MOBILE MEDICAL UNIT ADVISORY COUNCIL

HHS|HRSA – PINELLAS COUNTY BOARD OF COUNTY COMMISSIONERS
HEALTH CARE FOR THE HOMELESS GRANT | #H80CS00024

MEETING AGENDA

JULY 28, 2015 | 11:30 AM – 1:00 PM
JWB, 14155 58TH STREET NORTH, CLEARWATER FL 33760 | ROOM 185
CONFERENCE CALL-IN: DIAL 1-727-582-2255; PASSCODE: 718007

Welcome | Introductions

1. **Chairman's Report**
   - i) Approval of Minutes, July 2, 2015
   - ii) Unfinished Business/Follow-Up
2. **Governance/Operations**
   - i) Change in Scope – Portable Clinical Care – *Elisa DeGregorio*
   - ii) MMU/Safe Harbor Calendar – *Drew Wagner*
   - iii) Site Visit Compliance Update – *Elisa DeGregorio*
3. **Fiscal**
   - i) Notice of Awards – *Elisa DeGregorio*
   - ii) Expanded Services Grant Application – *Elisa DeGregorio*
   - iii) Service Area Competition Grant Application – *Elisa DeGregorio*
4. **Clinical**
   - *i)* MMU Client Trend Report – *Dr. Chitra Ravindra/Rhonda O'Brien*
   - ii) Policies and Procedures – *Dr. Chitra Ravindra/Rhonda O'Brien*
     - (1) Credentialing & Privileging
     - (2) Hospital Admitting & Tracking
   - iii) Patient Centered Medical Home Update – *Dr. Chitra Ravindra/Rhonda O'Brien*
5. **Other Updates**
   - i) Bayside Health Clinic Update – *Elisa DeGregorio*
   - ii) New Business

Adjournment | Next Meeting: Thursday, September 3, 2015 @ 3:00 pm, Pinellas Hope

TAB 1 - MINUTES

Minutes from the July 2, 2015 meeting of the Mobile Medical Unit Advisory Council

Minutes of the Monthly Meeting of the Mobile Medical Unit Advisory Council (MMUAC) July 2, 2015 | 3:00 pm

Location of Meeting:
Pinellas Hope
5726 126th Ave N
Clearwater, FL. 33760

Present at Meeting: Don Dean* (Chairman), Laurie Lampert, Dianne Clark, Valerie Leonard*, Tom Wedekind, Mark Dufva, Alaina Robinson*, Sgt. Zachary Haisch, and Rhonda Abbott (phone). Staff and community members present: Rhonda O'Brien, Drew Wagner, Dale Williams, and Elisa DeGregorio. (*Consumer)

The regular meeting of the Mobile Medical Unit Advisory Committee (MMUAC) was called to order at 3:05 p.m. on July 2, 2015 at Pinellas Safe Harbor by Chairman Don Dean.

I. Chairman's Report

i. **Appointment of Members to Fill Vacancies on the MMUAC:** Per the Bylaws of the Mobile Medical Unit Advisory Council, Chairman Don Dean appointed the following individual to fill vacancies on the MMUAC: Sgt. Zachary Haisch of the Pinellas County Sheriff's Office and Alaina Robinson, Consumer, will serve as an interim appointee for the remainder of the year.

Resignation: Don Dean announced his resignation from the MMUAC immediately following this meeting. He thanked everyone for their support.

Officers Vacancy: Per the Bylaws of the MMUAC, Article VIII, Section D, The unexpired term of an officer not completing his or her term shall be filled by a majority vote of the MMUAC. The group chose to make nominations at this meeting rather than wait to the next meeting. Tom Wedekind nominated Valerie Leonard as the Chairperson. Dianne Clark seconded the motion. Valerie expressed her interest and noted that she is attending school, but that this would be something she would love to do. **The Council voted unanimously to appoint Valerie Leonard as Chairperson.** The Council also chose to fill the remaining vacancies of the Officer positions for Vice Chairperson and Secretary. Valerie Leonard nominated Alaina Robinson to serve as Vice Chairperson. Laurie Lampert seconded the nomination. T**he Council voted unanimously to appoint Alaina Robinson as Vice-Chairperson.** Tom Wedekind nominated Mark Dufva to serve as the Secretary. Alaina Robinson seconded the nomination. **The Council voted unanimously to appoint Mark Dufva as the Secretary of the Council.**

ii. **Approval of Previous Minutes**: A correction on the location of the meeting from Pinellas Safe Harbor to Pinellas Hope was made. A motion to approve the minutes dated June 2, 2015, was made by Dianne Clark, seconded by Laurie Lampert and **unanimously approved**.

iii. **Unfinished Business**: In follow-up to last month's meeting, the following items were discussed:

a. **Healthcare Industry Definition:** At the May meeting, Dianne Clarke asked to clarify the 10% of income from the healthcare industry as a composition requirement of the MMUAC. Ms. DeGregorio communicated with the Project Officer at HRSA who said that "The intent

of this requirement is to ensure that non-patient board members are representative of the community currently served by the health center and contribute to the overall expertise of the board by providing a variety of expertise (i.e., not all from the health care industry). Health centers should define in either bylaws or other board-approved policy the term "health care industry" for the purposes of board composition.

Ms. DeGregorio presented a recommended definition using the U.S. Department of Labor's North American Industry Classification System (NAICS) for the Health Care and Social Assistance Sector. The definition recommended and approved by the MMUAC is as follows:

The Health Care Industry Sector comprises establishments providing medical care exclusively, continuing with those providing health care assistance for individuals. Subsectors include Ambulatory Health Care Services, Hospitals,, and Nursing and Residential Care Facilities (NAICS 621, 622, and 623 respectively). All industries in the sector share this commonality of process, namely, labor inputs of health practitioners or social workers with the requisite expertise.

The definition does not to include those establishments from the Manufacturing (Medical Devices, Pharmaceutical) or Finance and Insurance (Health Insurance) sectors.

b. **Alternative Site for Clinic Services at Pinellas Hope when Van is unavailable:** Mark Dufva spoke with Pam Long, Pinellas Hope Director, and suggested that there is no firm resolution and that Pam Long and Laurie Lampert would be the identified point of contact for the County when a change in the schedule occurs. The staff at Pinellas Hope will make every effort to accommodate the services, but it should be noted that there is a big impact to daily operations. This past week, Laurie noted, that the staff were able to make accommodations by asking for the County to start clinic a little later at 10:30 am to accommodate a group using the Library that date. Dale Williams thanked Mark Dufva and reiterated the County's commitment to work through Pam and Laurie when the situation arises.

c. **Tent at Pinellas Hope:** At the last meeting, Don Dean requested that the County consider purchasing a tent that could be placed near the Mobile Medical Unit for clients waiting for services. Mark Dufva asked to look into it as a Pinellas Hope request rather than the County, and reported back that Pinellas Hope would purchase the tent for its residents. He asked Don and Drew Wagner to identify the location and size, and report back to Pam with the specifications.

d. **Five-Year Cap on Residency at Pinellas Hope:** Mark Dufva reported back that for the 80 units of Pinellas Hope II, there is nothing officially in writing that limits a resident's stay to five years. There may have been some confusion regarding the St. Pete Housing Authority vouchers, but he reiterated that there is nothing in writing and that a resident could renew their lease, within their requirements and services offered, annually. Valerie Leonard thanked Mark for the clarification and asked Mark to come to one of the Tenant Council meetings to reiterate that information.

e. **Eligibility by Non-Homeless/Permanent Supportive Housing:** The staff clarified in writing the eligibility policy and placed the updated policy for their review and approval in the Policy & Procedure manual. The policy clarified that the MMU accepts both homeless and non-

homeless individuals. The grant allows up to 25% non-homeless to use the MMU. With approximately 2000 unduplicated patients annually, that allows for up to 500 non-homeless. We have yet to come close to reaching that number and staff does not foresee it being an issue in the near future. **The policy was reviewed and unanimously approved by the Council as part of the full Policy and Procedure manual.**

iv. **Future Meeting Dates/Room Availability:** At the June meeting of the Council, Laurie Lampert informed the board that the room being used to host the MMUAC meetings at Pinellas Hope would no longer be available on Tuesday afternoons at 3:00 pm due to schedule changes on the campus with other classes. She added that the room would be available on Thursdays at 3:00 pm if the board wanted to change the date of future meetings. The July meeting was changed from July 7th to July 2nd and the Council approved the change for all future meetings.

II. Governance/Operations

i. **Board Orientation:** Elisa DeGregorio, Grants Manager, Pinellas County Human Services provided a brief orientation for all Council members that covered key requirements of the health center program including the needs assessment, accessible hours of operation/location, after hours coverage, staffing requirements, quality improvement/assurance plan, hospital admitting privileges and continuum of care and program data reporting systems. Ms. DeGregorio recommended that next month we would cover strategic planning. A copy of the presentation was included in the meeting packet.

ii. **MMU Calendar:** The July and August calendars (included in the meeting packet) for the MMU and Safe Harbor were presented to the Council by Andrew Wagner.

Mr. Wagner informed the Council that the generator on the Van broke down on Monday, June 29th and was in the County's Fleet department for repair. He did not expect it back until Wednesday, July 8th. He has informed each location and arranged to hold inside clinic for each day that the van was not available.

The Clinic would be closed on July 3rd in observance of Independence Day.

Mr. Wagner also noted that he will be short staffed in July due to one staff member going on FMLA and other staff taking scheduled vacations. He also noted that Dr. Mungara would be gone for 4-6 weeks in the late summer, early fall as he has in past years for vacation. DOH would provide a substitute doctor during that time.

iii. **Site Visit Status of Conditions Update:** Elisa DeGregorio, Grants Manager, provided an update on the on-going effort to lift the conditions on the grant that were identified as a result of the site visit in 2014. Seven conditions were placed on the grant, of which one condition has been completely lifted regarding the Sliding Scale Discount Fee Program. As of 6/2/15, all six conditions have been placed into the 120 day implementation period; however HRSA did extend the due dates due to realignment of the grant budget period that recently occurred. The new dates are as follows:

i. Credentialing and Privileging – was due June 3, 2015, now due September 19, 2015
ii. Hospital Admitting – was due September 2, 2015, now due September 19, 2015
iii. Board Authority – was due September 2, 2015, now due September 19, 2015
iv. After Hours Coverage- was due September 2, 2015, now due September 19, 2015
v. OB/GYN Services - due September 24, 2015

vi. Mental Health/Substance Abuse Services) - due September 24, 2015

This month, the board would be reviewing the After Hours policy for approval.

III. Fiscal

i. **Notice of Awards:** Ms. DeGregorio reported that were no new Notice of Awards issued since the last meeting.

ii. **Expanded Services Grant Application:** Ms. DeGregorio reported that on June 26, 2015, HRSA released the Expanded Services grant opportunity for existing health centers. A summary page was included in the meeting packet. The County is eligible for $230,572 in funding to expand services for its patients. Ms. DeGregorio asked the Council for input on the type of services they may like to see and for their approval to submit the application. The application is due on July 20, 2015.

The Council discussed some ideas for consideration including smoking cessation, care coordination for behavioral health patients, navigational services to inform clients of the various benefit programs available in the county. Rhonda Obrien also mentioned that staff was considering Diabetes education. Dianne Clark asked about HEP-C, and staff reported that while there are several clients with HEP-C, the cost to treat the disease is quite expensive, but that the County has been referring patients to Dr. Wallace in St. Petersburg, who has a clinic dedicated to HEP-C.

The Council approved submitting the application, and Ms. DeGregorio committed to informing the Council about the final services agreed upon by the staff with input from the Council.

iii. **Service Area Competition (SAC):** Ms. DeGregorio informed the Council that the County would be submitting a competitive application for renewal of the current program grant through the SAC application process. The grant opportunity will become available on July 28th to the County at which time we will know the amount of funding we are eligible for as well as the patient population target for the area. We would have more information at the next meeting of the Council. The application will be due on September 28th in Grants.gov with supplemental information due October 14th in the grants management system, EHB.

IV. Clinical

i. Trend Report for Patient Counts/Encounters: The Trend Report for Unduplicated Patients and Qualified Medical Encounters for April and May were provided in the meeting packet. Rhonda O'Brien of the Health Department was attending the meeting and provided the report. She noted that from January 1, 2015 to April 30, 2015, the MMU/Safe Harbor saw 1,024 unduplicated patients and from January 1, 2015 to May 31, 2015, the program saw 1,165 unduplicated patients. The report also details the information by site, by month and by month cumulative for the total number of unduplicated patients and for the total number of qualified medical encounters. This information is used by staff to determine our penetration and if we are on track to meet our patient target given to us by HRSA, which for 2015 is 2,390 unduplicated patients. This number is a combination of the core grant and expanded services grant the County was awarded last year.

It was noted by Ms. O'Brien and Mr. Wagner, that while we are doing well so far this year, we will begin to see a decrease in the numbers over the summer due to a variety of factors including the decrease in staff in July, the van being down for a week in June/July and due to the fact that many

clients return north for the summer and come back in the fall. Staff will continue to monitor the numbers each month.

Dianne Clark noted that the Qualified Medical Encounters seems to indicate that the patients come back often. Ms. O'Brien indicated that while many do tend to come back 3-4x, there is actually a significant number of individuals who have only come once. Ms. O'Brien recently ran a user encounter report which showed that approximately 600 patients have only come once. She offered to run that report for the next meeting.

In follow-up to the previous discussions regarding **St. Vincent de Paul in St. Petersburg,** Drew Wagner reported an increase in clients at the location and that several discussions had occurred with staff at St. Vincent's and with surrounding providers to increase patient encounters. The trend report for unduplicated patients from January 1, 2015 to April 30, 2015 showed 52 patients and for January 1, 2015 to May 31, 2015 shows 71 patients.

ii. **Policy and Procedure Manual:** Ms. DeGregorio referred the Council to the full Policy and Procedure manual in their meeting packet. The manual was last approved at the November 4th meeting of the Council, however, with there now being many new members; we wanted to provide the full manual for their review. Ms. DeGregorio noted the following updates to the manual: 1) name change from Health and Community Services to Human Services throughout, 2) the updated pharmacy list, and 3) the updated specialty care provider list.

Next, Ms. DeGregorio referred the Council to page 6 for the **After Hours policy**. This policy is one of the required submissions to necessary to resolve the site visit condition on this subject. The policy clearly states the procedure in which the staff is to follow including making a notation of the call in the electronic health record. The policy prompted further discussion about the availability of the After Hours service and when to use the After Hours service vs. 911. All clients have access to the After Hours care phone number which is located on the back of their blue card provided upon enrollment and it is posted on the Van. Staff reiterated that all medical emergencies should call 911. Minor ailments for which you or I might call our primary care doctor for after hours care are the same things that MMU patients may call the After Hours number for.

Ms. DeGregorio also reviewed the **Eligibility Policy** as stated earlier in the meeting.

Dianne Clark made a motion to accept the changes to the Manual. Alaina Robinson seconded. **The Council unanimously approved the changes to the Policy and Procedure Manual.**

iii. **Patient Centered Medical Home:** Ms. DeGregorio informed the Council that the staff was scheduled to meet for a full-day session in late June with UCF, however, we were informed that the account executive assigned to our center was leaving for a new job and that we would be assigned a new account executive shortly. On June 22nd we were assigned our new representative and Ms. O'Brien and Ms. DeGregorio has a brief introductory call with her on July 1st. We will be rescheduling our work session and planning a bi-weekly call with the representative starting in July.

V. **Other Updates**

i. **Bayside Health Clinic:** Ms. DeGregorio informed the Council that the Construction Contract for Phase II Design-Build services was presented to the Board of County Commissioners on June 23, 2015 and unanimously approved. A ground-breaking event is scheduled for July 28th at 10:00 am. A copy of the invitation is included in the meeting packet and would be emailed as well. The Council is strongly encouraged to attend the event.

ii. **New Business:** Laurie Lampert asked if the respite center at Pinellas Hope would be something that could be more widely used by MMU patients and would the group be interested if she were to open up a dialogue with Baycare who funds the respite center. Currently the respite by contract only accepts referrals from St. Anthony's Hospital/Baycare clients only. Ms. DeGregorio noted that respite care is currently not an approved service of the health center grant.

The meeting was adjourned at 4:54 pm.

The next meeting will be held at 3:00 p.m. on August 6, 2015 at Pinellas Hope.

TAB 2 – CHANGE IN SCOPE

Elisa DeGregorio recently had a discussion with the Project Officer, Dalana Johnson, regarding the definition of sites and use of medical teams for encounters in locations when the van is unavailable.

The Project Officer made us aware of an alternative for sites in this case called “Portable Clinical Care” which is an “Activity” documented in Form C of the Scope of Project.

Portable Clinical Care (see page 8 of PIN 2008-01).

Adding this to our Scope of Project would give us more flexibility to deliver services to the homeless populations in the County.

Any change in scope would need to be reviewed, approved, and documented in the minutes of the MMUAC.

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

POLICY INFORMATION NOTICE

DOCUMENT NUMBER: 2008-01

DATE ISSUED: December 31, 2007
DATE REVISED: January 13, 2009

DOCUMENT NAME: Defining Scope of Project and Policy for Requesting Changes

TO: Health Center Program Grantees
Primary Care Associations
National Cooperative Agreements

The purpose of this Policy Information Notice (PIN) is to define what constitutes the scope of project for health centers funded under section 330 of the Public Health Service (PHS) Act, to specify which types of changes in scope of project require prior approval and to describe the process for health centers seeking to make changes in the approved scope of project. This PIN supersedes PINs 2000-04 and 2002-07, "Scope of Project Policy."

Scope of project defines the activities that the total approved section 330 grant-related project budget supports, the parameters for using these grant funds, the basis for Medicare and Medicaid Federally Qualified Health Center reimbursements, Federal Tort Claims Act coverage, 340B Drug Pricing eligibility and other essential benefits. Therefore, proper recording of scope of project is critical in the oversight and management of programs funded under section 330 of the PHS Act.

In this PIN, the Health Resources and Services Administration (HRSA) has updated several policies related to scope of project to clarify and improve the recording of critical information for health centers supported under the Health Center Program. Among the clarifications, HRSA has updated the definition of a service site and established site category types to assist health centers in reporting sites supported under the Health Center Program. HRSA also has included additional guidance to clarify the requirements for recording the service delivery method for required and additional services which will assist grantees to better represent the manner in which services under a health center's approved scope of project are available to the target population.

In implementing these policy clarifications, HRSA will provide all grantees with an opportunity to update their scope of project information. HRSA will work with grantees to resolve any potential issues.

This PIN also establishes expectations for the timely implementation of any request for prior approval to add or delete a service or add, delete or relocate a new service site. The effective date of an approved change in scope will be no earlier than the date of receipt of a complete application or, in cases where a grantee is not able to determine the exact date by which the

change in scope will be fully accomplished, grantees will be allowed up to 120 days following the date of the NGA indicating approval for the change in scope to implement the change (e.g., open the site or begin providing a new service). Therefore, a grantee should carefully consider its ability to accomplish the requested change within this anticipated timeframe prior to submitting a request.

HRSA will continue to utilize an electronic process, through the HRSA Electronic Handbooks (EHBs), for processing requests for prior approval of changes in scope of project. This electronic system provides for efficient processing, review and decision-making on the requested changes. However, because of the importance of the scope of project, it is crucial that grantees submit change in scope requests, to the extent practicable, 60 days in advance of the desired implementation date. It is HRSA's goal to communicate decisions on these requests within 60 days of receipt of a complete request.[1]

All grantees considering a change in scope are encouraged to carefully review this PIN prior to initiating a request. In considering a change in scope, all grantees should review the proposal with their Board of Directors and consult with their Project Officer.

If you have any questions or require further guidance on the policies detailed in this PIN, please contact the Office of Policy and Program Development on 301-594-4300. If you have any questions or require further guidance on the process for submitting requests for prior approval for changes in scope of project, please contact your Project Officer.

James Macrae
Associate Administrator

Attachment

[1] Please see PIN 2009-03 available at http://bphc.hrsa.gov/policy/pin0903.htm.

TABLE OF CONTENTS

I. PURPOSE

The purpose of this Policy Information Notice (PIN) is to describe the Health Resources and Services Administration's (HRSA) policy for an approved scope of project for health centers funded under section 330 of the Public Health Service (PHS) Act,[2] the five components of an approved scope of project, and the policy and process for health centers seeking prior approval to make changes in the approved scope of project. This PIN supersedes PINs 2000-04 and 2002-07, "Scope of Project Policy."

II. APPLICABILITY

This PIN applies to all HRSA health service delivery grants awarded under section 330 of the PHS Act, including the Community Health Center, Migrant Health Center, Health Care for the Homeless, and Public Housing Primary Care Programs collectively referred to as "grantees" or "grantee health centers." The grantee named on the Notice of Grant Award (NGA) is the entity legally accountable to HRSA for performance of the health center activities as detailed and documented in the application for section 330 funding. Please note that only the grantee of record (the organization named on the NGA) can request a change in the approved scope of project. Changes in scope involving subrecipients or subcontractors must be the submitted by the grantee of record.[3]

III. DEFINING SCOPE OF PROJECT

The scope of project defines the activities that the total approved section 330 grant-related project budget supports.[4] Specifically, the scope of project defines the approved service sites, services, providers, service area(s) and target population(s) which are supported (wholly or in part) under the total section 330 grant-related project budget. A grantee's scope of project must be consistent with applicable statutory and regulatory requirements, Health Center Program Requirements, and the mission of the health center.[5]

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[2] Organizations that are designated under the FQHC Look-Alike Program that are seeking a change to their approved scope of project should follow the process outlined in PINs for FQHC Look-Alikes on http://bphc.hrsa.gov/policy/.

