Health Center Site Visit Guide

For HRSA Grantees

OCTOBER 2012

The Health Center Site Visit Guide is a review instrument used by the Health Resources and Services Administration (HRSA) to assess an organization's compliance with key section 330 Health Center Program requirements as well as a resource to assist grantees in identifying areas for performance improvement. Health centers may also use this Guide as a self-assessment resource as it provides a series of prompting questions to assess both program requirements and performance improvement areas.

The Bureau of Primary Health's (BPHC) user-friendly Technical Assistance (TA) website http://www.bphc.hrsa.gov/technicalassistance/index.html also provides a variety of resources that support both the program requirements and performance improvement areas outlined within this site visit guide. Resources include but are not limited to easy access to HRSA/BPHC policy documents, an organized listing of TA resources, training opportunities (webinars, meetings, conference calls, etc.) and links to the websites of BPHC Cooperative Agreement partners that provide training and TA for all health centers, assistance to health centers serving special populations (e.g., migrant and seasonal farmworkers, homeless, residents of public housing) or disadvantaged populations (e.g., LGBT, elderly), and assistance to health centers with specific services or needs (e.g., oral health, children in schools, capital development). **Please note that the BPHC TA website is continually updated as new TA opportunities arise, and health centers and consultants are encouraged to check the website frequently.**

In addition, BPHC's Technical Assistance contractor, Management Solutions Consulting Group, Inc. (MSCG) provides a Consultant Resource Center available at http://www.mscginc.com/Resources. The Resource Center is a repository of vetted sample documents shared by consultants, as well as publications from BPHC, NACHC, and other BPHC Cooperative Agreement partners. Documents are arranged categorically within the Resource Center and it is recommended that consultants use and share **only** these documents and publications with BPHC grantees. If there are other items consultants wish to add to the Resource Center, they must first be vetted before they can be used onsite via the process outlined in Resource Center. Please note that all documents that are not HRSA/BPHC publications and are found within the MSCG Consultant Resource Center 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.

We hope you find the Health Center Site Visit Guide a useful resource tool as we work together to improve the health of the Nation's underserved communities and vulnerable populations.

NOTE: The Health Center Site Visit Guide is updated annually. Therefore, please delete all previous versions of this guide that you may have downloaded and use only the most current version available on the BPHC website at http://www.bphc.hrsa.gov/policiesregulations/centerguide.html.

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SECTION II: SERVICES			
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2	Required and Additional Services	Health center provides all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established written arrangements and referrals. **Note:** Health centers requesting funding to serve homeless individuals and their families must provide substance abuse services among their required services.	5
3	Staffing	Health center maintains a core staff as necessary to carry out all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established arrangements and referrals. Staff must be appropriately licensed, credentialed and privileged.	10
4	Accessible Hours of Operation / Locations	Health center provides services at times and locations that assure accessibility and meet the needs of the population to be served.	14
5	After Hours Coverage	Health center provides professional coverage for medical emergencies during hours when the center is closed.	15
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.	16

^ NOTE: To access the desired page, press the Control button on your keyboard and click on the applicable page number.

SECTION II: SERVICES			
No.	**Title**	**Program Requirement**	**Page^**
7	**Sliding Fee Discounts**	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.	17

8	**Quality Improvement / Assurance Plan**	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: *
		    o be conducted by physicians or by other licensed health professionals under the supervision of physicians;*
		    o be based on the systematic collection and evaluation of patient records;* and
		    o identify and document the necessity for change in the provision of services by the health center and result in the institution of such change, where indicated.*
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SECTION III: MANAGEMENT AND FINANCE			
No.	**Title**	**Program Requirement**	**Page^**
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.	24

SECTION III: MANAGEMENT AND FINANCE			
No.	Title	Program Requirement	Page^
10	Contractual/Affiliation Agreements	Health center exercises appropriate oversight and authority over all contracted services, including assuring that any subrecipient(s) meets Health Center Program requirements.	25
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.	27
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.	28
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.	32
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.	35
15	Program Data Reporting Systems	Health center has systems which accurately collect and organize data for program reporting and which support management decision making.	36
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.	41

SECTION IV: GOVERNANCE			
No.	Title	Program Requirement	Page^
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 **Note:** Upon a showing of good cause the Secretary may waive, for the length of the project period, the monthly meeting requirement in the case of a health center that receives a grant pursuant to subsection (g), (h), (i), or (p).	44
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).	48

SECTION IV: GOVERNANCE			
No.	**Title**	**Program Requirement**	**Page^**
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.*	52

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

APPENDICES		
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SUMMARY OF UPDATES TO HEALTH CENTER SITE VISIT GUIDE		
Please note—the following changes have been made to the Health Center Site Visit Guide in accordance with updates and clarifications of the Health Center Program Requirements, HRSA/BPHC policy, and the Health Center Required Performance Measures. Therefore, users of the Site Visit Guide are reminded to delete/discard all previous versions and use only this most current version.		
Section	Requirement	Change
II. Services	After Hours Coverage	The language and citations of this program requirement have been expanded to better align with the Health Center Program's implementing regulations.
	Sliding Fee Discounts	The language and citations of this program requirement have been expanded to better align with the Health Center Program's statute and implementing regulations.
III. Management and Finance	Key Management Staff	The citations for this program requirement have been expanded and the language of this program requirement has been clarified to better align with grant regulations.
	Collaborative Relationships	The term "Federally Qualified Health Center" has been replaced with the term "health centers (section 330 grantees and FQHC Look-Alikes)" within this program requirement to align with terminology in other BPHC documents and publications. The citations for this program requirement have also been expanded.
IV. Governance	Board Composition	The language of this program requirement has been modified slightly to clarify that the requirement that board members represent the demographics of the individuals being served applies only to the patient majority and not the entire board.

<table>
<tr><th colspan="3">SUMMARY OF UPDATES TO HEALTH CENTER SITE VISIT GUIDE</th></tr>
<tr><td colspan="3">Please note—the following changes have been made to the Health Center Site Visit Guide in accordance with updates and clarifications of the Health Center Program Requirements, HRSA/BPHC policy, and the Health Center Required Performance Measures. Therefore, users of the Site Visit Guide are reminded to delete/discard all previous versions and use only this most current version.</td></tr>
<tr><th>Section</th><th>Requirement</th><th>Change</th></tr>
<tr><td>Appendix C</td><td colspan="2">The summary and details of Appendix C: Health Center Performance Measures have been updated to reflect all calendar year 2012 HRSA/BPHC Uniform Data System (UDS) reporting measures which will include three new performance measures.</td></tr>
<tr><td>Appendix D</td><td colspan="2">Appendix D: Capital and Other Grant Progress Review has been updated to reflect the most recent award information for capital grants made under Patient Protection and Affordable Care Act (ACA). As a requirement of ARRA and ACA funding, health centers must report on their progress on creating or retaining jobs, increasing new patients and visits, and completing capital improvement projects as a result of each award as appropriate. Consultants will continue to use this supplement to review progress on implementing ARRA and ACA grant funded activities, document contributing or restricting factors to progress <u>(including touring and photographing visual progress as appropriate)</u> and identify TA needs as necessary as part of all Operational Site Visits.</td></tr>
<tr><td>Throughout Site Visit Guide</td><td colspan="2">Organizations that are receiving section 330 Health Center Program grant funds through a New Access Point (NAP) award for the first time (previously referred to as "New Starts") are now referred to throughout the Health Center Site Visit Guide as "Newly Funded" grantees.</td></tr>
</table>

Note to Consultants Conducting Site Visits to Newly Funded Health Center Program Grantees

For Newly Funded Health Center Program grantees (organizations receiving Federal section 330 support for the first time), which may or may not have been operating a primary care clinic prior to grant award, it is HRSA's expectation that full operational capacity, in terms of the projected staffing, sites, services and patient levels presented in the New Access Point application, will be achieved within 2 years of receiving Federal section 330 support and that the third year of funding will represent the project at full operational capacity for a 12-month period of time. Full operational capacity for a center should be determined using the projected provider levels required by the center to operate at its full level of services (i.e., at the full-range of services required by section 330 statute, regulations, and Health Center Program Requirements).

While the 19 requirements included in this guide apply to all health centers (existing and Newly Funded grantees), throughout their review consultants are requested to pay particular attention to the specific compliance and performance improvement status and technical assistance needs of Newly Funded grantee organizations that may be providing primary care services for the first time.

SECTION I: Need

Program Requirement 1: NEEDS ASSESSMENT

1.A Program Requirement

Authority: Section 330(k)(2) and Section 330(k)(3)(J) of the PHS Act)
Documents/Resources to Review: 1) Most recent Needs Assessment(s); 2) Service Area Map.

Requirements	Questions	Yes/No
Health center has a documented assessment of the needs of its target population, and has updated its service area when appropriate.	Does the grantee have a written needs assessment?	
	Does the grantee have a clearly defined service area?	

1.B Performance Improvement

Additional Documents/Resources to Review: 1) HRSA/BPHC Service Area Overlap Policy Information Notice 2007-09 (for site visits with service area overlap concerns); 2) UDS Mapper tool, available online (requires login) at http://www.udsmapper.org; 3) HRSA Geospatial Data Warehouse.

	Prompting Questions for Performance Improvement Discussions	Response
1	Is the needs assessment comprehensive in terms of encompassing the entire service area and/or target population(s)? If not, should it be modified or expanded?	
2	When was the last needs assessment completed or updated?	
3	Has the grantee updated their service area based on recent data (e.g., annual patient origin data)? If not, is this recommended?	
4	If updated, was the assessment reviewed and approved by the Board? If yes, when?	
5	What priority needs were identified?	
6	What action(s) was taken to address them?	
7	Does the grantee's defined service area take into account geographic, demographic and/or other relevant factors?	
8	Are there any concerns or issues around service area overlap?	

SECTION II: Services

Program Requirement 2: REQUIRED AND ADDITIONAL SERVICES

2.A Program Requirement

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

*Documents/Resources to Review:*1) Clinical Practice Protocols and related Operating Policies and Procedures; 2) Documentation of services provided via formal written agreements and/or via formal written referral arrangements; 3) Health center's official scope of project for services (EHB BHCMIS Form 5A); 4) HRSA/BPHC Scope of Project Policies; 5) HRSA/BPHC HIV/AIDS Testing, Care and Treatment Program Assistance Letters.

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 provide additional health services (defined in section 330(b)(2)) as appropriate and necessary, either directly or through established written arrangements and referrals. ***Note:*** Grantees that receive (section 330(h)) funding to serve homeless individuals and their families must provide substance abuse services among their required services. ***Required health center services include:***	Please indicate if the services are provided: • Directly by the grantee (**D**) • By formal written agreement (**A**) (grantee pays/bills) • By formal (**F**) written referral arrangement (grantee does not pay/bill but maintains responsibility for the patient's treatment plan and will be providing and/or paying/billing for appropriate follow-up care based on the outcome of the referral) • By informal (**I**) referral (grantee does not pay)—**Informal referral arrangements <u>are not</u> acceptable for the provision of a required service, nor are they included in the scope of project.** • Not provided (**N**)	

	Clinical Services	
1	General Primary Medical Care	
2	Diagnostic Laboratory	
3	Diagnostic X-Ray	
4	Screenings	
4.a.	Cancer	
4.b.	Communicable diseases	
4.c.	Cholesterol	

Requirements		Questions	Response
4.d.	Blood lead test for elevated blood lead level		
4.e.	Pediatric vision, hearing, and dental		
5	Emergency Medical Services		
6	Voluntary Family Planning		
7	Immunizations		
8	Well Child Services		
9	Gynecological Care		
10	Obstetrical Care		
11	Prenatal and Perinatal Services		
12	Preventive Dental		
13	Referral to Mental Health *(Grantee does not pay for the services) Note:* All health centers are required to provide mental health services at minimum, by formal referral arrangement(s). However, if they choose to do so, centers may also provide these services directly or via formal written agreements as Additional (Optional) Services.		F
14	Referral to Substance Abuse *(Grantee does not pay for the services)) Note:* All health centers are required to provide substance abuse services at minimum, by formal referral arrangement(s). However, if they choose to do so, centers may also provide these services directly or via formal written agreements as Additional (Optional) Services.		F
15	Referral to Specialty Services *(Grantee does not pay for the services)*		F
16	Pharmacy		
17	Substance Abuse services *(Required only for grantees receiving funding for Health Care for the Homeless; optional for other grantees)*		
17.a.	Detoxification		
17.b.	Outpatient treatment		
17.c.	Residential treatment		
17.d.	Rehabilitation (non hospital settings)		
Non-Clinical Services			
1	Case Management		
1.a.	Counseling/Assessment		

