The BPHC Newfè CdzyŘŜŘ ¢! Web Guide
Resources for New and Existing Grantees

Developed by:

The U.S. Department of Health and Human Services (HHS)
Health Resources and Services Administration (HRSA)
Bureau of Primary Health Care (BPHC)
Office of Training and Technical Assistance Coordination (OTTAC)

The BPHC Newly Funded TA Web Guide is a self assessment tool designed to help new BPHC grantees provide high-quality primary health care from the day they open their doors for business. The Guide is a central hub for links to HRSA-approved templates, information pages, and policy documents, and many other resources. The intent of the Web Guide is to help Health Center grantees improve their quality and efficiency, work within Health Center Program Requirements, and access Federal policies, programs and resources intended for the specific needs of Health Centers.

This document is a printable version of all of the content available on the Web Guide. It was developed by the BPHC Office of Training and Technical Assistance Coordination and is hosted at:
http://bphc.hrsa.gov/technicalassistance/index.html

Contents

Introduction

Welcome to the BPHC bŜǿfê CdzyŘŜŘ ¢! Web Guide!

Purpose: This site is designed to assist new and existing Health Center Grantees in their efforts to establish and promote an organizational culture that is committed to continuous performance improvement and the delivery of high quality, effective and safe patient care. There are many resources in the Web Guide to help Grantees achieve full implementation and compliance with Health Center program requirements as well as access to many Federal programs and resources intended to benefit and support health center best practices. The Web Guide contains suggested programmatic practices, printable questions to assist with self assessments, and dozens of links to sample documents, information pages, and policy information. While the Web Guide was built primarily with Newly Funded Health Centers in mind, much of the content may be beneficial to existing grantees as well. To begin, please click on any of the headers listed below that may be of interest to you.

Web Guide Content and Structure: Below is a listing of Health Center-related topics, covering federal programs of special interest to Health Centers such as 340b drug pricing and the Federal Tort Claims Act, as well as pages for each of the 19 Health Center Program Requirements.

The Web Guide site contains portions of the Health Center Site Visit Guide, adapted for grantee use. The Health Center Site Visit Guide is commonly used by BPHC personnel and consultants to assess grantee compliance with program requirements, Program Information Notices (PINs), Program Assistance Letters (PALs), and the adaptation of highly recommended performance improvement activities.

How to Prepare: Your most recent Section 330 grant application and Notice of Award (NoA) are the documents that define the Scope of Work you have agreed to carry out as a BPHC grantee. It will be very helpful to have these documents on-hand as you review the Web Guide, especially in answering the questions found throughout the guide. The EHB user guide to New Access Point grantees is also a good reference for helping new and existing grantees navigate the electronic system for official submissions to HRSA.

Regarding Non-Federal Technical Assistance Resources: BPHC's Technical Assistance contractor, Management Solutions Consulting Group (MSCG) hosts an online Consultant Resource Center that houses many resources cited in the Web Guide. While the Resource Center has many valuable templates and documents, **all non-Federal resources cited in the Web Guide are meant to be used only as "sample" documents. They are for use as aids to consultants and grantees, but are not considered official guidance by BPHC.** These documents and the 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.

Regarding Key Questions: Within this resource there are over 30 sets of questions derived from the Health Center Site Visit Guide for each of the 19 Health Center Program Requirements. These questions are commonly used by BPHC personnel and consultants to assess grantee compliance with program requirements and to identify areas for performance improvement activities. Grantees may find it beneficial to work with the questions and/or checklists on their own, or in conjunction with a site visit. **Web Guide questions are intended as self-assessment tools. They do not assure complete conformity to program rules. Such assessments are determined through an iterative process with Project Officers,**

annual continuation applications, performance reports, site visits with specialized consultants, and other programmatic resources.

We hope you find the Newly Funded TA Web Guide a useful resource tool as we work together to improve the health of the Nation's underserved communities and vulnerable populations.

1. Getting Started

1a. Your Notice of Award and First Steps

This section covers the information found in your Notice of Award, highlighting important information that you will need to refer to periodically.

Contact Your Federal Project Officer and introduce yourself (listed on your NoA). Your Project Officer (PO) is your primary point of contact for programmatic issues such as: health center program requirements, performance improvement, technical assistance needs, and other services and responsibilities directly related to the Health Center Program.

- Confirm the timing of your Federal funding (Project and Budget Period start dates/end dates).
- Confirm when the next Federal grant application is due, and whether it is competitive or a progress report ("Service Area Competition (SAC) vs Budget Period Progress Report (BPR).
- Discuss program and grant conditions that are listed in your NoA.

Set up times to communicate with your Project Officer periodically, e.g., monthly, quarterly, to keep each other posted on developments (Note that your Project Officer will also contact you soon after you have received your NoA and will also want to set up periodic calls). Grantees should also contact Project Officers whenever they have questions and/or wish to talk through possible changes/adjustments in plans, staffing, etc. that were described in the approved application.

Contact Your Grants Management Specialist to introduce yourself (listed on your NoA-note that your Grants Management Specialist may also participate on the introductory call your Project Officer sets up soon after you have received your NoA). Your Grants Management specialist is your point for contact for matters related to administrative management of your grant, such as drawdown, Federal payment management systems, and regular financial reporting.
Confirm details and conditions noted on your NoA, or requests that involve significant changes to the budget that was approved as part of the most recent grant, if necessary.

Review HRSA's Grants Management Workshop Presentation Materials (October 2010) that covered management of your grant, reporting requirements, Electronic Handbook overview, terms and conditions and other aspects of HHS/HRSA grants management, found here.

Enroll in the HHS Payment Management System. Payment of grants to grantees occurs through the HHS PMS, a fully automated and full service centralized grants payment and cash management system. If you have not done so already, contact your Grants Management Specialist (GMS), listed on your NoA, to begin setting up your PMS account.

Locate your organization's important documents prior to talking to your project officer, including:

- Bylaws
- Articles of Incorporation
- Most recent NoA
- Most recent health center grant application
- Most recent strategic plan
- Most recent financials

Official Points of Contact in Grants.Gov and EHB. Send a letter or email to the Federal project officer and to the grants management specialist requesting an official change of contact in Grants.gov for any grants you have from the Federal government. This includes setting permissions for staff to register to work on specific grant functions. You will need prior approval from your project officer to change your profile as an Authorizing Organization Representative (AOR). Pay particular attention to maintaining current contact information in EHB for your organization. In addition, please make sure you have at least one other individual in your organization registered in EHB who can access and submit documents as needed if the Authorizing Official is not able to/absent. For more information on EHB, please contact the HRSA Help Desk at bphchelpline@hrsa.gov or 1-877-974-BPHC Monday through Friday (except Federal holidays) 8:30 AM to 5:30 PM (ET).

Review financials, ensuring that you are on schedule to draw down and obligate Federal funding, as approved, prior to the conclusion of the grant period. Federal funding should not sit in an interest-bearing account for more than 72 hours. Please refer to 45 CFR Part 74.22 and/ or consult your Grants Management Specialist for additional information.

For a useful guide to HRSA-related terminology, click here.

Contact other key people in your State for introductions and background.

Contact your State Primary Care Office (PCO) responsible for shortage designations. Some States also have recruitment assistance (including J1 Visa Waivers) and State primary care grant resources. PCOs are listed here.

Contact your State's Primary Health Care Association (PCA). State/Regional PCAs are private, non-profit organizations that provide training and technical assistance to health centers and other safety-net providers, support the development of health centers in their State, and enhance the operations and performance of health centers. Your PCA can offer assistance with understanding and implementing Health Center Program requirements such as governance, grants management, clinical or quality improvement support, training or orientation of new staff, and answering general questions. Here is the contact information for the PCAs.

Consider asking your PCA about mentoring opportunities with other health centers in your State or region.

1b. Medicare/Medicaid/Other Payment

This section provides a brief overview of the steps needed to enable your health center to be reimbursed by Medicare and Medicaid under the FQHC payment system. Detailed information on this topic is available in PAL 2011-04, "Process for Becoming Eligible for Medicare Reimbursement under the FQHC Benefit."

Medicare and Medicaid's Reimbursement System for FQHCs: Both Medicare and Medicaid have payment systems that are unique to Federally Qualified Health Centers (FQHCs.) These systems are designed to reflect the relatively higher intensity of health center patients and the broader range of services that health centers provide. Payment is made on a per-visit basis, meaning that FQHCs receive a standardized, predetermined amount for each visit, regardless of which services were actually provided.

Note that being approved for a health center grant through Section 330 or receiving a designation as a Look-Alike is not sufficient for a health center to be reimbursed under the FQHC payment system. Rather, a health center must apply to be enrolled in each program as an FQHC, and this application must be approved, before payment under the FQHC system begins. Under Medicare (and many State Medicaid programs,) payment as an FQHC is not retroactive to services provided prior to the date the application was approved. For these services, health centers may bill Medicare under the name of individual providers, and will be reimbursed based on traditional payment systems (e.g., the physician fee schedule under Medicare.)

Enrolling and Billing Under Medicare

How to prepare and submit a Medicare Enrollment Application: For information on how to prepare and where to submit a Medicare enrollment application, see PAL 2011-04, "Process for Becoming Eligible for Medicare Reimbursement under the FQHC Benefit."

Importance of prompt submission of Medicare enrollment application: Given that reimbursement under the Medicare FQHC system does not begin until the date the enrollment application is approved, health centers are strongly advised to submit this application as soon as possible and to remain in regular contact with the Medicare contractor about how the review process is progressing. Medicare regulations State that health centers must be operational on the date that they submit the enrollment application. Therefore, health centers are strongly encouraged to have the application ready for submission on the first day the site becomes operational.

Each permanent and seasonal site must be enrolled individually: Medicare considers each permanent and seasonal health center site to be a unique FQHC. Therefore, each site must enroll individually and receive a unique Medicare Billing Number.

Billing under the FQHC per-visit payment system: Once it has been approved as a FQHC, a health center submits claims to its Medicare contractor using CMS Form UB-04, which must be submitted electronically.

