Office of the Senior Vice President & CEO FQHC Clinics

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Hello!

Welcome to the Valleywise Community Health Center Governing Council (VCHCGC). To prepare you in your role, this binder has been developed to include a copy of the Essential Documents for the Operations of the VCHCGC. These documents include materials and guidelines that are essential to your role; however; it cannot incorporate all material and information necessary for the undertaking business of a VCHCGC member.

Every effort was made to provide you with the materials that are current. We welcome suggestions regarding additional information that would be of assistance to you.

It is important that members of the Governing Council have an understanding of the full range of services and programs provided by Federally Qualified Health Centers (FQHCs). As new members are appointed. The FQHC CEO coordinates with department heads to provide tours of the FQHC facilities and meetings with key staff members.

Please contact the FQHC CEO's office if you have any questions or concerns:

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Valleywise Community Health Centers

HRSA Compliance Manual

HRSA Health Center Program | BUREAU OF PRIMARY HEALTH CARE

Health Center Program Compliance Manual

Last updated: August 20, 2018

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Introduction

Applicability

This Health Center Program Compliance Manual ("Compliance Manual") applies to all health centers that apply for[1] or receive Federal award funds under the Health Center Program authorized by section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b) ("section 330"), as amended (including sections 330(e), (g), (h), and (i)), as well as subrecipient organizations[2] and Health Center Program look-alikes. Look-alikes do not receive Federal funding under section 330 of the PHS Act; however, to receive look-alike designation and associated Federal benefits, look-alikes must meet the Health Center Program requirements.[3] For the purposes of this document, the term "health center" refers to entities that apply for or receive a Federal award under section 330 of the PHS Act (including section 330 (e), (g), (h) and (i)), section 330 subrecipients, and organizations designated as look-alikes.

This Compliance Manual does not apply to activities conducted outside of a health center's Health Resources and Services Administration (HRSA)-approved scope of project.[4]

Purpose

The purpose of the Compliance Manual is to provide a consolidated resource to assist health centers in understanding and demonstrating compliance with Health Center Program requirements. The Compliance Manual also addresses HRSA's approach to determining eligibility for and exercising oversight over the Health Center Program and details the requirements for obtaining deemed PHS employee status under section 224 (g)-(n) and (q) of the PHS Act.[5]

The Compliance Manual identifies requirements found in the Health Center Program's authorizing legislation and implementing regulations, as well as certain applicable grants regulations.[6] These requirements form the foundation of the Health Center Program and support the core mission of this innovative and successful model of primary care. The Compliance Manual does not provide guidance on requirements in areas beyond Health Center

[1] Notices of Funding Opportunity (NOFOs) may include specified timelines for new awardees to demonstrate compliance with the requirements specified in this Manual following receipt of the Federal Health Center Program award.
[2] 42 U.S.C. 1395x(aa)(4)(A)(ii) and 42 U.S.C. 1396d(l)(2)(B)(ii).
[3] Sections 1861(aa)(4)(B) and 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1395x(aa)(4)(B) and 42 U.S.C. 1396d(l)(2)(B)(iii)).
[4] See http://www.bphc.hrsa.gov/programrequirements/scope.html for more information on scope of project.
[5] Health Center FTCA Medical Malpractice Program procedures and information, as set forth in the FTCA Health Center Policy Manual, are not superseded by this Manual. See Appendix A for additional policy issuances which remain in effect.
[6] Section 330 of the PHS Act (42 U.S.C. §254b), as amended, 42 CFR Part 51c and 42 CFR Part 56 for Community and Migrant Health Centers, respectively, and 45 CFR Part 75.

Program requirements or outside HRSA's oversight authority. In addition, the Compliance Manual is not intended to address best or promising practices or performance improvement strategies that may support effective operations or organizational excellence.

Health Center Program non-regulatory policy issuances that remain in effect after release of the Compliance Manual are listed in Appendix A. With the exception of these policies, the Compliance Manual supersedes other previous Health Center Program non-regulatory policy issuances (Policy Information Notices (PINs), Program Assistance Letters (PALs), Regional Office Memoranda, Regional Program Guidance memoranda, and other non-regulatory materials) related to Health Center Program compliance or eligibility requirements. In case of any conflict between a provision of the Compliance Manual and other HRSA-disseminated non-regulatory materials related to compliance and/or eligibility requirements, the provisions of the Compliance Manual control. Previously published issuances that are superseded by this Manual include, but are not limited to:

- **PIN 1994-07:** Migrant Voucher Program Guidance
- **PINs 1997-27 and 1998-24**: Affiliation Agreements of Community & Migrant Health Centers and Amendment to PIN 1997-27 Regarding Affiliation Agreements of Community and Migrant Health Centers
- **PINs 2001-16 and 2002-22**: Credentialing and Privileging of Health Center Practitioners and Clarification of BPHC Credentialing & Privileging Policy Outlined in PIN 2001-16
- **PAL 2006-01:** Dual Status-Health Centers that are both FQHC Look-Alikes and Section 330 Grantees
- **PIN 2010-01:** Confirming Public Agency Status under the Health Center Program and FQHC Look-Alike Program
- **PIN 2013-01:** Health Center Program Budgeting and Accounting Requirements
- **PIN 2014-01**: Health Center Program Governance
- **PIN 2014-02**: Sliding Fee Discount and Related Billing and Collections Program Requirements
- **PAL 2014-08**: Health Center Program Requirements Oversight[7]
- **PAL 2014-11**: Applicability of PAL 2014-08: Health Center Program Requirements Oversight to Look-Alikes

The Compliance Manual serves as the foundation for HRSA's eligibility and compliance-related determinations and for HRSA's review processes for the Health Center Program. HRSA will update or amend the Compliance Manual as needed to provide further policy clarification with respect to demonstrating compliance with Health Center Program requirements.

Structure of the Health Center Program Compliance Manual

[7] PAL 2014-08 superseded PAL 2010-01, "Enhancements to Support Health Center Program Requirements Monitoring," which was issued April 8, 2010.

Chapters in the Compliance Manual are generally organized as follows:

- **Authority**: Lists the applicable statutory and regulatory citations.[8]

- **Requirements**: States the statutory and regulatory requirements.

- **Demonstrating Compliance**: Describes how health centers would demonstrate to HRSA their compliance with the **Requirements** by fulfilling all elements in this section.

  Note*: Health centers that fail to demonstrate compliance as described in this Manual will receive a condition of award/designation. In responding to such conditions, health centers could demonstrate their compliance to HRSA either by submitting documentation as described in the Demonstrating Compliance sections of the Manual or by the health center proposing an alternative means of demonstrating compliance with the specified Requirements, which would include submitting an explanation and documentation that explicitly demonstrate compliance. All responses to conditions are subject to review and approval by HRSA (see Chapter 2: Health Center Program Oversight).*

- **Related Considerations**: Describes areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing a requirement. When specific examples are provided, they are not intended to be an all-inclusive list. All related considerations are offered with the understanding that health center decision-making and implementation are consistent with all applicable statutory, regulatory, and policy requirements.

Additional Health Center Responsibilities

In addition to the requirements included in this Compliance Manual, organizations receiving Health Center Program Federal awards, including subrecipients, are also subject to other applicable award-related statutory, regulatory, and policy requirements (see 45 CFR Part 75 and the U.S. Department of Health and Human Services (HHS) Grants Policy Statement (GPS),[9] Notices of Funding Opportunity (NOFOs),[10] and Notices of Award (NoAs)). As such, the Compliance Manual does not constitute an exhaustive listing of all requirements that may be included in terms and conditions stated in NOFOs, NoAs, and other applicable laws, regulations, and policies.

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[8] These citations include requirements under the Uniform Administrative Requirements for all HHS awards (45 CFR Part 75) which are applicable to organizations receiving Federal funding under the Health Center Program (45 C.F.R. 75.101).

[9] Further grants policy information may be found in the HHS Grants Policy Statement and the HRSA SF-424 Application Guide. See http://www.hrsa.gov/grants/index.html for more information.

[10] Individual NOFOs may contain specific additional terms and conditions of award beyond those identified in this Manual.

Health centers (including look-alikes) are subject to the distinct statutory, regulatory, and policy requirements of other Federal programs that they may be eligible for and participate in as a result of the Health Center Program award or designation, such as:

- Federally Qualified Health Center (FQHC) status, payment rates, and requirements under Titles XVIII (Medicare) and XIX (Medicaid) of the Social Security Act;[11]
- The 340B Drug Pricing Program;[12]
- The National Health Service Corps (NHSC) Program; and
- The Health Center FTCA Medical Malpractice Program (with the exception of the deeming requirements included in the Compliance Manual).[13]

Each health center is responsible for maintaining its operations, including developing and implementing its own operating procedures, in compliance with **all** Health Center Program requirements and all other applicable Federal, state, and local laws and regulations.[14] This includes but is not limited to those protecting public welfare, the environment and prohibiting discrimination; state facility and licensing laws; state scope of practice laws; Centers for Medicare and Medicaid Services (CMS) Conditions for Coverage for FQHCs;[15] and State Medicaid requirements. In fulfilling all of these oversight and compliance responsibilities, a health center may wish to consult its private legal counsel. Health centers may also direct questions to the designated points of contact for these programs.

[11] 42 U.S.C. 1396a(a)(15) and 42 U.S.C. 1396(a)(bb); and 42 U.S.C. 1395l(a)(1)(Z) and 42 U.S.C. 1395m(o).
[12] Section 340B of the PHS Act, as amended (42 U.S.C. 256b).
[13] Section 224(g)-(n) and (q) of the PHS Act (42 U.S.C. 233(g)-(n), and (q)).
[14] 42 CFR 51c.304(d)(3)(v).
[15] 42 CFR Part 491.

Chapter 1: Health Center Program Eligibility

Organizations applying for funding or designation under the Health Center Program must demonstrate that they are eligible organizations under the Health Center Program statute and regulations. Specifically, organizations applying for funding as health centers or designation as look-alikes must be private non-profit entities or public agencies.[1] Organizations applying for look-alike designation are also subject to certain additional statutory eligibility requirements.[2]

In addition to the eligibility requirements described in this Chapter, organizations may be required to comply with certain additional eligibility requirements described in Notices of Funding Opportunity (NOFOs) or look-alike application instructions in order to receive a Health Center Program award or look-alike designation.

Non-Profit Organizations

An organization would demonstrate to HRSA that it is a private non-profit entity by submitting one of the following types of documentation:

- A copy of a currently valid IRS tax exemption certificate;
- A statement from a state taxing body, state attorney general, or other appropriate state official certifying that the applicant organization has a non-profit status and that none of the net earnings accrue to any private shareholders or individuals;
- A certified copy of the organization's official certificate of incorporation or similar document (for example, articles of incorporation) showing the state or tribal seal that clearly establishes nonprofit status; or
- Any of the above documents for a state or local office of a national parent organization and a statement signed by the parent organization that the applicant organization is a local non-profit affiliate.

Public Agency Organizations

An organization would demonstrate to HRSA that it is a public agency by submitting one of the following types of documentation:

- A current dated letter affirming the organization's status as a State, territorial, county, city, or municipal government; a health department organized at the State, territory, county, city or municipal level; or a subdivision or municipality of a United States (U.S.)

[1] Section 330(e)(1)(A) of the PHS Act, 42 CFR 51c.103, and 42 CFR 56.103.
[2] Sections 1861(aa)(4)(b) and 1905(l)(2)(B) of the Social Security Act.

affiliated sovereign State formally associated with the U.S. (for example, Republic of Palau);

- A copy of the law that created the organization and that grants one or more sovereign powers (for example, the power to tax, eminent domain, police power) to the organization (for example, a public hospital district);

- A ruling from the State Attorney General affirming the legal status of an entity as either a political subdivision or instrumentality of the State (for example, a public university); or

- A "letter ruling" which provides a positive written determination by the Internal Revenue Service of the organization's exempt status as an instrumentality under Internal Revenue Code section 115.

Tribal or Urban Indian Organizations

Native American tribal organizations, including those defined under the Indian Self-Determination Act[3] or the Indian Health Care Improvement Act[4],[5] are eligible to apply for Health Center Program funding or designation. Such organizations would demonstrate their eligibility to HRSA by providing applicable documentation as described in either the Non-Profit Organizations or Public Agency Organizations sections above.

Additional Eligibility Requirements for Look-Alike Designation

In addition to demonstrating that it is either a private non-profit entity or a public agency, an organization applying for look-alike designation must demonstrate to HRSA that it satisfies all of the following requirements:

1. It is currently delivering primary health care services to patients within the proposed service area.

2. It is not owned, controlled, or operated by another entity. Specifically, the organization applying for look-alike designation:

    a. **Owns and controls** the organization's assets and liabilities (for example, the organization does not have a sole corporate member, is not a subsidiary of another organization), and as such will be able to ensure that the benefits that accrue through look-alike designation as a Federally Qualified Health Center

[3] The text of the Indian Self-Determination Act may be found at 25 U.S.C. Ch 46 (http://uscode.house.gov/view.xhtml?path=/prelim@title25/chapter46&edition=prelim).
[4] The text of the Indian Health Care Improvement Act may be found at 25 U.S.C. Ch 18: http://uscode.house.gov/view.xhtml?path=/prelim@title25/chapter18&edition=prelim.
[5] Per section 330(k)(3)(H), tribal or urban Indian organizations are exempt from Health Center Program governance requirements.

(FQHC) are distributed to the Health Center Program project (for example, FQHC payment rates, 340B Drug Pricing); and

b. **Operates** the Health Center Program project. At a minimum, the look-alike applicant organization demonstrates that it maintains a Project Director/Chief Executive Officer (CEO) who will carry out independent, day-to-day oversight of health center activities solely on behalf of the governing board of the applicant organization.

3. It is not currently receiving funding as a Health Center Program Federal award recipient.[6]

   Organizations will not be awarded Federal funding or look-alike designation that would result in "dual status," whereby the organization becomes both a Federal awardee under section 330 and a look-alike designee. For example, an organization that is currently a Health Center Program awardee would no longer be awarded new look-alike designation status through the Initial Designation process, nor would an organization that is currently a Health Center Program look-alike be awarded Health Center Program funding unless, at the same time, it proposes to include all of its health center sites within the scope of the Health Center Program award.

   Health centers that currently have dual status as of the date of release of the Compliance manual will be permitted to maintain such status as long as subsequent Service Area Competition and Renewal of Designation applications are approved by HRSA.

[6] Health centers may not maintain or obtain look-alike designation if they are already receiving a Federal award under section 330 of the Public Health Service Act. Under Section 1905(l)(2)(B) of the Social Security Act: "The term "Federally-qualified health center" means an entity which … (i) is receiving a grant under section 254b of this title…or (ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and (II) meets the requirements to receive a grant under section 254b of this title…or (iii) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant, including requirements of the Secretary that an entity may not be owned, controlled, or operated by another entity."

Chapter 2: Health Center Program Oversight

Note: This chapter contains revisions based on the Bipartisan Budget Act of 2018. View the revisions.

Health centers must comply with all Health Center Program requirements and other applicable Federal statutes, regulations, and the terms and conditions of their award or look-alike designation.[1] In keeping with the Health Resources and Services Administration (HRSA)/Bureau of Primary Health Care's (BPHC) oversight responsibilities, HRSA/BPHC monitors and supports health centers in complying with these requirements.

The purpose of this chapter is to:

- Set forth HRSA/BPHC's oversight process for the purposes of monitoring compliance with Health Center Program requirements and assists health centers in maintaining compliance with these requirements.
- Describe when and how HRSA pursues remedies for non-compliance, including taking enforcement action(s) in cases where health centers fail to comply with Health Center Program requirements and other applicable Federal statutes, regulations, and the terms and conditions of the award or look-alike designation.
- Clarify when and how compliance with program requirements and past performance[2] is considered in award or designation decisions.

HRSA/BPHC's Progressive Action process is implemented through its Electronic Handbooks (EHB) system. The EHB system facilitates the tracking of compliance with program conditions placed on a health center's award or designation.[3] This system also communicates these conditions through Notices of Award (NoAs) or Notices of Look-Alike Designation (NLDs), documents the health center's response to these conditions, and documents removal of these conditions when appropriate.[4]

Program Oversight

United States (U.S.) Department of Health and Human Services (HHS) grants regulations, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal

[1] Section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b), as amended, 42 CFR Part 51c and 42 CFR Part 56 for Community and Migrant Health Centers, respectively, and 45 CFR Part 75.
[2] 42 CFR 51c.305 and 45 CFR 75.205(c)(3).
[3] Throughout this document, requirements or conditions of award are "requirements of Federal designation" for organizations designated by HRSA as look-alikes (see section 1861(aa)(4)(B) and section 1905(l)(2)(B) of the Social Security Act), which must also meet all of the requirements of the Health Center Program.
[4] In the EHB, a health center's response to a condition of award/designation is referred to as a "submission". The removal or lifting of a condition occurs once a submission that adequately addresses the required corrective action has been reviewed, approved by HRSA, and marked as "met" within the EHB.

Awards (Uniform Regulations)[5] require HRSA to "manage and administer the Federal award in a manner so as to ensure that Federal funding is expended and associated programs are implemented in full accordance with U.S. statutory and public policy requirements, including, but not limited to, those protecting public welfare, the environment, and prohibiting discrimination."[6]

Consistent with applicable laws and HRSA's program oversight responsibilities, health centers are assessed for compliance with these requirements and are provided an opportunity to remedy areas of non-compliance whenever reasonably possible. Immediate enforcement action may be taken against health centers in limited circumstances that are further addressed below.

HRSA may impose specific award conditions[7] if an applicant or recipient/designee:

- Demonstrates undue risk in such areas[8] as:
  - Financial stability;
  - Quality of management systems and ability to meet required management standards;
  - History of performance, specifically the applicant's record in managing previous Federal awards (timeliness of compliance with applicable reporting requirements and conformance to the terms and conditions of previous Federal awards);
  - Findings from reports and audits; and
  - Ability to effectively implement statutory, regulatory, or other requirements imposed on non-Federal entities.
- Has a history of failure to comply with the general or specific terms and conditions of a Federal award/designation;
- Fails to meet expected performance goals [as prescribed in the terms or conditions of the Federal award or designation]; or
- Is not otherwise responsible.[9]

Specific award conditions may include, but are not limited to, the following:

- Requiring payments as reimbursements rather than advance payments;[10]

[5] 2 CFR Part 200.
[6] 45 CFR 75.300.
[7] 45 CFR 75.207(a).
[8] 45 CFR 75.205(c).
[9] 45 CFR 75.207(a).
[10] This is also known as "Restricted Drawdown." When a Federal award recipient is placed on restricted drawdown, all drawdowns of Federal funds from the Payment Management System (PMS) must have approval of HRSA's Office of Federal Assistance Management, Division of Grants Management Operations, and must comply with all applicable requirements before funds are drawn.

- Withholding authority to proceed to the next phase of the project until receipt of evidence of acceptable performance within a given period of performance;
- Requiring additional, more detailed financial reports;
- Requiring additional project monitoring;
- Requiring the non-Federal entity to obtain technical or management assistance; or
- Establishing additional prior approvals.[11]

If it is determined that noncompliance cannot be remedied by imposing such additional conditions, one or more of the following actions may be taken as appropriate in the circumstances:

- Temporarily withhold cash payments pending further action;
- Disallow all or part of the cost of the activity or action not in compliance;
- Wholly or partly suspend award activities or terminate the Federal award;[12]
- Initiate suspension or debarment proceedings;[13]
- Withhold further Federal awards for the project or program; or
- Take other remedies that may be legally available.[14]

Progressive Action Overview

In circumstances where HRSA has determined that a health center has failed to demonstrate compliance with one or more of the Health Center Program requirements, a condition(s) will be placed on the award/designation, which will follow the Progressive Action policy and process. Such determinations are typically based upon findings from the review of the Service Area Competition (SAC)/Renewal of Designation (RD) application, a site visit, other compliance-related activities, or through other means.[15] Program conditions placed on the health center's award or look-alike designation describe the:

- Nature of the finding and the requirement it relates to;
- Reason why the condition(s) is being imposed;

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[11] 45 CFR 75.207(b).

[12] *Termination* means the ending of a Federal award, in whole or in part at any time prior to the planned end of period of performance [project period] (45 CFR 75.2). Health Center Program look-alikes will receive formal notification of de-designation as they do not receive a Federal Health Center Program award.

[13] *Suspension of award activities* means an action by HRSA requiring the recipient to cease all activities on the award pending corrective action by the recipient, including restricting the ability to draw down any funds associated with the Federal award (45 CFR 75.375) and is a separate action from suspension under HHS regulations (2 CFR Part 376) (45 CFR 75.2).

[14] 45 CFR 75.371.

[15] HRSA may also assess compliance with requirements through audit data, Uniform Data System (UDS) or similar performance reports, Medicare/Medicaid reports, external accreditation, or other Federal, state, or local findings or reports as applicable, and may conduct onsite verification of compliance at any point within a project/designation period or prior to any final Health Center Program award/designation decisions.

- Nature of the action(s) needed to remove the condition;
- Time allowed for completing the additional requirement (satisfying the condition(s) through submission of appropriate documentation or specific actions taken), if applicable; and
- Method for requesting reconsideration of the condition.[16]

HRSA is committed to providing a reasonable period of time for these organizations to take corrective actions necessary to demonstrate compliance. Progressive Action is designed to provide a time-phased approach for resolution of compliance issues with program requirements. This Progressive Action process is not intended to address or be used for the oversight and enforcement of all Federal requirements that may be applicable to the award or designation, particularly those with implications for patient safety (see Immediate Enforcement Actions below).

Should a health center fail to adequately address conditions through Progressive Action, HRSA may utilize available remedies, including terminating all or part of the Federal award/designation status before the health center's current project end date.[17] Such action may be accompanied by a competition to identify another organization to carry out a service delivery program consistent with Federal requirements.[18]

Progressive Action Process

In circumstances where HRSA has determined that a health center has failed to demonstrate compliance with one or more Health Center Program requirements, relevant conditions are placed on the health center's award/designation and communicated through Notices of Award (NoAs) or Notices of Look-Alike Designation (NLDs). In responding to such conditions, health centers could demonstrate their compliance to HRSA either by submitting documentation as described in the Demonstrating Compliance sections of the Manual, or by the health center proposing an alternative means of demonstrating compliance with the specified requirements, which would include submitting an explanation and documentation that explicitly demonstrates compliance. All responses to conditions are subject to review and approval by HRSA.

The Progressive Action process provides a uniform structure and a time-phased approach for notifying health centers of the failure to demonstrate compliance and for receiving health center responses to an identified condition(s) as supported within HRSA's EHB. Through this process, health centers are able to efficiently and effectively respond to conditions, and HRSA is able to promptly review these responses and proceed to next steps, including removal of

[16] Imposed conditions will include the method for submitting responses to conditions, which would include an opportunity to inform HRSA of any request to reconsider the placement of the condition.
[17] 45 CFR 75.371 and 45 CFR 75.372.
[18] Health Center Program look-alikes that have had their designation period terminated by HRSA under such circumstances or for which HRSA has not renewed a look-alike designation may reapply for look-alike designation through the initial designation application process at any time.

conditions, as warranted. In addition, the EHB supports the Progressive Action process by clearly noting condition response deadlines in the health center's EHB task list and providing periodic reminders to health centers during the condition response timeframe.

The Progressive Action process includes four distinct condition phases (detailed below), structured to provide specified timeframes for health centers to provide responses that demonstrate compliance, either in the manner prescribed by this Manual or via alternative means. After initial notification of the compliance issue, a health center will be notified via a NoA/NLD at each Progressive Action phase as to the acceptability of the response and whether further action is needed. If the health center fails to respond by the specified deadline or HRSA determines that the health center's response does not demonstrate compliance, the health center will be notified and the next Progressive Action phase will be activated.

- Phase One: An initial NoA/NLD is issued with a condition detailing the specific area(s) where compliance with a requirement has not been demonstrated. Phase One provides ninety (90) days for the health center to submit appropriate documentation that demonstrates compliance or, where applicable, that the health center has developed an adequate action plan (see Implementation Phase below) for how its organization will demonstrate compliance with the requirement.[19]
- Phase Two: Phase Two provides an additional sixty (60) days for the health center to submit appropriate documentation that demonstrates compliance or that the health center has developed an adequate action plan for how its organization will demonstrate compliance with the requirement (See Implementation Phase below).
- Phase Three: Phase Three provides an additional thirty (30) days for the health center to submit appropriate documentation that demonstrates compliance or that the health center has developed an adequate action plan for how its organization will demonstrate compliance with the requirement (See Implementation Phase below).
- Implementation Phase (where applicable): Implementation Phase provides one hundred twenty (120) days for the health center to implement the HRSA-approved action plan and submit appropriate documentation that demonstrates compliance with the program requirement.[20]

HRSA recognizes that health centers may need to make programmatic and organizational changes in response to a condition. Therefore, the Progressive Action process is designed to provide health centers with a reasonable amount of time to take appropriate action in response to a condition and for prompt HRSA review and decision-making. For example, in Phase One, a health center is given 90 days to either demonstrate compliance with the identified program requirement or develop and submit an action plan detailing the steps the health center will implement in order to demonstrate compliance with the requirement. If this plan is approved, a

[19] Conditions afford a 120-day Implementation Phase when a HRSA-approved corrective action plan would require additional time for the health center to implement related programmatic and organizational changes.
[20] The implementation phase follows HRSA's approval of an adequate action plan submitted in Phase One, Two, or Three.

NoA/NLD will be issued with an "Implementation Phase" condition notifying the health center that HRSA has approved the action plan and that within 120 days it must submit documentation that compliance with the requirement has been demonstrated in accordance with the HRSA-approved plan.

Conditions in Phase Two (60-day) and Phase Three (30-day)[21] state that if the health center does not adequately address the condition within the allotted timeframe (the last opportunity being Phase Three), the organization will be determined to have failed to comply with the terms and conditions of the Health Center Program award or designation. As a result, the health center's current project end date may be shortened through the termination of all or part of the Federal award or designation status.

Immediate Enforcement Actions

HRSA may determine that certain findings related to a health center, as a consequence of their nature and/or urgency, cannot be remedied by imposing specific award conditions per the Progressive Action process described above. In such cases, based on the circumstances, HRSA may take one or more of the following immediate remedies:

- Temporarily withhold cash payments (from the Federal award) pending further action;
- Disallow all or part of the cost of the activity or action not in compliance;
- Wholly or partly suspend award activities or terminate the Federal award;
- Initiate suspension or debarment proceedings;
- Withhold further Federal awards for the project or program; or
- Take other remedies that may be legally available.[22]

Situations that cannot be remedied through use of the Progressive Action process and that may require HRSA to apply such immediate enforcement actions include:

- Findings that a health center, in responding to the terms or conditions of award/designation, misrepresented the actions it took to correct areas of non-compliance. For example, a site visit reveals that HRSA lifted a Progressive Action condition based on false or misrepresented information submitted by the health center.

- Documented public health or welfare concerns. Examples may include threats to health center patient safety, violations of state scope of practice regulations or guidelines, inappropriate or illegal prescribing practices, lack of appropriate infection control procedures, and occupational or environmental hazards.

[21] The BPHC website includes a public Health Center Profile for each individual health center that displays data on the status of a health center's compliance with Health Center Program requirements based on the presence of any active 60- and/or 30-day Progressive Action conditions. See http://bphc.hrsa.gov/uds/datacenter.aspx?q=d to view individual health center data.
[22] 45 CFR 75.371.

- Failure of the health center organization to demonstrate operational capacity to continue or maintain its health center service delivery program. For example, a health center has ceased operations and is no longer providing primary care services or is providing only minimal services.

- A determination that continued funding would not be in the best interest of the Federal Government. For example, a health center organization's inclusion as an excluded entity on the U.S. Department of Health and Human Services Office of Inspector General's List of Excluded Individuals/Entities (LEIE) and/or inclusion on the System for Award Management (SAM) Excluded Parties List System (EPLS),[23] or as an organization that is not qualified per the Federal Awardee Performance and Integrity Information System (FAPIIS).[24]

Program Compliance and Application Review and Selection

Project/designation period length is based on an assessment of a health center's compliance with program requirements. Therefore, an existing health center that fails to demonstrate compliance with all Health Center Program requirements may only be awarded Federal Service Area Competition (SAC) funding for a one-year project/designation period.[25]

Further, if a current Health Center Program Federal award recipient has been awarded two consecutive one-year project periods as a result of noncompliance with any Health Center Program requirements, and review of a subsequent SAC application would result in a third consecutive one-year project period due to noncompliance with Program requirements, HRSA will not fund a third consecutive one-year project period.[26] In such circumstances, HRSA may announce a new competition for the service area, in order to identify an organization that can carry out a service delivery program consistent with Health Center Program requirements.

[23] The Government Services Administration administers the SAM EPLS. The SAM is available at https://www.sam.gov.

[24] The FAPIIS is available at https://www.fapiis.gov/fapiis/index.action.

[25] Section 330(e)(1)(B) of the PHS Act (42 U.S.C. 254b(e)(1)(B)). In addition, a health center that fails to demonstrate compliance with all Health Center Program requirements, including those in Section 330(k)(3) of the PHS Act, must submit, within 120 days of grant funding, an implementation plan for compliance for HRSA approval. Additional information related to this implementation plan will be included in the applicable Notices of Funding Opportunity and Look-Alike Designation/Renewal of Designation application instructions.

[26] Section 330(e)(4) of the PHS Act states that "Not more than two grants may be made under subparagraph (B) of paragraph (1) for the same entity." While such organizations may apply for future Health Center Program funding under 45 CFR 75.205(c)(3), HRSA may consider factors, including an applicant's history of performance if it has been a prior recipient of Federal awards or designation when making competitive awards. These factors include, but are not limited to, unsuccessful Progressive Action condition resolution and current compliance with Health Center Program requirements and regulations.

Consistent with the approach regarding Federal award recipients, HRSA will not renew a Health Center Program look-alike organization's designation if the organization has received two consecutive one-year designation periods and the review of the subsequent RD application would result in a third consecutive one-year designation period. Look-alikes whose designation period has not been renewed may reapply for look-alike designation through the initial designation application process at any time.[27]

In addition, project/designation period length determinations may be impacted by a comprehensive evaluation of the risks to the Health Center Program posed by each applicant if it were to receive an award/designation for a new project or designation period, or for supplemental funding. The specific criteria for determining project period length are further detailed in the applicable Service Area Competition (SAC) Notices of Funding Opportunity (NOFOs) and Look-Alike Renewal of Designation (RD), or supplemental funding application instructions. A health center's ability to demonstrate compliance with program requirements is critical to ensuring continued Federal award support and may, in certain cases, directly impact award decisions for supplemental funding, as outlined in the specific NOFO.

[27] See http://www.bphc.hrsa.gov/programopportunities/lookalike/index.html for more information on the Health Center Program look-alike application process.

Chapter 3: Needs Assessment

Note: This chapter contains revisions based on the Bipartisan Budget Act of 2018. View the revisions.

Authority

Section 330(k)(2) and Section 330(k)(3)(J) of the PHS Act; and 42 CFR 51c.104(b)(2-3), 42 CFR 51c.303(k), 42 CFR 56.104(b)(2), 42 CFR 56.104(b)(4), and 42 CFR 56.303(k)

Requirements

- The health center must define and annually review the boundaries of the catchment area to be served [service area], including the identification of the medically underserved population or populations within the catchment area in order to ensure that the:
    - Size of this area is such that the services to be provided through the center (including any satellite service sites) are available and accessible to the residents of the area promptly and as appropriate;
    - Boundaries of such area conform, to the extent practicable, to relevant boundaries of political subdivisions, school districts, and areas served by Federal and State health and social service programs; and
    - Boundaries of such area eliminate, to the extent possible, barriers resulting from the area's physical characteristics, its residential patterns, its economic and social groupings, and available transportation.

- The health center must assess the unmet need for health services in the catchment or proposed catchment area of the center based on the population served, or proposed to be served, utilizing, but not limited to, the following factors:
    - Available health resources in relation to the size of the area and its population, including appropriate ratios of primary care physicians in general or family practice, internal medicine, pediatrics, or obstetrics and gynecology to its population;
    - Health indices for the population of the area, such as infant mortality rate;
    - Economic factors affecting the population's access to health services, such as percentage of the population with incomes below the poverty level; and
    - Demographic factors affecting the population's need and demand for health services, such as percentage of the population age 65 and over.

Demonstrating Compliance

A health center would demonstrate compliance with these requirements by fulfilling all of the following:

a. The health center identifies and annually reviews its service area[1] based on where current or proposed patient populations reside as documented by the ZIP codes reported on the health center's Form 5B: Service Sites. In addition, these service area ZIP codes are consistent with patient origin data reported by ZIP code in its annual Uniform Data System (UDS) report (for example, the ZIP codes reported on the health center's Form 5B: Service Sites would include the ZIP codes in which at least 75 percent of current health center patients reside, as identified in the most recent UDS report).

b. The health center completes or updates a needs assessment of the current or proposed population at least once every three years,[2] for the purposes of informing and improving the delivery of health center services. The needs assessment utilizes the most recently available data[3] for the service area and, if applicable, special populations and addresses the following:
    - Factors associated with access to care and health care utilization (for example, geography, transportation, occupation, transience, unemployment, income level, educational attainment);
    - The most significant causes of morbidity and mortality (for example, diabetes, cardiovascular disease, cancer, low birth weight, behavioral health) as well as any associated health disparities; and
    - Any other unique health care needs or characteristics that impact health status or access to, or utilization of, primary care (for example, social factors, the physical environment, cultural/ethnic factors, language needs, housing status).

Related Considerations

The following points describe areas where health centers have discretion with respect to decision-making, or may be useful for health centers to consider when implementing these requirements:

- The health center determines the most appropriate methodologies, tools, and formats for conducting needs assessments (for example, quantitative or qualitative data sources,

[1] Also referred to as "catchment area" in the Health Center Program implementing regulation in 42 CFR 51c.102.
[2] Compliance may be demonstrated based on the information included in a Service Area Competition (SAC) or a Renewal of Designation (RD) application. Note that in the case of a Notice of Funding Opportunity for a New Access Point or Expanded Services grant, HRSA may specify application-specific requirements for demonstrating an applicant has consulted with the appropriate agencies and providers consistent with Section 330(k)(2)(D) of the Public Health Service Act. Such application-specific requirements may require a completed or updated needs assessment more recent than that which was provided in an applicant's SAC or RD application.
[3] In cases where data are not available for the specific service area or special population, health centers may use extrapolation techniques to make valid estimates using data available for related areas and population groups. Extrapolation is the process of using data that describes one population to estimate data for a comparable population, based on one or more common differentiating demographic characteristics. Where data are not directly available and extrapolation is not feasible, health centers should use the best available data describing the area or population to be served.

focus groups, patient surveys).

- The health center determines how to complete or update its needs assessments (for example, fulfilling the criteria of a Notice of Funding Opportunity (NOFO), participating in community-wide needs assessments, responding to changes within the community).

- The health center may choose to include additional indicators relevant to its service area and population within its needs assessments.

- The health center may choose to include an additional focus on a specific underserved subset of the service area population (for example, children; persons living with HIV/AIDS; elderly persons), as part of its overall assessment of need in its service area.

Chapter 4: Required and Additional Health Services

Note: This chapter contains revisions based on the Bipartisan Budget Act of 2018. View the revisions.

Authority

Section 330(a)-(b), Section 330(h)(2), and Section 330(k)(3)(K) of the PHS Act; and 42 CFR 51c.102(h) and (j), 42 CFR 56.102(l) and (o), and 42 CFR 51c.303(l)

Requirements

- The health center must provide the required primary health services listed in section 330(b)(1) of the PHS Act.

- A health center that receives a Health Center Program award or look-alike designation under section 330(h) of the PHS Act to serve individuals experiencing homelessness must, in addition to these required primary health services, provide substance use disorder services.

- The health center may provide additional (supplemental) health services that are appropriate to meet the health needs of the population served by the health center, subject to review and approval by HRSA.

- All required and applicable additional health services must be provided through one or more service delivery method(s): directly, or through written contracts and/or cooperative arrangements (which may include formal referrals).

- A health center which serves a population that includes a substantial proportion of individuals of limited English-speaking ability must:
    - Develop a plan and make arrangements for interpretation and translation that are responsive to the needs of such populations for providing health center services to the extent practicable in the language and cultural context most appropriate to such individuals; and
    - Provide guidance to appropriate staff members with respect to cultural sensitivities and bridging linguistic and cultural differences.

Demonstrating Compliance

A health center would demonstrate compliance with these requirements by fulfilling all of the following:

a. The health center provides access to all services included in its HRSA-approved scope of project[1] (Form 5A: Services Provided) through one or more service delivery methods,[2] as described below:[3]

   - ***Direct***: If a required or additional service is provided directly by health center employees[4] or volunteers, this service is accurately recorded in Column I on Form 5A: Services Provided, reflecting that the health center pays for and bills for direct care.

   - ***Formal Written Contract/Agreement:***[5] If a required or additional service is provided on behalf of the health center via a formal contract/agreement between the health center and a third party (including a subrecipient),[6] this service is accurately recorded in Column II on Form 5A: Services Provided, reflecting that the health center pays for the care provided by the third party via

[1] In accordance with 45 CFR 75.308 (Uniform_Administrative_Requirements: Revision of Budget and Program Plans), health centers must request prior approval from HRSA for a change in the scope or the objective of the project or program (even if there is no associated budget revision requiring prior written approval). This prior approval requirement applies, among other things, to the addition or deletion of a service within the scope of project. These changes require prior approval from HRSA and must be submitted by the health center as a formal change in scope request. See http://www.bphc.hrsa.gov/programrequirements/scope.html for further details on scope of project, including descriptions of the services listed on Form 5A: Services Provided available at: https://www.bphc.hrsa.gov/programrequirements/scope/form5aservicedescriptors.pdf.

[2] The Health Center Program statute states that health centers may provide services "either through the staff and supporting resources of the center or through contracts or cooperative arrangements." 42 U.S.C. 254b(a)(1) The Health Center Program Compliance Manual utilizes the terms "Formal Written Contract/Agreement" and "Formal Written Referral Arrangement" to refer to such "contracts or cooperative arrangements." For more information on documenting service delivery methods within the HRSA-approved scope of project on Form 5A: Services Provided, see: http://bphc.hrsa.gov/programrequirements/scope/form5acolumndescriptors.pdf.
Other Health Center Program requirements apply when providing services through contractual agreements and formal referral arrangements. Such requirements are addressed in other chapters of the Manual where applicable.

[3] See Chapter 9: Sliding Fee Discount Program for more information on sliding fee discount program requirements and how they apply to the various service delivery methods.

[4] For purposes of the HRSA-approved scope of project (Form 5A: Services Provided), HRSA/BPHC utilizes Internal Revenue Service (IRS) definitions to differentiate contractors and employees. Typically, an employee receives a salary on a regular basis and a W-2 from the health center with applicable taxes and benefit contributions withheld.

[5] See Chapter 12: Contracts and Subawards for more information on program requirements around contracting.

[6] For purposes of the HRSA-approved scope of project (Form 5A: Services Provided), services provided via "contract/formal agreement" are those provided by practitioners who are not employed by or volunteers of the health center (for example, an individual provider with whom the health center has a contract; a group practice with which the health center has a contract; a locum tenens staffing agency with which the health center contracts; a subrecipient organization). Typically, a health center will issue an Internal Revenue Service (IRS) Form 1099 to report payments to an individual contractor. See the FTCA Health Center Policy Manual for information about eligibility for Federal Tort Claims Act (FTCA) coverage for covered activities by covered individuals, which extends liability protections for eligible "covered individuals," including governing board members and officers, employees, and qualified individual contractors).

the agreement. In addition, the health center ensures that such contractual agreements for services include:

- How the service will be documented in the patient's health center record; and
- How the health center will pay for the service.

◦ ***Formal Written Referral Arrangement***: If access to a required or additional service is provided and billed for by a third party with which the health center has a formal referral arrangement, this service is accurately recorded in Column III on Form 5A: Services Provided, reflecting that the health center is responsible for the act of referral for health center patients and any follow-up care for these patients provided by the health center subsequent to the referral.[7] In addition, the health center ensures that such formal referral arrangements for services, at a minimum, address:

- 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).

b. Health center patients with limited English proficiency are provided with interpretation and translation (for example, through bilingual providers, on-site interpreters, high quality video or telephone remote interpreting services) that enable them to have reasonable access to health center services.

c. The health center makes arrangements and/or provides resources (for example, training) that enable its staff to deliver services in a manner that is culturally sensitive and bridges linguistic and cultural differences.

Related Considerations

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

[7] For purposes of the HRSA-approved scope of project (Form 5A: Services Provided), access to services provided via "formal referral arrangements" are those referred by the health center but provided and billed for by a third party. Although the service itself is not included within the HRSA-approved scope of project, the act of referral and any follow-up care provided by the health center subsequent to the referral are considered to be part of the health center's HRSA-approved scope of project. For more information on documenting service delivery methods within the HRSA-approved scope of project on Form 5A: Services Provided, see: http://bphc.hrsa.gov/programrequirements/scope/form5acolumndescriptors.pdf.

- The health center governing board determines which, if any, additional health services to offer in order to meet the health needs of the population served by the health center (subject to review and approval by HRSA).

- The health center determines how to make services accessible in a culturally and linguistically appropriate manner,[8] based on its patient population.

- The health center determines the level or intensity of required and additional services, as well as the method for delivering these services, based on factors such as the needs of the population served, demonstrated unmet need in the community, provider staffing, and collaborative arrangements.

- The health center may, through policies and operating procedures, prioritize the availability of additional services within the approved scope of project to individuals who utilize the health center as their primary care medical home.

[8] See the National Standards for Culturally and Linguistically Appropriate Services (CLAS) published by the U.S. Department of Health and Human Services at https://www.thinkculturalhealth.hhs.gov/. For additional information and guidance. Additional cultural/linguistic competency and health literacy tools, resources and definitions are available online at https://www.hrsa.gov/cultural-competence/index.html and https://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy/index.html.

Chapter 5: Clinical Staffing

Authority

Sections 330(a)(1), (b)(1)-(2) of the PHS Act; and 42 CFR 51c.303(a), 42 CFR 51c.303(p), 42 CFR 56.303(a), and 42 CFR 56.303(p)

Requirements

- The health center must provide the required primary and approved additional health services[1] of the center through staff and supporting resources of the center or through contracts or cooperative arrangements.

- The health center must provide the health services of the center so that such services are available and accessible promptly, as appropriate, and in a manner that will assure continuity of service to the residents of the center's catchment area.

- The health center must utilize staff that are qualified by training and experience to carry out the activities of the center.

Demonstrating Compliance

A health center would demonstrate compliance with these requirements by fulfilling all of the following:

a. The health center ensures that it has clinical staff[2] and/or has contracts or formal referral arrangements in place with other providers or provider organizations to carry out all required and additional services included in the HRSA-approved scope of project.[3]

b. The health center has considered the size, demographics, and health needs (for example, large number of children served, high prevalence of diabetes) of its patient

[1] These terms are defined in section 330(b) of the Public Health Service (PHS) Act. For more information, see http://bphc.hrsa.gov/programrequirements/scope.html.

[2] Clinical staff includes licensed independent practitioners (for example, Physician, Dentist, Physician Assistant, Nurse Practitioner), other licensed or certified practitioners (for example, Registered Nurse, Licensed Practical Nurse, Registered Dietitian, Certified Medical Assistant), and other clinical staff providing services on behalf of the health center (for example, Medical Assistants or Community Health Workers in states, territories or jurisdictions that do not require licensure or certification).

[3] Health centers seeking coverage for themselves and their providers under the Health Center FTCA Medical Malpractice Program should review the statutory and policy requirements for coverage, as discussed in the FTCA Health Center Policy Manual.

population in determining the number and mix of clinical staff necessary to ensure reasonable patient access to health center services.

c. The health center has operating procedures for the initial and recurring review (for example, every two years) of credentials for all clinical staff members (licensed independent practitioners (LIPs), other licensed or certified practitioners (OLCPs), and other clinical staff providing services on behalf of the health center) who are health center employees, individual contractors, or volunteers. These credentialing procedures would ensure verification of the following, as applicable:
    - Current licensure, registration, or certification using a primary source;
    - Education and training for initial credentialing, using:
        - Primary sources for LIPs[4]
        - Primary or other sources (as determined by the health center) for OLCPs and any other clinical staff;
    - Completion of a query through the National Practitioner Data Bank (NPDB);[5]
    - Clinical staff member's identity for initial credentialing using a government-issued picture identification;
    - Drug Enforcement Administration (DEA) registration; and
    - Current documentation of basic life support training.

d. The health center has operating procedures for the initial granting and renewal (for example, every two years) of privileges for clinical staff members (LIPs, OLCPs, and other clinical staff providing services on behalf of the health center) who are health center employees, individual contractors, or volunteers. These privileging procedures would address the following:
    - Verification of fitness for duty, immunization, and communicable disease status;[6]
    - For initial privileging, verification of current clinical competence via training, education, and, as available, reference reviews;
    - For renewal of privileges, verification of current clinical competence via peer review or other comparable methods (for example, supervisory performance reviews); and
    - Process for denying, modifying or removing privileges based on assessments of clinical competence and/or fitness for duty.

[4] In states in which the licensing agency, specialty board or registry conducts primary source verification of education and training, the health center would not be required to duplicate primary source verification when completing the credentialing process.

[5] The NPDB is an electronic information repository authorized by Congress. It contains information on medical malpractice payments and certain adverse actions related to health care practitioners, entities, providers, and suppliers. For more information, see http://www.npdb.hrsa.gov.

[6] The CDC has published recommendations and many states have their own recommendations or standards for provider immunization and communicable disease screening. For more information about CDC recommendations, see http://www.cdc.gov/vaccines/adults/rec-vac/hcw.html.

e. The health center maintains files or records for its clinical staff (for example, employees, individual contractors, and volunteers) that contain documentation of licensure, credentialing verification, and applicable privileges, consistent with operating procedures.

f. If the health center has contracts with provider organizations (for example, group practices, locum tenens staffing agencies, training programs) or formal, written referral agreements with other provider organizations that provide services within its scope of project, the health center ensures[7] that such providers are:
   - Licensed, certified, or registered as verified through a credentialing process, in accordance with applicable Federal, state, and local laws; and
   - Competent and fit to perform the contracted or referred services, as assessed through a privileging process.

Related Considerations

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- The health center determines its staffing composition (for example, use of nurse practitioners, physician assistants, certified nurse midwives) and its staffing levels (for example, full- and/or part-time staff).

- The health center determines who has approval authority for credentialing and privileging of its clinical staff.

- The health center determines how credentialing will be implemented (for example, a health center may contract with a credentials verification organization (CVO) to perform credentialing activities or it may have its own staff conduct credentialing), including whether to have separate credentialing processes for LIPs versus other provider types.

- The health center determines how it assesses clinical competence and fitness for duty of its staff (for example, regarding clinical competence, a health center may utilize peer review conducted by its own providers or may contract with another organization to conduct peer review).

- The health center determines (consistent with its established privileging criteria) whether to deny, modify, or remove privileges of its staff; whether to use an appeals process in conjunction with such determinations; and whether to implement corrective action plans in conjunction with the denial, modification, or removal of privileges.

[7] This may be done, for example, through provisions in contracts and cooperative arrangements with such organizations or health center review of the organizations' credentialing and privileging processes.

- The health center determines (consistent with its contracts/cooperative arrangements) whether to disallow individual providers or organizations from providing health services on the health center's behalf.

Chapter 6: Accessible Locations and Hours of Operation

Authority

Section 330(k)(3)(A) of the PHS Act; and 42 CFR 51c.303(a) and 42 CFR 56.303(a)

Requirements

- The required primary health services of the health center must be available and accessible in the catchment [service] area of the center promptly, as appropriate, and in a manner which ensures continuity of service to the residents of the center's catchment area.

Demonstrating Compliance

A health center would demonstrate compliance with these requirements by fulfilling all of the following:

a. The health center's service site(s) are accessible to the patient population relative to where this population lives or works (for example, in areas immediately accessible to public housing for health centers targeting public housing residents, or in shelters for health centers targeting individuals experiencing homelessness, or at migrant camps for health centers targeting agricultural workers). Specifically, the health center considers the following factors to ensure the accessibility of its sites:
    - Access barriers (for example, barriers resulting from the area's physical characteristics, residential patterns, or economic and social groupings); and
    - Distance and time taken for patients to travel to or between service sites in order to access the health center's full range of in-scope services.

b. The health center's total number and scheduled hours of operation across its service sites are responsive to patient needs by facilitating the ability to schedule appointments and access the health center's full range of services within the HRSA-approved scope of project[1] (for example, a health center service site might offer extended evening hours 3 days a week based on input or feedback from patients who cannot miss work for appointments during normal business hours).

[1] Services provided by a health center are defined at the awardee/designee level, not by individual site. Thus, not all services must be available at every health center service site; rather, health center patients must have reasonable access to the full complement of services offered by the center as a whole, either directly or through formal written established arrangements. See http://www.bphc.hrsa.gov/programrequirements/scope.html for further details on scope of project, including services and column descriptors listed on Form 5A: Services Provided.

c. The health center accurately records the sites in its HRSA-approved scope of project[2] on its Form 5B: Service Sites in HRSA's Electronic Handbooks (EHB).

Related Considerations

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- The health center determines which methods to use for obtaining patient input on the accessibility of its service sites and hours of operation (for example, annual survey, focus groups, input from patient board members).

- The health center determines how to measure and consider distance and travel time to or between the health center's sites when assessing its impact on patient access to the health center's services.

- The health center determines how to support patient access to the various service sites included within its HRSA-approved scope of project (for example, whether to provide patient transportation between service sites or use mobile service sites). The health center also determines which service(s) to provide at each site within its HRSA-approved scope of project.

[2] In accordance with 45 CFR 75.308(c)(1)(i), health centers must request prior approval from HRSA for a "Change in the scope or the objective of the project or program (even if there is no associated budget revision requiring prior written approval)." This prior approval requirement applies to the addition, deletion, or replacement of a service site. These changes require prior approval from HRSA and must be submitted by the health center as a formal change in scope request. See http://www.bphc.hrsa.gov/programrequirements/scope.html for further details on scope of project.

Chapter 7: Coverage for Medical Emergencies During and After Hours

Authority

Section 330(b)(1)(A)(IV) and Section 330(k)(3)(A) of the PHS Act; and 42 CFR 51c.102(h)(4), 42 CFR 56.102(l)(4), 42 CFR 51c.303(a), and 42 CFR 56.303(a)

Requirements

- To assure continuity of the required primary health services of the center, the health center must have:
  - Provisions for promptly responding to patient medical emergencies during the health center's regularly scheduled hours; and
  - Clearly defined arrangements for promptly responding to patient medical emergencies after the health center's regularly scheduled hours.

Demonstrating Compliance

A health center would demonstrate compliance with these requirements by fulfilling all of the following:

a. The health center has at least one staff member trained and certified in basic life support present at each HRSA-approved service site (as documented on Form 5B: Service Sites) to ensure the health center has the clinical capacity to respond to patient medical emergencies[1] during the health center's regularly scheduled hours of operation.[2]

b. The health center has and follows its applicable operating procedures when responding to patient medical emergencies during regularly scheduled hours of operation.

c. The health center has after-hours coverage operating procedures, which may include formal arrangements[3] with non-health center providers/entities, that ensure:
   - Coverage is provided via telephone or face-to-face by an individual with the qualification and training necessary to exercise professional judgment in assessing a health center patient's need for emergency medical care;

[1] Medical emergencies may, for example, include those related to physical, oral, behavioral, or other emergent health needs.
[2] See Chapter 6: Accessible Location and Hours of Operation for more information on hours of operation.
[3] See Chapter 12: Contracts and Subawards for more information on oversight over such arrangements.

- Coverage includes the ability to refer patients either to a licensed independent practitioner for further consultation or to locations such as emergency rooms or urgent care facilities for further assessment or immediate care as needed; and
- Patients, including those with limited English proficiency,[4] are informed of and are able to access after-hours coverage, based on receiving after-hours coverage information and instructions in the language(s), literacy levels, and formats appropriate to the health center's patient population needs.

d. The health center has documentation of after-hours calls and any necessary follow-up resulting from such calls for the purposes of continuity of care.[5]

Related Considerations

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- The health center determines the means by which after-hours coverage is provided to health center patients. Examples include: telephone coverage by health center providers, primary care services after hours to address urgent medical conditions on an extended or 24-hour basis at certain service sites, after-hours phone coverage arrangements with other community providers,[6] or "nurse call" lines.

- The health center determines how to make patients aware of the availability of, and procedures for, accessing professional coverage after hours. Examples include after-hours instructions that are: integrated into an automated message on the health center's main phone line explaining how to access after-hours coverage, posted on the door of all health center service sites, provided as part of the initial patient registration process, posted on the health center's website, and/or provided as patient brochures or cards.

[4] Under Section 602 of Title VI of the Civil Rights Act and the Department of Health and Human Services implementing regulations (45 C.F.R. Section 80.3(b)(2)), recipients of Federal financial assistance, including health centers, must take reasonable steps to ensure meaningful access to their programs, services, and activities by eligible Limited English Proficient (LEP) persons. See http://www.hhs.gov/ocr/civilrights/resources/laws/summaryguidance.html for further guidance on translating vital documents for LEP persons.

[5] See Chapter 8: Continuity of Care and Hospital Admitting for more information on continuity of care.

[6] Health centers that are deemed under the Federal Tort Claims Act (FTCA) should ensure that they are familiar with the applicable restrictions on FTCA coverage for services provided to non-health center patients. Review the FTCA Health Center Policy Manual for further information.

Chapter 8: Continuity of Care and Hospital Admitting

Authority

Section 330(k)(3)(A) and 330(k)(3)(L) of the PHS Act; and 42 CFR 51.c.303(a) and 42 CFR 56.303(a)

Requirements

- The health center must provide the required primary health services of the center promptly and in a manner which will assure continuity of service to patients within the center's catchment area (service area).

- The health center must develop an ongoing referral relationship with one or more hospitals.

Demonstrating Compliance

A health center would demonstrate compliance with these requirements by fulfilling all of the following:

a. The health center has documentation of:
    - Health center provider[1] hospital admitting privileges (for example, provider employment contracts or other files indicate the provider(s) has admitting privileges at one or more hospitals); and/or
    - Formal arrangements between the health center and one or more hospitals or entities (for example, hospitalists, obstetrics hospitalist practices) for the purposes of hospital admission of health center patients.

b. The health center has internal operating procedures and, if applicable, related provisions in its formal arrangements with non-health center provider(s) or entity(ies) that address the following areas for patients who are hospitalized as inpatients or who visit a hospital's emergency department (ED):[2]
    - Receipt and recording of medical information related to the hospital or ED visit, such as discharge follow-up instructions and laboratory, radiology, or other results; and
    - Follow-up actions by health center staff, when appropriate.

[1] In addition to physicians, various provider types may have admitting privileges, if applicable, based on scope of practice in their State (for example, Nurse Practitioners, Certified Nurse Midwives).
[2] Health center patients may be admitted to a hospital setting through a variety of means (for example, a visit to the Emergency Department (ED) may lead to an inpatient hospital admission, or a health center patient may be directly admitted to a unit of the hospital, such as labor and delivery).

c. The health center follows its operating procedures and formal arrangements as documented by:
    - Receipt and recording of medical information related to the hospital or ED visit, such as discharge follow-up instructions and laboratory, radiology, or other results; and
    - Evidence of follow-up actions taken by health center staff based on the information received, when appropriate.

Related Considerations

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- The health center determines the number and type(s) of hospitals with which its providers will have admitting arrangements based on the services included in the HRSA-approved scope of project (Form 5A: Services Provided), the patient population served, and the service area.

- The health center determines whether the most appropriate means for hospital admitting is to use its own providers, have arrangements with non-health center providers, or both.

- The health center determines the most appropriate formats and mechanisms for discharge planning and tracking (for example, use of community-wide shared electronic health record, patient hospitalization tracking log).

Chapter 9: Sliding Fee Discount Program

Note: This chapter contains revisions based on a technical correction. View the revisions.

Authority

Section 330(k)(3)(G) of the PHS Act; 42 CFR 51c.303(f), 42 CFR 51c.303(g), 42 CFR 51c.303(u), 42 CFR 56.303(f), 42 CFR 56.303(g), and 42 CFR 56.303(u)

Requirements

- The health center must operate in a manner such that no patient shall be denied service due to an individual's inability to pay.[1]

- The health center must prepare a schedule of fees or payments for the provision of its services consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation and must prepare a corresponding schedule of discounts [sliding fee discount schedule (SFDS)] to be applied to the payment of such fees or payments, by which discounts are adjusted on the basis of the patient's ability to pay.

- The health center must establish systems for [sliding fee] eligibility determination.

- The health center's schedule of discounts must provide for:
    - A full discount to individuals and families with annual incomes at or below those set forth in the most recent Federal Poverty Guidelines (FPG) [100 percent of the FPG], except that nominal charges for service may be collected from such individuals and families where imposition of such fees is consistent with project goals; and
    - No discount to individuals and families with annual incomes greater than twice those set forth in such Guidelines [200 percent of the FPG].

Demonstrating Compliance

A health center would demonstrate compliance with these requirements by fulfilling all of the following:

[1] See Chapter 16: Billing and Collections for more information on waiving or reducing charges due to a patient's inability to pay.

a. The health center has a sliding fee discount program[2] that applies to all required and additional health services[3] within the HRSA-approved scope of project for which there are distinct fees.[4]

b. The health center has board-approved policy(ies) for its sliding fee discount program that apply uniformly to all patients and address the following areas:
   - Definitions of income[5] and family;
   - Assessment of all patients for sliding fee discount eligibility based only on income and family size, including methods for making such assessments;
   - The manner in which the health center's sliding fee discount schedule(s) (SFDS(s)) will be structured in order to ensure that patient charges are adjusted based on ability to pay; and
   - *Only applicable to health centers that choose to have a nominal charge for patients at or below 100 percent of the FPG*: The setting of a flat nominal charge(s) at a level that would be nominal from the perspective of the patient (for example, based on input from patient board members, patient surveys, advisory committees, or a review of co-pay amount(s) associated with Medicare and Medicaid for patients with comparable incomes) and would not reflect the actual cost of the service being provided.[6]

c. For services provided directly by the health center (Form 5A: Services Provided, Column I), the health center's SFDS(s) is structured consistent with its policy and provides discounts as follows:
   - A full discount is provided for individuals and families with annual incomes at or below 100 percent of the current FPG, unless a health center elects to have a nominal charge, which would be less than the fee paid by a patient in the first sliding fee discount pay class above 100 percent of the FPG.
   - Partial discounts are provided for individuals and families with incomes above 100 percent of the current FPG and at or below 200 percent of the current FPG, and

[2] A health center's sliding fee discount program consists of the schedule of discounts that is applied to the fee schedule and adjusts fees based on the patient's ability to pay. A health center's sliding fee discount program also includes the related policies and procedures for determining sliding fee eligibility and applying sliding fee discounts.

[3] See Chapter 4: Required and Additional Health Services for more information on requirements for services within the scope of the project.

[4] A distinct fee is a fee for a specific service or set of services, which is typically billed for separately within the local health care market.

[5] Income is defined as earnings over a given period of time used to support an individual/household unit based on a set of criteria of inclusions and exclusions. Income is distinguished from assets, as assets are a fixed economic resource while income is comprised of earnings.

[6] Nominal charges are not "minimum fees," "minimum charges," or "co-pays."

those discounts adjust based on gradations in income levels and include at least three discount pay classes.[7]
    - No discounts are provided to individuals and families with annual incomes above 200 percent of the current FPG.[8]

d. For health centers that choose to have more than one SFDS, these SFDSs would be based on services (for example, having separate SFDSs for broad service types, such as medical and dental, or distinct subcategories of service types, such as preventive dental and additional dental services) and/or on service delivery methods (for example, having separate SFDSs for services provided directly by the health center and for in-scope services provided via formal written contract) and no other factors.

e. The health center's SFDS(s) has incorporated the most recent FPG.

f. The health center has operating procedures for assessing/re-assessing all patients for income and family size consistent with board-approved sliding fee discount program policies.

g. The health center has records of assessing/re-assessing patient income and family size except in situations where a patient has declined or refused to provide such information.

h. The health center has mechanisms for informing patients of the availability of sliding fee discounts (for example, distributing materials in language(s) and literacy levels appropriate for the patient population, including information in the intake process, publishing information on the health center's website).

i. For in-scope services provided via contracts (Form 5A: Services Provided, Column II, Formal Written Contract/Agreement), the health center ensures that fees for such services are discounted as follows:
    - A full discount is provided for individuals and families with annual incomes at or below 100 percent of the current FPG, unless a health center elects to have a nominal charge, which would be less than the fee paid by a patient in the first sliding fee discount pay class above 100 percent of the FPG.
    - Partial discounts are provided for individuals and families with incomes above 100 percent of the current FPG and at or below 200 percent of the current FPG, and those discounts adjust based on gradations in income levels and include at least three discount pay classes.

[7] For example, a SFDS with discount pay classes of 101 percent to 125 percent of the FPG, 126 percent to 150 percent of the FPG, 151 percent to 175 percent of the FPG, 176 percent to 200 percent of the FPG, and over 200 percent of the FPG would have four discount pay classes between 101 percent and 200 percent of the FPG.
[8] See Chapter 16: Billing and Collections, if the health center has access to other grants or subsidies that support patient care.

- No discounts are provided to individuals and families with annual incomes above 200 percent of the current FPG.

j. For services provided via formal referral arrangements (Form 5A: Services Provided, Column III), the health center ensures that fees for such services are either discounted as described in element "c." above or discounted in a manner such that:
   - Individuals and families with incomes above 100 percent of the current FPG and at or below 200 percent of the FPG receive an equal or greater discount for these services than if the health center's SFDS were applied to the referral provider's fee schedule; and
   - Individuals and families at or below 100 percent of the FPG receive a full discount or a nominal charge for these services.

k. Health center patients who are eligible for sliding fee discounts and have third-party coverage are charged no more for any out-of-pocket costs than they would have paid under the applicable SFDS discount pay class.[9] Such discounts are subject to potential legal and contractual restrictions. [10]

l. The health center evaluates, at least once every three years, its sliding fee discount program. At a minimum, the health center:
   - Collects utilization data that allows it to assess the rate at which patients within each of its discount pay classes, as well as those at or below 100 percent of the FPG, are accessing health center services;
   - Utilizes this and, if applicable, other data (for example, results of patient satisfaction surveys or focus groups, surveys of patients at various income levels) to evaluate the effectiveness of its sliding fee discount program in reducing financial barriers to care; and
   - Identifies and implements changes as needed.

Related Considerations

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

[9] For example, an insured patient receives a health center service for which the health center has established a fee of $80, per its fee schedule. Based on the patient's insurance plan, the co-pay would be $60 for this service. The health center also has determined, through an assessment of income and family size, that the patient's income is 150 percent of the FPG and thus qualifies for the health center's SFDS. Under the SFDS, a patient with an income at 150 percent of the FPG would receive a 50 percent discount of the $80 fee, resulting in a charge of $40 for this service. Rather than the $60 co-pay, the health center would charge the patient no more than $40 out-of-pocket, consistent with its SFDS, as long as this is not precluded or prohibited by the applicable insurance contract.

[10] Such limitations may be specified by applicable Federal or state programs, or private payor contracts.

- The health center determines whether to establish a nominal charge for individuals and families at or below 100 percent of the FPG.

- The health center determines how to document income and family size in health center records.

- The health center determines whether to take into consideration the characteristics of its patient population when developing definitions for income and family size and procedures for assessing patient eligibility for SFDS. For example, the health center may consider the availability of income documentation for individuals experiencing homelessness, build in cost of living considerations when calculating income, permit self-declaration of income and family size.

- The health center determines how and with what frequency to re-assess patient eligibility for the SFDS.

- The health center determines whether to identify individuals who refuse to provide information on income and family size as ineligible for SFDS.

- The health center determines how to make patients aware of sliding fee discounts (for example, signage, registration process).

- The health center determines:
    - Whether to establish more than three discount pay classes above 100 percent of the FPG and up to and including 200 percent of the FPG;
    - What income range to establish for each discount pay class above 100 percent of the FPG and up to and including 200 percent of the FPG;
    - What method to use for discounting fees above 100 percent of the FPG and up to and including 200 percent of the FPG (for example, percentage of fee, fixed/flat fee per discount pay class); and
    - Whether to establish multiple SFDSs (for example, separate SFDSs for medical services and dental services) including, if appropriate, different nominal charges for each SFDS.

Chapter 10: Quality Improvement/Assurance

Authority

Section 330(k)(3)(C) of the PHS Act; and 42 CFR 51c.110, 42 CFR 51c.303(b), 42 CFR 51c.303(c), 42 CFR 51c.304(d)(3)(iv-vi), 42 CFR 56.111, 42 CFR 56.303(b), 42 CFR 56.303(c), and 42 CFR 56.304(d)(4)(v-vii)

Requirements

- The health center must have an ongoing quality improvement/assurance (QI/QA) system that includes clinical services and [clinical] management and maintains the confidentiality of patient records.

- The health center's ongoing QI/QA system must provide for all of the following:
    - Organizational arrangements, including a focus of responsibility, to support the quality assurance program and the provision of high quality patient care; and
    - Periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the center. Such assessments must:
        - Be conducted by physicians or by other licensed health professionals under the supervision of physicians;
        - Be based on the systematic collection and evaluation of patient records;
        - Assess patient satisfaction, achievement of project objectives, and include a process for hearing and resolving patient grievances; and
        - Identify and document the necessity for change in the provision of services by the center and result in the institution of such change, where indicated.

- The health center must maintain the confidentiality of patient records, including all information as to personal facts and circumstances obtained by the health center staff about recipients of services. Specifically, the health center must not divulge such information without the individual's consent except as may be required by law or as may be necessary to provide service to the individual or to provide for medical audits by the Secretary of HHS or his/her designee with appropriate safeguards for confidentiality of patient records.

Demonstrating Compliance

A health center would demonstrate compliance with these requirements by fulfilling all of the following:

a. The health center has a board-approved policy(ies) that establishes a QI/QA program.[1] This QI/QA program addresses the following:
   - The quality and utilization of health center services;
   - Patient satisfaction and patient grievance processes; and
   - Patient safety, including adverse events.

b. The health center designates an individual(s) to oversee the QI/QA program established by board-approved policy(ies). This individual's responsibilities would include, but would not be limited to, ensuring the implementation of QI/QA operating procedures and related assessments, monitoring QI/QA outcomes, and updating QI/QA operating procedures.

c. The health center has operating procedures or processes that address all of the following:
   - Adhering to current evidence-based clinical guidelines, standards of care, and standards of practice in the provision of health center services, as applicable;
   - Identifying, analyzing, and addressing patient safety and adverse events and implementing follow-up actions, as necessary;
   - Assessing patient satisfaction;
   - Hearing and resolving patient grievances;
   - Completing periodic QI/QA assessments on at least a quarterly basis to inform the modification of the provision of health center services, as appropriate; and
   - Producing and sharing reports on QI/QA to support decision-making and oversight by key management staff and by the governing board regarding the provision of health center services.

d. The health center's physicians or other licensed health care professionals conduct QI/QA assessments on at least a quarterly basis, using data systematically collected from patient records, to ensure:
   - Provider adherence to current evidence-based clinical guidelines, standards of care, and standards of practice in the provision of health center services, as applicable; and
   - The identification of any patient safety and adverse events and the implementation of related follow-up actions, as necessary.

e. The health center maintains a retrievable health record (for example, the health center has implemented a certified Electronic Health Record (EHR))[2] for each patient, the

[1] See Chapter 19: Board Authority for more information on the health center governing board's role in approving policies.

[2] CMS and the Office of the National Coordinator for Health Information Technology (ONC) have established standards and other criteria for structured data that Electronic Health Records (EHRs) must use in order to qualify for CMS incentive programs. For health centers that participate in these CMS Incentive Programs, further information is available at https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Certification.html.

format and content of which is consistent with both Federal and state laws and requirements.

f. The health center has implemented systems (for example, certified EHRs and corresponding standard operating procedures) for protecting the confidentiality of patient information and safeguarding this information against loss, destruction, or unauthorized use, consistent with Federal and state requirements.

Related Considerations

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- The health center determines whether the position designated with responsibility for the QI/QA program (for example, Clinical Director, QI Director) is full-time, part-time, or combined with another position, and whether it is filled by an employee or via contract.

- The health center determines whether the position designated with responsibility for the QI/QA program is filled by a physician, other licensed health care professional (for example, registered nurse, nurse practitioner), or other qualified individual (for example, an individual with a Master of Public Health or a Master of Healthcare Administration).

- The health center determines which QI/QA methodology(ies) to use.

- The health center determines the type of patient health record system that it will use.

- The health center determines the format, content, and focus of QI/QA reports.

Chapter 11: Key Management Staff

Note: This chapter contains revisions based on the Bipartisan Budget Act of 2018. View the revisions.

Authority

Section 330(k)(3)(H)(ii), and 330(k)(3)(I)(i) of the PHS Act; 42 CFR 51c.104(b)(4), 42 CFR 51c.303(p), 42 CFR 56.104(b)(5), and 42 CFR 56.303(p); and 45 CFR 75.308(c)(1)(ii)(iii)

Requirements

- The health center must have position descriptions for key personnel [also referred to as key management staff] that set forth training and experience qualifications necessary to carry out the activities of the health center.

- The health center must maintain sufficient key personnel [also referred to as key management staff] to carry out the activities of the health center.

- The health center must request prior approval from HRSA for a change in the key person specified in the Health Center Program award or Health Center Program look-alike designation.

- The health center must directly employ its Project Director/CEO.[1]

Demonstrating Compliance

***A health center would demonstrate compliance with these requirements by fulfilling all of the following*:**

a. The health center has determined the makeup of and distribution of functions among its key management staff[2] and the percentage of time dedicated to the Health Center

[1] While the position title of the key person who is specified in the award/designation may vary, for the purposes of the Health Center Program, this Chapter will utilize the term "Project Director/CEO" when referring to this key person. Under 45 CFR 75.2, the term "Principal Investigator/Program Director (PI/PD)" means the individual(s) designated by the recipient to direct the project or program being supported by the grant. The PI/PD is responsible and accountable to officials of the recipient organization for the proper conduct of the project, program, or activity. For the purposes of the Health Center Program, "Project Director/CEO" is synonymous with the term "PI/PD."

[2] Examples of key management staff may include Project Director/CEO, Clinical Director/Chief Medical Officer, Chief Financial Officer, Chief Operating Officer, Nursing/Health Services Director, or Chief Information Officer.

Program project for each position, as necessary to carry out the HRSA-approved scope of project.

b. The health center has documented the training and experience qualifications, as well as the duties or functions, for each key management staff position (for example, in position descriptions).

c. The health center has implemented, as necessary, a process for filling vacant key management staff positions (for example, vacancy announcements have been published and reflect the identified qualifications).

d. The health center's Project Director/CEO is directly employed by the health center,[3] reports to the health center's governing board[4] and is responsible for overseeing other key management staff in carrying out the day-to-day activities necessary to fulfill the HRSA-approved scope of project.

e. If there has been a post-award change in the Project Director/CEO position,[5] the health center requests and receives prior approval from HRSA.

Related Considerations

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- The health center's governing board determines when a less than full time Project Director/CEO position is sufficient to oversee the day-to-day activities of the HRSA-approved scope of project.

- The health center determines when and if it is appropriate and necessary to contract for key management staff positions (other than the CEO, who may not be a contractor), rather than directly employ such individuals.

[3] Public agency health centers utilizing a co-applicant structure would demonstrate compliance with the statutory requirement for direct employment of the Project Director/CEO by demonstrating that the public agency, as the Health Center Program awardee/designee of record, directly employs the Project Director/CEO. Refer to related requirements in Chapter 19: Board Authority regarding public agencies with co-applicants.

[4] Refer to related requirements in Chapter 19: Board Authority regarding the selection and dismissal of the Project Director/CEO by the health center board as part of its oversight responsibilities for the Health Center Program project.

[5] Such changes include situations in which the current Project Director/CEO will be disengaged from involvement in the Health Center Program project for any continuous period for more than 3 months or will reduce time devoted to the project by 25 percent or more from the level that was approved at the time of award [see: 45 CFR 75.308(c)(1)(ii) and (iii)].

- The health center determines key management staff position titles (for example, utilizing the title “CEO” or “Project Director”) and how functions are distributed among its key management staff positions (for example, determining in a smaller health center whether it is appropriate to combine the CEO and CFO functions).

Chapter 12: Contracts and Subawards

Note: This chapter contains revisions based on the Bipartisan Budget Act of 2018. View the revisions.

Authority

Section 330(k)(3)(I) and Section 330(q) of the PHS Act; 42 CFR 51c.113, 42 CFR 56.114, 42 CFR 51c.303(t), and 42 CFR 56.303(t); 45 CFR Part 75 Subpart D; and Section 1861(aa)(4)(A)(ii) and Section 1905(l)(2)(B)(ii) of the Social Security Act

Requirements

Contracts: Procurement and Monitoring[1]

- The health center must determine[2] whether an individual agreement that will result in disbursement of Federal funds will be carried out through a contract or a subaward and structure the agreement accordingly.[3]

- The health center must request and receive approval from HRSA to contract for [substantive programmatic] work[4] under its Health Center Program award.

- The health center must use its own documented procurement procedures which reflect applicable State, local, and tribal laws and regulations, provided that for procurement actions paid for in whole or in part under the Federal award, the procurements conform with 45 CFR Part 75.

[1] All procurement standards included in 45 CFR Part 75 apply for procurement actions paid for in whole or in part under the Federal award. These standards do not relieve the non-Federal entity of any contractual responsibilities under its contracts. HRSA will not substitute its judgment for that of the non-Federal entity unless the matter is primarily a Federal concern. Violations of law will be referred to the local, tribal, state, or Federal authority having proper jurisdiction.

[2] 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."

[3] Specifically, the purpose of a subaward is to carry out a portion of the Federal award and creates a Federal assistance relationship with the subrecipient, while the purpose of a contract is to obtain goods or services for the health center's own use and creates a procurement relationship with the contractor.

[4] For the purposes of the Health Center Program, contracting for substantive programmatic work applies to contracting with a single entity for the majority of health care providers. The acquisition of supplies, material, equipment, or general support services is not considered programmatic work. Substantive programmatic work may be further defined within HRSA Notices of Funding Opportunity (NOFOs) and applications.

- The health center must perform a cost or price analysis in connection with every procurement action paid for in whole or in part by the Federal award in excess of the Simplified Acquisition Threshold.[5]

- The health center must conduct all procurement transactions paid for in whole or in part by the Federal award, in a manner that provides full and open competition consistent with the standards of 45 CFR 75.328. Procurements by non-competitive proposals[6] are allowable only when:
    - The item is available only from a single source;
    - The public exigency or emergency for the requirement will not permit a delay resulting from competitive solicitation;
    - The non-competitive proposal is specifically authorized by HRSA (or, in the case of a subrecipient, the Federal award recipient) in response to a written request from the Federal award recipient or subrecipient; or
    - Competition is determined to be inadequate after soliciting a number of sources.

- Health center contracts with other providers for the provision of health services within the HRSA-approved scope of project must include a schedule of rates and method of payment for such services.

- The health center must oversee contractors to ensure their performance is in accordance with the terms, conditions, and specifications of their contracts and to assure compliance with applicable Federal requirements.[7]

- The health center must retain financial records, supporting documents, statistical records, and all other records pertinent to the Health Center Program award carried out under contracts for a period of three years from the date of the submission of the final expenditures report to HHS.

[5] *Simplified acquisition threshold* means the dollar amount below which a non-Federal entity may purchase property or services using small purchase methods. Non-Federal entities adopt small purchase procedures in order to expedite the purchase of items costing less than the simplified acquisition threshold. The simplified acquisition threshold is set by the Federal Acquisition Regulation at 48 CFR subpart 2.1 and in accordance with 41 U.S.C. 1908. The acquisition threshold is periodically adjusted for inflation.

[6] As defined by 45 CFR 75.329(f), procurement by "noncompetitive proposals" is procurement through solicitation of a proposal from only one source.

[7] The health center is responsible, in accordance with good administrative practice and sound business judgment, for the settlement of all contractual and administrative issues arising out of procurements paid for in whole or in part under the Federal award. These issues include, but are not limited to, source evaluation, protests, disputes, and claims.

Subawards: Monitoring and Management

- The Health Center Program awardee must determine whether an individual agreement that will result in disbursement of Federal funds will be carried out through a contract or a subaward and structure the agreement accordingly.[8] With respect to subawards:
    - The health center awardee must make documented, case-by-case determinations whether the agreement it makes for the disbursement of Federal program funds casts the party receiving the funds in the role of a subrecipient, consistent with the characteristics outlined in 45 CFR 75.351; [9]
    - The health center awardee must identify subawards as such to the subrecipient, and provide all applicable information to the subrecipient as described in 45 CFR 75.352(a)(1), including the total amount of the Federal Award committed to the subrecipient by the health center awardee;
    - If any of the data elements contained in 45 CFR 75.352(a)(1) change, the health center awardee must include the change(s) in a subsequent subaward modification.

- The Health Center Program awardee must request and receive approval from HRSA to make a subaward under the Federal award.

- The Health Center Program awardee must ensure that, at the time of making a subaward, each subrecipient, which is a subawardee of Federal funds, complies with all applicable requirements specified in the Federal award (including those found in section 330 of the PHS Act, implementing program regulations, and grants regulations in 45 CFR Part 75).

- The Health Center Program awardee must monitor the ongoing activities of the subrecipient to ensure that the subaward is used for authorized purposes and that the subrecipient maintains compliance with all applicable requirements specified in the Federal award (including those found in section 330 of the PHS Act, implementing program regulations, and grants regulations in 45 CFR Part 75).

- The Health Center Program awardee must retain financial records, supporting documents, statistical records, and all other records pertinent to the Health Center Program award as carried out under any subawards for a period of three years from the date of the submission of the final expenditures report to the health center awardee.

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[8] Specifically, the purpose of a subaward is to carry out a portion of the Federal award and create a Federal assistance relationship with the subrecipient, while the purpose of a contract is to obtain goods or services for the health center's own use and creates a procurement relationship with the contractor.

[9] 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."

- The Health Center Program awardee must consider whether the results of the subrecipient's audits, on-site reviews, or other monitoring indicate conditions that necessitate adjustments to the Health Center Program awardee's own records and whether the Health Center Program awardee must consider taking enforcement action against noncompliant subrecipients as described in 45 CFR 75.371.

Demonstrating Compliance

A health center would demonstrate compliance with these requirements by fulfilling all of the following:

Contracts: Procurement and Monitoring

a. The health center has written procurement procedures that comply with Federal procurement standards, including a process for ensuring that all procurement costs directly attributable to the Federal award are allowable, consistent with Federal Cost Principles.[10]

b. The health center has records for procurement actions paid for in whole or in part under the Federal award that include the rationale for method of procurement, selection of contract type, contractor selection or rejection, and the basis for the contract price. This would include documentation related to noncompetitive procurements.

c. The health center retains final contracts and related procurement records, consistent with Federal document maintenance requirements, for procurement actions paid for in whole or in part under the Federal award.[11]

d. The health center has access to contractor records and reports related to health center activities in order to ensure that all activities and reporting requirements are being carried out in accordance with the provisions and timelines of the related contract (for example, performance goals are achieved, Uniform Data System (UDS) data are submitted by appropriate deadlines, funds are used for authorized purposes).

e. If the health center has arrangements with a contractor to perform substantive programmatic work,[12] the health center requested and received prior approval from HRSA as documented by:

[10] See 45 CFR 75 Subpart E: Cost Principles.
[11] See 45 CFR 75.361 for HHS retention requirements for records.
[12] For the purposes of the Health Center Program, contracting for substantive programmatic work applies to contracting with a single entity for the majority of health care providers. The acquisition of supplies, material, equipment, or general support services is not considered programmatic work. Substantive programmatic work may be further defined within HRSA Notices of Funding Opportunity (NOFOs) and applications.

- An approved competing continuation/renewal of designation application or other competitive application, which included such an arrangement; or
- An approved post-award request for such arrangements submitted within the project period (for example, change in scope).

f. The health center's contracts that support the HRSA-approved scope of project include provisions that address the following:
   - The specific activities or services to be performed or goods to be provided;
   - Mechanisms for the health center to monitor contractor performance; and
   - Requirements for the contractor to provide data necessary to meet the recipient's applicable Federal financial and programmatic reporting requirements, as well as provisions addressing record retention and access, audit, and property management.[13]

Subawards: Monitoring and Management

g. If the health center has made a subaward, the health center requested and received prior approval from HRSA as documented by:
   - An approved competing continuation/renewal of designation application or other competitive application, which included the subrecipient arrangement; or
   - An approved post-award request for such subrecipient arrangements submitted within the project period (for example, change in scope).

h. The health center's subaward(s) that supports the HRSA-approved scope of project includes provisions that address the following:
   - The specific portion of the HRSA-approved scope of project to be performed by the subrecipient;
   - The applicability of all Health Center Program requirements to the subrecipient;
   - The applicability to the subrecipient of any distinct statutory, regulatory, and policy requirements of other Federal programs associated with their HRSA-approved scope of project;[14]
   - Mechanisms for the health center to monitor subrecipient compliance and performance;
   - Requirements for the subrecipient to provide data necessary to meet the health center's applicable Federal financial and programmatic reporting requirements,

[13] For further guidance on these requirements, see the HHS Grants Policy Statement, at http://www.hrsa.gov/grants/hhsgrantspolicy.pdf.

