance with an SFDS that meets the SFDS criteria above? | |
| | **For services provided via formal written referral arrangements (Form 5A, Column III):** Is the referred service discounted for health center patients in accordance with an SFDS that meets the SFDS criteria above, or in a manner that provides greater discounts as described in the note below?<br><br>***Note:*** *A health center may enter into a formal written referral arrangement that results in* greater discounts *to patients than they would receive under the health center's own sliding fee discount program (e.g., the referral provider may offer the service free of charge for all individuals at or below 250% FPG), as long as*<br>• *All health center patients at or below 200 percent of the FPG receive a greater discount for these services than if the health center's SFDS were applied to the referral provider's fee schedule; and*<br>• *Patients at or below 100 percent of the FPG receive no charge or only a nominal charge for these services.* | |
| The health center assesses all patients for eligibility for sliding fee discounts, and applies the discounts accordingly. | Are all health center patients assessed for income and family size (unless the patient declines/refuses to be assessed)? | |
| | Are all patients informed of their eligibility for sliding fee discounts? | |
| | Are all insured patients that are eligible for the SFDS, charged no more than they would have owed under the SFDS? If not, can the health center document that it is subject to limitations on further discounting amounts required by the insurer due to applicable Federal and State law for Medicare and Medicaid and/or terms and conditions of private payor contracts? | |

## Program Requirement 8: QUALITY IMPROVEMENT / ASSURANCE PLAN

*Authority:* Section 330(k)(3)(C) of the PHS Act, 45 CFR Part 74.25 (c)(2)-(3), and 42 CFR Part 51c.303(c)(1)-(2)

*Documents to Review Onsite or in Advance:* 1) Quality improvement/quality assurance (QI/QA) plan and related and/or supporting policies and/or procedures (e.g., incident reporting system, risk management policies, patient safety policies) 2) Clinical Director's job description 3) HIPAA-compliant patient confidentiality and medical records policies and/or procedures 4) Clinical care policies and/or procedures 5) Clinical information tracking policies and/or procedures

*Related HRSA Resources:* 1) Accreditation and Patient Centered Medical/Health Home Initiatives: http://www.bphc.hrsa.gov/policiesregulations/policies/qualityrisk.html 2) Quality Improvement Resources: http://www.hrsa.gov/quality/index.html
3) ECRI Institute Clinical Risk Management Program provided on behalf of HRSA: https://www.ecri.org/Clinical_RM_Program/Pages/default.aspx
( http://bphc.hrsa.gov/exitdisclaimer/hrsaexitdisclaimer.html )
NOTE: Portions of program requirements notated by an asterisk "*" indicate regulatory requirements that are recommended, ***but not required***, for health centers that receive funds/designation solely for Health Care for the Homeless (section 330(h)) and/or the Public Housing Primary Care (section 330(i)) Programs.

| Requirements | Questions | Response |
|---|---|---|
| Health center has an ongoing Quality Improvement/ Quality Assurance (QI/QA) program that: | Does the health center's QI/QA program: | |
| Includes clinical services and management. | Address both clinical services and management (inclusive of all services in scope, e.g., primary care, dental, behavioral health)?<br><br>***Note:*** *"clinical services and management"" is describing* both *"clinical services" and "clinical management." Therefore, in order to meet compliance with this requirement, the QI/QA plan or program* does NOT *have to address administrative management or financial management nor include related measures as these are addressed in other program requirements.* | |

| Requirements | Questions | Response |
|---|---|---|
| Maintains the confidentiality of patient records. | Include medical records policies and/or procedures that address the following areas (applicable for health centers with paper and/or electronic health records)<br>• Establishing and maintaining a clinical record for every patient receiving care at the health center,<br>• Privacy and Confidentiality (in accordance with HIPAA),<br>• Procedures to enable patients to give consent for release of medical record information, and<br>• Security of current and archived medical record information? | |
| Includes a clinical director whose focus of responsibility is to support the QI/QA program and the provision of high quality patient care.* | Does the health center have a clinical director with primary responsibility for carrying out the QI/QA program across the health center?<br><br>***Note:*** *Clinical directors may be full or part-time staff and should have appropriate training/background (e.g., MD, RN, MPH) as determined by the needs/size of the health center.* | |
| Includes periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the health center.* | As part of the QI/QA program, does the health center conduct periodic assessments of the appropriateness of both the utilization and quality of services (e.g., peer review, review and analysis of clinical performance measure trends and outcomes)? | |

| Requirements | Questions | Response |
| --- | --- | --- |
| These assessments shall: | Are these assessments | |
| Be conducted by physicians or by other licensed health professionals under the supervision of physicians.* | Conducted by physicians or licensed health professionals under physician supervision? | |
| Be based on the systematic collection and evaluation of patient records.* | Based on the systematic collection and evaluation of patient records? | |
| Identify and document the necessity for change in the provision of services by the health center.* | Used to identify and document necessary changes? | |
| Result in the institution of such change, where indicated.* | Used to inform and change the provision of services if necessary? Specifically, are these results shared or reviewed by key management staff to inform health center operations and reported to the governing board on a regular basis? | |

## SECTION III: MANAGEMENT AND FINANCE

### Program Requirement 9: KEY MANAGEMENT STAFF

*Authority:* Section 330(k)(3)(I) of the PHS Act, 42 CFR Part 51c.303(p), and 45 CFR Part 74.25(c)(2)-(3)

