VENTURA COUNTY
HEALTH CARE AGENCY

Origination:	*N/A*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*N/A*
Owner:	*Lizeth Barretto: Ambulatory Care, Staff Services Manager*
Policy Area:	*Administrative - Fiscal*
References:	

AC.26 Sliding Fee Discount Payment Program

Policy:

In accordance with the Health Resources and Services Administration (HRSA) Compliance Manual, the Ventura County Health Care Agency (VCHCA), Ambulatory Care Department, provides a Sliding Fee Discount Program (SFDP) to all individuals and families with annual incomes at or below 200% of the current Federal Poverty Guidelines (FPG) as published annually in the Federal Register. This policy applies to all medical, specialty, dental, vision, and behavioral health services provided at VCHCA health centers funded by HRSA as described in Section 330 of the Public Health Service Act.

The SFDP is established to ensure that uniform and reasonable fees and discounts are consistently and appropriately applied to all ambulatory care patients. Eligibility is determined by the patient's: 1) household size and 2) annual income relative to a discount schedule based on federal poverty income guidelines.

Procedures:

1. No aspect of the SFDP, including VCHCA's fees themselves, the procedures for assessing patient eligibility, or the procedures for collecting payments, will create barriers to health care services.
2. All services within VCHCA's approved scope of project for which VCHCA charges patients is offered on the SFDP and is available to patients regardless of their ability to pay.
3. VCHCA will assure that patients are aware of the SFDP by posting clear notices in waiting rooms, other prominent areas of the health centers, and its website. All notices will be written in appropriate languages and literacy levels. All new patients will have the SFDP explained to them during the registration process.
4. All patients will be asked to submit an application providing their family size and income level at their first visit as required by HRSA. To qualify for the SFDP, patients will be asked to bring information verifying their family size and income to their scheduled visit. Patients may bring any of the following documents to determine their income and family size: Federal/State Income Tax Returns for the most recent year, Unemployment and/or Disability statements, W2 and/or 1099 forms, Workers' Compensation statements, pay stubs, or a letter from a patient's employer indicating gross income. The patient's assets or the assets of the patient's family will not be considered when determining eligibility for the SFDP. Income also excludes Cal Fresh.
5. A "patient's family" is defined as: 1) for persons 18 years of age and older, spouse, domestic partner and dependent children under 21 years of age, whether living at home or not; and 2) for persons under 18 years of age, parent, caregiver, relatives, and other children under 21 years of age of the parent or caretaker relative. Family size is self-reported. All family members listed in the SFDP application are

eligible to receive the same discount as the person applying.

6. Patients must be re-certified annually, on their SFDP anniversary date, or sooner if they experience a change in family size or income.
7. If the patient does not have income information at their first visit, they will be asked to complete a self-declaration form and to bring proof of income and family size to their subsequent visit. This also applies to any patient declaring no job and/or no income. These patients will be categorized in a designated payer category.
8. Those patients that choose not to provide information required by VCHCA to determine income and family size, even after being informed that they may qualify for discounts, are viewed as declining eligibility for sliding fee discounts. VCHCA will consider these patients to be ineligible for such discounts and will classify the patients as self-pay.
9. Registration staff will review the completed income and family size information provided by patients and determine which class of discount they qualify for; the class will be documented on the staff section of the patient application. A patient whose family income does not exceed 200% of the FPG shall be eligible for the SFDP. If the patient qualifies for the SFDP, the completed paperwork is then scanned into the system and the patient is classified into the appropriate financial category.
10. For patients with incomes at or below 100% of the FPG, VCHCA provides a nominal fee per visit. VCHCA ensures the nominal fee(s) are "nominal" from a patient's perspective. The nominal fee per visit would be less than the fee paid by a patient in the first sliding fee discount class above 100% of the FPG. Families with annual incomes at or below 100% FPG, that are hospitalized, may apply to VCHCA's Charity Care Program for a full discount on extraordinary medical services.
11. Patients and their families with incomes between 100% and 200% of the FPG will qualify for one of three sliding fee discount pay classes.
12. Individuals and families with annual incomes above 200% of the FPG do not qualify for the SFDP. However, other patient discount programs through VCHCA are available.
13. Patients with third-party coverage are also eligible for the SFDP. Subject to legal and contractual limitations, the charge for each pay class is the maximum amount an eligible patient is required to pay for any service, regardless of insurance status. If, however, the third-party contract(s) with VCHCA require(s) the collection of certain amounts from patients, VCHCA will honor the contractual agreement and charge patients on a sliding fee scale when services result in out-of-pocket costs where VCHCA is not contractually bound. Sliding fee scale discounts may apply to third-party co-pays and deductibles for eligible patients.
14. The Sliding Fee Scale and its accompanying nominal fee(s) may vary depending on the type of service provided and no other factor.
15. After determining a patient is eligible for the SFDP, Registration staff will collect the appropriate amount due from a patient and post the payment to the patient's account.
16. If a patient cannot pay the amount due at the time of the visit, the patient will be balance billed. Patients will not be refused access to care due to inability to pay.
17. SFDP shall be permitted to make payments of the discounted amount over a period of time with no interest accruing or being charged; refer to Payment Plans policy.
18. The VHCHA will review its SFDP policy and update the Federal Poverty guidelines and Discount Scales (attached) annually.

