Preparing for a HRSA Operational Review

A Proactive Approach
Friend or Foe?
The purpose of the site visit is to provide direct support to grantees on key health center program requirement(s) and to identify any area(s) for potential performance or operational improvements. The team will create a report with the preliminary findings and recommendations from the site visit team that have been identified by the consultants as a result of the site visit process. This report is not exhaustive, but identifies any key program requirement findings/recommendation(s) as well as any recommended area(s) for performance or operational improvement.
What is Evaluated?

- SECTION 1: Need
- SECTION 2: Services
- SECTION 3: Management and Finance
- SECTION 4: Governance
- SECTION 5: Clinical Performance Measures
<table>
<thead>
<tr>
<th>Program Requirement Number</th>
<th>Program Requirement</th>
<th>Technical Assistance (TA) Type</th>
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<tbody>
<tr>
<td>1.</td>
<td>Needs Assessment: Health center demonstrates and documents the <em>needs of its target population</em>, updating its service area, when appropriate. (Section 330(k)(2) and Section 330(k)(3)(J) of the PHS Act)</td>
<td>NEED</td>
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<td>2.</td>
<td>Required and Additional Services: Health center <em>provides all required primary, preventive, enabling health services</em> and additional health services as appropriate and necessary, either directly or through established written arrangements and referrals. (Section 330(a) of the PHS Act) <strong>Note:</strong> Health centers requesting funding to serve homeless individuals and their families must provide substance abuse services among their required services. (Section 330(h)(2) of the PHS Act)</td>
<td>SERVICES</td>
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<td>3.</td>
<td>Staffing Requirement: Health center <em>maintains a core staff</em> as necessary to carry out all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established arrangements and referrals. Staff must be appropriately licensed, credentialed and privileged. (Section 330(a)(1), (b)(1)-(2), (k)(3)(C), and (k)(3)(I) of the PHS Act)</td>
<td>SERVICES</td>
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<td><strong>Accessible Hours of Operation/Locations:</strong> Health center provides <em>services at times and locations that assure accessibility</em> and meet the needs of the population to be served. (Section 330(k)(3)(A) of the PHS Act)</td>
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<td>5.</td>
<td><strong>After-Hours Coverage:</strong> Health center provides professional <em>coverage during hours when the center is closed.</em> (Section 330(k)(3)(A) of the PHS Act)</td>
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<td>6.</td>
<td><strong>Hospital Admitting Privileges and Continuum of Care:</strong> Health center physicians have admitting privileges at one or more referral hospitals, or other such <em>arrangement to ensure continuity of care.</em> In cases where hospital arrangements (including admitting privileges and membership) are not possible, health center must firmly establish arrangements for hospitalization, discharge planning, and patient tracking. (Section 330(k)(3)(L) of the PHS Act)</td>
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Sliding Fee Discounts: Health center has a system in place to determine eligibility for patient discounts adjusted on the basis of the patient’s ability to pay.

- This system must provide a full discount to individuals and families with annual incomes at or below 100% of the Federal poverty guidelines (only nominal fees may be charged) and for those with incomes between 100% and 200% of poverty, fees must be charged in accordance with a sliding discount policy based on family size and income.*
- No discounts may be provided to patients with incomes over 200% of the Federal poverty guidelines.*
- No patient will be denied health care services by the health center due to an individual’s inability to pay for such services, assuring that any fees or payments required by the center for such services will be reduced or waived. (Section 330(k)(3)(G) of the PHS Act, 42 CFR Part 51c.303(f)), and 42 CFR Part 51c.303(u))

Note: Portions of program requirements notated by an asterisk (*) indicate regulatory requirements that are recommended but not required for grantees that receive funds solely for Health Care for the Homeless (Section 330(h)) and/or the Public Housing Primary Care (Section 330(i)) Programs.
| 8. | **Quality Improvement/Accurance Plan:** Health center has an ongoing Quality Improvement/Quality Assurance (QI/QA) program that includes clinical services and management, and that maintains the confidentiality of patient records. The QI/QA program must include:

  - a *clinical director* whose focus of responsibility is to support the quality improvement/assurance program and the provision of high quality patient care;*
  - *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 health center; and such assessments shall:
    - 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;* and
    - identify and document the necessity for change in the provision of services by the health center and result in the institution of such change, where indicated.*