*Documents to Review Onsite or in Advance:* 1) Health center organizational chart 2) Key management staff position descriptions and biographical sketches 3) Key management vacancy announcements (if applicable) 4) Health center's official scope of project for services and sites (Form 5A and Form 5B) 5) UDS Summary Report

| Requirements | Questions | Response |
|---|---|---|
| Health center maintains a fully staffed health center management team as appropriate for the size and needs of the center. If applicable, prior approval by HRSA of a change in the Project Director/ Executive Director/CEO position is required. | Does the health center have a Chief Executive Officer or Executive Director/Project Director? | |
| | Is the key management team's size and composition appropriate for the size and needs of the health center? | |
| | Is the team fully staffed with each of the key management positions listed in the health center's most recent organizational chart and/or staffing profile filled as appropriate? If not, is the health center actively recruiting for the vacancy and/or implementing interim measures to address the key management capacity roles?<br><br>***Note:*** *If a Health Center Program grantee has an open position for, or pending change in, the CEO/Project Director position, this change will require a "Prior Approval Request" that must be submitted/processed via the HRSA Electronic Handbooks (EHB) Prior Approval Module. Grantees should contact their Project Officer for further information as needed. Look-alikes should contact their Project Officer for information on how to submit documentation for an open position for, or pending change in, the CEO/Project Direction position.* | |

## Program Requirement 10: CONTRACTUAL / AFFILIATION AGREEMENTS

*Authority:* Section 330(k)(3)(I)(ii) of the PHS Act, 42 CFR Part 51c.303(n) and (t), Section 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act, and 45 CFR Part 74.1(a)(2)

*Documents to Review Onsite or in Advance:* 1) Contract(s) or sub-award(s) (subrecipient agreements) for a substantial portion of the health center project 2) Memorandum of Understanding (MOU)/Agreement (MOA) for a substantial portion of the health center project 3) Contract with another organization for core primary care providers 4) Contract with another organization for staffing the health center including any contracted key management staff (e.g., CEO, CMO, CFO) 5) Any other key affiliation agreements, if applicable 6) Procurement and/or other policies and/or procedures that support oversight of contracts or affiliations

*Related HRSA Resources:* 1) Affiliation Agreement Policies (PINs 97-27 and 98-24): http://bphc.hrsa.gov/policiesregulations/policies/governance.html 2) Federal procurement grant regulations (45 CFR Part 74.41-74.48): http://go.usa.gov/B3hd, applicable to contractual agreements in scope 3) Health Center Collaboration (PAL 2011-02): http://bphc.hrsa.gov/policiesregulations/policies/pal201102.html

| Requirements | Questions | Response |
|---|---|---|
| Health center exercises appropriate oversight and authority over all contracted services. | Does the health center have written board-approved policies and supporting operating procedures that ensure appropriate procurement and oversight over all contracted services and/or subrecipients, including provisions for the monitoring and evaluation of contractor and/or subrecipient performance by the health center? | |
| | Are appropriate provisions in place to assure that none of the health center's contracts or affiliation agreements have the potential to | |
| | Limit the health center's authority? | |
| | Compromise the health center's compliance with Health Center Program requirements in terms of corporate structure, governance, management, finance, health services, and/or clinical operations? | |
| Health center assures that any subrecipient(s) meets the Health Center Program requirements. *Applies only to grantees with subrecipients.* | **For grantees with subrecipient arrangements ONLY:** Does the grantee have assurances in place that the subrecipient organization complies with all Health Center Program statutory and regulatory requirements? | |

## Program Requirement 11: COLLABORATIVE RELATIONSHIPS

*Authority:* Section 330(k)(3)(B) of the PHS Act and 42 CFR Part 51c.303(n)

*Documents to Review Onsite or in Advance:* 1) Letters of Support 2) Memoranda of Agreement/Understanding 3) Other relevant documentation of collaborative relationships

*Related HRSA Resources:* 1) Health Center Collaboration (PAL 2011-02): http://bphc.hrsa.gov/policiesregulations/policies/pal201102.html 2) UDS Mapper tool: http://www.udsmapper.org ( http://bphc.hrsa.gov/exitdisclaimer/hrsaexitdisclaimer.html )

<table>
<tr><th>Requirements</th><th>Questions</th><th>Response</th></tr>
<tr><td>Health center makes effort to establish and maintain collaborative relationships with other health care providers, including other health centers, in the service area of the center.</td><td rowspan="2">Does the health center work to establish and maintain collaborative relationships (formal and/or informal) with other health care providers in its service area, in particular other health centers? Such providers may include, but are not limited to:<br>• Health centers (Health Center Program grantees and look-alikes)<br>• Rural health clinics<br>• Critical access hospitals<br>• Health departments<br>• Other major private provider groups serving low income and/or uninsured populations</td><td rowspan="2"></td></tr>
<tr><td>The health center secures letter(s) of support from existing health centers (section 330 grantees and FQHC Look-Alikes) in the service area or provides an explanation for why such letter(s) of support cannot be obtained.</td></tr>
</table>

## Program Requirement 12: FINANCIAL MANAGEMENT AND CONTROL POLICIES

*Authority:* Section 330(k)(3)(D) and (q) of the PHS Act and 45 CFR Parts 74.14, 74.21, and 74.26

*Documents to Review Onsite or in Advance:* 1) Most recent independent financial audit and management letter, including audit corrective action plans based on prior year audit findings, if applicable 2) Most recent A-133 Compliance Supplement (grantees only) 3) For Newly Funded Grantees: Most recent monthly financial statements if a first audit has not been completed 4) Financial management/accounting and internal control policies and/or procedures 5) Chart of accounts 6) Balance sheet 7) Income statement 8) Most recent Health Center Program required financial performance measures/UDS Report 9) Most recent Income Analysis (Form 3)

*Related HRSA Resources:* 1) Office of Management and Budget Circular A-133 2) Health Center Budgeting and Accounting Requirements (PIN 2013-01): http://www.bphc.hrsa.gov/policiesregulations/policies/pin201301.html 3) HRSA Federal Financial Report Information (FFR) Resources: http://www.hrsa.gov/grants/manage/