19. The VCHA Community Health Center Board (CHC) will evaluate the SFDP at least once every three years by: a) collecting utilization data to assess the rate at which patients using the SFDP are accessing services, b) utilize other data, such as patient surveys, to evaluate the effectiveness of the SFDP in reducing barriers to care, and c) identify and implement changes to the SFDP as needed.

All revision dates:

Attachments

No Attachments

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Origination:	*N/A*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*9/28/2023*
Owner:	*Lizeth Barretto: Ambulatory Care, Staff Services Manager*
Policy Area:	*Ambulatory Care - Administrative*
References:	*HRSA Compliance Manual*

AC.20 Federal Grants Management

Policy:

Grants will be managed in accordance with the regulatory requirements associated with each grant. Federal grants will be managed in accordance with Uniform Guidance per 2 CFR 200. Total additional costs associated with new grants, including estimated indirect costs, must be identified for all grants. Upon expiration, all approved matching funding and all positions funded by the grant will be re-evaluated unless other revenue has been identified. The VCHCA department receiving the grant is responsible for adhering to all policies and procedures attached to the grant by the grantor and any reference to regulations or rules included in any notice of grant award. Awarded federal funds are not to be expended for restricted activities. All reports that VCHCA is required to submit to the funding agencies, and federal or state governments are to be submitted within the timeframes required by the grant. The CHC Board of Directors will review and approve grant budgets, narratives and reports as required.

Purpose:

To establish clear procedures and VCHCA's position regarding application, acceptance, budgeting, and administration of grants when VCHCA is the grantee. VCHCA desires to obtain grant funding to provide services that the CHC Board of Directors determines beneficial to the patients in VCHCA's service area.

Procedures:

Grant Budgeting and Accounting

Department heads are responsible for maintaining accurate grant budgets and must ensure the grant expenditure and revenue transactions are coded appropriately. Each grant source will be assigned a unique fund account code to record fiscal transactions. For each federal program, VCHCA must report revenue and expenditures separately. Each federal award will be identified separately in the Chart of Accounts. In the event the accounting software is not able to generate income statement details by fund code, supporting Excel schedules will perform the same function. All grant expenditures must be supported by adequate source documentation as required by the grantor agency and any related regulatory documents.

Grant related transactions will be recorded by accounting in a timely manner (at least monthly). Month-end reconciliations are conducted to ensure financial information is accurate. Any salary and fringe benefit costs

incurred by grant support staff for a federal grant must be identified and entered onto the Federally-Supported Personnel Justification Table.

Budgets included in grant applications to the Health Resources and Services Administration (HRSA) will only include revenues and expenditures associated with the health center's federal scope of project. These HRSA budgets will include a separate budget breakdown for the Section 330 funding proposed for the application period. The budget will show which projected costs are supported by the Section 330 grant and which projected costs are supported by other sources of non-grant funds. For ease of management, the expense categories proposed for grant funding will be selected with an eye toward simplicity.

