

For HRSA Health Center Program Grantees and Look-Alikes

JANUARY 2014/FISCAL YEAR 2014

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 type of site visits are Operational Site Visits (OSVs) which 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, while the purpose and focus of OSVs and other sites visits conducted by BPHC is 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 three years. Therefore, generally OSVs will take place 18 months into a typical three-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: It is expected that the outcome of all site visits will be an objective, in-depth assessment of the health center's compliance and/or performance status. Specifically:

- The site visit will be 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, 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 as well as 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. Therefore, 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, 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, residents of public housing) or for 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 Resource Center. Please note that all documents that are not HRSA/BPHC publications posted in the Samples and Templates 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.

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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.	<u>12</u>

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7	Health center has a system in place to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay. • 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.* • No discounts may be provided to patients with incomes over 200 % of the Federal poverty guidelines.* • 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.		<u>13</u>
8	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: • a clinical director whose focus of responsibility is to support the quality improvement/assurance program and the provision of high quality patient care;* • 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: * • be conducted by physicians or by other licensed health professionals under the supervision of physicians;* • be based on the systematic collection and evaluation of patient records;* and • 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.*		<u>15</u>

SECTION III: MANAGEMENT AND FINANCE			
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9	Key Management Staff	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.	<u>18</u>

	SECTION III: MANAGEMENT AND FINANCE		
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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.	<u>19</u>
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.	<u>20</u>
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.	<u>21</u>
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.	<u>23</u>
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.	<u>24</u>
15	Program Data Reporting Systems	Health center has systems which accurately collect and organize data for program reporting and which support management decision-making.	<u>25</u>
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.	<u>26</u>

	SECTION IV: GOVERNANCE		
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17	Board Authority	 Health center governing board maintains appropriate authority to oversee the operations of the center, including: holding monthly meetings; approval of the health center grant application and budget; selection/dismissal and performance evaluation of the health center CEO; selection of services to be provided and the health center hours of operations; 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 establishment of general policies for the health center. 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. 	<u>28</u>
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: Governing board has at least 9 but no more than 25 members, as appropriate for the complexity of the organization.* 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.* 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. 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). 	<u>32</u>
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. 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.*	<u>35</u>

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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.

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SUMMARY OF UPDATES TO HEALTH CENTER PROGRAM SITE VISIT GUIDE: JANUARY 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
Overview: Health Center Program Site Visits and Site Visit Guide	A new overview has been added to provide a summary of the purpose and process for Health Center Program site visits and the guide itself. This overview also clarifies that the guide is to be utilized for both Health Center Program grantee and look-alike site visits. Any areas that are not applicable to look-alikes are noted throughout the guide.
	 Questions for assessing and documenting compliance have been clarified and streamlined for all program requirements. In addition, questions for the governance requirements have been updated to align with the 2014 Health Center Program Governance Policy Information Notice.
I. Need II. Services III. Management and Finance IV. Governance	 Performance improvement questions have been removed from all program requirement sections. Consultants will focus on performance improvement in the areas of clinical and financial performance (see <u>Section V</u>).
	 Documents which consultants are expected to review onsite or in advance have been separated from general HRSA resources, such as Policy Information Notices and Program Assistance Letters (PINs and PALs), which are provided as background for each program requirement.
	The review of clinical and financial performance is now a separate section of the Site Visit Guide.
V. Clinical and Financial Performance	 Instructions and questions for assessing and documenting progress and performance on the clinical and financial measures have been clarified and streamlined.

SUMMARY OF UPDATES TO HEALTH CENTER PROGRAM SITE VISIT GUIDE: JANUARY 2014

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Section	Updates
VI. Capital and Other Grant Progress Review	 The Capital and Other Grant Progress Review is now a separate section of the Site Visit Guide. It was included as an appendix in previous versions of the guide. The instructions and review questions have been updated and streamlined to focus on active one-time capital awards supported with funds made available by the Affordable Care Act (ACA). Consultants will continue to use this section of the guide to review and document progress on completing ACA capital grant funded activities as part of all Operational Site Visits.
VII. Innovative/Best Practices	This new section and guidance regarding documenting Innovative/Best Practices has been added to align with the standardized site visit report format for Operational Site Visits.
Appendices	Appendix B: Optional Program Requirement/Performance Improvement Summary Grid, and Appendix C: Health Center Performance Measures have been removed from the Site Visit Guide. Please note that information on Health Center Program performance measures is available on the BPHC website at http://www.bphc.hrsa.gov/policiesregulations/performancemeasures/index.html and national, state and individual grantee data are available at http://bphc.hrsa.gov/uds/datacenter.aspx

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	Does the health center have a written needs assessment?	
of its target population, and has updated its service area when appropriate.	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 other policies and 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 procedures.