[3] A subrecipient is an organization that "(ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and (II) meets the requirements to receive a grant under section 330 of such Act . . ." (§1861(aa)(4) and §1905(l)(2)(B) of the Social Security Act). Subrecipients must be compliant with all of the requirements of section 330 to be eligible to receive FQHC reimbursement from both Medicare and Medicaid. The subrecipient arrangement must be documented through a formal written contract/agreement (Section 330(a)(1) of the PHS Act).

[4] Note: a "change in scope of project" under section 330 is not the same as "change in the scope of services" in Medicaid as defined in the Benefits Improvement and Protection Act (BIPA) of 2000, Section 702. The Centers for Medicare and Medicaid Services (CMS) and State Medicaid Agencies define the term "change in the scope of services" as a mechanism for adjusting the Medicaid reimbursement rate of a FQHC due to "a change in the type, intensity, duration and /or amount of services." A State approved "change in the scope of service" can result in an increase or decrease in FQHC Medicaid reimbursement. "Change in the scope of services" is defined differently in each State's Medicaid Plan. The State Medicaid Agency must be contacted directly if a change in scope of services is being requested by a health center. Please see Section VI.B. (page 27) of this PIN for additional information.

[5] For more information regarding the operation of health centers, please refer to the Health Center Program Requirements found at http://bphc.hrsa.gov/about/requirements/index.html.

A health center's scope of project is important because it:

- Stipulates the total approved section 330 grant-related project budget, specifically defining the services, sites, providers, target population, and service area for which grant funds have been approved. This total project budget includes program income and other non-section 330 funds.

- Determines the maximum potential scope of coverage (subject to certain exceptions) of the Federal Tort Claims Act (FTCA) program that provides medical malpractice coverage for deemed health centers and most individual employees (see page 26 of this PIN for more information on FTCA coverage).

- Provides the necessary site information which enables covered entities to purchase discounted drugs for their patients under the section 340B Drug Pricing Program (see page 28 of this PIN for more information on the 340B Drug Pricing Program).

- Defines the approved service sites and services necessary for State Medicaid Agencies to calculate payment rates under the Prospective Payment System (PPS) or other State-approved alternative payment methodology (see PAL 2001-09 posted on http://www.bphc.hrsa.gov/policy/ and section 1902(bb) of the Social Security Act).[6]

- Defines the approved service sites necessary for the Centers for Medicare and Medicaid Services (CMS) to determine a health center's eligibility for Federally Qualified Health Center (FQHC) Medicare all-inclusive rate.

It is important to note that certain benefits, i.e., utilization of section 330 funds and related program income, FQHC Medicaid reimbursement, Medicare FQHC reimbursement, FTCA coverage, and 340B Drug Pricing benefits, require that activities be part of the section 330 approved scope of project and do not apply to activities that are not part of the approved scope of project. A section 330 grantee's approved scope of project may be part of a larger health care delivery system and, as such, must be distinctly defined within that context. Section 330 funded health centers may carry out other activities (i.e., other lines of business) that are not part of their scope of project and, thus, are not subject to section 330 requirements and expectations. For example, a grantee corporation may run a day care center that is not within the scope of the Federal project and does not use section 330 funds or related program income for support; therefore, it would not be eligible for the benefits that extend to activities within the grantee's scope of project such as FTCA coverage or Medicare or Medicaid reimbursement. In addition, the revenue generated from other activities (in the example above, the day care center) should be sufficient to support direct costs of the activity plus a reasonable share of overhead to ensure that section 330 funds and other grant-related income are not used inappropriately to support costs outside the approved scope of project.

[6] All Program Information Notices (PINs) and Program Assistance Letters (PALs) are available on the HRSA web site at http://www.bphc.hrsa.gov/policy/.

NOTE: While identification as a service site within a scope of project is required for participation in the FTCA, 340B Drug Pricing, and FQHC programs, it is not a guarantee that these benefits will be realized. Each of these programs has a specific application process and a comprehensive set of requirements, of which scope of project is only one. In other words, identification as a service site within a scope of project is necessary, but not sufficient, to ensure participation in the other programs. To participate, all of the requirements of the other programs must also be met. For additional information, see Section VI of this PIN.

A. Role of the Board in Scope of Project

The governing board of a health center provides leadership and guidance in support of the health center's mission and is legally responsible for ensuring that the health center is operating in accordance with applicable Federal, State and local laws and regulations. The health center governing board is responsible for establishing and approving the health center's scope of project. The annual application for section 330 funds details the scope of project supported by the grant and, per section 330(k)(3)(H) of the PHS Act (42 U.S.C. 254b), the health center governing board must approve the health center's application. It is the responsibility of the governing board to approve the overall plan and budget for the health center, the hours of operation for the health center sites, as well as the selection of the services provided by the health center. In fulfilling these responsibilities to accurately and completely delineate the health center's scope of project, the health center governing board is assuring that the health center will effectively utilize its available resources in pursuing its mission. As the board is responsible for the oversight of the health center operations, all requests for change in scope of project must be approved by the health center's governing board with approval documented in the board minutes.

B. Five Core Elements Of Scope Of Project

Five core elements constitute scope of project and address these fundamental questions:

- Where will services be provided (service sites)?
- What services will be provided (services)?
- Who will provide the services (providers)?
- What geographic area will the project serve (service area)?
- Who will the project serve (target population)?

1. Service Sites

A service site is any location where a grantee, either directly or through a sub-recipient or established arrangement,[7] provides primary health care services to a defined service area or target population (discussed respectively in Sections III.B.4. and III.B.5. of this PIN). Sites may be permanent, seasonal, mobile van, migrant voucher or intermittent as defined further below based on many factors and as

[7] Here and throughout this document "established arrangements" are intended to mean an arrangement where a service is provided through a formal written contract or cooperative arrangements (Section 330(a)(1) of the PHS Act).

appropriate for providing health care services to the target population. A service site may provide comprehensive primary care services or may provide a single service such as oral or mental health services, based on the identified needs in the community/population. Only those service sites listed on Form 5-Part B: Service Sites from the most recent approved application for Federal support or approved change in scope request are a part of a grantee's approved scope of project.

a) Definition of a Service Site

Service sites are defined as locations where all of the following conditions are met:

- health center encounters are generated by documenting in the patients' records face-to-face contacts between patients and providers;
- providers exercise independent judgment in the provision of services to the patient;
- services are provided directly by or on behalf of the grantee, whose governing board retains control and authority over the provision of the services at the location; and
- services are provided on a regularly scheduled basis (e.g., daily, weekly, first Thursday of every month).[8] However, there is no minimum number of hours per week that services must be available at an individual site.

b) Permanent Service Sites

Permanent sites meet the definition of a service site above at a fixed address specified on Form 5 – Part B: Service Sites. These sites are open year round and may be operated on a full-time or part-time basis as appropriate to meet the needs of the target population. Services at a permanent site may be offered either directly or through an established arrangement. The name and address of each permanent service site at which the grantee provides care must be listed on Form 5 – Part B: Service Sites.

c) Seasonal Service Sites

Due to the seasonality of employment, shelter, or the mobility of patients served, grantees may operate some service sites on a seasonal basis or for only part of the year. Seasonal sites meet the definition of a service site above but operate at a fixed location for less than 12 months during the year. When open, seasonal sites may be operated on a full-time or part-time basis as appropriate to meet the needs of the target population. Grantees should list the name and address of each seasonal site on Form 5 – Part B: Service Sites and indicate the approximate number of months that the site is open during the year.

[8] Note the statutory requirement in section 330(k)(3) of the PHS Act that "primary health services of the center will be available and accessible in the catchment area of the center promptly, as appropriate, and in a manner which assures continuity." In addition, note the regulatory requirement in 42 CFR 51c.303(m) that community health centers "must be operated in a manner calculated ... to maximize acceptability and effective utilization of services."

d) Special Instructions for Recording Mobile Van Sites

A fully-equipped mobile van that is staffed by health center clinicians providing direct primary care services (e.g., primary medical or oral health services) at various locations on behalf of the grantee is considered a service site. Mobile vans must meet the definition of a service site above, except that services do not need to be provided on a regularly scheduled basis, although this is encouraged to provide continuity and access to care for the target population. A grantee should separately list each mobile van (i.e., Mobile Van #1, Mobile Van #2, etc.) as a site on Form 5 – Part B: Service Sites. The specific locations where the van provides direct health care services do not need to be listed.

Vans that are not equipped or utilized for direct patient care are not service sites. These vans may be used by a grantee to transport patients or staff or to support and facilitate outreach or other enabling services. These vans should be listed on Form 5 – Part C: Other Activities (discussed in detail below), in the application for Federal support with a brief description of how the van is used.

e) Intermittent Sites

Grantees may utilize intermittent sites to provide direct primary health care services to the target population. Intermittent sites meet the definition of a service site above but operate on a regular scheduled basis for a short period of time (two months or less) at locations that change frequently as necessary to continue services to the target population. Generally, these sites are established to assure access to care for more mobile populations, such as homeless persons or migrant or seasonal farmworkers and their families, who may not be in one area for an extended period of time and, therefore, may not access services at a grantee's permanent or seasonal sites. Often, intermittent sites are established at migrant camps or homeless shelters that are open for only a short time to bring health care services directly to the target population and will be closed and re-opened at a new location as the population moves or the availability of space changes. The following are examples of potential locations for intermittent sites: 1) Shelters - Family, Adult, Homeless, Runaway Youth; 2) Day Shelters, Soup Kitchens, or Homeless Service Centers; 3) Outdoor Encampments; 4) Migrant Camps.

Grantees should list intermittent sites as a category on Form 5 – Part B: Service Sites. The specific locations where the grantee establishes an intermittent site to provide the services do not need to be listed; however, the number of such locations should be indicated on Form 5 – Part B: Service Sites and should be updated at least annually in the grantee's application for Federal support.

f) Migrant Voucher Screening Sites

Migrant Voucher Programs are established when there is insufficient sustained demand in an area for health care services from migrant and seasonal farmworkers

to warrant establishing a permanent or seasonal service site. Often migrant voucher grantees do not provide direct health care services; rather, the grantee may establish a screening site(s) where the clinical needs of a patient are assessed and then a referral for care is made to a local provider through an established contractual arrangement. The local provider will provide the primary care services to those individuals who are referred by the voucher program. Under these arrangements, services are provided on behalf of the health center through a contractual arrangement; however, services under the contracts are generally not provided on a regular scheduled basis but instead on an as-needed basis.

Grantees should list each migrant voucher assessment/screening site as a category on Form 5 – Part B: Service Sites. As the functions of migrant voucher screening sites are predominantly administrative, where little clinical services are provided, the assessment/screening sites should be listed as administrative sites. Those voucher locations which meet the requirements of a service site should be listed as administrative/service site. The specific locations where the grantee maintains contracts for direct services do not need to be listed; however, the number of such locations should be indicated on Form 5 – Part B: Service Sites and should be updated at least annually in the grantee's application for Federal support.

g) Other Activities

Grantees often provide activities that are included in the scope of project at locations that: (1) do not meet the definition of a service site, (2) are conducted on an irregular timeframe/schedule and (3) offer a limited activity from within the full complement of health center activities included within the scope of project. These activities and locations, where clinicians and project staff go from time-to-time to seek out, engage and serve persons eligible for the project's services, are covered under the scope of the project; however, compiling an exhaustive list of such activities and locations is impractical and, therefore, should be included as general categories of activities at various locations as part of the approved scope of project.

"Other activities" may also include (1) locations for off-site activities required by the health center and documented as part of the employment agreement or contract between the health center and a provider (e.g., health center physicians providing coverage at the hospital emergency room or participating in hospital call coverage for unassigned patients in order to maintain their hospital admitting privileges) and/or (2) locations where the only services delivered do not generate encounters (i.e., filling prescriptions, taking X-rays, conducting street outreach or providing health education, etc.).

Some examples of other activities include:

- Immunizations. Providing immunizations at 15 different senior centers. Grantees should list the activity as "immunizations," the location as "senior centers" and the frequency as appropriate (e.g., four times per year).

- Admitting. Following the health center's patients to the hospital (admitting privileges). Grantees should list the activity as "admitting," the location as "hospital" and the frequency as appropriate (e.g., as required for on call arrangement, three times per week) and indicate in the description the specific hospital(s) with which the health center has such arrangements and whether health center providers see non-health center patients as part of his/her admitting privileges.

- Medical Rounds. Grantees should list the activity as "medical rounds," the location as "hospital" and the frequency as appropriate (e.g., as required for patient care, twice per week) and indicate in the description the specific hospital(s) with which the health center has such arrangements and whether the health center providers see non-health center patients as part of his/her admitting privileges.

- Home Visits. If it is the policy of the grantee that providers occasionally make home visits to health center patients, the grantee should list the activity as "home visits," the location as "patients' homes" and the frequency as appropriate (e.g., as required for patient care, five times per month).

- Health Fairs. If it is the policy of the grantee to occasionally participate in health fairs, the grantee should list the activity as "health fairs," the location as appropriate (e.g., various schools, community service centers) and the frequency as appropriate (e.g., three times per year).

- Non-Clinical Outreach. If it is the policy of the grantee that staff conduct outreach where no clinical services are offered, the grantee should list the activity as "non-clinical outreach," the location as appropriate (e.g., community neighborhoods, schools, community service centers) and the frequency as appropriate (e.g., weekly).

- Portable Clinical Care. If it is the policy of the grantee that providers conduct clinical care as part of a mobile team (for example, as part of a primary care street outreach team to serve a homeless individuals or utilizing portable dental equipment to provide oral health services at schools), the grantee should list the activity as "portable clinical care," the types of locations as appropriate (e.g., street, temporary shelters, schools, soup kitchens, labor camps) and the frequency as appropriate (e.g., weekly).

- Health Education. Grantees should list the activity as "health education," the location as appropriate (e.g., community service centers, schools) and the frequency as appropriate (e.g., six times per year).

All "other activities," their locations, estimated frequency and a brief description of the activity should be identified and briefly described on Form 5 – Part C: Other Activities in the annual application for Federal support. In addition, these activities should be described in the grant application, as they contribute to the provision of comprehensive primary care services. For items listed on Form 5-Part C, grantees should ensure that adequate and appropriate documentation has been secured to support and enable performance of these activities.

2. Services

a) Requirements and Discussion of Services

Section 330 funded health centers are required to provide, either directly or through an established arrangement, a set of primary health care services. These are defined in section 330 of the PHS Act as health services related to family medicine, internal medicine, pediatrics, obstetrics and gynecology, diagnostic laboratory and radiological services, pharmaceutical services as appropriate, and defined preventive health services. (For the complete list of required services see section 330(b)(1)(A) of the PHS Act). 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.

Services provided by the grantee are defined for the organization/entity, not by individual site. Not all services must be available at every grantee service site; rather, the patients must have reasonable access to the full complement of services offered by the center as a whole, either directly or through formal established arrangements.

Because health centers provide service to diverse populations, health centers should assure services are provided in culturally and linguistically appropriate manner based on the target population(s).

Health centers may also provide "additional health services" defined in the section 330 statute as "services that are not included as required primary health services and that are appropriate to meet the needs of the population served by the health center…"[9] Grantees are reminded that once a service is included in the approved scope of project, it must be available equally to all patients regardless of ability to pay and available through a sliding fee scale.[10] Grantees, therefore, should thoroughly investigate the costs, benefits, and risks to the grantee before providing these services. In general, a grantee should demonstrate that all required primary health services are available to all patients before proposing to add additional health services.

[9] Section 330(b)(2) of the PHS Act.

[10] Section 330(k)(3)(G) of the PHS Act., 42 C.F.R. Part 51c.303(f).

Health centers often provide both clinical and non-clinical services. Generally, clinical services are those services related to the provision of direct care and include medical, dental, mental health, substance abuse, diagnostic laboratory and X-ray, and pharmacy services. Non-clinical services are those services that support and assist in the delivery of medical care and facilitate patient access to care, often described as enabling services. These include case management, outreach, transportation, translation and interpretation, health education and eligibility assistance.

The specific range of services that are available at a health center may vary based on provider qualifications and licensing requirements. Many professional, State and/or local certifying/licensing boards require and/or sanction levels or types of service based on a provider's qualifications. Similarly, State and/or local certifying bodies may require different accrediting or licensing standards for facilities. If a grantee determines that all professional, State, and local qualifications necessary for a grantee provider to provide a specific service have been met, and State and local standards/accreditation requirements of the facility have also been fully met, the procedures or levels of service sanctioned by the certifying board are included in the grantee's scope of project. For example, if the grantee employs an obstetrician who performs colposcopy, that service would be appropriate to be included in the scope of the center's project because that procedure is a normal part of the practice of obstetrics and is recognized as such under State certifying boards.

As a reminder, all providers of medical, dental, and mental health services (whether required or additional services) must be properly credentialed and privileged (i.e., appropriately trained and licensed) to perform the activities and procedures expected of them by the grantee. It is the responsibility of the grantee to ensure that all necessary credentialing of providers and licensing of the facility(ies) to provide a service, are completed before requesting that a service be included in the scope of project. (See PIN 2002-22 for additional guidance on the credentialing of providers.)

b) Delivery Method and Scope of Project

In order to ensure the availability of comprehensive services for their patients, health centers may utilize one or more of the following delivery methods to provide a service:

(1) Direct by Grantee and/or Formal Written Agreement
When a service is provided directly by the grantee (Form 5-Part A, Column I) or through a formal written contract/agreement (Form 5-Part A, Column II), the grantee is accountable for providing and/or paying/billing for the direct care. Services provided by the grantee may include, but are not limited to, those rendered by salaried employees, certain contractors, National Health Service Corps staff, and sub-recipients. In most cases, services delivered by the grantee are provided on-site at a service delivery location listed on Form 5- Part B: Service Sites. If the service is provided

by formal written agreement, the agreement must describe how the service will be documented in the patient record and if applicable, how the grantee will pay and/or bill for the service.

(2) Formal Written Referral Arrangement
Under a formal written referral arrangement (Form 5-Part A, Column III), the grantee maintains responsibility for the patient's treatment plan and will be providing and/or paying/billing for appropriate follow-up care based on the outcome of the referral. These referral arrangements should be formally documented in a written agreement that at a minimum describes the manner by which the referral will be made and managed and the process for referring patients back to the grantee for appropriate follow-up care.

Under these types of formal referral arrangements, if the actual service is provided and paid/billed for by another entity, then the SERVICE IS NOT included in the grantee's scope of project. However, establishment of the referral arrangement and any follow-up care provided by the grantee subsequent to the referral is considered to be part of the grantee's scope of project. For example, a grantee may have a referral arrangement for diagnostic X-ray with a hospital. As part of the referral arrangement, the hospital performs the diagnostic X-ray, bills the patient for the services and provides feedback and/or results to the grantee for appropriate follow-up care. The diagnostic X-ray service would NOT be part of the grantee's scope of project but the establishment of the referral and follow-up care provided by the grantee would be part of the grantee's scope of project.

(3) Informal Referral Arrangments or Agreements
Under informal referral arrangements or agreements (these arrangements are not captured on Form 5-Part A and are not a part of the grantee's scope of project), a grantee refers a patient to another provider who is responsible for the treatment plan and billing for the services provided and no grant funds are used to pay for the care provided. These informal arrangements/agreements are not required by HRSA to be documented in a written agreement and do not require the other provider to refer patients back to the grantee for appropriate follow-up care. For services provided by informal referral arrangements or agreements, the referral and the service and any follow-up care provided by the other entity, are considered outside of the grantee's scope of project.

Required primary health services must be provided directly by the grantee or through an established arrangement[11] such as through a formal agreement or through a formal referral arrangement. In addition, required services provided directly by the grantee or by formal agreements or formal referral arrangements must be offered on a sliding fee scale and available equally to all

[11] Section 330 (a)(1) of the PHS Act.

patients regardless of ability to pay. Therefore, informal referral arrangements are not acceptable for the provision of a required service.

Grantees should ensure that all agreements/contracts/arrangements with other providers and organizations comply with section 330 requirements and administrative regulations for the Department of Health and Human Services.[12] Grantees should also ensure that providers for any formal arrangements/agreements are properly credentialed and licensed to perform the activities and procedures expected of them by the grantee.

Note: FTCA and 340B Drug Pricing coverage does not extend to all types of contractual and referral arrangements. Health centers should refer to FTCA-related guidances, listed on page 26 of this PIN, and to Federal Register, Vol. 61, No. 207, page 55156-8, "Patient and Entity Eligibility" for clarification of the 340B Drug Pricing benefit for referrals. Remember, FTCA and 340(B) each has its own independent requirements that must be met for participation.

c) Recording Services and Delivery Method

The services provided by a grantee under the section 330 grant and the method in which they are provided must be documented on Form 5 – Part A: Services Provided. Services are reported on Form 5-Part A: Services Provided in aggregate for the grantee, not on a site-by-site basis. Since more than one delivery method may apply for a given service, more than one type of service delivery method may be indicated on the Form. Grantees must indicate at least one delivery method for each required service listed on Form 5-Part A. Only those services listed on this Form from the most recent annual application for Federal support or approved change in scope request are considered to be part of a grantee's scope of project.

