Migrant Health Program Primary Care Effectiveness Review

BPHC BUREAU OF PRIMARY HEALTH CARE

POLICY INFORMATION NOTICE

98-07

Date: March 6, 1998

Document Title: Migrant Health Program Primary Care Effectiveness Review

To: Migrant Health Programs

Enclosed is the Primary Care Effectiveness (PCER) protocol for Migrant Health Programs (MHP). These are programs which are unlike traditional Migrant Health Centers (MHC) in that they are generally in areas where the numbers and/or density of farmworkers cannot justify the establishment of a MHC. These programs often arrange or contract for services for farmworkers through local health care resources. Because of the differences between the traditional health center model and the MHP model, an adaptation of the Bureau's PCER protocol was undertaken.

The Migrant Health Voucher Program Guidance, PIN 94-7 should also be used as a reference guide during the review process. We would like to acknowledge the work of members of the MHP working group and in particular the work of Dr. Ben Duggar, with the Center for Health Policy Studies, in the development of the enclosed protocol.

If you have any questions about this guidance, please contact Jack Egan, Acting Director, Migrant Health Branch, Division of Community and Migrant Health, telephone (301) 594-4303.

Sincerely yours,

Marilyn H. Gaston, M.D.
Assistant Surgeon General
Associate Administrator
Director

Enclosure

March, 1998

MIGRANT HEALTH PROGRAM
PRIMARY CARE EFFECTIVENESS REVIEW
SPECIAL INSTRUCTIONS

A Primary Care Effectiveness Review (PCER) is a comprehensive onsite performance review protocol to support continuous quality improvements for all Bureau of Primary Health Care (BPHC) services delivery grantees. In addition to its intended use as part of the competitive renewal grant application review process, the PCER should serve as a useful tool for service delivery grantees to identify opportunities for improvements, needs for technical assistance, and for conducting periodic self-assessments of their operations. The PCER reviews elements of the clinical and administrative systems of a grantee which are either required by law, regulation or program expectations, or recommended as good practice.

The PCER for a Migrant Health Program is similar in intent to that for Migrant Health Centers (MHCs), although the content has been modified to reflect the differing level of expectations and requirements. Migrant Health Programs are not required to meet the same regulations for governance as do MHCs, for example. Migrant Health Programs may be housed within larger organizations, may be very small in size, operate on a minimal budget for only a few months each year, and have few paid staff. Migrant Health Programs may contract state-wide for services, or may serve a well defined and limited geographic area. Similarly, arrangements with service delivery providers may vary widely, thus leading to differences in acceptable practices for "credentialling" those with whom the Migrant Health Program contracts. The PCER site visit protocol and instruments for MHCs include five modules, while the PCER for Migrant Health Programs include only four (the modules for Administration and Governance have been combined). However, the goals and the general protocols for conducting the PCER are the same, and those individuals participating in a PCER should review the Introduction and General Instructions included in Policy Information Notice 95-26, issued July 13, 1995. Each program should be evaluated on effectiveness of required client services, given the challenges of seasonal jumps in patient numbers; seasonal staff that have to be trained in a short period of time and the inherent challenges of providing care to a mobile population.

The opening meeting with the Migrant Health Program (MHP) staff should be used, in part, to allow the staff to outline the local situation and how it has impacted on operations. For example, there may be only one physician in the community willing to see migrants, and if this physician chooses to limit the number of referrals seen, the MHP may be forced to rely more heavily on the local hospital outpatient department than would be the case in a community with a larger more responsive supply of physicians. Because not all such situations can be anticipated, the PCER team

must evaluate how well the program has recognized and solved operational problems within the context of the local environment. This will require flexibility in the application of the PCER instrument, good judgment, and common sense by the review team. What is reasonable to expect from a program with a half million dollar per year budget and five full time staff may be unreasonable for a program with $100,000 per year budget and no full time year round staff. In general, programs have fewer year round staff, therefore some may not have the specialized staff that traditional MHCs may have. Reviewers are encouraged to consider what is feasible, given the size of the program and the local environment, and to judge achievement against that standard.

As an example of the need for flexibility, consider the issue of credentialling of physicians. Primary source verification of licenses, board certifications, malpractice insurance coverage, and history of sanctions or other adverse actions would be appropriate before contracting for capitated services with a physician in a network model HMO. However, the MHP is not an insurance program and does not contract with the patient or the employer to guarantee the provision of a fixed benefit package. Many MHPs merely facilitate access to locally available health care resources and may or may not agree to provide some level of reimbursement to certain service providers under certain circumstances, depending on funding availability. Sending four patients a year to a provider, and reimbursing that provider a total of $80 per year would not warrant a full credentialling. What then is reasonable? To protect the patient there should be some assurance that the provider to which the MHP refers a patient is operating within his or her competence and license. Alternatives for meeting this requirement will vary, and reviewers will need to judge what the MHP has done against what is reasonable and feasible for that MHP operating in that environment.

Although the PCER instrument represents a standardized protocol, it should be applied with Migrant Health Programs in a flexible manner. The standard criteria for judging each element will be whether the MHP has done what is reasonable, given the circumstances. Opportunities for feasible improvements should be pointed out, as should inappropriate or inadequate operations. The experience which PCER team members bring may be of great value to the MHP being reviewed, and the members are urged to share their observations and ideas for improvements with MHP staff. The challenge to the team will be to determine whether or not the MHP being reviewed represents the best that BPHC can support to serve this population at this time in this community and, if not, how can and should the MHP operations be improved.

MIGRANT HEALTH PROGRAM
PRIMARY CARE
EFFECTIVENESS REVIEW

Reviewer's Manual
for

ADMINISTRATION

Migrant Health Program Grantee: _____

Date of Review: _____

Reviewer's Signature: _____

March, 1998

PRIMARY CARE EFFECTIVENESS REVIEW
MIGRANT HEALTH PROGRAM
ADMINISTRATION PROTOCOL

TABLE OF CONTENTS

MIGRANT HEALTH PROGRAM
PRIMARY CARE EFFECTIVENESS REVIEW
ADMINISTRATIVE PROTOCOL

I. INTRODUCTION TO ADMINISTRATIVE PROTOCOL

The reviewer should refer to the Introduction and General Instructions for conduct of a PCER (BPHC Policy Information Notice 95-26), and to the special instructions for adapting the PCER for use with a Migrant Health Program (programs which do not follow the traditional medical clinic model and which are often referred to as "voucher" programs). The Migrant Health Program (MHP) PCER is only to be used if the grantee does not directly provides through its employees a significant proportion of the medical and/or dental services delivered to migrant and seasonal farmworkers and members of their families (MSFWs), but does assumes some degree of financial responsibility when referring patients to local health care providers. Because a MHP may differ radically from a Migrant Health Center (MHC), it will be helpful if the reviewer is familiar with the concepts and special requirements and rules described in "Migrant Health Voucher Program Guidance", Policy Information Notice 94-7. The Administrative Protocol is one of four review documents designed for use in conducting a primary care effectiveness review of elements of MHPs which are either ***required*** by law, regulation or program expectations, or ***recommended*** as good practice. The reviewer is reminded to work closely with other reviewers since areas of review involve overlap and the perspectives of other team members are relevant to constructing an overall impression of the program.

NOTE: The program expectations and much of the conceptualization of administrative structures at Section 329 grantees generally assume that these are community based health centers. Many MHPs are operated by community based organizations (CBOs), but some are not. When reviewing programs which are housed in county or state health departments some of the questions, especially those which relate to institutional policies and procedures which may be set in local statute or regulation, may be difficult or impossible to address and should be noted as "N/A" (not applicable) on the instrument.

In order to best utilize on-site time, certain documents should be reviewed prior to the visit.

- Notice of Grant Award for past three years
- Grant application - background section

Additional documents will be available at the time of the visit including:

- Organizational chart
- Grant application - current
- Staff listing: name, title, date of hire
- Wage and salary structure
- Mission statement
- Bylaws
- Administrative policy and procedures manual
- Staff orientation procedures
- Provider profile (nursing and midlevel employed staff and for principle contract providers)
- Affirmative action policy
- Community and user characteristics
- Recent TA reports (optional)
- Job descriptions
- Personnel policies
- Personnel files
- Fringe benefits

- Performance appraisals
- Lists of contracts and leases
- Provider contract files
- Hours of operation by month (many voucher programs operate only during the agricultural season)
- Floor plans/space plans for all buildings regularly used for voucher program operations (do not include space donated by local hospital or other provider)
- Insurance policies
- Staff meeting minutes
- Strategic plan
- Licenses and certifications
- Capital improvement plan and budget
- Comparability of pay analyses
- Incident reports/claims history

II. CORPORATE ORGANIZATION AND STRUCTURE

1. Is there evidence that the most recent copies of the articles of incorporation and bylaws have been sent to the Regional Office for the Institutional File?

   Yes ___ No ___

   SOURCES/NOTES _____

   _____

2. Is there a process to ensure that licenses are current?

   Yes ___ No ___

   SOURCES/NOTES _____

   _____

3. If any laboratory testing is performed by the MHP, is there evidence to show that laboratories (both contract and onsite) are appropriately certified under the CLIA regulations?

   Yes ___ No ___

   SOURCES/NOTES _____

   _____

4. Is there evidence that the organization is in compliance with OSHA regulations?

   Yes ___ No ___

   SOURCES/NOTES _____

   _____

5. Is the BPHC funded organization a part of a larger organization, such as a local or state health department or a multi-service community based organization?

Part of a public agency?	Yes ___	No ___
Part of a larger organization?	Yes ___	No ___
Have a separate executive director?	Yes ___	No ___

- *If yes,* does the MHP director have full responsibility or appropriate control over both the day-to-day operations of the MHP and the budget approved in the BPHC/HRSA grant?

  Yes ___ No ___

- Is there a Migrant Advisory Council or similar entity for assuring consumer input into the periodic review and revision of program policies and procedures?

  Yes ___ No ___

SOURCES/NOTES _____

_____

6. Does the organizational chart:
   a) Show either all positions or all critical positions in the MHP?

      Yes ___ No ___

   b) Identify clear lines of authority for all staff, programs, and departments reporting directly or indirectly to the MHP director?