Related HRSA Resources: 1) Scope of Project Policies: http://www.bphc.hrsa.gov/policiesregulations/policies/managefinance.html 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.

NOTE: 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.

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	For any required services currently listed on the health center's Form 5A, in Column I as being provided <u>directly</u> by the health center, are these services available across the various health center site(s)?	
in section 330(b)(2)) as appropriate and necessary, either directly or through established written arrangements and	Note: Not all services must be available at all sites	
referrals. 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?	
required services.	If the health center provides any required services (per the health center through an outside organization/provider, either through a <u>formal written</u>	

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Requirements	Questions	Response
	5A, Column II) or a formal written referral arrangement (Form 5A, Colum two questions must be addressed.	in III) the following
	Note : Reviewing a sample of these agreements/ arrangements may be acceptable in case where the health center offers numerous services ONLY via these service delivery method	
	For required 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 the service will be documented in the health center's patient record; • How the health center will pay and/or bill for the service; and • How the health center's policies and procedures, including the availability of the sliding fee discount program, will apply?	
	For required services provided via formal written referral arrangements (Form 5A, Column III): Is an MOU, MOA, or other formal agreement in place 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? Is the referred service available equally to all health center patients, regardless of ability to pay? Note: The referred service must be available equally but not necessarily via the same provider Is the referred service available on a sliding fee discount schedule for all health center patients? Note: the referral providers sliding fee discount schedule does not have to match the one utilized by the health center but must at a minimum provide discounts based on income and family size for individuals at or below 200% of the current Federal Poverty Guidelines and provide no charge or only a nominal fee for individuals at or below 100% of the current Federal Poverty Guidelines. Is tracking and follow-up care for referred patients provided	

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Requirements	Questions	Response
	by the health center?	
	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: • 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)? • Are auxiliary aids and services readily available and responsive to the needs of patients with disabilities (e.g., sign language interpreters, TTY lines)? • 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, etc.) provided to patients in the appropriate languages, literacy levels, and/or alternative formats (for patients with disabilities) and in a timely manner? • 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 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)? 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? <i>Note:</i> 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 <u>credentialing and privileging policies and procedures</u> 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"

Notes:

- 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 approved policies and procedures (including methods to assess compliance with these policies and procedures).
- o Health centers may choose to have additional standards and/or processes as part of their credentialing and privileging policies and procedures that go above and beyond these minimum requirements.

Credentialing or Privileging Activity	"Licensed or Certified Health Care Practitioner"	
	Licensed <u>independent</u> practitioner (LIP) Examples: Physician, Dentist, Physician Assistant, Nurse Practitioner	Other licensed or certified practitioner Examples: Registered nurse, Licensed practical nurse, Certified medical assistant, Registered dietician
A. CREDENTIALING	METHOD	
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
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

8. Immunization and PPD status	Secondary source	Secondary source
9. Life support training (if applicable)	Secondary source	Secondary source
11. Drug Enforcement Administration (DEA) registration	Secondary source, if applicable	Secondary source, if applicable
12. Hospital admitting privileges	Secondary source, if applicable	Secondary source, if applicable
B. INITIAL GRANTING OF PRIVILEGES	METHOD	
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
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 Policies: http://www.bphc.hrsa.gov/policiesregulations/policies/managefinance.html 2) UDS Mapper tool: 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 <u>times</u> 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 <u>locations</u> that assure	Is the <u>location(s)</u> (as documented on Form 5B) at which services are provided accessible to the population to be served?	
accessibility and meet the needs of the population to be served.	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 procedures 2) Agreements, systems and/or contracts that support after hours coverage, if applicable 3) Most recent Form 5A: Services Provided, see "Emergency Medical Services."