<table>
<tr><th colspan="3">Requirements</th><th>Questions</th><th>Response</th></tr>
<tr><td>1.b.</td><td colspan="3">Referral</td><td></td></tr>
<tr><td>1.c.</td><td colspan="3">Follow-up/Discharge Planning</td><td></td></tr>
<tr><td>1.d.</td><td colspan="3">Eligibility Assistance</td><td></td></tr>
<tr><td>2</td><td colspan="3">Health Education</td><td></td></tr>
<tr><td>3</td><td colspan="3">Outreach</td><td></td></tr>
<tr><td>4</td><td colspan="3">Transportation</td><td></td></tr>
<tr><td rowspan="3">5</td><td colspan="3">Translation (Required for grantees serving a substantial number of patients with limited English proficiency): For grantees providing translation services:</td><td>Yes/No</td></tr>
<tr><td>a</td><td colspan="2">Does the type of interpretation/translation service(s) provided appear to be appropriate for the size/needs of the grantee (e.g., bilingual providers, onsite interpreter, language telephone line)?</td><td></td></tr>
<tr><td>b</td><td colspan="2">Are the Registration Form, Sliding Fee Scale, After Hours contact instructions and other pertinent documents or messages provided to patients in the appropriate languages?</td><td></td></tr>
<tr><td>6</td><td colspan="3">Substance Abuse related Harm/Risk Reduction services—e.g., educational materials, nicotine gum/patches. (Required only for grantees receiving funding for Health Care for the Homeless; optional for other grantees.)</td><td></td></tr>
<tr><td rowspan="5">I</td><td colspan="3">For all required services (listed above), provided by an outside organization/provider, either through a formal written agreement or a formal written referral arrangement:</td><td>Yes/No</td></tr>
<tr><td>a</td><td colspan="2">For services provided via formal written agreement(s), does the written agreement (e.g., MOA, MOU, contract) in place between the health center and outside organization/provider describe:
• how the service will be documented in the patient record?
• how the grantee will pay and/or bill for the service?
• how the grantee's policies and procedures including the applicability of a sliding fee discount schedule?</td><td></td></tr>
<tr><td>b</td><td colspan="2">For services provided via formal written referral arrangements:
• An MOU, MOA, or other formal agreement exists 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.
• The referred service (no necessarily via the same provider) is available equally to all health center patients, regardless of ability to pay.
• The referred service is available on a sliding fee discount schedule for all health center patients.
• Tracking and follow-up care for referred patients is provided by the health center.</td><td></td></tr>
<tr><td>c</td><td colspan="2">Has the license of the outside provider been verified?</td><td></td></tr>
<tr><td>d</td><td colspan="2">Has the certification of the lead provider been verified?</td><td></td></tr>
<tr><td>II</td><td colspan="3">Are all Required Services listed in scope provided on a sliding fee discount schedule?</td><td></td></tr>
</table>

2.B Performance Improvement

Additional Documents/Resources to Review: 1) HRSA Culture, Language and Health Literacy Resources; 2) HRSA Clinical Resources; 3) HRSA Office of Pharmacy Affairs Resources; 4) HRSA/BPHC Special Populations PINs and PALs.

Prompting Questions for Performance Improvement Discussions		Response
Which of the following Additional (optional) services does the grantee provide? Indicate how they are provided:		
• Directly by the grantee (**D**)		
• By formal written agreement (**A**) (grantee pays/bills)		
• By formal (**F**) written referral arrangement (grantee does not pay/bill but maintains responsibility for the patient's treatment plan and will be providing and/or paying/billing for appropriate follow-up care based on the outcome of the referral)		
• By informal (**I**) referral (grantee does not pay. Grantee refers a patient to another provider who is responsible for the treatment plan and billing for the services provided and no grant funds are used to pay for the care provided. In addition, in such informal arrangement, the other provider is not required to refer patients back to the grantee for appropriate follow-up care. Informal referral arrangements are not included in the official scope of project).		
• Not provided (**N**)		
Clinical Services		
1	Urgent Medical Care	
2	Dental Services:	
2.a.	Restorative	
2.b.	Emergency	
3	Behavioral Health Services:	
3.a.	Treatment/Counseling	
3.b.	Developmental Screening	
3.c.	24-Hour Crisis	
4	Substance Abuse Services	
5	Comprehensive Eye Exams and Vision Services	
6	Recuperative Care	
7	Environmental Health Services	

Prompting Questions for Performance Improvement Discussions			Response
8	Occupational-Related Health Services *(generally applies to grantees serving migrant and seasonal farmworkers):*		
8.a.	Screening for Infectious Diseases		
8.b.	Injury Prevention Programs		
9	Occupational Therapy		
10	Physical Therapy		
11	Podiatry		
12	Rehabilitation (Non-Hospital Settings)		
13	Specialty Service (Specify)		
14	Other Service (Specify)		
Non-Clinical Services			
1	WIC		
2	Nutrition (not WIC)		
3	Child Care		
4	Housing Assistance		
5	Employment and Education Counseling		
6	Food Bank/Meals		
7	Other (Specify)		
I	Are all Additional Services listed in scope provided on a sliding fee discount schedule?		
II	Regarding cultural competency:		
	a	Are there cultural competency training opportunities for the staff?	
	b	If yes, how frequently are these trainings offered? If no, are there plans to establish these trainings?	
	c	Are the following employees bilingual: Operator, Front Desk staff, Cashier?	
III	If the health center provides on-site emergency services:		Yes/No
	a	Is a crash cart on site?	
	b	If yes, is content-compliance monitoring documented?	

		Prompting Questions for Performance Improvement Discussions	Response
	c	Does the grantee have written protocols for "in-house" emergency care?	
	d	Is the staff adequately trained and currently certified in emergency procedures?	
	e	Do procedures exist for the orderly transfer of patient to the hospital via EMS?	
IV	Is the grantee's pharmacy provider:		Yes/No
	a	Located in-house or off-site?	
	b	If off-site, is it owned by the grantee?	
	c	A participant in the Federal Drug Pricing (340B) program?	
V	If the grantee provides pharmacy services either on-site or through an off-site provider that it owns or manages:		Yes/No
	a	Has a clinical committee established a formulary to ensure cost-effective prescribing?	
	b	Is there a policy regarding acceptance, stocking, logging, and recording of dispensed sample medications?	
VI	Regarding specialty services:		
	a	What is the level of specialist availability for referrals?	
	b	Are there written procedures and tracking mechanisms in place for specialty referrals?	
	c	Is there a system for following-up on missed specialty care appointments?	
	d.	If the grantee provides any specialty services directly, are these services clearly recorded in the scope of project?	

SECTION II: Services

Program Requirement 3: STAFFING

3.A Program Requirement

Authority: Section 330(a)(1), (b)(1)-(2), (k)(3)(C), and (k)(3)(I) of the PHS Act
Documents/Resources to Review: 1) Staffing Profile; 2*)* Provider Contracts, Agreements, and any Subrecipient Arrangements related to staffing (as applicable); 3) Credentialing and Privileging Policies and Procedures; 4) HRSA/BPHC Credentialing Policies (Policy Information Notices 2002-22 and 2001-16).

Requirements	Questions	Yes/No
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?	
	Are all health center providers appropriately credentialed to perform the activities and procedures detailed within the health center's approved scope of project? *Appropriate documentation must include written confirmation of credentialing (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 all health center sites.*	
	Are the health center's credentialing and privileging policies and procedures adequate so as to assure that all health center providers are/will be appropriately licensed, credentialed and privileged to perform the activities and procedures detailed within the health center's approved scope of project? *These policies and procedures must address 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 and its sites.*	

3.B Performance Improvement

Additional Documents/Resources to Review: 1) Personnel Manual; 2) Personnel Files Checklist/Matrix; 3) Position descriptions; 4) Staff evaluation forms; 5) Provider contracts; 6) Orientation guide for new staff; 7) Employee satisfaction surveys; 8) HRSA Workforce and National Health Service Corps Resources

Prompting Questions for Performance Improvement Discussions			Response
1	Budgeted vs. actual staffing levels		
	a	What is the budgeted FTE provider staffing for the current calendar year?	
	b	What is the actual FTE provider staffing?	
	c	What is the budgeted FTE administrative staff for the current calendar year?	
	d	What is the actual FTE administrative staff?	
2	Personnel Policies / Employee Handbook		

Prompting Questions for Performance Improvement Discussions			Response
	a	Does the center have a personnel manual?	
	b	When was it most recently approved by the Board?	
	c	Does each new employee receive a copy of the personnel manual?	
	d	Do employees receive policy updates as available?	
3	Personnel Files		
	a	Are personnel files maintained in a secure location with restricted access?	
	b	Are there rules on accessing and releasing information from personnel files?	
	c	Is access to the files recorded?	
	d	Is there a standard format for non-clinical personnel files, for clinical personnel files, and for terminated personnel files?	
	e	Are personnel's medical files maintained in location separate from patient medical records?	
4	Position Descriptions (PDs)		
	a	Are PDs maintained in a central location?	
	b	Are PDs written for all categories of staff?	
	c	Do all PDs have a standard format?	
5	Job Descriptions		
	a	Do employees have a current job description?	
	b	Have employees signed their job description?	
	c	Are employees' jobs consistent with their descriptions?	
6	Performance Evaluations		
	a	Are evaluations conducted at least annually?	
	b	Is there a standard form used for evaluations?	
	c	Do the employees sign the evaluations?	
	d	Do the supervisors sign the evaluations?	
	e	Do the evaluations include a place for employee comments?	
	f	Is there an employee appeal and/or grievance process?	
7	Clinical Staff		
	a	Is a provider with training in pediatrics available to see patients during all normal operating hours?	

Prompting Questions for Performance Improvement Discussions			Response
	b	Is a provider with training in OB/Gyn available to see patients during all normal operating hours?	
	c	Is a provider with training in adult primary care available to see patients during all normal operating hours?	
	d	Are clinical staff being hired in a timely manner?	
	e	Is there adequate leave and funding for continuing professional education?	
	f	Is there a provider recruitment and retention plan in place, if not does provider recruitment and retention need to be addressed?	
	g	Are QI/QA/CQI responsibilities included in medical staff members' job descriptions?	
8	Provider Credentialing and Privileging		
	a	Is there a formal provider credentialing and privileging process (for insurance companies and other third-party payors as well as clinical privileges)?	
	b	Has the Board approved this process?	
	c	Are providers required to complete the privileging process before starting to see patients?	
9	Do employment contracts address:		
	a	Contract length?	
	b	On-call requirements?	
	c	Cross coverage requirements?	
	d	Compensation and incentives?	
	e	Continuing education?	
	f	Moonlighting?	
	g	Conflict of Interest and Non-compete provisions?	
	h	Malpractice coverage?	
	i	Provider expectations (number of patients to see, etc.)	
10	Is there a standardized orientation for new employees?		
11	Is there a standard format for agendas and minutes from staff meetings?		
12	Employee Satisfaction Surveys		
	a	Does the center conduct employee satisfaction surveys?	
	b	If yes, how does the center respond to information gained from the surveys?	

SECTION II: Services

Program Requirement 4: ACCESSIBLE HOURS OF OPERATION / LOCATIONS

4.A Program Requirement

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

Documents/Resources to Review: 1) Hours of Operation; 2) Most recent EHB BHCMIS 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) Service Area Map with site locations noted; 4) HRSA/BPHC Scope of Project Policies.

Requirements	Questions	Yes/No
Health center provides services at times that assure accessibility and meet the needs of the population to be served.	Are the times that services are provided appropriate to ensure access for the population to be served?	
Health center provides services at locations that assure accessibility and meet the needs of the population to be served.	Is the location(s) at which services are provided accessible to the population to be served? **Note:** Health centers that receive targeted funding for Public Housing Primary Care (PHPC) should be able to document that service sites are immediately accessible to the targeted public housing communities.	

4.B Performance Improvement

Additional Documents/Resources to Review: Most recent EHB BHCMIS Form 5C: Other Activities/Locations

	Prompting Questions for Performance Improvement Discussions	Response
1	Are there additional times that the grantee could be open that would increase accessibility for the population to be served?	
2	Are the hours of operation posted in the appropriate languages for the population(s) served?	
3	Is the internal/external signage (including exit signs) clear, properly placed, and sufficient in number?	
4	Is the size of the facility adequate for the population to be served?	

SECTION II: Services

Program Requirement 5: AFTER HOURS COVERAGE

5.A Program Requirement

Authority: Section 330(k)(3)(A) of the PHS Act and 42 CFR Part 51c.102(h)(4)
Documents/Resources to Review: 1) Health center's policies and procedures and/or agreements for after-hours coverage; 2) HRSA/BPHC Health Center Collaboration Program Assistance Letter 2011-02.