**Note:** *Regarding efficiency and provider productivity—HRSA/BPHC does not enforce specific productivity guidelines (e.g., 4200/2100) that may create incentives that are inconsistent with the purpose of the Health Center Program (e.g., discourage providers from using regular visits as opportunities to provide preventive services, discourage providers from using more efficient and patient-friendly approaches to care, such as phone consults and e-mail). Instead of measuring provider productivity, HRSA reviews cost per patient as one of the required Health Center Performance Measures to evaluate efficiency, consistent with the patient centered medical home model.*

| Requirements | Questions | Response |
|---|---|---|
| Health center maintains accounting and internal control systems that: | Are the health center's accounting and internal control systems | |
| Are appropriate to the size and complexity of the organization. | Appropriate to the organization's size and complexity? Specifically, does the health center's accounting system provide for<br>• Separate identification of Federal and non-Federal transactions, and<br>• A chart of accounts that reflects the general ledger accounts? | |
| Reflect Generally Accepted Accounting Principles (GAAP). | Reflective of GAAP, including accumulation of costs? | |

| Requirements | Questions | Response |
|---|---|---|
| Separate functions in a manner appropriate to the organization’s size in order to safeguard assets and maintain financial stability. | Designed to separate functions in a manner appropriate to the organization’s size in order to safeguard assets? | |
| | Designed to separate functions in a manner appropriate to the organization’s size in order to maintain financial stability? | |
| Health center assures that | | |
| An annual independent financial audit is performed in accordance with Federal audit requirements. | Is a financial audit performed annually, in accordance with Federal requirements, including if applicable, the A-133 Compliance Supplement?<br><br>***Note:*** *A complete audit includes: 1) Auditor’s Report; 2) A-133 Compliance Supplement (grantees only); and 3) Reports to board/Management letters issued by the auditor.* | |
| A corrective action plan addressing all findings, questioned costs, reportable conditions, and material weaknesses cited in the Audit Report is submitted. | *If Applicable for health centers with corrective action plans:* Did the health center’s corrective action plan address all previous findings, questioned costs, reportable conditions, and material weaknesses found in the Audit Report? | |

## Program Requirement 13: BILLING AND COLLECTIONS

*Authority:* Section 330(k)(3)(F) and (G) of the PHS Act

*Documents to Review Onsite or in Advance:* 1) Policies and/or procedures for billing and collection 2) Encounter form(s) 3) Most recent Income Analysis (Form 3) 4) Managed care or any other third party payor contracts 5) Most recent Health Center Program required financial performance measures/UDS Report

*Related HRSA Resources*: 1) Sliding Fee Discount and Related Billing and Collections Program Requirements (PIN 2014-02): http://bphc.hrsa.gov/policiesregulations/policies/pin201402.html 2) Process for Becoming Eligible for Medicare Reimbursement under the FQHC Benefit (PAL 2011-04): http://bphc.hrsa.gov/policiesregulations/policies/pal201104.html 3) Centers for Medicare and Medicaid Services (CMS) FQHC Resource Information: https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html?redirect=/center/fqhc.asp

| Requirements | Questions | Response |
|---|---|---|
| Health center has systems in place to make reasonable efforts to collect and receive reimbursement for its costs in providing health services. | Does the health center have documentation of participation in Medicaid and the Children's Health Insurance Program (CHIP)? | |
| | Does the health center make reasonable efforts to collect appropriate reimbursement from Medicare, Medicaid, CHIP, Marketplace qualified health plans, and any other public assistance programs, and private third party payors that are available to its patients? | |
| | Does the health center make reasonable efforts to secure payment from patients for amounts owed for services in a manner that does not create barriers to care? | |
| These systems include written policies and procedures addressing billing and collections. | Does the health center have written, board-approved policies and supporting operating procedures for billing and collections, including, but not limited to: | |
| | • Provisions for waiving charges that identify circumstances with specified criteria for when charges will be waived, and specific health center staff with the authority to approve the waiving of charges? | |
| | • If the health center has "refusal to pay" policies, do these policies or supporting operating procedures define: | |
| | ○ What constitutes "refusal to pay"? | |

| Requirements | Questions | Response |
|---|---|---|
| | ○ What individual circumstances are to be considered in making such determinations? | |
| | ○ What collection efforts/enforcement steps are to be taken when these situations occur (e.g., offering grace periods, establishing payment plans, meetings with a financial counselor)? | |

## Program Requirement 14: BUDGET

*Authority*: Section 330(k)(3)(D) and (k)(3)(I)(i) of the PHS Act and 45 CFR Part 74.25

*Documents to Review Onsite or in Advance:* 1) Annual budget 2) If applicable, operating plan 3) Most recent Income Analysis (Form 3) 4) Most recent Staffing Profile

*Related HRSA Resources:* 1) Health Center Budgeting and Accounting Requirements (PIN 2013-01): http://www.bphc.hrsa.gov/policiesregulations/policies/pin201301.html 2) HRSA Federal Financial Report Information (FFR) Resources: http://www.hrsa.gov/grants/manage/

