



# PROGRAM ASSISTANCE LETTER

**DOCUMENT NUMBER:** 2011-05

**DOCUMENT NAME:** Calendar Year 2012 Requirements for Federal Tort Claims Act (FTCA) Medical Malpractice Coverage for Health Centers

**DATE:** May 18, 2011

**TO:** Health Center Program Grantees  
National Cooperative Agreements  
Primary Care Associations  
Primary Care Offices

## I. PURPOSE

The purpose of this Program Assistance Letter (PAL) is to describe the Health Resources and Services Administration's (HRSA) process for Health Center Program grantees to submit Federal Tort Claims Act (FTCA) deeming applications for calendar year (CY) 2012. Eligible grantees and subrecipients may be deemed by HRSA as employees of the Public Health Service (PHS) for purposes of FTCA medical malpractice coverage under the Federally Supported Health Centers Assistance Acts (FSHCAA) of 1992 (Pub. L. 102-501) and 1995 (Pub. L. 104-73). This PAL supersedes PAL 2010-06, "Calendar Year 2011 Requirements for Federal Tort Claims Act (FTCA) Medical Malpractice Coverage."

This PAL is intended to clarify, refine and disseminate the requirements for the CY 2012 FTCA deeming and renewal application submissions. Technical Assistance (TA) for these clarifications will be made available on June 8, 2011. Following the conclusion of the call, grantees will be able to access an archived version of the TA call online at <http://www.bphc.hrsa.gov/ftca>.

## II. BACKGROUND

The CY 2012 FTCA application process has undergone significant changes to further the goal of ensuring the delivery of high quality health care to medically underserved and vulnerable populations. HRSA believes that to reduce risk and ensure patient safety, greater attention

must be placed on systems that help prevent and mitigate errors.

HRSA evaluates health centers' implementation of their risk management and quality improvement/quality assurance policies and procedures during the deeming process. Through this assessment, a greater understanding can be gained regarding tangible steps that need to be taken to improve quality, increase safety and reduce risk.

### **III. APPLICABILITY**

This PAL applies to eligible grantees that are public and private nonprofit entities receiving grant funding under section 330 of the PHS Act, including Community Health Centers, Migrant Health Centers, Health Care for the Homeless Centers, and Public Housing Primary Care Centers, collectively referred to as “grantees.”

Eligible subrecipients for purposes of FTCA coverage are those entities receiving funds from a covered section 330 grantee under a grant or contract to provide a full range of services on behalf of the covered entity. Subrecipient entities are eligible for coverage only if they provide a full range of health care services on behalf of an eligible grantee and only for those services carried out under the grant-funded project. All subrecipient entities seeking FTCA deeming must be identified on the grantee’s current Scope of Services (Form 5B).

This PAL contains the instructions for grantees submitting either:

1. An FTCA application requesting initial deeming; or
2. An annual redeeming application for deeming coverage for CY 2012 (January 1, 2012 – December 31, 2012).

Please note that only the grantee of record (the organization named on the Notice of Grant Award) can submit a request to HRSA for FTCA deeming coverage. Requests for coverage for a subrecipient must be submitted on behalf of the subrecipient by the grantee of record. Health centers requesting FTCA coverage on behalf of a subrecipient are required to submit a separate and complete deeming application in accordance with the deeming guidelines specified within agency policies and this PAL.

### **IV. MECHANISM FOR SUBMITTING FTCA APPLICATIONS**

All FTCA deeming applications must be submitted electronically through the FTCA deeming module within the HRSA Electronic Handbook (EHB). This module supports electronic web-based functionality for the deeming process including grantee completion and submission of applications, HRSA review and processing of applications, and electronic notice of deeming status to grantees. The EHB system will be available to begin receiving CY 2012 deeming applications on May 26, 2011.

The EHB is designed to streamline the grants administration process and enable grantees to

communicate with HRSA and conduct activities electronically. The EHB can be accessed from anywhere on the Internet using a standard web browser at <https://grants.hrsa.gov/webexternal/>. When a grantee submits a FTCA application, the EHB will assign a tracking number. Grantees may create and submit a FTCA application in one session, or create and save part of the application and return as many times as necessary to complete the request before submitting it for HRSA review. Grantees are responsible for ensuring that their deeming application(s) have been successfully submitted to HRSA through the EHB.

