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Health Center Quarterly Report (HCQR)

Reporting Manual

For the Quarter Ending December 31, 2012

TABLE OF CONTENTS

OVERVIEW 3
INTRODUCTION 4
GENERAL INSTRUCTIONS 4
Who Submits Reports and Reporting Periods 4
How Many Reports are Submitted 5
Due Dates and Revisions to Reports 5
How and Where to Submit Data 5
Training, Technical Assistance, and Additional Resources 6
Designated Point of Contact 6
Cover Page: Form SF-PPR – Page 1 7
Line 8. Final Report 7
Line 10. Performance Narrative 7
Line 10a. *Cumulative* New Unduplicated Patients 8
Line 10b. *Cumulative* New Unduplicated Uninsured Patients 8
Line 11. Other Attachments 9
Form SF-PPR Page 2: Staffing and Utilization 9
Personnel by Major Service Category: Lines 1 through 35 9
Full Time Equivalents (FTEs): COLUMN A 10
Cumulative Visits by Service Provided: COLUMN B 13
Cumulative Patients by Service Provided: COLUMN C 14
Form SF-PPR Page 3 – CIP and FIP Project Completion Status 15
Form SF-PPR Page 3A – CIP and FIP Project: Earned Value Management (EVM) 17
Form SF-PPR Page 4: CIP and FIP Closeout Report 18
Reporting Forms (SF-PPR Pages 1, 2, 3, 3a and 4) 20
Appendix A: Visit Definitions 27

HEALTH CENTER QUARTERLY REPORTING MANUAL

OVERVIEW

This is the Fifteenth edition of the HCQR Manual, *and replaces an earlier edition issued in December 2012.* This manual supports submission of the **H**ealth **C**enter **Q**uarterly **R**eport (HCQR) for health centers receiving funding under the American Recovery and Reinvestment Act (ARRA or Recovery Act). Grantees are required to submit quarterly HCQRs that report programmatic progress on all health centers ARRA funding received. The Fifteenth HCQR will be due on January 10, 2013 with an extension of January 14, 2012 and will include programmatic information on the New Access Point (NAP), Increased Demand for Services (IDS), Capital Improvement Program (CIP), and Facility Investment Program (FIP) grants. The HCQR includes separate tables to report on each of the health center ARRA funding opportunities. HRSA's goal is to collect programmatic information on ARRA supported health center grants without duplicating information reported to the standard Federal ARRA reporting system.

The ARRA, signed into law February 17, 2009, provides approximately $500 million in grants to: support new health center sites and service areas; increase services and providers at existing sites; and address spikes in uninsured patients. It also provides $1.5 billion in grants to support health center construction, renovation and equipment, and the acquisition of health information technology systems.

The Recovery Act was enacted to, among other goals:

- preserve and create jobs;
- promote economic recovery; and
- help people most impacted by the recession.

The ARRA grants awarded to health centers are designed to support efforts in all three of these national goal areas. All ARRA supported grantees (including health centers) are required to report quarterly (Section 1512 federal reporting) on a standard set of elements that will be publicly displayed at the Recovery.gov web site. *In addition to these reports,* health centers will report separately, through the HCQR, on a limited number of Health Center Program performance elements. These HCQRs will permit HRSA to report on and demonstrate the impact of health center activities funded under the ARRA.

HCQRs provide a *quarterly* profile of ARRA supported staff positions, including the number of construction workers employed as a result of CIP and FIP grants. In addition, they provide a *cumulative* count of the number of *new* patients (and *new* uninsured patients) served; the number of visits provided to these new patients; and progress toward completion of capital projects. Grantees are asked to report patients in both a "duplicated format" where the same patient may be counted as both a medical and a dental patient (for example) and in an "*unduplicated format"* where each new patient is counted only once.

For the Fifteenth reporting period ending December 31, 2012, grantees will submit program-specific information on activities included in their NAP, IDS, CIP, and FIP grants as applicable. The HRSA's Electronic Handbook Book (EHB) will combine these reports into a summary report covering all ARRA funded activities.

INTRODUCTION

This is the Fifteenth edition of the HRSA's HCQR Manual *and replaces the manual issued on September 2012*. **This manual currently addresses the program specific reporting requirements for NAP, IDS, CIP, and FIP activities funded under the ARRA.** The most recent version of the HCQR manual will always be available at http://bphc.hrsa.gov/recovery/.

The manual includes a brief introduction to the HCQR system, instructions for submitting the HCQR, definitions of terms as they are used in the HCQR, and detailed instructions for completing each table. Care should be taken in reviewing definitions as they are not necessarily the same as may be used in other BPHC activities or in earlier versions of this manual.

The HCQR is an integrated reporting system used by all BPHC-supported health center grantees receiving support through the following ARRA grants:

- **Increased Demand for Services (IDS)**
- **New Access Point (NAP)**
- **Capital Improvement Program (CIP)**
- **Facility Investment Program (FIP)**

HRSA is collecting program-specific data on the ARRA grants to health centers to ensure compliance with legislative mandates and to report to Congress, OMB, and other policy makers on program accomplishments. To meet these objectives, HRSA requires grantees to report on a limited set of Health Center Program performance elements consistent with the application guidances and awards. These data include:

- The number of jobs (measured in FTEs) that are supported as a result of the ARRA award.
- The number of new patients that received services as a result of the ARRA award.
- The number of visits that new patients received.
- The number of new uninsured patients that received services as a result of the ARRA award.
- Progress toward completion of Capital Improvement Program projects.
- Progress toward completion of Facility Investment Program projects.

With the exception of the FTE data, HCQRs are ***cumulative***. Thus, non-employment data (patients and visits) reported in the most recent HCQR are included and updated in the next HCQR.

GENERAL INSTRUCTIONS

This section describes submission requirements including who submits HCQR reports, when and where to submit the HCQR report, and how data are submitted.

Who Submits Reports and Reporting Periods

Reports should be submitted directly by the health center **grantee** as the direct recipient of one or more HRSA/BPHC ARRA grants. All ARRA-supported health centers are required to submit HCQRs. With the exception of data on FTEs, grantees will report on the entire ARRA award period, from the time they were first funded through the end date of their award.

*The **Certified Authorizing Official** must separately certify the accuracy of the HCQR as the final step in the EHB submissions process. This is done by entering HRSA's EHB using their login I.D. and password and checking the box indicating that they have read and approve the submission.*
Until this is done the report is not officially "submitted."

How Many Reports are Submitted

Grantees will file only one HCQR per quarter. The HCQR has separate sections for each of the four potential ARRA grants. The EHB will prompt a grantee to complete the appropriate reports based on the types of ARRA funding received.

Due Dates and Revisions to Reports

HCQR reports may be worked on starting the day after the close of the quarter, and, are generally due ten days after the close of the quarter. Grantees should begin reporting on each separate ARRA grant beginning with the initial date of award in accordance with the following schedule:

Report Number	Period Covered*	Due Date
1	Initial award – 6/30/09	<completed>
2	Initial award – 9/30/09	<completed>
3	Initial award – 12/31/09	<completed>
4	Initial award – 3/31/10	<completed>
5	Initial award – 6/30/10	<completed>
6	Initial award – 9/31/10	<completed>
7	Initial award – 12/31/10	<completed>
8	Initial award – 3/31/11	<completed>
9	Initial award – 6/30/11	<completed>
10	Initial award – 9/30/11	<completed>
11	Initial award – 12/31/11	<completed>
12	Initial award – 3/31/12	<completed>
13	Initial award – 6/30/12	<completed>
14	Initial award – 9/30/12	<completed>
15	Initial award – 12/3/12	01/14/2013
* This is the period covered for reporting on everything *except* employment. FTE data are reported quarterly for the indicated quarter only and are *not* cumulative.		