***Note:*** *Beginning with applications for Fiscal Year 2014 funding, HRSA is requiring that along with a total budget, which includes a budget breakdown of all health center scope of project funding, grantees must also submit a separate budget breakdown for the Health Center Program funds and non-grant funds proposed for the application period. That is, the budget must show which costs are supported by the section 330 grant and which projected costs are supported by other non-grant funds. HRSA will allow individual health centers discretion regarding how they propose to allocate the total budget between section 330 grant funds and non-grant funds, provided the budgeting complies with all applicable HHS policies. The requirement for a separate Federal budget breakdown is not applicable to look-alikes.*

| Requirements | Questions | Response |
|---|---|---|
| Health center has developed a budget that reflects the costs of operations, expenses, and revenues (including the Federal grant) necessary to accomplish the service delivery plan, including the number of patients to be served. | Does the health center maintain an annual total budget/operational budget that reflects expenses and revenues (including the Federal grant, as applicable) necessary to accomplish the service delivery plan?<br><br>***Note:*** *The total budget must include projections for all revenue sources to support the scope of project, including fees, premiums, and third-party reimbursements reasonably expected to be received to support operations, and State, local, private and other operational funding provided to the health center.* | |
| | ***(Grantees only)*** Are there budgetary controls in effect (e.g., comparison of budget with actual expenditures on a monthly basis) to preclude drawing down Federal funds in excess of:<br>• Total funds authorized on the Notice of Award?<br>• Total funds available for any cost category, if restricted, on the Notice of Award? | |

## Program Requirement 15: PROGRAM DATA REPORTING SYSTEMS

*Authority:* Section 330(k)(3)(I)(ii) of the PHS Act

*Documents to Review Onsite or in Advance:* 1) Most recent UDS report and UDS Health Center Trend Report 2) Most recent Clinical and Financial Performance Measures Forms 3) Clinical and financial information systems (e.g., EHR, practice management systems, billing systems)
***Note:*** *Look-alike initial designation applicants will not have UDS data.*

Related HRSA Resources: 1) HRSA/BPHC UDS Reporting Information: http://www.bphc.hrsa.gov/healthcenterdatastatistics/index.html
2) HRSA Federal Financial Report Information (FFR) Resources: http://www.hrsa.gov/grants/manage/

| Requirements | Questions | Response |
|---|---|---|
| Health center has systems in place which | | |
| Accurately collect and organize data for program reporting. | Does the health center have appropriate systems and capacity in place for collecting and organizing the data required for UDS, FFR, Clinical and Financial Performance Measures (submitted with the annual renewal applications), and any other Health Center Program reporting requirements (e.g., those necessary for supplemental funding)? | |
| Support management decision-making. | Is information from the health center's data reporting and needs assessments used to inform and support management decision-making? | |

## Program Requirement 16: SCOPE OF PROJECT

*Authority:* 45 CFR Part 74.25

*Documents to Review Onsite or in Advance:* 1) Health Center UDS Trend Report 2) Health center's official scope of project for sites and services ( Forms 5A, 5B, and 5C) 3) Most Recent Form 2 Staffing Profile 4) Notice of Award and information for any recent New Access Point or other supplemental grant awards

*Related HRSA Resources:* 1) Scope of Project Information and Policies: http://bphc.hrsa.gov/about/requirements/scope/ 2) HRSA/BPHC UDS Reporting Information: http://www.bphc.hrsa.gov/healthcenterdatastatistics/index.html

| Requirement | Questions | Response |
|---|---|---|
| Health center maintains its funded scope of project (sites, services, service area, target population and providers), including any increases based on recent grant awards. | *Is the health center's scope of project accurate,* in terms of services and sites observed while onsite, when compared to the approved scope of project as documented by the health center on its current Form 5A and Form 5B (e.g., A health center has 10 sites listed on its Form 5B, but is operating 8 sites because it closed the other 2 sites, and failed to submit the appropriate change in scope request to delete these sites; a health center is offering a specialty service, but this service is not recorded on Form 5A because the health center did not submit a change in scope request to add this new service; a health center has only informal referral arrangements in place for some additional services listed on Form 5A, and these should not be included on the form.)? | |

| Requirement | Questions | Response |
|---|---|---|
| | ***(Grantees Only)*** Has the grantee received any additional BPHC grant awards in the last 3 years that have expanded its funded scope of project (e.g., New Access Point, Service Expansion, Expanded Medical Capacity)? If yes, *has the grantee successfully implemented the newly funded activity(ies)* within the expected timeframe (e.g., hired new staff, expanded services, opened new sites, begun or completed minor alterations and renovations, as applicable)?<br><br>**For grantees that received a FY 2013 or FY 2014 New Access Point Award (Satellite or Newly Funded):** Is at least one full-time, permanent primary care site open and operational? | |

# SECTION IV: GOVERNANCE

## Program Requirement 17: BOARD AUTHORITY

*Authority:* Section 330(k)(3)(H) of the PHS Act and 42 CFR Part 51c.304

*Documents to Review Onsite or in Advance:* 1) Organizational/corporate bylaws 2) Minutes of recent board meetings 3) Health center policies and/or procedures 4) Board annual meeting schedule 5) *If Applicable:* Co-Applicant Agreement for public centers 6) List of board committees

*Related HRSA Resources:* 1) Health Center Program Governance (PIN 2014-01): http://bphc.hrsa.gov/policiesregulations/policies/governance.html 2) Affiliation Agreement Policies (PINs 97-27 and 98-24): http://bphc.hrsa.gov/policiesregulations/policies/governance.html

NOTES:

- Portions of program requirements notated by an asterisk "*" indicate regulatory requirements that are recommended, ***but not required***, for health centers that receive funds/designation solely for Health Care for the Homeless (section 330(h)) and/or the Public Housing Primary Care (section 330(i)) Programs.
- Per section 330(k)(3)(H) of the PHS Act, Health Center Program governance requirements including these specific board authority requirements, **do not apply to health centers operated by Indian tribes, tribal groups, or Indian organizations under the Indian Self-Determination Act or urban Indian organizations under the Indian Health Care Improvement Act**. However, such health centers must still have a governing body.