[14] Subrecipients are generally eligible to receive FQHC payment rates under Medicaid and Medicare, 340B Drug Pricing, and Federal Tort Claims Act (FTCA) coverage. However, such benefits are not automatically conferred and may require additional actions and approvals (for example, submission and approval of a subrecipient FTCA deeming application).

as well as provisions addressing record retention and access, audit, and property management;[15] and
- Requirements that all costs paid for by the Federal subaward are allowable consistent with Federal Cost Principles.[16]

i. The health center monitors the activities of its subrecipient to ensure that the subaward is used for authorized purposes and that the subrecipient maintains compliance with all applicable requirements specified in the Federal award (including those found in section 330 of the PHS Act, implementing program regulations and grants regulations in 45 CFR Part 75). Specifically, the health center's monitoring of the subrecipient includes:
   - Reviewing financial and performance reports required by the health center in order to ensure performance goals are achieved, UDS data are submitted by appropriate deadlines, and funds are used for authorized purposes;
   - Ensuring that the subrecipient takes timely and appropriate action on all deficiencies pertaining to the subaward that may be identified through audits, on-site reviews, and other means; and
   - Issuing a management decision for audit findings pertaining to the subaward.[17]

j. The health center retains final subrecipient agreements and related records, consistent with Federal document maintenance requirements.[18]

Related Considerations

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- The health center determines the methods it will utilize to monitor contractor activities and performance. Such monitoring could include:
  - Periodic evaluations of contractor performance (for example, results from reviews of invoices and records, reports from staff of contractor activity) that are shared with the board and management staff; and/or
  - Documentation at the time of contract completion or renewal that the contractor has met the terms, conditions, and specifications of the contract.

- The health center determines the methods it will utilize to settle any contractual or administrative issues arising out of procurements, with respect to contracts (for

[15] For further guidance on these requirements, see the HHS Grants Policy Statement, at http://www.hrsa.gov/grants/hhsgrantspolicy.pdf.
[16] See 45 CFR 75 Subpart E: Cost Principles.
[17] Per 45 CFR 75.521, the management decision [issued by the health center to the subrecipient] must clearly state whether or not the audit finding is sustained, the reasons for the decision, and the expected auditee action to repay disallowed costs, make financial adjustments, or take other action.
[18] See 45 CFR 75.361 for HHS retention requirements for records.

example protests, disputes, claims) or how to take enforcement actions in the case of subawards.

- The health center determines the methods it will utilize to monitor subrecipient compliance and performance with Health Center Program requirements. Such monitoring could include:
    - Receiving/reviewing copies of the subrecipient governing board's meeting minutes;
    - Performing site visits;
    - Conducting regular check-in calls and updates regarding Health Center Program requirements or new Health Center Program policies;
    - Receiving/reviewing the subrecipient's annual audit;
    - Conducting periodic joint meetings between the two entities' boards, or between the health center's key management staff and the subrecipient's board;
    - Receiving/reviewing periodic written reports from the subrecipient; and/or
    - Sharing data and creating systems for the sharing of financial and medical records for the purpose of Health Center Program data reporting.

Chapter 13: Conflict of Interest

Authority

Section 330(a)(1) and 330(k)(3)(D) of the PHS Act; 42 CFR 51c.113 and 42 CFR 56.114; and 45 CFR 75.327

Requirements

- The health center must maintain written standards of conduct covering conflicts of interest[1] and governing the actions of its employees engaged in the selection, award, or administration of contracts that comply with all applicable Federal requirements.

- No employee, officer, or agent[2] of the health center may participate in the selection, award, or administration of a contract supported by a Federal award if he or she has a real or apparent conflict of interest.

- Officers, employees, and agents of the health center may neither solicit nor accept gratuities, favors, or anything of monetary value from contractors or parties to subcontracts.

- The health center's standards of conduct must provide for disciplinary actions to be applied for violations of such standards by officers, employees, or agents of the health center.

- If the health center has a parent, affiliate, or subsidiary organization that is not a State, local government, or Indian tribe, the health center also must maintain written standards of conduct covering organizational conflicts of interest.

Demonstrating Compliance

A health center would demonstrate compliance with these requirements by fulfilling all of the following:

[1] A conflict of interest arises when the employee, officer, or agent (including but not limited to any member of the governing board), any member of his or her immediate family, his or her partner, or an organization which employs or is about to employ any of the parties indicated herein, has a financial or other interest in or a tangible personal benefit from a firm considered for a contract. See: 45 CFR 75.327(c)1.

[2] An agent of the health center includes, but is not limited to, a governing board member, an employee, officer, or contractor acting on behalf of the health center.

a. The health center has and implements written standards of conduct that apply, at a minimum, to its procurements paid for in whole or in part by the Federal award. Such standards:
    - Apply to all health center employees, officers, board members, and agents involved in the selection, award, or administration of such contracts;
    - Require written disclosure of real or apparent conflicts of interest;
    - Prohibit individuals with real or apparent conflicts of interest with a given contract from participating in the selection, award, or administration of such contract;[3]
    - Restrict health center employees, officers, board members, and agents involved in the selection, award, or administration of contracts from soliciting or accepting gratuities, favors, or anything of monetary value for private financial gain from such contractors or parties to sub-agreements (including subrecipients or affiliate organizations);[4] and
    - Enforce disciplinary actions on health center employees, officers, board members, and agents for violating these standards.

b. If the health center has a parent, affiliate, or subsidiary that is not a State, local government, or Indian tribe, the health center has and implements written standards of conduct covering organizational conflicts of interest[5] that might arise when conducting a procurement action involving a related organization. These standards of conduct require:
    - Written disclosure of conflicts of interest that arise in procurements from a related organization; and
    - Avoidance and mitigation of any identified actual or apparent conflicts during the procurement process.

c. The health center has mechanisms or procedures for informing its employees, officers, board members, and agents of the health center's standards of conduct covering conflicts of interest, including organizational conflicts of interest, and for governing its actions with respect to the selection, award and administration of contracts.

d. In cases where a conflict of interest was identified, the health center's procurement records document adherence to its standards of conduct (for example, an employee

[3] This includes, but is not limited to, prohibiting board members that are employees or contractors of a subrecipient of the health center from participating in the selection, award, or administration of that subaward. This also includes prohibiting board members who are employees of an organization that contracts with the health center from participating in the selection, award, or administration of that contract.

[4] Health centers may set standards for situations in which the financial interest is not substantial or the gift is an unsolicited item of nominal value. See *Related Considerations* in this chapter.

[5] Organizational conflicts of interest mean that because of relationships with a parent company, affiliate, or subsidiary organization, the health center is unable or appears to be unable to be impartial in conducting a procurement action involving a related organization. See: 45 CFR 75.327(c)(2).

whose family member was competing for a health center contract was not permitted to participate in the selection, award, or administration of that contract).

Related Considerations

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- The health center determines the appropriate methods for employees, officers, board members, and agents to disclose real or apparent conflicts of interest, as it applies to the procurement process.

- The health center determines how to inform its employees, officers, board members, and agents about the health center's standards of conduct (for example, inclusion within operating procedures or staff manuals, as part of disclosure forms/statements, employee and board orientations or trainings).

- The health center determines whether to establish additional standards of conduct that are not addressed by Federal requirements.

- The health center determines whether to set standards that define when a financial interest is not substantial or a gift is an unsolicited item of nominal value and, therefore, could be accepted by employees, officers, board members, and agents of the health center.

Chapter 14: Collaborative Relationships

Note: This chapter contains revisions based on the Bipartisan Budget Act of 2018. View the revisions.

Authority

Section 330(k)(3)(B) of the PHS Act; and 42 CFR 51c.303(n), 42 CFR 56.303(n), and 42 CFR 51c.305(h)

Requirements

- The health center has made and must continue to make every reasonable effort to establish and maintain collaborative relationships, including with other health care providers that provide care within the catchment area [service area], local hospitals, and specialty providers in the catchment area of the center, to provide access to services not available through the health center and to reduce the non-urgent use of hospital emergency departments.

- To the extent possible, the health center must coordinate and integrate project activities with the activities of other federally-funded, as well as State and local, health services delivery projects and programs serving the same population.

Demonstrating Compliance

A health center would demonstrate compliance with these requirements by fulfilling all of the following:

a. The health center documents its efforts to collaborate with other providers or programs in the service area, including local hospitals, specialty providers, and social service organizations (including those that serve special populations), to provide access to services not available through the health center in order to support
    - Reductions in the non-urgent use of hospital emergency departments;
    - Continuity of care across community providers; and
    - Access to other health or community services that impact the patient population.

b. The health center documents its efforts to coordinate and integrate activities with other federally-funded, as well as State and local, health services delivery projects and programs serving similar patient populations in the service area (at a minimum, this would include establishing and maintaining relationships with other health centers in the service area).

c. If the health center expands[1,2] its HRSA-approved scope of project:
   - The health center obtains letters or other appropriate documents specific to the request or application that describe areas of coordination or collaboration with health care providers serving similar patient populations in the service area (health centers, rural health clinics, local hospitals including critical access hospitals, health departments, other providers including specialty providers, as applicable); or
   - If such letters or documents cannot be obtained from these providers, the health center documents its attempts to coordinate or collaborate with these health care providers (health centers, rural health clinics, local hospitals including critical access hospitals, health departments, other providers including specialty providers, as applicable) on the specific request or application proposal.

Related Considerations

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- The health center determines how to document collaboration or coordination with providers and organizations in its service area (for example, through a memorandum of agreement, letters, membership on a city-wide community health planning council).

[1] Expanding the HRSA-approved scope of project may occur by adding sites or services through change-in-scope requests, New Access Point competitive applications, or other supplemental funding applications.
[2] Additional requirements for documented collaboration may apply based on specific Notices of Funding Opportunity (NOFOs), Notices of Award (NOAs), look-alike designation instructions, or other Federal statutes, regulations, or policies.

Chapter 15: Financial Management and Accounting Systems

Note: This chapter contains revisions based on the Bipartisan Budget Act of 2018. View the revisions.

Authority

Sections 330(e)(5)(D), 330(k)(3)(D), 330(k)(3)(N), and 330(q) of the PHS Act; 42 CFR 51c.113, 42 CFR 56.114, 42 CFR 51c.303(d), and 42 CFR 56.303(d); and 45 CFR Part 75 Subparts D, E and F

Requirements

- The health center must maintain effective control over, and accountability for, all funds, property, and other assets in order to adequately safeguard all such assets and ensure that they are used solely for authorized purposes.

- The health center must have written policies and procedures in place to ensure the appropriate use of Federal funds in compliance with applicable Federal statutes, regulations, and the terms and conditions of the Federal award.

- The health center must develop and utilize financial management and control systems in accordance with sound financial management procedures which ensure at a minimum:
    - The fiscal integrity of grant financial transactions and reports; and
    - Ongoing compliance with Federal statutes, regulations, and the terms and conditions of the Health Center Program award or designation.

- The health center's financial management system must specifically identify in its accounts all Federal awards, including the Federal award made under the Health Center Program, received and expended and the Federal programs under which they were received (see 45 CFR 75.302). This financial management system must also provide for all of the following:
    - Accurate, current, and complete disclosure of the financial results of each Federal award or program in accordance with the reporting requirements (see 45 CFR 75.341 and 75.342);
    - Records that identify the source (receipt) and application (expenditure) of funds for federally-funded activities. These records must contain information pertaining to Federal awards, authorizations, obligations, unobligated balances, assets, expenditures, income, and interest, and be supported by source documentation (see: 45 CFR 75.302(b)(3));

- Written procedures that minimize the time elapsing between the transfer of Federal award funds from HHS and the disbursement of these funds by the health center (see 45 CFR 75.305);
- Written procedures for assuring that expenditures of Federal award funds are allowable in accordance with the terms and conditions of the Federal award and with the Federal Cost Principles (see 45 CFR Part 75 Subpart E).

- A health center that expends $750,000 or more in Federal awards during its fiscal year must have a single or program-specific audit conducted for that year in accordance with the provisions of 45 CFR Part 75 Subpart F.

- The health center must use any non-grant funds as permitted under section 330, and may use such funds for such other purposes as are not specifically prohibited under section 330, if such use furthers the objectives of the [health center] project.

Demonstrating Compliance

A health center would demonstrate compliance with these requirements by fulfilling all of the following:

a. The health center has and utilizes a financial management and internal control system that reflects Generally Accepted Accounting Principles (GAAP) for private non-profit health centers or Government Accounting Standards Board (GASB) principles for public agency health centers[1] and that ensures at a minimum:
   - Health center expenditures are consistent with the HRSA-approved total budget[2] and with any additional applicable HRSA approvals that have been requested and received;[3]
   - Effective control over, and accountability for, all funds, property, and other assets associated with the Health Center Program project;
   - The safeguarding of all assets to assure they are used solely for authorized purposes in accordance with the terms and conditions of the Health Center

[1] GAAP and GASB are used as defined in 45 CFR Part 75.

[2] A health center's "total budget" includes the Health Center Program Federal award funds and all other sources of revenue in support of the HRSA-approved Health Center Program scope of project. For additional detail, see Chapter 17: Budget.

[3] Per 45 CFR 75.308, post-award, Federal award recipients are required to report significant deviations from budget or project scope or objective, and are required to request prior approvals from HHS awarding agencies for budget and program plan revisions (re-budgeting). "Re-budgeting, or moving funds between direct cost budget categories in an approved budget, is considered significant when cumulative transfers for a single budget period exceeds 25 percent of the total approved budget (inclusive of direct and indirect costs and Federal funds and required matching or cost sharing). The base used for determining significant re-budgeting excludes carryover balances but includes any amounts awarded as supplements."

Program award/designation;[4] and
- The capacity to track the financial performance of the health center, including identification of trends or conditions that may warrant action by the organization to maintain financial stability.

b. The health center's financial management system is able to account for all Federal award(s) (including the Federal award made under the Health Center Program) in order to identify the source[5] (receipt) and application (expenditure) of funds for federally-funded activities in whole or in part. Specifically, the health center's financial records contain information and related source documentation pertaining to authorizations, obligations, unobligated balances, assets, expenditures, income, and interest under the Federal award(s).

c. The health center has written procedures for:
   - Drawing down Federal award funds in a manner that minimizes the time elapsing between the transfer of the Federal award funds from HRSA and the disbursement of these funds by the health center; and
   - Assuring that expenditures of Federal award funds are allowable in accordance with the terms and conditions of the Federal award and with the Federal Cost Principles[6] in 45 CFR Part 75 Subpart E.

d. If a health center expends **$750,000 or more in award funds from all Federal sources** during its fiscal year, the health center ensures a single or program-specific audit is conducted and submitted for that year in accordance with the provisions of 45 CFR Part 75, Subpart F: Audit Requirements and ensures that subsequent audits demonstrate corrective actions have been taken to address all findings, questioned costs, reportable conditions, and material weaknesses cited in the previous audit report, if applicable.

e. The health center can document that any non-grant funds generated from Health Center Program project activities, in excess of what is necessary to support the HRSA-approved total Health Center Program project budget, were utilized to further the objectives of the project by benefiting the current or proposed patient population and were not utilized for purposes that are specifically prohibited by the Health Center Program.

Related Considerations

[4] The requirement to safeguard federal assets as described in this bullet substantially reflects the requirement to have written policies and procedures in place to ensure the appropriate use of Federal funds in compliance with applicable Federal statutes, regulations, and the terms and conditions of the Federal award. See Section 330(k)(3)(N) of the Public Health Service Act.

[5] Federal program and Federal award identification would include, as applicable, the Catalog of Federal Domestic Assistance (CFDA) title and number, Federal award identification number and year, name of the HHS awarding agency, and name of the pass-through entity, if any.

[6] The cost principles are set forth in 45 CFR Part 75, Subpart E.

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- The health center determines which accounting software and related systems to use for financial management.

- The health center determines the type, frequency, and format of financial reports used to support the board and the key management staff's ability to carry out its oversight responsibilities.

- The health center determines which specific actions to take in response to negative financial trending and its method for monitoring the results of those actions.

Chapter 16: Billing and Collections

Authority

Section 330(k)(3)(E), (F), and (G) of the PHS Act; and 42 CFR 51c.303(e), (f), and (g) and 42 CFR 56.303(e), (f), and (g)

Requirements

- The health center must prepare a schedule of fees for the provision of its services consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation.

- The health center must assure that any fees or payments required by the center for health care services will be reduced or waived in order to assure that no patient will be denied such services due to an individual's inability to pay for such services.

- The health center must establish systems for eligibility determination and for billing and collections [with respect to third party payors].

- The health center must make every reasonable effort to enter into contractual or other arrangements to collect reimbursement of its costs with the appropriate agency(s) of the State which administers or supervises the administration of:
  - A State Medicaid plan approved under title XIX of the Social Security Act (SSA) [42 U.S.C. 1396, et seq.] for the payment of all or a part of the center's costs in providing health services to persons who are eligible for such assistance; and
  - The Children's Health Insurance Program (CHIP) under title XXI of the SSA [42 U.S.C. 1397aa, et seq.] with respect to individuals who are State CHIP beneficiaries.

- The health center must make and continue to make every reasonable effort to collect appropriate reimbursement for its costs on the basis of the full amount of fees and payments for health center services without application of any discount when providing health services to persons who are entitled to:
  - Medicare coverage under title XVIII of the SSA [42 U.S.C. 1395 et seq.];
  - Medicaid coverage under a State plan approved under title XIX of the SSA [42 U.S.C. 1396 et seq.]; or
  - Assistance for medical expenses under any other public assistance program (for example, CHIP), grant program, or private health insurance or benefit program.

- The health center must make and continue to make every reasonable effort to secure payment for services from patients, in accordance with health center fee schedules and the corresponding schedule of discounts.

Demonstrating Compliance

A health center would demonstrate compliance with these requirements by fulfilling all of the following:

a. The health center has a fee schedule for services that are within the HRSA-approved scope of project and are typically billed for in the local health care market.

b. The health center uses data on locally prevailing rates and actual health center costs to develop and update its fee schedule.

c. The health center participates in Medicaid, CHIP, Medicare, and, as appropriate, other public or private assistance programs or health insurance.

d. The health center has systems, which may include operating procedures, for billing and collections that address:
   - Educating patients on insurance and, if applicable, related third-party coverage options available to them;
   - Billing Medicare, Medicaid, CHIP, and other public and private assistance programs or insurance in a timely manner, as applicable;[1] and
   - Requesting applicable payments from patients, while ensuring that no patient is denied service based on inability to pay.

e. If a health center elects to offer additional billing options or payment methods (for example, payment plans, grace periods, prompt or cash payment incentives), the health center has operating procedures for implementing these options or methods and for ensuring they are accessible to all patients regardless of income level or sliding fee discount pay class.

f. The health center has billing records that show claims are submitted in a timely and accurate manner to the third party payor sources with which it participates (Medicaid, CHIP, Medicare, and other public and private insurance) in order to collect reimbursement for its costs in providing health services[2] consistent with the terms of such contracts and other arrangements.

g. The health center has billing records or other forms of documentation that reflect that the health center:
   - Charges patients in accordance with its fee schedule and, if applicable, the sliding fee discount schedule;[3] and

[1] For information on Federal Tort Claims Act (FTCA) coverage in cases where health centers are using alternate billing arrangements in which the covered provider is billing directly for services provided to covered entity patients, refer to the FTCA Health Center Policy Manual, Section I.E: Eligibility and Coverage, Coverage Under Alternate Billing Arrangements.

[2] This includes services that the health center provides directly (Form 5A: Services Provided, Column I) or provides through a formal written contract/agreement (Form 5A: Services Provided, Column II).

[3] See Chapter 9: Sliding Fee Discount Program for more information on the sliding fee discount schedule.

- Makes reasonable efforts to collect such amounts owed from patients.

h. The health center has and utilizes board-approved policies, as well as operating procedures, that include the specific circumstances when the health center will waive or reduce fees or payments required by the center due to any patient's inability to pay.

i. If a health center provides supplies or equipment that are related to, but not included in, the service itself as part of prevailing standards of care[4] (for example, eyeglasses, prescription drugs, dentures) and charges patients for these items, the health center informs patients of such charges ("out-of-pocket costs") prior to the time of service.[5]

j. If a health center elects to limit or deny services based on a patient's refusal to pay, the health center has a board-approved policy that distinguishes between refusal to pay and inability to pay and notifies patients of:
   - Amounts owed and the time permitted to make such payments;
   - Collection efforts that will be taken when these situations occur (for example, meeting with a financial counselor, establishing payment plans); and
   - How services will be limited or denied when it is determined that the patient has refused to pay.

Related Considerations

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- The health center determines how to consider both locally prevailing charges and actual costs for services when setting the fee schedule, as well as the data used to determine locally prevailing charges (for example, Medicare, Medicaid, private providers, or commercial sources).

- The health center determines whether to charge a single fee for related health center services, medically-related supplies, and/or equipment. Examples include, but are not limited to, charging a single fee for a well-child visit and the immunizations provided during that visit or combining all prenatal care visits and labs into a single fee.

- The health center determines whether to participate in a specific insurance plan based on its patient population and the costs and benefits of such participation.

[4] These items differ from supplies and equipment that are included in a service as part of prevailing standards of care and are reflected in the fee schedule (e.g., casting materials, bandages).
[5] See Chapter 15: Financial Management and Accounting Systems for related information on revenue generated from such charges.

- If a health center has a funding source that subsidizes or covers all or part of the fees for certain services for specific patients (in accordance with the terms and conditions of such funding sources), the health center may use such funding sources to support discounts greater than those available through the health center's sliding fee discount program.[6]

- If a health center elects to provide its patients access to supplies or equipment (for example, eyeglasses, prescription drugs, dentures) that are related to, but not included in, the service itself as part of prevailing standards of care, the health center determines how to charge its patients for such supplies or equipment (for example, flat discounts, at cost, sliding fee discounts).

- If a health center limits or denies services to patients based on refusal to pay, the health center determines how and when such patients may be permitted to rejoin the practice.

[6] Health centers that have questions on the appropriate use of other Federal, state, local, or private funds should refer to those program sources for additional guidance. See Chapter 9: Sliding Fee Discount Program for information on the Health Center Program requirements related to the sliding fee discount program.

Chapter 17: Budget

Authority

Section 330(e)(5)(A) and Section 330(k)(3)(I)(i) of the PHS Act; and 45 CFR 75.308(a) and 45 CFR 75 Subpart E

Requirements

- The health center must develop an annual budget that:
  - Identifies the projected costs of the Health Center Program project;
  - Identifies the projected costs to be supported by Health Center Program [award] funds, consistent with Federal Cost Principles[1] and any other requirements or restrictions on the use of Federal funding; and
  - Includes all other non-Federal revenue sources that will support the Health Center Program project, including:
    - State, local, and other operational funding; and
    - Fees, premiums, and third-party reimbursements which the health center may reasonably be expected to receive for its operation of the Health Center Program project.

- The health center must submit this budget annually by a date specified by HRSA for approval through the Federal award or designation process.

Demonstrating Compliance

A health center would demonstrate compliance with these requirements by fulfilling all of the following:

a. The health center develops and submits to HRSA (for new or continued funding or designation from HRSA) an annual budget, also referred to as a "total budget,"[2,3] that reflects projected costs and revenues necessary to support the health center's proposed or HRSA-approved scope of project.

b. In addition to the Health Center Program award, the health center's annual budget includes all other projected revenue sources that will support the Health Center Program project, specifically:

[1] See 45 CFR Part 75 Subpart E: Cost Principles.
[2] A health center's "total budget" includes the Health Center Program Federal award funds and all other sources of revenue in support of the health center scope of project.
[3] Any aspects of the requirement that relate to the use of Health Center Program Federal award funds are not applicable to look-alikes.

- Fees, premiums, and third-party reimbursements and payments that are generated from the delivery of services;
- Revenues from state, local, or other Federal grants (for example, Ryan White, Healthy Start) or contracts;
- Private support or income generated from contributions; and
- Any other funding expected to be received for purposes of supporting the Health Center Program project.

c. The health center's annual budget identifies the portion of projected costs to be supported by the Federal Health Center Program award. Any proposed costs supported by the Federal award are consistent with the Federal Cost Principles[4] and the terms and conditions[5] of the award.

d. If the health center organization conducts other lines of business (i.e., activities that are not part of the HRSA-approved scope of project), the costs of these other activities are not included in the annual budget for the Health Center Program project.[6]

Related Considerations

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- The health center determines how to allocate projected costs between Health Center Program award funds, consistent with Federal requirements, and other projected revenue sources within the annual budget.

[4] See 45 CFR Part 75 Subpart E: Cost Principles.
[5] For example, health centers may not use HHS Federal award funds to support salary levels above the salary limitations on Federal awards.
[6] As these other lines of business are not included in the health center's total budget, they are not subject to Health Center Program requirements and not eligible for related Health Center Program benefits (for example, payment as a FQHC under Medicare/Medicaid/CHIP, 340B Program eligibility, Federal Tort Claims Act (FTCA) coverage).

Chapter 18: Program Monitoring and Data Reporting Systems

Authority

Section 330(k)(3)(I)(ii) of the PHS Act; 42 CFR 51c.303(j) and 42 CFR 56.303(j); and 45 CFR 75.342(a) and (b)

Requirements

- The health center must establish systems for monitoring program performance to ensure:
  - Oversight of the operations of the Federal award [or designation]-supported activities in compliance with applicable Federal requirements;
  - Performance expectations [as described in the terms or conditions of the Federal award or designation] are being achieved; and
  - Areas for improvement in program outcomes and productivity [efficiency and effectiveness] are identified.

- The health center must compile and report data and other information as required by HRSA, relating to:
  - Costs of health center operations;
  - Patterns of health center service utilization;
  - Availability, accessibility, and acceptability of health center services; and
  - Other matters relating to operations of the Health Center Program project, as required.

- The health center must submit required data and information to HRSA in a timely manner and with such frequency as prescribed by HRSA.

Demonstrating Compliance

A health center would demonstrate compliance with these requirements by fulfilling all of the following:

a. The health center has a system in place for overseeing the operations of the Federal award-supported activities to ensure compliance with applicable Federal requirements and for monitoring program performance. Specifically:
   - The health center has a system in place to collect and organize data related to the HRSA-approved scope of project, as required to meet HHS reporting requirements, including those data elements for Uniform Data System (UDS) reporting; and

- The health center submits timely, accurate, and complete UDS reports in accordance with HRSA instructions and submits any other required HHS and Health Center Program reports.

b. The health center produces data-based reports on: patient service utilization; trends and patterns in the patient population;[1] and overall health center performance, as necessary to inform and support internal decision-making and oversight by the health center's key management staff and by the governing board.

Related Considerations

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- In fulfilling HRSA reporting obligations, the health center determines the type of data system(s) (for example, type of Electronic Health Record software, use of practice management system) it will utilize based on its needs and the size and complexity of the health center's operations.

- The health center determines the number, format, and types of reports the system generates to support governing board and key management staff internal decision making.

[1] Examples of data health centers may analyze as part of such reports may include patient access to and satisfaction with health center services, patient demographics, quality of care indicators, and health outcomes.

Chapter 19: Board Authority

Note: This chapter contains revisions based on the Bipartisan Budget Act of 2018. View the revisions.

Authority

Section 330(k)(3)(H) of the PHS Act; 42 CFR 51c.303(i), 42 CFR 56.303(i), 42 CFR 51c.304(d), and 42 CFR 56.304(d); and 45 CFR 75.507(b)(2)

Requirements[1]

- The health center must establish a governing board[2] that has specific responsibility for oversight of the Health Center Program project.
- The health center governing board must develop bylaws which specify the responsibilities of the board.
- The health center governing board must assure that the center is operated in compliance with applicable Federal, State, and local laws and regulations.
- The health center governing board must hold monthly meetings[3,4] and record in meeting minutes the board's attendance, key actions, and decisions.
- The health center governing board must approve the selection and termination/dismissal of the health center's Project Director/Chief Executive Officer (CEO).
- The health center governing board must have authority for establishing or adopting policies for the conduct of the Health Center Program project and for updating these

[1] The governing board of a health center operated by Indian tribes, tribal groups, or Indian organizations under the Indian Self-Determination Act or Urban Indian Organizations under the Indian Health Care Improvement Act is exempt from the specific board authority requirements discussed in this chapter. Section 330(k)(3)(H) of the PHS Act.

[2] For public agencies that elect to have a co-applicant, these authorities and functions apply to the co-applicant board.

[3] Where geography or other circumstances make monthly, in-person participation in board meetings burdensome, monthly meetings may be conducted by telephone or other means of electronic communication where all parties can both listen and speak to all other parties.

[4] Boards of organizations receiving a Health Center Program award/designation only under section 330(g) may meet less than once a month during periods of the year, as specified in the bylaws, where monthly meetings are not practical due to health center patient migration out of the area. 42 CFR 56.304(d)(2).

policies when needed. Specifically, the health center governing board must have authority for:

- Adopting policies for financial management practices and a system to ensure accountability for center resources (unless already established by the public agency as the Federal award or designation recipient), including periodically reviewing the financial status of the health center and the results of the annual audit to ensure appropriate follow-up actions are taken;[5]
- Adopting policy for eligibility for services including criteria for partial payment schedules;[6]
- Establishing and maintaining general personnel policies for the health center (unless already established by the public agency as the Federal award or designation recipient), including those addressing selection and dismissal procedures, salary and benefit scales, employee grievance procedures, and equal opportunity practices; and
- Adopting health care policies including quality-of-care audit procedures.

- The health center governing board must adopt health care policies including the:
  - Scope and availability of services to be provided within the Health Center Program project, including decisions to subaward or contract for a substantial portion of the services;[7,8]
  - Service site location(s);[9] and
  - Hours of operation of service sites.

- The health center governing board must review and approve the annual Health Center Program project budget.[10]

- The health center must develop its overall plan for the Health Center Program project under the direction of the governing board.

- The health center governing board must provide direction for long-range planning, including but not limited to identifying health center priorities and adopting a three-year plan for financial management and capital expenditures.

[5] See Chapter 15: Financial Management and Accounting Systems for more information on the related requirements.
[6] See Chapter 9: Sliding Fee Discount Program for more information on the related requirements.
[7] See Chapter 4: Required and Additional Health Services for more information on the requirements associated with providing services within the HRSA-approved scope of project.
[8] See Chapter 12: Contracts and Subawards for more information on the requirements associated with such arrangements.
[9] See Chapter 6: Accessible Locations and Hours of Operation for more information on the requirements associated with health center service sites and hours of operation.
[10] See Chapter 17: Budget for more information on the requirements of the Health Center Program project budget.

- The health center governing board must assess the achievement of project objectives through evaluation of health center activities, including service utilization patterns, productivity [efficiency and effectiveness] of the center, and patient satisfaction.

- The health center governing board must ensure that a process is developed for hearing and resolving patient grievances.

Demonstrating Compliance

A health center would demonstrate compliance with these requirements by fulfilling all of the following:

a. The health center's organizational structure, articles of incorporation, bylaws, and other relevant documents ensure the health center governing board maintains the authority for oversight of the Health Center Program project, specifically:
    - The organizational structure and documents do not allow for any other individual, entity or committee (including, but not limited to, an executive committee authorized by the board) to reserve approval authority or have veto power over the health center board with regard to the required authorities and functions;[11]
    - In cases where a health center collaborates with other entities in fulfilling the health center's HRSA-approved scope of project, such collaboration or agreements with the other entities do not restrict or infringe upon the health center board's required authorities and functions; and
    - For public agencies with a co-applicant board;[12] the health center has a co-applicant agreement that delegates the required authorities and functions to the co-applicant board and delineates the roles and responsibilities of the public agency and the co-applicant in carrying out the Health Center Program project.

b. The health center's articles of incorporation, bylaws, or other relevant documents outline the following required authorities and responsibilities of the governing board:
    - Holding monthly meetings;
    - Approving the selection (and termination or dismissal, as appropriate) of the health center's Project Director/CEO;
    - Approving the annual Health Center Program project budget and applications;

[11] This does not preclude an executive committee from taking actions on behalf of the board in emergencies, on which the full board will subsequently vote.

[12] Public agencies are permitted to utilize a co-applicant governance structure for the purposes of meeting Health Center Program governance requirements. Public centers may be structured in one of two ways to meet the program requirements: 1) the public agency independently meets all the Health Center Program governance requirements based on the existing structure and vested authorities of the public agency's governing board; or 2) together, the public agency and the co-applicant meet all Health Center Program requirements.

- Approving health center services and the location and hours of operation of health center sites;
- Evaluating the performance of the health center;
- Establishing or adopting policy[13] related to the operations of the health center; and
- Assuring the health center operates in compliance with applicable Federal, State, and local laws and regulations.

c. The health center's board minutes and other relevant documents confirm that the board exercises, without restriction, the following authorities and functions:
   - Holding monthly meetings where a quorum is present to ensure the board has the ability to exercise its required authorities and functions;
   - Approving the selection, evaluation and, if necessary, the dismissal or termination of the Project Director/CEO from the Health Center Program project;
   - Approving applications related to the Health Center Program project, including approving the annual budget, which outlines the proposed uses of both Health Center Program award and non-Federal resources and revenue;
   - Approving the Health Center Program project's sites, hours of operation and services, including decisions to subaward or contract for a substantial portion of the health center's services;
   - Monitoring the financial status of the health center, including reviewing the results of the annual audit, and ensuring appropriate follow-up actions are taken;
   - Conducting long-range/strategic planning at least once every three years, which at a minimum addresses financial management and capital expenditure needs; and
   - Evaluating the performance of the health center based on quality assurance/quality improvement assessments and other information received from health center management,[14] and ensuring appropriate follow-up actions are taken regarding:
     - Achievement of project objectives;
     - Service utilization patterns;
     - Quality of care;
     - Efficiency and effectiveness of the center; and
     - Patient satisfaction, including addressing any patient grievances.

[13] The governing board of a health center is generally responsible for establishing and/or approving policies that govern health center operations, while the health center's staff is generally responsible for implementing and ensuring adherence to these policies (including through operating procedures).

[14] For more information related to the production of reports associated with these topics, see Chapter 18: Program Monitoring and Data Reporting Systems, Chapter 15: Financial Management and Accounting Systems, and Chapter 10: Quality Improvement/Assurance.

d. The health center board has adopted, evaluated at least once every three years, and, as needed, approved updates to policies in the following areas: Sliding Fee Discount Program, Quality Improvement/Assurance, and Billing and Collections.[15]

e. The health center board has adopted, evaluated at least once every three years, and, as needed, approved updates to policies that support financial management and accounting systems and personnel policies. However, in cases where a public agency is the recipient of the Health Center Program Federal award or designation and has established a co-applicant structure, the public agency may establish and retain the authority to adopt and approve policies that support financial management and accounting systems and personnel policies.

Related Considerations

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- The health center board determines how to carry out required responsibilities, functions, and authorities in areas such as the following:
  - Whether to establish standing committees, including the number and type of such committees (for example, executive, finance, quality improvement, personnel, planning).
  - Whether to seek input or assistance from other organizations or subject matter experts (for example, joint committees for health centers that collaborate closely with other organizations, consultants, community leaders).
  - How often the Project Director/CEO performance is evaluated.

- The health center determines how to set quorum for board meetings consistent with state, territorial or other applicable law.

- The health center board determines the format of its long-range/strategic planning.

- For public agencies with co-applicant boards, the co-applicant board and the public agency determine how to collaborate in carrying out the Health Center Program project (for example, shared project assessment, public agency participation on board committees, joint preparation of grant applications).

[15] Policies related to billing and collections that require board approval include those that address the waiving or reducing of amounts owed by patients due to inability to pay, and if applicable those that limit or deny services due to refusal to pay.

Chapter 20: Board Composition

Authority

Section 330(k)(3)(H) of the PHS Act; and 42 CFR 51c.304 and 42 CFR 56.304

Requirements[1,2]

- The health center's governing board must consist of at least 9 and no more than 25 members.[3]

- The majority [at least 51 percent] of the health center board members must be patients[4] served by the health center. These health center patient board members must, as a group, represent the individuals who are served by the health center in terms of demographic factors, such as race, ethnicity, and gender.

- Non-patient health center board members must be representative of the community served by the health center and must be selected for their expertise in relevant subject areas, such as community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social service agencies within the community.

- Of the non-patient health center board members, no more than one-half may derive more than 10 percent of their annual income from the health care industry.[5]

- A health center board member may not be an employee of the center, or spouse or child, parent, brother or sister by blood or marriage of such an employee.[6] The project

[1] The governing board of a health center operated by Indian tribes, tribal groups, or Indian organizations under the Indian Self-Determination Act or Urban Indian Organizations under the Indian Health Care Improvement Act is exempt from the specific board composition requirements discussed in this document. Section 330(k)(3)(H) of the PHS Act.

[2] For public agencies that elect to have a co-applicant, these board composition requirements apply to the co-applicant board.

[3] 42 CFR 51c.304(a) and 42 CFR 56.304(a) permit that the requirement regarding board size may be waived by the Secretary for good cause shown. HRSA will not grant such waivers except where the health center has demonstrated to HRSA an inability to meet the requirement.

[4] Patient board members are also often referred to as "user" or "consumer" board members. However, for the purposes of this chapter, only the term "patient" or "non-patient" board member will be used for ease of reference.

[5] Per the regulations in 42 CFR 56.304, for health centers awarded/designated solely under section 330(g) of the PHS Act, no more than two-thirds of the non-patient board members may derive more than 10 percent of their annual income from the health care industry.

[6] While no board member may be an employee of the health center, 42 CFR 51c.107 permits the health center to use Federal award funds to reimburse board members for these limited purposes: 1) reasonable expenses actually incurred by reason of their participation in board activities (e.g., transportation to board meetings, childcare during board meetings); or 2) wages lost by reason of participation in the activities of such board members if the member

director [Chief Executive Officer (CEO)] may be a non-voting, ex-officio member of the board.

- The health center bylaws or other internal governing rules must prescribe the process for selection and removal of all governing board members. This selection process must ensure that the governing board is representative of the health center patient population. The selection process in the bylaws or other rules is subject to approval by HRSA.

- In cases where a health center receives an award/designation under section 330(g), 330(h) and/or 330(i) and does not receive an award/designation under section 330(e), the health center may request approval from HRSA for a waiver of the patient majority board composition governance requirement by showing good cause.

Demonstrating Compliance

A health center would demonstrate compliance with these requirements by fulfilling all of the following:

a. The health center has bylaws or other relevant documents that specify the process for ongoing selection and removal of board members. This board member selection and removal process does not permit any other entity, committee or individual (other than the board) to select either the board chair or the majority of health center board members,[7] including a majority of the non-patient board members.[8]

b. The health center has bylaws or other relevant documents that require the board to be composed as follows:
    - Board size is at least 9 and no more than 25 members,[9] with either a specific number or a range of board members prescribed;
    - At least 51 percent of board members are patients served by the health center. For the purposes of board composition, a patient is an individual who has received at least one service in the past 24 months that generated a health

is from a family with an annual family income less than $10,000 or if the member is a single person with an annual income less than $7,000. For section 330(g)-only awarded/designated health centers, 42 CFR 56.108 permits the use of grant funds for certain limited reimbursement of board members as follows: 1) for reasonable expenses actually incurred by reason of their participation in board activities (e.g., transportation to board meetings, childcare during board meetings); 2) for wages lost by reason of participation in the activities of such board members. Health centers may wish to consult with their legal counsel and auditor on applicable state law regarding reimbursement restrictions for non-profit board members and implications for IRS tax-exempt status.

[7] An outside entity may only remove a board member who has been selected by that entity as an organizational representative to the governing board.

[8] For example, if the health center has an agreement with another organization, the agreement does not permit that organization to select either the chair or a majority of the health center board.

[9] For the purposes of the Health Center Program, the term "board member" refers only to voting members of the board.

center visit, where both the service and the site where the service was received are within the HRSA-approved scope of project;
- Patient members of the board, as a group, represent the individuals who are served by the health center in terms of demographic factors, such as race, ethnicity, and gender;
- Non-patient members are representative of the community served by the health center or the health center's service area;
- Non-patient members are selected to provide relevant expertise and skills such as:
  - Community affairs;
  - Local government;
  - Finance and banking;
  - Legal affairs;
  - Trade unions and other commercial and industrial concerns; and
  - Social services;
- No more than one-half of non-patient board members derive more than 10 percent of their annual income from the health care industry; and
- Health center employees,[10,11] and immediate family members (i.e., spouses, children, parents, or siblings through blood, adoption, or marriage) of employees may not be health center board members.

c. The health center has documentation that the board is composed of:
   - At least 9 and no more than 25 members;
   - A patient[12] majority (at least 51 percent);
   - Patient board members, as a group, represent the individuals who are served by the health center in terms of demographic factors, such as race, ethnicity, and gender, consistent with the demographics reported in the health center's Uniform Data System (UDS) report;[13]

[10] For the purposes of health center board composition, an employee of the health center would include an individual who would be considered a "common-law employee" or "statutory employee" according to the Internal Revenue Service criteria, as well as an individual who would be considered an employee for state or local law purposes.
[11] In the case of public agencies with co-applicant boards, this includes employees or immediate family members of both the co-applicant organization and the public agency component (for example, department, division, or sub-agency) in which the Health Center Program project is located.
[12] A legal guardian of a patient who is a dependent child or adult, a person who has legal authority to make health care decisions on behalf of a patient, or a legal sponsor of an immigrant patient may also be considered a patient of the health center for purposes of board representation. Students who are health center patients may participate as board members subject to state laws applicable to such non-profit board members.
[13] For health centers that have not yet made a Uniform Data System (UDS) report, this would be assessed based on demographic data included in the health center's application.

- Representative(s) from or for each of the special population(s)[14] for those health centers that receive any award/designation under one or more of the special populations section 330 subparts, 330(g), (h), and/or (i); and
- As applicable, non-patient board members:
  - Who are representative of the community in which the health center is located, either by living or working in the community, or by having a demonstrable connection to the community;
  - With relevant skills and expertise in areas such as community affairs, local government, finance and banking, legal affairs, trade unions, other commercial and industrial concerns, or social services within the community; and
  - Of whom no more than 50 percent earn more than 10 percent of their annual income from the health care industry.[15]

d. The health center verifies periodically (for example, annually or during the selection or renewal of board member terms) that the governing board does not include members who are current employees of the health center, or immediate family members of current health center employees (i.e., spouses, children, parents, or siblings through blood, adoption, or marriage).

e. In cases where a health center receives an award/designation under section 330(g), 330(h) and/or 330(i), does not receive an award/designation under section 330(e), and requests a waiver of the patient majority board composition requirements, the health center presents to HRSA for review and approval:
   - "Good cause" that justifies the need for the waiver by documenting:
     - The unique characteristics of the population (homeless, migratory or seasonal agricultural worker, and/or public housing patient population) or service area that create an undue hardship in recruiting a patient majority; and
     - Its attempt(s) to recruit a majority of special population board members within the past three years; and
   - Strategies that will ensure patient participation and input in the direction and ongoing governance of the organization by addressing the following elements:
     - Collection and documentation of input from the special population(s);
     - Communication of special population input directly to the health center governing board; and

[14] Representation could include advocates for the health center's section 330 (g), (h), or (i) patient population (for example, those who have personally experienced being a member of, have expertise about, or work closely with the current special population). Such advocate board members would count as "patient" board members only if they meet the patient definition set forth in this chapter.

[15] For example, in a 9 member board with 5 patient board members, there could be 4 non-patient board members. In this case, no more than 2 non-patient board members could earn more than 10 percent of their income from the health care industry.

- Incorporation of special population input into key areas, including but not limited to: selecting health center services; [16] setting hours of operation of health center sites;[17] defining budget priorities;[18] evaluating the organization's progress in meeting goals, including patient satisfaction;[19] and assessing the effectiveness of the sliding fee discount program.[20]

f. For health centers with approved waivers, the health center has board minutes or other documentation that demonstrates how special population patient input is utilized in making governing board decisions in key areas, including but not limited to: selecting health center services; setting hours of operation of health center sites; defining budget priorities; evaluating the organization's progress in meeting goals, including patient satisfaction; and assessing the effectiveness of the sliding fee discount program.

Related Considerations

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- Within the range of 9 to 25 board members, the health center determines the appropriate board size for its organization.

- In addition to race, ethnicity, and gender, the health center determines other relevant demographic or geographic factors to consider when selecting patient or non-patient board members.

- In cases where language or literacy may present a barrier to board members' evaluation of written materials, the health center determines how to make accommodations to ensure the meaningful participation of such board members.

- The health center board determines whether to include non-voting, ex-officio members including, for example, the Project Director/CEO, other health center staff members, or community members on the board, consistent with what is permitted under other applicable laws.

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[16] See Chapter 4: Required and Additional Health Services for more information on providing services within the HRSA-approved scope of project.
[17] See Chapter 6: Accessible Locations and Hours of Operation for more information on health center service sites and hours of operation.
[18] See Chapter 17: Budget for more information on the Health Center Program project budget.
[19] See Chapter 19: Board Authority for more information on the health center board's required authorities.
[20] See Chapter 9: Sliding Fee Discount Program for more information on requirements for health center sliding fee discount programs.

- The health center determines within its policies how to define "health care industry" for purposes of board composition and how to determine the percentage of annual income of each non-patient board member derived from the health care industry.

- For health centers with a HRSA-approved waiver, the health center board determines which strategies[21] to use for receiving input from the special population and ensuring the special population's participation in the direction and ongoing governance of the health center.

[21] For example, a health center could utilize an advisory council of special population representatives, could conduct regular focus groups with the special population, or could have one or more patients from the special population serving on the board.

Chapter 21: Federal Tort Claims Act (FTCA) Deeming Requirements

Authority

Section 224(g)-(n), 224(q) of the PHS Act (42 U.S.C. 233(g)-(n) and (q)); and 42 CFR Part 6

Requirements

In order to obtain deemed Public Health Service employment status under sections 224(g)-(n) of the PHS Act[1] for themselves and for their "covered individuals,"[2] Health Center Program awardees and subrecipients (including those defined as subrecipients under the Health Center FTCA Medical Malpractice Program regulations),[3] hereafter referred to as a "health center" in this chapter, must submit for approval by HRSA an annual deeming application that demonstrates the health center:

- Has implemented appropriate policies and procedures to reduce the risk of malpractice and the risk of lawsuits arising out of any health or health-related functions performed by the health center;
- Has reviewed and verified the professional credentials, references, claims history, fitness, professional review organization findings, and license status of its physicians and other licensed or certified health care practitioners;
- Has no history of claims under section 224 of the PHS Act or, if such a history exists, fully cooperates with the Attorney General in defending against any such claims, and takes any necessary steps to assure against such claims in the future; and
- Will fully cooperate with the Attorney General and other applicable agencies in providing required information under section 224 of the PHS Act.

***Note**: A health center's deemed employment status[4] does not imply FTCA coverage in all cases, as health center providers must also comply with statutory individual eligibility requirements,*

[1] The text of section 224 of the PHS Act may be found at: http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section233&num=0&edition=prelim

[2] "Covered individuals" is defined by the FTCA Health Center Policy Manual to mean "governing board members, officers, employees, and certain individual contractors." The term does not include volunteer health professionals of deemed health centers, who may be deemed as PHS employees under section 224(q), and as to whom an individual deeming application is required.

[3] *Subrecipient*, as used in this chapter means, as described in 42 CFR 6.2, an entity that receives a Federal award or a contract from a covered entity to provide a full range of health services on behalf of the covered entity. *Covered entity* means an entity as described in 42 CFR 6.3 which has been deemed by the Secretary, in accordance with 42 CFR 6.5, to be covered by 42 CFR Part 6.

[4] Deemed employment status extends to covered individuals based on evidence of their relationship with the covered entity (i.e., officer, governing board member, health center employee, qualified individual contractor, or volunteer health professional), pursuant to section 224(g)-(n) and (q) of the PHS Act, and 42 CFR Part 6. Volunteer health professionals may receive deemed employment status based on individual applications by the sponsoring,

and covered actions must be taken within the scope of deemed PHS employment. When FTCA matters become the subject of litigation, the U.S. Department of Justice and the Federal courts may assume significant roles in certifying or determining whether or not a given activity falls within the scope of employment for purposes of FTCA coverage. For more information, review the FTCA Health Center Policy Manual available at: https://bphc.hrsa.gov/ftca/pdf/ftcahcpolicymanualpdf.pdf.

Demonstrating Compliance

A health center would demonstrate compliance with the FTCA requirements by providing documentation in its annual deeming application, in the form and manner prescribed by HRSA, and consistent with (but not necessarily limited to) the following:

Credentialing and Privileging / Quality Improvement and Quality Assurance

a. The health center is currently compliant with all of the credentialing and privileging requirements of Chapter 5: Clinical Staffing and all requirements within Chapter 10: Quality Improvement/Assurance prior to the deeming determination.

Risk Management

a. The health center has and currently implements an ongoing health care risk management program to reduce the risk of adverse outcomes that could result in medical malpractice or other health or health-related litigation and that requires the following:
    - Risk management across the full range of health center health care activities;
    - Health care risk management training for health center staff;
    - Completion of quarterly risk management assessments by the health center; and
    - Annual reporting to the health center board which includes: completed risk management activities; status of the health center's performance relative to established risk management goals; and proposed risk management activities that relate and/or respond to identified areas of high organizational risk.

b. The health center has risk management procedures that address the following areas for health center services and operations:
    - Identifying and mitigating the health care areas/activities of highest risk within the health center's HRSA-approved scope of project, including but not limited to tracking referrals, diagnostics, and hospital admissions ordered by health center providers;
    - Documenting, analyzing, and addressing clinically-related complaints and "near misses" reported by health center employees, patients, and other individuals;

deemed health center. Whether a specific activity is covered by the FTCA will also require a determination or certification that the activities at issue occurred within the scope of deemed PHS employment.

- Setting and tracking progress related to annual risk management goals;
- Developing and implementing an annual health care risk management training plan for all staff members based on identified areas/activities of highest clinical risk for the health center (including, but not limited to, obstetrical procedures and infection control) and any non-clinical trainings appropriate for health center staff (including HIPAA medical record confidentiality requirements); and
- Completing an annual risk management report for the board and key management staff.

c. The health center provides reports to the board and key management staff on health care risk management activities and progress in meeting goals at least annually, and provides documentation to the board and key management staff showing that any related follow-up actions have been implemented.

d. The health center has a health care risk management training plan for all staff members and documentation showing that such trainings have been completed by the appropriate staff, including all clinical staff, at least annually.

e. The health center designates an individual(s) (for example, a risk manager) who oversees and coordinates the health center's health care risk management activities and completes risk management training annually.

Claims Management

a. The health center has a claims management process for addressing any potential or actual health or health-related claims, including medical malpractice claims, that may be eligible for FTCA coverage. In addition, this process ensures:
   - The preservation of all health center documentation related to any actual or potential claim or complaint (for example, medical records and associated laboratory and x-ray results, billing records, employment records of all involved clinical providers, clinic operating procedures); and
   - Any service-of-process/summons that the health center or its provider(s) receives relating to any alleged claim or complaint is promptly sent to the HHS Office of the General Counsel, General Law Division, per the process prescribed by HHS and as further described in the FTCA Health Center Policy Manual.

b. The health center has a designated individual(s) who is responsible for the management and processing of claims-related activities and serves as the claims point of contact.

c. The health center informs patients using plain language that it is a deemed Federal PHS employee[5] via its website, promotional materials, and/or within an area(s) of the health center that is visible to patients.

d. If a history of claims under the FTCA exists, the health center can document that it:
   - Cooperated with the Attorney General, as further described in the FTCA Health Center Policy Manual; and
   - Implemented steps to mitigate the risk of such claims in the future.

Related Considerations

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- The health center determines how to obtain its health care risk management training (for example, through one of HRSA's national cooperative agreements or technical assistance contracts) and which trainings to require for covered individuals and the individual(s) designated with risk management responsibilities (for example, risk manager).

- The health center determines what other types of liability coverage to obtain, such as private "gap" or "tail" insurance, directors and officer insurance, and general liability insurance, for activities that may not be eligible for FTCA coverage.

- The health center determines how to conduct and document the completion of quarterly risk management assessments.

- With the exception of health centers that use volunteer health professionals, as to which requirements are prescribed by law,[6] the health center determines how to inform patients that it is a deemed Federal Public Health Service employee.

[5] For example: "This health center receives HHS funding and has Federal Public Health Service (PHS) deemed status with respect to certain health or health-related claims, including medical malpractice claims, for itself and its covered individuals." For more information, see http://www.bphc.hrsa.gov/ftca/.
[6] Section 224(q)(2)(D) of the PHS Act.

Appendix A: Health Center Program Non-Regulatory Policy Issuances That Remain in Effect

The following policy issuances most often referred to as Policy Information Notices (PINs) remain in effect and are not superseded by the Health Center Program Compliance Manual:

PIN 2007-09 Service Area Overlap: Policy and Process (http://bphc.hrsa.gov/programrequirements/policies/pin200709.html)

PIN 2007-15 Health Center Emergency Management Program Expectations (https://bphc.hrsa.gov/about/pdf/pin200715.pdf)

PIN 2008-01 Defining Scope of Project and Policy for Requesting Changes (http://bphc.hrsa.gov/programrequirements/policies/pin200801.html)

PIN 2009-02 Specialty Services and Health Centers' Scope of Project (http://bphc.hrsa.gov/programrequirements/policies/pin200902purpose.html)

PIN 2009-05 Policy for Special Population-Only Grantees Requesting a Change in Scope to Add a New Target Population (http://bphc.hrsa.gov/programrequirements/policies/pin200905specialpops.html)

The following HRSA/BPHC policy documents and resources also remain in effect and are not superseded by the Health Center Program Compliance Manual:

Federal Tort Claims Act Health Center Policy Manual (https://bphc.hrsa.gov/ftca/pdf/ftcahcpolicymanualpdf.pdf)

Additional Scope of Project/Change in Scope Resources (http://bphc.hrsa.gov/programrequirements/scope.html)

Site Visit Resources (http://bphc.hrsa.gov/programrequirements/svguide.html)

Uniform Data System (UDS) Resources (http://bphc.hrsa.gov/datareporting/reporting/index.html)

Glossary

Note: This chapter contains revisions based on the Bipartisan Budget Act of 2018. View the revisions.

330(g) Migratory and Seasonal Agricultural Worker (MSAW): For the purposes of health centers receiving a Health Center Program award or designation under section 330(g) of the Public Health Service Act, the population served includes:

- Migratory agricultural workers who are individuals whose principal employment is in agriculture, and who have been so employed within the last 24 months, and who establish for the purposes of such employment a temporary abode;
- Seasonal agricultural workers who are individuals whose principal employment is in agriculture on a seasonal basis and who do not meet the definition of a migratory agricultural worker;
- Individuals who are no longer employed in migratory or seasonal agriculture because of age or disability who are within such catchment area; and/or
- Family members of the individuals described above.

Agriculture refers to farming in all its branches, as defined by the North American Industry Classification System under codes 111, 112, 1151, and 1152.
(Section 330(g) of the PHS Act)

330(h) Homeless Population: For the purposes of health centers receiving a Health Center Program award or designation under section 330(h) of the Public Health Service Act, the population served includes individuals:

- Who lack housing (without regard to whether the individual is a member of a family);
- Whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations;
- Who reside in transitional housing; and/or
- Who reside in permanent supportive housing or other housing programs that are targeted to homeless populations.

Under section 330(h) a health center may continue to provide services for up to 12 months to formerly homeless individuals whom the health center has previously served but are no longer homeless as a result of becoming a resident in permanent housing and may also serve children and youth at risk of homelessness, homeless veterans, and veterans at risk of homelessness.
(Section 330(h) of the PHS Act)

330(i) Residents of Public Housing: For the purpose of health centers receiving a Health Center Program award or designation under section 330(i) of the Public Health Service Act, the population served includes residents of public housing and individuals living in areas immediately accessible to public housing. Public housing includes public housing agency-developed, owned or assisted low-income housing, including mixed finance projects, but

excludes housing units with no public housing agency support other than Section 8 housing vouchers. (Section 330(i) of the PHS Act)

Additional Services (Additional Health Services): Services that are not included as required primary health services and that may be offered as appropriate to meet the health needs of the population served by the health center. (Section 330(b)(2) of the Public Health Service Act)

Awardee (award recipient): *Formerly referred to as "grantee."* A public or nonprofit non-Federal organization that carries out the Federal award under the Health Center Program as a recipient or subrecipient. (45 CFR 75.2)

Co-Applicant: For public agency health centers only. The established body that serves as a public center's governing board when the public agency determines that it cannot meet the Health Center Program governing board requirements directly. (Section 330(r)(2)(A) of the Public Health Service Act)

Contract: A contract is used for the purpose of obtaining goods and services needed to carry out the project or program under a Federal award. It does not include a legal instrument, even if the health center considers it a contract, when the substance of the transaction meets the definition of a Federal award or subaward. Characteristics of a contract are when the contractor:

(1) Provides the goods and services within normal business operations;
(2) Provides similar goods or services to many different purchasers;
(3) Normally operates in a competitive environment;
(4) Provides goods or services that are ancillary to the operation of the Federal program; and
(5) Is not subject to compliance requirements of the Federal program as a result of the relationship (although similar requirements may apply for other reasons, including as a result of contractual provisions).

(45 CFR 75.2 and 45 CFR 75.351)

Credentialing: The process of assessing and confirming the license or certification, education, training, and other qualifications of a licensed or certified health care practitioner.

EHB: HRSA's Electronic Handbooks: HRSA's Web-based grants interface, used for all Health Center Program award or designation management activities.

Federal award (award, Federal grant): The Federal financial assistance that a non-Federal entity receives directly from a Federal awarding agency, such as HRSA, or indirectly from a pass-through entity. For the purposes of the Compliance Manual (unless specified differently), this refers to Federal award funding under section 330 of the Public Health Service Act or the "Health Center Program award." (45 CFR 75.2)

Federal Poverty Guidelines (FPG): The Federal Poverty Guidelines (FPG) are a simplification of

the poverty thresholds, which are updated each year by the Census Bureau, and are used for administrative purposes — for instance, determining financial eligibility for certain Federal programs. The guidelines reflect annual income levels below which a person or family is considered to be living in poverty, and the amounts increase according to the size of the family. The guidelines are updated annually by HHS in the Federal Register. (https://aspe.hhs.gov/poverty-guidelines)

Federally Qualified Health Center (FQHC): A Medicare/Medicaid designation administered by CMS. Eligible organizations include organizations receiving grants under section 330 of the PHS Act, look-alikes, and certain tribal organizations. (Section 1861(aa)(4)(B) and section 1905(l)(2)(B) of the SSA)

Fitness for duty *Formerly referred to as "health fitness"***:** Fitness for duty, for purposes of this Compliance Manual, means the ability to perform the duties of the job in a safe, secure, productive, and effective manner.

Form 5A: Services Provided: Official documentation of the required and additional health services (See Chapter 4: Required and Additional Health Services) included in a health center's HRSA-approved scope of project, and their corresponding mode(s) of service delivery. This form is contained in the health center's folder in EHB. (http://bphc.hrsa.gov/programrequirements/scope.html)

Form 5B: Service Sites: Official documentation of the service delivery sites (see Service Site) included in a health center's HRSA-approved scope of project. This form is contained in the health center's folder in EHB. (http://bphc.hrsa.gov/programrequirements/scope.html)

Limited English Proficiency (LEP): LEP persons include individuals who do not speak English as their primary language and/or who have a limited ability to read, write, speak, or understand English; and who may be eligible to receive language assistance with respect to the particular service, benefit, or encounter. (http://www.hhs.gov/civil-rights/index.html)

Look-Alike: Organizations that do not receive a Health Center Program Federal award but are designated by HRSA as meeting Health Center Program requirements. (Section 1861(aa)(4)(B) and section 1905(l)(2)(B) of the SSA)

Non-Federal Entity: A State, local government, Indian tribe, institution of higher education (IHE), or nonprofit organization that carries out a Federal award as a recipient or subrecipient. (45 CFR 75.2)

Pass-Through Entity: A non-Federal entity that provides a subaward to a subrecipient to carry out part of a Federal program. (45 CFR 75.2)

Primary Source Verification: Verification by the original source of a specific credential of the accuracy of a qualification reported by an individual health care practitioner. Primary source

verification could include direct correspondence, telephone, fax, e-mail, or paper or online reports received from original sources (for example, telephone confirmation from an educational institution that the individual graduated with the degree[s] listed on his or her application, confirmation through a state's database that a provider's license is current, reports from credentials verification organizations).

Privileging: The process of authorizing a health care practitioner's specific scope and content of patient care services.

Required Services (Required Health Services): Required services are those services that a health center must provide, as defined in Section 330(b)(1) of the Public Health Service Act. (Section 330(a)(1) of the Public Health Service Act)

Scope of Project: Defines the service sites, services, providers, service area(s), and target population included in the HRSA-approved Health Center Program project. (Policy Information Notice 2008-01: Defining Scope of Project and Policy for Requesting Changes)

Service Area (also referred to as a "catchment area"): The precise boundaries, as defined by the health center, of the geographic area to be served under the Health Center Program project, including identified medically underserved population or populations within that area. (42 CFR 51c.102)

Service Site: Locations where a health center either directly or through a subrecipient or contractual arrangement provides services and where all of the following conditions are met:

- Health center encounters are generated by documenting in the patients' records face-to-face contacts between patients and providers;
- Providers exercise independent judgment in the provision of services to the patient;
- Services are provided directly by or on behalf of the health center, whose governing board retains control and authority over the provision of the services at the location; and
- Services are provided on a regularly scheduled basis. (Policy Information Notice 2008-01: Defining Scope of Project and Policy for Requesting Changes)

Special Population [Special Medically Underserved Population]: HRSA may award funding or designation under sections 330(g), (h), or (i) of the PHS Act for the delivery of services to a special medically underserved population. See definitions for 330(g) Migratory and seasonal agricultural workers; 330(h) Homeless individuals; and 330(i) Residents of public housing.

Subaward: An award provided by a pass-through entity to a subrecipient for the subrecipient to carry out part of a Federal award received by the pass-through entity. It does not include payments to a contractor or payments to an individual that is a beneficiary of a Federal program. A subaward may be provided through any form of legal agreement, including an agreement that the pass-through entity considers a contract. See also "Pass-Through Entity." (45 CFR 75.2)

Subrecipient: Per 45 CFR 75.2, a non-Federal entity that receives a subaward from a pass-through entity to carry out part of a Federal program but does not include an individual that is a beneficiary of such program. A subrecipient may also be a recipient of other Federal awards directly from a Federal awarding agency.

Characteristics which would lend support to the classification of the non-Federal entity as a subrecipient include when the non-Federal entity:

(1) Determines who is eligible to receive what Federal assistance;
(2) Has its performance measured in relation to whether objectives of a Federal program were met;
(3) Has responsibility for programmatic decision making;
(4) Is responsible for adherence to applicable Federal program requirements specified in the Federal award; and
(5) In accordance with its agreement, uses the Federal funds to carry out a program for a public purpose specified in authorizing statute, as opposed to providing goods or services for the benefit of the pass-through entity. (45 CFR 75.2)

Uniform Data System (UDS): The UDS is a core set of information appropriate for reviewing the operation and performance of health centers. The UDS annually collects a variety of information, including patient demographics, services provided, staffing, clinical indicators, utilization rates, costs, and revenues. (http://bphc.hrsa.gov/datareporting/reporting/index.html)

Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (45 CFR Part 75): *Sometimes referred to as the "HHS grant regulations."* Final requirements for Federal awards to non-Federal entities located in Title 2 of the Code of Federal Regulations as adopted by HHS at 45 CFR Part 75. These requirements supersede and streamline requirements from previous OMB Circulars A-21, A-87, A-110, and A-122 ; Circulars A-89, A-102, and A-133; and the guidance in Circular A-50 on Single Audit Act follow-up. (45 CFR Part 75)

Volunteer Health Professional (VHP): For the purposes of being deemed as PHS employees for the purposes of liability protections under section 224(q) of the PHS Act, a health care practitioner shall be considered to be a volunteer health professional at a deemed health center if the following conditions are met:

(1) The service is provided to patients at the sponsoring health center facilities or through offsite programs or events carried out by the sponsoring health center;
(2) The deemed health center is sponsoring the health care practitioner;
(3) The health care practitioner does not receive any compensation for the service from the patient, the sponsoring health center, or any third-party payer (including reimbursement under any insurance policy, health plan, or Federal or state health benefits program). However, the health care practitioner may receive repayment from the health center for reasonable expenses incurred in providing the service to the

patient;

(4) Before the service is provided, the health care practitioner or the deemed health center posts a clear and conspicuous notice at the site where the service is provided of the extent to which the legal liability of the health care practitioner is limited pursuant to subsection 224(q);

(5) At the time service is provided, the VHP is licensed or certified in accordance with applicable Federal and state laws regarding the provision of the service; and

(6) The sponsoring health center must maintain all relevant documentation certifying that the VHP meets the requirements to be considered a volunteer.

(Section 224(q) of the PHS Act)

Valleywise Community Health Centers

HRSA Site Visit Protocol

HRSA Health Center Program

BUREAU OF PRIMARY HEALTH CARE

Health Center Program Site Visit Protocol

Last updated: February 27, 2020

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INTRODUCTION

Purpose

The purpose of Health Resources and Services Administration (HRSA) site visits[1] is to support the effective oversight of the Health Center Program. Operational Site Visits (OSVs) provide an objective assessment and verification of the status of each Health Center Program awardee or look-alike's compliance with the statutory and regulatory requirements of the Health Center Program. In addition, HRSA conducts site visits to assess and verify look-alike initial designation applicants for eligibility and compliance with Health Center Program requirements to inform initial designation determinations. For the purposes of this document, the term "health center" refers to entities that apply for or receive a federal award under section 330 of the Public Health Service (PHS) Act (including section 330 (e), (g), (h) and (i)), section 330 subrecipients, and organizations designated as look-alikes.

HRSA uses the Health Center Program Compliance Manual ("Compliance Manual") as the basis for determining whether health centers have demonstrated compliance with the statutory and regulatory requirements of the Health Center Program. The Health Center Program Site Visit Protocol (SVP) is the tool for assessing compliance with Health Center Program requirements during OSVs. The SVP is designed to provide HRSA the information necessary to perform its oversight responsibilities using a standard and transparent methodology that aligns with the Compliance Manual. In addition to assessing compliance with all Health Center Program requirements, the SVP also includes sections for the following:

- An analysis of one or more performance measure(s)
- Identification, as applicable, of promising practices

During the OSV, at the health center's request, the site visit team may share recommendations or limited technical assistance on various areas of health center operations that fall outside the scope of the compliance review. Such recommendations/technical assistance information will not be included in the final site visit report.

HRSA conducts OSVs at least once per project/designation period. For health centers with a 1-year project/designation period, the OSV will take place 2–4 months into the project/designation period. For health centers with a 3-year project/designation period, the OSV will take place 14–18 months into the project/designation period. HRSA strongly encourages all health centers to review and utilize the Compliance Manual, the SVP, and all other site visit resources to prepare

[1] The U.S. Department of Health and Human Services (HHS) Uniform Administrative Requirements (45 CFR 75.342) permit HRSA to "make site visits, as warranted by program needs." In addition, 45 CFR 75.364 states that**,** "The HHS awarding agency, Inspectors General, the Comptroller General of the United States, and the pass-through entity, or any of their authorized representatives, must have the right of access to any documents, papers, or other records of the non-federal entity which are pertinent to the federal award, in order to make audits, examinations, excerpts, and transcripts. The right also includes timely and reasonable access to the non-federal entity's personnel for the purpose of interview and discussion related to such documents."

for site visits and to help regularly assess and assure ongoing compliance with the Health Center Program.

Site Visit Report and Compliance Determinations

HRSA develops and shares a site visit report with the health center within 45 days after the site visit. The report conveys the site visit findings and final compliance determinations. In circumstances where HRSA determines that a health center has failed to demonstrate compliance with one or more of the Health Center Program requirements, HRSA will place a condition(s) on the award/designation.[2]

The Federal Tort Claims Act (FTCA) Program also uses the site visit report to support FTCA deeming decisions, and to identify technical assistance needs for FTCA-deemed health centers.[3,4] In circumstances where the site visit report contains FTCA risk and claims management findings that require follow-up, the FTCA Program will develop and share a Corrective Action Plan (CAP) with the health center. The health center is expected to respond to the CAP and address findings before the next FTCA deeming cycle.

Health centers and look-alike initial designation applicants should use the site visit report and the Compliance Manual to understand the compliance findings and to obtain guidance for resolving non-compliance findings.[5] Health centers may contact their HRSA Health Center Program staff primary point-of-contact for additional information regarding compliance findings and submissions in response to conditions.

Site Visit Protocol Structure

Each Compliance Manual chapter that addresses Health Center Program requirements has a corresponding section in the SVP. Similar to the Compliance Manual, the SVP also contains a section on the FTCA Program risk management and claims management requirements.

Each of these SVP sections contains the following components:

- ***Statute and Regulations*:** The supporting statute and regulations for the associated program requirements.

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[2] For additional information on how HRSA pursues remedies for non-compliance, including progressive action, see Health Center Program Compliance Manual, Chapter 2: Health Center Program Oversight.
[3] Unresolved Health Center Program conditions related to clinical staffing and/or quality improvement/assurance, requirements that apply to both Health Center Program and FTCA deeming, may impact FTCA deeming if they are not resolved by the time that HRSA makes annual FTCA deeming decisions.
[4] Health centers that have question regarding the FTCA Program or FTCA deeming requirements may contact Health Center Program Support at 1–877–464–4772 or https://www.hrsa.gov/about/contact/bphc.aspx.
[5] Look-alike initial designation applicants must be compliant with all Health Center Program requirements at the time of application and should refer to the look-alike Initial Designation application for further guidance on how HRSA will address findings of non-compliance at a pre-designation OSV.

- ***Primary and Secondary Reviewers*:** The member of the site visit team who serves as the primary reviewer for that section, based on expertise (governance/administrative, fiscal, or clinical), and an optional or suggested secondary reviewer who may add expertise and assistance as needed. The site visit team confers and works together on compliance assessments.

- ***Documents Checklist for Health Center Staff*:** The list of documents a health center provides to the site visit team prior to the site visit or onsite.[6]
    - Documents provided *prior to the site visit* are to be sent **at least 2 weeks prior to the start of the site visit.**
    - Documents provided *by the start of the site visit* are to be ready **when the site visit team arrives onsite.**
    - In cases where a sample (for example, sample of patient records) is referenced in the list of documents to be provided by the health center, **the health center is expected to provide (or "pull") the sample and have it ready when the site visit team arrives onsite**.
        - When the SVP allows for a range in the sample size, the health center should take into account its size and complexity when determining sample size.
        - If the sample provided by the health center is not sufficient to allow the HRSA site visit team to assess the program requirement, the team may complete additional sampling in coordination with the health center.
    - ***Documents not provided by the close of the first day of the site visit will not be considered in the compliance assessment by the site visit team.***

- ***Demonstrating Compliance Elements*:** The elements from the Compliance Manual that describe how health centers would demonstrate their compliance with the applicable Health Center Program requirements.[7]

- ***Site Visit Team Methodology*:** The methods a site visit team uses to assess compliance with the corresponding demonstrating compliance elements. Methods

[6] Site visit teams, including consultants, are authorized representatives of HRSA and thus may review a health center's policies and procedures, financial or clinical records, and other relevant documents, in order to assess and verify compliance with Health Center Program and FTCA deeming requirements. Site visit teams are also subject to confidentiality standards, including Health Insurance Portability and Accountability Act (HIPAA). Consultants who violate such standards are in violation of their contract, and could be subject to Title 18, United States Code, Section 641. While it is permissible for health centers to request that HRSA staff and/or consultants sign additional confidentiality statements, this should be communicated prior to or at the beginning of the site visit to avoid any disruption or delay in the site visit process.

[7] A small subset of elements are not assessed during a site visit because HRSA assesses them by other means (for example, competitive application review, look-alike Renewal Designation application review, HRSA Division of Grants Management Office (DGMO) review).

include but are not limited to reviews of policies and procedures, samples of files and records, site tours, and interviews.[8]

- ***Site Visit Findings*:** The site visit team's responses to the series of questions based on the related methodologies. These findings are included in the health center's site visit report and form the basis for determining whether a health center has demonstrated compliance with Health Center Program requirements.

[8] Interviews with health center staff are intended to supplement and assist the site visit team in its review of policies, procedures, and other documentation.

NEEDS ASSESSMENT

Primary Reviewer: Governance/Administrative Expert
Secondary Reviewer: Clinical Expert

Authority: *Section 330(k)(2) and Section 330(k)(3)(J) of the Public Health Service (PHS) Act; and 42 CFR 51c.104(b)(2-3), 42 CFR 51c.303(k), 42 CFR 56.104(b)(2), 42 CFR 56.104(b)(4), and 42 CFR 56.303(k)*

Document Checklist for Health Center Staff

Documents Provided at the Start of the Site Visit:

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

Demonstrating Compliance

Element a: Service Area Identification and Annual Review

The health center identifies and annually reviews its service area[1] based on where current or proposed patient populations reside as documented by the ZIP codes reported on the health center's Form 5B: Service Sites. **In addition, these service area ZIP codes are consistent with patient origin data reported by ZIP code in its annual Uniform Data System (UDS) report (for example, the ZIP codes reported on the health center's Form 5B: Service Sites would include the ZIP codes in which at least 75 percent of current health center patients reside, as identified in the most recent UDS report).**

***Note:** HRSA assesses whether the health center has demonstrated compliance with this portion of element "a" through its review of the competing continuation application (Service Area Competition (SAC) or Renewal of Designation (RD)). No onsite review of this portion of element "a" related to determining the consistency of service area zip codes and patient origin data is required.*

Site Visit Team Methodology

- Interview Project Director/CEO and other key management staff regarding service area analysis process.
- Review health center's Form 5B: Service Sites.

[1] Also referred to as "catchment area" in the Health Center Program implementing regulation in 42 CFR 51c.102.

Site Visit Findings

1. Does the health center utilize patient origin data to identify and review its service area (as reflected by the zip codes included in the Form 5B site entries)?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

2. Is this service area review process completed at least annually?

   ***Note**: The annual review of a health center's service area may be conducted in a number of ways (for example, as part of submission of a competitive application or as a "stand-alone" activity during the year, such as review of annual UDS patient origin data or other data on where patients reside).*
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

Element b: Update of Needs Assessment

The health center completes or updates a needs assessment of the current or proposed population at least once every 3 years,[2] for the purposes of informing and improving the delivery of health center services. The needs assessment utilizes the most recently available data[3] for the service area and, if applicable, special populations and addresses the following:

- Factors associated with access to care and health care utilization (for example, geography, transportation, occupation, transience, unemployment, income level, educational attainment);
- The most significant causes of morbidity and mortality (for example, diabetes, cardiovascular disease, cancer, low birth weight, behavioral health) as well as any associated health disparities; and

[2] Compliance may be demonstrated based on the information included in a Service Area Competition (SAC) or a Renewal of Designation (RD) application. Note that in the case of a Notice of Funding Opportunity for a New Access Point or Expanded Services grant, HRSA may specify application-specific requirements for demonstrating an applicant has consulted with the appropriate agencies and providers consistent with Section 330(k)(2)(D) of the PHS Act. Such application-specific requirements may require a completed or updated needs assessment more recent than that which was provided in an applicant's SAC or RD application.

[3] In cases where data are not available for the specific service area or special population, health centers may use extrapolation techniques to make valid estimates using data available for related areas and population groups. Extrapolation is the process of using data that describes one population to estimate data for a comparable population, based on one or more common differentiating demographic characteristics. Where data are not directly available and extrapolation is not feasible, health centers should use the best available data describing the area or population to be served.

- Any other unique health care needs or characteristics that impact health status or access to, or utilization of, primary care (for example, social factors, the physical environment, cultural/ethnic factors, language needs, housing status).

Site Visit Team Methodology

- Review most recent needs assessment and documentation (for example, studies, resources, reports) used to develop the needs assessment.
- Interview Project Director/CEO and other key management staff regarding utilization of needs assessment(s).

Site Visit Findings

3. Does the health center complete or update a needs assessment of the current population at least once every 3 years?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

4. Is the needs assessment based on the most recently available data for the service area and, if applicable, special populations?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

5. Does the needs assessment address all of the following:

   - Factors associated with access to care and health care utilization (for example, geography, transportation, occupation, transience, unemployment, income level, educational attainment);
   - The most significant causes of morbidity and mortality (for example, diabetes, cardiovascular disease, cancer, low birth weight, behavioral health) as well as any associated health disparities; and
   - Any other unique health care needs or characteristics that impact health status or access to, or utilization of, primary care (for example, social factors, the physical environment, cultural/ethnic factors, language needs, housing status).

   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

6. Was the health center able to provide at least one example of how it utilized the results of its needs assessment(s) to inform and improve the delivery of health center services?

   ***Note**: If the health center is part of a larger organization (for example, a health department, mental health or social service agency), consider whether the needs assessment(s) provides data that are relevant and specific enough to inform the delivery of health center services.*
   ☐ YES ☐ NO

   If No, an explanation is required:
   _____

REQUIRED AND ADDITIONAL HEALTH SERVICES

Primary Reviewer: Clinical Expert
Secondary Reviewer: N/A

Authority: *Section 330(a)-(b), Section 330(h)(2), and Section 330(k)(3)(K) of the Public Health Service (PHS) Act; and 42 CFR 51c.102(h) and (j), 42 CFR 56.102(l) and (o), and 42 CFR 51c.303(l)*

Document Checklist for Health Center Staff

Documents Provided Prior to 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. Sites selected are those 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

Documents Provided at the Start of the 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 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 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)

☐ 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 (LEP)

Demonstrating Compliance

Element a: Providing and Documenting Services within Scope of Project

The health center provides access to all services included in its HRSA-approved scope of project[1] (Form 5A: Services Provided) through one or more service delivery methods,[2] as described below:[3]

- ***Direct***: If a required or additional service is provided directly by health center employees[4] or volunteers, this service is accurately recorded in Column I on Form 5A: Services Provided, reflecting that the health center pays for and bills for direct care.
- ***Formal Written Contract/Agreement***:[5] If a required or additional service is provided on behalf of the health center via a formal contract/agreement between the health center and a third party (including a subrecipient),[6] this service is accurately recorded in

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[1] In accordance with 45 CFR 75.308 (Uniform Administrative Requirements: Revision of Budget and Program Plans), health centers must request prior approval from HRSA for a change in the scope or the objective of the project or program (even if there is no associated budget revision requiring prior written approval). This prior approval requirement applies, among other things, to the addition or deletion of a service within the scope of project. These changes require prior approval from HRSA and must be submitted by the health center as a formal Change in Scope request. See http://www.bphc.hrsa.gov/programrequirements/scope.html for further details on scope of project, including descriptions of the services listed on Form 5A: Services Provided available at: https://www.bphc.hrsa.gov/programrequirements/scope/form5aservicedescriptors.pdf.

[2] The Health Center Program statute states in 42 U.S.C. 254b(a)(1) that health centers may provide services "either through the staff and supporting resources of the center or through contracts or cooperative arrangements." The Health Center Program Compliance Manual utilizes the terms "Formal Written Contract/Agreement" and "Formal Written Referral Arrangement" to refer to such "contracts or cooperative arrangements." For more information on documenting service delivery methods within the HRSA-approved scope of project on Form 5A: Services Provided, see: http://bphc.hrsa.gov/programrequirements/scope/form5acolumndescriptors.pdf. Other Health Center Program requirements apply when providing services through contractual agreements and formal referral arrangements. Such requirements are addressed in other chapters of the Manual where applicable.

[3] See [Health Center Program Compliance Manual] Chapter 9: Sliding Fee Discount Program for more information on sliding fee discount program requirements and how they apply to the various service delivery methods.

[4] For purposes of the HRSA-approved scope of project (Form 5A: Services Provided), HRSA/BPHC utilizes Internal Revenue Service (IRS) definitions to differentiate contractors and employees. Typically, an employee receives a salary on a regular basis and a W-2 from the health center with applicable taxes and benefit contributions withheld.

[5] See [Health Center Program Compliance Manual] Chapter 12: Contracts and Subawards for more information on program requirements around contracting.

[6] For purposes of the HRSA-approved scope of project (Form 5A: Services Provided), services provided via "contract/formal agreement" are those provided by practitioners who are not employed by or volunteers of the health center (for example, an individual provider with whom the health center has a contract; a group practice with which the health center has a contract; a locum tenens staffing agency with which the health center contracts; a subrecipient organization). Typically, a health center will issue an IRS Form 1099 to report payments to an individual contractor. See the Federal Tort Claims Act (FTCA) Health Center Policy Manual for information about eligibility for FTCA coverage for covered activities by covered individuals, which extends liability protections for eligible "covered individuals," including governing board members and officers, employees, and qualified individual contractors.

Column II on Form 5A: Services Provided, reflecting that the health center pays for the care provided by the third party via the agreement. In addition, the health center ensures that such contractual agreements for services include:
  - How the service will be documented in the patient's health center record; and
  - How the health center will pay for the service.
- ***Formal Written Referral Arrangement***: If access to a required or additional service is provided and billed for by a third party with which the health center has a formal referral arrangement, this service is accurately recorded in Column III on Form 5A: Services Provided, reflecting that the health center is responsible for the act of referral for health center patients and any follow-up care for these patients provided by the health center subsequent to the referral.[7] In addition, the health center ensures that such formal referral arrangements for services, at a minimum, address:
  - 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).

