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New Health Center Compliance Manual and Its Impact on the Program Requirements

Webinar #3: Chapters 5 and 10

Credentialing & Privileging and Quality Improvement

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This webinar series is co-sponsored by the National Association of Community Health Centers (NACHC)

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- Practices in areas of nonprofit law, corporate and business law, and health care law.
- Focus on assisting non-profits with regulatory, transactional, risk management, and corporate compliance matters.
- Ms. Evans was formerly in-house counsel at a large, multi-site non-profit in Washington, D.C. where she was responsible for identifying and managing legal risk issues.

AGENDA

- **Chapter 5: Clinical Staffing**
- **Chapter 10: Quality Improvement/Assurance**
  - **Authority**
  - **Requirements**
  - **Demonstrating Compliance**
  - **Related Considerations**
  - **Crosswalk to Site Visit Guide**

COMPLIANCE MANUAL

- August 28, 2017: HRSA issued the final Health Center Program Compliance Manual – was effective immediately
- Separate chapters for each requirement
  - Legal authority – statutory/regulatory citations
  - Requirements – statutory/regulatory requirements
  - Demonstrating compliance – how health centers can demonstrate compliance with the requirements – must meet all elements
  - Related Considerations – areas for which health center retains discretion in making decisions on how to implement compliance elements
    - Not within HRSA's purview to assess compliance
    - Not considered "musts" or even "should's" – clarifies what centers "could" do in their sole discretion

COMPLIANCE MANUAL

- Aligns credentialing/privileging requirements and the quality improvement/assurance requirements with the FTCA deeming requirements for the same areas
- Includes chapter on health center program eligibility (eliminates designation of any new dual grantee and look-alike entities)
- Includes chapter on HRSA/BPHC's oversight process for monitoring compliance with Health Center Program Requirements
    - Remedies for non-compliance, including enforcement action(s)
    - When and how compliance with program requirements and past performance is considered in award or designation decisions
    - Similar to current Progressive Action Process

COMPLIANCE MANUAL

- Serves as consolidated resource and definitive guidance for interpreting Program Requirements and FTCA requirements
- Supersedes many current PINs / PALs (including SFDP, governance and budgeting/accounting), and "summary of health center program requirements"
- Deletes "Scope of Project" as a separate requirement – 18 requirements now
- Will not supersede
  - Scope guidance
  - Service area overlap policy (PIN 2007-09)
  - Emergency management program expectations (PIN 2007-15)
  - FTCA Manual and deeming PALs
  - UDS Manual and resources

COMPLIANCE MANUAL

- Applies only to activities included in the health center's scope of project
- Does not provide guidance on requirements in areas beyond HRSA purview (such as 340B, Medicaid, Medicare)
- Webpage:
  - Compliance Manual
  - Frequently Asked Questions
  - Responses to Comments received by HRSA during the notice and comment period (2017)

https://www.bphc.hrsa.gov/programrequirements/compliancemanual/index.html

COMPLIANCE MANUAL: PROGRAM REQUIREMENTS COMPARISON

#	Site Visit Guide (FY 2015)	#	Draft Compliance Manual
		1	**Health Center Program Eligibility**
		2	**Health Center Program Oversight**
1	Needs Assessment	3	Needs Assessment
2	Required and Additional Services	4	Required and Additional Services
3	Staffing	5	**Clinical** Staffing
4	Accessible Hours of Operation/Locations	6	Accessible Locations and Hours of Operation
5	After Hours Coverage	7	Coverage for **Medical Emergencies During and** After Hours
6	Hospital Admitting Privileges and Continuum of Care	8	**Continuity of Care** and Hospital Admitting
7	Sliding Fee Discounts	9	Sliding Fee Discount **Program**
8	Quality Improvement / Assurance Plan	10	Quality Improvement/Assurance
9	Key Management Staff	11	Key Management Staff
10	Contractual / Affiliation Agreements	12	Contracts and **Subawards**