All HCQR reports will be finalized by the end of the month in which they are submitted. With the exception of the FTE data, or in the event of mistaken reporting of program data, grantees may submit "corrected" cumulative data in the subsequent quarterly report. *Because the EHB will check submitted data against the prior report, any report which shows a reduced number in a cell should include an explanation.*

How and Where to Submit Data

Reporting will be on-line using a web based data collection system that is completely integrated within the HRSA's EHBs. Health center grantees will use their EHB user name and password to log into the EHB in order to complete their HCQR submission. The system will present users with electronic forms that will guide them in completing the appropriate reports.

To access the HCQR report, go to EHB and open your H80 grant handbook. Click "Performance Reports". The HCQR is listed there along with any other performance reports that may be due.

Users will be able to work on the forms, save them online, return to complete them later, and do so in a collaborative manner. This approach allows grantees to distribute the data entry process among multiple

users if required. Business rules that check for questionable quantitative and qualitative data will be applied to ensure that the data submitted meets legislative and programmatic requirements.

Training, Technical Assistance, and Additional Resources

HRSA will maintain the web site http://bphc.hrsa.gov/recovery/ which will be an ongoing, regularly updated, source for additional information about the BPHC ARRA grants. Included on this site will be frequently asked questions (FAQs) covering each of the ARRA funding opportunities and the reporting process, notification of training sessions that will be conducted to keep grantees updated, technical assistance call recordings and materials, as well as the latest version of this HCQR Manual and reporting forms. The following additional technical assistance resources are available:

- System Help Assistance about the HCQR and about accessing the HRSA's EHB can be obtained from the BPHC Helpline at 1-877-974-BPHC (2742) weekdays from 8:30 AM to 5:30 PM EDT.

- Program specific reporting requirements assistance about HCQR can be obtained at 866-UDS-HELP from 8:30 AM to 5:00 PM EDT.

Note: Extended hours for technical assistance support will be available as reporting deadlines approach. An email communication will be sent that will provide those dates and time.

DESIGNATED POINT OF CONTACT

You will be required to identify the name and contact information for the individual responsible for the HCQR submission for each ARRA grant award. This person may or may not be the person who is the "Certified Authorizing Official" for the program. This is the person that BPHC will contact if there are any questions relating to the HCQR submission. Because this person and/or their contact information may change over the life of the project, grantees will be required to enter/validate this information for each HCQR. Because a grantee may have a different point of contact for each ARRA grant (NAP, IDS, CIP, and/or FIP), separate contacts may be listed for each grant. Only one point of contact may be listed for a CIP and/or FIP grant even if the grant includes multiple projects.

COVER PAGE: FORM SF-PPR – PAGE 1

The HCQR includes a two or three page form to be completed for *each* ARRA grant received. The grantee's EHB will automatically display those sections of the report (IDS, NAP, CIP, and/or FIP) which are to be completed, based on the types of ARRA funding received. While it is understood that the grantee will be integrating the operation of these grants in a manner which optimizes services to the community, *a separate section must be submitted for reporting on each grant and/or grant-supported project*. Each section of the report should be capable of being read and reviewed separately and in isolation from the other sections. In general, the report will cover program specific data elements detailed in the application narrative and budget for the specific grant project, as reflected in the Notice of Grant Award (NGA).

*The EHB will combine the information from the different grant-specific and/or project specific reports into an integrated data presentation. If a grantee has multiple grant awards (e.g., a NAP and IDS),an ARRA-supported employee, patient or visit may be reported on only **ONE** of the ARRA health center grants received so that adding the separate reports together will give an accurate picture of the grantee's total ARRA supported activities.* Grantees should use the information (budget and narrative forms) submitted with their funded ARRA grants as a guide to determine under which ARRA grant a given employee, patient or visit is to be counted.

There will be an SF-PPR Page 1 form for each of the ARRA grants that a grantee receives. The lines discussed below will be on each of these forms and must be completed as described. Some information, such as the progress report, may be the same on multiple forms. *Do not reference another SF-PPR page 1 form; each report must be presented independently.*

Line 8. Final Report

Grantees will indicate that the report is a "Final Report" *only* when they have completed the full scope of the ARRA grant, incurred all of the cost for the grant scope, and have drawn down and expended all ARRA grant funds.

The April 2011 HCQR/1512 Reports will be the final reports for most H8A (NAP) and H8B (IDS) grants if they have completed all activities and used all awarded funds : The original Project Period End Date was 2/28/11 for H8A grants and 3/26/11 for H8B grants. If the grantee received an Extension without the health center is required to continue ARRA Section 1512 and HCQR reporting for extended grants.

In the case of CIP and/or FIP, grantees were invited to propose multiple projects within the grant. When a grantee has multiple CIP and/or FIP projects, the "Final Report" box should be checked *only when **all** CIP and/or FIP projects that make up the total CIP or FIP grant have been completed.* Completion of each project requires the submission of a SF-PPR 3 and SF-PPR 4 Form. While the SF-PPR 3 and SF-PPR 4 forms are required at the completion of *each* project, the entire CIP or FIP grant is not complete until all projects are complete.

Line 10. Performance Narrative

Describe key activities undertaken during the reporting period including information about any goals or objectives which were accomplished as well as the key factors which are contributing to or restricting the performance and success of the ARRA supported activities. The narrative will be limited to 2000 characters (about 1 page). In the case of CIP and FIP grants, each project funded (as defined on SF-PPR-3) should be discussed briefly, if only to say that it has not yet started, is underway or that it has been completed.

Line 10a. *Cumulative* New Unduplicated Patients

Please note: Since 2006, persons served by BPHC-supported health centers have been referred to as "patients." Inconsistent language, referring to such persons as "clients", or "users" has led to some confusion in the past. There is no intent to exclude individuals who are referred to by a grantee as "clients" or "users." Also, as of 2009, reportable interactions between providers and patients are referred to as "visits." This term has the same meaning as "encounters" as defined in earlier BPHC reporting.

For the purposes of reporting on this line, an ARRA supported new patient is an individual who had ***never*** been seen by the grantee prior to receipt of its ARRA funding, and who has subsequently had at least one visit as a result of ARRA funding. [Note: This line uses a more narrow definition of a new patient than in SF-PPR 2 discussed below.]

Line 10a reports *the total cumulative unduplicated new patients to date* seen by the grantee as a result of the ARRA funding. A new patient is counted only once for Line 10a, regardless of the number or frequency of services accessed. For example, a patient seen only once by a physician is counted once, and a patient seen by a physician, dentist, psychologist, and health educator a total of 25 times is also counted once.

Line 10a is cumulative. Therefore, a patient reported on this line will be included in the total count for all subsequent reporting for the entire two year period of the ARRA grant, even if they have not been seen in the current quarter.

*NOTE: If a grantee has multiple grant awards (e.g., a NAP and an IDS) a new ARRA-supported patient may be counted under only **ONE** of the ARRA-supported grants.* Grantees should use the information (budget and narrative forms) submitted with their funded ARRA grants as a guide to determine under which ARRA grant a given patient is to be counted.