How Medicare per-visit payment rates are set: Initially a FQHC will be assigned an "interim per visit rate" by its Medicare contractor, based on an estimate of its costs for caring for Medicare patients. At

the end of the first fiscal year, the FQHC files a "Medicare Cost Report" which reports its actual costs. The Medicare contractor reviews this report and determines a per visit rate. It then adjusts this rate downward if it determines that the individual providers did not meet productivity standards, and/or if the rate exceeds the Upper Payment Limits established by CMS. The Medicare contractor then determines the total amount due based on this final rate, and compares it to the amount actually paid. If the amount paid was less than the amount owed, the Medicare contractor pays the difference to the FQHC; if the amount due is less than the amount already paid, then the FQHC must repay the Medicare contractor. Therefore, new FQHCs are encouraged to closely monitor their costs versus per visit rates throughout their first year, as they could either owe or receive a potentially large amounts based on this adjustment.

Once the first cost report is submitted and accepted, the rate determined based on that report will be used in the following year, with another adjustment being made (if necessary) after the year is over.

Reimbursement for Medicare Advantage (Managed Care) Patients: FQHCs are guaranteed to receive their full per-visit rate for their Medicare patients who participate in managed care plans. In these situations, the FQHC negotiates payment rates directly with the Managed Care Organization (MCO), and receives reimbursement directly from the MCO. The FQHC must then bill Medicare for the difference between what the MCO paid and what how much they would have received under the standard per-visit payment system. This amount is called the "wrap-around" payment, and Medicare contractors are required to make these payments not less often than every 3 months.

Enrolling and Billing Under Medicaid

Enrolling in Medicaid: Each State Medicaid program establishes its own policies about how health centers are to enroll, and when reimbursement under the FQHC system begins. For example, many States require a health center to be approved by Medicare as an FQHC before it can apply to Medicaid. Also, some States make payments under the FQHC system retroactive to the date the health center applied or became operational, while others make no retroactive adjustments. To determine the policies in your State, contact your State Medicaid Office or Primary Care Association.

Billing under the Medicaid FQHC per-visit payment system: Each State determines how FQHCs are to bill Medicaid. To determine the practices in your State, contact your State Medicaid office or Primary Care Association.

How Medicaid payment rates are set: In most States, the per-visit payment rates made to FQHCs under Medicaid are referred to as "Prospective Payment System" (PPS) rates. For a new FQHC, the base rate is set by the Medicaid office, based on the FQHC's first year costs, the rates in effect for similar FQHCs in the area, or a combination of both. In future years, this base rate is increased annually using CMS's estimate of health care inflation. It is very important that new FQHCs ensure that the initial PPS rates are set appropriately, as once they are established it is very difficult to change them, other than by the annual inflation update.

State Medicaid programs have the option of using an Alternative Payment Mechanism (APM) instead of a PPS. For an APM to be permissible, it must, 1. result in total payments at least as high as under the PPS, and 2. be approved by the health center. Again, it is important that health centers closely study a proposed APM system before accepting it.

Reimbursement for patients in managed care: Similar to Medicare, FQHCs are guaranteed to receive their full per-visit rate for their Medicaid patients who participate in managed care plans. As with Medicare, the FQHC negotiates payment rates directly with the Managed Care Organization (MCO) and the FQHC bills Medicaid for the difference between what the MCO paid and how much it would have received under the standard per-visit payment system. State Medicaid programs are required to issue these "wrap-around payments" at least once every four months.

For additional information about Medicare and Medicaid, see the CMS FQHC website. This site includes additional links to policies, billing/payment, enrollment/recertification, listserv signup, coding, coverage, manuals and a range of other resources.

Enrolling as a participating provider with commercial and managed care payers active in the area. Health centers should develop a list of the largest commercial insurance providers in their community, and request enrollment applications from them as soon as possible. To find a list of payers, go to the National Association of Insurance Commissioners web site and click on your State.

Each private insurer – including each MCO operating under either Medicare or Medicaid – will have its own enrollment forms and requirements. New health centers are encouraged to obtain and submit these applications as soon as possible.

Insurance, Fees and Billing

Contact Your State Compensation Insurance Commission for worker's compensation fee schedule and forms. The US Department of Labor has many resources on this topic. Information on worker's compensation can be found by selecting your State here.

Develop a Fee Schedule. It is important to determine reasonable costs or the locally prevailing charges for all services in your approved scope of project (e.g. primary care, dental, mental health, substance abuse, etc.). Your financial auditor, PCA, or NACHC may be able to provide TA. Medicare / Medicaid charges are publicly available information to help you get started in developing your listing of fees for all office visits, procedures, and services. Medicare schedules are found here. Medicaid schedules are found here. The schedule of fees is also the first step in developing the corresponding schedule of discounts (sliding fee discount schedule/sliding fee scale) that must be applied to all services in the approved scope of project for patients without insurance (see Program Requirement 7 for more information on Sliding Fee requirements).

Develop Accounts Receivable systems and policies. This should be part of a larger Financial Policies and Procedures Manual. The National Association of Community Health Centers (NACHC) and/or your PCA may have additional TA resources on this topic. Order CPT, HCPCS, ICD-9/10 and other coding manuals if you are doing your own billing.

Complete the EHB Scope Verification Module. Grantees are allowed up to 120 days following the date of the Notice of Award (NoA) indicating approval for the change in scope to implement the change (e.g. open the site or begin providing a new service) …" The foundation for this policy is the Bureau of Primary Health Care's (BPHC) expectation for the timely implementation of change in scope requests (CIS) and/or scope changes occurring via approved applications to add a new service or a new service site. Timely implementation is defined as fully implementing approved scope changes within 120 days

from the date of the Notice of Award approving the change. Grantees are now able to **verify** implementation of these changes within EHB, whereas previously grantees have had to provide verification by way of a paper post award submission (e.g., email, fax or phone conversation). See PAL 2009-11 for more information.

1c. 340B Drug Pricing

What is the 340B Drug Pricing Program?

The 340B Drug Pricing Program is administered by HRSA's Office of Pharmacy Affairs (OPA). The 340B Program limits the cost of covered outpatient drugs to certain Federal grantees, including section 330-funded health centers. Participation in the Program results in significant savings estimated to be 20% to 50% on the cost of pharmaceuticals for safety-net providers. The purpose of the 340B Program is to enable these entities to stretch scarce Federal resources, reaching more eligible patients and providing more comprehensive services.

Related Legislation

The 340B Drug Pricing Program resulted from enactment of Public Law 102-585, the Veterans Health Care Act of 1992, which is codified as Section 340B of the Public Health Service Act.

How to Enroll

To enroll in the 340B program, health centers must submit the appropriate registration form to the HRSA Office of Pharmacy Affairs. Registration forms are located on the 340B database.

340B Prime Vendor Program

In addition to the cost savings available through the 340B Program, the 340B Prime Vendor Program (PVP) provides additional savings to 340B participants registered with the Prime Vendor. The Prime Vendor Program (PVP) provides drug distribution and price negotiation services for covered entities, and has been able to negotiate additional discounts below the 340B price for more than 2,800 brand name and generic drugs. The PVP is free to all 340B covered entities, but the covered entity must enroll in the PVP. For more information, call 1-888-340-2787 or visit the PVP website. Please note that the NoA contains the following term regarding grantee responsibility on this topic: "If your organization purchases or reimburses for outpatient drugs, an assessment must be made to determine whether the organization drug acquisition practices meet Federal requirements regarding cost-effectiveness and reasonableness (See 42 CFR Part 50, Subpart E, and OMB Circulars A-122 and A-87 regarding cost principles). If your organization is eligible to be a covered entity under Section 340B of the Public Health Service Act and the assessment shows that participating in the 340B Drug Pricing Program and its Prime Vendor Program is the most economical and reasonable manner of purchasing or reimbursing for covered outpatient drugs (as defined in section 340B), failure to participate may result in a negative audit finding, cost disallowance or grant funding offset."

Links and Additional Resources

HRSA Office of Pharmacy Affairs 340B Program Website.

The HRSA Pharmacy Services Support Center (PSSC) assists HRSA grantees and eligible health care sites optimize the value of the 340B Program and provide clinically and cost effective pharmacy services that improve medication use and advance patient care. Contact the PSSC at 1-800-628-6297 or at PSSC@aphanet.org.

340B Prime Vendor Program, 340B University: https://www.340bpvp.com/resource-center/340b-university.html*.

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1d. Federal Tort Claims Act

What is the Federal Tort Claims Act (FTCA)?
The Federally Supported Health Centers Assistance Act of 1992 and 1995 granted medical malpractice liability protection through the Federal Tort Claims Act (FTCA) to HRSA-supported health centers. Under the Act, health centers are considered Federal employees and are immune from lawsuits, with the Federal government acting as their primary insurer.

Overview
Since its enactment in 1946, the Federal Tort Claims Act (FTCA) has been the legal mechanism for compensating people who have suffered personal injury by the negligent or wrongful action of employees of the U.S. government. Under Section 224 of the Public Health Service Act, as amended by the Federally Supported Health Centers Assistance Act of 1992 and 1995, employees of eligible health centers may be deemed to be Federal Employees qualified for protection under the FTCA. Eligible health centers must submit an original deeming and annual renewal deeming application to BPHC. FTCA coverage is not assured from year to year. Each year, health centers are approved after they demonstrate that they meet all the requirements of the FTCA program.

There is no cost to participating health centers or their providers, and they are not liable for any settlements or judgments that are made. The Federal Government assumes responsibility for these costs. Covered individuals (i.e., governing board members, officers, employees, and certain individual contractors) are considered Federal Employees immune from suit for covered activities. Covered activities are acts or omissions in the performance of medical, surgical, dental, or related functions resulting in personal injury, including death, and occurring within the scope of employment. More specifically, covered activities include those activities that:

- Are approved within each covered individual's scope of employment (this term includes activities within an applicable individual contract for services with the health center);
- Are within the scope of the approved Federal section 330 grant project of the deemed health center; and
- Take place during the provision of services to health center patients and, in certain circumstances, to non-health center patients.

A patient who alleges acts of medical malpractice by a deemed health center, for covered activities, cannot sue the center or the provider directly, but must file an administrative claim with the appropriate agency of the Federal government before filing suit. Additionally, FTCA litigation must be filed in Federal district court.