Service delivery methods should be updated at least annually in the grantee's application for Federal support. If services are provided, regardless of method, at a location that meets the definition of service site, the location should be listed on Form 5 – Part B: Service Sites.

3. Providers

a) Requirements and Discussion of Providers

Providers are individual health care professionals who deliver services to health center patients on behalf of the health center. They assume primary responsibility for assessing the patient and documenting services in the patient's record. Providers include only those individuals who exercise independent judgment as to the services rendered to the patient during an encounter.

[12] 45 C.F.R. Part 74.

Grantees utilize a variety of mechanisms for provider staffing in order to maximize access to comprehensive, efficient, cost-effective, and quality health care.[13] For instance, grantees may directly employ or contract with individual providers, may have arrangements with other organizations or may utilize volunteers. Grantees are encouraged to carefully consider the benefits and risks associated with each type of staffing arrangement because of the impact it may have on management and operations. It is preferable that grantees directly employ providers; however, there can be certain situations under which it may be necessary and appropriate for grantees to engage in alternative arrangements. Grantees must ensure that for all contracted clinical staff or volunteers, there is a separate, written agreement.

As a reminder, all providers of medical, dental and mental health services must be appropriately trained and properly credentialed and licensed to perform the activities and procedures expected of them by the grantee. It is the responsibility of the health center to ensure that all necessary credentialing of providers has been completed. (See PIN 2002-22 for additional guidance on the credentialing of providers.)

b) Instructions for Recording Providers

The type and number of clinical providers including volunteers and other staff must be listed on Form 2: Staffing Profile. Providers and other staff are reported in aggregate for the grantee, not on a site-by-site basis. Providers should be updated at least annually in the grantee's application for Federal support.

c) FTCA Considerations

Please note that the definition of "provider" under the scope of project may not be consistent with the definition of provider under FTCA. Individuals covered by FTCA may include others, such as lab and radiology technicians, as described in section 224 of the PHS Act. Likewise, not all provider arrangements in the scope of project are covered by FTCA. For example, volunteer providers, physicians contracted under a professional corporation or employed by another corporation, as well as interns/residents/medical students not employed by the health center may be included as part of scope of project, but are not covered under FTCA. If providers are employees of another company, the health center would still need to have a separate written agreement with the providers.

Also of note, moonlighting, defined as engaging in professional activities outside of the provider's employment responsibilities to the primary employer (in this case the health center), is not a part of the grantee's approved scope of project. Therefore, neither the grantee nor the moonlighting provider may receive FTCA coverage for moonlighting activities.

[13] For health centers funded under section 330(e) and/or section 330(g), please see PIN 98-24, Amendment to PIN 97-27, Regarding Affiliation Agreements of Community and Migrant Health Centers, for further discussion of affiliation arrangements.

4. Service Area

a) Requirements and Discussion of Service Area

The concept of a service or "catchment" area has been part of the Health Center Program since its beginning. Although in general, the service area is the area in which the majority of the health center's patients reside, health centers may use other geographic or demographic characteristics to describe their service area. The Health Center Program's authorizing statute requires that each grantee periodically review its catchment area to:

(i) ensure that the size of such area is such that the services to be provided through the center (including any satellite) are available and accessible to the residents of the area promptly and as appropriate;[14]

(ii) ensure that the boundaries of such area conform, to the extent practicable, to relevant boundaries of political subdivisions, school districts, and Federal and State health and social service programs; and

(iii) ensure that the boundaries of such area eliminate, to the extent possible, barriers to access to the services of the center, including barriers resulting from the area's physical characteristics, its residential patterns, its economic and social grouping, and available transportation.

Public Health Service Act sec. 330(k)(3)(J)

This periodic assessment of service area should be incorporated into a grantee's annual application for Federal support. Routine patient origin studies/analyses will help to ensure that the reported service area is accurate.

The service area should, to the extent practicable, be identifiable by county and by census tracts within a county. Describing service areas by census tracts enables analysis of service area demographics. Service areas may also be described by other political or geographic subdivisions (e.g., county, township, zip codes as appropriate). Starting with calendar year (CY) 2005 Uniform Data System (UDS) data, grantees annually report information on the aggregate geographic area in which its patients reside. This enables grantees and HRSA to better identify service areas. The service area must be federally designated as a Medically Underserved Area in full or in part or contain a federally designated Medically Underserved Population (MUP).[15]

b) Recording Service Area

The service area for the grantee must be listed by census tracts and zip codes on Form 5 – Part B: Service Sites. Census tracts and zip codes for the service area are reported on a site-by-site basis. In general, those census tracts and/or zip codes

[14] Primary health services of the center must also be provided "in a manner which assures continuity." (PHS Act, section 330(k)(3)(A).)

[15] This requirement is not applicable to health centers requesting or receiving funding only under section 330(g), (h), and/or (i) of the PHS Act, since those centers are applying to serve populations already recognized as underserved.

listed on this Form from the most recent annual application for Federal support and/or approved change in scope request form the basis for determining service area for a grantee's scope of project. The service area for each service site should be updated at least annually in the grantee's application for Federal support.

5. Target Population

a) Requirements and Discussion of Target Population

Health centers are required to serve a "medically underserved, or special medically underserved population."[16] Each health center must define an underserved population from within the established service area to which it will direct its services. The underserved populations often face barriers in accessing health care services and disparities in their health status which are addressed through the health center operation.

This target population is usually a subset of the entire service area population, but in some cases, may include all residents of the service area if it is determined that the entire population of the service area is underserved, and lacking access to adequate comprehensive, culturally competent quality primary health care services. Although a grantee may serve diverse populations at several sites, the target population is reported in aggregate at the grantee level not on a site-by-site basis.

Section 330(e) grantees are required to make services available to all residents of the health center's service area, regardless of the individual's ability to pay.[17] Health centers may also extend services to those residing outside the service area. However, HRSA recognizes that health centers must operate in a manner consistent with sound business practices. Nonetheless, health centers should address the acute care needs of all who present for service, regardless of residence.

Some health centers receive funding to target a special population within a community. There are three such special populations: migrant and seasonal agricultural workers and their families, persons who are homeless, and/or residents of public housing. Grantees receiving special populations funding (i.e., grants under only section 330(g), (h), and/or (i) of the PHS Act) are not subject to the requirement to make services available to all residents of the service area.[18] However, these grantees are expected to address the acute care needs of anyone who presents for service. Individuals who are not members of the special population(s) served by a special populations-only grantee may then be referred to more appropriate settings for their non-acute health care needs.

[16] Section 330(a)(1) of the PHS Act.

[17] Section 330(a)(1)(B) of the PHS Act.

[18] Section 330(a)(2) of the PHS Act.

b) Recording Target Population

Information on the grantee's target population must be listed on Form 4: Community and Target Population Characteristics. Demographic, income, insurance status and other information on the service area and target population should be recorded on this Form in aggregate for the grantee as a whole, not on a site-by-site basis, and should be updated at least annually in the grantee's application for Federal support.

IV. CHANGE IN SCOPE REQUESTS

Some changes in the approved scope of project require prior approval from HRSA before being initiated; others may be implemented by the grantee without prior approval. In all cases, any changes proposed and/or implemented by a grantee must assure continued compliance with the applicable statutory, regulatory and policy requirements. In reviewing a request to change the approved scope of project, HRSA will consider whether the request furthers the mission of the health center by increasing or maintaining access, and improving or maintaining the quality of care for the target population. Requests must not result in the diminution of the grantee's total level or quality of health services currently provided to the target population. Additionally, grantees are reminded that a request to change the approved scope of project must not shift resources away from providing approved services for the target population, and must be accomplished without additional Health Center Program funding. As appropriate, changes in the approved scope of project also must assure continued service to a Medically Underserved Area (MUA) or a Medically Underserved Population (MUP). (Please note, a service site does not have to be located in an MUA in order to serve people living in the area.)

A. CHANGE IN SCOPE REQUESTS THAT REQUIRE PRIOR APPROVAL

1. Types of Change in Scope Requests that Require Prior Approval

Based on applicable section 330 program regulations, 42 CFR Part 51c.107(c), 45 CFR Parts 74 and 92, and HHS Grants Policy Statement, prior approval is required for significant changes in the approved budget or program plan including scope of project.[19] The following five types of changes are considered significant and, therefore, require prior approval from HRSA:

- **Adding a service site** not included on Form 5 – Part B: Service Sites, of the grantee's most recent application for Federal support or approved change in scope request.
- **Adding a service** not included on Form 5 – Part A: Services Provided, of the grantee's most recent application for Federal support or approved change in scope request.
- **Relocating a service site** that was included on Form 5 – Part B: Service Sites, of the grantee's most recent application for Federal support or approved change in scope request.

[19] Any activity that results in significant re-budgeting also requires prior approval. See DHHS Grants Policy Statement (HHS GPS): page II-55. ftp://ftp.hrsa.gov/grants/hhsgrantspolicystatement.pdf.

- **Deleting a service site** that was included on Form 5 – Part B: Service Sites, of the grantee's most recent application for Federal support or approved change in scope request.
- **Deleting a service** that was included on Form 5 – Part A: Services Provided, of the grantee's most recent application for Federal support or approved change in scope request.

Grantees should include in their change in scope request a detailed discussion of any potential impact on the total approved section 330 project budget, services provided, number of patients served, and number and type of providers. Any unique circumstances that are expected to impact the ability of the grantee to meet the expectations for change in scope requests must be fully explained and documented.

Note: Any request for change in scope of project must be accomplished without additional section 330 funds. Requests for change in scope of project must be approved by the Board of Directors of the grantee with approval documented in the Board minutes prior to submission to HRSA.

Because of the importance of the scope of project, it is expected that grantees will submit any change in scope request requiring prior approval **at least 60 days in advance of their desired implementation date**, to the extent practicable, following the process described in Section V of this PIN (see page 24).

2. Special Instructions for Adding a Service Site[20]

   a) Adding Sites in the Same Building, Complex or Campus

   Health centers may identify an opportunity to add a new location that meets the definition of a service delivery site (see page 5) within the same building or complex/campus where they are already have an established service delivery site providing services to the target population. In such an instance, a health center must complete a change in scope for prior approval to add the new site if the site would have a separate physical address including a different suite/office/building number. For example, a change in scope of project is required if a grantee operates a site at 345 Main Street, Suite #4 and will be adding a new site at 345 Main Street, Suite #12. If the location does not create a separate physical address, no change in scope is required.

   b) Adding Migrant Voucher Screening Sites

   If a grantee needs to add a new migrant voucher screening site, the grantee must submit a change in scope request for prior approval to add the new screening

[20] All approved change in scope requests to add a new service site must be reported to the State Medicaid Agency and the Medicare Fiscal Intermediary within 90 days of approval. See Section VI of this PIN for further information regarding notification to the State Medicaid Agencies and the Medicare Fiscal Intermediary.

location. No change in scope request is necessary to add/delete the specific locations where the grantee maintains contracts for direct services.

c) Changing from Intermittent to Permanent or Seasonal Sites

Grantees may determine that demand for primary care services from the target population at an intermittent site exceeds their expectation to provide services at that location for only a short period of time. If a grantee determines that the intermittent site should be operated for more than the expected period of time for an intermittent site (two months or less), and the site meets the definition of a service site (see page 5), the grantee must complete a change in scope request to add the location as a permanent or seasonal service site.

d) Sites Offering a Single Service

Although grantees are not required to provide all services at all service sites, patients must have reasonable access to the full complement of comprehensive services offered by the health center as a whole. The establishment of a single service or limited service site must be in a location that allows reasonable access to the full complement of services from the health center or access to the required services on a sliding fee scale basis through formal arrangements with other providers in the community.

3. Special Instructions for Adding a Service

While grantees may deliver a service by several different methods, a service will only be included in the grantee's scope of project if it is delivered directly by the grantee or through a formal written agreement such as a contract, purchase agreement, and/or written arrangement as recorded Form 5- Part A, Services, Columns I and II. **Although the arrangement with another provider under a formal referral arrangement (recorded under Column III on Form 5 – Part A) is within a grantee's scope of project, the actual service provided by the other provider under the arrangement is not included in a grantee's scope of project;** therefore, if a grantee has been providing a service only through a formal or informal referral arrangement and wishes to begin providing this service directly or through formal agreement as part of their scope of project (e.g., the service is **ONLY** recorded in Column III and is being moved to Columns I and/or II on Form 5- Part A), the grantee MUST submit a change in scope request to add the service to the scope of project and begin providing this service.

Cases where a grantee moves a service(s) from one site to another site in the approved scope of project do not require prior approval. However, in doing so, grantees should assure that the population accessing the service at the original site will continue to have reasonable access to the service once it is relocated.

4. Special Instructions for Relocation of a Site

Health centers may engage in different types of relocations to maximize access to services for the target population. In some cases, this may involve complete relocation, and in others, only partial relocation.

Grantees moving **all** clinical services from an approved permanent or seasonal service site to a new location must submit a request for prior approval to relocate the service site. Requests for relocation will be examined to assure continued access for the populations served by the service site to be relocated. Such requests should demonstrate that the relocation furthers the mission of the health center by increasing or maintaining access and improving or maintaining the quality of care for the target population currently served by the grantee. Requests for relocation must not result in the diminution of the grantee's total level or quality of health services currently provided to the target population.

Cases where a grantee is moving only a portion of its current clinical services from an approved permanent or seasonal service site to a new location that is not a part of the approved scope of project, are not considered a relocation of the service site but rather, the addition of a new service site. In this situation, the grantee must submit a change in scope request to add a service site for the new location as the existing site will continue to operate as a service site, meeting the definition described above in III.B.1. (see page 5).

Changes in locations for intermittent sites (when operated for two months or less) are not considered relocations and, therefore, do not require prior approval. However, if an intermittent site becomes a permanent or seasonal site (i.e., will be operated for more than two months), the grantee must submit a change in scope request to add the site as a permanent or seasonal site.

5. Special Instructions for Deleting a Site or Service

There may be circumstances that require grantees to cease operation of a site or the provision of a particular service. Because of the potential implication on access to care for the target population, any request to delete a service or service site from a grantee's scope of project will not be approved without a full examination of the issues surrounding the perceived need to delete the site or service. Grantees are reminded that the deletion of a site or a service must not result in elimination or reduction in access to required services under section 330 of the PHS Act for populations currently served by the health center. Grantees must demonstrate that the requested deletion will not reduce access to services or the ability of current patients to receive the same level of care. As a reminder, grantees must provide all required services directly or through an established arrangement (i.e., a formal written contract/agreement or a formal written referral arrangement); therefore, a grantee may not request to delete a required service.

6. Special Considerations for Changes in Scope of Project

   a) Future Federal Funding to Support a Change in Scope Request

   A key requirement for every change in scope request is that the grantee must document that the requested change can be fully accomplished with no additional Federal support. In other words, in a request to add a site or service a grantee must demonstrate that adequate revenue will be generated to cover all expenses as well as an appropriate share of overhead costs incurred by the health center in administering the new site or service. If additional Federal funds will be necessary to fully implement the proposed change in scope, it will not be approved. Grantees that require additional Federal grant support to implement the proposed change should consider competitive funding opportunities. Specific eligibility for additional Federal support will be included in each announced funding opportunity.

   Grantees considering submitting a change in scope to add a service delivery site that will be the basis for later submission of a competitive grant application (i.e., for Expanded Medical Capacity) should proceed with care. As stated previously, a change in scope request must include only the level of services that can be maintained without additional Federal support. Grantees are strongly advised against establishing a new service or site that is dependent on new future grant support, since such support is not guaranteed.

   b) Financial Impact

   While many grantees have undertaken changes to their scope of project to improve their financial viability, changes in scope of project that are not carefully planned may pose high risks. A complete financial analysis of the impact of a change in scope is imperative to ensure long-term viability of the health center. In particular, grantees should examine the overall costs of the activity and the potential for reimbursement as part of this analysis. **Approval of a change in scope request is contingent on submission of a budget demonstrating break-even (worst case scenario) or the potential for generating additional revenue.** Grantees are strongly encouraged to thoroughly review any change in scope request that could result in a significant increase or decrease in the total budget of the health center. Because unforeseen events may occur making original projections inaccurate, grantees should continually monitor the progress of their requested change in scope and be prepared to take action should revenues fail to meet or exceed expenses. Additional revenue obtained through the addition of a new service or site must be invested in activities that further the objectives of the approved health center project, consistent with and not specifically prohibited by section 330(e)(5)(D)(3).

   c) Impact on Neighboring Health Centers

   Health centers should coordinate and collaborate with other section 330 grantees, FQHC Look-Alikes, State and local health services delivery projects, and programs in the same or adjacent service areas serving underserved populations to create a

community-wide service delivery system. Section 330 of the PHS Act specifically requires that applicants for health center funding have made "and will continue to make every reasonable effort to establish and maintain collaborative relationships with other health care providers in the catchment area of the center."[21] The goal of collaboration is to utilize the strengths of all involved organizations to best meet the overall health care needs of the area's underserved population. In addition, continued collaboration among providers will help to ensure that organizations are aware of and, where possible, maximize the benefits of, all organizations.

When a change in scope of project (e.g., the addition or relocation of a service site) is proposed, it is essential that a grantee consider the population(s) served by other existing providers of care, including other section 330 funded health centers, and the impact of the proposed change in scope on the viability of these neighboring health centers. Meeting the health care needs of the community and target population, ensuring that limited Federal grant dollars are used efficiently and effectively to provide access to as many underserved people as possible and the potential impact of a change in scope request on a neighboring health center(s) are key in decisions related to service area overlap.

The potential for service area overlap through a change in scope request will prompt further review, analysis and resolution before HRSA will be able to make a final decision on a health center's request. When a proposed change in scope has the potential to create a service area overlap, documentation of support, and/or cooperation from a neighboring health center(s) in the form of a Board of Directors-endorsed letter is desirable. If the health center is not able to document the support of other local providers for its request, it should provide an explanation for the lack of such documentation. In cases where there may be a service area overlap, additional information such as patient origin studies/analyses or an onsite visit may be necessary prior to a final HRSA decision. (See Service Area Overlap PIN, 2007-09 dated March 12, 2007 available at http://www.bphc.hrsa.gov/policy/pin0709.htm.)

7. Criteria for Prior Approval of a Change in Scope Request

All requests for change in scope of project requiring prior approval (see in Section IV.A. of this PIN on page 16), will be reviewed to determine if the request:

1) will not require any additional section 330 funding to be accomplished;
2) does not shift resources away from providing services for the current target population;

3) furthers the mission of the health center by increasing or maintaining access and improving or maintaining quality of care for the target population;

[21] Section 330(k)(3)(B) of the PHS Act.

4) is fully consistent with section 330 of the PHS Act and Health Center Program Expectations including appropriate governing board representation for changes in service sites and populations served;

5) provides for appropriate credentialing and privileging of providers;

6) does not eliminate or reduce access to a required service;

7) does not result in the diminution of the grantee's total level or quality of health services currently provided to the target population;

8) continues to serve a Medically Underserved Area (MUA) in whole or in part, or Medically Underserved Population (MUP)[22] [Please note that a service site does not have to be located in an MUA to serve it];

9) demonstrates approval from the health center's Board of Directors, with approval documented in the Board minutes; and

10) does not significantly affect the current operation of another health center located in the same or adjacent service area, preferably, but not necessarily, by documenting support to the extent possible from any neighboring health centers.

B. OTHER CHANGE IN SCOPE REQUESTS

The following changes are not considered significant[23] and, therefore, do not require prior approval. Each grantee is expected to discuss any such changes and/or updates in the next application for Federal support.

- **Adding a service to a site where both the service and site are already within the approved scope of project.** If a grantee currently provides a service within the scope of project, no prior approval is necessary to add the service to a service site already in the approved scope of project. For example, a grantee provides mental health services at one service site and chooses to add that service to another service site already within the approved scope of project; no request for prior approval of the change is necessary. The service and service site must be previously documented on Form 5 – Part A: Services Provided and Form 5 – Part B: Service Sites, respectively, of the grantee's most recent application for Federal support or approved change in scope request.

- **Change in the number of intermittent sites**, previously documented on Form 5 – Part B: Service Sites, of the grantee's most recent application for Federal support

[22] Required for health centers funded under section 330(e).

[23] Based on applicable section 330 program regulations, 42 CFR Part 51c.107(c), 45 CFR Parts 74 and 92, and HHS Grants Policy Statement.

or approved change in scope request. The number of such sites should be updated at least annually in the application for Federal support.

- **Change to providers** listed on Form 2: Staffing Profile of the grantee's most recent application for Federal support or approved change in scope request. Only those requests affecting providers that are linked with changes in sites or services require prior approval. No change in scope request is required in cases where a grantee changes the type of provider used to provide a service under the approved scope of project. For example, if the grantee has been providing mental health services using a social worker and decides to add a psychologist, and there is no change in the services provided (i.e., mental health), the grantee does not need to request prior approval to make this change.

- **Change to the hours of operation of a service site** previously approved on Form 5 – Part B: Service Sites, of the grantee's most recent application for Federal support or approved change in scope request. The hours for each site should be updated at least annually in the application for Federal support.

Note that any change in scope of project must be accomplished without additional section 330 funds.