> ***Special Instructions for ARRA-NAP projects only:*** NAP awards have been made to grantees who are receiving grant support from BPHC for the first time (new start), or to grantees which are adding a new site to their existing scope of project (satellite) with NAP grant support.
>
> - For ARRA NAP *new start grantees only,* all patients served by the health center are considered to be new patients because they are new to the Health Center Program as a result of ARRA funding.
> - For ARRA NAP *satellite grantees,* only those patients who are seen at the new site and *have not received services at another health center site* are considered to be new patients.
>
> ***Special instructions for ARRA-CIP projects only:*** Although CIP funds were awarded to address pressing capital improvement needs, not to support the direct provision of services, grantees may have proposed to increase the number of patients served as a result of their CIP project(s). This could be, for example, by constructing new exam rooms or by improving efficiency through a HIT project. In addition, adding an operational service site to your section 330 scope of project as part of your CIP may increase the number of NEW patients served. *The sections of SF-PPR-1 which address new patients will become available for reporting once ALL of the CIP project(s) have been completed.*
>
> ***Special instructions for ARRA-FIP projects only:*** FIP funds support major capital construction and alteration/repair/renovation (A/R/R) projects, not the direct provision of services. Grantees may nonetheless have proposed to increase the number of patients served as a result of their FIP project(s). *The sections of SF-PPR-1 which address new patients will become available for reporting once ALL of the FIP project(s) have been completed.*

Line 10b. *Cumulative* New Unduplicated Uninsured Patients

Grantees will report the number of new uninsured patients served by the health center as a result of the ARRA grant. It is recognized that patients may be uninsured for some or all of the time that they are

receiving services at the health center. Therefore, the definition of an uninsured patient is a person who is uninsured for some or all of the two year+ period of the ARRA grant. For reporting purposes on Line 10b, a patient is considered uninsured if they meet one of the following three criteria:

- New patients (as defined above) who are uninsured—specifically, uninsured means that they do not have ***medical*** insurance at the first time they receive services. Once they have been counted as uninsured they remain in the cumulative count.
- New patients (as defined above) who are insured when they first receive services but who subsequently ***become*** uninsured. Once they have been counted as uninsured they remain in the cumulative count.
- *Existing insured patients* (i.e., a patient who had been seen by the grantee as an insured patient prior to initial ARRA grant support) who subsequently lost their insurance (on or after February 17, 2009) and were seen at the health center as an uninsured patient. Once they have been counted as uninsured they remain in the cumulative count. (Note: these patients are ***not*** included on Line 10a as new ARRA patients.)

The definition specifically *excludes* the following:

- A patient who has medical insurance but who is seen exclusively in the dental clinic for services which are not covered by insurance; and
- A patient who is *underinsured*, even if they pay for the care themselves.

Line 10b reports *the total unduplicated **uninsured** ARRA-supported patients seen to date* by the grantee. A new uninsured patient is counted only once on Line 10b, regardless of the number or frequency of services accessed. For example, a patient seen only once by a physician is counted once and a patient seen by a physician, dentist, psychologist, and health educator a total of 25 times is also counted just once. Line 10b is cumulative. Therefore, once a patient is reported as uninsured, the patient is subsequently included in all the cumulative reporting on this element, regardless of whether or not they are seen during the current reporting quarter.

Line 11. Other Attachments

You may, at your own discretion, add additional information that helps to "tell the story" of the impact of the ARRA grant by attaching additional documents. This may include descriptions of activities undertaken, of how individual patients were served by the grant (while maintaining patient confidentiality protections), or how the grant impacted the lives of individual providers or employees. Supporting documentation on the progress or completion of CIP or FIP projects may also be included. Copies of newspaper stories or other documents may be included if they are first scanned into a PDF format. Attachments *may not be used* to extend the required narrative in Line 10 of the SF-PPR Page 1.

FORM SF-PPR PAGE 2: STAFFING AND UTILIZATION

Personnel by Major Service Category: Lines 1 through 35

The lines on this form correspond to the same lines that are used in the HRSA/BPHC UDS report. Personnel are allocated to positions based on the work they perform, and not necessarily their job title. Thus, an RN may be the health educator for the program and will be counted as a health educator, not a nurse. (See the UDS manual for further discussion of this topic.)

A separate SF-PPR 2 form must be completed for each ARRA grant received: NAP, IDS, CIP, and/or FIP. CIP and FIP grantees will be required to complete **one** SF-PPR 2 for the entire/whole scope of their CIP grant and **one** SF-PPR 2 for the entire/whole scope of their FIP grant regardless of the number of separate CIP or FIP projects funded. In addition, for CIP and FIP grants, Lines 1 through 29a will not be completed. See below for further information on CIP and FIP FTE reporting.

Full Time Equivalents (FTEs): COLUMN A

HCQR remains consistent with the federal ARRA reporting guidance and process. Three critical changes have been mandated:

1. FTEs will no longer be separated into "retained" and "created" categories. Instead, one column labeled "FTEs" will encompass both groups of jobs.
2. FTEs will no longer be collected on a cumulative basis. The jobs data reported in this and subsequent HCQRs will be for the reporting quarter only. This change applies ***only*** to the FTE section of this form. All other data on this and other forms continue to be collected on a cumulative basis.
3. Grantees whose budgets are made up of a combination of ARRA grants and other funds (i.e., first and third party program income, and other Federal, State or local grants or contracts) must pro-rate or allocate the jobs to the ARRA grant funds and all other funds. Only that portion of jobs supported with ARRA funds will be reported in the HCQR.

This form includes FTE staffing information on all individuals who were either *hired* with ARRA funds or *retained* as a result of these funds. Do not include new staff who are hired to fill an existing position as a result of normal staff turnover and where that position had not specifically been targeted for elimination prior to ARRA. For example, in the event that an existing part time position is expanded to include more hours or to become full time, *that portion of the FTE which was added with ARRA funding* is considered to be supported by ARRA. Thus, for an RN who was working half time whose position is expanded to full time, only the added hours will be considered when calculating FTE staff positions for the purposes of HCQR (see below for more information).

In addition, an FTE that had been proposed for elimination or which would have been cut – in whole or in part – if it were not for the ARRA funds should be reported. The definition includes existing FTEs that were scheduled for termination as well as those that would have been eliminated through attrition. A position which was scheduled to be eliminated, for example, on September 1, 2010, would be reported for the first time in the HCQR report for period ending September 30, 2010. Also included is a position that was reduced to .5 FTE from 1.0 FTE but as a result of ARRA funding is restored to 1.0 FTE. The hours in the restored .5 FTE would be included in the calculation of FTE positions (see below for more information). A staff FTE reported in the fifth reporting period who continues employment in the seventh reporting period is considered ARRA supported and is still reported.

Overall, the requirement for reporting jobs is based on a simple calculation. This calculation converts all work, including full time, part-time and temporary jobs, into "full time equivalent" (FTE) jobs. In order to perform the calculations, a recipient will need the total number of paid hours that are directly funded by the Recovery Act. *Beginning with the third reporting period,* positions that are funded with a combination of BPHC-ARRA grant and other funds are to be reported only to the extent that ARRA funds are used. Grantees are responsible for allocating positions or portions of positions between ARRA grant support and other funds, and are to report only on the portion supported by ARRA. Some examples might help illustrate this:

- ARRA funds and another *targeted* grant. Grantee receives a separate grant to hire an outreach worker to support its new IDS program. The outreach worker is *not* reported on the HCQR.
- ARRA funds and another general grant. Grantee receives general revenue support from the County (or any other form of unrestricted support) to expand services. ARRA support for the IDS program is $400,000 and the other grant is $100,000. Grantee will report 80% of all FTEs in the program as ARRA supported on the HCQR *and will not report the other 20%.*
- ARRA funds and patient service revenues. Grantee allocates $400,000 of its ARRA funding to support its medical program. The medical program also receives[1] a total of $200,000 from patients, Medicare, Medicaid, and other third party payors for medical services related to the ARRA grant

[1] For ease of calculation, grantee should use a cash basis for both the ARRA funds *drawn down* during the period and the earnings *received* during the reporting period.

activities. Two-thirds of each ARRA employee's time is allocated to the ARRA grant activities and reported on the HCQR. The other one-third, supported by first and third party payors, *is not reported.*

- Time limited other support. Grantee receives full support from the State for two outreach workers. The funding began February 1, 2009 and ended on July 31, 2010. When the outside support ended on July 31, 2010, the workers were then paid by ARRA grant funds from August 1, 2010 through September 30, 2010. The grantee will report the two FTEs for two thirds of the reporting quarter or 1.33 FTEs. The other 0.67 FTEs that worked on outside funds are *not* reported. The reporting quarter is July 1, 2010 – September 30, 2010.