      Yes ___ No ___

SOURCES/NOTES _____

_____

7. Are the clinical staff and clinical director (whether on-staff or through contract) adequately involved in the management of the program?

   Yes ___ No ___

SOURCES/NOTES _____

_____

8. *In large organizations, such as health departments or multi-service organizations,*

   a) Does the organizational chart show clear lines of authority and the relationships between the programs and between the programs and the overall corporation or governmental entity?

      Yes ___ No ___

b) Is there a secondary level of supervision of services and programs?

Yes ___ No ___

c) Is there evidence of appropriate systems (e.g., internal referral or case management) for facilitating interaction between separate programs or departments to ensure the effective delivery of multiple services to patients?

___ Programs and departments fully integrated
___ Some integrative systems in place
___ Little or no integration in place

SOURCES/NOTES _____

_____

d) Is there a system in place to manage and coordinate operations among sites (e.g., centralization of key staff positions, MIS, medical records, clinical director, etc.)?

Yes ___ No ___

SOURCES/NOTES _____

_____

III. COMMUNICATION AND COLLABORATION

1. Does a structure exist which promotes communications and interaction between:

	YES	NO
Staff and contract clinicians and administrators?		
Staff clinicians and board?		
Staff clinicians and support staff?		
Administrators and the board?		
Administrators and support staff?		

SOURCES/NOTES _____

_____

1. Do employees have the opportunity to define problems? Do they participate in solving problems?

Define problems? Yes ___ No ___
Solve problems? Yes ___ No ___

SOURCES/NOTES _____

_____

2. Do those who must implement policies and procedures have input into shaping them?

Yes ___ No ___

SOURCES/NOTES _____

_____

3. Is there a mechanism for assuring that solutions for identified problems are implemented? Are implemented solutions evaluated to determine whether or not the problems are successfully resolved?

Implement solutions? Yes ___ No ___
Evaluate solutions? Yes ___ No ___

SOURCES/NOTES _____

_____

4. *As appropriate to its size,* is there evidence of a top management "team" that meets at least monthly (during the preseason preparation, during the season, and at least once post-season for seasonal programs) to coordinate services and interaction between programs, to communicate critical information, and to alert one another of problems and opportunities? Alternatively, is this done some other way?

Yes ___ No ___

SOURCES/NOTES _____

_____

5. *As appropriate to its size,* is there evidence that middle management staff meets regularly and by this and other means communicates effectively with top management?

Yes ___ No ___

SOURCES/NOTES _____

_____

6. Is the organization developing a "team management" approach at all levels?

Yes ___ No ___

SOURCES/NOTES _____

_____

IV. STRATEGIC AND SHORT TERM PLANNING

1. Are key administrative personnel familiar with the local health care environment and its likely impact on the MHP operations? (e.g., competition and changing supply of primary care providers, hospitals and clinics, and pharmacies, may either reduce or increase the ability of the MHP to negotiate referral arrangements at favorable prices)

   Yes ___ No ___

   SOURCES/NOTES _____

   _____

2. Is there a strategic planning process in place at the MHP, as required?

   Yes ___ No ___

   If yes:

   a) Does it include an environmental analysis including health services marketplace changes, an areawide perspective on the changing numbers of MSFWs and periods during which migrants are present?

      Yes ___ No ___

   b) Does it include an analysis of the other sources of services for MSFWs and their respective roles?

      Yes ___ No ___

   c) Does it include a reassessment of this organization's mission?

      Yes ___ No ___

   d) Is there a specific assessment of future demand for MHP services, including vouchered services, and alternatives for meeting this demand?

      Yes ___ No ___

   e) Is there a specific assessment of future demand for enabling services (e.g., transportation, outreach, interpreter)?

      Yes ___ No ___

   f) Is there a plan for capacity needs in 3 years for:

Medical/dental/pharmacy services?	Yes ___	No ___
Enabling services?	Yes ___	No ___
Staffing?	Yes ___	No ___
Facilities?	Yes ___	No ___
Equipment?	Yes ___	No ___

      If yes, are these plans written?

      Yes ___ No ___

   g) Is there evidence to show that the capital plan fits the organization's needs?

      Yes ___ No ___

h) Is there evidence of Board (Migrant Advisory Council) involvement and approval in the planning process?

Yes ___ No ___

i) Is the staff generally aware of goals and objectives of the plan? Interview sample of three employees. Use worksheet attached as guide to employee interviews. Record numbers below.

Yes ___ No ___

j) Is the plan periodically reviewed and adjusted *as required*?

Yes ___ No ___ Latest review date: ___/___/___

k) Is there a plan in place for reviewing annual plans?

Yes ___ No ___

If no:

a) Has there been discussion at the Board (Migrant Advisory Council) regarding strategic planning - - the process, how to get started, commitment, etc.?

Yes ___ No ___

b) What has precluded the Board (Migrant Advisory Council) from initiating the strategic planning process?

SOURCES/NOTES _____

_____

3. Are budgets developed as part of the annual, strategic and capital plans?

Annual plan?	Yes ___	No ___
Strategic?	Yes ___	No ___
Capital?	Yes ___	No ___

SOURCES/NOTES _____

_____

4. Have the 1992 Total Budget Amendments and BPHC's relaxation of the total budget concept been considered or used in planning or budgeting?

Competitive salary adjustments	Considered ___ Used ___
Minor renovations	Considered ___ Used ___
Reserve	Considered ___ Used ___
Short term interest	Considered ___ Used ___
Other	Considered ___ Used ___

SOURCES/NOTES _____

_____

5. Is the organization reasonably prepared for changes in the competitive environment and opportunities for negotiating as the result of managed care growth and, if not, does it have a reasonable plan for getting prepared?

Contracting with physicians/clinics	Yes ___	No ___
Contracting with pharmacies	Yes ___	No ___
Contracting with dentists and other providers	Yes ___	No ___

SOURCES/NOTES _____

_____

V. PERSONNEL POLICIES AND PROCEDURES

V.A. Personnel Manual

1. Are all the elements listed below included in the Personnel Policies and Procedures Manual and readily identifiable? (check all those included)

___ Maintenance of the policy and procedure system
___ ADA
___ Equal employment opportunity/non-discrimination
___ Affirmative action plan
___ Employment status
___ Hours of employment and overtime rules
___ Compensation schedules
___ Fringe benefits and leave
___ Staff development
___ Orientation of new employees
___ Initial probation period (if any)
___ Extension of probation (if permitted)
___ Standards of conduct
___ Conflict of interest
___ Sexual harassment
___ Restrictions on outside employment
___ Personnel records
___ Performance evaluations
___ Disciplinary procedures, actions, and appeals
___ Severance pay
___ Employee grievances
___ Nepotism
___ Drug free workplace notification
___ Impaired health workers
___ Staff development

(services coordinator model programs may not require testing and vaccinations appropriate for clinical personnel)

___ HBV vaccination
___ TB testing
___ Post exposure follow-up
___ HIV testing

SOURCES/NOTES _____

_____

2. Is the manual sufficiently detailed to inform an employee of his or her rights and responsibilities?

Yes ___ No ___

3. Is the manual sufficiently detailed to protect the voucher program in employee disputes over rules?

Yes ___ No ___

SOURCES/NOTES _____

_____

4. When was the manual most recently reviewed and/or updated? Who was responsible for the review? What evidence of the review is available in writing?

Manual updated within last year	Yes ___	No ___
Reviewed by member of management team	Yes ___	No ___
Evidence of review in writing	Yes ___	No ___
Signed	Yes ___	No ___
Dated	Yes ___	No ___

SOURCES/NOTES _____

_____

5. Have employees received copies of the personnel manual and copies of updates to the manual? Interview sample of three employees. Use worksheet attached at end of protocol as guide to employee interviews. Record numbers below.

Manual received	Yes ___	No ___
Updates received	Yes ___	No ___

SOURCES/NOTES _____

_____

6. Are there separate policies for different groups of employees? Are the policy differences and the individuals to whom they apply clearly documented?

Separate policies	Yes ___	No ___
Differences clear	Yes ___	No ___
Applicability clear	Yes ___	No ___

SOURCES/NOTES _____

_____

V.B. Job Descriptions

1. Are there written job descriptions for the CEO, CFO, and Medical Director, *as required?*
   Yes ___ No ___

SOURCES/NOTES _____

_____

Are job descriptions written in a standard format that includes all critical information about the position?

Physical capacity	Yes ___	No ___
Scope of work responsibilities	Yes ___	No ___
Education/training	Yes ___	No ___
Supervision	Yes ___	No ___
Impact of error	Yes ___	No ___
Where work is done	Yes ___	No ___

SOURCES/NOTES _____

_____

2. Do written job descriptions include the following information?

Job title	Yes ___	No ___
Place of employment (if relevant)	Yes ___	No ___
Salary information	Yes ___	No ___
Qualifications, as appropriate, including:		
Education, including degrees	Yes ___	No ___
Work experience	Yes ___	No ___
Licenses or certifications	Yes ___	No ___
Skills	Yes ___	No ___
Language requirements	Yes ___	No ___
Cultural experience	Yes ___	No ___
Responsibilities	Yes ___	No ___
To whom position reports	Yes ___	No ___
Who (if anyone) position will supervise	Yes ___	No ___
Physical requirements (ADA required)	Yes ___	No ___

SOURCES/NOTES _____

_____

3. Is a file with all current job descriptions maintained in a centralized place?
   Yes ___ No ___

SOURCES/NOTES _____

_____

4. Are employees expected to sign file copies of job descriptions, or is there other evidence that employees received a copy of their job description?

Sign? Yes ___ No ___
Other? Yes ___ No ___

SOURCES/NOTES _____

_____

5. Can employees describe their job in terms that are consistent with the job description? Interview sample of three employees. Use worksheet attached at end of protocol as guide to employee interviews. Record number below.