C. Change in Scope During Emergencies for Health Centers

During an emergency, health centers are likely to play an important role in delivering critical services and assisting in the local community response. **Health centers deemed under FTCA should refer to PIN 2007-16, "Federal Tort Claims Act (FTCA) Coverage for Consolidated Health Center Program Grantees Responding to Emergencies." (See http://www.bphc/policy/pin0716/.)**

For the purposes of this section, an "emergency" or "disaster" is defined as an event affecting the overall target population and/or the community at large, which precipitates the declaration of a state of emergency at a local, State, regional, or national level by an authorized public official such as a governor, the Secretary of the U.S. Department of Health and Human Services, or the President of the United States. Examples include, but are not limited to: hurricanes, floods, earthquakes, tornadoes, wide-spread fires, and other natural/environmental disasters; civil disturbances; terrorist attacks; collapses of significant structures within the community (e.g., buildings, bridges); and infectious disease outbreaks and other public health threats.

In situations where an emergency has not been officially declared, but the health center is unable to operate, HRSA will evaluate on a case-by-case basis whether extraordinary circumstances justify a determination that the situation faced by the health center constitutes an "emergency."

HRSA recognizes that during an emergency, health centers are likely to participate in an organized State or local response and provide primary care services at temporary

locations. Temporary locations include any place that provides shelter to evacuees and victims of an emergency. It also includes those locations where mass immunizations or medical care is provided as part of a coordinated effort to provide temporary medical infrastructure where is it most needed. These temporary locations will be considered part of a health center's scope of project if all of the following conditions are met:

1. Services provided are on a temporary basis;

2. Temporary locations are within the health center's service area or neighboring counties, parishes, or other political subdivisions adjacent to the health center's service area;

3. Services provided by health center staff are within the approved scope of project; and

4. All activities of health center staff are conducted on behalf of the health center.

To assure that the emergency response at temporary locations is considered part of the center's scope of project, the health center must provide the following information to its HRSA Project Officer by phone, e-mail, or fax: (1) health center name; (2) the name of a health center representative and this person's contact information; and (3) a brief description of the emergency response activities. Health centers must submit this information as soon as practicable but no later than 15 calendar days after initiating emergency response activities. HRSA will determine on a case by case basis whether extraordinary circumstances justify an exception to this 15-day requirement. If the HRSA Project Officer is not available, the health center should contact the BPHC's main phone line at 301-594-4110.

If a health center needs to continue operating at a temporary location beyond 90 days from the onset of the emergency, the health center must submit a formal change in scope request to add the site. Health centers are expected to submit the formal request with sufficient time for HRSA processing.

V. PROCESS FOR CHANGE IN SCOPE OF PROJECT REQUESTS

All grantees considering a change in scope are encouraged to carefully review this PIN prior to initiating a request. In considering a change in scope, all grantees should review the proposal with their Board of Directors and consult with their Project Officer.

A. MECHANISM TO SUBMIT REQUESTS FOR PRIOR APPROVAL

An electronic process through HRSA's Electronic Handbook (EHB) has been developed for obtaining prior approval for the five types of change in scope of project requests requiring prior approval (see page 16 of this PIN). The EHB is designed to streamline the grants administration process and enable grantees to communicate with HRSA and conduct activities electronically. The EHB can be accessed from anywhere on the Internet using a standard web browser https://grants.hrsa.gov/webexternal/. When a grantee initiates a change in scope request, the EHB will assign a tracking number.

Grantees may create and submit a change in scope request in one session, or create and save part of a request, using the assigned tracking number to return as many times as necessary to complete the request before submitting it for HRSA review.

B. Change in Scope Determinations and Timeline

Because of the importance of scope of project, it is expected that grantees will request prior approval at least 60 days in advance of their desired implementation date for changes in scope for service delivery sites and services provided. There may be circumstances where submitting a change in scope request early may not be possible; however, the goal is to minimize these occurrences through careful planning. Timely submission of a change in scope request is important to ensure Medicaid and Medicare FQHC reimbursement, FTCA coverage, and 340B Drug Pricing benefits for the specific site/service, as appropriate.

If additional information or clarification is needed, the Project Officer will notify the grantee of the deficiencies of the request through the EHB, and the grantee will be given 60 days to provide the additional information. If the requested information is not provided by the grantee by the end of 60 days, the change in scope request will be denied and the grantee will be notified of this decision through the EHB. If a request is denied, the grantee will have to submit a new request for prior approval in order to implement the change in scope.

Due to the varying complexity of requests, in some cases it may be necessary to extend the HRSA review period if additional analysis, such as an on-site consultation, is warranted. In those cases, the grantee will be notified through the EHB within the initial 60 day review period of the potential delays in processing the request.

HRSA will indicate the final decision within 60[24] days of a complete change in scope request in one of the following two ways:

1) Notice of Grant Award (NGA) indicating approval; or
2) an email through EHB indicating disapproval.

C. Effective Date of Approval

The effective date of an approved change in scope will be no earlier than the date of receipt of a complete request for prior approval. In cases where a grantee is not able to determine the exact date by which a change in scope (i.e., adding a site or service) will be fully accomplished, grantees will be allowed up to 120 days following the date of the NGA indicating approval for the change in scope to implement the change (e.g., open the site or begin providing a new service). Therefore, grantees should carefully consider their ability to accomplish the requested change within this anticipated timeframe prior to submitting a request. If a grantee does not or is unable to implement the requested change in scope within 120 days of approval, the grantee must immediately notify the Project Officer in

[24] Please see PIN 2009-03 available at http://bphc.hrsa.gov/policy/pin0903.htm on the revision made to PIN 2008-01.

writing with an appropriate justification for the unanticipated delay and a detailed plan for completing the requested scope change. The BPHC will consider, on a case by case basis, exceptions to the 120 implementation requirement only if the grantee provides sufficient and compelling justification of the unique and unavoidable circumstances that will prevent the grantee from meeting this expectation.

As a reminder, all grantees should ensure that any application for Federal support documents the total scope of project and all activities added through an approved change in scope of project during the preceding budget period.

VI. ADDITIONAL SCOPE OF PROJECT POLICY ISSUES

A. SCOPE OF PROJECT AND FTCA COVERAGE

FTCA coverage is limited to staff and services that are documented as being within the approved scope of project and included in provider employment agreements or contracts. **The requirements and other information regarding FTCA coverage and the deeming process can be found in the following PINs and PALs**:

- PIN 1999-08, "Health Centers and The Federal Tort Claims Act"
- PIN 2001-11, "Clarification of Policy for Health Centers Deemed Covered Under the Federal Tort Claims Act for Medical Malpractice"
- PIN 2001-16, "Credentialing and Privileging of Health Center Practitioners"
- PIN 2002-22, "Clarification of Bureau of Primary Care Credentialing and Privileging Policy Outlined in Policy Information Notice 2001-16"
- PIN 2002-23, "New Requirements for Deeming under the Federally Supported Health Centers Assistance Act"
- Program Assistance Letter (PAL) 99-15, "Questions and Answers on the Federal Tort Claims Act Coverage for Section 330, Deemed Grantees"
- PAL 2005-01, "Federal Tort Claims Act Policy Clarification on Coverage of Corporations under Contract with Health Centers"
- PAL 2001-25, "Procedures for General Inquiries on Federal Tort Claims Act Coverage"
- PIN 2005-19, "Federal Tort Claims Act Coverage for Deemed Consolidated Health Center Program Grantees Responding to Hurricane Katrina."
- PIN 2007-16, "Federal Tort Claims Act (FTCA) Coverage for Health Center Program Grantees Responding to Emergencies"

These PINs and PALs can be found online at http://bphc.hrsa.gov/policy/.

Questions concerning FTCA should be directed to:

FTCA Program
DHHS/HRSA/BPHC
5600 Fishers Lane, Room 15C-26
Rockville, MD 20857
Phone: 301-594-2469
Fax: 301-594-5224

Email: HealthCenterFTCA@hrsa.gov

B. SCOPE OF PROJECT AND FQHC MEDICAID PPS OR ALTERNATIVE METHODOLOGY REIMBURSEMENT

After a change in scope of project that may generate a FQHC Medicaid reimbursement (e.g., PPS or APM) adjustment is approved, it is the responsibility of the grantee to notify its State Medicaid Agency of the change(s) within 90 days following HRSA approval.

Most State Medicaid Agencies require a HRSA approved change in scope project to process requests for changes in Medicaid PPS or APM (e.g., rate for new starts or rate increase/decrease). **Please note that the change in scope of project for grantees discussed under this PIN is not the same as a change in the scope of services for increased/decreased reimbursement (PPS or APM) through Medicaid.** The CMS and State Medicaid Agencies define the term "change in the scope of services" to refer to a mechanism for adjusting the reimbursement rate of a FQHC due to "a change in the type, intensity, duration, and/or amount of services." The HRSA approved change in scope modifies the services or sites in the grantee's scope of project for the section 330 grant. It does not approve a "change in the scope of services" for State Medicaid reimbursement purposes. Grantees should contact their State Medicaid Agency for further information about their "change in the scope of services" policy and procedures.

C. SCOPE OF PROJECT AND MEDICARE FQHC COST-BASED REIMBURSEMENT

After a change in scope of project is approved, it is the responsibility of each grantee to notify its Medicare Fiscal Intermediary in a timely manner following the HRSA approval for the purposes of receiving the Medicare FQHC reimbursement rate.

In order for any new service delivery site(s) to be recognized by Medicare as a FQHC and be reimbursed the FQHC all-inclusive rate, a complete CMS 855A Form must be filed with the appropriate Medicare Fiscal Intermediary. (A copy of the CMS 855A Form is available at http://www.cms.hhs.gov/cmsforms/downloads/cms855a.pdf.) For each new site added to the approved scope of project, a health center must submit the CMS 855A Form, a copy of the HRSA Notice of Grant award that includes the address for applicable site(s) being enrolled, along with the necessary accompanying documents (see page 41 of CMS-855A) to the appropriate Fiscal Intermediary. In addition, the Medicare Fiscal Intermediary should be notified within 30 days of all site address changes and changes in ownership. All other changes to enrollment should be reported within 90 days.

A unique National Provider Identifier (NPI) number is necessary for each site when completing the CMS 855A Form. The NPI is a standard unique health identifier for health care providers and is assigned by the National Plan and Provider Enumeration System (NPPES). The NPI is necessary for HIPAA standard transactions under Medicare. Those transactions include the electronic claim, eligibility inquiry and response, claim status inquiry and response, payment and remittance advice, prior authorization/referral, and coordination of benefits transactions. **Grantees are required to obtain a NPI for each service site in order to bill Medicare, Medicaid and other payers.**

Complete instructions for completing the NPI application process is available at http://www.cms.hhs.gov/NationalProvdentStand/03_apply.asp#TopOfPage. Grantees can obtain a NPI number(s) in two ways: 1) by going to the CMS website at https://nppes.cms.hhs.gov to fill out an application on-line; or 2) by completing a paper application form (CMS-10114) available from http://www.cms.hhs.gov/forms or by calling the NPI Enumerator at 1-800-465-3203 to request a copy.

D. Scope of Project and The Section 340B Drug Pricing Program

Health centers qualify as covered entities under the section 340B Drug Pricing Program. Please note, however, that while identification as a service site within a scope of project is necessary for participation in 340B, the program has its own requirements that must be met. For information on participating in the 340B Program, please call the Office of Pharmacy Affairs at 1-800-628-6297 or 301-594-4353, or visit the following website http://www.hrsa.gov/opa.

E. Scope of Project and Accreditation

Grantees accredited by an external accrediting body, e.g., the Joint Commission, are responsible for notifying the accrediting body of organizational changes if required by the accrediting body, as these may result in a requirement for an extension survey. Please refer to the accrediting body's policies and procedures for further guidance.

VII. CONTACT INFORMATION

If you have any questions or require further guidance on the scope of project policy detailed in this PIN, please contact the Office of Policy and Program Development at 301-594-4300. If you have questions or require additional assistance regarding the process for requesting prior approval of changes in scope, please contact your Project Officer.

TAB 2 – CALENDAR

Attached are the calendars for August and September for the mobile van and Safe Harbor.

August 2015 Mobile Medical Unit Calendar

(VAN Maintenance Every Monday 3:30 – 5:00)

Monday	*Tuesday*	*Wednesday*	*Thursday*	*Friday*
3 **Clearwater** SVDP Soup Kitchen 1340 Pierce Street Clearwater, FL. 33756 **8:30am – 12:30 pm** ***12:30 pm – 3:30 pm*** *	**4** **St Petersburg** SVDP Center of Hope 401 15th Street North St. Petersburg, Fl 33713 **8:30am –5:00 pm**	**5** **No Services Training and Office day**	**6** **St. Petersburg** Salvation Army ARC 5885 66th St. North St. Petersburg, FL. 33709 **8:30am –5:00 pm** MMUAC Meeting 3:00 pm Pinellas Hope	**7** **St. Petersburg** Salvation Army One Stop 1400 4th St. South St. Petersburg, FL. 33701 **8:30am – 4:00 pm**
10 **Clearwater** SVDP Soup Kitchen 1340 Pierce Street Clearwater, FL. 33756 **8:30am – 12:30 pm** ***12:30 pm – 3:30 pm*** *	**11** **Clearwater** Pinellas Hope 5726 126th Ave. North Clearwater, FL 33760 **8:30am – 5:00 pm**	**12** **Clearwater** Pinellas Hope 5726 126th Ave. North Clearwater, FL 33760 **8:30am –5:00 pm** (Van located in back parking area)	**13** **St. Petersburg** Salvation Army ARC 5885 66th St. North St. Petersburg, FL. 33709 **8:30am –5:00 pm**	**14** **St. Petersburg** Salvation Army One Stop 1400 4th St. South St. Petersburg, FL. 33701 **8:30am – 4:00 pm**
17 **Clearwater** SVDP Soup Kitchen 1340 Pierce Street Clearwater, FL. 33756 **8:30am – 12:30 pm** ***12:30 pm – 3:30 pm*** *	**18** **St Petersburg** SVDP Center of Hope 401 15th Street North St. Petersburg, Fl 33713 **8:30am –5:00 pm**	**19** **Clearwater** Pinellas Hope 5726 126th Ave. North Clearwater, FL 33760 **8:30am –5:00 pm** (Van located in back parking area)	**20** **St. Petersburg** Salvation Army ARC 5885 66th St. North St. Petersburg, FL. 33709 **8:30am – 5:00 pm**	**21** **St. Petersburg** Salvation Army One Stop 1400 4th St. South St. Petersburg, FL. 33701 **8:30am – 4:00 pm**
24 **Clearwater** SVDP Soup Kitchen 1340 Pierce Street Clearwater, FL. 33756 **8:30am – 12:30 pm** ***Staff Meeting*** ***12:30 – 3:30 pm***	**25** **Clearwater** Pinellas Hope 5726 126th Ave. North Clearwater, FL 33760 **8:30am – 5:00 pm**	**26** **Clearwater** Pinellas Hope 5726 126th Ave. North Clearwater, FL 33760 **8:30am –5:00 pm** (Van located in back parking area)	**27** **St. Petersburg** Salvation Army ARC 5885 66th St. North St. Petersburg, FL. 33709 **8:30am – 5:00 pm**	**28** **St. Petersburg** Salvation Army One Stop 1400 4th St. South St. Petersburg, FL. 33701 **8:30am – 4:00 pm**
31 **Clearwater** SVDP Soup Kitchen 1340 Pierce Street Clearwater, FL. 33756 **8:30am – 12:30 pm** ***12:30 pm – 3:30 pm*** *				

No Appointment Necessary--Walk-ups Preferred

www.pinellascounty.org/humanservices 727-453-7866

*We see Turning Point clients during that time.

August 2015 Safe Harbor Calendar

Monday	*Tuesday*	*Wednesday*	*Thursday*	*Friday*
3 **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00pm** **Nurse Only**	**4** **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00pm**	**5** **Clearwater** Safe Harbor 14840 49th St. No Clearwater, FL. 33762 **8:30am – 5:00pm** **Nurse Only**	**6** **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00pm**	**7** **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00pm**
10 **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00pm**	**11** **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00pm** **Dental Screening 8:30 to 12:00**	**12** **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **1:00 pm – 5:00pm**	**13** **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00pm** **Nurse Only**	**14** **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00pm** **Nurse Only**
17 **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00pm**	**18** **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00pm**	**19** **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00pm**	**20** **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00pm**	**21** **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00pm**
24 **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 12:30 pm** ***Staff Meeting*** ***12:30 – 3:30pm***	**25** **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00pm**	**26** **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00pm**	**27** **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00pm**	**28** **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00pm**
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No Appointment Necessary--Walk-ups Preferred

www.pinellascounty.org/humanservices 727-453-7866

September 2015 Mobile Medical Unit Calendar

(VAN Maintenance Every Monday 3:30 – 5:00)

Monday	Tuesday	Wednesday	Thursday	Friday
	1 **St Petersburg** SVDP Center of Hope 401 15th Street North St. Petersburg, Fl 33713 **8:30am –5:00 pm**	**2** **Clearwater** Pinellas Hope 5726 126th Ave. North Clearwater, FL 33760 **8:30am –5:00 pm** (Van located in back parking area)	**3** **St. Petersburg** Salvation Army ARC 5885 66th St. North St. Petersburg, FL. 33709 **8:30am –5:00 pm** MMUAC Meeting 3:00 pm Pinellas Hope	**4** **St. Petersburg** Salvation Army One Stop 1400 4th St. South St. Petersburg, FL. 33701 **8:30am – 4:00 pm**
7 **NO SERVICES** **LARBOR DAY**	**8** **Clearwater** Pinellas Hope 5726 126th Ave. North Clearwater, FL 33760 **8:30am – 5:00 pm**	**9** **Clearwater** Pinellas Hope 5726 126th Ave. North Clearwater, FL 33760 **8:30am –5:00 pm** (Van located in back parking area)	**10** **St. Petersburg** Salvation Army ARC 5885 66th St. North St. Petersburg, FL. 33709 **8:30am –5:00 pm**	**11** **St. Petersburg** Salvation Army One Stop 1400 4th St. South St. Petersburg, FL. 33701 **8:30am – 4:00 pm**
14 **Clearwater** SVDP Soup Kitchen 1340 Pierce Street Clearwater, FL. 33756 **8:30am – 12:30 pm** ***12:30 pm – 3:30 pm*** *	**15** **St Petersburg** SVDP Center of Hope 401 15th Street North St. Petersburg, Fl 33713 **8:30am –5:00 pm**	**16** **Clearwater** Pinellas Hope 5726 126th Ave. North Clearwater, FL 33760 **8:30am –5:00 pm** (Van located in back parking area)	**17** **St. Petersburg** Salvation Army ARC 5885 66th St. North St. Petersburg, FL. 33709 **8:30am – 5:00 pm**	**18** **St. Petersburg** Salvation Army One Stop 1400 4th St. South St. Petersburg, FL. 33701 **8:30am – 4:00 pm**
21 **Clearwater** SVDP Soup Kitchen 1340 Pierce Street Clearwater, FL. 33756 **8:30am – 12:30 pm** ***Staff Meeting*** ***12:30 – 3:30 pm***	**22** **Clearwater** Pinellas Hope 5726 126th Ave. North Clearwater, FL 33760 **8:30am – 5:00 pm**	**23** **Clearwater** Pinellas Hope 5726 126th Ave. North Clearwater, FL 33760 **8:30am –5:00 pm** (Van located in back parking area)	**24** **St. Petersburg** Salvation Army ARC 5885 66th St. North St. Petersburg, FL. 33709 **8:30am – 5:00 pm**	**25** **St. Petersburg** Salvation Army One Stop 1400 4th St. South St. Petersburg, FL. 33701 **8:30am – 4:00 pm**
28 **Clearwater** SVDP Soup Kitchen 1340 Pierce Street Clearwater, FL. 33756 **8:30am – 12:30 pm** ***12:30 pm – 3:30 pm*** *	**29** **St Petersburg** SVDP Center of Hope 401 15th Street North St. Petersburg, Fl 33713 **8:30am –5:00 pm**	**30** **Clearwater** Pinellas Hope 5726 126th Ave. North Clearwater, FL 33760 **8:30am –5:00 pm** (Van located in back parking area)		

No Appointment Necessary--Walk-ups Preferred

www.pinellascounty.org/humanservices 727-453-7866

*We see Turning Point clients during that time.

September 2015 Safe Harbor Calendar

Monday	*Tuesday*	*Wednesday*	*Thursday*	*Friday*
	1 **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00pm**	**2** **Clearwater** Safe Harbor 14840 49th St. No Clearwater, FL. 33762 **8:30am – 5:00pm**	**3** **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00pm**	**4** **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00pm**
7 **NO SERVICES** **LARBOR DAY**	**8** **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00pm** **Dental Screening 8:30 to 12:00**	**9** **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **1:00 pm – 5:00pm**	**10** **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00pm** **Nurse Only**	**11** **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00pm** **Nurse Only**
14 **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00pm**	**15** **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00pm**	**16** **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00pm**	**17** **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00pm**	**18** **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00pm**
21 **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 12:30 pm** ***Staff Meeting*** ***12:30 – 3:30pm***	**22** **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00pm**	**23** **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00pm**	**24** **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00pm**	**25** **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00pm**
28 **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00 pm**	**29** **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00pm**	**30** **Clearwater** Safe Harbor 14840 49th St. No. Clearwater, FL. 33762 **8:30am – 5:00pm**		

No Appointment Necessary--Walk-ups Preferred

www.pinellascounty.org/humanservices 727-453-7866

TAB 2 – SITE VISIT COMPLIANCE UPDATE

On Friday, July 17th at 5:51 pm, we received email notification from HRSA of deadline submission date changes affecting our grant.