Grantees will use the number of paid hours in a full-time schedule for reporting FTEs for a quarter. For example, if a quarter has precisely 12 full weeks and four days that are paid, employees or organizations that work a 40 hour work week will use 512 hours to represent a full time employee. The formula for reporting can be represented as:

$$\frac{\text{Recovery Act Funded Hours Paid (Qtr 9)}}{\text{Quarterly Hours in a Full-Time Schedule (Qtr 9)}}$$

Example:

On October 1, 2010, a grantee hired two full-time employees and one half-time employee working half days using ARRA funds. They worked for the grantee for the entire seventh reporting quarter. To convert paid hours to the number of FTEs for the quarterly report, the grantee must aggregate all hours paid to these employees through the reporting quarter and divide by the number of hours in a full time schedule – in this case, 528 hours.

In this example, the total full-time hours paid for 2 employees equals 1056 hours [i.e., 528 hours per full-time employee (the total number of hours for the quarter) x 2 employees = 1056 hours] and the total hours paid for 1 half time employee equals 264 hours (i.e., 528 hours per full-time employee for the seventh quarterly reporting) x 0.5 employee = 264 hours).

Together, in this example, the total number of hours worked for the quarter equals 1320 hours. This number should then be divided by a full time schedule for the quarter (528 hours) which equals 2.5 FTEs for the quarterly report.

$$\frac{\text{Total full-time hours paid}}{\text{Total hours in the quarter}} \quad \frac{(528 \text{ hrs} \times 2) + (264 \text{ hrs} \times 1) = 1320 \text{ hrs}}{528 \text{ hrs}} \quad = 2.5 \text{ FTEs}$$

Reporting *for FTEs only* is not cumulative. The FTE count resets at the beginning of each quarter. In the example above, the 2.5 FTEs reported in the seventh quarterly report will remain the same until the completion of the project assuming the same number of employees is paid for the maximum number of hours in each quarter. However, if the number of hours worked changes in any quarter, the number of FTEs will also change

The example in the table below shows the FTE calculations for eight quarters for full-time, part-time, and temporary workers.

Period	10/09 -12/09	1/10 - 3/10	4/10 - 6/10	7/10 - 9/10	10/10 - 12/10	1/11 - 3/11	4/11 - 6/11	7/11 - 9/11	10/11 - 12/11	1/12 - 3/12	4/12 - 6/12	7/12 - 9/12	10/12 - 12/12
Report #	3	4	5	6	7	8	9	10	11	12	13	14	15
Full time schedule	520	512	520	528	520	544	520	512	520	512	520	512	520
Full time employee #1 (e.g., Physician)	520	512	520	528	520	544	520	512	520	512	520	512	520
Full time employee #2 (e.g., Nurse Practitioner)	520	512	520	528	520	544	520	512	520	512	520	512	520
Part time (1/2 time) employee #3 (e.g., RN)	260	256	260	264	260	272	260	256	260	256	260	256	260
Temp employee (650 hrs) (e.g., Administrative)	0	0	200	200	50	0	0	0	0	0	0	0	0
Total hours worked	1300	1280	1500	1520	1350	1360	1300	1280	1300	1280	1300	1280	1300
Quarterly FTE	2.5	2.5	2.88	2.88	2.60	2.60	2.88	2.5	2.5	2.5	2.88	2.5	2.5

Special Instructions for CIP and FIP Projects. Grantees are expected to report only administrative and/or construction staff for CIP and FIP projects; therefore, Lines 1 through 29a will be grayed out on SF-PPR 2 for these projects. While data may be entered in the administrative lines, it is not expected that a grantee will do so unless, for example, a new IT system requires input to the billing process; thus, a patient billing staff FTE may be reported on Line 30b. FTEs reported on the CIP or FIP SF-PPR 2 will be only those staff which are newly hired to support the CIP or FIP project, or those whose positions were scheduled for termination and were retained (or restored) as a result of ARRA funding. As noted above, only that portion of a job that is supported with ARRA funding is reported.

The following are provided as examples of staff that might be included in a CIP or FIP SF-PPR 2 report if they were supported by the ARRA CIP or FIP grant.

- **Line 30a – Management and Support Staff.** Include project managers hired to supervise the CIP or FIP project.
- **Line 30b – Fiscal and Billing Staff.** May include billing or coding experts hired with ARRA CIP or FIP budgeted funds to organize and implement a new/expanded HIT system or an EHR.
- **Line 30c – IT Staff.** New or retained IT staff, supported by ARRA grant funds, who will be a part of the construction/renovation/and/or implementation of a new IT, HIT, or certified EHR.
- **Line 31 – Facility Staff.** Staff (new and/or retained) who will be responsible for the facility during and after the construction, alteration, repair, and renovation period. Existing staff whose responsibilities are broadened to include a CIP or FIP facility are not to be allocated to the CIP or FIP project.

- **Line 32 – Patient Support Staff.** New or retained staff who are employed to implement a CIP EHR project such as additional medical records staff responsible for scanning old records into an EHR or abstracting existing charts into EHR templates to permit rapid implementation of an EHR.
- **Line 35 – Construction Related Staff.** Individuals who are employed in the construction phase of a CIP or FIP project. "Construction Related Staff" does not include reporting of visits or patients. As a result, it comes *after* the total line (Line 34).

Grantees with CIP or FIP construction projects, A/R/R projects, or projects that involve the installation of equipment (IT or non-IT related) should obtain from their contractors the number of paid hours for all related construction staff including supervisors and allocated corporate construction staff. In the event that a grantee hires its own staff to do some or all of the construction, A/R/R or installation work (referred to as "Force Account Labor" or FAL programs), the grantee will report the same data, but for its own staff, including supervisors. (Grantees with FAL programs should refer to the HRSA FAQ available at http://bphc.hrsa.gov/recovery/cip/ta_assistance/faqfal.htm for further information.)

***Cumulative* Visits by Service Provided: COLUMN B**

A visit is a documented, face-to-face contact between a patient and a provider who exercises independent professional judgment in the provision of services to the individual. *All visits that are generated as a result of ARRA funding* are to be reported, *including those that are generated by providers that weren't hired/retained as a result of the ARRA funding but have increased capacity that is filled with new patients as a result of the ARRA funding or were supported by program income or other grants or contracts.* Thus, it is possible to count in column B the visits generated by a provider who is a part of the IDS or other ARRA grant even though the FTE for that provider is not reported in column A (FTEs). (A complete, comprehensive definition of a visit is included as Appendix A.)

For the purpose of this table, grantees are to report on the number of visits made by all new patients (as defined in SF-PPR 1 – Line 10a) AND those current health center patients that have received a NEW SERVICE as a result of ARRA funding over the two year project period. [Note: This table uses a broader definition of a new patient than on Line 10a of SF-PPR 1 discussed above to account for the expansion of services supported through ARRA.] For example:

- If a grantee hires a pediatrician who assumes part of the existing case load of a family practitioner, the visits for a new patient seen by the family practitioner would be counted.
- If a grantee extends the hours of service at site A to include evenings and Saturdays and as a result, *existing* patients are served during the extended hours while *new* patients are seen during normal hours, the visits for these new patients would be counted, but not the visits of the existing patients.
- If a grantee expands their dental services with ARRA support and a medical patient who never had dental care before now begins to receive this care, he/she will be counted as a new dental patient and his/her *dental visits* (but *not* the medical visits) will be reported. This patient will *not,* however, be counted as a new patient on SF-PPR 1.

In those cases where a comprehensive collection of data is overly costly or burdensome and thus disrupts the grantee's ability to effectively implement the underlying mission of the grant, a grantee may consider reporting on new patients, services provided, and visits for only those patients who had not been seen at the health center prior to receipt of ARRA funding.