Site Visit Team Methodology

- In conjunction with the CEO and/or other relevant staff, review the accuracy of the health center's Form 5A: Services Provided.
- Interview CMO and/or other clinical staff responsible for service delivery, including contracted or referred services.
- For any service delivered **via Column II (whether or not the service is also delivered via Column I and/or Column III)**, the following reviews of the formal written contract(s)/agreement(s) for the service and a related review of a selection of patient records will take place:

  Review of Contracts/Agreements:
  - Review **at least one but no more than three** written contracts/agreements for EACH Required and EACH Additional 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.*

  Review of Patient Records:
  - Based on three Required Services and two Additional Services: Review three to five health center patient records for patients who have received these services in the past 24 months from a contracted provider(s)/organization(s). If the same patient has received more than one of these services, the same record can be used for assessing those services.

[7] For purposes of the HRSA-approved scope of project (Form 5A: Services Provided), access to services provided via "formal referral arrangements" are those referred by the health center but provided and billed for by a third party. Although the service itself is not included within the HRSA-approved scope of project, the act of referral and any follow-up care provided by the health center subsequent to the referral are considered to be part of the health center's HRSA-approved scope of project. For more information on documenting service delivery methods within the HRSA-approved scope of project on Form 5A: Services Provided, see: http://bphc.hrsa.gov/programrequirements/scope/form5acolumndescriptors.pdf.

- For any service delivered **via Column III (whether or not the service is also delivered via Column I and/or Column II)**, the following reviews of the formal written referral arrangement(s) for the service and a related review of a selection of patient records will take place:

  Review of Referral Arrangements:
  - Review **at least one but no more than three** written referral arrangements for EACH Required and EACH Additional 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.*

  Review of Patient Records:
  - Based on three Required Services and two Additional Services: Review three to five health center patient records for patients who have received these services in the past 24 months from a referral provider(s)/organization(s). If the same patient has received more than one of these services, the same record can be used for assessing those services.

Notes:

- *The primary focus of this portion of the site visit is on validating the actual provision of the various required and additional services.*
- *When reviewing the provisions for enabling services (for example, transportation, translation, outreach) provided via Column II or III, compliance is demonstrated even if the related contracts or referral arrangements do not address all of the provisions (for example, documentation in the patient record, follow-up care) required for clinical services (for example, general primary medical care, preventive dental).*
- *Any findings regarding the structure or availability of a health center's SLIDING FEE DISCOUNT PROGRAM as it relates to the SERVICES listed on Form 5A (for example, health center is providing an additional service directly, but the service is NOT discounted through the health center's sliding fee discount program) will be assessed and documented under the Sliding Fee Discount Program section.*
- *Follow-up from hospital admissions or hospital visits will be reviewed in the Continuity of Care and Hospital Admitting section.*

Site Visit Findings

1. **Form 5A, Column I:**

   - Are all services listed in Column I on the health center's current Form 5A being provided by the health center directly?
     ☐ YES ☐ NO ☐ NOT APPLICABLE

   Note: *Select "Not Applicable" if the health center does not offer any services via Column I.*

   If No, an explanation is required, including specifying any missing services:

   _____

2. **Form 5A, Column II:**

- Does the health center maintain formal written contracts/agreements for services listed in Column II on its current Form 5A?
  ☐ YES ☐ NO ☐ NOT APPLICABLE

- Do these contracts/agreements document how the health center will pay for the service(s) and how the service(s) will be documented in the patient's health center record?
  ☐ YES ☐ NO ☐ NOT APPLICABLE

- Was the health center able to produce patient records from the past 24 months that document receipt of specific contracted services?
  ☐ YES ☐ NO ☐ NOT APPLICABLE

Note: *Select "Not Applicable" for each of the above questions if the health center does not offer any services via Column II.*

If No or Not Applicable was selected for any of the above, an explanation is required providing details on the specific service(s):

_____

3. **Form 5A, Column III:**

   - Does the health center maintain formal written referral arrangements for services listed in Column III on its current Form 5A?
     ☐ YES ☐ NO ☐ NOT APPLICABLE

   - Does the health center have a process for making, tracking, and managing referrals for these services with the referral provider(s) (for example, process for tracking whether patient presented at the referral provider or the outcomes of the referral visit)?
     ☐ YES ☐ NO ☐ NOT APPLICABLE

   - Is there documentation in the patient record of appropriate follow-up care and information that resulted from these referrals (for example, exchange of patient record information, receipt of lab results)?
     ☐ YES ☐ NO ☐ NOT APPLICABLE

   Note: *Select "Not Applicable" for each of the above questions if the health center does not offer any services via Column III.*

   If No or Not Applicable was selected for any of the above, an explanation is required providing details on the specific service(s):

   _____

4. Considering the overall scope of project (i.e., all services on Form 5A across the various Columns), were services recorded on Form 5A consistent with how they were offered by the health center at the time of the site visit?
   ☐ YES ☐ NO

   If No, an explanation is required, including specifying any discrepancies observed:

Element b: Ensuring Access for Limited English Proficient Patients

Health center patients with limited English proficiency (LEP) are provided with interpretation and translation (for example, through bilingual providers, on-site interpreters, high quality video or telephone remote interpreting services) that enable them to have reasonable access to health center services.

Site Visit Team Methodology

- Review Uniform Data System (UDS) patient demographic data.
- Review sample of translated health center documents.
- Review access to interpretation services (for example, on-site interpreter(s), contract(s) for interpretation services).
- Interview health center clinical leadership and providers regarding patient language needs (for example, most common primary languages spoken by the patient population) and the role of cultural competency in the delivery of health center services (for example, training of front desk and clinical staff in cultural knowledge, attitudes, and beliefs of patient population).

Site Visit Findings

5. Does the health center provide access to interpretation for health center patients with LEP?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

6. Was the health center able to provide an example of a key document (i.e., documents that enable patients to access health center services) translated into different languages for its patient population?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

Element c: Providing Culturally Appropriate Care

The health center makes arrangements and/or provides resources (for example, training) that enable its staff to deliver services in a manner that is culturally sensitive and bridges linguistic and cultural differences.

Site Visit Team Methodology

- Review UDS patient demographic data.
- Review sample of translated health center documents.
- Review access to interpretation services (for example, on-site interpreter(s), contract(s) for interpretation services).
- Interview health center clinical leadership and providers regarding patient language needs (for example, most common primary languages spoken by the patient population) and the role of cultural competency in the delivery of health center services (for example, training of front desk and clinical staff in cultural knowledge, attitudes, and beliefs of patient population).

Site Visit Findings

7. Was the health center able to provide an example of how it delivers services in a manner that is culturally appropriate for its patient population (for example, culturally appropriate health promotion tools)?
   ☐ YES ☐ NO

   If No, an explanation is required:
   _____

CLINICAL STAFFING

Primary Reviewer: Clinical Expert
Secondary Reviewer: Governance/Administrative Expert (as needed)

Authority: *Sections 330(a)(1), (b)(1)-(2), and (k)(3)(I)(ii)(II)-(III) of the Public Health Service (PHS) Act; and 42 CFR 51c.303(a), 42 CFR 51c.303(p), 42 CFR 56.303(a), and 42 CFR 56.303(p)*

Document Checklist for Health Center Staff

Documents Provided Prior to Site Visit:

- ☐ Credentialing and privileging procedures (including Human Resource procedures, if applicable)
- ☐ Website URL (if applicable)
- ☐ Current staffing profile (name, position, FTE, hire date). Indicate staff with interpretation/translation capabilities (i.e., bilingual, multilingual)

Documents Provided at the Start of the Site Visit:

- ☐ Needs Assessment(s) or related studies or resources
- ☐ 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 (LIPs) 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)

Demonstrating Compliance

Element a: Staffing to Provide Scope of Services

The health center ensures that it has clinical staff[1] and/or has contracts or formal referral arrangements in place with other providers or provider organizations to carry out all required and additional services included in the HRSA-approved scope of project.[2]

Site Visit Team Methodology

- Interview CMO/Clinical Director and/or equivalent health center leadership regarding scope of services, current clinical staffing, and recruitment and retention process(es).
- Tour at least one to two health center site(s) where the majority of required services are delivered.
- Review current staffing profile.
- Review health center's Form 5A for background and alignment of services with staffing. Refer to Required and Additional Health Services documentation for further details on the staffing for services provided via contracts/agreements and written referral arrangements.

Site Visit Findings

1. Does the health center's current clinical staffing makeup (for example, employees, volunteers, contracted and referral providers) enable it to carry out the approved scope of project (i.e., the list of Required and Additional services on Form 5A)?
   ☐ YES ☐ NO

   If No, an explanation is required specifying what staffing is lacking and for which services:
   _____

Element b: Staffing to Ensure Reasonable Patient Access

The health center has considered the size, demographics, and health needs (for example, large number of children served, high prevalence of diabetes) of its patient population in determining the number and mix of clinical staff necessary to ensure reasonable patient access to health center services.

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[1] Clinical staff includes licensed independent practitioners (for example, physician, dentist, physician assistant, nurse practitioner), other licensed or certified practitioners (for example, registered nurse, licensed practical nurse, registered dietitian, certified medical assistant), and other clinical staff providing services on behalf of the health center (for example, medical assistants or community health workers in states, territories or jurisdictions that do not require licensure or certification).
[2] Health centers seeking coverage for themselves and their providers under the Health Center Federal Tort Claims Act (FTCA) Medical Malpractice Program should review the statutory and policy requirements for coverage, as discussed in the FTCA Health Center Policy Manual.

Site Visit Team Methodology

- Interview CMO/Clinical Director and/or equivalent health center leadership (for example, Dental Director, Pharmacist) regarding how the number and mix of clinical staff support patient access.
- Review health center's needs assessment documentation and Uniform Data System (UDS) Summary Report (number of patients served annually, patient demographics, primary diagnosis, and clinical quality and outcome measures).
- Assess the type and range of services provided through review of the health center's Form 5A and other resources as appropriate (for example, website, health center presentation during the Entrance Conference, observation during site visit tour(s), and interviews with clinical leadership).

Site Visit Findings

2. Was the health center able to provide one to two examples of how the mix (for example, pediatric and adult providers) and number (for example, full or part time staff, use of contracted providers) of clinical staff is responsive to the size, demographics, and needs of its patient population?
   ☐ YES ☐ NO

   If No, an explanation is required specifying why the example(s) did not show how the mix and number of clinical staff are responsive to the health center's patient population:

   _____

3. Given the number of patients served annually (based on most recent UDS), is the number and mix of current staff (considering the overall scope of project—i.e., all sites and all service delivery methods) sufficient to ensure reasonable patient access to health center services?
   ☐ YES ☐ NO

   If No, an explanation is required, including specific examples of why there is not reasonable patient access to health center services:

   _____

Element c: Procedures for Review of Credentials

The health center has operating procedures for the initial and recurring review (for example, every 2 years) of credentials for all clinical staff members (licensed independent practitioners (LIPs), other licensed or certified practitioners (OLCPs), and other clinical staff providing services on behalf of the health center) who are health center employees, individual contractors, or volunteers. These credentialing procedures would ensure verification of the following, as applicable:

- Current licensure, registration, or certification using a primary source;
- Education and training for initial credentialing, using:

  - Primary sources for LIPs[3]
  - Primary or other sources (as determined by the health center) for OLCPs and any other clinical staff;
- Completion of a query through the National Practitioner Data Bank (NPDB);[4]
- Clinical staff member's identity for initial credentialing using a government-issued picture identification;
- Drug Enforcement Administration (DEA) registration; and
- Current documentation of basic life support training.

Site Visit Team Methodology

- Review the health center's credentialing procedures (including Human Resource procedures, if applicable) for LIPs and OLCPs.
- If the health center utilizes other clinical staff who do not require licensure or certification to provide services on behalf of the health center (for example, non-certified medical/dental assistants, community health representatives, case managers), review the health center's credentialing procedures for those other clinical staff.
- Review any contracts the health center has with CVOs (if applicable).
- Interview the individual(s) that conduct or have responsibility for the credentialing of clinical staff to determine:
  - Whether education and training for LIPs is confirmed through:
    - Primary source verification obtained by the health center, or
    - The state licensing body, because the state licensing body conducts primary source verification of education and training for LIPs.
  - The health center's method(s) for tracking timelines for the recurring review of credentials of existing providers as well as tracking of date-sensitive credentials (such as professional licenses, DEA registration) to ensure currency.

Notes:

- *If a health center does not have "other clinical staff," the health center does not have to include such staff in its operating procedures.*
- *The health center determines whether to have separate credentialing processes for LIPs versus other provider types. For example, the health center determines what specific aspects of the credentialing process (such as verification of current licensure, registration, or certification) might not apply to "other clinical staff."*
- *For OLCPs and any other clinical staff, the health center determines the sources used for verification of education and/or training. In states in which the licensing agency, specialty board, or registry conducts primary source verification of education and training, the health center may consider the state's primary verification of state licensure or Board certification to be adequate verification of education and training.*

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[3] In states in which the licensing agency, specialty board or registry conducts primary source verification of education and training, the health center would not be required to duplicate primary source verification when completing the credentialing process.

[4] The NPDB is an electronic information repository authorized by Congress. It contains information on medical malpractice payments and certain adverse actions related to health care practitioners, entities, providers, and suppliers. For more information, see http://www.npdb.hrsa.gov.

Site Visit Findings

4. **Initial Credentialing Only:** Do the health center's credentialing procedures require verification of the following for all clinical staff (LIPs, OLCPs, and other clinical staff who are health center employees, individual contractors, or volunteers), as applicable, upon hire:

   - Clinical staff member's identity using a government-issued picture identification?
     ☐ YES ☐ NO

   - Verification by the health center or the state (licensing agency, specialty board, or registry) of the education and training of LIPs using a primary source?
     ☐ YES ☐ NO

   - Verification of the education and/or training of OLCPs and, as applicable, other clinical staff using a primary or secondary source, as determined by the health center?
     ☐ YES ☐ NO

   If No was selected for any of the above, an explanation is required:

   _____

5. **Initial and Recurring Credentialing Procedures:** Do the health center's credentialing procedures require verification of the following for all clinical staff (LIPs, OLCPs, and other clinical staff who are health center employees, individual contractors, or volunteers) upon hire AND on a recurring basis:

   - Current licensure, registration, or certification using a primary source for LIPs and OLCPs?
     ☐ YES ☐ NO

   - Completion of a query through the NPDB?
     ☐ YES ☐ NO

   - DEA registration (as applicable)?
     ☐ YES ☐ NO

   - Current documentation of basic life support training (or comparable training completed through licensure or certification)?
     ☐ YES ☐ NO

   If No was selected for any of the above, an explanation is required:

   _____

Element d: Procedures for Review of Privileges

The health center has operating procedures for the initial granting and renewal (for example, every 2 years) of privileges for clinical staff members (LIPs, OLCPs, and other clinical staff providing services on behalf of the health center) who are health center employees, individual contractors, or volunteers. These privileging procedures would address the following:

- Verification of fitness for duty, immunization, and communicable disease status;[5]
- For initial privileging, verification of current clinical competence via training, education, and, as available, reference reviews;
- For renewal of privileges, verification of current clinical competence via peer review or other comparable methods (for example, supervisory performance reviews); and
- Process for denying, modifying or removing privileges based on assessments of clinical competence and/or fitness for duty.

Site Visit Team Methodology

- Review the health center's privileging procedures (including Human Resource procedures, if applicable) for LIPs, OLCPs, and other clinical staff providing services on behalf of the health center to assess procedures for: verification of fitness for duty and immunization and communicable disease status; clinical competence; and modification or removal of privileges.
- Interview individual(s) or committee that completes or has approval authority for privileging of clinical staff to determine:
    - How fitness for duty, immunization, and communicable disease status are verified
    - How clinical competence is assessed for initial granting of privileges
    - How clinical competence is assessed for renewal of clinical privileges
    - What the health center's processes are for modifying or removing privileges

Note: *If a health center does not have "other clinical staff," the health center does not have to include such staff in its operating procedures.*

Site Visit Findings

6. Do the health center's operating procedures address both the initial granting and renewal of privileges for all clinical staff (LIPs, OLCPs, and other clinical staff who are health center employees, individual contractors, or volunteers)?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

7. Do the health center's privileging procedures require verification of the following for all clinical staff (LIPs, OLCPs, and other clinical staff who are health center employees, individual contractors, or volunteers) upon hire and on a recurring basis:

    - Fitness for duty?
      ☐ YES ☐ NO

[5] The CDC has published recommendations and many states have their own recommendations or standards for provider immunization and communicable disease screening. For more information about CDC recommendations, see http://www.cdc.gov/vaccines/adults/rec-vac/hcw.html.

- Immunization and communicable disease status?
  ☐ YES ☐ NO

- Current clinical competence?
  ☐ YES ☐ NO

If No was selected for any of the above, an explanation is required:

_____

8. Does the health center have criteria and processes for modifying or removing privileges based on the outcomes of clinical competence assessments?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

Element e: Credentialing and Privileging Records

The health center maintains files or records for its clinical staff (for example, employees, individual contractors, and volunteers) that contain documentation of licensure, credentialing verification, and applicable privileges, consistent with operating procedures.

Site Visit Team Methodology

- Interview health center staff regarding credentialing and privileging records.
- Review sample of files that contain credentialing and privileging information: four to five LIP files; four to five OLCP files; and, only if applicable, two to three files for other clinical staff.
- Conduct the review of the file sample together with the health center individual(s) responsible for maintaining credentialing and privileging documentation.

Note: *Please utilize the Credentialing and Privileging File Review Resource to assist in this review and for examples of documentation methods and sources.*

Site Visit Findings

9. Based on the review of the sample of provider files, did the files contain up-to-date (as defined by the health center in its operating procedures) documentation of licensure and credentialing of these clinical staff (employees, individual contractors, and volunteers)?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

10. Based on the review of the sample of provider files, did the files contain up-to-date (as defined by the health center in its operating procedures) documentation of privileging decisions (for example, an up-to-date privileging list for each provider) for these clinical staff (employees, individual contractors, and volunteers)?
    ☐ YES ☐ NO

If No, an explanation is required:

_____

Element f: Credentialing and Privileging of Contracted or Referral Providers

If the health center has contracts with provider organizations (for example, group practices, locum tenens staffing agencies, training programs) or formal, written referral agreements with other provider organizations that provide services within its scope of project, the health center ensures[6] that such providers are:

- Licensed, certified, or registered as verified through a credentialing process, in accordance with applicable federal, state, and local laws; and
- Competent and fit to perform the contracted or referred services, as assessed through a privileging process.

Site Visit Team Methodology

- Interview health center staff involved in overseeing and managing services provided via contracts and/or referral arrangements regarding related credentialing and privileging processes.
- Review **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.
- Review **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.

Note: *If possible, conduct the review of the contract(s)/agreement(s), referral arrangement(s), or related documentation together with health center staff involved in overseeing and managing services provided via contracts and/or referral arrangements.*

Site Visit Findings

11. Was the health center able to ensure through provisions in contracts or through other means (for example, health center review of the contracted organizations' credentialing and privileging processes) that contracted services (Form 5A, Column II) are provided by organizations that:

    - Verify provider licensure, certification, or registration through a credentialing process?
      ☐ YES ☐ NO ☐ NOT APPLICABLE

[6] This may be done, for example, through provisions in contracts and cooperative arrangements with such organizations or health center review of the organizations' credentialing and privileging processes.

- Verify providers are competent and fit to perform the contracted service(s) through a privileging process?
  ☐ YES ☐ NO ☐ NOT APPLICABLE

Notes:

- *Select "Not Applicable" if the health center does not offer any services via Column II.*
- *For Column II services that involve a contract with provider organization(s), the credentialing and privileging process for the provider(s) may either be conducted by the provider organization(s) or may be conducted by the health center. Individual contractors are credentialed and privileged by the health center (see demonstrating compliance element "c").*

If No was selected for any of the above, an explanation is required:

_____

12. Was the health center able to ensure through provisions in written referral arrangements or through other means (for example, health center review of the credentialing and privileging processes of the referral organization(s)) that referred services (Form 5A, Column III) are provided by organizations that:

- Verify provider licensure, certification, or registration through a credentialing process?
  ☐ YES ☐ NO ☐ NOT APPLICABLE

- Verify providers are competent and fit to perform the referred service(s) through a privileging process?
  ☐ YES ☐ NO ☐ NOT APPLICABLE

Notes:

- *Select "Not Applicable" if the health center does not offer any services via Column III.*
- *In all cases for Column III services, the credentialing and privileging process for providers is external (i.e., conducted by the referral provider/organization).*

If No was selected for any of the above, an explanation is required:

_____

ACCESSIBLE LOCATIONS AND HOURS OF OPERATION

Primary Reviewer: Governance/Administrative Expert
Secondary Reviewer: Clinical Expert

Authority: *Section 330(k)(3)(A) of the Public Health Service (PHS) Act; and 42 CFR 51c.303(a) and 42 CFR 56.303(a)*

Document Checklist for Health Center Staff

Documents Provided Prior to Site Visit:

- ☐ 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 (if updated since last application submission to HRSA)

Documents Provided at the Start of the Site Visit:

- ☐ Patient satisfaction surveys or other forms of patient input
- ☐ Needs assessment(s) or related studies or resources

Demonstrating Compliance

Element a: Accessible Service Sites

The health center's service site(s) are accessible to the patient population relative to where this population lives or works (for example, in areas immediately accessible to public housing for health centers targeting public housing residents, or in shelters for health centers targeting individuals experiencing homelessness, or at migrant camps for health centers targeting agricultural workers). Specifically, the health center considers the following factors to ensure the accessibility of its sites:

- Access barriers (for example, barriers resulting from the area's physical characteristics, residential patterns, or economic and social groupings); and
- Distance and time taken for patients to travel to or between service sites in order to access the health center's full range of in-scope services.

Site Visit Team Methodology

- Review Service Area Map.
- Review needs assessment(s) or related studies or resources.
- Review status of any special populations funding or designation.
- Interview health center staff and board members, walking through considerations either for one to two sites already in scope OR a site added to scope within the past year.

Site Visit Findings

1. Does the health center take the following factors, including those specific to special population(s) (if applicable), into consideration in determining where to locate its sites:

    - Access barriers (for example, the health center has considered the ways patients access health center sites)?
      ☐ YES ☐ NO

    - Distance and time taken for patients to travel to or between service sites in order to access the health center's full range of in-scope services (for example, if some in-scope services are located only at certain sites, the health center facilitates access to these services for the entire patient population)?
      ☐ YES ☐ NO

    If No was selected for any of the above, an explanation is required:

    _____

Element b: Accessible Hours of Operation

The health center's total number and scheduled hours of operation across its service sites are responsive to patient needs by facilitating the ability to schedule appointments and access the health center's full range of services within the HRSA-approved scope of project[1] (for example, a health center service site might offer extended evening hours 3 days a week based on input or feedback from patients who cannot miss work for appointments during normal business hours).

Site Visit Team Methodology

- Review health center's Form 5B to assess overall range of hours of operation and addresses of sites.
- Review needs assessment(s) or related studies or resources.
- Review patient satisfaction surveys or other forms of patient input.

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[1] Services provided by a health center are defined at the awardee/designee level, not by individual site. Thus, not all services must be available at every health center service site; rather, health center patients must have reasonable access to the full complement of services offered by the center as a whole, either directly or through formal written established arrangements. See http://www.bphc.hrsa.gov/programrequirements/scope.html for further details on scope of project, including services and column descriptors listed on Form 5A: Services Provided.

- Interview relevant health center staff and board members to have them provide one to two examples of how hours are responsive to patient need.

Site Visit Findings

2. Has the health center taken patient needs into consideration in setting the hours of operation of its sites (for example, within available resources, the hours correspond to most requested appointment times or align with the most in-demand services)?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

Element c: Accurate Documentation of Sites within Scope of Project

The health center accurately records the sites in its HRSA-approved scope of project[2] on its Form 5B: Service Sites in HRSA's Electronic Handbooks (EHBs).

Site Visit Team Methodology

- Review health center's Form 5B.
- Review latest list of site addresses provided by health center and compare to those sites listed on the most current Form 5B in the EHBs.
- Interview relevant health center staff.

Site Visit Findings

3. Was the health center able to attest that its Form 5B is an accurate reflection of all active sites in scope?
   ☐ YES ☐ NO

   If No, an explanation is required, including specifying whether the health center can document that any necessary Change in Scope requests have been submitted to HRSA (for example, request to delete an inactive site has been submitted via the EHBs):

   _____

[2] In accordance with 45 CFR 75.308(c)(1)(i), health centers must request prior approval from HRSA for a "Change in the scope or the objective of the project or program (even if there is no associated budget revision requiring prior written approval)." This prior approval requirement applies to the addition or deletion of a service site. These changes require prior approval from HRSA and must be submitted by the health center as a formal Change in Scope request. See http://www.bphc.hrsa.gov/programrequirements/scope.html for further details on scope of project.

COVERAGE FOR MEDICAL EMERGENCIES DURING AND AFTER HOURS

Primary Reviewer: Clinical Expert
Secondary Reviewer: TBD

Authority: *Section 330(b)(1)(A)(IV) and Section 330(k)(3)(A) of the Public Health Service (PHS) Act; and 42 CFR 51c.102(h)(4), 42 CFR 56.102(l)(4), 42 CFR 51c.303(a), and 42 CFR 56.303(a)*

Document Checklist for Health Center Staff

Documents Provided Prior to Site Visit:

- ☐ Operating procedures for addressing medical emergencies during health center's hours of operation
- ☐ Operating procedures for responding to patient medical emergencies after hours
- ☐ Staffing schedules for up to five service delivery sites that identify the individual(s) with current certification in basic life support at each site

Documents Provided at the Start of the Site Visit:

- ☐ 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 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 (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

Demonstrating Compliance

Element a: Clinical Capacity for Responding to Emergencies During Hours of Operation

The health center has at least one staff member trained and certified in basic life support present at each HRSA-approved service site (as documented on Form 5B: Service Sites) to ensure the health center has the clinical capacity to respond to patient medical emergencies[1] during the health center's regularly-scheduled hours of operation.[2]

Site Visit Team Methodology

- Interview health center clinical leadership.
- Review operating procedures for provisions that ensure that all service delivery sites have at least one individual per site present during the health center's regularly-scheduled hours of operation to respond to patient medical emergencies.
- Using staffing schedules for up to five service delivery sites, request that clinical leadership identify the individual(s) with current certification in basic life support present at each site during the health center's regularly-scheduled hours of operation.

Site Visit Findings

1. Was there documentation that the health center ensures at least one staff member (clinical or non-clinical) trained and certified in basic life support is present at each HRSA-approved service delivery site to respond to patient medical emergencies during the health center's regularly-scheduled hours of operation?
   ☐ YES ☐ NO

   If No, an explanation is required, including stating what, if any, provisions the health center has in place to respond to patient medical emergencies during regularly-scheduled hours of operation at its site(s):

   _____

Element b: Procedures for Responding to Emergencies During Hours of Operation

The health center has and follows its applicable operating procedures when responding to patient medical emergencies during regularly-scheduled hours of operation.

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[1] Medical emergencies may, for example, include those related to physical, oral, behavioral, or other emergent health needs.
[2] See [Health Center Program Compliance Manual] Chapter 6: Accessible Location and Hours of Operation for more information on hours of operation.

Site Visit Team Methodology

- Review health center's operating procedures for responding to medical emergencies.
- Interview CMO, Clinical Director, and/or equivalent leadership regarding how the health center HAS or WOULD follow its operating procedure when responding to a patient emergency.

Site Visit Findings

2. Were you able to confirm that the health center has operating procedures for responding to patient medical emergencies during the health center's regularly-scheduled hours of operation?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

3. Was the health center able to describe how it either has responded to or is prepared to respond to (for example, staff training or drills on use of procedures) patient medical emergencies during regularly-scheduled hours of operation?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

Element c: Procedures or Arrangements for After-Hours Coverage

The health center has after-hours coverage operating procedures, which may include formal arrangements[3] with non-health center providers/entities, that ensure:

- Coverage is provided via telephone or face-to-face by an individual with the qualification and training necessary to exercise professional judgment in assessing a health center patient's need for emergency medical care;
- Coverage includes the ability to refer patients either to a licensed independent practitioner for further consultation or to locations such as emergency rooms or urgent care facilities for further assessment or immediate care as needed; and
- Patients, including those with limited English proficiency (LEP),[4] are informed of and are able to access after-hours coverage, based on receiving after-hours coverage information and instructions in the language(s), literacy levels, and formats appropriate to the health center's patient population needs.

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[3] See [Health Center Program Compliance Manual] Chapter 12: Contracts and Subawards for more information on oversight over such arrangements.

[4] Under Section 602 of Title VI of the Civil Rights Act and the Department of Health and Human Services implementing regulations (45 CFR Section 80.3(b)(2)), recipients of federal financial assistance, including health centers, must take reasonable steps to ensure meaningful access to their programs, services, and activities by eligible limited English proficient (LEP) persons. See http://www.hhs.gov/ocr/civilrights/resources/laws/summaryguidance.html for further guidance on translating vital documents for LEP persons.

Site Visit Team Methodology

- Review the health center's operating procedures or, if applicable, other documentation of arrangements for responding to patient medical emergencies after hours.
- Review provider on-call schedules and answering service contract (if applicable).
- Review instructions or information provided to patients for accessing after-hours coverage.
- Using contact information for after-hours coverage (for example, phone number provided by front desk staff, on signage, in brochures, on health center's website), call the health center once the health center is closed.
- Interview CMO, Clinical Director, and/or equivalent health center leadership and, if applicable, outreach or front desk staff regarding methods of informing patients of after-hours coverage.

Site Visit Findings

4. Does the health center have written operating procedures or other documented arrangements for responding to patient medical emergencies after hours?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

5. Based on the interview with clinical leadership and/or front desk staff, is information provided to patients at all health center service sites (as listed on Form 5B) on how to access after-hours coverage?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

6. Has the health center addressed barriers that patients might face in attempting to utilize the health center's after-hours coverage? This would include barriers due to LEP or literacy levels.
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

7. Did the results from the call made to the health center after hours confirm the following:

   - You were connected to an individual with the qualification and training necessary to exercise professional judgment to address an after-hours call?
     ☐ YES ☐ NO

   - This individual can refer patients to a covering licensed independent practitioner for further consultation or to locations such as emergency rooms or urgent care facilities for further assessment or immediate care?
     ☐ YES ☐ NO

- Provisions are in place for calls received from patients with LEP?
  ☐ YES ☐ NO

If No was selected for any of the above, an explanation is required:

_____

Element d: After-Hours Call Documentation

The health center has documentation of after-hours calls and any necessary follow-up resulting from such calls for the purposes of continuity of care.[5]

Site Visit Team Methodology

- Interview CMO, Clinical Director, and/or equivalent health center leadership.
- Review the health center's operating procedures or, if applicable, other documentation of arrangements (for example, contract with nurse call line) for responding to patient medical emergencies after hours.
- Review three samples of after-hours documentation within the patient record (a screenshot of the record is also acceptable) provided by the health center, including associated documentation of follow-up. The samples will be based on after-hours calls that necessitated follow-up by the health center.
  Note: *If the health center has fewer than three after-hours calls that required follow-up, the health center will make up the difference with after-hours call documentation that did not require follow-up.*
- Request to view documentation or systems/methods for tracking, recording, and storing after-hours call coverage interactions and, if applicable, related follow-up.

Site Visit Findings

8. Does the health center document after-hours calls or, if no such calls have been received, does the health center have the capacity to document such calls?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

9. Does the health center (based on review of systems or the sample of records) provide the necessary follow-up, based on the nature of after-hours calls (for example, health center contacts the patient within a prescribed number of days to check in on the patient's condition, schedule an appointment)?

[5] See [Health Center Program Compliance Manual] Chapter 8: Continuity of Care and Hospital Admitting for more information on continuity of care.

Note: *For health centers that had no after-hours calls that required follow-up (for example, a newly-funded health center that has just started its operations), a review of operating procedures and results of the interview(s) with health center staff can be used when responding to this question.*

☐ YES ☐ NO

If No, an explanation is required:

_____

CONTINUITY OF CARE AND HOSPITAL ADMITTING

Primary Reviewer: Clinical Expert
Secondary Reviewer: N/A

Authority: *Section 330(k)(3)(A) and 330(k)(3)(L) of the Public Health Service (PHS) Act; and 42 CFR 51.c.303(a) and 42 CFR 56.303(a)*

Document Checklist for Health Center Staff

Documents Provided Prior to Site Visit:

- ☐ 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

Documents Provided at the Start of the Site Visit:

- ☐ 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

Demonstrating Compliance

Element a: Documentation of Hospital Admitting Privileges or Arrangements

The health center has documentation of:

- Health center provider[1] hospital admitting privileges (for example, provider employment contracts or other files indicate the provider(s) has admitting privileges at one or more hospitals); and/or

[1] In addition to physicians, various provider types may have admitting privileges, if applicable, based on scope of practice in their state (for example, nurse practitioners, certified nurse midwives).

- Formal arrangements between the health center and one or more hospitals or entities (for example, hospitalists, obstetrics hospitalist practices) for the purposes of hospital admission of health center patients.

Site Visit Team Methodology

- Interview health center clinical leadership (for example, CMO, Clinical Director) on processes for ensuring continuity of care for patients that require inpatient hospitalization.
- Review documentation of EITHER:
    - Provider hospital admitting privileges that address delivery of care in a hospital setting to health center patients by health center providers; OR
    - Formal arrangements with non-health center provider(s) or entity(ies) (for example, hospitalists) that address hospital admissions of health center patients.

Site Visit Findings

1. Does the health center have:

    - Documentation of hospital admitting privileges (if select health center providers assume responsibility for admitting and following hospitalized patients); and/or
    - Formal arrangements with non-health center provider(s) or entity(ies) (such as a hospital, hospitalist group, or obstetrics practice) that address health center patient hospital admissions?
      ☐ YES ☐ NO

    If Yes OR No, an explanation is required specifying the health center's arrangement(s) for hospital admissions:

    _____

Element b: Procedures for Hospitalized Patients

The health center has internal operating procedures and, if applicable, related provisions in its formal arrangements with non-health center provider(s) or entity(ies) that address the following areas for patients who are hospitalized as inpatients or who visit a hospital's emergency department (ED):[2]

- Receipt and recording of medical information related to the hospital or ED visit, such as discharge follow-up instructions and laboratory, radiology, or other results; and
- Follow-up actions by health center staff, when appropriate.

[2] Health center patients may be admitted to a hospital setting through a variety of means (for example, a visit to the ED may lead to an inpatient hospital admission, or a health center patient may be directly admitted to a unit of the hospital, such as labor and delivery).

Site Visit Team Methodology

- Review health center internal operating procedures and/or documentation from arrangements with non-health center provider(s) or entity(ies) to assess continuity of care provisions.
- Interview health center staff regarding continuity of care.

Site Visit Findings

2. Did the health center's internal operating procedures and/or arrangements with non-health center provider(s) or entity(ies), if applicable, address the following:

    - How the health center will obtain or receive medical information related to patient hospital or ED visits and record such information (for example, discharge follow-up instructions and laboratory, radiology, or other results)?
      ☐ YES ☐ NO

    - Follow-up by the health center staff, when appropriate?
      ☐ YES ☐ NO

    If No was selected for any of the above, an explanation is required:

    _____

Element c: Post-Hospitalization Tracking and Follow-up

The health center follows its operating procedures and formal arrangements as documented by:

- Receipt and recording of medical information related to the hospital or ED visit, such as discharge follow-up instructions and laboratory, radiology, or other results; and
- Evidence of follow-up actions taken by health center staff based on the information received, when appropriate.

Site Visit Team Methodology

- Have a health center clinical staff member navigate the reviewer through 5–10 health center patient records.
- Interview relevant health center staff regarding access to medical information related to hospital and ED visits and associated follow-up actions by health center staff.

Site Visit Findings

3. Based on the review of sampled records and interview, was there documentation of:

    - Medical information related to the hospital or ED visit, such as discharge follow-up instructions and laboratory, radiology, or other results?
      ☐ YES ☐ NO

- Follow-up actions taken by health center staff based on the information received, when appropriate?
  ☐ YES ☐ NO

Note: *For a health center that has had no patients who have been hospitalized in the past 12 months (for example, a newly-funded health center that has just started its operations), a review of operating procedures and results of the interview with health center staff can be used to respond to these questions.*

If No was selected for any of the above, an explanation is required:

_____

SLIDING FEE DISCOUNT PROGRAM

Primary Reviewer: Fiscal Expert
Secondary Reviewer: Governance/Administrative Expert

Authority: *Section 330(k)(3)(G) of the Public Health Service (PHS) Act; 42 CFR 51c.303(f), 42 CFR 51c.303(g), 42 CFR 51c.303(u), 42 CFR 56.303(f), 42 CFR 56.303(g), and 42 CFR 56.303(u)*

Document Checklist for Health Center Staff

Documents Provided Prior to 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)

Documents Provided at the Start of the Site Visit:

- ☐ 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
- ☐ 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 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 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*
- ☐ 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)
- ☐ 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

Demonstrating Compliance

Element a: Applicability to In-Scope Services

The health center has a sliding fee discount program (SFDP)[1] that applies to all required and additional health services[2] within the HRSA-approved scope of project for which there are distinct fees.[3]

Site Visit Team Methodology

- Interview health center staff involved in implementing SFDP policies (for example, key management staff, eligibility and outreach staff, front desk staff, billing staff, office manager, case managers) including, time permitting, a walk-through of the SFDS screening and enrollment process.
- Review the health center's SFDP policy(ies), procedures, schedule(s) (single or multiple SFDSs, if applicable), and any related policies, procedures, forms, and materials.
- Review health center's Form 5A: Services Provided.

Site Visit Findings

1. Are ALL services within the approved scope of project offered on a sliding fee discount schedule (SFDS) (for Columns I and II) or offered under any other type of discount (for Column III)? "Services" refers to all Required and Additional services across all applicable service delivery methods listed on the health center's Form 5A for which there are distinct fees.

   ***Notes**:*
   - *Please include any findings regarding the specific STRUCTURE of the SFDS for services in Columns I, II, and III within applicable elements "c," "i," and "j."*
   - *Services (for example, transportation, translation, other non-clinical services) on Form 5A that are not billed for in the local health care market may be excluded from the health center's fee schedule and, therefore, from the health center's SFDS.*

   ☐ YES ☐ NO

   If No, an explanation is required, including specifying which in-scope services are excluded from sliding fee discounts or any other type of discount:

   _____

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[1] A health center's sliding fee discount program consists of the schedule of discounts that is applied to the fee schedule and adjusts fees based on the patient's ability to pay. A health center's SFDP also includes the related policies and procedures for determining sliding fee eligibility and applying sliding fee discounts.

[2] See [Health Center Program Compliance Manual] Chapter 4: Required and Additional Health Services for more information on requirements for services within the scope of the project.

[3] A distinct fee is a fee for a specific service or set of services, which is typically billed for separately within the local health care market.

Element b: Sliding Fee Discount Program Policies

The health center has board-approved policy(ies) for its SFDP that apply uniformly to all patients and address the following areas:

- Definitions of income[4] and family;
- Assessment of all patients for sliding fee discount eligibility based only on income and family size, including methods for making such assessments;
- The manner in which the health center's SFDS(s) will be structured in order to ensure that patient charges are adjusted based on ability to pay; and
- *Only applicable to health centers that choose to have a nominal charge for patients at or below 100 percent of the Federal Poverty Guidelines (FPG)*: The setting of a flat nominal charge(s) at a level that would be nominal from the perspective of the patient (for example, based on input from patient board members, patient surveys, advisory committees, or a review of co-pay amount(s) associated with Medicare and Medicaid for patients with comparable incomes) and would not reflect the actual cost of the service being provided.[5]

Site Visit Team Methodology

- Interview board member(s) and key management staff.
  ***Note**: Interviews may be conducted in collaboration with the governance/administrative expert.*
- Review the health center's SFDP policy(ies).
  ***Note**: This may be combined with the policy review conducted for element "a."*
- Review any other related policies, procedures, and documents provided by the health center, if applicable.
- If the board-approved SFDP policy does not state a specific amount for nominal charge(s), review other documentation (for example, board minutes, reports) of board involvement in setting the amount of nominal charge(s).

Site Visit Findings

2. Does the health center's SFDP policy include language or provisions that address all of the following:

   - Uniform applicability to all patients?
     ☐ YES ☐ NO

   - Income and family (or "household") (for example, any inclusions or exclusions in how they are defined)?
     ☐ YES ☐ NO

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[4] Income is defined as earnings over a given period of time used to support an individual/household unit based on a set of criteria of inclusions and exclusions. Income is distinguished from assets, as assets are a fixed economic resource while income is comprised of earnings.
[5] Nominal charges are not "minimum fees," "minimum charges," or "co-pays."

- Methods for assessing patient eligibility based only on income and family size?
  ☐ YES ☐ NO

- The manner in which SFDS(s) are structured to ensure charges are adjusted based on ability to pay (for example, flat fee amounts differ across discount pay classes, a graduated percent of charges for patients with incomes above 100 percent and at or below 200 percent of FPG)?
  ☐ YES ☐ NO

- The setting of a nominal charge(s) for patients at or below 100 percent FPG?

  Note: *Select "Not Applicable" if the health center does not charge patients at or below 100 percent FPG.*
  ☐ YES ☐ NO ☐ NOT APPLICABLE

If No was selected for any of the above, an explanation is required:

_____

3. Does the health center's policy ensure that any/all charge(s) for patients at or below 100 percent of the FPG will be:

   - A flat fee?
     ☐ YES ☐ NO ☐ NOT APPLICABLE

   - Nominal from a patient's perspective?
     ☐ YES ☐ NO ☐ NOT APPLICABLE

   - Not based on the actual cost of the service?
     ☐ YES ☐ NO ☐ NOT APPLICABLE

   Note*: The health center's SFDP policy may state how the nominal charge will be determined AND/OR the amount of the nominal charge(s). 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) may be utilized.*

   If No was selected for any of the above, an explanation is required:

   _____

Element c: Sliding Fee for Column I Services

For services provided directly by the health center (Form 5A: Services Provided, Column I), the health center's SFDS(s) is structured consistent with its policy and provides discounts as follows:

- A full discount is provided for individuals and families with annual incomes at or below 100 percent of the current FPG, unless a health center elects to have a nominal charge, which would be less than the fee paid by a patient in the first sliding fee discount pay class above 100 percent of the FPG.

- Partial discounts are provided for individuals and families with incomes above 100 percent of the current FPG and at or below 200 percent of the current FPG, and those discounts adjust based on gradations in income levels and include at least three discount pay classes.[6]
- No discounts are provided to individuals and families with annual incomes above 200 percent of the current FPG.[7]

Site Visit Team Methodology

- Review the structure of the health center's SFDS(s) for Column I services.
  ***Note**: For health centers that utilize multiple SFDSs, the structure of each SFDS must be reviewed, including, if applicable, any nominal charges.*
- Interview key management staff.

Site Visit Findings

In responding to the question(s) below, please note:
The questions relate to services provided directly by the health center (Form 5A: Services Provided, Column I).

4. For patients with incomes at or below 100 percent of FPG, does the SFDS(s):

   - Provide a full discount (no nominal charge(s))?
     ☐ YES ☐ NO

   - Require only a nominal charge(s) ("fee")?
     ☐ YES ☐ NO

   If No was selected for BOTH of the above, an explanation is required:

   _____

5. If the health center has a nominal charge(s), is the nominal charge(s) less than the fee that would be paid by patients in the first sliding fee discount pay class above 100 percent of FPG?
   ☐ YES ☐ NO ☐ NOT APPLICABLE

   If No, an explanation is required:

   _____

6. For patients with incomes above 100 percent and at or below 200 percent of the FPG, does the SFDS(s) provide partial discounts adjusted in accordance with gradations in

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[6] For example, a SFDS with discount pay classes of 101 percent to 125 percent of the FPG, 126 percent to 150 percent of the FPG, 151 percent to 175 percent of the FPG, 176 percent to 200 percent of the FPG, and over 200 percent of the FPG would have four discount pay classes between 101 percent and 200 percent of the FPG.
[7] See [Health Center Program Compliance Manual] Chapter 16: Billing and Collections, if the health center has access to other grants or subsidies that support patient care.

income levels and consist of at least three discount pay classes (i.e., as patient income increases, the discounts decrease accordingly)?
☐ YES ☐ NO

If No, an explanation is required:

_____

7. For patients with incomes above 200 percent of the FPG, is the SFDS(s) structured so that such patients are not eligible for a sliding fee discount under the Health Center Program?

   ***Note**: Health centers that provide sliding fee discounts to patients with incomes above 200 percent of the FPG may do so as long as such discounts are supported through other funding sources (for example, Ryan White Part C award).*
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

Element d: Multiple Sliding Fee Discount Schedules

For health centers that choose to have more than one SFDS, these SFDSs would be based on services (for example, having separate SFDSs for broad service types, such as medical and dental, or distinct subcategories of service types, such as preventive dental and additional dental services) and/or on service delivery methods (for example, having separate SFDSs for services provided directly by the health center and for in-scope services provided via formal written contract) and no other factors.

Site Visit Team Methodology

- Review each different SFDS in use and the basis for the separate discount schedule(s) (if applicable).
- Interview key management staff.

Site Visit Findings

8. Does the health center have more than one SFDS?
   ☐ YES ☐ NO

9. **If Yes:** Is each SFDS based either on service or service delivery method and no other factors (for example, patient insurance status, location of site, other demographic or patient characteristics)?
   ☐ YES ☐ NO ☐ NOT APPLICABLE

   If No, an explanation is required:

   _____

Element e: Incorporation of Current Federal Poverty Guidelines

The health center's SFDS(s) has incorporated the most recent FPG.

Site Visit Team Methodology

- Review the SFDS(s) for the income ranges and family size.
- Review current FPG and related resources available at: https://aspe.hhs.gov/poverty-guidelines.

Site Visit Findings

10. Based on the review of the health center's current SFDS(s), has the health center incorporated the current FPG in the calculations for all of the discount pay classes?
☐ YES ☐ NO

    If No, an explanation is required:

    _____

Element f: Procedures for Assessing Income and Family Size

The health center has operating procedures for assessing/re-assessing all patients for income and family size consistent with board-approved SFDP policies.

Site Visit Team Methodology

- Interview health center staff involved in implementing SFDP policies (for example, key management staff, eligibility and outreach staff, front desk staff, billing staff, office manager, case managers) including, time permitting, a walk-through of the SFDS screening and enrollment process.
- Review the health center's SFDP policy(ies), procedures, schedule(s) (single or multiple SFDSs, if applicable), and any related policies, procedures, forms, and materials. ***Note**: This may be combined with the policy review conducted for element "a."*

Site Visit Findings

11. Does the health center have operating procedures for assessing/re-assessing all patients (regardless of insurance status) for income and family size?
☐ YES ☐ NO

    If No, an explanation is required:

    _____

12. Are these procedures consistent with the board-approved policy for the SFDP?
☐ YES ☐ NO

    If No, an explanation is required:

    _____

Element g: Assessing and Documenting Income and Family Size

The health center has records of assessing/re-assessing patient income and family size except in situations where a patient has declined or refused to provide such information.

Site Visit Team Methodology

- Review a sample of 5–10 records, files, or other forms of documentation of patient income and family size. The health center will specifically provide a sample that includes records for:
  - Uninsured and insured patients
  - Initial assessments for income and family size as well as re-assessments
- Interview key management staff.

Site Visit Findings

13. Did the review of the sample indicate that the health center is consistently assessing and re-assessing patient income and family size?
    ☐ YES ☐ NO

    If No, an explanation is required:

    _____

Element h: Informing Patients of Sliding Fee Discounts

The health center has mechanisms for informing patients of the availability of sliding fee discounts (for example, distributing materials in language(s) and literacy levels appropriate for the patient population, including information in the intake process, publishing information on the health center's website).

Site Visit Team Methodology

- Site tour(s), interviews with health center staff (for example, eligibility and outreach staff, front desk staff, billing staff, office manager, case managers), and review of mechanisms for informing patients.
- Interview key management staff.

Site Visit Findings

14. Based on site tours, interviews, and review of related materials, does the health center have mechanisms for informing patients of the availability of sliding fee discounts and how to apply for such discounts?
    ☐ YES ☐ NO

    If No, an explanation is required:

    _____

Element i: Sliding Fee for Column II Services

For in-scope services provided via contracts (Form 5A: Services Provided, Column II, Formal Written Contract/Agreement), the health center ensures that fees for such services are discounted as follows:

- A full discount is provided for individuals and families with annual incomes at or below 100 percent of the current FPG, unless a health center elects to have a nominal charge, which would be less than the fee paid by a patient in the first sliding fee discount pay class above 100 percent of the FPG.
- Partial discounts are provided for individuals and families with incomes above 100 percent of the current FPG and at or below 200 percent of the current FPG, and those discounts adjust based on gradations in income levels and include at least three discount pay classes.
- No discounts are provided to individuals and families with annual incomes above 200 percent of the current FPG.

Site Visit Team Methodology

- Interview health center staff involved in administering contracts for services.
  For any service delivered via Column II (whether or not the service is also delivered via Column I and/or Column III), review at least one but no more than three written contracts/agreements for EACH Required and EACH Additional Service.
  Notes:
  - *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.*
  - *The fiscal expert may wish to collaborate with the clinical expert on this review because the same sample is used in Required and Additional Health Services.*

Site Visit Findings

In responding to the question(s) below, please note:

- *The questions relate to services provided via contracts (Form 5A: Services Provided, Column II).*
- *Services (for example, transportation, translation, other non-clinical services) on Form 5A that are not billed for in the local health care market may be excluded from the health center's fee schedule and, therefore, from the health center's SFDS.*

15. Does the health center provide services via contracts/agreements (Form 5A: Services Provided, Column II)?
    ☐ YES ☐ NO

16. For patients receiving service(s) through these contracts/agreements, has the health center ensured that sliding fee discounts are provided in a manner that meets all Health Center Program requirements (for example, health center applies its own SFDS to amounts owed by eligible patients; contract contains specific sliding fee provisions; contracted services are provided by another health center which applies an SFDS that meets structural requirements)?
    ☐ YES ☐ NO ☐ NOT APPLICABLE

If No, an explanation is required:

---

17. For patients with incomes at or below 100 percent of FPG, has the health center ensured that such patients are:

    - Provided a full discount (no nominal charge(s))?
      ☐ YES ☐ NO ☐ NOT APPLICABLE

    - Assessed a nominal charge(s) ("fee")?
      ☐ YES ☐ NO ☐ NOT APPLICABLE

    If No was selected for BOTH of the above, an explanation is required:

    ---

18. If there is a nominal charge, is the nominal charge less than the fee that would be paid by patients in the first sliding fee discount pay class above 100 percent of FPG?
    ☐ YES ☐ NO ☐ NOT APPLICABLE

    If No, an explanation is required:

    ---

19. For patients with incomes above 100 percent and at or below 200 percent of the FPG, does the SFDS(s) provide partial discounts adjusted in accordance with gradations in income levels and consist of at least three discount pay classes (i.e., as patient income increases, the discounts decrease accordingly)?
    ☐ YES ☐ NO ☐ NOT APPLICABLE

    If No, an explanation is required:

    ---

20. For patients with incomes above 200 percent of the FPG, is the SFDS(s) structured so that such patients are not eligible for a sliding fee discount under the Health Center Program?

    Note: *Health centers that provide sliding fee discounts to patients with incomes above 200 percent of the FPG may do so as long as such discounts are supported through other funding sources (for example, Ryan White Part C award).*
    ☐ YES ☐ NO ☐ NOT APPLICABLE

    If No, an explanation is required:

Element j: Sliding Fee for Column III Services

For services provided via formal referral arrangements (Form 5A: Services Provided, Column III), the health center ensures that fees for such services are either discounted as described in element "c" above or discounted in a manner such that:

- Individuals and families with incomes above 100 percent of the current FPG and at or below 200 percent of the FPG receive an equal or greater discount for these services than if the health center's SFDS were applied to the referral provider's fee schedule; and
- Individuals and families at or below 100 percent of the FPG receive a full discount or a nominal charge for these services.

Site Visit Team Methodology

- Interview health center staff involved in administering referral arrangements for services.
- For any service delivered via Column III (whether or not the service is also delivered via Column I and/or Column II), review at least one but no more than three written referral arrangements for EACH Required and EACH Additional Service.
  Notes:
  - *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.*
  - *The fiscal expert may wish to collaborate with the clinical expert on this review because the same sample is used in Required and Additional Health Services.*

Site Visit Findings

In responding to the question(s) below, please note:

- *The questions relate to services provided via formal referral arrangements (Form 5A: Services Provided, Column III).*
- *Services (for example, transportation, translation, other non-clinical services) on Form 5A that are not billed for in the local health care market may be excluded from the health center's fee schedule and, therefore, from the health center's SFDS.*

21. Does the health center provide services via formal referral arrangements (Form 5A: Services Provided, Column III)?
    ☐ YES ☐ NO

22. For patients receiving service through these referral arrangements, has the health center ensured that sliding fee discounts are EITHER provided in a manner that meets the structural requirements noted in element "c" OR discounted in a manner such that:

    - Individuals and families with incomes above 100 percent of the current FPG and at or below 200 percent of the FPG receive an **equal or greater discount** for these services than if the health center's SFDS were applied to the referral provider's fee schedule (for example, health center has a referral arrangement with organizations that charge no fee at all for patients at or below 200 percent of the FPG); and
    - Individuals and families at or below 100 percent of the FPG receive a full discount or a nominal charge for these services?
      ☐ YES ☐ NO ☐ NOT APPLICABLE

    If No, an explanation is required, including describing the format and type of any discount(s) provided:

    _____

Element k: Applicability to Patients with Third-Party Coverage

Health center patients who are eligible for sliding fee discounts and have third-party coverage are charged no more for any out-of-pocket costs than they would have paid under the applicable SFDS discount pay class.[8] Such discounts are subject to potential legal and contractual restrictions.[9]

Site Visit Team Methodology

- Interview health center staff involved in implementing SFDP policies (for example, key management staff, eligibility and outreach staff, front desk staff, billing staff, office manager, case managers) including, time permitting, a walk-through of the SFDS screening and enrollment process.
- Review the health center's SFDP policy(ies), procedures, schedule(s) (single or multiple SFDSs, if applicable), and any related policies, procedures, forms, and materials. ***Note**: This may be combined with the policy review conducted for element "a."*
- Interview relevant health center staff to determine whether the health center is subject to legal or contractual restrictions on sliding fee discounts for patients with third-party coverage. If so, the health center will produce the specific documentation of such restrictions.

Site Visit Findings

23. Based on interviews and a review of related documents, does the health center ensure that patients who are eligible for sliding fee discounts and who have third-party coverage are charged no more for any out-of-pocket costs (for example, deductibles, co-pays, and services not covered by the plan) than they would have paid under the applicable SFDS discount pay class?
    ☐ YES ☐ NO

    If No, an explanation is required, including describing any legal or contractual restrictions that the health center has documented:

    _____

Element l: Evaluation of the Sliding Fee Discount Program

The health center evaluates, at least once every 3 years, its SFDP. At a minimum, the health center:

- Collects utilization data that allows it to assess the rate at which patients within each of its discount pay classes, as well as those at or below 100 percent of the FPG, are accessing health center services;

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[8] For example, an insured patient receives a health center service for which the health center has established a fee of $80, per its fee schedule. Based on the patient's insurance plan, the co-pay would be $60 for this service. The health center also has determined, through an assessment of income and family size, that the patient's income is 150 percent of the FPG and thus qualifies for the health center's SFDS. Under the SFDS, a patient with an income at 150 percent of the FPG would receive a 50 percent discount of the $80 fee, resulting in a charge of $40 for this service. Rather than the $60 co-pay, the health center would charge the patient no more than $40 out-of-pocket, consistent with its SFDS, as long as this is not precluded or prohibited by the applicable insurance contract.

[9] Such limitations may be specified by applicable federal or state programs, or private payor contracts.

- Utilizes this and, if applicable, other data (for example, results of patient satisfaction surveys or focus groups, surveys of patients at various income levels) to evaluate the effectiveness of its SFDP in reducing financial barriers to care; and
- Identifies and implements changes as needed.

Site Visit Team Methodology

- Interview relevant health center staff involved in evaluating the SFDP.
- Interview board member(s) and key management staff.
  ***Note**: Interviews may be conducted in collaboration with the governance/administrative expert.*
- Review data, reports or any other relevant materials used to evaluate the SFDP.

Site Visit Findings

24. Does the health center evaluate the effectiveness of the SFDP in reducing financial barriers to care?
    ☐ YES ☐ NO

    If No, an explanation is required:

    _____

25. **If Yes:** Is this evaluation conducted at least once every 3 years?
    ☐ YES ☐ NO ☐ NOT APPLICABLE

    If No, an explanation is required:

    _____

26. Does the health center collect utilization data in order to assess whether patients within each of its discount pay classes are accessing health center services?
    ☐ YES ☐ NO

    If No, an explanation is required:

    _____

27. **If Yes:** Does the health center utilize these data (and, if applicable, any other data, such as collections or patient survey data) to evaluate the effectiveness of its SFDP?
    ☐ YES ☐ NO ☐ NOT APPLICABLE

    If No, an explanation is required:

    _____

28. Has the health center implemented any follow-up actions based on evaluation results (for example, changes to SFDP policy by board, implementation of improved eligibility screening processes or notification methods for sliding fee discounts)?
    ☐ YES ☐ NO

    If No, an explanation is required:

    _____

QUALITY IMPROVEMENT/ASSURANCE

Primary Reviewer: Clinical Expert
Secondary Reviewer: N/A

Authority: *Section 330(k)(3)(C) of the Public Health Service (PHS) Act; and 42 CFR 51c.110, 42 CFR 51c.303(b), 42 CFR 51c.303(c), 42 CFR 51c.304(d)(3)(iv-vi), 42 CFR 56.111, 42 CFR 56.303(b), 42 CFR 56.303(c), and 42 CFR 56.304(d)(4)(v-vii)*

Document Checklist for Health Center Staff

Documents Provided Prior to Site Visit:

- ☐ Policy(ies) that establishes 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

Documents Provided at the Start of the Site Visit:

- ☐ Sample of patient satisfaction results
- ☐ Sample of two QI/QA assessments from the past year and/or the related reports resulting from these assessments
- ☐ Job or position description(s) of individual(s) who oversee the QI/QA program
- ☐ 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) that include clinic visit note(s) and/or summary of care
  Note: *The same sample of patient records utilized for reviewing other program requirement areas also may be used for this sample*
- ☐ Documentation for related systems that support QI/QA (if applicable) (for example, event reporting system, tracking resolutions and grievances, dashboards)
- ☐ Schedule of QI/QA assessments

Demonstrating Compliance

Element a: QI/QA Program Policies

The health center has a board-approved policy(ies) that establishes a QI/QA program.[1] This QI/QA program addresses the following:

- The quality and utilization of health center services;
- Patient satisfaction and patient grievance processes; and
- Patient safety, including adverse events.

Site Visit Team Methodology

- Interview individual(s) designated to oversee the QI/QA program and related staff that support QI/QA.
- Review the health center's policy(ies) for the QI/QA program.
  Notes:
  - *The title of the QI/QA policy may vary from health center to health center (for example, this document may be called a "QI/QA plan").*
  - *If the board has not approved the QI/QA policy(ies), address this under Board Authority.*

Site Visit Findings

1. Does the health center have a QI/QA program that addresses the following areas:

   - The quality and utilization of health center services?
     ☐ YES ☐ NO

   - Patient satisfaction and patient grievance processes?
     ☐ YES ☐ NO

   - Patient safety, including adverse events?
     ☐ YES ☐ NO

   If No was selected for any of the above, an explanation is required, specifying which areas were not addressed:

   _____

Element b: Designee to Oversee QI/QA Program

The health center designates an individual(s) to oversee the QI/QA program established by board-approved policy(ies). This individual's responsibilities would include, but would not be

[1] See [Health Center Program Compliance Manual] Chapter 19: Board Authority for more information on the health center governing board's role in approving policies.

limited to, ensuring the implementation of QI/QA operating procedures and related assessments, monitoring QI/QA outcomes, and updating QI/QA operating procedures.

Site Visit Team Methodology

- Review job/position description(s) or other documents for background on the responsibilities of the individual(s) overseeing the QI/QA program.
- Interview individual(s) designated to oversee the QI/QA program to further understand their role(s) and responsibilities.

Site Visit Findings

2. Does the health center have a designated individual(s) to oversee the QI/QA program?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

3. Based on the interview(s) and review of the job/position description(s) or other documentation, do the responsibilities of this individual(s) include:

   - Ensuring the implementation of QI/QA operating procedures?
     ☐ YES ☐ NO
   - Ensuring QI/QA assessments are conducted?
     ☐ YES ☐ NO
   - Monitoring QI/QA outcomes?
     ☐ YES ☐ NO
   - Updating QI/QA operating procedures, as needed?
     ☐ YES ☐ NO

   If No was selected for any of the above, an explanation is required:

   _____

Element c: QI/QA Procedures or Processes

The health center has operating procedures or processes that address all of the following:

- Adhering to current evidence-based clinical guidelines, standards of care, and standards of practice in the provision of health center services, as applicable;
- Identifying, analyzing, and addressing patient safety and adverse events and implementing follow-up actions, as necessary;
- Assessing patient satisfaction;
- Hearing and resolving patient grievances;
- Completing periodic QI/QA assessments on at least a quarterly basis to inform the modification of the provision of health center services, as appropriate; and

- Producing and sharing reports on QI/QA to support decision-making and oversight by key management staff and by the governing board regarding the provision of health center services.

Site Visit Team Methodology

- Interview individual(s) responsible for the QI/QA program.
- Review the health center's 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
- Review sample of patient satisfaction results.
- Review related systems and/or documentation that support QI/QA.
- Review schedule of QI/QA assessments.
- Review sample of two QI/QA assessments from the past year and/or the related reports resulting from these assessments.

Site Visit Findings

4. Does the health center have operating procedures and/or related systems that address:

    - Adherence to current, applicable evidence-based clinical guidelines, standards of care, and standards of practice (for example, provider access to EHR clinical decision-making support, job aids, protocols, and/or other sources of evidence-based care)?
      ☐ YES ☐ NO

    - A process for health center staff to follow for identifying, analyzing, and addressing overall patient safety, including adverse events?
      ☐ YES ☐ NO

    - A process for implementing follow-up actions related to patient safety and adverse events, as necessary?
      ☐ YES ☐ NO

    - A process for the health center to assess patient satisfaction (for example, fielding patient satisfaction surveys, conducting periodic patient focus groups)?
      ☐ YES ☐ NO

    - A process for hearing and resolving patient grievances?
      ☐ YES ☐ NO

    - Completion of periodic QI/QA assessments on at least a quarterly basis?
      ☐ YES ☐ NO

If No was selected for any of the above, an explanation is required, including specifying which areas were not addressed:

_____

5. Does the health center share reports on QI/QA, including data on patient satisfaction and patient safety with key management staff and the governing board?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

6. Was the health center able to share an example(s) of how these reports support decision-making and oversight by key management staff and the governing board regarding the provision of health center services and responses to patient satisfaction and patient safety issues?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

Element d: Quarterly Assessments of Clinician Care

The health center's physicians or other licensed health care professionals conduct QI/QA assessments on at least a quarterly basis, using data systematically collected from patient records, to ensure:

- Provider adherence to current evidence-based clinical guidelines, standards of care, and standards of practice in the provision of health center services, as applicable; and
- The identification of any patient safety and adverse events and the implementation of related follow-up actions, as necessary.

Site Visit Team Methodology

- Interview individual(s) responsible for the QI/QA program.
- Review the health center's operating procedures or processes that address periodic QI/QA assessments.
- Review related systems and/or documentation that support QI/QA.
- Review schedule of QI/QA assessments.
- Review sample of two QI/QA assessments from the past year and/or the related reports resulting from these assessments.

Site Visit Findings

7. Are the health center's QI/QA assessments conducted by physicians or other licensed health care professionals (such as nurse practitioner, registered nurse, or other qualified individual) on at least a quarterly basis?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

8. Are these QI/QA assessments based on data systematically collected from patient records?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

9. Do these assessments demonstrate that the health center is tracking and, as necessary, addressing issues related to the quality and safety of the care provided to health center patients (for example, use of appropriate medications for asthma, early entry into prenatal care, HIV linkages to care, response initiated as a result of a recent adverse event)?
   ☐ YES ☐ NO

   If No, an explanation is required, including specifying which areas the health center is not tracking and/or addressing:

   _____

Element e: Retrievable Health Records

The health center maintains a retrievable health record (for example, the health center has implemented a certified Electronic Health Record (EHR))[2] for each patient, the format and content of which is consistent with both federal and state laws and requirements.

Site Visit Team Methodology

- In conjunction with a health center's clinical staff member(s), review the sample of 5–10 health center patient records.
  Note: *The same sample of patient records utilized for reviewing other program requirement areas also may be used for this sample.*

Note: *Issues related to timeliness, accuracy and completeness of data retrieval used for Uniform Data System (UDS) reporting are covered under Program Monitoring and Data Reporting Systems.*

Site Visit Findings

10. Does the health center maintain an individual health record that is easily retrievable?
    ☐ YES ☐ NO

[2] The Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) have established standards and other criteria for structured data that EHRs must use in order to qualify for CMS incentive programs. For health centers that participate in these CMS incentive programs, further information is available at https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Certification.html.

If No, an explanation is required:

_____

11. Does the health center have a process for ensuring that the format and content of its health records are consistent with applicable federal and state laws and requirements (for example, the health center has implemented a certified EHR)?
☐ YES ☐ NO

    If No, an explanation is required:

    _____

Element f: Confidentiality of Patient Information

The health center has implemented systems (for example, certified EHRs and corresponding standard operating procedures) for protecting the confidentiality of patient information and safeguarding this information against loss, destruction, or unauthorized use, consistent with federal and state requirements.

Site Visit Team Methodology

- Review health information technology (medical record) systems and procedures for maintaining and monitoring the confidentiality, privacy, and security of protected health information (PHI).
- Interview applicable staff (such as CMO, health information technology personnel, Compliance or Security Officer) on compliance with current federal and state requirements related to confidentiality, privacy, and security of protected health information, and actions taken by the health center to comply with these provisions across all sites (for example, staff training).

Site Visit Findings

12. Do the health center's health information technology or other record keeping procedures address current federal and state requirements related to confidentiality, privacy, and security of protected health information (PHI) including safeguards against loss, destruction, or unauthorized use?
☐ YES ☐ NO

    If No, an explanation is required:

    _____

13. Does the health center ensure its staff are trained in confidentiality, privacy, and security?
☐ YES ☐ NO

    If No, an explanation is required:

    _____

KEY MANAGEMENT STAFF

Primary Reviewer: Governance/Administrative Expert
Secondary Reviewer: Fiscal and Clinical Expert (as needed)

Authority: *Section 330(k)(3)(H)(ii), and 330(k)(3)(I)(i) of the Public Health Service (PHS) Act; 42 CFR 51c.104(b)(4), 42 CFR 51c.303(p), 42 CFR 56.104(b)(5), and 42 CFR 56.303(p); and 45 CFR 75.308(c)(1)(ii)(iii)*

Document Checklist for Health Center Staff

Documents Provided Prior to Site Visit:

- ☐ Health center organization chart(s) with names and titles of key management staff (if updated since last submission to HRSA)
- ☐ Position descriptions of key management staff (if updated since last submission to HRSA)
- ☐ Bios or resumes for key management staff (if updated since last application submission to HRSA)
- ☐ Co-applicant agreement (if applicable) (if updated since last application submission to HRSA)
- ☐ Human Resources procedures relevant to recruiting and hiring of key management staff (if applicable, for health centers with key management staff vacancies)

Documents Provided at the Start of the Site Visit:

- ☐ 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)

Demonstrating Compliance

Element a: Composition and Functions of Key Management Staff

The health center has determined the makeup of and distribution of functions among its key management staff[1] and the percentage of time dedicated to the Health Center Program project for each position, as necessary to carry out the HRSA-approved scope of project.

[1] Examples of key management staff may include Project Director/CEO, Clinical Director/Chief Medical Officer, Chief Financial Officer, Chief Operating Officer, Nursing/Health Services Director, or Chief Information Officer.

Site Visit Team Methodology

- Review Form 2: Staffing Profile and review the position descriptions or contracts for key management staff from the most recent Service Area Competition (SAC)/Renewal of Designation (RD) application, and if applicable, review any new job descriptions.
- Review the health center organization chart(s).
- Interview various members of the health center's key management staff to determine how key functions are distributed and carried out.

Site Visit Findings

1. Was the health center able to justify how the distribution of functions and allocation of time for each key management position is sufficient to carry out the approved scope of the health center project (for example, Is there a clear justification for a part-time Project Director/CEO or for the lack of a dedicated CFO position)?
   ☐ YES ☐ NO

   If No, an explanation is required, including describing why the distribution of functions and allocation of time for each key management position is insufficient to carry out the scope of project:

   _____

Element b: Documentation for Key Management Staff Positions

The health center has documented the training and experience qualifications, as well as the duties or functions, for each key management staff position (for example, in position descriptions).

Site Visit Team Methodology

N/A – *HRSA assesses whether the health center has demonstrated compliance with this element through its review of the competing continuation application (SAC or RD). No onsite review of this element is required.*

Site Visit Findings

N/A – *HRSA assesses whether the health center has demonstrated compliance with this element through its review of the competing continuation application (SAC or RD). No onsite review of this element is required.*

Element c: Process for Filling Key Management Vacancies

The health center has implemented, as necessary, a process for filling vacant key management staff positions (for example, vacancy announcements have been published and reflect the identified qualifications).

Site Visit Team Methodology

- Review health center organization chart(s) and compare to current key management staff. Note if there are any vacancies.
- If a key management staff vacancy is noted, review Human Resources procedures relevant to recruiting and hiring of key management staff and interview person(s) responsible for health center hiring/Human Resources functions and documentation associated with filling the vacancy.

Site Visit Findings

2. Does the health center have any vacant key management positions?
   ☐ YES ☐ NO

3. **If Yes:** Will or has the health center implement(ed) a process for filling this position?
   ☐ YES ☐ NO ☐ NOT APPLICABLE

   If No, an explanation is required, including specifying which position(s) are vacant:

   _____

Element d: CEO Responsibilities

The health center's Project Director/CEO[2] is directly employed by the health center,[3] reports to the health center's governing board[4] and is responsible for overseeing other key management staff in carrying out the day-to-day activities necessary to fulfill the HRSA-approved scope of project.

Site Visit Team Methodology

- Review health center organization chart(s).
- Review position descriptions or contracts for key management staff and, if necessary, any other documentation of key management reporting structures.

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[2] While the position title of the key person who is specified in the award/designation may vary, for the purposes of the Health Center Program, [the Health Center Program Compliance Manual Chapter 11: Key Management Staff utilizes] the term "Project Director/CEO" when referring to this key person. Under 45 CFR 75.2, the term "Principal Investigator/Program Director (PI/PD)" means the individual(s) designated by the recipient to direct the project or program being supported by the grant. The PI/PD is responsible and accountable to officials of the recipient organization for the proper conduct of the project, program, or activity. For the purposes of the Health Center Program, "Project Director/CEO" is synonymous with the term "PI/PD."

[3] Public agency health centers utilizing a co-applicant structure would demonstrate compliance with the statutory requirement for direct employment of the Project Director/CEO by demonstrating that the public agency, as the Health Center Program awardee/designee of record, directly employs the Project Director/CEO. Refer to related requirements in [Health Center Program Compliance Manual] Chapter 19: Board Authority regarding public agencies with co-applicants.

[4] Refer to related requirements in [Health Center Program Compliance Manual] Chapter 19: Board Authority regarding the selection and dismissal of the Project Director/CEO by the health center board as part of its oversight responsibilities for the Health Center Program project.

- Review the Project Director/CEO's Form W-2 or, if a Form W-2 has not yet been issued by the health center, documentation of receipt of salary directly from the health center.
- For public agencies with a co-applicant board, review the co-applicant agreement.
- Interview Project Director/CEO.

Site Visit Findings

4. Is the Project Director/CEO directly employed by the health center as confirmed by a Form W-2 (or, if a Form W-2 has not yet been issued by the health center, documentation of receipt of salary directly from the health center such as a pay stub)?

   Note: *The Project Director/CEO is directly employed by the health center if the Project Director/CEO: (1) receives a salary directly from the health center; (2) is issued a W-2 that lists only the health center as the Project Director/CEO's employer; and (3) has an employment agreement entered into with the health center that outlines the activities required to be performed by the Project Director/CEO.*
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

5. Does the Project Director/CEO report to the health center board?

   Note: *In a public center with a co-applicant board where the public center employs the Project Director/CEO, the Project Director/CEO may report both to the co-applicant board and to another board or individual within the public agency.*
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

6. Does the Project Director/CEO oversee other key management staff in carrying out the day-to-day activities of the health center project?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

Element e: HRSA Approval for Project Director/CEO Changes

If there has been a post-award change in the Project Director/CEO position,[5] the health center requests and receives prior approval from HRSA.

[5] Such changes include situations in which the current Project Director/CEO will be disengaged from involvement in the Health Center Program project for any continuous period for more than 3 months or will reduce time devoted to the project by 25 percent or more from the level that was approved at the time of award [see: 45 CFR 75.308(c)(1)(ii) and (iii)].

Site Visit Team Methodology

- Determine whether there has been a change in the Project Director/CEO since the start of the current project or designation period.
    - If yes, review prior approval documentation submitted to HRSA.

Site Visit Findings

7. Has there been a change in the Project Director/CEO position since the start of the current project or designation period?

   ***Note**: This ONLY includes situations in which the Project Director/CEO was disengaged from involvement in the project for any continuous period for more than 3 months or reduced time devoted to the project by 25 percent or more from the level that was approved at the time of award.*
   ☐ YES ☐ NO

8. **If Yes:** Was the health center able to produce documentation of its request for prior approval and the related approval from HRSA (unless still under review by HRSA) for this change?
   ☐ YES ☐ NO ☐ NOT APPLICABLE

   If No, an explanation is required:
   _____

CONTRACTS AND SUBAWARDS

Primary Reviewer: Fiscal Expert
Secondary Reviewer: Governance/Administrative Expert

Authority: *Section 330(k)(3)(l) and Section 330(q) of the Public Health Service (PHS) Act; 42 CFR 51c.113, 42 CFR 56.114, 42 CFR 51c.303(t), and 42 CFR 56.303(t); 45 CFR Part 75 Subpart D; and Section 1861(aa)(4)(A)(ii) and Section 1905(l)(2)(B)(ii) of the Social Security Act*

Document Checklist for Health Center Staff

Documents Provided Prior to Site Visit:

- ☐ Procedures for purchasing and procurement, including, if applicable or separate, procedures for contracting and contract management
- ☐ Most recent annual audit and management letters
- ☐ 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 (if updated since last application submission to HRSA) (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."*

Documents Provided at the Start of the Site Visit:

- ☐ 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 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)
- 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)

Demonstrating Compliance

Is this a Look-Alike Site Visit?
☐ YES ☐ NO

NOTE*: Because look-alikes do not receive federal funding under section 330 of the PHS Act, any aspects of a requirement that relate to the use of Health Center Program federal award funds are not applicable to look-alikes.*

Contracts: Procurement and Monitoring

Element a: Procurement Procedures

The health center has written procurement procedures that comply with federal procurement standards, including a process for ensuring that all procurement costs directly attributable to the federal award are allowable, consistent with federal cost principles.[1]

Site Visit Team Methodology

- Review health center's procedures for purchasing and procurement, including any related to contracting and contract management.
- Interview health center staff involved in contract procurement and monitoring.

Site Visit Findings

1. Does the health center have written procedures for procurement?
   ☐ YES ☐ NO

[1] See 45 CFR 75 Subpart E: Cost Principles.

If No, an explanation is required:

_____

2. Do these procedures, at a minimum, ensure that all procurements directly attributable to the federal award will be conducted in a manner providing full and open competition[2] and will only include costs allowable, consistent with federal cost principles (for example, do the procedures contain relevant references or citations to 45 CFR Part 75 Subpart E: Cost Principles)?

   Note: *Select "Not Applicable" if the health center is a look-alike.*
   ☐ YES ☐ NO ☐ NOT APPLICABLE

   If No, an explanation is required:

   _____

Element b: Records of Procurement Actions

NOT APPLICABLE FOR LOOK-ALIKES

The health center has records for procurement actions paid for in whole or in part under the federal award that include the rationale for method of procurement, selection of contract type, contractor selection or rejection, and the basis for the contract price. This would include documentation related to noncompetitive procurements.

Site Visit Team Methodology

- Review sample of half or five (whichever is less) contracts AND related supporting procurement documentation for actions that were $25,000 or more that **utilize federal award funds** (not applicable to look-alikes and as applicable for awardees).
  Note: *The same sample of contracts/agreements is to be utilized for the review of both Contracts and Subawards and Conflict of Interest.*

Site Visit Findings

3. Does the health center have any:
   - Active contracts paid for in whole or in part with federal award funds?
     ☐ YES ☐ NO ☐ NOT APPLICABLE
   - Contracts that had a period of performance which ended less than 3 years ago and that were paid for in whole or in part with federal funds?
     ☐ YES ☐ NO ☐ NOT APPLICABLE

4. Based on the review of the sample of contracts, was there supporting documentation of the procurement process that addressed the following:

[2] As defined by 45 CFR 75.329(f), procurement by "non-competitive proposals" is procurement through solicitation of a proposal from only one source.

- Rationale for the procurement method?
  ☐ YES ☐ NO ☐ NOT APPLICABLE
- Selection of contract type?
  ☐ YES ☐ NO ☐ NOT APPLICABLE
- Contractor selection or rejection?
  ☐ YES ☐ NO ☐ NOT APPLICABLE
- Basis for the contract price?
  ☐ YES ☐ NO ☐ NOT APPLICABLE

If No was selected for any of the above, an explanation is required:

_____

Element c: Retention of Final Contracts

NOT APPLICABLE FOR LOOK-ALIKES

The health center retains final contracts and related procurement records, consistent with federal document maintenance requirements, for procurement actions paid for in whole or in part under the federal award.[3]

Site Visit Team Methodology

- Review sample of half or five (whichever is less) contracts AND related supporting procurement documentation for actions that were $25,000 or more that **utilize federal award funds** (not applicable to look-alikes and as applicable for awardees).
  Note: *The same sample of contracts/agreements is to be utilized for the review of both Contracts and Subawards and Conflict of Interest.*

Site Visit Findings

5. Was the health center able to produce final contracts that have been awarded within the past 3 years?
   ☐ YES ☐ NO ☐ NOT APPLICABLE

   If No, an explanation is required:

   _____

Element d: Contractor Reporting

The health center has access to contractor records and reports related to health center activities in order to ensure that all activities and reporting requirements are being carried out in

[3] See 45 CFR 75.361 for HHS retention requirements for records.

accordance with the provisions and timelines of the related contract (for example, performance goals are achieved, Uniform Data System (UDS) data are submitted by appropriate deadlines, funds are used for authorized purposes).

Site Visit Team Methodology

- Review 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 that were selected from the list of contracts provided prior to the site visit.

Site Visit Findings

6. Based on the review of the sample, does the health center have access to records and reports as necessary to oversee contractor performance?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

Element e: HRSA Approval for Contracting Substantive Programmatic Work

If the health center has arrangements with a contractor to perform substantive programmatic work,[4] the health center requested and received prior approval from HRSA as documented by:

- An approved competing continuation/renewal of designation application or other competitive application, which included such an arrangement; or
- An approved post-award request for such arrangements submitted within the project period (for example, change in scope).

Site Visit Team Methodology

- Review complete list of contracts (provided prior to the site visit) to identify those that support *substantive programmatic work*.
- Interview key management or other health center staff involved in procurement or contract oversight.
- Review the documentation identified by the health center that includes HRSA's approval of the contracting arrangement for *substantive programmatic work*.

[4] For the purposes of the Health Center Program, contracting for substantive programmatic work applies to contracting with a single entity for the majority of health care providers. The acquisition of supplies, material, equipment, or general support services is not considered programmatic work. Substantive programmatic work may be further defined within HRSA Notices of Funding Opportunity (NOFOs) and applications.

Site Visit Findings

7. Based on the list of contracts reviewed and interview(s) with health center staff, does this health center currently contract with a single entity for the majority of health care providers (i.e., substantive programmatic work)?
   ☐ YES ☐ NO

8. **If Yes:** Was the health center able to produce documentation of prior approval by HRSA (i.e., the arrangement was included in a HRSA-approved application or post-award request)?
   ☐ YES ☐ NO ☐ NOT APPLICABLE

   If No, an explanation is required:

   _____

Element f: Required Contract Provisions

The health center's contracts that support the HRSA-approved scope of project include provisions that address the following:

- The specific activities or services to be performed or goods to be provided;
- Mechanisms for the health center to monitor contractor performance; and
- Requirements for the contractor to provide data necessary to meet the recipient's applicable federal financial and programmatic reporting requirements, as well as provisions addressing record retention and access, audit, and property management.[5]

Site Visit Team Methodology

- Review entire sample of contracts that support the HRSA-approved scope of project.

Site Visit Findings

9. Does the health center have one or more contracts to provide health center services or to acquire other goods and services in support of the HRSA-approved scope of project?
   ☐ YES ☐ NO

10. **If Yes:** Based on the sample of contracts reviewed, do these contracts contain provisions that address the following areas:

    - Specific activities or services to be performed or goods to be provided by the contractor?
      ☐ YES ☐ NO ☐ NOT APPLICABLE

    - How the health center will monitor contract performance?
      ☐ YES ☐ NO ☐ NOT APPLICABLE

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[5] For further guidance on these requirements, see the HHS Grants Policy Statement, at http://www.hrsa.gov/grants/hhsgrantspolicy.pdf.