(Section 330(k)(3)(C) of the PHS Act, 45 CFR Part 74.25 (c)(2), (3) and 42 CFR Part 51c.303(c)(1-2)) | SERVICES |
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<th>9.</th>
<th><strong>Key Management Staff:</strong> Health center maintains a fully staffed health center management team as appropriate for the size and needs of the center. Prior approval by HRSA of a change in the Project Director/Executive Director/CEO position is required. (Section 330(k)(3)(I) of the PHS Act, 42 CFR Part 51c.303(p) and 45 CFR Part 74.25(c)(2),(3))</th>
<th>MANAGEMENT AND FINANCE</th>
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<td>10.</td>
<td><strong>Contractual/Affiliation Agreements:</strong> Health center exercises appropriate oversight and authority over all contracted services, including assuring that any subrecipient(s) meets Health Center program requirements. (Section 330(k)(3)(I)(ii), 42 CFR Part 51c.303(n), (t)), Section 1861(aa)(4) and Section 1905(l)(2)(B) of the Social Security Act, and 45 CFR Part 74.1(a) (2))</td>
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<td>11.</td>
<td><strong>Collaborative Relationships:</strong> Health center <em>makes efforts</em> to <em>establish and maintain collaborative relationships</em> with other health care providers, including other health centers, in the service area of the center. The health center secures letter(s) of support from existing health centers (Section 330 grantees and FQHC Look-Alikes) in the service area or provides an explanation for why such letter(s) of support cannot be obtained. (Section 330(k)(3)(B) of the PHS Act and 42 CFR Part 51c.303(n))</td>
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<td>12.</td>
<td><strong>Financial Management and Control Policies:</strong> Health center maintains <em>accounting and internal control systems</em> appropriate to the size and complexity of the organization reflecting <em>Generally Accepted Accounting Principles (GAAP)</em> and separates functions appropriate to organizational size to safeguard assets and <em>maintain financial stability</em>. Health center assures an annual independent financial audit is performed in accordance with Federal audit requirements, including submission of a corrective action plan addressing all findings, questioned costs, reportable conditions, and material weaknesses cited in the Audit Report. (Section 330(k)(3)(D), Section 330(q) of the PHS Act and 45 CFR Parts 74.14, 74.21 and 74.26)</td>
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<td><strong>Billing and Collections:</strong> Health center has systems in place to maximize collections and reimbursement for its costs in providing health services, including written billing, credit, and collection policies and procedures. (Section 330(k)(3)(F) and (G) of the PHS Act)</td>
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<td><strong>Budget:</strong> Health center has developed a budget that reflects the costs of operations, expenses, and revenues (including the Federal grant) necessary to accomplish the service delivery plan, including the number of patients to be served. (Section 330(k)(3)(D), Section 330(k)(3)(I)(i), and 45 CFR Part 74.25)</td>
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<td><strong>Program Data Reporting Systems:</strong> Health center has systems which accurately collect and organize data for program reporting and which support management decision making. (Section 330(k)(3)(I)(ii) of the PHS Act)</td>
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<td><strong>Scope of Project:</strong> Health center maintains its funded scope of project (sites, services, service area, target population, and providers), including any increases based on recent grant awards. (45 CFR Part 74.25)</td>
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**Board Authority:** Health center governing board maintains appropriate authority to oversee the operations of the center, including:

- holding monthly meetings;
- approval of the health center grant application and budget;
- selection/dismissal and performance evaluation of the health center CEO;
- selection of services to be provided and the health center hours of operations;
- measuring and evaluating the organization’s progress in meeting its annual and long-term programmatic and financial goals and developing plans for the long-range viability of the organization by engaging in strategic planning, ongoing review of the organization’s mission and bylaws, evaluating patient satisfaction, and monitoring organizational assets and performance;* and
- establishment of general policies for the health center.

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

**Note:** In the case of public centers (also referred to as public entities) with co-applicant governing boards, the public center is permitted to retain authority for establishing general policies (fiscal and personnel policies) for the health center. (Section 330(k)(3)(H) of the PHS Act and 42 CFR 51c.304(d)(iii) and (iv))
• **Board Composition:** The health center governing board is composed of individuals, a majority of whom are being served by the center and, this majority as a group, represent the individuals being served by the center in terms of demographic factors such as race, ethnicity, and sex. Specifically: governing board has at least 9 but no more than 25 members, as appropriate for the complexity of the organization.*

• the remaining non-consumer members of the board shall be representative of the community in which the center’s service area is located and shall be selected for their expertise in community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social service agencies within the community.*

• no more than one half (50%) of the non-consumer board members may derive more than 10% of their annual income from the health care industry.*

**Note:** Upon a showing of good cause, the Secretary may waive, for the length of the project period, the patient majority requirement in the case of a health center that receives a grant pursuant to subsection (g), (h), (i), or (p) (Section 330(k)(3)(H) of the PHS Act and 42 CFR Part 51c.304)
| 19.  | **Conflict of Interest Policy:** Health center bylaws or written corporate board approved policy include provisions that prohibit conflict of interest by board members, employees, consultants, and those who furnish goods or services to the health center.  
  
- No board member shall be an employee of the health center or an immediate family member of an employee. The Chief Executive may serve only as a non-voting ex-officio member of the board.*  
(45 CFR Part 74.42 and 42 CFR Part 51c.304(b)) | GOVERNANCE |
Dental OPR Prep

1. Needs Assessment
   - Identify the target population(s) to be served—focus populations
Dental OPR Prep

1. Services
   • What is your scope of service?
   • Where do you refer patients for services that you don’t deliver?
   • Do you have any kind of written agreement in place with these providers?
   • How do you track referrals to make sure the patient got the necessary care?
1. Staffing

- All providers’ licensure on file and up to date
- Are providers credentialed and privileged for the services they are providing? Is there documentation of this? (privileging form)
- Job descriptions for each dental staff member and up to date?
- Does your staff have copies of their job descriptions?
Dental OPR Prep Staffing Cont.