Requirements	Questions	Yes/No
Health center provides professional coverage for medical emergencies during hours when the center is closed.	Is professional coverage for medical emergencies available to health center patients after the center's regularly scheduled hours through clearly defined arrangements?	

5.B Performance Improvement

	Prompting Questions for Performance Improvement Discussions	Response
1	What specific mechanisms/arrangements does the health center have for after hours coverage (e.g., does it include the health center clinicians, does it use other community clinicians)?	
2	Do all patients receive a written or verbal explanation regarding the procedures for accessing emergency medical/dental care after hours?	
3	Does the general phone system provide information on how to access emergency care after hours?	
4	Is any written information about accessing care after hours provided in the appropriate languages/literacy levels of the health center's patient population?	
5	Is the answering service and/or provider able to communicate in the appropriate languages to serve the population?	
6	Does the coverage system have established mechanisms for patients needing care to be seen in an appropriate location and assure timely follow-up by health center clinicians for patients seen after-hours?	

SECTION II: Services

Program Requirement 6: HOSPITAL ADMITTING PRIVILEGES AND CONTINUUM OF CARE

6.A Program Requirement

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

Documents/Resources to Review: 1) Hospital Admitting Privileges Agreements/Documentation; 2) Most recent EHB BHCMIS Form 5C: Other Activities/Locations (hospitals where health center providers have admitting privileges should be noted on the form); 3) HRSA/BPHC Health Center Collaboration Program Assistance Letter 2011-02.

Requirements	Questions	Yes/No
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.	Do the health center's physicians admit and follow hospitalized patients?	
	If not, is there a formal, written agreement outlining arrangements for:	
	• Hospitalization?	
	• Discharge planning?	
	• Patient tracking?	

6.B Performance Improvement

		Prompting Questions for Performance Improvement Discussions	Response
1		Do the formal written agreements with the hospital(s) address:	
	a	Compensation for services rendered?	
	b	Admission notification?	
	c	Discharge follow-up?	
	d	Exchange of information?	
2		How is continuum of care ensured for homeless and/or migrant/seasonal farmworker patients?	
3		When health center physicians do not follow patients in the hospital, how is continuity of care ensured?	

SECTION II: Services

Program Requirement 7: SLIDING FEE DISCOUNTS

7.A Program Requirement

Authority: Section 330(k)(3)(G) of the PHS Act, 42 CFR Part 51c.303(f)), and 42 CFR Part 51c.303(u)
Documents/Resources to Review: 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 Sliding Fee Discount Schedule; 4) Sliding fee signage and/or notification methods; 5) Most recent Federal Poverty Guidelines; 6) HRSA/BPHC Scope of Project Policies.

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

	Requirements	Questions	Yes/No
1	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?	
		Does the health center have an established sliding fee discount schedule(s)?	
		Are there signs in the lobby and at the front desk or other mechanisms for communicating the availability of the sliding fee discount schedule for eligible low-income patients?	
2	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's schedule of fees and corresponding sliding fee discount schedule(s) cover the cost of all services (i.e., medical, dental, mental health, etc.) within the approved scope of project?	
		Is the sliding fee discount schedule(s) based on a schedule of fees or payments 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 implementing procedures that support the sliding fee discount schedule program and which assure that it is applied equally to all eligible patients?	
		Is the sliding fee discount schedule based on the most recent Federal Poverty Guidelines?	

Requirements			Questions	Yes/No
3	a	Individuals and families with annual incomes at or below 100% of the Federal poverty guidelines must receive a full discount. (Only nominal fees may be charged.)*	Do individuals and families at or below 100% of the Federal poverty guidelines receive a full discount, other than perhaps nominal fees?	
	b	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 between 100% and 200% of the Federal poverty guidelines charged a fee (partial discount) according to a sliding fee discount schedule(s) based on family size and income?	
	c	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 charged a non-discounted rate?	

7.B Performance Improvement

Additional Documents/Resources to Review: 1) Sliding Fee Application Form/Eligibility Criteria; 2) Self-Declaration Form (if applicable); 3) Payment agreement form (if applicable).

Prompting Questions for Performance Improvement Discussions			Response
1	Are the following items available in languages and/or literacy levels appropriate to the patient population?		
	a	Signs in the lobby and the cashier's desk announcing the availability of discounts?	
	b	Description of the how the sliding fee discount schedule (SFDS) works?	
2	Are all patients evaluated during registration to determine eligibility for insurance and/or related third party coverage and assisted with applying for such coverage, as appropriate, prior to and/or as part of determining their eligibility for the sliding fee discount?		
3	If the health center charges a nominal fee to individuals below 100% of poverty, is the fee reasonable and aligned with program goals?		
4	Is the health center's schedule of fees/payments and corresponding SFDS and any nominal fees, reviewed and updated on an annual or other regular basis as appropriate? Note that at minimum, the SFDS must be revised annually to reflect annual updates to the Federal Poverty Guidelines.		
5	To apply for the SFDS, the patients are required to complete an application form that:		
	a	Requests their name?	
	b	Reflects or requires documentation of family size?	

Prompting Questions for Performance Improvement Discussions			Response
	c	Lists all forms of income as defined in the related board approved SFDS policy(ies)?	
	d	Includes a statement about the consequences of providing false information?	
	e	Requires the patient's signature?	
	f	Requires a staff person's verification and signature?	
	g	If the grantee serves a substantial number of patients with limited English proficiency or low literacy levels, is the SFDS form explained verbally and/or in the appropriate language?	
	h	If the health center serves special populations with unique characteristics and needs (e.g., homeless, migrant/seasonal farmworkers) are eligibility and documentation requirements appropriate for these populations?	
6	For services the health center provides via a formal written referral arrangement where the health center does not pay (i.e., Form 5A, Column III), does the agreement between the health center and the referral provider include conditions which require that the service is available to all health center patients regardless of their ability to pay and offered on a SFDS? Is the health center afforded an opportunity to review the outside provider's sliding fee discount schedule?		
7	Does the center provide medically related supplies or equipment (e.g., dentures, durable medical equipment, etc.) that are directly tied to the provision of a particular health center service, but are not typically included within the service charge, on some type of sliding fee discount schedule?		
8	Does the health center utilize more than two or three separate sliding fee discount schedules (e.g., primary care, dental, behavioral health)? If so, are these multiple SFDSs routinely evaluated to ensure that they do not inadvertently create a barrier to care?		
9	Are billing and collections for amounts owed based on the sliding fee discount schedule, conducted in an efficient, respectful and culturally appropriate manner to assure that administrative procedures do not themselves present a barrier to care, and that patient privacy and confidentiality is protected throughout the process?		

SECTION II: Services

Program Requirement 8: QUALITY IMPROVEMENT / ASSURANCE PLAN

8.A Program Requirement

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/Resources to Review: 1) Quality Improvement /Quality Assurance (QI/QA) plan and related policies and procedures (including Incident Reporting System and Risk Management Policies); 2) Clinical Director's job description; 3) HIPAA-Compliant Patient Confidentiality Policies and Procedures; 4) Clinical Care Policies and Procedures; 5) Clinical Information Tracking Policies and Procedures; 6) HRSA/BPHC Federal Tort Claims Act (FTCA) Health Center Policy Manual (if applicable).

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

		Requirements	Questions	Yes/No
1		Health center has an ongoing Quality Improvement/ Quality Assurance (QI/QA) program that:	Does the health center's QI/QA program:	
	a	Includes clinical services and management.	Address both clinical services and management (inclusive of all services in scope e.g., primary care, dental, behavioral health, etc.)?	
	b	Maintains the confidentiality of patient records.	b.1. Maintain a clinical record for every patient receiving ongoing care at the health center?	
			b.2. Ensure that medical records are properly secured during times when the medical record staff is not present?	
			b.3. Include procedures to enable patients to give consent for release of medical record information?	
			b.4. Include appropriate procedures for signing-out patient records?	
			b.5. Include a follow-up procedure to pursue unreturned medical records?	
	c	Includes a **clinical director** whose focus of responsibility is to support the QI/QA program and the provision of high quality patient care.*	c.1. Have a clinical director? *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.*	

Requirements			Questions	Yes/No
			c.2. Have a clinical director with clear primary responsibility for carrying out the QI/QA program across the health center, including working with other individual(s) or committee(s) as appropriate?	
	d	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.*	Include periodic assessments of the appropriateness of both the utilization and quality of services?	
2	These assessments (see d, above) shall:		Are these assessments (see d., above):	
	a	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?	
	b	Be based on the systematic collection and evaluation of patient records.*	Based on the systematic collection and evaluation of patient records?	
	c	Identify and document the necessity for change in the provision of services by the health center.*	Used to identify and document necessary changes?	
	d	Result in the institution of such change, where indicated.*	Used to inform and change the provision of services if necessary?	

8.B Performance Improvement

*Additional Documents/Resources to Review:*1) Risk Management Policies and Procedures; 2) Incident Report Forms, Reporting, and Tracking; 3) Safety Officer and Safety Committee Descriptions; 4) Medical Record policies and procedures; 5) HRSA/BPHC Quality Improvement/Quality Assurance Program Assistance Letters regarding Accreditation and Patient Centered Medical/Health Home Initiatives; 6) HRSA Quality Improvement Resources; 7) ECRI Institute Clinical Risk Management Program provided on behalf of HRSA (available to health center grantees and free clinics); 8) HHS OIG Quality and Compliance Resources; 9) HRSA Health Center Patient Satisfaction Survey.

Prompting Questions for Performance Improvement Discussions		Response
1	Was the QI/ QA plan reviewed and approved by the Board? When?	

Prompting Questions for Performance Improvement Discussions			Response
2	Is the health center currently accredited or will the health undergo accreditation from a national organization such as the Accreditation Association of Ambulatory Health Care (AAAHC) or the Joint Commission (TJC, formerly known as the Joint Commission on Accreditation of Healthcare Organizations)?		
3	Is the health center participating in the HRSA Patient-Centered Medical/Health Home (PCMHH) Initiative to gain recognition under the medical home program offered in partnership with the National Committee for Quality Assurance (NCQA)?		
4	Are the roles and responsibilities of the following clearly defined in the QI/QA plan?		
	a	The Board	
	b	Management Staff	
	c	Clinical Director	
5	Does the QI/QA plan address all operations areas of the health center, incorporating indicators for:		
	a	Clinical issues?	
	b	Environmental issues?	
	c	Management issues?	
	d	Financial issues?	
	e	Patient experience?	
6	Regarding reports:		
	a	Are the results of QI audits reported to appropriate Board or staff committees, nursing, pharmacy, providers, etc.?	
	b	Is there an effective method to assure information reported is accurate, timely and available in formats to allow board, staff, and other stakeholders to make informed decisions?	
7	When deficiencies are identified:		
	a	Are there follow-up reports to the Board?	
	b	Are Action Plans implemented to correct the deficiencies?	
8	Regarding medical records:		
	a	Is there an individual qualified by training or experience responsible for the supervision and direction of the medical records system?	
	b	Are portable immunization or prenatal records made available to the patients?	

Prompting Questions for Performance Improvement Discussions			Response
	c	Is there a standardized content and organization for medical records?	
	d	Is the medical record system compliant with HIPAA?	
	e	If the health center does not have Electronic Health Records (EHR), is the medical record storage area adequate for the current and future growth needs of physical charts?	
	f	Are the needs of any/all special populations targeted by the health center integrated into the QI/QA program?	
9	Risk Management		
	a	Is there a Safety Committee and / or Safety Officer?	
	b	Is there a written procedure to report/track incidents/potential risks? Does it state who is responsible to track and report?	
	c	Are incidents analyzed, patterns observed and improvements made to reduce future risks?	
	d	Does the center meet the requirements to be deemed eligible for FTCA professional liability coverage?	
	e	Is there any pending litigation under FTCA?	
10	Does the grantee have appropriate insurance coverage in place for the following (either via FTCA or another provider/source):		
	a	General liability?	
	b	Directors and officers liability?	
	c	Malpractice, including any tail or gap coverage?	
	d	Property?	
	e	Business interruption/revenue loss?	
	f	Automobile/ vehicle?	

SECTION III: Management and Finance

Program Requirement 9: KEY MANAGEMENT STAFF

9.A Program Requirement

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/Resources to Review: 1) Health center organizational chart; 2) Key management staff position descriptions and biographical sketches; 3) Key management vacancy announcements (if applicable).