For additional information or technical assistance on how to submit a FTCA application, please visit <http://www.bphc.hrsa.gov/ftca/healthcenters/hcappprocess.html>. Additional technical assistance for EHB and this PAL will be made available during the month of May and will be available online with other technical assistance information.

#### **V. OVERVIEW OF NEW APPLICATION REQUIREMENTS**

In this PAL, HRSA has provided additional guidance regarding application deadlines and various information requests. Specifically, after receiving a change request for additional or updated information, grantees will be required to resubmit their applications in a timely manner. Initial applicants and redeeming applicants will have 10 business days to resubmit their applications after receiving notice. If the grantee fails to respond, the application may be deemed incomplete and therefore voided. Please see sections VI and VII of this PAL for additional details.

Please also pay special attention to the following additional information requested to be submitted in the deeming application:

1. Minutes from the last six QI/QA committee meetings (please provide explanation if less than 6);
2. Minutes from the last six Board meetings evidencing oversight of QI/QA activities (please provide explanation if less than 6);
3. Credentialing and privileging policies; and
4. Clinical policies and procedures in the following areas: referral tracking, hospitalization tracking, x-ray tracking, and lab results tracking.

#### **VI. INITIAL FTCA APPLICATIONS**

All grantees considering FTCA coverage are encouraged to carefully review the FTCA policies and regulations found on the HRSA website at <http://www.bphc.hrsa.gov/FTCA/>, as well as the Health Centers Program policy page found at <http://www.bphc.hrsa.gov/policiesregulations/policies/index.html>. They should also consult with their Project Officer prior to submitting an initial request.

Health centers may submit an initial application at any time during the year. Due to the number of applications, the detailed nature of the application, and the potential for incomplete application submissions, grantees should request FTCA coverage at least **90** days in advance of their desired coverage start date.

Once a complete initial FTCA application is submitted (see section VIII below), HRSA will conclude its review within 30 days. Please note that a FTCA deeming application is not considered complete until all required documentation and associated site visits have been completed. If additional information or clarification is needed, HRSA will notify the grantee through the EHB, and the grantee will be given **10 business days from the date of such EHB notification** to provide the requested information to complete its application. If the requested information is not submitted within 10 business days of notification, the FTCA application will be considered incomplete, marked "VOID" in the EHB system, and returned to the grantee. The grantee will be required to submit a new application. Grantees that do not submit complete applications in a timely manner may not receive deemed status (i.e., FTCA coverage) on the date desired. Grantees are responsible for ensuring that the information needed to complete its application has been successfully submitted to HRSA through the EHB. Additionally, initial grantees are advised to maintain their own private malpractice insurance until they receive an official deeming determination from HRSA.

Within 30 days after a complete initial FTCA application has been received by HRSA, HRSA will provide notification to the contact person identified by the health center of a final determination through the EHB. Eligible entities will be covered under applicable FTCA regulations only on and after the effective date of the approval of their deeming application by HRSA.

## **VII. FTCA RENEWAL APPLICATION**

All currently deemed grantees must submit a FTCA renewal application for themselves and any subrecipients (as applicable) by **July 11, 2011** in order to be eligible to be deemed for the entirety of CY 2012, without a gap in coverage. **Grantees who do not submit an application for redeeming will have the option of reapplying for coverage as an initial applicant on or after January 1, 2012. Please note that eligible entities (grantees and grantees on behalf of subrecipients) that miss the deadline may experience a gap in anticipated FTCA coverage and should consider purchasing private medical malpractice insurance.**

If additional information or clarification is needed to support an application, HRSA will notify the grantee through the EHB. The grantee will be given **10 business days from the date of such EHB notification** to submit the requested information. It is critical that grantees provide a timely response to all requests for information in order to assure a timely review and notification. Grantees that do not provide a responsive submission, within 10 business days after receiving notice, will have their application deemed incomplete, marked "VOID" in the EHB system, and returned. Grantees that do not submit complete applications in a timely manner may not receive deemed status (i.e., FTCA coverage) prior to January 1, 2012. Please

note that grantees who do not submit a complete application are likely to experience a gap in coverage and should consider purchasing private insurance coverage. Grantees are responsible for ensuring that the information needed to complete their deeming application has been successfully submitted to HRSA through the EHB. If an FTCA application is voided, the grantee will be required to submit a new FTCA application for review.

