

Health Center Program Site Visit Protocol:

Consolidated Documents Checklist for Health Center Staff

Last updated: August 20, 2018

NOTE: This consolidated checklist contains documents used to assess multiple program requirements during Operational Site Visits. It is intended to complement the Site Visit Protocol, which is the primary tool for assessing compliance with Health Center Program requirements during operational site visits.

Please refer to the Health Center Program Site Visit Protocol:

<https://www.bphc.hrsa.gov/programrequirements/svprotocol.html>.

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GOVERNANCE

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

Pre-Site Visit

- Co-applicant agreement (if applicable) (if updated since last application submission to HRSA/BPHC)
- Articles of Incorporation (if updated since last application submission to HRSA/BPHC)
- Bylaws (if updated since last application submission to HRSA/BPHC)
- Form 6A or Board Roster (if updated since last application submission to HRSA/BPHC)

On-Site Visit

- Board minutes [health center to research and provide relevant minutes] for:
 - most recent 12 months
 - any prior meetings in the past 3 years to demonstrate that board authorities were explicitly exercised, including approving key policies on:
 - Sliding Fee Discount Program
 - 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
- Board calendar or work plan
- Strategic plan or long term planning documents within the past 3 years
- Most recent evaluation of Project Director/CEO
- Documentation regarding board member representation (e.g., 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 (e.g., board minutes, board meeting handouts, board packets)

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

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 (e.g., 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 (if updated since last application submission to HRSA/BPHC)
- Health center organization chart(s) with names of key management staff (if updated since last submission to HRSA/BPHC)
- 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 (if updated since last submission to HRSA/BPHC)
- Bios or resumes for key management staff (if updated since last application submission to HRSA/BPHC)
- HR procedures relevant to recruiting and hiring of key management staff (if applicable, for health centers with key management staff vacancies)

On-Site Visit

- Service area reports or analysis documentation
- Contracts for key management staff (if applicable)
- Documentation associated with filling key management staff vacancies (if applicable) (e.g., job advertisements, revised position descriptions)
- Project Director/CEO employment agreement (for the purposes of provisions regarding Project Director/CEO selection, evaluation, and dismissal or termination)
- Project Director's/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 (e.g., pay stub)
- Collaborative or contractual agreements with outside entities that may impact the health center board's authorities or functions
- Documentation (e.g., 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, evidence of membership on a city-wide community health planning council) 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
- 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 (e.g., email or other correspondence of requests and responses for coordination)
- Example(s) of methods used to inform patients of the health center's deemed status (e.g., website, promotional materials, statements posted within an area(s) of the health center visible to patients)

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*

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 (e.g., registration and scheduling, financial eligibility, screening, enrollment, patient notifications, billing and collections)
- List of provider and program/site billing numbers for Medicare, Medicaid and CHIP or any other documentation of participation (e.g., individual provider NPIs)
- Current Fee Schedule for each service area (medical, dental, behavioral health, etc.)
- 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 (for context and background on budget development process)
- 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
- All subrecipient agreements (if updated since last application submission to HRSA/BPHC) (not applicable to look-alikes and as applicable for awardees)
- 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 (if updated since last application submission to HRSA/BPHC)
- For Look-Alike Initial Designation only:* Agreements with parent corporation, affiliate, subsidiary, or subrecipient 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 (e.g., completed SFDS application or eligibility screening records). Ensure that the sample includes uninsured and insured patient categories
- Data, reports, or any other relevant materials used to evaluate the SFDP
- Complete list of all contracts for goods or services for procurement actions that were \$25,000 or more and include costs directly attributable to the federal Health Center Program award (not applicable to look-alikes and as applicable for awardees)
 - From the above list of all contracts, a sample of half or five (**whichever sample size is smaller**) current contracts AND related supporting procurement documentation (not applicable to look-alikes and as applicable for awardees)
- Sample of **up to** five final contracts that support the HRSA-approved scope of project, including Column II service contracts, **regardless of whether the costs of such contracts are directly attributable to the federal award** (if applicable). **Note:** *The same sample of contracts utilized for reviewing other program requirement areas may also be used for this sample*
 - Sample of two to three reports or records from contractors selected for the sample above (e.g., monthly invoices or billing reports, data run of patients served, visits provided)
- 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)
- Sample of supporting documentation for one to two procurements supported with federal funds from the past 3 years (can be same sample as used for Contracts and Subawards)
- Manuals or documentation of the financial management system(s) used by the health center (e.g., 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 (e.g., financial records, receipts, invoices) to support expenditures made under the federal Health Center Program award for the last quarter
- Aged Accounts Receivable (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 (for context on billing and collections efforts)
- ❑ Collection rate by payor source (Medicaid, CHIP, Medicare, and, as applicable, other public and private insurance) gathered from billing records for the past 1-2 years
- ❑ 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 (e.g., routine primary care, preventive dental, behavioral health, OB) for a total of at least 15 total records reviewed:
 - Ensure the sample includes patients that are eligible for the health center's sliding fee discount program (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 sliding fee discount program (i.e., incomes above 200 percent FPG)
- ❑ Sample of two to three billing records where patient fees were waived or reduced
- ❑ Documentation of methods 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 (e.g., 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) (e.g., 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, and Federal Tort Claims Act (FTCA) Deeming Requirements*