Visits that are purchased from non-staff providers on a fee-for-service basis *using ARRA funds* are also counted in this column, even though no corresponding FTEs are included in Column A. To be counted in this column, these purchased services must meet the following criteria:

- The service was provided to a patient of the grantee by a provider that is not part of the grantee's staff (neither salaried nor contracted on the basis of time worked),
- The service was paid for in full (or in part) by the grantee using ARRA funds or funds generated from ARRA supported services, and

- The service otherwise meets the above definition of a visit.

This category ***does not include unpaid referrals, or referrals where only nominal amounts are paid,*** or referrals for services that would otherwise not be counted as visits.

Visits reported in this column are *cumulative* from the initial ARRA grant award. Thus, all visits reported for the first time in one quarter *will also be included* in visits reported in subsequent quarters. Eventually, the report will include the visits for the entire ARRA grant period.

***Cumulative* Patients by Service Provided: COLUMN C**

For the purpose of this table, grantees are to report on the number of new patients served (as defined in SF-PPR 1 – Line 10a) and those current health center patients that have received a new service as a result of ARRA funding over the two year project period. [Note: This table uses a broader definition of a new patient than for Line 10a of SF-PPR 1 discussed above, to account for the expansion of services supported through ARRA.]

ARRA-supported new patients are reported in Column C *only once* within each category of service (e.g., medical), regardless of the number of visits generated. For example, a patient who receives multiple types of services (e.g., medical and dental) *should* be counted under each category of service but *only once for each category*. Thus, a new patient receiving only medical services is reported once on Line 15 (as a medical patient) regardless of the number of medical visits. A new patient receiving medical, dental, and enabling services is reported once as a medical patient (Line 15), once as a dental patient (Line 19) and once as an enabling patient (Line 29), but is counted *only* once on each appropriate line in Column C, regardless of the number of visits reported in Column B.

A current health center patient that is accessing a new service as a result of the ARRA funding, should be reported as a new patient only once under the category of new service accessed (e.g., medical) regardless of the number of visits the patient generates in accessing that new service. For example, if a "medical-only" patient at the health center is now seen for the first time in the newly expanded dental program as a result of ARRA funding, that patient *would be counted as a new dental patient and their dental visits (only) would be reported.* Also, individuals who only receive services for which no visits are generated (e.g., laboratory tests, transportation, health education or smoking cessation classes, immunizations, flu shots) are not included in the patient count reported in Column C.

An individual patient may be counted **only** once in **each** of the following categories:

- Medical care services patients (Line 15)
- Dental services patients (Line 19)
- Mental health services patients (Line 20)
- Substance abuse services patients (Line 21)
- Patients of other professional services (Line 22)
- Enabling services patients (Line 29)

Grantees reporting visits in Column B for any of these six categories are required to identify the unduplicated number of patients who received this type of visit in Column C. Since patients must have at least one documented visit, it is not possible for the number of patients to exceed the number of visits.

In those cases where a comprehensive collection of data is overly costly or burdensome and thus disrupts the grantee's ability to effectively implement the underlying mission of the program, a grantee may consider reporting on new patients, services provided, and visits for only those patients who had not been seen at the health center prior to receipt of ARRA funding.

Detailed ARRA-Supported Activities:
FORM SF-PPR PAGE 3 – CIP AND FIP PROJECT COMPLETION STATUS

Many health centers received CIP funding and/or FIP funding to support more than one project. There will be one SF-PPR 3 for each CIP and/or FIP project. The EHB will pre-populate many of the elements of SF-PPR page 3 with data already in the system. This will include information about the grantee (name, grant number); information about the report (period end date and tracking number); information about the specific project [the Project Number, Project Title, Project Type (Construction, A/R/R, IT/Equipment, HIT, or EHR)], and project award amount.

For *each* CIP and/or FIP project, the following data elements will be reported as appropriate:

- **Project Number, Title, Type, and Amount.** This information will be pre-populated. Grantees should review the information to verify that it is correct. Grantees will neither be required nor be able to enter data in these fields. If there is a question about data in these fields, please call the BPHC Help Line 1-877-974-BPHC (2742).
- **Line 1. Project Status.** Grantees will select from the categories (Not started, Less than or equal to 50% Complete, Greater than 50% Complete, or Completed) to indicate the status of the project at the end of the reporting period. This estimate should be based on the definitions below, and should be an accurate reflection of current status of the project.
- **Line 2. Project Narrative.** Describe key activities undertaken during the reporting period including information about any milestones reached as well as the key factors which are contributing to or restricting the performance and success of the ARRA-supported project. Any minor changes to projects should also be presented here. (If a grantee wishes to make a major change requiring prior approval from HRSA, it should immediately contact its C81 Project Officer and Grants Management Specialist.) The narrative will be limited to 2000 characters.

The four categories of project completion status are defined as:

Project Status	Definition
Not Started	No costs for this project have been incurred AND project has not yet been initiated
Less than or equal to 50% Complete	Less than 50% of purchase(s)/work has been completed
Greater than 50% and Less than 100% Complete	Between 51% and 99% of purchase(s)/work has been completed
Completed	100% of the costs for this project have been incurred AND 100% of purchase(s)/work has been completed

If a grantee indicates on Line 1 that a project is "Completed," a series of three questions must be answered.

- Line 1a: "Do the total project costs incurred reflect the approved budget for this project, and have all of the funds for this project been drawn down from the PMS account? HRSA recognizes that project budgets may change during the course of the project period. Any changes to the project budget should have been discussed with and approved by the assigned Grants Management Specialist. [ ]Yes [ ]No. If No, please explain."
- Line 1b. "Does the scope of work of the project reflect the scope of work as proposed by the grantee and approved by HRSA? [ ]Yes [ ]No. If No, please explain."

- Line 1c. "Are you prepared to complete and submit the following forms and documents to HRSA (which will be requested through your Electronic Hand Book Grant Portfolio)? [ ]Yes [ ]No. If No, please explain."

Project Type	Documents
IT/Equipment, HIT, EHR	Project completion certification
A/R/R (Alteration, Repair, or Renovation)	Project completion certification, after photos
Construction	Project completion certification, after photos

If one or more of the answers to questions 1a, 1b, or 1c above is "no," grantees must provide an explanation. Although a project will usually be complete only when the response to all three questions is "yes," if a grantee determines that an explanation is sufficient for any "no" responses to demonstrate completion, they will be advised to proceed to the next page by clicking on the "SF-PPR Page 4 – Closeout Data" button. A grantee may revise and change the project status on the SF-PPR 3 report by clicking on the "go to previous page" button on the SF PPR 4. If further analysis by BPHC identifies that the project is not complete, according to the definitions of project status above, the grantee may be required to correct and update the SF PPR 3 form during the next HCQR reporting.

For more information on the Project Completion requirements (including templates), please see the resources available under the "Project Implementation and Completion" sections of http://bphc.hrsa.gov/recovery/cip/ and http://bphc.hrsa.gov/recovery/fip/.

Note, as stated above, once a project is reported as "Completed," the grantee will be directed to complete SF-PPR 4 - Close Out report for this project.

- **Line 3. Attachments (Not Required).** Grantees are encouraged to attach additional documentation that helps to "tell the story" on the implementation of the health center's CIP and/or FIP projects. This may include pictures of renovations or new equipment in place, purchase orders or delivery schedules for equipment, training contracts or agendas for new HIT or EHR systems, etc. Copies of pictures or documents included should first be scanned into a PDF format. Attachments *may not be used* to extend the required narrative in section 10 of the SF-PPR Page 1.

