Acing Your HRSA Operational Site Visit!

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Your Presenter

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Agenda

- The Operational Site Visit
- OSV Resources
- Hot Tips to Acing the OSV
- Logistical Changes to the OSV
- Post OSV Activities

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The Operational Site Visit (OSV)

OSVs provide an **objective** assessment and verification of the status of each Health Center Program awardee or look-alike's compliance with the 18 Program Requirements.[1]

In addition to assessing compliance, the OSV also includes sections for the following:

- An analysis of one or more performance measure(s) – currently, Diabetes
- Identification, as applicable, of promising practices
- A review of 340B requirements for those health centers that participate in the HRSA Office of Pharmacy Affairs 340B Drug Pricing Program.
- A review of FTCA risk and claims management compliance for those health centers that are FTCA deemed

The Operational Site Visit (OSV)

How Often

For newly funded or newly designate health centers, HRSA will conduct OSV's within 10-14 months of the project or designation period.

After health center's first OSV, HRSA will return generally around 18 months within the project or designation period.

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The Operational Site Visit (OSV)

Structure

Reviewers	Meetings	Activities
• Governance/Admin • Clinical • Fiscal	• Pre-OSV Call • Opening Conference • Exit Conference • Closed Board Meeting	• Clinic Tour(s) • Document Review • Interviews with staff

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Health Center Program Requirements

1. Needs Assessment	11. Conflict of Interest
2. Required and Additional Health Services	12. Collaborative Relationships
3. Clinical Staffing	13. Financial Management and Accounting Systems
4. Accessible Locations and Hours of Operation	14. Billing and Collections
5. Coverage for Medical Emergencies During and After Hours	15. Budget
6. Continuity of Care and Hospital Admitting	16. Program Monitoring and Data Reporting Systems
7. Sliding Fee Discount Program	17. Board Authority
8. Quality Improvement/Assurance	18. Board Composition
9. Key Management Staff	Federal Tort Claims Act (FTCA) Deeming
10. Contracts and Subawards	*Review of FTCA compliance will not be used for the purposes of assessing compliance with Health Center Program Requirements*

OSV Prep Resources

Site Visit Protocol	Compliance Manual
• Provides a thorough review of each program requirement • List documents requested for the site visit • Details how a health center demonstrates compliance, for each element • Provides details of how the reviewer will assess compliance during the site visit.	A consolidated resource that helps health centers understand, and how to demonstrate compliance.

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Hot Tips to Acing Your OSV

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Tip #1 : Start Preparing Early

- Notification will be sent at least six months prior to the OSV, start the process at that time.

- Create an OSV Prep Board Calendar that projects what is needed to go before the Board for approval, and designate what will be presented each month leading up to OSV.

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Tip #1 : Start Preparing Early

- Begin by reviewing board minutes (up to 3 years prior) to identify that the board has reviewed, and if needed, approved the following policies:
  - Sliding Fee Discount Program
  - Quality Improvement/Assurance Program
  - Billing and Collections (policy for waiving or reducing patient fees, and if applicable, refusal to pay)
  - Financial Management and Accounting Systems
  - Personnel
  - Needs Assessment

Tip #2 : Review Forms 5A and 5B

- Any formal changes to scope, Forms 5A and 5B, will require at least 60 days for HRSA to review and approve, so start the process early
- Only consider referral relationships that you have a formal arrangement (contract or MOU) with a specific service provider.
- Most non-compliance is found in review of Form 5A Column III referral agreements - only keep what you must in Column III.
- You only need to provide one compliant contract for each service that is provided by referral (listed under Column II or Column III)

REFERENCE: Updating Form 5A
https://bphc.hrsa.gov/sites/default/files/bphc/programrequirements/pdf/updatingform5a.pdf

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Tip #2a : Review Forms 5A and 5B

- 340B participating health centers, have 340B P&Ps ready
- Review OPAIS for consistency of 340B contracts
- Providing dental x-rays does not mean health center provides diagnostic radiology

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Tip #2a : Review Forms 5A and 5B

- Do you have translation assistance for uninsured patients, or for patients who rely on sign language?

- All Independent Contracted providers are considered column II service providers

REFERENCE: Form 5A Service Descriptors
https://bphc.hrsa.gov/sites/default/files/bphc/programrequirements/scope/form5aservicedescriptors.pdf

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Tip #3 : Compliant Referral Service Contracts

All referral services contracts must include language specific to:

1. Sliding Fee Discount compliance for column III services
2. Details of how the health center will pay for services for column II services
3. Ensuring providers are credentialed and privileged through a defined process
4. Details of how reports from service providers are returned to the health center and entered into a patient's record

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Tip #4 : Conduct Three Necessary Analysis

1. Service Area Analysis, Chapter 3: Needs Assessment. *Required at the Start of the Site Visit.*

"The health center identifies and **annually reviews** its service area 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."

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Tip #4 : Conduct Three Necessary Analysis

2. Sliding Fee Discount Program Analysis, Chapter 9: SFDP. *Required at the Start of the Site Visit.*

"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 to evaluate the effectiveness of its sliding fee discount program in reducing financial barriers to care.

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Tip #4 : Conduct Three Necessary Analysis

3. Fee Schedule Analysis, Chapter 16: Billing & Collections, *Required at Start of Visit*

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

Medicare publishes prevailing charges by geographic region, use that data in comparison to health center costs per procedure to evaluate fee schedule

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Tip #5 : Thorough Review of SFDP

The Sliding Fee Discount Program has the most elements to demonstrate compliance at 12 total elements.