- Data reporting expectations and intervals for such reporting?
  ☐ YES ☐ NO ☐ NOT APPLICABLE

- Provisions for record retention and access, audit, and property management?
  ☐ YES ☐ NO ☐ NOT APPLICABLE

If No was selected for any of the above, an explanation is required:

_____

Subawards: Monitoring and Management

Element g: HRSA Approval to Subaward

NOT APPLICABLE FOR LOOK-ALIKES

If the health center has made a subaward,[6] the health center requested and received prior approval from HRSA as documented by:

- An approved competing continuation/renewal of designation application or other competitive application, which included the subrecipient arrangement; or
- An approved post-award request for such subrecipient arrangements submitted within the project period (for example, change in scope).

Site Visit Team Methodology

- Review Form 8: Health Center Agreements.
- Review most recent annual audit and management letters to determine if subrecipients were identified in the audit report, including the amount of the subawards.
- Review all subrecipient agreements.
- Review the documentation identified by the health center that includes HRSA's approval of the subrecipient arrangement.

Site Visit Findings

11. Has the health center made any subawards (new or continuing) during the current project period?
    ☐ YES ☐ NO ☐ NOT APPLICABLE

12. Was the health center able to produce documentation of prior approval by HRSA of the subrecipient arrangement (i.e., arrangement was included in the last approved Service Area Competition (SAC) application or was approved through a separate post-award request)?
    ☐ YES ☐ NO ☐ NOT APPLICABLE

[6] Specifically, the purpose of a subaward is to carry out a portion of the federal award and creates a federal assistance relationship with the subrecipient, while the purpose of a contract is to obtain goods or services for the health center's own use and creates a procurement relationship with the contractor.

If No, an explanation is required:

_____

Element h: Subaward Agreement

NOT APPLICABLE FOR LOOK-ALIKES

The health center's subaward(s) that supports the HRSA-approved scope of project includes provisions that address the following:

- The specific portion of the HRSA-approved scope of project to be performed by the subrecipient;
- The applicability of all Health Center Program requirements to the subrecipient;
- The applicability to the subrecipient of any distinct statutory, regulatory, and policy requirements of other federal programs associated with their HRSA-approved scope of project;[7]
- Mechanisms for the health center to monitor subrecipient compliance and performance;
- Requirements for the subrecipient to provide data necessary to meet the health center's applicable federal financial and programmatic reporting requirements, as well as provisions addressing record retention and access, audit, and property management;[8] and
- Requirements that all costs paid for by the federal subaward are allowable consistent with federal cost principles.[9]

Site Visit Team Methodology

- Review all subrecipient agreements.

Site Visit Findings

13. Does the health center's subrecipient agreement(s) include provisions that address the following:

    - The portion of the health center project that will be carried out by the subrecipient (i.e., sites, services provided) and how?
      ☐ YES ☐ NO ☐ NOT APPLICABLE

    - All Health Center Program requirements applying to the subrecipient?
      ☐ YES ☐ NO ☐ NOT APPLICABLE

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[7] Subrecipients are generally eligible to receive Federally Qualified Health Center (FQHC) payment rates under Medicaid and Medicare, 340B Drug Pricing Program, and Federal Tort Claims Act (FTCA) coverage. However, such benefits are not automatically conferred and may require additional actions and approvals (for example, submission and approval of a subrecipient FTCA deeming application).
[8] For further guidance on these requirements, see the HHS Grants Policy Statement, at http://www.hrsa.gov/grants/hhsgrantspolicy.pdf.
[9] See 45 CFR 75 Subpart E: Cost Principles.

- The applicability of any other distinct statutory, regulatory, and policy requirements of associated programs and benefits (for example, requirements that will apply if the subrecipient participates in the 340B Drug Pricing Program)?
  ☐ YES ☐ NO ☐ NOT APPLICABLE

- Mechanisms for the health center to monitor subrecipient compliance and performance?
  ☐ YES ☐ NO ☐ NOT APPLICABLE

- The data the subrecipient must collect and report back to the awardee (for example, UDS data)?
  ☐ YES ☐ NO ☐ NOT APPLICABLE

- Record retention and access, audit, and property management (if applicable); and
  ☐ YES ☐ NO ☐ NOT APPLICABLE

- Requirements that all costs paid for under the subaward are consistent with federal cost principles?
  ☐ YES ☐ NO ☐ NOT APPLICABLE

If No was selected for any of the above, an explanation is required:

_____

Element i: Subrecipient Monitoring

NOT APPLICABLE FOR LOOK-ALIKES

The health center monitors the activities of its subrecipient to ensure that the subaward is used for authorized purposes and that the subrecipient maintains compliance with all applicable requirements specified in the federal award (including those found in section 330 of the PHS Act, implementing program regulations and grants regulations in 45 CFR Part 75). Specifically, the health center's monitoring of the subrecipient includes:

- Reviewing financial and performance reports required by the health center in order to ensure performance goals are achieved, UDS data are submitted by appropriate deadlines, and funds are used for authorized purposes;
- Ensuring that the subrecipient takes timely and appropriate action on all deficiencies pertaining to the subaward that may be identified through audits, on-site reviews, and other means; and
- Issuing a management decision for audit findings pertaining to the subaward.[10]

[10] Per 45 CFR 75.521, the management decision [issued by the health center to the subrecipient] must clearly state whether or not the audit finding is sustained, the reasons for the decision, and the expected auditee action to repay disallowed costs, make financial adjustments, or take other action.

Site Visit Team Methodology

- Review all subrecipient agreements.
- Review documentation of subrecipient monitoring.
- Review sample of financial and performance reports received from the subrecipient.
- Interview health center staff who provide oversight of subrecipient activities.

Site Visit Findings

14. Does the health center monitor the activities of the subrecipient to ensure the subrecipient maintains compliance with all Health Center Program requirements and all other applicable requirements specified in the federal award?
☐ YES ☐ NO ☐ NOT APPLICABLE

    If No, an explanation is required:

    _____

15. Does the health center receive and review financial and performance reports in order to ensure:

    - Performance goals are achieved?
      ☐ YES ☐ NO ☐ NOT APPLICABLE
    - UDS data are submitted by appropriate deadlines?
      ☐ YES ☐ NO ☐ NOT APPLICABLE
    - Funds are used for authorized purposes?
      ☐ YES ☐ NO ☐ NOT APPLICABLE

    If No was selected for any of the above, an explanation is required:

    _____

16. Does the health center have a process for ensuring that the subrecipient takes timely and appropriate action on deficiencies that may be identified through audits, on-site reviews, or other means (including issuing a management decision for audit findings pertaining to the subaward)?
☐ YES ☐ NO ☐ NOT APPLICABLE

    If No, an explanation is required:

    _____

Element j: Retention of Subaward Agreements and Records

NOT APPLICABLE FOR LOOK-ALIKES

The health center retains final subrecipient agreements and related records, consistent with federal document maintenance requirements.[11]

Site Visit Team Methodology

- Review all subrecipient agreements.
- Review documentation of subrecipient monitoring.
- Review sample of financial and performance reports received from the subrecipient.

Site Visit Team Findings

17. Was the health center able to produce final (executed) subrecipient agreements that have been awarded within the past 3 years and related financial and other performance records?
    ☐ YES ☐ NO ☐ NOT APPLICABLE

    If No, an explanation is required:

    _____

[11] See 45 CFR 75.361 for HHS retention requirements for records.

CONFLICT OF INTEREST

Primary Reviewer: Fiscal Expert
Secondary Reviewer: Governance/Administrative Expert

Authority: *Section 330(a)(1) and 330(k)(3)(D) of the Public Health Service (PHS) Act; 42 CFR 51c.113 and 42 CFR 56.114; and 45 CFR 75.327*

Document Checklist for Health Center Staff

Documents Provided Prior to Site Visit:

- ☐ Procedures for purchasing and procurement, including, if applicable or separate, procedures for contracting and contract management
- ☐ Two most recent annual audits and management letters

Documents Provided at the Start of the Site Visit:

- ☐ Documentation containing the health center's standards of conduct (for example, articles of incorporation, bylaws, board manual, employee manual, policies and procedures, disclosure forms)
- ☐ For contracts 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*
- ☐ 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
- ☐ Agreements with parent corporation, affiliate, subsidiary, or subrecipient organization (if applicable)

Demonstrating Compliance

Is this a Look-Alike Site Visit?
☐ YES ☐ NO

NOTE*: Because look-alikes do not receive federal funding under section 330 of the PHS Act, any aspects of a requirement that relate to the use of Health Center Program federal award funds are not applicable to look-alikes.*

Element a: Standards of Conduct

NOT APPLICABLE FOR LOOK-ALIKES

The health center has and implements written standards of conduct that apply, at a minimum, to its procurements paid for in whole or in part by the federal award. Such standards:

- Apply to all health center employees, officers, board members, and agents[1] involved in the selection, award, or administration of such contracts;
- Require written disclosure of real or apparent conflicts of interest;[2]
- Prohibit individuals with real or apparent conflicts of interest with a given contract from participating in the selection, award, or administration of such contract;[3]
- Restrict health center employees, officers, board members, and agents involved in the selection, award, or administration of contracts from soliciting or accepting gratuities, favors, or anything of monetary value for private financial gain from such contractors or parties to sub-agreements (including subrecipients or affiliate organizations);[4] and
- Enforce disciplinary actions on health center employees, officers, board members, and agents for violating these standards.

Site Visit Team Methodology

- Interview health center Project Director/CEO, board member(s), and other relevant staff involved in procurement and/or Human Resources regarding the health center's standards of conduct.
- Review relevant documents where standards of conduct relative to procurement are contained.
- Review process for disclosing real or apparent conflicts of interest in writing by employees, officers, board members, and agents of the health center (for example, board minutes documenting disclosure(s), standard form(s) to report disclosure(s)). ***Note:*** *Signed disclosure statements or forms from all health center staff and board members are NOT required to demonstrate compliance. The purpose of the review is to assess whether the health center has a mechanism in place for health center staff and board members to disclose real or apparent conflicts of interest when they arise.*

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[1] An agent of the health center includes, but is not limited to, a governing board member, an employee, officer, or contractor acting on behalf of the health center.
[2] A conflict of interest arises when the employee, officer, or agent (including but not limited to any member of the governing board), any member of his or her immediate family, his or her partner, or an organization which employs or is about to employ any of the parties indicated herein, has a financial or other interest in or a tangible personal benefit from a firm considered for a contract. See: 45 CFR 75.327(c)1.
[3] This includes, but is not limited to, prohibiting board members that are employees or contractors of a subrecipient of the health center from participating in the selection, award, or administration of that subaward. This also includes prohibiting board members who are employees of an organization that contracts with the health center from participating in the selection, award, or administration of that contract.
[4] Health centers may set standards for situations in which the financial interest is not substantial or the gift is an unsolicited item of nominal value. See *Related Considerations* in [Health Center Program Compliance Manual] Chapter 13: Conflict of Interest.

Site Visit Findings

1. Was the health center able to provide document(s) that contain its written standards of conduct for the selection, award and administration of contracts that, at a minimum, apply to its procurements paid for in whole or in part by the federal award?
   ☐ YES ☐ NO ☐ NOT APPLICABLE

   If No, an explanation is required:

   _____

2. Do these written standards of conduct:

   - Apply to all health center employees, officers, board members, and agents involved in the selection, award, or administration of such contracts?
     ☐ YES ☐ NO ☐ NOT APPLICABLE
   - Require written disclosure of any real or apparent conflicts of interest?
     ☐ YES ☐ NO ☐ NOT APPLICABLE
   - Prohibit individuals with a real or apparent conflict of interest with a given contract from participating in the selection, award, or administration of such contract?
     ☐ YES ☐ NO ☐ NOT APPLICABLE
   - Prohibit accepting gratuities, favors, or anything of monetary value?
     ☐ YES ☐ NO ☐ NOT APPLICABLE
   - Provide for disciplinary actions for violating the conflict of interest requirements?
     ☐ YES ☐ NO ☐ NOT APPLICABLE

   If No was selected for any of the above, an explanation is required, including specifying which areas were not addressed:

   _____

3. Does the health center have a process for disclosing real or apparent conflicts of interest in writing by employees, officers, board members, and agents of the health center should such conflicts arise?

   ☐ YES ☐ NO ☐ NOT APPLICABLE

   If No, an explanation is required:

   _____

Element b: Standards for Organizational Conflicts of Interest

If the health center has a parent, affiliate, or subsidiary that is not a state, local government, or Indian tribe, the health center has and implements written standards of conduct covering

organizational conflicts of interest[5] that might arise when conducting a procurement action involving a related organization. These standards of conduct require:

- Written disclosure of conflicts of interest that arise in procurements from a related organization; and
- Avoidance and mitigation of any identified actual or apparent conflicts during the procurement process.

Site Visit Team Methodology

- Review agreements with parent corporation, affiliates, subsidiaries, and subrecipients (if applicable).
- Review two most recent annual audits and management letters for any references to related party transactions.

Site Visit Findings

4. Does the health center have a parent, affiliate or subsidiary that is not a state, local government, or Indian tribe?
   ☐ YES ☐ NO

5. **If Yes:** Was the health center able to provide document(s) that contain its written standards of conduct for the selection, award, and administration of contracts that involve the related party or organization?
   ☐ YES ☐ NO ☐ NOT APPLICABLE

   If No, an explanation is required:

   _____

6. Do the health center's organizational conflict of interest standards prevent or mitigate any identified or apparent conflicts of interest?
   ☐ YES ☐ NO ☐ NOT APPLICABLE

   If No, an explanation is required:

   _____

Element c: Dissemination of Standards of Conduct

The health center has mechanisms or procedures for informing its employees, officers, board members, and agents of the health center's standards of conduct covering conflicts of interest, including organizational conflicts of interest, and for governing its actions with respect to the selection, award and administration of contracts.

[5] Organizational conflicts of interest mean that because of relationships with a parent company, affiliate, or subsidiary organization, the health center is unable or appears to be unable to be impartial in conducting a procurement action involving a related organization. See: 45 CFR 75.327(c)(2).

Site Visit Team Methodology

- Review documentation containing the health center's standards of conduct, including, if applicable, those covering organizational conflict of interest.
- Review sample of written disclosures with respect to real or apparent conflicts of interest completed by employees, officers, board members, and agents of the health centers.
- Interview health center Project Director/CEO, board member(s), and other relevant staff involved in procurement and/or Human Resources regarding mechanisms or procedures for informing employees, officers, board members, and agents of the health center's standards of conduct.

Site Visit Findings

In responding to the question(s) below, please note:

- *For look-alikes, this element is applicable ONLY for those look-alikes that have a parent, affiliate, or subsidiary that is not a state, local government, or Indian tribe as identified in the assessment of element "b."*
- *For all other look-alikes, select "Not Applicable."*

7. Does the health center inform employees, officers, board members, and agents of its conflict of interest standards of conduct?
   ☐ YES ☐ NO ☐ NOT APPLICABLE

   If No, an explanation is required:

   _____

Element d: Adherence to Standards of Conduct

In cases where a conflict of interest was identified, the health center's procurement records document adherence to its standards of conduct (for example, an employee whose family member was competing for a health center contract was not permitted to participate in the selection, award, or administration of that contract).

Site Visit Team Methodology

- Review 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.*
- In cases where a real or apparent conflict of interest was identified in the procurement action, review 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.
- Review audits and management letters for any findings related to conflicts of interest.

Site Visit Findings

In responding to the question(s) below, please note:

- *For look-alikes, this element is applicable ONLY for those look-alikes that have a parent, affiliate, or subsidiary that is not a state, local government, or Indian tribe as identified in the assessment of element "b."*
- *For all other look-alikes, select "Not Applicable."*

8. Were any conflicts of interest (real or apparent), including organizational conflicts of interest, identified in the past 3 years that were associated with procurement involving federal funds?
   ☐ YES ☐ NO ☐ NOT APPLICABLE

9. **If Yes**: Was the health center able to produce documentation that it adhered to its standards of conduct related to the identified conflict(s) of interest, including the completion of written disclosures?
   ☐ YES ☐ NO ☐ NOT APPLICABLE

   If No, an explanation is required:
   _____

COLLABORATIVE RELATIONSHIPS

Primary Reviewer: Governance/Administrative Expert
Secondary Reviewer: Clinical Expert

Authority: *Section 330(k)(3)(B) of the Public Health Service (PHS) Act; and 42 CFR 51c.303(n), 42 CFR 56.303(n), and 42 CFR 51c.305(h)*

Document Checklist for Health Center Staff

Documents Provided at the Start of the Site Visit:

- ☐ 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
- ☐ 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.*

Demonstrating Compliance

Element a: Coordination and Integration of Activities

The health center documents its efforts to collaborate with other providers or programs in the service area, including local hospitals, specialty providers, and social service organizations (including those that serve special populations), to provide access to services not available through the health center in order to support:

- Reductions in the non-urgent use of hospital emergency departments;
- Continuity of care across community providers; and
- Access to other health or community services that impact the patient population.

Site Visit Team Methodology

- Interview Project Director/CEO regarding collaboration activities, including example(s) of how the health center's collaborative relationship(s) supports each of the following:
  - Reductions in the non-urgent use of hospital emergency departments;
  - Continuity of care across community providers; and
  - Access to other health or community services that impact the patient population.
- Review Collaboration section and any relevant attachments from most recent Service Area Competition (SAC) and other awards (for example, New Access Point).
- Review sample of MOUs, MOAs or any other documentation of collaboration with other community providers or organizations, including local hospitals, specialty providers, and social service organizations (including those that serve special populations).

Site Visit Findings

1. Does the health center have documentation of its efforts to collaborate with other providers or programs in the service area, specifically local hospitals, specialty providers, and social service organizations (including those that serve special populations), to provide access to services not available through the health center?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

2. Was the health center able to provide at least one documented example of how its collaborative relationship(s) supports each of the following:

   - Reductions in the non-urgent use of hospital emergency departments;
   - Continuity of care across community providers; and
   - Access to other health or community services that impact the patient population?

   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

Element b: Collaboration with Other Primary Care Providers

The health center documents its efforts to coordinate and integrate activities with other federally-funded, as well as state and local, health services delivery projects and programs serving similar patient populations in the service area (at a minimum, this would include establishing and maintaining relationships with other health centers in the service area).

Site Visit Team Methodology

- Review Uniform Data System (UDS) Mapper to identify other health centers with sites in the service area.
- Interview health center Project Director/CEO regarding coordination with other federally-funded, state, and local health services delivery projects and programs serving similar

patient populations in the service area (at a minimum, other health centers in the service area).
- Review relevant documentation of efforts to coordinate or documentation of established coordination.

Site Visit Findings

In responding to the question(s) below, please note:
The health center determines how to document collaboration or coordination with providers and organizations in its service area. For example, documentation of collaborative relationship(s) that support reductions in emergency department use may be in the form of meeting minutes or evidence of membership in an emergency room diversion program.

3. Does the health center have documentation of its efforts to coordinate and integrate activities with other federally-funded, state, and local health services delivery projects and programs serving similar patient populations in the service area?
☐ YES ☐ NO

   If No, an explanation is required, including stating if there are no other federally-funded, state, or local health services delivery projects or programs serving similar patient populations in the service area:

   _____

4. Was the health center able to document established relationships with at least one health center in the service area?

   Note: Only select "Not Applicable" if there are no other health centers in the service area.
☐ YES ☐ NO ☐ NOT APPLICABLE

   If No or Not Applicable, an explanation is required:

   _____

Element c: Expansion of HRSA-Approved Scope of Project

If the health center expands[1,2] its HRSA-approved scope of project:

- *The health center obtains letters or other appropriate documents specific to the request or application that describe areas of coordination or collaboration with health care providers serving similar patient populations in the service area (health centers, rural health clinics, local hospitals including critical access hospitals, health departments, other providers including specialty providers, as applicable); or*

[1] Expanding the HRSA-approved scope of project may occur by adding sites or services through Change in Scope requests, New Access Point competitive applications, or other supplemental funding applications.
[2] Additional requirements for documented collaboration may apply based on specific Notices of Funding Opportunity (NOFOs), Notices of Award (NOA), look-alike designation instructions, or other federal statutes, regulations, or policies.

- *If such letters or documents cannot be obtained from these providers, the health center documents its attempts to coordinate or collaborate with these health care providers (health centers, rural health clinics, local hospitals including critical access hospitals, health departments, other providers including specialty providers, as applicable) on the specific request or application proposal.*

Site Visit Team Methodology

N/A – *HRSA assesses whether the health center has demonstrated compliance with this element through its review of Change in Scope requests and/or competing applications. No onsite review of this element is required.*

Site Visit Findings

N/A – *HRSA assesses whether the health center has demonstrated compliance with this element through its review of Change in Scope requests and/or competing applications. No onsite review of this element is required.*

FINANCIAL MANAGEMENT AND ACCOUNTING SYSTEMS

Primary Reviewer: Fiscal Expert
Secondary Reviewer: Governance/Administrative Expert

Authority: *Sections 330(e)(5)(D), 330(k)(3)(D), 330(k)(3)(N), and 330(q) of the Public Health Service (PHS) Act; 42 CFR 51c.113, 42 CFR 56.114, 42 CFR 51c.303(d), and 42 CFR 56.303(d); and 45 CFR Part 75 Subparts D, E and F*

Document Checklist for Health Center Staff

Documents Provided Prior to Site Visit:

- ☐ 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)
- ☐ Two most recent annual audits and management letters

Documents Provided at the Start of the Site Visit:

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

Demonstrating Compliance

Is this a Look-Alike Site Visit?
☐ YES ☐ NO

***NOTE**: Because look-alikes do not receive federal funding under section 330 of the PHS Act, any aspects of a requirement that relate to the use of Health Center Program federal award funds are not applicable to look-alikes.*

Element a: Financial Management and Internal Control Systems

The health center has and utilizes a financial management and internal control system that reflects Generally Accepted Accounting Principles (GAAP) for private non-profit health centers or Government Accounting Standards Board (GASB) principles for public agency health centers[1] and that ensures at a minimum:

- Health center expenditures are consistent with the HRSA-approved total budget[2] and with any additional applicable HRSA approvals that have been requested and received;[3]
- Effective control over, and accountability for, all funds, property, and other assets associated with the Health Center Program project;
- The safeguarding of all assets to assure they are used solely for authorized purposes in accordance with the terms and conditions of the Health Center Program award/designation;[4] and
- The capacity to track the financial performance of the health center, including identification of trends or conditions that may warrant action by the organization to maintain financial stability.

Site Visit Team Methodology

- Interview health center's CFO and/or other relevant staff and, if applicable, contractors who have responsibility for the health center's financial management systems.
- Review the two most recent audits and management letters.
- Review financial management, accounting, and internal control procedures and systems.
- Review sample of periodic financial reports provided to the board and key management staff including the most recent interim financial statements.
- Review Aged Accounts Receivable and Aged Accounts Payable.

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[1] GAAP and GASB are used as defined in 45 CFR Part 75.
[2] A health center's "total budget" includes the Health Center Program federal award funds and all other sources of revenue in support of the HRSA-approved Health Center Program scope of project. For additional detail, see [Health Center Program Compliance Manual] Chapter 17: Budget.
[3] Per 45 CFR 75.308, post-award, federal award recipients are required to report significant deviations from budget or project scope or objective, and are required to request prior approvals from HHS awarding agencies for budget and program plan revisions (re-budgeting). "Re-budgeting, or moving funds between direct cost budget categories in an approved budget, is considered significant when cumulative transfers for a single budget period exceeds 25 percent of the total approved budget (inclusive of direct and indirect costs and federal funds and required matching or cost sharing). The base used for determining significant re-budgeting excludes carryover balances but includes any amounts awarded as supplements."
[4] The requirement to safeguard federal assets as described in this bullet substantially reflects the requirement to have written policies and procedures in place to ensure the appropriate use of federal funds in compliance with applicable federal statutes, regulations, and the terms and conditions of the federal award. See Section 330(k)(3)(N) of the PHS Act.

Site Visit Findings

1. Does the health center's financial management and internal control system reflect GAAP or GASB principles?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

2. Is the health center able to track actual expenditures in comparison to the Health Center Program project budget?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

3. Do the health center's financial management and internal control systems have the capacity to account for the expenditure of Health Center Program project funds (for example, segregation of funds) and safeguard the use of associated assets and property (for example, procedures for inventory management, maintaining property records)?
   ☐ YES ☐ NO

   If No, an explanation is required regarding the health center's inability to account for expenditures and/or safeguard assets:

   _____

4. Was the health center able to demonstrate a capacity to track its financial performance for the purposes of monitoring financial stability?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

Element b: Documenting Use of Federal Funds

NOT APPLICABLE FOR LOOK-ALIKES

The health center's financial management system is able to account for all federal award(s) (including the federal award made under the Health Center Program) in order to identify the source[5] (receipt) and application (expenditure) of funds for federally-funded activities in whole or in part. Specifically, the health center's financial records contain information and related source documentation pertaining to authorizations, obligations, unobligated balances, assets, expenditures, income, and interest under the federal award(s).

[5] Federal program and federal award identification would include, as applicable, the Catalog of Federal Domestic Assistance (CFDA) title and number, federal award identification number and year, name of the HHS awarding agency, and name of the pass-through entity, if any.

Site Visit Team Methodology

- Have CFO or other financial staff walk through the health center's use of the last quarter of federal Health Center Program award funds, starting from drawdown through obligation and payment of such funds for authorized expenditure.
- Review sample of source documentation to support expenditures made under the federal Health Center Program award for the last quarter.

Site Visit Findings

5. Based on the sample, does the health center have a financial management system that is able to account for the Health Center Program federal award and related expenditures (for example, in chart of accounts) made under the award? Specifically, do the health center's financial records contain relevant information and related source documentation?
   ☐ YES ☐ NO ☐ NOT APPLICABLE

   If No, an explanation is required:

   _____

Element c: Drawdown, Disbursement and Expenditure Procedures

NOT APPLICABLE FOR LOOK-ALIKES

The health center has written procedures for:

- Drawing down federal award funds in a manner that minimizes the time elapsing between the transfer of the federal award funds from HRSA and the disbursement of these funds by the health center; and
- Assuring that expenditures of federal award funds are allowable in accordance with the terms and conditions of the federal award and with the federal cost principles[6] in 45 CFR Part 75 Subpart E.

Site Visit Team Methodology

- Review health center's procedures for drawdown, disbursement, and expenditure of federal award funds utilizing the federal Payment Management System (PMS).
- Interview CFO or other health center individuals authorized to draw down and expend federal award funds.

Site Visit Findings

6. Does the health center have written procedures for drawing down federal funds?
   ☐ YES ☐ NO ☐ NOT APPLICABLE

[6] The cost principles are set forth in 45 CFR Part 75, Subpart E.

If No was selected, an explanation is required:

_____

7. Does the health center have written procedures with provisions or steps that:

   - Limit the drawdown to minimum amounts needed to cover allowable project costs?
     ☐ YES ☐ NO ☐ NOT APPLICABLE

   - Time drawdowns in a manner that minimizes the time elapsing between the transfer of the federal award funds from HRSA and the disbursement of these funds by the health center?
     ☐ YES ☐ NO ☐ NOT APPLICABLE

   If No was selected for any of the above, an explanation is required:

   _____

8. Does the health center have written procedures with specific provisions or steps that ensure all expenditures utilizing federal award funds are allowable in accordance with:

   - The terms and conditions of the federal award, including those that limit the use of federal award funds?
     ☐ YES ☐ NO ☐ NOT APPLICABLE

   - The federal cost principles in 45 CFR Part 75 Subpart E?
     ☐ YES ☐ NO ☐ NOT APPLICABLE

   If No was selected for any of the above, an explanation is required:

   _____

Element d: Submitting Audits and Responding to Findings

If a health center expends **$750,000 or more in award funds from all federal sources** during its fiscal year, the health center ensures a single or program-specific audit is conducted and submitted for that year in accordance with the provisions of 45 CFR Part 75, Subpart F: Audit Requirements and ensures that subsequent audits demonstrate corrective actions have been taken to address all findings, questioned costs, reportable conditions, and material weaknesses cited in the previous audit report, if applicable.

Site Visit Team Methodology

- Review most recent audit and management letter.
- If there are any audit findings, questioned or unallowable costs, reportable conditions, material weaknesses, or significant deficiencies noted, interview the health center's CFO and/or other relevant health center individuals regarding status of corrective actions.

Site Visit Findings

9. Did the health center expend $750,000 or more in federal award funds during its last complete fiscal year?
   ☐ YES ☐ NO

10. **If Yes**: Has (i.e., audit is complete at the time of site visit) or will (i.e., audit is in progress at the time of site visit) the health center ensure an audit is conducted in accordance with federal audit requirements?
    ☐ YES ☐ NO ☐ NOT APPLICABLE

    If No, an explanation is required:

    _____

11. Based on review of the most recent audit and management letter, were there any findings, questioned or unallowable costs, reportable conditions, material weaknesses, or significant deficiencies, including any cited in the previous audit report?
    ☐ YES ☐ NO ☐ NOT APPLICABLE

12. **If Yes:** Has the health center either completed corrective actions to address the finding(s) or was the health center able to document steps it is currently taking to address the finding(s)?
    ☐ YES ☐ NO ☐ NOT APPLICABLE

    If No, an explanation is required:

    _____

Element e: Documenting Use of Non-Grant Funds

The health center can document that any non-grant funds generated from Health Center Program project activities, in excess of what is necessary to support the HRSA-approved total Health Center Program project budget, were utilized to further the objectives of the project by benefiting the current or proposed patient population and were not utilized for purposes that are specifically prohibited by the Health Center Program.

Site Visit Team Methodology

- Interview the health center's CFO and/or Project Director/CEO or other relevant health center individuals.
- Review policies, procedures, or systems that govern and track the use of non-grant funds (if applicable).

Site Visit Findings

13. In the last complete fiscal year, did the health center generate revenue from health center activities that was then utilized for activities outside the scope of the project?
    ☐ YES ☐ NO

14. **If Yes:** Was the health center able to document that these funds were used:

    - To support activities that benefit the current patient population?
      ☐ YES ☐ NO ☐ NOT APPLICABLE

    - For purposes that are not specifically prohibited by the Health Center Program?
      ☐ YES ☐ NO ☐ NOT APPLICABLE

    If No was selected for any of the above, an explanation is required:

    _____

BILLING AND COLLECTIONS

Primary Reviewer: Fiscal Expert
Secondary Reviewer: Governance/Administrative Expert (as needed)

Authority: *Section 330(k)(3)(E), (F), and (G) of the Public Health Service (PHS) Act; and 42 CFR 51c.303(e), (f), and (g) and 42 CFR 56.303(e), (f), and (g)*

Document Checklist for Health Center Staff

Documents Provided Prior to Site Visit:

- ☐ Registration, Eligibility, Outreach, and Enrollment Procedures
- ☐ 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)
- ☐ List of provider and program/site billing numbers for Medicaid, CHIP, Medicare, or any other documentation of participation (for example, individual provider NPIs)

Documents Provided at the Start of the Site Visit:

- ☐ 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 accounts receivable (A/R) less than 120 days, days in A/R (for context on billing and collections efforts)
- ☐ 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 records reviewed:
  - Ensure the sample includes patients that are eligible for the health center's sliding fee discount program (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 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)

Demonstrating Compliance

Element a: Fee Schedule for In-Scope Services

The health center has a fee schedule for services that are within the HRSA-approved scope of project and are typically billed for in the local health care market.

Site Visit Team Methodology

- Review fee schedule(s).
- Compare the health center fee schedule to Form 5A required and additional services.
- Interview CFO/financial or billing staff.
- Review most recent data and documentation of analysis used for determining and setting fees.

Site Visit Findings

1. Does the fee schedule include fees for all in-scope services typically billed for in the local health care market?

   ***Note**: Services (for example, transportation, translation, other non-clinical services) on Form 5A that are not billed for in the local health care market may be excluded from the health center's fee schedule.*
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

Element b: Basis for Fee Schedule

The health center uses data on locally prevailing rates and actual health center costs to develop and update its fee schedule.

Site Visit Team Methodology

- Review fee schedule(s).
- Compare the health center fee schedule to Form 5A required and additional services.
- Interview CFO/financial or billing staff.
- Review most recent data and documentation of analysis used for determining and setting fees.

Site Visit Findings

2. Did the health center use data on locally prevailing rates and actual health center costs to develop its current fee schedule(s)?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

Element c: Participation in Insurance Programs

The health center participates in Medicaid, CHIP, Medicare, and, as appropriate, other public or private assistance programs or health insurance.

Site Visit Team Methodology

- Review list of provider and program/site billing numbers or any other documentation of participation in Medicaid, CHIP, and Medicare.
- Review documentation (if applicable) of participation in other public or private program or health insurance plans.
- Interview CFO/financial or billing staff.

Site Visit Findings

3. Does the health center have documentation of its participation in Medicaid, CHIP, and Medicare?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

4. Does the health center participate in other public or private assistance programs or health insurance?
   ☐ YES ☐ NO

   If No, an explanation is required, including the justification that the health center provided as to why it is not appropriate to participate in any other programs or insurance plans:

   _____

Element d: Systems and Procedures

The health center has systems, which may include operating procedures, for billing and collections that address:

- Educating patients on insurance and, if applicable, related third-party coverage options available to them;
- Billing Medicare, Medicaid, CHIP, and other public and private assistance programs or insurance in a timely manner, as applicable;[1] and
- Requesting applicable payments from patients, while ensuring that no patient is denied service based on inability to pay.

Site Visit Team Methodology

- Interview staff involved in the billing and collections process as well as staff involved in educating patients on insurance options (for example, front desk staff, billing office staff, outreach and enrollment staff).
- Review billing and collections systems including third-party payor billing procedures and/or contracts.
- Review contracts with outside organizations that conduct billing or collections on behalf of the health center (if applicable).
- Review eligibility, education, and, if applicable, enrollment procedures (for example, new patient registration and screening procedures).

Site Visit Findings

5. Was the health center able to provide at least one example of how it educates patients on the availability of insurance coverage options?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

6. Does the health center have systems in place for billing Medicare, Medicaid, CHIP and other public and private assistance programs or insurance?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

7. Does the health center have a system(s) in place for collecting balances owed by patients?
   ☐ YES ☐ NO

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[1] For information on Federal Tort Claims Act (FTCA) coverage in cases where health centers are using alternate billing arrangements in which the covered provider is billing directly for services provided to covered entity patients, refer to the FTCA Health Center Policy Manual, Section I: E. Eligibility and Coverage, Coverage Under Alternate Billing Arrangements.

If No, an explanation is required:

_____

8. When requesting payment(s) from patients, do the health center's billing and collections systems/procedures ensure that no patient is denied service based on inability to pay?
☐ YES ☐ NO

   If Yes OR No, an explanation is required, including describing the systems or procedures:

   _____

Element e: Procedures for Additional Billing or Payment Options

If a health center elects to offer additional billing options or payment methods (for example, payment plans, grace periods, prompt or cash payment incentives), the health center has operating procedures for implementing these options or methods and for ensuring they are accessible to all patients regardless of income level or sliding fee discount pay class.

Site Visit Team Methodology

- Review billing and collections systems and any related procedures for additional billing options or payment methods (if applicable).

Site Visit Findings

9. Does the health center offer additional billing options or payment methods (for example, payment plans, grace periods, prompt or cash payment incentives)?
☐ YES ☐ NO

   If Yes, an explanation is required specifying what additional billing options or payment methods are offered by the health center:

   _____

10. **If Yes:** Does the health center have operating procedures for implementing these options or methods?
☐ YES ☐ NO ☐ NOT APPLICABLE

    If No, an explanation is required:

    _____

11. Does the health center ensure these options or methods are accessible to all patients regardless of income level or sliding fee discount pay class?
☐ YES ☐ NO ☐ NOT APPLICABLE

    If No, an explanation is required:

    _____

Element f: Timely and Accurate Third-Party Billing

The health center has billing records that show claims are submitted in a timely and accurate manner to the third-party payor sources with which it participates (Medicaid, CHIP, Medicare, and other public and private insurance) in order to collect reimbursement for its costs in providing health services[2] consistent with the terms of such contracts and other arrangements.

Site Visit Team Methodology

- Review sample of claims submission data to compare initial billing dates to service dates.
- Review third-party payor billing procedures.
- Interview CFO and staff involved in the billing and collections process.

Site Visit Findings

12. Does the health center submit claims within 14 business days from the date of service?
☐ YES ☐ NO

    If No, an explanation is required stating the timeline for claims submissions and how the health center ensures timely submission of claims to third-party payors:

    _____

13. Was the health center able to document that it corrects and resubmits claims that have been rejected due to accuracy?
☐ YES ☐ NO

    If No, an explanation is required, including specifying any cases in which Medicaid, CHIP, Medicare, or any other third-party payor has suspended payments to the health center and why:

    _____

Element g: Accurate Patient Billing

The health center has billing records or other forms of documentation that reflect that the health center:

- Charges patients in accordance with its fee schedule and, if applicable, the sliding fee discount schedule (SFDS);[3] and
- Makes reasonable efforts to collect such amounts owed from patients.

---

[2] This includes services that the health center provides directly (Form 5A: Services Provided, Column I) or provides through a formal written contract/agreement (Form 5A: Services Provided, Column II).
[3] See [Health Center Program Compliance Manual] Chapter 9: Sliding Fee Discount Program for more information on the SFDS.

Site Visit Team Methodology

- Review fee schedule and the appropriate corresponding SFDS, including sliding fee schedules that differ by service (if applicable) (for example, Dental SFDS).
- Review billing and collections systems and any related procedures and interview staff involved in collections.
- Review sample of billing and payment records for charges requested from patients. The health center will provide 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 records. The health center will ensure that the records include patients that are eligible for the health center's SFDP (i.e., incomes at or below 200 percent FPG). If applicable, the health center will include records for patients that are not eligible for the SFDP (i.e., incomes above 200 percent FPG).

Site Visit Findings

14. Are patients billed for services in accordance with the health center's fee schedule and are the correct discounts applied to these charges (if applicable)?
    ☐ YES ☐ NO

    If No, an explanation is required:

    _____

15. Does the health center attempt to collect amounts owed for charges, co-pays, nominal charges, or discounted fees (for example, health center sends statements for outstanding balances, makes phone calls)?
    ☐ YES ☐ NO

    If No, an explanation is required:

    _____

Element h: Policies or Procedures for Waiving or Reducing Fees

The health center has and utilizes board-approved policies, as well as operating procedures, that include the specific circumstances when the health center will waive or reduce fees or payments required by the center due to any patient's inability to pay.

Site Visit Team Methodology

- Review policies and procedures that contain provision(s) to waive or reduce fees owed by patients.
- Review a sample of two to three billing records where patient fees were waived or reduced.

Site Visit Findings

16. Does the health center have a provision(s) in policy and procedure that addresses circumstances or criteria related to a patient's inability to pay (regardless of patient income level) to ensure that fees or payments will be waived or reduced?
☐ YES ☐ NO

    If Yes OR No, an explanation is required, including specifying whether the health center waives or reduces fees or payments:

    _____

17. Does the health center follow the provision(s) in its policies and procedures for waiving or reducing fees or payments?
☐ YES ☐ NO ☐ NOT APPLICABLE

    If No, an explanation is required:

    _____

Element i: Billing for Supplies or Equipment

If a health center provides supplies or equipment that are related to, but not included in, the service itself as part of prevailing standards of care[4] (for example, eyeglasses, prescription drugs, dentures) and charges patients for these items, the health center informs patients of such charges ("out-of-pocket costs") prior to the time of service.[5]

Site Visit Team Methodology

- Interview staff involved in billing.
- Review billing procedures and methods for notifying patients of additional costs for supplies and equipment related to but not included in the service (if applicable).

Site Visit Findings

18. Does the health center provide and charge patients for supplies and equipment related to but not included in the service itself (for example, eyeglasses, dentures)?
☐ YES ☐ NO

19. **If Yes:** Does the health center have a method for notifying patients about out-of-pocket costs for such supplies and equipment, in advance of service provision?
☐ YES ☐ NO ☐ NOT APPLICABLE

    If No, an explanation is required:

    _____

[4] These items differ from supplies and equipment that are included in a service as part of prevailing standards of care and are reflected in the fee schedule (for example, casting materials, bandages).
[5] See [Health Center Program Compliance Manual] Chapter 15: Financial Management and Accounting Systems for related information on revenue generated from such charges.

Element j: Refusal to Pay Policy

If a health center elects to limit or deny services based on a patient's refusal to pay, the health center has a board-approved policy that distinguishes between refusal to pay and inability to pay and notifies patients of:

- Amounts owed and the time permitted to make such payments;
- Collection efforts that will be taken when these situations occur (for example, meeting with a financial counselor, establishing payment plans); and
- How services will be limited or denied when it is determined that the patient has refused to pay.

Site Visit Team Methodology

- Interview staff responsible for billing and collections.
- Review billing and collection policies and procedures.
- Review refusal to pay policy (if applicable).
- Review documentation of cases where the health center has applied its refusal to pay policy within the past 2 years (if applicable).

Site Visit Findings

20. Does the health center limit or deny services to patients who refuse to pay?
    ☐ YES ☐ NO

21. **If Yes:** Does the health center have a refusal to pay policy?
    ☐ YES ☐ NO ☐ NOT APPLICABLE

    If No, an explanation is required:

    _____

22. Does the health center:

    - Distinguish between refusal to pay and inability to pay?
      ☐ YES ☐ NO ☐ NOT APPLICABLE
    - Notify patients of amounts owed and the time permitted to make such payments?
      ☐ YES ☐ NO ☐ NOT APPLICABLE
    - Notify patients of collection efforts that will be taken when these situations occur (for example, meeting with a financial counselor, establishing payment plans)?
      ☐ YES ☐ NO ☐ NOT APPLICABLE
    - Notify patients how services will be limited or denied when it is determined that the patient has refused to pay?
      ☐ YES ☐ NO ☐ NOT APPLICABLE

If Yes OR No, an explanation is required, including specifying whether the health center has a policy or procedure that addresses these areas:

_____

23. In cases where the health center has limited or denied services to a patient(s) due to refusal to pay, was the determination consistent with health center policy or procedure?
☐ YES ☐ NO ☐ NOT APPLICABLE

If Yes OR No, an explanation is required, including how the determination was made:

_____

BUDGET

Primary Reviewer: Fiscal Expert
Secondary Reviewer: N/A

Authority: *Section 330(e)(5)(A) and Section 330(k)(3)(I)(i) of the Public Health Service (PHS) Act; and 45 CFR 75.308(a) and 45 CFR 75 Subpart E*

Document Checklist for Health Center Staff

Documents Provided Prior to Site Visit:

- ☐ Updated Annual Budget for the health center project (if updated since last application submission to HRSA)
- ☐ Financial Management Procedures (for context and background on budget development process)
- ☐ Most recent annual audit and management letters or audited financial statements (as reference for any other lines of business)

Documents Provided at the Start of the Site Visit:

- ☐ 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)

Demonstrating Compliance

Element a: Annual Budgeting for Scope of Project

The health center develops and submits to HRSA (for new or continued funding or designation from HRSA) an annual budget, also referred to as a "total budget,"[1,2] that reflects projected costs and revenues necessary to support the health center's proposed or HRSA-approved scope of project.

Site Visit Team Methodology

- Review health center's most current annual budget for the health center project.

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[1] A health center's "total budget" includes the Health Center Program federal award funds and all other sources of revenue in support of the health center scope of project.
[2] Any aspects of the requirement that relate to the use of Health Center Program federal award funds are not applicable to look-alikes.

- Review Budget to Actual Comparison Reports for the current fiscal year and the prior fiscal year.
- Review Financial Management Procedures.
- Review health center's approved scope of project (Form 5A and 5B), including any special populations funding or designation. Determine if there has been any change in the scope of project since the last Health Center Program application which impacts the current budget.
- Interview health center Project Director/CEO, CFO, and/or financial staff to understand budget formulation process (for example, budget assumptions), including any variances or questions raised by the review of Budget to Actual Comparison Reports.

Site Visit Findings

1. Has the health center developed an annual operating budget that is reflective of the projected costs and revenues necessary to support the health center's HRSA-approved scope of project (i.e., reflects revenue and expenses for all sites, services, and activities within the scope of project)?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

Element b: Revenue Sources

In addition to the Health Center Program award, the health center's annual budget includes all other projected revenue sources that will support the Health Center Program project, specifically:

- *Fees, premiums, and third-party reimbursements and payments that are generated from the delivery of services;*
- *Revenues from state, local, or other federal grants (for example, Ryan White, Healthy Start) or contracts;*
- *Private support or income generated from contributions; and*
- *Any other funding expected to be received for purposes of supporting the Health Center Program project.*

Site Visit Team Methodology

***N/A** – HRSA assesses whether the health center has demonstrated compliance with this element through its review of the competing continuation application (Service Area Competition (SAC) or Renewal of Designation (RD)). No onsite review of this element is required.*

Site Visit Findings

***N/A –** HRSA assesses whether the health center has demonstrated compliance with this element through its review of the competing continuation application (SAC or RD). No onsite review of this element is required.*

Element c: Allocation of Federal and Non-Federal Funds

The health center's annual budget identifies the portion of projected costs to be supported by the federal Health Center Program award. Any proposed costs supported by the federal award are consistent with the federal cost principles[3] and the terms and conditions[4] of the award.

Site Visit Team Methodology

***N/A –** HRSA assesses whether the health center has demonstrated compliance with this element through its review of the competing continuation application (SAC or RD). No onsite review of this element is required.*

Site Visit Findings

***N/A –** HRSA assesses whether the health center has demonstrated compliance with this element through its review of the competing continuation application (SAC or RD). No onsite review of this element is required.*

Element d: Other Lines of Business

If the health center organization conducts other lines of business (i.e., activities that are not part of the HRSA-approved scope of project), the costs of these other activities are not included in the annual budget for the Health Center Program project.[5]

Site Visit Team Methodology

- Interview health center Project Director/CEO, CFO, and/or financial staff to determine whether the health center operates other lines of business.
- Review any separate organizational budget(s) (if applicable).
- Review health center's approved scope of project (Form 5A and 5B).
- Review most recent audit or audited financial statements to determine if there are other lines of business.

***Note:** Net revenue from other lines of business may be included in the health center project's operating budget.*

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[3] See 45 CFR Part 75 Subpart E: Cost Principles.
[4] For example, health centers may not use HHS federal award funds to support salary levels above the salary limitations on federal awards.
[5] As these other lines of business are not included in the health center's total budget, they are not subject to Health Center Program requirements and not eligible for related Health Center Program benefits (for example, payment as a Federally Qualified Health Center (FQHC) under Medicare/Medicaid/CHIP, 340B Drug Pricing Program eligibility, Federal Tort Claims Act (FTCA) coverage).

Site Visit Findings

2. Does the health center engage in any other lines of business (i.e., the health center serves other populations or operates sites, services, or activities that are NOT within the HRSA-approved scope of project)?
   ☐ YES ☐ NO

3. **If Yes:**

   - Can the health center document that these other lines of business are fully supported by non-health center project revenues?
     ☐ YES ☐ NO ☐ NOT APPLICABLE

   - Can the health center document that all expenses from such other lines of business are excluded from the annual operating budget for the health center project?
     ☐ YES ☐ NO ☐ NOT APPLICABLE

   If No was selected for any of the above, an explanation is required:

   _____

PROGRAM MONITORING AND DATA REPORTING SYSTEMS

Primary Reviewer: Fiscal Expert
Secondary Reviewer: Governance/Administrative Expert

Authority: *Section 330(k)(3)(I)(ii) of the Public Health Service (PHS) Act; 42 CFR 51c.303(j) and 42 CFR 56.303(j); and 45 CFR 75.342(a) and (b)*

Document Checklist for Health Center Staff

Documents Provided at the Start of the Site Visit:

- ☐ 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

Demonstrating Compliance

Element a: Collecting and Organizing Data

The health center has a system in place for overseeing the operations of the federal award-supported activities to ensure compliance with applicable federal requirements and for monitoring program performance. Specifically:

- The health center has a system in place to collect and organize data related to the HRSA-approved scope of project, as required to meet HHS reporting requirements, including those data elements for Uniform Data System (UDS) reporting; and
- **The health center submits timely, accurate, and complete UDS reports in accordance with HRSA instructions and submits any other required HHS and Health Center Program reports.**

***Note:** HRSA will assess whether the health center has demonstrated compliance in terms of submitting timely, accurate, and complete UDS reports based on internal HRSA UDS reporting information. No onsite review of this portion of element "a" is required.*

Site Visit Team Methodology

- Interview relevant health center staff tasked with data management, collection, or reporting.
- Review health center's Electronic Health Records (EHR), practice management system, or other data collections systems or methods, which may include participation in a Health Center Controlled Network. This may include a navigation of the systems or methods, if helpful.
- Confer with Operational Site Visit team members for input on related data systems (for example, systems used to support Quality Improvement/Quality Assurance, Financial Management and Accounting, Billing and Collections).

Site Visit Findings

In responding to the question(s) below, please note:
Findings related to financial management and accounting systems capacity or quarterly Quality Improvement/Quality Assurance assessments are to be assessed and documented within the Financial Management and Accounting Systems requirement and *Quality Improvement/Assurance requirement, respectively, and do NOT need to be repeated here.*

1. Does the health center have systems or methods in place to collect and organize data, including ensuring the integrity of such data, for the purposes of overseeing the health center project and for monitoring and reporting on program performance?
   ☐ YES ☐ NO

   If No, an explanation is required, including specifying any deficiencies in the health center's methods or safeguards for ensuring the integrity of data:

   _____

Element b: Data-Based Reports

The health center produces data-based reports on: patient service utilization; trends and patterns in the patient population;[1] and overall health center performance, as necessary to inform and support internal decision-making and oversight by the health center's key management staff and by the governing board.

Site Visit Team Methodology

- Review one to two samples of internal health center data reports (for example, monthly board reports, dashboards, presentations).
- Interview health center key management staff and board members regarding the receipt and relevance of health center data-based reports.

[1] Examples of data health centers may analyze as part of such reports may include patient access to and satisfaction with health center services, patient demographics, quality of care indicators, and health outcomes.

Site Visit Findings

2. Do the health center's program data reporting systems or methods result in the production of relevant reports that can inform and support internal decision-making and oversight by key management staff and the governing board? This would include, but is not limited to, the production of reports regarding:

   - Patient service utilization?
     ☐ YES ☐ NO

   - Trends and patterns in the patient population?
     ☐ YES ☐ NO

   - Overall health center clinical, financial, or operational performance?
     ☐ YES ☐ NO

   If No was selected for any of the above, an explanation is required:

   _____

BOARD AUTHORITY

Primary Reviewer: Governance/Administrative Expert
Secondary Reviewer: N/A

Authority: *Section 330(k)(3)(H) of the Public Health Service (PHS) Act; 42 CFR 51c.303(i), 42 CFR 56.303(i), 42 CFR 51c.304(d), and 42 CFR 56.304(d); and 45 CFR 75.507(b)(2)*

Document Checklist for Health Center Staff

Documents Provided Prior to Site Visit:

- ☐ Health center organization 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)
- ☐ Articles of Incorporation (if updated since last application submission to HRSA)
- ☐ Bylaws (if updated since last application submission to HRSA)
- ☐ Co-applicant agreement (if applicable) (if updated since last application submission to HRSA)
- ☐ Position description for the Project Director/CEO
- ☐ Board calendar or other related scheduling documents for most recent 12 months

Documents Provided at the Start of the Site Visit:

- ☐ Board minutes for:
  - most recent 12 months
  - any other relevant meetings from the past 3 years that demonstrate 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
- ☐ Sample board packets from two board meetings within the past 12 months
- ☐ Board committee minutes OR committee documents from the past 12 months
- ☐ Strategic plan or long term planning documents within the past 3 years
- ☐ Most recent evaluation of Project Director/CEO
- ☐ Project Director/CEO employment agreement (for the purposes of provisions regarding Project Director/CEO selection, evaluation, and dismissal or termination)
- ☐ Agreements with parent corporation, affiliate, subsidiary, or subrecipient organization (if applicable)
- ☐ Collaborative or contractual agreements with outside entities that may impact the health center board's authorities or functions

Demonstrating Compliance

1. Is the health center operated by an Indian tribe, tribal group, or Indian organization under the Indian Self-Determination Act or an Urban Indian Organization under the Indian Health Care Improvement Act?[1]
   ☐ YES ☐ NO

   NOTE: IF "YES" WAS SELECTED, NONE OF THE QUESTIONS FOR ANY OF THE ELEMENTS IN THE BOARD AUTHORITY SECTION ARE APPLICABLE.

Element a: Maintenance of Board Authority Over Health Center Project

The health center's organizational structure, articles of incorporation, bylaws, and other relevant documents ensure the health center governing board maintains the authority for oversight of the Health Center Program project, specifically:

- The organizational structure and documents do not allow for any other individual, entity or committee (including, but not limited to, an executive committee authorized by the board) to reserve approval authority or have veto power over the health center board with regard to the required authorities and functions;[2]
- In cases where a health center collaborates with other entities in fulfilling the health center's HRSA-approved scope of project, such collaboration or agreements with the other entities do not restrict or infringe upon the health center board's required authorities and functions; and
- For public agencies with a co-applicant board,[3] the health center has a co-applicant agreement that delegates the required authorities and functions to the co-applicant board and delineates the roles and responsibilities of the public agency and the co-applicant in carrying out the Health Center Program project.

Site Visit Team Methodology

- Review organizational chart(s) (health center project and, if applicable, corporate), articles of incorporation, bylaws, and other relevant corporate or governing documents.
- Review health center's current Forms 5A and 5B to determine current HRSA-approved scope of project.

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[1] The governing board of a health center operated by Indian tribes, tribal groups, or Indian organizations under the Indian Self-Determination Act or Urban Indian Organizations under the Indian Health Care Improvement Act is exempt from the specific board authority requirements discussed in [Health Center Program Compliance Manual Chapter 19: Board Authority]. Section 330(k)(3)(H) of the PHS Act.
[2] This does not preclude an executive committee from taking actions on behalf of the board in emergencies, on which the full board will subsequently vote.
[3] Public agencies are permitted to utilize a co-applicant governance structure for the purposes of meeting Health Center Program governance requirements. Public centers may be structured in one of two ways to meet the program requirements: 1) the public agency independently meets all the Health Center Program governance requirements based on the existing structure and vested authorities of the public agency's governing board; or 2) together, the public agency and the co-applicant meet all Health Center Program requirements.

- Review any collaborative or contractual agreements with outside entities that may impact the health center board's authorities or functions.
- Review co-applicant agreement (if applicable).
- Review agreements with parent corporation, affiliate, subsidiary, or subrecipient organization (if applicable).

Site Visit Findings

In responding to the question(s) below, please note:
In a public agency/co-applicant health center arrangement, the public agency is not considered to be an outside entity as it is the award recipient.

2. Do health center documents and agreements contain language or provisions that allow:

   - Any other individual, entity, or committee (including, but not limited to, an executive committee authorized by the board) to reserve or have approval/veto power over the health center board with regard to the required authorities and functions?
     ☐ YES ☐ NO

   - Any of the health center's collaborations or agreements with other entities to restrict or infringe upon the health center board's required authorities and functions?
     ☐ YES ☐ NO

   If Yes was selected for any of the above, an explanation is required:

   _____

3. **For public agencies with a co-applicant board:** Does the health center have a co-applicant agreement that delegates the required authorities and functions to the co-applicant board and that delineates the roles and responsibilities of the public agency and the co-applicant in carrying out the health center project?
   ☐ YES ☐ NO ☐ NOT APPLICABLE

   If No, an explanation is required:

   _____

Element b: Required Authorities and Responsibilities

The health center's articles of incorporation, bylaws, or other relevant documents outline the following required authorities and responsibilities of the governing board:

- Holding monthly meetings;[4,5]

[4] Where geography or other circumstances make monthly, in-person participation in board meetings burdensome, monthly meetings may be conducted by telephone or other means of electronic communication where all parties can both listen and speak to all other parties.
[5] Boards of organizations receiving a Health Center Program award/designation only under section 330(g) may meet less than once a month during periods of the year, as specified in the bylaws, where monthly meetings are not practical due to health center patient migration out of the area. 42 CFR 56.304(d)(2).

- Approving the selection (and termination or dismissal, as appropriate) of the health center's Project Director/CEO;
- Approving the annual Health Center Program project budget and applications;
- Approving health center services and the location and hours of operation of health center sites;
- Evaluating the performance of the health center;
- Establishing or adopting policy[6] related to the operations of the health center; and
- Assuring the health center operates in compliance with applicable federal, state, and local laws and regulations.

Site Visit Team Methodology

- Review the health center's articles of incorporation, bylaws, and other relevant corporate or governing documents.
- Review co-applicant agreement (if applicable).

Site Visit Findings

4. Do the health center's articles of incorporation, bylaws (either for the health center board or, if applicable, the co-applicant health center board), or other corporate documents (for example, co-applicant agreement) outline the following required authorities and responsibilities:

    - Holding monthly meetings?
      ☐ YES ☐ NO

    - Approving the selection (and termination or dismissal, as appropriate) of the health center's Project Director/CEO?
      ☐ YES ☐ NO

    - Approving the health center's annual budget and applications?
      ☐ YES ☐ NO

    - Approving health center services and the location and hours of operation of health center sites?
      ☐ YES ☐ NO

    - Evaluating the performance of the health center?
      ☐ YES ☐ NO

    - Establishing or adopting policy related to the operations of the health center?
      ☐ YES ☐ NO

[6] The governing board of a health center is generally responsible for establishing and/or approving policies that govern health center operations, while the health center's staff is generally responsible for implementing and ensuring adherence to these policies (including through operating procedures).

- Assuring the health center operates in compliance with applicable federal, state, and local laws and regulations?
  ☐ YES ☐ NO

If No was selected for any of the above, an explanation is required, including specifying which authorities/responsibilities are not addressed in such documents:

_____

Element c: Exercising Required Authorities and Responsibilities

The health center's board minutes and other relevant documents confirm that the board exercises, without restriction, the following authorities and functions:

- Holding monthly meetings where a quorum is present to ensure the board has the ability to exercise its required authorities and functions;
- Approving the selection, evaluation and, if necessary, the dismissal or termination of the Project Director/CEO from the Health Center Program project;
- Approving applications related to the Health Center Program project, including approving the annual budget, which outlines the proposed uses of both Health Center Program award and non-federal resources and revenue;
- Approving the Health Center Program project's sites, hours of operation and services, including decisions to subaward or contract for a substantial portion of the health center's services;
- Monitoring the financial status of the health center, including reviewing the results of the annual audit, and ensuring appropriate follow-up actions are taken;
- Conducting long-range/strategic planning at least once every 3 years, which at a minimum addresses financial management and capital expenditure needs; and
- Evaluating the performance of the health center based on quality assurance/quality improvement assessments and other information received from health center management,[7] and ensuring appropriate follow-up actions are taken regarding:
  - Achievement of project objectives;
  - Service utilization patterns;
  - Quality of care;
  - Efficiency and effectiveness of the center; and
  - Patient satisfaction, including addressing any patient grievances.

[7] For more information related to the production of reports associated with these topics, see [Health Center Program Compliance Manual] Chapter 18: Program Monitoring and Data Reporting Systems, Chapter 15: Financial Management and Accounting Systems, and Chapter 10: Quality Improvement/Assurance.

Site Visit Team Methodology

- Interview Project Director/CEO regarding board roles and responsibilities (for example evaluating health center performance, approving applications, conducting long-range planning, process for evaluating health center policies).
- Interview board (co-applicant board in the case of a public agency-co-applicant model) regarding how it carries out board functions, specifically:
    - How Project Director/CEO reports to the board
    - Board roles and responsibilities (for example evaluating health center performance, approving applications, conducting long-range planning, process for evaluating health center policies)

  Note: *The goal is to interview a majority of board members as a group. If this is not possible, interview officers and at least one patient member. If group interview is not possible, interview individually*.
- If conducting a review for a public agency health center, interview relevant public agency staff (for example, leadership, staff within the unit of the public agency related to the health center project) about their various roles and responsibilities.
- Review board calendar or other related scheduling documents for most recent 12 months.
- Review board minutes for most recent 12 months and any other relevant meeting minutes from the past 3 years that demonstrate board authorities were explicitly exercised.
- Review any relevant board committee minutes OR committee documents for most recent 12 months that support board functions and activities.
- Review sample of board packets for most recent 12 months.
- Review strategic planning or related documents from within the past 3 years.
- Review most recent Project Director/CEO evaluation documentation.
- Review the position description and employment agreement for the Project Director/CEO.

Site Visit Findings

5. Do board minutes document that the board met monthly for the past 12 months and had a quorum (quorum is determined by the health center) present that enabled the board to carry out its required authorities and functions?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

6. Based on your review of board minutes, other relevant documents, and interviews conducted with the Project Director/CEO and board members, were there examples of how the board exercises the following authorities and functions:

   - Approving the selection of, evaluating, and, if necessary, approving the dismissal or termination of the Project Director/CEO from the health center project?
     ☐ YES ☐ NO

   - Approving applications related to the health center project, including approving the annual budget, which outlines the proposed uses of both federal Health Center Program award and non-federal resources and revenue?
     ☐ YES ☐ NO

- Approving the health center project's sites, hours of operation, and services, including (if applicable) decisions to subaward or contract for a substantial portion of the health center's services?
  ☐ YES ☐ NO

- Monitoring the financial status of the health center, including reviewing the results of the annual audit and ensuring appropriate follow-up actions are taken?
  ☐ YES ☐ NO

- Conducting long-range/strategic planning at least once every 3 years, which at a minimum addresses financial management and capital expenditure needs?
  ☐ YES ☐ NO

If No was selected for any of the above, an explanation is required, including specifying any restrictions on the board in carrying out these authorities and functions:

_____

7. Based on your review of board minutes, other relevant documents, and interviews conducted with the Project Director/CEO and board members, were there examples of how the board evaluates the performance of the health center based on quality assurance/quality improvement assessments and other information received from health center management?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

8. **If Yes:** Based on these performance evaluations, were there also examples of follow-up actions reported back to the board regarding:

   Note: *Only select "Not Applicable" for an item below if follow-up action was not necessary*.

   - Achievement of project objectives?
     ☐ YES ☐ NO ☐ NOT APPLICABLE

   - Service utilization patterns?
     ☐ YES ☐ NO ☐ NOT APPLICABLE

   - Quality of care?
     ☐ YES ☐ NO ☐ NOT APPLICABLE

   - Efficiency and effectiveness of the center?
     ☐ YES ☐ NO ☐ NOT APPLICABLE

   - Patient satisfaction, including addressing any patient grievances?
     ☐ YES ☐ NO ☐ NOT APPLICABLE

   If No OR Not Applicable was selected for any of the above, an explanation is required:

   _____

Element d: Adopting, Evaluating, and Updating Health Center Policies

The health center board has adopted, evaluated at least once every 3 years, and, as needed, approved updates to policies in the following areas: Sliding Fee Discount Program (SFDP), Quality Improvement/Assurance, and Billing and Collections.[8]

Site Visit Team Methodology

- Review board minutes from the past 3 years to confirm that the board has reviewed and, if needed, approved updates to the following policies:
  - SFDP
  - Quality Improvement/Assurance Program
  - Billing and Collections (policy for waiving or reducing patient fees and, if applicable, refusal to pay)
- Interview same board members as previously identified regarding the board's evaluation of the health center's SFDP, quality improvement/assurance program, and billing and collections policies and any related updates.

Site Visit Findings

9. Within the last 3 years, has the board adopted or evaluated health center policies in the following areas:

   - SFDP?
     ☐ YES ☐ NO

   - Quality Improvement/Assurance Program?
     ☐ YES ☐ NO

   - Billing and Collections (policy for waiving or reducing patient fees and, if applicable, refusal to pay)?
     ☐ YES ☐ NO

   If No was selected for any of the above, an explanation is required:

   _____

10. Was the health center able to provide one to two examples, if applicable, of how it has modified or updated its policies as a result of these evaluations?
    ☐ YES ☐ NO ☐ NOT APPLICABLE

    If No or Not Applicable, an explanation is required:

    _____

[8] Policies related to billing and collections that require board approval include those that address the waiving or reducing of amounts owed by patients due to inability to pay, and, if applicable, those that limit or deny services due to refusal to pay.

Element e: Adopting, Evaluating, and Updating Financial and Personnel Policies

The health center board has adopted, evaluated at least once every 3 years, and, as needed, approved updates to policies that support financial management and accounting systems and personnel policies. However, in cases where a public agency is the recipient of the Health Center Program federal award or designation and has established a co-applicant structure, the public agency may establish and retain the authority to adopt and approve policies that support financial management and accounting systems and personnel policies.

Site Visit Team Methodology

- Review board minutes from the past 3 years to confirm that the board has reviewed and, if needed, approved updates to the following policies:
    - Financial Management and Accounting Systems
    - Personnel
- Interview same board members as previously identified regarding their process for evaluating financial management and accounting systems and personnel policies.
- Review the co-applicant agreement to determine if the public agency retains authority for adopting and approving personnel and financial management policies (if applicable; ONLY if conducting a site visit for a public agency health center with a co-applicant board).

Site Visit Findings

In responding to the question(s) below, please note:
The content and extent of a health center's financial management and personnel policies may vary. For example, some financial management policies may address procurement, but the lack thereof does not indicate non-compliance. Assessing compliance with respect to procurement procedures is addressed in Contracts and Subawards.

11. Within the last 3 years, has the board evaluated health center policies that support the following areas:

    - Financial management and accounting systems?
      ☐ YES ☐ NO ☐ NOT APPLICABLE

    - Personnel?
      ☐ YES ☐ NO ☐ NOT APPLICABLE

    Note: *For health centers where the public agency retains the authority to adopt and approve the policies listed, select "Not Applicable" for the above questions.*

    If No was selected for any of the above, an explanation is required:

    _____

BOARD COMPOSITION

Primary Reviewer: Governance/Administrative Expert
Secondary Reviewer: N/A

Authority: *Section 330(k)(3)(H) of the Public Health Service (PHS) Act; and 42 CFR 51c.304 and 42 CFR 56.304*

Document Checklist for Health Center Staff

Documents Provided Prior to Site Visit:

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

Documents Provided at the Start of the Site Visit:

- ☐ 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)

Demonstrating Compliance

1. Is the health center operated by an Indian tribe, tribal group, or Indian organization under the Indian Self-Determination Act or an Urban Indian Organization under the Indian Health Care Improvement Act?[1]
   ☐ YES ☐ NO

   NOTE: IF "YES" WAS SELECTED, <u>NONE</u> OF THE QUESTIONS FOR <u>ANY</u> OF THE ELEMENTS IN THE BOARD COMPOSITION SECTION ARE APPLICABLE.

[1] The governing board of a health center operated by Indian tribes, tribal groups, or Indian organizations under the Indian Self-Determination Act or Urban Indian Organizations under the Indian Health Care Improvement Act is exempt from the specific board composition requirements discussed in [the Health Center Program Compliance Manual]. Section 330(k)(3)(H) of the PHS Act.

Element a: Board Member Selection and Removal Process

The health center has bylaws or other relevant documents that specify the process for ongoing selection and removal of board members. This board member selection and removal process does not permit any other entity, committee or individual (other than the board) to select either the board chair or the majority of health center board members,[2] including a majority of the non-patient board members.[3]

Site Visit Team Methodology

- Review organizational chart(s) (health center project and, if applicable, corporate), articles of incorporation, bylaws, or other relevant corporate or governing documents and co-applicant agreement (if applicable).

Note: *Bylaw provisions regarding composition are to be assessed for compliance with Health Center Program requirements as noted in the Health Center Program Compliance Manual and are not to be assessed beyond those requirements.*

Site Visit Findings

2. Do the bylaws or other documentation specify an ongoing selection and removal process for board members?
   ☐ YES ☐ NO

   If No, an explanation is required:
   _____

3. Do the bylaws or other documentation in any way limit the health center's ability to select or remove its own board members, specifically the ability to select any of the following:

   - The board chair?
     ☐ YES ☐ NO
   - The majority of health center board members?
     ☐ YES ☐ NO
   - The majority of the non-patient board members?
     ☐ YES ☐ NO

   If Yes was selected for any of the above, an explanation is required describing how the health center board is limited in its board member selection or removal process:
   _____

[2] An outside entity may only remove a board member who has been selected by that entity as an organizational representative to the governing board.
[3] For example, if the health center has an agreement with another organization, the agreement does not permit that organization to select either the chair or a majority of the health center board.

Element b: Required Board Composition

The health center has bylaws or other relevant documents that require the board to be composed[4] as follows:

- Board size is at least 9 and no more than 25 members,[5] with either a specific number or a range of board members prescribed;
- At least 51 percent of board members are patients served by the health center. For the purposes of board composition, a patient is an individual who has received at least one service in the past 24 months that generated a health center visit, where both the service and the site where the service was received are within the HRSA-approved scope of project;
- Patient members of the board, as a group, represent the individuals who are served by the health center in terms of demographic factors, such as race, ethnicity, and gender;
- Non-patient members are representative of the community served by the health center or the health center's service area;
- Non-patient members are selected to provide relevant expertise and skills such as:
    - Community affairs;
    - Local government;
    - Finance and banking;
    - Legal affairs;
    - Trade unions and other commercial and industrial concerns; and
    - Social services;
- No more than one-half of non-patient board members derive more than 10 percent of their annual income from the health care industry;[6] and
- Health center employees[7,8,9] and immediate family members (i.e., spouses, children, parents, or siblings through blood, adoption, or marriage) of employees may not be health center board members.

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[4] For public agencies that elect to have a co-applicant, these board composition requirements apply to the co-applicant board.
[5] For the purposes of the Health Center Program, the term "board member" refers only to voting members of the board.
[6] Per the regulations in 42 CFR 56.304, for health centers awarded/designated solely under section 330(g) of the PHS Act, no more than two-thirds of the non-patient board members may derive more than 10 percent of their annual income from the health care industry.
[7] For the purposes of health center board composition, an employee of the health center would include an individual who would be considered a "common-law employee" or "statutory employee" according to the Internal Revenue Service (IRS) criteria, as well as an individual who would be considered an employee for state or local law purposes.
[8] In the case of public agencies with co-applicant boards, this includes employees or immediate family members of both the co-applicant organization and the public agency component (for example, department, division, or sub-agency) in which the Health Center Program project is located.
[9] While no board member may be an employee of the health center, 42 CFR 51c.107 permits the health center to use federal award funds to reimburse board members for these limited purposes: 1) reasonable expenses actually incurred by reason of their participation in board activities (for example, transportation to board meetings, childcare during board meetings); or 2) wages lost by reason of participation in the activities of such board members if the member is from a family with an annual family income less than

Site Visit Team Methodology

- Review the health center articles of incorporation, bylaws, or other relevant corporate or governing documents and co-applicant agreement (if applicable).

Site Visit Findings

4. Do the bylaws or other corporate or governing documentation include provisions that ensure:

   - Board size is at least 9 and no more than 25 members, with either a specific number or a range of board members prescribed?
     ☐ YES ☐ NO

   - At least 51 percent of board members are patients served by the health center?

     Note: *Select "Not Applicable" only if the health center has an approved waiver*.
     ☐ YES ☐ NO ☐ NOT APPLICABLE

   - Patient members of the board, as a group, represent the individuals who are served by the health center in terms of demographic factors, such as race, ethnicity, and gender?
     ☐ YES ☐ NO

   - Non-patient members are representative of the community served by the health center or the health center's service area?
     ☐ YES ☐ NO

   - Non-patient members are selected to provide relevant expertise and skills such as community affairs, local government, finance and banking, legal affairs, trade unions and other commercial and industrial concerns, and social services?
     ☐ YES ☐ NO

   - No more than one-half of non-patient board members derive more than 10 percent of their annual income from the health care industry?[10]
     ☐ YES ☐ NO

$10,000 or if the member is a single person with an annual income less than $7,000. For section 330(g)-only awarded/designated health centers, 42 CFR 56.108 permits the use of grant funds for certain limited reimbursement of board members as follows: 1) for reasonable expenses actually incurred by reason of their participation in board activities (for example, transportation to board meetings, childcare during board meetings); 2) for wages lost by reason of participation in the activities of such board members. Health centers may wish to consult with their legal counsel and auditor on applicable state law regarding reimbursement restrictions for non-profit board members and implications for IRS tax-exempt status.

[10] Per the regulations in 42 CFR 56.304, for health centers awarded/designated solely under section 330(g) of the PHS Act, no more than two-thirds of the non-patient board members may derive more than 10 percent of their annual income from the health care industry.

- Health center employees and immediate family members (i.e., spouses, children, parents, or siblings through blood, adoption, or marriage) of employees may not be health center board members?
  ☐ YES ☐ NO

If No was selected for any of the above, an explanation is required:

_____

Element c: Current Board Composition

The health center has documentation that the board is composed of:

- At least 9 and no more than 25 members;
- A patient[11] majority (at least 51 percent);
- Patient board members, as a group, represent the individuals who are served by the health center in terms of demographic factors, such as race, ethnicity, and gender, consistent with the demographics reported in the health center's Uniform Data System (UDS) report;[12]
- Representative(s) from or for each of the special population(s)[13] for those health centers that receive any award/designation under one or more of the special populations section 330 subparts, 330(g), (h), and/or (i); and
- As applicable, non-patient board members:
  - Who are representative of the community in which the health center is located, either by living or working in the community, or by having a demonstrable connection to the community;
  - With relevant skills and expertise in areas such as community affairs, local government, finance and banking, legal affairs, trade unions, other commercial and industrial concerns, or social services within the community; and
  - Of whom no more than 50 percent earn more than 10 percent of their annual income from the health care industry.[14]

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[11] A legal guardian of a patient who is a dependent child or adult, a person who has legal authority to make health care decisions on behalf of a patient, or a legal sponsor of an immigrant patient may also be considered a patient of the health center for purposes of board representation. Students who are health center patients may participate as board members subject to state laws applicable to such non-profit board members.
[12] For health centers that have not yet made a UDS report, this would be assessed based on demographic data included in the health center's application.
[13] Representation could include advocates for the health center's section 330 (g), (h), or (i) patient population (for example, those who have personally experienced being a member of, have expertise about, or work closely with the current special population). Such advocate board members would count as "patient" board members only if they meet the patient definition set forth in the [Health Center Program Compliance Manual] Chapter 20: Board Composition.
[14] For example, in a 9 member board with 5 patient board members, there could be 4 non-patient board members. In this case, no more than 2 non-patient board members could earn more than 10 percent of their income from the health care industry.

Site Visit Team Methodology

- Interview board members (concurrent with interviews for Board Authority requirements).
- Review current board roster or Form 6A.
- Review documentation regarding board member representation.
- Review clinical or billing records to confirm the patient status of board members.
- Review UDS data for an overview of patient population demographic factors (race, ethnicity, and gender).
- Review background information on health center to confirm special populations funding or designation (if applicable).

Site Visit Findings

5. Is the health center board currently composed of at least 9 and no more than 25 members?
   ☐ YES ☐ NO

   If No, an explanation is required, including specifying the number of total board members:

   _____

6. Are at least 51 percent of health center board members classified by the health center as patients?

   Note: *Select "Not Applicable" only if the health center has an approved waiver.*
   ☐ YES ☐ NO ☐ NOT APPLICABLE

   If No, an explanation is required, including specifying the number of total board members and how many (if any) are current patients of the health center:

   _____

7. Were you able to confirm that individuals classified by the health center as patient board members have actually received at least one in-scope service at an in-scope site within the past 24 months that generated a health center visit?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

8. **For health centers with special populations funding/designation**: Was the health center able to identify one or more board member(s) who serves as a representative <u>from or for</u> each of the health center's funded/designated special population(s) (individuals experiencing homelessness, migratory and seasonal agricultural workers, residents of public housing)?
   ☐ YES ☐ NO ☐ NOT APPLICABLE

   If No, an explanation is required:

   _____

9. Are patient board members as a group representative of the health center's patient population in terms of race, ethnicity, and gender?

   Note: *Select "Not Applicable" only if the health center has an approved waiver.*
   ☐ YES ☐ NO ☐ NOT APPLICABLE

   If No, an explanation is required regarding why patient board members as a group are not representative of the health center's patient population and what efforts the health center has made to recruit representative board members:

   _____

10. For the health center's non-patient board members, do all such board members either live or work in the community where the health center is located?
    ☐ YES ☐ NO

    If No, an explanation is required describing whether/how board members who do not live or work in the community have a demonstrable connection to the community:

    _____

11. Do the non-patient board members have relevant skills and expertise in a variety of areas that support the board's governance and oversight role (for example, community affairs, local government, finance, banking, legal affairs, trade unions, major local employers or businesses, social services)?
    ☐ YES ☐ NO

    If No, an explanation is required:

    _____

12. Do any non-patient board members earn more than 10 percent of their annual income from the health care industry?[15]

    Note: *The health center determines how to define "health care industry" and how to determine the percentage of annual income of each non-patient board member derived from the health care industry.*
    ☐ YES ☐ NO

    If Yes, an explanation is required that includes the number of non-patient board members who earn more than 10 percent of their annual income from the health care industry and the total number of non-patient board members:

    _____

Element d: Prohibited Board Members

The health center verifies periodically (for example, annually or during the selection or renewal of board member terms) that the governing board does not include members who are current

[15] Per the regulations in 42 CFR 56.304, for health centers awarded/designated solely under section 330(g) of the PHS Act, no more than two-thirds of the non-patient board members may derive more than 10 percent of their annual income from the health care industry.

employees of the health center, or immediate family members of current health center employees (i.e., spouses, children, parents, or siblings through blood, adoption, or marriage).

Site Visit Team Methodology

- Interview board members (concurrent with interviews for Board Authority requirements).
- Review current board roster or Form 6A.
- Review documentation regarding board member representation.

Site Visit Findings

13. Has the health center verified that the current board does not include any members who are:

    - Employees of the health center?[16,17]
      ☐ YES ☐ NO

    - Immediate family members of current health center employees (i.e., spouses, children, parents, or siblings through blood, adoption, or marriage)?
      ☐ YES ☐ NO

    Note: *The health center board determines whether to include non-voting, ex-officio members such as the Project Director/CEO or community members on the board, consistent with what is permitted under other applicable laws.*

    If No was selected for any of the above, an explanation is required:

    _____

Element e: Waiver Requests

In cases where a health center receives an award/designation under section 330(g), 330(h) and/or 330(i), does not receive an award/designation under section 330(e), and requests a waiver of the patient majority board composition requirements, the health center presents to HRSA for review and approval:

- *"Good cause" that justifies the need for the waiver by documenting:*
  - *The unique characteristics of the population (homeless, migratory or seasonal agricultural worker, and/or public housing patient population) or service area that create an undue hardship in recruiting a patient majority; and*
  - *Its attempt(s) to recruit a majority of special population board members within the past 3 years; and*

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[16] For the purposes of health center board composition, an employee of the health center would include an individual who would be considered a "common-law employee" or "statutory employee" according to the IRS criteria, as well as an individual who would be considered an employee for state or local law purposes.
[17] In the case of public agencies with co-applicant boards, this includes employees or immediate family members of both the co-applicant organization and the public agency component (for example, department, division, or sub-agency) in which the Health Center Program project is located.

- *Strategies that will ensure patient participation and input in the direction and ongoing governance of the organization by addressing the following elements:*
    - *Collection and documentation of input from the special population(s);*
    - *Communication of special population input directly to the health center governing board; and*
    - *Incorporation of special population input into key areas, including but not limited to: selecting health center services;[18] setting hours of operation of health center sites;[19] defining budget priorities;[20] evaluating the organization's progress in meeting goals, including patient satisfaction;[21] and assessing the effectiveness of the sliding fee discount program (SFDP).[22]*

Site Visit Team Methodology

N/A – *HRSA assesses whether the health center has demonstrated compliance with this element through its review of the competing continuation application (Service Area Competition (SAC) or Renewal of Designation (RD)). No onsite review of this element is required.*

Site Visit Findings

N/A – *HRSA assesses whether the health center has demonstrated compliance with this element through its review of the competing continuation application (SAC or RD). No onsite review of this element is required.*

Element f: Utilization of Special Population Input

For health centers with approved waivers, the health center has board minutes or other documentation that demonstrates how special population patient input is utilized in making governing board decisions in key areas, including but not limited to: selecting health center services; setting hours of operation of health center sites; defining budget priorities; evaluating the organization's progress in meeting goals, including patient satisfaction; and assessing the effectiveness of the SFDP.

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[18] See [Health Center Program Compliance Manual] Chapter 4: Required and Additional Health Services for more information on providing services within the HRSA-approved scope of project.
[19] See [Health Center Program Compliance Manual] Chapter 6: Accessible Locations and Hours of Operation for more information on health center service sites and hours of operation.
[20] See [Health Center Program Compliance Manual] Chapter 17: Budget for more information on the Health Center Program project budget.
[21] See [Health Center Program Compliance Manual] Chapter 19: Board Authority for more information on the health center board's required authorities.
[22] See [Health Center Program Compliance Manual] Chapter 9: Sliding Fee Discount Program for more information on requirements for health center SFDPs.

Site Visit Team Methodology

- **For health centers with an approved waiver:** Review the health center's HRSA-approved waiver Form 6B.
- Review documented examples from the health center on the use of special populations input.
- Interview board members (concurrent with interviews for Board Authority requirements).

Site Visit Findings

14. **For health centers with approved waivers only:** Does the health center collect and document input from the special population(s)?

