Gina Capra (00:00:01):

Hello, and welcome everyone to our three-part compliance and operational site visit training series. On behalf of the National Association of Community Health Centers, I'm very pleased to welcome you today. My name is Gina Capra, Senior Vice President of Training and Technical Assistance here at NACHC. Our NACHC team has thoughtfully designed this training series for you. We hope you'll enjoy the well-organized content, as well as enjoying our top notch faculty. These are current experienced HRSA site visit reviewers. These faculty also bring years of service as health center staff. We will certainly benefit from their unique operational perspective on how to achieve program compliance and how to demonstrate compliance in the Bureau of Primary Health Care's all virtual site visit setting. Just last week, I spoke with senior staff from HRSA's Bureau of Primary Health Care. They indicated that the all virtual OSVs are continuing this year fairly smoothly, and with the monitoring success that they need to report to Congress and the US Health and Human service officials.

From January to June 2021, 277 health center OSVs were conducted. For the upcoming six months, July through December 2021, 290 health center OSVs are scheduled or will be scheduled. So the opportunity for each of you to demonstrate your health center's compliance remains intact. This, in turn, enables the Bureau of Primary Health Care to assure legislators and funders that health centers around the country are maintaining continuous compliance with the fundamental program requirements. This, in turn, provides the launching point, or springboard, for Congress, Health and Human Service officials, and our local communities to have absolute confidence in the organizational effectiveness of local community health centers.

It's been quite a year and a half. You and your colleagues have risen to the challenge of battling the COVID-19 pandemic and caring for your local communities, while thinking ahead to recovery and maintenance of operations. This is evidenced by your participation today in this training. It is inspiring to see we have close to 150 participants today, representing health centers from many states and territories, big and small health centers, urban and rural, all coming together around a shared common goal. Is that shared common goal to prepare and pass the OSV with flying colors? Or is the common goal to affirm and improve your health center's continuous state of compliance? Or is the common goal even grander? I believe it is.

I believe we are here today because we are all committed to the health center mission, through which you all serve 30 million underserved individuals around the country each year. You ensure there is access to affordable culturally and linguistically competent care. You ensure there are high quality services offered in primary care, behavioral health, and dental. And your dedication to continuous compliance also means that critical social and enabling services are present in your communities, from transportation and benefits enrollment assistance to housing referrals and food pantries. Your attention and effort brings stability, continuity, and the ability to respond to emergencies like this pandemic.

In just the last week, health centers administered 100,000 COVID-19 vaccines around the country, of which 80% were administered to racial and ethnic minorities. Just last week, health centers delivered 22,000 COVID vaccine doses to adolescents, our newest eligible population group. So to say thank you does not seem enough, but please accept my thanks to you and your colleagues for all you do. Keep up the good work, stay strong and energized, and remember that you are not alone. We are in this together.

Thanks for the opportunity to address you today. I'm grateful to have had a few minutes to welcome you and kick off what I hope will be a fun and informative training series for you. With that, I'm so pleased to introduce my colleague, Ted Henson, who is your lead facilitator and the designer of this training series. Ted, thanks for all you do in support of our health center heroes.

Ted Henson (00:05:12):

Thank you, Gina. Thank you so much for those wonderful remarks. I love what you said about the common goal of all health centers on today's webinar, which is around really fulfilling the health center mission. And that's why we're all here. An important part of that is compliance.

So with that, I'm excited to kick off our annual webinars series that we've done for the last four years now on the operational site visit. If you remember that first one, if you were around back in 2018, it was really around the OSV. And I'm so excited to welcome this faculty because this faculty is not just excellent at what they do, but they really make sure that we at NACHC are focused on working with health centers to create a culture of continuous compliance. So while you will get really great detailed strategies and insights on how to do well and prepare for the OSV, the focus is really on beyond and on those systems that will get you towards compliance and the high performing operations.

So with that, I want to spend just a couple minutes of our time together to really level set so we're all on the same page about what we hope to accomplish. So as you know, because you signed up for today's webinar, we really want to make sure we do three things through the next three webinars. That is to describe HRSA's process and tools for assessing compliance with our Health Center Program requirements. We want to make sure that each reviewer, when they go through their chapters, identifies at least three pain points or common areas of conditions found throughout the OSV. And as someone who's worked closely with this faculty, I can assure you, they deliver way more than three pain points and common non-compliance areas, so you'll be well taken care of there. And implement specific strategies or processes for ensuring continuous compliance. Once again, this is exactly what we're designing this to do. To make sure it's not just a point in time, but it's really around that system approach.

So with that being said, hopefully all of you are familiar with these two documents that you see before you. These are the two main tools HRSA uses to assess compliance. The Health Center Program Compliance Manual, as many of you will know, was released for the first time in August 2017, actually during a CHI conference session on the operational site visit. That was a dramatic moment. They have updated it since then. And they've also updated, most recently in May of this year, their Health Center Program site visit protocol. You will hear both of these documents mentioned a lot over the next three webinars. In fact, the way we have structured this webinars series is to make sure that all of the chapters of the compliance manual will be covered.

So as you can see, today, we will be focused on the chapters under the governance and admin column. On Wednesday, we will have financial chapters that Renee will cover, and then we'll have clinical chapters on Thursday. Making sure I get my days correct this summer because I get brain fog. And we will also make sure within those, we will have made sure that each presenter will talk about what you need to do to be compliant, the pain points, and then also areas around and will get you towards continuous compliance.

We have presented variations of this slide at past conferences. This was adapted from a slide deck that we did last year that one of our faculty helped develop based on a presentation that HRSA did around some of the most common challenges, the most common non-compliant areas that are identified to the OSV. And as you can see, we will do a lot of these on Thursday when Kyle talks about clinical staffing elements, but all of our reviewers do regular reviews and are really well versed at speaking with the issues they see for their chapter. So while we are going to talk about the most common challenges, you'll also get some of the insights for some of the other ones that might not be as common, but were really around developing best practices.

And again, I just wanted to make sure we're all aware. So today is the first webinar. It's the overview of the Health Center Compliance Program and the governance requirements. On Wednesday, we'll be talking about fiscal, and Thursday, as I mentioned, around clinical. So you're welcome to attend all three webinars. If you have members of your staff that you want them to attend on the Wednesday, like your fiscal staff, your billing staff, you can also do that. But we want to make sure you realize that this is a series and it's going to be an integrated approach.

And we have great faculty. So as I've referenced here, the people I've worked with, I think all of you all have worked with for at least four or five years in different capacities. Today, we'll be hearing from Jen Genua-McDaniel. It's hard not to say Jen, but [inaudible 00:09:53] Jennifer Genua-McDaniel, who's had many years working at a health center, so she can speak to her experiences working as a CEO of a health center, and also the long-time consultant working in a variety of capacities with health centers. She has worked a lot as a MSCG reviewer, and she'll have the proper disclaimer when she goes into her presentation. I've also worked with Jen around New Start, around Look-Alikes and public entities.

Next, we'll hear from, on our second webinar, Renee Filson, who's at Principal Fiscal Solutions. Renee also brings a lot of experience working with federally qualified health centers from across the country. She's worked not just as a OSV reviewer, but also as an interim CFO, and also done strategic work with health centers from across the country, notably with some health centers from a recent Look-Alike learning collaborative in which I was involved with. So thank you, Renee.

And then last but not least will be Kyle Vath, who is out of Ohio. He also brings a lot of experience. You are both a nurse, but then also, you're the developer and CEO and co-founder of RegLantern, or RegLantern. Sorry. RegLantern. And you have worked a lot with preparing health centers for the OSV, but also with creating the systems and tools for being continuously compliant. So Kyle will have a great perspective on that on Thursday.

So without further ado, I'm going to turn things over to Jen, and let you take away the governance portion of today's webinar. And we will reserve some time at the end of the webinar for questions and answers. So if you do have questions, please put them in the Q&A feature in the bottom right corner, and we'll get to them at the end of the webinar. Thanks, Jen.