| Requirements | Questions | Response |
|---|---|---|
| Health center governing board maintains appropriate authority to oversee the operations of the center, including all of the following:<br><br>***Note****: Look-alikes may not be owned, controlled or operated by another entity; therefore, parent-subsidiary arrangements, network corporations, etc., may not be eligible for designation.* | | |
| Holding monthly meetings | Does the board meet monthly? | |
| | Does the health center maintain records/minutes of the monthly board meetings? | |

| Requirements | Questions | Response |
|---|---|---|
| | Do these records/minutes verify and document the board's functioning (e.g., record major actions and decisions made by the board for the health center)?<br><br>***Note:*** *Health Center Program statutory and regulatory requirements do not mandate a particular format or length for board minutes.* | |
| Approval of the health center grant application and budget; | Does the board approve the applications related to the health center project, including grants/designation applications and other HRSA requests regarding scope of project? | |
| | Does the board approve the annual health center budget and audit? | |
| | Are these reviews and approvals documented in the board minutes? | |
| Selection/dismissal and performance evaluation of the health center CEO; | Does the board evaluate the performance of the health center's CEO's/ED's , with clear authority to select a new CEO/ED and/or dismiss the current CEO/ED if needed? | |
| | Is this review documented in the board minutes? | |
| Selection of services to be provided and the health center hours of operations; | Does the board select the services (beyond those required in law, i.e., "Required Services") to be provided by the health center, as well as the location and mode of delivery of those services? | |
| | Does the board determine the hours during which services are provided at health center sites, ensuring that these are appropriate and responsive to the community's needs? | |
| | Are these reviews and approvals documented in the board minutes? | |
| Measuring and evaluating the organization's progress in meeting its annual and long-term programmatic and financial goals and developing plans for the long-range viability of the organization by engaging in strategic planning, ongoing review of the organization's mission and bylaws, evaluating patient satisfaction, and monitoring organizational assets and performance;* and | Does the board evaluate the health center's progress in meeting its annual and long-term goals (e.g., clinical, financial, operational)? | |
| | Does the board receive appropriate information that enables it to evaluate the health center's progress and engage in long-term strategic planning (e.g., health center patient satisfaction data, QI/QA information, results of the annual audit)? | |
| | Does the board engage in long-term strategic planning, which would include regular updating of the health center's mission, goals, and plans, when appropriate? | |
| | Are these activities documented in the board minutes? | |

<table>
<tr><th>Requirements</th><th>Questions</th><th>Response</th></tr>
<tr><td rowspan="2">Establishment of general policies for the health center.<br><br>Note: In the case of public agencies (also referred to as public entities, e.g., State, county, or local health departments) with co-applicant governing boards, the public agency is permitted to retain authority for establishing general policies (fiscal and personnel policies) for the public center (section 330(k)(3)(H) of the PHS Act and 42 CFR 51c.304(d)(iii) and (iv)).</td><td>Does the board establish general policies for the health center that are consistent with Health Center Program and applicable grants management requirements (with the exception of fiscal and personnel policies in the case of public centers.[3])?<br><br>Examples of specific health center policies to be approved and monitored by the board include, but are not limited to: board member selection and dismissal procedures, employee salary and benefit scales, employee grievance procedures, equal opportunity practices, codes of conduct, quality improvement systems, fee schedules for services, the sliding fee discount program, billing and collections, financial policies that assure accountability for health center resources, and avoidance of conflict of interest.</td><td></td></tr>
<tr><td>Do the health center bylaws specify or address each of the following topics (if not, indicate whether the topic is addressed in another board-related document):<br>• Health center mission<br>• Authorities, functions, and responsibilities of governing board as a whole<br>• Board membership (size and composition) and individual member responsibilities<br>• Process for selection/removal of board members<br>• Election of officers<br>• Recording, distribution and storage of minutes<br>• Meeting schedule and quorum<br>• Officer responsibilities, terms of office, selection/removal processes<br>• Description of standing committees (which may include, but are not limited to: executive, finance, quality improvement, personnel, and</td><td></td></tr>
</table>

[3] A public center with an approved co-applicant board arrangement does not need further justification for the public agency to retain authority for the establishment of the following types of general policy—***Fiscal Policies:*** Internal control procedures to ensure sound financial management procedures, and purchasing policies and standards. ***Personnel Policies:*** Employee selection, performance review/evaluations, and dismissal procedures (Note: The co-applicant governing board must approve the selection, performance evaluation, retention, and dismissal of the health center's CEO or Executive Director.); employee compensation, including wage and salary scales and benefit packages; position descriptions and classification; employee grievance procedures; and equal opportunity practices.

| Requirements | Questions | Response |
| --- | --- | --- |
| | planning committees) and the process for the creation of ad-hoc committees<br>• Provisions regarding conflict of interest<br>• Provisions regarding board dissolution | |
| | **For public agencies with co-applicant arrangements ONLY (i.e., public centers):** Does the public agency have a formal agreement with the co-applicant board that describes | |
| | The delegation of authority and define the roles, responsibilities, and authorities of each party in the oversight and management of the health center, including any shared roles and responsibilities in carrying out the governance functions? | |
| | The exercise of any retained authorities by the public agency? | |

## Program Requirement 18: BOARD COMPOSITION

*Authority:* Section 330(k)(3)(H) of the PHS Act and 42 CFR Part 51c.304

*Documents to Review Onsite or in Advance:* 1) Composition of board of directors/most recent Form 6A: Board Composition 2) Organizational/corporate bylaws 3) Board member application and disclosure forms 4) *If Applicable:* Form 6B: Waiver of Governance Requirements 5) UDS Summary Report

*Related HRSA Resources:* 1) Health Center Program Governance (PIN 2014-01): http://bphc.hrsa.gov/policiesregulations/policies/governance.html 2) Affiliation Agreement Policies (PINs 97-27 and 98-24): http://bphc.hrsa.gov/policiesregulations/policies/governance.html

NOTES:

- Portions of program requirements notated by an asterisk "*" indicate regulatory requirements that are recommended, ***but not required***, for health centers that receive funds/designation solely for Health Care for the Homeless (section 330(h)) and/or the Public Housing Primary Care (section 330(i)) Programs.
- Per section 330(k)(3)(H) of the PHS Act, Health Center Program governance requirements including these specific board composition requirements, **do not apply to health centers operated by Indian tribes, tribal groups, or Indian organizations under the Indian Self-Determination Act or urban Indian organizations under the Indian Health Care Improvement Act**. However, such health centers must still have a governing body.

| Requirements | Questions | Response |
|---|---|---|
| The health center's governing board meets the following requirements | | |
| A majority of the board members are individuals ("consumers" or "patients"; also previously known as "users") served by the organization. | Are a majority of members of the board (at least 51 percent), individuals (patients) who are served by the health center?<br><br>These patient board members must be a current registered patient of the health center and must have accessed the health center in the past 24 months to receive at least one or more in-scope service(s) that generated a health center visit (visits are defined as documented, face-to-face contacts between a patient and a provider who exercises independent professional judgment in the provision of services to the patient)<br><br>***Note:*** *For health centers funded/designated* ***solely*** *under section 330(g) to serve migratory and seasonal agricultural workers, a majority of members of the board (51 percent) must be* ***EITHER*** *migratory and/or seasonal agricultural workers (current or retired due to age or disability) and/or members of their families who* | |

| Requirements | Questions | Response |
| --- | --- | --- |
| | *are health center patients.*<br>**Answer "Waiver" if the health center has a waiver for this requirement; respond to question for health centers with waivers below.**[4] | |
| | **Health centers with approved waivers ONLY:** Are appropriate mechanisms being implemented in accordance with the approved waiver that ensure patient input and participation in the organization, direction, and ongoing governance of the health center? Specifically, is there<br>• A method(s) for collecting and documenting patient input?<br>• A process for formally communicating the input directly to the health center governing board (e.g., monthly or quarterly presentations of the advisory group to the full board, monthly or quarterly summary reports from patient surveys)?<br>• Evidence that patient input is being used by the governing board in such areas as: 1) selecting health center services; 2) setting health center operating hours; 3) defining budget priorities; 4) evaluating the organization's progress in meeting goals, including patient satisfaction; and 5) other relevant areas of governance that require and benefit from patient input? | |
| As a group, these "patient" or "consumer" board members represent the individuals being served by the health center in terms of demographic factors such as race, ethnicity, and sex. | As a group, do the patient board members reasonably represent the individuals who are served by the health center in terms of race, ethnicity, and sex?<br><br>**Answer "Waiver" if the health center has a waiver for this requirement; respond to question for health centers with waivers above.** | |

[4] Waivers may only be requested by health centers requesting/receiving targeted funding/designation ***solely*** to serve migratory and seasonal agricultural workers (section 330(g)), homeless individuals (section 330(h)), and/or residents of public housing (section 330(i)) and that are **NOT** requesting general (Community Health Center - section 330(e)) funds/designation. **These health centers are still required to fulfill all other statutory board responsibilities and requirements.**

| Requirements | Questions | Response |
|---|---|---|
| | Health centers that receive **funding/designation** under ***multiple section 330 subparts (section 330(e) and also section 330(g), (h), and/or (i))*** to serve **migratory and seasonal agricultural workers, homeless individuals, and/or residents of public housing ONLY**. For such health centers, at a minimum, there must be at least one board member that is representative of each of the special populations for which the health center receives section 330 funding/designation.<br><br>Does the board include a representative(s) from and/or for each of these special populations group(s), as appropriate (e.g., a patient who is a current member of the special population, an advocate who has personally experienced being a member of, represents, or has expertise in, or works closely with the special population)? | |
| The board has at least 9 but no more than 25 members, as appropriate for the complexity of the organization.* | Does the board have between 9 and 25 members? | |
| | Do the health center's bylaws define either a specific number of board members or define a limited range? | |
| | Is the size of the board appropriate for the complexity of the organization and the diversity of the community served? | |
| The remaining non-consumer members of the board shall be representative of the community in which the center's service area is located and shall be selected for their expertise in community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social service agencies within the community.* | Are the remaining (non-patient/non-consumer) board members representative of the community currently served by the health center? | |
| | Is the board comprised of members with a broad range of skills, expertise, and perspectives? Such areas include, but are not limited to: finance, legal affairs, business, health, managed care, social services, labor relations, and government. ***Note:*** *Any one board member (patient or non-patient) may be considered as having expertise in one or more of these areas. In addition, the board does not necessarily have to include specific expertise in all six of these areas and/or may include additional areas of expertise beyond these areas, as appropriate.* | |
| No more than one half (50%) of the non-consumer board members may derive more than 10% of their annual income from the health care industry.* | Do no more than 50% of the non-patient/non-consumer board members derive more than 10% of their annual income from the health care industry?<br>***Note:*** *For health centers funded/designated* ***solely*** *under section 330(g) to serve migratory and seasonal agricultural workers, no more than* ***two-thirds*** *of the non-patient board representatives may derive more than 10 percent of their annual income from the health care industry.* | |

## Program Requirement 19: CONFLICT OF INTEREST POLICY

*Authority:* 45 CFR Part 74.42 and 42 CFR Part 51c.304(b)

*Documents to Review Onsite or in Advance:* 1) Corporate Bylaws 2) Most recent update of Conflict of Interest policy and related procedures 3) Procurement policies and/or procedures

*Related HRSA Resources:* 1) Health Center Program Governance (PIN 2014-01): http://bphc.hrsa.gov/policiesregulations/policies/governance.html 2) Affiliation Agreement Policies (PINs 97-27 and 98-24): http://bphc.hrsa.gov/policiesregulations/policies/governance.html 3) Federal procurement grant regulations (45 CFR Part 74.41-74.48): http://go.usa.gov/B3hd