Sample: # Yes ___ # No ___

SOURCES/NOTES _____

_____

V.C. Performance Evaluations

1. Do policies call for written, signed, and dated evaluations of all employees by a supervisor at a stipulated point in time, at least annually *as required?*

Yes ___ No ___

SOURCES/NOTES _____

_____

2. Is a standard form used to evaluate comparable employees?

Always ___ Sometimes ___ Rarely ___

SOURCES/NOTES _____

_____

Does the evaluation process require employees to sign evaluations to certify that they have received a copy and have had an opportunity to discuss the evaluation, whether or not they concurred with the findings?

Yes ___ No ___

a) Do supervisors sign the performance evaluation to certify they have discussed findings with employee?

Employee signature Yes ___ No ___
Supervisor signature Yes ___ No ___

b) Is the performance appraisal reviewed and signed by the second level supervisor?

Yes ___ No ___

SOURCES/NOTES _____

_____

3. Do employees have the right to submit a written comment with their evaluation, which will be filed with their evaluation as a part of their personnel file? Do they have the right to appeal their evaluation?

Right to comment? Yes ___ No ___
Right to appeal? Yes ___ No ___

SOURCES/NOTES _____

_____

V.D. Personnel Files

1. Review a sample of five files and note number which includes the following items. If information is kept in separate file, do not sample but check for existence of file.

Item Checked	Number Present	Number Absent	Kept in Separate File
*W-4 form, if not kept separately	____	____	____
*I-9 (for all hired after 10/1/88)	____	____	____
Most recent job description	____	____	____
Completed employment application form or resume	____	____	____
*Position or salary changes	____	____	____
Disciplinary communications	____	____	____
Replies to disciplinary communications	____	____	____
Performance evaluations	____	____	____
Replies to performance evaluations	____	____	____
Employee signature on performance evaluations	____	____	____
Evidence employee meets job description requirements	____	____	____
*Accrued vacation, if not kept separately	____	____	____
*Accured sick leave, if not kept separately	____	____	____
Evidence of:			
Employment references	____	____	____
Professional education references	____	____	____
Additional position-specific items such as:			
Continuing education records	____	____	____
Current licenses and certifications	____	____	____
Auto insurance verification, if necessary	____	____	____
Employment contract	____	____	____
Items applicable only if program directly provides health services:			
Malpractice insurance	____	____	____
DEA registration	____	____	____

Evidence of National Pract. Data Bank inquiry	____	____	____
Life support training	____	____	____
Definition of privileges	____	____	____
Current contracts	____	____	____
NP/PA/CNM Supervision agreements	____	____	____

* indicates items frequently kept in a separate place

If specific information is not in files, identify on the list above and comment separately if it is believed that these items should be added to the standard personnel files.

SOURCES/NOTES _____

_____

2. Do terminated employee files include the following? Review sample of three terminated personnel files and record results below:

Items	Number Present	Number Absent	Total
Termination action forms	____	____	____
Evidence of exit interviews	____	____	____
Evidence of compliance with COBRA insur. requirements	____	____	____
Evidence of action on pension plan, if appropriate	____	____	____

SOURCES/NOTES _____

_____

3. Are personnel files maintained in a secure, centralized or appropriate site-specific area with restricted access and rules on availability and release of information?

Yes ___ No ___

SOURCES/NOTES _____

_____

4. Are personnel files maintained in a reasonably standard format to facilitate the routine location of materials?

Yes ___ No ___

SOURCES/NOTES _____

_____

V.E. Compensation Comparability

Note: Because many MHPs operate seasonally with most staff only employed for a few months each year, compensation comparability may be impossible to determine. In such cases the MHP should have other written justification for compensation levels.

1. Are compensation comparability surveys conducted periodically to determine the going rates for comparable positions nationally, in the local area, or both? When was the last survey done?

Survey conducted? Yes ___ No ___ Date of last survey: ___/___/___

SOURCES/NOTES _____

_____

2. Is the program's employee compensation schedule and benefits package comparable to the competition?

Yes ___ No ___

If compensation is lower at the MHP, does this hamper its ability to hire and retain competent employees?

Always ___ Sometimes ___ Never ___

If this is negatively affecting staff turnover, have reasonable plans been established to deal with the lack of comparability?

Yes ___ No ___

SOURCES/NOTES _____

_____

V.F. Recruitment and Retention

1. Is there an ongoing process of anticipating and addressing the organization's provider recruitment and retention needs?

Yes ___ No ___

SOURCES/NOTES _____

_____

2. Has there been input into this process from providers, administrators, and the Board?

Yes ___ No ___

SOURCES/NOTES _____

_____

3. Based on retention and timeliness of filling vacancies, does the provider recruitment and retention plan appear to be effective?

Yes ___ No ___

SOURCES/NOTES _____

_____

4. Is regular attention given to retention and recruitment of all key administrative positions?

Yes ___ No ___

SOURCES/NOTES _____

_____

5. Based on retention and timeliness of filling vacancies, does the administrative recruitment and retention plan appear to be reasonable?

Yes ___ No ___

SOURCES/NOTES _____

_____

VI. RISK MANAGEMENT AND LIABILITY PROTECTION

1. If the MHP employs clinical staff who directly deliver health services has it been "deemed" eligible for FTCA professional liability coverages?

Yes ___ No ___

2. *If yes,* are changes in coverage supported by cost benefit analyses and, if so, have the changes in coverage been implemented?

Cost benefit from FTCA	Yes ___	No ___
Coverage changes made	Yes ___	No ___

SOURCES/NOTES _____

_____

3. Does the organization have the following insurance coverage? (check policies)

	Yes	No	Expiration Date
Corporate liability	___	___	_____
General liability	___	___	_____
Motor vehicles:			
Program vehicles	___	___	_____
Employee vehicles	___	___	_____
Natural disasters	___	___	_____
Fidelity bonding	___	___	_____
Directors and officers	___	___	_____

SOURCES/NOTES _____

_____

4. Is a written procedure in place to ensure timely reporting and tracking of all incidents or potential risks (both medical and non-medical) which could lead to exposure and loss?

Yes ___ No ___

SOURCES/NOTES _____

_____

5. Are incidents analyzed for patterns which suggest a need for system change?

Yes ___ No ___

SOURCES/NOTES _____

_____

6. Have patterns been used to improve adequacy or reduced risks?

Yes ___ No ___

SOURCES/NOTES _____

_____

7. Do staff members indicate awareness of the incident policy and the need for timely reporting? Interview sample of three employees using worksheet at end of protocol. Record numbers below:

SOURCES/NOTES _____

_____

8. Are there named individuals with responsibility for tracking and reporting all reportable incidents?

Yes ___ No ___

SOURCES/NOTES _____

_____

9. Are facilities inspected at least annually for fire and safety risks?

Yes ___ No ___

SOURCES/NOTES _____

_____

10. Is there evidence of disaster and/or fire drills occurring at least annually?

Yes ___ No ___

SOURCES/NOTES _____

_____

11. Has the corporation obtained an independent review of the adequacy of its insurance coverage and risk management?

Yes ___ No ___

SOURCES/NOTES _____

_____

VII. NETWORKING, COLLABORATING, AND LINKAGES

1. Does the organization have current signed contracts or memoranda of understanding with private providers and health service organizations for providing services to program patients?

Community health centers	Yes ___	No ___
Private physician (solo or group)	Yes ___	No ___
Hospital outpatient dept.	Yes ___	No ___
Health departments	Yes ___	No ___
Dentists	Yes ___	No ___
Pharmacies	Yes ___	No ___
Other (specify): _____		

SOURCES/NOTES _____

_____

2. Are contractors routinely evaluated to assure compliance with terms of the agreements?

Yes ___ No ___

SOURCES/NOTES _____

_____

3. Does the voucher program staff participate in local or regional coordinating committees, task forces, provider councils, or other similar groups?

Many ___ Some ___ Few ___ None ___

SOURCES/NOTES _____

_____

4. Has the organization established linkages with:

Type of Organization	Yes	No
County medical society	___	___
County dental society	___	___
Managed care/integrated systems networks	___	___
Local hospital	___	___
CHCs in same or contiguous areas	___	___
Health department	___	___
WIC	___	___
Migrant Head Start	___	___
Migrant Education	___	___
JPTA agency	___	___
Medicaid eligibility determination agency	___	___
Other (specify): _____		

SOURCES/NOTES _____

_____

5. Does the organization have a contract management process in place to review the potential for obtaining more favorable rates, recompeting, or renewal of existing contracts annually in advance of the agricultural season?

Yes ___ No ___

SOURCES/NOTES _____

_____

6. Has the organization developed any affiliations with health professional training programs or institutions as a means of obtaining supplemental staff during the seasonal influx of migrants? Are the effects of the additional short term staff on space, operating costs, and patient volume reasonable?

Affiliations developed	Yes ___	No ___
Provides supplemental staff	Yes ___	No ___
Space requirements met	Yes ___	No ___
Operating costs reasonable	Yes ___	No ___
Favorable effects on patient volume	Yes ___	No ___
Favorable effects on services provided to existing patients	Yes ___	No ___

SOURCES/NOTES _____

_____

7. Does the MHP collaborate with other organizations working with or serving migrant farmworkers?

Yes ___ No ___ Not Applicable ___

8. Does the MHP collaborate with other organizations which:

Work with or serve migrant and/or seasonal farmworkers?	Yes __	No __	Not Applicable __
Serve low income populations in need of perinatal services?	Yes __	No __	Not Applicable __
Serving low income populations in need of pediatric services?	Yes __	No __	Not Applicable __
Provide health education, outreach through lay health workers?	Yes __	No __	Not Applicable __

SOURCES/NOTES _____

_____

VIII. FACILITY

Clinical reviewers may be asked to complete this section for some of the sites in a multisite organization.

VIII.A. Access

1. Is the facility readily accessible to its target populations?

Geographic location	Yes ___	No ___
Culture, as appropriate	Yes ___	No ___
Bilingual staff, as appropriate	Yes ___	No ___
Availability of transportation	Yes ___	No ___
Other (specify): _____		

SOURCES/NOTES _____

_____

2. Is there adequate parking for both employees and MHP users?

Yes ___ No ___

SOURCES/NOTES _____

_____

3. Are there signs clearly posted in all appropriate languages indicating that no eligible farmworkers will be denied services based solely on their lack of income and indicating that a sliding fee or co-payment schedule is available?