- Try to avoid column III services
- Refresher trainings with applicable staff on SFDP procedures
- Ensure there is documentation of informing patients of fees not covered by discount (lab, supplies, etc) at the time of service provision
- Ensure there is proper posting of SFDP:
  - Waiting room
  - Website
  - Patient brochures

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Tip #6 : Tracking Logs

- Be prepared to demonstrate appropriate documentation of after-hours calls

"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."

Chapter 7, Coverage for Medical Emergencies During and After Hours, *Element D – After Hours Call Documentation*

- Also provide documentation for follow-up for messages left during after-hours
- Sufficient data tracking, six months is requested

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Tip #6 : Tracking Logs

- Review hospitalization tracking log against hospitalization tracking procedures

"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."

Chapter 8, Continuity of Care, *Element C - Post-Hospitalization Tracking and Follow-Up*

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Tip #7 : QI Assessments

- HRSA expects at least 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"

Chapter 10, QI/QA, *Element D – Quarterly Assessments of Clinician Care*

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Tip #8 : QI Related Procedures

- Not all QI related procedures need to be independent procedures. Include most as part of the QI Program/Plan

QI Related Procedure	Independent or Part of QI Plan
Clinical Guidelines	Independent
Patient safety and adverse events, including implementation of follow-up actions	Independent
Patient Satisfaction	Part of QI Plan
Patient Grievances	Independent
Periodic QI/QA assessments	Part of QI Plan
QI/QA report generation and oversight	Part of QI Plan

Tip #9 : Credentialing Packets

- Ensure credentialing packets reflect credentialing procedures
- Select or create compliant credentialing files for each provider type:
  - 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
- Select or create compliant credentialing files for each service type
- Select or create compliant at least one recredentialing file

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Tip #10 : Budget & Accounting Presentation

For health centers with out of scope activities:

- Prepare a budget that segregates the health center program scope from agency's overall scope of services/programs.

- Segregate health center program financial reporting to easily determine costs that are in scope versus out of scope.

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Tip #11 : Board Prep

- Identify early which consumer board members have not had an eligible visit within the last two years.
- Review Bylaws:
  - Did all committees meet and as often as detailed in Bylaws, and are there minutes for all meetings?
  - Make sure Bylaws easily detail board authority and that minutes provided demonstrate board authority
- Provide a board cheat sheet that summarizes board authority over the last year
- Make sure board is available to participate in OSV

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Tip #12 : Consistent Patient Information

- The following information must be provided to patients in all print communications (website, brochures):
  1. SFDP information
  2. After Hours information
  3. FTCA Deeming

- The following information has to be consistent with Form 5B:
  1. Clinic site addresses
  2. Clinic site hours
  3. Clinic site phone numbers

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Tip #13 : Prepare C-Suite

- Identify early who will lead each program requirement

G/A*	Clinical	Fiscal
• Needs Assessment • Locations/Hours • Key Mgmt Staff • Collaborative Relationships • Board Authority • Board Composition	• R&A Services • Clinical Staffing • Medical Emergencies • Continuity of Care • QI/QA • FTCA • Performance Analysis	• SFDP • Contracts & Subawards • Financial Mgmt & Acct Systems • Billing & Collections • Budget • Program Monitoring

*G/A: Governance/Administration

Tip #14 : Prepare Service Sites

- Walk through selected sites and look for:
  1. Clear postings of hours that are consistent with EHB
  2. Clear postings of after hours instructions
  3. Clear postings of SFDP
- Make sure postings are eye-level, easy to read, and attractive

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Tip #15 : Be Organized

- Provide the pre-visit documents timely
- Utilize Dropbox, but note that HRSA PO cannot access Dropbox on government laptops
- Have a jump drive for each reviewer and HRSA PO
- Make one master copy of all documents printed
- Create two table of contents for the documents requested prior to visit and documents requested at the start of the visit

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Logistical Changes to the OSV

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No Last Minute Changes

- The reviewers cannot accept any changes to documents to demonstrate compliance ***during*** the OSV
- HRSA will allow a 14 day grace period after the OSV to submit changes before the release of the report

Health Center PO will not attend

- HRSA wants an unbiased Health Center Program representative to attend OSV

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Post OSV Activities

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Site Visit Report

- Health centers will receive their OSV report within 45 days after site visit
- FTCA will use the report to support FTCA deeming decisions and identify TA needs for FTCA deemed health centers
- Office of Pharmacy Affairs uses the report to assess 340B compliance and will follow-up with health centers if findings indicate non-compliance with the 340B program

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Progressive Action Process

Health Centers that were unable to clear findings during the 14 day window will receive a new Notice of Award that lists the condition(s) due to non-compliance.

- Phase I – 90 Days to respond with appropriate documentation to demonstrate compliance or an adequate **plan** to address condition
- Phase II – Additional 60 Days to demonstrate compliance or produce a plan
- Phase III – Additional 30 days, you should not get to Phase III
- Implementation Phase – 120 days to implement plan and submit documentation that demonstrates compliance

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Penalty for failing to address condition(s)

Health Centers that were unable to clear conditions during the Progressive Action process are now at risk for the health center's current project end date to be shortened through the termination of all or part of the Federal award or designation status

Health Centers that remain in the Progressive Action process by the time their next SAC application is submitted is only eligible for a one year project period.

HRSA will not fund a SAC application that would result in a third consecutive one year renewal, and it will not re-designate a Look-Alike application if it would result in a third consecutive one year designation.

Thank you!

Questions?

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