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

Requirements	Questions	Response
	Is professional coverage for medical emergencies available to health center patients after the center's regularly scheduled hours through clearly defined arrangements?	
Health center provides professional coverage for medical emergencies during hours when the center is closed.	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
	Does the health center have arrangements for the hospitalization of all health center patients as needed (e.g., labor and delivery, emergencies, children, adults, etc.)? <i>Note:</i> 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, etc.).	
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 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) Implementing policies and procedures for the sliding fee discount program 4) Sliding fee signage and/or notification methods 5) Sliding fee application form(s)/eligibility criteria.

Related HRSA Resources: 1) Most recent Federal Poverty Guidelines: http://aspe.hhs.gov/poverty/index.cfm 2) Scope of Project Policies: http://www.bphc.hrsa.gov/policiesregulations/policies/managefinance.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 must assure that no patient will be denied services due to their inability to pay for such services.	Are all health center patients provided services regardless of ability to pay?	
	Are there mechanisms for communicating the availability of the sliding fee discount schedule to patients, including in languages/formats appropriate for patients with LEP or disabilities?	
Health center has a system in place to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay. Under this system:	Does the health center have established sliding fee discount schedule(s), which apply to the fees charged for all services (e.g., medical, dental, mental health) within the approved scope of project (i.e., both Required and Additional services as documented on Form 5A Columns I and/or II)?	
	Is the sliding fee discount schedule(s) based on a fee schedule that is consistent with locally prevailing rates or charges and designed to cover the reasonable costs of operation?	
	Does the health center have written board-approved policies and procedures that support the implementation of the sliding fee discount program and which assure that it is applied equally to all eligible patients?	

Requirements	Questions	Response
	Is the sliding fee discount schedule utilizing the most recent Federal Poverty Guidelines with discount categories determined based on income level and family size?	
	Specifically:	
Individuals and families with annual incomes at or below 100% of the Federal poverty guidelines must receive a full discount or only nominal fees may be charged.*	Do individuals and families at or below 100% of the Federal Poverty Guidelines receive a full discount, or pay a nominal charge only based on board-approved policies?	
Individuals and families with incomes between 100% and 200% of the Federal poverty guidelines must be charged a fee in accordance with a sliding discount policy based on family size and income.*	Are individuals and families with incomes above 100% and at or below 200% of the Federal Poverty Guidelines charged a fee (partial discount) according to a sliding fee discount schedule(s) approved by the board?	
Individuals and families with incomes over 200% of the Federal poverty guidelines may not receive discounts.*	Are individuals and families above 200% of the Federal Poverty Guidelines excluded from the sliding fee discount program based on board-approved policies?	

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 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 procedures 4) Clinical care policies and procedures 5) Clinical information tracking policies and 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
(
https://www.ecri.org/Clinical_RM_Program/Pages/default.aspx
(
http://bphc.hrsa.gov/exitdisclaimer/hrsaexitdisclaimer.html
) 4) HHS OIG Quality and Compliance Resources: http://oig.hhs.gov/compliance/compliance-resource-material.asp.

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)? 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 procedures that address the following areas (applicable for health centers with paper and/or electronic health records): • Establishing and maintaining a clinical record for every patient receiving care at the health center? • Privacy and Confidentiality (in accordance with HIPAA)? • Procedures to enable patients to give consent for release of medical record information? • Security of current and archived medical record information?	
Includes a <u>clinical director</u> 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? Note: clinical directors may be full or part-time staff and should have appropriate training/background (e.g., MD, RN, MPH, etc.) 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
	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?	
Health center maintains a fully staffed health center management team as appropriate for the size and needs of	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?	
the center. If applicable, prior approval by HRSA of a change in the Project Director/ Executive Director/CEO position is required.	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" which 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(I)(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 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/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
	Does the health center have board-approved policies and 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?	
Health center exercises appropriate oversight and authority	Are appropriate provisions in place to assure that none of the health center's contracts or affiliation agreements have the potential to:	
over all contracted services.	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. <i>Applies only to grantees with subrecipients</i> 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://bphc.hrsa.gov/exitdisclaimer/hrsaexitdisclaimer.html).

Requirements	Questions	Response
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.	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:	
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.	 Health centers (Health Center Program grantees and lookalikes). Rural health clinics. Critical access hospitals. Health departments. Other major private provider groups serving low income and/or uninsured populations. 	

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 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) 10) If applicable, health center's Financial Recovery Plan.