Yes ___ No ___

SOURCES/NOTES _____

_____

4. Are separate clinic sessions, clinical space, waiting areas, or sites made for some groups of patients, such as adolescents, all residents of a labor camp, etc.? If so, are these arrangements appropriate?

Yes ___ No ___

SOURCES/NOTES _____

_____

5. When a patient is referred with a voucher to a local provider, are arrangements also made for:

Transportation to the provider's office	Yes ___	No ___
Interpreter services during the visit	Yes ___	No ___
Patient education to promote compliance	Yes ___	No ___
Follow-up if a return visit is needed	Yes ___	No ___

SOURCES/NOTES _____

_____

6. When a patient is referred with a voucher to a local primary care physician, what are the average waiting times to be seen for:

An acute condition
___ Immediate
___ Within 24 hours
___ Longer than 24 hours

An OB/GYN routine checkup
___ Immediate
___ Within 24 hours
___ Longer than 24 hours

SOURCES/NOTES _____

_____

7. Has the MHP had to turn away patients because of a shortfall in available funds for vouchers?

Yes ___ No ___

SOURCES/NOTES _____

_____

8. Is external and internal signage clear, consistent, and posted in all appropriate languages?

Yes ___ No ___

SOURCES/NOTES _____

_____

9. Is the facility in compliance with Section 504 (Rehabilitation Act of 1973) provisions for handicap access including, but not limited to the following? (check if present)

___ Clearly marked entrance ramps
___ Corridor width adequate for wheel chairs
___ Elevators in multi-storied buildings that have been appropriately modified
___ Toilets which can accommodate the handicapped
___ Handicapped parking spaces
___ TTD communication entry or translation for deaf

SOURCES/NOTES _____

_____

10. Does the facility comply with the new requirements of the Americans with Disabilities Act (ADA)? *If not,* has it been determined what needs to be done to comply?

Complies	Yes ___	No ___
Needed corrections identified	Yes ___	No ___

If corrections needed, can the cost of complying with ADA be covered? If not, is there a plan for achieving compliance (describe below).

Yes ___ No ___

SOURCES/NOTES _____

_____

11. Does the waiting area have culturally appropriate health promotion/disease prevention material, such as magazines, pamphlets, tapes, VCR and other sources?

Yes ___ No ___

SOURCES/NOTES _____

_____

12. Have specific referral providers been identified who have facilities which meet handicapped requirements?

Yes ___ No ___

SOURCES/NOTES _____

_____

VIII.B. SAFETY AND MAINTENANCE

1. Have appropriate steps been taken to assure the safety of property, staff, and patients?

   Yes ___ No ___

   SOURCES/NOTES _____

   _____

2. Is the exterior of the facility, including all buildings and grounds, clean and well maintained?

   Yes ___ No ___

   SOURCES/NOTES _____

   _____

   Is the interior of the facility clean, well-maintained, pleasant and suitable for the number of staff and patients?

   Yes ___ No ___

   SOURCES/NOTES _____

   _____

3. Are the MHP facility exits and escape routes clearly marked? Is the facility in compliance with fire and safety codes as demonstrated by certificates from the local fire marshall on file in the program office *as required*?

   Exits clearly marked? All ___ Some ___ Few/None ___
   Certification on file? Yes ___ No ___

   SOURCES/NOTES _____

   _____

4. Does the facility comply with the requirements for hazardous waste disposal?

   Yes ___ No ___

   SOURCES/NOTES _____

   _____

5. Are adequate accommodations made for patients to limit exposure to contagious illness, such as separate waiting areas, isolation rooms, ultraviolet lights, etc.?

   Yes ___ No ___

SOURCES/NOTES _____

_____

6. Is there evidence of routine TB testing for all program employees, volunteers, and other appropriate individuals with patient contact?

Yes ___ No ___

SOURCES/NOTES _____

_____

7. Is there evidence of education regarding infection control/universal precautions for all program employees, volunteers, et al.?

Yes ___ No ___

SOURCES/NOTES _____

_____

8. Are there appropriate supplies available to support universal precautions?

Yes ___ No ___

SOURCES/NOTES _____

_____

VIII.C. Efficiency

1. Is the patient flow smooth?

Entrance, check-in, and waiting	Yes ___	No ___	Not applicable ___
Centrally located nursing station	Yes ___	No ___	Not applicable ___
Convenient phlebotomy/lab.	Yes ___	No ___	Not applicable ___
Patient bathroom(s) with pass-through to lab.	Yes ___	No ___	Not applicable ___
Adequate exam. rooms for # providers	Yes ___	No ___	Not applicable ___
Provider conf. room(s) for meeting with patients/families	Yes ___	No ___	Not applicable ___
Pick up voucher, cashier, and exit	Yes ___	No ___	Not applicable ___

SOURCES/NOTES _____

_____

2. Does the space provide adequate privacy and confidentiality in the following areas:

Registration/intake	Yes ___	No ___	Not applicable ___
Pick-up voucher, cashier, check-out	Yes ___	No ___	Not applicable ___
Exam/treatment room	Yes ___	No ___	Not applicable ___
Consult room	Yes ___	No ___	Not applicable ___
Lab/ancillary services	Yes ___	No ___	Not applicable ___

SOURCES/NOTES _____

_____

3. Is there a children's activity room or another way to keep children occupied without disturbing adult patients in the waiting area?

Yes ___ No ___

SOURCES/NOTES _____

_____

4. Is there adequate space for family conferences with providers, health education classes, and large group meetings?

Family conferences	Yes ___	No ___	
Health education classes	Yes ___	No ___	Not applicable ___
Large group meetings	Yes ___	No ___	Not applicable ___

SOURCES/NOTES _____

_____

5. Is the overall quantity and layout of space adequate? Note indications for this appraisal such as personal observations, staff interviews, floor or space plans, exam rooms per provider, space ratios and other indications.

Space adequate	Yes ___	No ___
Layout adequate	Yes ___	No ___

SOURCES/NOTES _____

_____

IX. EMPLOYEE INTERVIEW WORKSHEET

Area of compliance (list position of interviewee below)	1	2	3	4	5
Received copy of pers. manual or notified of review policies					
Routinely provided with policy manual updates					
General awareness of strategic plans					

Positions of interviewees:

1. _____
2. _____
3. _____
4. _____
5. _____

PRIMARY CARE EFFECTIVENESS REVIEW
MIGRANT HEALTH PROGRAM
MANAGEMENT INFORMATION SYSTEMS PROTOCOL

TABLE OF CONTENTS

MIGRANT HEALTH PROGRAM
PRIMARY CARE
EFFECTIVENESS REVIEW

Reviewer's Manual
for

MANAGEMENT INFORMATION SYSTEMS

Migrant Health Program Grantee: _____

Date of Review: _____

Reviewer's Signature: _____

March, 1998

MIGRANT HEALTH PROGRAM
PRIMARY CARE EFFECTIVENESS REVIEW
MANAGEMENT INFORMATION SYSTEMS PROTOCOL

I. INTRODUCTION TO MANAGEMENT INFORMATION SYSTEMS PROTOCOL

The reviewer should refer to the Introduction and General Instructions for conducting a Primary Care Effectiveness Review (PCER), as described in BPHC Policy Information Notice 95-26, to obtain a general familiarity with the PCER concepts. Use of the PCER has been adapted for a Migrant Health Program (programs which do not follow the traditional medical clinic model) and special instructions for this application are described in the Introduction and Special Instructions to the present manual. Migrant Health Programs depend on local health care resources often, but not always, reimbursed through issuance of vouchers or through contracts to meet many or all of the medical and dental health care needs of migrant farmworkers. Because a Migrant Health Program (MHP) may differ radically from a Migrant Health Center (MHC), it will be helpful if the reviewer is familiar with the concepts and requirements described in the "Migrant Health Voucher Program Guidance", Policy Information Notice 94-7.

The Management Information Systems (MIS) Protocol is one of four review documents designed for use in conducting a primary care effectiveness review of elements of MHPs which are either ***required*** by law, regulation or program expectations, or ***recommended*** as good practice. Each member of a PCER review team is reminded to work closely with the other reviewers, since areas of review involve overlap and the perspectives of other team members are relevant to constructing an overall impression of the program.

In order to best utilize on-site time, certain documents should be reviewed prior to the visit.

- Notice of Grant Award for past three years
- Grant application - background section
- BHCDANET report
- UDS report - most recent

Additional documents will be available at the time of the visit including:

- Organizational chart
- Grant application - current
- MIS policies and procedures
- Sample of patient records
- Information Systems support contracts - hardware, software, and data processing services
- Regularly issued MIS reports
- Copies of voucher/referral forms, daily log sheets, encounter forms, and other data collection forms

II. UDS PROCESS AND DATA VERIFICATION

II.A. Users

1. Is a system in place that provides annual unduplicated counts of users (using BPHC guidelines)?

Note: Although all C/MHCs must unduplicate users among service sites, some MHPs cover entire states and subcontract with multiple organizations to provide widely dispersed service sites. Further, some farmworkers may migrate within state to work different crops, continuing to utilize the MHP but

through different entry points. Therefore, it has been determined that MHPs need not unduplicate counts across those service sites which serve distinctly separate agricultural areas, and for which separate medical records would be opened for the same individual if seen by the MHP in each.

Medical	Yes ___	No ___	
Dental	Yes ___	No ___	N/A ___

SOURCES/NOTES _____

_____

2. Are current-year users readily identifiable in the patient charts, routine reports, or through a field in the MIS automated files?