Jennifer Genua-McDaniel (00:11:33):

Awesome. Thank you to Gina and thank you, Ted, for that great introduction. I just want to make sure, Ted, can you hear me okay and see me all right with everybody?

Ted Henson (00:11:45):

Yes, I can.

Jennifer Genua-McDaniel (00:11:46):

Okay. Awesome. So as Ted mentioned, we are going to be discussing the overview and looking at some of the changes that HRSA has made by going virtual. And then I'm going to take some time and really talk about the governance program requirements. So I just want to, as you know, have some disclaimers. So MSCG, or the Management Strategist Consulting Group, they are the contractor that HRSA uses to provide technical assistance and virtual or operational site visits. Just wanted to make sure that you all know that this is not endorsed by them or by HRSA or the Bureau of Primary Health Care, or BPHC. I'm actually an independent contractor, so not employed, but I am independently contracted with them to do site visits and technical assistance. And also wanted to make sure we're not providing legal

advice today. And then if you have any specific questions, your project officer is a wonderful resource to go to. If I maybe don't have an answer or my colleagues don't, I would honestly check with your project officer as well.

So today on our agenda, as Ted described earlier, I'm going to really go through the process and tools for assessing compliance by using the site visit protocol, and as well, the HRSA Compliance Manual. And then I wanted to help you identify some opportunities through the admin governance sections that may be considered non-compliant. And then how do you take that to the next level? So it's not just a point in time visit, but how do you continue to maintain compliance? How do you use it in everyday use? And then how do you leverage that in order maybe to leverage for funding or steward of other grants? So as Ted had said earlier and Gina, we're really trying to take it to the next level.

So first, obviously, I want to thank all of you that are on this webinar today. I know it has not been easy. Both Renee, Kyle, and I have private clients and we've also worked doing virtual site visits. COVID has affected each and every one of us. I know there are health centers out there that have had loss of life, not only with the staff, but board members. So we all just wanted to extend our sympathy, and also thank you very much for the work you do. I know it's not done. We're dealing with variants and you're working towards vaccination rates. But we just wanted to let you know that we appreciate the work you do, and so thank you so much for your service.

So what do we really need to know? What is the actual nitty gritty of what we need to know? Well, as Ted mentioned earlier, the Health Center Program, the Compliance Manual, has not changed. So yes, that came out in August 2018. And what HRSA has done just recently in May is actually updated the site visit protocol. And what happened is it really aligned it to the Compliance Manual. HRSA has been collecting evaluations through site visits, through primary care associations, through NACHC, and they have compiled all of your feedback, heard what you had to say. They even asked us as reviewers to say, "Hey, how can we make this easier for health centers?" And what they did is they took everything together, heard what you said, and they further aligned it with the Compliance Manual. And we're really thankful. That's why when we say, "Hey, please fill out your survey at the end," that's the reason why it's important, because you have a voice in these documents.

So what was really updated and what was not? So as we know, the Compliance Manual was not updated, but also how virtual site visits are completed. If some of you have had them, it's the exact same way, only everything is virtual. HRSA is currently using the GoToMeeting platform, so I would suggest if you have a site visit coming up, please download that and familiarize yourself with that program. I know there's a lot of tools out there, but this is the tool that HRSA is currently using. Okay? So just make sure you have that.

The other thing that has not been updated, just so you know, is I put on the left of this slide, these are the program requirements that have not been updated. So quality, budget, program monitoring, board authority, and promising practices. For this webinar, even though they haven't been updated, for example, admin governance, I'm still going to talk about board authority because I have a couple tips I'm going to provide. Okay?

Now, what's been clarified? Well, we're excited just because we'll have a couple slides, the document checklist. If you recall, you've heard about documents beforehand, documents during the start of the visit. Now HRSA has heard you and consolidated it, so it's just one document request list. The other change has been is the performance analysis. If you recall, HRSA is still working on... Diabetes is still the clinical metrics that HRSA has chosen. But now during the virtual site visit, that has been discontinued, so you won't be doing a performance analysis. You can still work on it, and you'll work on it separately with your project officer. And then the biggest thing that they've actually clarified, which I'm really excited about, is the protocol. So they've actually done clarifications on methodologies, so

how to assess compliance. Made it easier not only for reviewers, but for health centers. Some questions to assess compliance and then clarification on how to assess compliance. So actually, Kyle and Renee and I have been using the new site visit protocol, and it's actually made even our reviews much easier as well.

So here are some of the updates. This is the update to the document request list. You can either find this online on the HRSA website, and I have a list of resources at the end, or if you're having a site visit, this will be provided to you by either your project officer or the team lead. So you're going to notice, there's going to be no more documents prior, documents at the start. Now there's one list. And so I want to make clear, all documents have to be in two weeks before your visit. So if you're having a visit, look at when your visit is, and those documents have to be in two weeks ahead of time. If you have maybe a problem and you're having difficulty uploading those documents and you're not going to make that two week period, please talk to the team lead, and also to the HRSA team and the federal representative.

The other update is health centers with sub-recipients. So you ask, "Hey, am I a sub-recipient?" More than likely, you're not. What I would check is your notice of award. And essentially, what a sub-recipient is, is you as the health center act as HRSA, and you have to make sure that whoever that pass through dollars is, they meet all 93 elements. So what HRSA has done is, yes, they really drove down and focused on to assess compliance with just three specific areas. It doesn't mean that you don't have to meet the rest of them, but HRSA is just taking a sample methodology. And those three are board authority, board composition, and sliding fee. So that's a big change, and I know that Renee will talk about that in her section.

And then lastly, I don't know if there's any participants that are Look-Alikes or are trying to be a look alike, but it's been wonderful because HRSA went ahead and aligned the Look-Alike application to apply with the Compliance Manual and the protocol, so has really tried to streamline it.

So let's get into the meat of our topic today. And as I go through, I may say to you, hey, make a note about this or write this. So essentially, if I say that, please just make a note. And then if you have any questions at the end, I will be taking questions. And I also told Ted, if I don't get to all of them, what I can do is if he sends me a list, I'd be happy to answer as well.

So the first area is chapter three, needs assessment. Really, what this looks at is when you wrote your grant to HRSA, what does the need say? Or you wrote your competing grant or your renewal. So every year, you have to submit a report. Are you serving the patients and what are their needs? And so the modification for this one, and I put in here just what the question is, it's actually in element A. So what HRSA is trying to clarify is they're going to... You have to take your form 5B and look at those zip codes, and then the reviewers are going to take your most recent UDS, and they're going to look to compare to see if you have zip codes on your UDS, or vice versa, that are not on that form. Okay?

And that's what it says, that it doesn't essentially mean if you don't have that, it's not an element of non-compliance. Because as you can tell, you're going to have, as an example, so let's say you opened up a site and you've already submitted your UDS in February. Some of the things may not match. But HRSA just wants to make sure that the patients, where the patient's coming from, and is that accurately reflected on your form 5B? So that's one of the changes.

And if you think about it, why is this important? Why do we want to know where our patients are coming from? Well, one, we really need to standardize that data. Is it updated? I know there's a question in the needs assessment question is, do you annually look at it? And normally, we annually look at it when we submit our UDS data to see, do we need to add a site somewhere? Are we missing some zip codes? Are patients coming from somewhere that we perhaps aren't serving yet? And also, this is

unique, that data, because it also helps you to figure out if you need to add services. And also, talking with your board. So you can say, okay, we're getting patients from this area. Do we need to add a site?" Our patients are requesting maybe we add a type of service, a podiatrist. Our diabetes rates are going up. Our A1Cs are high. How do we fix that? And that's where this data comes, because the needs assessment, it's not just numbers, it's looking at your qualitative data. What is-

PART 1 OF 4 ENDS [00:23:04]

Jennifer Genua-McDaniel (00:23:01):

Qualitative data. What is it saying about if you have special populations, right? What do are patients need? Do they need housing? Do they need transportation? These are all things that we need to ask ourselves. Sometimes we get this. How we develop our needs assessment is through patient surveys. And it's really important. It's not just yes or no, but we want to use open-ended questions. So really our patients can get that explanation. And this should be an everyday practice because as we know, the needs assessment equals or helps our strategic plan. Because when we have a strategic plan, that's the foundation to expand sites, locations, services. How do we know what our patients need if we don't ask them? And then based on that need, how do we strategically do that? The other thing that needs assessment does is with everyday practice, we're now doing a lot more tele-health, aren't we? Some health centers are 100% tele-health depending on the area they're in.

