≜HRSA
Health Center Program

BUREAU OF PRIMARY HEALTH CARE

Health Center Program Site Visit Protocol:

Consolidated Documents Checklist by Topic Area

Last updated: February 27, 2020

NOTE: This consolidated checklist outlines the documents used during the Operational Site Visits (OSV). This resource is organized by topic area (Governance, Management and Administrative, Fiscal, and Clinical) and outlines what documents are provided prior to the site visit versus onsite. It complements the Site Visit Protocol (SVP), which is the primary tool for assessing compliance with Health Center Program requirements during OSVs. Refer to the Health Center Program Compliance Manual as the principal resource to assist health centers in understanding and demonstrating compliance with Health Center Program requirements and the SVP for complete guidance on the conduct of OSVs.

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GOVERNANCE

Program Requirements: Key Management Staff, Board Authority, Board Composition, and Federal Tort Claims Act (FTCA) Deeming Requirements

NOTE: *Do not submit a document on this checklist that was included in the last application that initiated your current project or designation period (for example, Service Area Competition) unless you have updated the document(s).*

Pre-Site Visit
- ☐ Co-applicant agreement (if applicable)
- ☐ Articles of Incorporation
- ☐ Bylaws
- ☐ Form 6A or Board Roster
- ☐ Board calendar or other related scheduling documents for most recent 12 months

On-Site Visit
- ☐ Board minutes for:
    - most recent 12 months
    - any other relevant meetings in the past 3 years to demonstrate that board authorities were explicitly exercised, including approving key policies on:
        - Sliding Fee Discount Program (SFDP)
        - Quality Improvement/Assurance Program
        - Billing and Collections (policy for waiving or reducing patient fees and if applicable, refusal to pay)
        - Financial Management and Accounting Systems
        - Personnel
- ☐ Board meeting minutes and/or most recent report(s) (within past 12 months) to the board that include the status of risk management activities
- ☐ Board committee minutes OR committee documents from the past 12 months
- ☐ Sample board packets from two board meetings within the past 12 months
- ☐ Strategic plan or long term planning documents within the past 3 years
- ☐ Most recent evaluation of Project Director/CEO
- ☐ Documentation regarding board member representation (for example, applications, bios, disclosure forms)
- ☐ Clinical or billing records within the past 24 months to verify board member patient status
- ☐ For health centers with approved waivers, examples of the use of special populations input (for example, board minutes, board meeting handouts, board packets)
- ☐ If the board-approved SFDP policy does not state a specific amount for nominal charge(s), other documentation (for example, board minutes, reports) of board involvement in setting the amount of nominal charge(s)

MANAGEMENT AND ADMINISTRATION

Program Requirements: Needs Assessment, Clinical Staffing, Accessible Locations and Hours of Operation, Key Management Staff, Collaborative Relationships, Board Authority, Board Composition, and Federal Tort Claims Act (FTCA) Deeming Requirements

NOTE: Do not submit a document on this checklist that was included in the last application that initiated your current project or designation period (for example, Service Area Competition) unless you have updated the document(s).

Pre-Site Visit
- ☐ Website URL (if applicable)
- ☐ List of health center sites, including site addresses, hours of operation by site, and information on what general services (for example, medical, oral health, behavioral health) are offered at each service site
  Note: *These may be presented in separate documents or as references to health center websites*
- ☐ Uniform Data System (UDS) Mapper Service Area Map
- ☐ Health center organizational chart(s) with names of key management staff
- ☐ Corporate organization chart(s) (only applicable for public agencies or for organizations with a parent or subsidiary)
- ☐ Position description for the Project Director/CEO
- ☐ Position descriptions of key management staff
- ☐ Bios or resumes for key management staff
- ☐ Human Resources procedures relevant to recruiting and hiring of key management staff (if applicable, for health centers with key management staff vacancies)
- ☐ Example(s) of methods used to inform patients of the health center's deemed status (for example, website, promotional materials, statements posted within an area(s) of the health center visible to patients)