After a complete FTCA application has been received and reviewed, HRSA will provide notification to the contact person identified by the health center of the program's deeming determination through the EHB.

#### **VIII. COMPLETE FTCA APPLICATION PACKAGE: INITIAL AND RENEWAL APPLICANTS**

To be considered complete, an initial or renewal application must contain **all** of the following documentation within EHB:

1. Quality Improvement/Quality Assurance (QI/QA) Plan, with clear documentation that the Board reviewed and approved the plan within three (3) years of the date of submission to HRSA (**e.g., on or after July 11, 2008 for a renewal application**). Specifically, the QI/QA plan must be approved, dated, and contain the signature of the Board of Directors. If the Plan has not been approved by the Board within the last three years, the application will be returned to the grantee without further review until the plan is resubmitted with a timely Board signature indicating review/approval, as described herein.
2. Minutes for the last six QI/QA committee meetings that clearly document QI/QA activities.
3. Minutes for the last six Board meetings, to the extent that these reflect Board approval of QI/QA activities. (*Please remove any information not related to QI/QA activities.*)
4. Credentialing and privileging policies and procedures. Please note, credentialing and privileging policies and procedures must be approved, signed and dated by the Board.
5. A list of all licensed and certified staff members at all health center sites including employed or contracted practitioners, volunteers and locum tenems, with evidence of credentialing and privileging within the last two years (**e.g., all credentialing must have been documented to have taken place on or after July 11, 2009 for a renewal application**). For the purposes of this application, documentation of a credentialing date within the last two years is required in accordance with Policy Information Notice 2002-22. *If any listed individual's most recent credentialing did not occur within the last two years, the application will be returned to the grantee as further described above.*

The credentialing list must be in an **Excel Spreadsheet** and include the following for all licensed and certified staff members (please see attachment 1 for an example):

- Name and Professional Designation (e.g., MD/DO, RN, CNM, DDS, LPN, PA, MA, NP, etc.);
- Title/Position;
- Specialty;
- Employment Status (full-time employee, part-time employee, contractor or volunteer);
- Hire Date;
- Initial Credentialing Date (the first time the individual was credentialed by your organization);
- Most Recent Credentialing Date (must be within past two years); and
- Next Expected Credentialing Date (if known).

The purpose of this credentialing and privileging documentation is to show that the grantee has reviewed and verified required credentialing information. Inclusion of practitioners on this listing does not infer the deeming (or absence of deeming) for any individual or practitioner, as this is based on satisfaction of statutory deeming criteria under 42 U.S.C. 233(h).

6. Health center policies and procedures for the following:
  - Referral tracking
  - Hospitalization tracking
  - X-ray tracking
  - Lab results tracking
7. Statement verifying that any professional liability claims or allegations were internally analyzed, and that appropriate actions were implemented in response to any liability claims or allegations as needed. The statement should include the following:
  - Name of provider(s) involved
  - Area of practice/Specialty
  - Date of occurrence
  - Summary of allegations
  - Status and outcome of claim
8. Electronic signature of the **Executive Director** certifying the contents of the application. *If the FTCA application is not signed by the Executive Director, the application will be returned to the grantee as further described above.*
9. Deeming Applications for any subrecipient(s) that appear on the health center's most recent Form 5B, who are requesting FTCA coverage.

Please note that deeming applications by eligible entities must be submitted in the form and manner prescribed by HRSA and must demonstrate that the entity seeking FTCA coverage has successfully implemented all deeming requirements set forth in law and further described herein. Applications that do not meet the applicable requirements will not be approved, and affirmative deeming determinations will not be issued in those cases.

## **IX. SITE VISITS**

To obtain additional information regarding implementation of risk management and QI/QA policies and procedures and provide assistance for other program purposes, HRSA may conduct site visits. If HRSA determines that a site visit is required, grantees will be provided with reasonable prior notice. Factors that may prompt a site visit include, but are not limited to:

1. Conditions placed by HRSA on the health center's 330 grant funding;
2. Review of the health center's FTCA application;
3. Prior site visit findings; and/or
4. Claims.