These claims are reviewed and/or litigated by the U.S. Department of Health and Human Services, Office of the General Counsel and the Department of Justice according to FTCA requirements. HRSA pays for all settlements and judgments from a separately appropriated Health Center FTCA Judgment Fund. To learn how your Health Center can become deemed under FTCA, go here.

Related Legislation, Regulations, and Policies

Congress enacted FTCA medical malpractice protection for Federally-supported health centers through the Federally Supported Health Centers Assistance Act (FSHCAA) of 1992 (P.L. 102-501) and FHSCAA of 1995 (P.L. 104-73), later codified as 42 U.S.C. Section 233 (a) – (n).

HRSA/BPHC has issued numerous Program Information Notices (PINs) and Program Assistance Letters (PALs) related to the Health Center FTCA Program. In 2011, PIN 2011-01, the FTCA Health Center Policy Manual was released. The Manual is the primary source for information on the FTCA for the Health Center Program grantees and related stakeholders. It consolidates all of the major FTCA PINs and PALs into one document.

Links and Additional Resources:
FTCA Program Home Page.

FTCA Overview Presentation.

FTCA Deeming Module User Guide.

FTCA Policies.

For more information, please contact the Bureau of Primary Health Care Help Line at 1-877-974-BPHC or bphchelpline@hrsa.gov.

1e. National Health Service Corps

What is the National Health Service Corps?
The National Health Service Corps (NHSC), through scholarship and loan repayment programs, helps Health Professional Shortage Areas (HPSAs) in the United States get the medical, dental, and mental health providers they need. Since 1972, more than 30,000 clinicians have served in the Corps, expanding access to health care services and improving the health of people who live in urban and rural areas where health care is scarce. About half of all NHSC clinicians work in HRSA-supported Health Centers, delivering preventive and primary care services to patients regardless of their ability to pay. Health Centers automatically qualify as NHSC sites. See the NHSC Service Site Reference Manual for more information.

Full- and Half-Time NHSC Opportunities
The NHSC offers both full- and half-time positions. Qualifying providers can search for all NHSC job opportunities here. The Affordable Care Act contains provisions allowing current providers to convert from full-time to half-time. More information on this opportunity is found here.

Scholarship
The NHSC Scholarship is a competitive program that pays tuition, fees and provides a living stipend to students enrolled in accredited medical (MD or DO), dental, nurse practitioner, certified nurse midwife, and physician assistant training. Upon graduation, scholarship recipients serve as primary care providers between 2 and 4 years in a community-based site in a high-need HPSA that has applied to and been approved by the NHSC as a service site.

Awards are made to applicants most committed to serving underserved people and most likely to build successful careers in HPSAs and meet future needs for care throughout the Nation.

Loan Repayment
The NHSC Loan Repayment Program offers fully trained primary care physicians (MD or DO), family nurse practitioners, certified nurse midwives, physician assistants, dentists, dental hygienists, and certain mental health clinicians $60,000 to repay student loans in exchange for 2 years serving in a community-based site in a high-need HPSA that has applied to and been approved by the NHSC as a service site. After completing their 2 years of service, loan repayors may apply for additional years of support.

The loan repayment program recruits both clinicians just completing training and seasoned professionals to meet the immediate need for care throughout the Nation.

Links and Additional Resources:
NHSC Home Page.

NHSC Loan Repayment Information.

NHSC and Indian Health Service (IHS) Collaborative Program Fact Sheet.

1f. HIT and Meaningful Use

What is Health Information Technology?
Health IT is healthcare information technology - the use of computer applications to record, store, protect, retrieve, and transfer clinical, administrative, and financial information electronically within health care settings. The ultimate goal of health IT is to improve population health and the quality and efficiency of patient care.

Why Implement Health IT?
Recent research demonstrates that increased use of information technology is an important step in improving quality of care and patient safety. The recent focus on health IT adoption was initiated by the Institute of Medicine (IOM) report in 1999, To Err is Human: Building a Safer Health System, which highlighted improved use of computerized applications as a core strategy for improving safety and quality of the healthcare system.

Health IT has received substantial support from Federal agencies. The Agency for Health Research and Quality (AHRQ) funded the National Resource Center for Health IT (NRC) in 2004 and approximately $166 million in health IT projects throughout the United States. HRSA has supported the adoption of health IT by health centers, other safety net providers and ambulatory care providers since the 1980s through various grant programs ranging from operational funding to funding dedicated to EHR implementation.

What is HRSA's Vision for Health IT?
The Health Resources and Services Administration (HRSA) and its Office of Health Information Technology and Quality (OHITQ) have begun to play a unique and critical role in the national strategy for health IT. HRSA's vision is to leverage the power of health IT to improve patient outcomes, quality, and reduce health disparities for people who are uninsured, isolated, or medically vulnerable. As part of its mission, HRSA aims to provide health centers, other safety net providers, and ambulatory care providers with tools to successfully implement health IT in a manner appropriate for their and their patients' needs and abilities. The HIT Toolbox Series is a central component of this effort. In addition, OHITQ has initiated a Health IT Technical Assistance Center to support grantees that use the toolbox or who are otherwise engaged in health IT implementation.

Financial incentives are available for the "meaningful use" of Electronic Health Records (EHRs)

The American Recovery and Reinvestment Act (ARRA) created financial incentives for health centers and other providers to make "Meaningful Use" of Electronic Health Records (EHRs): ARRA created financial incentives to encourage health care providers to adopt and use EHRs. The term "meaningful use" is often used to refer to these payments, as a provider must use the HIT in a "meaningful" way (e.g., for e-prescribing) in order to be eligible for the payments.

Incentive payments are made to individual providers; rather than the health centers: The ARRA statute requires that incentive payments must be made to *individual* providers, rather than to the health center itself. This is the case even if the EHR-related expenses that resulted in the incentive payments were paid by the health center. Providers may choose to give their incentive payments to their health center, through a process known as "assignment." However, providers are **not** required to assign their payments. Also, providers may use the payments for any purpose (professional or personal) they choose.

Health Center providers will get their payments through Medicaid: While both Medicare and Medicaid will be offering incentive payments to eligible providers to use EHRs, all providers must choose to receive payments from only one of these programs. Because of the way they are reimbursed, health center providers are only eligible to receive payments through Medicaid.
To apply for these payments, contact your State Medicaid agency. The policies and timelines for applying vary by State.

Amount and duration of payments:

Payments will cover up to 85% of allowable costs and be spaced out over 6 years: These payments may cover up to 85 percent of "allowable costs" for the ***acquisition, implementation (including training), upgrade, maintenance***, and use of a "certified electronic health record" system, and will be made over a 6-year period.

Maximum payment per provider is $63,750: A provider's "allowable costs" may not exceed $25,000 in the first year that he or she requests payment, and $10,000 for each of the next 5 years; thus the maximum allowable 6-year costs per eligible professional will be $75,000 ($25,000 plus 5 times $10,000), and the maximum Federal payment will be $63,750 per eligible professional (85 percent of $75,000) over a period of six years.

Providers must begin to receive incentive payments by 2014: Health center providers may request their first year of payments any year between 2011 and 2014. Starting in 2015, first-year applications will no longer be accepted.

Definition of "Eligible Providers" (EPs)

Requirements to be an "Eligible Provider" at a health center: To be an "Eligible Provider" for the incentive payments, an individual health center provider must:

- Be licensed:
    - Physicians (primarily doctors of medicine and doctors of osteopathy)
    - Nurse practitioner
    - Certified nurse-midwife
    - Dentist
    - Physician assistant who furnishes services in a Federally Qualified Health Center or Rural Health Clinic that is led by a physician assistant.
- Have at least 30 percent of their patient volume attributable to "needy individuals", defined as patients covered by Medicaid or CHIP; receiving charity care; and/or paying for their care on a sliding-fee scale basis.
- Demonstrate "meaningful use" of the EHR system, meaning that they are "engaged in efforts to adopt such a system" in their first year, and that they can show they are using it through use of certain billing and reporting methods in years 2 through 6.

Only some Physician Assistants are eligible: The statute limits "eligible providers" to physicians, dentists, certified nurse mid-wives, nurse practitioners and only those physician assistants who are practicing in a health center that is led by a PA. For a health center to be considered to be "PA-led," at least one of the following requirements must be met:

- A PA must be the primary provider in the health center: or

- A PA must serve as a clinical or medical director at a clinical site of practice

(Note that the only PAs who are eligible to receive Medicaid incentive payments are those who work at health centers or RHCs; PAs working at any other types of organization are not eligible.)

Links and Additional Resources:

HRSA Health IT and Quality Website: Tools for Improving Quality.

HRSA Health IT Adoption Toolboxes.

HRSA Health IT and Quality Resource Toolbox.

HRSA Health IT for Children's Health Toolbox.

Rural Health IT Adoption Toolbox.

HRSA Health IT and Quality Webinar Archives.

Centers for Medicare & Medicaid Services EHR Incentive Programs.

Centers for Medicare & Medicaid Services Path to Payment page. Guidance on how to apply for and receive incentive payments.

HRSA: Medicare and Medicaid EHR Incentive Programs FQHCs' FAQs.

HHS Office of the National Coordinator for Health Information Technology.

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2. Need

2a. Program Requirement 1: Needs Assessment

Requirement: Health center has a documented assessment of the needs of its target population, and has updated its service area if/when appropriate.

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

Questions from review of the bŜøfè CdzyŘŜŘ I ŜI·fűK /ŜyűŜ Application and current status:

- Do you have a current written needs assessment and a plan for periodically updating this needs assessment?
- Do you have a clearly defined target population to be served and a service delivery plan that is based on the needs assessment?

Links and Additional Resources:

Your grant application's Form 1A: "General Information Worksheet" contains information on your proposed target population. This link is for reference purposes only.

BPHC Health Center Need Policy Page.

Data Resources for Demonstrating Need for Primary Care Services: A guide on how to find, extrapolate, and utilize data to make informed decisions and maintain a good understanding of community needs in your service area.