NOTE: Portions of program requirements notated by an asterisk "*" indicate regulatory requirements that are recommended, ***but not required***, for health centers that receive funds/designation solely for Health Care for the Homeless (section 330(h)) and/or the Public Housing Primary Care (section 330(i)) Programs.

| Requirements | Questions | Response |
|---|---|---|
| Health center's bylaws or written, corporate-board-approved policy includes provisions that:<br><br>Prohibit conflict of interest by board members, employees, consultants and those who furnish goods or services to the health center. | Do the bylaws and/or other written board-approved policy document(s) or supporting operating procedures, including those pertaining to procurement (i.e., *when Federal grant funds are used to procure supplies and other expendable property, equipment, real property, and other services)*, include and/or address the following:<br><br>• Written standards of conduct governing the performance of health center employees engaged in the award and administration of contracts?<br><br>• Prohibit health center employees, board members, or agents from participating in the selection, award, or administration of a contract supported by Federal funds if a real or apparent conflict of interest would be involved? Such a conflict would arise when a health center employee, board member or agent, or any member of his or her immediate family, his or her partner, or an organization that employs, or is about to employ, any of the parties indicated herein, has a financial or other interest in the firm selected for an award. | |

| Requirements | Questions | Response |
|---|---|---|
| | • Prohibit board members, employees, and agents of the health center from soliciting or accepting gratuities, favors, or anything of monetary value from contractors or parties to subagreements? However, health centers may set standards for situations in which the financial interest is not substantial or the gift is an unsolicited item of nominal value.<br><br>• Provide in the standards of conduct, for disciplinary actions to be applied for violations of such standards by board members, employees, or agents of the health center? | |
| State that no board member shall be an employee of the health center or an immediate family member of an employee.*<br><br>***Note:*** *This particular aspect of the requirement related to board composition is not applicable to health centers operated by Indian tribes or tribal, or urban Indian organizations.* | No current board member(s) is an employee of the health center or an immediate family member (i.e., spouse, child, parent, brother or sister by blood, adoption, or marriage) of an employee? | |
| Ensure that the Chief Executive may serve only as a non-voting, ex-officio member of the board.*<br><br>***Note:*** *This particular aspect of the requirement related to board composition is not applicable to health centers operated by Indian tribes or tribal, or urban Indian organizations.* | The CEO/ED is not a voting member of the Board? | |

## SECTION V: CLINICAL AND FINANCIAL PERFORMANCE

***Documents to Review Onsite or in Advance:*** 1) UDS Trend, Comparison, and Summary Reports 2) Quality improvement/quality assurance plan 3) Most recent audit 4) Clinical and Financial Performance Measure Forms from most recent SAC/Designation application
***Note: Look-alike initial designation applicants will not have UDS data.***

***Related HRSA Resources:*** 1) Clinical and Financial Performance Measures (required Health Center Program performance measures): http://bphc.hrsa.gov/policiesregulations/performancemeasures/ 2) Health Center Data (information on Uniform Data System (UDS) reporting and the most recent UDS Manual): http://bphc.hrsa.gov/healthcenterdatastatistics/index.html 3) Healthy People 2020 Goals: http://www.hrsa.gov/grants/apply/assistance/SAC/healthypeopleandmeasures.pdf 4) HRSA Health Information Technology Resources: http://www.hrsa.gov/healthit/index.html

***Site Visit Clinical and Financial Performance Measure Analysis:*** One to two required Clinical Measures *and* one to two required Financial Measures *must be identified for analysis during the site visit*. The Site Visit Team must confer with the HRSA/BPHC Project Officer on measure selection. In addition, the following points are suggested to assist in identifying measures with outcomes that require performance improvement:

- *Which measure(s) or trends impact the largest number of patients or scope of the project?*
- *Is there significant room for improvement? For example, is there a significant gap between the health center's goal or the Healthy People 2020 goal and its current performance? Is there a significant gap between the health center's performance and the performance of other health centers with similar patient populations/characteristics (as noted in the Health Center Trend Report)?*
- *Is there a negative historical trend (as noted in the Health Center Trend Report) for the performance measure that suggests an intervention is necessary to turn the direction of the performance trend?*
- *Has the health center developed and implemented actions to improve performance on the selected measure?*

| For the 1 to 2 Performance Measures selected for review, address | Response |
|---|---|
| Reason(s) for selecting the measure | |
| Performance measure status and trend | |
| Key factors (internal and external) contributing to, and/or restricting, the health center's performance on the measure | |
| Health center's current and/or proposed actions to improve performance on the measure | |

## SECTION VI: CAPITAL AND OTHER GRANT PROGRESS REVIEW

**Background:** The Patient Protection and Affordable Care Act (Affordable Care Act), signed into law on March 23, 2010, provides $1.5 billion to support major construction and renovation at health centers nationwide. Affordable Care Act (ACA) grants have, or will include:

- $732 million for Capital Development projects to 144 additional applications that had originally been submitted under the American Recovery and Reinvestment Act (ARRA) Facilities Improvement Program (FIP)
- $200 million ($50 million per year for 4 years) for construction, renovation, and/or equipment through the School-Based Health Centers Capital (SBHCC) program; the SBHCC program awarded $95 million for 278 grants in FY 2011 (the FY 2011 awards included the available FY 2010 funding), $14 million for 45 grants in FY 2012, and $80 million for 197 grants in FY 2013.
- $629 million for 171 grants for the Capital Development – Building Capacity Grant Program for renovation, expansion, and/or construction of a facility
- $100 million for 230 grants for the Capital Development – Immediate Facility Improvements Program to address immediate and pressing capital needs in existing health centers