    Note: *Select "Not Applicable" only if the health center does not have an approved waiver.*
    ☐ YES ☐ NO ☐ NOT APPLICABLE

    If No, an explanation is required:

    _____

15. Was the health center able to provide at least one example of how special population input has impacted board decision-making (for example, selecting health center services; setting hours of operation of health center sites; defining budget priorities; evaluating the organization's progress in meeting goals, including patient satisfaction; or assessing the effectiveness of the SFDP)?
    ☐ YES ☐ NO ☐ NOT APPLICABLE

    If No, an explanation is required:

    _____

FEDERAL TORT CLAIMS ACT (FTCA) DEEMING REQUIREMENTS

ONLY TO BE COMPLETED FOR HEALTH CENTERS THAT ARE CURRENTLY FTCA DEEMED

Primary Reviewer: Clinical Expert
Secondary Reviewer: N/A

Notes:

- *Please find below observations regarding the review of FTCA requirements regarding Risk and Claims Management.*
- *The FTCA Program uses the site visit report to support programmatic decisions, including but not limited to FTCA deeming decisions, and to identify technical assistance needs for FTCA deemed health centers. In circumstances where the site visit report contains FTCA risk and claims management findings that require follow-up, the FTCA Program will develop and share a Corrective Action Plan (CAP) with the health center. HRSA expects the health center to respond to the CAP and address findings.*
- *Unresolved Health Center Program conditions related to Clinical Staffing and/or Quality Improvement/Assurance requirements that apply to both Health Center Program and FTCA deeming may impact FTCA deeming if they are not resolved by the time that HRSA makes annual FTCA deeming decisions.*
- *Health centers that have questions regarding the FTCA Program or FTCA deeming requirements may contact Health Center Program Support at 1–877–464–4772 or https://www.hrsa.gov/about/contact/bphc.aspx.*

Authority: *Section 224(g)-(n), 224(q) of the Public Health Service (PHS) Act (42 U.S.C. 233(g)-(n) and (q)); and 42 CFR Part 6*

Document Checklist for Health Center Staff

Documents Provided Prior to Site Visit:

- ☐ 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, Human Resources, Quality Improvement/Quality Assurance, Admin, Clinical, Infection Control)*
- ☐ Claims management process policy(ies)/procedures
- ☐ Most recent HRSA-approved FTCA deeming application
- ☐ Risk management training plan and documentation of completed training

- ☐ 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)

Documents Provided at the Start of the Site Visit:

- ☐ 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
- ☐ Board meeting minutes and/or most recent report(s) (within past 12 months) to the board that include the status of risk management activities
- ☐ 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)

Demonstrating Compliance

Is the health center currently deemed under the Health Center Federal Tort Claims Act (FTCA) Program?
☐ YES ☐ NO

NOTE: IF "NO" WAS SELECTED, <u>NONE</u> OF THE QUESTIONS FOR <u>ANY</u> OF THE ELEMENTS IN THIS FTCA SECTION ARE APPLICABLE.

<u>Risk Management</u>

Element a: Risk Management Program

The health center has and currently implements an ongoing health care risk management program to reduce the risk of adverse outcomes that could result in medical malpractice or other health or health-related litigation and that requires the following:

- Risk management across the full range of health center health care activities;
- Health care risk management training for health center staff;
- Completion of quarterly risk management assessments by the health center; and
- Annual reporting to the health center board which includes: completed risk management activities; status of the health center's performance relative to established risk management goals; and proposed risk management activities that relate and/or respond to identified areas of high organizational risk.

Element b: Risk Management Procedures

The health center has risk management procedures that address the following areas for health center services and operations:

- Identifying and mitigating the health care areas/activities of highest risk within the health center's HRSA-approved scope of project, including but not limited to tracking referrals, diagnostics, and hospital admissions ordered by health center providers;
- Documenting, analyzing, and addressing clinically-related complaints and "near misses" reported by health center employees, patients, and other individuals;
- Setting and tracking progress related to annual risk management goals;
- Developing and implementing an annual health care risk management training plan for all staff members based on identified areas/activities of highest clinical risk for the health center (including, but not limited to, obstetrical procedures and infection control) and any non-clinical trainings appropriate for health center staff (including Health Insurance Portability and Accountability Act (HIPAA) medical record confidentiality requirements); and
- Completing an annual risk management report for the board and key management staff.

Element c: Reports on Risk Management Activities

The health center provides reports to the board and key management staff on health care risk management activities and progress in meeting goals at least annually, and provides documentation to the board and key management staff showing that any related follow-up actions have been implemented.

Element d: Risk Management Training Plan

The health center has a health care risk management training plan for all staff members and documentation showing that such trainings have been completed by the appropriate staff, including all clinical staff, at least annually.

Element e: Individual who Oversees Risk Management

The health center designates an individual(s) (for example, a risk manager) who oversees and coordinates the health center's health care risk management activities and completes risk management training annually.

Site Visit Team Methodology

- Review risk management policy(ies), procedure(s), and/or protocols.
- Review health care risk management training plan.
- Review training records to verify that appropriate staff, including all clinical staff, completed risk management training at least annually.
- Review documentation of last two quarterly risk management assessments that address one or more areas of risk.
- Review relevant board meeting minutes and most recent report(s) (within past 12 months) to the board on the status of risk management activities.

- Interview the health center individual(s) (for example, health center risk manager) who oversees and coordinates the health center's risk management activities on implementation of related policies, procedures, training, assessment, reporting, and follow-up actions.
- Interview other health center clinical leadership and individuals as necessary.

Site Visit Findings

1. Does the health center currently have an individual(s) who oversees and coordinates the health center's risk management activities?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

2. Do the health center's risk management policies or procedures apply to all services and sites within the health center's scope of project?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

3. How does the health center identify and mitigate areas/activities of highest patient safety risk? Describe if and how this informs or aligns with the health center's overall risk management program (for example, staff training, establishment of risk management goals, changes in clinical safety practices).

   An explanation is required, including one to two examples:

   _____

4. Was the health center able to provide examples of how it documents, analyzes, and addresses clinically-related complaints and "near misses" reported by health center employees, patients, and other individuals?
   ☐ YES ☐ NO

   If Yes OR No, an explanation is required, including describing the examples:

   _____

5. Was the health center able to produce documentation of its last two quarterly risk management assessments?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

6. Was the health center able to provide a copy of a report on the status of risk management activities and progress in meeting risk management goals that was presented within the past 12 months to the board and key management staff?
   ☐ YES ☐ NO

If No, an explanation is required:

_____

7. What follow-up actions has the health center implemented based on its risk management assessments and its reporting to the board and key management staff?

   An explanation is required, including explaining the health center's reasoning if no related follow-up actions have been implemented:

   _____

8. Does the health center's training plan require risk management training for relevant clinical staff on obstetrical services?

   Notes:
   - *Health centers that do not directly provide obstetrical services such as labor and delivery but provide prenatal and postpartum care must provide relevant training to clinical staff.*
   - *Select "Not Applicable" if the health center provides all obstetrical services including prenatal and postpartum care to patients through direct referral to another provider.*

   ☐ YES ☐ NO ☐ NOT APPLICABLE

   If No, an explanation is required as to why such trainings are not included in the training plan:

   _____

9. Does the health center's training plan require risk management training for clinical staff on infection prevention and control for all departments?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

10. Does the health center's training plan also require training for all relevant staff on HIPAA medical record confidentiality requirements?
    ☐ YES ☐ NO

    If No, an explanation is required.

    _____

11. Does the health center have documentation that all relevant staff completed training in accordance with the health center's annual risk management training plan?
    ☐ YES ☐ NO

    If No, an explanation is required, including stating what follow-up actions, if any, the health center has or will implement to assure all relevant staff complete training:

    _____

Claims Management

Element a: Claims Management Process

The health center has a claims management process for addressing any potential or actual health or health-related claims, including medical malpractice claims, that may be eligible for FTCA coverage. In addition, this process ensures:

- The preservation of all health center documentation related to any actual or potential claim or complaint (for example, medical records and associated laboratory and x-ray results, billing records, employment records of all involved clinical providers, clinic operating procedures); and
- Any service-of-process/summons that the health center or its provider(s) receives relating to any alleged claim or complaint is promptly sent to the HHS Office of the General Counsel, General Law Division, per the process prescribed by HHS and as further described in the FTCA Health Center Policy Manual.

Element b: Claims Activities Point-of-Contact

The health center has a designated individual(s) who is responsible for the management and processing of claims-related activities and serves as the claims point of contact.

Element c: Informing Patients of FTCA Deemed Status

The health center informs patients using plain language that it is a deemed federal PHS employee[1] via its website, promotional materials, and/or within an area(s) of the health center that is visible to patients.

Element d: History of Claims: Cooperation and Mitigation

If a history of claims under the FTCA exists, the health center can document that it:

- Cooperated with the Attorney General, as further described in the FTCA Health Center Policy Manual; and
- Implemented steps to mitigate the risk of such claims in the future.

Site Visit Team Methodology

- Interview designated individual(s) responsible for claims management.
- Review claims management process policy(ies)/procedures.
- Review claims management and claims history section of the FTCA application.

[1] For example: "This health center receives HHS funding and has federal PHS deemed status with respect to certain health or health-related claims, including medical malpractice claims, for itself and its covered individuals." For more information, see http://www.bphc.hrsa.gov/ftca/.

- Review example(s) of language used to inform patients that the health center is a deemed federal PHS employee.
- For health centers with **closed** claims from within the past 5 years under the FTCA: Review for each **closed** claim documentation of steps implemented to mitigate the risk of such claims in the future.

Site Visit Findings

1. Does the health center currently have an individual(s) who is responsible for the management and processing of claims-related activities and who serves as the claims point of contact?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

2. Was the health center able to describe how it has (if health center has a history of claims under FTCA) or would (if no claims history) manage health or health-related claims? Specifically, was the health center able to demonstrate how it has or would:

   - Preserve claims-related documentation (for example, medical records and associated laboratory and x-ray results, billing records, employment records of all involved clinical providers, clinic operating procedures); and
   - Promptly communicate with HHS Office of the General Counsel, General Law Division regarding any actual or potential claim or complaint?

   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

3. Does the health center inform patients (using plain language) that it is a deemed federal PHS employee via its website, promotional materials, and/or within an area(s) of the health center that is visible to patients?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

4. **For health centers with a history of closed claims under the FTCA within the past 5 years:** For each **closed** claim, what steps has the health center implemented to mitigate the risk of such claim in the future?
   ☐ NOT APPLICABLE

   An explanation is required:

   _____

PERFORMANCE ANALYSIS

Primary Reviewer: Clinical Expert
Secondary Reviewer: Governance/Administrative Expert

Note: *The health center should prepare in advance for the on-site Performance Analysis discussion. Key staff should meet to discuss the current Uniform Data System (UDS) diabetes data, contributing and restricting factors, any planned or ongoing performance improvement activities, and the documents to be provided at the start of the visit and be prepared to discuss with reviewer(s) during the site visit.*

Authority*: 45 CFR 75.301*

Document Checklist for Health Center Staff

Documents Provided Prior to Site Visit by BPHC Staff:

- ☐ UDS Summary Report
- ☐ UDS Health Center Trend Report
- ☐ UDS Health Center Performance Comparison Report
- ☐ Clinical Performance Measure Form from most recent Service Area Competition (SAC) or Renewal of Designation (RD) application
- ☐ Progress update on clinical measure performance from most recent Budget Period Progress Report (BPR) or Annual Certification (AC) submission
- ☐ Report on relevant targeted technical assistance provided by HRSA within the last two project periods, as applicable

Documents Provided at the Start of the Site Visit by Health Center:

- ☐ Examples of health center performance improvement activities related to diabetes control (for example, 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 (for example, Plan-Do-Study-Act (PDSA) cycle data, diabetes control data more recent or more detailed than that reported in UDS)
- ☐ 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

Performance Analysis

Health Center Participants

- Project Director/CEO
- CMO/Clinical Director(s) and QI/QA Director
- Other QI/QA staff
- Providers and other key management staff (if available)

Notes:

- The Diabetes Control measure must be selected for review.
- **It is recommended that all health center staff responsible for the QI/QA program participate in the Performance Analysis planning and root cause analysis discussion that occurs during the site visit.**
- While this performance analysis process will focus on the diabetes control measure, the health center can subsequently replicate and apply this process to any area in which it desires improvement (for example, clinical, governance, fiscal).

Site Visit Team Methodology

A minimum of 1 hour should be devoted to the Performance Analysis root cause discussion. The health center may elect to have a longer discussion with the reviewer(s). The third day of the visit may allow for additional time to discuss performance improvement, particularly in the instance when the exit conference is less than 1 hour.

- Review the health center's stated goal for the measure (included in most recent SAC or RD application) and review UDS trend and performance data (and any more recent health center performance data, if available) for the measure together with the health center staff.
- Lead the health center in a root cause analysis of its performance on the UDS Diabetes Control measure, including a review of the contributing and restricting factors the health center self-identified in its most recent application, as well as a discussion of other applicable factors the health center may not have identified.
    - Ask the health center to list the factors in order of priority. Specifically list the factors that have the strongest influence on the trend line first.
    - Ask the health center to include factors that are internal and external, as well as factors that are current and anticipated.
    - Discuss root causes for each of the factors.
    - Consider how the health center's goal for the measure might be impacted by these factors and root causes and/or how they might impact future actions the health center should commit to in order to reach its goal.
- Identify the top three action steps the health center will or is taking to address the identified root causes necessary to improve performance on the measure's outcome. ***Note:*** *These three actions will become the health center's Action Plan that will be monitored by HRSA for 1 year. Health centers will be expected to report progress on a quarterly basis on these actions.*
    - These action steps must directly address and align with the factors and their root causes identified in the root cause analysis.

- This may include encouraging the health center to revise or disregard existing action steps or interventions that are not effective and do not address the root causes of the restricting or contributing factor(s).
- The three actions must be specific, measurable, achievable, results-focused, and time-bound (S.M.A.R.T.). For example, "By December 31, 2019, increase retinal screening completion rates by 10 percent; establish the baseline for this measure by January 31, 2019; train three additional staff on the use of the scanner by March 31, 2019; subsequent monthly reporting and tracking of completion rates."
- For health centers that are already top quartile performers for the measure, identify root causes of the contributing factors that will be important to focus on in order to maintain the positive performance.
- Encourage the health center to engage in continued root cause analysis to improve performance on other measures and areas.

Site Visit Findings

1. **Select a clinical performance measure for review.**

1.1 **Document Data for the Clinical Measure:** *Complete this table by entering the most recent 3 years of UDS data for the selected measure. Please enter the data in ascending order by year (for example, Diabetes Control measure data for Calendar Years: 2015-2016-2017). Data for Adjusted Quartile Ranking and data for National and State Averages are for the most recent calendar year. If data are not available for a particular year, please enter "0."*

20XX	20XX	20XX	Adjusted Quartile Ranking (1–4)	State Average	National Average
0.00%	0.00%	0.00%		0.00%	0.00%

1.2 **Contributing and Restricting Factors:** Review the below list of categories and definitions of common health center Contributing and Restricting Factors. In the first column, select ALL applicable categories that are Contributing Factor(s) to the health center's success with the performance measure. Contributing factors are those that push the trend in the desired direction. In the second column, select ALL applicable categories that are Restricting Factor(s) to the health center's success with the performance measure. Restricting factors are those that create barriers to improved performance. In the last column, briefly describe the factors. If the health center's Contributing (or Restricting) Factor(s) include characteristics not reflected by the categories below, select "Other" and summarize the missing characteristic(s).

Select All That Apply		**Categories**	**Category Definitions**	**Factor Details**
Contributing Factor(s)	***Restricting Factor(s)***			
☐	☐	**QI/QA Program**	Utilization of a structured, on-going program for planning, implementing, measuring, and reporting the impact of quality improvement interventions on patient care processes and outcomes. Includes having a designated individual(s) to oversee the Program (PDSA cycle is a common method used in QI/QA Programs).	
☐	☐	**Clinical Care Guidelines/Protocols**	Implementation of national, state, population-specific, or other clinical care guidelines/protocols by clinical staff during patient assessment and treatment. Often will involve evidence-based clinical standards and practices. Includes staff training on the details of the guideline/protocol.	
☐	☐	**Education, Counseling and Other Support Provided to Patients**	Provision of educational resources, counseling or other support to patients related to health care prevention and/or disease management. Often involves a focus on self-care management options.	

Select All That Apply		**Categories**	**Category Definitions**	**Factor Details**
Contributing Factor(s)	***Restricting Factor(s)***			
☐	☐	**Population–Specific Strategies**	Implementation of population-specific strategies to support optimal patient outcomes. Population may be defined based on BPHC's special populations (for example, farmworkers, homeless), age (for example, school aged), linguistic, geographic or other characteristic shared across the population.	
☐	☐	**Clinician Capacity**	Appropriate number and types of clinicians and appropriate utilization of clinicians (for example, team-based care) to support optimal provision of patient care.	
☐	☐	**Facility Capacity**	Physical space to support optimal provision of patient care. Includes the appropriate number and/or types of clinical care spaces (for example, patient care rooms) and the design or lay-out of clinical spaces within and across departments.	
☐	☐	**Information Technology**	Training on and use of an electronic data system to document and report patient care and outcomes. Can involve decision support features that support clinicians' follow-up patient care.	

Select All That Apply		**Categories**	**Category Definitions**	**Factor Details**
Contributing Factor(s)	***Restricting Factor(s)***			
☐	☐	**Patient Access to Low-Cost Medications and Related Supplies**	Patient access to the medications and supplies needed to support optimal clinical outcomes. (HRSA's 340B Drug Pricing Program and pharmaceutical companies' patient assistance programs are common methods for supporting such patient access).	
☐	☐	**Partnerships**	Collaborations with other health centers, community providers, or other organizations to support optimal clinical outcomes.	
☐	☐	**Other Health Center Operational Processes**	Implementation of other health center operational processes that support optimal clinical care and outcomes (for example, appointment scheduling, patient satisfaction assessments, or good customer service practices). Includes any related training of staff.	
☐	☐	**OTHER Category**	Unique contributing or restricting factor(s).	

1.3 **Recommended Activities**: Document the three recommended activities or action steps the health center will commit to doing or that the health center is currently doing to improve performance on the measure. When responding, ensure all activities or action steps address and align with factors identified in the root cause analysis and will support the health center to improve or maintain performance on the measure. Ensure actions are S.M.A.R.T. as these will be monitored by HRSA for a minimum of 1 year as a part of the health center's diabetes Action Plan.

PROMISING PRACTICES

Primary Reviewer: Based on Promising Practice identified
Secondary Reviewer: Optional

Authority: *45 CFR 75.301*

Overview

A promising practice refers to an activity, procedure, approach, or policy that leads to, or is likely to lead to, improved outcomes or increased efficiency for health centers. The site visit team will use this section of the report to document any promising practices observed during the course of the site visit. **No more than two promising practices can be listed for each visit and the site visit team should closely follow the guidance below in determining whether anything rises to the level of a promising practice.**

Promising Practices may be identified in one or more of the following:

- Health Center Program requirement areas
- Health center clinical performance
- Medical, oral, and behavioral health care and/or enabling service or the integration of these services to meet the needs of the health center's target population
- Health center administration and operations (for example, staff recruitment/education)

HRSA collects these promising practices to share externally with others (for example, via BPHC website, other health centers, and technical assistance partners).

Site Visit Team Methodology

- If a promising practice is identified, assign it to one of three major categories: 1) Clinical Services, 2) Governance, or 3) Management and Finance
    - If applicable, select a subcategory to classify the Promising Practice type further.
    - More than one subcategory and item may be linked to the Promising Practice. Examples of subcategories include:
        - Behavioral Health - Mental Health
        - Preventive Health - Cancer Screening
        - Business Operations - Patient Cycle Time
- Description of a promising practice should include the following four components:
    - **Context section**: Clearly describe the health center's innovation, challenge, or issue.
    - **Description section**: Describe the practice that the health center implemented in seeking a solution to the challenge or issue.
    - **Outcome section**: Describe the result, including the quantitative and/or qualitative data that the health center used in determining the effectiveness of their practice.
    - **Implementation section**: State how this practice can be implemented in other health centers. Please list any special needs or costs associated with this activity. What were the required elements for the health center's successful implementation

(for example, board approval, policy, funding, collaborative partners and resources, facility, transportation, community acceptance)?

- Complete the **Permission to Share** and **Point of Contact** sections. Complete the Relevant Documentation section.

Site Visit Findings

1. Were any promising practices identified as part of this site visit?
   ☐ YES ☐ NO

2. If yes, select the most appropriate category for this promising practice: Clinical Services, Governance, or Management and Finance. Then select all subcategory elements that apply.

   _____

3. **Context:** Clearly describe the health center's innovation, challenge, or issue.

   _____

4. **Description:** In detail, describe the practice implemented.

   _____

5. **Outcome:** Use quantitative and/or qualitative data to show how the practice was effective.

   _____

6. **Implementation section**: State how this practice can be implemented in other health centers. Please list any special needs or costs associated with this activity. What were the required elements for the health center's successful implementation (for example, board approval, policy, funding, collaborative partners and resources, facility, transportation, community acceptance)?

   _____

7. Did the health center consent to share this practice with others (for example, via BPHC website, other health centers, and technical assistance partners)?
   ☐ YES ☐ NO

8. Please provide the name, phone number, and email address for the staff person who should be reached for further information.

   _____

9. List any relevant documentation related to the promising practice (for example, policy, forms, patient education handout).

   _____

ELIGIBILITY REQUIREMENTS FOR LOOK-ALIKE INITIAL DESIGNATION APPLICANTS

Primary Reviewer: Governance/Administrative Expert
Secondary Reviewer: N/A

Authority: *Sections 1861(aa)(4)(b) and 1905(l)(2)(B) of the Social Security Act.*

Document Checklist for Health Center Staff

Documents Provided Prior to Site Visit:

- ☐ Most recent annual audit and management letters or audited financial statements (if audits are not available)
- ☐ Health center organization 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)
- ☐ Agreements with parent corporation, affiliate, subsidiary or other controlling organization (if applicable)
- ☐ Co-applicant agreement (if applicable) (if updated since last application submission to HRSA)
- ☐ Position description for the Project Director/CEO

Documents Provided at the Start of the Site Visit:

- ☐ Health center selection of three to five 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) that document the provision of various Required and Additional Services
- ☐ Sample of up to three Medicare or Medicaid claims or other billing documents that demonstrate under what organizational entity or unit billing is conducted
- ☐ Contracts for substantive programmatic work[1] (i.e., contracting with a single entity for the majority of health care providers)
- ☐ Project Director/CEO employment agreement

[1] For the purposes of the Health Center Program, contracting for substantive programmatic work applies to contracting with a single entity for the majority of health care providers. The acquisition of supplies, material, equipment, or general support services is not considered programmatic work. Substantive programmatic work may be further defined within HRSA Notices of Funding Opportunity (NOFOs) and applications.

1. Is this a Look-Alike Initial Designation Site Visit?
   ☐ YES ☐ NO

   NOTE: IF "NO" WAS SELECTED, <u>NONE</u> OF THE QUESTIONS IN THIS LOOK-ALIKE INITIAL DESIGNATION SECTION ARE APPLICABLE.

Site Visit Team Methodology

- Confirm that applicant is currently delivering primary care services through tour of service delivery sites (one or more sites as listed on Form 5B); and
- Review selection of three to five health center patient records (either using live navigation of the EHR, screenshots from EHR, or actual records if the records are not electronic/EHR records) that document the provision of various Required and Additional Health Services.

Site Visit Findings

2. Is the applicant **currently delivering primary health care services** to patients within the proposed service area?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

Site Visit Team Methodology

- Interview CFO/financial staff of the applicant organization and board members (for example, board chair, board treasurer) regarding ownership and operation of the applicant organization.
- Review most recent annual audit and management letters or audited financial statements of the applicant organization.
- Review Medicare or Medicaid claims or other billing documents that demonstrate under what organizational entity or unit billing is conducted.
- Review bylaws of applicant organization, and if applicable, the co-applicant agreement for public agency applicants with a co-applicant governing board.
- Review any documents related to the applicant's parent company, affiliate, subsidiary or other controlling organization that has a substantial role in the operations of the applicant organization (if applicable).

Site Visit Findings

3. Was the applicant (i.e., the organization applying for look-alike designation) able to document that it currently **owns and controls the organization's assets and liabilities** (for example, the applicant organization does not have a sole corporate member, is not a subsidiary of another organization)?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

4. Does the applicant have safeguards in place to ensure the benefits that accrue through look-alike designation as a Federally Qualified Health Center (FQHC) (for example, FQHC payment rates, 340B Drug Pricing Program eligibility) will only be distributed to the Health Center Program project?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

Site Visit Team Methodology

- Review applicant's current organization chart(s).
- Review Project Director/CEO position description and employment agreement.
- Interview Project Director/CEO.
- Review bylaws of applicant organization.
- Review co-applicant agreement (if applicable).
- Review contracts for substantive programmatic work under the proposed health center project (if applicable).

Site Visit Findings

5. Was the applicant (i.e., the organization applying for look-alike designation) able to document that it operates the Health Center Program project (i.e., the services and activities included in the look-alike application)?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

6. Does the look-alike applicant organization have a Project Director/CEO in place who carries out independent, day-to-day oversight of health center activities (i.e., the services and activities included in the look-alike application), solely on behalf of the governing board of the applicant organization?
   ☐ YES ☐ NO

   If No, an explanation is required:

   _____

Valleywise Community Health Centers

Co-Applicant Operational Agreement

CO-APPLICANT OPERATIONAL ARRANGEMENT

Between the

MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT

(Public Agency)

and the

VALLEYWISE COMMUNITY HEALTH CENTERS GOVERNING COUNCIL

(Co-Applicant)

This Co-Applicant Operational Arrangement (Arrangement) is entered into by and between the Maricopa County Special Health Care District Board of Directors (Board), and the Valleywise Community Health Centers Governing Council (Governing Council or Co-Applicant) (collectively the Parties).

WHEREAS, the Maricopa County Special Health Care District (District), a political subdivision of the state of Arizona, is statutorily empowered to operate pursuant to Title 48, Chapter 31, of the Arizona Revised Statutes and A.R.S. § 48-5501 et. seq. and acting through its Board, is authorized to accept and utilize federal and state funds and enter into agreements with other entities for the delivery and supervision of health care services at District operated health care facilities; and,

WHEREAS, the Co-Applicant, through its Governing Council, is organized to provide governance and oversight of Federally Qualified Health Center (FQHC) clinics owned and operated by the District that provide primary and preventive health care and related services (including, but not limited to, ancillary services), regardless of an individual's or family's ability to pay; and,

WHEREAS, since 2019, the Parties have co-applied for, and have been awarded by the Health Resources and Services Administration (HRSA) within the United States Department of Health and Human Services (DHHS), designation to operate a public center pursuant to Section 330 of the Public Health Service Act, which includes the FQHC clinics (the Health Center Program"); and,

WHEREAS, the Parties agree that the District, having received FQHC designation from HRSA, will serve as the Public Agency and, as applicable, the recipient of federal funding, which may include Section 330 grant funding; and that the Governing Council will serve as the Co-Applicant, consistent with the requirements of Section 330 and applicable HRSA policies and pronouncements; and that the District acting as the Public Agency and the Governing Council acting as the Co-Applicant, together constitute the Health Center Project under HRSA policy; and,

WHEREAS, the Parties understand that Section 330, which was enacted by Congress, permits a public entity to operate a public center and to retain general policy-making authority; and,

WHEREAS, HRSA policy has stated (i) that a public center may consist of a public entity and a co-applicant which, when combined, meet the Section 330 governance requirements; and (ii) that many public entities are required by law to retain final authority for certain types of activities; and,

WHEREAS, in order to accomplish their shared interests, the Board and Governing Council, acting collectively as the public center, wish to clarify and define their respective roles and responsibilities and their shared duties with regard to the governance and operation of the FQHC clinics in a manner consistent with the requirements of Section 330, it's implementing regulations, HRSA policies and the Compliance Manual.

NOW THEREFORE, in consideration of the promises and mutual covenants set forth in this Arrangement, the Parties agree as follows;

1. Governing Council's Governance Authorities and Responsibilities

The Governing Council's governance authorities and responsibilities shall comply with the requirements of Section 330, its implementing regulations, HRSA policies and the Compliance Manual. The Governing Council shall specifically exercise the following authorities and responsibilities regarding the management and operation of the FQHC clinics:

1.1 Annually review the service area by zip codes reported on Form 5B: Service Sites;

1.2 Complete or update a community needs assessment of the current patient population at least once every three (3) years to improve the delivery of health care services;

1.3 Review and approve additional health services, if any, to offer in order to meet the health needs of the patient population served by the FQHC clinics, subject to Board approval;

1.4 Annually review a list of FQHC clinics, including addresses, hours of operation by clinic, and information on general services offered at each clinic reported on Form 5B: Service Sites;

1.5 Approve location of any new FQHC clinic or closure of existing FQHC clinic as long as it is consistent with the District's facility, strategic, business, financial, and capital plans;

1.6 Ensure written operating procedures exist for responding to patient medical emergencies during each FQHC clinics regularly scheduled hours of operation;

1.7 Ensure written operating procedures exist for responding to patient medical emergencies after regularly scheduled hours of operation;

1.8 Ensure written operating procedures are in place to obtain medical information related to a FQHC clinic patient's hospital or emergency department visit;

1.9 Review evaluate, and approve a sliding fee discount program for the FQHC clinics at least every three (3) years. Evaluation should include the effectiveness of the sliding fee discount program in reducing financial barriers to care, and the rate which patients within each discount category are accessing services;

1.10 Annually review and approve a sliding fee discount schedule for the FQHC clinics based on the most recent Federal Poverty Guidelines;

1.11 Review and approve at least every two (2) years a Quality Improvement/Quality Assurance (QI/QA) program for the FQHC clinics that addresses the quality and utilization of services, patient satisfaction, patient grievance process and patient safety including adverse events;

1.12 Ensure that QI/QA data, including patient satisfaction, patient grievance and patient safety, is shared with the Governing Council at least quarterly;

1.13 Ensure written quality of care audit procedures are in place and audit is shared with the Governing Council annually;

1.14 Select/hire the Project Director/Chief Executive Officer of the FQHC clinics after receiving prior approval from HRSA and as set forth in Paragraph 6 below;

1.15 Annually evaluate the Project Director/Chief Executive Officer's performance as set forth in Paragraph 6 below;

1.16 Dismiss/terminate the Project Director/Chief Executive Officer from the Health Center Program if necessary, as set forth in Paragraph 6 below and notify HRSA;

1.17 Approve changes to Project Director/Chief Executive Officer's job description;

1.18 Approve changes to organization chart including titles and names of key management staff;

1.19 Comply with the District's written Code of Conduct and Ethics; and Conflicts of Interest and Gift policy;

1.20 Submit written disclosure to Clerk if a real or apparent conflict of interest was identified by a Governing Council member;

1.21 Make reasonable efforts to establish and maintain collaborative relationships, including with other specialty providers that provide care within Maricopa County, to provide access to services not available at the FQHC clinics and to reduce the non-urgent use of hospital emergency departments; and with social service organizations to support community services that impact patients of the FQHC clinics;

1.22 Track the financial performance of the FQHC clinics, including identification of trends or conditions that may warrant action to maintain financial stability;

1.23 Review and accept the annual fiscal year audit of the District, which includes certain financial information about the FQHC clinics;

1.24 Maintain control over, and accountability for, all funds, in order to adequately safeguard and ensure that they are used solely for authorized purposes;

1.25 Ensure written policies and procedures are in place to ensure the appropriate use of federal funds in compliance with applicable federal statutes, regulations, and the terms and conditions of the federal award;

1.26 Ensure written billing and collections policies and procedures are in place and include provisions to waive or reduce fees owed by patients; a policy for refusal to pay; and procedures for notifying patients of additional costs for supplies and equipment related to the services;

1.27 Develop and approve an annual operating and capital budget for the FQHC clinics to be incorporated into the District's annual budget for Board approval. The budget should be reflective of the costs and revenues necessary to support the FQHC clinics scope of project;

1.28 Submit timely, accurate, and complete Uniform Data System (UDS) reports;

1.29 Annually review data-based reports on: patient service utilization; trends and patterns in the patient population; and overall health center performance including achievement of FQHC clinics objectives; and efficiency and effectiveness of the FQHC clinics, for oversight by the Governing Council;

1.30 Approve application for HRSA grant funding, subject to Board approval;

1.31 Approve changes in scope of project for the FQHC clinics subject to Board approval;

1.32 Annually evaluate the operations of the FQHC clinics including compliance with applicable federal requirements, performance expectations such as financial and patient volumes, patterns of health service utilization;

1.33 Ensure the existence of a co-applicant arrangement that delegates the required authorities and responsibilities to the Governing Council and delineates the authorities and responsibilities of the Board;

1.34 Hold monthly meetings where a quorum is present;

1.35 Conduct and approve a long-range, strategic plan at least once every three (3) years that identifies FQHC clinic priorities and addresses financial management and capital expenditure needs, that is consistent with the District's facility, strategic, business, financial and capital plans; and

1.36 On an annual basis, submit an attestation that the Governing Council has operated; and each Governing Council Member has performed his/her duties, in a manner that is compliant with the provisions of this Arrangement; and that each Governing Council member has completed their annual compliance training and sign the District's Code of Conduct and Ethics attestation form.

2. Composition of the Governing Council

2.1 The composition of the Governing Council, as set forth in the Governing Council's bylaws, shall comply with the requirements of Section 330, its implementing regulations, HRSA policies and the Compliance Manual.

2.2 The Governing Council must consist of at least 9 and no more than 25 members.

2.3 The majority (at least 51%) of the Governing Council members must be patients served by the FQHC clinics. A patient is someone who has received in-scope services within the last 24 months. The patient Governing Council members must represent the patients served by the FQHC clinics in terms of demographics such as race, ethnicity, and gender.

2.4 Non-patient Governing Council members must be representative of the community served by the FQHC clinics and must be selected for their expertise in relevant subject areas such as community affairs, local government, finance, legal, trade unions, education, business labor relations and social service agencies within the community.

2.5 Ensuring that the non-patient Governing Council members, no more than one-half may derive more than 10% of their annual income from the health care industry. Health care industry is defined as hospitals, other health care institutions, nurses, doctors, dentist, and other licensed healthcare professionals whose primary responsibility is providing primary preventative and therapeutic healthcare services.

2.6 Employees and immediate family members (spouse, child, parent, or sibling, by blood, adoption, or marriage) of the Maricopa County Special Health Care District dba Valleywise Health, or any other hospital or health care institution, may not be members of the Governing Council.

2.7 The Governing Council will make its best efforts to ensure that each of the five (5) Directorship District's is represented when recruiting and approving new Governing Council members.

2.8 The Governing Council will submit an annual report to the Board reflecting the Governing Council's membership structure.

3. Governing Council's Bylaws

3.1 The Governing Council agrees that any proposed amendments to the bylaws must be consistent with the requirements of Section 330, its implementing regulations, HRSA policies, the Compliance Manual, and the terms of this Arrangement.

3.2 The bylaws must outline the following required authorities and responsibilities of the Governing Council: hold monthly meetings; approval of the selection of the Project Director/Chief Executive Officer; approval of the dismissal/termination of the Project Director/Chief Executive Officer; approval of annual budget for the FQHC clinics; approval of location of any new FQHC clinic or closure of existing FQHC clinic as long as it is consistent with the District's facility, strategic, business and capital plans; approval of FQHC clinics hours of operation; annual evaluation of the performance of the FQHC clinics; and assurance that the FQHC clinics operate in compliance with applicable Federal, State and local laws and regulations.

3.3 Prior to adopting amendments to the bylaws, the Governing Council will provide the Board a copy of the proposed amendments with sufficient time to permit the Board to review and ensure that any revision is consistent with the requirements of Section 330, its implementing regulations, HRSA policies, Compliance Manual, and the terms of this Arrangement. The Board shall approve the proposed amendments at the next regularly scheduled Board meeting and thereafter, notify the Governing Council of approval. The Board may only disapprove an amendment to the bylaws if the amendment is inconsistent with the requirements of Section 330, its implementing regulations, HRSA policies, the Compliance Manual, and the terms of this Arrangement. The Board will provide the Governing Council with reason(s) for such disapproval within seven (7) calendar days after non-approval.

3.4 The bylaws will include similar language as in the Board's bylaws that allow for four (4) or more Governing Council members to place an item on the Governing Council's meeting agenda.

3.5 The bylaws will include provisions for the filling of vacancies on the Governing Council that arise as a result of retirement, resignation, or the removal of a member of the Governing Council, where the removal is based upon good cause, including but not limited to, violations of the District's Code of Conduct and Ethics, Conflicts of Interest and Gift policy or actions that are unbecoming of the member.

4. Governing Council's Duty Regarding Potential Members of Governing Council

4.1 The Governing Council will provide District staff with a completed Governing Council membership application and Acknowledgement and Authorization for Background Check form, with sufficient advance time to permit District staff to review the application to ensure there is no conflict of interest in fact or in appearance, and to receive back the completed background screening. District staff will notify the Governing Council about any identified conflict of interest with regard to the potential member, in a timely manner, but in no event, later than the next regularly scheduled Executive Committee meeting. The obligations noted in Paragraph 5.32 are incorporated by reference in this Paragraph 4.1.

5. Board's Authorities and Responsibilities

The Board, acting through staff, shall exercise the following governance and operational authorities and responsibilities with respect to the FQHC clinics, which includes but are not limited to:

5.1 Consider for approval additional health services, if any, as recommended by the Governing Council. to offer in order to meet the health needs of the patient population served by the FQHC clinics;

5.2 Ensure that the FQHC clinics have clinical staff and/or has contracts in place to carry out all required and additional services included in the HRSA-approved scope of project;

5.3 Ensure operating procedures are in place for credentialing and privileging for all clinical staff members providing services on behalf of the FQHC clinics;

5.4 Ensure records for clinical staff that contain documentation of licensure, credentialing verification, and applicable privileges consistent with operating procedures, are maintained;

5.5 Ensure operating procedures are in place for FQHC clinics' patients that are hospitalized as inpatients or who visited the Valleywise Health Medical Center's Emergency Department;

5.6 Ensure position descriptions of key management staff are maintained by the District's Human Resources;

5.7 Ensure there are District Human Resources procedures relevant to recruiting and hiring of key management staff of the FQHC clinics;

5.8 Adopt policies for financial management practices and a system to ensure accountability for FQHC clinics resources;

5.9 Establish and maintain general personnel policies including those addressing selection and dismissal procedures, salary and benefit scales, employee grievance procedures, and equal opportunity practices;

5.10 Contract with other providers for the provision of health services within the HRSA-approved scope of project and ensure their performance is in accordance with the terms, conditions, and specifications of their contracts and to assure compliance with applicable Federal requirements

5.11 Ensure that contracts with providers for the provision of health services with the HRSA-approved scope of project include a schedule of rates and method of payment to providers for health services that are provided at the within the HRSA-approved scope of project at the FQHC clinics;

5.12 Retain financial records, supporting documents, statistical records, and all other records pertinent to contracts for a period of three years;

5.13 Ensure that written procurement procedures comply with Federal procurement standards;

5.14 Perform periodic evaluations of contractors' performance including that contractors have met the terms, conditions, and specifications of contracts;

5.15 Maintain a written District Code of Conduct and Ethics and Conflicts of Interest and Gift policy;

5.16 Maintaining records for procurement actions paid for in whole or in part under the Federal award that include the rationale for method of procurement, selection of contract type, contractor selection or rejection, and the basis for the contract price. This would include documentation related to noncompetitive procurements;

5.17 Maintain mechanism to ensure the District's Code of Conduct and Ethics is disseminated to Board and Governing Council, employees, medical staff, and agents of the District when there are changes;

5.18 Ensure Board and Governing Council, employees, medical staff, and agents of the District, adhere to the District's Code of Conduct and Ethics by requiring an annual attestation;

5.19 Contract with external auditor to perform an annual fiscal year audit of the District, which includes the FQHC clinics, to determine the fiscal integrity of financial transactions and operations of the District to be in compliance with HRSA requirements; and in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in Government Auditing Standards, used by the Comptroller General of the United States;

5.20 Utilize a financial management and internal control system that reflects Generally Accepted Accounting Principles (GAAP) or Government Accounting Standards Board (GASB) principles;

5.21 Maintain a list of provider and program/site billing numbers for Medicaid, CHIP and Medicare;

5.22 Maintain written operating procedures for implementing billing options or payments methods and ensure they are accessible to patients regardless of income level;

5.23 Ensure claims are submitted in a timely and accurate manner to third party payor sources;

5.24 Annually, adopt a District budget that shall consist of at the very least, a one (1) year operating budget, a one (1) year capital budget, and one (1) year cash flow budget, and an annual operating and capital budget for the FQHC clinics;

5.25 Consider approval of application for HRSA grant funding, as recommended by the Governing Council;

5.26 Consider approval of changes in scope of project for the FQHC clinics, as recommended by the Governing Council;

5.27 Ensure a system is in place to oversee the operations of the Federal award-supported activities to ensure compliance with applicable Federal requirements and for monitoring program performance;

5.28 Produce data-based reports on: patient service utilization; trends and patterns in the patient population; and overall health center performance, for oversight by the Governing Council;

5.29 Ensure a system is in place for the Governing Council to compile accurate data to complete annual Uniform Data System (UDS) reports;

5.30 Review the long-range, strategic plan for the FQHC clinics as recommended by the Governing Council, that identifies FQHC clinic priorities and addresses financial management and capital expenditure needs;

5.31 Obtain and maintain all licenses, permits, certifications and approvals necessary for the operation of the FQHC clinics;

5.32 In support of the Governing Council's responsibility referenced in Paragraph 4.1 above, the Board's review of the Governing Council applicant will also include a background check (as per the District's Human Resource Policies), a review of the Department of Health and Human Services' Exclusion List, and consideration of any other federal or state regulatory requirements applicable to citizens sitting as Governing Council members. District staff will inform the Governing Council, in a timely manner (see Paragraph 4.1), in situations where a Governing Council applicant may be prohibited from serving as a Governing Council member due to the presence or absence of a negative background report, and/or the Governing Council applicant's real or apparent conflict of interest, and/or if there is otherwise a statutory or regulatory requirement. The Board's approval of the applicant does not constitute a formal endorsement of the applicant as an official member of the Governing Council. The Governing Council will formally vet the applicant and the applicant must gain approval by formal vote of the Governing Council;

5.33 On an annual basis, submit an attestation that the Board has operated; and each Board member has performed his/her duties, in a manner that is compliant with the provisions of this Arrangement; and that each Board member has completed their annual compliance training and sign the District's Code of Conduct and Ethics attestation form.

6. Project Director/Chief Executive Officer

6.1 The Project Director/Chief Executive Officer (CEO of the FQHC Clinics) shall be a full-time District employee. The CEO has the responsibility for the general management, supervision, and direction of the FQHC clinics, and must work within the District organizational reporting structure on matters of finance, quality, human resources, strategy, service, and operations, consistent with policies and programs established by the District.

6.2 The CEO shall report to the Governing Council. As a District employee, the CEO shall also report to the District's President and CEO or designee.

6.3 The CEO shall be selected via a nomination and search process under which the District's Human Resources Department recruits candidates with input from the Governing Council and thereafter provides a recommendation to the Governing Council. The Governing Council then selects an individual from the list of proposed candidates. If the Governing Council rejects all individuals from the District's list of proposed candidates, then the District's Human Resources Department will provide the Governing Council with a list of additional proposed candidates. This process shall continue until the Governing Council approves an individual proposed by the District's Human Resources Department.

6.4 The Governing Council will annually review and evaluate the CEO's performance applicable to the Health Center Program in a quantifiable and transparent manner that is consistent with the District's Human Resources policies and will report its findings to the District's Chief Financial Officer and to Human Resources. In addition, the CEO, as a District employee, will be evaluated by the District's Chief Financial Officer in accordance with the District's Human Resources policies.

6.5 Removal or Reassignment of the CEO:

6.5.1 Removal by the Governing Council.

6.5.1.1 The Governing Council shall have independent authority to remove the CEO from his or her position as CEO of the FQHC Clinics. Removal of the CEO by the Governing Council pursuant to this Paragraph shall not constitute a termination of employment of the CEO by the District or otherwise impede the continuation of the CEO's employment relationship with the District in another capacity.

6.5.1.2 Any personnel action proposed by the Governing Council with regard to the CEO must be taken consistent with the District's Human Resources policies.

6.5.1.3 The Governing Council acknowledges that the District President and CEO possesses the sole power to terminate the employment of the CEO of the FQHC Clinics.

6.5.2 Removal or Reassignment by District.

6.5.2.1 In the event that the District intends to terminate the CEO from the position as the CEO of the Health Center Project or to reassign him/her to a position other than the CEO of the FQHC Clinics, the District will inform the Governing Council and request approval from the Governing Council at a special meeting, for the termination or reassignment. However, if the termination or reassignment is related to the CEO's malfeasance, as referenced in the District's Human Resources policies, then the District may terminate or reassign the CEO immediately and thereafter notify the Governing Council and HRSA of such action.

6.6 The Governing Council and the District will ensure that their conduct under this Paragraph 6 is performed consistent with the terms of this Arrangement, HRSA policies and Compliance Manual.

7. Coordination of Shared Duties by Parties

7.1 The CEO of the FQHC clinics shall coordinate with the District's President and CEO, the Parties' efforts to meet their respective obligations under this Arrangement and shall cooperate with each other to communicate and resolve any issues between the Parties.

7.2 The Parties shall collaborate to assure Governing Council members and Board members are informed as to their respective duties, authority, and obligations under this Arrangement.

8. Record Keeping and Reporting

8.1 The Parties shall maintain all financial records, reports, documents, statistical records, books, papers or other records related to this Arrangement that will enable them to meet all state and federal reporting requirements. Such records are to be maintained for a period established by the Arizona State Library, Achieves, and Public Records.

8.2 The Parties agree that the District is the legal custodian of all medical records established and maintained relating to diagnosis and treatment of any patients served at any of the FQHC clinics.

9. Insurance

For purposes of liability and insurance coverage, both Parties will be deemed to be an agent of the District for any acts arising under the terms of this Arrangement. The scope of such insurance coverage will be governed by the terms of the Amended and Restated Maricopa County Special Health Care District's Risk Management Insurance and Self Insurance Plan.

10. Ownership of Property Acquired with any Grant Funds and Procurement

Should the District receive Federal grant support from HRSA pursuant to Section 330, the District shall be the titleholder to any and all property purchased with Section 330 grant funds, as applicable. The District shall further assure that all contracts procured and executed by the District are done consistent with the District's Procurement Code and applicable state and federal law and regulations.

11. Applicable Laws, Regulations, and Policies

This Arrangement shall be governed by and construed in accordance with the laws of the state of Arizona and applicable federal laws, regulations, HRSA policies and the Compliance Manual, as may be amended.

12. Non-Discrimination

Each Party agrees that it will not discriminate on any basis, directly or indirectly, with regard to the provision of health care services under this Arrangement. In addition, each Party and its agents, employees, contractors and subcontractors, will not discriminate against any individual with regard to their application for employment or employment status under the terms of this Arrangement.

13. Term

13.1 The initial term of this Arrangement shall be from July 1, 2020 to June 30, 2023 (Initial Term), unless terminated in accordance with the terms of Paragraph 14 below. Thereafter, this Arrangement may be renewed by the Parties for one additional three (3) year term upon their mutual written agreement. Any additional term is also subject to the termination terms in Paragraph 14 below. In the event that at the end of the Initial Term, the Parties have not been able to finalize the terms of the subsequent Arrangement, the Initial Term may continue on a month-to-month basis, but not to exceed a period of three (3) months after the last day of the Initial Term.

13.2 Subject to any Federal or state regulatory approval which might require the termination or operation of the FQHC clinics, nothing in this Arrangement is intended to require, nor should be construed to require, that the FQHC clinics remain in operation or that the District apply for any grant funding, including Section 330 funding.

14. Termination

14.1 Either Party may terminate this Arrangement without cause upon ninety (90) days prior written notice.

14.2 The Parties may terminate this Arrangement upon mutual agreement giving thirty (30) days prior written notice.

14.3 This Arrangement shall terminate immediately upon the effective date of non-renewal or termination of the Section 330 grant or FQHC award status, as applicable, or upon the loss of any license, permit or other authorization required by law or regulation for operation of the FQHC clinics.

14.4 Either Party may terminate this Arrangement for cause in the event that the other Party fails to meet material obligations under this Arrangement. Such for cause termination shall require a thirty (30) days' prior written notice of intent to terminate during which period the Party that has allegedly failed to meet the material obligation may attempt to cure such failure or demonstrate that no such failure has occurred. Any dispute between the Parties regarding whether a breach of a material obligation has occurred, or that such a breach has been satisfactorily cured, will be resolved in accordance with Paragraph 15 of this Arrangement. If the Parties are unable to resolve the dispute through informal negotiations within a reasonable period of time of the commencement of such discussions (not to exceed thirty [30] days), then either Party may terminate this Arrangement.

14.5 For cause termination or termination for mutual convenience shall not become effective unless and until the HRSA issues its written approval of such termination, if such notice is required by law or HRSA policy.

15. Alternative Dispute Resolution

The Board and the Governing Council shall use their best efforts to carry out the terms of this Arrangement in a spirit of cooperation and agree to resolve by negotiation any disputes arising hereunder. In the event the Parties are unable to resolve the dispute through informal negotiations within a reasonable period of time of the commencement of such discussions (not to exceed thirty [30] days), the Parties shall attempt formal mediation or arbitration, consistent with the Rules of Procedure for the Maricopa County Superior Court, if they mutually agree to do so. Any decision by a mediator or arbitrator shall be final and not subject to appeal or legal challenge.

16. Proprietary Information and Confidentiality

16.1 The Parties shall maintain the confidentiality of all information regarding the health and health care of any patients receiving services in the FQHC clinics in accordance with all applicable state and federal laws, including HIPAA (Health Insurance Portability and Accountability Act) and the HITECH (Health Information Technology for Economic and Clinical Health) Act.

16.2 Neither Party shall disclose to any entity or person, any confidential or proprietary information, which it possesses, that is directly or indirectly related to the other Party and which arises under the terms of this Arrangement, without the prior written approval of the other Party or as required by law.

17. Notices

All notices permitted or required by this Arrangement shall be in writing and delivered personally or via USPS first class postage prepaid, Certified and Return Receipt Requested, addressed to the other Party at the address set forth below:

For the Governing Council:
Chair, Valleywise Community Health Centers Governing Council
Conference and Administration Center
2601 East Roosevelt Street
Phoenix, AZ 85008

For the Maricopa County Special Health Care District Board of Directors:
Chair, Board of Directors
Conference and Administration Center
2601 East Roosevelt Street
Phoenix, AZ 85008

18. Assignment

Neither Party shall have the right to assign, delegate or transfer this Arrangement, or any of its rights and obligations hereunder, without the express prior written consent of the other Party.

19. Severability

If any provision of this Arrangement or the application of such provision is held to be invalid, the remaining provisions of this Arrangement shall not be affected thereby.

20. Amendments

Any amendment to this Arrangement shall be in writing, approved, and signed by both Parties.

21. Waiver

Waiver by either Party to this Arrangement of any breach or of any provision hereof by either Party shall not operate as a waiver by such Party of any subsequent breach.

22. No Agency

Neither Party is, nor shall be deemed to be an employee, agent, or legal representative of the other Party for any purpose. The Governing Council may not enter into any contracts in the name of or on behalf of the District or Board.

23. Third-Party Beneficiaries

No third party shall obtain any right, debt, liability or obligation under any provision of this Arrangement.

24. Survival

Paragraphs 8, 9, 10, 15, 16, 17, 21, 22, 23, and 24, shall survive the termination of this Arrangement without regard to the cause of termination.

25. Entire Agreement

This Arrangement constitutes the entire agreement of the Parties with respect to the Parties' operation of the FQHC as a public center and supersedes all prior oral and unsigned agreements.

Signatures Appear on the following Page

IN WITNESS WHEREOF, the Parties have caused this Co-Applicant Operational Arrangement to be executed by their duly authorized representatives.

Chair
Valleywise Community Health Centers Governing Council

By: _____

Print: Ryan D. Winkle

Title: Chair, VCHCGC

Date: June 3, 2020

Chair, Board of Directors
Maricopa County Special Health Care District

By: _____

Print: Mark G. Dewane

Title: Chair, Board of Directors

Date: June 29, 2020

Valleywise Community Health Centers

Governing Council Bylaws

Maricopa County Special Health Care District's
Valleywise Community Health Centers Governing Council
Bylaws

ARTICLE I: NAME

The name of the governing authority shall be the Valleywise Community Health Centers Governing Council (Governing Council). The Governing Council is organized to provide governance and oversight of Federally Qualified Health Center (FQHC) Clinics owned and operated by the Maricopa County Special Health Care District (District) dba Valleywise Health, that provide primary and preventive health care and related services (including, but not limited to, ancillary services). The District was awarded designation by Health Resources and Services Administration (HRSA) to operate Federally Qualified Health Center (FQHC) Clinics.

ARTICLE II: PURPOSE AND OBJECTIVES

The purpose of the Governing Council is to serve as the Co-Applicant, consistent with the requirements of applicable HRSA policies and pronouncements in order to meet the Section 330 of the Public Health Service Act governance requirements.

ARTICLE III: GOVERNING COUNCIL MEMBERSHIP

Section I: Members

A. There shall be no less than nine and no more than 17 voting members on the Governing Council.

1. The majority (at least 51%) of the Governing Council members must be patients served by Valleywise Health's FQHC Clinics. A patient is someone who has received at least one HRSA approved in-scope services within the last 24 months. Patient Governing Council members represent the patients served by the FQHC Clinics in terms of demographic factors, such as race, ethnicity, and gender.

2. Non-patient Governing Council members must be representative of the community served by the FQHC Clinics and must be selected for their expertise in relevant subject areas, such as community affairs, local government, finance, legal, trade unions, education, business, labor relations, and social service agencies within the community.

3. No more than 1/2 of the non-patient Governing Council members may derive more than 10% of their annual income from the health care industry. Health care industry is defined as hospitals, other health care institutions, nurses, doctors, dentist, and other licensed healthcare professionals whose primary responsibility is providing primary preventative and therapeutic healthcare services.

4. All members must reside in the service area (Maricopa County).

B. Candidates will be subject to a background check; a formal vetting process including but not limited to confirmation of skills and experience noted in application, and interviews with past and current associates; a screening for real or apparent conflicts of interest; and a review for exclusion from participating in any Federal or State health care program.

C. The Governing Council may appoint a member of the District Board of Directors (Board) to serve on the Governing Council as a non-voting member to serve a one-year term effective July 1. The Board member's status on the Governing Council will terminate should the Board member's status cease.

D. The Governing Council will act as the governing authority for all member appointments.

E. Employees and immediate family members (spouse, child, parent, or sibling, by blood, adoption, or marriage) of the Maricopa County Special Health Care District dba Valleywise Health, or any other hospital or health care institution, as defined in A.R.S. § 36-401, may not be members of the Governing Council.

Section II: Voting Members Responsibilities

A. Be informed about the FQHC Clinics strategic plan, programs and services.

B. Attend a minimum of 3/4 of the Governing Council meetings with in a 12-month period, calculated on a rolling basis.

C. Actively participate in at least one standing committee.

D. Attend a minimum of 3/4 of committee meetings, which assigned to, with in a 12-month period, calculated on a rolling basis.

E. Prepare for Governing Council and committee meetings by reading materials in advance.

F. Review data and information provided to the Governing Council to make informed decisions.

G. Adhere to the Governing Council's bylaws and District polices.

H. Maintain confidentiality of matters of the FQHC Clinics and District.

I. Participate in the HRSA Operational Site Visit.

J. Participate in the selection of the Chief Executive Officer (CEO) when applicable.

K. Participate in the evaluation of the CEO.

L. Recommend possible members to the Governing Council assist in Governing Council member recruitment when requested.

M. Participate in Governing Council orientation and ongoing education.

N. Support decisions of the Governing Council once they are made.

O. Disclose any potential and actual conflict of interest and if/when one arises, disclose it in writing to the District's Assistant Clerk.

Section III: Terms

A. Governing Council members shall take an oath or affirmation set forth in A.R.S. § 38-231 after appointment to the Governing Council and prior to serving. All oaths shall be filed with the District's Clerk of the Board.

B. Terms are up to three years in length, which commences after taking an oath and ends June 30 of the third year. Due to timing, it is possible that the first term may not be a full three years.

C. Voting members are eligible to serve for a maximum of three terms.

D. Resignations from the Governing Council shall be in writing and filed with the District's Assistant Clerk

Section IV: Vacancies

A. Upon the vacancy of a member, however created, the vacancy shall be filled according to the process set forth in Article III, Section I.

Section V: Removal

A. When a member fails to meet responsibilities as specified in Article III, Section II, the member may be removed.

B. Any member of the Governing Council may be removed at any time by a 2/3 vote of the voting members of the Governing Council at any regular or special meeting of the Governing Council for cause, including but not limited to:

1. Violations of the District's Code of Conduct and Ethics.

2. Violations of the District's Conflicts of Interest and Gift Policy.

3. Actions that are unbecoming of the Governing Council.

4. For any basis that is provided for or permitted under Arizona law, including A.R.S. § 38-291.

Section VI. Compensation

A. Governing Council members shall serve without compensation. However, each member is allowed reimbursement of expenses from approved travel, and reimbursement of mileage to and from Valleywise Community Health Centers Governing Council meetings.

ARTICLE IV: MEETINGS

Section I: Regular Meetings

The Governing Council shall hold monthly meetings where a quorum is present.

Section II: Additional Meetings

Additional meetings of the Governing Council may be held in a manner that is consistent with the Arizona Open Meetings Law, A.R.S. § 38-431 et. seq.

Section III: Emergency Meetings

Emergency meetings of the Governing Council may be held in a manner that is consistent with the Arizona Open Meeting Law, A.R.S. § 38-431 et. seq.

Section IV: Place of Meetings

All meetings of the Governing Council shall be at the Valleywise Health Medical Center campus, unless otherwise specified with proper notice to Governing Council members, staff, and the public.

Section V. Remote Meetings

The Governing Council may hold a remote meeting through technological means after providing proper notice and an agenda in accordance with the Arizona Open Meeting Law A.R.S. § 38-431 et. seq.

Section VI. Conduct of Meeting

Governing Council meetings shall be conducted using Parliamentary Procedures, also known as rules of order. Rules are intended to maintain decorum and for the timely and orderly progression of the meeting.

Section VII: Open and Public

All meetings will be held in a manner that is consistent with the Arizona Open Meeting Law, A.R.S. § 38-431 et. seq.

Section VIII: Quorum and Voting Requirements

A. A quorum shall consist of a majority of the voting Governing Council members.

B. A quorum is necessary to conduct Governing Council business. Governing Council members shall attend meetings in person, or when circumstances, dictate, telephonically. As much notice as possible, but no less than 24 hours, should be given if Governing Council members need to participate telephonically so that arrangements can be made.

C. A majority vote of the Governing Council members is required to take any action.

D. Each voting Governing Council member present at a meeting shall be entitled to one vote. Voting must comply with the Arizona Open Meetings Law, A.R.S. § 38-431 et. seq.

E. There shall be no vote by proxy.

F. If after 10 minutes from the scheduled start of any meeting a quorum is not present, the meeting cannot be called to order and will be rescheduled until such date and hour as a quorum may be reached.

G. The FQHC Clinics CEO shall attend all meetings of the Governing Council but shall not be entitled to vote.

Section IX: Notice, Agenda and Supportive Materials

A. A written notice of each regular meeting of the Governing Council, specifying the date, time and place, and a written agenda, shall be emailed to the Governing Council members no less than five calendar days before the meeting.

B. Supportive materials, if any, shall be emailed to the Governing Council members with the meeting notice and agenda.

C. The following shall have the right to place an item on the agenda of any Governing Council meeting: The Governing Council Chair, The FQHC Clinics CEO, or any voting Governing Council member. The Governing Council Chair shall have the right to reject an item placed on the agenda.

D. If the Governing Council Chair rejects an item placed on the agenda, four voting Governing Council members acting together, shall have the right to override the Governing Council Chair's rejection and place the item on the agenda as requested despite the Governing Council Chair's rejection. The request by the four Governing Council members shall be made in writing to the Governing Council Chair, FQHC CEO, and District's Assistant Clerk, and relate solely to identifying the subject matter of the item to be placed on the agenda with no discussion, consideration or deliberation of the matter.

Section X: Minutes and Documents

The District's Assistant Clerk shall keep the minutes of the Governing Council meetings. Official minutes and supporting documents, shall be maintained by the District's Assistant Clerk.

ARTICLE V: LIMITATIONS OF GOVERNING COUNCIL AUTHORITY

The Governing Council's governance authorities and responsibilities shall comply with the requirements of Section 330, its implementing regulations, and HRSA policies. The Governing Council shall specifically exercise the authorities and responsibilities contained within the Co-Applicant Operational Arrangement (Arrangement) between the District and the Governing Council.

ARTICLE VI: GOVERNING COUNCIL AUTHORITIES AND RESPONSIBILITIES

A. Subject to the limitations imposed in Article V, the duties of the Governing Council shall be as follows:

1. Annually review the service area by zip codes reported on Form 5B: Service Sites;

2. Complete or update a community needs assessment of the current patient population at least once every 3 years to improve the delivery of health care services;

3. Review and approve additional health services, if any, to offer in order to meet the health needs of the patient population served by the FQHC Clinics, subject to Board approval;

4. Annually review a list of FQHC Clinics, including addresses, hours of operation by clinic, and information on general services offered at each clinic reported on Form 5B: Service Sites;

5. Approve location of any new FQHC Clinic or closure of existing FQHC clinic as long as it is consistent with the District's facility, strategic, business, financial, and capital plans;

6. Ensure written operating procedures exist for responding to patient medical emergencies during each FQHC Clinics regularly scheduled hours of operation;

7. Ensure written operating procedures exist for responding to patient medical emergencies after regularly scheduled hours of operation;

8. Ensure written operating procedures are in place to obtain medical information related to a FQHC Clinic patient's hospital or emergency department visit;

9. Review, evaluate, and approve a sliding fee discount program for the FQHC Clinics at least every 3 years. Evaluation should include the effectiveness of the sliding fee discount program in reducing financial barriers to care, and the rate which patients within each discount category are accessing services;

10. Annually review and approve a sliding fee discount schedule for the FQHC Clinics based on the most recent Federal Poverty Guidelines;

11. Review and approve at least every 2 years a Quality Improvement/Quality Assurance (QI/QA) program for the FQHC Clinics that addresses the quality and utilization of services, patient satisfaction, patient grievance process and patient safety including adverse events;

12. Ensure that QI/QA data, including patient satisfaction, patient grievance and patient safety, is shared with the Governing Council at least quarterly;

13. Ensure written quality of care audit procedures are in place and audit is shared with the Governing Council annually;

14. Select/hire the Project Director/CEO of the FQHC Clinics after receiving prior approval from HRSA and as set forth in Paragraph 6 of the Arrangement between the District and Governing Council;

15. Annually evaluate the Project Director/CEO's performance as set forth in Paragraph 6 of the Arrangement between the District and Governing Council;

16. Dismiss/terminate the Project Director/CEO from the Health Center Program if necessary, as set forth in Paragraph 6 of the Arrangement between the District and Governing Council and notify HRSA;

17. Approve changes to Project Director/CEO's job description;

18. Approve changes to organization chart including titles and names of key management staff;

19. Comply with the District's written Code of Conduct and Ethics; and Conflicts of Interest and Gift policy;

20. Submit written disclosure to the District's Assistant Clerk if a real or apparent conflict of interest was identified by a Governing Council member;

21. Make reasonable efforts to establish and maintain collaborative relationships, including with other specialty providers that provide care within Maricopa County, to provide access to services not available at the FQHC Clinics and to reduce the non-urgent use of hospital emergency departments; and with social service organizations to support community services that impact patients of the FQHC Clinics;

22. Track the financial performance of the FQHC Clinics, including identification of trends or conditions that may warrant action to maintain financial stability;

23. Review and accept the annual fiscal year audit of the District, which includes certain financial information about the FQHC Clinics;

24. Maintain control over, and accountability for, all funds, in order to adequately safeguard and ensure that they are used solely for authorized purposes;

25. Ensure written policies and procedures are in place to ensure the appropriate use of federal funds in compliance with applicable federal statutes, regulations, and the terms and conditions of the federal award;

26. Ensure written billing and collections policies and procedures are in place and include provisions to waive or reduce fees owed by patients; a policy for refusal to pay; and procedures for notifying patients of additional costs for supplies and equipment related to the services;

27. Develop and approve an annual operating and capital budget for the FQHC Clinics to be incorporated into the District's annual budget for Board approval. The budget should be reflective of the costs and revenues necessary to support the FQHC Clinics scope of project;

28. Submit timely, accurate, and complete Uniform Data System (UDS) reports;

29. Annually review data-based reports on: patient service utilization; trends and patterns in the patient population; and overall health center performance including achievement of FQHC Clinics objectives; and efficiency and effectiveness of the FQHC Clinics, for oversight by the Governing Council;

30. Approve application for HRSA grant funding, subject to Board approval;

31. Approve changes in scope of project for the FQHC Clinics subject to Board approval;

32. Annually evaluate the operations of the FQHC Clinics including compliance with applicable federal requirements, performance expectations such as financial and patient volumes, patterns of health service utilization;

33. Ensure the existence of a co-applicant arrangement that delegates the required authorities and responsibilities to the Governing Council and delineates the authorities and responsibilities of the Board;

34. Hold monthly meetings where a quorum is present;

35. Conduct and approve a long-range, strategic plan at least once every three (3) years that identifies FQHC Clinic priorities and addresses financial management and capital expenditure needs, that is consistent with the District's facility, strategic, business, financial and capital plans; and

36. On an annual basis, submit an attestation that the Governing Council has operated; and each Governing Council Member has performed his/her duties, in a manner that is compliant with the provisions of the Arrangement between the District and Governing Council; and that each Governing Council member has completed their annual compliance training and sign the District's Code of Conduct and Ethics attestation form.

ARTICLE VII: OFFICERS

Section I: Officer Designation

There shall be a Chair, a Vice Chair, and a Treasurer, known as officers of the Governing Council. The Governing Council officers shall be elected by voting Governing Council members.

Section II: Powers and Duties of Officers

A. Chair

1. The Chair shall lead the Governing Council members and ensure that the Governing Council fulfills its responsibilities.

2. The Chair shall convene, preside, and maintain order over Governing Council meetings.

3. The Chair shall plan and carry out the agenda for Governing Council meetings.

4. Annually, the incoming Chair will appoint or reappoint the Standing Committee Chairs and will appoint a voting Governing Council member as a Member at Large to the Executive Committee.

B. Vice Chair

1. The Vice Chair shall assist the Chair in his or her duties as needed.

2. In the absence of the Chair, or in the event of the Chair's resignation or the inability to perform duties, the Vice Chair shall perform the duties of Chair until an election can be held in accordance with Article VII, Section VII.

C. Treasurer

1. The Treasurer shall report the financial performance of the FQHC Clinics at the monthly Governing Council meetings.

2. The Treasurer shall serve as the Chair of the Finance Committee

Section III: Elections

A. Voting Governing Council members interested in serving as a Governing Council officer shall contact the District's Assistant Clerk in writing of his or her interest in serving. Governing Council members may also contact the District's Assistant Clerk in writing, to nominate fellow voting Governing Council members for an officer position. All nominations shall be submitted no later than the first Monday in April of every year.

1. The FQHC CEO will contact nominated candidates to determine their willingness to serve as an officer.

2. The current Chair and the FQHC CEO may nominate additional voting Governing Council members if necessary, to complete the ballot of nominees for each officer position.

B. By the first Monday in May of every year, the District's Assistant Clerk will transmit to the Governing Council members in writing, the names of the persons running for each officer position.

C. Election of officers will be held at the regularly scheduled June Governing Council meeting. Voting Governing Council members must attend the meeting in person or telephonically in order to vote.

Section IV: Term

The term of each office for the Chair, Vice Chair and Treasurer shall be one year, commencing on July 1 of each year. Voting Governing Council members can serve in any officer role for a maximum of 3 terms during his/her service on the Council.

Section V: Resignation

Resignations shall be in writing and filed with the District's Assistant Clerk.

Section VI: Removal

Any officer may be removed from his or her elected position by a majority vote of the Governing Council.

Section VII: Vacancies

A. Upon the vacancy of an officer, however created, voting Governing Council members interested in filling the position shall contact the District's Assistant Clerk in writing of his or her interest in serving within five business days of the announcement.

B. The District's Assistant Clerk will transmit to the Governing Council in writing, the names of the persons running for the vacant position.

C. The election will be held at the next regularly scheduled Governing Council meeting. Voting Governing Council members must attend the meeting in person or telephonically in order to vote.

D. The term will be effective immediately.

ARTICLE VIII: COMMITTEES

Section I: Standing Committees

The following are considered standing committees of the Governing Council:

A. Executive Committee: The purpose of the Executive Committee is to ensure the Governing Council carries out its due-diligence function related to the healthy development and operation of the Governing Council, its committees, and performance of the individual Governing Council member by equipping them with the proper tools and motivation to carry out his or her responsibilities.

B. Finance Committee: The purpose of the Finance Committee is to: (1) recommend an annual operating budget for the FQHC Clinics; (2) provide oversight of the financial performance of the FQHC Clinics; and (3) review the annual audit performed by an independent, external auditor.

C. Compliance and Quality Committee: The purpose of the Compliance and Quality Committee is to: (1) ensure the quality of care provided at the FQHC Clinics; (2) ensure patient safety and satisfaction provided throughout the FQHC Clinics; (3) ensure compliance with HRSA Program requirements.

D. Strategic Planning and Outreach Committee: The purpose of the Strategic Planning and Outreach Committee is to identify, develop, and implement strategic planning and outreach initiatives to identify FQHC Clinics health equity priorities to address health care needs in Maricopa County.

Section II: Term

A. Members of standing committee shall be appointed by the Governing Council.

B. Members of standing committees shall serve his or her terms in accordance with the appropriate committee charter.

Section III: Vacancies

Vacancies on any standing committee will be filled in the same manner as provided in the case of the original appointment.

Section IV: Minutes and Documents

A. The District's Assistant Clerk shall keep the minutes of each standing committee meetings. Official minutes and supporting documents, shall be maintained by the District's Assistant Clerk.

B. Each standing committee shall report its activities to the Governing Council at the next regularly scheduled Governing Council meeting including, at minimum, the agenda items discussed.

Section V: Quorum and Voting Requirements

A. A quorum shall consist of a majority of the voting committee members.

B. A quorum is necessary to conduct committee business. Committee members shall attend meetings in person, or when circumstances, dictate, telephonically. As much notice as possible, but no less than 24 hours, should be given if committee members need to participate telephonically so that arrangements can be made.

C. A majority vote of the committee members is required to take any action.

D. Each voting committee member present at a meeting shall be entitled to one vote. Voting must comply with the Arizona Open Meetings Law, A.R.S. § 38-431 et. seq.

E. There shall be no vote by proxy.

F. If after 10 minutes from the scheduled start of any committee meeting a quorum is not present, the meeting cannot be called to order and will be rescheduled until such date and hour as a quorum may be reached.

Section VI. Attendance and Removal

Unless expressly provided otherwise by committee charter, failure to attend a minimum of 3/4 of committee meetings which assigned to within a 12-month period, calculated on a rolling basis, or two consecutive committee meetings, may result in removal of a committee member by a majority vote of the Governing Council.

Section VII: Ad Hoc and Advisory Committees

A. The Governing Council has the authority to create ad hoc or advisory committees, to assist with Governing Council functions.

B. Any voting Governing Council member may suggest the creation of an ad hoc or advisory committee when it appears necessary.

C. An ad hoc or advisory committee shall be established upon the majority vote of the Governing Council.

D. Ad hoc and advisory committees shall limit their activities to the purposes for which they are commissioned and be limited in time to the task for which they are created.

E. Ad hoc and advisory committees shall only have those powers as specifically outlined in writing upon by the Governing

F. Ad hoc and advisory committees shall report to the Governing Council.

G. The continuation of any ad hoc or advisory committee shall be reviewed annually.

H. Ad hoc and advisory committees shall disband upon of completion of its work.

I. Members of an ad hoc or advisory committee shall be appointed by the Governing Council. The chair of an ad hoc or advisory committee must be a voting member of the Governing Council.

J. The Governing Council may involve citizens of Maricopa County as members to serve on an ad hoc or advisory committee, who need not be members of the Governing Council, but whose expertise can benefit and add value to the committee. Such citizens shall serve without compensation

Section VIII: Term

Members of ad hoc or advisory committees shall serve his or her terms in accordance with the appropriate committee charter.

Section IX: Vacancies

Vacancies on any ad hoc or advisory committee will be filled in the same manner as provided in the case of the original appointment.

Section X: Minutes and Documents

A. The District's Assistant Clerk shall keep the minutes of any ad hoc or advisory committee meetings. Official minutes and supporting documents, shall be maintained by the District's Assistant Clerk.

B. Each ad hoc or advisory committee shall report its activities to the Governing Council at the next regularly scheduled Governing Council meeting including, at minimum, the agenda items discussed.

Section XI: Quorum and Voting Requirements

A. A quorum shall consist of a majority of the voting ad hoc or advisory committee members.

B. A quorum is necessary to conduct ad hoc or advisory committee business. Ad hoc or advisory committee members shall attend meetings in person, or when circumstances, dictate, telephonically. As much notice as possible, but no less than 24 hours, should be given if committee members need to participate telephonically so that arrangements can be made.

D. A majority vote of the ad hoc or advisory committee members is required to take any action.

E. Each voting ad hoc or advisory committee member present at a meeting shall be entitled to one vote. Voting must comply with the Arizona Open Meetings Law, A.R.S. § 38-431 et. seq.

F. There shall be no vote by proxy.

G. If after 10 minutes from the scheduled start of any ad hoc or advisory committee meeting a quorum is not present, the meeting cannot be called to order and will be rescheduled until such date and hour as a quorum may be reached.

Section XII. Attendance and Removal

Unless expressly provided otherwise by committee charter, failure to attend a minimum of 3/4 of ad hoc or advisory committee meetings with in a 12-month period, calculated on a rolling basis, or two consecutive committee meetings, may result in removal of a committee member by a majority vote of the Governing Council.

ARTICLE IX: MISCELLANEOUS

Section I: Adoption and Amendments

A. Prior to adopting amendments to the bylaws, the Governing Council will provide the Board a copy of the proposed amendments with sufficient time to permit the Board to review. The Board shall approve the proposed amendments at the next regularly scheduled Board meeting and thereafter, notify the Governing Council of approval. The Board may only disapprove an amendment to the bylaws if the amendment is inconsistent with the requirements of Section 330, its implementing regulations, HRSA policies, the Compliance Manual, or the terms of the Arrangement between the District and Governing Council. The Board will provide the Governing Council with reason(s) for such disapproval within seven (7) calendar days after non-approval.

B. Proposed bylaw amendments shall be submitted to the Governing Council at least 7 calendar days prior to the meeting at which the proposed amendments are scheduled to be voted upon.

Section II: Preservation of Confidential Information

The Governing Council shall comply with all federal and state laws and regulations regarding the protection of confidential, privileged or proprietary information and all such provisions shall apply to all standing, ad hoc and advisory committees and their members, both during committee service and thereafter.

Section III: Discrimination

No discrimination shall be exercised by the Governing Council or by any person against or in favor of any person because of race, color, religion, sex, sexual orientation, national origin, marital status, political beliefs, age, veteran status, disability, or ability to pay, or age in the admission, treatment, or participation in any of its health care programs, services and activities, any employment matters, or any person doing business with Governing Council, pursuant to federal, state or local laws.

Section IV: Patient's Rights

The Governing Council shall respect patient confidentiality, patient rights, and will comply with Valleywise Health policies.

Section V: Office

The official office of the Governing Council and its members is at Valleywise Health Medical Center, 2601 East Roosevelt Street, Phoenix, Arizona, 85008.

Approved by the Governing Council on 11/04/2020

_____ 11/04/2020

Chair, Valleywise Community Health Centers Governing Council Date

Valleywise Community Health Centers

Committee Charters

Valleywise Community Health Centers Governing Council
Executive Committee Charter

Purpose

The purpose of the Executive Committee (Committee) of the Valleywise Community Health Centers Governing Council (Governing Council) is to ensure the Governing Council carries out its due-diligence function related to the healthy development and operation of the Governing Council, its committees, and performance of the individual Governing Council member by equipping them with the proper tools and motivation to carry out his or her responsibilities.

Membership

Membership shall consist of the Governing Council Chair, Governing Council Vice Chair, Governing Council Treasurer, the Governing Council's standing committee chairs, and a member at large. The Chief Executive Officer of the Federally Qualified Health Center (FQHC) Clinics is an ex officio non-voting member of the Committee.

Responsibilities

1. Determine if extenuating circumstances as defined in policy 89103 F, Excused Absences, warrant the excusal of a Governing Council member's absence from a Governing Council or Committee meeting.

2. Make recommendations to the Valleywise Community Health Centers Governing Council regarding the removal of a Governing Council member.

3. Ensure a healthy Governing Council culture exists.

4. Ensure Governing Council members have clearly defined roles and responsibilities.

5. Ensure Governing Council Officers have clearly defined roles and responsibilities.

6. Ensure a written succession plan exists for Governing Council Officers and Committee Chairs.

7. At least every three (3) years review the Governing Council's committees' structures and effectiveness.

8. At least every three (3) years review the Governing Council Bylaws and Mission statement and make recommendations for suggested revisions to the Governing Council.

9. At least every three (3) years review the Committee Charter and make recommendations for suggested revisions to the Governing Council.

Meetings

Meetings will be held quarterly. Additional meetings can be scheduled at the discretion of the Committee Chair.

Meeting Procedures

1. The Committee Chair will facilitate all meetings. The Committee Vice Chair will facilitate meetings in the Chair's absence.

2. Committee members must attend in person or, when circumstances dictate, telephonically. A quorum shall consist of a majority of the voting Committee members, which is necessary for the Committee to meet and to take action.

3. Minutes shall be recorded and maintained for each Committee meeting in compliance with Arizona Open Meeting Law and shall contain all actions taken by the Committee. Minutes recorded or maintained for Executive Session discussions, however, will be kept confidential pursuant to A.R.S. § 38-431.03.

4. The Committee will report its actions to the Governing Council at the next regularly scheduled Governing Council meeting.

Valleywise Community Health Centers Governing Council
Finance Committee Charter

Purpose

The purpose of the Finance Committee (Committee) of the Valleywise Community Health Centers Governing Council (Governing Council) is to: (1) recommend an annual operating budget for the Valleywise Health Federally Qualified Health Center (FQHC) Clinics; (2) provide oversight of the financial performance of the Valleywise Health FQHC Clinics; and (3) review the annual audit performed by an independent, external auditor.

Membership

The Committee shall consist of a Chair, who is the Treasurer of the Governing Council, a Vice Chair, and no more than three (3) additional Governing Council members. The Committee Chair will recommend, and the Committee will appoint a Vice Chair. The Chief Executive Officer of the FQHC Clinics is an ex-officio, non-voting member of the Committee. In addition, the following Valleywise Health staff members will serve on the Committee as non-voting members: Chief Financial Officer, Vice President of Financial Services, and Director of Financial Planning and Decision Support. In accordance with the Governing Council Bylaws, voting members are appointed by the Governing Council. The Governing Council shall seek voting members preferably with knowledge in the area of accounting, finance or business. Voting members shall serve for a four (4) year term.

Responsibilities

In conjunction with Valleywise Health staff, the Committee will:

1. Review and make recommendations to the Governing Council to approve additional health services to offer in order to meet the health needs of the patient population served by the FQHC Clinics.
    - Review quarterly referral report

2. Review, evaluate, and make recommendations to the Governing Council to approve a sliding fee discount program for the FQHC Clinics at least every three (3) years. Evaluation should include the effectiveness of the sliding fee discount program in reducing financial barriers to care, and the rate which patients within each discount category are accessing services.
    - Review monthly financial performance and payor mix information
    - Review quarterly financial summary by clinic

3. Annually review and make recommendations to the Governing Council to approve a sliding fee discount schedule for the FQHC Clinics based on the most recent Federal Poverty Guidelines.
    - Review annual Federal Poverty Guidelines
    - Review monthly financial performance and payor mix information
    - Review quarterly financial summary by clinic
    - Review sliding fee discount program

4. Track the financial performance of the FQHC Clinics, including identification of trends or conditions that may warrant action to maintain financial stability.
    - Review monthly financial performance and payor mix information
    - Review quarterly financial summary by clinic
    - Review annual fiscal year audit
    - Review annual profitability/cost accounting report

5. Review and make recommendations to the Governing Council to accept the annual fiscal year audit of the District, which includes certain financial information about the FQHC Clinics.
    - Review annual fiscal year audit

6. Maintain control over, and accountability for, all funds, in order to adequately safeguard and ensure that they are used solely for authorized purposes.
    - Review monthly financial performance and payor mix information
    - Review quarterly Governing Council department budget
    - Review quarterly capital expenditures report
    - Review quarterly financial summary by clinic
    - Annual review of fiscal year audit

7. Review and make recommendations to the Governing Council to approve an annual operating and capital budget for the FQHC Clinics to be incorporated into the District's annual budget.
    - Review annual operating budget
    - Review annual capital budget

8. Annually review data-based reports on: patient service utilization; trends and patterns in the patient population; and overall health center performance including achievement of FQHC Clinics objectives; and efficiency and effectiveness of the FQHC Clinics, for oversight by the Governing Council.
    - Review monthly ambulatory operational dashboard – financial section
    - Review monthly financial performance and payor mix information
    - Review quarterly financial summary by clinic
    - Annual review of profitability/cost accounting report
    - Review quarterly referral report

9. Annually evaluate the operations of the FQHC Clinics including compliance with applicable federal requirements, performance expectations such as financial and patient volumes, patterns of health service utilization.
    - Review monthly ambulatory operational dashboard – financial section
    - Review monthly financial performance and payor mix information
    - Review quarterly financial summary by clinic
    - Annual review of profitability/cost accounting report
    - Review quarterly referral report

Meetings

Meetings will be held monthly. Additional meetings can be scheduled at the discretion of the Committee Chair.