> *Grantees determined to be non-compliant with one or more Health Center Program requirements receive relevant program conditions, which are communicated through Notices of Award (NoAs). BPHC uses the HRSA Electronic Handbooks (EHB) system to facilitate the electronic submission and tracking of compliance with program requirements. HRSA has become aware that an EHB system error inadvertently occurred in early in late May 2015 and early June 2015, when your H80 budget period was extended. This error caused an inadvertent extension of some condition submission due dates in the EHB system. HRSA has now corrected this system error.* ***Through this corrective process, all active condition deadlines that were subject to this error and had an original submission due date occur on or before July 31, 2015 have been extended until 11:59 EDT on August 1, 2015; all condition deadlines that were subject to this error and had submission due dates on or after August 1, 2015, will revert to the original condition deadline as stated in the original Notice of Award (NoA).*** *Please contact your Project Officer or Grants Management Specialist with any questions.*

The credentialing & privileging condition originally had a due date in June 2015, was changed in error to September 19th and now has been moved back to August 1st.

The hospital admitting and board authority conditions originally had a due date of September 2nd were changed in error to September 19th and now have been moved back to September 2nd.

Due to these date changes, we needed to move up the originally scheduled August 6th meeting of the MMUAC to take action on these items prior to the new deadlines.

Failing to take action would result in these conditions moving into a 60-day Progressive Action, which is a red flag on the grant that if escalated any further, would result in no additional funding and even freezes on the current funding.

Site Visit Conditions Follow-Up (as of 7/27/15)

Credentialing & Privileging – due 8/1

- ☐ **P&P:** Updated to reflect feedback from HRSA
- ☐ **Template Checklist:** C-P File Template updated to reflect feedback from HRSA
- ☐ **Excel Tracking File:** Updated, comprehensive list
- ☐ **Board Meeting Minutes:** Documenting privilege approval for all current LIPs – August Mtg.
- ☐ **Template Privileging Request Forms** – no changes needed?

Board Authority – due 9/2

- ☐ **Co-Applicant Agreement:** Approved at June MMUAC mtg; in contract review for BCC for Aug 18 mtg
- ✓ **ByLaws:** Approved at June MMUAC mtg.
- ☐ **Board Meeting Minutes:** Submission of four (4) months of minutes (Sept, Aug, July, June)

Hospital Tracking – due 9/2

- ☐ **P&P:** How will the MMU be notified when patients self-present for ED visit/admission; and to ensure follow-up in the event patients fail to set up an appointment?
- ✓ **Tracking Log:** Added a column for date of follow-up appt. - complete
- ☐ **Documentation:** Need QI Committee Meeting Minutes and/or Copies of completed Hospital Tracking Log

Substance Abuse – due 9/24

- ✓ **Contract:** Copy of signed contract – complete
- ✓ **P&P:** Copy of Policy with Approval Date – complete
- ☐ **Documentation:** Need QI Committee Meeting Minutes and/or Copies of completed Patient Referral Tracking Forms/Logs

OB/Pre-Natal – due 9/24

- ✓ **Contract:** Copy of signed contract – complete
- ☐ **P&P:** Updated to reflect feedback from HRSA
- ☐ **P&P:** Copy of Policy with Approval Date – review at July/Aug meeting?
- ☐ **Documentation:** Need QI Committee Meeting Minutes and/or Copies of completed Patient Referral Tracking Forms/Logs

After Hours – due 9/19 (SUBMITTED JULY 6, 2015)

- ✓ **P&P:** Updated for presentation to MMUAC at July mtg.

CONDITION #1: *ARRANGEMENTS FOR HOSPITAL ADMITTING AND CONTINUITY OF CARE*

Due: ~~September 19, 2015~~ – September 2, 2015

Submissions needed to lift the 120-day implementation condition

1. **Board-approved Internal Patient Hospital Admission Tracking Policy** reflecting the changes discussed during the 90 day condition

2. **Revised Hospital Admission/ED Visit Tracking Form/Log** reflecting the changes discussed during the 90 day condition

3. **Documentation of implementation of the Internal Patient Hospital Admission Tracking Policy.** Examples of acceptable documentation of implementation include:
   a. QI Committee Meeting minutes discussing internal hospital admission tracking policy development/revision(s) and implementation activities**;**

   and/or

   b. Copies of completed Hospital Admission/ED Visit Tracking Forms/Logs demonstrating policy implementation. ***ALL patient identifiers must be removed prior to submission*.**

CONDITION #2: *AFTER HOURS COVERAGE*

Due: September 19, 2015 – SUBMITTED JULY 6TH

Submissions needed to lift the 120-day implementation condition

1. **Board-approved After Hours Policy** reflecting the changes discussed during the 90 day condition

CONDITION #3: *SUBSTANCE ABUSE SERVICES*

Due: September 24, 2015

Submissions needed to lift the 120-day implementation condition and demonstrate compliance:

1. Documentation of the Grantee's provision of the following required service(s): substance abuse and mental health services.
   - Copy of the **signed Agreement** between Pinellas County and the Florida Department of Health in Pinellas County for substance abuse and mental health services.

2. **Board-approved Patient Referral Tracking Policy** reflecting the changes discussed during the 90 day condition (noted above).

3. **Documentation of implementation of the Patient Referral Tracking Policy.** Examples of acceptable documentation of implementation include:

a. QI Committee Meeting minutes discussing patient referral tracking policy development/revision(s) and implementation activities;

and/or

b. Copies of completed Patient Referral Tracking Forms/Logs demonstrating policy implementation. ALL patient identifiers should be removed prior to submission.

CONDITION #5: *CREDENTIALING & PRIVILEGING*

Due: ~~September 19, 2015~~ – August 1, 2015

Comments below are labeled for each document included in your submission and additional information necessary to demonstrate compliance.

1. Board-approved Credentialing and Privileging (C-P) Policy, reflecting the changes based on your previous submission: The policy states it is applicable for LIPs only. There is no mention of the required documentation, via both primary or secondary source verification, for credentialing. One example of a required form is listed as optional (i.e. the health attestation statement is identified in the policy as "if desired by the applicant"). No specifications relevant to the chart in PIN 2002-22 is included, no mention of a privileging process for both LIPs and Other Certified/Licensed Practitioners, no indication of approval authority, no appeal process included for LIPs, and no indication of re-privileging/re-credentialing.

2. Template C-P file checklist(s) for LIPs AND other licensed/certified providers used to ensure that all providers' C-P files have all documents consistent with the chart in PIN 2002-22. The provided checklist includes the required documentation for credentialing per PIN 2002-22. There is no notation of primary vs. secondary verification, however with an updated policy that is alignment with PIN 2002-22, this could be cross referenced. The checklist lacks any documentation required for approved privileges or current competencies assessment(s).

3. Excel spreadsheet tracking all LIP and other licensed/certified providers' C-P status and due dates The provided list of providers for the center (1RN, 1LPN, 2MD, 1ARNP) does not appear exhaustive. Required credentialing documents are listed. Several required areas are "in process" for all 5 listed practitioners, this includes "Verification of Education/Health Fitness/Approval Authority/Immunization & PPD status". An updated and comprehensive list is requested.

4. Board Meeting minutes documenting privilege approval for all current LIPs

5. Template privileging request forms for licensed independent practitioners (LIPs) AND other licensed/certified providers

CONDITION #6: *REQUIRED OR ADDITIONAL SERVICES (OB/GYN)*

Due: September 24, 2015

Please see the required submission details below.

1. Documentation of the Grantee's provision of the following required service(s): Prenatal and OB/GYN services.
    - Copy of the signed Agreement between Pinellas County and the Florida Department of Health in Pinellas County for Prenatal and OB/GYN services.

2. Board-approved Patient Referral Tracking Policy reflecting the changes discussed during the 90-day condition

3. Documentation of implementation of the Patient Referral Tracking Policy. Examples of acceptable documentation of implementation include:
    - QI Committee Meeting minutes discussing patient referral tracking policy development/revision(s) and implementation activities;

    and/or

    - Copies of completed Patient Referral Tracking Forms/Logs demonstrating policy implementation. ALL patient identifiers should be removed prior to submission.

CONDITION #7: *BOARD AUTHORITY*

Due: ~~September 19, 2015~~ – September 2, 2015

Submissions needed to lift the 120-day implementation condition and demonstrate compliance:

1. **Bylaws:** The bylaws have some missing elements as outlined in PIN 2014-01. Specifically, the bylaws do not address the recording, distribution, and storage of the meeting minutes or provisions for dissolution of the board. In addition, the grantee must ensure that the bylaws of the MMU advisory council are consistent with any related actions outlined in the co applicant agreement with the Pinellas Co. Board of County Commissioners.

2. **Board Meeting minutes:** The meeting minutes do not provide enough detail in order to demonstrate the oversight and activities of the board. The meeting minutes should also address approval of all documents submitted in response to the condition submission. When submitting the 120 day progressive action submission please ensure that you submit at least 4 months of board minutes.

3. **Co-Applicant Agreement:** For the hiring of the Executive Director, it would not be acceptable for the BCC to have final authority over the hiring/firing. In providing health center oversight, the board (including the co-applicant board of a public center) must retain and exercise the following authorities in relation to the ED, regardless of whether this individual is directly employed or contracted by the health center (MMU):
    - Select and if necessary, dismiss the ED. In the case of the public centers where the ED might also be an employee of the public agency, the co-applicant board must have the authority to dismiss this individual from leading the health center, however, this in no way implies that the public agency must dismiss this individual as an employee (e.g., this individual could be re-assigned to another position within this public agency and the co-applicant board would begin a search for a new ED).
    - Evaluate the performance of the ED. While public centers consisting of a public agency with co-applicant boards might coordinate on the ED's evaluation if they are also an employee of the public agency, the co-applicant board is never relieved of its duties to evaluate the performance of the ED. This required board authority also continues to apply in situations where a health center has a contracted ED.
    - Approve the health center's grant application and annual budget, which includes the CEO's compensation package. Given the requirement for the board to approve the annual budget and with it, the CEO/ED's compensation package, it is recommended that the evaluation of the CEO/ED by the board also be conducted, at a minimum on an annual basis to inform this aspect of budget approval.
    - The health center (MMU) board must retain the unrestricted authorities, functions and responsibilities of approving the annual health center budget and audit.

However, we also strongly recommend in the PIN 2014-01 that while the co-applicant board must retain the decision-making on duties and authorities beyond the general types of fiscal and personnel policies that the public center can retain as described in the PIN, the co-applicant arrangement should allow for the co-applicant board and public agency to work collaboratively.

NOTICE OF AWARDS

H80CS00024 – 14-07 (Dated 7/9/2015)

This is a carry-over of funds from the Expanded Services grant awarded in September of 2014. Because our grant budget period starts in October, we had to request a carryover for the funds into the current budget period. This funding was previously awarded and approved/accepted by the County (10/21/14).

1. DATE ISSUED: 07/06/2015	**2. PROGRAM CFDA:** 93.224	
3. SUPERSEDES AWARD NOTICE dated: 05/27/2015 except that any additions or restrictions previously imposed remain in effect unless specifically rescinded.		
4a. AWARD NO.: 6 H80CS00024-14-07	**4b. GRANT NO.:** H80CS00024	**5. FORMER GRANT NO.:** H66CS00382
6. PROJECT PERIOD: **FROM:** 11/01/2001 **THROUGH:** 02/29/2016		
7. BUDGET PERIOD: **FROM:** 11/01/2014 **THROUGH:** 02/29/2016		

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

NOTICE OF AWARD
AUTHORIZATION (Legislation/Regulation)
Public Health Service Act, Title III, Section 330
Public Health Service Act, Section 330, 42 U.S.C. 254b
Affordable Care Act, Section 10503

8. TITLE OF PROJECT (OR PROGRAM): HEALTH CENTER CLUSTER

9. GRANTEE NAME AND ADDRESS:
Pinellas County Board of County Commissioners
315 Court Street
Clearwater, FL 33756-5165
DUNS NUMBER:
055200216
BHCMIS # 042040

10. DIRECTOR: (PROGRAM DIRECTOR/PRINCIPAL INVESTIGATOR)
Maureen Freaney
Pinellas County Board of County Commissioners
2189 Cleveland Street
Clearwater, FL 33765-3242

11.APPROVED BUDGET:(Excludes Direct Assistance)

[ ] Grant Funds Only

[X] Total project costs including grant funds and all other financial participation

a . Salaries and Wages :	$42,832.00
b . Fringe Benefits :	$18,723.00
c . Total Personnel Costs :	$61,555.00
d . Consultant Costs :	$0.00
e . Equipment :	$0.00
f . Supplies :	$12,189.00
g . Travel :	$1,439.00
h . Construction/Alteration and Renovation :	$0.00
i . Other :	$247,751.00
j . Consortium/Contractual Costs :	$1,058,730.00
k . Trainee Related Expenses :	$0.00
l . Trainee Stipends :	$0.00
m . Trainee Tuition and Fees :	$0.00
n . Trainee Travel :	$0.00
o . TOTAL DIRECT COSTS :	$1,381,664.00
p . INDIRECT COSTS (Rate: % of S&W/TADC) :	$0.00
q . TOTAL APPROVED BUDGET :	$1,381,664.00
i. Less Non-Federal Share:	$423,929.00
ii. Federal Share:	$957,735.00

12. AWARD COMPUTATION FOR FINANCIAL ASSISTANCE:

a. Authorized Financial Assistance This Period	**$957,735.00**
b. Less Unobligated Balance from Prior Budget Periods	
i. Additional Authority	$0.00
ii. Offset	$0.00
c. Unawarded Balance of Current Year's Funds	$0.00
d. Less Cumulative Prior Awards(s) This Budget Period	$778,138.00
e. AMOUNT OF FINANCIAL ASSISTANCE THIS ACTION	**$179,597.00**

13. RECOMMENDED FUTURE SUPPORT: (Subject to the availability of funds and satisfactory progress of project)

YEAR	TOTAL COSTS
Not applicable	

14. APPROVED DIRECT ASSISTANCE BUDGET:(In lieu of cash)

a. Amount of Direct Assistance	$0.00
b. Less Unawarded Balance of Current Year's Funds	$0.00
c. Less Cumulative Prior Awards(s) This Budget Period	$0.00
d. AMOUNT OF DIRECT ASSISTANCE THIS ACTION	**$0.00**

15. PROGRAM INCOME SUBJECT TO 45 CFR 75.307 SHALL BE USED IN ACCORD WITH ONE OF THE FOLLOWING ALTERNATIVES:
A=Addition B=Deduction C=Cost Sharing or Matching D=Other **[D]**

Estimated Program Income: $1,764.00

16. THIS AWARD IS BASED ON AN APPLICATION SUBMITTED TO, AND AS APPROVED BY HRSA, IS ON THE ABOVE TITLED PROJECT AND IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE IN THE FOLLOWING:

a. The grant program legislation cited above. b. The grant program regulation cited above. c. This award notice including terms and conditions, if any, noted below under REMARKS. d. 45 CFR Part 75 as applicable. In the event there are conflicting or otherwise inconsistent policies applicable to the grant, the above order of precedence shall prevail. Acceptance of the grant terms and conditions is acknowledged by the grantee when funds are drawn or otherwise obtained from the grant payment system.

REMARKS: (Other Terms and Conditions Attached **[X]Yes [ ]No**)
Prior Approval Request Tracking Number PA-00045374. Prior Approval Request Type: Carryover of Unobligated Balances

Electronically signed by Sheila Gale , Grants Management Officer on : 07/06/2015

17. OBJ. CLASS: 41.51 **18. CRS-EIN:** 1596000800A2 **19. FUTURE RECOMMENDED FUNDING:** $581,256.00

FY-CAN	CFDA	DOCUMENT NO.	AMT. FIN. ASST.	AMT. DIR. ASST.	SUB PROGRAM CODE	SUB ACCOUNT CODE
14 - 3980879	93.224	15H80CS00024	$179,597.00	$0.00	HCH	HealthCareCenters_15

HRSA Electronic Handbooks (EHBs) Registration Requirements

The Project Director of the grant (listed on this NoA) and the Authorizing Official of the grantee organization are required to register (if not already registered) within HRSA's Electronic Handbooks (EHBs). Registration within HRSA EHBs is required only once for each user for each organization they represent. To complete the registration quickly and efficiently we recommend that you note the 10-digit grant number from box 4b of this NoA. After you have completed the initial registration steps (i.e.,created an individual account and associated it with the correct grantee organization record), be sure to add this grant to your portfolio. This registration in HRSA EHBs is required for submission of noncompeting continuation applications. In addition, you can also use HRSA EHBs to perform other activities such as updating addresses, updating email addresses and submitting certain deliverables electronically. Visit https://grants3.hrsa.gov/2010/WebEPSExternal/Interface/common/accesscontrol/login.aspx to use the system. Additional help is available online and/or from the HRSA Call Center at 877-Go4-HRSA/877-464-4772.

Terms and Conditions

Failure to comply with the remarks, terms, conditions, or reporting requirements may result in a draw down restriction being placed on your Payment Management System account or denial of future funding.

Grant Specific Term(s)

1. This Notice of Award authorizes the carryover of an unobligated balance in the amount of $179,597 from budget period 11/1/2013-10/31/2014 into the current budget period. These funds can only be used for the purposes stated in your Prior Approval request. Please be advised that if the final resolution of the audit determines that the unobligated balance of Federal Funds requested for the carryover is incorrect, HRSA is not obligated to make additional Federal Funds available to cover the shortfall.

All prior terms and conditions remain in effect unless specifically removed.

Contacts

NoA Email Address(es):

Name	Role	Email
Maureen Freaney	Program Director	njackson@co.pinellas.fl.us

Note: NoA emailed to these address(es)

Program Contact:

For assistance on programmatic issues, please contact Dalana Johnson at:
MailStop Code: 17-89
Central Southeast Division
5600 Fishers Ln
Rockville, MD, 20852-1750
Email: djohnson1@hrsa.gov
Phone: (301) 443-7182

Division of Grants Management Operations:

For assistance on grant administration issues, please contact Vincent Mani at:
5600 Fishers Lane
Rockville, MD, 20857-
Email: vmani@hrsa.gov
Phone: (301) 945-0900

TAB 3 - EXPANDED SERVICES GRANT APPLICATION

Submitted: July 20, 2015
Award Amount: $230,572
Award Date: September 2015

Pinellas County is working diligently to meet the healthcare needs of the homeless population in Pinellas County. Through the 2014 Expanded Services opportunity, the County was able to successfully reduce the number of calls/trips to the emergency room from one of the busiest homeless shelters in the County. Building on that success, in 2015, the County is proposing to add a 3rd part-time medical team to the program. This team will provide an additional 20 hours of service to our clients.

Based on national standards (Cambden Group), and review of our own program data, we anticipate serving an additional 550 new unduplicated patients through 2100 qualified medical encounters by December 31, 2017. Using data from our healthcare for the homeless program, our clients tend to have more chronic and severe issues resulting in an average of six (6) visits per year. To accomplish this, we will review our needs assessment and target areas that either have yet to be served by the program, and/or by providing additional hours in areas of the county where we are currently limited in providing service consistent with the need. The County will continue to work to reduce unnecessary ER visits and provide services/access to more homeless individuals.

In addition, the County is looking at providing the maximum allowable funding towards enabling services. The enabling services will be targeted towards care coordination of behavioral health (including substance abuse) for all existing clients. Behavioral health services are provided by referral to a subcontract provider. Since our program is limited to a mobile van and small clinic inside a homeless shelter, the full need of wraparound services is provided by referral to qualified, contracted providers in the County. Since these providers are often located off-site from the medical services, the clients have difficulty following up and getting the services needed. Funding will enable the program to hire additional staff whose primary responsibility will be to coordinate the referral and tracking process of medical clients needing behavioral health services. We anticipate reaching an additional 700 existing health center patients. Patients will benefit by better coordination and follow-up with the health center and contracted services necessary to effectively care for each patient.

HRSA will be performing monthly network and server maintenance activities on Wednesday, July, 22nd, 2015 8:00 P.M. through Thursday, July 23rd, 2015 3:00 A.M. ET. Please ensure that you save your work and log off prior to the start of these activities to prevent unintentional loss of data.