***Note to Consultants:*** *As part of the site visit preparation process, the Health Center (H80) Project Officer must contact the BPHC Capital Development Branch Project Officer for each Capital grant to provide information to the consultant(s) on the current status of each grant project and related issues. These Project Officers must be notified of the dates of the expected site visit as well.*

**Documents and Items to Review Prior to and/or During Site Visit:** 1) Notices of Award for all ACA Capital Grants (C8A, C8B, C12) to review the scope of the approved work, including any updates and changes to the project(s) and any terms or conditions 2) For Capital grants with construction, alterations, or renovations, visually tour/review the progress of construction or alterations/renovations, and if possible, take photos to attach to the site visit report 3) For Capital grants with equipment purchases, compare the equipment listed in the approved budget with the equipment purchased

***Related HRSA Resources:*** 1) Health Center Capital Development Programs Web page: http://www.bphc.hrsa.gov/policiesregulations/capital/index.html

| Awards | For the Capital Grant(s) reviewed, address all of the following: | Response |
| --- | --- | --- |
| ACA Capital Grants: Capital Development (CD), Capital Development – Building Capacity (CD-BC), Capital Development – Immediate Facility Improvements (CD-IFI), and School-based Health Center Capital (SBHCC) grants. | Current status of capital project | |
| | Key Factors (internal and external) contributing to, and/or restricting, the completion of the project and the project timeline (e.g., significant updates or modifications to the awarded project such as change in physical location, change in design/layout of the project) | |
| | Grantee's current or proposed actions to complete the project | |

## SECTION VII: INNOVATIVE/BEST PRACTICES

**Background:** A best practice refers to an activity, procedure, approach, or policy that leads to, or is likely to lead to, improved outcomes or increased efficiency for health centers. Alongside best practices are innovative practices. Similar to best practices, innovative practices also improve health center quality. However, when first developed or implemented, innovative practices are novel—of a type not seen before, original, or fresh. Over time, innovative practices may become best practices when their effectiveness has been demonstrated across different settings and when their adoption is encouraged by experts. Both best practices and innovative practices are effective approaches to improving health center quality.

**Innovative/Best Practices Documentation:** Time permitting, and as appropriate, as part of the site visit, consultants should consider if they have observed any innovative or best practices of the health center that would be important to briefly document in the Site Visit Report. Best practices or innovative practices that are most important to document are those that address one or more of these areas:

- Any of the 19 Key Program Requirement Areas: http://www.bphc.hrsa.gov/about/requirements/index.html (e.g., a health center has a very high functioning governing board.)
- Any of the required Health Center Clinical and/or Financial Performance Measures: http://www.bphc.hrsa.gov/policiesregulations/performancemeasures/index.html (e.g., a health center has consistent success in childhood immunization rates.)
- Medical, oral, and behavioral health care, and/or enabling service needs of the health center's target population

Consultants may also wish to consider documenting best or innovative practices addressing one or more of these initiatives/areas:

- HRSA Strategic Plan Priorities: http://www.hrsa.gov/about/strategicplan.html
- Healthy People 2020 Objectives: http://www.healthypeople.gov/2020/default.aspx
- AHRQ preventive and primary health care practice guidelines: http://www.ahrq.gov/professionals/clinicians-providers/index.html
- The CMS Meaningful Use (MU) incentive programs for Electronic Health Records: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html
- The HRSA Patient-Centered Medical/Health Home (PCMHH) Initiative: http://bphc.hrsa.gov/policiesregulations/policies/pal201101.html
- The National HIV/AIDS Strategy (NHAS): http://aids.gov/federal-resources/national-hiv-aids-strategy/overview/

## APPENDIX A: Cross-Cutting Reference Documents And Websites

| Cross-Cutting Reference Documents |
|---|
| Authorizing Legislation of the Health Center Program: Section 330 of the Public Health Service Act (42 U.S.C. §254b) http://www.bphc.hrsa.gov/about/requirements/index.html |
| Program Regulations (42 CFR Part 51c and 42 CFR Parts 56.201-56.604 for Community and Migrant Health Centers) http://www.bphc.hrsa.gov/about/requirements/index.html |
| Grants Regulations (45 CFR Part 74) http://www.bphc.hrsa.gov/about/requirements/index.html |
| Health Center Program Requirements Overview Slides http://www.bphc.hrsa.gov/about/requirements/index.html |
| BPHC Policy Information Notices and Program Assistance Letters (PINS and PALS) http://www.bphc.hrsa.gov/policiesregulations/policies/index.html |
| Health Center Program Requirements Oversight Program Assistance Letter (PAL 2014-08) http://www.bphc.hrsa.gov/policiesregulations/policies/pal201408.html |
| HRSA Program Integrity Resources http://www.hrsa.gov/grants/manage/programintegrity/index.html |
| Access To Medical Care For Individuals With Mobility Disabilities (including guidance on accessible medical equipment) http://www.hhs.gov/ocr/civilrights/understanding/disability/adamobilityimpairmentsgudiance.pdf |
| Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html |
| **Useful Websites** |
| Health Resources and Services Administration (HRSA) website http://www.hrsa.gov/ |
| HRSA Bureau of Primary Health Care (BPHC) website http://bphc.hrsa.gov/ |
| HRSA BPHC Technical Assistance (TA) Web page http://www.bphc.hrsa.gov/technicalassistance/index.html *Please note that all documents that are not HRSA/BPHC publications, and are found within the Samples and Templates Resource Center on the BPHC website were made possible by contract number HHSH232200864001C from the Health Resources and Services Administration (HRSA), Bureau of Primary Health Care. The contents of such documents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA.* |
| Newly Funded Technical Assistance Guide http://www.bphc.hrsa.gov/technicalassistance/newguide/index.html |