Anytime during the project grant year, if VCHCA re-budgets among the federal project budget categories or adjusts dollar amounts within a category, VCHCA will seek prior approval from HRSA if the change(s) fall(s) above an established HRSA threshold for reporting such change(s).

VCHCA's accounting department will identify all expenditures of Section 330 federal grant funds and will follow HRSA requirements described in 45 CFR 75 Subpart E, and as such, will be accounted for separately.

In accounting for grant funds, the accounting department will ensure adequate records are maintained for all grant awards including the Health Center Program to identify the source (receipt) and application (expenditure) of funds associated with every grant funding source separately and in aggregate. Revenues and expenditures not associated by a funding source will be separately identifiable. Every federal award has its own GL account as there is no commingling of funds. The total revenue or expenditures of grant funded line items may be equal to or less than the grand total of all revenue or expenses for those line items, but shall never exceed the grand total.

VCHCA will document that any non-grant funds generated from the Health Center Program project activities, in excess of what is necessary to support the HRSA-approved total project budget, were utilized to further the objectives of the project by benefiting the current or proposed patient population and were not utilized for purposes that are specifically prohibited by HRSA.

VCHCA will ensure that any fixed assets purchased with federal funds are appropriately recorded and used for the approved purchase. Under no circumstances shall federal funds be used for restricted activities, including but not limited to the purchase of sterile needles or syringes for the hypodermic injection of any illegal drug.

Grant Reporting and Auditing:

The County Auditor-Controller's office is responsible for ensuring that all grant funds are expended in accordance with specific grant requirements and regulations and is responsible for ensuring that fiscal and programmatic reporting requirements are followed. Departments are encouraged to contact the accounting department to receive guidance in report preparations and to obtain on-line information or reports necessary to preparing required reports. The reports will be maintained by the accounting department for review by auditors, grantor representatives, and other agencies. Reports will be approved by the CHC Board of Directors as required and appropriate. The CHC Board should also approve any amendments that would increase or decrease the overall grant budget or changes that would change the gran period or alter programmatic requirements.

Financial reports will be maintained until all audits have been accepted by the grantor for three fiscal years, or

for such other length as is specified by the grantor. All grants are subject to periodic review by the accounting department, CFO, representative of the grantor, or by VCHCA external auditors. The accounting department will have grant files and supporting documentation available for annual audit. Any audit finding and/or questioned costs resulting from an audit will require a written Corrective Action Plan to the Board of Directors and the grantor, if required by the grantor.

The HRSA Section 330 grant will be applied for at the discretion of the CHC Board of Directors. VCHCA must submit a comprehensive budget to the HRSA Bureau of Primary Health Care (BPHC) that outlines how the funds will be spent. This application is usually due to HRSA 120 days prior to the start of the grant period. Each different grant applied through this process will have specific budgets that follow required formats.

On an annual basis, all grants are summarized on and reconciled to the general ledger. General ledger (GL) accounts are labeled explicitly by CFDA title (or other grant ID if not a federal grant) and number.

Federal Financial Report (FFR):

At the conclusion of the HRSA grant period, VCHCA is required to submit a Federal Financial Report (SF-425) that determines how VCHCA spent the funds. If VCHCA did not spend all of the federal funds as outlined in the grant award, VCHCA may be required to refund any unobligated balance to HRSA. The CFO will submit the report within the reporting deadline communicated in the grant requirements.

In the event the agency anticipates that all the funding cannot be spent during the project period, a request for a "carryover" may be filed within grant deadline requirements for consideration by HRSA. A "carryover" situation should be avoided through ongoing communication by accounting with the appropriate grant department(s) and VCHCA senior management.

The FFR summarizes the drawdowns of federal dollars for each quarter. VCHCA will complete the report according to the Payment Management System (PMS) requirements and due dates. The CFO must approve completion and submission of the report.

Uniform Data System (UDS) Report:

VCHCA will submit the Uniform Data System report by February 15 of each year, or according to other required submission date(s) as dictated by HRSA. VCHCA will complete the report based on HRSA instructions. On an annual basis, a summary report of the prior calendar year's activities, as reflected by the UDS report, will be presented to the CHC Board of Directors.