#	Site Visit Guide (FY 2015)	#	Draft Compliance Manual
		13	**Conflict of Interest (moved from #19)**
11	Collaborative Relationships	14	Collaborative Relationships
12	Financial Management and Control Policies	15	Financial Management and **Accounting** Systems
13	Billing and Collections	16	Billing and Collections
14	Budget	17	Budget
15	Program Data Reporting Systems	18	Program **Monitoring** and Data Reporting Systems
16	**Scope of Project**	NA	**(Incorporated into other requirements, as appropriate)**
17	Board Authority	19	Board Authority
18	Board Composition	20	Board Composition
19	**Conflict of Interest Policy**		**(Moved to #13)**
		21	**Federal Tort Claims Act (FTCA) Deeming Requirements**

SITE VISIT PROTOCOL

- Site Visit Guide was replaced by a new Site Visit Protocol (SVP), which is aligned with the Health Center Program Compliance Manual
  - Issued early January – effective for Operational Site Visits, New Grantee Site Visits and FQHC Look-Like Designation Site Visits on or after January 22, 2018
  - More prescriptive on reviewers than prior Site Visit Guides – see below
- For each Chapter, the following are identified
  - Statutory and regulatory authority (consistent with the Manual)
  - Primary and secondary reviewers

SITE VISIT PROTOCOL

- For each Chapter, the following are identified (cont.)
  - Documents lists: (1) documents sent prior to site visit; and (2) documents provided on-site – **NO OTHER DOCUMENTS SHOULD BE REQUESTED**
  - Which "Demonstrating Compliance" elements from the Manual will be assessed off-site by HRSA and which will be assessed on-site by review team
  - Assessment methodology (policy/procedure review, samples of files and records, interviews, site tours) that should be used by the reviewers to determine compliance with each on-site element
  - Questions to determine site visit findings

  https://www.bphc.hrsa.gov/programrequirements/svguide.html

IMPACT ON OPERATIONAL SITE VISITS

- OSV is still a 3 day on-site audit of a health center's compliance with the requirements of the Compliance Manual
  - Three reviewers (admin/governance, clinical, financial) who are consultants acting as "authorized representatives of HRSA"
  - Either project officer or another person from HRSA operations divisions will be on site
  - Elements of on-site process unchanged from prior process – entrance conference, facility visits, document reviews, interviews and exit conference
  - Should be able to make minor revisions to policies (if board is available to approve) and procedures while review team is on site – no revisions after they leave!

IMPACT ON OPERATIONAL SITE VISITS

- Reviews should be more objective
  - Has the center established and implemented required policies, procedures, etc. that include all elements/bullets for "Demonstrating Compliance" sections of Manual and SVP?
  - SVP is more proscriptive with respect to review process (documents, review methodologies)
  - Greater level of focus on health center implementation – not just compliance on paper – review of sample charts and records to assess implementation
  - Assessment should not discuss whether the reviewer thinks what you have in place is "good" or "bad"

IMPACT ON OPERATIONAL SITE VISITS

- Final reports should be issued by HRSA within 45 days of the site visit
  - Before finalizing the reports, HRSA will review the findings and may adjust the reports accordingly
  - Report will include findings and final compliance determinations
  - Non-compliance will result in grant conditions
  - Report will also be used by FTCA to support deeming decisions and identify TA needs – but no conditions on FTCA elements that are not also part of program requirements (credentialing and privileging, QI/A)

CHAPTER 5: CLINICAL STAFFING - AUTHORITY

Sections 330(a)(1), (b)(1)-(2) of the PHS Act

42 CFR 51c.303(a)

Provide the health services of the center so that such services are available and accessible promptly, as appropriate, and in a manner which will assure continuity of service to the residents of the center's catchment area.

42 CFR 51c.303(p)

Provide sufficient staff, qualified by training and experience, to carry out the activities of the center.