DETAILED ARRA-SUPPORTED ACTIVITIES:
FORM SF-PPR PAGE 3A – CIP AND FIP PROJECT: EARNED VALUE MANAGEMENT (EVM)

Construction and alteration/repair/renovation projects that were funded through the CIP and/or FIP with a total project cost (federal and non-federal) of $1 million or greater are required to utilize and report on Earned Value Management (EVM) within HCQR. EVM is an analysis tool that allows project managers to effectively identify cost-overruns and timeline deviations during the construction project, so that the impact may be mitigated.

***This requirement does NOT pertain to IT/Equipment, HIT, and EHR projects, nor does it apply to alteration/repair/renovation or construction projects with a total cost (federal and non-federal) of less than $1 million. The HCQR module will not present this section for these projects.*

The status of the project's schedule (On Time, Ahead of Schedule, or Behind Schedule) and budget (On Budget, Over Budget, or Under Budget) will be reported. For a project schedule's status, a grantee should refer to the baseline data provided in its most recently HRSA-approved CIP application (estimated costs to be incurred in the project, and the estimated construction start and completion dates). The grantee should then compare the estimated costs and timeframes with the actual costs and timeframes for each calendar year quarter. To ensure it has accurate baseline and comparison data, the grantee should consult with its construction management team to collect and analyze the following data elements:

- Reporting Period
- Planned Start Date
- Planned Completion Date
- Total Project Cost
- Planned % of Project Completed
- Actual Start Date
- Actual Completion Date
- Actual % of Project Completed
- Actual Cost of Work Performed
- Cost Variance
- Schedule Variance

Depending on the status indicated, a series of follow-up questions will be shown within the HCQR to determine how each scenario will be addressed. If the project status is On Time and On Budget, no further follow-up is needed.

- **Line 1. Project Schedule.** This line is used to **r**eport the status of the project. The CIP and/or FIP project status must be marked as one of the following:
  [ ] On Time
  [ ] Behind Schedule
  [ ] Ahead of Schedule

Depending on the response to the Schedule question, the following questions will be asked:

Behind Schedule

1a. Is the project expected to remain behind schedule?
- If yes, provide a revised completion date and identify how the total estimated project cost will be affected in the text box provided.
- If no, indicate how the schedule will get back on track and whether or not the total estimated project cost will be affected in the text box provided.

Ahead of Schedule

1b. Is the project expected to remain ahead of schedule?

- If yes, provide a revised completion date and indicate whether or not the total estimated project cost will be affected within the text box provided.
- If no, indicate within the text box provided that the project will be completed by the estimated project completion date.

- **Line 2. Project Budget.** This line is used to report the status of the budget. The CIP and/or FIP budget status must be marked as on of the following;
  [ ] On Budget
  [ ] Under Budget
  [ ] Over Budget

Depending on the response to the Budget question, the following questions will be asked:

Under Budget:

2a. Will the project incur enough costs to allow for the drawdown of all the Federal funds by the project completion date?

- If yes, indicate in the text box provided the strategy to utilize the excess funds, if possible (i.e., purchase additional equipment).
- If no, indicate in the text box provided that the grantee organization is aware that the remaining funds will be de-obligated.

Over Budget:

2b. Is the project anticipated to remain over budget for the completion construction schedule (i.e., the total project cost at completion will be greater than the original proposed budget)?

- If yes, will additional funds be secured, or have additional funds been secured, to allow for the completion of the project on time?
  - If yes, indicate within the text box provided the source(s) and amount(s) of funding that will be/have been secured.
  - If no, provide a timeline for adjusting the project scope to align with the adjusted costs within the text box provided.
- If no, provide revised plan/supporting documentation to identify when and how the budget will no longer exceed original budget estimates.

FORM SF-PPR PAGE 4: CIP AND FIP CLOSEOUT REPORT

The SF-PPR Page 4 form will be included *only* when an ARRA CIP or FIP project has been marked as "Completed." There will be one SF-PPR 4 form for each project.

- **Line 1. Square Feet Increased.** This line will only be available for construction projects marked as "Completed" on the SF-PPR 3. The final square footage added as a result of the CIP or FIP project will be reported.

- **Line 2. Square Feet Improved.** This line will be available for all Construction *or* A/R/R projects marked as "Completed" on the SF-PPR 3. The final square footage improved as a result of the CIP or FIP project will be reported. Note that improved space resulting from IT/HIT/EHR projects should *not* be included on Line 2.

- **Line 3a – 3c. Certified EHR Users.** This line will be available *only* for Certified EHR projects (not including enhanced or expanded IT or HIT systems) marked as "Completed" on the SF-PPR 3. Data reported includes:

  - **Line 3a. Number of Clinicians with EHR:** Report *only* the number of primary care clinical providers (i.e., physicians; nurse practitioners; physician assistants; and certified nurse midwives) who have new or improved access to a certified EHR system which has been purchased or upgraded with ARRA and related funding.

  - **Line 3b. Number of Other Staff with EHR (not applicable for FIP reporting):** Report the number of other clinical staff, including dentists, mental health professionals, nurses, and other clinical support staff, who have new or improved access to a certified EHR system which has been purchased or upgraded with ARRA and related funding.

  - **Line 3c. Number of Patients with an EHR (not applicable for FIP reporting):** Report the number of patients projected to have an EHR within one year of the implementation of the EHR project. "Implementation of the Project" is interpreted to mean the date that the first record (other than test records) is entered into the system. For those grantees "phasing-in" the EHR over a period of time, the implementation date may be before or at the same time as the "completion" of the project. *Do not* report estimated capacity for the system.

- **Line 4a – 4d. Project Costs.** The total of Lines 4b + 4d *will be the actual total cost* of the CIP or FIP project. Unlike the reporting of staff on SF-PPR Page 2, *all funds expended on the program* are reported here. Data reported includes:

  - **Line 4b. Actual Amount of CIP or FIP Funds Expended on the Project:** Report the total amount of CIP or FIP grant funds expended on the project. This should include funds already expended as well as those necessary to cover outstanding costs incurred but not yet paid.

  - **Line 4d. Actual Amount of Non-CIP or FIP Funds Expended on the Project:** Report the total amount of CIP or FIP project costs being paid using *non-ARRA* grant funds. This should include non-ARRA funds already expended as well as those necessary to cover outstanding costs incurred but not yet paid using any other non-ARRA funds including capital reserves, other grants or contracts, donations, etc.

- **Line 5a – 5b. Project Completion Dates.** These lines will be used to report proposed and actual project completion dates.

  - **Line 5a. Proposed Project Completion Date:** This is system populated data.

  - **Line 5b. Actual Project Completion Date:** Report the completion date only if your project has been marked as complete.

ARRA PERFORMANCE PROGRESS REPORT
CONTACT INFORMATION

10c. Designated Point of Contact			
IDS Point of Contact	Title	Phone	Fax
	Name	Email	
NAP Point of Contact	Title	Phone	Fax
	Name	Email	
CIP Point of Contact	Title	Phone	Fax
	Name	Email	
FIP Point of Contact	Title	Phone	Fax
	Name	Email	
			OMB Control Number: 0970-0334

ARRA PERFORMANCE PROGRESS REPORT
SF-PPR PAGE 1

SF-PPR PAGE 1 - SUMMARY	
8. Is this your Final HCQR? [ ] Yes [ ] No	
10a. Total New Patients (Unduplicated)	10b. Total New Uninsured Patients
10. Performance Narrative	
Other Attachments << File name: *This will indicate name of the file that was attached if any* >>	
	OMB Control Number: 0970-0334