Additionally, site visits are conducted to ensure that the requirements under the relevant statutory authority contained within 42 U.S.C. 233(h) have been implemented. Site visit reviewers will assess whether the grantee has:

- Implemented appropriate policies and procedures to reduce the risk of malpractice and the risk of lawsuits arising out of any health or health-related functions performed by the entity;
- Reviewed and verified the professional credentials, references, claims history, fitness, professional review organization findings, and license status of its physicians and other licensed or certified health care practitioners, and, where necessary, has obtained the permission from these individuals to gain access to this information; and
- No history of claims being filed against the United States as a result of the application this section to the entity or its officers, employees, or contractors as provided for under this section, or, if such a history exists, has fully cooperated with the Attorney General in defending against any such claims and either has taken, or will take, any necessary corrective steps to assure against such claims in the future.

## **X. ADDITIONAL USEFUL RESOURCES: RISK MANGAMENT RESOURCES**

Ongoing risk management is essential to the provision of quality health care services. HRSA is committed to ensuring that health centers have access to risk management resources. On the HRSA/FTCA website, <http://bphc.hrsa.gov/ftca/riskmanagement>, you will find useful risk management webinars, tool kits, and current risk management related articles.

**XI. CONTACT INFORMATION**

For programmatic support regarding the FTCA Program, application requirements (including credentialing, QI/QA Plan, etc.), and technical/EHB support, please contact:

FTCA/BPHC Help Line  
Phone: 1-877-974-BPHC (877-974-2742)  
9:00 AM to 5:30 PM (ET)  
Email: [BPHChelpline@hrsa.gov](mailto:BPHChelpline@hrsa.gov)

James Macrae  
Associate Administrator for Primary Care

**Attachment 1**

**Credentialing Excel Spreadsheet Example**

	A	B	C	D	E	F	G	H	I	J	K
1	First Name	Last Name	Title	Professional Designation	Specialty	Employee Status	Contractor	Date of Hire or Contract	Date of Initial Credentialing	Current Credentialing Date	Next Recredential Due
2	Great	Provider	Immunization Nurse	LVN	Nursing	FTE		8/26/2002	5/13/2003	7/24/2008	7/1/2010
3	Wonderful	Staff	HIV Medical Case Mgr	LCSW	Social Work	FTE		10/25/1999	5/13/2003	8/28/2008	8/1/2010
4	Skilled	Provider2	Relief Pharmacist	RPh	Pharmacy	PTE		10/24/2002	3/11/2003	9/25/2008	9/1/2010
5	Toothy	Mender	Staff Dentist	DDS	General Dentistry	FTE		9/8/2008	9/9/2008		9/1/2010
6	Bebe	Centered	Relief Pediatrician	MD	Pediatrics	PTE		11/15/2006	11/14/2006	10/23/2008	10/1/2010
7	Great	Docford	Contract Physician	MD	Family Practice		X	9/1/2002	3/11/2003	10/23/2008	10/1/2010
8	Friendly	Childress	Staff Pediatrician	DO	Pediatrics	FTE		11/27/2006	11/14/2006	10/23/2008	10/1/2010
9	Smart	Gummer	Dental Director	DDS	General Dentistry	FTE		11/16/2004	11/5/2004	12/9/2008	11/1/2010
10	Phyllis	Perscrip	Relief Pharmacist	RPh	Pharmacy	PTE		12/5/2008	11/11/2008		11/1/2010
11	Caring	Papsmer	Contract OB/GYN	MD	OB/GYN		X	2/1/2003	3/11/2003	1/8/2009	1/1/2011