Requirements		Questions	Response
1	Health center maintains a fully staffed health center management team as appropriate for the size and needs of the center. If applicable, prior approval by HRSA of a change in the Project Director/ Executive Director/CEO position is required.	Does the health center have a Chief Executive Officer or Executive Director/Project Director?	
		Is the management team's size and composition appropriate for the size and needs of the health center?	
		Is the team fully staffed, with each of the positions listed above filled as appropriate? ***Note:*** If the grantee has an open position for or pending change in the Project Director position, the PO and/or consultant may wish to remind the grantee that this change will required a "Prior Approval Request" which must be submitted/ processed via the EHB Prior Approval Module and to contact their Project Officer for further information as needed.	

9.B Performance Improvement

Prompting Questions for Performance Improvement Discussions		Response
1	What is the composition of the management team (e.g., does it include a Clinical Director, Chief Financial Officer, Chief Operating Officer and Chief Information Officer or other key management staff)?	
2	Are key management staff directly employed by the health center? If not, what arrangements are in place for these staff?	
3	Are key strategic planning goals tied to the performance evaluations for senior management staff?	
4	What is the Chief Financial Officer's professional background?	

		Prompting Questions for Performance Improvement Discussions	Response
5		Regarding the Clinical or Medical Director/CMO:	
	a	Does he/she advise the CEO and Board on clinical issues, including QI/QA?	
	b	Does he/she have the lead responsibility to hire/dismiss clinical staff?	
	c	Does he/she have sufficient time in his/her weekly schedule to adequately carry out the dual responsibilities of provider and administrator?	
6		Are methods in place to ensure competency in key positions?	
7		If the health center has multiple sites, what systems are in place to manage/coordinate operations among the sites?	
8		Are there opportunities for improved communication, interaction, or support between the Key Management Team and the Governing Board?	

SECTION III: Management and Finance

Program Requirement 10: CONTRACTUAL / AFFILIATION AGREEMENTS

10.A Program Requirement

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

Documents/Resources to Review: 1) Contracts for core providers, including key management staff if applicable (e.g., CMO, CIO, CFO); 2) Contracts or MOAs/MOUs for other substantial portion(s) of the project; 3) Subrecipient Agreement(s) if applicable; 4) Any other key affiliation agreements if applicable; 5) Procurement policies and procedures; 6) HRSA/BPHC Affiliation Agreement Policy Information Notices (PINs 97-27 and 98-24); 7) Federal procurement grant regulations (45 CFR Part 74.41-74.48)) applicable to all contractual arrangements in scope.

	Requirements	Questions	Yes/No
1	Health center exercises appropriate oversight and authority over all contracted services.	Do any of the grantee's contracts or affiliation agreements have the potential to:	
		a. Threaten the grantee's integrity?	
		b. Limit its autonomy?	

	Requirements	Questions	Yes/No
		c. Compromise its compliance with Federal program requirements in terms of corporate structure, governance, management, finance, health services, and/or clinical operations?	
2	Health center assures that any subrecipient(s) meets the Health Center Program requirements ***Applies <u>only</u> to grantees s with subrecipients***	**For grantees with subrecipient arrangements ONLY:** Does the grantee have assurances in place that the subrecipient organization complies with all Health Center Program statutory and regulatory requirements?	

10.B Performance Improvement

Additional Documents/Resources to Review: HRSA/BPHC Health Center Collaboration Program Assistance Letter 2011-02.

		Prompting Questions for Performance Improvement Discussions	Response
1	Do the health center's contractual arrangements:		
	a	Contain appropriate provisions around the activities to be performed, time schedules, the policies and procedures to be followed in carrying out the agreement, and the maximum amount of money for which the grantee may become liable to the contractor under the agreement?	
	b	Require the contractor to maintain appropriate financial, program and property management systems and records and provide the health center, HHS and the U.S. Comptroller General with access to such records?	
	c	Require the submission of financial and programmatic reports to the health center?	
	d	Comply with any other applicable Federal procurement standards set forth in 45CFR Part 74 (including conflict of interest standards)?	
	e	Include a provision that such contract is subject to termination (with administrative, contractual, and legal remedies) in the event of breach by the contractor?	
2	Does the Governing Board review, and if necessary approve all new affiliations so as to maintain appropriate oversight over all sites and services within the federally approved scope of project?		
3	Is the health center able to address any specific legal or fiscal concerns related to new or renewed affiliation agreements, including contracts, with their own legal counsel and/or auditor?		

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SECTION III: Management and Finance

Program Requirement 11: COLLABORATIVE RELATIONSHIPS

11.A Program Requirement

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

Documents/Resources to Review: 1) Letters of Support; 2) Memoranda of Agreement/Understanding; 3) HRSA/BPHC Health Center Collaboration Program Assistance Letter 2011-02.

	Requirements	Questions	Yes/No
1	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 with other health care providers in its service area, in particular other health centers?	
2	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.	If there is another health center in the health center's service area, was the grantee able to secure letter(s) of support from the health center(s) for its most recent Service Area Competition or other competitive grant application?	
		If the health center was unable to get letter(s) of support from the other health center(s) in the service area, did it explain why and is it working to improve or implement collaborative relationships with these health centers?	

11.B Performance Improvement

Additional Documents/Resources to Review: 1) UDS Mapper tool, available online (requires login) at http://www.udsmapper.org; 2) HRSA/BPHC Health Center Emergency Management Program Expectations PIN 2007-15.

		Prompting Questions for Performance Improvement Discussions	Response
1		How could the grantee strengthen its working relationships with area:	
	a	Other nearby health centers (Section 330 supported, FQHC Look-Alike, Free Clinics, etc.)?	
	b	Public health departments/entities?	
	c	Private providers?	

Prompting Questions for Performance Improvement Discussions			Response
	d	Rural Health Clinics?	
	e	Hospitals?	
	f	Other community stakeholders, including social service providers?	
2	If the grantee was unable to secure a letter of support from the existing FQHC(s) in the service area, what steps could the grantee take to improve this relationship?		
3	Does the grantee have any collaborative relationships that support its emergency preparedness and management plan/activities?		

SECTION III: Management and Finance

Program Requirement 12: FINANCIAL MANAGEMENT AND CONTROL POLICIES

12.A Program Requirement

Authority: Section 330(k)(3)(D), Section 330(q) of the PHS Act and 45 CFR Parts 74.14, 74.21 and 74.26
Documents/Resources to Review: 1) Most recent independent financial audit and management letter, including Audit Corrective Action plans based on prior year audit findings, if applicable; 2) For Newly Funded Grantees: Most recent monthly financial statements if a first audit has not been completed; 3) Financial Management/Accounting and Internal Control Policies and Procedures; 4) Office of Management and Budget Circular A-133 Office of Management and Budget Circular A-133.

Requirements			Questions	Yes/No
1	Health center maintains accounting and internal control systems that:		Are the grantee's accounting and internal control systems:	
	a	Are appropriate to the size and complexity of the organization.	Appropriate to the organization's size and complexity?	
	b	Reflect Generally Accepted Accounting Principles (GAAP).	Reflective of GAAP?	
	c	Separate functions in a manner appropriate to the organization's size in order to safeguard	Designed to separate functions in a manner appropriate to the organization's size in order to safeguard assets?	

Requirements			Questions	Yes/No
		assets and maintain financial stability.	Designed to separate functions in a manner appropriate to the organization's size in order to maintain financial stability?	
2	Health center assures that:			
	a	An annual independent financial audit is performed in accordance with Federal audit requirements. *Note: A complete audit includes:1) Auditor's Report; 2) A-133 Compliance Supplement; and 3) Reports to Board/Management letters issued by the auditor.*	Is an audit performed annually, in accordance with Federal requirements, including the A-133 Compliance Supplement?	
	b	A corrective action plan addressing all findings, questioned costs, reportable conditions, and material weaknesses cited in the Audit Report is submitted.	*If Applicable:* Did the grantee's corrective action plan address all findings, questioned costs, reportable conditions, and material weaknesses found in the Audit Report?	
			Does the Board review the grantee's corrective actions regularly?	

12.B Performance Improvement

Additional Documents/Resources to Review: 1) Chart of Accounts; 2) Encounter Report; 3) Provider Productivity Report; 4) Balance Sheet; 5) Income Statement; 6) Most recent Health Center Required Financial Performance Measures/UDS Report (see Appendix C for further detail); 7) Most recent Income Analysis (Form 3); 8) Corporate compliance plan (if applicable); 9) HRSA/BPHC Financial Recovery Plan Policy Information Notice 2002-18.

Prompting Questions for Performance Improvement Discussions			Response
1	Is there a monthly cash budget for the health center with monthly projections for at least 12 months?		
2	Are monthly financial statements prepared for review by the Finance Committee and Board?		
3	Do the statements include a(n):		
	a	Comparative balance sheet?	
	b	Income statement showing variances from budget?	
	c	Report on encounter activity compared to budget by payor type?	
	d	Report on monthly provider productivity	
	e	Comparative report on the status of receivables (either an aging summary or a report of days of income in receivables or both?)	
4	Do the last three monthly financial statements reveal:		
	a	Adequate cash on hand/working capital?	
	b	A reasonable level of accounts receivable?	

Prompting Questions for Performance Improvement Discussions			Response
	c	A reasonable level of accounts payable?	
5	Are expenses appropriately allocated to:		
	a	Cost centers?	
	b	Multiple funding sources?	
	c	Multiple sites?	
6	Regarding disbursements:		
	a	Does the health center have written purchasing and cash disbursements policies?	
	b	Is there a reasonable separation of disbursement duties?	
	c	In some manner, is every disbursement reviewed and approved by two people?	
	d	Is this two-person review and approval documented?	
7	Regarding the chart of accounts:		
	a	Is it adequate to yield good financial statements?	
	b	Does it provide adequate income data by major payer with discount and allowance information and expense information at an acceptable object level?	
8	Are the accounting procedures adequate to result in financial statements that reflect the financial results from operations, including:		
	a	Accounting for patient services revenues and accounts receivable?	
	b	Preparing monthly estimates for:	
		• Contractual allowances?	
		• Allowances for doubtful accounts?	
		• Grants and contracts receivable?	
		• Wrap around settlements for Medicaid Managed Care?	
		• Settlements and other receivables?	
		• Prepaid expenses?	
	c	Capturing:	
		• Accounts payable?	
		• Accrued payroll?	
		• Uncompensated absences?	
		• Deferred and unearned revenue?	
		• Depreciation expense?	
		• Bad debt write-off?	
9	Does the health center know the expected breakeven point for operations in terms of patient volume and mix to ensure viable fiscal operations?		

Prompting Questions for Performance Improvement Discussions			Response
10	Does the health center update its operational plan in the event actual experience is not meeting projections, i.e., number of patients to be seen in the calendar year, total revenues, productivity goals/number of encounters by type (medical, dental, mental health), and other elements from the UDS report?		
11	Regarding Managed Care Contracts:		
	a	Are all health center providers approved providers? If not, why not?	
	b	Is health center staff aware of all managed care contracts in place and the degree of financial risk associated with each?	
	c	Does the health center's practice management system enable it to manage the risks/ rewards?	
	d	Are there clear requirements for prior authorization and utilization of specific panel specialists?	
	e	Are written policies and procedures in place that describe the utilization review process and management of this data?	
	f	Who is responsible for keeping up with and monitoring the managed care contracts and review of data reported?	
	g	Is the health center and/or its providers listed in the enrollment documents/website for all of the Managed Care Organizations with which it is participating?	
12	For each of the following payor groups: Medicaid, Medicare, CHIP, Self-Pay, and Private Insurance:		
	a	What is the projected penetration rate on an annual basis?	
	b	What is the projected penetration rate on a monthly basis?	
	c	What has been the actual monthly penetration rate experience to date?	
13	Does the health center record gross charges in the patient registration system and appropriate adjustments based on allowances for payor types in order to report the correct patient accounts receivable by payor source?		
14	Does the health center have access to a line of credit to assure availability of operating cash?		
15	Regarding the annual audit:		
	a	How is the auditor selected? Is an RFP issued?	
	b	What is the role of the Board in selecting an auditor?	
	c	Does the Board review and approve the annual audit?	
16	Are full fee for service charges recorded for every encounter regardless of payer source (including for capitated services) and appropriate allowances being recorded in offsetting accounts?		
17	Regarding signatory policies:		
	a	Who are the authorized signers?	
	b	Who primarily signs checks?	
	c	Is more than one signature required to clear financial transactions?	