ARRA PERFORMANCE PROGRESS REPORT
SF-PPR PAGE 2 Staffing and Utilization

Grantee Name	Grant Number	BHCMIS ID	Reporting Period End Date	Tracking Number

	Personnel by Major Service Category	FTEs (a)	Visits (b)	New Patients (c)
1.	Family Physicians			
2.	General Practitioners			
3.	Internists			
4.	Obstetrician/Gynecologists			
5.	Pediatricians			
7.	Other Specialty Physicians			
8.	**Subtotal Physicians (Sum lines 1-7)**			
9a.	Nurse Practitioners			
9b.	Physician Assistants			
10.	Certified Nurse Midwives			
10a.	**Subtotal Mid-Levels (Sum lines 9a-10)**			
11.	Nurses			
12.	Other Medical Personnel			
13.	Laboratory Personnel			
14.	X-Ray Personnel			
15.	**Total Medical (Sum lines 8+10a through 14)**			
16.	Dentists			
17.	Dental Hygienists			
18.	Dental Assistance, Aides, Techs			
19.	**Total Dental Services (Sum lines 16-18)**			
20a.	Psychiatrists			
20a1.	Licensed Clinical Psychologists			
20a2.	Licensed Clinical Social Workers			
20b.	Other Licensed Mental Health Providers			
20c.	Other Mental Health Staff			
20.	**Total Mental Health (Sum lines 20a-20c)**			
21.	**Substance Abuse Services**			
22.	**Other Professional Services** Specify:			
23.	**Pharmacy Personnel**			
24.	Case Managers			
25.	Patient/Community Education Specialists			
26.	Outreach Workers			
27.	Transportation Staff			
27a.	Eligibility Assistance Workers			
27b.	Interpretation Staff			
28.	Other Enabling Services			
29.	**Total Enabling Services (Sum lines 24-28)**			
29a.	**Other Programs/Services** Specify:			
30a.	Management and Support Staff			
30b.	Fiscal and Billing Staff			
30c.	IT Staff			
30.	**Subtotal Administrative Staff (Sum lines 30a-30c)**			
31.	Facility Staff			
32.	Patient Support Staff			
33.	**Total Administrative & Facility (Sum lines 30-32)**			
34.	**Grand Total (Sum lines 15+19+20+21+22+23+29+29a+33)**			
35.	**Construction Related Staff**			

OMB Control Number: 0970-0334

DETAILED ARRA-SUPPORTED ACTIVITIES
FORM SF-PPR PAGE 3 CIP AND FIP PROJECT REPORT

Grantee Name	Grant Number	BHCMIS ID	Reporting Period End Date	Tracking Number

<<*Project Number>><<Project Title>>* *(System populated data)*

Project Type	*(System populated data)*	Awarded Amount for the Project	*(System populated data)*
1. Project Status	[ ] Not Started [ ] Less than or equal to 50% Complete [ ] Greater than 50% and Less than 100% Complete [ ] Completed		

Questions 1a through 1c are applicable only if Project status is Completed.

1a. Do the total project costs incurred reflect the approved budget for this project, and have all of the funds for this project been drawn down from the PMS account? HRSA recognizes that project budgets may change during the course of the project period. Any changes to the project budget should have been discussed with and approved by the assigned Grants Management Specialist.

[ ] Yes [ ] No

If No, please explain *(maximum 2000 characters)*

1b. Does the scope of work of the project reflect the scope of work as proposed by the grantee and approved by HRSA?

[ ] Yes [ ] No

If No, please explain *(maximum 2000 characters)*

1c. Are you prepared to complete and submit the following forms and documents to HRSA (which will be requested through your Electronic Hand Book Grant Portfolio)?

[ ] Yes [ ] No

If No, please explain *(maximum 2000 characters)*

2. Project Specific Narrative: *(maximum 2000 characters)*

3. Attachment(s) (*attach other documents as needed or as instructed by the awarding Federal Agency*):

<<name of attachment(s)>>

OMB Control Number: 0970-0334

DETAILED ARRA-SUPPORTED ACTIVITIES
FORM SF-PPR PAGE 3A CIP AND FIP PROJECT EVM DATA

Grantee Name	Grant Number	BHCMIS ID	Reporting Period End Date	Tracking Number

<<*Project Number>><<Project Title>>* *(System populated data)*			
Project Type	*(System populated data)*	Awarded Amount for the Project	*(System populated data)*
Project Status	*(System populated data)*	Total Estimated Project Cost	*(System populated data)*
1. Project Schedule	[ ] On Time [ ] Behind Schedule [ ] Ahead of Schedule	2. Project Budget	[ ] On Budget [ ] Under Budget [ ] Over Budget

If **Behind Schedule**, please answer the questions below:

1a. Is the project expected to remain behind schedule?

[ ] Yes, I will provide a revised completion date and identify how the total estimated project cost will be affected in the text box provided.

1. Original total estimated project cost: *(System populated data)*
2. Total estimated project cost (if revised): $_____
3. Original project completion date: *(System populated data)*
4. Revised project completion date: _____ (MM/YYYY)

[ ] No, I will indicate how the schedule will get back on track and whether or not the total estimated project cost will be affected in the text box provided.

Explanation (maximum 2000 characters):

If **Ahead of Schedule**, please answer the questions below:

1b. Is the project expected to remain ahead of schedule?

[ ] Yes, I will provide a revised completion date and indicate whether or not the total estimated project cost will be affected within the text box provided.

1. Original total estimated project cost: *(System populated data)*
2. Revised total estimated project cost: $_____
3. Original project completion date: *(System populated data)*
4. Revised project completion date: _____ (MM/YYYY)

[ ] No, I will indicate within the text box provided that the project will be completed by the estimated project completion date.

Explanation *(maximum 2000 characters):*

If **Under Budget**, please answer the questions below:

Grantee Name	Grant Number	BHCMIS ID	Reporting Period End Date	Tracking Number

2a. Will the project incur enough costs to allow for the drawdown of all the Federal funds by the project completion date?

[ ] Yes, I will indicate in the text box provided the strategy to utilize the excess funds, if possible (i.e., purchase additional equipment).

[ ] No, I will indicate in the text box provided that the grantee organization is aware that the remaining funds will be de-obligated.

Explanation *(maximum 2000 characters):*

If **Over Budget**, please answer the questions below:

2b. Is the project anticipated to remain over budget for the completion construction schedule (i.e., the total project cost at completion will be greater than the original proposed budget)?

[ ] Yes

If Yes to 2b. above answer the following questions:

2b.1 Will additional funds be secured, or have additional funds been secured, to allow for the completion of the project on time?

[ ] Yes, I will indicate within the text box provided the source(s) and amount(s) of funding that will be/have been secured

[ ] No, I will provide a timeline for adjusting the project scope to align with the adjusted costs within the text box provided.

[ ] No, I will provide a revised plan/supporting documentation to identify when and how the budget will no longer exceed original budget estimates (which will be requested via EHB submissions).

Explanation *(maximum 2000 characters):*

OMB Control Number: 0970-0334

DETAILED ARRA-SUPPORTED ACTIVITIES
FORM SF-PPR PAGE 4 CIP AND FIP PROJECT CLOSEOUT REPORT

Grantee Name	Grant Number	BHCMIS ID	Reporting Period End Date	Tracking Number

<<*Project Number>><<Project Title>> (System populated data)*			
Square Footage Data *(Applicable only for completed projects of the type – 'Construction', and ' Alteration/Repair/Renovation')*			
1. Square Feet Increased *(Construction projects only)*		2. Square Feet Improved (*Construction and Alteration/Repair/Renovation projects only)*	
Certified EHR Users *(Applicable only for completed projects of the type – 'Certified EHR – Related Purchase')*			
3a. Number of Clinicians with EHR		3b. Number of Other Staff with EHR	
3c. Number of Patients with an EHR			
Project Costs *(Applicable only for all projects that are completed)*			
4a. CIP or FIP funds awarded for this project	(S*ystem populated data)*	4b. Actual amount of CIP or FIP funds expended on the project	
4c. Projected amount of non-CIP or non-FIP funds i.e., state, local, and other funds - including other federal funds - proposed for this project	*(System populated data)*	4d. Actual amount of non-CIP or non-FIP funds expended on the project	
Project Completion Dates *(Applicable only for all projects that are completed)*			
5a. Proposed project completion date	(S*ystem populated data)*		
5b. Actual project completion date	(MM/YYYY)		
			OMB Control Number: 0970-0334

APPENDIX A: VISIT DEFINITIONS

Visit definitions are needed both to determine who is counted as a patient and to report visits by type of service. **Visits are defined as documented, face-to-face contacts between a patient and a provider who exercises independent professional judgment in the provision of services to the patient. To be included as a visit, services rendered must be documented in a chart in the possession of the grantee.** Visits which are provided by contractors, **and paid for by the grantee,** such as Migrant Voucher visits or out-patient or in-patient specialty care associated with an at-risk managed care contract, are considered to be visits to be counted on the HCQR to the extent that they meet all other criteria. In these instances, a summary of the visit may appear in the grantee's charts.