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.bphc.hrsa.gov/grants/manage/ 4) Creating a Financial Recovery Plan (PIN 2002-18): http://www.bphc.hrsa.gov/policiesregulations/policies/pin200218.html.

Note: Regarding efficiency and provider productivity - HRSA/BPHC does not enforce specific productivity guidelines (e.g., 4200/2100) which 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 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: separate identification of Federal and non-Federal transactions? a chart of accounts that reflects the general ledger accounts?	
Reflect Generally Accepted Accounting Principles (GAAP). Reflective of GAAP, including accumulation of costs?		

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Requirements	Questions	Response
Separate functions in a manner appropriate to the organization's size in order to safeguard assets and	Designed to separate functions in a manner appropriate to the organization's size in order to safeguard assets?	
maintain financial stability.	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? 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 procedures for credit, collection, and billing 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) Process for Becoming Eligible for Medicare Reimbursement under the FQHC Benefit (PAL 2011-04): http://bphc.hrsa.gov/policiesregulations/policies/pal201104.html 2) 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
1	Health center has systems in place to maximize collections and reimbursement for its costs in providing health services.	Does the health center participate in or make every reasonable effort to participate in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), Marketplace qualified health plans, and any other public assistance programs that are available to its patients? Does the health center have Medicare and Medicaid provider numbers, where applicable (e.g., do all Permanent and Seasonal Sites on Form 5B have Medicare CMS Certification Numbers)? Does the health center make every reasonable effort to collect reimbursement for services provided to persons covered by private health insurance? Does the health center make reasonable efforts to secure payment from patients for amounts owed for services based on their established sliding fee discount schedule in a manner that assures that no patient will be denied services based on an inability to pay?	
	These systems include written policies and procedures addressing:	Does the health center have written board-approved policies and procedures	for:
2	Billing	Billing?	
	Credit	Credit?	
	Collections	Collections?	

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 nongrant 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?	
	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.	
including the number of patients to be served.	 (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: total funds authorized on the Notice of Award? total funds available for any cost category, if restricted, on the Notice of Award? 	

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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 that 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 Policies: http://www.bphc.hrsa.gov/policiesregulations/policies/managefinance.html 2) HRSA/BPHC UDS Reporting Information: http://www.bphc.hrsa.gov/healthcenterdatastatistics/index.html

Requirement	Questions	Response
	Has the health center <u>significantly reduced its scope of project</u> in terms of sites or services (e.g., stopped offering additional services, closed service sites) in the past 3 years?	
Health center maintains its funded scope of project (sites, services, service area, target population and providers), including any increases based on recent grant awards.	(Grantees Only) Has the grantee received any additional BPHC grant awards in the last 3 years that have expanded their 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, reached the projected patient or visit levels if applicable)? 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?	

Requirement	Questions	Response
	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 documented by the health center on its current Form 5A and Form 5B (e.g., a health center has 10 sites listed on their Form 5B but is operating 8 sites because it closed the other 2 sites but failed to submit the appropriate change in scope request to delete these sites; 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; health center has only informal referral arrangements in place for some additional services listed on Form 5A and thus these should not be included on the form)?	

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 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/policies/governance.html 2) Affiliation Agreement Policies (PINs 97-27 and 98-24): http://bphc.hrsa.gov/policies/governance.html.

NOTES:

- o 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, <u>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.</u>

Requirements	Questions	Response		
Health center governing board maintains appropriate authority to	oversee the operations of the center, including all of the following:			
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.				
	Does the board meet monthly?			
Holding monthly meetings	Health centers with previously approved waivers ONLY: Has the health center begun or completed a plan to transition the board to holding monthly meetings?			
	Note: HRSA has issued a final Governance Policy Information Notice (PIN), which no longer permits health centers to waive the health center			

Requirements	Questions	Response
	program requirement to hold MONTHLY governing board meetings. Based on submission of an application prior to the PIN's release when such waivers were permitted (FY 2014 and prior), health centers are being afforded a reasonable timeframe to develop and submit a plan to come into compliance with the requirement to meet monthly. Does the health center maintain records/minutes of the monthly board meetings? 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)?	
	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?	
Selection of services to be provided and the health center hours of operations;	Is this review documented in the board minutes? 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	Does the board evaluate the health center's progress in meeting its annual and long-term goals (e.g., clinical, financial, operational, etc.)? Does the board engage in long-term strategic planning, which would include regular updating of the health center's mission, goals, and plans, as appropriate?	