And we need to understand the challenges. If you have patients that perhaps are Medicare age, they may have difficulty with connectivity. Do they understand how to use their platform? And we really need to ask those questions when it comes to that needs assessment. And also, needs assessment can also help us with thinking about maybe some other lines of businesses. Maybe we need to look at population health, partnering for pantry, maybe daycare, grocery stores. These are other lines of businesses that when we look at a population health standpoint, it's not just providing that treatment. As health centers, right, we need to look at from a prevention standpoint. And then looking at other maybe service lines, a lot of health centers now are going to the holistic route. So looking at acupuncture, maybe adding a chiropractor to help compliment Western medicine. These are all things that, from a needs assessment perspective, we really need to think about.

And then finally looking to see what is in our area and is it duplicated? So these are some of the things that needs assessment. So the most important thing that we've learned in that section is making sure you look at your form 5B and your [inaudible 00:25:29] to make sure you have those zip codes. Okay. The next section is chapter six, accessible locations and hours of operation. This one, the biggest area of opportunities, or non-compliance honestly revolves around form 5B. And that is actually what HRSA has clarified a little bit. So if you can see, sometimes we have changes in scope in, right, especially as you're preparing for a site visit, you may have something in, you have a change in scope number. Now HRSA allows the reviewer to document it. So it says, is there a change in form 5B if yes, has it been submitted? So I can go in and say, yes, change in scope has been submitted. Here's the change in scope number.

And so that also allows HRSA on the backend to say, yes, it's been completed or no, it hasn't. So accessible locations and hours of operations, what this looks at is one, are there any barriers to your patients for them to access your care not only through hours, but where they're located. So this, again, as we know, goes back to the needs assessment. So do you need to add more hours? You really need to look at that data.

So if you ask your patients, if you have perhaps individuals that work nine to five and they can't get in and you close at 5:30, do you need to look at maybe your hours to extend it? There's nothing in

the requirements that say that you have to have Saturday hours, or Sunday hours, or extended hours. What you're looking at is what you offer, is it a barrier to care? And that's what you have to think about. And remember any changes that you made, so when you look at, and I know Kyle will talk about form 5A on a later day, any change that you make to form 5A, which is your services, B, your locations an hour, or C, your others, they need a board approval. Okay. And in your board minutes, you're going to say, we've looked at the hours of operations.

We know with COVID, we've had some staffing issues. You can say, due to staffing issues, we're going to temporarily change our hours. Now, as you know, HRSA provided with COVID, you did not have to submit a change in scope because it was a state of emergency and it wasn't permanent. So if you're thinking of changing your hours, give the reviewer some concept in your board meeting minutes. Okay. So after your board approves the change in scope, you're going to go into your EHP and create that change in scope. And don't forget those instructions and I have the link at the very end, you're going to need a UDS map. You're going to need some MOU's. You're going to have to really show collaboration. Okay.

The other thing you want to think about with locations and hours of operation is asking your patients, looking at your patient surveys, thinking about, okay, is tele-health working? Are you able to get to an appointment? Do we not offer transportation or vouchers? Or are you going to partner with Uber Health, so to speak. You really want to look at what your patients are telling you. And if you notice this question, this is actually one of my favorite questions I got from a health center. It says, does the cost for your visit keep from coming in to receive care? You're not asking the patient are my fees too high, because that's not what we want to know. We want to know if that signing fee discount program and those classes, and Renee will talk about that. Whether that's a barrier from coming in. And if it is, then we know we need to look at that. And if it's not, that's okay too. Because your patients are going to tell you what they need. So that's just something to think about.

And then when we look at it with everyday practice, if your patients, if you're looking at your locations and you're at capacity, you can look at, okay, based on the data, the needs assessment, maybe we need to add another location. Maybe we need to add a podiatrist, looking at a retina view for diabetics. And this all comes into, once you do a financial analysis, it could bring in revenue, it could bring in service lines opportunities. But again, we need to remember if we're going to add more services, we need to think about our staff. Because we know that COVID fatigue is real, initiative fatigue is real. So you really need to balance that out. As if you're going to add something you're going to have to either add staff or give them more responsibilities. Okay.

And then finally, you're going to be known. Think about the reputation of your health center. If you have accessible locations, you're decreasing barrier, you're going to have a great reputation within your community. And remember, today's patients experience is tomorrow's reputation. Patients, communities, it's sometimes it's all word of mouth, social media platforms. We know that there's a lot out there. So we really want to make sure that we're providing a positive patient experience. Okay.

So this is the first hot spot. So please take note of this. When I'm doing admin governance, this is the one thing I noticed. Form 5B here, your hot sites. Site type, there's different types of site type. Sometimes health centers forget to add that if you have an administrative site where you only, perhaps your CEO, executive director, COO, CFO are there, and there's also a clinical practice. HRSA has a dropdown box that says service delivery site and admin site. You need to add that. So sometimes you have an admin site and it's not listed on form 5B. So why is this important? One, you want to take credit for if you have some sites, you need to make sure you take credit.

And two, if you have Federal Torts Claim Act or FTCA, federal malpractice, your admin site is included because it covers the entire organization. So if you don't have a service delivery site slash

admin site or an admin site only, what I would highly recommend is just print out your form 5B and go through it line by line. Okay. The other thing I noticed is sometimes Medicare billing numbers. So and this goes with Renee, with the fiscal consultant, because I'll go through form 5B and say, Renee, could you please check on site A, B, and C. They don't have a Medicare number listed. And you know, each site has to have a Medicare number. You cannot bill Medicare under one site. Each site has to have that.

And then finally, I would also make sure that your website, if you have a website, is reflective of form 5B. So whatever is most recent, if you go through and you're missing a site and it's not on your form 5B, make sure that everything is reflective of your care. It's kind of like a puzzle. We have all these moving pieces because this will affect Renee in the fiscal portion. It could affect the clinical consultant, it could affect Kyle, it can affect needs assessment. So this is really important. And you'll notice when I talk about reflective of current practice, that is the most important thing. Okay. So what you're doing is what's reflected.

The next section is chapter 11, key management staff. And so essentially this chapter talks about, is your staff appropriate to oversee the HRSA federal funding? Do you have enough staff to oversee that project? And so the best part is you as a health center, get to decide, and you tell the reviewers that, or you show them through the staffing profile. And this is also related to the CEO or the project director, executive director. And so what this will look at, so this is the change and it's our clarification, I like to say. If you look at element A, only if you've had a change and what it talks about, have you had a change in the project director or CEO? So whoever is designating or overseeing the health center, if it's a line of business, you have different lines, that health center, some health centers have lines of businesses. Who is seeing that project director? And so what this is saying for the reviewers, this is on my side, is if there has please review the notice of award. Because what that means is once the board approves the new project director or CEO, you now have to do what's called a prior authorization and send it to HRSA and say, hey, HRSA, hey, project officer, we have a new CEO. Here's the information, here's the board approval. And then what ends up happening is that they approve it and send you a notice of award. And so if you've had someone, a new one and what it says, as the start of the current project or designation period. So if your project period is one year, or two years, or three years. So within those, if you've had a new CEO, just make sure that you provide to say, yes, we have this and here's the documentation that we need. A little bit more about chapter 11. Regardless, really look at your organizational chart. When you submit documents for review, the one thing that the reviewer will look at is if you could please you as a health center, get to define what key management staff is. But I don't know that if you don't give me the FTE's. So whoever you designate as key management, you as a health center, get to decide, but I need to see whether it's a 1.0, are they full time? Are they part-time? Is your medical director a 0.5? Do you have a COO? Is your CFO and COO together? I just need to know who you would designate as key management and what those FTEs are. Okay.