CHAPTER 5: CLINICAL STAFFING - REQUIREMENTS

- The health center must provide the required primary and approved additional health services of the center through staff and supporting resources of the center or through contracts or cooperative arrangements.
- The health center must provide the health services of the center so that such services are available and accessible promptly, as appropriate, and in a manner that will assure continuity of service to the residents of the center's catchment area.
- The health center must utilize staff that are qualified by training and experience to carry out the activities of the center.

CHAPTER 5: CLINICAL STAFFING - DEMONSTRATING COMPLIANCE

- The health center ensures that it has **clinical staff** and/or has contracts or formal referral arrangements in place with other providers or provider organizations **to carry out all required and additional services included in the HRSA-approved scope of project**.
- The health center has considered **the size, demographics, and health needs** (for example, large number of children served, high prevalence of diabetes) **of its patient population** in determining the **number and mix of clinical staff** necessary to ensure reasonable **patient access** to health center services.

CHAPTER 5: CLINICAL STAFFING - DEMONSTRATING COMPLIANCE

- The health center has **operating procedures** for the initial and recurring review (for example, every two years) of credentials for all clinical staff members (licensed independent practitioners (LIPs), other licensed or certified practitioners (OLCPs), and other clinical staff providing services on behalf of the health center) who are health center employees, individual contractors, or volunteers.

CHAPTER 5: CLINICAL STAFFING - DEMONSTRATING COMPLIANCE

These **credentialing procedures** would ensure verification of the following, as applicable:

- Current licensure, registration, or certification using a primary source;
- Education and training for initial credentialing, using:
  - Primary sources for LIPs
  - Primary or other sources (as determined by the health center) for OLCPs and any other clinical staff;
- Completion of a query through the National Practitioner Databank (NPDB);

CHAPTER 5: CLINICAL STAFFING - DEMONSTRATING COMPLIANCE

These **credentialing procedures** would ensure verification of the following, as applicable (CONTINUED):

- Clinical staff member's identity for initial credentialing using a government issued picture identification;
- Drug Enforcement Administration (DEA) registration; and
- Current documentation of basic life support training.

CHAPTER 5: CLINICAL STAFFING - DEMONSTRATING COMPLIANCE

The health center has **operating procedures** for the initial granting and renewal (for example, every two years) of **privileges** for clinical staff members (LIPs, OLCPs, and other clinical staff providing services on behalf of the health center) who are health center employees, individual contractors, or volunteers. These **privileging procedures** would address the following:

- Verification of fitness for duty, immunization, and communicable disease status;
- For initial privileging, verification of current clinical competence via training, education, and, as available, reference reviews;

CHAPTER 5: CLINICAL STAFFING - DEMONSTRATING COMPLIANCE

These **privileging procedures** would address the following (continued):

- For renewal of privileges, verification of current clinical competence via peer review or other comparable methods (for example, supervisory performance reviews); and
- Process for denying, modifying or removing privileges based on assessments of clinical competence and/or fitness for duty.

CHAPTER 5: CLINICAL STAFFING - DEMONSTRATING COMPLIANCE

- The health center maintains **files or records for its clinical staff** (for example, employees, individual contractors, and volunteers) that contain documentation of licensure, credentialing verification, and applicable privileges, consistent with operating procedures.

CHAPTER 5: CLINICAL STAFFING - DEMONSTRATING COMPLIANCE

- If the health center has **contracts with provider organizations** (for example, group practices, locum tenens staffing agencies, training programs) or formal, **written referral agreements** with other provider organizations that provide services within its scope of project, the health center **ensures** that such providers are:
  - Licensed, certified, or registered as verified through a **credentialing process**, in accordance with applicable Federal, state, and local laws; and
  - Competent and fit to perform the contracted or referred services, as assessed through a **privileging process**.