**Checklist of Required Attachments**

<b>ATTACHMENTS</b>	
<b>Please check the attachments included with this application</b>	
<input type="checkbox"/>	<b>Attachment A</b> – Policies and Procedures for tracking system
<input type="checkbox"/>	<b>Attachment B</b> – Copy of Health Center’s Quality Improvement/Assurance Plan*
<input type="checkbox"/>	<b>Attachment C</b> – Last six meeting minutes of QI/QA committee minutes that clearly document QI/QA activities
<input type="checkbox"/>	<b>Attachment D</b> – Last six meeting minutes of the Board that are related to QI/QA activities
<input type="checkbox"/>	<b>Attachment E</b> – List of Licensed or Certified Health Care Practitioners
<input type="checkbox"/>	<b>Attachment F</b> – Credentialing and Privileging policy*
<input type="checkbox"/>	<b>Attachment G</b> – Review of Professional Liability History (as applicable)
<input type="checkbox"/>	<b>Attachment H</b> – Other Supporting Documentation
<input type="checkbox"/>	Subrecipient Application(s) and Supporting Documentation (as applicable)
<b>LEGEND</b>	
*	All the fields marked with * must be approved, dated and signed by the Board.

**Attachment 2**

**Application for Health Center Program Grantees for  
Medical Malpractice Coverage Under the  
Federal Tort Claims Act**

<b>DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration</b>	<b>FOR HRSA USE ONLY</b>	
	Grantee Name	Application Type
<b>CONTACT INFORMATION</b>	Application Tracking Number	Grant Number

<b>CONTACT INFORMATION (Please include Salutation next to the name) All the fields marked with * are required.</b>	
* EXECUTIVE DIRECTOR NAME: <i>(Must electronically sign and certify the FTCA application prior to submission)</i>	
* Email: * Direct Phone: Fax:	
* MEDICAL DIRECTOR NAME:	
* Email: * Direct Phone: Fax:	
* RISK MANAGER NAME: <i>(It is recommended that the risk manager be a health care provider or an individual with at least one year of clinical risk management experience)</i>	
* Email: * Direct Phone: Fax:	
* PRIMARY DEEMING CONTACT NAME: <i>(Individual responsible for completing application)</i>	
* Email: * Direct Phone: Fax:	
* ALTERNATE DEEMING CONTACT NAME: <i>(Individual responsible for assisting with the application)</i>	
* Email: * Direct Phone: Fax:	

<b>DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration</b>	<b>FOR HRSA USE ONLY</b>	
	Grantee Name	Application Type
<b>REVIEW OF RISK MANAGEMENT SYSTEMS</b>	Application Tracking Number	Grant Number

<b>REVIEW OF RISK MANAGEMENT SYSTEMS (Section 224(h)(1))</b> All the fields marked with * are required.
* 1. The organization conducts periodic assessments to identify, prevent and monitor medical malpractice risk. [ ] YES [ ] NO - (If 'No', then please enter explanation below)
* 2. Identify policies/procedures implemented regarding the appropriate supervision of clinical and non-clinical staff. <b>(Please limit response to 4000 characters, approximately 1 page)</b>
* 3A. There are medical record policies and procedures that address the following: Privacy (HIPAA) – [ ] YES [ ] NO Completeness of documents – [ ] YES [ ] NO Archiving Procedures – [ ] YES [ ] NO Please enter explanation if at least one of the above is answered "NO"
* 3B. Medical records are periodically reviewed to determine quality, completeness, and legibility. [ ] YES [ ] NO - (If 'No', then please enter explanation below)
* 4. There are policies/procedures that address the following: Triage – [ ] YES [ ] NO Walk-in Patients – [ ] YES [ ] NO Telephone Triage – [ ] YES [ ] NO No Show Appointments – [ ] YES [ ] NO Please enter explanation if at least one of the above is answered 'NO'
* 5. There are clinical protocols that define appropriate treatment and diagnostic procedures for selected medical conditions. [ ] YES [ ] NO - (If 'No', then please enter explanation below)
* 6. There is a tracking system for patients who require follow-up of referrals, hospitalization, x-ray, and lab results. Referral tracking – [ ] YES [ ] NO Hospitalization tracking – [ ] YES [ ] NO X-Ray tracking – [ ] YES [ ] NO Lab results tracking – [ ] YES [ ] NO <b>If 'No', then please enter explanation below</b>
<b>ATTACHMENT A</b> - Please upload the health center's clinical policies and procedures for each of the above.