Annual Independent Audit:

VCHCA will arrange for an independent annual financial audit of its fiscal year according to Government Auditing Standards and the OMNI Circular. If the health center expends $750,000 or more in award funds from all federal sources during its fiscal year, it will ensure a single or program-specific audit is conducted and submitted no later than nine (9) months following the end of the fiscal year in accordance with the provisions of 45 CFR Part 75, Subpart F. It will strive to demonstrate corrective actions have been taken to address all findings, questioned costs, reportable conditions, and material weaknesses cited in the previous report, if applicable.

Federal HRSA Section 330 Grant Funds Drawdowns:

VCHCA ensures federal funds are not drawn down until they have been spent. VCHCA draws down its HRSA grant funding ratably; accordingly, 1/12 of the base funding is drawn each month. Reimbursement for additional awards, such as Quality Improvement, Expansion, or other earmarked funding is drawn only after payments for services have been made by VCHCA. This ensures goods and services funded via HRSA have met all the County of Ventura's requirements for procurement, receipt, implementation, and supporting documentation prior to payments.

Supporting documentation for the base grant as well as for earmarked funding is retained as support for grant funds drawn and can be readily reconciled to the supporting accounting schedules. Said schedules will identify each grant by name and ID number, grant period, transaction date, description, transaction number, draw amount, award amount, and remaining grant balance. Multiple Section 330 grants are further broken down by sub-program codes.

Only designated parties are permitted to authorize expenses and draw funds for grants. A minimum of two levels of approval are required for grant-related expenditures.

Allowability of Costs:

Internal controls ensure funds are only drawn for allowable expenses in accordance with 45 CFR 75.420-477. To be allowable under a federal award, costs must be reasonable, allocable and adequately documented. A cost is reasonable if it does not exceed what a prudent person would incur under similar circumstances. A cost is allocable to a federal award to the extent the goods or services benefited the program. A cost is adequately documented if it is supported by accounting records and source documentation such as purchase orders, invoices, payroll reports, etc.

Non-federal Grants:

On a monthly basis, any non-federal grant revenue is calculated on a related schedule utilizing the relevant expense details used to calculate the grant revenue based on the terms of the grant. The revenue is then recorded in the general ledger.

Receipt of Federal Funds:

Federal grant funds are received from each granting agency via wire transfer to the Ventura County Auditor-Controller's department. Funds can be traced from the Payment Management System (PMS) to the County's bank account as VCHCA cannot maintain separate bank accounts.
A reconciliation between GL revenues and expenditures to PMS drawdowns is performed on a regular basis.

All revision dates:

Attachments

No Attachments

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Origination:	*N/A*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*N/A*
Owner:	*Lizeth Barretto: Ambulatory Care, Staff Services Manager*
Policy Area:	*Ambulatory Care - Administrative*
References:	*HRSA Compliance Manual*

AC.08 Credentialing and Privileging

Policy:

It is the policy of the Ventura County Health Care Agency (VCHCA) Community Health Center (CHC) that all licensed independent practitioners (LIPs), other licensed or certified practitioners (OLCPs), and other clinical staff providing services on behalf of the health centers who are employees, individual contractors, locum tenens, or volunteers of the County of Ventura or an affiliated clinic will be subject to a credentialing process. Individuals will be credentialed at the time of initial appointment and updated every two (2) years thereafter for re-appointment.

Purpose:

To help ensure the safest care to the patients of the VCHCA and meet the standards set by the Bureau of Primary Care (BPHC) Health Resources and Services Administration (HRSA) Compliance Manual.

Procedure:

All LIPs must have credentialing privileges approved by both the Ventura County Board of Supervisors and the CHC Board of Directors. CHC Credentialing is a multi-step process. All qualified applicants will receive an application for medical staff membership and/or clinical privileges.

Credentialing LIPs and Allied Health Professionals

Initial:

All LIPs and allied health professionals, including but not limited to, physicians, dentists, nurse practitioners, physician assistants, and psychologists with or without supervision within the scope of their license and privileges will be primary source credentialed by the VCHCA credentialing staff prior to initial appointment and every two (2) years thereafter. All Practitioners will utilize Ventura County Medical Center (VCMC) application and approved privileging forms.