CHAPTER 5: CLINICAL STAFFING - RELATED CONSIDERATIONS

- The health center determines its staffing composition (for example, use of nurse practitioners, physician assistants, certified nurse midwives) and its staffing levels (for example, full- and/or part-time staff).
- The health center determines who has approval authority for credentialing and privileging of its clinical staff.

CHAPTER 5: CLINICAL STAFFING - RELATED CONSIDERATIONS

- The health center determines how credentialing will be implemented (for example, a health center may contract with a credentials verification organization (CVO) to perform credentialing activities or it may have its own staff conduct credentialing), including whether to have separate credentialing processes for LIPs versus other provider types.
- The health center determines how it assesses clinical competence and fitness for duty of its staff (for example, regarding clinical competence, a health center may utilize peer review conducted by its own providers or may contract with another organization to conduct peer review).

CHAPTER 5: CLINICAL STAFFING - RELATED CONSIDERATIONS

- The health center determines (consistent with its contracts/cooperative arrangements) whether to disallow individual providers or organizations from providing health services on the health center's behalf.

CHAPTER 5: CLINICAL STAFFING

Site Visit Guide:
Program Requirement #3

- Everything had to be in board-approved policy
- Health center had to credential providers contracted through entities/groups
- Required re-credentialing every 2 years

2017 Compliance Manual: Chapter 5

- Operational procedure only
- Health center can rely on credentialing by entity/group, with contractual assurance
- Re-credential according to procedures (*for example every two years)*

CHAPTER 5: CLINICAL STAFFING

Site Visit Guide: Program Requirement #3

- For non-LIPs, health center needed to check credentials only on licensed/certified clinical staff (OLCPs)
- Education/training for LIPs re-verified every re-credentialing period
- Process to deny/modify privileges and appeal privilege reduction/denial

2017 Compliance Manual: Chapter 5

- For non-LIPs, health center must have process for all clinical staff treating patients, even if not certified (e.g., noncertified MAs/CHWs)
- Verify education and training for LIPs at initial credentialing only
- Process for denial/ modification, appeals no longer required

CHAPTER 5: CLINICAL STAFFING

Site Visit Guide: Program Requirement #3

- At least one practitioner on-site with basic life support training (in emergency coverage)
- Fitness for duty part of credentialing (e.g., verified by external sources)
- Peer review for providers, competency for others at health center option

2017 Compliance Manual: Chapter 5

- All LIPs have to have BLS certification
- Fitness for duty part of privileging (and added mental health fitness, specifies CDC immunization schedule)
- Peer review for providers, competency system for other clinical staff

CHAPTER 5: CLINICAL STAFFING

- **SVP Element a:** Staffing to Provide Scope of Services
  - Interview, Tour 1-2 sites, Review of Staffing Profile/Form 5A
  - Determination whether staffing enables health center to carry out the approved scope of project
- **SVP Element b:** Staffing to Ensure Patient Access
  - Interview, Review Needs Assessment, UDS Summary, Form 5A and other resources (website, presentation, observations during site visit tour)
  - Determination of whether the health center can provide 1-2 examples of how the mix and number of staff is responsive to size, demographics and needs of the population
  - Based on the number of patients served, is the number and mix of staff sufficient to ensure reasonable patient access to health center services

CHAPTER 5: CLINICAL STAFFING

- **SVP Element c:** Procedures for Review of Credentials
  - Review credentialing procedures for LIPs, OLCPs and **other clinical staff** (if applicable), review contracts with CVOs, interview staff
  - Review of procedures for initial and recurring credentialing

- **SVP Element d:** Procedures for Review of Privileges
  - Review privileging procedures for LIPs, OLCPs and **other clinical staff**, interview staff
  - Review of procedures for initial and recurring privileging