The UDS Mapper: A useful tool for determining service areas, and assessing service area overlap, among other concerns. You will need to sign up for a free account.

HRSA Geospatial Data Warehouse: Information and assistance about HRSA's mapping features and the applications to assist you in creating a map of your neighborhood or potential service area.

Table 1: Needs Assessment Questions
This checklist is intended to help assess whether a grantee's needs assessment follows recommended practices.

#	Question	Answer
1.	Does the needs assessment encompass all activities that are intended to be in scope? If not, should any request for change be considered?	
2.	When was the last needs assessment completed or updated?	
3.	Was it reviewed and approved by the Board? If yes, when?	
4.	What priority needs have been identified?	
5.	What action has been taken to address them?	
6.	Is there a plan for the grantee to update their service area based on more recent data? If not, is this recommended?	

3. Services

3a. Program Requirement 2: Required and Additional Services

This page contains information and checklists to help assess whether a grantee provides all of the required services directly or through written arrangements and referrals, as well as optional services for consideration.

Requirement: 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.

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

Where to Look for Answers: 1) Clinical Practices and Operating Policies and Procedures, 2) Documentation of services provided via formal written agreements and/or via formal written referral arrangements. Review the status of required clinical and non-clinical services in Form 5A as submitted in the Newly Funded Health Center application. The services listed require verification within 120 days of award. Please see PIN 2008-01 for information and instructions regarding how to update the scope of project.

Links and Additional Resources:

BPHC Health Center Services Policy Page.

The MSCG Resource Center Services Page*.

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Table 2: Required Non-Clinical Services Questions
This checklist is useful for decisions related to referrals to required services and translation services. A thorough needs assessment can help determine what services should be included, and in what ways.

#	Question	Answer
1	For grantees providing interpretation/translation services (Required only for grantees serving a substantial number of patients with limited English proficiency; optional for other grantees.):	**Yes/No**
1.a.	Does the type of interpretation/translation services provided appear to be appropriate for the size/needs of the grantee (e.g., bilingual providers, onsite interpreter, language telephone line)?	
1.b.	Are the Registration Form, Sliding Fee Scale, and other pertinent documents provided to patients in the appropriate languages?	
2	For all required services, provided by an outside organization/provider, either through agreement or formal referral:	**Yes/No**

#	Question	Answer
2.a.	Is a contract or written agreement (e.g., MOA/MOU) in place with the outside organization/provider that at minimum describes services and fees or the manner by which the referral will be made and managed, and the process for referring patients back to the grantee for appropriate follow-up care?	
2.b.	For formal referral arrangements, is the health center appropriately tracking and providing follow-up care for referred patients?	
2.c.	Does the outside organization/provider offer the service to health center patients based on a sliding fee discount schedule?	
2.d.	Is the service available equally to all health center patients, regardless of ability to pay?	
2.e.	Has the license of the outside provider been verified?	
2.f.	Has the certification of the lead provider been verified?	

Table 3: Additional Services Questions

This checklist is useful for decisions related to cultural competency, on-site emergency services, pharmacy services, and referrals to specialists. A thorough needs assessment can help determine what services should be included, and in what ways.

#	Question	Answer
1	Regarding cultural competency:	
1.a.	Are there cultural competency training opportunities for the staff?	
1.b.	If yes, how frequently are these trainings offered? If no, are there plans to establish these trainings?	
1.c.	Are the following employees bilingual: Operator, Front Desk staff, Cashier?	
2	Regarding on-site emergency services:	**Yes/No**
2.a.	Is a crash cart on site?	
2.b.	If yes, is content-compliance monitoring documented?	
2.c.	Does the grantee have written protocols for “in-house” emergency care?	
2.d.	Is the staff adequately trained and currently certified in emergency procedures?	
2.e.	Do procedures exist for the orderly transfer of patient to the hospital via EMS?	
3	Is the grantee’s pharmacy provider:	**Yes/No**
3.a.	Located in-house or off-site?	
3.b.	If off-site, is it owned by the grantee?	
3.c.	A participant in the Federal Drug Pricing (340B) program?	
4	If the grantee provides pharmacy services either on-site or through an off-site provider that it owns or manages:	**Yes/No**
4.a.	Has a clinical committee established a formulary to ensure cost-effective prescribing?	

#	Question	Answer
4.b.	Is there a policy regarding acceptance, stocking, logging, and recording of dispensed sample medications?	
5	Regarding referrals to specialists:	
5.a.	What is the level of specialist availability for referrals?	
5.b.	Are there written procedures and tracking mechanisms in place for specialty referrals?	
5.c.	Is there a system for following-up on missed specialty care appointments?	

3b. Program Requirement 3: Staffing

Requirement: 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.

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

Questions based on review of the application and implementation status:

- Is the core staff, (those responsible for carrying out both clinical and enabling services) appropriate for serving the patient population?
- Are all staff appropriately credentialed and licensed?

Documents to Review for Answers: 1) Staffing Profile; 2) Contracts, Agreements, and Subrecipient Arrangements related to staffing (as applicable); 3) Credentialing and Privileging Policies and Procedures; 4) Personnel Manual; 5) Personnel Files Checklist/Matrix; 6) Position descriptions; 7) Staff evaluation forms; 8) Provider contracts; 9) Orientation guide for new staff; 10) Employee satisfaction surveys

Links and Additional Resources:

Your grant application's Form 2: "Proposed Staffing Profile" contains information on your proposed staffing plan. This link is for reference purposes only.

HRSA Policy Information Notice (PIN) 2002-22: Clarification of Bureau of Primary Health Care Credentialing & Privileging Policy Outlined in PIN 01-16.

The MSCG Resource Center Policy Template.
The MSCG Resource Center's main page for personnel documents; See the documents,

- Employee Handbook CHC*,
- Safety Net Dental Clinic Manual Credentialing and Privileging section*, and
- Personnel Policies and Procedures*.

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Table 4: Staffing Questions

These questions will be useful for decisions related to budgeting for staff, personnel policies, credentialing, performance and several other key human resources functions that health centers routinely perform.

#	Question	Answer
1	Budgeted vs. actual staffing levels	
1.a.	What is the budgeted FTE provider staffing for the current calendar year?	
1.b.	What is the actual FTE provider staffing?	
1.c.	What is the budgeted FTE administrative staff for the current calendar year?	
1.d.	What is the actual FTE administrative staff?	
2	Personnel Policies / Employee Handbook	
2.a.	Does the center have a personnel manual?	
2.b.	When was it most recently approved by the Board?	
2.c.	Does each new employee receive a copy of the personnel manual?	
2.d.	Do employees receive policy updates as available?	
3	Personnel Files	
3.a.	Are personnel files maintained in a secure location with restricted access?	
3.b.	Are there rules on accessing and releasing information from personnel files?	
3.c.	Is access to the files recorded?	
3.d.	Is there a standard format for non-clinical personnel files, for clinical personnel files, and for terminated personnel files?	
3.e.	Are personnel's medical files maintained in location separate from patient medical records?	
4	Position Descriptions (PDs)	
4.a.	Are PDs maintained in a central location?	
4.b.	Are PDs written for all categories of staff?	
4.c.	Do all PDs have a standard format?	
5	Job Descriptions	
5.a.	Do employees have a current job description?	
5.b.	Have employees signed their job description?	
5.c.	Are employees' jobs consistent with their descriptions?	
6	Performance Evaluations	
6.a.	Are evaluations conducted at least annually?	
6.b.	Is there a standard form used for evaluations?	
6.c.	Do the employees sign the evaluations?	
6.d.	Do the supervisors sign the evaluations?	

#	Question	Answer
6.e.	Do the evaluations include a place for employee comments?	
6.f.	Is there an employee appeal process?	
7	Clinical Staff	
7.a.	Is a provider with training in pediatrics available to see patients during all normal operating hours?	
7.b.	Is a provider with training in OB/Gyn available to see patients during all normal operating hours?	
7.c.	Is a provider with training in adult primary care available to see patients during all normal operating hours?	
7.d.	Are clinical staff being hired in a timely manner?	
7.e.	Is there adequate leave and funding for continuing professional education?	
7.f.	Does provider recruitment and retention need to be addressed?	
7.g.	Are QI/QA/CQI responsibilities included in medical staff members' job descriptions?	
8	Provider Credentialing and Privileging	
8.a.	Is there a formal provider credentialing and privileging process (for insurance companies and other third-party payors as well as clinical privileges)?	
8.b.	Has the Board approved this process?	
8.c.	Are providers required to complete the privileging process before starting to see patients?	
9	Do employment contracts address:	
9.a.	Contract length?	
9.b.	On-call requirements?	
9.c.	Cross coverage requirements?	
9.d.	Compensation and incentives?	
9.e.	Continuing education?	
9.f.	Moonlighting?	
9.g.	Conflict of Interest and Non-compete provisions?	
9.h.	Malpractice coverage?	
9.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	
12.a.	Does the center conduct employee satisfaction surveys?	
12.b.	If yes, how does the center respond to information gained from the surveys?	

3c. Program Requirement 4: Accessible Hours of Operation/Locations

Requirements:

- Health center provides services at **times** that assure accessibility and meet the needs of the population to be served.
- Health center provides services at **locations** that assure accessibility and meet the needs of the population to be served.

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

Where to Look for Answers: 1) Hours of Operation, 2) Most recent Form 5B: Service Sites [Note that the form lists only the TOTAL number of hours per week each site is open, not the specific schedule], 3) Service Area Map with site locations noted.

Links and Additional Resources:
HRSA Health Center Patient Satisfaction Survey.

The MSCG Resource Center Services Page*.

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Table 5: Accessible Hours of Operation and Locations Questions
These questions are intended to help grantees self-assess how well they are meeting the accessibility needs of their target population(s).

#	Question	Answer
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 posted in the appropriate languages for the population?	
3	Is the internal/external signage (including exit signs) clear, properly placed, and sufficient in number?	
4	Is the size of the facility adequate to the population to be served?	

3d. Program Requirement 5: After Hours Coverage

Requirements:

- Health center provides professional coverage during hours when the center is closed.

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

Where to Look for Answers: Policy for after-hours coverage.