The following documentation will be required as part of the application (as applicable):

- Professional license
- Medical Education training
- Board certification
- Curriculum vitae (CV)

- Drug Enforcement Administration (DEA) registration number
- National Provider Identifier (NPI) number
- Government-issued picture identification (driver's license or passport)
- Social Security number
- Hospital affiliation and professional work history
- Verification of fitness for duty, immunization, and communicable disease status
- Peer references

Credentialing staff will perform primary source verification of current licensure, certifications, education, training, and current clinical competence through peer reference verifications and prior affiliations. Credentialing staff will also query the National Practitioner Data Bank (NPDB), Office of the Inspector General (OIG), and EPLS/SAMA for exclusions on each CHC practitioner.

Verification of fitness will be completed by self-attestation, peer references, or, if deemed necessary by professional evaluation as determined by the CHC Medical Director. Practitioners will also complete a request for delineation of privileges.

In addition, practitioners must comply with the VCMC Employee Health policy requirements and provide a copy of the following:

- Hepatitis B vaccination
- PPD test and any other medical documentation required by the Employee Health policy
- Life support training (CPR, ACLS, PALS per requested privileges)
- Proof of malpractice coverage for practitioners employed by contractual organizations

Completed credentialing reports will be reviewed by the CHC Medical Director, whose recommendations will be submitted to the CHC Board for approval. All practitioner credentialing files will be securely maintained in the Medical Staff Services Department at VCMC. The content of the file is protected under California Evidence Code 1157.

Applicants will be notified in writing of the Board of Supervisors and CHC Board of Directors' decision to approve privileges.

Re-appointment:

After initial credentialing, re-appointment will occur every two (2) years. LIPs, allied health professionals and OLCPs will be primary source verified by the credentialing staff with the most current copy of any credentials as they are renewed. An NPDB query will also be performed. Each practitioner will provide peer references for the two (2) year performance period, and/or any relevant performance information, and a delineation of privileges form to the VCMC Medical Director and credentialing staff. Upon approval by the Board of Supervisors, the CHC Medical Director will make recommendations to the CHC Board of Directors for re-appointment and privileging. Those not maintaining appropriate credentials will be released from employment.

Privileging:

The CHC Medical Director will submit to the CHC Board of Directors a credentialing report of all practitioner initial and two-year re-appointments for review. The CHC Board will decide whether to approve and grant privileges for practitioners to provide health care services within the CHC. The Board, together with the VCMC and CHC Medical Directors, may deny, modify, or remove privileges based on assessments of clinical competence and/or fitness for duty.

Appeals Process:

In the event of an adverse privileging decision (denied, revoked, or limited), LIPs are entitled to the hearing and appellate review process outlined in the Medical Staff Bylaws. Allied Health professionals will be afforded procedural rights under the Medical Staff Bylaws. OLCPs may appeal an adverse decision in writing to the VCMC Medical Director, who will review the relevant documents and make a recommendation to the CHC Board of Directors. The CHC Board will review the documents and recommendation, and make a final determination on the appeal. Any denials, modifications, or removal of privileges will be communicated in writing.

Issuance of Temporary Privileges:

Temporary privileges may be granted in accordance with Joint Commission (TJC) and HRSA standards for up to 120 days to fulfill an urgent patient care need. The credentialing process must be completed and the available information must support, with reasonable certainty, a favorable determination regarding the applicant's qualifications, ability, and judgment to exercise the privileges requested. VCHCA does not grant temporary privileges for administrative purposes only.

In the event the CHC Board is unable to approve privileges due to a lack of a quorum at a monthly meeting or other unforeseen circumstance, the CHC Medical Director, Executive Committee of the CHC Board of Directors and CHC Executive Director may issue privileges on a temporary basis.

Credentialing Other Licensed and/or Certified Personnel (OLPs)

Initial:

Other licensed and/or certified clinical personnel (OLCPs) which include, but are not limited to, registered nurses (RNs), licensed practical nurses (LPNs), registered dieticians (RDs), licensed clinical social workers (LCSWs), and Certified Medical Assistants (CMAs) will be credentialed upon employment and at a minimum every two (2) years, unless license or certification is for a shorter period of time.