On-Site Visit
- ☐ Service area reports or analysis documentation
- ☐ Project Director/CEO employment agreement
- ☐ Project Director/CEO's Form W-2 or, if a Form W-2 has not yet been issued, documentation of receipt of salary directly from the health center (for example, pay stub)
- ☐ Contracts for key management staff (if applicable)
- ☐ Documentation associated with filling key management staff vacancies (if applicable) (for example, job advertisements, revised position descriptions)
- ☐ Collaborative or contractual agreements with outside entities that may impact the health center board's authorities or functions
- ☐ Documentation of established collaboration with other providers and organizations in the health center's service area, including local hospitals, specialty providers, and social service organizations, to provide access to services not available through the health center

> ***Note:*** *Examples of collaboration or coordination documentation may include but are not limited to memoranda of agreement (MOAs) or memoranda of understanding (MOUs); letters; monthly collaboration meeting agendas with health center leaders; cross-referral of patients between health centers; or evidence of membership in a city-wide community health planning council or emergency room diversion program*

☐ Documentation of coordination efforts with other federally-funded, state, and local health services delivery projects and programs serving similar patient populations in the service area. At a minimum, this includes documentation of efforts to establish coordination with one or more health centers in the service area (for example, email or other correspondence of requests and responses for coordination)

> ***Note:*** *Examples of collaboration or coordination documentation may include but are not limited to memoranda of agreement (MOAs) or memoranda of understanding (MOUs); letters; monthly collaboration meeting agendas with health center leaders; cross-referral of patients between health centers; or evidence of membership in a city-wide community health planning council or emergency room diversion program*

FISCAL

Program Requirements: Required and Additional Health Services, Sliding Fee Discount Program, Contracts and Subawards, Conflict of Interest, Financial Management and Accounting Systems, Billing and Collections, Budget, and Board Authority

NOTE: *Do not submit a document on this checklist that was included in the last application that initiated your current project or designation period (for example, Service Area Competition) unless you have updated the document(s).*

Pre-Site Visit

☐ Sliding Fee Discount Program (SFDP) policy(ies)
☐ SFDP procedure(s)
☐ Sliding Fee Discount Schedule (SFDS), including, SFDSs that differ by service or service delivery method (if applicable)
☐ Any related policies, procedures, forms and materials that support the SFDP (for example, registration and scheduling, financial eligibility, screening, enrollment, patient notifications, billing and collections)
☐ List of provider and program/site billing numbers for Medicaid, CHIP, Medicare, or any other documentation of participation (for example, individual provider NPIs)
☐ Current Fee Schedule for each service area (for example, medical, dental, behavioral health)
☐ Billing and Collections policies or procedures and systems including:
   • provision(s) to waive or reduce fees owed by patients;
   • third-party payor billing procedures and/or contracts;
   • refusal to pay policy (if applicable); and
   • procedures for notifying patients of additional costs for supplies and equipment related to but not included in the service (if applicable)
☐ Procedures for purchasing and procurement, including, if applicable or separate, procedures for contracting and contract management
☐ Financial Management Procedures
☐ Financial management and internal control procedures (may also be in the form of financial/accounting policies, manuals or other related documents)
☐ Procedures for drawdown, disbursement and expenditure of federal award funds (may be included in the financial management and internal control procedures or may be separate)
☐ Policies and/or procedures that govern and track the use of non-grant funds (if applicable)
☐ Registration, Eligibility, Outreach and Enrollment Procedures
☐ If the health center has contracts that support the HRSA-approved scope of project (i.e., to provide health center services or to acquire other goods and services), provide a complete list of these contracts. Include all active contracts and all contracts that had a period of performance which ended less than 3 years ago. In the list, include all of the following information for each contract:

- Whether the health center utilizes federal award funds to pay in whole or in part for the contract (not applicable to look-alikes);
- Contractor/contract organization;
- Value of the contract (if there is a federal share, state the federal share amount);
- Brief description of the good(s) or service(s) provided; and
- Period of performance/timeframe (for example, ongoing contractual relationship, specific duration)

☐ All subrecipient agreements (not applicable to look-alikes and as applicable for awardees)
Note: Per 45 CFR 75.351(c): "In determining whether an agreement between a pass-through entity [Health Center Program awardee] and another non-federal entity casts the latter as a subrecipient or a contractor, the substance of the relationship is more important than the form of the agreement. All of the characteristics [listed above; see 45 CFR 75.351(a) and (b)] may not be present in all cases, and the pass-through entity [Health Center Program awardee] must use judgment in classifying each agreement as a subaward or a procurement contract."