Links and Additional Resources: There are no applicable resources on this topic. Your State PCA may have more information on this topic.

Table 6: After Hours Coverage Questions
These questions are intended to help grantees self-assess how well they are meeting the after-hours accessibility needs of their target populations.

#	Question	Answer
1	Is professional medical coverage available to patients when the center is closed?	
2	Does the general phone system provide information on how to access emergency care after hours?	
3	Is the answering service and/or provider able to communicate in the appropriate languages to serve the population?	
4	Is the written information and/or phone message about accessing care after hours provided in the appropriate languages?	
5	What mechanisms/arrangements does the grantee have for after hours coverage (e.g., does it include the health center clinicians, does it use other community clinicians)?	
6	Do all patients receive a written or verbal explanation regarding the procedures for accessing emergency medical/dental care after hours?	
7	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?	

3e. Program Requirement 6: Hospital Admitting Privileges and Continuum of Care

Requirements:

- Health center physicians have admitting privileges at one or more referral hospitals, or other arrangements to ensure continuity of care.
- If hospital arrangements (including admitting privileges and membership) are not possible, does the applicant organization have firmly established arrangements for hospitalization, discharge planning, and patient tracking to ensure continuity of care?

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

Where to Look for Answers: 1) Hospital Agreements, 2) Most recent Form 5C: Other Activities/Locations (hospitals where health center providers have admitting privileges should be noted on the form)

Links and Additional Resources: There are no applicable resources on this topic. Your State PCA may have more information on this topic.

Table 7: Hospital Admitting Privileges and Continuum of Care Questions
These questions are intended to help grantees self-assess how well they are meeting the Continuum of Care needs of their target population.

#	Question	Answer
1	Do the health center's physicians admit and follow hospitalized patients?	
2	If not, is there a formal, written agreement outlining arrangements for: • Hospitalization? • Discharge planning? • Patient tracking?	
3	When physicians do not follow patients in the hospital, how is continuity of care ensured?	
4	Do the formal written agreements with the hospital(s) address: • Compensation for services rendered? • Admission notification? • Discharge follow-up? • Exchange of information?	
5	How is a continuum of care ensured for homeless patients?	

3f. Program Requirement 7: Sliding Fee Discounts

Requirements:

- 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 the Federal poverty guidelines, 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.

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

Documents to Review for Answers: 1) Fee Schedule/Schedule of Charges; 2) Sliding Fee Schedule/Schedule of Discounts; 3) Eligibility Standards/Policy for patient discounts; 4) Sliding Fee Application Form; 5) Self-Declaration Form; 6) Payment agreement form

Links and Additional Resources:

Your grant application's Form 3: "Income Analysis Form." Part 1 of this form contains information on your sliding fee scale. This link is for reference purposes only.

HRSA, BPHC TA resources page for sliding fee scale, with links to slide scale fee regulations, poverty guidelines, and requirements.*

HHS definitions and measures of poverty.

The MSCG Resource Center Management and Finance*:
See the documents: Info on SFDS from BPHC website*,

- Sample Sliding Fee Discount Policy and Procedures*,
- Sample Sliding Fee Eligibility Application*, and
- Sample Sliding Fee Scale*.

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Table 8: Sliding Fee Scale Questions

These questions are intended to help assess that a grantee has implemented a sliding fee discount program.

#	Question	Answer
1.a.	Are all health center patients provided services regardless of ability to pay?	
1.b.	Are there mechanisms (such as signs) for communicating the availability of discounts for eligible low-income persons?	
2.a.	Does the health center's fee schedule(s) cover the cost of all types of visits (i.e. medical, dental, etc.), procedures, lab tests, and other ancillary services within the approved scope of project?	
2.b.	Is the schedule of fees or payments consistent with locally prevailing rates or charges and designed to cover the reasonable costs of operation?	
2.c.	Does the health center have a written policy for the sliding fee discount schedule so as to assure it is applied equally to all patients?	
3.a.	Do individuals and families below 100% of poverty receive a full discount, other than perhaps nominal fees?	
3.b.	Are individuals and families between 100% and 200% of poverty charged a fee according to a sliding fee discount policy based on family size and income?	
3.c.	Are individuals and families above 200% of poverty charged a non-discounted rate?	
3.d	Does the health center have a written policy for the sliding fee discount schedule that assures it will be applied equally to all patients?	

Table 9: Additional Sliding Fee Scale Questions

These questions are intended to help grantees improve the purpose and function of their sliding fee discount program.

#	Question	Answer
1	Are the following items available in languages appropriate to the patient mix?	
1.a.	Are the mechanisms for announcing the availability of discounts adequate and appropriate given the space and population being served?	
1.b.	Description of the how the sliding fee discount schedule (SFDS) works?	
2	Are all patients evaluated during registration to determine eligibility for the SFDS?	
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 there a mechanism in place that assures that the health center's schedule of fees/payments and corresponding SFDS is reviewed and updated on an annual or other regular basis as appropriate?	
5	To apply for the SFDS, the patients are required to complete an application form that:	
5.a.	Requests their name and date of birth?	
5.b.	Reflects or requires documentation of family size?	
5.c.	Lists all forms of income?	
5.d.	Includes a statement about the consequences of providing false information?	
5.e.	Requires the patient's signature?	
5.f.	Requires a staff person's verification and signature?	
5.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?	

3g. Program Requirement 8: Quality Improvement/Assurance Plan

Requirements:
Health center has an ongoing Quality Improvement/Quality Assurance (QI/QA) program that includes clinical services and management, and that maintains the confidentiality of patient records. The QI/QA program must include:

- a clinical director whose focus of responsibility is to support the quality improvement/assurance program and the provision of high quality patient care;
- periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the health center; and such assessments shall:
    be conducted by physicians or by other licensed health professionals under the supervision of physicians; be based on the systematic collection and evaluation of patient records; and identify and document the necessity for change in the provision of services by the health center and result in the institution of such change, where indicated.

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

Documents to Review for Answers: 1) QI/QA plan, 2) Clinical Director's job description

Links and Additional Resources:

The BPHC Quality, Risk Management and Quality Improvement Page.

HRSA Quality Improvement Page; see "Tips for Implementing Your Quality Improvement Program," "How to Leverage Resources to Design a Successful Health Center Quality Improvement Program," and "Maximizing the Effectiveness of Quality Improvement Plans."

The Agency for Healthcare Research and Quality maintains the "Innovations Exchange" where you can go to find evidence based research and tools to help solve clinical quality and patient care process problems. In addition, AHRQ's Center for Primary Care, Prevention, and Clinical Partnerships (CP3) expands the knowledge base for clinical providers and patients and to assure the translation of new knowledge and systems improvement into primary care practice. CP3 supports and conducts research to improve the access, effectiveness, and quality of primary and preventive health care services in the United States – more information is available at the CP3 website.

Report to Congress: Efforts to Expand and Accelerate Health Center Program Quality Improvement.

The MSCG Resource Center Quality Assurance Page*
See:

- QI Policies and Procedures*,
- How to Develop a Risk Management Plan*,
- Sample Performance Improvement Plan-Primary Health Care*, and
- Sample Risk Management Plan*.

The MSCG Resource Center Clinical Documentation* page.
See:

- Guideline for Records Maintenance*.

The MSCG Resource Center: Sample Performance Improvement Plan*.

The MSCG Resource Center: Health Care Plan* page.

The ECRI Institute: Clinical Risk Management Program* page.

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Table 10: Quality Improvement/Assurance Plan Questions

These questions are intended to assist in assessing the quality of the quality improvement/assurance plan.

#	Question	Answer
1	Does the health center's QI/QA program:	
1.a.	Address both clinical services and management?	
1.b.	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?	
1.c.	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. 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?	
1.d.	Include periodic assessments of the appropriateness of both the utilization and quality of services?	
2	Are these assessments (see 1d., above):	
2.a.	Conducted by physicians or licensed health professionals under physician supervision?	
2.b.	Based on the systematic collection and evaluation of patient records?	
2.c.	Used to identify and document necessary changes?	
2.d.	Used to inform and change the provision of services if necessary?	

Table 11: Additional Quality Improvement/Assurance Questions

These questions are intended to assist grantees with continuous quality improvement.

#	Question	Answer
1	Is there a mechanism in place to assure that the QI/ QA plan is reviewed and approved by the Board on a regular basis?	
2	Are the roles and responsibilities of the following clearly defined in the QA/QI plan?	
2.a.	The Board	
2.b.	Management Staff	

#	Question	Answer
2.c.	Clinical Director	
3	Does the QI/QA plan address all operations areas of the health center, incorporating indicators for:	
3.a.	Clinical issues?	
3.b.	Environmental issues?	
3.c.	Management issues?	
3.d.	Financial issues?	
3.e.	Patient experience?	
4	Regarding reports:	
4.a.	Are the results of QI audits reported to appropriate committees, nursing, pharmacy, providers, etc.?	
4.b.	Is there an effective method to assure information reported is accurate, timely and available in formats to allow board, staff, and stake holders to make informed decisions?	
5	When deficiencies are identified:	
5.a.	Are there follow-up reports to the Board?	
5.b.	Are Action Plans implemented to correct the deficiencies?	
6	Regarding medical records:	
6.a.	Is there an individual qualified by training or experience responsible for the supervision and direction of the medical records system?	
6.b.	Are portable immunization or prenatal records made available to the patients?	
6.c.	Is there a standardized content and organization for medical records?	
6.d.	Is the medical record system compliant with HIPAA?	
6.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?	
6.f.	Are migrant farmworkers and other mobile populations informed of the availability of bridge case-management/record transfer and tracking services provided by the Migrant Clinicians Health Network?	
7	Risk Management	
7.a.	Is there a Safety Committee and / or Safety Officer?	
7.b.	Is there a written procedure to report/track incidents/potential risks? Does it State who is responsible to track and report?	
7.c.	Are incidents analyzed, patterns observed and improvements made to reduce future risks?	
7.d.	Does the center meet the requirements to be deemed eligible for FTCA professional liability coverage?	
7.e.	Is there any pending litigation under FTCA?	