The other thing that I look at sometimes, and this is, remember, this is about continuous compliance. So how do we, remember the program requirements are the floor, not the ceiling, and we want to get to transformative and generative. And so think about job descriptions. Again, are they reflective of current practice? Are they outdated? Are there certain things that we need to add? I've seen job descriptions where they say experience in Lotus 1, 2, 3. Now we know that is really outdated.

So what I suggest is really go through that and see what you really need in there and update them. And make sure they're reflective of what you're doing. Okay. Sometimes we have those other duties as assigned in the job description. So trying and like, yes, we probably need that, but please make sure that you have everything that's reflective.

The biggest question I get asked is about the CEO. So they have to be an employee and they're paid as a W-2 employee. Yes, they can have a contract, but it's a W-2. Sometimes I see employment agreements or a contract. What I look for is a pay stub, just to show that they're paid as a W-2 employee. If you currently have an interim CEO, this is a question that has come up a lot. And sometimes we have executive searches or staffing agencies. They cannot be a 1099 even if they're interim. That interim CEO must be a W-2 employee. That is a HRSA speculation. So regardless of whether they're interim, and they're an employee, HRSA does not make a differentiation. They have to be a W-2 employee. You can have a contract, but they have to be paid as a W-2 employee. They can't be a 1099, which is a contractor.

So how do we take key management staff and look at it in everyday practice? Well, first of all, if you're thinking right back to hours and needs assessment, if you're thinking of adding staff, you really want to look at whether your staff is able to handle what you're wanting them to do. So think about a gap analysis. I do a lot of these. So when you look at a gap analysis, are the job descriptions reflective? Allocation and functions of duty. Are employees able to handle the work in order to oversee that scope of project? So what you told HRSA you were going to do, are you able to do it? And do you need to maybe add staff or maybe align a little bit better, that it's reflective of what they're good at.

The other thing you want to look at it and we call it HR. It's now being called, people in culture. It doesn't matter what you call it. But you really want to look at the talent that you have. Our individuals, are our biggest asset, our employees are our asset. And they're going through burnout right now, COVID fatigue. So we want to be really generative and forward thinking. We have some health centers right now that are doing a hybrid model where they're allowing staff to work from home to help with childcare. So really think about what does your organization need to be successful? Because at the end of the day, if your organization is successful, patients can feel it. And you're able to be compliant with the program requirements.

This one, the next one is chapter 13, conflict of interest. So there's a couple of changes here. One, this used to be the fiscal consultant that reviewed it. It's now is coming back to the admin governance. So I, as the admin governance consultant, a reviewer, I'm going to be reviewing this one. And remember a conflict of interest, and we're going to go into this, there's nothing wrong with conflict. It's how we handle it as a health center. And the biggest clarification was, if you look at the samples that you're supposed to provide previously, it used to say 25 provide contracts. If you've had any different provide contracts to see if you had any conflicts of interest, it used to say $25,000 or more. HRSA has removed that. It's also removed that for the fiscal portion. If you notice, now I put a little note, it says for procurement or contracts that utilize the largest amounts of federal awards. So in contracts that have ended three years ago.

So what HRSA wants to see is if you have any contracts that you've utilized federal funds for, maybe some expansion, oral health. And then did you have anything that was a conflict of interest? So did you perhaps had a board member who owned a construction company? How did you handle that if you're in a rural area? Did you have an employee that has a spouse, or a partner, or significant other that works at a lumber yard, that you need lumber? How do you handle those conflicts? Okay. And that's really what HRSA at the end of the day, this is what this chapter is looking at. And then again, this is in order to provide, as we talked about, it was just a clarification on samples. Okay. So if there was a conflict, so let's say in the instance where there was a conflict, is it disclosed on the conflict of interest?

Okay. And I'm going to give you a personal example. I sit on a board of directors and the board, the health center was going for bid for a new auditor. One of the auditors was my CPA firm that does work for me. So what happened is I disclosed it. It was in the board meeting minutes and I did not participate in the discussion or the voting. So did I have a conflict? Yes. And so if this health center goes

through the review, it's going to be noted. They would provide that. They actually went with the A133, the auditor that I use, but it will show they can provide that contract and board meeting minutes documenting that I abstained and then my conflict of interest. So that's just kind of one example to show what that means.

This is an area, please if you notice, I made some notes here. A standard conflict of interest, notice it does not say it can be a policy, it can be a procedure. Okay. Doesn't have to be a policy. But if you notice what I said was written standards of conduct. So what I'm going to suggest is that you pull your HR handbook, your bylaws, standard of conduct, whatever you have, because you have to make sure it applies to everybody, employees, officers, board members, and agents. And if remember, agents is someone that represents your health center. So in the protocol there's a footnote that says what agents is. So here's what I'm going to suggest. Make a little star here. Is go through your things and just make sure you have these bullets that I've listed here. So these are all the things that you have. And then what is the process for disclosing?

It needs be written. So just a little note. How do you disclose conflicts? Okay. So just make sure your procedure matches because remember, I'm going to look at your HR handbook, your bylaws, and your standard of conduct. So I'm going to look at all three to see if they match, if it's the same thing. Okay. And reason we have this and looking at continuous compliance, so how do we work on every day, is that it mitigates risk for your health center. Yes, you carry federal insurance, you carry Gap insurance, your D&O insurance, but we want to make sure it mitigates your risk. We don't want to do anything that puts your health center at risk. So a best practice is I would have, and this is a best practice. I differentiate between what you must do and what is a best practice.

So a best practice is I would have all your employees when they first start, sign a conflict of interest and see if they need to be updated yearly. A requirement for your A133 audit, it only says that key management and your board members. So I'm looking at from compliance standpoint, key management and board of directors. But from a best practice, I would have everybody sign a conflict of interest.

And then finally, remember, as I said earlier, we're going to have conflicts. It happens. It happens, but it's how that conflict was processed and how it was handled. Okay. So how do we work in everyday practice? Again, I'm using that reflective of your current process. So if your procedure or your policy does not match what you're doing, change your procedure. That's all you have to do. Put in writing what you're doing. I think that's the really important part. Okay. And then be like we said, be mindful of conflicts. They're going to have them, it's going to happen. It's what you do with them. That's the most important part. And then always have the signed conflict of interest. For this requirement, if you don't have any conflicts, you don't have to. If you look at the documentation it says, only if you have a conflict...

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Jennifer Genua-McDaniel (00:46:00):

If you look at the documentation, it says only if you have a conflict in the past three years. So if you say, "Hey Jen, we didn't have anything." Then you don't... there's nothing for me to provide, then that would be no, they did not have a conflict. Okay, and as we said earlier, think about also your auditing requirements and what your A133 audit says. So again, here's the second... I'm going to give you another second tip. So as I said earlier, your hotspots, make sure your procedure has all those that I've outlined, and go through, make sure it has all the required language and then make sure all your documents, like a piece of the puzzle, come together and make sure they have everything.

Okay. And then again, samples, it's going to be the same samples that you're going to use for chapter 12, Contracts and Subawards. So those samples, those are the samples you're going to use for chapter 13. And then I don't know if you've seen this, this is... I'm so excited HRSA did this, this link, and hopefully you can get it, go and get it. This is the site visit protocol sampling review. It's not in a PDF, so if you link on it, it's an actual site on the HRSA website and it tells you all of the samples, contracts, everything that you need to supply and what they need to be, along with the timeframe. This is the most amazing thing. And so when I act as the team lead and also work with clients, I have also attached this to say, "Hey, these are the samples that you need to prepare." It's very clear and straightforward.