Medical	Yes ___	No ___	
Dental	Yes ___	No ___	N/A ___

SOURCES/NOTES _____

_____

3. Can the MHPs counts of users be verified in reports or other documents? Are all of the users counted?

Medical	Yes ___	No ___	
Dental	Yes ___	No ___	N/A ___

SOURCES/NOTES _____

_____

4. Review the MHP's definitions for eligible individuals, are they consistent with BPHC criteria?

Seasonal Farm Workers and Family Members	Yes ___	No ___
Migrant Farm Workers and Family Members	Yes ___	No ___

SOURCES/NOTES _____

_____

5. *If users can be traced to individuals:* N/A ___

a) Can a sample of users selected by the reviewer be verified by reviewing charts? (use a sample of 25 records for medical and dental users)

Medical users	Yes ___	No ___
Dental users	Yes ___	No ___

b) Can a sample of users selected from daily logs, appointment log, or encounter forms be verified on the MIS listing of users counted? (use a sample of 25 records for medical and dental)

Medical users	Yes ___	No ___
Dental users	Yes ___	No ___

c) Do the tests indicate that user data are accurately reported? If "no", fully explain in notes.

Yes ___ No ___

SOURCES/NOTES _____

_____

II.B. Encounters

1. Is a system in place that accurately captures and counts the number of encounters provided at the MHP or at off site locations? Does it capture all encounters? Are encounters attributed to the correct provider classification based on who provided the preponderance of services or who had primary responsibility for the visit? When a nurse or midlevel at the MHP provides services independently, is the encounter counted separately from a subsequent off site referral encounter?

System exists	Yes ___	No ___
Captures all encounters	Yes ___	No ___
Correctly attributes	Yes ___	No ___
Correct separation of nurse or midlevel independent encounters	Yes ___	No ___

SOURCES/NOTES _____

_____

2. Can MHP staff identify the current year's encounters from reports or from the MIS?

Yes ___ No ___

SOURCES/NOTES _____

_____

3. Can encounters reported on UDS Table 5 be traced to these reports or other documents?

Yes ___ No ___

SOURCES/NOTES _____

_____

4. *If encounters can be traced to individuals:* N/A ___

a) Can a random sample of 25 encounters be verified by reviewing charts?

Yes ___ No ___

b) Can a random sample of 25 visits from daily logs, encounter forms and/or vouchers be traced to the UDS count?

Yes ___ No ___

SOURCES/NOTES _____

_____

III. SYSTEM DESCRIPTION

Is the MHP's MIS:

MANUAL ___ (Complete Section III.A.)

AUTOMATED ___ (Complete Section III.B.)

MIXED ___ (Complete both Sections)

III.A. Manual Systems

1. Briefly describe the MHP's manual MIS system, including function(s) and person(s) responsible for its overall operation:

SOURCES/NOTES _____

_____

_____

_____

_____

2. Is the system adequate to provide all needed information?

Yes ___ No ___

If no, can the manual system be improved sufficiently or is a new, automated system necessary or economically appropriate?

IMPROVABLE ___ AUTOMATE ___

SOURCES/NOTES _____

_____

III.B. Automated Systems

1. Briefly describe the MHP's automated MIS, including function(s) and person(s) responsible for its overall operation:

SOURCES/NOTES _____

_____

_____

_____

_____

2. Are written policies and procedures in place that cover:

Data entry	Yes ___	No ___
Data editing	Yes ___	No ___
Data backup	Yes ___	No ___
System security	Yes ___	No ___
Physical protection	Yes ___	No ___

SOURCES/NOTES _____

_____

3. a) Does the system allow for a reasonable level of security?

Yes ___ No ___

b) Is access to the system controlled by passwords?

Yes ___ No ___

If yes, are passwords changed at least at the start of each season?

Yes ___ No ___

c) Are appropriate limitations to changes in data restricted to persons with a high security level?

Yes ___ No ___

SOURCES/NOTES _____

_____

4. Back-up system:

   a) How often are back-ups performed?

      Total system _____

      Data only _____

      If less than weekly, is back-up adequate? Yes ___ No ___

   b) Are back-ups stored in appropriate locations? Yes ___ No ___

   c) How long are back-ups maintained? Period: _____

   d) Are back-ups periodically verified?

      Yes ___ No ___

   SOURCES/NOTES _____

   _____

5. Do system users feel that there are enough terminals, or do they express the need for more?

   ENOUGH ___ NEED MORE ___

   After viewing the system, does the reviewer feel that there are enough terminals for efficient operation of the system?

   Yes ___ No ___

   SOURCES/NOTES _____

   _____

6. Is there sufficient hard disk space for the next 24 months?

   Yes ___ No ___

   If no, what plans for expansion have been made? Plans: _____

   SOURCES/NOTES _____

   _____

7. How often are data purged from the system?

Patient information _____
Transaction data _____
Appointment/Schedule data _____

SOURCES/NOTES _____

_____

8. Are at least 36 months of transaction data available? *If no*, how many months?

Yes ___ No ___

Number of months normally maintained _____

SOURCES/NOTES _____

_____

9. Are arrangements in place for hardware maintenance?

Yes ___ No ___

If no, how is servicing provided? _____

SOURCES/NOTES _____

_____

10. Have problems with current hardware caused disruptions significant enough to impact the operation of the MHP?

Yes ___ No ___

SOURCES/NOTES _____

_____

11. If software problems occur, from whom is support obtained? _____

SOURCES/NOTES _____

_____

12. Have problems with current software caused disruptions significant enough to impact the operation of the MHP?

Yes ___ No ___

SOURCES/NOTES _____

_____

13. Is vendor support considered adequate, given the current environment?

Yes ___ No ___

SOURCES/NOTES _____

_____

14. Is system documentation current and up-to-date? *If not,* is this a problem with the vendor?

Yes ___ No ___

SOURCES/NOTES _____

_____

IV. SYSTEM FLEXIBILITY / VERSATILITY

1. Evaluate system flexibility and versatility. Can the following modifications to the system be made? Can system modifications be done in-house or do changes require outside support? Can modifications be accomplished in a timely manner?

		Flexibility and Versatility			
Selected Modifications	**Example**	**In-house**	**Outside support**	**Timely**	**Not timely**
Reclassifying existing variables	Alter current categories in existing variables (e.g., country of origin) to add new ones (e.g., Haiti) or to group data differently.				
Cross-tabulating new variables	Cross tabulate existing demo. variables (e.g., language, sex, class of pay, etc.) to look for a subgroup (e.g., those from Mexico with non-working family members present)				
	Cross tabulate existing services variables (e.g., type visit, diagnosis, referral, etc.) to look at new relationships or to select data for a given subgroup (e.g., brief visits, skin rash, prescription voucher, etc.)				
	Cross-tabulate existing demographic variables with exiting service variables to look at new relationships or to select data from a given subgroup.				
Adding new variables	Add new demographic variables (e.g., collect both Mexican and U.S. SSNs).				
	Add new service variable (e.g., number of revisits preauthorized).				

SOURCES/NOTES _____

_____

2. Is there an internal MIS user group (consisting of both end users of information, such as MHP providers and management team, as well as data operators)? *If so,* who is involved?

Yes ___ No ___

SOURCES/NOTES _____

_____

3. Does the reviewer feel that the system is sufficiently flexible to deal with the MHP's current and future data needs?

Current? Yes ___ No ___
Future? Yes ___ No ___

SOURCES/NOTES _____

_____

V. COLLECTION OF CRITICAL INFORMATION

V.A. Patient-based Data

1. Are demographic data collected on all new patients entering the system?

Yes ___ No ___

SOURCES/NOTES _____

_____

2. Are the data screened to verify their accuracy and completeness?

Yes ___ No ___

SOURCES/NOTES _____

_____

3. Is a system in place to satisfactorily identify and correct incomplete or inaccurate data?

Identify Yes ___ No ___
Correct Yes ___ No ___

SOURCES/NOTES _____

_____

4. Is a process in place for updating these data when necessary?

Yes ___ No ___

If yes, when are the data updated?

Describe process: _____

Is this done for all users or for all in the subgroup?

Yes ___ No ___

SOURCES/NOTES _____

_____

5. Given the size and complexity of the MHP and the demand for data, does the reviewer feel that the data collected are adequate?

Yes ___ No ___

If no, what additional data should the MHP be collecting? _____

SOURCES/NOTES _____

_____

V.B. Billing Data

1. Are service data collected on all encounters provided to users?

Yes ___ No ___

If yes, describe below who is responsible for collecting the data for encounters at the MHP, at a referral provider's office, at the migrant's home or camp, and at a work site?

SOURCES/NOTES _____

_____

_____

2. Are the data routinely screened to verify accuracy and completeness?

Yes ___ No ___

If yes, who is responsible for verification? _____

SOURCES/NOTES _____

_____

3. Are the encounter data maintained in a computerized system?

Yes ___ No ___

If yes, can data in the system be related to other MIS data?

Yes ___ No ___

SOURCES/NOTES _____

_____

4. Are encounters, issued vouchers and returned vouchers entered into the system by close of business the following working day?

Encounters	Yes ___	No ___
Issued vouchers	Yes ___	No ___
Returned vouchers	Yes ___	No ___

If no, how many days in arrears is data entry? _____

SOURCES/NOTES _____

_____

5. Given the size and complexity of the MHP and the demand for data, does the reviewer feel that the data collected are adequate?

Yes ___ No ___

If no, what additional data should the health center be collecting? _____

SOURCES/NOTES _____

_____

_____

V.C. Utilization Data

1. Does the MIS collect data that permit the total service history of a single patient to be readily reviewed?

   Yes ___ No ___

   SOURCES/NOTES _____

   _____

2. Are "other" health encounters (e.g., outreach, promotora, case management) routinely captured by the MIS?

   Yes ___ No ___

   SOURCES/NOTES _____

   _____

3. Does the MIS collect data that permit a review of utilization by persons described by a set of given characteristics (e.g., women 18-40 years of age with a diagnosis of diabetes)?

   Yes ___ No ___

   SOURCES/NOTES _____

   _____

4. *If yes,* are such data collected routinely for all types of patients, place of visit and sources of payment?

   Yes ___ No ___ NA ___

   If no, which are excluded? _____

   SOURCES/NOTES _____

   _____

V.D. Productivity Data

1. Are data collected which would help to determine the productivity of each credentialed health professional employed by the MHP?

   Yes ___ No ___ N/A ___

   SOURCES/NOTES _____

   _____

2. Are weighted productivity measures available in addition to the encounter data required by BPHC (e.g., RBRVS, other RVUs or charges)?