#	Question	Answer
8	Out-of-Scope Activities	
8.a.	Is the center involved in out-of-scope activity (e.g., renting space to another organization, providing services not included in defined scope of service)?	
8.b.	If yes, does the center have coverage separate from FTCA for this activity?	
8.c.	If yes, is the center expending Federal funds on out of scope services?	
9	Does the grantee have insurance coverage in place for the following:	
9.a.	General liability?	
9.b.	Directors and officers liability?	
9.c.	Malpractice, including any tail or gap coverage?	
9.d.	Property?	
9.e.	Business interruption/revenue loss?	
9.f.	Automobile/ vehicle?	

4. Management and Finance

4a. Program Requirement 9: Key Management Staff

Requirement: Health center maintains a fully staffed health center management team as appropriate for the size and needs of the center. Prior review by HRSA of final candidates for Project Director/Executive Director/CEO position is required.

Authority: Section 330(k)(3)(H)(ii) of the PHS Act and 45 CFR Part 74.25 (c)(2),(3)

Where to look for answers: 1) Key Management Staff job descriptions, 2) Performance Evaluation forms for key management staff, 3) Staffing/ Organizational Chart

Links and Additional Resources:
Executive Officer Performance Assessment*.

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Table 12: Key Management Staff Questions
These questions are intended to help grantees self-assess whether they are maintaining a fully staffed health center management team.

#	Question	Answer
1.	Does the health center have a Chief Executive Officer or Executive Director/Project Director?	
2.	Does the management team include a Clinical Director, Nursing/Health Services Director, Chief Financial Officer, and Chief Information Officer or other key management staff as appropriate for the size of the organization?	
3.	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 Project Director, the Project Officer and/or consultant may wish to remind the grantee that this is a "Prior Approval Request" that must be submitted/ processed via the EHB Prior Approval Module and to contact their Project Officer for further information as needed.	

Table 13: Additional Key Management Staff Questions
These questions are intended to help in assessing how a grantee can improve their management practices for key management staff.

#	Question	Answer
1.	Are key management staff directly employed by the health center?	
2.	Are key strategic planning goals tied to the performance evaluations for senior management staff?	
3.	What is the Chief Financial Officer's professional background?	
4.	For the Clinical or Medical Director:	
4.a.	Does he/she advise the CEO and Board on clinical issues, including QA/QI?	
4.b.	Does he/she have the lead responsibility to hire/dismiss clinical staff?	
4.c.	Does he/she have sufficient time in his/her weekly schedule to adequately carry out the dual responsibilities of provider and administrator?	
4.d.	Are methods in place to ensure competency in key positions?	
4.e.	If the health center has multiple sites, what systems are in place to manage/ coordinate operations among the sites?	
4.f.	Are there opportunities for improved communication, interaction, or support between the Senior Management Team and the Board?	

4b. Program Requirement 10: Contractual/Affiliation Agreements

Requirements: Health center exercises appropriate oversight and authority over all contracted services. Health center assures that any sub recipient(s) meets the Health Center Program requirements

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)))

Links and Additional Resources:

Your grant application's Form 8: "Health Center Affiliation Certification and Health Center Affiliation Checklist" contains your existing agreements with other entities. This link is for reference purposes only.

PIN 1997-27: Affiliation Agreements.

PIN 1998-24: Amendment to PIN 1997-27 Regarding Affiliation Agreements of Community & Migrant Health Centers.

Table 14: Contractual/Affiliation Agreements Questions
These questions are intended to help assess the grantee's affiliations with other entities, with specific interest in formal agreements.

#	Question	Answer
1.	Do any of the grantee's contracts or affiliation agreements have the potential to:	
1.a.	Threaten the grantee's integrity?	
1.b.	Limit its autonomy?	
1.c.	Compromise its compliance with Federal program requirements in terms of corporate structure, governance, management, finance, health services, and/or clinical operations?	
2.	**For grantees with subrecipient arrangements ONLY:** Does the grantee have a system in place to assure that the subrecipient organization complies with all Health Center Program statutory and regulatory requirements on an ongoing basis?	

4c. Program Requirement 11: Collaborative Relationships

Requirements:

- 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 Federally Qualified Health Center(s) in the service area or provides an explanation for why such letter(s) of support cannot be obtained

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

Questions from review of the bŜøfè CdzyŘŜŘ I ŜI·fűK /ŜyűŜ application and current status:

- 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?
- If there is another Federally Qualified Health Center(s) (FQHC), rural health clinic, critical access hospital or other safety net provider in the health center's service area? Was the grantee able to secure letter(s) of support from these organizations?
- If the health center was unable to get letter(s) of support from these other safety net providers, why not and is the grantee working to improve or implement collaborative relationships with these organizations?

Documents to Review for Answers: 1) Letters of Support; 2) Memorandums of Agreement/Understanding

Links and Additional Resources:

UDS Mapper tool, available here (free login required).

PIN 97-27: Affiliation Agreements of Community and Migrant Health Centers.

PIN 98-24: Amendment to PIN 97-27 Regarding Affiliation Agreements of Community and Migrant Health Centers.

Program Assistance Letter (PAL) 2011-02: Health Center Collaboration

Table 15: Collaborative Relationships Questions
This checklist is intended to help assess how a grantee can improve its working relationships with other community stakeholders in their area.

#	Question	Answer
1	How could the grantee strengthen its working relationships with area:	
1.a.	Hospitals?	
1.b.	Public health departments/entities?	
1.c.	Private providers?	
1.d.	Elected officials?	
1.e.	Other nearby health centers?	
1.f.	Other community stakeholders, including social service providers?	
2	If the grantee was unable to secure a letter of support from the existing health center(s) in the service area, what steps could the grantee take to improve this relationship?	

4d. Program Requirement 12: Financial Management and Control Policies

Requirements:
Health center maintains accounting and internal control systems that:

- Are appropriate to the size and complexity of the organization.
- Reflect Generally Accepted Accounting Principles (GAAP).
- Separate functions in a manner appropriate to the organization's size in order to safeguard assets and maintain financial stability.

Health center assures that:

- 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.
- A corrective action plan addressing all findings, questioned costs, reportable conditions, and material weaknesses cited in the Audit Report is submitted.

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

Questions from review of the bŜǿfè CdzyŘŜŘ I ŜI·fűK /ŜyűŜ application and current status:

- Are the grantee's accounting and internal control systems:
  - Appropriate to the organization's size and complexity?
  - Reflective of GAAP?
  - Designed to separate functions in a manner appropriate to the organization's size in order to safeguard assets?
  - Designed to separate functions in a manner appropriate to the organization's size in order to maintain financial stability?
- Is an audit performed annually, in accordance with Federal requirements?
- Did the grantee's corrective action plan address all findings, questioned costs, reportable conditions, and material weaknesses (if applicable) found in the Audit Report?
- Does the Board review the grantee's corrective actions regularly?

Documents to Review for Answers: 1) Chart of Accounts, 2) Visit Report, 3) Provider Productivity Report, 4) Balance Sheet, 5) Income Statement, 6) Health Center Required Financial Performance Measures

Links and Additional Resources:

The BPHC Health Center Management and Finance Policy Page.

Printer-Friendly Updated FY 2012 Clinical and Financial Performance Measures:

The MSCG Resource Center Financial Management and Control Policies Page*.

The MSCG Resource Center Business Plan page*.

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Table 16: Financial Management and Control Policies Questions

These questions are intended to assess how well the grantee's financial practices are in line with requirements and general rules of accounting.

#	Questions	Answers
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):	
3.a.	Comparative balance sheet?	
3.b.	Income statement showing variances from budget?	
3.c.	Report on visit activity compared to budget by payor type?	
3.d.	Report on monthly provider productivity	
3.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:	
4.a.	Adequate cash on hand/working capital?	
4.b.	A reasonable level of accounts receivable?	
4.c.	A reasonable level of accounts payable?	
5	Are expenses appropriately allocated to:	
5.a.	Cost centers?	
5.b.	Multiple funding sources?	
5.c.	Multiple sites?	
6	Regarding disbursements:	
6.a.	Does the health center have written purchasing and cash disbursements policies?	
6.b.	Is there a reasonable separation of disbursement duties?	
6.c.	In some manner, is every disbursement reviewed and approved by two people?	
6.d.	Is this two-person review and approval documented?	
7	Regarding the chart of accounts:	
7.a.	Is it adequate to yield good financial statements?	
7.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:	
8.a.	Accounting for patient services revenues and accounts receivable?	

#	Questions	Answers
8.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?	
8.c.	Capturing: • Accounts payable? • Accrued payroll? • Uncompensated absences? • Deferred and unearned revenue? • Depreciation expense? • Bad debt write-off?	

Table 17: Additional Financial Management and Control Policies Questions

These questions are intended to help grantees improve their financial management and control policies.

#	Question	Answer
9	Does the health center know the expected breakeven point for operations in terms of patient volume and mix to ensure viable fiscal operations?	
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 visits by type (medical, dental, mental health), and other elements from the UDS tables?	
11	Regarding Managed Care contracts:	
11.a.	Are all health center providers approved providers? If not, why not?	
11.b.	Is health center staff aware of all managed care contracts in place and the degree of financial risk associated with each?	
11.c.	Does the health center's practice management system enable it to manage the risks/ rewards?	
11.d.	Are there clear requirements for prior authorization and utilization of specific panel specialists?	
11.e.	Are written policies and procedures in place that describe the utilization review process and management of this data?	
11.f.	Who is responsible for keeping up with and monitoring the managed care contracts and review of data reported?	
11.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, Self-Pay, and Private Insurance:	
12.a.	What is the <u>projected</u> penetration rate on an <u>annual</u> basis?	
12.b.	What is the <u>projected</u> penetration rate on a <u>monthly</u> basis?	
12.c.	What has been the <u>actual monthly</u> penetration rate experience to date?	