The next one I have is chapter 14, Collaborative Relationships. This one... Essentially this requirement says, how well do you work within your community? How well do you work within your service area? And who do you work with? And here's the best part, this is the reason why this is one of my favorite chapters. As a health center, you get to decide what you show the reviewers in terms of collaborative relationships, and this is what the clarification talks about. So if you notice, I put a little note that you, as a health center... And I took this right from the protocol, you as a health center, get to decide and document what collaboration means to you. So we'll go through a couple areas and think about what you have as an organization. So, the biggest thing is these are the documented examples that you need. So take a moment, think about your health center, and see... Think about a documented example of how your health center reduces in the non-urgent use of hospital emergency departments. So think about how do you work with your hospital to help reduce ER visits? Do you have a referral agreement? Do they have brochures? Do you provide education? Do you sit as part of a collaborative? Think about that.

The next one is a documented example of how you work to provide continuity of care across community partners. Do you work with food pantries? Do you have maybe a partnership with, I don't know, a homeless shelter to provide care or public housing. And remember it says documented example, so you get to decide the documentation. It could be an MOU, it could be an email that says, "Hi, Jen, thank you so much for participating in this collaborative or coalition. Here are the things we discussed." You get to decide. And finally, how do you work within your community to, to help your patients have access to other health or community services that impact the patient population? Food insecurities, maybe shelter, going through COVID. We've had maybe me individuals that aren't able to work that can't afford electricity, things like that. It could be anything it's just HRSA wants to see that you're collaboratin with your community.

And again, it can be done as we said, anything that you decide to show, okay. And so, one way to continue compliance is you're going to evaluate your service area. Do you have a list of individuals that you work with or communities? And don't forget, one of the questions is, Do you have a health center in your service area? And if you do, how do you collaborate? And if you don't that's okay, too. So if you don't, you're the only one, it's a very rural area. All we put is N/A and I write, "No, the health center doesn't have any other, it's a very rural area."

So you get to decide. And maybe through this list, and again, through your needs assessment, strategic planning. Maybe through this list, you think about, oh, we don't partner with this individual or this agency, we should see how we partner. And remember, if you have special populations funding... So if you're... primarily you get funding for homeless, migrant and seasonal agricultural workers, public housing, those types, those are the official recognized ones. Think about how you work with them, in their community.

And then looking at everyday practice. We want to collaborate. We really try and work as health centers to duplicate what we have in our service area, because remember we cannot be all things to all people, right? We really need to think about our patients. How can we partner? Are there things that

maybe we cannot provide? We may not be able to... I mean, having a grocery store as a health center is very minute, I don't think a lot of health centers actually have a grocery store. So why don't we partner with the local grocery store to do a collaboration for a dietician. And then that's how we get that opportunity to have that collaborative relationship and increase our reputation. We want to have a good reputation in our, in our community or in our service area.

Ted, I noticed... Do we want to do a couple of questions? Would that be helpful? Or should we wait to the end? Since we're going to do board authority and board composition. What are your thoughts?

Ted Henson (00:52:37):

I think you're doing a really great job of time management, Jen. So if we want to jump to a couple of questions, I think that's smart. There were a couple on change in scope, I don't know if you saw.

Jennifer Genua-McDaniel (00:52:47):

Yes, I didn't see them yet. So if you could, read them or how would you like me to handle it?

Ted Henson (00:52:53):

Well, the first was in your... Came up when you were discussing form 5B, is adding the Medicare billing number on 5B a self-service change or does it require a full change in scope?

Jennifer Genua-McDaniel (00:53:04):

It actually is a self-monitored change. So when you go in, it'll... Actually, I was just in the DHB this morning to help with the change in scope. So when you go in, HRSA now has under the form 5B, they've added a second section that says self-monitored changes and there're categories. So yes, it's a self-monitored change. And, side note, hours of operations used to be a full change in scope. I just noticed they need that self-monitored. So very excited. Yeah.

Ted Henson (00:53:36):

That's great. And we'll... That's was a good segue to the second question, which there's only one place for hours of operations on from 5B, and it asks for numbers of hours per week. How was this answered if you're after hours vary and then the second part was, is this self service change or change of scope [inaudible 00:53:56]

Jennifer Genua-McDaniel (00:53:56):

Yeah, absolutely, and maybe Kyle could think about it with his topic. Usually what form 5B, it says number of hours patients are seen in the health center, so it does not include after hours. And then yes, it's now self monitored.

Ted Henson (00:54:14):

Self monitored. And this... Another form 5B question just came in Jen. Can you please repeat, should an admin only site be included on form 5B? Admin officer, that includes HR department and finance department only?

Jennifer Genua-McDaniel (00:54:28):

Yes, I would most definitely put that as a site. And again, HRSA has a specific... If it's an admin only, it's a separate one that you can do. They've changed the EHV, I don't know from when, but I just noticed that this morning. So yes, they have a section. When you go into form 5B it says "Admin only click here."

Ted Henson (00:54:52):

Okay. While we're there, more form 5B questions coming in. So this is a question for satellite clinics. The Medicare number is the same as the parents clinic, form 5B does not allow for duplication of the number, so it is not listed on the satellite. Is this a concern?

Jennifer Genua-McDaniel (00:55:09):

Let's leave this question for Renee, because normally what I see is the Medicaid number is the same, and then Medicare needs to have a separate... It's an 855A form. So if we can get the individual who wrote that, just FYI, Ted, write that down, and we can provide some additional details.

Ted Henson (00:55:35):

Okay. I will. I know Renee's sort of attending, so I can just also ping her to see if she's able to answer today, but if not, we'll bring it up to Cynthia, on...

Jennifer Genua-McDaniel (00:55:43):

Perfect. Oh, there she is. Renee, do you... Sorry, I don't want to put you on the spot, but...

Renee (00:55:51):

No, that's fine, go ahead and put me on the spot. I think I would just need a little more information. By a satellite site, is this like a mobile unit or what type of site is it, to actually clarify that? Usually if it's a mobile unit, I want to say that if it's the same as their main site, that is acceptable, but I'd need a little bit more information before I gave my blessing.

Jennifer Genua-McDaniel (00:56:14):

Perfect.

Ted Henson (00:56:16):

Thank you. Realtime answers there, I appreciate that. And Cynthia, feel free to put more information into the Q and A. We have time for two more jen? You good?

Jennifer Genua-McDaniel (00:56:25):

Sounds great. I was just looking to see if there's anything else.

Ted Henson (00:56:28):

So this one... Can you clarify conflict of interest management and board staff on hire or annually?

Jennifer Genua-McDaniel (00:56:36):

Yeah, normally... So required, so I'm going to say person required or A133 required annually for key management and board because of the audit. And then if you want to have other staff do it, I would do it annually. And the reason I say that, at most do it on hire, but if they'd been there for a long time,

things may change. So normally I see it initially on higher for everybody and then annually for management and board.

Ted Henson (00:57:13):

Great.

Renee (00:57:14):

Jen, can I just add real quick... I'm sorry, I don't mean to interrupt, cause I used to do the conflict of interest. I would also caution that when you're determining your key management staff, make sure you're defining that somewhere in your policy and procedure, your written procedure, so there's no question when you have a reviewer on site. And then I would also caution, cause I made a note when I do my fiscal, that a lot of times this is very similar to your procurement policy, this information Jen is going to be looking for in other areas. So make sure if you have a large enough staff and maybe your key management necessarily doesn't include somebody that does purchasing, you may want to include your person purchasing department as well, thank you.

Jennifer Genua-McDaniel (00:57:54):

Thank you Renee. Good point because... Renee I'm glad you brought that up, because when they look at the documents, that's what I'm also looking at, is the procurement. It's not just conflict of interest, but it's the procurement. So how are they purchasing things? So thank you Renee.

Ted Henson (00:58:12):

Great, and there was another question. Is there a document detailing the naming convention for the documents list?

Jennifer Genua-McDaniel (00:58:18):

Yes, there is. It's on the HRSA website, but I'm going to tell you Ted, it was just updated in June. So if it's okay with you... I don't know how to get this, I want the participants to have the most recent. Is it okay if I send it to you and then you can send it out?

Ted Henson (00:58:34):

That would be great. And then what we will do is make sure that when folks have access, we will send it out as an attachment, but when people have access to the link, it'll be part of their package of documents.