CHAPTER 5: CLINICAL STAFFING

- **SVP Element e:** Credentialing and Privileging Records
  - Review sample of C&P files (4-5 LIPs, 4-5 OLCPs, and if applicable 2-3 other clinical staff) with the individual responsible for maintaining the files

  https://bphc.hrsa.gov/programrequirements/pdf/c_and_p_file_review_resource.pdf
  - Determination of whether C&P files are complete and up to date
- **SVP Element f:** Credentialing and Privileging of Referral Providers
  - Review of contracts and referral agreements (2-3 in Form 5A Column II and 2-3 in Form 5A Column III) (Both for Required and Additional Services)
  - Demonstration that health center ensures that the referral providers (in both Column II and Column III) are credentialing and privileging their staff members

CHAPTER 10: QI/QA - AUTHORITY

Section 330(k)(3)(C) of the PHS Act

42 CFR 51c.110

All information as to personal facts and circumstances obtained by the project staff about recipients of services shall be held confidential, and shall not be divulged without the individual's consent except as may be required by law or as may be necessary to provide service to the individual or to provide for medical audits by the Secretary or his designee with appropriate safeguards for confidentiality of patient records. Otherwise, information may be disclosed only in summary, statistical, or other form which does not identify particular individuals.

42 CFR 51c.303(b)

Implement a system for maintaining the confidentiality of patient records in accordance with the requirements of § 51c.110 of subpart A.

CHAPTER 10: QI/QA - AUTHORITY

42 CFR 51c.303(c)

- *Have an ongoing quality assurance program which provides for the following:*

  (1) *Organizational arrangements, including a focus of responsibility, to support the quality assurance program and the provision of high quality patient care;*

  (2) *Periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the center. Such assessments shall (continued):*

CHAPTER 10: QI/QA - AUTHORITY

42 CFR 51c.303(c)

- *Such assessments shall:*

  (i) *Be conducted by physicians or by other licensed health professionals under the supervision of physicians;*

  (ii) *Be based on the systematic collection and evaluation of patient records; and*

  (iii) *Identify and document the necessity for change in the provision of services by the center and result in the institution of such change, where indicated.*

CHAPTER 10: QI/QA - AUTHORITY

42 CFR 51c.304(d)(3)(iv-vi)

The governing board shall have specific responsibility for:

- *Evaluating center activities including services utilization patterns, productivity of the center, patient satisfaction, achievement of project objectives, and development of a process for hearing and resolving patient grievances;*
- *Assuring that the center is operated in compliance with applicable Federal, State, and local laws and regulations; and*
- *Adopting health care policies including scope and availability of services, location and hours of services, and quality-of-care audit procedures.*

CHAPTER 10: QI/QA - REQUIREMENTS

- The health center must have an ongoing quality improvement/assurance (QI/QA) system that includes clinical services and [clinical] management and maintains the confidentiality of patient records.
- The health center's ongoing QI/QA system must provide for all of the following:
  - Organizational arrangements, including a focus of responsibility, to support the quality assurance program and the provision of high quality patient care; and
  - Periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the center.

CHAPTER 10: QI/QA - REQUIREMENTS

Such assessments must:

- Be conducted by physicians or by other licensed health professionals under the supervision of physicians
- Be based on the systematic collection and evaluation of patient records
- **Assess patient satisfaction, achievement of project objectives, and include a process for hearing and resolving patient grievances**
- Identify and document the necessity for change in the provision of services by the center and result in the institution of such change, where indicated

CHAPTER 10: QI/QA - REQUIREMENTS

The health center must maintain the confidentiality of patient records, including all information as to personal facts and circumstances obtained by the health center staff about recipients of services. Specifically, the health center must not divulge such information without the individual's consent except as may be required by law or as may be necessary to provide service to the individual or to provide for medical audits by the Secretary of HHS or his/her designee with appropriate safeguards for confidentiality of patient records.

CHAPTER 10: QI/QA DEMONSTRATING COMPLIANCE

- The health center has a board-approved policy(ies) that establishes a QI/QA program. This QI/QA program addresses the following:
  - The quality and utilization of health center services;
  - Patient satisfaction and patient grievance processes; and
  - Patient safety, including adverse events.
- The health center designates an individual(s) to oversee the QI/QA program established by board-approved policy(ies). This individual's responsibilities would include, but would not be limited to, ensuring the implementation of QI/QA operating procedures and related assessments, monitoring QI/QA outcomes, and updating QI/QA operating procedures).