#	Question	Answer
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:	
15.a.	How is the auditor selected? Is an RFP issued?	
15.b.	What is the role of the Board in selecting an auditor?	
15.c.	Does the Board review and approve the annual audit?	
16	Are full fee for service charges recorded for every visit regardless of payer source (including for capitated services) and appropriate allowances being recorded in offsetting accounts?	
17	Regarding signatory policies:	
17.a.	Who are the authorized signers?	
17.b.	Who primarily signs checks?	
17.c.	Is more than one signature required to clear financial transactions?	
17.d.	Is there a dollar threshold established for requiring more than one signature? What is it?	
17.e.	Do policies prohibit signing checks made payable to self?	

4e. Program Requirement 13: Billing and Collections

Requirements:
Health center has systems in place to maximize collections and reimbursement for its costs in providing health services. These systems include written policies and procedures addressing:

- Billing
- Credit
- Collections

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

Documents to Review for Answers: 1) Policies and procedures for credit, collection, and billing; 2) Visit form

Links and Additional Resources:

Your grant application's Form 3: "Income Analysis Form" contains your assumptions and projections for billing and collections. This link is for reference purposes only.

MSCG Resource Center Billing and Collections Page*

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Table 18: Billing and Collections Questions
These questions are intended to help grantees in assessing their practices regarding health center billing and collections.

#	Questions	Answers
1	Health center has systems in place to maximize collections and reimbursement for its costs in providing health services.	
1.a.	Does the visit form include all billable services (on-site and off-site)?	
1.b.	Does the grantee have Medicare and Medicaid provider numbers?	
2	Does the grantee have Board approved written policies and procedures for:	
2.a.	Billing	
2.b.	Credit	
2.c.	Collections	

Table 19: Additional Billing and Collections Questions
These questions are intended to help grantees in streamlining and improving the efficiency of their billing and collection processes.

#	Question	Answer
1	Visit Form	
1.a.	Does the health center have a visit form?	
1.b.	Does the visit form reflect the scope of practice of each provider?	
1.c.	Do the ICD and CPT Codes reflect the most current updates?	
1.d.	Do the ICD and CPT Codes meet State billing coding requirements?	
1.e.	Are all visits recorded in the MIS within 24 hours of service? If not, what is the lag time?	
1.f.	Is a procedure in place to identify and find missing visit forms on a timely basis?	
1.g.	Are off-site visits reported and billed on a timely basis?	
1.h.	How does the grantee know if all off-site activity is being reported?	
2	Medicaid and Medicare	
2.a.	Are Medicare and Medicaid billed electronically and is the appropriate billing number used?	
2.b.	If not, how does the grantee address systems problems that arise?	
2.c.	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?	
2.d.	Are Medicare and Medicaid and other material third party payers billed at least weekly?	
2.e.	What is the billing procedure?	
3	Other Third-Party Billing	
3.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?	
3.b.	If a third party billing is not responded to in 30 days, are effective follow-up procedures done?	
4	Self-Pay	
4.a.	Is payment at the time of service encouraged?	
4.b.	If self pay billings are not paid in 30 days, what is done?	
5	Accounts Receivable	
5.a.	How many days of net revenue are tied up in accounts receivable?	
5.b.	Are the indicators acceptable or are receivable collections lagging?	
5.c.	Are rejected claims corrected and resubmitted within a week? If not, what is the lag time?	

4f. Program Requirement 14: Budget

Requirements:
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.

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

Documents to Review for Answers:
Annual health center budget and business plans.

Links and Additional Resources:

Your grant application's Form 3: "Income Analysis Form" contains your budgetary assumptions. This link is for reference purposes only.

MSCG Resource Center Financial Management Page*

MSCG Resource Center Business Plan Page*

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Table 20: Budget Questions
These questions are intended to assess whether a grantee has an appropriate process for creating and reviewing health center operating plans and budgets.

#	Questions	Answers
1.	Does grantee have an annual operating/ business plan?	
2.	Has the annual operating/ business plan been approved by the Board? If so, when?	
3.	How often does the Board review variance from the operating plan/ budget?	
4.	Does the grantee have a capital plan?	
5.	Has the capital plan been approved by the Board? If so, when?	

4g. Program Requirement 15: Program Data Reporting Systems

Requirements:
Health center has systems in place which:

- Accurately collect and analyze data for program reporting.
- Support management decision making.

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

Documents to Review for Answers:
1) Most recent UDS report and UDS Health Center Trend Report (if available; may not be applicable to Newly Funded Health Centers); 2) Most recent Clinical and Financial Performance Measures (if available; may not be applicable to Newly Funded Health Centers) 3) Strategic Plan; 4) Annual Operating Plan; 5) Capital Plan

Links and Additional Resources:

BPHC UDS Website.

Federal Financial Report (FFR) Quick Guide.

- In addition, an audio replay and transcript of a FFR training session is available on the HRSA Grants web page here.

Health Center Clinical and Financial Performance Measures.

Program Assistance Letter (PAL) 2008-06, Background and Purpose of the Performance Measure Implementation for Health Center Program Grantees.

PAL 2010-04, Uniform Data System Changes for Calendar Year 2010.

National Association of Community Health Centers, Business Planning Guide*.

MSCG Resource Center Practice Management Information System Page*.

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Table 21: Program Data Reporting Systems Questions These questions are intended to help grantees assess whether their data reporting systems are adequate for measuring clinical and financial performance.

#	Questions	Answers
1.	Does the grantee have systems in place for collecting and organizing the data required for UDS and FFR reporting?	
2.	(If applicable) Has grantee submitted UDS by deadline?	
3.	Does the grantee have systems in place for collecting and organizing the performance data required in the Clinical and Financial Performance Measures Forms (submitted with the annual renewal applications)?	
4.	Does grantee have a long-term (3 year) strategic plan?	
5.	Has the strategic plan been approved by the Board? If so, when?	
6.	Do the plans reflect the grantee's needs assessment?	

Table 22: Additional Program Data Reporting Systems Questions
These questions are intended to help grantees assess their data reporting systems' capacity to support clinical and financial performance improvement. For Newly Funded Health Centers, these questions can be used to begin assessing their readiness for data collection and reporting.

Performance Measures Questions
1. In reviewing the health center's Clinical Performance Measures, identify a clinical measure to focus on based on the following criteria: • 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 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? • For the 1 to 2 Clinical Performance Measures selected for review, please address the following:
1.a. What were the reasons for selecting the measure(s)?
1.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.

1.c. Are there any factors (internal, external, etc.) contributing to and/or restricting the grantee's performance on these measure(s)?
1.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?
1.e. What additional steps/actions are recommended for the grantee to address any restricting factors and to improve performance on the measure(s)?
1.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 a financial measure (see BPHC Performance Measures webpage for the complete list of required measures) to focus on based on the following criteria: • 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 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?
2.a. What were the reasons for selecting the measure(s)?
2.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.
2.c. Are there any factors (internal, external, etc.) contributing to and/or restricting the grantee's performance?
2.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? On these measure(s)?

2.e. What additional steps/actions are recommended for the grantee to address any restricting factors and to improve performance on the measure(s)?
2.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:
3.a. How often does the clinical staff review the Clinical Performance Measures?
3.b. How often does the management/financial staff review the Financial Performance Measures?
3.c. How often does the Board review/approve the Clinical And Financial Performance Measures?
3.d. Does the management information system supply data required for developing and monitoring the Clinical and Financial Performance Measures?
3.e. Are the measures monitored and integrated into the Quality Improvement/Management program? How?
4. At what stage is the grantee in the planning process (i.e., long term strategic plan, short term strategic plan, operating/business plan, capital plan)?
Practice Management Information System (PM) Questions
5. General Capacities:
5.a. Does the health center operate its own PM or collaborate with another organization on PM?
5.b. Does the PM have a CHC/ FQHC module?
5.c. Have all modules purchased for the PM been activated?

5.d. Indicate if the following PM applications are operated by the center (C), by another entity (E), or not automated (N): • Billing • Capitation management • General ledger • Registration • Scheduling • Patient tracking • Referral tracking • Records • Pharmacy • Word processing • E-mail • Internet access • Spreadsheet
6. Support and Maintenance
6.a. Does the Center have a contract with a software vendor for patient registration to support the maintenance and other support needs?
6.b. If not, how does the grantee address systems problems that arise?
7. Policies: Are there documented PM policies and procedures that address:
7.a. Data collection
7.b. Organization
7.c. Storage
7.d. Maintenance
7.e. Security
7.f. Presentation
7.g. External access
7.h. Transfer of information
7.i. Technology and deployment?
8. Back-up
8.a. Are there appropriate data backup procedures?

8.b. Is backup data stored off-site?
8.c. What is the frequency of transfer off site?
9. Reports
9.a. Are there reports available to meet the needs of: • Management staff • The Board • Billing staff • Clinical staff
9.b. Is the grantee familiar with UDS reporting requirements?
9.c. Is the PM able to generate the data needed to meet UDS reporting requirements?
9.d. Is there a specific method to ensure that the UDS data is accurate?
9.e. Is the grantee familiar with FFR reporting requirements?
9.f. Is the PM able to generate the data needed to meet FFR reporting requirements?
9.g. Is there a specific method to ensure that the FFR data is accurate?
10. Future Needs
10.a. Is there a system in place for assessing MIS needs?
10.b. If the grantee does not have an Electronic Health Record (EHR), when does it plan to obtain one?

4h. Program Requirement 16: Scope of Project

Requirements:
Health center maintains its funded scope of project (sites, services, service area, target population and providers), including any increases based on recent grant awards.

Authority:
Authority: 45 CFR Part 74.25

Questions based on review of the bŜǿfê CdzyŘŜŘ IŜI·fűK /ŜyűŜ application and current status:

- Is the grantee prepared to carry out their funded scope of project in terms of number of patients served, visits, services available, providers, and/or sites? (If applicable)
- Do the Forms 5A, 5B, and 5C match current plans/practice and is there a plan in place to verify services within 120 days?

Documents to Review for Answers:
1) EHB Scope Reports – Forms 5A, 5B and 5C; 2) Applications (specifically Form 1-A) for recent section 330 grant awards

Links and additional resources:
PIN 08-01: Defining Scope of Project and Policy for Requesting Changes.

PIN 09-03: Technical Revision to PIN 08-01, Defining Scope of Project and Policy for Requesting Changes.