Jennifer Genua-McDaniel (00:58:43):

Okay, perfect, thank you. Thanks. Well, thanks Ted, I wanted to take a little break cause I don't want everyone to think that, here I am babbling on, so I'm glad we did a little Q and A. So our next section is chapter 19, Board Authority. Now remember, as we said earlier, board authority has not changed, but this is a huge one. And, this is an area that I always see a lot of noncompliance, so I'm going to give you some little tips. So remember elements, I'm going to go through elements A and B are strictly related to the bylaws, okay. So when you go through that, look at elements, A and B, take your bylaws and check, "Yep. I have this, I have this, I have this." Okay?

Element C is related to, okay A and B you said you do all of this, so C is the implementation of A and B, and then D and E is the approval of policies. And so I always get the question, What is a must

have? What do I have to have the board approve? And so I'm going to make sure I go through this. And I don't know if we have any public agencies or co-applicant. So where you have a health department, a hospital, public agency, and they have a health center board, it's a very different model of care. But for board authority, the other thing I'm going to look at, if you're a co-applicant is looking at the language of the co-applicant agreement. So you need to have in there, delegations of duties, what the roles are, if some delineation, if there was a disagreement between the two, what happens? Okay.

So if we look at... We already know that A and B is related to the bylaws, but then the biggest thing I get is, okay, element C. And this is literally, I'm going to tell you, yes-no questions. So what HRSA says what I get is, in the past 12 months, has the board demonstrated element C? And I'm going to just show you, it talks about, Did you have a meeting with a quorum? I know right now with COVID you were able to meet telephonically, I'm going to... or through conferencing. I'm going to be [inaudible 01:00:56] I'm going to tell you, HRSA still requires a monthly meeting with a quorum. If you did not have one that will be documented, okay.

The other thing is, did you approve, or if you had a new CEO or project director, or an evaluation, did you approve all these things? So I'm not going to go through them, but what I'm... I'm going to show you. I provided a handout for Ted to hand out to everybody. I took all of these and I use it during my review and actually give it to the health center is, I'll document where I find certain things and where I didn't. Because as you know, I'm imperfect too.

So if I'm on a site visit for her HRSA, what I always say to the health center is, "Okay, I missed it. Can you please show me where this is?" Because we're imperfect too. And as a side note, it's okay to save to the reviewers," I don't see where this is in the compliance manual or the protocol I'm really trying to learn. Can you please show me where this is?" So these are the things that need to be completed by the board. And I'm going to break down the last one, because this is the one that I always get questions on.

And so what this says is, "Does the board evaluate the performance of the health center? Not only based on quality, but other information and looking at action followups." And it gives, if you notice, five. Project objectives, service utilization, quality of care, effectiveness, or patient satisfaction. And what I wanted to do today is... Notice this is going to be a hotspot, it's a helpful tip. I'm going to give you some suggestions, these are just suggestions that you can use when I get a question as, how do you evaluate the performance of the health center? What things do I have to put in my board meeting minutes? So, evaluating the performance of your health center, when you... I look for your achievement of project objectives.

So do you have, did you apply for cares funding or COVID funding? What you wrote, did you do what you told HRSA you would do? What are those goals with those grant funding? And then what about completion of various projects? I had a health center recently that used funding to improve their HVAC system. That's a performance, I want to know about that project, how does that help those patients? Did they put a negative pressure room in? That type of stuff or any other projects. Do you look at your strategic plan? What are those goals? So I'm looking at what you've said you started out to be, and whether that's been completed.

The next area is evaluation based on service utilization patterns. So, how do you evaluate? What do you, as a board or you, a staff look at? Do you look at number of patients? What is your no-shows? Departmental trends. We had on average... I don't know if health centers are seen this, but we're seeing a 20 to 30 percent increase in depression, PTSD, ADD, so behavioral health measures. What is that telling us? What does that tell us about what COVID has done to us? We had dental close. What did you, what did you do with that?

Also looking at integration rates by service lines. And what that means is, does your patient... so let's say you have a medical patient, do they also see dental? Behavioral health? If you have OB pediatrics. What service line has this one patient touch? So then you can see if you're having an effect. And this is kind of something newer that we're looking at, is that integration, it's not just co-location right, it's integration. It's using patient centered healthcare home, making sure that our patients are getting what we need. And then what your patient trends are telling you by your health center. So if maybe telehealth is... 80% is telehealth and patients don't want to come back in, what does that say? Are they afraid? Are you in a hotspot? What is your, what do your vaccination rates look like? And so these are... Anything can be considered a service utilization pattern, you get to decide that. But that's kind of some of the stuff in the meetings I'm looking for in the meeting minutes.

Next is quality of care. So think about your clinical metrics, your measures, it's not just UDS. Think about your chart closure times, wait times, operational goals, anything that is considered quality of care. And what I want to see is... I don't want to see, cause I don't know if I only get meeting minutes, "Mrs. Smith presented the QI meeting. No discussion, all in favor." That doesn't tell me anything because I just get those minutes. So I need to know we discussed the... "Dr. Jones provided an overview of the diabetes metrics, noticed a 10% decrease because patients are coming in. We've had an issue, we've looked at, these are the clinical metrics." They don't have to present everything. I just want to see that that's happening. "Board member Jennifer asked a question as to whether we need to increase hours. Dr. Jones said, I think it's a matter of doing callbacks for patients." So I'm looking at some type of a discussion. So that's evaluating, when look at quality of care, is how well are you treating those patients? What is your dental... looking at dental, are you asking depression screening measures within dental? Are you co-locating dental? So those are some types of things.

The next one is efficiency and effectiveness of the health center. So how efficient and how effective is your health center running? These can be your financial data, your measures, your fiscal measures, what your strategic plan is, what your day's cash on hand. You have as a... FQHC's, you have those five fiscal measures. And for the FQHC lookalikes, I believe you have three, three or four. Those are those measures that you want to know about. And then looking at your strategic plan. Remember your strategic plan, the minimum requirement is financial management and capital expenditure needs. So I want to see those two things on top of whatever else you have in your strategic plan.

So these are things that you need to document in your meeting minutes. And then lastly, I'm going to look at, and even when I talk with the board regarding patient satisfaction or addressing any patient grievances. Now, remember, we want to make sure... Remember board meeting minutes are legal documents, right? Too much is not good, too little is not enough. And maybe you present this quarterly or you present it within your risk management. But as a board, as a staff, we want to know what our patients are thinking. How do they feel about telehealth? How do they feel about the care they get? Is it clean? Is there enough parking? What about areas that maybe aren't so great? I had the example about callbacks for referrals or callback for labs. Do you call back critical lab values right away? These are all areas that if you know there's something you need to work at, you can turn it into a plan, do a study act or PDSA and make it part of your quality. And that's where patient satisfaction is really important.

And then finally, this is another question I always get. If you notice, this is a best practice, I'm not saying it's a compliance. But think about it, if you only report patient satisfaction one time a year, how are you supposed to fix something if the reports' from January, and you're reporting it at the end of the year. So I would say...

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Jennifer Genua-McDaniel (01:09:00):

...and you're reporting it at the end of the year. So I would say regular surveys, focus on what you need, but then report quarterly to the board. That is the best practice. So that would be really helpful.

And then finally, here's the biggest question I get. These are the nitty-gritty, this is what your board needs to approve. So within the last three years, has the board adopted, evaluated the following? Now remember, it's a sliding fee discount program, so if you have policies in your sliding fee, it's not just the sliding fee scale, it's your entire program that those policies need to be approved. You have your quality improvement or quality assurance program, so your policies. If risk management and sentinel events is part of your QI program, and that's a policy and quality improvement, then HRSA says it's your program. It's all those policies in there.