- Do you have a formal orientation to dental for new staff?
- Where are you with budgeted vs. actual staff? Do you have open positions? What is being done to fill these positions?
- Do you maintain employee files in the dental area? Are these files locked and secure?
- Do you have any contracted staff? If so, do you have copies of their current contracts on file?
1. Accessible Hours of Operations/Locations

- Are you open at times that assure accessibility and meet the needs of your patients? (e.g., evening/early morning/Saturday hours)
- Do you offer services at locations that assure accessibility and meet the needs of patients?
- Can everyone in your defined service area get to your dental program?
- If not, do you bring portable/mobile services to them?
Dental OPR Prep

1. How do you address patients who call after hours?
   - Is there a phone message?
   - Is it in the language(s) your patients speak?
   - Is there written information on what to do after hours in all relevant languages?
Dental OPR Prep

7. Fees and Sliding fee scale discounts

• Is there signage about the availability of discounts for eligible patients?
• Does the dental fee schedule cover the cost of visits?
• Are fees consistent with locally prevailing rates and designed to cover the reasonable costs of operations?
• Do patients at or below 100% receive free care in addition to paying nominal fees?
• Do you have discounts for patients between 101% and 200% based on family size and income?
Dental OPR Prep (Fees Cont.)

- Are patients above 200% of FPL charged full fees?
- Are new patients evaluated during registration to determine their eligibility for the sliding fee scale?
  Do you require patients to provide proof of income?
- Are fees reviewed annually? When was the last time your dental fees were reviewed?
Dental OPR Prep

8. Quality Improvement/Quality Assurance

- If you have paper charts, are they secured when staff is not present?
- Do you have a clinical director for dental?
- Do you have a process for periodic chart reviews? If so, who does them and how often? How are the results shared and used? Is there a formal process to follow up on deficiencies noted during chart audits? Are formal action plans developed? How are they documented? Are they followed up to make sure the deficiencies were corrected?
Dental OPR Prep (QI/QA Cont.)

- Are medical records standardized in content and organization?
- Is patient information handled in a way that is HIPAA compliant?
- Is there a process within dental to report/track incidents/adverse outcomes?
- What happens with these reports?
- Is the dental program tracking any clinical outcome measures? Which? Where are they reported? How are the results used?
Dental OPR Prep

9. Management/Finance

- Does dental have a director? Is this person considered part of the Health Center leadership team?
- Does he/she have regularly scheduled time for administrative duties?
11. Collaborations

- Are there any collaborations in place between the dental program and other community organizations? (e.g., hospital ERs, Public Health Depts., private dentists in the community, other health and human service organizations, public schools, Head Starts)
Dental OPR Prep


• Does the dental program leadership receive a monthly statement of revenue and expenses broken out for each site?
• Report of provider productivity?
• Aging report for dental broken out by payer source?
• Does the dental director know the breakeven number for visits and payer mix?
Dental OPR Prep Finance Cont.

- Does the dental program regularly review its financial viability and develop strategies to respond to negative variances?
- Does the dental director know what the current payer mix is in dental?
- Are gross charges and net revenue tracked and reported by payer type?
- Are full fees charged for all services with appropriate adjustments being recorded?
Dental OPR Prep

13. Billing and Collections

- Are there written policies for billing, credit and collections?
- Are dental codes updated annually using the latest CDT code book?
- How is billing done? Through the medical practice management system? Through the dental PMS? If done through Medical, how do charges get into the medical system? Via HL7 interface or do they have to be entered manually? If entered manually, by whom and when? Who checks to make sure procedures were completely and accurately entered?
Dental OPR Prep

- How are claims submitted to Medicaid and 3rd party insurers?
- Who is responsible for dental billing? Are they trained in dental billing?
- Are patients asked to pay at the time of the visit? What percentage do? Is this tracked and reported anywhere? What is the follow-up with patients who have outstanding balances?
- What is the process for managing denied claims? Does anyone review and report reasons for dental denials?
Dental OPR Prep

14. Budget

- Is there an annual operating budget for dental?
- Did the dental leadership provide input into the development of the budget?
Dental OPR Prep

15. Program Data Reporting: Clinical Performance Measures for Dental

• Pick one or two
• Why were these selected?
• What was the baseline and how is performance being tracked?
• What action steps are being taken to improve performance? Or eliminate restricting factors?
Dental OPR Prep

16. Scope of Project

- What is the current visit capacity of dental?
- What percentage of that capacity has been reached?
- If capacity has been reached, what strategies are being considered to expand capacity (eg, more providers, more operatories, more hours of operation, more sites)
- If currently planning dental expansion, has a pro forma been completed detailing additional expenses, additional revenue and visit projections?
Partnering to Strengthen and Preserve the Oral Health Safety Net

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