Documents required, as applicable:

- Copy of license or certification (primary source credentialing)
- Education/training
- Supervisory evaluation per job description
- Competency tests
- Resume
- Government-issued identification
- Social Security number
- Hepatitis B vaccination
- PPD test and any other medical documentation required by the Employee Health policy
- Life support training (CPR)
- NPDB query

Re-appointment:

OLCPs will be reviewed every two (2) years or sooner as appropriate by Human Resources staff. Supervisory

evaluation will assess verification of competence. An NPDB query will also be performed, including partner or sub-recipient positions that are reimbursed for by HRSA funding.

All revision dates:

Attachments

No Attachments

VENTURA COUNTY
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Origination:	*N/A*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*9/28/2023*
Owner:	*Lizeth Barretto: Ambulatory Care, Staff Services Manager*
Policy Area:	*Ambulatory Care - Administrative*
References:	*HRSA Compliance Manual*

AC.03 Coverage for Medical Emergencies During and After Hours

POLICY:

Ventura County Health Care Agency Ambulatory Care assures continuity of required primary health care services of each health center by promptly responding to patient medical emergencies both during, and after, the health centers' regularly scheduled hours.

Ventura County Health Care Agency (VCHCA) Ambulatory Care, all Federally Qualified Health Centers (FQHC) providers and non-FQHC clinics has established a process for patients to receive clinical advice when the health center is closed, and delegation and monitoring of contractor performance with regard to compliance with HRSA program requirements in accordance with the Bureau of Primary Health Care (BPHC) HRSA Health Center Compliance Manual Chapter 7 and *Section 330(b)(1)(A)(IV) and Section 330(k)(3)(A) of the PHS Act; and 42 CFR 51c.102(h)(4), 42 CFR 56.102(l)(4), 42 CFR 51c.303(a), and 42 CFR 56.303(a).*

PROCEDURE:

Definitions:

- Health Resources and Services Administration (HRSA) – The primary federal agency for improving health and achieving health equity through access to quality services, a skilled health workforce, and innovative programs.
- Federally Qualified Health Center (FQHC) – Includes all organizations receiving grants under Section 330 of the Public Health Service Act that qualify for enhanced reimbursement from Medicare and Medicaid.
- Community Health Center (CHC) – The collective primary clinics subject to the HRSA grant requirements.
- FQHC Provider – Licensed Independent Practitioner (LIP) employed or contracted to provide clinical services at any of the County of Ventura's Federally Qualified Health Centers collectively known as the Community Health Center (CH).

Coverage During Health Center Hours

1. The health center has at least one staff member trained and certified in basic life support present at each HRSA-approved service site during the health center's regularly scheduled hours of operation.

2. In the event of any emergency, licensed staff will follow its applicable operating procedures when responding to medical emergencies, including but not limited to, the following:

- determine the need for resuscitation efforts and administer CPR if warranted
- determine the need to call 911
- remain with the patient and follow the instructions of EMS personnel, if applicable
- if applicable, communicate case information directly with EMS staff upon their arrival
- complete an internal Incident Report and submit it through the proper channels
- document the electronic medical record
- ensure a follow-up visit is performed

Coverage After Health Center Hours

Extended Hours:

1. Each FQHC location will offer clearly defined arrangements for promptly responding to patient medical emergencies. All FQHCs have the capability of referring patients to a local urgent care site if medically indicated. Extended hours may be offered early a.m., evenings or weekends.
2. Each FQHC location will post the clinic hours and after hours information at the clinic for the public to see.
3. The hours and after hours information for the CHC shall be accessible to the public through posting on the VCHCA website.

After-Hours Telephone Access:

1. When the health center is closed, phone lines are transferred to a contracted answering service vendor each time a patient calls. FQHC providers are responsible for offering professional after-hours coverage and for ensuring that the contracted vendor has current provider call schedules and current contact information. The Health Care for the Homeless Clinic and some non-FQHCs provide a recorded message after hours directing callers to either urgent care or emergency room locations.
2. When life-threatening emergency situations are identified patients are instructed to call 911 or go to the nearest emergency room. The after hour access answering service and/or the provider on call should make reasonable attempts to find out which hospital the patient is being transported to. Subsequently, a call may be placed to the facility, when appropriate, and report of the emergency situation and disposition is made to their personal clinician the following day.
3. Non-life threatening situations: Calls received by the after-hours answering service that are determined appropriate for a provider call back using the triage criteria and decision-support tools should be immediately forwarded to the on call provider. Calls placed to the on call provider should include patient demographic (name, date of birth, telephone number), personal clinician, and clinical symptom information that is necessary to locate the patient's electronic health record for review.
4. On call providers are expected to contact patients within a reasonable time frame after receiving the call to provide clinical advice as needed. Clinical advice provided is documented in the clinical record at the time of the call.
5. The answering service records the time each call is received, the time the call is closed, and the disposition of the call (e.g., instructed to go the ER or time the provider was contacted, etc.). Each FQHC has access to documentation of after-hours calls and provides any necessary follow-up resulting from such calls for the purposes of continuity of care.

After-Hours Access - Secure Messaging

Patients may seek and access health center providers and other care team members using the patient portal. On call providers monitor messages submitted after hours and interact with patients when clinically indicated.

Clinical advice provided is documented in the clinical record at the time it is provided. Messages not requiring an after-hours provider response (request for appointment, medication refill request, etc.) are responded to the following business day by health center staff. The patient portal is not a twenty-four hour response system and is not appropriate for emergencies.

All revision dates:

Attachments

No Attachments

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Last Approved:	*N/A*
Last Revised:	*N/A*
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Owner:	*Lizeth Barretto: Ambulatory Care, Staff Services Manager*
Policy Area:	*Ambulatory Care - Administrative*
References:	*HRSA Compliance Manual*

AC.07 Ambulatory Care Contracts and Sub-awards

POLICY:

To establish a process for Ventura County Health Care Agency (HCA) Ambulatory Care to monitor and track Ambulatory Care clinic and FQHC provider contractor performance. In compliance with HRSA program requirements in accordance with **45 CFR Part 75 – Subpart D Post Federal Award Requirements:** The recipient's performance should be measured in a way that will help the HHS awarding agency and other non-Federal entities to improve program outcomes, share lessons learned, and spread the adoption of promising practices. The HHS awarding agency should provide recipients with clear performance goals, indicators, and milestones as described in §75.210.

PROCEDURE:

Definitions:

- Health Resources and Services Administration (HRSA) – The primary federal agency for improving health and achieving health equity through access to quality services, a skilled health workforce, and innovative programs.
- Federally Qualified Health Center (FQHC) – Includes all organizations receiving grants under Section 330 of the Public Health Service Act that qualify for enhanced reimbursement from Medicare and Medicaid.
- Community Health Center (CHC) – The collective primary clinics subject to the HRSA grant requirements.
- Environment of care (EOC) rounds – Mock survey event to ensure regulatory compliance and readiness.
- Uniform Data System (UDS) –. A standardized reporting system that provides consistent information about health centers. This report is submitted annually to HRSA by the CHC.

Procurement

The health center is governed by the written procurement policies and procedures of the Ventura County Purchasing Department. The Purchasing department maintains procurement records for both competitive and non-competitive purchases, including but not limited to, the rationale for method of procurement, selection of contract type, contract selection or rejection, and the basis for the contract price. The Purchasing department also ensures that any real or apparent conflicts of interest are disclosed.

Fiscal

The Fiscal department ensures that all procurement costs directly attributable to a Federal award are allowable. They also maintain procurement records for items paid in whole or in part by Federal funds for a minimum of three (3) years from the date of the final expenditures report. These records include, but are not limited to, payment records, supporting documentation, related statistical records, and grant tracking.

Monitoring and Management

The health center will determine if an award will be carried out through a contract or a sub-award. Any sub-awards will first require approval from HRSA. The health center contracts must: a) specify the activities or services to be performed or goods to be provided; b) address mechanisms to monitor contractor performance; and (c) include requirements for the contractor to meet all Federal programmatic and financial reporting requirements, address record retention and record access, audit provisions, and property management.

Contractor performance will be monitored through regular EOC rounds, regular review and analysis of UDS measures, and review of required monthly productivity reports.

All FQHC staff will participate in regular training to ensure compliance with HRSA program requirements.

All revision dates:

Attachments

No Attachments