So you have sliding fee, QI/QA, billing and collections policies. And I'm going to give you a little tip, because I've been seeing this. Some reviewers will make this a not-met because they're looking for a policy and a separate approval for policy for waiving or reducing patient fees. Because if you read the protocol, it says, "Billing and collections, including policy for waving or reducing fees and refusal to pay if applicable." So I'm going to give you a little tip to not have to worry about it. Not only approve your billing and collections policy, but make a motion, a second motion to approve a policy for waiving or reducing patient fees. Okay? And then if you have a refusal to pay policy, that needs to be approved as well. Some health centers do. Some health centers don't. If you don't, that's fine, because it's if applicable. Then finance management and accounting systems, and then personnel.

So these are the five things, five must-haves. And then HRSA, if you notice, will have a footnote that says, "These are not inclusive." Are these the must-haves? Yes. But if there are other policies that govern your health center that the board needs to approve... And I'm going to give you a little tip. In your notice of award, when you get your notice of award, it's 16 pages in two- point font. Read in there, because there's some things that need to be approved. Okay? So these are the HRSA compliance, but don't forget there's other stuff as well. And then if you're a public entity or a co-applicant agreement, if you're co-applicant says that financial management, accounting, and personnel, that the public entity retains it, then these two sections are not applicable. That's just for you. So this is the biggest... Here's the slide that's important. What needs to be to be approved. So these are the five.

And then how we look at everyday practice when it comes to governance? So one, make sure you keep a calendar. And I'm going to show you what I provided as a sample. And then meeting minutes. Make sure meeting minutes are key, as we talked about. We need consistent documentation. And then I know that NACHC has some resources as well. And then don't forget, if your health center uses a consent agenda... And a consent agenda takes everything that is reports, that is informational, and it's a blanket approval, and so a lot of health centers will do that, if they're generative-thinking or forward-thinking. Remember, anything that requires a HRSA approval should not be in a consent agenda and needs to be discussed, so you can pull it out of a consent agenda. Okay? It can't be a blanket approval. And then finally, this is what I provided as a sample. This is what I use. And so what I've taken is those elements C, D and E. I've turned it into a graph. I made this into a Word document, so you can put your health center name. And then you can say, "Okay, monthly meetings with quorum? Yes, I've done that monthly." It says, "Approval or evaluation of the health center CEO." You can put the date of the board meeting minutes. Let's say it's January. And the approval or the motion to approve is on page two. So you can kind of go through and use this, and hopefully this can be a resource to you.

And then these... This is a hot spot, so please make a note. Not only were the other ones a hot spot, but I'm noticing when I'm doing reviews... I've noticed the board approval of the required authorities, they're being discussed, but not being made motions. So in particular the approval of the CEO, the audit, anything that's related to the health center project budget and application, what I need

to see if it's in discussion in an executive session... You know how you make the motion to go in executive session. Do your discussion. You don't have to take minutes. I need a motion to come out of executive session, and then I need a motion to approve the performance evaluation discussed in executive session. First, seconded, all in favor, any opposed, and then motion carried. So please remember that. I've been reading meeting minutes where it's being done, it's just not documented. I don't see a motion for approval. And HRSA requires that board approval for those.

And then last but not least, of course, is chapter 20, which is board composition. And I'm happy that they've done some clarification with this one. The first clarification is Form 6A, Board Characteristics. Before, you didn't have to provide it. And I always would ask for it, because as you know, when you submit it three years ago with your [SAC 01:15:06] or your grant, it may have changed. You may have had new board members. Maybe board members have left. So my biggest advice is, again, reflective of your current practice. Remember, the visit is a point-in-time visit, so we need to make sure that is... The board members that you have now is what you're going to need.

The clarification as well that we have is in Element A, so it's a board member selection and removal process, and it talks about how the bylaws or how the health center documents board member selection or removal. And so remember, this is related to the bylaws, so I'm going to give you a little hint. What I would normally do is take this question and rewrite it and put it in your bylaws. So you can say, "Sample FQHC does not limit in selecting or removing the chair, the majority of the board members, and majority of the non-patient board members." This is related directly to the bylaws. So HRSA wants to make sure that board rep member removals, that there isn't any limitation, so you don't have someone else making that decision. You as a governing board does.

Okay. And then here we go back again. It's amazing how these are all puzzles, right? Element C is related to your current board composition. And now what HRSA is looking at is making sure that your health center... And this, again... Remember board governance, having a board, is the essence of our whole entire existence as health centers. It's written in the federal law. And so you really have to look at why, how your board is represented of the UDS characteristics. And it says, is race, ethnicity, and gender consistent with the demographics in the health centers UDS? And the question is, if they're not, one, why aren't they? And two, what is the board doing to be able to recruit board members? So we really want to make sure that our board is generally represented based on the patients that we serve. And it may be hard to recruit board members, especially if maybe your patients, your service area is 10, 20, 30% Hispanic Latino, their preferred language is Spanish. Sometimes it can be hard. But as long as you have something in place or some type of process that you're going through to say, "Yes, it's difficult, but here's what we're doing. Here are the steps that we're taking," that's all HRSA wants to see.

Okay. And then lastly, as you know, we need to make sure that the board, again, is representative. You need to have between nine and 25 members. And remember, 51% are served by the health center. The biggest question I get is, if we give flu shots, if they get a COVID vaccine, does that count as a visit? The legal answer, I would say, or the answer, is yes, because it's a visit, and they've received one in-scope service in the past 24 months that generated notice, a health center visit where the site and the service is in scope. But I want you to think about it thinking further. So from an ethical, moral issue, if they just get a flu shot once a year, and they're counted as patients, is that truly a generative-thinking organization or board? So we want them to be integrated and to be able to provide good feedback as board members.

And then these are also the other ways to think about patients that are served by the health center. So you could have a legal guardian of a patient who is dependent, has a dependent child or adult. That's really helpful if you have pediatrics and you have individuals that have children. And then the last two is a person who has legal authority to make healthcare decisions on behalf of a patient, or a

legal sponsor of an immigrant patient. Okay. And how we assess the 51%... I do not like to look at billing records... Or I'm sorry, patient records. I like to see the EOBs to see whether they've had one visit of in-scope services. So it can be medical, dental, behavioral health, anything that has generated a health center visit.

And then how do we look at our patients or our demographics? Look at creating kind of like a board matrix. And you're going to need this to see what board members that would help with your organization, especially those... If you have special populations funding, you need to make sure that you have at least one or more board member who represents that patient population. We want to make sure that they have a voice too, especially if you're receiving funds for them, for that service area, to help those patients. And then finally, as you know, this is kind of standardized. It's in the law. Health center employees and immediate family members, so spouses, children, siblings, through blood, adoption, and marriage of employees may not be health center employees. That is just straight from the compliance manual.

Here's a hot spot, so please take note, because I'm going to tell you that this is in the compliance manual, but it's not in the protocol, which... I find it very interesting. HRSA has now added it as a footnote underneath, but it never used to be. So one of the questions is, do any non-patient board members earn more than 10% of their annual income from the healthcare industry? Now, there's a footnote, but what it says is the health center determines healthcare industry and how to determine the percentage of income. So here's the deal. I can't answer the question unless you tell me what it is. In the compliance manual it says under other considerations that the health center has to determine that within their policies. So I'm going to strongly make the suggestion that you decide... Look in your bylaws. If you have governance policies, please, please look in there. And provide the reviewer a definition for healthcare industry.

And I've been allowed to share, I have this as our definition that we have on our board, and you are more than welcome to use it. I see something really simple. Sometimes I see doctors, nurses, dentists, they're considered healthcare individuals. You can make it as defined as... You get to decide, as long as I have something. But I just wanted to show you, this is a hot spot, because I am unable to answer that question, so I really need you as a health center to define it for me.

And then, again, as we know, with everyday practice, you really want to look at recruiting board members. We know it's key to our health center program, having a matrix, mentorship programs for new board members. Because even though I know about health centers, I'm going to tell you, I got the lecture of, I was in the weeds. So someone who's well versed as me, I had to learn to be a board member. So having a mentor or working together with the chair is really important. And then remember, if you have a good board, your staff will see that. You want to be the provider and the employer of choice, especially now. Patients have a choice of where they go. Even employees, we have a choice of where we want to work. And so we want to make sure that we have this cohesive organization, we have a good culture, and we really want to be forward-thinking. So how can we as boards... How do we support our staff?