☐ Two most recent annual audits and management letters or audited financial statements (if audits are not available)

☐ Updated Annual Budget for the health center project

☐ *For Look-Alike Initial Designation only*: Agreements with parent corporation, affiliate, subsidiary or other controlling organization (if applicable)

On-Site Visit

☐ Sample of key health center documents (for example, materials/application used to assess eligibility for the health center's sliding fee discount program, intake forms for clinical services, instructions for accessing after-hours services) translated for patients with limited English proficiency

☐ Sample of 5–10 records, files or other forms of documentation of patient income and family size. Ensure the sample includes records for:
- Uninsured and insured patients
- Initial assessments for income and family size as well as re-assessments

☐ Data, reports, or any other relevant materials used to evaluate the SFDP

☐ If the health center is subject to legal or contractual restrictions regarding sliding fee discounts for patients with third-party coverage, the health center will produce documentation of such restrictions

☐ Based on the list of contracts provided prior to the site visit that support the HRSA-approved scope of project:
- Sample of half or five (whichever is less) contracts AND related supporting procurement documentation for actions of $25,000 or more that **utilize federal award funds**
Note: The same sample of contracts/agreements is to be utilized for the review of both Contracts and Subawards and Conflict of Interest
- Sample of half or five (whichever is less) contracts AND related supporting procurement documentation for actions that **do NOT utilize federal award funds**

☐ Two to three reports or records (for example, monthly invoices or billing reports, data run of patients served, visits provided) drawn from the sample of contractors selected from the list provided prior to the site visit

☐ Documentation of prior approval for contracts for the performance of substantive work (i.e., contracting with a single entity for the majority of health care providers) under the federal award (if applicable)

☐ Documentation of prior approval of subrecipient arrangement(s) (not applicable to look-alikes and as applicable for awardees)

☐ Documentation of subrecipient monitoring methods (not applicable to look-alikes and as applicable for awardees)

☐ Sample of financial and performance reports from the subrecipient (not applicable to look-alikes and as applicable for awardees)

☐ Agreements with parent corporation, affiliate, subsidiary, or subrecipient organization (if applicable)

☐ Manuals or documentation of the financial management system(s) used by the health center (for example, financial accounting software, practice management system)
Note: *Some or all of the financial management system(s) may be contracted out or carried out via a Health Center Controlled Network*

☐ Sample of periodic financial reports provided to the board and key management staff (selected from the past 6 months) including the most recent interim financial statements

☐ Sample of source documentation (for example, financial records, receipts, invoices) to support expenditures made under the federal Health Center Program award for the last quarter

☐ Aged Accounts Receivable (A/R) (as of most recent interim financial statements)

☐ Aged Accounts Payable (as of most recent interim financial statements)

☐ Current data on the following metrics: collection ratios, bad debt write off as a percentage of total billing, collections per visit, charges per visit, percentage of A/R less than 120 days, days in A/R

☐ Sample of claims submission data to compare initial billing dates to service dates. For the sample, randomly choose 5 records for patient visits reflective of the health center's major third-party payors from across at least 3 unique services (for example, routine primary care, preventive dental, behavioral health, obstetrics) for a total of at least 15 records reviewed

☐ Sample of billing and payment records for charges requested from patients. For the sample, randomly choose 5 records for patient visits from across at least 3 unique services (for example, routine primary care, preventive dental, behavioral health, obstetrics) for a total of at least 15 total records reviewed:
- Ensure the sample includes patients that are eligible for the health center's SFDP (i.e., incomes at or below 200 percent of the Federal Poverty Guidelines (FPG))
- If applicable, include records for patients that are not eligible for the SFDP (i.e., incomes above 200 percent FPG)