Meeting Procedures

1. The Committee Chair will facilitate all meetings. The Committee Vice Chair will facilitate meetings in the Chair's absence.

2. Committee members must attend in person or, when circumstances dictate, telephonically. A quorum shall consist of a majority of the voting Committee members, which is necessary for the Committee to meet and take legal action.

3. Minutes shall be recorded and maintained for each Committee meeting in compliance with Arizona Open Meeting Law and shall contain all actions taken by the Committee. Minutes recorded or maintained for Executive Session discussions, however, will be kept confidential pursuant to A.R.S. § 38-431-03.

4. The Committee will report its actions to the Governing Council at the next regularly scheduled Governing Council meeting.

Valleywise Community Health Centers Governing Council
Ad Hoc Membership Committee Charter

Purpose

The purpose of the Membership Committee (Committee) of the Valleywise Community Health Centers Governing Council (Governing Council) is to recruit, screen, and recommend candidates to serve on the Governing Council of the Federally Qualified Health Centers designated sites and to assure that the Council is meeting Health Resources & Services Administration's (HRSA) Program Requirements regarding representation on the Governing Council.

Membership

The Committee shall consist of a Chair, a Vice Chair, and no more than three (3) additional Governing Council members. A voting member of the Council will serve as the Committee Chair. The Committee Chair will recommend, and the Committee will appoint a Vice Chair. The Chief Executive Officer of the Federally Qualified Health Center (FQHC) Clinics is an ex-officio, non-voting member of the Committee. In accordance with the Governing Council Bylaws, voting members are appointed by the Governing Council.

Responsibilities

1. Develop, review and make recommendations to the Governing Council regarding the criteria for qualifications of potential applicants for membership on the Governing Council. Potential applicants should represent the individuals being served by the FQHC Clinics in terms of demographic factors such as race, ethnicity, and sex. Priority will be given to representation of Valleywise Health's most vulnerable patient base.

2. Seek and identify potential applicants. These new applicants are to be representative of the community and allow the ratio of user members and non-user members to be maintained.

3. Actively recruit and screen new applicants. This includes seeking community assistance (which may include local civic, religious and community organizations) in identifying persons interested and qualified for the positon.

4. Conduct appropriate inquiries into the qualifications of interested applicants for the Governing Council.

5. Maintain an awareness of the needs of the Governing Council when recruiting prospective candidates.

6. Promote retention of existing Governing Council members.

7. Along with the CEO, oversee new Governing Council member orientation program as defined in policy 89102 F, Valleywise Community Health Centers Governing Council Member Orientation.

Meetings

Meetings will be held monthly or as needed. Additional meetings can be scheduled at the discretion of the Committee Chair.

Meeting Procedures

1. The Committee Chair will facilitate all meetings. The Committee Vice Chair will facilitate meetings in the Chair's absence.

2. Committee members must attend in person or, telephonically. A quorum shall consist of a majority of the voting Committee members, which is necessary for the Committee to meet and to take action.

3. Minutes shall be recorded and maintained for each Committee meeting in compliance with Arizona Open Meeting Law and shall contain all actions taken by the Committee. Minutes recorded or maintained for Executive Session discussions, however, will be kept confidential pursuant to A.R.S. § 38-431.03.

4. The Committee will report its actions to the Governing Council at the next regularly scheduled Governing Council meeting.

Valleywise Community Health Centers Governing Council
Strategic Planning and Outreach Committee Charter

Purpose

The purpose of the Strategic Planning and Outreach Committee (Committee) of the Valleywise Community Health Centers Governing Council (Governing Council) is to identify, develop, and implement strategic planning and outreach initiatives to identify Valleywise Health Federally Qualified Health Centers (FQHC) Clinics health equity priorities to address health care needs in Maricopa County.

Membership

The Committee shall consist of a Chair, a Vice Chair and no more than three (3) additional Governing Council members. A voting member of the Governing Council will serve as the Committee Chair. The committee Chair will recommend, and the Committee will appoint a Vice Chair. The Chief Executive Officer of the FQHC Clinics is an ex-officio, non-voting member of the Committee. In addition, the following Valleywise Health staff members will serve on the Committee as non-voting members: Vice President of Marketing and Communications, Vice President of Strategic Planning and Business Development, and Director of FQHC Operations. In accordance with the Governing Council Bylaws, voting members are appointed by the Governing Council. The Governing Council shall seek voting members preferably with knowledge in the area of community affairs, and social services. Voting members shall serve for a four (4) year term.

Responsibilities

In conjunction with Valleywise Health staff, the Committee will:

1. Conduct and approve a long-range, strategic plan at least once every three (3) years that identifies FQHC clinic priorities and addresses financial management and capital expenditure needs, that is consistent with the District's facility, strategic, business, financial and capital plans.

2. At least every three (3) years review the Committee Charter and make recommendation for suggested revisions to the Governing Council.

Meetings

Meetings will be held as needed. Additional meetings can be scheduled at the discretion of the Committee Chair.

Meeting Procedures

1. The Committee Chair will facilitate all meetings. The Committee Vice Chair will facilitate meetings in the Chair's absence.

2. Committee members must attend in person or, when circumstances dictate, telephonically. A quorum shall consist of a majority of the voting Committee members, which is necessary for the Committee to meet and to take action.

2. Minutes shall be recorded and maintained for each Committee meeting in compliance with Arizona Open Meeting Law and shall contain all actions taken by the Committee. Minutes recorded or maintained for Executive Session discussions, however, will be kept confidential pursuant to A.R.S. § 38-431.03.

3. The Committee will report its actions to the Council at the next regularly scheduled Governing Council meeting.

Valleywise Community Health Centers Governing Council
Compliance and Quality Committee Charter

Purpose

The purpose of the Compliance and Quality Committee (Committee) of the Valleywise Community Health Centers Governing Council (Governing Council) is to: (1) ensure the quality of care provided at the Valleywise Health Federally Qualified Health Center (FQHC) Clinics; (2) ensure patient safety and satisfaction provided throughout the Valleywise Health FQHC Clinics; (3) ensure compliance with Health Resources & Services Administration's (HRSA) Program requirements.

Membership

The Committee shall consist of a Chair, a Vice Chair, and no more than three (3) additional Governing Council members. A voting member of the Governing Council will serve as the Committee Chair. The Committee Chair will recommend, and the Committee will appoint a Vice Chair. The Chief Executive Officer of the FQHC Clinics is an ex-officio, non-voting member of the Committee. In addition, the following Valleywise Health staff members will serve on the Committee as non-voting members: FQHC Medical Director, FQHC Quality Medical Director, Vice President of Quality Management, Ambulatory Director of Nursing, and Chief Compliance Officer. In accordance with the Governing Council Bylaws, voting members are appointed by the Governing Council. The Governing Council shall seek voting members preferably with knowledge in the area of quality/health care services. Voting members shall serve for a four (4) year term.

Responsibilities

In conjunction with Valleywise Health staff, the Committee will:

1. Review and make recommendation to the Governing Council to acknowledge receipt of a community needs assessment for the FQHC Clinics service area at least once every three (3) years.
    - Review patient survey questions for conducting community needs assessment

2. Review and make recommendations to the Governing Council for any additional health services to offer in order to meet the health needs of the patient population served by the FQHC clinics.
    - Community needs assessment
    - Annual UDS report

3. Review and make recommendations to the Governing Council to approve a Quality Improvement/Quality Assurance (QI/QA) Plan for the FQHC Clinics at least every two (2) years.

4. Ensure that QI/QA data, including patient satisfaction, patient grievance and patient safety, is shared with the Governing Council at least quarterly.
    - Review monthly quality metrics
        - Review action plans for improvement
    - Review annual patient grievances and complaints report
    - Review quarterly patient satisfaction report
        - Review action plans for improvement
    - Review annual HRSA national/state UDS comparison data

5. Ensure written quality of care audit procedures are in place and audit is shared with the Governing Council annually.
    - Review annual quality of care audit for the FQHC clinics

6. Submit timely, accurate, and complete UDS reports.
    - Review and make recommendations to the Governing Council to accept annual USD report submitted to HRSA

7. Annually review data-based reports on: patient service utilization; trends and patterns in the patient population; and overall health center performance including achievement of FQHC clinics objectives; and efficiency and effectiveness of the FQHC clinics, for oversight by the Governing Council.
    - Community needs assessment
    - Annual UDS report

8. Annually evaluate the operations of the FQHC clinics including compliance with applicable federal requirements, performance expectations such as financial and patient volumes, patterns of health service utilization.
    - Review and make recommendations to the Governing Council to approve an annual compliance work plan for the FQHC clinics
    - Review and make recommendations to the Governing Council to approve an annual internal audit work plan for the FQHC clinics
    - Review quarterly compliance work plan updates
    - Review quarterly internal audit work plan updates
    - Review FQHC clinics staff annual compliance education training results
    - Review monthly quality metrics
    - Review quarterly patient satisfaction report

9. At least every three (3) years review the Committee Charter and make recommendations for suggested revisions to the Governing Council.

Meetings

Meetings will be held monthly. Additional meetings can be scheduled at the discretion of the Committee Chair.

Meeting Procedures

1. The Committee Chair will facilitate all meetings. The Committee Vice Chair will facilitate meetings in the Chair's absence.

2. Committee members must attend in person or, when circumstances dictate, telephonically. A quorum shall consist of a majority of the voting Committee members, which is necessary for the Committee to meet and to take action.

3. Minutes shall be recorded and maintained for each Committee meeting in compliance with Arizona Open Meeting Law and shall contain all actions taken by the Committee. Minutes recorded or maintained for Executive Session discussions, however, will be kept confidential pursuant to A.R.S. § 38-431.03.

4. The Committee will report its actions to the Governing Council at the next regularly scheduled Governing Council meeting.

Valleywise Community Health Centers

Roles and Responsibilities

ROLE DESCRIPTION FOR MEMBERS
of the
Valleywise Community Health Center Governing Council (VCHCGC)

Every member of a nonprofit board owes:
The Duty of Care
The Duty of Loyalty
The Duty of Obedience.

These are traditional terms that continue to be used to describe the standards of conduct and attention a Council member must meet in carrying out his/her responsibilities to the organization. If the Council member fully understands and carries out these duties, he/she will fulfill the responsibilities as a Council member as well as act as a positive and energizing influence on the Council as a whole.

THE DUTY OF CARE
The duty of care means that the Council member is expected to exercise the same level of judgment that any other competent and prudent person would exercise in a similar situation. No one expects the Council member to never make mistakes or to never take risks. What is expected is that the Council member should be reasonably careful when making decisions.

THE DUTY OF LOYALTY
This is the fundamental duty to be faithful to the organization. It means that the Council member owes undivided allegiance to the Valleywise Communiy Health Center when making decisions affecting the Federally Qualified Health Center Clinics. In other words, the Council member can never use information obtained in his/her position as a Council member for personal gain.

Any discussion of duty of loyalty needs to include the subject of conflict of interest. The Valleywise Community Health Centers Governing Council must comply with the Maricopa County Special Health Care District's conflict of interest and gift policy

Most States and the Federal Government have explicit regulations regarding conflict of interest. It is important that the conflict be disclosed by the Council member and that the member refrains from voting on the issue. The meeting minutes should reflect such noted conflict and the member's abstention from the vote.

THE DUTY OF OBEDIENCE
The Council member is expected to be faithful to the VCHCGC's mission. Council members also have a legal obligation to voice their own opinions about how the Council should accomplish the VCHCGC's mission and ensure that any objections to a Council action are recorded in the Council minutes. However, once the Council makes a decision or sets policy, the individual Council member is not permitted to act in any way that is inconsistent with that policy or the goals of the VCHCGC. It is important to keep in mind that a nonprofit health center relies heavily on the public trust. The public has a right to expect that each Council member will never compromise or violate that trust.

VALLEYWISE COMMUNITY HEALTH CENTER GOVERNING COUNCIL
Members Do's and Don'ts

HEALTH CENTER COUNCIL MEMBERS DO'S

Do know the Valleywise Community Health Centers Governing Council's mission, purpose, and goals as well the Federally Qualified Health Center (FQHC) Clinics programs and services

Do get to know FQHC Clinics strengths and weaknesses

Do pitch in enthusiastically and willingly

Do make sure you have all the information before expressing an opinion or a judgment

Do get acquainted with the other Council members, the Valleywise Community Health Centers Governing Council's Chief Executive Officer and staff

Do come to meetings, and come prepared to participate

Do ask questions

Do respect the majority once decisions are made and actions are taken even if you disagree

Do support the Valleywise Community Health Centers Governing Council's CEO and staff, and understand that they are operating with limited resources

Do avoid any possible conflict of interest

Do maintain a sense of fairness, ethics, and personal integrity

Do understand the FQHC financial statements and help the Council plan for future revenue and expenses

HEALTH CENTER COUNCIL MEMBERS DON'TS

Don't speak for the Council, unless authorized to do so

Don't ask the Valleywise Community Health Centers Governing Council's CEO or staff for special favors

What does Governance mean?

Governance means to guide and make decisions for an organization. It is the legal process carried out by a Council to ensure the health and effectiveness of an organization.

Elements of good governance and examples of best practice:

1. Council recruitment
    a. Seeks new members with specific competencies and skills based on current and future needs
    b. Considers the needs to patients, employee and the community when recruiting new members

2. Council structure
    a. Is the right size for the organization's needs
    b. Committee structure is effective
    c. Have clearly defined roles and responsibilities

3. Council culture
    a. Established behavior expectations
    b. Mutual trust
    c. Participation and engagement from all members

4. Council education and development
    a. Council orientation program
    b. Ongoing educational opportunities

5. Council evaluation
    a. Conducts a Council assessment at least every three years
    b. Committee assess their own performance
    c. Evaluates the qualifications and competencies for appointing and reappointing members

6. Continuous governance improvement
    a. Continuously evaluates, monitors and track performance for effectiveness
    b. Reviews processes and procedures for necessity

7. Council succession planning
    a. Has a formal process and written policy on succession planning
    b. Has leadership position descriptions
    c. Has a process to identify and develop Council leaders

The Council-Management Relationship

Council's Roles	*Management's Roles*
Select, evaluate, and support the CEO.	Run the organization in line with Council direction. Keep the Council educated and informed. Seek the Council's counsel.
Approve high-level organizational goals and policies.	Recommend goals and policies, supported by background information.
Make major decisions.	Frame decisions in the context of the mission and strategic vision, and bring the Council well-documented recommendations.
Oversee management and organizational performance.	Bring the Council timely information in concise, contextual, or comparative formats. Communicate with candor and transparency. Be responsive to requests for additional information.
Act as external advocates and diplomats in public policy, fundraising, and stakeholder/ community relations.	Keep the Council informed, bring recommendations, and mobilize Council members to leverage their external connections to support the organization.

Governance or Management?

Seven Guiding Questions

Is it big?

The bigger the impact of a decision, the more the Council ought to play a role in shaping and understanding the action and its possible consequences. Organizational decisions impacting roughly 10 percent or more of Federally Qualified Health Center Clinics revenues or activities are strategic decisions.

Is it about the future?

Councils make their impact on what the organization will look like five or more years down the road. The Council should be involved in the Federally Qualified Health Center Clinic's long-term vision and an integrated, three-to-five-year strategic and financial plan.

Is it core to the mission?

As a fiduciary, the Council is the guardian of the mission. Management should bring the Council well-documented analyses and recommendations to help Council members strike the right balance when mission and financial realities come in conflict.

Is a high-level policy decision needed to resolve a situation?

A policy sets forth principles, guidelines, or practices to be applied in certain situations. Policies should be compiled into a policy manual that is available for reference at any Council or committee meeting and distributed to every Council member.

Is a red flag flying?

Committees should routinely review dashboards and other performance reports, but when should they get into more detail discussing results and raising questions? Council members should know the red flags that signal the need for closer inquiry. Committees should focus on trends. One rule of thumb states that statistically significant over or underperformance on a strategic, quality, or financial indicator over at least three reporting periods constitutes a trend.

Is a watchdog watching?

If Congress, IRS, the state attorney general, or the news media care, the Council should care. Hot button issues of the moment include community benefit, charity care, executive compensation, medical errors, and publicly available quality results.

Does the CEO want and need the Council's support?

If the CEO asks for Council advice or intervention, Council members should respond. Sometimes CEOs want the Council to challenge management to raise the bar for performance, which gives the CEO the Council's backing to ask more from senior leadership and the medical staff.

Valleywise Community Health Centers

Community Needs Assessment

Valleywise Health
Maricopa County Special Health Care District

Community Needs Assessment
April 2020

Completed by:
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Valleywise Health Overview

Valleywise Health is the only public teaching hospital and health care system in Arizona providing primary and specialty care services predominantly to underserved, low-income, and ethnically diverse populations. Over a remarkable 140+ year history, Valleywise Health has built a reputation of quality healthcare, places compassion at the forefront, and is renowned for ethical stewardship of community resources and financial investment.

The Valleywise Health mission is "to provide exceptional care, without exception, every patient, every time." Valleywise Health employs a comprehensive approach to continual excellence of healthcare, clinical training, and population health research.

Overall, Valleywise Health experiences 550,000 visits annually and the system of care includes:

- Valleywise Health Medical Center – 325 beds
- Arizona Burn Center – 2nd largest in the U.S.; 45 beds and 5,000 visits annually
- Level 1 – Adult Trauma
- Level 2 – Pediatric Trauma
- 1 FQHC with 12 locations throughout Maricopa County including McDowell Health Center, the largest Primary Care serving Persons Living with HIV in AZ
- 3 Behavioral Health Centers – 361 beds
- Refugee Health Primary Care, serving over 3,000 women and children from 49 countries representing 41 different languages

Valleywise Health encompasses the largest medical teaching program in Maricopa County, training 400 residents and providing 3,194 student rotations in 13 accredited programs.

Valleywise Health serves as the healthcare safety net for Maricopa County in Arizona. The health system serves people of many races and nationalities who come from diverse cultures and numerous languages and dialects are spoken. An internal staff of 30 interpreters provides services for more than 70 languages. Interpretation services include in-person, access to real-time translation utilizing the phone-based World-Wide Interpreters and services for the hearing impaired.

In FY 2019, Valleywise Health achieved over 14,411 acute admissions, 396,391 ambulatory patient visits, and provided 3,600 patients with acute psychiatric care. Of inpatient and ambulatory individuals, nearly 73% and 83% are, respectably, racial and ethnic minorities.

The Valleywise Health ambulatory patient base is 73% ethnically/racially diverse, of which 57% are Hispanic and nearly 10% are African-American. Over 30% of patients are non-English speaking. Ethnically diverse children comprise the clear majority of Valleywise Health pediatric patients: in FY16, nearly 90% of all children were of racial/ethnic diversity, with 74% Hispanic.

Parents/caregivers of Valleywise Health pediatric patients experience high levels of unemployment and face numerous challenges and barriers. Ninety-six percent of children obtaining services at any Valleywise Health facility receive benefits through AHCCCS (State of Arizona Medicaid), the Valleywise Health Financial Assistance Program (sliding fee scale), or are self-pay.

With a focus on health disparities, Valleywise Health is dedicated to addressing the Social Determinants of Health for pediatric patients and their families. Valleywise Health is certified as a NCQA Medical Home, providing patient-centered and comprehensive care. A robust care coordination program, embedded into all Valleywise Health medical clinics, helps to ensure children and families receive access to not only medical care but social services, too. Strong community partnerships include providing early literacy programs at the four clinic-based Valleywise Health Family Learning Centers, supplying free lunches in collaboration with a local food bank, and a monthly food distribution program.

Valleywise Health's Federally Qualified Health Center sites (FQHC) offer outpatient primary care on the Valleywise Health campus in the Comprehensive Healthcare Center – Phoenix, as well as inside 11 Community Health Centers (FHC) located throughout Maricopa County. The FQHCs located within the CHC include: The Internal Medicine Clinic, Antepartum Testing Center, Women's Care Clinic, Arizona Children's Center Pediatric Clinic, Dental Clinic, and the Diabetes Outreach Clinic.

All designated FQHC primary care clinics receive leadership oversight by the HRSA-sanctioned Valleywise Community Health Centers Governing Council. Member responsibilities include ensuring the organization is community-based and responsive to the needs of the population it serves.

Valleywise Health FQHCs serve adult and pediatric patients, providing primary care services including:

- Adolescent care
- Teen pregnancy
- Refugee care
- Diabetes outreach education
- Behavioral health care
- Adult and pediatric dental
- Cardiology
- Radiology
- Laboratory and pharmacy services

Outside of the designated FQHC scope of work, Valleywise Health offers a wide range of specialty services including: gastroenterology, infectious diseases, rheumatology, neurology, endocrinology, dermatology, sports medicine, urology, oncology, breast care, dialysis, general and specialized surgery, hand and plastics, orthopedics, ear-nose-throat, ophthalmology, specialty pediatrics, cardio-pulmonary care, and physical and occupational therapy.

Valleywise Health Patient Demographics: Valleywise Health UDS Reports – 2019 (Abbreviated*)

*****_Below are select Valleywise Health UDS Reports submitted for the purposes of discussion. Attachment 1 contains the full Valleywise Health UDS Report as submitted to HRSA_

UDS Reports – 2019
Table 3A: Patients By Age And By Sex Assigned At Birth – Universal

S. No	Age Groups	Male Patients (a)	Female Patients (b)
1.	Under Age 1	1,402	1,385
2.	Age 1	824	764
3.	Age 2	736	726
4.	Age 3	712	712
5.	Age 4	711	668
6.	Age 5	686	670
7.	Age 6	604	590
8.	Age 7	557	527
9.	Age 8	530	520
10.	Age 9	525	547
11.	Age 10	611	561
12.	Age 11	688	716
13.	Age 12	640	612
14.	Age 13	585	606
15.	Age 14	570	616
16.	Age 15	575	590
17.	Age 16	539	669
18.	Age 17	510	779
Subtotal Patients (Sum Lines 1-18)		12,005	12,258
19.	Age 18	457	739
20.	Age 19	365	778
21.	Age 20	351	745
22.	Age 21	298	788
23.	Age 22	347	689
24.	Age 23	323	780
25.	Age 24	321	767
26.	Age 25-29	1,995	4,126
27.	Age 30-34	2,201	3,921
28.	Age 35-39	2,373	4,101
29.	Age 40-44	2,417	4,200
30.	Age 45-49	2,622	3,966
31.	Age 50-54	2,716	3,353
32.	Age 55-59	2,695	3,132
33.	Age 60-64	2,275	2,678
Subtotal Patients (Sum Lines 19-33		21,756	34,763

S. No	Age Groups	Male Patients (a)	Female Patients (b)
34.	Age 65-69	1,314	1,531
35.	Age 70-74	707	983
36.	Age 75-79	415	576
37.	Age 80-84	233	392
38.	Age 85 and over	146	299
Subtotal Patients (Sum Lines 34-38)		2,815	3,781
39.		36,576	50,802

UDS Reports – 2019
Table 3B: Demographic Characteristics – Universal

S. No	Patients by Race	Demographic Characteristics			
		Hispanic/Latino (a)	Non-Hispanic/Latino (b)	Unreported/Refused to Report Ethnicity (c)	Total (d)
1.	Asian	35	2,108		2,143
2a.	Native Hawaiian	4	32		36
2b.	Other Pacific Islander	88	495		583
2.	Total Hawaiian/Other Pacific Islander (Sum Lines 2a+2b)	92	527		619
3.	Black/African American	245	11,539		11,784
4.	American Indian/Alaska native	107	853		960
5.	White	50,354	17,995		68,309
6.	More than one race	63	227		290
7.	Unreported/Refused to report race	1,704	1,490	79	3,273
8.	Total Patients (Sum lines 1+2+3 through 7)	52,600	34,699	79	87,378

S. No	Patients by Language	Number (a)
12.	Patients Best Served in a Language Other Than English	34,252

S. No	Patients by Sexual Orientation	Number (a)
13.	Lesbian or Gay	1,440
14.	Straight (not lesbian or gay)	37,900
15.	Bisexual	391
16.	Something else	123
17.	Don't know	45,941
18.	Chose not to disclose	1,583
19.	Total Patients (Sum Lines 13-18)	87,378

S. No	Patients by Gender Identity	Number (a)
20.	Male	36,475
21.	Female	50,734
22.	Transgender Male/ Female-to-Male	56
23.	Transgender Female/ Male-to-Female	61
24.	Other	10
25.	Chose not to disclose	42
26.	Total Patients (Sum Lines 20-25)	87,378

UDS Reports – 2019
Table 4: Selected Patient Characteristics – Universal

S. No	Characteristic	Number of Patients (a)
Income as Percent of Poverty Guideline		
1.	100% and below	51,284
2.	101-150%	15,764
3.	151-200%	7,657
4.	Over 200%	10,281
5.	Unknown	2,392
6.	Total (Sum Lines 1-5)	87,378

Principal Third Party Medical Insurance Source		0-17 Years Old (a)	18 and Older (b)
7.	None/Uninsured	1,725	20,144
8a.	Regular Medicaid (Title XIX)	20,312	24,999
8b.	CHIP Medicaid	7	0
8.	Total Medicaid (Sum Lines 8a+8b)	20,319	24,999
9a.	Dually Eligible (Medicare and Medicaid)	7	5,066
9.	Medicare (Inclusive of Dually Eligible and other Title XVIII beneficiaries	9	7,024
10a.	Other Public Insurance Non-CHIP (Specifically: Refugee Medical)	105	3
10b.	Other Public Insurance CHIP	3	0
10.	Total Public Insurance (Sum Lines 10a+10b)	108	3
11.	Private Insurance	2,102	10,945
12.	Total (Sum Lines 7+8+9+10+11)	24,263	63,115

Managed Care Utilization						
S. No	Payer Category	Medicaid (a)	Medicare (b)	Other Public including Non-Medicaid CHIP (c)	Private (d)	Total (e)
13a.	Capitated Member Months	0	0	0	0	0
13b.	Fee-for-service Member Months	856,757	81,427	0	0	938,184
13c.	Total Member Months (Sum Lines 13a+13b)	856,757	81,427	0	0	938,184

S. No	Special Populations	Number of Patients (a)
14.	Migratory (330g grantees only)	
15.	Seasonal (330g grantees only)	
16.	Total agricultural workers or dependents (All Health Centers Report This Line)	68
17.	Homeless shelter (330h grantees only)	
18.	Transitional (330h grantees only)	
19.	Doubling up (330h grantees only)	
20.	Street (330h grantees only)	
21.	Other (330h grantees only)	
22.	Unknown (330h grantees only)	
23.	Total Homeless (All Health Centers Report This Line)	372
24.	Total School Based Health Center Patients (All Health Centers Report This Line)	0
25.	Total Veterans (All Health Centers Report This Line)	762
26.	Total Patients Served at a Health Center Located in or Immediately Accessible to a Public Housing Site (All Health Centers Report This Line)	87,378

Table 6A: Selected Diagnoses and Services Rendered – Universal

S. No	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
Selected Infectious and Parasitic Diseases				
1-2.	Symptomatic/Asymptomatic HIV	B20, B97.35, O98.7-, Z21	12,774	3,865
3.	Tuberculosis	A15- through A19-	36	18
4.	Sexually transmitted infections	A50- through A64- (exclude A63.0), M02.3-	1,297	924
4a.	Hepatitis B	B16.0-B16.2, B16.9, B17.0, B18.0,B18.1, B19.10, B19.11, Z22.51	319	169
4b.	Hepatitis C	B17.10, B17.11, B18.2, B19.20,B19.21	1,139	695
Selected Diseases of the Respiratory System				
5.	Asthma	J45-	5,447	3,645
6.	Chronic obstructive pulmonary diseases	J40- through J44-, J47-	3,201	2,022
Selected Other Medical Conditions				
7.	Abnormal breast findings, female	C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.81-, C50.91-, C79.61-,D05-, D48.6-, N63-, R92-	1,475	1,194
8.	Abnormal cervical findings	C53-, C79.82, D06-, R87.61-, R87.810, R87.820	1,901	1,254
9.	Diabetes mellitus	E08- through E13-, O24- (excludes O24.41-)	31,466	10,444
10.	Heart disease (selected)	I01-, I02- (exclude I02.9), I20- through I25-, I27-, I28-, I30- through I52-	5,786	2,892
11.	Hypertension	I10- through I16-	37,081	15,846
12.	Contact dermatitis and other eczema	L23- through L25-, L30- (exclude L30.1, L30.3,L30.4, L30.5), L55- through L59- (exclude L57.0 through L57.4)	2,329	1,917
13.	Dehydration	E86-	177	171
14.	Exposure to heat or cold	T33-, T34-, T67-, T68-, T69-	10	10
14a.	Overweight and obesity	E66-, Z68- (exclude Z68.1,Z68.20 through Z68.24, Z68.51, Z68.52)	16,390	11,777
Selected Childhood Conditions (limited to ages 0 through 17)				
15.	Otitis Media and Eustachian tube disorders	H65- through H69-	1,915	1,510
16.	Selected perinatal medical conditions	A33-, P22- through P29- (exclude P29.3), P35- through P96- (exclude P54-, P91.6-, P92-, P98.81), R78.81, R78.89	786	558
17.	Lack of expected normal physiological development (such as delayed milestone; failure to gain weight; failure to thrive); Nutritional deficiencies in children only. Does not include sexual or mental development.	E40- through E46-, E50- through E63-, P92-, R62- (exclude R62.7), R63.2, R63.3	91,529	1,085

Table 6A: Selected Diagnoses and Services Rendered – Universal

S. No	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
Selected Mental Health and Substance Abuse Conditions				
18.	Alcohol related disorders	F10-, G62.1	1,035	627
19.	Other substance disorders (excluding tobacco use disorders)	F11- through F19- (exclude F17-),G62.0, O99.32-	2,943	1,494
19a.	Tobacco use disorder	F17-	2,912	2,158
20a.	Depression and other mood disorders	F30- through F39-	9,596	5,195
20b.	Anxiety disorders including PTSD	F06.4, F40- through F42-, F43.0, F43.1-, F93.0	9,125	5,034
20c.	Attention deficit and disruptive behavior disorders	F90- through F91-	716	527
20d.	Other mental disorders excluding drug or alcohol dependence	F01- through F09- (exclude F06.4), F20- through F29-, F43- through F48- (exclude F43.0- and F43.1-),F50- through F59- (exclude F55-), F60- through F99- (exclude F84.2, F90-, F91-,F98-), R45.1, R45.2, R45.5, R45.6, R45.7, R45.81, R45.82, R48.0	7,063	4,377

S. No	Service Category	Applicable ICD-10-CM Code or CPT-4/11 Code	Number of Visits (a)	Number of Patients (b)
Selected Diagnostic Tests/Screenings/Preventative Services				
21.	HIV test	CPT-4: 86689: 86701 through 86703, 87389 through 87391	7,794	7,104
21a.	Hepatitis B test	CPT-4: 86704, 86706, 87515 through 87517	3,424	3,371
21b.	Hepatitis C test	CPT-4: 86803, 86804, 87520 through 87522	3,295	3,203
22.	Mammogram	CPT-4: 77052, 77057, 77065, 77066, 77067 OR ICD-10: Z12.31	7,762	6,938
23.	Pap test	CPT-4: 88141 through 88155, 88164 through 88167, 88174, 88175 OR ICD-10: Z01.41-, Z01.42, Z12.4 (exclude Z01.411 and Z01.419)	7,641	7,428
24.	Selected immunizations: Hepatitis A, Hemophilus Influenza B (HiB), Pneumococcal, Diphtheria, Tetanus, Pertussis (DTaP) (DTP) (DT), Mumps, Measles, Rubella, Poliovirus, Varicella, Hepatitis B Child	CPT-4: 90633, 90634, 90645 through 90648, 90670, 90696 through 90702, 90704 through 90716, 90718 through 90723, 90743, 90744, 90748	20,114	15,343
24a.	Seasonal Flu vaccine	CPT-4: 90654 through 90662, 90672, 90673, 90685 through 90688	16,084	14,903

Table 6A: Selected Diagnoses and Services Rendered – Universal

S. No	Diagnostic Category	Applicable ICD-10-CM Code or CPT-4/11 Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
25.	Contraceptive management	ICD-10: Z30-	6,704	4,513
26.	Health supervision of infant or child (ages 0 through 11)	CPT-4:99381 through 99383, 99391 through 99393	22,210	13,335
26a.	Childhood lead test screening (9 to 72 months)	CPT-4: 83655	2,210	2,152
26b.	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	CPT-4: 99408, 99409 HCPCS: G0396, G0397, H0050	0	0
26c.	Smoke and tobacco use cessation counseling	CPT-4: 99406, 99407 OR HCPCS: S9075 OR CPT-II: 4000F, 4001F	6,570	5,390
26d.	Comprehensive and intermediate eye exams	CPT-4: 92002, 92004, 92012, 92014	0	0

S. No	Service Category	Applicable ADA Code	Number of Visits (a)	Number of Patients (b)
Selected Dental Services				
27.	I. Emergency services	ADA: D9110	27	27
28.	II. Oral exams	ADA: D0120, D0140, D0145, D0150, D0160, D0170, D0171, D0180	12,005	9,497
29.	Prophylaxis – adult or child	ADA: D1110, D1120	5,581	4,260
30.	Sealants	ADA: D1351	523	460
31.	Fluoride treatment – adult or child	ADA: D1206, D1208	4,027	3,005
32.	III. Restorative Services	ADA: D21xx through D28xx	4,177	2,370
33.	IV. Oral Surgery (extractions and other surgical procedures)	ADA: D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7251, D7260, D7261, D7270, D7272, D7280, D7290 through D7294	3,109	2,559
34.	V. Rehabilitative services (Endo, Pedo, Prostho, Ortho)	ADA: D3xxx, D4xxx, D5xxx, D6xxx, D8xxx	2,708	1,448

Sources of Codes:
ICD-10-CM (2019)-National Center for Health Statistics (NCHS)
CPT (2019)-American Medical Association (AMA)
Code on Dental Procedures and Nomenclature CDT Code (2019)-Dental Procedure Codes. American Dental Association (ADA)
Note: 'X' in a code denotes any number including the absence of a number in that place. Dashes (-) in a code indicate that additional characters are required. ICD10-CM codes all have at least four digits. These codes are not intended to reflect if a code is billable or not. Instead, they are used to point out that other codes in the series are to be considered.

Prenatal Care Provided By Referral Only (Check If Yes): No

Section A – Age Categories For Prenatal Care Patients		
	Demographic Characteristics Of Prenatal Care Patients	
S. No	Age	Number of Patients (a)
1.	Less than 15 years	4
2.	Ages 15-19	266
3.	Ages 20-24	703
4.	Ages 25-44	1,776
5.	Ages 45 and over	9
6.	Total Patients (Sum Lines 1-5)	2,758

Section B – Early Entry Into Prenatal Care			
S. No	Early Entry Into Prenatal Care	Women Having First Visit with Health Center (a)	Women Having First Visit with Another Provider (b)
0.	First Trimester	1,562	187
1.	Second Trimester	697	89
2.	Third Trimester	176	47

Section C – Childhood Immunization Status (CIS)				
S. No	Childhood Immunization Status (CIS)	Total Patients with 2nd Birthday (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Immunized (c)
10.	Measure: Percentage of children 2 years of age who received age appropriate vaccines by their 2nd birthday	1,491	1,491	644

Section D – Cervical Cancer Screening				
S. No	Cervical Cancer Screening	Total Female Patients Aged 23 through 64 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Tested (c)
11.	Measure: Percentage of women 23 - 64 years of age, who were screened for cervical cancer	29,191	29,191	13,906

Section E – Weight Assessment and Counseling for Nutrition and Physical Activity of Children and Adolescents				
S. No	Weight Assessment and Counseling for Nutrition and Physical Activity of Children and Adolescents	Total Patients Aged 3 through 17 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Counseling and BMI Documented (c)
12.	Measure: Percentage of patients 3 - 17 years of age with a BMI percentile, and counseling on nutrition and physical activity documented	15,873	15,873	11,013

Section F – Preventative Care and Screening: Body Mass Index (BMI) Screening and Follow-Up-Plan				
S. No	Preventative Care and Screening: Body Mass Index (BMI) Screening and Follow- Up-Plan	Total Patients 18 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with BMI Charted and Follow-Up Plan Documented as Appropriate (c)
13.	Measure: Percentage of patients 18 years and older with (1) BMI documented and (2) follow-up plan documented if BMI is outside normal parameters	51,108	51,108	32,368

Section G – Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention				
S. No	Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention	Total Patients Aged 18 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Screened for Tobacco Use and Provided Intervention If a Tobacco User (c)
14a.	Measure: Percentage of patients 18 years and older who (1) were screened for tobacco use one or more times within 24 months and if identified to be a tobacco user (2) received cessation counseling intervention	41,684	41,684	36,012

Section H – Use of Appropriate Medications for Asthma				
S. No	Use of Appropriate Medications for Asthma	Total Patients Aged 5 through 64 with Persistent Asthma (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Acceptable Plan (c)
16.	Measure: Percentage of patients 5 through 64 years of age identified as having persistent asthma and were appropriately ordered medication	1,530	1,530	1,309

Section I – Coronary Artery Disease (CAD): Lipid Therapy				
S. No	Coronary Artery Disease (CAD): Lipid Therapy	Total Patients Aged 18 and Older with CAD Diagnosis (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Prescribed a Lipid Lowering Therapy (c)
17.	Measure: Percentage of patients 18 years of age and older with a diagnosis of CAD who were prescribed a lipid lowering therapy	14,421	14,421	9,767

Section J – Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet				
S. No	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	Total Patients Aged 18 and Older with IVD Diagnosis or AMI, CABG, or PCI Procedure (a)	Charts Sampled or EHR Total (b)	Number of Patients With Documentation of Aspirin or Other Antiplatelet Therapy (c)
18.	Measure: Percentage of patients 18 years of age and older with a diagnosis of IVD or AMI, CABG, or PCI Procedure with aspirin or another antiplatelet	2,330	2,330	1,882

Section K – Colorectal Cancer Screening				
S. No	Colorectal Cancer Screening	Total Patients Aged 50 through 75 (a)	Charts Sampled or EHR Total (b)	Number of Patients With Appropriate Screening for Colorectal Cancer (c)
19.	Measure: Percentage of patients 50 through 75 years of age who had appropriate screening for colorectal cancer	19,577	19,577	9,640

Section L – HIV Linkage to Care				
S. No	HIV Linkage to Care	Total Patients First Diagnosed with HIV (a)	Charts Sampled or EHR Total (b)	Number of Patients Seen Within 90 Days of First Diagnosis of HIV (c)
20.	Measure: Percentage of patients whose first ever HIV diagnosis was made by health center staff between October 1 of the prior year and September 30 of the measurement year and who were seen for follow-up treatment within 90 days of that first ever diagnosis	3	3	2

Section M – Preventative Care and Screening: Screening for Depression and Follow-Up Plan				
S. No	Preventative Care and Screening: Screening for Depression and Follow-Up Plan	Total Patients Aged 12 and Older (a)	Charts Sampled or EHR Total (b)	Number of Patients Screened for Depression and Follow-Up Plan Documented as Appropriate (c)
21.	Measure: Percentage of patients 12 years of age and older who were (1) screened for depression with a standardized tool and, if screening was positive, (2) had a follow-up plan documented	58,277	58,277	41,959

Section N – Dental Sealants for Children between 6-9 Years				
S. No	Dental Sealants for Children between 6-9 Years	Total Patients Aged 6 through 9 at Moderate to High Risk for Caries (a)	Charts Sampled or EHR Total (b)	Number of Patients with Sealants to First Molars (c)
22.	Measure: Percentage of children 6 through 9 years of age, at moderate to high risk of caries who received a sealant on a first permanent molar	518	518	332

Table 7: Health Outcomes and Disparities

S. No	Prenatal Services	Total (i)
0	HIV Positive Pregnant Women	44
2	Deliveries Performed by Health Center's Provider	1,852

Section A: Deliveries and Birth Weight

S. No	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: < 1500 grams (1b)	Live Births: 1500 – 2499 grams (1c)	Live Births: >= 2500 grams (1d)
Hispanic/Latino					
1a.	Asian	0	4	3	45
1b1.	Native Hawaiian	0	0	0	0
1b2.	Other Pacific Islander	2	0	0	16
1c.	Black/African American	5	8	23	250
1d.	American Indian/Alaska Native	1	0	2	15
1e.	White	1,196	0	14	138
1f.	More Than One Race	4	1	1	3
1g.	Unreported/Refused to Report Race	11	0	0	15
Subtotal Hispanic/Latino (Sum Lines 1a-1g)		1,220	13	43	482
Non-Hispanic/Latino					
2a.	Asian	46	0	5	49
2b1.	Native Hawaiian	0	0	0	0
2b2.	Other Pacific Islander	16	0	1	14
2c.	Black/African American	256	3	14	188
2d.	American Indian/Alaska Native	15	0	2	12
2e.	White	142	1	8	148
2f.	More Than One Race	3	0	0	1
2g.	Unreported/Refused to Report Race	15	0	5	11
Subtotal Non-Hispanic/Latino (Sum Lines 2a-2g)		493	4	35	423
Unreported/Refused to Report Ethnicity					
h.	Unreported/Refused to Report Race and Ethnicity	0	0	0	0
i.	Total (Sum Lines 1a-h)	1,713	32	109	1,692

Section B: Controlling High Blood Pressure				
S. No	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension 2(a)	Charts Sampled or EHR Total (2b)	Patients with HTN Controlled (2c)
Hispanic/Latino				
1a.	Asian	13	13	8
1b1.	Native Hawaiian	3	3	2
1b2.	Other Pacific Islander	6	6	3
1c.	Black/African American	37	37	17
1d.	American Indian/Alaska Native	17	17	8
1e.	White	7,627	7,627	4,023
1f.	More Than One Race	4	4	0
1g.	Unreported/Refused to Report Race	278	278	159
Subtotal Hispanic/Latino (Sum Lines 1a-1g)		7,985	7,985	4,220
Non-Hispanic/Latino				
2a.	Asian	490	490	261
2b1.	Native Hawaiian	11	11	6
2b2.	Other Pacific Islander	89	89	44
2c.	Black/African American	2,474	2,474	1,187
2d.	American Indian/Alaska Native	113	113	15
2e.	White	3,890	3,890	2,173
2f.	More Than One Race	17	17	10
2g.	Unreported/Refused to Report Race	217	217	116
Subtotal Non-Hispanic/Latino (Sum Lines 2a-2g)		7,301	7,301	3,812
h.	Unreported/Refused to Report Race and Ethnicity	2	2	1
i.	Total (Sum Lines 1a-h)	15,288	15,288	8,033

Section C: Diabetes: Hemoglobin A1c Poor Control					
S. No	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3a)	Charts Sampled or EHR Total (3b)	Patients with Hba1c < 8% (3d1)	Patients with Hba1c > 9% Or No Test During Year
Hispanic/Latino					
1a.	Asian	4	4	4	0
1b1.	Native Hawaiian	1	1	1	0
1b2.	Other Pacific Islander	9	9	9	3
1c.	Black/African American	21	21	9	12
1d.	American Indian/Alaska Native	16	16	8	8
1e.	White	6,565	6,565	4,420	2,145
1f.	More Than One Race	2	2	1	1
1g.	Unreported/Refused to Report Race	211	211	130	81
Subtotal Hispanic/Latino (Sum Lines 1a-1g)		6,829	6,829	4,579	2,250
Non-Hispanic/Latino					
2a.	Asian	253	253	213	40
2b1.	Native Hawaiian	6	6	3	3
2b2.	Other Pacific Islander	57	57	36	21
2c.	Black/African American	1,258	1,258	856	402
2d.	American Indian/Alaska Native	116	116	70	46
2e.	White	1,947	1,947	1,398	549
2f.	More Than One Race	10	10	7	3
2g.	Unreported/Refused to Report Race	133	133	103	30
Subtotal Non-Hispanic/Latino (Sum Lines 2a-2g)		3,780	3,780	2,686	1,094
Unreported/Refused to Report Ethnicity					
h.	Unreported/Refused to Report Race and Ethnicity	11	11	5	4
i.	Total (Sum Lines 1a-h)	10,620	10,620	6,672	3,348

Maricopa County: The Valleywise Health Service Area

The Geography of Maricopa County

Maricopa County is geographically located in the south-central portion of Arizona and spans a total area of 9,224 miles; 9,200 miles of land mass and 24 miles of water. Twenty-five cities and towns are located in Maricopa County. The largest city—Phoenix—is both the County seat and the State capital.

Maricopa County is the 14th largest county in land area in the continental United States and larger than seven states. Individuals and corporations make up 30% of total land ownership, with the remainder publicly owned.

The Gender, Age, Housing Units, and Citizen Voting Estimates of Maricopa County

The 2013-2017 American Community Survey 5-Year Estimate data reveal a gender demographic population of 50.5% female, a median age of 36.0 years, 1,699,628total housing units, and citizen voting population of 2,778,337.

Total Population: 4,088,549	Of Total Population:	% of Total Population
Male	2,055,464	49.5
Female	2,100,037	50.5
Under 5 years old	277,362	6.7
5 to 9 years	288,625	6.9
10 to 14 years	291,300	7.0
15 to 19 years	282,478	6.8
20 to 24 years	285,123	6.9
25 to 34 years	596,251	14.3
35 to 44 years	547,697	13.2
45 to 54 years	534,321	12.9
55 to 59 years	243,810	5.9
60 to 64 years	221,890	5.3
65 to 74 years	341,640	8.2
75 to 84 years	173,830	4.2
85 years and older	71,174	1.7
Median Age (years):	36.0	

Total Housing Units in Maricopa County	1,699,628
CITIZEN, VOTING AGE POPULATION	
Citizen, 18 years and older population	**2,778,337**
Male	**1,355,200**
Female	**1,423,137**

The Race and Hispanic Origin Estimates of Maricopa County

The 2013-2017 American Community Survey 5-Year Estimate data reveal detailed race and Hispanic Origin population percentages:

RACE		**% Representation**
Total Population	**4,155,501**	
One Race	**4,011,502**	**96.5**
Two or More Races	**143,999**	**3.5**

The table below presents data available for Race Alone/or in Combination with one or more Other Races:

Total population	**4,155,501**	
White	3,365,553	81.0
Black or African American	273,545	6.6
American Indian and Alaska Native	117,941	2.8
Asian	207,985	5.0
Native Hawaiian and Other Pacific Islander	19,177	0.5
Some other race	328,219	7.9

The data presented in the table below captures the Hispanic or Latino or Race composite for Maricopa County:

Total population	4,155,501	% Representation
Hispanic or Latino (of any race)	1,271,746	30.6
Mexican	1,127,982	27.1
Puerto Rican	27,854	0.7
Cuban	10,378	0.2
Other Hispanic or Latino	105,532	2.5
Not Hispanic or Latino	2,883,755	69.4
White alone	2,340,105	56.3
Black or African American alone	211,288	5.1
American Indian and Alaska Native alone	64,102	1.5
Asian alone	160,439	3.9
Native Hawaiian and Other Pacific Islander alone	7,919	0.2
Some other race alone	5,834	0.1
Two or more races	94,128	2.3
Two races including Some other race	3,537	0.1
Two races excluding Some other race, and Three or more races	90,591	2.2

The 2020 Federal Poverty Guidelines

The chart below presents data at **100%** of the 2020 Poverty Guidelines for the 48 Contiguous States and the District of Columbia (Federal Register, Vol. 85, No. 12, January 17, 2020, pp. 3060

SEX	Population Size	Less than 50% FPL	Less than 100% FPL	Less than 125% FPL
Male	2,023,814	6.9%	14.8%	19.2%
Female	2,077,494	8.0%	16.6%	21.5%
AGE				
Under 18 years	1,014,676	10.4%	22.5%	28.8%
Related children of Householder under 18 years	1,010,104	10.0%	22.2%	28.5%
18-64 years	2,506,287	7.2%	14.7%	18.8%
65 years and over	580,345	3.4%	8.4%	12.5%
RACE				
One Race	3,960,005	7.4%	15.7%	20.3%
White	3,203,614	6.7%	14.1%	18.4%
Black or African American	217,162	11.3%	21.9%	27.7%
American Indian and Alaska Native	76,697	13.2%	26.3%	33.5%
Asian	162,060	6.4%	12.0%	15.4%
Native Hawaiian and Other Pacific Islander	8,635	8.7%	17.3%	22.8%
Some Other Race	291,837	11.5%	27.9%	35.4%
Two or more Races	141,303	8.2%	16.3%	21.3%
Hispanic or Latino Origin	1,256,273	11.3%	26.0%	33.7%
White Alone, Not Hispanic or Latino Origin	2,312,393	5.0%	9.6%	12.5%

Income Statistics in the Past 12 Months in Maricopa County

The 2013-2017 American Community Survey Estimates for Household, Families, Married-Couple, and Non-family Households (represented in 2017 inflation-adjusted amounts) are shown categorically:

Subject	Households	Families	Married Couple Families	Non-family Households
Total	1,489,533	976,254	709.031	513,279
Less than $10,000	6.4%	4.7%	2.1%	11.3%
$10,000 to $14,999	4.1%	2.6%	1.5%	7.2%
$15,000 to $24,999	9.1%	6.7%	4.4%	14.2%
$25,000 to $34,999	9.5%	8.1%	6.4%	12.8%
$35,000 to $49,999	13.7%	12.4%	10.7%	16.4%
$50,000 to $74,999	18.6%	19.1%	19.0%	16.9%
$75,000 to $99,999	12.6%	14.1%	15.8%	8.9%
$100,000 to $149,999	14.4%	17.4%	21.0%	7.6%
$150,000 to $199,999	5.7%	7.3%	9.3%	2.3%
$200,000 or more	5.9%	7.6%	9.9%	2.4%
Median Income (dollars)	$58,580	$69,647	$83,903	$38,629
Mean Income (dollars)	$80,793	$92,705	$107,802	$54,013

Educational Attainment Demographics for Maricopa County

Below are the 2013-2017 American Community Survey Estimates for educational attainment, by age, gender, and race:

Subject	Estimate
Population: 18-24 years	**394,023**
Less than high school graduate	**62,403**
High school graduate (includes equivalency)	**126,281**
Some college or associate's degree	**170,115**
Bachelor's degree or higher	**35,224**
Population: 25 years and over	**2,730,613**
Less than 9th grade	**165,101**
9th to 12th grade, no diploma	**187,226**
High school graduate (includes equivalency)	**621,894**
Some college, no degree	**666,344**
Associate's degree	**231,276**
Bachelor's degree	**546,841**
Graduate or professional degree	**311,931**
Population: 25-34 years	**596,251**
High school graduate or higher	**521,967**
Bachelor's degree or higher	**183,278**
Population: 35-44 years	**547,697**
High school graduate or higher	**462,438**
Bachelor's degree or higher	**181,704**
Population: 45-64 years	**1,000,021**
High school graduate or higher	**876,236**
Bachelor's degree or higher	**316,838**
Population: 65 years and over	**586,644**
High school graduate or higher	**517,645**
Bachelor's degree or higher	**176,962**

Veteran Status Demographics for Maricopa County

The table below presents the 2013-2017 American Community Survey Estimates for veteran status, characterized by period of service, sex, age, race, education, poverty level, and disability status:

Subject	Total	Veterans	Non-Veterans
Civilian aged 18 years and over	**3,119,960**	**253,803**	**2,866,157**
SEX			
Male	**1,525,484**	**232,104**	**1,293,380**
Female	**1,594,476**	**21,699**	**1,572,777**
AGE			
18 to 34 years	**987,034**	**22,435**	**964,599**
35 to 54 years	**1,080,608**	**59,259**	**1,021,349**
55 to 64 years	**465,674**	**45,553**	**420,121**
65 t0 74 years	**341,640**	**64,567**	**277,073**
75 years and over	**245,004**	**61,989**	**183,015**

Area Health Resources

The Area Health Resource File is a collection of data compiled from more than 50 sources, including the American Medical Association, the American Hospital Association, the U.S. Census Bureau, the Centers for Medicare and Medicaid Services, the U.S. Bureau of Labor Statistics, and the National Center for Health Statistics. The American Medical Association maintains the *Physician Masterfile,* which contains information on nearly all the Doctors of Medicine and Doctors of Osteopathic Medicine in the nation.

A Primary Care Physicians Ratio (PCP ratio) is the ratio of the defined population area to total primary care physicians. Primary care physicians include non-federal, practicing physicians—both allopathic and osteopathic—under 75 years old—specializing in general practice medicine, family medicine, internal medicine, and pediatrics.

Maricopa County	# of Primary Care Physicians: 3,030	PCP Ratio: 1,420:1 Z Score: -.90

Source: http://www.countyhealthrankings.org/app/arizona/2020/measure/factors/4/data

Access to healthcare providers is one component of healthcare; healthcare insurance is another. The table below reveals the health insurance coverage status of Maricopa County's non-institutionalized civilian population:

HEALTH INSURANCE COVERAGE	Estimate
Civilian noninstitutionalized population	4,125,142
With health insurance coverage	3,617,250
With private health insurance	2,660,755
With public coverage	1,367,095
No health insurance coverage	507,892
Civilian noninstitutionalized population under 19 years	1,086,405
No health insurance coverage	97,246
Civilian noninstitutionalized population 19 to 64 years	2,458,392
In labor force:	1,902,029
Employed:	1,795,320
With health insurance coverage	1,533,664
With private health insurance	1,391,676
With public coverage	180,294
No health insurance coverage	261,656
Unemployed:	106,709
With health insurance coverage	70,928
With private health insurance	37,757
With public coverage	35,970

No health insurance coverage	**35,781**
Not in labor force:	**556,363**
With health insurance coverage	**449,426**
With private health insurance	**270,085**
With public coverage	**210,209**
No health insurance coverage	**106,937**

Source: 2013-2017 American Community Survey 5 Year Estimates: Selected Economic Characteristics

Systemic Barrier to Care: Access

In order for a community to deliver effective, high quality, and culturally competent care, access to the healthcare system is required. Despite the growing need, underserved populations often lack access to care. This lack of access affects every aspect of a person's life, including their physical, mental, and emotional wellness. When individuals are able to access primary care on a routine basis, they are less likely to experience serious health conditions. Consistent access to primary care also has the ability to prevent disease, detect chronic diseases and provide treatment at an early stage, and increase one's lifespan. (U.S. Department of Health and Human Services, Healthy People, 2020).

Many people believe the healthcare system in the United States is broken. The high cost of medical insurance paired with the lack of healthcare providers–specifically primary care providers–drastically impacts one's access to care. This reality applies to Arizonans, as well. It is not uncommon for Arizonans to lack a personal primary care physician and place where they receive routine medical care. Additionally, the decentralization of medical services–dental, mental health, substance, abuse, and other healthcare services–serves as a greater barrier to individuals receiving the comprehensive care they need. Those who live in Medically Underserved Areas are particularly affected by this separation of healthcare services. Furthermore, shortages among healthcare providers and the physical distance one must travel to receive care pose significant barriers to many populations.

A federal Medically Underserved Area/Population (MUA/P) designation identifies areas or populations as having a need for medical services based on demographic data that show that the area/population has either too few primary care providers, high infant mortality, high poverty, and/or high elderly population (www.azdhs.gov).

Currently, Arizona contains 36 Medically Underserved Areas and 11 Medically Underserved Populations; Maricopa County contains **12** MUAs and **3** MUPs (www.muafind.hrsa.gov).

Health Professional Shortage Areas (HPSAs) are federal designations that apply to areas, population groups, or facilities in which unmet healthcare needs are present. HPSAs can be designated in primary care, dental care, or mental health. HPSAs fall into one of three types of classifications:

- **Geographic**: based on the ratio between the number of full-time equivalent (FTE) clinical providers and the patient population within a given area. This designation indicates that all individuals, who are not living in a detention facility, in the area of designation, have insufficient access to care.

- **Population**: This designation indicates that a subpopulation of individuals living in the area of designation has insufficient access to care. Population groups include those below 200% of federal poverty level, groups on Medicaid, migrant farm workers, tribal, or homeless populations.

- ☐ **Facility**: This designation indicates that individuals served by a specific health facility have insufficient access to care. The types of facilities that can be designated include federal and state correctional institutions, public and nonprofit healthcare facilities, Indian Health Service facilities and state and county mental hospitals.

Currently Maricopa County has 30 primary medical care, 27 dental, and 40 mental health identified HPSAs (www.hrsa.gov).

Maricopa County Health Indicators

The Behavioral Risk Factor Surveillance System (BRFSS) is the nation's premier system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services.

Established in 1984 with 15 states, BRFSS now collects data in all 50 states as well as the District of Columbia and three U.S. territories. BRFSS completes more than 400,000 adult interviews each year, making it the largest continuously conducted health survey system in the world (www.cdc.gov/brfss).

In Arizona, the 2016 (most recent) Behavioral Risk Factor Surveillance System Maricopa County Report details medical-provider diagnosed conditions by sex, age, group and race/ethnicity for several health indicators and reveals the prevalence of each (Maricopa County Department of Public Health, Office of Epidemiology. *Maricopa County Health Status Special Report 2016, Behavioral Risk Factor Surveillance System*. Phoenix (AZ): 2018).

The statistics are culled from data in the Arizona Department of Health Services annual files. The survey methodology is telephone-based (both land lines and cell phones included) and is randomized.

Table 1: Self-Reported Health Indicators by Sex, Age Group, and Race/Ethnicity

Self-Reported Health Indicators	Male %	Female %	18-24 %	25-34 %	35-44 %	45- 54 %	55-64 %	65+ %	White, non-Hispanic %	Hispanic %	Total %
Health Status: Excellent, Very Good, Good	83.2	82.2	91.8	87.7	86.7	78.8	73.4	78.7	85.6	73.6	82.7
BMI - Overweight	39.4	29.9	21.1	29.1	33.7	39.6	41.9	40.3	36.9	32.8	34.7
BMI - Obese	29.0	27.6	13.8	28.4	32.9	35.5	31.7	25.6	25.9	34.8	28.3

Note: Overweight and obesity are based on the respondent's self-reported height and weight

Table 2: Self-Reported Health Behaviors by Sex, Age Group, and Race/Ethnicity

Self-Reported Health Indicators	Male %	Female %	18-24 %	25-34 %	35-44 %	45- 54 %	55-64 %	65+ %	White, non-Hispanic %	Hispanic %	Total %
Physical Activity - Met aerobic recommendation	67.8	52.9	79.5	64.9	57.6	54.6	53.0	55.4	63.7	51.9	60.5
Physical Activity - Met muscle strengthening recommendation	32.7	23.7	38.2	33.8	31.8	19.9	23.0	24.5	30.3	25.4	28.4
Physical Activity - Met at least one guideline	55.2	46.0	65.1	55.6	50.9	41.9	45.2	48.1	54.3	40.9	50.8
Fruit and Vegetable Consumption - 5 or more servings / day	14.4	19.3	10.3	18.1	18.9	17.4	18.9	15.7	16.9	13.3	16.8
Seat Belt Use - Always	85.1	90.5	82.0	83.8	89.5	88.2	90.6	91.7	89.1	85.1	87.9
Ever Had an HIV Test	36.2	37.5	28.4	53.2	55.8	40.1	29.2	13.4	33.8	41.0	36.8

Table 3: Medical Provider Diagnosed Conditions by Sex, Age Group, and Race/Ethnicity

Has a Medical Provider Ever Told You that You Have/Had	Male %	Female %	18-24 %	25-34 %	35-44 %	45- 54 %	55-64 %	65+ %	White, non-Hispanic %	Hispanic %	Total %
Coronary Heart Disease	5.3	2.8	0.0	0.2	2.8	2.3	5.8	11.6	4.7	3.2	4.0
Heart Attack	4.8	2.3	0.0	0.1	1.1	3.8	5.3	9.7	4.1	2.4	3.5
Stroke	3.6	2.6	0.0	2.2	1.9	1.7	4.2	7.3	3.5	2.2	3.1
Diabetes	11.6	8.8	0.5	3.5	2.1	13.3	20.2	19.7	9.9	11.1	10.2
Asthma	13.7	14.5	11.3	15.2	13.6	16.4	15.4	12.6	15.6	11.0	14.1
Chronic Obstructive Pulmonary Disorder	5.5	6.7	1.7	4.4	2.7	6.8	8.8	11.1	7.1	4.7	6.1
Depressive Disorder	12.7	19.6	11.1	18.1	14.0	19.1	20.8	13.6	18.9	11.4	16.2
Skin Cancer	7.5	7.7	0.0	0.2	2.8	5.4	11.2	23.1	11.6	1.1	7.6
Arthritis	19..0	29.4	2.7	6.4	12.0	26.3	40.3	53.0	30.2	14.8	24.3
Kidney Disease	3.1	3.5	0.8	0.7	1.3	4.2	5.2	7.2	3.9	2.7	3.3

Note on Asthma: Includes adults who currently have asthma, as well as adults who formerly had asthma

Table 4: Self-Reported Alcohol and Cigarette Usage by Sex, Age Group, and Race/Ethnicity

Alcohol and Smoking	Male %	Female %	18-24 %	25-34 %	35-44 %	45- 54 %	55-64 %	65+ %	White, non-Hispanic %	Hispanic %	Total %
Binge Drinking	21.8	10.9	20.7	23.1	23.0	15.8	11.7	4.5	17.1	15.7	16.2
Heavy Drinking	6.5	6.7	8.0	7.5	4.6	8.3	6.5	5.3	8.2	2.8	6.6
Current Smoker	14.9	11.1	6.6	18.3	13.6	15.6	15.0	7.5	14.3	8.8	13.0
Former Smoker	27.6	21.0	4.6	18.4	21.2	26.5	27.6	41.0	29.8	15.8	24.2

Table 5: Vaccination Status by Sex, Age Group, and Race/Ethnicity

Vaccinations	Male %	Female %	18-24 %	25-34 %	35-44 %	45- 54 %	55-64 %	65+ %	White, non-Hispanic %	Hispanic %	Total %
Annual Influenza Vaccine	30.4	38.2	25.5	23.3	26.1	32.2	42.0	54.2	37.9	29.3	34.4
Pneumonia Vaccine	38.8	36.0	35.2	26.0	16.7	23.3	34.3	74.7	41.4	29.9	37.3

Table 6: Health Care Coverage and Utilization by Sex, Age Group, and Race/Ethnicity

Healthcare Coverage and Utilization	Male %	Female %	18-24 %	25-34 %	35-44 %	45- 54 %	55-64 %	65+ %	White, non-Hispanic %	Hispanic %	Total %
Healthcare Coverage	81.6	83.9	76.1	82.5	80.3	85.1	89.2	xx	92.0	64.7	82.8
Usual Source of Healthcare	65.4	78.0	56.2	54.0	63.6	78.2	81.3	93.9	77.7	62.9	71.9
Routine Check-up within past year (anything less than 12 months ago)	61.1	70.3	57.7	56.0	53.8	66.9	70.1	87.1	69.3	59.2	65.8
Could Not Afford Needed	11.3	17.8	14.2	20.8	15.9	17.5	14.9	4.8	11.3	22.1	14.6

Note: Healthcare Coverage is defined as: Males and females 18-64 years old

Table 7: Cancer & Preventative Health screenings by Sex, Age Group, and Race/Ethnicity

Have You or Anyone in Your Household Had...	Male %	Female %	18-24 %	25-34 %	35-44 %	45- 54 %	55-64 %	65+ %	White, non-Hispanic %	Hispanic %	Total %
Mammogram	xx	64.6	16.2	16.6	50.6	89.8	96.9	97.8	72.1	50.6	64.6
Sigmoidocscopy or Colonoscopy	68.2	67.9	xx	xx	xx	42.4	68.1	80.6	71.7	53.8	68.0
Prostate-Specific Antigen (PSA) Test	52.3	xx	xx	xx	10.4	39.2	54.4	81.1	59.4	33.4	52.3

Notes: Mammogram: Females only
Sigmoidocscopy/Colonoscopy: Males and females greater than 49 years old
PSA: Males greater than 39 years old

Table 8: Health Inequities by Sex, Age Group, and Race/Ethnicity

Have You or Anyone in Your Household	Male %	Female %	18-24 %	25-34 %	35-44 %	45- 54 %	55-64 %	65+ %	White, non-Hispanic %	Hispanic %	Total %
Food Security - Received food stamps or food benefit card, past 12 months	9.9	14.2	15.9	18.0	12.7	14.9	9.0	2.9	8.5	20.9	12.0
Food Security - Received food through the WIC Program, past 12 months	5.7	4.0	10.0	9.8	7.2	2.0	1.5	0.1	2.1	13.8	4.9
Food Security - Children, aged 5-18 yrs, received free or reduced-cost lunches at school, past 12 months	22.5	40.7	xx	26.9	31.8	25.9	xx	xx	21.5	49.0	32.6

Table 9: Current Environmental-Related Health Conditions by Sex, Age Group, and Race/Ethnicity

Self-Reported Environmental Health Conditions	Male %	Female %	18-24 %	25-34 %	35-44 %	45- 54 %	55-64 %	65+ %	White, non-Hispanic %	Hispanic %	Total %
Asthma - Adults who currently have asthma	7.2	10.3	7.6	8.3	6.1	11.2	11.2	8.4	10.1	6.1	8.8

Note: Includes only adults who currently have asthma

Valleywise Health FQHC Locations

Site Id: BPS-LAL-013860
Name: McDowell Healthcare Center
Address: 1101 N Central Ave, Phoenix, AZ 85004-1818

Form 5B Service Area Zip Codes: 85006, 85008, 85014, 85004, 85034

Overview of Address

State Name: Arizona
County Name: Maricopa
Congressional District Name: Arizona District 07
Congressional District Representative Name: Ruben Gallego
ZIP Code: 85004
Post Office Name: Phoenix
FIPS Code (State + County + Tract number) Census Tract: 04013113000
Census Tract Number: 113000
FIPS Code (State + County + Minor Civil Division) County Subdivision: 0401392601
County Subdivision Name: Phoenix

In a Dental Health HPSA: Yes
HPSA Name: Low Income-Central City Village
ID: 6041975610
Designation Type: HPSA Population
Score: 25

HPSA Name: Phoenix-South Central
ID: 604999040N
Designation Type: HPSA Geographic High Needs
Score: 25

In a Mental Health HPSA: Yes
HPSA Name: Maricopa County
ID: 704013
Designation Type: HPSA Geographic
Score: 21

In a Primary Care HPSA: Yes
HPSA Name: Low Income-Central City Village
ID: 1041499689
Designation Type: HPSA Population

Score: 21

HPSA Name: Low Income - Phoenix-South Central
ID: 10499904N9
Designation Type: HPSA Population
Score: 25

In a MUA/P: Yes
Service Area Name: Low Inc - South Central Phoenix
ID: 07338
Designation Type: Medically Underserved Population

HPSA Data as of 5/04/2020
MUA Data as of 5/04/2020

McDowell FHC	2018		2020	
	Total	%	Total	%
Question #1- How would you describe your overall health?				
Excellent	5	10%	9	17%
Very Good	16	32%	13	25%
Good	17	34%	20	38%
Fair	11	22%	8	15%
Poor	1	2%	3	6%
Question #2- Where do you go for routine healthcare?				
Physician's office	39	78%	37	63%
Health Department	3	6%	6	10%
Emergency Room	1	2%	4	7%
Urgent Care Clinic	1	2%	3	5%
Clinic in a Grocery/Drug store	0	0%	2	3%
I do not receive routine healthcare	1	2%	5	8%
Other	7	14%	2	3%
Question #3- Can you get an appointment at this doctor's office when you need it?				
Yes	38	76%	49	94%
No	9	18%	3	6%
Question #4- If you answered "No" to question 3, please choose all that apply.				

McDowell FHC	2018		2020	
	Total	%	Total	%
No Appointment available	7	14%	3	43%
Cannot afford it	0	0%	0	0%
Cannot take time off from work	0	0%	1	14%
No transportation	1	2%	2	29%
Clinic hours	0	0%	0	0%
No specialist in my community for my condition	0	0%	1	14%
Other	2	4%	0	0%
Question #5- The clinic hours meet my needs?				
Yes	39	78%	51	96%
If No I would prefer Appointments at the following times	0	0%	2	4%
Weekdays before 7am	4	8%	2	22%
Saturday Morning	4	8%	2	22%
Sunday Morning	1	2%	1	11%
Weekday After 5:30pm	5	10%	1	11%
Saturday Afternoon	4	8%	2	22%
Sunday Afternoon	1	2%	1	11%
Question #6- What type of healthcare coverage do you have?				
Medicare	12	24%	20	32%
AHCCCS	33	66%	28	44%
Commercial Health Insurance	5	10%	10	16%
Copa Care/Sliding fee discount program	0	0%	0	0%
No healthcare coverage	1	2%	0	0%
Other	9	18%	5	8%
Question #7- Please select the top 3 health challenges you face.				
Cancer	3	6%	4	4%
Diabetes	8	16%	7	8%
Overweight	7	14%	7	8%
Breathing Problems	7	14%	8	9%
High Blood Pressure/Stroke	16	32%	10	11%
Dental Care	15	30%	6	6%
Heart Disease	3	6%	1	1%
Pain	12	24%	13	14%
Depression/Mental health issues	11	22%	14	15%
Alcohol use	0	0%	1	1%
Drug use	4	8%	3	3%
None	0	0%	4	4%
Other	12	24%	15	16%
Question #8- Please choose all statements below that apply to you.				