And then finally, I wanted to make sure... These are all the resources that I list. Hopefully you'll be able to have access to it. And then these are the resources that, Ted, I know you had provided to me. These are awesome. I think some of them... I know I've created some of these with you and Emily, but these are amazing resources, and I just am thankful. And then here is my information, in case you have any questions.

Ted Henson (01:23:39):

Thank you, Jen. Great job always. And we have some time for some questions that have come in, and we might go over a little bit, if that's okay for everyone. But the first thing I do want to address is just a general question around when these slides will be available. So just to clarify, I think the recording for this webinar will be available within two weeks, but you should have received the slides. We will make sure we send them out today, and we'll send them out every day for the webinar, in addition to other resources that have been discussed. So Jen mentioned the [inaudible 01:24:14] review guide, and I went ahead and just created a PDF of that, so we'll also send that out to everyone. Thank you, Jen, for referencing that. And then when you're done with this course, you'll receive a link to all the archive recordings, and all the handouts will be included. But to answer the question, you will have access to the slides immediately. It will be the recording that will take a little bit of time.

So, Jen, a bunch of questions around board approval, if that's okay.

Jennifer Genua-McDaniel (01:24:38):

[crosstalk 01:24:38]

Ted Henson (01:24:37):

Many of the things you say that the board must approve are done at the health center, within a committee of the board. The minutes of these meetings go to the full board. They then accept and approve the minutes of the committee. Is this sufficient?

Jennifer Genua-McDaniel (01:24:52):

It is. But I also advise that the board also discusses, so they're not going to just... You can't just say, " Please see the report." At least provide a couple sentences. And the biggest one I use... And Renee, I know you and I have talked about this, is you have a finance committee, you have finance, they submit the minutes, but... Renee, correct me if I'm wrong. Sometimes the finance director can just give a little blurb of what was talked about and that's it. Renee, [crosstalk 01:25:20]

Renee Filson (01:25:21):

Absolutely. Doing finance, if they just kind of talk about where they are year over year to date as well as for the month, and it's just a little blurb in the minutes, that should suffice.

Jennifer Genua-McDaniel (01:25:32):

Yep. That's all I want to see. And if other board members had questions, because the minutes will have everything of the committee and what they've done. I just want to make sure others that are not on the committee, if they had any questions.

Ted Henson (01:25:45):

Thank you, Jen. How do bylaws approve and remove board members? What is the specific statement that you mentioned that HRSA uses?

Jennifer Genua-McDaniel (01:25:54):

Oh, it's actually... I can go back to the slides, Ted. It's actually in the element. Sorry, I'm going pretty quickly, Ted. Apologize for that.

Ted Henson (01:26:05):

[crosstalk 01:26:05].

Jennifer Genua-McDaniel (01:26:05):

Okay. It's actually right here. So what they can say is that there's no limitations in selecting or removing any of the following. And I know if you look at... It's right here, Ted, but I also have some sample language. I don't know if you would like that, or the health center would, because it talks about how does a health center... There's another question that says, how does a health center remove or resign... How do they remove board members? So I can provide that in there. It needs to be in the bylaws. Ted, I'll send that to you as well. Make a note.

Ted Henson (01:26:43):

Please do. [inaudible 01:26:44] if we stay on that question, what if you find that a board member has family that just recently hired by the clinic? How much time is allowed for that board member to resign?

Jennifer Genua-McDaniel (01:26:54):

Well, that's going to be a decision based by the health center, because... I'm going to give you an example. As soon as that happens, you're out of compliance. HRSA doesn't have a set period of time, so you probably want to take action sooner rather than later. And I use the example, Ted... You have nine board members. Let's say you lose one, because nine is the minimum. As soon as you go down to eight, you're out of compliance. HRSA considers that out of compliance.

Ted Henson (01:27:23):

So perhaps it would be better for the person to proactively resign before the person is hired?

Jennifer Genua-McDaniel (01:27:29):

Correct. Correct.

Ted Henson (01:27:31):

Okay. We recently had... We're seeing all these questions, Jen. We recently had a board member move out of state, leaving us with only eight current board members. Should we include updates in our board minutes about current recruitment activities until we get back to having a minimum number of members? What else would you recommend? [crosstalk 01:27:48].

Jennifer Genua-McDaniel (01:27:48):

Yes, I love that idea. Absolutely. And see, here's the thing. Things happen, right? It happens. A board member leaves. And that's where we really need to be proactive. So talk about your board recruitment strategy. I would strongly recommend having more than nine, 10 or 11, so if that happens, you're not out of compliance. So yes, just talk about that. The best way to recruit board members, as I always say... Staff, your providers, your front desk staff, they know who your patients are, if you're looking for that. So I think that's important.

Ted Henson (01:28:21):

Okay. Coming from you, that's reassuring. [Inaudible 01:28:24].

Jennifer Genua-McDaniel (01:28:26):

[crosstalk 01:28:26] will say this. If they're having a site visit coming up, remember, it's a point-of-visit, so please have nine when your site visit happens.

Ted Henson (01:28:36):

Okay. I'm sure we could see a lot of heads shaking if this was in person.

Jennifer Genua-McDaniel (01:28:39):

[inaudible 01:28:39] nine.

Ted Henson (01:28:41):

I don't know if I quite understand this. How do we handle providing information about board member visits to you? Or do you review this during the [inaudible 01:28:48]?

Jennifer Genua-McDaniel (01:28:49):

Yeah. So HRSA... You're going to do the Citrix ShareFile to upload your documents. Usually I'll see the board member visits in the board meeting minutes. Sometimes there's a discussion where the medical director provides that. I'll look for that as well. I know Renee does program monitoring, but that's also a section, so I sometimes... Since we all share stuff, even though I have my section, I'll look at other people's folders. And so program monitoring, I look for... There should be some patient stuff in there, or service utilization.

Ted Henson (01:29:22):

Okay. We'll do two more quick ones. And Renee, you might want to pop back on, because I know one was a clarifying one, but... So actually, why don't you clarify the question around Medicare number and the satellite sites first?

Renee Filson (01:29:38):

Sure. Okay. Let me go ahead and say, first and foremost, CMS does have FQHC requirements listed. They have like a provider manual. So I always say, "Go look there." Make sure you understand what CMS is asking. However, I do want to state that the only exception to not having a Medicare number for that site is if, one, it's not a permanent location, nor is it seasonal. So if it's not permanent nor is it seasonal, you do not have to have a CMS Medicare number. If it is permanent, and it is year-round, you do need to have a number. So again, go out to CMS for the clarification. They have a FQHC provider manual.

Ted Henson (01:30:22):

Thank you. And then this one came in. Can you please repeat the strategic plan requirements for fiscal measures?

Jennifer Genua-McDaniel (01:30:29):

Yes. It's financial management and capital expenditures, are the minimum requirements.

Ted Henson (01:30:38):

Excellent. I think that's all of our questions. Wow, we actually answered them all.

Jennifer Genua-McDaniel (01:30:45):

Good. And I was going to say, Ted, if there's any that come in or have any questions, I'd be happy... Just send me a list, so that way everybody can get the answers as well.

Ted Henson (01:30:55):

So that's a good way to end, Jen. If there are additional questions, feel free to send them to me, thenson@nachc.org or to the trainings at nachc.org that you've been receiving the links from. Also, we will follow up just with another reminder email today with the additional documents that Jen had referenced and the ones that we've converted, so the handouts in addition to the slides. So once Jan, you have that information ready, we'll send that on. And then we'll send another email out on Wednesday with a reminder email with the links to Renee's webinar and with the handout for that one as well. So with that, thank you, everyone. Thank you, Jen. Amazing as always. Renee and Kyle, thank you for being here. And we'll see everyone back on Wednesday at 1:00 PM Eastern. Take care.

PART 4 OF 4 ENDS [01:31:43]