		Prompting Questions for Performance Improvement Discussions	Response
	d	Is there a dollar threshold established for requiring more than one signature? What is it?	
	e	Do policies prohibit signing checks made payable to self?	
18		Regarding efficiency and provider productivity: *Note: HRSA/BPHC does not enforce specific productivity guidelines (e.g., 4200/2100) so as not to promote 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 (see Appendix C) to evaluate efficiency, consistent with the medical home model.*	
	a	Is efficiency and/or provider productivity tracked and reported on a regular basis?	
	b	Does the Medical/Clinical Director receive productivity report data and discuss the data with the CEO, CFO, and individual providers?	
	c	Is the provider productivity adequate per the:	
		• Any benchmarks established by the health center itself?	
		• Health center's projected revenue?	
		• National Medicare/Medicaid benchmarks?	
	d	Do provider contracts reflect any expected efficiency/productivity expectations?	
	e	Is compliance with the Fair Labor Standards Act as amended, applicable?	

SECTION III: Management and Finance

Program Requirement 13: BILLING AND COLLECTIONS

13.A Program Requirement

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

Documents/Resources to Review: 1) Policies and procedures for credit, collection, and billing; 2) Encounter form; 3) Most recent income analysis (Form 3); 4) HRSA/BPHC Program Assistance Letter 2011-04: Process for Becoming Eligible for Medicare Reimbursement under the FQHC Benefit.

			Requirements	Questions	Yes/No
1	Health center has systems in place to maximize collections and reimbursement for its costs in providing health services.			Does the grantee participate in or to make every reasonable effort to participate in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), and any other public assistance programs that are available to its patients?	
				Does the grantee have Medicare and Medicaid provider numbers?	
				Does the grantee make every reasonable effort to collect reimbursement for services provided to persons covered by private health insurance?	
				Does the grantee 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?	
2	These systems include written policies and procedures addressing:			Does the grantee have written policies and procedures for:	
	a	Billing		Billing?	
	b	Credit		Credit?	
	c	Collections		Collections?	

13.B Performance Improvement

Additional Documents/Resources to Review: 1) Most recent Health Center Required Financial Performance Measures/UDS Report (see Appendix C for further detail); 2) Centers for Medicare and Medicaid Services (CMS) FQHC Resource Information.

		Prompting Questions for Performance Improvement Discussions	Response
1	Encounter Form		
	a	Does the health center have an encounter form?	
	b	Does the encounter form include all billable services (on-site and off-site)?	
	c	Does the encounter form reflect the scope of practice of each provider?	
	d	Do the ICD and CPT Codes reflect the most current updates?	
	e	Do the ICD and CPT Codes meet State billing coding requirements?	
	f	Are all encounters recorded in the MIS within 24 hours of service? If not, what is the lag time?	
	g	Is a procedure in place to identify and find missing encounter forms on a timely basis?	
	h	Are off-site encounters reported and billed on a timely basis?	
	i	How does the grantee know if all off-site activity is being reported?	
2	Medicaid and Medicare		

Prompting Questions for Performance Improvement Discussions			Response
	a	Are all sites that are considered either "permanent" or "seasonal" under the grantee's scope of project enrolled individually in Medicare with their own CMS certification number (CCN)?	
	b	Are Medicare and Medicaid billed electronically?	
	c	If not, how does the grantee address systems problems that arise?	
	d	Have the interim PPS rates been set? If yes:	
		• What is the interim PPS rate for Medicare?	
		• What is the interim PPS rate for Medicaid	
		• Do these rates appear reasonable?	
	e	Are Medicare and Medicaid and other material third party payers billed at least weekly?	
	f	What is the billing procedure?	
3	Other Third-Party Billing		
	a	Are "cross over" patients billed to the secondary payer within a week of payment by the primary payer? If not, what is the lag time?	
	b	If a third party billing is not responded to in 30 days, are effective follow-up procedures done?	
4	Self-Pay		
	a	Is payment at the time of service encouraged?	
	b	If patients cannot pay at time of service, are there policies and procedures in place to address this (e.g., grace periods, payments plans, etc.)?	
	c	If self-pay billings are not paid in 30 days, what is done?	
	d	What is done with accounts that are 90 days delinquent?	
	e	If the health center enters into a contract with an outside organization to carry out particular health center policies and procedures related to billing and collections, is the health center able to ensure that program requirements continue to be met (e.g., health center can maintain sufficient control and oversight over the contracted services, including monitoring their impact on the patients/community, and amending the contract, as needed, etc.)	
5	Accounts Receivable		
	a	How many days of net revenue are tied up in accounts receivable?	
	b	Are the indicators acceptable or are receivable collections lagging?	
	c	Are rejected claims corrected and resubmitted within a week? If not, what is the lag time?	

SECTION III: Management and Finance

Program Requirement 14: BUDGET

14.A Program Requirement

Authority: Section 330(k)(3)(D), Section 330(k)(3)(I)(i), and 45 CFR Part 74.25

Documents/Resources to Review: 1) Annual Budget; 2) Operating Plan; 3) Most recent Health Center Required Financial Performance Measures/UDS Report (see Appendix C for further detail).

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 grantee maintain an annual budget and related operating/ business plan?	
	Has the annual budget and related operating/ business plan been approved by the Board? If so, when?	
	How often does the Board review variance from the operating plan/ budget to ensure it continues to reflect the costs necessary to accomplish the service delivery plan?	

14.B Performance Improvement

Additional Documents/Resources to Review: 1) Capital Plan (if applicable).

	Prompting Questions for Performance Improvement Discussions	Response
1	Does the grantee have a capital plan?	
2	Has the capital plan been approved by the Board? If so, when?	
3	Does the annual budget appear reasonable and appropriate in terms of accomplishing the service delivery plan, in particular the project number of patients to be served?	

SECTION III: Management and Finance

Program Requirement 15: PROGRAM DATA REPORTING SYSTEMS

15.A Program Requirement

Authority: Section 330(k)(3)(I)(ii) of the PHS Act
Documents/Resources to Review: 1) Most recent UDS report and UDS Health Center Trend Report; 2) Most recent Clinical and Financial Performance Measures Forms (see Appendix C for further detail); 3) Strategic Plan; 4) Annual Operating Plan; 5) HRSA/BPHC UDS Reporting Information; 6) HRSA Federal Financial Report Information (FFR) Resources.

	Requirements	Questions	Response
Health center has systems in place which:			
a	Accurately collect and organize data for program reporting.	Does the grantee have appropriate systems and capacity in place for collecting and organizing the data required for UDS and FFR reporting?	
		(If applicable) Has grantee submitted UDS by deadline?	
		Does the grantee have appropriate systems and capacity in place for collecting and organizing the performance data required in the Clinical and Financial Performance Measures Forms (submitted with the annual renewal applications)?	
b	Support management decision making.	Is information from the grantee's data reporting and needs assessments used to inform and support management decision making?	
		Does grantee have a long-term (3 year) strategic plan?	
		Has the strategic plan been approved by the Board? If so, when?	

15.B Performance Improvement

Additional Documents/Resources to Review: 1) Appendix C of Site Visit Guide; 2) Quality Improvement/Quality Assurance Plan; 3) HRSA Health Information Technology Resources.

Prompting Questions for Performance Improvement Discussions				Response
1	In reviewing the health center's Clinical Performance Measures, identify **one to two required clinical measures** *(see Appendix C for the complete list of required measures)* to focus on during the site visit. The following criteria are suggested to assist in selecting the most appropriate measures: • *Will the health center be in jeopardy if the current and projected trend of the performance measure does not change?* • *Which measure(s) impacts the largest number of patients?* • *Is there significant room for improvement? For example, is there a significant gap between the grantee's goal and their current performance? Or is there a significant gap between the grantees performance and the performance of other health centers with similar client populations and resources (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*	**For the 1 to 2 Clinical Performance Measures selected for review, please address the following:**		
		a	What were the reasons for selecting the measure(s)?	
		b	How is the health center doing (i.e., trend) with respect to the performance measure(s)? ***If appropriate, consultants are encouraged to present trend data in graph or chart formats.***	
		c	Are there any factors (internal, external, etc.) contributing to and/or restricting the grantee's performance on these measure(s)?	
		d	What has the health center done or proposed to do to improve performance on the measure(s) (if appropriate) and are these steps/actions feasible?	
		e	What additional steps/actions are recommended for the grantee to address any restricting factors and to improve performance on the measure(s)?	

	Prompting Questions for Performance Improvement Discussions			Response
	intervention is necessary to turn the direction of the performance trend? • *Is the grantee committed to developing and implementing an action plan to improve performance on the selected measure?*	f	What role and/or technical assistance could BPHC or other partners provide to assist the grantee in improving performance on the measure(s), if applicable?	
2	In reviewing the health center's Financial Performance Measures, identify **one to two required financial measures** *(see Appendix C for the complete list of required measures)* to focus on during the site visit. The following criteria are suggested to assist in selecting the most appropriate measures: • *Will the health center be in jeopardy if the current and projected trend of the performance measure does not change?* • *Which measure(s) impacts the largest number of patients?* • *Is there significant room for improvement? For example, is there a significant gap between the grantee's goal and their current performance? Or is there a significant gap between the grantees performance and the performance of other health centers with similar client populations and resources (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*	**For the 1 to 2 Financial Performance Measures selected for review, please address the following:**		
		a	What were the reasons for selecting the measure(s)?	
		b	How is the health center doing (i.e., trend) with respect to the performance measure(s)? ***If appropriate, consultants are encouraged to present trend data in graph or chart formats.***	
		c	Are there any factors (internal, external, etc.) contributing to and/or restricting the grantee's performance on these measure(s)?	
		d	What has the health center done or proposed to do to improve performance on the measure(s) (if appropriate) and are these steps/actions feasible?	
		e	What additional steps/actions are recommended for the grantee to address any restricting factors and to improve performance on the measure(s)?	

Prompting Questions for Performance Improvement Discussions					Response
		intervention is necessary to turn the direction of the performance trend? • *Is the grantee committed to developing and implementing an action plan to improve performance on the selected measure?*	f	What role and/or technical assistance could BPHC or other partners provide to assist the grantee in improving performance on the measure(s), if applicable?	
3	Regarding the Clinical and/or Financial Performance Measures:				
	a	How often does the clinical staff review the Clinical Performance Measures?			
	b	How often does the management/financial staff review the Financial Performance Measures?			
	c	How often does the Board review the Clinical And Financial Performance Measures?			
	d	Does the management information system supply data required for developing and monitoring the Clinical and Financial Performance Measures?			
	e	Are the measures monitored and integrated into the QI/QA/Management program? How?			
4	At what stage is the grantee in the strategic planning process (i.e., long term strategic plan, short term strategic plan, operating/business plan, capital plan)?				
All of the following questions address the Practice Management Information System (PM) or other Health Information Technology (HIT):					
5	General Capacities:				
	a	Does the health center operate its own PM/HIT or collaborate with another organization on PM/HIT?			
	b	Does the PM/HIT have a Health Center/ FQHC module?			
	c	Have all modules purchased for the PM/HIT been activated?			
	d	Indicate if the following PM/HIT applications are operated by the center (C), by another entity (E), or not automated (N):			
		• Billing			
		• Capitation management			
		• General ledger			
		• Registration			
		• Scheduling			
		• Patient tracking			

Prompting Questions for Performance Improvement Discussions			Response
		• Referral tracking	
		• Records	
		• Pharmacy	
		• Word processing	
		• E-mail	
		• Internet access	
		• Spreadsheet	
6	Support and Maintenance		
	a	Does the Center have a contract with a software vendor for patient registration to support the maintenance and other support needs?	
	b	If not, how does the grantee address systems problems that arise?	
7	Policies: Are there documented PM/HIT policies and procedures that address:		
	a	Data collection	
	b	Organization	
	c	Storage	
	d	Maintenance	
	e	Security	
	f	Presentation	
	g	External access	
	h	Transfer of information	
	i	Technology and deployment?	
8	Back-up		
	a	Are there appropriate data backup procedures?	
	b	Is backup data stored off-site?	
	c	What is the frequency of transfer off site?	
9	Reports		
	a	Are there reports available to meet the needs of:	

		Prompting Questions for Performance Improvement Discussions	Response
		• Management staff	
		• The Board	
		• Billing staff	
		• Clinical staff	
	b	Is the grantee familiar with UDS reporting requirements?	
	c	Is the PM/HIT able to generate the data needed to meet UDS reporting requirements?	
	d	Is there a specific method to ensure that the UDS data is accurate?	
	e	Is the grantee familiar with FFR reporting requirements?	
	f	Is the PM able to generate the data needed to meet FFR reporting requirements?	
	g	Is there a specific method to ensure that the FFR data is accurate?	
10	Future Needs		
	a	Is there a system in place for assessing future HIT needs?	
	b	If the grantee has an Electronic Health Record (EHR) in place, is it working towards meeting national Meaningful Use standards?	
	c	If the grantee does not have an Electronic Health Record (EHR), does it plan to obtain one?	