☐ Sample of two to three billing records where patient fees were waived or reduced

☐ Documentation of methods used for notifying patients of additional costs for supplies and equipment related to but not included in the service (if applicable)

☐ Documentation of cases where the health center has applied its refusal to pay policy within the past 2 years (if applicable)

- ☐ Documentation related to Determination of Fee schedule based on health center costs and locally prevailing rates (for example, operating costs for service delivery, relative value units (RVUs) or other relevant data sources, Medicare/Medicaid cost reports)
- ☐ Documentation of participation in other public or private program or health insurance plans (if applicable) (for example, list or copy of third-party payor contracts including any managed care contracts)
- ☐ Contracts with outside organizations that conduct billing or collections on behalf of the health center (if applicable)
- ☐ Budget to Actual Comparison Reports for the current fiscal year and the prior fiscal year
- ☐ Separate organizational budget(s) (if applicable) (in situations where the health center has an organizational budget that is separate from the budget for the health center project)
- ☐ *For Look-Alike Initial Designation only*: Sample of up to three Medicare or Medicaid claims or other billing documents that demonstrate under what organizational entity or unit billing is conducted

CLINICAL

Program Requirements: Required and Additional Health Services, Clinical Staffing, Coverage for Medical Emergencies During and After Hours, Continuity of Care and Hospital Admitting, Quality Improvement/Assurance, Federal Tort Claims Act (FTCA) Deeming Requirements, and Performance Analysis

NOTE: *Do not submit a document on this checklist that was included in the last application that initiated your current project or designation period (for example, Service Area Competition) unless you have updated the document(s).*

Pre-Site Visit

☐ For services delivered via Column I of the health center's current Form 5A: Services Provided, provide a list of service sites to be toured. Select sites where the majority of services are provided directly by the health center. If the health center has more than one service site, the list must include at least two health center service sites (to the extent that geography and time allow)

☐ For health centers with Column III services, operating procedures for tracking and managing referred services

☐ Credentialing and privileging procedures (including Human Resource (HR) procedures, if applicable)

☐ Current Staffing Profile (name, position, FTE, hire date). Indicate staff with interpretation/translation capabilities (i.e., bilingual, multilingual)

☐ Staffing schedules for up to five service delivery sites that identify the individual(s) with current certification in basic life support at each site

☐ Operating procedures for addressing medical emergencies during health center's hours of operation

☐ Operating procedures for responding to patient medical emergencies after hours

☐ Health center's internal operating procedures and/or documentation from arrangements with non-health center provider(s) for tracking of patient hospitalization and continuity of care

☐ Policy(ies) that establish the Quality Improvement/Quality Assurance (QI/QA) program

☐ QI/QA-related operating procedures or processes that address:
- clinical guidelines, standards of care, and/or standards of practice
- patient safety and adverse events, including implementation of follow-up actions
- patient satisfaction
- patient grievances
- periodic QI/QA assessments
- QI/QA report generation and oversight

☐ Systems and/or procedures for maintaining and monitoring the confidentiality, privacy and security of patient records

☐ Risk management policy(ies) and related operating procedures or protocols (including but not limited to procedures for tracking referrals, diagnostics, and hospital admissions ordered by health center providers, incident reporting for clinically-related complaints, and "near misses")

> ***Note:*** *Health centers may have distinct "risk management" operating procedures OR these may be included or integrated within other health center operating procedures or protocols (for example, HR, QI/QA, Admin, Clinical, Infection Control)*

- ☐ Claims management process policy(ies)/procedures
- ☐ Most recent HRSA-approved Federal Tort Claims Act (FTCA) deeming application
- ☐ Risk management training plan and documentation of completed training

On-Site Visit

- ☐ If a Column I service(s) cannot be observed during the site tours, provide documentation of service(s) provision in a current patient record
- ☐ For services delivered via Column II of the health center's current Form 5A (whether or not the service is also delivered via Column I and/or Column III):

