Bureau of Primary Health Care/Management Solutions Consulting Group
Frequently Asked Questions
Site Visit Report Format Training

Q: What is the difference between the Program Requirements and Performance Improvement sections?

A: The Program Requirements issues are listed in the "Summary of Key Health Center Program Requirements" document. All other areas of concern should be documented under the Performance Improvement section of the report.

Q: The Program Requirements area appears to require inflexibility on the reviewer's part. Most often, noncompliance is not an issue, but rather some variation of compliance exists. Issues of non-compliance can range along a continuum from no compliance to almost compliant making the determination somewhat subjective. How should the consultant respond?

A: The consultant should document any issues where there is clear evidence that the grantee is not meeting the program requirement. If a determination of non-compliance is not totally clear or possible from the site visit, please identify the issue for follow-up in the performance improvement section.

Q: Define how the "Specific Actions Taken" section could be utilized.

A: The "Specific Actions Taken" section should list the specific outcomes of the site visit. The response should consist of bulleted actions taken during the site visit.

Q: How should consultants address issues that cross over two or more sections within the report format?

A: When a particular issue impacts more that one section within the report format, the consultant(s) should thoroughly document findings and recommendations in the first section and than make reference in the following section the area in which the topic was addressed. Consultant teams will need to work closely together to make sure each area (if applicable) is fully addressed from their respective areas for expertise.

Q: How should consultants document their comments to indicate: 1) The area was not reviewed as part of the task order or 2) There were no program requirement or performance improvement issues identified as part of the task order?

A: If the area was not part of the review the consultant should indicate “N/A (not applicable)”. If the area was reviewed and the grantee was found to be fully compliant with program requirements and/or performance improvement areas the consultant should indicate “No areas reviewed were out of compliance with program requirements” and “No performance improvement areas identified”.

Q: What is the purpose of the required consultant report?

A: The Consolidated Team Report must be completed for every site visit. The report format reflects the Program Analysis and Recommendations (PAR) tool that is currently utilized within BPHC. They are designed to enable Project Officers and grantees to readily utilize information provided within the technical assistance site visit report. The Consolidated Team Report is for BPHC PO’s to use and send directly to the grantee. Consultants should consider convening a post-site visit conference call with the grantee PO as an opportunity to convey information about the grantee and activities at the site that BPHC should be aware of but that would not otherwise be contained in the formal written report.

Q: Can you explain how the Needs Assessment relates to the Health Care Plan?

A: Information provided on need should serve as the basis for, and align with, the proposed activities and goals described in the health care and business plans.

Q: Which program requirement issues should be reviewed on-site?

A: Consultants should focus only on any program requirements identified in the site visit task order and/or other program requirements discovered onsite that are of concern out of the 24 program requirements listed in the Summary of Key Health Center Program Requirements attached to the Consolidated Team Report format when assessing program requirement issues. All other issues fall under performance improvement.

Q: How should compliance regarding sub-recipients be assessed?

A: In a sub-recipient relationship, each organization (grantee and sub-recipients) must be in compliance with all applicable section 330 requirements. However, it is the grantee’s responsibility to assure that the sub-recipient is operating in compliance (as noted in the SAC guidance).

Q: Which takes precedence when determining compliance – health center regulations, statute or program expectations?

A: Both statute and regulations are used in determining compliance. In the rare circumstances where regulations conflict with statute, statute takes precedence. Within the PAR, all requirements are based in either statute and/or regulations. This is also stated in Block 16 of each Notice of Grant Award (NGA). The Program Expectations document is useful in providing examples and additional language for performance improvement as it expands on and goes beyond issues of compliance.

Q: What behavioral and oral health services are required?

A: Required oral health services include preventive dental services and pediatric dental screenings. Required behavioral health services include referral to mental health services (if they do not provide themselves or by arrangement) and case management services. HCH grantees are also required to substance abuse services.

If the grantee has other behavioral and oral health services within their scope of project, then patients must have reasonable access to these services.

Q: If a service is in a grantee's scope of project, what are the requirements for having those service providers on site?

A: A service can be included in the scope of project if it is provided directly by the grantee, or through a formal written arrangement where the grantee pays/bills for the service. A referral arrangement is in scope if there is a formal, written referral arrangement (even if the actual service is provider for and paid/billed by another entity.)

Patients must have reasonable access to the full complement of services (in scope) offered by the center as a whole. However, as far as on site hours (from the Scope of Service PIN): "The specific amount and level of these services will vary by grantee based on a number of factors including, among others, the population served, demonstrated unmet need in the community, provider staffing, collaborative arrangements and/or licensing requirements." This does not mean that there is a requirement on the number of on-site hours or on the referral arrangements, but the grantee should make sure that patients have "reasonable" access.

Q: At what point are grantees <u>required</u> to start using the new formats and new measures for the health care and business plans? (Some people seemed to think we can't require until they go through a SAC; others thought it could be required in all BPRs after a certain date, but weren't sure what the date was.)

A: Grantees are *required* to start using the new formats and new measures for the health care and business plans when they submit their SAC. It is recommended that grantees start incorporating the new formats and measures now, just to make it easier for them to transition to when it's required.