Requirements	Questions	Response
satisfaction, and monitoring organizational assets and performance;* and	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, etc.)? Are these activities documented in the board minutes?	
	Does the board establish general policies and procedures 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)?	
Establishment of general policies for the health center. 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	Examples of specific health center policies and procedures 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.	
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)).	Do the health center bylaws specify or address each of the following (if not, indicate whether the topic is addressed in another board-related document): Health center mission. Authorities, functions, and responsibilities of governing board as a whole.	
	 Board membership (size and composition) and individual member responsibilities. Process for selection/removal of board members. Election of officers. Recording, distribution and storage of minutes. 	

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 that 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
	 Meeting schedule and quorum. Officer responsibilities, terms of office, selection/removal processes. Description of standing committees (which may include but are not limited to executive, finance, quality improvement, personnel, and planning committees) and the process for the creation of ad-hoc committees. Provisions regarding conflict of interest. Provisions regarding board dissolution. 	
	From From the public agencies with co-applicant arrangements ONLY (i.e., public composes the public agency have a formal agreement with the co-applicant board 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/policies/governance.html 2) Affiliation Agreement Policies (PINs 97-27 and 98-24): 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:

- o 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, <u>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.</u>

Requirements	Questions	Response
The health center's governing board meets the following r	requirements:	
	Are a majority of members of the board (at least 51 percent), individuals (patients) who are served by the health center?	
A majority of the board members are individuals ("consumers" or "patients"; also previously known as "users") served by the organization.	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)	
	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. Answer "Waiver" if the health center has a waiver for this requirement respond to question for health centers with waivers below. 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:	
	A method(s) for collecting and documenting patient input?	
	 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)? 	
	 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? Answer "Waiver" if the health center has a waiver for this requirement and 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.	
	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)?	
	Does the board have between 9 and 25 members?	
The board has at least 9 but no more than 25 members, as appropriate for the complexity of the organization.*	Does the current board size comply with the health center's bylaws, which must 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	Are the remaining (non-patient/non-consumer) board members representative of the community currently served by the health center?	
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.*	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? 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 procedures.

Related HRSA Resources: 1) Health Center Program Governance (PIN 2014-01): http://bphc.hrsa.gov/policiesregulations/policiesregulations/policiesregulations/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:	Do the bylaws and/or other written board-approved policy document(s) 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? • There are written standards of conduct governing the performance of health center employees engaged in the award and administration of contracts.	
Prohibit conflict of interest by board members, employees, consultants and those who furnish goods or services to the health center.	Health center employees, board members, or agents are prohibited 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.	
	The board members, employees, and agents of the health center are	

Requirements	Questions	Response
	prohibited 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.	
	The standards of conduct provide 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.*	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?	
Note: This particular aspect of the requirement related to board composition is <u>not</u> applicable to health centers operated by Indian tribes or tribal, or urban Indian organizations.		
State that the Chief Executive may serve only as a non-voting, ex-officio member of the board.*	The CEO/ED is not a voting member of the Board?	
Note: This particular aspect of the requirement related to board composition is <u>not</u> applicable to health centers operated by Indian tribes or tribal, or urban Indian organizations.		

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 that 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 their 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?

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For the 1 to 2 Performance Measures selected for review, address all of the following:	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 the following:

- \$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 four 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 BPHC Capital Development Branch Project Officer for each Capital Grant must be contacted by the Health Center (H80) Project Officer 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
	Current status of capital project.	
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.	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 the following:

- Any of the 19 Key Program Requirement Areas: http://www.bphc.hrsa.gov/about/requirements/index.html (e.g., health center has a very high functioning governing board).
- Any of the required Health Center Clinical and/or Financial Performance Measures:
 <u>http://www.bphc.hrsa.gov/policiesregulations/performancemeasures/index.html</u>
 (e.g., health center has had 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 the following:

- 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

Enhancements to Support Health Center Program Requirements Monitoring (PAL 2010-01) http://www.bphc.hrsa.gov/policiesregulations/policies/pal201001.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/adamobility/mpairmentsgudiance.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/policyquidancedocument.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 within the BPHC TA 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/newquide/index.html