Application for Federal Assistance SF-424

OMB Approval No. 4040-0004
Expiration Date 8/31/2016

*** 1. Type of Submission**
- ☐ Preapplication
- ☑ Application
- ☐ Changed/Corrected Application

*** 2. Type of Application**
- ☐ New
- ☐ Continuation
- ☑ Revision

* If Revision, select appropriate letter(s):

* Other (Specify)

*** 3. Date Received:**

4. Applicant Identifier:

*** 5.a Federal Entity Identifier:**
Application #:132112
Grants.Gov #:

5.b Federal Award Identifier:
H80CS00024

*** 6. Date Received by State:**

7. State Application Identifier:

8. Applicant Information:

* a. Legal Name: PINELLAS, COUNTY OF

* b. Employer/Taxpayer Identification Number (EIN/TIN): 59-6000800

* c. Organizational DUNS: 055200216

d. Address:

* Street1: 440 Court Street, 2nd floor
Street2:
* City: CLEARWATER
County:
* State: FL
Province:
* Country: US: United States
* Zip / Postal Code: 33756-5338

e. Organization Unit:

Department Name: Human Services

Division Name:

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:
* First Name: Elisa
Middle Name: Middle Name:
Last Name: DeGregorio
Suffix:
Title: Grants Manager
Organizational Affiliation:
* Telephone Number: (727) 464-8434
Fax Number:
* Email: edegregorio@pinellascounty.org

9. Type of Applicant 1: B: County Government
Type of Applicant 2:
Type of Applicant 3:
* Other (specify):

*** 10. Name of Federal Agency:** N/A

11. Catalog of Federal Domestic Assistance Number: 93.527
CFDA Title: Affordable Care Act (ACA) Grants for New and Expanded Services Under the Health Center Program

*** 12. Funding Opportunity Number:** HRSA-15-153
* Title: Health Center Expanded Services

13. Competition Identification Number: 6558
Title: Health Center Expanded Services

Areas Affected by Project (Cities, Counties, States, etc.):
See Attachment

*** 15. Descriptive Title of Applicant's Project:** Pinellas County - Health Center Program - Expanded Services 2015

Project Description:
See Attachment

16. Congressional Districts Of:

* a. Applicant	FL-13	* b. Program/Project	FL-13

Additional Program/Project Congressional Districts:
See Attachment

17. Proposed Project:

* a. Start Date:	9/1/2015	* b. End Date:	12/31/2017

18. Estimated Funding ($):

* a. Federal	$230,572.00
* b. Applicant	$0.00
* c. State	$0.00
* d. Local	$0.00
* e. Other	$0.00
* f. Program Income	$0.00
* g. TOTAL	$230,572.00

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☐ a. This application was made available to the State under the Executive Order 12372 Process for review on

☑ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☐ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent Of Any Federal Debt(If "Yes", provide explaination in attachment.)**

☐ Yes ☑ No

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

☐ I Agree

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix:		* First Name:	Elisa
Middle Name:			
* Last Name:	DeGregorio		
Suffix:			
* Title:	Grants Manager		
* Telephone Number:	(727) 464-8434	Fax Number:	
* Email:	edegregorio@pinellascounty.org		
* Signature of Authorized Representative:	Elisa DeGregorio	* Date Signed:	

OMB Approval No. 4040-0004

Expiration Date 8/31/2016

SF-424A: BUDGET INFORMATION - Non-Construction Programs

SECTION A - BUDGET SUMMARY						
Grant Program Function or Activity	Catalog of Federal Domestic Assistance Number	Estimated Unobligated Funds		New or Revised Budget		
		Federal	Non-Federal	Federal	Non-Federal	Total
Health Care for the Homeless	93.224	$0.00	$0.00	$230,572.00	$0.00	$230,572.00
Total		**$0.00**	**$0.00**	**$230,572.00**	**$0.00**	**$230,572.00**

SECTION C - NON-FEDERAL RESOURCES				
Grant Program Function or Activity	Applicant	State	Other Sources	TOTALS
Health Care for the Homeless	$0.00	$0.00	$0.00	**$0.00**
Total	**$0.00**	**$0.00**	**$0.00**	**$0.00**

SF-424B: ASSURANCES, NON-CONSTRUCTION PROGRAMS

OMB Approval No. 4040-0007

Expiration Date 06/30/2014

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C.§§1681- 1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee- 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s)under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. 45 CFR 75, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

* SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	* TITLE
Elisa DeGregorio	Grants Manager
* APPLICANT ORGANIZATION	* DATE SUBMITTED
PINELLAS, COUNTY OF	

Program Review Form - Review

00132112: PINELLAS, COUNTY OF **Due Date: 07/20/2015 (Due In: 0 Days)**

Announcement Number: HRSA-15-153
Announcement Name: Health Center Expanded Services
Application Type: Revision (Supplemental)
Grant Number: H80CS00024
Total Federal Requested Amount: $230,572.00
Maximum Eligible Amount: $230,572.00
Target Population Type(s): Health Care for the Homeless
Service Types Selected: Enabling Services (EN),Medical Services (MS)

Resources

View

FY 2015 ES User Guide | Funding Opportunity Announcement

Federal Budget Information Table

As of 07/20/2015 04:18:34 PM
OMB Number: 0915-0285 **OMB Expiration Date:** 9/30/2016

Areas of Expansion	Service Category	Federal Funds Requested	Percentage % of Total ES Funds	Federal Funds Requested for Equipment	If you requested to use federal funds for Equipment in Year 1, describe how you will use those funds in future years for non-equipment purposes
[X]	Enabling Services (EN)				
	Case Management	$28,626.00	12.42%	$0.00	
	Eligibility Assistance	$17,488.00	7.58%	$0.00	
	Health Education	$0.00	N/A	$0.00	
	Outreach	$0.00	N/A	$0.00	
	Transportation	$0.00	N/A	$0.00	
	Translation	$0.00	N/A	$0.00	
	Additional Enabling/Supportive Services (e.g., support access to legal services/legal aid)	$0.00	N/A	$0.00	
	Total Enabling Services	$46,114.00	20.00%	$0.00	N/A
[X]	Medical Services (MS)	$184,458.00	80.00%	$0.00	
[ ]	Oral Health Services (OH)	$0.00	N/A	$0.00	
[ ]	Behavioral Health Services (BH)	$0.00	N/A	$0.00	
[ ]	Pharmacy Services (PS)	$0.00	N/A	$0.00	
[ ]	Vision Services (VS)	$0.00	N/A	$0.00	
	Total	$230,572.00	100.00 %	$0.00	

Form 5A Changes

Review the currently approved Form 5A for your organization. Are modifications necessary to ensure that the services that you will be proposing for expansion are recorded accurately on your Form 5A ? If yes, describe the proposed changes below.
[NO]

Federal Object Class Categories

As of 07/20/2015 04:18:34 PM
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Total Proposed Budget	Amount
Section 330 Federal funding (from Total Federal - New or Revised Budget on Section A – Budget Summary)	$230,572.00

Non-Federal funding (from Total Non-Federal - New or Revised Budget on Section A – Budget Summary)	$0.00
Total	$230,572.00

Budget Categories

Object Class Category	Federal	Non-Federal	Total
a. Personnel	$0.00	$0.00	$0.00
b. Fringe Benefits	$0.00	$0.00	$0.00
c. Travel	$1,000.00	$0.00	$1,000.00
d. Equipment	$0.00	$0.00	$0.00
e. Supplies	$8,408.00	$0.00	$8,408.00
f. Contractual	$221,164.00	$0.00	$221,164.00
g. Construction	N/A	N/A	N/A
h. Other	$0.00	$0.00	$0.00
i. Total Direct Charges (sum of a - h)	$230,572.00	$0.00	$230,572.00
j. Indirect Charges	$0.00	$0.00	$0.00
k. Total Budget Specified in this application (sum of i - j)	$230,572.00	$0.00	$230,572.00

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OMB Number: 0915-0285 **OMB Expiration Date:** 9/30/2016

Form 5A - Required Services

Service Type	Column I - Direct (Health Center Pays)	Column II - Formal Written Contract/Agreement (Health Center Pays)	Column III - Formal Written Referral Arrangement (Health Center DOES NOT pay)
General Primary Medical Care	[X]	[X]	[_]
Diagnostic Laboratory	[_]	[X]	[_]
Diagnostic Radiology	[_]	[X]	[_]
Screenings	[_]	[X]	[_]
Coverage for Emergencies During and After Hours	[_]	[X]	[_]
Voluntary Family Planning	[_]	[_]	[X]
Immunizations	[_]	[X]	[_]
Well Child Services	[_]	[X]	[_]
Gynecological Care	[_]	[X]	[X]
Obstetrical Care			
Prenatal Care	[_]	[_]	[X]
Intrapartum Care (Labor & Delivery)	[_]	[_]	[X]
Postpartum Care	[_]	[_]	[X]
Preventive Dental	[_]	[X]	[_]
Pharmaceutical Services	[_]	[X]	[_]
HCH Required Substance Abuse Services	[_]	[_]	[X]
Case Management	[X]	[X]	[X]
Eligibility Assistance	[X]	[X]	[_]
Health Education	[X]	[X]	[_]
Outreach	[X]	[_]	[_]
Transportation	[X]	[_]	[_]

Service Type	Column I - Direct (Health Center Pays)	Column II - Formal Written Contract/Agreement (Health Center Pays)	Column III - Formal Written Referral Arrangement (Health Center DOES NOT pay)
Translation	[X]	[X]	[_]

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Form 5A - Additional Services

Service Type	Column I - Direct (Health Center Pays)	Column II - Formal Written Contract/Agreement (Health Center Pays)	Column III - Formal Written Referral Arrangement (Health Center DOES NOT pay)
Additional Dental Services	[_]	[X]	[_]
Behavioral Health Services			
Mental Health Services	[_]	[X]	[X]
Substance Abuse Services	[_]	[_]	[_]
Optometry	[_]	[_]	[_]
Recuperative Care Program Services	[_]	[_]	[_]
Environmental Health Services	[_]	[_]	[X]
Occupational Therapy	[_]	[_]	[X]
Physical Therapy	[_]	[X]	[_]
Speech-Language Pathology/Therapy	[_]	[_]	[_]
Nutrition	[_]	[_]	[X]
Complementary and Alternative Medicine	[_]	[_]	[_]
Additional Enabling/Supportive Services	[X]	[_]	[X]

Staffing Impact

As of 07/20/2015 04:18:34 PM
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Staffing Categories	Total New FTEs Proposed (Direct Hire and/or Contracted Staff)
Enabling Services (EN)	1.00
Case Managers	0.50
Patient/Community Education Specialists	0.00
Outreach Workers	0.00
Transportation Staff	0.00
Eligibility Assistance Workers	0.50
Interpretation Staff	0.00
Other Enabling Services Staff	0.00
Total Enabling Services (EN)	1.00
Medical Services (MS)	1.80
Oral Health Services (OH)	N/A
Behavioral Health Services (BH)	N/A
Pharmacy Services (PS)	N/A
Vision Services (VS)	N/A
Facility (Administrative) and Non-Clinical Support Staff	0.10

Patients Impact

As of 07/20/2015 04:18:34 PM
OMB Number: 0915-0285 **OMB Expiration Date:** 9/30/2016

Patients Impact Questions

1. As a direct result of this funding, how many NEW patients do you predict will access services at your health center? 550

	NEW Patients by Service Category (as applicable)					
	Enabling Services (EN)	Medical Services (MS)	Oral Health Services (OH)	Behavioral Health Services (BH)	Pharmacy Services (PS)	Vision Services (VS)
Projected **NEW** Patients	0	550	N/A	N/A	N/A	N/A
Total **NEW** patients for all services	550					

2. As a direct result of this funding, how many current/existing health center patients will access newly expanded services to which they did not previously have access? 700

	EXISTING Patients by Service Category (as applicable)				
	Enabling Services (EN)	Oral Health Services (OH)	Behavioral Health Services (BH)	Pharmacy Services (PS)	Vision Services (VS)
Projected **EXISTING** Patients	700	N/A	N/A	N/A	N/A
Total **EXISTING** patients for all services	700				

New Patients by Population Type

Population Type	NEW Patients Projected
Total NEW Patients	**550**
General Underserved Community	0
Migratory and Seasonal Agricultural Workers	0
People Experiencing Homelessness	550
Public Housing Residents	0
Total	**550**

Project Narrative

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Need

Describe the need to expand or begin providing the proposed service(s), and how this proposal will respond to the health care needs of the target population (with reference to relevant special populations, demographic characteristics, and/or access to care/health status indicators).

Pinellas County continues to work diligently to meet the medical needs of the homeless population and still faces several challenges facing this population including:

Pinellas County Homeless Point in Time Count
The 2015 Point in Time (PIT) Homeless Count for Pinellas County revealed 6,853 adults and children who reported to be homeless on the night of January 28, 2015. The PIT count includes those who are without housing considered “unsheltered” individuals or families, those who are in a homeless shelter, transitional housing, safe haven or hotel and individuals and families who were considered to be at-risk of becoming homeless.

Impact of No Medicaid Expansion in Florida
The National Health Care for the Homeless Council calculates that there are approximately 174,192 Healthcare for the Homeless (HCH) patients who were uninsured in 2012 and live in states that have not chosen the ACA’s Medicaid expansion, including Florida. In Florida there are 35,106 (67%) HCH patients who were uninsured and 80% of all HCH patients live below 100% of the FPL. In total, of all non-expansion states, 74% of the HCH patients were uninsured compared to 55% in expansion states. The Council concludes that those living in non-expansion states will only see marginal changes to the rates of uninsured.

Unmet Medical Needs of Homeless Population
On May 31, 2014, the Tampa Bay Times newspaper wrote about the demands that Pinellas homeless shelters are putting on the EMS system by using it as a primary health care provider. The paper reported on the number of EMS trips emanating from Safe Harbor and Pinellas Hope, two of the county’s largest homeless shelters. Safe Harbor has been one of the biggest users of the EMS since it opened in 2011, when it topped the list of EMS calls in the County with 537. In 2013, it was third on the list with 545 calls. Pinellas Hope was eleventh on the list with 356 calls. If you add the costs of the first responders and ambulance costs, the estimated total cost of Safe Harbor to Pinellas' EMS system was about $502,048 in 2013.

In 2014, Pinellas County expanded service to shelter residents at these locations and has been successful at diverting a number of visits to the emergency rooms. Building off this success, the County would like to use additional ES funding to continue this trend.

Response

Describe the following:
1. An appropriate timeline for project implementation that demonstrates operational readiness within 120 days of award for the provision of new and expanded existing services.

Pinellas County contracts with the Florida Department of Health in Pinellas County (DOH) to provide medical and preventive care services

to the uninsured, low-income, and homeless populations in the County. DOH currently provides medical staffing for the program including physicians, nurses, case managers, and support staff. DOH currently provides two medical teams that provide services through our Mobile Medical Unit (mobile van) and at the Safe Harbor homeless shelter within our approved scope. Using this funding opportunity to expand services, DOH will be contracted to add a 3rd part-time team of clinical providers for the proposed medical and enabling services for our clients.

Within 120 days of award, the identified FTEs will be hired and trained to begin providing services.DOH has an open advertisement for medical positions. Candidates will be selected and hired within 30 of award announcement. Also DOH will announce available openings to existing trained qualified staff (700+) which may result in reassignments filling positions quickly. DOH will also offer opportunity to existing staff to work overtime while recruitment efforts are underway.

2. How the health center will ensure that all proposed services are or will be integrated into the existing service delivery model.

The Healthcare for the Homeless program includes medical and preventive care services for homeless individuals in Pinellas County. Using a mobile van, a team of providers/staff visit different sites throughout the county to deliver services to this population. The sites/locations and hours are determined by the staff and reviewed and approved by the governing body based on an annual needs assessment.

The governing body and staff have discussed this proposed funding opportunity to expand services and developed a program that will both expand services to new, unduplicated patients, in addition to providing new enabling services to our existing clients.

3. How the health center will ensure that all proposed services are accessible without regard to ability to pay through a sliding fee discount program.

Pinellas County offers a sliding fee discount program for medical services which are provided to all eligible clients regardless of ability to pay. Services provided on the Mobile Medical Unit are free of charge for individuals whose income is below 100% of the Federal Poverty, there are instances where a fee assessment is conducted and/or where fees may occur. Unless otherwise specified, clients will be charged for medical / clinical services based upon a sliding fee scale based on family size and income. The sliding scale will be based on the current fiscal year's federal poverty level guidelines published in the Federal Register each January.

Signage inside the Mobile Medical Unit, posted in both English and Spanish, announces the availability of the Sliding Scale Fee and Pinellas County's policy of not denying services based on a patient's ability to pay.

A full policy is outlined in the program's Policy & Procedure manual and is reviewed annually with the governing board.

4. How the health center plans to ensure that all patients will have reasonable access to any proposed new services, as appropriate. Include details about any services or staff proposed under the Other Enabling Services category on Form 5A and/or the Staffing Impact Form.

Pinellas County is proposing to add a 3rd part-time team of medical/support staff to our program. This team will provide 20 hrs/week of medical services. We anticipate expanding our hours to include evening hours and at least one weekend day. Initially, the extra hours will be used on our mobile van and/or at the Safe Harbor homeless shelter location (approved within scope) both which have additional service needs. After 90 days of implementation, staff and our governing body will conduct a review of the utilization and needs of the clients by location, and a consistent schedule will be determined. Staff and the governing body review the utilization trends monthly and will make adjustments as needed to maximize utilization and penetration throughout the county.

Pinellas County is also proposing enabling services as part of the expansion. This will include a more comprehensive care coordination effort for clients needing behavioral healthcare services. Funding will support new staff dedicated to providing follow-up and tracking of client referrals. All clients needing behavioral health (including substance abuse) will benefit from this service.

5. If any services will be provided by a Formal Written Agreement (via Column II on Form 5A), describe how the health center maintains oversight over all services provided via contracts/agreements or sub-recipient arrangements in accordance with Health Center Program requirements. If services are not provided via Formal Written Agreement, indicate that this question is not applicable.

Pinellas County contracts with the Florida Department of Health in Pinellas County for services provided for this program. The contract is renewed annually with approval from the Board of County Commissioners according to all purchasing guidelines. The co-applicant board also reviews and approves the budget and contract with the provider. The contract specifically details the scope of work, timeline, budget, and goals and objectives of the program. Performance measures are provided monthly to the County. The County's Human Services department under the Planning & Contracts division oversees and maintains the contract on behalf of the County. Bi-weekly meetings are held with the contractor to review issues, opportunities, and discuss additional needs of the program. A copy of the contract is available for review upon request.

Impact

Describe the following:
The impact of the proposed project, including the number of 1) proposed new patients, 2) existing patients with increased access to services (as applicable), and 3) new providers.
Include a detailed explanation for how the projections were calculated (including data sources).

Pinellas County is working diligently to meet the healthcare needs of the homeless population in Pinellas County. Through the 2014 Expanded Services opportunity, the County was able to successfully reduce the number of calls/trips to the emergency room from one of the busiest homeless shelters in the County. Building on that success, in 2015, the County is proposing to add a 3rd part-time medical team to the program. This team will provide an additional 20 hours of service to our clients.

Based on national standards (Cambden Group), and review of our own program data, we anticipate serving an additional 550 new unduplicated patients through 2100 qualified medical encounters by December 31, 2017. Using data from our healthcare for the homeless program, our clients tend to have more chronic and severe issues resulting in an average of six (6)visits per year. To accomplish this, we will review our needs assessment and target areas that either have yet to be served by the program, and/or by providing additional hours in areas of the county where we are currently limited in providing service consistent with the need. The County will continue to work to reduce unnecessary ER visits and provide services/access to more homeless individuals.

In addition, the County is looking at providing the maximum allowable funding towards enabling services. The enabling services will be targeted towards care coordination of behavioral health (including substance abuse) for all existing clients. Behavioral health services are provided by referral to a subcontract provider. Since our program is limited to a mobile van and small clinic inside a homeless shelter, the full need of wraparound services is provided by referral to qualified, contracted providers in the County. Since these providers are often located off-site from the medical services, the clients have difficulty following up and getting the services needed. Funding will enable the program to hire additional staff whose primary responsibility will be to coordinate the referral and tracking process of medical clients needing behavioral health services. We anticipate reaching an additional 700 existing health center patients. Patients will benefit by better coordination and follow-up with the health center and contracted services necessary to effectively care for each patient.

Equipment List

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Alert:
This form is not applicable to you as you have not requested federal funds for the Equipment category in the Federal Object Class Categories form of this application.

Summary Verification Form

As of 07/20/2015 04:18:34 PM
OMB Number: 0915-0285 **OMB Expiration Date:** 9/30/2016

Application Summary	
Total number of New Patients projected to access care as a result of Expanded Services funding by December 31, 2017: To make changes, visit the Patient Impact Form. **Note:** Calendar Year 2017 Uniform Data System (UDS) Reports are expected to reflect the patient projection increase included in this application. Future funding may be reduced if UDS data demonstrate that projections are not met.	550
Maximum amount of Federal funding eligible to be requested per year:	$230,572.00
Total Federal funding requested per year for the Expanded Services proposal: To make changes, visit the Federal Budget Information Table and the Budget Information - Section A-C Form, as needed.	$230,572.00

Form 5A Summary

Summary of changes to Form 5A : Services proposed in the Expanded Services application
The table below indicates the services on Form 5A that were added or modified in this ES application. Services that are currently in-scope and that do not require modification as part of the ES proposal are not listed here. Click Here to view the full list of ALL services included in your organization's approved scope of project (also available in the Resources section above).
Changes to Form 5A are NOT REQUIRED. Applicants may propose to use Expanded Services funding to support the expansion of existing services in scope.
Note: Within 120 days of award, health centers will be required to verify that the Form 5A changes summarized below have been implemented. Health centers should NOT propose new services if they will not meet the 120-day implementation deadline. Applications proposing to expand services through an equipment purchase in Year 1 that will not begin provision of a new service until Year 2 of the project must submit a Change in Scope request to add the service to scope closer to the time that provision of the new service will begin.
If the proposed updates listed below are not correct, visit Form 5A and make changes as needed.