CHAPTER 10: QI/QA
DEMONSTRATING COMPLIANCE

- The health center has operating procedures or processes that address all of the following:
  - Adhering to current evidence-based clinical guidelines, standards of care, and standards of practice in the provision of health center services, as applicable;
  - Identifying, analyzing, and addressing patient safety and adverse events and implementing follow-up actions, as necessary;
  - Assessing patient satisfaction;
  - Hearing and resolving patient grievances;

CHAPTER 10: QI/QA DEMONSTRATING COMPLIANCE

- The health center has operating procedures or processes that address all of the following:
  - Completing periodic QI/QA assessments on at least a quarterly basis to inform the modification of the provision of health center services, as appropriate; and
  - Producing and sharing reports on QI/QA to support decision-making and oversight by key management staff and by the governing board regarding the provision of health center services.

CHAPTER 10: QI/QA
DEMONSTRATING COMPLIANCE

- The health center's physicians or other licensed health care professionals conduct QI/QA assessments on at least a quarterly basis, using data systematically collected from patient records, to ensure:
  - Provider adherence to current evidence-based clinical guidelines, standards of care, and standards of practice in the provision of health center services, as applicable; and
  - The identification of any patient safety and adverse events and the implementation of related follow-up actions, as necessary.

CHAPTER 10: QI/QA
DEMONSTRATING COMPLIANCE

- The health center maintains a retrievable health record (for example, the health center has implemented a certified Electronic Health Record (EHR)) for each patient, the format and content of which is consistent with both Federal and state laws and requirements.
- The health center has implemented systems (for example, certified EHRs and corresponding standard operating procedures) for protecting the confidentiality of patient information and safeguarding this information against loss, destruction, or unauthorized use, consistent with Federal and state requirements.

CHAPTER 10: QI/QA RELATED CONSIDERATIONS

- The health center determines whether the position designated with responsibility for the QI/QA program (for example, Clinical Director, QI Director) is full-time, part-time, or combined with another position, and whether it is filled by an employee or via contract.
- The health center determines whether the position designated with responsibility for the QI/QA program is filled by a physician, other licensed health care professional (for example, registered nurse, nurse practitioner), or other qualified individual (for example, an individual with a Master of Public Health or a Master of Healthcare Administration).

CHAPTER 10: QI/QA RELATED CONSIDERATIONS

- The health center determines which QI/QA methodology(ies) to use.
- The health center determines the type of patient health record system that it will use.
- The health center determines the format, content, and focus of QI/QA reports. The health center determines the type of patient health record system that it will use.

CHAPTER 10: QI/QA

Site Visit Guide: Program Requirement #3

- At least one practitioner on-site with basic life support training (in emergency coverage)
- Fitness for duty part of credentialing (e.g., verified by external sources)
- Peer review for providers, competency for others at health center option

2017 Compliance Manual: Chapter 5

- All LIPs have to have BLS certification
- Fitness for duty part of privileging (and added mental health fitness, specifies CDC immunization schedule)
- Peer review for providers, competency system for other clinical staff

CHAPTER 10: QI/QA

Site Visit Guide: Program Requirement #8

- Effective interpretation (but not required) that the CMO must be responsible for QI/QA
  - Physician or physician-directed
- Cover utilization, quality outcomes, patient satisfaction

2017 Compliance Manual: Chapter 10

- Health center may determine who is responsible
  - Appropriate credential – e.g., physician, other licensed professional, MPH, etc. (health center discretion)
- Adds process for patient grievances to QI/QA

CHAPTER 10: QI/QA

Site Visit Guide: Program Requirement #8

- Silent on patient safety/adverse events
- Incorporate board review of QI/QA outcomes