Further elaborations of the definitions and criteria for defining and reporting visits are included below.

1. To meet the criterion for "independent professional judgment," the provider must be acting on his/her own when serving the patient and not assisting another provider. For example, a nurse assisting a physician during a physical examination by taking vital signs, taking a history or drawing a blood sample **is not** credited with a separate visit. Independent judgment implies the use of the professional skills associated with the profession of the individual being credited with the visit and unique to that provider or other similarly or more intensively trained providers.

2. To meet the criterion for "documentation," the service (and associated patient information) must be recorded in written or electronic form. The patient record does not have to be a full and complete health record in order to meet this criterion. For example, if an individual receives services on an emergency basis and these services are documented, the documentation criterion is met even though some portions of the health record are not completed. Screenings at health fairs, immunization drives for children or the elderly and similar public health efforts do not result in visits regardless of the level of documentation.

3. When a behavioral health provider renders services to several patients simultaneously, the provider can be credited with a visit for each person only if the provision of services is noted in **each** person's health record. Such visits are limited to behavioral health services. Examples of such non-medical "group visits" include: family therapy or counseling sessions and group mental health counseling during which several people receive services and the services are noted in each person's health record. In such situations, **each** patient is normally billed for the service. Medical visits must be provided on an individual basis. Patient education or health education classes (e.g., smoking cessation) are not credited as visits.

4. A visit may take place in the health center or at any other site or location in which project-supported activities are carried out. Examples of other sites and locations include mobile vans, hospitals, patients' homes, schools, nursing homes, homeless shelters, and extended care facilities. Visits also include contacts with patients who are hospitalized, where health center medical staff member(s) follow the patient during the hospital stay as physician of record or where they provide consultation to the physician of record provided they are being paid by the grantee for these services. A reporting entity may not count more than one inpatient visit per patient per day.

5. Such services as drawing blood, collecting urine specimens, performing laboratory tests, taking x-rays, giving immunizations or other injections, and filling/dispensing prescriptions do not constitute visits, regardless of the level or quantity of supportive services.

6. Under certain circumstances a patient may have more than one visit with the health center in a day. The number of visits per service delivery location per day is limited as follows. Each patient may have, at a maximum:
   - One medical visit (physician, nurse practitioner, physicians assistant, certified nurse midwife, or nurse).
   - One dental visit (dentist or hygienist).
   - One "other health" visit *for each type of "other health" provider* (nutritionist, podiatrist, speech therapist, acupuncturist, optometrist, etc.).

- One enabling service visit *for each type of enabling provider* (case management or health education).
- One mental health visit.
- One substance abuse visit.

If multiple medical providers deliver multiple services on a single day (e.g., an Ob-Gyn provides prenatal care and in Internist treats hypertension) *only one of these visits may be counted on the HCQR. While some third party payors may recognize these as billable, only one of them is* ***countable.*** *The decision as to which provider gets credit for the visit on the HCQR is up to the grantee. Internally, the grantee may follow any protocol it wishes in terms of crediting providers with visits.*

7. A provider may be credited with no more than one visit with a given patient in a single day, regardless of the types or number of services provided.

8. The visit criteria **are not** met in the following circumstances:
   - When a provider participates in a community meeting or group session that is **not** designed to provide clinical services. Examples of such activities include information sessions for prospective patients, health presentations to community groups (high school classes, PTA, etc.), and information presentations about available health services at the center.
   - When the only health service provided is part of a large-scale effort, such as a mass immunization program, screening program, or community-wide service program (e.g., a health fair).
   - When a provider is primarily conducting outreach and/or group education sessions, not providing direct services.
   - When the **only** services provided are lab tests, x-rays, immunizations or other injections, TB tests or readings, and/or prescription refills.
   - Services performed under the auspices of a WIC program or a WIC contract.

Further definitions of visits for different provider types follow:

PHYSICIAN VISIT – A visit between a physician and a patient.

NURSE PRACTITIONER VISIT – A visit between a Nurse Practitioner and a patient in which the practitioner acts as an independent provider.

PHYSICIAN ASSISTANT VISIT – A visit between a Physician Assistant and a patient in which the practitioner acts as an independent provider.

CERTIFIED NURSE MIDWIFE VISIT – A visit between a Certified Nurse Midwife and a patient in which the practitioner acts as an independent provider.

NURSE VISIT (MEDICAL) – A visit between an R.N., L.V.N., or L.P.N. and a patient in which the nurse acts as an independent provider of medical services exercising independent judgment, such as in a triage visit. Services which meet this criteria may be provided under standing orders of a physician, under specific instructions from a previous visit, or under the general supervision of a physician, Nurse Practitioner, Physicians Assistant, or Certified Nurse Midwife (NP/PA/CNM) who has no direct contact with the patient during the visit, but must still meet the requirement of exercising independent professional judgment. (Note that some states prohibit an LVN or an LPN to exercise independent judgment, in which case no visits would be counted for them. Note also that, under no circumstances are services provided by Medical Assistants or other non-nursing personnel counted as nursing visits.)

DENTAL SERVICES VISIT – A visit between a dentist or dental hygienist and a patient for the purpose of prevention, assessment, or treatment of a dental problem, including restoration. NOTE: A dental hygienist is credited with a visit only when s/he provides a service independently, not jointly with a dentist. Two visits may **not** be generated during a patient's visit to the dental clinic in one day, regardless of the number of clinicians who provide services or the volume of service (number of procedures) provided.

MENTAL HEALTH VISIT – A visit between a licensed mental health provider (psychiatrist, psychologist, LCSW, and certain other Masters Prepared mental health providers licensed by specific states) or an unlicensed mental health provider credentialed by the center, and a patient, during which mental health services (i.e., services of a psychiatric, psychological, psychosocial, or crisis intervention nature) are provided.

SUBSTANCE ABUSE VISIT – A visit between a substance abuse provider (e.g., a mental health provider or a credentialed substance abuse counselor, rehabilitation therapist, psychologist) and a patient during which alcohol or drug abuse services (i.e., assessment and diagnosis, treatment, aftercare) are provided.

OTHER PROFESSIONAL VISIT – A visit between a provider, other than those listed above and a patient during which other forms of health services are provided. Examples are provided in Appendix A.

CASE MANAGEMENT VISIT – A visit between a case management provider and a patient during which services are provided that assist patients in the management of their health and social needs, including patient needs assessments, the establishment of service plans, and the maintenance of referral, tracking, and follow-up systems. These must be face to face with the patient. Third party interactions on behalf of a patient are not counted in case management visits.

HEALTH EDUCATION VISIT – A one-on-one visit between a health education provider and a patient in which the services rendered are of an educational nature relating to health matters and appropriate use of health services (e.g., family planning, HIV, nutrition, parenting, and specific diseases). Participants in health education classes are not considered to have had visits. Some individuals trained as pharmacists now work as health educators and perform health education work. They should be classified as health educators and have those services counted as health education visits. This *does not include* the normal education that is a required part of the dispensing of any medicine in a pharmacy.