Required Services	Currently Approved Form 5A			Updated Form 5A		
Service Type	Column I (Direct – Health Center Pays)	Column II (Formal Written Contract – Health Center Pays)	Column III (Formal Referral – Health Center DOES NOT pay)	Column I (Direct – Health Center Pays)	Column II (Formal Written Contract – Health Center Pays)	Column III (Formal Referral – Health Center DOES NOT pay)
There were no changes made to the Form 5A list of Required Services in this application						

Additional Services	Currently Approved Form 5A			Updated Form 5A		
Service Type	Column I (Direct – Health Center Pays)	Column II (Formal Written Contract – Health Center Pays)	Column III (Formal Referral – Health Center DOES NOT pay)	Column I (Direct – Health Center Pays)	Column II (Formal Written Contract – Health Center Pays)	Column III (Formal Referral – Health Center DOES NOT pay)
There were no changes made to the Form 5A list of Additional Services in this application						

Have all necessary changes to Form 5A been captured in the Expanded Services application?	[X] Yes [ ] No
[ ] Note(s): • **Note: Form 5A modifications that are not included in the ES application will require submission of a Change in Scope request post-award to ensure that the Form 5A accurately reflects the services to be provided as part of the ES-funded project.**	

Will the Expanded Services project be implemented at one or more health center sites included in the applicant organization's currently approved scope on Form 5B ?	[X] Yes [ ] No

Close Window

TAB 3 – SERVICE AREA COMPETITION

Through the FY 2016 Service Area Competition (SAC), HRSA will award approximately, $1.2 billion in funding to an estimated 465 SAC applicants. A SAC application is a request for federal financial assistance to continue support of comprehensive primary health care services in a service area currently served by a Health Center Program grantee whose project period is ending in FY 2016.

Eligible Applicants
Applicants must be public or nonprofit private entities, such as tribal, faith-based, or community-based organizations, that propose to serve a service area and its associated population to ensure continued access to comprehensive, culturally competent, quality primary health care services for communities and vulnerable populations served by the Health Center Program. Applicants must meet all Eligibility Requirements listed in Section III of the Funding Opportunity Announcement (FOA).

Due Dates:

Project Period Start Date	HRSA Announcement Number	Expected Funding Opportunity Announcement Release	Grants.gov Deadline (11:59 PM ET)	HRSA EHB Deadline (5:00 PM ET)
March 1, 2016	HRSA-16-005	July 28, 2015	September 28, 2015	October 14, 2015

Funding Availability

Patient Target

TAB 4 – CLINICAL

Clinical policies and procedures and the monthly trend report will be provided on-site on the day of the meeting.

XIII. CREDENTIALING & PRIVILEGING

The Credentialing & Privileging Policy was reviewed and approved by the MMUAC on 7/28/2015.

The purpose of the policy and procedure is to assure that all Health centers assess the credentials of each licensed or certified health care practitioner to determine if they meet Health Center standards. This applies to all health center practitioners, employed or contracted, volunteers and locum tenens, at all health center sites.

This policy and procedure meets the requirements in the Bureau of Primary Care Credentialing and Privileging Policy http://bphc.hrsa.gov/policiesregulations/policies/pin200222.html and http://bphc.hrsa.gov/programrequirements/pdf/pin200116.pdf

DEFINITIONS

Credentialing is the process of assessing and confirming the qualifications of a licensed or certified health care practitioner.

Licensed or Certified Health Care Practitioner is an individual required to be licensed, registered, or certified by the State of Florida. These individuals included, but are not limited to, physicians, dentists, dental hygienist, nurse practitioners, registered nurses, and certified medical assistants. These are divided into two categories:

1. **Licensed Independent Practitioner (LIP):** physician, dentists, nurse practitioners or any other individual permitted by law and the organization to provide care and services without direction or supervision, within the scope of the individual's licensed and consistent with individually granted clinical privileges (from Joint Commission on Accreditation of Health care Organizations (JCAHO) 202-2203 Comprehensive Accreditation Manual for Ambulatory Care.
2. **Other licensed or Certified Practitioners**: An individual who is licensed, registered, or certified but is not permitted by law to provide patient care services without direction or supervision. Examples include, but are not limited to medical assistants, licensed practical nurses, and dental assistants.

Primary Source Verification is verification by the original source of a specific credential to determine the accuracy of a qualification reported by an individual health care practitioner. Examples of primary source verification include, but are not limited to, direct correspondence, telephone verification, internet verification, and reports from credentials verification organizations. The Education Commission for Foreign Medical Graduates (EDFMG), the American Board of Medical Specialties, the American Osteopathic Association Physician Database, or the American Medical Association (AMA) Masterfile can be used to verify education and training. The use of credentials verification organizations (CVO's) or hospitals that meet JCAHO's "Principles of CVO's is also an acceptable method of primary source verification.

Secondary Source Verification is not considered an acceptable form of primary source verification. This method may be used when primary source verification is not required. Examples of secondary source verification methods include, but are not limited to, the original credential, notarized copy of the credential, a copy of the credential (when the copy is made from an original by approved Health Center staff).

Privileging or competency is the process of authorizing a licensed or certified health care practitioner's specific scope and content of patient care services. This is performed in conjunction with an evaluation of a individual's clinical qualifications and/or performance.

RESPONSIBILITY

Applicant: Provides documentation for Credentialing and Privileging.

Human Resources and the Program Hiring manager or designee: Works together to ensure applicant provides all documentation required, and maintains documentation for the initial Credentialing and Privileging, and for the renewals.

Quality Assurance Coordinator: Chairs the Credentialing and Privileging Team.

County Medical Director: Reviews and evaluates the Tracking templates and supporting documents, and gives approval for Credentialing and Privileging. Completes Verification of Fitness Form (Appendix N). Presents requests to the Mobile Medical Unit Advisory Council Board for review and final approval.

Medical Executive Committee: Reviews Request for Clinical Privileges for LIP's and gives approval.

Mobile Medical Unit Advisory Council: Maintains final approval, and documents in meeting minutes.

Credentialing and Privileging Team: Develops and maintains the policy and procedure, and strategies for on-going tracking and monitoring. Meets quarterly.

CREDENTIALING REQUIREMENTS

Licensed Independent Practitioners:

Credentialing Requirements will be completed prior to the individual being allowed to provide patient care services; and will include the following.

1. Credentialing of LIPs will include **primary** source verification of the following:
   - Current License
   - Relevant education, training or experience
   - Current competence; and
   - Health fitness, or the ability to perform the requested privileges, can be determined by a statement from the individual that is confirmed either by the director of a training program, chief of staff/services at a hospital where privileges exist, or a licensed physician designated by the organization. (See Verification of Fitness Form, Appendix N.)

2. Credentialing of LIPs will include **secondary** source verification of the following:
   - Government issued picture identification
   - Drug Enforcement Administration registration (as applicable)
   - Hospital admitting privileges (as applicable)
   - Immunization and PPD status; and
   - Life support training (as applicable)

3. The Health center will query the national Practitioner Data Bank (NPDB) for each practitioner.

4. The determination that a LIP meets the credentialing requirements will be stated in writing by the Health Center's governing board. Ultimate approval authority is vested in the governing board which may review recommendations from the County Medical Director, or County Health Department Director.

Other Licensed or Certified Health Care Practitioners

1. Credentialing of other licensed or certified health care practitioners includes **primary source verification** of the individual's licensed, registration, or certification only. Education and training will include **secondary source verification** methods. Verification of current competence is accomplished through a thorough review of clinical qualifications and performance. Secondary source verification of the following will include:

   - Government issued picture identification
   - Immunization and PPD status;
   - Drug Enforcement Administration registration (as applicable)
   - Hospital Admitting privileges (as applicable), and
   - Life support training (as applicable)

2. The Health center will query the national Practitioner Data Bank (NPDB) for each practitioner.

3. The determination that a LIP meets the credentialing requirements will be stated in writing by the Health Center's governing board. Ultimate approval authority is vested in the governing board which may review recommendations from the County Medical Director, or County Health Department Director.

PRIVILEGING

Privileging requirements will include the following:

1. Initial granting of privileges to LIPs and Other health care practitioners will be performed by the health center with ultimate approval authority vested in the governing board which may review recommendations from the County Medical Director, or Health Department Director, and the Medical Executive Committee. (See Request for Clinical Privileges, Appendix O and P)

2. For other licensed or certified health care practitioners, privileging may be completed during the orientation process via a supervisory evaluation based on the job description.

3. Temporary privileges may be granted if the Health Center follows guidelines specified by JCAHO.

Privileging revision or renewal requirements are as follows:

1. The revision or renewal of a LIP's privileges will occur at least every 2 years and will include primary verification of expiring or expired credentials a synopsis of peer review results for the 2 year period and/or any relevant performance improvement information. Similar to the initial granting of privileges, approval of subsequent privileges is vested in the governing board which may review recommendations from the County Medical Director, or County Health Department Director and Medical Executive Committee.

2. The revision or renewal of privileges of other licensed or certified health care practitioners will occur at a minimum of every 2 years. Verification is by supervisory evaluation of performance that assures that the individual is competent to perform the duties described in the job description.

3. The Heath center has an appeal process for LIP's and certified health care practitioners if a decision is made to discontinue or deny clinical privileges.

Table of Requirements: Comparative Summary

Credentialing or Privileging Activity Requirements for Credentialing and Privileging	"Licensed or Certified Health Care Practitioner	
	Licensed Independent Practitioner (LIP)	Other licensed or certified practitioner
Examples of Staff	Physician, Dentists, Nurse Practitioner	RN, LPN, CMA, Dental Hygienist
A. Credentialing	**Method**	
1. Verification of licensure, registration or certification	Primary Source	Primary Source
2. Verification of education	Primary Source	Secondary Source
3. Verification of training	Primary Source	Secondary Source
4. Verification of current competence	Primary Source, written	Supervisory evaluation per job description
5. Health fitness (ability to perform the requested privileges)	Confirmed statement	Supervisory evaluation per job description
6. Approval authority	Governing body (usually concurrent with privileging)	Supervisory evaluation per job description
7. Government issued picture identification, immunizations and PPD status, and life support training	Secondary source	Secondary source
8. Drug Enforcement Administration (DEA)	Secondary source, if applicable	Secondary source, if applicable
B. Initial Granting of Privileges	**Method**	
1. Verification of current competence to provide services specific to each of the organization's care delivery settings	Primary source, based on peer review and/or performance improvement data	Supervisory evaluation per job description
2. Approval authority	Governing Body (usually concurrent with Credentialing)	Supervisory evaluation per job description
C. Renewal or revision of privileges	**Method**	
1. Frequency	At least every 2 years	At least every 2 years
2. Verification of current licensure, registration or certification	Primary Source	Primary Source
3. Verification of current competence	Primary source based on peer review and/or performance improvement data	Supervisory evaluation per job description
4. Approval authority	Governing body	Supervisory function per job description
5. Appeal to discontinue appointment or deny clinical privileges	Process required	Organization option

PEER REVIEW

The Peer Review is an essential part of improving the quality of health care delivery. Peer Review assesses the clinical competency and stability of performance of Licensed Independent Practitioners (LIPs). The American Medical Association (AMA) supports the medical peer review process and recommends that peer review evaluations should be based upon appropriateness, medical necessity, and efficient of services in order to assure quality medical care.

An internal peer review is a cost effective way to protect the clients, the examiners, the agency and the public again fraud and abuse. The peer review also helps determine whether the medical record documentation supports the codes submitted to the insurers, documentation guidelines are accurate, complete and succinct and standard of care of outpatient evaluation and management (E/M) services are reviewed.

The process is integral to monitoring the accepted standards of care in providing medical services within a contract. It's also a valuable educational tool for LIP's to improve their coding and documentation skills.

Program managers will be responsible for the Peer Review process within their department, for their LIP's. The Primary Care program manager will be responsible for Peer review process for their LIP's; and the Dental program manager will be responsible for the Peer review process for the Dental LIP's.

- Each department will be represented by a member of the Credentialing and Privileging Team, and the Medical Executive Committee.
- Quarterly Peer Reviews will be scheduled for completion before the annual Performance Evaluation period.
- All LIPs will review 10 records of another LIP of equal training using the Peer Review Audit Form Template, see Appendix Q.
- A random selection of 10 charts for each LIP will be provided for the Peer Review.
- Findings will be summarized and shared with the program team, and the county Medical Director. If needed, Corrective action plans for improvement will be developed, implemented and monitored.
- Peer Review participation, performance, and a summary of findings will be documented and utilized in the LIPs annual performance evaluation, and submitted to the Medical Executive Committee for review and approval for Credentialing and Privileging, Clinical Privileges.

QUALITY ASSURANCE

1. The Credentialing and Privileging team is responsible for developing and overseeing the Credentialing and Privileging. The team is chaired by the Quality Assurance Coordinator, and includes the following:
   - County Medical Director
   - Human Resources Director
   - Medical Services Division Director, or designee
   - Nursing Director
   - Quality Assurance Coordinator

   Scheduled Quarterly meetings will be held with an agenda. Attendance and minutes will be documented.

   Further aim of the team will include developing methods for tracking Credentialing and Privileging activities to improve processes.

2. The Medical Executive Committee is responsible for reviewing and evaluating the tracking templates and supporting documents, and gives approval for Privileging of the LIP's. This is approval is in addition to the approval by the County Medical Director. The committee is co-chaired by the County Medical Director and the Human Services Health Administrator, and includes the following:
   - County Medical Director
   - Human Services Health Administrator
   - Nursing Director
   - Medical Services Program Manager
   - Sr. Dentist

   Scheduled Quarterly meetings will be held with an agenda. Attendance and minutes will be documented.

APPENDIX M – CREDENTIALING & PRIVILEGING CHECKLIST

Reviewed and Approved by MMUAC on 7/28/2015

Credentialing and Privileging activities are tracked by the Credentialing and Privileging Team at the Florida Department of Health Pinellas County. The following items are tracked for each individual Licensed Individual Practitioner (LIP) and/other licensed/certified providers to ensure that all providers C-P files have all documents consistent with the chart in PIN 2002-22 for health center programs.

1. Verification of License, registration or certification
2. Verification of Education (Primary Verification for LIP's & Secondary for others)
3. Verification of Training (Primary Verification for LIP's & Secondary for others)
4. Verification of Current competence (Annual Performance Eval done & QTR Peer Review)
5. Government issued picture identification
6. Immunization and PPD status
7. Life support training (if applicable)
8. Drug Enforcement Administration DEA registration
9. Hospital admitting privileges
10. Results of National Practitioner Data Bank (NPDB) query have been obtained & evaluated
11. Completed an application
12. No current or previously successful challenge to licensure or registration
13. Not been subject to involuntary termination of medical staff membership at another organization
14. Not been subject to involuntary limitation, reduction, denial or loss of clinical privileges
15. Trained in Peer Review and has participated in Peer Review
16. Requested Clinical Privleges
17. Health Fitness (ability to perform the requested privileges)
18. Approval Authority

APPENDIX N – VERIFICATION OF FITNESS FORM

Reviewed and Approved by MMUAC on 7/28/2015

Date

Name of applicant: _____

Position: _____
(Attached copy of Position Description or Requested Privileges)

Verification of fitness

It is my professional opinion that the individual is:

☐ Fit to provide services in the Center and Mobile Medical Unit/Safe Harbor without limitation.

☐ Fit to provide services in the Center and Mobile Medical Unit/Safe Harbor under the following conditions:

_____

_____

☐ Not fit to provide services in the Center and/or Mobile Medical Unit/Safe Harbor.

By: _____ _____
[Signature of Physician] [Date]

Chitra Ravindra, MD, MPH, MBA, FAFP County Medical Director

Florida Department of Health
in Pinellas County • Program name if desired
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TWITTER:HealthyFLA
FACEBOOK:FLDepartmentofHealth
YOUTUBE: fldoh
FLICKR: HealthyFla
PINTEREST: HealthyFla

APPENDIX O: REQUEST FOR CLINICAL PRIVILEGES (PHYSICIAN)

Reviewed and Approved by MMUAC on 7/28/2015

Qualifications

To be eligible to apply for clinical core privileges in family medicine, the initial applicant must meet the following criteria:

- Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited residency in family medicine.

  or

- Current certification or active participation in the examination process (with achievement of certification within 3 years or initial appointment) leading to certification in family medicine by the American Board of Family Medicine or the American Osteopathic Board of Family Physicians.

  and

- Current active licensure to practice as a physician in the State of Florida

Required previous experience

- Applicants for initial appointment must be able to demonstrate current competence and provision of care, reflective of the scope of privileges requested or demonstrate successful completion of an ACGME or AOA accredited residency or clinical fellowship in a clinical setting within the past 12 months.

Reappointment requirements

- To be eligible to renew core privileges in family medicine, the applicant must have current demonstrated competency and quality, reflective of the scope of privileges requested for the past 24 months based on results of ongoing professional practice evaluation and outcomes.
- Evidence of current ability to perform privileges requested is required for all applicants for renewal of privileges.

Directions

Applicant
Check of the "Requested" box for each privilege requested. Applicants have the burden of producing information deemed adequate for a proper evaluation of current competence, current clinical activity and other qualifications and for resolving any doubts related to qualifications for requested privileges.

Family Practice Medical Director
Check the appropriate box for recommendation on the last page of this form. If recommended with conditions or not recommended, provide condition or explanation on the last page of this form.

Other Requirements
Note that privileges granted may only be exercised at the site(s) and setting(s) that have the appropriate equipment, license, staff, and other support required to provide the services defined in this document. Site-specific services may be defined.

This document is focused on defining qualifications related to competency to exercise clinical Privileges. The applicant must also adhere to any additional organizational, regulatory, or accreditation requirements that the organization is required to meet.

Applicant Name:

Privileges

☐ **Initial Appointment**
☐ **Reappointment**

OFFICE USE ONLY

Effective from:
_____/_____/_____

Effective to:
_____/_____/_____

Sites

The applicant may perform granted privileges at any of the Florida Department of Health, Pinellas County Health Plan Medical Homes, Mobile Medical Unit and the Safe Harbor Clinic, with the provision that privileges only be exercised when appropriate equipment, license, staff and other support are available.

Core Privileges

Family Medicine Core Privileges

☐ **Requested**

Evaluate, diagnose, treat, and provide consultation to adolescent and adult patients with illnesses, diseases and functional disorders of the circulatory, respiratory endocrine, metabolic, musculoskeletal, hematopoietic, gastroenteric, and genitourinary systems. Assess, tabilize, and determine disposition of patients with emergency conditions consistent with policy regarding emergencies. The core privileges in this specialty include the procedures on the procedure list and such other procedures that are extensions of the same techniques and skills.

Pediatric Core Privileges

Criteria

Must qualify for and be granted privileges in family medicine, plus:

Required previous experience

Demonstrated current competence and evidence of the provision of care, reflective of the scope of privileges requested, to at least 10 pediatric patients in the past 12 months.

Maintenance of privilege

Demonstrated current competence and evidence of the provision of care to at least 25 pediatric patients in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

☐ **Requested**

Evaluate, diagnose, and treat pediatric patients up to age 18 with common illnesses, injuries or disorders. This includes the care of the normal newborn as well as the uncomplicated premature infant equal to or greater than 36 weeks gestation. Assess, stabilize, and determine disposition of patients with emergency conditions consistent with policy regarding emergencies. The core privileges in this specialty include the procedures on the procedure list and such other procedures that are extensions of the same techniques and skills.

Gynecology Core Privileges

Criteria
Must qualify for and be granted privileges in family medicine, plus:

Required previous experience
Demonstrated current competence and evidence of provision of care, reflective of the scope of privileges requested to at least 10 gynecologic outpatients in the past 12 months.

Maintenance of privilege
Demonstrated current competence and evidence of provision of care, reflective of the scope of privileges requested to at least 25 gynecologic outpatients in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

☐ **Requested**

Evaluate, diagnose, treat and provide consultation to post-pubescent female patients with disorders of the female reproductive system and the genitourinary system. Assess, stabilize, and determine disposition of patients with emergent conditions consistent with policy regarding emergencies. The core privileges in this specialty include the procedures on the procedure list and such other procedures that are extensions of the same techniques and skills.

Core Procedure List

This list is a sampling of procedures included in the core. This is not intended to be an all-encompassing list but rather reflective of the categories/types of procedures included in the core. **If you wish to exclude any procedures please strike through those procedures that you do not wish to request, initial and date.**

General

1. Burns care, minor superficial
2. Incision and drainage abscess
3. Perform history and physical exam
4. Remove non-penetrating foreign body from the eye, nose, or ear
5. Suture uncomplicated lacerations
6. Blood Glucose Point of Care Testing
7. Hemoglobin A1c Point of Care Testing
8. Influenza Point of Care Testing
9. Mononucleosis Point of Care Testing
10. Pregnancy Point of Care Testing
11. Strep A Point of Care Testing
12. Urinalysis Point of Care Testing
13. Fecal Occult Blood Point of Care Testing
14. Suture and Staple removal
15. Staple removal

Pediatrics

1. Incision and drainage abscess
2. Perform history and physical exam
3. Remove non-penetrating corneal foreign body
4. Suture uncomplicated lacerations
5. Blood Glucose Point of Care Testing
6. Hemoglobin A1c Point of Care Testing
7. Influenza Point of Care Testing
8. Mononucleosis Point of Care Testing
9. Pregnancy Point of Care Testing
10. Strep A Point of Care Testing
11. Urinalysis Point of Care Testing
12. Fecal Occult Blood Point of CareTesting

Gynecology

1. Biopsy of Cervix, endometrium (Pap)
2. Perform history and physical exam
3. Removal of foreign body from vagina
4. Blood Glucose Point of Care Testing
5. Hemoglobin A1c Point of Care Teting
6. Influenza Point of Care Testing
7. Mononucleosis Point of Care Testing
8. Pregnancy Point of Care Testing
9. Strep A Point of Care Testing
10. Urinalysis Point of Care Testing
11. Fecal Occult Blood Point of Care Testing

Acknowledgement of Practitioner

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform and that I wish to exercise at designated Florida Department of Health, Pinellas County sites including the Mobile Medical Unit and Safe Harbor Clinic, and I understand that:

A. In exercising any clinical privileges granted, I am constrained by the Florida Department of Health, Pinellas County policies and rules applicable generally and any applicable to the particular situation.

B. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the appropriate policies or related documents.

_____ _____

Signature Date

Service Line Medical Director Recommendation

I have reviewed the requested clinical privileges and supporting documentation for the above names applicant and make the following recommendation(s):

☐ Recommend all requested privileges

☐ Recommend all requested privileges with the changes as noted below

The following privilege(s) are granted with conditions and/or modifications:

	Privilege	Condition/Modification
1.	_____	_____
2.	_____	_____

The following privilege(s) are not granted:

	Privilege	Explanation
1.	_____	_____
2.	_____	_____

_____ _____

Family Practice Medical Director Signature Date

OFFICE USE ONLY

Medical Executive Committee: Action: _____ Date_____

Board of Directors: Action: _____ Date_____

APPENDIX P: REQUEST FOR CLINICAL PRIVILEGES (NURSING/CMA)

Reviewed and Approved by MMUAC on 7/28/2015

Privileged and Confidential

Date: _____

Print Name: _____

Hire Date: _____

Procedure	Requested	Provider Approval	Special Conditions or Comments
Venipuncture			
Injections (subcutaneous)			
Injections (transdermal)			
Injections (intramuscular)			
Blood Pressure			
Suture Removal			
Staple Removal			
Pulse			
Finger-sticks/Heel-stick			
EKG			
WBC Machine			
Incentive Spirometer			
Tympanogram			
Glucometer			
Hemocue			
Urine Dipstick			
Rapid Flu			
Strep A testing			
HCG testing			
Mono spot			
HgA1c			
Influenza vaccine			
Hemoccult			
Nebulizer			

I hereby request the privileges identified above. Furthermore, I am physically and mentally capable to perform the above requested privileges.

_____ _____

Applicant Signature Date

The following recommendation is made to the Governing Board that has authority to grant or deny privileges:

On behalf of the Credentialing and Privileging Committee, the Medical Director recommends that Privileges for _____at the Florida Department of Health, Pinellas County Health Centers, Mobile Medical Unit and Safe Harbor Clinic are:

____Approved
____Approved with modifications
____Denied

Modifications:

_____ _____
Nursing Director Date

_____ _____
Medical Director Date

APPENDIX Q: PEER REVIEW TEMPLATE

Reviewed and Approved by MMUAC on 7/28/2015

Mobile Medical Unit (MMU) and Safe Harbor Clinic Peer Review Template

Example of Peer Review for **Diagnoses of Tobacco Use**

Time range of Peer Review: xx/xx/xx through xx/xx/xx
Date of Peer Review: xx/xx/xx
Name and title of the staff member performing the Peer Review: First and Last name, Title
Name and title of the staff member reviewed: First and Last name, Title
Resource: NextGen Electronic Health Record

Instructions: Complete for each of the 10 records; Sum each column*and divide by 10 to equal a percentage score. Legend: Yes=1; No=0. The measurement year is the calendar year.

Randomly selected Medical Visit with Provider (Physician, Physician Assistant or other Mid-Level Provider)		**Documented Medical Visit includes**			**Documented Standard of care is met- Tobacco Cessation Counseling during the measurement year**		
Documented active diagnoses of Tobacco Use	**Unique Client Identifier**	**Service Date**	***CPT code: 99201-99215**	***ICD-9 code 305.1**	***CPT Service Code for counseling 99406 or 99407**	***Counseling done at Point of Care**	***Counseling is a covered service.**
1		xx/xx/xx					
2		xx/xx/xx					
3		xx/xx/xx					
4		xx/xx/xx					
5		xx/xx/xx					
6		xx/xx/xx					
7		xx/xx/xx					
8		xx/xx/xx					
9		xx/xx/xx					
10		xx/xx/xx					
Totals			**Sum/10=%**	**Sum/10=%**	**Sum/10=%**	**Sum/10=%**	**Sum/10=%**

Mobile Medical Unit (MMU) and Safe Harbor Clinic Peer Review Template

Example of Peer Review for **Diagnoses of Diabetes Type 1 or 2**

Time range of Peer Review: xx/xx/xx through xx/xx/xx
Date of Peer Review: xx/xx/xx
Name and title of the staff member performing the Peer Review: First name, Last name and Title
Name and title of the staff member reviewed: First name, Last name and Title
Resource: NextGen Electronic Health Record

Instructions: Complete for each of the 10 records; Sum each column* and divide by 10 to equal a percentage score. Legend: Yes=1; No=0. The measurement year is the calendar year.

Randomly selected Medical Visit with Provider (Physician, Physician Assistant or other Mid-Level Provider)		**Documented Medical Visit includes**			**Documented standard of care met-HgA1c Testing during measurement year**		**Documented standard of care met-Blood Sugar Check during medical visit**	
Documented active diagnoses of Diabetes Type 1 or 2	**Unique Client ID**	**Service Date**	***CPT code: 99201-99215**	***ICD-9 code 250.xx**	***CPT code for HgA1c test 83036**	***Test done at point of care-CPT code for venipuncture service 36415**	***CPT code for Blood Sugar Check 36416**	***Test done at point of care**
1		xx/xx/xx						
2		xx/xx/xx						
3		xx/xx/xx						
4		xx/xx/xx						
5		xx/xx/xx						
6		xx/xx/xx						
7		xx/xx/xx						
8		xx/xx/xx						
9		xx/xx/xx						
10		xx/xx/xx						
Totals			**Sum/10=%**	**Sum/10=%**	**Sum/10=%**	**Sum/10=%**	**Sum/10=%**	**Sum/10=%**

Florida Department of Health in Pinellas County

Dental Program, Dental Hygienist-Other LIcensed Health Care Practitioners --Template C-P file check list for LIPS and other licensed/certified providers used to ensure that all provide

Resources: http://bphc.hrsa.gov/policiesregulations/policies/pin200222.html

Legend: Not applicable=NA

Credentialing and Privileging Activities tracking Template:	Kimberly Belick		Disraeli Calderon		Joyce OBrien		Nilo Ortega	
	Initial Tracking	Next tracking	Initial tracking	Next tracking	Initial tracking	Next tracking date	Initial tracking	Next tracking
1. Verification of License, registration or certification (Primary Verification)	07/25/15	02/27/16	07/25/15	02/27/16	07/25/15	02/27/16	07/25/15	02/27/16
2. Verification of Education (Secondary Verification)	07/25/15		07/25/15		07/25/15		07/25/15	
3. Verification of Training (Secondrary Verification)	07/25/15		07/25/15		07/25/15		07/25/15	
4. Verification of Current competence (Annual Performance Eval done)	07/15/15	07/14/16	07/15/15	07/14/16	07/15/15	07/14/16	07/15/15	07/14/16
5. Government issued picture identification	11/03/03		08/30/04		07/21/15		07/21/15	
6. Immunization and PPD status or equivalent	07/23/15	07/22/16	07/23/15	07/22/16	07/23/15	07/22/16	07/23/15	07/22/16
7. Life support training (if applicable)	1/28/2015	01/27/16			03/24/15	02/28/17	05/27/15	05/26/16
8. Drug Enforcement Administration DEA registration	NA	NA	NA	NA	NA	NA	NA	NA
9. Hospital admitting privileges	NA	NA	NA	NA	NA	NA	NA	NA
10. Results of National Practitioner Data Bank (NPDB) query have been obtained & evaluated	07/27/15	07/26/17	07/27/15	07/26/17	07/27/15	07/26/17	07/27/15	07/26/17
11. Completed an application	11/03/03		08/30/04		7/21/2015		03/17/11	
12. No current or previously successful challenge to licensure or registration	07/27/15	07/26/16	07/27/15	07/26/16	07/27/15	07/26/16	07/27/15	07/26/16
13. Not been subject to involuntary termination of medical staff membership at another organization	07/27/15	07/26/17	07/27/15	07/26/17	07/27/15	07/26/17	07/27/15	07/26/17
14. Not been subject to involuntary limitation, reduction, denial or loss of clinical privileges	07/27/15	07/26/17	07/27/15	07/26/17	07/27/15	07/26/17	07/27/15	07/26/17
15. Trained in Peer Review and has participated in Peer Review	NA	NA	NA	NA	NA	NA	NA	NA
16. Requested Clinical Privileges (Request Form completed)	07/27/15	07/26/16	07/27/15	07/26/16	07/27/15	07/26/16	07/27/15	07/26/16
17. Health Fitness (ability to perform the requested privileges)	07/27/15	07/26/16	07/27/15	07/26/16	07/27/15	07/26/16	07/27/15	07/26/16
18. Approval Authority by Mobile Medical Unit Advisory Council Board	7/28/2015	7/27/2017	7/28/2015	7/27/2017	7/28/2015	7/27/2017	7/28/2015	7/27/2017

Florida Department of Health in Pinellas County

MMU/Safe Harbor Template C-P file check list for LIPS and other licensed/certified providers used to ensure that all providers' C-P files have all documents consistenw with the chart in PIN 2002-22.

Resources: http://bphc.hrsa.gov/policiesregulations/policies/pin200222.html

Legend: Not applicable=NA

Credentialing and Privileging Activities tracking Template:	Festus Ageykum,PA-LIP		Carol Benvenuto, LPN		Marquise Gray, MA		Raju Mungara, M.D-LIP		Orneida Hernandez, LPN		Rhonda O'Brien, ARNP LIP		Chitra Ravindra, M.D.		Amy Streicher, RN	
	Initial tracking	Next tracking	Initial Tracking	Next tracking	Initial tracking	Next tracking	Initial tracking	Next tracking	Initial tracking	Next tracking date	Initial tracking	Next tracking	Initial tracking	Next tracking	Initial tracking	Next tracking
1. Verification of License, registration or certification	09/09/14	01/31/16	10/09/14	07/31/17	10/01/14	08/30/15	06/05/06	01/30/16	8/9/2013	07/30/17	08/24/14	04/29/16	04/20/09	03/30/16	05/08/13	04/29/16
2. Verification of Education (Primary Verification for LIP's & Secondary for others)	07/24/15		07/14/15		05/26/15		07/23/15		7/20/2015		07/22/15		07/23/15		07/14/15	
3. Verification of Training (Primary Verificaiton for LIP's & secondary for others)	07/24/15		07/14/15		05/26/15		07/23/15		8/9/2013		07/22/15		07/23/15		07/14/15	
4. Verification of Current competence (Annual Performance Eval done & QTR Peer Review)	07/15/15	07/14/16	07/15/15	07/14/16	07/15/15	07/14/16	07/15/15	07/14/16	07/15/15	07/14/16	07/15/15	07/14/16	07/15/15	07/14/16	07/15/15	07/14/16
5. Government issued picture identification	09/09/14		10/9/2014		10/01/14		06/05/06		08/09/13		08/24/14		04/20/09		05/08/13	
6. Immunization and PPD status or equivalent	09/09/14	09/01/15	10/9/2014	10/01/15	05/26/15	05/25/16	05/26/15	05/25/16	05/26/15	05/25/16	07/20/15	07/19/16	06/25/15	06/24/16	09/12/14	09/11/15
7. Life support training (if applicable)	09/09/14	3/5/2016	10/9/2014	07/31/17	10/01/14	10/01/16	01/14/15	01/13/17	02/25/15	02/24/17	10/30/13	10/29/15	03/26/14	03/25/16	05/03/14	05/02/16
8. Drug Enformcent Administration DEA registration	NA	NA	NA	NA	NA	NA	06/05/06	01/30/16	NA	NA	NA	NA	04/20/09	04/29/17	NA	NA
9. Hospital admitting privileges	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
10. Results of National Practitioner Data Bank (NPDB) query have been obtained & evaluated	09/09/14	09/01/16	10/09/14	10/08/16	10/01/14	09/30/16	08/25/14	08/24/16	08/27/14	08/26/16	08/24/14	08/24/16	08/25/14	08/24/16	08/27/14	08/26/16
11. Completed an application	09/09/14		10/09/14		10/01/14		06/05/06		8/9/2013		08/24/14		04/20/09		05/08/13	
12. No current or previously successful challenge to licensure or registration	09/09/14	09/01/16	10/09/14	10/08/16	10/01/14	09/30/16	08/25/14	08/24/16	08/27/14	08/26/16	08/24/14	08/24/16	08/25/14	08/24/16	08/27/14	08/26/16
13. Not been subject to involuntary termination of medical staff membership at another organization	09/09/14	09/01/16	10/09/14	10/08/16	10/01/14	09/30/16	08/25/14	08/24/16	08/27/14	08/26/16	08/24/14	08/24/16	08/25/14	08/24/16	08/27/14	08/26/16
14. Not been subject to involuntary limitation, reduction, denial or loss of clinical privileges	09/09/14	09/01/16	10/09/14	10/08/16	10/01/14	09/30/16	08/25/14	08/24/16	08/27/14	08/26/16	08/24/14	08/24/16	08/25/14	08/24/16	08/27/14	08/26/16
15. Trained in Peer Review and has participated in Peer Review	05/19/15	05/18/16	05/19/15	05/18/16	05/19/15	05/18/16	05/27/15	05/26/17	05/27/15	05/26/17	NA	NA	NA	NA	05/27/15	05/26/17
16. Requested Clinical Privileges (Request Form completed)	07/24/15	07/23/16	07/24/15	07/23/16	07/24/15	07/23/16	07/24/15	07/23/16	07/24/15	07/23/16	07/24/15	07/23/16	07/24/15	07/23/16	07/24/15	07/23/16
17. Health Fitness (ability to perform the requested privileges)	07/24/15	07/23/16	07/24/15	07/23/16	07/24/15	07/23/16	07/24/15	07/23/16	07/24/15	07/23/16	07/24/15	07/23/16	07/24/15	07/23/16	07/24/15	07/23/16
18. Approval Authority by Mobile Medical Unit Advisory Council Board	07/28/15	07/27/17	07/28/15	07/27/17	07/28/15	07/27/17	07/28/15	07/27/17	07/28/15	07/27/17	07/28/15	07/27/17	07/28/15	07/27/17	07/28/15	07/27/17

IN PATIENT HOSPITAL ADMISSION TRACKING

The Mobile Medical Unit client's may need to visit a hospital emergency department or be admitted to a hospital. The MMU, through Pinellas County Human Services (HS) department has agreements with hospitals in Pinellas County for services to MMU clients. This procedure establishes arrangements for health center clients that require hospitalization and ensures continuity of care in accordance with program requirements.

http://www.ncqa.org/Portals/0/Programs/Recognition/RPtraining/PCMH%202014%20Intro%20Training%20Slides%20Part%202%20-%20Standards%204-6%20rev%207.9.pdf

RESPONSIBILITY

Client:

- Client will be responsible for payment of emergency department treatment received at the hospital.
- Client will receive discharge instructions instructing the patient to call their MMU primary care doctor for follow-up, and present a copy to the MMU staff at the follow-up visit.
- Client will contact the MMU to schedule an appointment. The client will specifically request an appointment/visit, with the reason for visit: 1) an Emergency Department discharge or 2) Hospitalization discharge.

Hospital Staff:

- Cooperate with HS staff to enroll potential clients who appear eligible for PCHP based on financial screening done at the hospital sites.
- Provide services consistent with National Treatment guidelines.
- Shall obtain a release of information from the enrolled MMU client and provide discharge summaries to the MMU through the CHEDAS community module, or by fax to the MMU.

Pinellas Human Services and FL DOH Administration/Management:

- Work with hospitals to implement processes for discharge follow-up and patient tracking in order to assure appropriate communication and continuity of care between the hospital and the client's primary care medical home or the mobile medical unit.

Case Manager:

- Schedule the client's appointment in NextGen with reason for visit: 1) an Emergency Department discharge or 2) Hospitalization discharge.
- Initiate the Hospital Referral and Discharge Tracking Log during the check-in process for the visit.
- Scan Hospital discharge summary and/or hospital discharge records into the Physician's PAQ.

Nurse and Physician:

- If the physician requests emergency treatment for a client, the nurse will call 911. Client's current status is given to EMS personnel.
- The nurse will submit the referral via CHEDAS to be reviewed by the HS Utilization Management Unit.
- The nurse will complete a release of information upon client's return.
- The Physician will review for any needed follow up.

- In cases where hospital arrangements (including admitting privileges and membership) are not possible, the MMU clinical staff will (upon learning of a client's discharge from a hospital) contact the hospital to request discharge orders.
- Once received, the paperwork will be reviewed by the MMU physician and scanned into the electronic health record.
- The nurse maintains the Hospital Referral and Discharge Tracking Log (Appendix H).

PROCEDURE

Step 1- Develops the process for hospital referral and discharge follow-up and tracking.

- Administration/management works with hospitals to implement processes for discharge follow-up and Client tracking.
- Pinellas County HS staff provide training for their staff.
- DOH staff provides training for their staff.
- The client is activated, fully informed regarding the procedure and of their responsibilities.

Step 2- For Physician referrals to the emergency department

- If the physician requests emergency treatment for a client, the nurse will call 911. Client's current status is given to EMS personnel.
- The nurse will submit the referral in CHEDAS to be reviewed by the HS Utilization Management Unit.

Step 3- For Client Follow-up appointments

- Case manager schedules appointment for client in NextGen with reason for visit: 1) an Emergency Department discharge or 2) Hospitalization discharge.
- The Case Manager initiates the Hospital Referral and Tracking Log during the check-in process for the visit, and scans the hospital discharge summary and/or hospital discharge records into the Physician's PAQ.
- The Physician will review for any needed follow up.
- Upon learning of a client's discharge from a hospital, the MMU clinical staff will contact the hospital to request discharge orders.
- Once received, the paperwork will be reviewed by the MMU physician and scanned into the electronic health record.
- The nurse maintains the Hospital Referral and Discharge Tracking Log.

QUALITY ASSURANCE

Medical Record review occurs quarterly by the Quality Assurance Team. Records are reviewed with corrective action when applicable.

APPENDIX H – HOSPITAL ADMISSION/ED VISIT TRACKING LOG

Client Name (Last, First)	Client's Date of Birth	Date of Notification of Admission	Date of Admission	Reason for Admission (if known)	Date Discharge Plan Requested & Hospital Name	Discharge plan received and scanned into EHR (NextGen)	Discharge plan reviewed by provider	Date of Follow-up Appt.	Discharge plan reviewed with client

Mobile Medical Unit/Safe Harbor Team Meeting and Training provided by partners: FL DOH, Pinellas County and Department of Human Services Pinellas County

Date/Time: 6/17/15 from 1:30pm-4:30pm
Location: Human Services Pinellas County
2189 Cleveland St. Suite 230
Clearwater, FL 33765

Agenda		
1:30-1:45 PM	• Welcome and Introduction	Manager (Drew), Hosts, and trainer
1:45-3:00 PM	• NextGen Training-Updates	Training Hosts: Pam Schuler, Dale Williams and Kyminda Lehman. Trainer: Rachael McCrum from Nextgen
3:00-3:15	BREAK	
3:15-3:30 PM	• NextGen Training- continued with Questions and closing comments.	Same as above
3:30-4:00 PM	• Hospital Tracking Policy and Procedure Review; Training for coding Emergency Department and Hospital Discharge patient encounter visits in NextGen •	Chitra Ravindra, MD, MPH, MBA FAFP County Medical Director
4:00-4:30 PM	• NextGen Training for coding Nurse only, and other personnel medical encounters.	Rhonda O'Brien, ARNP Quality Assurance Coordinator

Mobile Medical Unit/Safe Harbor Team Meeting and Training

Attendance

Date/Time: 6/17/15

Attendance: Name and title	Attendance=A
Festus Agyekum, PA	A
Carol Benvenuto, LPN	A
Oneida P. Hernandez, LPN	A
Andrea Hooker, Senior Clerk	A
Marquise Gray, Health Educator	A
Florence Guillet, Social Services Counselor	A
Kyminda Lehman, BTS Information Technology Specialist	A
Marshall, Michelle, Case Manager	A
Miguel Marti-Flores, Senior Clerk	A
Dr. Raju Mungara, MD, Senior Physician	A
Rhonda O'Brien, ARNP, QA Coordinator	A
Dr. Chitra Ravindra, MD, County Medical Director	A
Pamela Schuler, Pinellas County Business Technology Services	A
Amy Streicher, RN	A
Stewart, Joanne, Case Manager	A
Andrew J. Wagner II, Manager	A
Dale Williams, Program Analyst -Pinellas County Human Services	A

Training and Meeting Minutes -Key Follow-up items

1. Attendees participated in the NextGen training-Updates which included opportunities for questions during and after the training.

Key follow-up items:
Further Nextgen training will be announced. Drew Wagner will report any issues to IT/BTS for resolution.

2. Appointment types for Emergency Department Discharges and Hospital Discharges will be utilized immediately for tracking and reporting.

Key follow-up items: Rhonda O'Brien will monitor via EPM report, and share with Dr. Ravindra and the team. Drew Wagner will report any issues/problems with this feature to IT/BTS.

3. Nurse only and other medical personnel encounters will be used when needed. These can only be used when there is no medical encounter for the said date. In other words, if the physician or the PA sees the patient and an encounter is documented, there is no "Nurse only" or "other Medical Personnel" encounter coded.

Key follow-up items: Rhonda O'Brien will monitor via EPM report, and share with Dr. Ravindra and the team. Drew Wagner will report any issues/problems with this feature to IT/BTS.

Next Team meeting and/or Training date will be announced.

TAB 5 – OTHER UPDATES

No Attachments