Pre-Site Visit

- ❑ For health centers with Column III services, operating procedures for tracking and managing referred services (as applicable for health centers that do not manage referrals electronically)

- Credentialing and privileging procedures (including Human Resource procedures, if applicable)
- Current Staffing Profile (name, position, FTE, hire date). Indicate staff with interpretation/translation capabilities (i.e., bilingual, multilingual)
- 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 (e.g., HR, Quality Improvement/Quality Assurance, Admin, Clinical, Infection Control)*
- Claims management process policy(ies)/procedures

On-Site Visit

- For services in Column I of the health center's current Form 5A:
 - Provide a schedule and plan to tour at least one to two health center sites where the majority of services are provided directly by the health center
 - If a service(s) cannot be observed during the site tours, provide documentation of service(s) provision in a current patient record
- For services in Column II of the health center's current Form 5A (if applicable):
 - Health center selection of three to five health center patient records (e.g., using live navigation of the Electronic Health Records (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 provided ONLY via formal written contracts/agreements
- For services in Column III of the health center's current Form 5A (if applicable):
 - Log or list of patients referred for one or more Required service(s) in the past 12-24 months and, if time permits, a list of patients referred for one or more Additional service(s) (provided ONLY via Form 5A, Column III) in the past 12-24 months. Using log/list(s), the clinical expert will select three to five records to review and the health center will provide these as health center patient records (e.g., using live navigation of the EHR, screenshots from the EHR, or actual records if the records are not electronic/EHR records) to assess the referral

process. **Note:** *This excludes follow-up from hospital admissions or hospital visits that will be reviewed in Continuity of Care and Hospital Admitting*

- Provider contracts, agreements and subrecipient arrangements (if applicable, based on service delivery methods indicated on Form 5A)
- Documentation of EITHER:
 - Provider hospital admitting privileges (e.g., 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 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)
- Recruitment and retention plan or related documents for clinical staff
- 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 (e.g., 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 (e.g., credentialing file for licensed independent practitioner (LIP) or other licensed or certified practitioner (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 (e.g., screenshots selected by the health center)
- Documentation demonstrating systems/methods of tracking, recording and storing of after-hours coverage interactions (e.g., log of patient calls) and, if applicable, related follow-up
- Sample of 5-10 health center patient records (e.g., 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) (e.g., event reporting system, tracking resolutions & grievances, dashboards)
- Job or position description(s) of individual(s) who oversee the QI/QA program
- Most recent HRSA-approved FTCA deeming application
- Risk management training plan and related tracking of training completion
- Documentation (e.g., 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 (e.g., 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 (e.g., targeted staff training, improved records management, implementation of new clinical protocols)
- Examples of health center performance improvement activities related to diabetes control (e.g., staff training, patient interventions, collaborative participation)
- Quality Improvement/Quality Assurance (QI/QA) reports or other internal clinical performance measure data or data analysis on diabetes control (e.g., PDSA cycle data, diabetes control data more recent or more detailed than that reported in 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)
- For Look-Alike Initial Designation only:* Health center selection of three to five health center patient records (e.g., using live navigation of the Electronic Health Records (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 provided **ONLY** via formal written contracts/agreements

OTHER

Program Requirements: *Needs Assessment, Required and Additional Health Services, 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*

On-Site Visit

- Needs Assessment(s) or related studies or resources
- For services in Column II of the health center's current Form 5A (if applicable):
 - Sample of **up to** three written contracts/agreements for EACH Required and EACH Additional service provided via Column II but NOT provided via Column I
 - One written contract/agreement for EACH Required and EACH Additional service provided via Column I AND Column II
- For services in Column III of the health center's current Form 5A (if applicable):
 - Sample of **up to** three written referral arrangements for EACH Required and EACH Additional service provided via Column III but NOT provided via Column I
 - One written referral arrangement for EACH Required and EACH Additional service provided via Column I AND Column III

- Patient satisfaction surveys or other forms of patient input
- Sample of patient satisfaction results
- Documentation containing the health center's standards of conduct (e.g., articles of incorporation, bylaws, board manual, employee manual, policies and procedures, disclosure forms)
- Sample of written disclosures with respect to real or apparent conflicts of interest completed by officers, employees, board members and agents of the health centers (e.g., forms, signed statements, employment contracts)
- Sample of program reports generated by the health center for the governing board or key management staff (e.g., 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)