SECTION III: Management and Finance

Program Requirement 16: SCOPE OF PROJECT

16.A Program Requirement

Authority: 45 CFR Part 74.25

Documents/Resources to Review: 1) Most recent Health Center UDS Trend Report; 2) Form 1A from most recent section 330 grant application (to review patient projections); 3) Health center's official scope of project (EHB BHCMIS Forms 5A, 5B and 5C); 4) Form 2 Staffing Profile from most recent section 330 grant application; 5) HRSA/BPHC Scope of Project Policies.

<table>
<tr><th>Requirement</th><th>Questions</th><th>Response</th></tr>
<tr><td rowspan="6">Health center maintains its funded scope of project (sites, services, service area, target population and providers), including any increases based on recent grant awards.</td><td>Has the grantee experienced any significant decreases in their funded scope of project in terms of:</td><td></td></tr>
<tr><td>Number of overall patients served?</td><td></td></tr>
<tr><td>Number of special populations (for which the grantee receives targeted funding) patients served?</td><td></td></tr>
<tr><td>Providers and/or services available (e.g., loss of providers and/or required or additional services)?</td><td></td></tr>
<tr><td>Sites (e.g., closures)?</td><td></td></tr>
<tr><td>Has the grantee received any additional BPHC grant awards in the last 5 years (e.g., New Access Point, Service Expansion, Expanded Medical Capacity, etc.)? If yes, have they successfully implemented the newly-funded activity (i.e., reached the projected patient or encounter levels, expanded services, opened new sites, added an EHR, etc.)?

NOTE: See Appendix D for additional requirements for reviewing ARRA and/or ACA-funded activities which may impact scope of project.</td><td></td></tr>
</table>

16.B Performance Improvement

Additional Documents/Resources to Review: 1) HRSA/BPHC Service Area Overlap Policy Information Notice 2007-09; 2) UDS Mapper tool, available online (requires login) at http://www.udsmapper.org.

<table>
<tr><th colspan="3">Prompting Questions for Performance Improvement Discussions</th><th>Response</th></tr>
<tr><td rowspan="7">1</td><td colspan="2">Based on the purpose/scope of the grant award received (NAP, SAC, other competitive awards, as applicable) are there market conditions that were not reflected in the grantee's application plans that have or may affect or impede goals for:</td><td></td></tr>
<tr><td>a</td><td>Growth in the number of patients?</td><td></td></tr>
<tr><td>b</td><td>Growth in the number of patient visits?</td><td></td></tr>
<tr><td>c</td><td>Addition of new service(s)?</td><td></td></tr>
<tr><td>d</td><td>Addition of new provider(s)?</td><td></td></tr>
<tr><td>e</td><td>Addition of new site(s)?</td><td></td></tr>
<tr><td>f</td><td>Other expansions / improvements (e.g., EHR implementation, construction, etc.)?</td><td></td></tr>
<tr><td>2</td><td colspan="2">Regarding current capacity:</td><td></td></tr>
</table>

		Prompting Questions for Performance Improvement Discussions	Response
	a	What is the capacity of the facility for medical and dental services?	
	b	Based on the center's market plan, when will the facility be at full capacity?	
	c	Are plans in place to expand the facility to meet the center's market projections?	
3		Regarding any planned expansions in terms of service area and/or sites:	
	a	If/what are the planned expansion areas?	
	b	Have the following been included in the planning phase:	
		• Staffing needs, including when to bring on appropriate management staff; i.e., Medical Director, CFO, billing, and collection staff?	
		• Establishing Medicaid and Medicare numbers to bill and collect?	
		• Funding sources to support the planned expansion?	
		• Purchasing and/or implementing a patient registration and billing system?	
		• Analysis of any service area overlap concerns?	
	c	**Newly Funded Grantees Only:** What things are left to be done that the grantee thinks are necessary to promote an effective Newly Funded Health Center operation?	
	d	**Recent New Access Point Grantees (Newly Funded Grantees or Satellite Awards to Existing Grantees) Only:** For new sites, is the physical site/facility occupied or are plans in place to ensure the facility can be up and running as needed and required in a timely manner?	
4		Out-of-Scope Activities/Other Lines of Business	
	a	Is the center involved in any out-of-scope activity(ies) (e.g., renting space to another organization, providing services not included in section 330 scope of service)?	
	b	If yes, does the center have liability coverage separate from FTCA for this out of scope activity/service/site?	
	c	If yes, is the revenue generated from any out of scope/other lines of business activities sufficient to support direct costs of the activity(ies) plus a reasonable share of overhead to ensure that section 330 funds and other grant-related income are not used inappropriately to support costs outside the approved scope of project?	

SECTION IV: Governance

Program Requirement 17: BOARD AUTHORITY

17. A Program Requirement

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

Documents/Resources to Review: 1) Corporate/Board Bylaws; 2) Minutes of Recent Board Meetings; 3) Governance Policies and Procedures; 4) Board Annual Meeting Schedule; 5) If Applicable: Form 6B: Waiver of Governance Requirements from most recent SAC or Newly Funded NAP application for eligible grantees; 6) Co-Applicant Agreement (for public center grantees).

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

	Requirements	Questions	Yes/No
Health center governing board maintains appropriate authority to oversee the operations of the center, including:			
a	Holding monthly meetings **Note:** Upon a showing of good cause the Secretary may waive, for the length of the project period, the monthly meeting requirement in the case of a health center that receives a grant pursuant to subsection (g), (h), (i), or (p). (section 330(k)(3)(H) of the PHS Act)	Does the board meet monthly? [†]**Answer "Waiver" if the grantee has a waiver for this requirement and respond to question for grantees with waivers below.**	
		Does the health center maintain minutes of the Board meetings?	
		Do the minutes appropriately document major issues/actions for the health center?	
		Health Centers with Approved Waivers ONLY: Are appropriate strategies being implemented to ensure regular oversight, if the Board does not meet monthly?	
b	Approval of the health center grant application and budget;	Does the Board review and approve the annual health center (renewal) application and budget?	
		Is this review and approval documented in the Board minutes?	
c	Selection/dismissal and performance evaluation of the health center CEO;	Does the Board conduct an annual review of the CEO's performance, with clear authority to select a new CEO and/or dismiss the current CEO if needed?	

[†] Waivers may only be requested by applicants requesting/receiving targeted funding ***solely*** to serve migrant and seasonal farmworkers (section 330(g)), people experiencing homelessness (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. **These grantees are still required to fulfill all other statutory Board responsibilities and requirements.**

Requirements		Questions	Yes/No
		Is this review documented in the Board minutes?	
d	Selection of services to be provided and the health center hours of operations;	Does the Board review and approve the services (both Required and Additional), as well as the location and mode of delivery of those services in the approved scope of project?	
		Does the Board review and approve the hours during which services are provided at health center sites, ensuring that these are appropriate and responsive to the community's needs?	
		Is this review and approval documented in the Board minutes?	
e	Measuring and evaluating the organization's progress in meeting its annual and long-term programmatic and financial goals and developing plans for the long-range viability of the organization by engaging in strategic planning, ongoing review of the organization's mission and bylaws, evaluating patient satisfaction, and monitoring organizational assets and performance;* and	Does the Board measure and evaluate the health center's progress in meeting annual and long term clinical and financial goals?	
		Does the Board engage in strategic and/or long term planning for the health center?	
		Does the Board review the health center's mission and bylaws as necessary on a periodic basis?	
		Does the Board receive appropriate information that enables it to evaluate health center patient satisfaction, organizational assets, and performance?	
		Are these activities documented in the Board minutes?	

	Requirements	Questions	Yes/No
f	Establishment of general policies for the health center. **Note:** In the case of public center grantees (also referred to as public entities or public agencies, e.g., State, county, or local health departments) 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 (section 330(k)(3)(H) of the PHS Act and 42 CFR 51c.304(d)(iii) and (iv)).	Does the Board establish general policies and procedures for the health center that are consistent with program and grants management requirements? Examples of specific health center policies and procedures that should 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, fee schedules for services, criteria for sliding fee discounts, financial policies that assure accountability for health center resources, and avoidance of conflict of interest. ✦***With the exception of fiscal and personnel policies in the case of public agency grantees.***	
		Do the health center bylaws specify the following: • 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. • 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 dissolution of the grantee corporation if necessary.	
		For Public Agency Grantees with Co-Applicant Arrangements ONLY: Does the public agency grantee have a formal agreement with the co-applicant board that stipulates:	

✦ In a co-applicant arrangement, the public agency (the grantee of record –e.g., the city health department) is permitted to retain responsibility for establishing general policies (fiscal and personnel policies) when constrained by State law in the delegation of certain government functions to private entities. The co-applicant structure, therefore, creates an arrangement that still adheres to the statutory intent of section 330 (allowing the majority of the health center's policy setting authorities to be carried out, to the greatest extent possible, by the patient/community-based (co-applicant) health center governing board) while satisfying local or State law pertaining to the public center. Thus, no justification is required for arrangements in which the public agency retains authority for the establishment of fiscal and personnel policies.

Requirements		Questions	Yes/No
		Roles, responsibilities, and the delegation of authorities of each party in the oversight and management of the public health center?	
		Any shared roles and responsibilities of each party in carrying out the governance functions?	

17.B Performance Improvement

Additional Documents/Resources to Review: 1) Sample of Board packets from recent meetings; 2) Annual Board orientation and training schedule; 3) List of Board Committees; 4) Meeting Schedule for Board Committees; 5) Board Recruitment plan; 6) Corporate Compliance Policies and Procedures (Compliance Officer, Compliance Committee); 7) HHS OIG Corporate Compliance Resources; 8) HRSA/BPHC Affiliation Agreement Policy Information Notices (PINs 97-27 and 98-24).

Prompting Questions for Performance Improvement Discussions			Response
1	Monthly Board Packets		
	a	Are monthly packets sent to Board members in advance of the meeting?	
	b	Do the packets include reports and recommended actions from Board committees?	
2	Is there a standard format for agendas and minutes for Board meetings?		
3	Do the bylaws specify expectations regarding meeting attendance and related policies for removal of inactive board members?		
4	When were the bylaws last reviewed and approved by the Board?		
5	Corporate Compliance: Has the Board:		
	a	Approved a corporate compliance plan?	
	b	Established a compliance committee?	
	c	Appointed a corporate compliance officer?	
6	Which Senior Management staff attends the Board meetings?		
7	Does the Board:		
	a	Implement a self-evaluation process? If yes, how frequently?	
	b	Review and approve the annual audit? (This question is also listed under 12B, Financial Management and Control Policies)	
	c	Is there an Annual Work Plan/Operational Plan reviewed by the board that is linked to the approved Strategic Plan and/or Clinical and Financial Performance Measures?	
8	Regarding the CEO/Project Director, does the Board:		
	a	Have a CEO/Project Director Recruitment and Retention Plan?	
	b	Have a Succession Plan in the event of a CEO/Project Director vacancy?	

Prompting Questions for Performance Improvement Discussions			Response
	c	Annually review staff compensation levels (i.e., salary, fringe benefits and incentives, as applicable), including those of the CEO/Project Director and other key staff, in the context of the grantee organization's size, complexity, location, and/or other factors?	
	d	Maintain documentation on how it established and approved salary levels and/or total compensation packages, in particular for the CEO/Project Director?	
9	Does the health center have any parent-subsidiary arrangements, in particular, when health centers exist as a subsidiary of another entity? If yes, what are its powers (e.g., appointment to the Board)? Note that the "parent" entity may not reserve or withhold powers that the health center governing board must exercise under the relevant statute and implementing regulations, as noted in sections 17.A and 18.A.		
10	**For Public Center Grantees with Co-Applicant Arrangements ONLY:**		
	a	Are there any performance improvement issues in terms of the implementation of shared roles and responsibilities (articulated in the co-applicant agreement) between the public center and co-applicant governing board?	
	b	If there is a high level of shared responsibility between the public agency and the co-applicant governing board in the operation of the public center and does the co-applicant agreement include provisions for dispute resolution?	

SECTION IV: Governance

Program Requirement 18: BOARD COMPOSITION

18.A Program Requirement

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

Documents/Resources to Review: 1) Composition of Board of Directors/Form 6A: Board Composition from most recent Continuation (SAC or BPR) or Newly Funded NAP application; 2) Corporate Bylaws; 3) Board member application and disclosure forms; 4) ***If Applicable:*** Form 6B: Waiver of Governance Requirements from most recent SAC or Newly Funded NAP application.