Yes ___ No ___ N/A ___

SOURCES/NOTES _____

_____

3. Are data collected which would help determine the productivity of all providers, including ancillary and support service providers, outreach workers, etc.?

Yes ___ No ___

If no, who is excluded? _____

SOURCES/NOTES _____

_____

V.E. Voucher Specific Fiscal Information

1. Are issued vouchers not yet returned tracked to provide estimates of potential fiscal liability?

Yes ___ No ___ NA ___

SOURCES/NOTES _____

_____

2. When a voucher is issued, is an estimated cost entered into the MIS (manual or automated), and is this amount updated if authorization is extended to additional visits/services? Is the actual charge when the voucher is returned compared with the updated estimate, and any discrepancy flagged for resolution?

Yes ___ No ___

If no for any part of the question, explain below how voucher payments are budgeted and controlled.

SOURCES/NOTES _____

_____

3. Are returned vouchers examined for completeness of the information on the services provided, diagnoses, prescriptions, and follow-up or continuing care requirements? Are these items entered into an MIS (automated or manual) for UDS and for outreach/case management scheduling?

Yes ___ No ___

SOURCES/NOTES _____

_____

VI. COMPILATION AND REPORTING OF DATA

VI.A. Patient-based Data

1. Are data on user volume and demographics regularly compiled and reported to MHP decision makers?

   Yes ___ No ___ (go to Section VI.B.)

   If yes, do data compilations extend beyond the age-sex data and number of encounters reported in Tables 3 and 5 of the UDS?

   Yes ___ No ___

   If yes, please describe: _____

   SOURCES/NOTES _____

   _____

2. How often and under what circumstances are these or other demographic data reported to MHP decision makers?

   Frequency: _____

   Circumstances: _____

   SOURCES/NOTES _____

   _____

3. Other than BPHC and other funding sources, who receives data on the demographics and volume of use of the MHP services, and do they consider the reports to be timely?

MHP top management staff	Yes ___	No ___	Timely ___	N/A ___
Governing board (if applic.)	Yes ___	No ___	Timely ___	N/A ___
Advisory board (if applic.)	Yes ___	No ___	Timely ___	N/A ___
Clinical staff (if applic.)	Yes ___	No ___	Timely ___	N/A ___
Outreach staff	Yes ___	No ___	Timely ___	N/A ___
Other _____	Yes ___	No ___	Timely ___	N/A ___

   SOURCES/NOTES _____

   _____

   _____

4. Based on the review of reports, does it appear to the reviewer that the MHP is receiving adequate demographic data for reporting, planning, evaluating, outreach and marketing needs?

Reporting	Yes ___	No ___	N/A ___
Planning	Yes ___	No ___	N/A ___
Evaluating	Yes ___	No ___	N/A ___
Outreach	Yes ___	No ___	N/A ___
Marketing	Yes ___	No ___	N/A ___

SOURCES/NOTES _____

_____

5. Are reports prepared to permit an analysis of trends, comparing the most recent month and YTD to that of the prior months and/or the same month the year prior and prior YTD?

Yes ___ No ___

SOURCES/NOTES _____

_____

VI.B. Service-based Data

1. Are the data on services provided to users regularly compiled and reported to decision makers?

Yes ___ No ___ (go to Section VI.C.)

If yes, do data compilations extend beyond the encounter data for Table 5 of the UDS?

Yes ___ No ___

SOURCES/NOTES _____

_____

2. Other than BPHC and other funding sources, who receives data on the services provided to the MHP's users, and do they consider the reports to be timely?

MHP top management staff	Yes ___	No ___	Timely ___	N/A ___
Governing board (if applic.)	Yes ___	No ___	Timely ___	N/A ___
Advisory board (if applic.)	Yes ___	No ___	Timely ___	N/A ___
Clinical staff (if applic.)	Yes ___	No ___	Timely ___	N/A ___
Outreach staff	Yes ___	No ___	Timely ___	N/A ___
Other _____	Yes ___	No ___	Timely ___	N/A ___

SOURCES/NOTES _____

_____

3. Do report users generally consider the reports to be an accurate reflection of the MHP's services?

Yes ___ No ___

SOURCES/NOTES _____

_____

4. Based on the review of the reports, does it appear to the reviewer that the MHP is receiving adequate service related utilization data for reporting, planning, evaluating, outreach and fee negotiating needs?

Reporting	Yes ___	No ___	N/A ___
Planning	Yes ___	No ___	N/A ___
Evaluating	Yes ___	No ___	N/A ___
Outreach	Yes ___	No ___	N/A ___
Fee negotiating	Yes ___	No ___	N/A ___

SOURCES/NOTES _____

_____

5. Are trend reports prepared comparing services utilized during the most recent month and YTD to that of the prior months and/or the same month the year prior and prior YTD?

Yes ___ No ___

SOURCES/NOTES _____

_____

VI.C. Utilization Data

1. Are reports generated that permit the MHP to determine the level of utilization (in dollars, encounters, or other variables) for either the entire user population or for special subgroups (e.g., local seasonal workers who do not migrate)?

Yes ___ No ___

SOURCES/NOTES _____

_____

2. Are trend reports prepared comparing utilization during the most recent month and YTD to that of the prior months and/or the same month the year prior and prior YTD?

Yes ___ No ___

SOURCES/NOTES _____

_____

VI.D. Productivity Data

1. Are reports generated that permit the MHP to identify the productivity levels for each provider as well as for groups of providers (e.g., a specific outreach worker and for all outreach workers, or a specific nurse practitioner and for all nurse practitioners)?

   Yes ___ No ___

   If yes,

   a) How often are productivity reports produced? _____

   b) Who receives the productivity reports? _____

   c) Are productivity levels adjusted to full-time equivalents for comparison purposes?

   Yes ___ No ___

   SOURCES/NOTES _____

   _____

2. Are trend reports prepared comparing productivity during the most recent month and YTD to that of the prior months and/or the same month the year prior and prior YTD?

   Yes ___ No ___

   SOURCES/NOTES _____

   _____

VI.E. Tracking and Recall

1. Is there an automated tracking system to follow patients by diagnosis, continuing care requirements, immunization status, etc.?

   Yes ___ No ___

   SOURCES/NOTES _____

   _____

2. Are the tracking systems designed in such a way that the MHP can modify the system and use it for a variety of purposes (e.g., recall of "at risk" patients for immunizations or periodic checks)?

   Yes ___ No ___

   SOURCES/NOTES _____

   _____

3. Does the reviewer think that the tracking and recall system is adequate for current needs?

Yes ___ No ___

SOURCES/NOTES _____

_____

VII. MIS STAFF

1. Who has primary responsibility for the MIS?

Name _____

Title _____

SOURCES/NOTES _____

_____

2. What other positions have MIS responsibilities (other than persons who do data input as a part of the front desk intake, appointment making, or which is incidental to their primary job)?

_____

3. Do any staff members have the capability to create new reports using the software's built in report generator?

Yes ___ No ___

SOURCES/NOTES _____

_____

4. Is access to source code available in the event that the vendor goes out of business?

Yes ___ No ___

SOURCES/NOTES _____

_____

5. Do any staff members have the ability to produce special reports outside of the report generator through downloading and database analysis?

Yes ___ No ___

SOURCES/NOTES _____

_____

6. Are the staff able and is the facility equipped to perform basic hardware installation and troubleshoot problems? (This includes swapping out equipment that is being replaced or is defective, as well as installing new equipment.)

Monitors	Yes ___	No ___	N/A ___
Printers	Yes ___	No ___	N/A ___
Floppy drives	Yes ___	No ___	N/A ___
Hard drives	Yes ___	No ___	N/A ___
Modems	Yes ___	No ___	N/A ___
Interfaces	Yes ___	No ___	N/A ___

SOURCES/NOTES _____

_____

7. Does the staff also have hardware responsibility (installation, upgrading, maintenance, training, etc.) for other office automation systems?

Yes ___ No ___ N/A ___

SOURCES/NOTES _____

_____

8. Does the MHP staff appear to have an adequate understanding of possible "work arounds" - ways in which information can be obtained through non-standard or routine reports?

Yes ___ No ___

SOURCES/NOTES _____

_____

9. Does the MHP staff also have software responsibility (installation, upgrading, training, support, etc.) for other office automation equipment?

Yes ___ No ___ N/A ___

If yes, for which of the following types of software is the MIS staff able to provide training and support? Support means installing software for the users' computer and printer, developing macros, and explaining and demonstrating commands. Indicate "no" if the software is used, but the MIS staff does not train or support. Indicate N/A if the software is not used in the MHP.

	Train	Support	No	N/A
Word processing	___	___	___	___
Spreadsheets	___	___	___	___
Databases	___	___	___	___
Desktop publishing	___	___	___	___
_____	___	___	___	___
_____	___	___	___	___

SOURCES/NOTES _____

_____

10. Does the reviewer feel that the MIS staff is adequate for the MHP's work needs, given the size, seasonal operations, and number of staff?

Yes ___ No ___

If no, does the MHP need more staff, or more skilled staff?

MORE STAFF _____ MORE SKILLS _____

SOURCES/NOTES _____

_____

VIII. OFFICE AUTOMATION SYSTEMS

1. Does the MHP use computer-based word processing, spread sheets, and/or databases?

Word processing	Yes ___	No ___
Spread sheet	Yes ___	No ___
Databases	Yes ___	No ___

SOURCES/NOTES _____

_____

2. Has the MHP standardized its software, or is more than one program used?

Word processing	Yes ___	No ___
Spread sheet	Yes ___	No ___
Databases	Yes ___	No ___

SOURCES/NOTES _____

_____

3. a. What type(s) of computer-based technology is available and how is it used?

_____

_____

b. Are modems available and what staff have access to use?

Yes ___ No ___

c. Does the MHP have an account with an internet access provider?

Yes ___ No ___

d. Does the MHP utilize e-mail? *If yes,* explain types of use.