McDowell FHC	2018		2020	
	Total	%	Total	%
Exercise 3 times per week	18	36%	18	17%
Eat at least 5 servings of fruits & vegetables	12	24%	9	8%
Eat fast food more than one per week	23	46%	17	16%
Smoke cigarettes	13	26%	16	15%
Chew tobacco	0	0%	1	1%
Use illegal drugs	5	10%	3	3%
Abuse or over use prescription drugs	0	0%	0	0%
Consume more than 4/5 alcoholic drinks	1	2%	0	0%
Use sunscreen or protective clothing	7	14%	10	9%
Receive a flu shot each year	26	52%	24	22%
Have access to a wellness program through my employer	2	4%	7	6%
None of the above apply to me	1	2%	3	3%
Question #9- Which of the following preventive procedures have you had in the past 12 months?				
Mammogram	4	8%	9	5%
Pap Smear	6	12%	8	4%
Prostate cancer screening	6	12%	3	2%
Flu shot	19	38%	26	14%
Colon/rectal exam	17	34%	10	5%
Blood Pressure	25	50%	19	10%
Blood sugar check	7	14%	17	9%
Skin cancer screening	0	0%	2	1%
Cholesterol screening	10	20%	14	8%
Vision Screening	11	22%	16	9%
Hearing Screening	6	12%	4	2%
Cardiovascular Screening	2	4%	3	2%
Bone Density test	1	2%	4	2%
Dental cleaning/x-rays	17	34%	18	10%
Physical exam	20	40%	24	13%
None of the above	4	8%	6	3%
Question #10- What is your gender?				
Female	10	20%	16	31%
Male	34	68%	30	59%
Transgender Female/Male to female	1	2%	3	6%
Transgender Male/Female to male	1	2%	1	2%
Other	0	0%	0	0%
Chose not to disclose	0	0%	1	2%
Question #11- What is your race?				
African American Black	12	24%	9	18%

McDowell FHC	2018		2020	
	Total	%	Total	%
Caucasian/White	23	46%	26	52%
Asian	0	0%	0	0%
American Indian/Alaska Native	0	0%	2	4%
Native Hawaiian/Pacific Islander	0	0%	1	2%
Hispanic	4	8%	8	16%
Other	6	12%	4	8%
Question #12- What is your current employment status?				
Employed full-time	6	12%	11	21%
Employed Part time	10	20%	9	17%
Student	1	2%	1	2%
Homemaker	1	2%	1	2%
Unemployed	16	32%	8	15%
Disabled	13	26%	16	31%
Retired	4	8%	6	12%
Question #13- What is your household income range?				
$0-$24,999	29	58%	32	64%
$25,000-$49,999	7	14%	9	18%
$50,000-$74,999	1	2%	0	0%
$75,000-$99,999	0	0%	0	0%
$100,000 or more	1	2%	1	2%
Don't Know	5	10%	8	16%
Question #14- What is the highest level of education you have completed?				
Some high school	7	14%	6	13%
High school graduate	10	20%	11	23%
Some college	20	40%	23	48%
College graduate	7	14%	8	17%

Site Id: BPS-LAL-009883
Name: South Central Family Health Center
Address: 33 W Tamarisk St, Phoenix, AZ 85041-2422

Form 5B Service Area Zip Codes: 85041, 85009, 85042, 85339, 85007

Overview of Address

State Name: Arizona
County Name: Maricopa
Congressional District Name: Arizona District 07
Congressional District Representative Name: Ruben Gallego
ZIP Code: 85041
Post Office Name: Phoenix
FIPS Code (State + County + Tract number) Census Tract: 04013115802
Census Tract Number: 115802
FIPS Code (State + County + Minor Civil Division) County Subdivision: 0401392601
County Subdivision Name: Phoenix

In a Dental Health HPSA: Yes
HPSA Name: Low Income-South Mountain Village and Guadalupe
ID: 6047717677
Designation Type: HPSA Population
Score: 25

HPSA Name: Phoenix-South Mountain
ID: 604999040K
Designation Type: HPSA Geographic High Needs
Score: 25

In a Mental Health HPSA: Yes
HPSA Name: Maricopa County
ID: 704013
Designation Type: HPSA Geographic
Score: 21

HPSA Name: South Mountain Village and Guadalupe
ID: 7048370173
Designation Type: HPSA Geographic High Needs
Score: 21

In a Primary Care HPSA: Yes
HPSA Name: Low Income-South Mountain Village and Guadalupe
ID: 1044237576
Designation Type: HPSA Population
Score: 25

HPSA Name: Phoenix-South Mountain
ID: 10499904LY
Designation Type: HPSA Geographic High Needs
Score: 25

In a MUA/P: No

HPSA Data as of 5/04/2020
MUA Data as of 5/04/2020

South Central FHC	2018		2020	
	Total	%	Total	%
Question #1- How would you describe your overall health?				
Excellent	3	6%	3	7%
Very Good	6	12%	6	14%
Good	19	38%	17	39%
Fair	18	36%	13	30%
Poor	2	4%	5	11%
Question #2- Where do you go for routine healthcare?				
Physician's office	26	52%	13	28%
Health Department	7	14%	5	11%
Emergency Room	2	4%	3	7%
Urgent Care Clinic	2	4%	6	13%
Clinic in a Grocery/Drug store	4	8%	2	4%
I do not receive routine healthcare	2	4%	6	13%
Other	2	4%	11	24%
Question #3- Can you get an appointment at this doctor's office when you need it?				
Yes	42	84%	40	95%
No	2	4%	2	5%

South Central FHC	2018		2020	
	Total	%	Total	%
Question #4- If you answered "No" to question 3, please choose all that apply.				
No Appointment available	1	2%	1	33%
Cannot afford it	0	0%	0	0%
Cannot take time off from work	0	0%	0	0%
No transportation	0	0%	1	33%
Clinic hours	0	0%	0	0%
No specialist in my community for my condition	0	0%	0	0%
Other	1	2%	1	33%
Question #5- The clinic hours meet my needs				
Yes	43	86%	39	91%
If No I would prefer Appointments at the following times	0	0%	4	9%
Weekdays before 7am	1	2%	2	15%
Saturday Morning	1	2%	3	23%
Sunday Morning	1	2%	1	8%
Weekday After 5:30pm	3	6%	2	15%
Saturday Afternoon	3	6%	3	23%
Sunday Afternoon	0	0%	2	15%
Question #6- What type of healthcare coverage do you have?				
Medicare	5	10%	9	18%
AHCCCS	30	60%	21	42%
Commercial Health Insurance	8	16%	7	14%
Copa Care/Sliding fee discount program	5	10%	9	18%
No healthcare coverage	0	0%	2	4%
Other	1	2%	2	4%
Question #7- Please select the top 3 health challenges you face.				
Cancer	1	2%	2	2%
Diabetes	11	22%	21	21%
Overweight	17	34%	8	8%
Breathing Problems	8	16%	5	5%
High Blood Pressure/Stroke	16	32%	14	14%
Dental Care	4	8%	4	4%
Heart Disease	0	0%	3	3%
Pain	10	20%	19	19%
Depression/Mental health issues	5	10%	7	7%
Alcohol use	0	0%	1	1%
Drug use	0	0%	0	0%
None	4	8%	4	4%

South Central FHC	2018		2020	
	Total	%	Total	%
Other	5	10%	11	11%
Question #8- Please choose all statements below that apply to you.				
Exercise 3 times per week	13	26%	18	23%
Eat at least 5 servings of fruits & vegetables	11	22%	15	19%
Eat fast food more than one per week	13	26%	10	13%
Smoke cigarettes	4	8%	3	4%
Chew tobacco	2	4%	0	0%
Use illegal drugs	1	2%	0	0%
Abuse or over use prescription drugs	1	2%	0	0%
Consume more than 4/5 alcoholic drinks	0	0%	0	0%
Use sunscreen or protective clothing	9	18%	8	10%
Receive a flu shot each year	19	38%	15	19%
Have access to a wellness program through my employer	7	14%	6	8%
None of the above apply to me	5	10%	5	6%
Question #9- Which of the following preventive procedures have you had in the past 12 months?				
Mammogram	15	30%	5	5%
Pap Smear	11	22%	10	9%
Prostate cancer screening	3	6%	1	1%
Flu shot	19	38%	11	10%
Colon/rectal exam	7	14%	5	5%
Blood Pressure	18	36%	16	15%
Blood sugar check	11	22%	12	11%
Skin cancer screening	0	0%	0	0%
Cholesterol screening	4	8%	10	9%
Vision Screening	9	18%	14	13%
Hearing Screening	5	10%	2	2%
Cardiovascular Screening	3	6%	3	3%
Bone Density test	0	0%	0	0%
Dental cleaning/x-rays	1	2%	6	5%
Physical exam	19	38%	11	10%
None of the above	3	6%	4	4%
Question #10- What is your gender?				
Female	25	50%	22	54%
Male	14	28%	19	46%
Transgender Female/Male to female	0	0%	0	0%
Transgender Male/Female to male	0	0%	0	0%
Other	0	0%	0	0%
Chose not to disclose	0	0%	0	0%

South Central FHC	2018		2020	
	Total	%	Total	%
Question #11- What is your race?				
African American Black	8	16%	5	14%
Caucasian/White	9	18%	11	31%
Asian	0	0%	0	0%
American Indian/Alaska Native	0	0%	0	0%
Native Hawaiian/Pacific Islander	0	0%	0	0%
Hispanic	14	28%	20	56%
Other	6	12%	0	0%
Question #12- What is your current employment status?				
Employed full-time	8	16%	12	27%
Employed Part time	3	6%	6	13%
Student	5	10%	2	4%
Homemaker	9	18%	6	13%
Unemployed	5	10%	11	24%
Disabled	9	18%	2	4%
Retired	1	2%	6	13%
Question #13- What is your household income range?				
$0-$24,999	24	48%	20	59%
$25,000-$49,999	4	8%	6	18%
$50,000-$74,999	0	0%	1	3%
$75,000-$99,999	0	0%	1	3%
$100,000 or more	1	2%	2	6%
Don't Know	6	12%	4	12%
Question #14- What is the highest level of education you have completed?				
Some high school	12	24%	6	20%
High school graduate	13	26%	9	30%
Some college	7	14%	13	43%
College graduate	5	10%	2	7%

Site Id: BPS-LAL-009886
Name: El Mirage Family Health Center
Address: 12428 W Thunderbird Rd, El Mirage, AZ 85335-3113

Form 5B Service Area Zip Codes: 85379, 85351, 85335, 85363

Overview of Address

State Name: Arizona
County Name: Maricopa
Congressional District Name: Arizona District 08
Congressional District Representative Name: (Vacancy)
ZIP Code: 85335
Post Office Name: El Mirage
FIPS Code (State + County + Tract number)
Census Tract: 04013060902
Census Tract Number: 060902
FIPS Code (State + County + Minor Civil Division) County Subdivision: 0401392601
County Subdivision Name: Phoenix

In a Dental Health HPSA: Yes
HPSA Name: Low Income-El Mirage and Youngtown
ID: 6049736571
Designation Type: HPSA Population
Score: 25

HPSA Name: El Mirage/Luke
ID: 604999040J
Designation Type: HPSA Geographic
Score: 25

In a Mental Health HPSA: Yes
HPSA Name: Maricopa County
ID: 704013
Designation Type: HPSA Geographic
Score: 21

HPSA Name: Low Income-El Mirage and Youngtown
ID: 7043791963
Designation Type: HPSA Population

Score: 21

In a Primary Care HPSA: Yes
HPSA Name: Low Income-El Mirage and Youngtown
ID: 1043742789
Designation Type: HPSA Population
Score: 25

HPSA Name: El Mirage
ID: 10499904P6
Designation Type: HPSA Geographic
Score: 25

In a MUA/P: Yes
Service Area Name: Maricopa Service Area
ID: 00128
Designation Type: Medically Underserved Area

HPSA Data as of 5/04/2020
MUA Data as of 5/04/2020

El Mirage FHC	2018		2020	
	Total	%	Total	%
Question #1- How would you describe your overall health?				
Excellent	4	8%	2	3%
Very Good	11	22%	17	23%
Good	23	46%	30	40%
Fair	11	22%	16	21%
Poor	1	2%	10	13%
Question #2- Where do you go for routine healthcare?				
Physician's office	25	50%	34	41%
Health Department	5	10%	6	7%
Emergency Room	2	4%	3	4%
Urgent Care Clinic	13	26%	14	17%
Clinic in a Grocery/Drug store	1	2%	8	10%
I do not receive routine healthcare	3	6%	12	14%
Other	0	0%	6	7%

El Mirage FHC	2018		2020	
	Total	%	Total	%
Question #3- Can you get an appointment at this doctor's office when you need it?				
Yes	45	90%	65	93%
No	3	6%	5	7%
Question #4- If you answered "No" to question 3, please choose all that apply.				
No Appointment available	3	6%	1	13%
Cannot afford it	0	0%	2	25%
Cannot take time off from work	0	0%	1	13%
No transportation	1	2%	0	0%
Clinic hours	0	0%	0	0%
No specialist in my community for my condition	0	0%	1	13%
Other	0	0%	3	38%
Question #5- The clinic hours meet my needs				
Yes	48	96%	66	92%
If No I would prefer Appointments at the following times	1	2%	6	8%
Weekdays before 7am	1	2%	3	18%
Saturday Morning	0	0%	4	24%
Sunday Morning	0	0%	1	6%
Weekday After 5:30pm	0	0%	6	35%
Saturday Afternoon	0	0%	2	12%
Sunday Afternoon	0	0%	1	6%
Question #6- What type of healthcare coverage do you have?				
Medicare	1	2%	8	11%
AHCCCS	25	50%	38	51%
Commercial Health Insurance	14	28%	8	11%
Copa Care/Sliding fee discount program	7	14%	11	15%
No healthcare coverage	0	0%	3	4%
Other	0	0%	7	9%
Question #7- Please select the top 3 health challenges you face.				
Cancer				
Diabetes	1	2%	2	2%
Overweight	8	16%	14	11%
Breathing Problems	12	24%	19	15%
High Blood Pressure/Stroke	6	12%	6	5%
Dental Care	12	24%	19	15%
Heart Disease	8	16%	7	5%
Pain	1	2%	2	2%
Depression/Mental health issues	11	22%	24	19%
Alcohol use	5	10%	10	8%

El Mirage FHC	2018		2020	
	Total	/o	Total	/o
Drug use	0	0%	0	0%
None	8	16%	13	10%
Other	4	8%	12	9%
Question #8- Please choose all statements below that apply to you.				
Exercise 3 times per week	24	48%	29	24%
Eat at least 5 servings of fruits & vegetables	14	28%	20	17%
Eat fast food more than one per week	11	22%	20	17%
Smoke cigarettes	6	12%	4	3%
Chew tobacco	0	0%	0	0%
Use illegal drugs	0	0%	0	0%
Abuse or over use prescription drugs	0	0%	0	0%
Consume more than 4/5 alcoholic drinks	0	0%	2	2%
Use sunscreen or protective clothing	16	32%	17	14%
Receive a flu shot each year	17	34%	12	10%
Have access to a wellness program through my employer	4	8%	10	8%
None of the above apply to me	3	6%	6	5%
Question #9- Which of the following preventive procedures have you had in the past 12 months?				
Mammogram	14	28%	12	8%
Pap Smear	8	16%	14	9%
Prostate cancer screening	3	6%	0	0%
Flu shot	12	24%	14	9%
Colon/rectal exam	6	12%	1	1%
Blood Pressure	18	36%	20	13%
Blood sugar check	11	22%	21	13%
Skin cancer screening	2	4%	6	4%
Cholesterol screening	3	6%	4	3%
Vision Screening	14	28%	17	11%
Hearing Screening	2	4%	3	2%
Cardiovascular Screening	1	2%	2	1%
Bone Density test	1	2%	2	1%
Dental cleaning/x-rays	12	24%	6	4%
Physical exam	15	30%	19	12%
None of the above	9	18%	17	11%
Question #10- What is your gender?				
Female	32	64%	53	78%
Male	16	32%	15	22%
Transgender Female/Male to female	0	0%	0	0%
Transgender Male/Female to male	0	0%	0	0%
Other	0	0%	0	0%

El Mirage FHC	2018		2020	
	Total	/o	Total	/o
Chose not to disclose	0	0%	0	0%
Question #11- What is your race?				
African American Black	13	26%	18	25%
Caucasian/White	6	12%	10	14%
Asian	4	8%	10	14%
American Indian/Alaska Native	11	22%	13	18%
Native Hawaiian/Pacific Islander	7	14%	13	18%
Hispanic	3	6%	5	7%
Other	3	6%	2	3%
Question #12- What is your current employment status?				
Employed full-time	14	28%	27	40%
Employed Part time	12	24%	21	31%
Student	2	4%	2	3%
Homemaker	5	10%	0	0%
Unemployed	2	4%	1	1%
Disabled	6	12%	16	24%
Retired				
Question #13- What is your household income range?				
$0-$24,999	8	16%	9	16%
$25,000-$49,999	13	26%	12	22%
$50,000-$74,999	13	26%	27	49%
$75,000-$99,999	9	18%	7	13%
$100,000 or more	13	26%	18	25%
Don't Know	6	12%	10	14%
Question #14- What is the highest level of education you have completed?				
Some high school	11	22%	13	18%
High school graduate	7	14%	13	18%
Some college	3	6%	5	7%
College graduate	3	6%	2	3%

Site Id: BPS-LAL-009884
Name: Mesa Family Health Center
Address: 59 S Hibbert, Mesa, AZ 85210-1414

Form 5B Service Area Zip Codes: 85210, 85233, 85202, 85021, 85204

Overview of Address

State Name: Arizona
County Name: Maricopa
Congressional District Name: Arizona District 09
Congressional District Representative Name: Kyrsten Sinema
ZIP Code: 85210
Post Office Name: Mesa
FIPS Code (State + County + Tract number) Census Tract: 04013421400
Census Tract Number: 421400
FIPS Code (State + County + Minor Civil Division) County Subdivision: 0401392601
County Subdivision Name: Phoenix

In a Dental Health HPSA: Yes
HPSA Name: Low Income-Mesa West
ID: 6044027591
Designation Type: HPSA Population
Score: 25

HPSA Name: Low Income - Tempe
ID: 604999040V
Designation Type: HPSA Population
Score: 25

In a Mental Health HPSA: Yes
HPSA Name: Maricopa County
ID: 704013
Designation Type: HPSA Geographic
Score: 21

HPSA Name: Mesa West
ID: 7042717891
Designation Type: HPSA Geographic High Needs

Score: 21

In a Primary Care HPSA: Yes
HPSA Name: Low Income-Mesa West
ID: 1047891575
Designation Type: HPSA Population
Score: 25

HPSA Name: Low Income - Tempe
ID: 104999040I
Designation Type: HPSA Population
Score: 25

In a MUA/P: No

HPSA Data as of 5/04/2020
MUA Data as of 5/04/2020

Mesa FHC	2018		2020	
	Total	%	Total	%
Question #1- How would you describe your overall health?				
Excellent	4	8%	12	24%
Very Good	6	12%	9	18%
Good	16	32%	20	41%
Fair	18	36%	8	16%
Poor	4	8%	0	0%
Question #2- Where do you go for routine healthcare?				
Physician's office	30	60%	34	65%
Health Department	8	16%	5	10%
Emergency Room	1	2%	0	0%
Urgent Care Clinic	4	8%	2	4%
Clinic in a Grocery/Drug store	2	4%	0	0%
I do not receive routine healthcare	1	2%	8	15%
Other	5	10%	3	6%
Question #3- Can you get an appointment at this doctor's office when you need it?				
Yes	37	74%	42	88%
No	11	22%	6	13%

Mesa FHC	2018		2020	
	Total	%	Total	%
Question #4- If you answered "No" to question 3, please choose all that apply.				
No Appointment available	8	16%	3	33%
Cannot afford it	2	4%	2	22%
Cannot take time off from work	1	2%	2	22%
No transportation	0	0%	1	11%
Clinic hours	0	0%	0	0%
No specialist in my community for my condition	1	2%	1	11%
Other	3	6%	0	0%
Question #5- The clinic hours meet my needs				
Yes	39	78%	42	89%
If No I would prefer Appointments at the following times	0	0%	5	11%
Weekdays before 7am	4	8%	3	38%
Saturday Morning	3	6%	0	0%
Sunday Morning	1	2%	0	0%
Weekday After 5:30pm	4	8%	4	50%
Saturday Afternoon	3	6%	1	13%
Sunday Afternoon	1	2%	0	0%
Question #6- What type of healthcare coverage do you have?				
Medicare	6	12%	3	6%
AHCCCS	30	60%	22	43%
Commercial Health Insurance	4	8%	11	22%
Copa Care/Sliding fee discount program	10	20%	10	20%
No healthcare coverage	1	2%	4	8%
Other	0	0%	1	2%
Question #7- Please select the top 3 health challenges you face.				
Cancer	1	2%	0	0%
Diabetes	11	22%	11	14%
Overweight	10	20%	11	14%
Breathing Problems	3	6%	4	5%
High Blood Pressure/Stroke	17	34%	14	18%
Dental Care	3	6%	2	3%
Heart Disease	1	2%	4	5%
Pain	18	36%	7	9%
Depression/Mental health issues	7	14%	4	5%
Alcohol use	0	0%	0	0%
Drug use	0	0%	0	0%
None	8	16%	5	6%

Mesa FHC	2018		2020	
	Total	%	Total	%
Other	12	24%	15	19%
Question #8- Please choose all statements below that apply to you.				
Exercise 3 times per week	22	44%	21	21%
Eat at least 5 servings of fruits & vegetables	20	40%	23	23%
Eat fast food more than one per week	15	30%	15	15%
Smoke cigarettes	6	12%	4	4%
Chew tobacco	1	2%	0	0%
Use illegal drugs	1	2%	0	0%
Abuse or over use prescription drugs	1	2%	0	0%
Consume more than 4/5 alcoholic drinks	2	4%	0	0%
Use sunscreen or protective clothing	13	26%	11	11%
Receive a flu shot each year	13	26%	17	17%
Have access to a wellness program through my employer	1	2%	5	5%
None of the above apply to me	9	18%	2	2%
Question #9- Which of the following preventive procedures have you had in the past 12 months?				
Mammogram	15	30%	10	7%
Pap Smear	8	16%	19	13%
Prostate cancer screening	1	2%	1	1%
Flu shot	15	30%	12	8%
Colon/rectal exam	3	6%	5	3%
Blood Pressure	23	46%	21	14%
Blood sugar check	19	38%	16	11%
Skin cancer screening	0	0%	2	1%
Cholesterol screening	12	24%	12	8%
Vision Screening	11	22%	11	7%
Hearing Screening	4	8%	1	1%
Cardiovascular Screening	5	10%	4	3%
Bone Density test	1	2%	1	1%
Dental cleaning/x-rays	9	18%	8	5%
Physical exam	15	30%	21	14%
None of the above	4	8%	7	5%
Question #10- What is your gender?				
Female	27	54%	36	77%
Male	18	36%	11	23%
Transgender Female/Male to female	0	0%	0	0%
Transgender Male/Female to male	0	0%	0	0%
Other	0	0%	0	0%
Chose not to disclose	0	0%	0	0%

Mesa FHC	2018		2020	
	Total	%	Total	%
Question #11- What is your race?				
African American Black	1	2%	2	5%
Caucasian/White	18	36%	18	44%
Asian	0	0%	1	2%
American Indian/Alaska Native	0	0%	0	0%
Native Hawaiian/Pacific Islander	1	2%	0	0%
Hispanic	21	42%	18	44%
Other	9	18%	2	5%
Question #12- What is your current employment status?				
Employed full-time	12	24%	15	33%
Employed Part time	7	14%	7	16%
Student	1	2%	4	9%
Homemaker	8	16%	9	20%
Unemployed	8	16%	3	7%
Disabled	4	8%	5	11%
Retired	2	4%	2	4%
Question #13- What is your household income range?				
$0-$24,999	18	36%	16	38%
$25,000-$49,999	5	10%	13	31%
$50,000-$74,999	0	0%	3	7%
$75,000-$99,999	1	2%	3	7%
$100,000 or more	0	0%	1	2%
Don't Know	14	28%	6	14%
Question #14- What is the highest level of education you have completed?				
Some high school	11	22%	5	14%
High school graduate	8	16%	11	30%
Some college	10	20%	13	35%
College graduate	4	8%	8	22%

Site Id: BPS-LAL-009887
Name: Sunnyslope Family Health Center
Address: 934 W Hatcher Rd, Phoenix, AZ 85021-3139

Form 5B Service Area Zip Codes: 85020, 85015, 85051, 85021, 85013, 85029

Overview of Address

State Name: Arizona
County Name: Maricopa
Congressional District Name: Arizona District 09
Congressional District Representative Name: Kyrsten Sinema
ZIP Code: 85021
Post Office Name: Phoenix
FIPS Code (State + County + Tract number) Census Tract: 04013104501
Census Tract Number: 104501
FIPS Code (State + County + Minor Civil Division) County Subdivision: 0401392601
County Subdivision Name: Phoenix

In a Dental Health HPSA: Yes
HPSA Name: Low Income-North Mountain Village
ID: 6041011716
Designation Type: HPSA Population
Score: 25

HPSA Name: Phoenix-Sunnyslope
ID: 604999040L
Designation Type: HPSA Geographic High Needs
Score: 25

In a Mental Health HPSA: Yes
HPSA Name: Maricopa County
ID: 704013
Designation Type: HPSA Geographic
Score: 21

HPSA Name: Low Income-North Mountain Village
ID: 7042074802
Designation Type: HPSA Population
Score: 21

In a Primary Care HPSA: Yes
HPSA Name: Low Income-North Mountain Village
ID: 1045671610
Designation Type: HPSA Population
Score: 25

HPSA Name: Phoenix Sunnyslope
ID: 104999040D
Designation Type: HPSA Geographic High Needs
Score: 25

In a MUA/P: Yes
Service Area Name: Phoenix Sunnyslope
ID: 07869
Designation Type: Medically Underserved Area

HPSA Data as of 5/04/2020
MUA Data as of 5/04/2020

Sunnyslope FHC	2018		2020	
	Total	%	Total	%
Question #1- How would you describe your overall health?				
Excellent	7	14%	6	12%
Very Good	9	18%	8	16%
Good	16	32%	16	31%
Fair	14	28%	13	25%
Poor	3	6%	8	16%
Question #2- Where do you go for routine healthcare?				
Physician's office	29	58%	27	50%
Health Department	5	10%	7	13%
Emergency Room	8	16%	1	2%
Urgent Care Clinic	4	8%	8	15%
Clinic in a Grocery/Drug store	0	0%	4	7%
I do not receive routine healthcare	3	6%	1	2%
Other	1	2%	6	11%

Sunnyslope FHC	2018		2020	
	Total	%	Total	%
Question #3- Can you get an appointment at this doctor's office when you need it?				
Yes	46	92%	40	89%
No	1	2%	5	11%
Question #4- If you answered "No" to question 3, please choose all that apply.				
No Appointment available	2	4%	3	43%
Cannot afford it	1	2%	0	0%
Cannot take time off from work	0	0%	3	43%
No transportation	0	0%	0	0%
Clinic hours	0	0%	0	0%
No specialist in my community for my condition	1	2%	0	0%
Other	2	4%	1	14%
Question #5- The clinic hours meet my needs				
Yes	43	86%	41	89%
If No I would prefer Appointments at the following times	0	0%	5	11%
Weekdays before 7am	6	12%	4	20%
Saturday Morning	1	2%	5	25%
Sunday Morning	0	0%	3	15%
Weekday After 5:30pm	2	4%	5	25%
Saturday Afternoon	1	2%	2	10%
Sunday Afternoon	0	0%	1	5%
Question #6- What type of healthcare coverage do you have?				
Medicare	3	6%	4	7%
AHCCCS	26	52%	22	41%
Commercial Health Insurance	6	12%	9	17%
Copa Care/Sliding fee discount program	13	26%	13	24%
No healthcare coverage	4	8%	3	6%
Other	1	2%	3	6%
Question #7- Please select the top 3 health challenges you face.				
Cancer	2	4%	2	2%
Diabetes	13	26%	17	19%
Overweight	14	28%	14	16%
Breathing Problems	11	22%	4	5%
High Blood Pressure/Stroke	17	34%	13	15%
Dental Care	8	16%	5	6%
Heart Disease	6	12%	5	6%
Pain	8	16%	10	11%
Depression/Mental health issues	46	92%	40	89%

Sunnyslope FHC	2018		2020	
	Total	%	Total	%
Alcohol use	2	4%	1	1%
Drug use	0	0%	0	0%
None	3	6%	8	9%
Other	8	16%	2	2%
Question #8- Please choose all statements below that apply to you.				
Exercise 3 times per week	18	36%	16	20%
Eat at least 5 servings of fruits & vegetables	14	28%	12	15%
Eat fast food more than one per week	12	24%	10	12%
Smoke cigarettes	11	22%	9	11%
Chew tobacco	0	0%	1	1%
Use illegal drugs	0	0%	0	0%
Abuse or over use prescription drugs	0	0%	0	0%
Consume more than 4/5 alcoholic drinks	0	0%	0	0%
Use sunscreen or protective clothing	14	28%	9	11%
Receive a flu shot each year	18	36%	13	16%
Have access to a wellness program through my employer	5	10%	6	7%
None of the above apply to me	3	6%	6	7%
Question #9- Which of the following preventive procedures have you had in the past 12 months?				
Mammogram	13	26%	16	11%
Pap Smear	16	32%	11	7%
Prostate cancer screening	1	2%	2	1%
Flu shot	20	40%	11	7%
Colon/rectal exam	3	6%	9	6%
Blood Pressure	26	52%	15	10%
Blood sugar check	20	40%	19	13%
Skin cancer screening	1	2%	6	4%
Cholesterol screening	17	34%	12	8%
Vision Screening	15	30%	15	10%
Hearing Screening	3	6%	6	4%
Cardiovascular Screening	5	10%	6	4%
Bone Density test	0	0%	1	1%
Dental cleaning/x-rays	7	14%	1	1%
Physical exam	11	22%	14	10%
None of the above	6	12%	3	2%
Question #10- What is your gender?				
Female	31	62%	29	66%
Male	12	24%	15	34%
Transgender Female/Male to female	0	0%	0	0%

Sunnyslope FHC	2018		2020	
	Total	%	Total	%
Transgender Male/Female to male	1	2%	0	0%
Other	0	0%	0	0%
Chose not to disclose	0	0%	0	0%
Question #11- What is your race?				
African American Black	3	6%	5	13%
Caucasian/White	16	32%	22	58%
Asian	1	2%	0	0%
American Indian/Alaska Native	1	2%	0	0%
Native Hawaiian/Pacific Islander	0	0%	0	0%
Hispanic	17	34%	11	29%
Other	3	6%	0	0%
Question #12- What is your current employment status?				
Employed full-time	13	26%	17	37%
Employed Part time	6	12%	2	4%
Student	1	2%	1	2%
Homemaker	12	24%	10	22%
Unemployed	1	2%	8	17%
Disabled	4	8%	5	11%
Retired	3	6%	3	7%
Question #13- What is your household income range?				
$0-$24,999	23	46%	21	49%
$25,000-$49,999	4	8%	13	30%
$50,000-$74,999	3	6%	1	2%
$75,000-$99,999	0	0%	0	0%
$100,000 or more	0	0%	0	0%
Don't Know	6	12%	8	19%
Question #14- What is the highest level of education you have completed?				
Some high school	10	20%	10	31%
High school graduate	11	22%	11	34%
Some college	9	18%	8	25%
College graduate	4	8%	3	9%

Site Id: BPS-LAL-009881
Name: Avondale Family Health Center
Address: 950 E Van Buren St, Avondale, AZ 85323-1506

Form 5B Service Area Zip Codes: 85395, 85392, 85323, 85353, 85340

Overview of Address

State Name: Arizona
County Name: Maricopa
Congressional District Name: Arizona District 03
Congressional District Representative Name: Raúl M. Grijalva
ZIP Code: 85323
Post Office Name: Avondale
FIPS Code (State + County + Tract number) Census Tract: 04013061200
Census Tract Number: 061200
FIPS Code (State + County + Minor Civil Division) County Subdivision: 0401392601
County Subdivision Name: Phoenix

In a Dental Health HPSA: Yes
HPSA Name: Low Income-Avondale
ID: 6048225739
Designation Type: HPSA Population
Score: 25

HPSA Name: Avondale/Tolleson Service Area
ID: 604999040Y
Designation Type: HPSA Geographic
Score: 25

In a Mental Health HPSA: Yes
HPSA Name: Maricopa County
ID: 704013
Designation Type: HPSA Geographic
Score: 21

In a Primary Care HPSA: Yes
HPSA Name: Low Income-Avondale
ID: 1044018123
Designation Type: HPSA Population
Score: 25

HPSA Name: Avondale/Tolleson
ID: 104999040C
Designation Type: HPSA Geographic
Score: 25

In a MUA/P: Yes
Service Area Name: Low Inc- Avondale/ Tolleson Service Area
ID: 07219
Designation Type: Medically Underserved Population

HPSA Data as of 5/04/2020
MUA Data as of 5/04/2020

Avondale FHC	2018		2020	
	Total	%	Total	%
Question #1- How would you describe your overall health?				
Excellent	4	8%	1	2%
Very Good	11	22%	8	16%
Good	17	34%	20	39%
Fair	13	26%	18	35%
Poor	2	4%	4	8%
Question #2- Where do you go for routine healthcare?				
Physician's office	30	60%	27	51%
Health Department	8	16%	6	11%
Emergency Room	3	6%	1	2%
Urgent Care Clinic	1	2%	10	19%
Clinic in a Grocery/Drug store	1	2%	1	2%
I do not receive routine healthcare	4	8%	2	4%
Other	2	4%	6	11%
Question #3- Can you get an appointment at this doctor's office when you need it?				
Yes	42	84%	43	90%
No	1	2%	5	10%
Questions #4- If you answered "No" to question 3, please choose all that apply.				

Avondale FHC	2018		2020	
	Total	%	Total	%
No Appointment available	0	0%	1	13%
Cannot afford it	0	0%	1	13%
Cannot take time off from work	2	4%	1	13%
No transportation	0	0%	1	13%
Clinic hours	0	0%	0	0%
No specialist in my community for my condition	0	0%	2	25%
Other	1	2%	2	25%
Question #5- The clinic hours meet my needs				
Yes	45	90%	45	96%
If No I would prefer Appointments at the following times	0	0%	2	4%
Weekdays before 7am	1	2%	2	18%
Saturday Morning	1	2%	2	18%
Sunday Morning	2	4%	2	18%
Weekday After 5:30pm	2	4%	2	18%
Saturday Afternoon	3	6%	2	18%
Sunday Afternoon	1	2%	1	9%
Question #6- What type of healthcare coverage do you have?				
Medicare	2	4%	8	13%
AHCCCS	33	66%	26	43%
Commercial Health Insurance	4	8%	11	18%
Copa Care/Sliding fee discount program	10	20%	12	20%
No healthcare coverage	2	4%	1	2%
Other	0	0%	3	5%
Question #7- Please select the top 3 health challenges you face.				
Cancer	0	0%	0	0%
Diabetes	11	22%	10	10%
Overweight	10	20%	14	14%
Breathing Problems	1	2%	6	6%
High Blood Pressure/Stroke	15	30%	13	13%
Dental Care	7	14%	4	4%
Heart Disease	2	4%	4	4%
Pain	5	10%	12	12%
Depression/Mental health issues	6	12%	13	13%
Alcohol use	0	0%	2	2%
Drug use	0	0%	1	1%
None	6	12%	5	5%
Other	5	10%	19	18%

Avondale FHC	2018		2020	
	Total	/o	Total	/o
Question #8- Please choose all statements below that apply to you.				
Exercise 3 times per week	21	42%	15	14%
Eat at least 5 servings of fruits & vegetables	15	30%	18	17%
Eat fast food more than one per week	9	18%	20	19%
Smoke cigarettes	6	12%	7	7%
Chew tobacco	0	0%	2	2%
Use illegal drugs	0	0%	2	2%
Abuse or over use prescription drugs	0	0%	0	0%
Consume more than 4/5 alcoholic drinks	1	2%	1	1%
Use sunscreen or protective clothing	13	26%	8	8%
Receive a flu shot each year	19	38%	20	19%
Have access to a wellness program through my employer	4	8%	7	7%
None of the above apply to me	2	4%	4	4%
Question #9- Which of the following preventive procedures have you had in the past 12 months?				
Mammogram	11	22%	8	7%
Pap Smear	12	24%	7	6%
Prostate cancer screening	1	2%	3	2%
Flu shot	20	40%	13	11%
Colon/rectal exam	5	10%	5	4%
Blood Pressure	16	32%	14	12%
Blood sugar check	9	18%	13	11%
Skin cancer screening	5	10%	3	2%
Cholesterol screening	11	22%	7	6%
Vision Screening	15	30%	12	10%
Hearing Screening	5	10%	4	3%
Cardiovascular Screening	1	2%	3	2%
Bone Density test	0	0%	1	1%
Dental cleaning/x-rays	8	16%	7	6%
Physical exam	8	16%	17	14%
None of the above	2	4%	4	3%
Question #10- What is your gender?				
Female	33	66%	32	73%
Male	8	16%	12	27%
Transgender Female/Male to female	1	2%	0	0%
Transgender Male/Female to male	2	4%	0	0%
Other	1	2%	0	0%
Chose not to disclose	0	0%	0	0%
Question #11- What is your race?				

Avondale FHC	2018		2020	
	Total	%	Total	%
African American Black	1	2%	5	13%
Caucasian/White	12	24%	11	29%
Asian	0	0%	1	3%
American Indian/Alaska Native	0	0%	0	0%
Native Hawaiian/Pacific Islander	0	0%	0	0%
Hispanic	24	48%	20	53%
Other	3	6%	1	3%
Question #12- What is your current employment status?				
Employed full-time	13	26%	9	20%
Employed Part time	4	8%	3	7%
Student	0	0%	6	14%
Homemaker	11	22%	5	11%
Unemployed	4	8%	9	20%
Disabled	5	10%	9	20%
Retired	2	4%	3	7%
Question #13- What is your household income range?				
$0-$24,999	12	24%	19	51%
$25,000-$49,999	6	12%	6	16%
$50,000-$74,999	3	6%	2	5%
$75,000-$99,999	1	2%	2	5%
$100,000 or more	2	4%	0	0%
Don't Know	7	14%	8	22%
Question #14- What is the highest level of education you have completed?				
Some high school	10	20%	11	35%
High school graduate	11	22%	9	29%
Some college	6	12%	7	23%
College graduate	3	6%	4	13%

Site Id: BPS-LAL-009893
Name: Guadalupe Family Health Center
Address: 5825 E Calle Guadalupe, Guadalupe, AZ 85283-2664

Form 5B Service Area Zip Codes: 85202, 85224, 85283, 85282, 85284

Overview of Address

State Name: Arizona
County Name: Maricopa
Congressional District Name: Arizona District 07
Congressional District Representative Name: Ruben Gallego
ZIP Code: 85283
Post Office Name: Tempe
FIPS Code (State + County + Tract number) Census Tract: 04013320002
Census Tract Number: 320002
FIPS Code (State + County + Minor Civil Division) County Subdivision: 0401392601
County Subdivision Name: Phoenix

In a Dental Health HPSA: Yes
HPSA Name: Low Income-South Mountain Village and Guadalupe
ID: 6047717677
Designation Type: HPSA Population
Score: 25

HPSA Name: Guadalupe
ID: 6049990405
Designation Type: HPSA Geographic High Needs
Score: 25

In a Mental Health HPSA: Yes
HPSA Name: Maricopa County
ID: 704013
Designation Type: HPSA Geographic
Score: 21

HPSA Name: South Mountain Village and Guadalupe
ID: 7048370173
Designation Type: HPSA Geographic High Needs

Score: 21

In a Primary Care HPSA: Yes
HPSA Name: Low Income-South Mountain Village and Guadalupe
ID: 1044237576
Designation Type: HPSA Population
Score: 25

HPSA Name: Guadalupe
ID: 1049990467
Designation Type: HPSA Geographic High Needs
Score: 25

In a MUA/P: Yes
Service Area Name: Guadalupe Service Area
ID: 00117
Designation Type: Medically Underserved Area

HPSA Data as of 5/04/2020
MUA Data as of 5/04/2020

Guadalupe FHC	2018		2020	
	Total	%	Total	%
Question #1- How would you describe your overall health?				
Excellent	6	12%	6	13%
Very Good	5	10%	13	28%
Good	19	38%	16	35%
Fair	17	34%	10	22%
Poor	3	6%	1	2%
Question #2- Where do you go for routine healthcare?				
Physician's office	33	66%	31	63%
Health Department	5	10%	5	10%
Emergency Room	1	2%	0	0%
Urgent Care Clinic	4	8%	4	8%
Clinic in a Grocery/Drug store	1	2%	1	2%
I do not receive routine healthcare	8	16%	6	12%
Other	1	2%	2	4%

Guadalupe FHC	2018		2020	
	Total	%	Total	%
Question #3- Can you get an appointment at this doctor's office when you need it?				
Yes	45	90%	48	100%
No	5	10%	0	0%
Question #4- If you answered "No" to question 3, please choose all that apply.				
No Appointment available	4	8%	0	0%
Cannot afford it	0	0%	0	0%
Cannot take time off from work	0	0%	0	0%
No transportation	0	0%	0	0%
Clinic hours	0	0%	0	0%
No specialist in my community for my condition	1	2%	0	0%
Other	5	10%	0	0%
Question #5- The clinic hours meet my needs				
Yes	42	84%	47	100%
If No I would prefer Appointments at the following times	0	0%	0	0%
Weekdays before 7am	5	10%	0	0%
Saturday Morning	0	0%	0	0%
Sunday Morning	1	2%	0	0%
Weekday After 5:30pm	3	6%	0	0%
Saturday Afternoon	2	4%	0	0%
Sunday Afternoon	1	2%	0	0%
Question #6- What type of healthcare coverage do you have?				
Medicare	8	16%	5	9%
AHCCCS	37	74%	22	40%
Commercial Health Insurance	7	14%	15	27%
Copa Care/Sliding fee discount program	1	2%	8	15%
No healthcare coverage	1	2%	2	4%
Other	2	4%	3	5%
Question #7- Please select the top 3 health challenges you face.				
Cancer	2	4%	1	1%
Diabetes	10	20%	12	14%
Overweight	8	16%	10	12%
Breathing Problems	5	10%	3	4%
High Blood Pressure/Stroke	15	30%	13	16%
Dental Care	5	10%	3	4%
Heart Disease	1	2%	5	6%
Pain	14	28%	9	11%
Depression/Mental health issues	3	6%	8	10%

Guadalupe FHC	2018		2020	
	Total	%	Total	%
Alcohol use	2	4%	1	1%
Drug use	1	2%	0	0%
None	12	24%	8	10%
Other	5	10%	10	12%
Question #8- Please choose all statements below that apply to you.				
Exercise 3 times per week	19	38%	25	26%
Eat at least 5 servings of fruits & vegetables	14	28%	20	21%
Eat fast food more than one per week	14	28%	10	10%
Smoke cigarettes	8	16%	5	5%
Chew tobacco	1	2%	0	0%
Use illegal drugs	2	4%	0	0%
Abuse or over use prescription drugs	1	2%	0	0%
Consume more than 4/5 alcoholic drinks	0	0%	0	0%
Use sunscreen or protective clothing	9	18%	15	16%
Receive a flu shot each year	23	46%	14	15%
Have access to a wellness program through my employer	6	12%	4	4%
None of the above apply to me	7	14%	3	3%
Question #9- Which of the following preventive procedures have you had in the past 12 months?				
Mammogram	8	16%	13	8%
Pap Smear	12	24%	15	10%
Prostate cancer screening	0	0%	1	1%
Flu shot	19	38%	14	9%
Colon/rectal exam	1	2%	11	7%
Blood Pressure	19	38%	20	13%
Blood sugar check	18	36%	10	7%
Skin cancer screening	0	0%	3	2%
Cholesterol screening	7	14%	8	5%
Vision Screening	12	24%	15	10%
Hearing Screening	3	6%	3	2%
Cardiovascular Screening	1	2%	5	3%
Bone Density test	4	8%	2	1%
Dental cleaning/x-rays	8	16%	10	7%
Physical exam	11	22%	18	12%
None of the above	8	16%	5	3%
Question #10- What is your gender?				
Female	31	62%	38	81%
Male	14	28%	9	19%
Transgender Female/Male to female	1	2%	0	0%
Transgender Male/Female to male	0	0%	0	0%

Guadalupe FHC	2018		2020	
	Total	%	Total	%
Other	2	4%	0	0%
Chose not to disclose	0	0%	0	0%
Question #11- What is your race?				
African American Black	5	10%	4	9%
Caucasian/White	15	30%	14	30%
Asian	2	4%	1	2%
American Indian/Alaska Native	8	16%	5	11%
Native Hawaiian/Pacific Islander	2	4%	2	4%
Hispanic	13	26%	18	39%
Other	2	4%	2	4%
Question #12- What is your current employment status?				
Employed full-time	14	28%	15	31%
Employed Part time	8	16%	10	20%
Student	2	4%	4	8%
Homemaker	5	10%	5	10%
Unemployed	6	12%	10	20%
Disabled	5	10%	1	2%
Retired	6	12%	4	8%
Question #13- What is your household income range?				
$0-$24,999	22	44%	20	48%
$25,000-$49,999	7	14%	8	19%
$50,000-$74,999	1	2%	1	2%
$75,000-$99,999	2	4%	2	5%
$100,000 or more	0	0%	2	5%
Don't Know	12	24%	9	21%
Question #14- What is the highest level of education you have completed?				
Some high school	15	30%	5	13%
High school graduate	9	18%	12	31%
Some college	9	18%	11	28%
College graduate	10	20%	11	28%

Site Id: BPS-LAL-009890
Name: Glendale Family Health Center
Address: 5141 W Lamar Rd, Glendale, AZ 85301-3423

Form 5B Service Area Zip Codes: 85301, 85051, 85303, 85019, 85302

Overview of Address

State Name: Arizona
County Name: Maricopa
Congressional District Name: Arizona District 07
Congressional District Representative Name: Ruben Gallego
ZIP Code: 85301
Post Office Name: Glendale
FIPS Code (State + County + Tract number) Census Tract: 04013092900
Census Tract Number: 092900
FIPS Code (State + County + Minor Civil Division) County Subdivision: 0401392601
County Subdivision Name: Phoenix

In a Dental Health HPSA: Yes
HPSA Name: Low Income-Glendale Central
ID: 6045048716
Designation Type: HPSA Population
Score: 25

HPSA Name: Glendale
ID: 6049990411
Designation Type: HPSA Geographic High Needs
Score: 25

In a Mental Health HPSA: Yes
HPSA Name: Maricopa County
ID: 704013
Designation Type: HPSA Geographic
Score: 21

HPSA Name: Glendale Central
ID: 7049538552
Designation Type: HPSA Geographic High Needs
Score: 21

In a Primary Care HPSA: Yes
HPSA Name: Glendale Central
ID: 1045510941
Designation Type: HPSA Geographic High Needs
Score: 25

HPSA Name: Glendale
ID: 1049990498
Designation Type: HPSA Geographic High Needs
Score: 25

In a MUA/P: Yes
Service Area Name: Glendale Service Area
ID: 07215
Designation Type: Medically Underserved Area

HPSA Data as of 5/04/2020
MUA Data as of 5/04/2020

Glendale FHC	2018		2020	
	Total	%	Total	%
Question #1- How would you describe your overall health?				
Excellent	2	4%	17	33%
Very Good	6	12%	12	24%
Good	20	40%	14	27%
Fair	17	34%	7	14%
Poor	4	8%	1	2%
Question #2- Where do you go for routine healthcare?				
Physician's office	28	56%	20	42%
Health Department	5	10%	13	27%
Emergency Room	5	10%	1	2%
Urgent Care Clinic	4	8%	3	6%
Clinic in a Grocery/Drug store	3	6%	0	0%
I do not receive routine healthcare	6	12%	6	13%
Other	1	2%	5	10%
Question #3- Can you get an appointment at this doctor's office when you need it?				
Yes	44	88%	47	92%

Glendale FHC	2018		2020	
	Total	%	Total	%
No	5	10%	4	8%
Question #4- If you answered "No" to question 3, please choose all that apply.				
No Appointment available	4	8%	0	0%
Cannot afford it	1	2%	2	40%
Cannot take time off from work	0	0%	1	20%
No transportation	2	4%	1	20%
Clinic hours	0	0%	0	0%
No specialist in my community for my condition	0	0%	0	0%
Other	1	2%	1	20%
Question #5- The clinic hours meet my needs				
Yes	48	96%	45	92%
If No I would prefer Appointments at the following times	1	2%	4	8%
Weekdays before 7am	3	6%	1	11%
Saturday Morning	0	0%	2	22%
Sunday Morning	0	0%	1	11%
Weekday After 5:30pm	1	2%	1	11%
Saturday Afternoon	0	0%	3	33%
Sunday Afternoon	0	0%	1	11%
Question #6- What type of healthcare coverage do you have?				
Medicare	7	14%	1	2%
AHCCCS	31	62%	28	53%
Commercial Health Insurance	1	2%	8	15%
Copa Care/Sliding fee discount program	15	30%	8	15%
No healthcare coverage	0	0%	2	4%
Other	1	2%	6	11%
Question #7- Please select the top 3 health challenges you face.				
Cancer	0	0%	0	0%
Diabetes	13	26%	13	21%
Overweight	6	12%	7	11%
Breathing Problems	4	8%	1	2%
High Blood Pressure/Stroke	16	32%	6	10%
Dental Care	3	6%	2	3%
Hear Disease	4	8%	2	3%
Pain	10	20%	5	8%
Depression/Mental health issues	6	12%	1	2%
Alcohol use	0	0%	0	0%
Drug use	0	0%	0	0%

Glendale FHC	2018		2020	
	Total	%	Total	%
None	13	26%	15	25%
Other	4	8%	9	15%
Question #8- Please choose all statements below that apply to you.				
Exercise 3 times per week	21	42%	16	20%
Eat at least 5 servings of fruits & vegetables	17	34%	22	27%
Eat fast food more than one per week	20	40%	18	22%
Smoke cigarettes	9	18%	0	0%
Chew tobacco	0	0%	0	0%
Use illegal drugs	0	0%	0	0%
Abuse or over use prescription drugs	0	0%	0	0%
Consume more than 4/5 alcoholic drinks	0	0%	0	0%
Use sunscreen or protective clothing	12	24%	3	4%
Receive a flu shot each year	18	36%	14	17%
Have access to a wellness program through my employer	0	0%	0	0%
None of the above apply to me	4	8%	9	11%
Question #9- Which of the following preventive procedures have you had in the past 12 months?				
Mammogram	11	22%	3	2%
Pap Smear	4	8%	21	16%
Prostate cancer screening	4	8%	0	0%
Flu shot	18	36%	18	14%
Colon/rectal exam	4	8%	3	2%
Blood Pressure	24	48%	15	12%
Blood sugar check	16	32%	19	15%
Skin cancer screening	3	6%	3	2%
Cholesterol screening	16	32%	5	4%
Vision Screening	10	20%	7	5%
Hearing Screening	3	6%	1	1%
Cardiovascular Screening	4	8%	2	2%
Bone Density test	1	2%	0	0%
Dental cleaning/x-rays	7	14%	9	7%
Physical exam	14	28%	12	9%
None of the above	11	22%	10	8%
Question #10- What is your gender?				
Female	33	66%	48	98%
Male	15	30%	1	2%
Transgender Female/Male to female	1	2%	0	0%
Transgender Male/Female to male	0	0%	0	0%
Other	0	0%	0	0%

Glendale FHC	2018		2020	
	Total	/o	Total	/o
Chose not to disclose	0	0%	0	0%
Question #11- What is your race?				
African American Black	2	4%	4	9%
Caucasian/White	16	32%	5	12%
Asian	1	2%	4	9%
American Indian/Alaska Native	0	0%	0	0%
Native Hawaiian/Pacific Islander	1	2%	0	0%
Hispanic	19	38%	28	65%
Other	9	18%	2	5%
Question #12- What is your current employment status?				
Employed full-time	9	18%	8	16%
Employed Part time	6	12%	8	16%
Student	3	6%	2	4%
Homemaker	11	22%	13	27%
Unemployed	9	18%	18	37%
Disabled	9	18%	0	0%
Retired	1	2%	0	0%
Question #13- What is your household income range?				
$0-$24,999	7	14%	16	37%
$25,000-$49,999	0	0%	8	19%
$50,000-$74,999	0	0%	0	0%
$75,000-$99,999	0	0%	1	2%
$100,000 or more	19	38%	0	0%
Don't Know	0	0%	18	42%
Question #14- What is the highest level of education you have completed?				
Some high school	19	38%	16	39%
High school graduate	11	22%	16	39%
Some college	6	12%	7	17%
College graduate	3	6%	2	5%

Site Id: BPS-LAL-009889
Name: Seventh Avenue Family Health Center
Address: 1205 S 7th Ave, Phoenix, AZ 85007-3913

Form 5B Service Area Zip Codes: 85034, 85003, 85007, 85004, 85009

Overview of Address

State Name: Arizona
County Name: Maricopa
Congressional District Name: Arizona District 07
Congressional District Representative Name: Ruben Gallego
ZIP Code: 85003
Post Office Name: Phoenix
FIPS Code (State + County + Tract number)
Census Tract: 04013114900
Census Tract Number: 114900
FIPS Code (State + County + Minor Civil Division) County Subdivision: 0401392601
County Subdivision Name: Phoenix

Dental Health HPSA: Yes
HPSA Name: Low Income-Central City Village
ID: 6041975610
Designation Type: HPSA Population
Status: Designated
Score: 25

In a Mental Health HPSA: Yes
HPSA Name: Maricopa County
ID: 704013
Designation Type: HPSA Geographic
Score: 21

In a Primary Care HPSA: Yes
HPSA Name: Low Income-Central City Village
ID: 1041499689
Designation Type: HPSA Population
Status: Designated
Score: 25

HPSA Name: Low Income - Phoenix-South Central
ID: 10499904N9
Designation Type: HPSA Population
Score: 25

In a MUA/P: Yes
Service Area Name: Rio Salado Service Area
ID: 07350
Designation Type: Medically Underserved Area

HPSA Data as of 5/04/2020
MUA Data as of 5/04/2020

7th Ave FHC	2018		2020	
	Total	/o	Total	/o
Question #1- How would you describe your overall health?				
Excellent	7	14%	5	11%
Very Good	7	14%	10	11%
Good	12	24%	15	11%
Fair	8	16%	15	11%
Poor	3	6%	2	11%
Question #2- Where do you go for routine healthcare?				
Physician's office	26	52%	32	65%
Health Department	3	6%	5	10%
Emergency Room	4	8%	0	0%
Urgent Care Clinic	3	6%	3	6%
Clinic in a Grocery/Drug store	0	0%	0	0%
I do not receive routine healthcare	1	2%	6	12%
Other	0	0%	3	6%
Question #3- Can you get an appointment at this doctor's office when you need it?				
Yes	27	54%	46	98%
No	8	16%	1	2%
Question #4- If you answered "No" to question 3, please choose all that apply.				
No Appointment available	2	4%	0	0%
Cannot afford it	3	6%	0	0%

7th Ave FHC	2018		2020	
	Total	/o	Total	/o
Cannot take time off from work	0	0%	0	0%
No transportation	0	0%	0	0%
Clinic hours	2	4%	0	0%
No specialist in my community for my condition	0	0%	0	0%
Other	0	0%	3	100%
Question #5- The clinic hours meet my needs				
Yes	39	78%	41	53%
If No I would prefer Appointments at the following times	0	0%	7	9%
Weekdays before 7am	4	8%	1	4%
Saturday Morning	4	8%	7	26%
Sunday Morning	1	2%	3	11%
Weekday After 5:30pm	4	8%	6	22%
Saturday Afternoon	2	4%	7	26%
Sunday Afternoon	1	2%	3	11%
Question #6- What type of healthcare coverage do you have?				
Medicare	2	4%	6	12%
AHCCCS	23	46%	24	48%
Commercial Health Insurance	7	14%	9	18%
Copa Care/Sliding fee discount program	1	2%	5	10%
No healthcare coverage	0	0%	1	2%
Other	0	0%	5	10%
Question #7- Please select the top 3 health challenges you face.				
Cancer	0	0%	3	4%
Diabetes	7	14%	11	13%
Overweight	10	20%	9	11%
Breathing Problems	4	8%	3	4%
High Blood Pressure/Stroke	7	14%	10	12%
Dental Care	5	10%	6	7%
Heart Disease	6	12%	1	1%
Pain	10	20%	14	16%
Depression/Mental health issues	7	14%	8	9%
Alcohol use	0	0%	1	1%
Drug use	0	0%	2	2%
None	2	4%	8	9%
Other	1	2%	9	11%
Question #8- Please choose all statements below that apply to you.				
Exercise 3 times per week	17	34%	11	15%
Eat at least 5 servings of fruits & vegetables	10	20%	4	5%

7th Ave FHC	2018		2020	
	Total	%	Total	%
Eat fast food more than one per week	5	10%	16	21%
Smoke cigarettes	5	10%	5	7%
Chew tobacco	1	2%	0	0%
Use illegal drugs	0	0%	0	0%
Abuse or over use prescription drugs	0	0%	0	0%
Consume more than 4/5 alcoholic drinks	0	0%	1	1%
Use sunscreen or protective clothing	8	16%	6	8%
Receive a flu shot each year	16	32%	17	23%
Have access to a wellness program through my employer	2	4%	7	9%
None of the above apply to me	1	2%	8	11%
Question #9- Which of the following preventive procedures have you had in the past 12 months?				
Mammogram	6	12%	5	5%
Pap Smear	7	14%	11	10%
Prostate cancer screening	0	0%	3	3%
Flu shot	14	28%	16	15%
Colon/rectal exam	1	2%	3	3%
Blood Pressure	10	20%	15	14%
Blood sugar check	8	16%	10	9%
Skin cancer screening	0	0%	4	4%
Cholesterol screening	6	12%	8	7%
Vision Screening	7	14%	9	8%
Hearing Screening	2	4%	2	2%
Cardiovascular Screening	2	4%	1	1%
Bone Density test	0	0%	0	0%
Dental cleaning/x-rays	1	2%	6	6%
Physical exam	12	24%	8	7%
None of the above	3	6%	7	6%
Question #10- What is your gender?				
Female	22	44%	30	65%
Male	12	24%	16	35%
Transgender Female/Male to female	0	0%	0	0%
Transgender Male/Female to male	0	0%	0	0%
Other	0	0%	0	0%
Chose not to disclose	0	0%	0	0%
Question #11- What is your race?				
African American Black	3	6%	10	22%
Caucasian/White	8	16%	9	20%
Asian	0	0%	0	0%

7th Ave FHC	2018		2020	
	Total	/o	Total	/o
American Indian/Alaska Native	0	0%	1	2%
Native Hawaiian/Pacific Islander	0	0%	1	2%
Hispanic	16	32%	24	52%
Other	0	0%	1	2%
Question #12- What is your current employment status?				
Employed full-time	12	24%	20	41%
Employed Part time	4	8%	2	4%
Student	2	4%	2	4%
Homemaker	5	10%	4	8%
Unemployed	6	12%	10	20%
Disabled	1	2%	9	18%
Retired	4	8%	2	4%
Question #13- What is your household income range?				
$0-$24,999	10	20%	23	52%
$25,000-$49,999	12	24%	7	16%
$50,000-$74,999	1	2%	5	11%
$75,000-$99,999	0	0%	1	2%
$100,000 or more	0	0%	1	2%
Don't Know	7	14%	7	16%
Question #14- What is the highest level of education you have completed?				
Some high school	7	14%	14	37%
High school graduate	8	16%	8	21%
Some college	9	18%	8	21%
College graduate	4	8%	8	21%

Site Id: BPS-LAL-009892
Name: Maryvale Family Health Center
Address: 4011 N 51st Ave, Phoenix, AZ 85031-2601

Form 5B Service Area Zip Codes: 85301, 85019, 85031, 85035, 85033

Overview of Address

State Name: Arizona
County Name: Maricopa
Congressional District Name: Arizona District 07
Congressional District Representative Name: Ruben Gallego
ZIP Code: 85031
Post Office Name: Phoenix
FIPS Code (State + County + Tract number) Census Tract: 04013109900
Census Tract Number: 109900
FIPS Code (State + County + Minor Civil Division) County Subdivision: 0401392601
County Subdivision Name: Phoenix

In a Dental Health HPSA: Yes
HPSA Name: Low Income-Maryvale Village
ID: 6045252259
Designation Type: HPSA Population
Score: 25

HPSA Name: Low Income - Phoenix-Central
ID: 60499904E7
Designation Type: HPSA Population
Score: 25

In a Mental Health HPSA: Yes
HPSA Name: Maricopa County
ID: 704013
Designation Type: HPSA Geographic
Score: 21

HPSA Name: Maryvale Village
ID: 7048959393
Designation Type: HPSA Geographic High Needs

Score: 21

In a Primary Care HPSA: Yes
HPSA Name: Low Income-Maryvale Village
ID: 1043099123
Designation Type: HPSA Population
Score: 25

HPSA Name: Low Income - Phoenix Central
ID: 10499904N8
Designation Type: HPSA Population
Score: 25

In a MUA/P: Yes
Service Area Name: West Phoenix
ID: 06218
Designation Type: Medically Underserved Area

HPSA Data as of 5/04/2020
MUA Data as of 5/04/2020

Maryvale FHC	2018		2020	
	Total	%	Total	%
Question #1- How would you describe your overall health?				
Excellent	11	22%	19	35%
Very Good	18	36%	14	26%
Good	15	30%	15	28%
Fair	5	10%	6	11%
Poor	1	2%	0	0%
Question #2- Where do you go for routine healthcare?				
Physician's office	27	54%	28	52%
Health Department	7	14%	7	13%
Emergency Room	6	12%	1	2%
Urgent Care Clinic	3	6%	3	6%
Clinic in a Grocery/Drug store	0	0%	0	0%
I do not receive routine healthcare	5	10%	8	15%
Other	5	10%	7	13%

Maryvale FHC	2018		2020	
	Total	%	Total	%
Question #3- Can you get an appointment at this doctor's office when you need it?				
Yes	40	80%	48	92%
No	7	14%	4	8%
Question #4- If you answered "No" to question 3, please choose all that apply.				
No Appointment available	4	8%	1	20%
Cannot afford it	1	2%	2	40%
Cannot take time off from work	0	0%	0	0%
No transportation	1	2%	0	0%
Clinic hours	0	0%	0	0%
No specialist in my community for my condition	0	0%	0	0%
Other	1	2%	2	40%
Question #5- The clinic hours meet my needs				
Yes	45	90%	48	92%
If No I would prefer Appointments at the following times	0	0%	4	8%
Weekdays before 7am	0	0%	2	25%
Saturday Morning	2	4%	2	25%
Sunday Morning	2	4%	0	0%
Weekday After 5:30pm	4	8%	4	50%
Saturday Afternoon	2	4%	0	0%
Sunday Afternoon	1	2%	0	0%
Question #6- What type of healthcare coverage do you have?				
Medicare	4	8%	3	5%
AHCCCS	30	60%	36	64%
Commercial Health Insurance	3	6%	2	4%
Copa Care/Sliding fee discount program	5	10%	4	7%
No healthcare coverage	3	6%	5	9%
Other	6	12%	6	11%
Question #7- Please select the top 3 health challenges you face.				
Cancer	1	2%	0	0%
Diabetes	3	6%	4	6%
Overweight	9	18%	13	21%
Breathing Problems	2	4%	2	3%
High Blood Pressure/Stroke	3	6%	3	5%
Dental Care	3	6%	5	8%
Hear Disease	3	6%	1	2%
Pain	5	10%	5	8%
Depression/Mental health issues	4	8%	2	3%

Maryvale FHC	2018		2020	
	Total	%	Total	%
Alcohol use	1	2%	1	2%
Drug use	1	2%	0	0%
None	17	34%	17	27%
Other	9	18%	10	16%
Question #8- Please choose all statements below that apply to you.				
Exercise 3 times per week	18	36%	18	20%
Eat at least 5 servings of fruits & vegetables	22	44%	25	28%
Eat fast food more than one per week	11	22%	12	13%
Smoke cigarettes	3	6%	1	1%
Chew tobacco	1	2%	0	0%
Use illegal drugs	2	4%	0	0%
Abuse or over use prescription drugs	1	2%	0	0%
Consume more than 4/5 alcoholic drinks	2	4%	0	0%
Use sunscreen or protective clothing	5	10%	13	15%
Receive a flu shot each year	15	30%	10	11%
Have access to a wellness program through my employer	4	8%	1	1%
None of the above apply to me	6	12%	9	10%
Question #9- Which of the following preventive procedures have you had in the past 12 months?				
Mammogram	4	8%	5	5%
Pap Smear	21	42%	19	19%
Prostate cancer screening	1	2%	1	1%
Flu shot	25	50%	13	13%
Colon/rectal exam	1	2%	1	1%
Blood Pressure	17	34%	10	10%
Blood sugar check	5	10%	10	10%
Skin cancer screening	1	2%	0	0%
Cholesterol screening	8	16%	7	7%
Vision Screening	4	8%	6	6%
Hearing Screening	2	4%	1	1%
Cardiovascular Screening	1	2%	2	2%
Bone Density test	1	2%	0	0%
Dental cleaning/x-rays	4	8%	6	6%
Physical exam	7	14%	9	9%
None of the above	4	8%	11	11%
Question #10- What is your gender?				
Female	36	72%	44	88%
Male	6	12%	6	12%
Transgender Female/Male to female	1	2%	0	0%

Maryvale FHC	2018		2020	
	Total	%	Total	%
Transgender Male/Female to male	0	0%	0	0%
Other	1	2%	0	0%
Chose not to disclose	1	2%	0	0%
Question #11- What is your race?				
African American Black	4	8%	3	7%
Caucasian/White	6	12%	8	20%
Asian	1	2%	0	0%
American Indian/Alaska Native	0	0%	0	0%
Native Hawaiian/Pacific Islander	0	0%	0	0%
Hispanic	22	44%	29	71%
Other	2	4%	1	2%
Question #12- What is your current employment status?				
Employed full-time	7	14%	6	11%
Employed Part time	1	2%	2	4%
Student	6	12%	5	9%
Homemaker	14	28%	20	38%
Unemployed	10	20%	18	34%
Disabled	1	2%	2	4%
Retired	1	2%	0	0%
Question #13- What is your household income range?				
$0-$24,999	13	26%	15	34%
$25,000-$49,999	6	12%	10	23%
$50,000-$74,999	0	0%	0	0%
$75,000-$99,999	1	2%	0	0%
$100,000 or more	0	0%	0	0%
Don't Know	16	32%	19	43%
Question #14- What is the highest level of education you have completed?				
Some high school	16	32%	9	24%
High school graduate	10	20%	19	51%
Some college	4	8%	8	22%
College graduate	2	4%	1	3%

Site Id: BPS-LAL-009891
Name: Comprehensive Healthcare Center
Address: 2525 E Roosevelt St, Phoenix, AZ 85008-4948

Form 5B Service Area Zip Codes: 85006, 85008, 85016, 85018, 85034

Overview of Address

State Name: Arizona
County Name: Maricopa
Congressional District Name: Arizona District 07
Congressional District Representative Name: Ruben Gallego
ZIP Code: 85008
Post Office Name: Phoenix
FIPS Code (State + County + Tract number)
Census Tract: 04013113400
Census Tract Number: 113400
FIPS Code (State + County + Minor Civil Division) County Subdivision: 0401392601
County Subdivision Name: Phoenix

In a Dental Health HPSA: Yes
HPSA Name: Low Income-Central City Village
ID: 6041975610
Designation Type: HPSA Population
Score: 25

HPSA Name: Phoenix-South Central
ID: 604999040N
Designation Type: HPSA Geographic High Needs
Score: 25

In a Mental Health HPSA: Yes
HPSA Name: Maricopa County
ID: 704013
Designation Type: HPSA Geographic
Score: 21

In a Primary Care HPSA: Yes
HPSA Name: Low Income-Central City Village
ID: 1041499689
Designation Type: HPSA Population

Score: 25

HPSA Name: Low Income - Phoenix-South Central
ID: 10499904N9
Designation Type: HPSA Population
Score: 25

In a MUA/P: Yes
Service Area Name: Low Inc - South Central Phoenix
ID: 07338
Designation Type: Medically Underserved Population

HPSA Data as of 5/04/2020
MUA Data as of 5/04/2020

CHC Internal Meds	2018		2020	
	Total	%	Total	%
Question #1- How would you describe your overall health?				
Excellent	7	14%	2	6%
Very Good	5	10%	5	16%
Good	21	42%	9	29%
Fair	13	26%	7	23%
Poor	3	6%	8	26%
Question #2- Where do you go for routine healthcare?				
Physician's office	29	58%	8	26%
Health Department	9	18%	6	19%
Emergency Room	0	0%	4	13%
Urgent Care Clinic	6	12%	7	23%
Clinic in a Grocery/Drug store	0	0%	1	3%
I do not receive routine healthcare	3	6%	3	10%
Other	1	2%	2	6%
Question #3- Can you get an appointment at this doctor's office when you need it?				
Yes	34	68%	25	89%
No	15	30%	3	11%
Question #4- If you answered "No" to question 3, please choose all that apply.				
No Appointment available	13	26%	2	67%
Cannot afford it	0	0%	0	0%

CHC Internal Meds	2018		2020	
	Total	%	Total	%
Cannot take time off from work	1	2%	0	0%
No transportation	1	2%	0	0%
Clinic hours	2	4%	0	0%
No specialist in my community for my condition	0	0%	1	33%
Other	0	0%	0	0%
Question #5- The clinic hours meet my needs				
Yes	43	86%	22	81%
If No I would prefer Appointments at the following times	0	0%	5	19%
Weekdays before 7am	1	2%	2	40%
Saturday Morning	1	2%	1	20%
Sunday Morning	1	2%	0	0%
Weekday After 5:30pm	3	6%	2	40%
Saturday Afternoon	3	6%	1	20%
Sunday Afternoon	0	0%	0	0%
Question #6- What type of healthcare coverage do you have?				
Medicare	10	20%	7	19%
AHCCCS	26	52%	13	36%
Commercial Health Insurance	3	6%	2	6%
Copa Care/Sliding fee discount program	14	28%	9	25%
No healthcare coverage	0	0%	4	11%
Other	0	0%	1	3%
Question #7- Please select the top 3 health challenges you face.				
Cancer	3	6%	4	6%
Diabetes	17	34%	16	25%
Overweight	11	22%	4	6%
Breathing Problems	3	6%	1	2%
High Blood Pressure/Stroke	14	28%	9	14%
Dental Care	9	18%	6	9%
Heart Disease	3	6%	0	0%
Pain	17	34%	9	14%
Depression/Mental health issues	5	10%	4	6%
Alcohol use	1	2%	1	2%
Drug use	0	0%	0	0%
None	2	4%	2	3%
Other	4	8%	9	14%
Question #8- Please choose all statements below that apply to you.				
Exercise 3 times per week	19	38%	8	20%
Eat at least 5 servings of fruits & vegetables	10	20%	9	23%

CHC Internal Meds	2018		2020	
	Total	%	Total	%
Eat fast food more than one per week	11	22%	4	10%
Smoke cigarettes	6	12%	3	8%
Chew tobacco	0	0%	0	0%
Use illegal drugs	0	0%	0	0%
Abuse or over use prescription drugs	0	0%	0	0%
Consume more than 4/5 alcoholic drinks	0	0%	0	0%
Use sunscreen or protective clothing	9	18%	3	8%
Receive a flu shot each year	14	28%	7	18%
Have access to a wellness program through my employer	5	10%	3	8%
None of the above apply to me	5	10%	3	8%
Question #9- Which of the following preventive procedures have you had in the past 12 months?				
Mammogram	17	34%	11	12%
Pap Smear	11	22%	7	8%
Prostate cancer screening	3	6%	1	1%
Flu shot	12	24%	8	9%
Colon/rectal exam	2	4%	4	4%
Blood Pressure	23	46%	8	9%
Blood sugar check	16	32%	10	11%
Skin cancer screening	3	6%	4	4%
Cholesterol screening	8	16%	4	4%
Vision Screening	13	26%	16	17%
Hearing Screening	1	2%	4	4%
Cardiovascular Screening	2	4%	2	2%
Bone Density test	4	8%	2	2%
Dental cleaning/x-rays	10	20%	3	3%
Physical exam	16	32%	5	5%
None of the above	3	6%	4	4%
Question #10- What is your gender?				
Female	30	60%	14	56%
Male	16	32%	10	40%
Transgender Female/Male to female	0	0%	1	4%
Transgender Male/Female to male	0	0%	0	0%
Other	0	0%	0	0%
Chose not to disclose	0	0%	0	0%
Question #11- What is your race?				
African American Black	8	16%	0	0%
Caucasian/White	12	24%	5	24%
Asian	1	2%	0	0%

CHC Internal Meds	2018		2020	
	Total	%	Total	%
American Indian/Alaska Native	0	0%	1	5%
Native Hawaiian/Pacific Islander	0	0%	0	0%
Hispanic	20	40%	13	62%
Other	0	0%	2	10%
Question #12- What is your current employment status?				
Employed full-time	11	22%	5	22%
Employed Part time	7	14%	1	4%
Student	2	4%	0	0%
Homemaker	10	20%	6	26%
Unemployed	2	4%	3	13%
Disabled	6	12%	4	17%
Retired	8	16%	4	17%
Question #13- What is your household income range?				
$0-$24,999	6	12%	6	35%
$25,000-$49,999	1	2%	1	6%
$50,000-$74,999	0	0%	1	6%
$75,000-$99,999	0	0%	0	0%
$100,000 or more	6	12%	1	6%
Don't Know	0	0%	8	47%
Question #14- What is the highest level of education you have completed?				
Some high school	6	12%	1	10%
High school graduate	11	22%	6	60%
Some college	9	18%	2	20%
College graduate	5	10%	1	10%

CHC Dental	2018		2020	
	Total	%	Total	%
Question #1- How would you describe your overall health?				
Excellent	11	22%	11	22%
Very Good	10	20%	9	18%
Good	24	48%	18	36%
Fair	4	8%	11	22%
Poor	0	0%	1	2%
Question #2- Where do you go for routine healthcare?				
Physician's office	24	48%	25	48%
Health Department	7	14%	4	8%
Emergency Room	5	10%	4	8%

CHC Dental	2018		2020	
	Total	%	Total	%
Urgent Care Clinic	5	10%	6	12%
Clinic in a Grocery/Drug store	1	2%	1	2%
I do not receive routine healthcare	4	8%	7	13%
Other	3	6%	5	10%
Question #3- Can you get an appointment at this doctor's office when you need it?				
Yes	47	94%	42	88%
No	2	4%	6	13%
Question #4- If you answered "No" to question 3, please choose all that apply.				
No Appointment available	1	2%	1	17%
Cannot afford it	1	2%	2	33%
Cannot take time off from work	0	0%	3	50%
No transportation	0	0%	0	0%
Clinic hours	0	0%	0	0%
No specialist in my community for my condition	0	0%	0	0%
Other	0	0%	0	0%
Question #5- The clinic hours meet my needs				
Yes	42	84%	42	91%
If No I would prefer Appointments at the following times	0	0%	4	9%
Weekdays before 7am	5	10%	2	22%
Saturday Morning	1	2%	2	22%
Sunday Morning	0	0%	0	0%
Weekday After 5:30pm	2	4%	4	44%
Saturday Afternoon	1	2%	1	11%
Sunday Afternoon	0	0%	0	0%
Question #6- What type of healthcare coverage do you have?				
Medicare	1	2%	3	6%
AHCCCS	30	60%	24	45%
Commercial Health Insurance	5	10%	7	13%
Copa Care/Sliding fee discount program	9	18%	14	26%
No healthcare coverage	4	8%	4	8%
Other	0	0%	1	2%
Question #7- Please select the top 3 health challenges you face.				
Cancer	0	0%	1	1%
Diabetes	4	8%	5	7%
Overweight	6	12%	8	11%
Breathing Problems	6	12%	2	3%

CHC Dental	2018		2020	
	Total	%	Total	%
High Blood Pressure/Stroke	8	16%	5	7%
Dental Care	15	30%	14	19%
Heart Disease	3	6%	6	8%
Pain	3	6%	8	11%
Depression/Mental health issues	5	10%	4	6%
Alcohol use	0	0%	0	0%
Drug use	0	0%	0	0%
None	15	30%	12	17%
Other	1	2%	7	10%
Question #8- Please choose all statements below that apply to you.				
Exercise 3 times per week	20	40%	23	28%
Eat at least 5 servings of fruits & vegetables	24	48%	12	15%
Eat fast food more than one per week	18	36%	17	21%
Smoke cigarettes	10	20%	4	5%
Chew tobacco	0	0%	0	0%
Use illegal drugs	0	0%	0	0%
Abuse or over use prescription drugs	0	0%	0	0%
Consume more than 4/5 alcoholic drinks	0	0%	0	0%
Use sunscreen or protective clothing	11	22%	7	9%
Receive a flu shot each year	22	44%	12	15%
Have access to a wellness program through my employer	5	10%	4	5%
None of the above apply to me	4	8%	3	4%
Question #9- Which of the following preventive procedures have you had in the past 12 months?				
Mammogram	7	14%	7	6%
Pap Smear	9	18%	14	11%
Prostate cancer screening	2	4%	3	2%
Flu shot	20	40%	10	8%
Colon/rectal exam	3	6%	6	5%
Blood Pressure	16	32%	13	10%
Blood sugar check	9	18%	13	10%
Skin cancer screening	1	2%	1	1%
Cholesterol screening	7	14%	10	8%
Vision Screening	11	22%	7	6%
Hearing Screening	4	8%	4	3%
Cardiovascular Screening	3	6%	2	2%
Bone Density test	1	2%	0	0%
Dental cleaning/x-rays	18	36%	9	7%
Physical exam	15	30%	16	13%
None of the above	3	6%	12	9%

CHC Dental	2018		2020	
	Total	%	Total	%
Question #10- What is your gender?				
Female	28	56%	33	66%
Male	20	40%	17	34%
Transgender Female/Male to female	0	0%	0	0%
Transgender Male/Female to male	0	0%	0	0%
Other	0	0%	0	0%
Chose not to disclose	0	0%	0	0%
Question #11- What is your race?				
African American Black	5	10%	8	18%
Caucasian/White	11	22%	10	22%
Asian	1	2%	1	2%
American Indian/Alaska Native	1	2%	0	0%
Native Hawaiian/Pacific Islander	1	2%	0	0%
Hispanic	19	38%	24	53%
Other	5	10%	2	4%
Question #12- What is your current employment status?				
Employed full-time	12	24%	12	25%
Employed Part time	5	10%	8	17%
Student	10	20%	5	10%
Homemaker	8	16%	8	17%
Unemployed	7	14%	11	23%
Disabled	2	4%	1	2%
Retired	1	2%	3	6%
Question #13- What is your household income range?				
$0-$24,999	17	34%	24	48%
$25,000-$49,999	9	18%	10	20%
$50,000-$74,999	0	0%	3	6%
$75,000-$99,999	0	0%	0	0%
$100,000 or more	0	0%	0	0%
Don't Know	11	22%	13	26%
Question #14- What is the highest level of education you have completed?				
Some high school	9	18%	14	37%
High school graduate	9	18%	17	45%
Some college	4	8%	4	11%
College graduate	7	14%	3	8%

Women's Clinic	2018		2020	
	Total	/o	Total	/o
Question #1- How would you describe your overall health?				
Excellent	22	44%	6	14%
Very Good	5	10%	13	30%
Good	10	20%	14	32%
Fair	6	12%	10	23%
Poor	0	0%	1	2%
Question #2- Where do you go for routine healthcare?				
Physician's office	8	16%	18	37%
Health Department	4	8%	5	10%
Emergency Room	0	0%	6	12%
Urgent Care Clinic	1	2%	3	6%
Clinic in a Grocery/Drug store	0	0%	1	2%
I do not receive routine healthcare	5	10%	9	18%
Other	25	50%	7	14%
Question #3- Can you get an appointment at this doctor's office when you need it?				
Yes	43	86%	40	93%
No	1	2%	3	7%
Question #4- If you answered "No" to question 3, please choose all that apply.				
No Appointment available	0	0%	1	17%
Cannot afford it	1	2%	2	33%
Cannot take time off from work	0	0%	1	17%
No transportation	0	0%	1	17%
Clinic hours	0	0%	0	0%
No specialist in my community for my condition	0	0%	0	0%
Other	1	2%	1	17%
Question #5- The clinic hours meet my needs				
Yes	29	58%	42	95%
If No I would prefer Appointments at the following times	0	0%	2	5%
Weekdays before 7am	1	2%	2	50%
Saturday Morning	18	36%	1	25%
Sunday Morning	19	38%	1	25%
Weekday After 5:30pm	2	4%	0	0%

Women's Clinic	2018		2020	
	Total	/o	Total	/o
Saturday Afternoon	14	28%	0	0%
Sunday Afternoon	19	38%	0	0%
Question #6- What type of healthcare coverage do you have?				
Medicare	1	2%	2	50%
AHCCCS	18	36%	1	25%
Commercial Health Insurance	19	38%	1	25%
Copa Care/Sliding fee discount program	2	4%	0	0%
No healthcare coverage	14	28%	0	0%
Other	19	38%	0	0%
Question #7- Please select the top 3 health challenges you face.				
Cancer	0	0%	1	2%
Diabetes	0	0%	2	3%
Overweight	3	6%	8	13%
Breathing Problems	2	4%	4	6%
High Blood Pressure/Stroke	4	8%	5	8%
Dental Care	1	2%	3	5%
Heart Disease	0	0%	2	3%
Pain	4	8%	10	16%
Depression/Mental health issues	2	4%	5	8%
Alcohol use	0	0%	0	0%
Drug use	0	0%	0	0%
None	28	56%	9	14%
Other	3	6%	14	22%
Question #8- Please choose all statements below that apply to you.				
Exercise 3 times per week	8	16%	10	14%
Eat at least 5 servings of fruits & vegetables	10	20%	12	17%
Eat fast food more than one per week	26	52%	9	13%
Smoke cigarettes	0	0%	2	3%
Chew tobacco	0	0%	2	3%
Use illegal drugs	0	0%	1	1%
Abuse or over use prescription drugs	0	0%	1	1%
Consume more than 4/5 alcoholic drinks	0	0%	0	0%
Use sunscreen or protective clothing	4	8%	11	15%
Receive a flu shot each year	8	16%	9	13%
Have access to a wellness program through my employer	2	4%	6	8%
None of the above apply to me	4	8%	8	11%
Question #9- Which of the following preventive procedures have you had in the past 12 months?				

Women's Clinic	2018		2020	
	Total	%	Total	%
Mammogram	23	46%	6	7%
Pap Smear	16	32%	16	19%
Prostate cancer screening	0	0%	0	0%
Flu shot	23	46%	12	14%
Colon/rectal exam	0	0%	1	1%
Blood Pressure	7	14%	13	15%
Blood sugar check	3	6%	11	13%
Skin cancer screening	1	2%	0	0%
Cholesterol screening	2	4%	3	4%
Vision Screening	3	6%	6	7%
Hearing Screening	1	2%	0	0%
Cardiovascular Screening	1	2%	1	1%
Bone Density test	0	0%	0	0%
Dental cleaning/x-rays	2	4%	5	6%
Physical exam	7	14%	7	8%
None of the above	5	10%	4	5%
Question #10- What is your gender?				
Female	45	90%	39	100%
Male	0	0%	0	0%
Transgender Female/Male to female	1	2%	0	0%
Transgender Male/Female to male	0	0%	0	0%
Other	0	0%	0	0%
Chose not to disclose	0	0%	0	0%
Question #11- What is your race?				
African American Black	2	4%	3	8%
Caucasian/White	5	10%	5	13%
Asian	0	0%	0	0%
American Indian/Alaska Native	0	0%	1	3%
Native Hawaiian/Pacific Islander	0	0%	1	3%
Hispanic	0	0%	27	71%
Other	35	70%	1	3%
Question #12- What is your current employment status?				
Employed full-time	6	12%	9	25%
Employed Part time	2	4%	5	14%
Student	2	4%	1	3%
Homemaker	11	22%	10	28%
Unemployed	21	42%	10	28%
Disabled	1	2%	1	3%
Retired	0	0%	0	0%

Women's Clinic	2018		2020	
	Total	/o	Total	/o
Question #13- What is your household income range?				
$0-$24,999	8	16%	21	54%
$25,000-$49,999	4	8%	3	8%
$50,000-$74,999	1	2%	0	0%
$75,000-$99,999	0	0%	2	5%
$100,000 or more	1	2%	1	3%
Don't Know	31	62%	12	31%
Question #14- What is the highest level of education you have completed?				
Some high school	24	48%	11	35%
High school graduate	6	12%	9	29%
Some college	4	8%	5	16%
College graduate	3	6%	6	19%

Site Id: BPS-LAL-009882
Name: Chandler Family Health Center
Address: 811 S Hamilton St, Chandler, AZ 85225-6308

Form 5B Service Area Zip Codes: 85286, 85249, 85224, 85233, 85225

Overview of Address

State Name: Arizona
County Name: Maricopa
Congressional District Name: Arizona District 09
Congressional District Representative Name: Kyrsten Sinema
ZIP Code: 85225
Post Office Name: Chandler
FIPS Code (State + County + Tract number) Census Tract: 04013523102
Census Tract Number: 523102
FIPS Code (State + County + Minor Civil Division) County Subdivision: 0401390561
County Subdivision Name: Chandler

In a Dental Health HPSA: No

In a Mental Health HPSA: Yes
HPSA Name: Maricopa County
ID: 704013
Designation Type: HPSA Geographic
Score: 21

In a Primary Care HPSA: No

In a MUA/P: Yes
Service Area Name: Chandler Primary Care Area
ID: 07269
Designation Type: Medically Underserved Area

HPSA Data as of 5/04/2020
MUA Data as of 5/04/2020

Chandler FHC	2018		2020	
	Total	%	Total	%
Question #1- How would you describe your overall health?				
Excellent	6	12%	8	16%
Very Good	10	20%	13	27%
Good	16	32%	16	33%
Fair	14	28%	11	22%
Poor	5	10%	1	2%
Question #2- Where do you go for routine healthcare?				
Physician's office	38	76%	26	49%
Health Department	2	4%	9	17%
Emergency Room	1	2%	2	4%
Urgent Care Clinic	0	0%	7	13%
Clinic in a Grocery/Drug store	0	0%	1	2%
I do not receive routine healthcare	5	10%	5	9%
Other	3	6%	3	6%
Question #3- Can you get an appointment at this doctor's office when you need it?				
Yes	46	92%	47	96%
No	4	8%	2	4%
Question #4- If you answered "No" to question 3, please choose all that apply.				
No Appointment available	3	6%	2	67%
Cannot afford it	1	2%	1	33%
Cannot take time off from work	0	0%	0	0%
No transportation	0	0%	0	0%
Clinic hours	0	0%	0	0%
No specialist in my community for my condition	0	0%	0	0%
Other	0	0%	0	0%
Question #5- The clinic hours meet my needs				
Yes	48	96%	47	96%
If No I would prefer Appointments at the following times	0	0%	2	4%
Weekdays before 7am	1	2%	2	50%
Saturday Morning	2	4%	0	0%
Sunday Morning	0	0%	0	0%
Weekday After 5:30pm	1	2%	2	50%
Saturday Afternoon	1	2%	0	0%

Chandler FHC	2018		2020	
	Total	%	Total	%
Sunday Afternoon	0	0%	0	0%
Question #6- What type of healthcare coverage do you have?				
Medicare	10	20%	2	4%
AHCCCS	27	54%	22	42%
Commercial Health Insurance	8	16%	14	26%
Copa Care/Sliding fee discount program	6	12%	11	21%
No healthcare coverage	3	6%	2	4%
Other	2	4%	2	4%
Question #7- Please select the top 3 health challenges you face.				
Cancer	1	2%	1	1%
Diabetes	15	30%	9	10%
Overweight	10	20%	10	11%
Breathing Problems	4	8%	2	2%
High Blood Pressure/Stroke	20	40%	10	11%
Dental Care	9	18%	7	8%
Hear Disease	5	10%	3	3%
Pain	18	36%	16	18%
Depression/Mental health issues	8	16%	10	11%
Alcohol use	1	2%	0	0%
Drug use	0	0%	1	1%
None	5	10%	5	6%
Other	6	12%	13	15%
Question #8- Please choose all statements below that apply to you.				
Exercise 3 times per week	21	42%	22	23%
Eat at least 5 servings of fruits & vegetables	16	32%	18	19%
Eat fast food more than one per week	13	26%	14	14%
Smoke cigarettes	6	12%	3	3%
Chew tobacco	1	2%	0	0%
Use illegal drugs	0	0%	0	0%
Abuse or over use prescription drugs	1	2%	0	0%
Consume more than 4/5 alcoholic drinks	0	0%	1	1%
Use sunscreen or protective clothing	14	28%	12	12%
Receive a flu shot each year	16	32%	17	18%
Have access to a wellness program through my employer	5	10%	6	6%
None of the above apply to me	7	14%	4	4%
Question #9- Which of the following preventive procedures have you had in the past 12 months?				
Mammogram	11	22%	6	5%

Chandler FHC	2018		2020	
	Total	/o	Total	/o
Pap Smear	9	18%	12	10%
Prostate cancer screening	0	0%	0	0%
Flu shot	16	32%	16	14%
Colon/rectal exam	4	8%	3	3%
Blood Pressure	29	58%	16	14%
Blood sugar check	18	36%	11	9%
Skin cancer screening	4	8%	2	2%
Cholesterol screening	12	24%	7	6%
Vision Screening	15	30%	7	6%
Hearing Screening	7	14%	1	1%
Cardiovascular Screening	5	10%	5	4%
Bone Density test	1	2%	1	1%
Dental cleaning/x-rays	8	16%	8	7%
Physical exam	17	34%	16	14%
None of the above	8	16%	6	5%
Question #10- What is your gender?				
Female	31	62%	37	77%
Male	17	34%	11	23%
Transgender Female/Male to female	0	0%	0	0%
Transgender Male/Female to male	1	2%	0	0%
Other	1	2%	0	0%
Chose not to disclose	1	2%	0	0%
Question #11- What is your race?				
African American Black	8	16%	3	7%
Caucasian/White	15	30%	10	22%
Asian	5	10%	2	4%
American Indian/Alaska Native	1	2%	0	0%
Native Hawaiian/Pacific Islander	0	0%	1	2%
Hispanic	17	34%	27	60%
Other	4	8%	2	4%
Question #12- What is your current employment status?				
Employed full-time	14	28%	14	28%
Employed Part time	5	10%	9	18%
Student	4	8%	3	6%
Homemaker	5	10%	7	14%
Unemployed	8	16%	10	20%
Disabled	4	8%	2	4%
Retired	7	14%	5	10%

Chandler FHC	2018		2020	
	Total	%	Total	%
Question #13- What is your household income range?				
$0-$24,999	24	48%	20	45%
$25,000-$49,999	7	14%	6	14%
$50,000-$74,999	3	6%	4	9%
$75,000-$99,999	0	0%	0	0%
$100,000 or more	1	2%	2	5%
Don't Know	8	16%	12	27%
Question #14- What is the highest level of education you have completed?				
Some high school	15	30%	15	36%
High school graduate	14	28%	10	24%
Some college	13	26%	7	17%
College graduate	5	10%	10	24%

Valleywise Health Maricopa County Special Health Care District Priority Needs

A review of data provides insight to the state of public health in Maricopa County Health District. Utilizing published Local, State, and Federal reports coupled with the Valleywise Health 2019 UDS as well as responses to the 2020 Valleywise Health FQHC Patient Survey allows for a greater understanding of and insight into the opportunities to focus resources and improve community health. To focus the efforts of the Valleywise Health FQHC priorities, two categories of intervention have been defined to allow greater specification of addressing priority health needs and access to care.

Priority Health Needs

Information has been provided for each FQHC site to clearly understand the individual needs of specific communities. However, given the limitations of resources, it is helpful to review the Valleywise Health FQHC Patient Health Needs Survey – All Sites while being mindful of the unique characteristics of site specific community health needs.