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

<table>
<tr><th colspan="2">Requirements</th><th>Questions</th><th>Yes/No</th></tr>
<tr><td colspan="3">The health center's governing board meets the following requirements:</td><td></td></tr>
<tr><td rowspan="2">a</td><td rowspan="2">A majority of the board members are individuals ("consumers" or "patients"; also previously known as "users") served by the organization.</td><td>Do a majority (at least 51%) of the Board members receive services (i.e., are registered patients) at the health center?
[†]Answer "Waiver" if the grantee has a waiver for this requirement and respond to question for grantees with waivers below.</td><td></td></tr>
<tr><td>Health Centers with Approved Waivers ONLY: Are appropriate alternative strategies being implemented to ensure consumer/patient participation and input (given board is not 51% consumers/ patients) in the direction and ongoing governance of the organization?</td><td></td></tr>
<tr><td>b</td><td>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.</td><td>As a group, do the "patient/consumer" Board members reasonably represent the individuals who are served by the health center in terms of race, ethnicity, and sex?
Answer "Waiver" if the grantee has a waiver for this requirement and respond to question for grantees with waivers above.</td><td></td></tr>
</table>

[†] Waivers may only be requested by applicants/grantees requesting/receiving targeted funding ***solely*** to serve migrant and seasonal farmworkers (section 330(g)), people experiencing homelessness (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. **These grantees are still required to fulfill all other statutory Board responsibilities and requirements.**

	Requirements	Questions	Yes/No
		The following question applies ONLY to grantees that receive targeted funding to serve migratory and seasonal farmworkers, individuals experiencing homelessness, and/or residents of public housing (sections 330(g), (h), and/or (i) respectively). At a minimum, there must be at least one board member that is representative of or for each of the special populations for which the health center receives section 330 funding. Does the Board include a representative(s) from and/or for each of these special populations group(s), as appropriate? *Note: Special population "advocates" that are not drawn directly from the special population (e.g., currently homeless individual) should be individuals that have personally experienced being a member of, represent, have expertise in, or work closely with the special population and thus can clearly communicate the needs/ concerns of the target population and represent this population on the board (e.g., formerly homeless individual, homelessness advocate, etc.).* *In addition, while the inclusion of "advocate" would meet the requirement for multi-funded (i.e., a health center that receives section 330(e) in addition one or more special populations funding stream) health centers to have representation of all the populations for which the health center receives funding, these advocates would not be included in calculating whether the governing board has met its overall patient/consumer-majority requirement unless they were also health center patients. Additionally, while advocates may represent special populations on the board as outlined above, all health centers should continue efforts to achieve representation by patients/consumers who are members of the targeted special population.*	
c	The board has at least 9 but no more than 25 members, as appropriate for the complexity of the organization.*	Does the Board have between 9 and 25 members?	
		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?	

Requirements		Questions	Yes/No
		Is the size of the board appropriate for the complexity of the organization and the diversity of the community served?	
d	The remaining non-consumer members of the board shall be representative of the community in which the center's service area is located and shall be selected for their expertise in community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social service agencies within the community.*	Are the remaining Board members representative of and/or drawn from the grantee's community and service area?	
		Does the Board include a member (or members) with expertise in any of the following:	
		• Community affairs?	
		• Local government?	
		• Finance?	
		• Legal affairs?	
		• Trade union or labor relations?	
		• Business?	
		• Social Services?	
		• Health?	
e	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 more than 50% of the non-patient/consumer Board members derive more than 10% of their annual income from the health care industry?	

18.B Performance Improvement

Additional Documents/Resources to Review: 1) Board Recruitment and Retention Plan; 2) Board orientation and training information.

Prompting Questions for Performance Improvement Discussions			Response
1	Does the health center have:		
	a	A Board recruitment and retention plan, which will help ensure Board development and stability?	
	b	An orientation program for new board members?	
	c	Plans for ongoing board member training?	
2	Does the overall expertise among the Board members appropriately reflect the health center's scope in terms of services/needs, target population, and service area?		
3	If possible, has Board composition/recruitment taken into account other key demographic factors such as socioeconomic status and age, in terms of reasonably representing individuals served by the health center?		

SECTION IV: Governance

Program Requirement 19: CONFLICT OF INTEREST POLICY

19.A Program Requirement

Authority: 45 CFR Part 74.42 and 42 CFR Part 51c.304(b)
Documents/Resources to Review: 1) Corporate Bylaws; 2) most recent update of Conflict of Interest policy and related procedures; 3) Procurement policies and procedures.

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

	Requirements	Questions	Yes/No
Health center's bylaws or written, corporate-board-approved policy includes provisions that:			
a	Prohibit conflict of interest by board members, employees, consultants and those who furnish goods or services to the health center.	Do the bylaws or another policy include this provision(s)?	
b	State that no Board member shall be 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.*	Is any current Board member(s) an employee of the health center or an immediate family member of an employee?	
c	State that the Chief Executive may serve only as a non-voting, ex-officio member of the Board.*	Does the CEO participate as a voting member of the Board?	

	Requirements	Questions	Yes/No
d	Address such issues as: • disclosure of business and personal relationships, including nepotism, that create an actual or potential conflict of interest; • extent to which a board member can participate in board decisions where the member has a personal or financial interest; • using board members to provide services to the center; • board member expense reimbursement policies; • acceptance of gifts and gratuities; • personal political activities of board members; and • statement of consequences for violating the conflict policy.	Do the bylaws or any separate conflict of interest policies and procedures include and/or address these provisions? *Note that when section 330 grantees procure supplies and other expendable property, equipment, real property, and other services, the health center's conflict of interest policy must specifically address the following:* • *The health center grantee must have written standards of conduct governing the performance of its employees engaged in the award and administration of contracts.* • *No health center employee, board member, or agent may participate 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 which 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 grantee shall neither solicit nor accept gratuities, favors, or anything of monetary value from contractors, or parties to subagreements. However, recipients 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 must provide for disciplinary actions to be applied for violations of such standards by board members, employers, or agents of the health center grantee.*	

19.B Performance Improvement

	Prompting Questions for Performance Improvement Discussions	Response
1	Are annual conflict of interest statements required from board members and key management staff?	
2	If yes, are the required statements on file?	
3	Does the Board allow related party transactions to take place? If yes, please describe.	

APPENDIX A: Cross-Cutting Reference Documents And Websites	
Cross-Cutting Reference Documents	
1	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
2	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
3	Grants Regulations (45 CFR Part 74) http://www.bphc.hrsa.gov/about/requirements/index.html
4	Health Center Program Requirements Overview Slides http://www.bphc.hrsa.gov/about/requirements/index.html
5	BPHC Policy Information Notices and Program Assistance Letters (PINS and PALS) http://www.bphc.hrsa.gov/policiesregulations/policies/index.html
6	Enhancements to Support Health Center Program Requirements Monitoring Program Assistance Letter 2010-01
Useful Websites	
1	Health Resources and Services Administration (HRSA) website http://www.hrsa.gov/
2	HRSA Bureau of Primary Health Care (BPHC) website http://bphc.hrsa.gov/
3	HRSA BPHC Technical Assistance (TA) website http://www.bphc.hrsa.gov/technicalassistance/index.html
4	Newly Funded Technical Assistance Guide http://www.bphc.hrsa.gov/technicalassistance/newguide/index.html
5	Management Solutions Consulting Group, Inc. Consultant Resource Center http://www.mscginc.com/Resources *Please note that all documents that are not HRSA/BPHC publications and are found within the MSCG Consultant Resource Center 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.*

APPENDIX B: Optional Program Requirement/Performance Improvement Summary Grid			
The following grid may be helpful in noting where a grantee stands on each requirement. A color-coding or lettering system may be used, such as:			
Y	Grantee is compliant with the requirement.	N	Grantee is not in compliance with the requirement.
F-U	Grantee is compliant, but follow-up is needed.	R	A recommendation for performance improvement has been offered.

Comp.	Perf Impr.	Requirement	Comments (e.g., reason for non-compliance, summary of performance improvement recommendation)
		1. Needs Assessment	
		2. Required and Additional Services	
		3. Staffing	
		4. Accessible Hours of Operation / Locations	
		5. After Hours Coverage	
		6. Hospital Admitting Privileges and Continuum of Care	
		7. Sliding Fee Discounts	
		8. Quality Improvement / Assurance Plan	
		9. Key Management Staff	
		10. Contractual/Affiliation Agreements	
		11. Collaborative Relationships	
		12. Financial Management and Control Policies	
		13. Billing and Collections	
		14. Budget	
		15. Program Data Reporting Systems	
		16. Scope of Project	
		17. Board Authority	
		18. Board Composition	
		19. Conflict of Interest Policy	

APPENDIX C: Health Center Performance Measures

In order to support the provision of high quality patient care, HRSA-funded health centers are expected to have ongoing quality improvement/assessment programs that include clinical services and quality management. To this end, the Health Center Program incorporates systems of quality assessment, quality improvement, and quality management that focus provider responsibilities on improving care processes and outcomes. In concert with performance improvement initiatives within the broader health care community, the Health Center Program incorporates quality-related performance measures that place emphasis on health outcomes and demonstrate the value of care delivered by health centers.

The Health Center required performance measures were thus selected to provide a balanced and comprehensive representation of health center services, clinically prevalent conditions among underserved communities, and the population across life cycles. Their use is familiar to the majority of health center grantees that have extensive experience working to improve the quality of perinatal, chronic, and preventative care services. Further, the performance measures are aligned with those of national standard setting organizations, and are commonly used by Medicare, Medicaid, and health insurance/managed care organizations to assess quality performance. The alignment of the performance measures across the Uniform Data System (UDS) and the grant applications (NAP, SAC, and BPR) also provides grantees with the opportunity to establish quality and performance goals for their organization and patient populations, and assess their progress toward these goals over time. The alignment furthers HRSA's objective to collect data in a way that minimizes grantee reporting burden, and helps document the value of the Health Center Program.

The required measures within Appendix C are reported by all grantees in the annual UDS and are included along with additional measures, in the Clinical and Financial Performance Measures Forms completed as part of their Fiscal Year 2013 Service Area Competition (SAC) and Budget Period Progress Report (BPR) applications. Please note that several new performance measures (Coronary Artery Disease – Lipid Therapy, Ischemic Vascular Disease – Aspirin Therapy, and Colorectal Cancer Screening) that will be included in calendar year 2012 UDS reporting for the first time, are also included in the list below. In preparing FY 2013 SAC applications or BPR submissions, applicants were encouraged, but NOT REQUIRED, to provide baselines or other data for these three new Calendar Year 2012 UDS clinical performance measures. All existing grantees as well as any newly funded applicants will be required to report on these new measures in their 2012 UDS Reports.

For the most recent information on UDS reporting, visit http://www.hrsa.gov/data-statistics/health-center-data/index.html and for additional information on the performance measures, visit http://www.bphc.hrsa.gov/policiesregulations/performancemeasures/index.html.

Clinical Performance Measure Detail

Outreach/Quality of Care Measures

Percentage of pregnant women beginning prenatal care in the first trimester

Numerator: All female patients who received perinatal care during the program year (regardless of when they began care) who initiated care in the first trimester either at the grantee's service delivery location or with another provider.

Denominator (Universe): Number of female patients who received prenatal care during the program year (regardless of when they began care), either at the grantee's service delivery location or with another provider. Initiation of care means the first visit with a clinical provider (MD, NP, CNM) where the initial physical exam was done and does not include a visit at which pregnancy was diagnosed or one where initial tests were done or vitamins were prescribed.

Percentage of children with 2nd birthday during the measurement year with appropriate immunizations

Numerator: Number of children who received all of the following: 4 DTP/DTaP, 3 IPV, 1 MMR, 2 Hib*, 3 HepB, 1VZV (Varicella), 4 Pneumococcal conjugate, 2 HepA, 2 or 3 RV, and 2 influenza vaccines prior to or on their 2nd birthday whose second birthday occurred during the measurement year, among those children included in the denominator.

Denominator: Number of children with at least one medical visit during the reporting period, who had their second birthday during the reporting period, who did not have a contraindication for a specific vaccine. This includes children who were first seen in the clinic prior to their second birthday, regardless of whether or not they came to the clinic for vaccinations or well child care.

** Note: While 2 Hib shots are required, HRSA recommends that 3 Hib shots be given per the CDC recommendation.*

Percentage of women 21-64 years of age who received one or more tests to screen for cervical cancer

Numerator: Number of female patients 24-64 years of age receiving one or more Pap tests during the measurement year or during the two years prior to the measurement year, among those women included in the denominator.

Denominator (Universe): Number of female patients 24-64 years of age as of December 31 of the measurement year who were seen for a medical encounter at least once during the measurement year and were first seen by the grantee before their 65th birthday.