    Contracts/Agreements:
    - **At least one but no more than three** written contracts/agreements for EACH Required and EACH Additional Health Service
    - To assist in the review, the health center should flag all relevant provisions within contracts/agreements related to:
        - How the service will be documented in the patient's health center record; and
        - How the health center will pay for the service

    Note: *The same sample of contracts/agreements is to be utilized for the review of both [Required and Additional Health Services](#) and [Sliding Fee Discount Program](#)*

    Patient Records:
    - Three to five health center patient records for patients who have received Required and Additional Health Services (**as specified in the methodology under demonstrating compliance element "a"**) in the past 24 months from a contracted provider(s)/organization(s)

- ☐ For services delivered via Column III of the health center's current Form 5A (whether or not the service is also delivered via Column I and/or Column II):

    Referral Arrangements:
    - **At least one but no more than three** written referral arrangements for EACH Required and EACH Additional Health Service
    - To assist in the review, the health center should flag all relevant provisions within referral arrangements related to:
        - The manner by which referrals will be made and managed; and
        - The process for tracking and referring patients back to the health center for appropriate follow-up care (for example, exchange of patient record information, receipt of lab results)

    Note: *The same sample of contracts/agreements is to be utilized for the review of both [Required and Additional Health Services](#) and [Sliding Fee Discount Program](#)*

    Patient Records:
    - Three to five health center patient records for patients who have received a required and additional service(s) (**as specified in the methodology under demonstrating compliance element "a"**) in the past 24 months from a referral provider(s)/organization(s)

☐ If services are provided via Column II or III, written contracts/agreements and written referral arrangements:
- **No more than three** contracts with provider organizations drawn from the sample that was pulled for the review of [Required and Additional Health Services](). Prioritize the review of any services that are offered only via Column II
- **No more than three** written referral arrangements drawn from the sample that was pulled for the review of [Required and Additional Health Services](). Prioritize the review of any services that are offered only via Column III

☐ Sample of files that contain credentialing and privileging information: four to five licensed independent practitioners (LIP) files; four to five other licensed or certified practitioners (OLCPs) files; and, only if applicable, two to three files for other clinical staff. The selected files should include:
- Representation from different disciplines and sites
- Directly employed and contracted providers in addition to volunteers (if applicable)
- Providers who do procedures beyond core privileges for their discipline(s)
- Newest provider (to assess timeliness of process and whether clinician was credentialed and privileged prior to delivering patient care)
- Re-credentialed/re-privileged provider

☐ Contract or agreement with Credentialing Verification Organization (CVO) or other entity used to perform credentialing functions (such as primary source verification) on behalf of the health center (if applicable)

☐ Provider on-call schedules and answering service contract (if applicable; for health centers whose own providers cover after-hours calls)

☐ Written arrangements with non-health center providers/entities (for example, formal agreements with other community providers, "nurse call" lines) for after-hours coverage (if applicable; for health centers that utilize non-health center providers)

☐ List of service delivery sites with names of at least one individual (clinical or non-clinical staff member) at each site trained and certified in basic life support, including a copy of that individual's current certification (for example, credentialing file for LIP or OLCP, certification of training if non-clinical staff)

☐ Instructions or information provided to patients for accessing after-hours coverage

☐ Three samples of after-hours clinical advice documentation in the patient record (for example, screenshots selected by the health center), including associated documentation of follow-up
Note: The samples will be based on after-hours calls that necessitated follow-up by the health center

☐ Documentation demonstrating systems/methods of tracking, recording, and storing of after-hours coverage interactions (for example, log of patient calls) and, if applicable, related follow-up

☐ Documentation of EITHER:
- Provider hospital admitting privileges (for example, hospital staff membership, provider employee contracts) that address delivery of care in a hospital setting to health center patients by health center providers; OR
- Formal arrangements with provider(s) or entity(ies) that address health center patient hospital admissions

☐ Sample of 5–10 health center patient records (for example, using live navigation of the Electronic Health Records (EHR), screenshots from the EHR, or actual records if the records are not electronic/EHR records) who have been hospitalized or had Emergency Department (ED) visits within the past 12 months.
Note: *The sample of patient records utilized for reviewing other program requirement areas may also be used for this sample*