Yes ___ No ___

SOURCES/NOTES _____

_____

_____

4. Does the MHP utilize the Bureau's *Access Bulletin Board* or internet web page?

Access Bulletin Board	Yes ___	No ___
Internet Web Page	Yes ___	No ___

SOURCES/NOTES _____

_____

_____

IX. OVERALL ASSESSMENT OF MANAGEMENT INFORMATION SYSTEMS

1. Based on the findings of this review, summarize your overall assessment of the MIS of the MHP. Consider the size and complexity of the MHP, needs for automated systems, effectiveness of MIS staff, the timeliness and adequacy of available information and flexibility and versatility of the MIS system.

SOURCES/NOTES _____

_____

_____

_____

_____

_____

_____

MIGRANT HEALTH PROGRAM
PRIMARY CARE
EFFECTIVENESS REVIEW

Reviewer's Manual
for

CLINICAL SYSTEMS

Migrant Health Program Grantee: _____

Date of Review: _____

Reviewer's Signature: _____

March, 1998

PRIMARY CARE EFFECTIVENESS REVIEW
MIGRANT HEALTH PROGRAM
CLINICAL PROTOCOL

TABLE OF CONTENTS

MIGRANT HEALTH PROGRAM
(non-clinic or voucher model)
PRIMARY CARE EFFECTIVENESS REVIEW
CLINICAL PROTOCOL

1. INTRODUCTION TO CLINICAL PROTOCOL

The reviewer should refer to the Introduction and General Instructions for details on conducting a Primary care Effectiveness Review (PCER) as described in Policy Information Notice 95-26. Use of the PCER as adapted for a Migrant Health Program (programs which do not follow the traditional medical clinic model) is described in the Introduction and General Instructions to the present manual, but a familiarity with the general PCER concepts will be helpful to the reviewer. Because a Migrant Health Program (MHP) may differ radically from a Migrant Health Center (MHC), it will also be helpful if the reviewer is familiar with the concepts and requirements described in the "Migrant Health Voucher Program Guidance", Policy Information Notice 94-7. The clinical systems protocol is one of four review documents which survey elements of the Migrant Health Program which are either required by law, regulation or program expectation, or recommended as good practice. The reviewer is reminded to work closely with other reviewers since areas of review involve overlap and the perspective of other team members is relevant to constructing an overall impression of the program.

In order to best utilize onsite time, certain documents should be reviewed prior to the visit.

- Notice of Grant Award for past three years
- Health care plan
- UDS, most recent, and prior UDS/BCRR for past three years
- List or description of services provided, both on-site and through referrals
- Provider profile, if applicable
- Grant Application - Clinical Plan, Clinical Program Description, and Progress Report
- Mid Year Assessment
- Any other significant correspondence and documents related to clinical issues

If the program grantee is a public agency, use whatever clinical/nursing policies, guidelines, and related documents provided. Additional documents which should be available at the time of the visit include the following (as appropriate to the professional credentials of on-site staff):

- Policies and procedures for intake, triage, and all clinical services, including on-site nursing, medical, dental, etc., off-site services provided at migrant camps, work sites, etc., referral to private physicians and dentists
- Quality improvement plan
- Quality improvement committee minutes, audits and protocols
- Principles of Practice
- Clinical Policies and Procedures for service eligibility, referral, discounts, coverage, schedules, handling of emergencies, telephone, patient grievances, safety, hazardous waste (if applicable), the handicapped, and other clinical concerns
- Sample of medical/dental records as requested by reviewer
- Sample provider contracts/agreements
- Clinical Measures Audit Report, if applicable
- Referral agreements with local providers
- Recruitment and retention plan, if applicable
- Clinical Director job description
- Perinatal care plan
- Drug formulary (if it exists)

- Evidence of health facilities compliance if on-site clinical services offered
- Ancillary service policy and procedures
- Clinical tracking system
- OSHA Bloodborne Pathogen Plan, if applicable
- Clinical protocols, as appropriate to on-site staffing
- State laws relevant to midlevel practitioners and pharmacy services delivered by MHP
- Clinical tracking logs
- Inservice training records, as appropriate to on-site staffing
- CLIA license, if applicable
- Facility license, if applicable
- Provider Personnel file, if applicable

Note that MHPs, by definition, are not classic medical model health centers. Although each represents one or more entry points into the health care system, at one extreme they may be staffed only by lay (non-clinical) personnel who check eligibility, perform a simple triage function and then formally refer migrants to local providers for care, often with a voucher which the provider accepts en lieu of payment by the migrant patient. At the other extreme the MHP may employ midlevel practitioners, or even contract physicians and dentists for short periods of time, and approach the on-site capabilities of a small MHC. In all cases the outreach, referral, and wrap-around or enabling services provided by the MHP are critical to the timely and effective receipt of care by migrants, but the clinical components may be partially or entirely the responsibility of local providers. Because of this diversity, the Clinical Systems Protocol for the Primary Care Effectiveness Review is divided into three levels within each of the sections.

The first level represents minimal requirements for all MHPs, including those with only a lay staff. The second level describes the additional expectations for MHPs that employ any licensed health professionals on-site, such as an LPN or RN, but whose services do not include the diagnosis or treatment of medical problems. The third level describes the further additions to expectations if mid-level or physician staff are employed on-site, even if only on a part-time or limited seasonal basis. Some MHPs may have all three levels present among their sites, or each level may apply to a specific site at different times of the year. In such situations the most demanding requirements applicable to the entire organization or to a specific service site should be applied by the reviewer. Reviewers dealing with such situations should consider exceptions when applying higher level requirements to sites which do not have, or during time periods of time when the site does not have, the higher level of medical capability physically present. The exceptions would be analogous to the requirements that C/MHCs have for dealing with patient inquiries or emergency needs during hours that the health center is closed.

II. PROJECT PLANNING AND TEAM COORDINATION

Level 1. Required For All Migrant Health Programs (MHPs)

1. Is there a licensed health professional designated as the clinical or medical director? (this may be a full or part-time employee, or a physician engaged on a consulting basis to provide medical director services, including participation in project planning, policy development, and quality assurance)

Yes ___ No ___

SOURCES/NOTES _____

_____

Is there a staff member familiar with the local health care environment and its likely impact on the MHP's access to local clinical resources? (e.g., competition, managed care, consolidation, health professions shortages, etc.)

Yes ___ No ___

If no, have arrangements been made to provide this type of knowledge to assist the MHP in responding to changes in the environment?

Yes ___ No ___

SOURCES/NOTES _____

_____

Level 2 and 3. Additional Expectations for MHPs Which Employ Any Licensed Health Professional(s)

1. Do the MHP clinical personnel believe that they have adequate input in the development of the MHP's strategic direction?

Yes ___ No ___

SOURCES/NOTES _____

_____

2. Do key clinical personnel feel that clinical staff are included as part of an overall team in the MHP's operations?

Yes ___ No ___

SOURCES/NOTES _____

_____

III. CLINICAL POLICIES AND PROCEDURES

III.A. MHP Operation Policies

Level 1. Requirements for All MHPs

1. Is there a procedure for orienting new clients to the MHP's services?

Yes ___ No ___

SOURCES/NOTES _____

_____

2. Do principles of practice (or operating policies and procedures) include the following:

Principles of Practice	Yes	No
Establish entry point hours that assure access and include at least one evening or weekend session per week during the period in which significant migrants are present?		
Establish appropriate policies and procedures for after-hours and weekend contacts by migrants to arrange referrals for urgent medical/dental services?		
Address telephone and walk-in triage?		
Address response to emergency medical/dental care needs?		
Define the scope of services for which the MHP will take financial responsibility, and how referrals and enabling services will be handled for clinical service needs beyond the scope financially supported by the MHP?		
Provide mechanisms to maximize continuity of care?		
Is there evidence of patient privacy during eligibility screening, consultation, and referral?		
Is confidentiality of information, records, etc. addressed?		
Do protocols allow for tracking of referred patients?		
Do protocols ensure that patient enabling service needs are assessed and offered when available?		

SOURCES/NOTES _____

_____

3. Is there a printed information notice for patients which gives the hours that the entry point is open, what to do after hours and on weekends for urgent medical/dental needs, where to go/call in an emergency, scope of services provided by/through the MHP, and an explanation of the sliding fee schedule and limitations of the MHP's financial responsibilities? Is it in language(s) appropriate to the target population?

Yes ___ No ___

SOURCES/NOTES _____

_____

Level 2 and 3. Additional Expectations for MHPs Which Employ Any Licensed Health Professional

1. Do principles of practice (or operating policies and procedures) include the following:

Principles of Practice	Yes	No
Define the scope of MHP employed health care provider practice?		
Establish provisions for privacy during examinations, treatments, and consultations		
Call for universal precautions to be routinely observed in all phases of service delivery?		
Define policies and procedures for reporting injuries and dealing with infection control?		
Define policies and procedures for handling hazardous wastes?		

SOURCES/NOTES _____

_____

III.B. Clinical Personnel Issues

Level 1. Requirements for All MHPs

1. Evaluate the role of the clinical director. Does the clinical director:

Role of Clinical Director	Yes	No
Have adequate time allocated to discharge the duties outlined in the job description? (*at a minimum for a lay staffed MHP a contracted clinical director should review clinically related policies and procedures, referral plans and agreements/contracts, referral and data collection forms prior to each season, and participate in a quality/UR assessment after each season)*		
Have a sensitivity to migrant cultural diversity to assure appropriate clinical policies and procedures?		
Have the authority, responsibility, training and experience necessary to lead any clinical staff employed by the MHP?		
Have the lead responsibility or substantive involvement in decisions concerning the initiation and/or renewal of referral agreements/contracts?		
Have responsibility for developing/implementing a UR quality management program?		

SOURCES/NOTES _____

_____

2. Are local clinicians and health care facilities with agreements or contracts with the MHP licensed in the jurisdiction in which they practice?

Yes ___ No ___

SOURCES/NOTES _____

_____

3. Does the current intake and triage staff profile adequately reflect the patients served? This includes language, age, and gender. (*Note that a small MHP entry point may have only one person to perform intake and triage - - bilingual capability would be necessary, but reflecting age and gender of patient profile would not be feasible)*

Yes ___ No ___

SOURCES/NOTES _____

_____

4. Does the intake and triage staff understand eligibility policy, fee setting policy, and policy for providing sliding fee discounts and the impact of these policies on delivery of care?