Percentage of patients age 2 to 17 years who had a visit during the current year and who had Body Mass Index (BMI) Percentile documentation, counseling for nutrition, and counseling for physical activity during the measurement year

Numerator: Number of child and adolescent patients age 3 to 17 years who had Body Mass Index (BMI) Percentile documentation, counseling for nutrition, and counseling for physical activity during the measurement year, among those patients included in the denominator.

Denominator: Number of child and adolescent patients age 3 to 17 years as of December 31 of the measurement year, who have been seen in the clinic at least once during the measurement year.

Percentage of patients age 18 years or older who had their Body Mass Index (BMI) calculated at the last visit or within the last six months *and,* if they were overweight or underweight, had a follow-up plan documented

Numerator: Number of adult patients age 18 years or older who had their Body Mass Index (BMI) calculated at the last visit or within the last six months *and,* if they were overweight or underweight, had a follow-up plan documented, among those patients included in the denominator.

Denominator: Number of adult patients age 18 years or older as of December 31 of the measurement year, who have been seen in the clinic at least once during the measurement year.

Percentage of patients age 18 years and older who were queried about tobacco use one or more times within 24 months

Numerator: Number of patients age 18 years and older who were queried about tobacco use one or more times during their most recent visit or within 24 months of their most recent visit, among those patients included in the denominator.

Denominator: Number of patients age 18 years and older who had at least one medical visit during the measurement year and have been seen for at least two office visits ever.

Percentage of patients age 18 years and older who are users of tobacco and who received (charted) advice to quit smoking or tobacco use

Numerator: Number of patients age 18 years and older who are users of tobacco and who received (charted) advice to quit smoking or tobacco use during their most recent visit or within 24 months of their most recent visit, among those patients included in the denominator.

Denominator: Number of patients age 18 years and older seen identified as users of tobacco during their most recent visit or within 24 months of

their most recent visit and who had at least one medical visit during the current year and have been seen for at least two visits ever.

Percentage of patients age 5 to 40 years with a diagnosis of persistent asthma (either mild, moderate, or severe) who were prescribed either the preferred long term control medication or an acceptable alternative pharmacological therapy during the current year

Numerator: Number of patients age 5 to 40 years included in the denominator with a diagnosis of persistent asthma (either mild, moderate, or severe) who were prescribed either the preferred long term control medication (inhaled corticosteroid) or an acceptable alternative pharmacological therapy (leukotriene modifiers, cromolyn sodium, nedocromil sodium, or sustained released methylxanthines) during the current year.

Denominator: Number of patients age 5 to 40 years with a diagnosis of persistent asthma (either mild, moderate, or severe) and who had at least one medical visit during the current year and have been seen for at least two visits ever.

Health Outcomes/Disparities Measures

Percentage diabetic patients whose HbA1c levels are less than 7 percent, less than 8 percent, less than or equal to 9 percent, or greater than 9 percent

Numerator: Number adult patients age 18 to 75 years with a diagnosis of Type 1 or Type 2 diabetes whose most recent HbA1c level during the measurement year is <7%, <8%, ≤9%, or >9%, among those patients in the denominator.

Denominator: Number of adult patients age 18 to 75 years as of December 31 of the measurement year with a diagnosis of Type 1 or Type 2 diabetes, who have had a visit at least twice during the reporting year and do not meet any of the exclusion criteria.

Percentage of adult patients with diagnosed hypertension whose most recent blood pressure was less than 140/90

Numerator: Patients 18 to 85 years of age with a diagnosis of hypertension with most recent systolic blood pressure measurement < 140 mm Hg and diastolic blood pressure < 90 mm Hg.

Denominator (Universe): All patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension and have been seen at least twice during the reporting year, and have a diagnosis of hypertension before June 30 of the measurement year.

Percentage of births less than 2,500 grams to health center patients

Numerator: Women in the "Universe" whose child weighed less than 2,500 grams during the measurement year, regardless of who did the delivery.

Denominator (Universe): Total births for all women who were seen for prenatal care during the measurement year regardless of who did the delivery.

NOTE: The Prenatal Health and Perinatal Health performance measures (*Percentage of pregnant women beginning prenatal care in the first trimester and Percentage of births less than 2,500 grams to health center patients*) are the only Clinical Performance Measures that can be marked "*Not Applicable*" on an ongoing basis. Such designation requires justification regarding referral and tracking practices (required regardless of applicability) in the Comments field of the performance measure forms. These performance measures cannot be marked "*Not Applicable*" if data for the measures was provided in the most recent SAC, NAP, or BPR. Applicants that assume primary responsibility for some or all of a patient's prenatal/perinatal care services (those who have selected the first or second columns on Form 5A for these services) are required to include and report on these performance measures.

NEW MEASURE ADDED IN 2012 UDS REPORTING: **Coronary Artery Disease, Lipid Therapy**

Numerator: Number of patients aged 18 years and older in the denominator who were prescribed or are taking a lipid-lowering therapy (based on current ACC/AHA guidelines).

Denominator: Number of patients aged 18 years and older with a diagnosis of CAD or who have had cardiac surgery (with at least one medical visit during the reporting period or two medical visits ever).

NEW MEASURE ADDED IN 2012 UDS REPORTING: **Ischemic Vascular Disease (IVD), Aspirin Therapy**

Numerator: Number of patients 18 years of age and older in the denominator who had documentation of use of aspirin or another antithrombotic during the measurement year.

Denominator: Number of patients 18 years of age and older (with at least one visit during the reporting period) who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) (during January 1 to November 1 of the year prior to the measurement year), or who had a diagnosis of Ischemic Vascular Disease (IVD) during the current or prior year.

NEW MEASURE ADDED IN 2012 UDS REPORTING: Colorectal Cancer Screening

Numerator: Number of adults in the denominator who had appropriate screening for colorectal cancer (includes colonoscopy ≤ 10 years, flexible sigmoidoscopy ≤ 5 years, or annual fecal occult blood test).

Denominator: Number of adults age 51 to 75 years who had at least one medical visit during the reporting period.

Additional Clinical Performance Measures

In addition to the above required UDS clinical measures, health centers must include one Behavioral Health (Mental Health or Substance Abuse) AND one Oral Health performance measure of their choice in the Clinical Performance Measures Form. In the BPR and SAC (for existing grantees applying to serve their current service area), grantees are expected to report on their previously developed behavioral and oral health performance measures.

- If new behavioral and/or oral health performance measures are being developed, grantees may utilize patient or agency-centered measures, based on the specific type/level of oral health or mental health/substance abuse services offered by the health center and/or on the mode of service delivery the center utilizes for these services (i.e., provided directly or via a formal written referral arrangement). For example, health centers may wish to focus on areas such as behavioral health screening, treatment, and referral or behavioral health patient outcomes. Such measures can be based on services provided by behavioral health or by primary care providers.

- When developing oral health measures, both BPR and SAC applicants are reminded that oral health screening is a required primary care service (as part of "Preventive Dental) and that the minimum requirement for behavioral health service is a formal referral.

Financial Viability/Cost Performance Measure Detail

Total cost per patient
Numerator: Total accrued cost before donations and after allocation of overhead

Denominator: Total number of patients (UDS Lines: T8AL17CC/T4L6A for existing grantees)

Medical cost per medical visit
Numerator: Total accrued medical staff and medical other cost after allocation of overhead (excludes lab and x-ray cost)

Denominator: Non-nursing medical encounters (excludes nursing (RN) and psychiatrist encounters). (UDS Lines: T8AL1CC + T8AL3CC/T5L15CB – TT5L11CB for existing grantees)

Change in net assets to expense ratio

Numerator: Ending Net Assets – Beginning Net Assets

Denominator: Total Expense
Note: Net Assets = Total Assets – Total Liabilities

Working capital to monthly expense ratio

Numerator: Current Assets – Current Liabilities

Denominator: Total Expense / Number of Months in Audit

Long term debt to equity ratio

Numerator: Long Term Liabilities

Denominator: Net Assets

NOTE: Only applicants that identify as Tribal, Urban Indian, or Public Center (formerly referred to as Public Entity grantees) are able to select "Not Applicable" for an audit related performance measure (*Change in Net Assets, Working Capital and/or Long Term Debt to Equity*). These applicants may choose to include substitute measures limited to the scope of Federal project (e.g., surplus or loss as a percent of total cost).

Other (Optional) Clinical or Financial Performance Measures

In addition to the required Clinical and Financial Performance Measures (including the self-defined oral and behavioral health measures) noted above, SAC and BPR applicants may choose to identify and include other measures relevant to their health center and/or target population. For example, grantees may add Clinical Performance Measures that focus on the quality of care for a key service or services provided to patients, including particular special populations served. Any additional Financial Performance Measures must focus on the organization's financial performance. All such measures must be quantitative (defined by a numerator and a denominator), and their progress must be tracked over time.

APPENDIX D: Capital and Other Grant Progress Review

Background: The American Recovery and Reinvestment Act (ARRA), signed into law February 17, 2009, provided nearly $2 billion in grants to health centers to support the Act's goals of job preservation and creation, economic recovery, help to people most impacted by the recession, increased economic efficiency, long-term economic investment in infrastructure, and the preservation of essential services. Health centers receiving funding under ARRA are required to submit quarterly reports on programmatic progress on these grants. ARRA grants to health centers have included approximately:

- $500 million for New Access Points (NAP) and Increased Demand for Services (IDS) awards to support new and existing health center grantees to meet spikes in uninsured populations by offering extended hours, expanding services, and/or increasing numbers of providers.
- $850 million for the Capital Improvement Program (CIP) to support the construction, repair, and renovation of health center sites nationwide, including the purchase of new equipment or health information technology, and expanding the use of certified electronic health records (EHR).
- $500 million for the Facility Investment Program (FIP) to address significant and pressing capital improvement needs in health centers, including modernization, renovation, and construction, while creating employment opportunities in underserved communities over a two-year period.

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 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).
- $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 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:

- Current ARRA Health Center Quarterly Report (HCQR) and/or ACA Quarterly Progress Report (QPR)
- Federal ARRA Section 1512 reports for all ARRA grants (http://www.federalreporting.gov/)
- Notices of Award for all Capital Grants (such as C81, C80, C8A, C8B, C12) to review scope of approved work including any updates and changes to the project(s)
- 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
- For Capital Grants with equipment purchases, compare the equipment listed in the approved budget with the equipment purchased
- For CIP grants, review progress on implementing health information technology (HIT) or electronic health record (EHR)

Awards		Questions	Response
a	Increased Demand for Services (IDS) and New Access Point (NAP) Awards	As a result of the ARRA award, what goals or objectives has the grantee accomplished from its IDS and NAP grants since the last Quarterly Report, including but not limited to: • new sites opened; • number of new patients that received services; • number of visits new patients received; • number of new uninsured patients that received services; and • number of jobs retained or created?	
		What factors, if any, are contributing to OR restricting the performance and success of the ARRA-supported activities?	
		What support and/or technical assistance could BPHC or other partners provide to assist the grantee in improving the progress or completion of ARRA activities, if applicable?	

	Awards	Questions	Response
b	Capital Grants: including C81 Capital Improvement Program (CIP), C80 Facility Investment Program (FIP), C8A Capital Development (CD), and C12 School-based Health Center Capital (SBHCC) grants. Also includes one-time funding for minor construction activities included within New Access Point (NAP) grants	As a result of the grant award, what goals or objectives has the grantee accomplished with its Capital Grant(s) since the last Quarterly Report, including but not limited to: • new equipment purchased; • construction completed and/or new sites opened; • alterations/renovations completed; and/or • HIT and/or certified EHR implemented?	
		What factors, if any, have impacted the expected project completion date for each project based upon a review of the most current project schedule?	
		What factors, if any, have impacted the implementation of HIT equipment and/or certified EHR (as applicable to the type of award)?	
		Will each project be completed by the project period end date?	
		What is the status of the following since the last Quarterly Report submission: • Reporting requirements and other submissions, such as the final design letter, construction contract, etc., if applicable; • Local building permits; and/or • Bidding of the construction contract?	

Awards		Questions	Response
		Have there been any significant updates/modifications to the awarded project(s), such as: • A change in the physical location of the project(s); • A change in the scope of work to be performed and/or the design/layout of the project(s); • An increase in the overall cost of the project(s); • A decrease in the overall cost of the project(s) due to favorable bidding that may result in some reallocation of grant funds; and/or • A change in the status of the non-Federal funding support needed for the project(s) (if the project(s) are not fully funded by a BPHC Capital grant)?	
		What support and/or technical assistance could BPHC or other partners provide to assist the grantee in improving the progress or completion of grant(s) activities, if applicable?	