Valleywise Health FQHC Patient Health Needs Survey: All Sites	2018		2020	
	Total	%	Total	%
Question #1- How would you describe your overall health?				
Excellent	155	16%	107	15%
Very Good	215	22%	150	22%
Good	337	35%	240	35%
Fair	219	23%	153	22%
Poor	36	4%	45	6%
Question #2- Where do you go for routine healthcare?				
Physician's office	569	59%	360	49%
Health Department	118	12%	89	12%
Emergency Room	51	5%	30	4%
Urgent Care Clinic	74	8%	79	11%
Clinic in a Grocery/Drug store	20	21%	22	3%
I do not receive routine healthcare	62	6%	84	11%
Other	71	7%	68	9%
Question #3- Can you get an appointment at this doctor's office when you need it?				
Yes	838	91%	622	93%
No	88	10%	49	7%
Question #4- If you answered "No" to question 3, please choose all that apply.				
No Appointment available	64	51%	107	15%
Cannot afford it	14	11%	14	19%

Valleywise Health FQHC Patient Health Needs Survey: All Sites	2018		2020	
	Total	%	Total	%
Cannot take time off from work	6	5%	13	18%
No transportation	10	8%	7	10%
Clinic hours	7	6%	0	0%
No specialist in my community for my condition	4	3%	6	8%
Other	21	17%	14	19%
Question #5- The clinic hours meet my needs				
Yes	857	76%	618	92%
If No I would prefer Appointments at the following times		52		8%
Weekdays before 7am	44	4%	28	19%
Saturday Morning	60	5%	31	21%
Sunday Morning	35	3%	13	9%
Weekday After 5:30pm	50	4%	39	27%
Saturday Afternoon	51	5%	24	17%
Sunday Afternoon	34	3%	10	7%
Question #6- What type of healthcare coverage do you have?				
Medicare	92	9%	79	11%
AHCCCS	583	57%	347	46%
Commercial Health Insurance	126	12%	120	16%
Copa Care/Sliding fee discount program	148	15%	122	16%
No healthcare coverage	39	4%	38	5%
Other	30	3%	46	6%
Question #7- Please select the top 3 health challenges you face.				
Cancer	23	2%	21	2%
Diabetes	162	11%	152	13%
Overweight	172	11%	142	12%
Breathing Problems	85	6%	51	4%
High Blood Pressure/Stroke	213	14%	144	12%
Dental Care	158	10%	74	6%
Heart Disease	52	3%	39	3%
Pain	182	12%	161	14%
Depression/Mental health issues	116	8%	97	8%
Alcohol use	16	1%	10	1%
Drug use	14	1%	7	1%
None	202	13%	115	10%
Other	116	8%	155	13%
Question #8- Please choose all statements below that apply to you.				
Exercise 3 times per week	365	20%	250	20%

Valleywise Health FQHC Patient Health Needs Survey: All Sites	2018		2020	
	Total	%	Total	%
Eat at least 5 servings of fruits & vegetables	310	17%	219	18%
Eat fast food more than one per week	281	15%	192	16%
Smoke cigarettes	118	6%	66	5%
Chew tobacco	21	1%	6	0%
Use illegal drugs	15	1%	6	0%
Abuse or over use prescription drugs	6	1%	1	0%
Consume more than 4/5 alcoholic drinks	12	1%	5	0%
Use sunscreen or protective clothing	203	11%	133	11%
Receive a flu shot each year	344	19%	201	16%
Have access to a wellness program through my employer	86	5%	72	6%
None of the above apply to me	97	5%	73	6%
Question #9- Which of the following preventive procedures have you had in the past 12 months?				
Mammogram	189	7%	116	7%
Pap Smear	196	7%	184	10%
Prostate cancer screening	56	2%	19	1%
Flu shot	337	13%	194	11%
Colon/rectal exam	102	4%	67	4%
Blood Pressure	343	13%	215	12%
Blood sugar check	255	10%	192	11%
Skin cancer screening	50	2%	36	2%
Cholesterol screening	177	7%	111	6%
Vision Screening	216	8%	158	9%
Hearing Screening	80	3%	36	2%
Cardiovascular Screening	56	2%	41	2%
Bone Density test	32	1%	14	1%
Dental cleaning/x-rays	190	7%	102	6%
Physical exam	287	11%	197	11%
None of the above	103	4%	100	6%
Question #10- What is your gender?				
Female	541	60%	471	73%
Male	326	36%	172	27%
Transgender Female/Male to female	23	3%	4	1%
Transgender Male/Female to male	4	1%	1	0%
Other	6	1%	0	0%
Chose not to disclose	3	1%	1	0%
Question #11- What is your race?				
African American Black	88	11%	68	11%

Valleywise Health FQHC Patient Health Needs Survey: All Sites	2018		2020	
	Total	%	Total	%
Caucasian/White	244	30%	182	31%
Asian	36	4%	11	2%
American Indian/Alaska Native	9	1%	11	2%
Native Hawaiian/Pacific Islander	9	1%	6	1%
Hispanic	332	42%	293	49%
Other	88	11%	24	4%
Question #12- What is your current employment status?				
Employed full-time	194	23%	171	26%
Employed Part time	116	14%	82	12%
Student	76	9%	46	7%
Homemaker	162	19%	117	18%
Unemployed	163	19%	142	22%
Disabled	96	11%	62	9%
Retired	55	6%	40	6%
Question #13- What is your household income range?				
$0-$24,999	362	47%	280	47%
$25,000-$49,999	149	19%	121	20%
$50,000-$74,999	25	3%	23	4%
$75,000-$99,999	18	2%	12	2%
$100,000 or more	11	1%	12	2%
Don't Know	214	28%	148	25%
Question #14- What is the highest level of education you have completed?				
Some high school	231	33%	132	26%
High school graduate	202	29%	160	31%
Some college	165	24%	143	28%
College graduate	104	15%	74	15%

Conclusion

After reviewing the health challenges reported by patients in the 2020 Valleywise Health FQHC Patient Health Needs Survey, the following represent the top three health challenges for the patient population:

Pain
While this is a more generalized health challenge with limited quantitative data on its incidence and pain management, 161 of the participants or 14% of the respondents indicated pain as a top health challenge. Steps have been taken on both a national and state level to combat opioid addiction and provide pain management resources, but it is still a pressing crisis in the U.S.

Diabetes
Thirteen percent of respondents, totaling 152 participants, listed Diabetes as a considerable health challenge. According to the 2019 UDS reports, 10,620 patients 18-75 years old have Diabetes. The breakdown of race and ethnicity is as follows: 6,829 Hispanic/Latino patients and 3,780 non-Hispanic/Latino patients. Only 11 patients refused to report race and ethnicity or went unreported.

High Blood Pressure/Stroke and Overweight
Both high blood pressure/stroke and overweight accounted for 12% of respondents, with 144 participants selecting each of these health challenges. The 2019 UDS reports indicate 15,288 patients ages 18-85 have hypertension. Of this patient population, 7,985 identify as Hispanic/Latino and 7,301 identify as Non-Hispanic/Latino. Two patients refused to report race and ethnicity or went unreported. As for weight, the UDS reports reveal that 11,777 patients can be classified as overweight/obese. Body Mass Index (BMI) is the routine measure of weight, and individuals with a BMI greater than 25.0 are considered overweight or obese. BMI assessment and counseling from health care providers, encouraging patients to incorporate exercise and improve their diet, are the standard measures of intervention for weight management. Of the 15,873 patients 3-17 years of age, 11,013 have documented BMI percentile and counseling for diet and exercise. For patients ages 18 and older, 32,368 of the 51,108 total patients documented BMI and a follow-up plan.

The 2016 Behavioral Risk Factor Surveillance System Maricopa County (BRFSS) report notes that of the respondents self-reported height and weight, 34.7% have a BMI-Overweight and 28.3% have a BMI-Obese. This coupled with self- report of exercise: physical activity met aerobic recommendation 60.5% and diet: fruit and vegetable consumption – 5 or more servings/day 16.8% further validate the need to focus resources on diet and exercise for chronic disease prevention.

Of the total patient population of Valleywise Health, 51,322 have an income between 100% below and over 200% below of the federal poverty guideline. Additionally, 372 patients reported being homeless in 2019. Economic and housing instability are social determinants of health and significantly impact a person's ability to access healthcare. As such, the social determinants of health must be taken into consideration when determining how to best meet the needs of the patient population.

Access to Care

Valleywise Health's target population faces multiple barriers to accessing health care services, including lack of providers, financial barriers, and transportation barriers. Maricopa County has several designated MUAs and MUPS as well as numerous HPSAs, which impact access to care and utilization across the county.

Valleywise Health has implemented a new care model at all FQHC clinics–Whole Person Care–which seeks to provide patient-centered care through fully integrated services. This model will ensure every patient has a medical home, eliminating health equity challenges by reducing barriers to care. Moreover, this new care model will allow patients to receive all of their care (across the continuum) through Valleywise Health.

Whole Person Care addresses all of the needs of a patient (and family) including primary care, managing behavioral health care, addressing chronic disease challenges and social determinant of health factors that impact a person's health. When care is integrated, studies have shown that patient outcomes are better, especially for patients with behavioral health needs.

Whole Person Care allows for a multi-disciplinary care team approach with all providers within Valleywise Health communicating via a patient's electronic health record (EHR), in person and via phone about appropriate care planning. Whole Person Care seeks to ensure providers are implementing appropriate population health management initiatives, such as preventative care measures, e.g. screenings, providing consistent primary care, as well as ongoing management of chronic care and behavioral health challenges. This care model also offers assistance with addressing the social determinants of health.

Moreover, Whole Person Care seeks to eliminate barriers, transforming the level of care provided by placing the patient and his/her caregiver(s) at the center of all services, assuring care is accessible, culturally competent, compassionate and coordinated, and therefore equitable.

Further engagement of the patient population was sought through the 2020 Valleywise Health FQHC Patient Health Needs Survey. Questions were included in the survey to get a sample of current challenges patients are experiencing to better help plan for the future facilities and model of care.

Valleywise Health FQHC Patient Health Needs Survey Access to Care Questions	2020	
	Total	%
Question #2- Where do you go for routine healthcare?		
Physician's office	360	49%
Health Department	89	12%
Emergency Room	30	4%
Urgent Care Clinic	79	11%
Clinic in a Grocery/Drug store	22	3%
I do not receive routine healthcare	84	11%
Other	68	9%
Question #3- Can you get an appointment at this doctor's office when you need it?		

Valleywise Health FQHC Patient Health Needs Survey Access to Care Questions	2020	
	Total	%
Yes	622	93%
No	49	7%
Question #4- If you answered "No" to question 3, please choose all that apply.	19	26%
No Appointment available	360	49%
Cannot afford it	14	19%
Cannot take time off from work	13	18%
No transportation	7	10%
Clinic hours	0	0%
No specialist in my community for my condition	6	8%
Other	14	19%
Question #5- The clinic hours meet my needs		
Yes	618	92%
If No I would prefer Appointments at the following times	52	8%
Weekdays before 7am	28	19%
Saturday Morning	31	21%
Sunday Morning	13	9%
Weekday After 5:30pm	39	27%
Saturday Afternoon	24	17%
Sunday Afternoon	10	7%
Question #6- What type of healthcare coverage do you have?		
Medicare	79	11%
AHCCCS	347	46%
Commercial Health Insurance	120	16%
Copa Care/Sliding fee discount program	122	16%
No healthcare coverage	38	5%
Other	46	6%

Recommendations

Maricopa County continues to be a thriving metropolitan area, attracting many new residents on a yearly basis. In fact, the population of Maricopa County has increased 17.5% from 2010 to 2019 (www.uscensus.gov). Given this growth, it is necessary to evaluate the needs of this diverse and shifting community.

Maintaining and, in some cases, improving the health and wellness of a community ought to be a top priority for any organization that provides health care for a community. That being said, this cannot be done without collaboration and innovation. Population health initiatives require partnership between the community members themselves and those who aim to provide quality healthcare.

The Valleywise Health Maricopa County Special Health Care District utilized qualitative and quantitative data to identify opportunities for improvement. Based on the service area demographics and patient health needs survey, Valleywise Health has determined areas of improvement. Pain management is an area where improvement is necessary. Given the limited data, the incidence and management of pain among the patient population needs to be further explored for a possible solution to be identified. Additionally, diet, exercise, and weight management are pressing issues for this population. If addressed, the overall health of the patient population has the potential to drastically improve and the incidence of chronic conditions like hypertension/stroke and Diabetes will likely decrease. Lastly, the social determinants of health need to be revisited to determine how they are impacting the patient population and what measures can be taken to improve health outcomes.

Valleywise Health Maricopa County Special Health Care District plays a vital role in improving the health and wellness of the community. As supported by the community, Whole Person Care is an integrated care model that allows patients to receive all of the health care services that they need on the care continuum from Valleywise Health service providers. In the coming years, Valleywise Health Maricopa County Special Health Care District and the Valleywise Community Health Centers Governing Council will continue to engage in community-based endeavors that Maricopa contribute to the health of the population and communities served.

Attachment 1

Valleywise Health UDS Reporting 2019

BHCMIS ID: 09E00911 - MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT, Phoenix, AZ

Program Name: Health Center 330

Submission Status: Review In Progress

Date Requested: 03/23/2020 5:07 PM EST

Date of Last Report Refreshed: 03/23/2020 5:07 PM EST

UDS Report - 2019

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Do you self-identify as an NMHC?: No

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BHCMIS ID: 09E00911 - MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT, Phoenix, AZ

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UDS Report - 2019

Patients by ZIP Code

ZIP Codes

ZIP Code (a)	None/Uninsured (b)	Medicaid/CHIP/Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
85001	5	11	10	3	**29**
85002	2	8	5	1	**16**
85003	95	500	118	68	**781**
85004	48	169	50	107	**374**
85005	4	14	0	2	**20**

ZIP Code (a)	None/Uninsured (b)	Medicaid/CHIP/Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
85006	491	1025	150	147	**1813**
85007	321	1171	303	123	**1918**
85008	1183	2936	247	539	**4905**
85009	1286	2355	223	255	**4119**
85012	18	37	15	21	**91**
85013	73	171	42	82	**368**
85014	132	259	69	93	**553**
85015	422	991	119	128	**1660**
85016	210	329	68	130	**737**
85017	700	1137	73	106	**2016**
85018	138	231	74	64	**507**
85019	483	817	70	110	**1480**
85020	230	294	79	84	**687**
85021	356	833	191	193	**1573**
85022	134	161	52	71	**418**
85023	130	166	36	51	**383**
85024	33	45	18	33	**129**
85027	63	102	14	27	**206**
85028	8	24	12	25	**69**
85029	320	539	112	134	**1105**
85031	626	1190	85	172	**2073**
85032	308	246	43	53	**650**
85033	794	1076	60	196	**2126**
85034	131	307	60	21	**519**
85035	713	1205	95	222	**2235**
85036	9	13	0	3	**25**
85037	449	617	72	188	**1326**

ZIP Code (a)	None/Uninsured (b)	Medicaid/CHIP/Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
85040	653	1803	272	297	**3025**
85041	918	2442	335	574	**4269**
85042	473	932	139	301	**1845**
85043	398	516	42	198	**1154**
85044	44	111	34	98	**287**
85045	9	10	6	10	**35**
85048	12	56	16	59	**143**
85050	38	33	4	22	**97**
85051	380	842	88	157	**1467**
85053	66	127	29	42	**264**
85054	9	3	0	3	**15**
85060	5	6	1	1	**13**
85063	3	22	2	6	**33**
85064	1	8	2	4	**15**
85066	5	15	11	6	**37**
85067	2	6	3	1	**12**
85069	2	15	6	3	**26**
85071	1	8	5	3	**17**
85074	1	7	2	6	**16**
85080	3	2	4	2	**11**
85082	4	9	4	2	**19**
85083	7	10	0	9	**26**
85085	10	22	9	23	**64**
85086	13	18	4	22	**57**
85087	1	7	2	3	**13**
85119	6	14	10	9	**39**
85120	34	55	19	19	**127**

ZIP Code (a)	None/Uninsured (b)	Medicaid/CHIP/Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
85122	19	27	9	23	**78**
85123	4	9	4	4	**21**
85128	2	10	6	7	**25**
85131	4	5	1	7	**17**
85132	4	14	4	9	**31**
85138	33	56	12	73	**174**
85139	18	39	11	22	**90**
85140	16	35	5	34	**90**
85142	29	48	20	66	**163**
85143	16	36	4	28	**84**
85194	3	4	1	3	**11**
85201	396	585	125	176	**1282**
85202	129	230	46	110	**515**
85203	205	274	48	93	**620**
85204	572	612	102	169	**1455**
85205	61	164	60	93	**378**
85206	76	101	29	55	**261**
85207	73	87	28	49	**237**
85208	74	93	22	40	**229**
85209	47	67	16	54	**184**
85210	384	650	108	173	**1315**
85211	4	15	1	5	**25**
85212	33	44	10	42	**129**
85213	60	124	28	56	**268**
85215	3	17	6	19	**45**
85224	114	259	51	163	**587**
85225	764	1901	292	554	**3511**

ZIP Code (a)	None/Uninsured (b)	Medicaid/CHIP/Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
85226	68	143	18	114	**343**
85233	39	110	23	72	**244**
85234	42	65	18	48	**173**
85244	3	16	5	12	**36**
85248	30	81	26	69	**206**
85249	39	91	33	80	**243**
85250	8	11	3	14	**36**
85251	82	81	15	29	**207**
85254	12	20	13	19	**64**
85255	8	7	1	12	**28**
85256	4	13	4	4	**25**
85257	46	89	23	45	**203**
85258	6	7	2	11	**26**
85259	5	10	2	5	**22**
85260	8	17	3	16	**44**
85262	4	3	3	1	**11**
85268	8	9	2	2	**21**
85281	149	286	61	76	**572**
85282	175	331	50	129	**685**
85283	211	814	142	252	**1419**
85284	10	31	8	30	**79**
85285	3	16	1	5	**25**
85286	134	276	57	179	**646**
85295	45	65	17	70	**197**
85296	28	68	10	60	**166**
85297	31	41	9	30	**111**
85298	32	32	19	20	**103**

ZIP Code (a)	None/Uninsured (b)	Medicaid/CHIP/Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
85301	875	2156	310	309	**3650**
85302	151	323	48	88	**610**
85303	266	541	60	139	**1006**
85304	56	114	29	37	**236**
85305	43	86	14	68	**211**
85306	45	78	18	33	**174**
85307	33	81	18	58	**190**
85308	56	89	27	53	**225**
85310	5	14	4	5	**28**
85311	0	16	3	3	**22**
85322	2	10	1	0	**13**
85323	587	2013	267	649	**3516**
85326	207	244	47	190	**688**
85329	45	109	36	25	**215**
85331	17	10	1	8	**36**
85335	368	1505	198	476	**2547**
85337	12	11	0	2	**25**
85338	180	351	62	243	**836**
85339	190	490	76	291	**1047**
85340	65	97	20	80	**262**
85345	177	380	67	136	**760**
85351	15	99	47	28	**189**
85353	326	575	89	254	**1244**
85354	51	44	4	9	**108**
85355	10	25	8	22	**65**
85361	18	32	10	14	**74**
85363	29	139	17	43	**228**

ZIP Code (a)	None/Uninsured (b)	Medicaid/CHIP/Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
85373	6	13	7	10	**36**
85374	59	123	19	54	**255**
85375	14	17	13	6	**50**
85378	33	105	33	28	**199**
85379	62	250	26	117	**455**
85381	26	45	14	47	**132**
85382	20	60	16	38	**134**
85383	19	27	4	30	**80**
85387	13	17	4	18	**52**
85388	21	60	14	42	**137**
85390	14	10	4	0	**28**
85392	146	315	41	225	**727**
85395	47	80	11	76	**214**
85396	39	59	10	38	**146**
85541	1	7	2	3	**13**

Other ZIP Codes

ZIP Code (a)	None/Uninsured (b)	Medicaid/CHIP/Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
Other ZIP Codes	130	286	101	185	**702**
Unknown Residence	4	6	2	4	**16**
Total	**21869**	**45429**	**7033**	**13047**	**87378**

Comments

Table 3A - Patients by Age and by Sex Assigned at Birth

Universal

Line	Age Groups	Male Patients (a)	Female Patients (b)
1	Under age 1	1402	1385
2	Age 1	824	764
3	Age 2	736	726
4	Age 3	712	712
5	Age 4	711	668
6	Age 5	686	670
7	Age 6	604	590
8	Age 7	557	527
9	Age 8	530	520
10	Age 9	525	547
11	Age 10	611	561
12	Age 11	688	716
13	Age 12	640	612
14	Age 13	585	606
15	Age 14	570	616
16	Age 15	575	590
17	Age 16	539	669
18	Age 17	510	779
19	Age 18	457	739
20	Age 19	365	778
21	Age 20	351	745

Line	Age Groups	Male Patients (a)	Female Patients (b)
22	Age 21	298	788
23	Age 22	347	689
24	Age 23	323	780
25	Age 24	321	767
26	Ages 25-29	1995	4126
27	Ages 30-34	2201	3921
28	Ages 35-39	2373	4101
29	Ages 40-44	2417	4200
30	Ages 45-49	2622	3966
31	Ages 50-54	2716	3353
32	Ages 55-59	2695	3132
33	Ages 60-64	2275	2678
34	Ages 65-69	1314	1531
35	Ages 70-74	707	983
36	Ages 75-79	415	576
37	Ages 80-84	233	392
38	Age 85 and over	146	299
39	**Total Patients (Sum of Lines 1-38)**	**36576**	**50802**

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Table 3B - Demographic Characteristics

Universal

Line	Patients by Race	Hispanic/Latino (a)	Non-Hispanic/Latino (b)	Unreported/Refused to Report Ethnicity (c)	Total (d) (Sum Columns a+b+c)

Line	Patients by Race	Hispanic/Latino (a)	Non-Hispanic/Latino (b)	Unreported/Refused to Report Ethnicity (c)	Total (d) (Sum Columns a+b+c)
1	Asian	35	2108		**2143**
2a	Native Hawaiian	4	32		**36**
2b	Other Pacific Islander	88	495		**583**
2	**Total Native Hawaiian/Other Pacific Islander (Sum Lines 2a + 2b)**	**92**	**527**		**619**
3	Black/African American	245	11539		**11784**
4	American Indian/Alaska Native	107	853		**960**
5	White	50354	17955		**68309**
6	More than one race	63	227		**290**
7	Unreported/Refused to report race	1704	1490	79	**3273**
8	**Total Patients (Sum of Lines 1 + 2 + 3 to 7)**	**52600**	**34699**	**79**	**87378**

Line	Patients Best Served in a Language Other than English	Number (a)
12	Patients Best Served in a Language Other than English	34252

Line	Patients by Sexual Orientation	Number (a)
13	Lesbian or Gay	1440
14	Straight (not lesbian or gay)	37900
15	Bisexual	391
16	Something else	123
17	Don't know	45941
18	Chose not to disclose	1583
19	**Total Patients (Sum of Lines 13 to 18)**	**87378**

Line	Patients by Gender Identity	Number (a)

Line	Patients by Gender Identity	Number (a)
20	Male	36475
21	Female	50734
22	Transgender Male/Female-to-Male	56
23	Transgender Female/Male-to-Female	61
24	Other	10
25	Chose not to disclose	42
26	**Total Patients (Sum of Lines 20 to 25)**	**87378**

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Table 4 - Selected Patient Characteristics

Universal

Income as Percent of Poverty Guideline

Line	Income as Percent of Poverty Guideline	Number of Patients (a)
1	100% and below	51284
2	101 - 150%	15764
3	151 - 200%	7657
4	Over 200%	10281
5	Unknown	2392
6	**TOTAL** (Sum of Lines 1-5)	**87378**

Line	Principal Third-Party Medical Insurance	0-17 years old (a)	18 and older (b)

Line	Principal Third-Party Medical Insurance	0-17 years old (a)	18 and older (b)
7	**None/Uninsured**	1725	20144
8a	Medicaid (Title XIX)	20312	24999
8b	CHIP Medicaid	7	
8	**Total Medicaid** (Line 8a + 8b)	**20319**	**24999**
9a	Dually Eligible (Medicare and Medicaid)	7	5066
9	**Medicare** (Inclusive of dually eligible and other Title XVIII beneficiaries)	9	7024
10a	**Other Public Insurance (Non-CHIP) (specify)** Refugee Medical	105	3
10b	Other Public Insurance CHIP	3	
10	**Total Public Insurance** (Line 10a + 10b)	**108**	**3**
11	**Private Insurance**	2102	10945
12	**TOTAL** (Sum of Lines 7 + 8 + 9 +10 +11)	**24263**	**63115**

Managed Care Utilization

Line	Managed Care Utilization	Medicaid (a)	Medicare (b)	Other Public Including Non-Medicaid CHIP (c)	Private (d)	TOTAL (e)
13a	Capitated Member Months	0	0	0	0	0
13b	Fee-for-service Member Months	856757	81427	0	0	938184
13c	**Total Member Months (Sum of Lines 13a + 13b)**	**856757**	**81427**	**0**	**0**	**938184**

Line	Special Populations	Number of Patients (a)

Line	Special Populations	Number of Patients (a)
16	**Total Agricultural Workers or Dependents** (All health centers report this line)	68
23	**Total Homeless** (All health centers report this line)	372
24	**Total School-Based Health Center Patients** (All health centers report this line)	0
25	**Total Veterans** (All health centers report this line)	762
26	**Total Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site** (All health centers report this line)	87378

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Table 5 - Staffing and Utilization

Universal

Medical Care Services

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
1	Family Physicians	19.68	59309		
2	General Practitioners	0			
3	Internists	8.58	26357		
4	Obstetrician/Gynecologists	7.57	20920		
5	Pediatricians	13.96	35219		
7	Other Specialty Physicians	0.19	279		
8	**Total Physicians** (Lines 1-7)	**49.98**	**142084**	**0**	
9a	Nurse Practitioners	23.04	62821		
9b	Physician Assistants	9.18	27027		
10	Certified Nurse Midwives	3.93	10156		
10a	**Total NPs, PAs, and CNMs (Lines 9a-10)**	**36.15**	**100004**	**0**	
11	Nurses	39.12			
12	Other Medical Personnel	99.42			
13	Laboratory Personnel	29.5			
14	X-ray Personnel	3.82			
15	**Total Medical** (Lines 8 + 10a through 14)	**257.99**	**242088**	**0**	**83278**

Dental Services

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
16	Dentists	10.54	22775		
17	Dental Hygienists	2.88			
17a	Dental Therapists	0			
18	Other Dental Personnel	20.08			
19	**Total Dental Services** (Lines 16-18)	**33.5**	**22775**	**0**	**10286**

Mental Health Services

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
20a	Psychiatrists	0.67	1204		
20a1	Licensed Clinical Psychologists	0			
20a2	Licensed Clinical Social Workers	0			
20b	Other Licensed Mental Health Providers	5.17	2530		
20c	Other Mental Health Staff	2	920		
20	**Total Mental Health** (Lines 20a-c)	**7.84**	**4654**	**0**	**1640**

Substance Use Disorder Services

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
21	**Substance Use Disorder Services**	**0**	**0**		**0**

Other Professional Services

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
22	**Other Professional Services Specify** Diabetic Educators	2.98	1960		1310

Vision Services

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
22a	Ophthalmologists	0	0		
22b	Optometrists	0	0		
22c	Other Vision Care Staff	0			
22d	**Total Vision Services** (Lines 22a-c)	**0**	**0**	**0**	**0**

Pharmacy Personnel

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
23	**Pharmacy Personnel**	6.29			

Enabling Services

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
24	Case Managers	12.99	0		
25	Patient/Community Education Specialists	0	0		
26	Outreach Workers	0			
27	Transportation Staff	0			
27a	Eligibility Assistance Workers	10.96			
27b	Interpretation Staff	6.95			
27c	Community Health Workers	0			
28	**Other Enabling Services Specify**	0			
29	**Total Enabling Services** (Lines 24-28)	**30.9**	**0**	**0**	**0**

Other Programs/Services

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
29a	**Other Programs/ Services Specify**	0			
29b	**Quality Improvement Staff**	1			

Administration and Facility

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
30a	Management and Support Staff	42.54			
30b	Fiscal and Billing Staff	13.05			
30c	IT Staff	28			
31	Facility Staff	22.3			
32	Patient Support Staff	85.34			
33	**Total Facility and Non-Clinical Support Staff (Lines 30a-32)**	**191.23**			

Grand Total

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
34	**Grand Total (Lines 15+19+20+21+22+22d+23+29+29a+29**	**531.73**	**271477**	**0**	

Selected Service Detail Addendum

Line	Personnel by Major Service Category: Mental Health Service Detail	Personnel (a1)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
20a01	Physicians (other than Psychiatrists)	101	10243		6894
20a02	Nurse Practitioners	38	5088		3583
20a03	Physician Assistants	15	2366		1702
20a04	Certified Nurse Midwives	7	99		80

Substance Use Disorder Detail

Line	Personnel by Major Service Category: Substance Use Disorder Detail	Personnel (a1)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
21a	Physicians (other than Psychiatrists)	93	4203		2562
21b	Nurse Practitioners (Medical)	36	1706		1349
21c	Physician Assistants	14	954		710
21d	Certified Nurse Midwives	6	43		37
21e	Psychiatrists	4	402		171
21f	Licensed Clinical Psychologists	0	0		0
21g	Licensed Clinical Social Workers	0	0		0
21h	Other Licensed Mental Health Providers	7	338		156

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Table 6A - Selected Diagnoses and Services Rendered

Universal

Selected Infectious and Parasitic Diseases

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
1-2	Symptomatic/Asymptomatic human immunodeficiency virus (HIV)	B20, B97.35, O98.7-, Z21	12774	3865
3	Tuberculosis	A15- through A19-, O98.0-	36	18
4	Sexually transmitted infections	A50- through A64- (exclude A63.0)	1297	924
4a	Hepatitis B	B16.0 through B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, O98.4-	319	169
4b	Hepatitis C	B17.10, B17.11, B18.2, B19.20, B19.21	1139	695

Selected Diseases of the Respiratory System

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
5	Asthma	J45-	5447	3645
6	Chronic lower respiratory diseases	J40- through J44-, J47-	3201	2022

Selected Other Medical Conditions

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
7	Abnormal breast findings, female	C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.81-, C50.91-, C79.81, D05-, D48.6-, D49.3-, N60-, N63-, R92-	1475	1194
8	Abnormal cervical findings	C53-, C79.82, D06-, R87.61-, R87.629, R87.810, R87.820	1901	1254
9	Diabetes mellitus	E08- through E13-, O24-(exclude O24.41-)	31466	10444
10	Heart disease (selected)	I01-, I02- (exclude I02.9), I20- through I25-, I27-, I28-, I30- through I52-	5786	2892
11	Hypertension	I10- through I16-, O10-, O11-	37081	15846
12	Contact dermatitis and other eczema	L23- through L25-, L30- (exclude L30.1, L30.3, L30.4, L30.5), L58-	2329	1917
13	Dehydration	E86-	177	171
14	Exposure to heat or cold	T33-, T34-, T67-, T68-, T69-, W92-, W93-	10	10
14a	Overweight and obesity	E66-, Z68- (exclude Z68.1, Z68.20 through Z68.24, Z68.51, Z68.52)	16390	11777

Selected Childhood Conditions (limited to ages 0 through 17)

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
15	Otitis media and Eustachian tube disorders	H65- through H69-	1915	1510
16	Selected perinatal/neonatal medical conditions	A33-, P19-, P22-through P29- (exclude P29.3), P35- through P96- (exclude P54-, P91.6-, P92-, P96.81), R78.81, R78.89	786	558
17	Lack of expected normal physiological development (such as delayed milestone, failure to gain weight, failure to thrive); nutritional deficiencies in children only. Does not include sexual or mental development.	E40- through E46-, E50- through E63-, P92-, R62- (exclude R62.7), R63.3	1529	1085

Selected Mental Health Conditions and Substance Use Disorders

Line	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
18	Alcohol-related disorders	F10-, G62.1, O99.31-	1035	627
19	Other substance-related disorders (excluding tobacco use disorders)	F11- through F19- (exclude F17-), G62.0, O99.32-	2943	1494
19a	Tobacco use disorder	F17-, O99.33-	2912	2158
20a	Depression and other mood disorders	F30- through F39-	9596	5195
20b	Anxiety disorders, including post-traumatic stress disorder (PTSD)	F06.4, F40- through F42-, F43.0, F43.1-, F93.0	9125	5034
20c	Attention deficit and disruptive behavior disorders	F90- through F91-	716	527
20d	Other mental disorders, excluding drug or alcohol dependence	F01- through F09- (exclude F06.4), F20- through F29-, F43- through F48- (exclude F43.0- and F43.1-), F50- through F99- (exclude F55-, F84.2, F90-, F91-, F93.0, F98-), O99.34-, R45.1, R45.2, R45.5, R45.6, R45.7, R45.81, R45.82, R48.0	7063	4377

Selected Diagnostic Tests/Screening/Preventive Services

Line	Service Category	Applicable ICD-10-CM Code or CPT-4/II Code	Number of Visits (a)	Number of Patients (b)

Line	Service Category	Applicable ICD-10-CM Code or CPT-4/II Code	Number of Visits (a)	Number of Patients (b)
21	HIV test	**CPT-4:** 86689, 86701 through 86703, 87389 through 87391, 87534 through 87539, 87806	7794	7104
21a	Hepatitis B test	**CPT-4:** 86704 through 86707, 87340, 87341, 87350	3424	3371
21b	Hepatitis C test	**CPT-4:** 86803, 86804, 87520 through 87522	3295	3203
22	Mammogram	**CPT-4:** 77065, 77066, 77067 OR **ICD-10:** Z12.31	7762	6938
23	Pap test	**CPT-4:** 88141 through 88153, 88155, 88164 through 88167, 88174, 88175 OR **ICD-10:** Z01.41-, Z01.42, Z12.4 (exclude Z01.411 and Z01.419)	7641	7428
24	Selected immunizations: hepatitis A; haemophilus influenzae B (HiB); pneumococcal, diphtheria, tetanus, pertussis (DTaP) (DTP) (DT); mumps, measles, rubella (MMR); poliovirus; varicella; hepatitis B	**CPT-4:** 90632, 90633, 90634, 90636, 90643, 90644, 90645, 90646, 90647, 90648, 90669, 90670, 90696, 90697, 90698, 90700, 90701, 90702, 90703, 90704, 90705, 90706, 90707, 90708, 90710, 90712, 90713, 90714, 90715, 90716, 90718, 90720, 90721, 90723, 90730, 90731, 90732, 90740, 90743, 90744, 90745, 90746, 90747, 90748	20114	15343
24a	Seasonal flu vaccine	**CPT-4:** 90630, 90653 through 90657, 90658, 90661, 90662, 90672, 90673, 90674, 90682, 90685 through 90689, 90749, 90756	16084	14903
25	Contraceptive management	**ICD-10:** Z30-	6704	4513
26	Health supervision of infant or child (ages 0 through 11)	**CPT-4:** 99381 through 99383, 99391 through 99393 **ICD-10:** Z00.1-	22210	13335
26a	Childhood lead test screening (9 to 72 months)	**ICD-10:** Z13.88 **CPT-4:** 83655	2210	2152
26b	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	**CPT-4:** 99408, 99409 **HCPCS:** G0396, G0397, G0443, H0050	0	0
26c	Smoke and tobacco use cessation counseling	**CPT-4:** 99406, 99407 OR **HCPCS:** S9075 OR **CPT-II:** 4000F, 4001F, 4004F	6570	5390
26d	Comprehensive and intermediate eye exams	**CPT-4:** 92002, 92004, 92012, 92014	0	0

Selected Dental Services

Line	Service Category	Applicable ADA Code	Number of Visits (a)	Number of Patients (b)

Line	Service Category	Applicable ADA Code	Number of Visits (a)	Number of Patients (b)
27	Emergency services	**ADA:** D0140, D9110	27	27
28	Oral exams	**ADA:** D0120, DO145, D0150, D0160, D0170, D0171, D0180	12005	9497
29	Prophylaxis-adult or child	**ADA:** D1110, D1120	5581	4260
30	Sealants	**ADA:** D1351	523	460
31	Fluoride treatment-adult or child	**ADA:** D1206, D1208 **CPT-4:**99188	4027	3005
32	Restorative services	**ADA:** D21xx through D29xx	4177	2370
33	Oral surgery (extractions and other surgical procedures)	**ADA:**D7xxx	3109	2559
34	Rehabilitative services (Endo, Perio, Prostho, Ortho)	**ADA:** D3xxx, D4xxx, D5xxx, D6xxx, D8xxx	2708	1448

Sources of Codes:
ICD-10-CM (2019)-National Center for Health Statistics (NCHS)
CPT (2019)-American Medical Association (AMA)
Code on Dental Procedures and Nomenclature CDT Code (2019)-Dental Procedure Codes. American Dental Association (ADA)
Note: "X" in a code denotes any number including the absence of a number in that place. Dashes (-) in a code indicate that additional characters are required. ICD-10-CM codes all have at least four digits. These codes are not intended to reflect if a code is billable or not. Instead, they are used to point out that other codes in the series are to be considered.

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Table 6B - Quality of Care Measures

Universal

[X]: Prenatal Care Provided by Referral Only (Check if Yes)

Section A - Age Categories for Prenatal Care Patients:

Demographic Characteristics of Prenatal Care Patients

Line	Age	Number of Patients (a)

Line	Age	Number of Patients (a)
1	Less than 15 years	4
2	Ages 15-19	266
3	Ages 20-24	703
4	Ages 25-44	1776
5	Ages 45 and over	9
6	**Total Patients** (Sum of Lines 1-5)	**2758**

Section B - Early Entry into Prenatal Care

Line	Early Entry into Prenatal Care	Women Having First Visit with Health Center (a)	Women Having First Visit with Another Provider (b)
7	First Trimester	1562	187
8	Second Trimester	697	89
9	Third Trimester	176	47

Section C - Childhood Immunization Status

Line	Childhood Immunization Status	Total Patients with 2nd Birthday (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Immunized (c)
10	MEASURE: Percentage of children 2 years of age who received age appropriate vaccines by their 2nd birthday	1491	1491	644

Section D - Cervical Cancer Screening

Line	Cervical Cancer Screening	Total Female Patients Aged 23 through 64 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Tested (c)
11	MEASURE: Percentage of women 23-64 years of age who were screened for cervical cancer	29191	29191	13906

Section E - Weight Assessment and Counseling for Nutrition and Physical Activity of Children and Adolescents

Line	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Total Patients Aged 3 through 17 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Counseling and BMI Documented (c)
12	MEASURE: Percentage of patients 3-17 years of age with a BMI percentile *and* counseling on nutrition *and* physical activity documented	15873	15873	11013

Section F - Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

Line	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Total Patients Aged 18 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with BMI Charted and Follow-Up Plan Documented as Appropriate (c)
13	MEASURE: Percentage of patients 18 years of age and older with (1) BMI documented and (2) follow-up plan documented if BMI is outside normal parameters	51108	51108	32368

Section G - Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Line	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Total Patients Aged 18 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Assessed for Tobacco Use *and* Provided Intervention if a Tobacco User (c)
14a	MEASURE: Percentage of patients aged 18 years of age and older who (1) were screened for tobacco use one or more times within 24 months, *and* (2) if identified to be a tobacco user received cessation counseling intervention	41684	41684	36012

Section H - Use of Appropriate Medications for Asthma

Line	Use of Appropriate Medications for Asthma	Total Patients Aged 5 through 64 with Persistent Asthma (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Acceptable Plan (c)
16	MEASURE: Percentage of patients 5 through 64 years of age identified as having persistent asthma and were appropriately ordered medication	1530	1530	1309

Section I - Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Line	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Total Patients Aged 21 and Older at High Risk of Cardiovascular Events (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Prescribed or On Statin Therapy (c)
17a	MEASURE: Percentage of patients 21 years of age and older at high risk of cardiovascular events who were prescribed or were on statin therapy	14421	14421	9767

Section J - Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet

Line	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	Total Patients Aged 18 and Older with IVD Diagnosis or AMI, CABG, or PCI Procedure (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Documentation of Aspirin or Other Antiplatelet Therapy (c)
18	MEASURE: Percentage of patients 18 years of age and older with a diagnosis of IVD or AMI, CABG, or PCI procedure with aspirin or another antiplatelet	2330	2330	1882

Section K - Colorectal Cancer Screening

Line	Colorectal Cancer Screening	Total Patients Aged 50 through 75 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Appropriate Screening for Colorectal Cancer (c)
19	MEASURE: Percentage of patients 50 through 75 years of age who had appropriate screening for colorectal cancer	19577	19577	9640

Section L - HIV Linkage to Care

Line	HIV Linkage to Care	Total Patients First Diagnosed with HIV (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Seen Within 90 Days of First Diagnosis of HIV (c)

Line	HIV Linkage to Care	Total Patients First Diagnosed with HIV (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Seen Within 90 Days of First Diagnosis of HIV (c)
20	MEASURE: Percentage of patients whose first ever HIV diagnosis was made by health center staff between October 1 of the prior year and September 30 of the measurement year and who were seen for follow-up treatment within 90 days of that first-ever diagnosis	3	3	2

Section M - Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Line	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Total Patients Aged 12 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Screened for Depression and Follow-Up Plan Documented as Appropriate (c)
21	MEASURE: Percentage of patients 12 years of age and older who were (1) screened for depression with a standardized tool *and*, if screening was positive, (2) had a follow-up plan documented	58277	58277	41959

Section N - Dental Sealants for Children between 6-9 Years

Line	Dental Sealants for Children between 6-9 Years	Total Patients Aged 6 through 9 at Moderate to High Risk for Caries (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Sealants to First Molars (c)
22	MEASURE: Percentage of children 6 through 9 years of age at moderate to high risk of caries who received a sealant on a first permanent molar	518	518	332

Table 7 - Health Outcomes and Disparities

Deliveries and Birth Weight

Line	Description	Patients (a)
0	HIV-Positive Pregnant Women	44
2	Deliveries Performed by Health Center's Providers	1852

Hispanic/Latino

Line	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: < 1500 grams (1b)	Live Births: 1500 - 2499 grams (1c)	Live Births: > = 2500 grams (1d)
1a	Asian	0	0	0	0
1b1	Native Hawaiian	0	0	0	0
1b2	Other Pacific Islander	2	0	0	2
1c	Black/African American	5	1	1	5
1d	American Indian/Alaska Native	2	1	1	2
1e	White	1196	16	63	1186
1f	More than One Race	4	0	0	4
1g	Unreported/Refused to Report Race	11	1	1	11
	Subtotal Hispanic/Latino	**1220**	**19**	**66**	**1210**

Non-Hispanic/Latino

Line	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: < 1500 grams (1b)	Live Births: 1500 - 2499 grams (1c)	Live Births: > = 2500 grams (1d)

Line	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: < 1500 grams (1b)	Live Births: 1500 - 2499 grams (1c)	Live Births: > = 2500 grams (1d)
2a	Asian	46	4	3	45
2b1	Native Hawaiian		0	0	0
2b2	Other Pacific Islander	16	0	0	16
2c	Black/African American	256	8	23	250
2d	American Indian/Alaska Native	15	0	2	15
2e	White	142	0	14	138
2f	More than One Race	3	1	1	3
2g	Unreported/Refused to Report Race	15	0	0	15
	Subtotal Non-Hispanic/Latino	**493**	**13**	**43**	**482**

Unreported/Refused to Report Race and Ethnicity

Line	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: < 1500 grams (1b)	Live Births: 1500 - 2499 grams (1c)	Live Births: > = 2500 grams (1d)
h	Unreported/Refused to Report Race and Ethnicity	0	0	0	0
i	**Total**	**1713**	**32**	**109**	**1692**

Controlling High Blood Pressure

Hispanic/Latino

Line	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2a)	Number Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)

Line	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2a)	Number Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)
1a	Asian	13	13	8
1b1	Native Hawaiian	3	3	2
1b2	Other Pacific Islander	6	6	3
1c	Black/African American	37	37	17
1d	American Indian/Alaska Native	17	17	8
1e	White	7627	7627	4023
1f	More than One Race	4	4	0
1g	Unreported/Refused to Report Race	278	278	159
	Subtotal Hispanic/Latino	**7985**	**7985**	**4220**

Non-Hispanic/Latino

Line	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2a)	Number Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)
2a	Asian	490	490	261
2b1	Native Hawaiian	11	11	6
2b2	Other Pacific Islander	89	89	44
2c	Black/African American	2474	2474	1187
2d	American Indian/Alaska Native	113	113	15
2e	White	3890	3890	2173
2f	More than One Race	17	17	10
2g	Unreported/Refused to Report Race	217	217	116
	Subtotal Non-Hispanic/Latino	**7301**	**7301**	**3812**

Unreported/Refused to Report Race and Ethnicity

Line	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2a)	Number Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)
h.	Unreported/Refused to Report Race and Ethnicity	2	2	1
i	**Total**	**15288**	**15288**	**8033**

Diabetes: Hemoglobin A1c Poor Control

Hispanic/Latino

Line	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3a)	Number Charts Sampled or EHR Total (3b)	Patients with HbA1c >9% or No Test During Year (3f)
1a	Asian	4	4	0
1b1	Native Hawaiian	1	1	0
1b2	Other Pacific Islander	9	9	3
1c	Black/African American	21	21	12
1d	American Indian/Alaska Native	16	16	8
1e	White	6565	6565	2145
1f	More than One Race	2	2	1
1g	Unreported/Refused to Report Race	211	211	81
	Subtotal Hispanic/Latino	**6829**	**6829**	**2250**

Non-Hispanic/Latino

Line	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3a)	Number Charts Sampled or EHR Total (3b)	Patients with HbA1c >9% or No Test During Year (3f)

Line	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3a)	Number Charts Sampled or EHR Total (3b)	Patients with HbA1c >9% or No Test During Year (3f)
2a	Asian	253	253	40
2b1	Native Hawaiian	6	6	3
2b2	Other Pacific Islander	57	57	21
2c	Black/African American	1258	1258	402
2d	American Indian/Alaska Native	116	116	46
2e	White	1947	1947	549
2f	More than One Race	10	10	3
2g	Unreported/Refused to Report Race	133	133	30
	Subtotal Non-Hispanic/Latino	**3780**	**3780**	**1094**

Unreported/Refused to Report Race and Ethnicity

Line	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3a)	Number Charts Sampled or EHR Total (3b)	Patients with HbA1c >9% or No Test During Year (3f)
h	Unreported/Refused to Report Race and Ethnicity	11	11	4
i	**Total**	**10620**	**10620**	**3348**

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Submission Status: Review In Progress

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Table 8A - Financial Costs

Universal

* Column c is equal to the sum of column a and column b.

Financial Costs of Medical Care

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
1	Medical Staff	36617793	9535746	**46153539**
2	Lab and X-ray	8198485	2134992	**10333477**
3	Medical/Other Direct	3380389	880297	**4260686**
4	**Total Medical Care Services** (Sum of Lines 1 through 3)	**48196667**	**12551035**	**60747702**

Financial Costs of Other Clinical Services

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
5	Dental	3791170	987269	**4778439**
6	Mental Health	1202007	313018	**1515025**
7	Substance Use Disorder	0	0	**0**
8a	Pharmacy not including pharmaceuticals	587086	152885	**739971**
8b	Pharmaceuticals	1198104		**1198104**
9	**Other Professional Specify:** Nutritionist	392260	102149	**494409**
9a	Vision	0	0	**0**
10	**Total Other Clinical Services** (Sum of Lines 5 through 9a)	**7170627**	**1555321**	**8725948**

Financial Costs of Enabling and Other Services

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
11a	Case Management	1711467		**1711467**
11b	Transportation	0		**0**
11c	Outreach	0		**0**
11d	Patient and Community Education	0		**0**
11e	Eligibility Assistance	563429		**563429**
11f	Interpretation Services	457701		**457701**
11g	**Other Enabling Services Specify:**	0		**0**
11h	Community Health Workers	0		**0**
11	**Total Enabling Services Cost (Sum of Lines 11a through 11h)**	**2732597**	**711603**	**3444200**
12	**Other Related Services Specify:** Cost of Leased Spaces	22042		**22042**
12a	Quality Improvement	114061	29703	**143764**
13	**Total Enabling and Other Services (Sum of Lines 11, 12, and 12a)**	**2868700**	**741306**	**3610006**

Facility and Non-Clinical Support Services and Totals

Line	Cost Center	Accrued Cost (a)	Allocation of Facility and Non-Clinical Support Services (b)	Total Cost After Allocation of Facility and Non-Clinical Support Services (c)
14	Facility	1743137		
15	Non-Clinical Support Services	13104525		
16	**Total Facility and Non-Clinical Support Services (Sum of Lines 14 and 15)**	**14847662**		
17	**Total Accrued Costs (Sum of Lines 4 + 10 + 13 + 16)**	**73083656**		**73083656**
18	**Value of Donated Facilities, Services, and Supplies Specify:**			0
19	**Total with Donations (Sum of Lines 17 and 18)**			**73083656**

Table 9D - Patient Related Revenue

Universal

				Retroactive Settlements, Receipts, and Paybacks (c)						
Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Collection of Reconciliati Wrap-Around Current Year (c1)	Collection of Reconciliati Wrap-Around Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty / Payback (c4)	Allowances (d)	Sliding Fee Discounts (e)	Bad Debt Write Off (f)
1	Medicaid Non-Managed Care	145107	27316	0	0	0	0	119174		
2a	Medicaid Managed Care (capitated)	0	0	0	0	0	0	0		
2b	Medicaid Managed Care (fee-for-service)	148572077	37072439	5650379	0	100528	0	107437974		
3	**Total Medicaid (Sum of Lines 1 + 2a + 2b)**	**148717184**	**37099755**	**5650379**	**0**	**100528**	**0**	**107557148**		
4	Medicare Non-Managed Care	22215277	5042789	0	0	0	0	17101675		
5a	Medicare Managed Care (capitated)	0	0	0	0	0	0	0		
5b	Medicare Managed Care (fee-for-service)	13359589	3476532	0	0	0	0	10247800		
6	**Total Medicare (Sum of Lines 4 + 5a + 5b)**	**35574866**	**8519321**	**0**	**0**	**0**	**0**	**27349475**		
7	Other Public, including Non-Medicaid CHIP, Non-Managed Care	1860414	137721	0	0	0	0	1514199		

				Retroactive Settlements, Receipts, and Paybacks (c)						
Line	Payer Category	Full Charges This Period (a)	Amount Collected This Period (b)	Collection of Reconciliati Wrap-Around Current Year (c1)	Collection of Reconciliati Wrap-Around Previous Years (c2)	Collection of Other Payments: P4P, Risk Pools, etc. (c3)	Penalty / Payback (c4)	Allowances (d)	Sliding Fee Discounts (e)	Bad Debt Write Off (f)
8a	Other Public, including Non-Medicaid CHIP, Managed Care (capitated)	0	0	0	0	0	0	0		
8b	Other Public, including Non-Medicaid CHIP, Managed Care (fee-for-service)	0	0	0	0	0	0	0		
9	**Total Other Public (Sum of Lines 7 + 8a + 8b)**	**1860414**	**137721**	**0**	**0**	**0**	**0**	**1514199**		
10	Private Non-Managed Care	46704614	7087364			0	0	38600115		
11a	Private Managed Care (capitated)	0	0			0	0	0		
11b	Private Managed Care (fee-for-service)	0	0			0	0	0		
12	**Total Private (Sum of Lines 10 + 11a + 11b)**	**46704614**	**7087364**			**0**	**0**	**38600115**		
13	**Self-pay**	80737704	4817358						73063073	
14	**TOTAL (Sum of Lines 3 + 6 + 9 + 12 + 13)**	**313594782**	**57661519**	**5650379**	**0**	**100528**	**0**	**175020937**	**73063073**	**0**

Table 9E - Other Revenues

BPHC Grants (Enter Amount Drawn Down - Consistent with PMS-272)

Line	Source	Amount (a)
1a	Migrant Health Center	0
1b	Community Health Center	112175
1c	Health Care for the Homeless	0
1e	Public Housing Primary Care	0
1g	**Total Health Center** (Sum Lines 1a through 1e)	**112175**
1k	Capital Development Grants, including School-Based Health Center Capital Grants	0
1	**Total BPHC Grants** (Sum of Lines 1g + 1k)	**112175**

Other Federal Grants

Line	Source	Amount (a)
2	Ryan White Part C HIV Early Intervention	41649
3	**Other Federal Grants Specify:** ReLink-Integrating Treatment & Transition; Ryan White Part D-Youth/Women/Children	426597
3a	Medicare and Medicaid EHR Incentive Payments for Eligible Provider	1557104
5	**Total Other Federal Grants** (Sum of Lines 2-3a)	**2025350**

Non-Federal Grants Or Contracts

Line	Source	Amount (a)

Line	Source	Amount (a)
6	**State Government Grants and Contracts Specify:** FTF-Care Coord-Cent Phx; FTF-Care Coord-NW/SW; FTF-Care Coord-E Maricopa; FTF-FLC; Reproductive Health (Indirect); CDC- HIV Prevention- TESTAZ; Emergency Preparedness- HPP; GOHS- Toddler Carseats/Helmets; First Episode Intervention Clinic; Refugee Health Promotion; ADHS-Viral Hepatitis; State Targeted Response to the Opioid Crisis; Well Woman Check	4414959
6a	**State/Local Indigent Care Programs Specify:**	0
7	**Local Government Grants and Contracts Specify:** Ryan White Part A-Primary Care (Salary/ERE/Indirect); Ryan White Part A-Mental Health (Indirect); Ryan White Part A-Substance Abuse (Indirect); Ryan White Part A-Oral Health (Salary/ERE/Indirect); Ryan White Part A-Cost Sharing (Indirect); Ryan White Part A-Health Literacy; Ryan White Part A-Non Med Case Mgt; Healthy Start	537164
8	**Foundation/Private Grants and Contracts Specify:** Maricopa Wings to Safety-Domestic Violence; Gilead Focus; Maricopa Cancert Treatment Program; Mountain Park; Other Misc Grants	334145
9	**Total Non-Federal Grants and Contracts (Sum of Lines 6 + 6A + 7 + 8)**	**5286268**
10	**Other Revenue (non-patient related revenue not reported elsewhere) Specify:** Avondale FHC and Glendale FHC Rent Received	22496
11	**Total Revenue (Sum of Lines 1 + 5 + 9 + 10)**	**7446289**

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Health Center Health Information Technology (HIT) Capabilities

HIT

1. Does your center currently have an Electronic Health Record (EHR) system installed and in use?:

[X]: Yes, installed at all sites and used by all providers

[_]: Yes, but only installed at some sites or used by some providers

[_]: No

1a. Is your system certified by the Office of the National Coordinator for Health IT (ONC) Health IT Certification Program?:

[X]: Yes

[_]: No

1a1.Vendor: Epic Systems Corporation (not including OCHIN)

Other (Please specify):

1a2.Product Name: Epic Ambulatory/Dentrix Enterprise

1a3.Version Number: February 2019/8.0 MCE

1a4.ONC-certified Health IT Product List Number: -0015EF1PA81XEZ3, 14.07.07.1624.DEC01.01.01.1.180403

1a1.Vendor: Select one

Other (Please specify):

1a2.Product Name:

1a3.Version Number:

1b. Did you switch to your current EHR from a previous system this year?:

[_]: Yes

[X]: No

1c. How many sites have the EHR system in use?:

1d. How many providers use the EHR system?:

1e. When do you plan to install the EHR system?:

[_]: a. 3 months

[_]: b. 6 months

[_]: c. 1 Year or more

[_]: d. Not planned

2. Does your center send prescriptions to the pharmacy electronically? (Do not include faxing.):

[X]: Yes

[_]: No

[_]: Not Sure

3. Does your center use computerized, clinical decision support, such as alerts for drug allergies, checks for drug-drug interactions, reminders for preventive screening tests, or other similar functions?:

[X]: Yes

[_]: No

[_]: Not Sure

4. With which of the following key providers/health care settings does your center electronically exchange clinical information? (Select all that apply):

[X]: Hospitals/Emergency rooms

[X]: Specialty clinicians

[_]: Other primary care providers

[_]: None of the above

[_]: Other (please describe)

Other (please describe):

5. Does your center engage patients through health IT in any of the following ways? (Select all that apply):

[X]: Patient portals

[X]: Kiosks

[X]: Secure messaging

[_]: Other (please describe)

[_]: No, we do not engage patients using HIT

Other (please describe):

6. Question removed.

7. How do you collect data for UDS clinical reporting (Tables 6B and 7)?:

[X]: We use the EHR to extract automated reports

[_]: We use the EHR but only to access individual patient charts

[_]: We use the EHR in combination with another data analytic system

[_]: We do not use the EHR

8. Question removed.

9. Question removed.

10. How does your health center utilize HIT and EHR data beyond direct patient care? (Select all that apply):

[X]: Quality improvement

[X]: Population health management

[_]: Program evaluation

[X]: Research

[_]: Other (please describe)

[_]: We do not utilize HIT or EHR data beyond direct patient care

Other (please describe):

11. Does your health center collect data on individual patients' social risk factors, outside of the data reportable in the UDS?:

[X]: Yes

[_]: No, but we are in planning stages to collect this information

[_]: No, we are not planning to collect this information

12. Which standardized screener(s) for social risk factors, if any, do you use? (Select all that apply):

[_]: Accountable Health Communities Screening Tools

[_]: Upstream Risks Screening Tool and Guide

[_]: iHELP

[X]: Recommend Social and Behavioral Domains for EHRs

[X]: Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)

[X]: Well Child Care, Evaluation, Community Resources, Advocacy Referral, Education (WE CARE)

[_]: WellRx

[_]: Other (please describe)

[_]: We do not use a standardized screener

Other (please describe):

Other Data Elements

Other Data Elements

1. Medication-Assisted Treatment (MAT) for Opioid Use Disorder

a. How many physicians, certified nurse practitioners, and physician assistants,[1] on-site or with whom the health center has contracts, have obtained a Drug Addiction Treatment Act of 2000 (DATA) waiver to treat opioid use disorder with medications specifically approved by the U.S. Food and Drug Administration (FDA) for that indication?: 15

b. How many patients received medication-assisted treatment for opioid use disorder from a physician, certified nurse practitioner, or physician assistant, with a DATA waiver working on behalf of the health center?: 10

2. Did your organization use telemedicine to provide remote clinical care services? ***(The term "telehealth" includes "telemedicine" services but encompasses a broader scope of remote healthcare services. Telemedicine is specific to remote clinical services whereas telehealth may include remote non-clinical services, such as provider training, administrative meetings, and continuing medical education, in addition to clinical services.)*****:**

[_]: Yes

[X]: No

2a1. Who did you use telemedicine to communicate with? (Select all that apply):

[_]: Patients at remote locations from your organization (e.g., home telehealth, satellite locations)

[_]: Specialists outside your organization (e.g., specialists at referral centers)

2a2. What telehealth technologies did you use? (Select all that apply):

[_]: Real-time telehealth (e.g., live videoconferencing)

[_]: Store-and-forward telehealth (e.g., secure email with photos or videos of patient examinations)

[_]: Remote patient monitoring

[_]: Mobile Health (mHealth)

2a3. What primary telemedicine services were used at your organization? (Select all that apply):

[_]: Primary care

[_]: Oral health

[_]: Behavioral health: Mental health

[_]: Behavioral health: Substance use disorder

[_]: Dermatology

[_]: Chronic conditions

[_]: Disaster management

[_]: Consumer health education

[_]: Provider-to-provider consultation

[_]: Radiology

[_]: Nutrition and dietary counseling

[_]: Other (Please specify)

Other (Please specify):

2b. If you did not have telemedicine services, please comment why (Select all that apply):

[_]: Have not considered/unfamiliar with telehealth service options

[_]: Policy barriers (Select all that apply)

[_]: Inadequate broadband/telecommunication service (Select all that apply)

[_]: Lack of funding for telehealth equipment

[_]: Lack of training for telehealth services

[_]: Not needed

[X]: Other (Please specify)

Other (Please specify): At this time Valleywise is looking into to developing and offering the service in the future.

Policy barriers (Select all that apply):

[_]: Lack of or limited reimbursement

[_]: Credentialing, licensing, or privileging

[_]: Privacy and security

[_]: Other (Please specify)

Other (Please specify):

Inadequate broadband/telecommunication service (Select all that apply):

[_]: Cost of service

[_]: Lack of infrastructure

[_]: Other (Please specify)

Other (Please specify):

3. Provide the number of all assists provided during the past year by all trained assisters (e.g., certified application counselor or equivalent) working on behalf of the health center (employees, contractors, or volunteers), regardless of the funding source that is supporting the assisters' activities. Outreach and enrollment assists are defined as customizable education sessions about affordable health insurance coverage options (one-on-one or small group) and any other assistance provided by a health center assister to facilitate enrollment.

Enter number of assists: 1

[1] With the enactment of the Comprehensive Addiction and Recovery Act of 2016, Public Law 114-198, opioid treatment prescribing privileges have been extended beyond physicians to include certain qualifying nurse practitioners (NPs) and physician assistants (PAs).

Workforce

1. Does your health center provide health professional education/training? Health professional education/training does not include continuing education units.:

[X]: Yes

[_]: No

1a. If yes, which category best describes your health center's role in the health professional education/training process?:

[_]: Sponsor [2]

[X]: Training site partner [3]

[_]: Other (please describe)

Other (please describe):

2. Please indicate the range of health professional education/training offered at your health center and how many individuals you have trained in each category within the last year.

	Medical	Pre-Graduate/Certificate (a)	Post-Graduate Training (b)
1.	Physicians	588	
	a. Family Physicians		63
	b. General Practitioners		
	c. Internists		120
	d. Obstetrician/Gynecologists		36
	e. Pediatricians		97
	f. Other Specialty Physicians		113
2.	Nurse Practitioners	21	
3.	Physician Assistants	5	
4.	Certified Nurse Midwives		
5.	Registered Nurses	2	
6.	Licensed Practical Nurses/Vocational Nurses		
7.	Medical Assistants	26	

	Dental	Pre-Graduate/Certificate (a)	Post-Graduate Training (b)

	Dental	Pre-Graduate/Certificate (a)	Post-Graduate Training (b)
8.	Dentists	6	8
9.	Dental Hygienists	36	
10.	Dental Therapists		

	Mental Health and Substance Use Disorder	Pre-Graduate/Certificate (a)	Post-Graduate Training (b)
11.	Psychiatrists		29
12.	Clinical Psychologists		
13.	Clinical Social Workers	2	
14.	Professional Counselors		
15.	Marriage and Family Therapists		
16.	Psychiatric Nurse Specialists		
17.	Mental Health Nurse Practitioners		
18.	Mental Health Physician Assistants		
19.	Substance Use Disorder Personnel		

	Vision	Pre-Graduate/Certificate (a)	Post-Graduate Training (b)
20.	Ophthalmologists		
21.	Optometrists		

	Other Professionals	Pre-Graduate/Certificate (a)	Post-Graduate Training (b)
22.	Chiropractors		
23.	Dieticians/Nutritionists		
24.	Pharmacists	38	3
25.	**Other please specify** SRNA, Doctorate of Behavioral Health-Clinical, Doctorate of Behavioral Health-Management, Nursing Cohorts, Nursing Preceptorship, Phlebotomy	61	

3. Provide the number of health center staff serving as preceptors at your health center.: 538

4. Provide the number of health center staff (non-preceptors) supporting health center training programs.: 49

5. How often does your health center implement satisfaction surveys for providers?:

[_]: Monthly

[_]: Quarterly

[_]: Annually

[_]: We do not currently conduct provider satisfaction surveys

[X]: Other (please describe)

Other (please describe): Immediately following a provider visit.

6. How often does your health center implement satisfaction surveys for general staff?:

[_]: Monthly

[_]: Quarterly

[_]: Annually

[_]: We do not currently conduct staff satisfaction surveys

[X]: Other (please describe)

Other (please describe): Survey is sent out after every visit.

[2] A sponsor hosts a comprehensive health profession education and/or training program, the implementation of which may require partnerships with other entities that deliver focused, time-limited education and/or training (e.g., a teaching health center with a family medicine residency program).

[3] A training site partner delivers focused, time-limited education and/or training to learners in support of a comprehensive curriculum hosted by another health profession education provider (e.g., month-long primary care dentistry experience for dental students).

BHCMIS ID: 09E00911 - MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT, Phoenix, AZ

Program Name: Health Center 330

Submission Status: Review In Progress

Date Requested: 03/23/2020 5:07 PM EST

Date of Last Report Refreshed: 03/23/2020 5:07 PM EST

UDS Report - 2019

Data Audit Report

Table 4-Selected Patient Characteristics

Edit 07245: Managed Care Enrollment in Question - The total Medicaid Managed Care Member Months reported on Table 4 Line 13c Column A suggests that Medicaid Managed Care annual enrollment exceeds total patients with Medicaid insurance (Line 8 Columns A+B) by 150% or greater. Please correct or explain.

Related Tables: Table 4(UR)

Jane Somerhiser (Health Center) on 02/14/2020 12:44 PM EST: Medicaid patients may be assigned to Valleywise, but that does not mean they visited Valleywise for treatment.

Edit 05870: Patient Count in Question - You report a high proportion of your total patients served at a health center located in or immediately accessible to a public housing site on line 26 (100)% compared to total patients. Please correct or explain.

Related Tables: Table 4(UR)

Jane Somerhiser (Health Center) on 02/14/2020 12:33 PM EST: All FHC clinics are located near public housing. One clinic that was not was closed early in the reporting year.

Edit 03805: Member Months in Question - A large number of Medicaid Managed Care member months (856757) is reported which reflects an average Medicaid member year enrollment of (71396.41) individuals. This is high compared to total patients with Medicaid insurance reported on Line 8 (45318). Please verify that more than 50% of Medicaid managed care enrollees did not seek services. Please correct or explain.

Related Tables: Table 4(UR)

Jane Somerhiser (Health Center) on 02/14/2020 12:35 PM EST: Medicaid patients may be assigned to Valleywise, but that does not mean they visited Valleywise for treatment.

Table 6B-Quality of Care Indicators

Edit 05778: Line 13 Universe in Question - You are reporting (84.96)% of total possible medical patients in the universe for the Adult Weight Screening and Follow-Up measure (line 13 Column A). This appears low compared to estimated medical patients in the age group being measured. Please review and correct or explain.

Related Tables: Table 6B, Table 3A(UR), Table 4(UR), Table 5(UR)

Alyson Roby (Reviewer) on 02/28/2020 2:34 PM EST: Further grantee explanation: 321 Patients have a denominator exception due to mapped data element "reason for not doing BMI follow up" where a decumented medical reason may exist during the current encounter or within the previous 12 months of the current encounter. 8,471 patients are being excluded from the measure due to a pregnancy diagnosis on the problem list, no BMI due to patient refusal or a palliative care order or encounter may exist in the medical record.

Table 7-Health Outcomes and Disparities

Edit 05468: Diabetic Universe in Question - The universe of diabetic patients reported on Table 7 is greater than the total diabetic patients reported on Table 6A. This is possible only if you have seen diabetic patients during the year without diagnosing them with diabetes. Please review and correct or explain.

Related Tables: Table 7, Table 6A(UR)

Alyson Roby (Reviewer) on 02/18/2020 2:18 PM EST: Not significant numbers.

Table 8A-Financial Costs

Edit 04136: Costs and FTE Questioned - Other Professional Services are reported on Table 8A, Line 9 (392260)(Nutritionist) and Table 5, Line 22 (2.98) (Diabetic Educators) . Review and confirm that FTEs relate to costs or correct.

Related Tables: Table 8A, Table 5(UR)

Alyson Roby (Reviewer) on 02/28/2020 2:35 PM EST: From grantee: Base salary for diabetic educator is approximately $98k/yr, plus 33.3% in benefits. Values entered are correct.

Edit 03977: Costs and FTE Questioned - Other Programs and Services are reported on Table 8A, Line 12 (22042) and Table 5, Line 29a (0). Review and confirm that FTEs relate to costs or correct.

Related Tables: Table 8A, Table 5(UR)

Jane Somerhiser (Health Center) on 02/14/2020 12:40 PM EST: Reported cost is lease expense and not FTE related. Therefore, there is no corresponding cost to report on Table 5, Line 29a.

Edit 01026: Overhead Costs Questioned on Line 12 - You report direct costs (22042) on Table 8A Line 12 Column a but no overhead allocation has been made.

Please check to see that the numbers are entered correctly.

Related Tables: Table 8A

Jane Somerhiser (Health Center) on 02/14/2020 12:39 PM EST: $22,042 in cost is lease expense. There is no overhead expense associated with lease expense. Numbers are correct.

Edit 06306: Costs and FTE Questioned - Quality Improvement is reported on Table 8A, Line 12a (114061) and Table 5, Line 29b (1). Review and confirm that FTEs relate to costs or correct.

Related Tables: Table 8A, Table 5(UR)

Jane Somerhiser (Health Center) on 02/14/2020 12:41 PM EST: Reviewed and confirmed that FTEs relate to costs reported.

Table 9D-Patient Related Revenue (Scope of Project Only)

Edit 05767: Charge to Cost Ratio Questioned - Total charge to cost ratio of (4.51) is reported which suggests that charges are more than costs. Please review the information reported across the tables and correct or explain.

Related Tables: Table 9D, Table 8A

Jane Somerhiser (Health Center) on 02/14/2020 12:43 PM EST: Gross charges typically exceed costs. This is a provider based facility, meaning we bill both Technical components as well as Professional components. Both charge and cost information has been reviewed and confirmed for calendar year 2019.

BHCMIS ID: 09E00911 - MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT, Phoenix, AZ

Program Name: Health Center 330

Submission Status: Review In Progress

Date Requested: 03/23/2020 5:07 PM EST

Date of Last Report Refreshed: 03/23/2020 5:07 PM EST

UDS Report - 2019

Comments

Report Comments

No comments

Table 7 Comments

Edit 5468: More patients qualify for Table 7 - A1C had medical visits other than diabetes in the reporting year.

Table 8A Comments

Edit 1026: $22,042 in cost is lease expense. There is no overhead expense associated with lease expense. Numbers are correct. Edit 4136: Reviewed and confirmed that FTEs relate to costs reported. Edit 3977: Reported cost is lease expense and not FTE related. Therefore, there is not corresponding cost to report on Table 5, Line 29a. Edit 6306: Reviewed and confirmed that FTEs relate to costs reported.

Table 9D Comments

Edit 5767: Gross charges typically exceed costs. This is a provider based facility, meaning we bill both Technical components as well as Professional components. Both charge and cost information has been reviewed and confirmed for calendar year 2019.

ODE Comments

These services are utilized in the hospital only at this time and not in any FQHC Clinic.

Attachment 2
Valleywise Health Patient Health Needs Survey (English) – 2020

Our Mission

Provide exceptional care, without exception, every patient, every time.

Valleywise Health
Federally Qualified Health Centers (FQHC)
Maricopa Special Health Care District

Patient Health Needs Survey 2020

Maricopa Integrated Health System's mission is to exceed the needs of our patients, their families, our physicians, and our staff through the delivery of high-quality, complete care to the people and communities we serve.

To ensure that we continue to exceed the needs of our patients and community, Maricopa Integrated Health System has launched a wide-ranging patient health needs survey effort at each of its primary care clinic sites. This survey will help us to:

- To ensure we meet your healthcare needs
- Identify current and future healthcare needs in our communities
- Increase community awareness of local and regional health problems
- Determine trends in demographics related to health care
- Improve and strengthen our programs and services

Your feedback is invaluable in helping us shape the future of healthcare in our local community. By taking this brief survey, you have the unique ability to provide insight into what you think are the most important and pressing healthcare needs of our local community and help Maricopa Integrated Health System develop programs and strategies to meet them.

Question #1 How would you describe your overall health? ○ Excellent ○ Very good ○ Good ○ Fair ○ Poor

Question #2 Where do you go for routine healthcare?

☐ Physician's office ☐ Health Department ☐ Emergency room ☐ Urgent care clinic ☐ Clinic in a grocery or drug store
☐ I do not receive routine healthcare ☐ Other – please list where you go for routine healthcare: _____

_____

Question #3 Can you get an appointment at this doctor's office when you need it? ○ Yes ○ No

Question #4 If you answered "No" to question 3, please choose all that apply.

☐ No appointment available ☐ Cannot afford it ☐ Cannot take time off from work ☐ No transportation

☐ No specialist in my community for my condition

☐ Other – please list why you are not able to visit a doctor when needed:

_____

Question #5 The clinic hours meet my needs. ○ Yes ○ No

If No - I would prefer appointments at the following times: (Please check all that Apply)

☐ Weekdays Before 7:00 am ☐ Weekdays After 5:30 pm

☐ Saturday Morning ☐ Saturday Afternoon

☐ Sunday Morning ☐ Sunday Afternoon

Question #6 What type of healthcare coverage do you have?

☐ Medicare ☐ AHCCCS ☐ Commercial health insurance (Examples: Cigna, Humana, Anthem Blue Cross)

☐ Sliding Fee Discount Program ☐ No Healthcare Coverage

☐ Other – please list what other type of health coverage you have:

_____

Question #7 Please select the top 3 health challenges you face.

☐ Cancer ☐ Diabetes ☐ Overweight ☐ Breathing problems ☐ High blood pressure / Stroke ☐ Dental care ☐ Heart disease
☐ Pain ☐ Depression / Mental health issues ☐ Alcohol use ☐ Drug use ☐ None
☐ Other – please list the other health challenges you face: _____

_____

Question #8 What else do you need to be healthier?

_____
_____
_____

Question #9 Please choose all statements below that apply to you.

☐ I exercise at least 3 times per week. ☐ I eat at least 5 servings of fruits and vegetables each day.
☐ I eat fast food more than once per week. ☐ I smoke cigarettes. ☐ I chew tobacco. ☐ I use illegal drugs.
☐ I abuse or overuse prescription drugs . ☐ I consume more than 4 alcoholic drinks (if female) or 5 (if male) per day.
☐ I use sunscreen or protective clothing for planned time in the sun. ☐ I receive a flu shot each year.
☐ I have access to a wellness program through my employer. ☐ None of the above apply to me.

Question #10 Which of the following preventive procedures have you had in the past 12 months?

☐ Mammogram (if woman) ☐ Pap smear (if woman) ☐ Prostate cancer screening (if man) ☐ Flu shot
☐ Colon/rectal exam ☐ Blood pressure check ☐ Blood sugar check ☐ Skin cancer screening ☐ Cholesterol screening
☐ Vision screening ☐ Hearing screening ☐ Cardiovascular screening ☐ Bone density test ☐ Dental cleaning/x-rays
☐ Physical exam ☐ None of the above

Question #11 What is your gender? ○ Female ○ Male
○ Transgender Female/Male-to-Female ○ Transgender Male/Female-to-Male ○ Other ○ Chose not to disclose

Question #12 What is your race? ○ African American/Black ○ Caucasian/White ○ Asian ○ American Indian/ Alaska Native
○ Native Hawaiian/ Pacific Islander ○ Other – please specify _____

Question #13 What is your current employment status? ○ Employed full-time ○ Employed part-time ○ Student ○ Homemaker
○ Unemployed ○ Disabled ○ Retired

Question #14 What is your household income range? ○ $0 - $24,999 ○ $25,000 - $49,999 ○ $50,000 - $74,999
○ $75,000 - $99,999 ○ $100,000 or more ○ Don't know

Question #15 What is the highest level of education you have completed? ○ Some high school ○ High school graduate
○ Some college ○ College graduate

Question #16 How can we make your doctor visit more beneficial for your health?_____
_____
_____

Thank you for your time and partnership to make our community a healthier one.

Attachment 3
Valleywise Health Patient Health Needs Survey (Spanish) – 2020

Nuestra misión

Proveer atención médica excepcional sin
excepción, a todo paciente, en todo momento.

Valleywise Health
Federally Qualified Health Centers (FQHC)
Maricopa Special Health Care District

Encuesta sobre las necesidades médicas del paciente de 2020

La misión de Valleywise Health es cumplir al máximo con las necesidades de nuestros pacientes, sus familias, nuestros médicos y nuestro personal, al ofrecer atención médica integral de alta calidad a las personas y comunidades a las que servimos.

Para asegurarnos de seguir cumpliendo al máximo con las necesidades de nuestros pacientes y de nuestra comunidad, en cada una de las clínicas de atención primaria de *Valleywise Health* hemos comenzado una encuesta para evaluar
todas las necesidades médicas de los pacientes. Esta encuesta nos ayudará a:

- que nos aseguremos de cumplir con sus necesidades de atención médica;
- identificar las necesidades de atención médica actuales y futuras en nuestras comunidades;
- aumentar la conciencia de la comunidad sobre los problemas de salud locales y regionales;
- determinar tendencias demográficas relacionadas con la atención médica;
- mejorar y fortalecer nuestros programas y servicios

Sus comentarios son indispensables para ayudarnos a crear el futuro de la atención médica en nuestra comunidad local. Al contestar esta encuesta breve, usted tiene la capacidad única de proveernos información acerca de las cosas que para usted son las necesidades médicas más importantes y urgentes de nuestra comunidad local y de ayudar a que Valleywise Health desarrolle programas y estrategias para cumplir con dichas necesidades.

Pregunta #1 ¿Cómo describiría su salud en general? ○ Excelente ○ Muy buena ○ Buena ○ Regular ○ Mala

Pregunta #2 ¿A dónde va para recibir atención médica de rutina?

☐ Consultorio de un médico ☐ Departamento de Salud ☐ Sala de urgencias ☐ Clínica de atención inmediata ☐ Clínica en un supermercado o farmacia ☐ No recibo atención médica de rutina ☐ Otro – por favor escriba a dónde va para recibir atención médica de rutina: _____

_____

Pregunta #3 ¿Puede programar una cita en este consultorio médico cuando la necesita? ○ Sí ○ No

Pregunta #4 Si contestó "No" en la pregunta 3, por favor seleccione todas las opciones que correspondan.

☐ No hay citas disponibles ☐ No puedo pagarla ☐ No puedo faltar al trabajo ☐ No tengo medio de transporte

☐ No hay especialista en mi comunidad para mi enfermedad

☐ Otro – por favor escriba por qué no puede ir al médico cuando necesita hacerlo:

_____

Pregunta #5 El horario de la clínica es conveniente para mí. ○ Sí ○ No

Si contestó “No” – Yo preferiría citas durante los siguientes horarios: (Por favor seleccione todas las opciones que correspondan).

☐ Entre semana antes de las 7:00 a. m.

☐ Entre semana después de las 5:30 p. m.

☐ Los sábados por la mañana

☐ Los sábados por la tarde

☐ Los domingos por la mañana

☐ Los domingos por la tarde

Pregunta #6 ¿Qué tipo de cobertura médica tiene usted?

☐ *Medicare* ☐ *AHCCCS* ☐ Seguro médico comercial (por ejemplo: *Cigna*, *Humana*, *Anthem Blue Cross*)

☐ Programa de descuento según los ingresos (escala proporcional) ☐ No tiene cobertura médica

☐ Otra – por favor escriba qué otro tipo de cobertura médica tiene usted:

_____

Pregunta #7 Por favor indique los 3 problemas de salud principales que enfrenta usted.

☐ Cáncer ☐ Diabetes ☐ Sobrepeso ☐ Problemas de la respiración ☐ Presión arterial alta / derrame o embolia cerebral ☐ Atención dental ☐ Enfermedad cardíaca ☐ Dolor ☐ Depresión / problemas de salud mental ☐ Uso de alcohol ☐ Uso de drogas ☐ Ninguno ☐ Otro – por favor escriba los otros problemas de salud que enfrenta usted: _____

_____

Pregunta #8 ¿Qué otra cosa necesita para estar más saludable?

_____

_____

_____

Pregunta #9 A continuación, por favor seleccione todas las declaraciones que correspondan.

☐ Hago ejercicio por lo menos 3 veces a la semana. ☐ Como al menos 5 porciones de frutas y verduras todos los días.

☐ Como comida rápida más de una vez a la semana. ☐ Fumo cigarros. ☐ Mastico tabaco. ☐ Uso drogas ilegales.

☐ Abuso de o uso de manera excesiva los medicamentos de venta con receta ☐ Al día consumo más de 4 bebidas alcohólicas (si es mujer) o 5 (si es hombre). ☐ Uso protector solar o ropa que me cubra la piel cuando tengo planes de exponerme al sol. ☐ Recibo una vacuna contra la gripe cada año. ☐ Por medio de mi trabajo tengo acceso a un programa de bienestar. ☐ Ninguna de las opciones anteriores.

Pregunta #10 En los últimos 12 meses, ¿cuáles de los siguientes procedimientos preventivos ha recibido usted?

☐ Mamografía (si es mujer) ☐ Prueba de Papanicolaou (si es mujer) ☐ Prueba de detección del cáncer de la próstata (si es hombre) ☐ Vacuna contra la gripe ☐ Examen colorrectal ☐ Revisión de la presión arterial ☐ Revisión del azúcar en la sangre ☐ Prueba de detección del cáncer de piel ☐ Examen de colesterol ☐ Examen de la vista ☐ Examen auditivo ☐ Pruebas de detección cardiovasculares ☐ Prueba de densidad ósea ☐ Limpieza/radiografía dental ☐ Examen físico ☐ Ninguna de las opciones anteriores

Pregunta #11 ¿Cuál es su sexo/género? ○ Femenino ○ Masculino ○ Mujer transgénero/Hombre-a-mujer ○ Hombre transgénero/Mujer-a-hombre ○ Otro ○ Prefiere no divulgarlo

Pregunta #12 ¿Cuál es su origen racial? ○ Afroamericano/negro ○ Caucásico/blanco ○ Asiático ○ Indígena americano/Nativo de Alaska ○ Nativo hawaiano/Nativo de las islas del Pacífico ○ Otro – por favor especifique _____

Pregunta #13 ¿Cuál es su situación laboral actual? ○ Empleado(a) tiempo completo ○ Empleado(a) medio tiempo ○ Estudiante ○ Se dedica al hogar ○ Desempleado(a) ○ Discapacitado(a) ○ Jubilado(a)

Pregunta #14 ¿Cuál es su nivel de ingresos familiares? ○ $0 a $24,999 ○ $25,000 a $49,999 ○ $50,000 a $74,999 ○ $75,000 a $99,999 ○ $100,000 o más ○ No sabe

Pregunta #15 ¿Cuál fue su nivel escolar más alto? ○ Estudió la preparatoria/el bachillerato pero no se graduó ○ Se graduó de la preparatoria/bachillerato ○ Fue a la universidad pero no se graduó ○ Se graduó de la universidad

Pregunta #16 ¿Cómo podríamos lograr que su consulta médica fuera más beneficiosa para su salud?_____
_____
_____

Gracias por su tiempo y colaboración para hacer de nuestra comunidad una comunidad más saludable.