<b>DEPARTMENT OF HEALTH AND HUMAN SERVICES</b> Health Resources and Services Administration	<b>FOR HRSA USE ONLY</b>	
	Grantee Name	Application Type
<b>QUALITY IMPROVEMENT/QUALITY ASSURANCE PLAN (QI/QA)</b>	Application Tracking Number	Grant Number

<b>QUALITY IMPROVEMENT/QUALITY ASSURANCE (QI/QA) PLAN</b> All the fields marked with * are required
* 1. Please upload the following:
<p>a. <b>ATTACHMENT B</b> - Upload and attach the QI/QA Plan that has been reviewed and approved by the Board (within the past 3 years) - The Board approval date must also appear on the attached QI/QA Plan and will be verified for consistency with the answer provided to Question 2.</p> <p>b. <b>ATTACHMENT C</b> - Upload last six meeting minutes of QI/QA committee that clearly document QI/QA activities.</p> <p>c. <b>ATTACHMENT D</b> - Upload last six meeting minutes of the Board that are related to QI/QA activities. <i>(Please remove information unrelated to the QI/QA activities)</i></p>
* 2. Please select the date the QI/QA Plan was approved by the Board.
Indicate date of last Board Approval: [ ]
<i>If the QI/QA Plan has not been reviewed and signed by the Board within the past 3 years, this application will be returned without further review.</i>
* 3. <b>QI/QA Process:</b> The process for improvement should be identified in the health center's QI/QA plan and should identify time specific intervals for assessment and analysis of performance. The process should demonstrate that the QI/QA committee utilizes reliable methodologies to denote an effective process. The QI/QA committee should implement corrective strategies that facilitate improved performance and outcomes for patients. It also should support an environment that promotes quality of care and service through the education and training of health care providers.
A. What is the process utilized in assessing clinical quality and risk issues on continuous basis? <b>(Please limit response to 4000 characters, approximately 1 page)</b> (Note pages where this appears in your QI/QA plan) [ ]
B. How do you identify potential problems and prevent adverse occurrences? <b>(Please limit response to 4000 characters, approximately 1 page)</b> (Note pages where this appears in your QI/QA plan) [ ]
C. What tools are used to systematically collect and analyze data? <b>(Please limit response to 4000 characters, approximately 1 page)</b> (Note pages where this appears in your QI/QA plan) [ ]

<p>D. How do you identify and document a system or process breakdown? <b>(Please limit response to 4000 characters, approximately 1 page)</b> (Note pages where this appears in your QI/QA plan)  <input type="checkbox"/></p>
<p>E. How are strategies for improvement implemented, continually monitored, and measured? <b>(Please limit response to 4000 characters, approximately 1 page)</b> (Note pages where this appears in your QI/QA plan)  <input type="checkbox"/></p>
<p>* 4. <b>QI/QA Committee:</b> The mission of the QI/QA committee should be to ensure the safety and quality of care and services provided to the health center's patients. The committee's goals are to ensure that the health center has developed an integrated process of continual assessment of the health center's needs. Collaborative engagement at all levels of providers at the health center will facilitate the best outcomes.</p> <p>Provide details of QI/QA committee structure:</p>
<p>A. Describe the structure of the QI/QA committee and list which health center staff members are a part of the committee. <b>(Please limit response to 4000 characters, approximately 1 page)</b> (Note pages where this appears in your QI/QA plan)  <input type="checkbox"/></p>
<p>B. How often does the Board receive reports from the QI/QA committee on QI/QA plan and progress? <b>(Please limit response to 4000 characters, approximately 1 page)</b> (Note pages where this appears in your QI/QA plan)  <input type="checkbox"/></p>
<p>C. What is the process for implementing policies and procedures, such as credentialing, risk management, clinical and operational? <b>(Please limit response to 4000 characters, approximately 1 page)</b> (Note pages where this appears in your QI/QA plan)  <input type="checkbox"/></p>
<p>D. How are recommendations from the QI/QA committee presented and approved by the Board? <b>(Please limit response to 4000 characters, approximately 1 page)</b> (Note pages where this appears in your QI/QA plan)  <input type="checkbox"/></p>

<b>DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration</b>	<b>FOR HRSA USE ONLY</b>	
	Grantee Name	Application Type
<b>REVIEW OF CREDENTIALING SYSTEMS</b>	Application Tracking Number	Grant Number

**REVIEW OF CREDENTIALING SYSTEMS (Section 224(h)(2))**  
All the fields marked with \* are required.

\* 1. All current health care personnel involved in direct patient care must be credentialed within the last two years, including all of the following:

- Licensed independent practitioners (e.g., physicians, nurse midwives, nurse practitioners)
- Licensed practitioners (e.g., RNs, LPNs)
- Certified practitioners/technicians (e.g., dental, lab, radiology)

**ATTACHMENT E – Upload and attach the credentialing list. (List MUST be in an Excel spreadsheet)**

- Be sure to include the following on the credentialing list:
- Name and Professional Designation (e.g., MD/DO, RN, CNM, DDS, etc.)
  - Title/Position
  - Specialty
  - Employment Status (full-time employee /part-time employee/contractor/volunteer)
  - Hire Date (or anticipated hire date)
  - Initial Credentialing Date (the first time the individual was credentialed by your organization)
  - Most Recent Credentialing Date (MUST BE WITHIN PAST 2 YEARS); and
  - Next Expected Credentialing Date (if known)

**Note:** The application will be returned without further review if the personnel are not credentialed within the last two years.

**ATTACHMENT F – Upload and attach the health center’s Credentialing and Privileging Policy**

\* 2. The health center’s credentialing verification procedures include all of the following:

- Current licensure, professional certification, and/or registration that is primary source verified
- Professional educational background/postgraduate training
  - primary source verification for licensed independent practitioners
  - secondary source verification for licensed and certified practitioners

YES

NO - (If ‘No’, then please enter explanation below)

<p>* 3. The health center has verified that each practitioner submitted evidence of the following for review:</p> <ul style="list-style-type: none"> <li>• Health fitness/fitness to perform duties</li> <li>• Immunization status</li> <li>• Professional references</li> <li>• Life support training, as applicable</li> <li>• DEA registration, as applicable</li> </ul>
<p><input type="checkbox"/> YES</p>
<p><input type="checkbox"/> NO - (If 'No', then please enter explanation below)</p>
<p>* 4. A National Practitioner Data Bank (NPDB) query is obtained and evaluated every two years for each licensed practitioner as part of the health center's credentialing process.</p>
<p><input type="checkbox"/> YES</p>
<p>Indicate date of last query to the NPDB: <input type="checkbox"/></p>
<p><input type="checkbox"/> NO - (If 'No', then please enter explanation below)</p>
<p>* 5. A history of previous malpractice liability claims and adverse actions (including but not limited to FTCA claims) is reviewed for each practitioner and for the organization.</p>
<p><input type="checkbox"/> YES</p>
<p><input type="checkbox"/> NO - (If 'No', then please enter explanation below)</p>
<p>* 6. The health center utilizes data from peer review and quality improvement/quality assurance activities to support its credentialing functions and these activities are overseen by the Board.</p>
<p><input type="checkbox"/> YES</p>
<p><input type="checkbox"/> NO - (If 'No', then please enter explanation below)</p>
<p>* 7. As part of the health center's privileging process, practitioners are granted privileges by the health center, at least every two years, specific to the services being provided at each care delivery site.</p>
<p><input type="checkbox"/> YES</p>
<p><input type="checkbox"/> NO - (If 'No', then please enter explanation below)</p>
<p>* 8. As part of the health center's privileging process, clinical privileges and medical staff membership at local hospitals and other admitting facilities are verified.</p>
<p><input type="checkbox"/> YES</p>
<p><input type="checkbox"/> NO - (If 'No', then please enter explanation below)</p>
<p>* 9. The integration of quality improvement/quality assurance and risk management facilitates the identification of potential problems and prevention of adverse occurrences. Prevention diminishes the potential for process failures. The quality and risk management process promotes a safer environment and empowers employees to be efficient quality care providers</p>
<p>A. Describe the health center's peer review process. <b>(Please limit response to 4000 characters, approximately 1 page)</b></p> <p><input type="checkbox"/></p>
<p>B. Who supervises this process and what are his or her responsibilities? <b>(Please limit response to 4000 characters, approximately 1 page)</b></p> <p><input type="checkbox"/></p>
<p>C. How is feedback on peer review communicated and documented? <b>(Please limit response to 4000 characters, approximately 1 page)</b></p> <p><input type="checkbox"/></p>