☐ Schedule of QI/QA assessments

☐ Sample of two QI/QA assessments from the past year and/or the related reports resulting from these assessments

☐ Documentation for related systems that support QI/QA (if applicable) (for example, event reporting system, tracking resolutions and grievances, dashboards)

☐ Job or position description(s) of individual(s) who oversee the QI/QA program

☐ Documentation (for example, board/committee minutes, supporting data, reports) of the last two quarterly risk management assessments of health center activities designed to reduce the risk of adverse outcomes (for example, environment of care, incident tracking, infection control, patient safety) that could result in medical malpractice or other health or health-related litigation

☐ For health centers with **closed** claims from within the past 5 years under the FTCA: For each **closed** claim, documentation of steps implemented to mitigate the risk of such claims in the future (for example, targeted staff training, improved records management, implementation of new clinical protocols)

☐ Examples of health center performance improvement activities related to diabetes control (for example, staff training, patient interventions, collaborative participation)

☐ QI/QA reports or other internal clinical performance measure data or data analysis on diabetes control (for example, Plan-Do-Study-Act (PDSA) cycle data, diabetes control data more recent or more detailed than that reported in Uniform Data System (UDS))
Note: *The same QI/QA assessments and/or related reports on diabetes control utilized for reviewing other program requirement areas may also be used for this sample*

☐ List of technical assistance and/or training needs that may support health center performance on diabetes control (self-identified by the health center, if applicable)

☐ Year-to-date UDS diabetes data

☐ *For Look-Alike Initial Designation only*: Health center selection of three to five health center patient records (for example, using live navigation of the EHR, screenshots from the EHR, or actual records if the records are not electronic/EHR records) that document the provision of various Required and Additional Services

OTHER

Program Requirements: Needs Assessment, Clinical Staffing, Accessible Locations and Hours of Operation, Sliding Fee Discount Program, Quality Improvement/Assurance, Conflict of Interest, and Program Monitoring and Data Reporting Systems

NOTE: Do not submit a document on this checklist that was included in the last application that initiated your current project or designation period (for example, Service Area Competition) unless you have updated the document(s).

On-Site Visit

☐ Most recent needs assessment and documentation (for example, studies, resources, reports) used to develop the needs assessment or related studies or resources

☐ For any service delivered via Column II (whether or not the service is also delivered via Column I and/or Column III), at least one but no more than three written contracts/agreements for EACH Required and EACH Additional Health Service
   Note: *The same sample of contracts/agreements is to be utilized for the review of both* [*Required and Additional Health Services*](#) *and* [*Sliding Fee Discount Program*](#)

☐ For any service delivered via Column III (whether or not the service is also delivered via Column I and/or Column II), at least one but no more than three written referral arrangements for EACH Required and EACH Additional Health Service
   Note: *The same sample of contracts/agreements is to be utilized for the review of both* [*Required and Additional Health Services*](#) *and* [*Sliding Fee Discount Program*](#)

☐ Patient satisfaction surveys or other forms of patient input

☐ Sample of patient satisfaction results

☐ Documentation containing the health center's standards of conduct (for example, articles of incorporation, bylaws, board manual, employee manual, policies and procedures, disclosure forms)

☐ In cases where a real or apparent conflict of interest was identified in the procurement action, related written disclosures (for example, board minutes documenting disclosure(s), standard form(s) to report disclosure(s)) completed by employees, officers, board members, and agents of the health centers

☐ Sample of program reports generated by the health center for the governing board or key management staff (for example, board packets from the past few months, reports provided to the Finance or Quality Improvement Committee, routine reports generated by the health center for key management staff) that include information on:
   • Patient service utilization
   • Trends and patterns in the patient population
   • Overall health center clinical, financial, or operational performance

☐ *For Look-Alike Initial Designation only*: Contracts for substantive programmatic work (i.e., contracting with a single entity for the majority of health care providers)