PIN 09-02: Specialty Services & Health Centers' Scope of Project

PIN 09-05: Policy for Special Populations-Only Grantees Requesting a Change in Scope to Add a New Target Population

Table 23: Scope of Project Questions
These questions are intended to help grantees assess whether their anticipated scope lines up with the approved application.

Scope of Project
1. Based on the purpose/scope of the grant award received (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:
1.a. Growth in the number of patients?
1.b. Growth in the number of visits?
1.c. Addition of new service(s)?
1.d. Addition of new provider(s)?
1.e. Addition of new site(s)?
1.f. Other expansions / improvements (e.g., EHR implementation, construction, etc.)?
2. Regarding current capacity:
2.a. What is the capacity of the facility for medical and dental services?
2.b. Based on the center's market plan, when will the facility be at full capacity?
2.c. Are plans in place to expand the facility to meet the center's market projections?
3. Regarding any planned expansions:
3.a. What are the expansion plans?
3.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?
3.c. What tasks remain to be completed that are necessary to promote an effective Newly Funded Health Center operations?
3.d. Is the physical site/facility occupied or plans in place to ensure the facility can be up and running as needed and required in a timely manner?

5. Governance

5a. Program Requirement 17: Board Authority

Requirements:
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 with co-applicant governing boards, the public agency 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).

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

Documents to Review for Answers:
1) Corporate Bylaws; 2) Minutes of Board Meetings; 3) Governance Policies and Procedures; 4) Corporate Compliance Policies and Procedures (Compliance Officer, Compliance Committee); 5) Corporate Compliance Plan; 6) Board Annual Meeting Schedule; 7) If Applicable: Form 6B: Waiver of Governance Requirements from Newly Funded Health Center NAP application.

Links and Additional Resources:
Your grant application's Form 6A: "Current Board Member Characteristics" contains basic information on your board structure. This link is for reference purposes only.

The BPHC Health Center Governance Policy Page.

The BPHC Governing Board Handbook.

The MSCG Resource Center Board Authority Page*.

The MSCG Resource Center Governance, Board Structure, Functions and Activities Page*.

The MSCG Resource Center: Board and Management Reports*.

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Table 24: Board Authority Questions These questions are intended to help grantees assess how well they are addressing Board Authority.

Note: Portions of program requirements notated by a double 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.

Board Authority
1. 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)
1.a. Does the board meet monthly?
1.b. Does the health center maintain minutes of the Board meetings?
1.c. Do the minutes appropriately document major issues/actions for the health center?
1.d. † **Health Centers with Approved Waivers ONLY:** Are strategies being implemented that ensure regular oversight, if the Board does not meet monthly?
2. Approval of the health center grant application and budget
2.a. Does the Board review and approve the annual health center (renewal) application and budget?
2.b. Is this review and approval documented in the Board minutes?
3. Selection/dismissal and performance evaluation of the health center CEO
3.a. 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?
3.b. Is this review documented in the Board minutes?
4. Selection of services to be provided and the health center hours of operations
4.a. Does the Board review and approve the services (beyond those required in law to be provided by the health center), as well as the location and mode of delivery of those services?
4.b. 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?
4.c. Is this review and approval documented in the Board minutes?

Board Authority
5. 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*
5.a. Does the Board measure and evaluate the health center's progress in meeting annual and long term clinical and financial goals?
5.b. Does the Board engage in strategic and/or long term planning for the health center?
5.c. Does the Board review the health center's mission and bylaws as necessary on a periodic basis?
5.d. Does the Board receive appropriate information that enables it to evaluate health center patient satisfaction, organizational assets, and performance?
5.e. Are these activities documented in the Board minutes?
6. Establishment of general policies for the health center. **Note:** In the case of public center grantees with co-applicant governing boards, the public agency 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)).
6.a. 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 center grantees with a co-applicant arrangement.**
6.b. 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 board dissolution.
6.c. **For Public Center Grantees with Co-Applicant Arrangements ONLY:**

Board Authority
Does the public center grantee have a formal co-applicant agreement, separate from the bylaws, with the co-applicant that stipulates: • Roles, responsibilities, and the delegation of authorities of each party in the oversight and management of the health center? • Any shared roles and responsibilities of each party in carrying out the governance functions?

† 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.**

✦ In a co-applicant arrangement, the public center (the grantee of record) 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 agencies. 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 by the patient/community-based (co-applicant) health center governing board) while satisfying local or State law pertaining to the public center. No justification is required for arrangements in which the public center retains authority for the establishment of the following types of general policy: fiscal and personnel policies.

Table 25: Additional Board Authority Questions

These questions are intended to help assess whether a grantee is implementing recommended practices for board authority.

Board Authority
1. Monthly Board Packets
1.a. Are monthly packets sent to Board members in advance of the meeting?
1.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 By-Laws 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:
5.a. Approved a corporate compliance plan?
5.b. Established a compliance committee?
5.c. Appointed a corporate compliance officer?
6. Which Senior Management staff attends the Board meetings?

Board Authority
7. Does the Board:
7.a. Implement a self-evaluation process? If yes, how frequently?
7.b. Review and approve the annual audit?
7.c. Have an Annual Work Plan linked to the approved Strategic Plan and/or Clinical and Financial Performance Measures?
8. Regarding the CEO, does the Board:
8.a. Have a CEO Recruitment and Retention Plan?
8.b. Have a Succession Plan in the event of a CEO vacancy?
8.c. Does the Board annually review staff compensation levels (i.e. salary, fringe benefits and incentives, as applicable), including the CEO/Project Director and other key staff, in the context of the grantee organization's size, complexity, location and/or other factors?
8.d. Does the Board maintain documentation on how it established and approved salary levels and/or total compensation packages?
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.
10. **For Public Center Grantees with Co-Applicant Arrangements ONLY:**
10.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?
10.b. If there is a high level of shared responsibility between the public center and the co-applicant Governing Board, does the co-applicant agreement include provisions for dispute resolution?

5b. Program Requirement 18: Board Composition

Requirements:
The health center Governing Board is composed of individuals, a majority of whom are being served by the center and, who 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: Portions of program requirements notated by a double-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.
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).

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

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

Links and Additional Resources:
HRSA Newly Funded Health Center NAP Application Page.

The MSCG Resource Center Board Composition Page*.

**Note: All non-Federal documents are for use as aids to consultants and grantees, the contents of such documents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA, and should not be considered official guidance by BPHC. Any "sample" documents must be tailored to the health center's unique circumstances and needs.*

Table 26: Board Composition Questions
These questions are intended to help grantees address Board Composition.

Board Composition
1. A majority of the Board members are individuals ("consumers" or "patients"; also previously known as "users") served by the organization.
1.a. Do a majority (at least 51%) of the Board members receive services (i.e. are 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.**
1.b. **Health Centers with Approved Waivers ONLY:** Have alternative strategies been operationalized that ensure consumer/patient participation and input (given board is not 51% consumers/ patients) in the direction and ongoing governance of the organization?
2. 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.
2.a. 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.**
2.b. **The following question applies <u>ONLY</u> 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), in addition to Community Health Center (section 330(e) funding). At a minimum, there must be at least one board member that is representative of each of the special populations for which the health center receives section 330 funding/designation.** Therefore, does the Board include a representative(s) from and/or for each of these special populations group(s), as appropriate? 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.). Note that while the inclusion of "advocate" would meet the requirement for multi-funded health centers to have representation of all the populations for which the health center receives funding/designation, these advocates would not be included in calculating whether the governing board met the patient/consumer-majority requirement unless they were also health center patients. Additionally, while advocates may represent special populations on the board as outlined above, health centers should continue efforts to achieve representation by patients/consumers who are members of the targeted special population.
3. The board has at least 9 but no more than 25 members, as appropriate for the complexity of the organization.
3.a. Does the Board have between 9 and 25 members?

Board Composition
3.b. 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?
3.c. Is the size of the Board appropriate for the complexity of the organization and the diversity of the community served?
4. 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.
4.a. Are the remaining Board members representative of and/or drawn from the grantee's community and service area?
4.b. 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?
5. 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.
5.a. Do more than 50% of the non-consumer Board members derive more than 10% of their annual income from the health care industry?

† 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.**

Table 27: Additional Board Composition Questions
These questions are intended to help assess whether a board's composition is in line with recommended practices.

Board Composition
1. Does the health center have:
1.a. A Board recruitment and retention plan, which will help ensure Board development and stability?
1.b. An orientation program for new Board members?
1.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. Has Board composition taken into account other key demographic factors such as socioeconomic status and age, in terms of reasonably representing individuals served by the health center?

5c. Program Requirement 19: Conflict of Interest Policy

Requirements:
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.**

Note: Portions of program requirements notated by a double 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.

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

Documents to Review for Answers:
1) Corporate Bylaws, 2) most recent update of Conflict of Interest policy

Links and Additional Resources:

The MSCG Resource Center Sample Conflict of Interest Disclosure*.

**Note: All non-Federal documents are for use as aids to consultants and grantees, the contents of such documents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA, and should not be considered official guidance by BPHC. Any "sample" documents must be tailored to the health center's unique circumstances and needs.*

Table 28: Conflict of Interest Questions
These questions are intended to help grantees assess the adequacy of their Conflict of Interest policies.

Conflict of Interest
Health center's bylaws or written, corporate-board-approved policy includes provisions that:
1. Prohibit conflict of interest by board members, employees, consultants and those who furnish goods or services to the health center.
1.a. Do the bylaws or policy include this provision(s)?
2. 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.
2.a. Is any current Board member(s) an employee of the health center or an immediate family member of an employee?
3. State that the Chief Executive may serve only as a non- voting, ex-officio member of the Board.
3.a. Does the CEO participate as a voting member of the Board? Address such issues as: • disclosure of business and personal relationships, including nepotism, that create an actual or

Conflict of Interest
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.
4. Do the bylaws or policy 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.

Table 29: Additional Conflict of Interest Questions
These questions are intended to help grantees assess whether they are in line with recommended practices for mitigating conflicts of interest.

Conflict of Interest
1. Are annual conflict of interest statements required?
2. If yes, are the required statements on file?
3. Does the Board allow related party transactions to take place? If yes, please describe.