2017 Compliance Manual: Chapter 10

- Requires formal processes for assessment of patient safety/adverse event outcomes
- Mandates at least quarterly board review of QI/QA data
- Board must direct changes to care delivery based on QI/QA results

CHAPTER 10: QI/QA

Site Visit Guide: Program Requirement #8

- HIPAA and HITECH to be followed
- Reports at health center discretion

2017 Compliance Manual: Chapter 10

- Adds safeguard of "all facts and circumstances learned about patients"
- Format/content of reports in health center discretion, but must show they support management/board decision-making
- Requires adoption of evidence-based clinical practices, and document adherence
- Discretion on QI methods – e.g., may choose something other than PDSA

CHAPTER 10: QI/QA

- **SVP Element a:** QI/QA Program Policies
  - Review of the policies that establish the QI/QA program and interview staff who oversee the program
  - Determination that the QI policies address quality and utilization; patient satisfaction and grievance processes; patient safety and adverse events
- **SVP Element b:** Designee to Oversee QI/QA Program
  - Review job/position descriptions and other documents on responsibilities of oversight of QI/QA Program and interview individuals with oversight responsibilities
  - Do job responsibilities include implementation of QI/QA operating procedures; ensuring QI/QA assessments are conducted; monitoring QI/QA outcomes; updating QI/QA procedures

CHAPTER 10: QI/QA

- **SVP Element c:** QI/QA Procedures and Processes
  - Review of procedures and processes that address a variety of QI/QA elements and interview individuals responsible for program re: same
  - Determination that the procedures and processes address certain QI elements; that the Board and key management receive QI reports (including specific data on patient satisfaction and safety); that reports supported decision-making
- **SVP Element d:** Quarterly Assessments of Clinician Care
  - Interview individuals responsible for the QI/QA program, review operation procedures re: periodic assessments, review schedule of assessments, review sample of two assessments
  - Determination of how assessments are conducted (and by whom) and whether assessments demonstrate that the health center is tracking and addressing issues related to patient care

CHAPTER 10: QI/QA

- **SVP Element e:** Retrievable Health Records
  - Review a sample of 5-10 patient records (with a clinical staff member)
  - Determination of whether there is a retrievable record in a structured format and that the health center that is consistent with federal and state laws and requirements
- **SVP Element f:** Confidentiality of Patient Information
  - Review HIT systems and procedures for maintaining and monitoring confidentiality and security of information and interview staff on how they maintain up-to-date knowledge about federal and state requirements
  - Determination that the health center's IT and recordkeeping procedures address current federal and state requirements and that its staff is trained on confidentiality, privacy and security

QUESTIONS??

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- Tuesday February 13th with Ted Waters
  - Internal Controls: Managing Your Grant Funds (Chapters 12, 13 and 15)
- Tuesday February 20th with Molly Evans:
  - Understanding the Roles of Management & Governance (Chapters 11, 19 and 20); the OSV Process As it Stands Today

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OTHER UPCOMING TRAINING EVENTS

Webinars		
Feb 8th @ 1 PM	HIPAA Breaches: Determining Whether a Breach Has Occurred and the Reporting Requirements	
Mar 13th @ 1 PM	Emergency Preparedness: Implementation Updates and Best Practices	
Live Trainings		
Feb 13th – 14th	Health Center Compliance Intensive: HIPAA Fundamentals (*designed for Compliance Officers and Privacy Officers*)	Washington, DC
Feb 21st -23rd	Federal Funding Academy	Austin, TX
Feb 27th – 28th	De-Mystifying the New Compliance Manual & Its Impact on the Program Requirements	Mesa, AZ
Feb 28th – Mar 1st	An In-Depth Look at the Federal Tort Claims Act (FTCA)	Mesa, AZ
Feb 28th – Mar 1st	340B Drug Discount Program: An Intensive Focus on Covered Entity Compliance	Washington, DC

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