D. How is patient confidentiality maintained during the medical record review process? <b>(Please limit response to 4000 characters, approximately 1 page)</b> [ ]
E. After completing peer assessment and medical record review, how is the data integrated and shared with staff and the board? <b>(Please limit response to 4000 characters, approximately 1 page)</b> [ ]
F. What methodology is used when developing strategies for improvement? <b>(Please limit response to 4000 characters, approximately 1 page)</b> [ ]

<b>DEPARTMENT OF HEALTH AND HUMAN SERVICES</b> Health Resources and Services Administration	<b>FOR HRSA USE ONLY</b>	
	Grantee Name	Application Type
<b>REVIEW OF PROFESSIONAL LIABILITY HISTORY</b>	Application Tracking Number	Grant Number

<b>REVIEW OF PROFESSIONAL LIABILITY HISTORY (Section 224(h)(3))</b>
<p><b>Please note: Health centers are expected to maintain their own records of medical malpractice claims as part of their risk management systems and in accordance with local practice requirements and guidelines.</b></p> <p>If a claim or lawsuit involving covered activities is presented or filed, it is essential that the covered entity preserve all potentially relevant documents. Once a covered entity or covered individual reasonably anticipates litigation—and it is reasonable to anticipate litigation once a claim or lawsuit is filed, whether administratively or in state or federal district court—the entity or individual must suspend any routine destruction and hold any documents relating to the claimant or plaintiff so as to ensure their preservation for purposes of claim disposition or litigation.</p>
<p><b>* 1. Have any professional liability claims or allegation been filed against the health center and/or its employees/contractors WITHIN THE LAST FIVE (5) YEARS?</b></p> <p>[ ] YES</p> <p><b>IF YES, you must upload and attach within EHB, a list of the allegations and whether such claims or allegations were internally analyzed and whether appropriate actions were implemented as needed. Attachment should also include:</b></p> <ol style="list-style-type: none"> <li>1) Name of provider(s) involved</li> <li>2) Area of practice/Specialty</li> <li>3) Date of occurrence</li> <li>4) Summary of allegations</li> <li>5) Status and outcome of claim</li> </ol> <p><b>ATTACHMENT G - Review of Professional Liability History</b></p> <p>[ ] NO</p>

<b>DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration</b>	<b>FOR HRSA USE ONLY</b>	
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<b>ADDITIONAL INFORMATION</b>	Application Tracking Number	Grant Number

**ADDITIONAL INFORMATION**

\* 1. Has your health center achieved one or more of the following designations from a national review body by demonstrating the ability to meet nationally recognized standards, guidelines, and measures related to quality assurance and quality improvement in health care organizations?

- Accreditation;
- Certification; and/or
- Recognition

YES  
 NO

**If 'Yes', then please select all that apply:**

The Joint Commission (TJC) for Ambulatory Care  
 Accreditation Association for Ambulatory Health Care (AAAHC)  
 Adjunct Medical Home Chapter *(If Applicable)*  
 National Committee for Quality Assurance (NCQA) Patient Centered Medical Home  
*(You must choose one of the sub options if the above option is checked)*

Recognition Level 1  
 Recognition Level 2  
 Recognition Level 3

Other  
 If 'Other', please enter the names of those organizations:

**Comments:**

\* 2. Has your health center's personnel participated in medical malpractice risk management training or related continuing education in the last 12 months?

YES – **If 'Yes', please list all medical malpractice trainings and related continuing education.**

NO - **(If 'No', then please enter explanation)**

\* 3. Describe the health center's plan for continuing education and annual medical malpractice/risk management training for all Health Center staff for the upcoming year. **(Please limit to 4000 characters, approximately 1 page)**

**CERTIFICATION AND SIGNATURES**

Completion of this section by a typed name will constitute signature on this application.

\* I [ ] declare under the penalty of perjury that all statements contained in this application and any accompanying documents are true and correct, with full knowledge that all statements made in this application are subject to investigation and that any false or dishonest answer to any question may be grounds for denial or subsequent revocation of coverage.

I understand that by printing my name I am signing this application.

*Please note – this must be signed by the Executive Director, as indicated in the Contact Information Section of the FTCA application. If not signed by the Executive Director, the application will be returned to the health center.*