Yes ___ No ___

SOURCES/NOTES _____

_____

5. Are policies and procedures in place to assure that all uncredentialed health workers employed by the MHP are provided with appropriate training and professional supervision (e.g., promotores de salud, outreach workers, medical interpreters)?

Yes ___ No ___

SOURCES/NOTES _____

_____

Level 2 and 3. Additional Expectations for MHPs Which Employ a Licensed Health Professional(s)

1. Are clinicians employed by the MHP licensed in the jurisdiction(s) served by the MHP?

Yes ___ No ___

SOURCES/NOTES _____

_____

2. Does the initial credentialing process ensure that clinical staff, referral staff and outside contractors possess the training (including board certification, as appropriate), experience, competence and eligibility for hospital privileges required for their job description?

MHP clinical staff	Yes ____	No ____
Referral staff	Yes ____	No ____
Outside contractors	Yes ____	No ____

SOURCES/NOTES _____

_____

3. Is the credentialing process approved by the Governing Board?

Note: If the MHP is housed within a large organization, it may be sufficient to have the credentialing process approved by the Advisory Board and Medical Director. Original source verification should be carried out for those clinicians employed by the MHP, while a similar level of review as that required by other payers may be extended to those private providers serving the entire community. As noted in the Migrant Health Voucher Program Guidance, contract and referral providers should have agreements with the MHP which require prompt notification of any change in licensure or suspension of privileges.

Yes ___ No ___

SOURCES/NOTES _____

_____

4. Is a system in place for the ongoing recredentialing of clinical staff, referral staff, and outside contractors that evaluates performance and licensure and certifies capability to continue to serve on the health center staff?

MHP clinical staff	Yes ____	No ____
Referral staff	Yes ____	No ____
Outside contractors	Yes ____	No ____

SOURCES/NOTES _____

_____

5. Are supporting documents present and current in clinical staff personnel files?

Document	YES 100%	NO 0%	SOME	N.A.
Professional school diploma				
Certification of residency training, as applicable				
Hospital privileges, as applicable				
Board certification, as applicable				
Immunization status				
PPD status				
Current license				
DEA registration, as applicable				
References				
Life support training				
Continuing professional education				
HIV training				
Annual performance evaluation				
Malpractice insurance or FTCA				
National Practitioner Data Bank Inquiries, as applicable				
Definition of privileges, as applicable				
Current contract, as applicable				
Supervision agreement (mid-level providers)				

Note: All of the above apply to providers employed by the MHP, as appropriate to their job description. Private providers serving the entire community and with whom the MHP negotiates a contract or agreement will provide, as a minimum, a copy of their current license and malpractice coverage. This documentation, in combination with their current contract or agreement and records of prior year annual utilization review or other evaluations conducted by the QM committee may be all of the information that it is feasible to compile on such providers.

SOURCES/NOTES _____

_____

6. Is the MHP's clinical provider compensation and benefits package competitive for the area? *(because MHPs generally operate on a seasonal basis, it may not be feasible to judge the competitiveness of the compensation and benefits for part-time employment)*

Compensation	Yes ___	No ___
Benefits package	Yes ___	No ___
On-call schedule	Yes ___	No ___

SOURCES/NOTES _____

_____

7. Is the number and mix of clinical and support staff appropriate to the requirements for arranging or providing comprehensive primary care services for all sites and services?

Yes ___ No ___

SOURCES/NOTES _____

_____

8. Is the number and mix of referral and contract providers sufficient to meet the primary care needs of the MHP patients who cannot be served directly by on-site staff?

Yes ___ No ___

SOURCES/NOTES _____

_____

9. Have there been changes in the key clinical staff since the last site visit or Grant Application? If so, why? What has been the impact of these changes?

Yes ___ No ___

SOURCES/NOTES _____

_____

10. Has turnover among the clinical provider staff been a problem during the previous 12 months?

Yes ___ No ___

If yes, have the issues involved with turnover been addressed?

Yes ___ No ___

SOURCES/NOTES _____

_____

11. Are the amounts paid to contract and referral providers reasonable and sufficient to sustain their involvement, and are these amounts established and controlled through a suitable mechanism?

Note: Payment of Medicaid rates is always acceptable. Rates may also be based on competitive bids where there is competition. MHPs which pay full charges should document the necessity. In all cases there should be some ceiling on the liability of the MHP, while maintaining sufficient reimbursement levels to assure the MHP patients continue to have access to necessary primary care services.

Yes ___ No ___

SOURCES/NOTES _____

_____

12. Do minutes of regular staff meetings reflect problem resolution and an interdisciplinary, coordinated approach to patient care?

Yes ___ No ___

SOURCES/NOTES _____

_____

13. Over the past year has the MHP provided adequate leave and funding for continuing professional education (CPE) for all providers and other clinical support and supervisory staff employed by the MHP? (*MHPs which employ clinical personnel for only a brief seasonal period are not expected to support the same level of CPE as would those employing year round staff. However, MHPs should attempt to provide opportunities for regularly returning key staff to periodically participate in Stream Forums, Annual Migrant Conferences, and other directly relevant educational programs)*

Yes ___ No ___

SOURCES/NOTES _____

_____

15. Does the clinical staff have access to computer based literature search services such as "Grateful Med "or "Lonesome Doc", and/or is there access to local or regional medical libraries and other sources of current clinical information? (*Internet browser and file download capabilities will suffice for small MHPs, provided that staff with training in the use of this capability is available to assist clinical staff))*

Yes ___ No ___

SOURCES/NOTES _____

_____

14. Have initial and continuing education activities been provided to clinical staff in the following areas:

CPE	INITIAL	CONTINUING	NEITHER
FULL TIME, YEAR ROUND STAFF			
HIV clinical care			
HIV counseling and testing			
Mental health and family violence			
Drug abuse, identification and referral			
Alcohol abuse, identification and referral			
Quality management			
Preventive care			
Perinatal services			
Quality improvement			
Psychosocial conditions			
ALL INCLUDING PART TIME SEASONAL STAFF			
Case management			
Cultural competence			
Migrant and seasonal populations			
Other areas which target community needs			
Infectious diseases			
Immunization practice			

SOURCES/NOTES _____

_____

16. Does the clinical staff understand eligibility policy, fee setting policy, and policy for providing sliding fee discounts and the impact of these policies on delivery of care?

Yes ___ No ___

SOURCES/NOTES _____

_____

17. Are written policies and procedures in place which require that volunteer and health profession students have a current license and malpractice coverage consistent with the services which they provide through the MHP?

Yes ___ No ___

SOURCES/NOTES _____

_____

III.C. Health Professions Education Linkages

Level 1. Requirements for All MHPs - None

Note: Although there are not requirements for affiliations with health professions education institutions by MHPs, these could be beneficial to all levels of programs and to their patients. If such exist, the reviewer should note such affiliations by level 1 MHPs under the section for levels 2 & 3.

Level 2 and 3. Expectations for MHPs Which Employ Any Licensed Health Professional

1. Has the MHP developed any affiliations with health professions training institutions? Do the affiliations appear to enhance recruitment, particularly for seasonal staffing? Do the affiliations positively affect patient care and is the implementation appropriate?

Affiliations	Yes ___	No ___	N/A ___
Enhance recruitment	Yes ___	No ___	N/A ___
Affect patient care	Yes ___	No ___	N/A ___
If yes,			
Accessibility and availability	Yes ___	No ___	N/A ___
Continuity and coordination	Yes ___	No ___	N/A ___
Comprehensiveness	Yes ___	No ___	N/A ___
Appropriate Implementation	Yes ___	No ___	N/A ___

SOURCES/NOTES _____

_____

2. Assess the health professions education affiliation on the following measures:

Health Professions Education Affiliation	YES	NO	N/A
Is the MHP Clinical Director responsible for managing the quality of care of those trained in the MHP under the health professions education affiliation?			
Does the MHP have a significant role in specification of characteristics or selection of trainees who participate in on-site clinical training?			
Do MHP staff have faculty appointments?			
Is there a faculty training program for MHP staff of affiliated institutions?			
Is there an appropriate orientation for trainees and faculty?			
Is there an appropriate evaluation program of the health professions affiliation? (includes patient satisfaction)			

SOURCES/NOTES _____

_____

III.D. Recruitment and Retention

Level 1. Requirements for All MHPs - None

Level 2 and 3. Additional Expectations for MHPs Which Employ Any Licensed Health Professional

1. Is there a written provider Recruitment and Retention Plan which includes:

Recruitment and Retention Plan	**YES**	**NO**
Estimated future projections of provider needs?		
A formalized process for orienting clinical providers, including but not limited to: Clinical Practice Guidelines/Protocols Cost effective practice (formulary, lab, etc.) Diagnosis and procedure coding Utilization management goals and expectations Financial aspects of eligibility, fees, discounts Encouragement to participate in clinical networks (MCN) and local, state, or Regional clinician organizations A detailed description of the compensation package		
Provision whereby clinical staff may provide input into MHP policies which directly affect their clinical practices?		
Provision for a formal exit interview of all departing clinical providers to elicit information which will contribute to improving the employment environment for clinical providers?		
Policies which provide for career enhancement for clinical providers, including potential opportunities for serving as: Mentors for health professions students/residents Faculty of health professions training institutions Participants in clinical or health service research projects		

SOURCES/NOTES _____

_____

III.E. Health Care Plan

Level 1. Requirements for All MHPs

1. In reviewing the health care plan, determine if:

Health Care Plan	**YES**	**NO**
There is a defined process for plan development which include staff participation		
The plan is based on an assessment of the migrant population needs/demands		
The Health Care Plan is tied to the strategic plan and mission statement of the MHP		

SOURCES/NOTES _____

_____

Level 2 and 3. Additional Expectations for MHPs Which Employ Any Licensed Health Professional

1. In reviewing the health care plan, determine if:

Health Care Plan	YES	NO
The clinical staff participated in its development and are familiar with the contents		
The objectives are realistic and tied to need and health impact		
The objectives are time framed and measurable		
The MHP MIS supplies data required for development of the clinical component of the plan, including the development of health promotion/disease prevention strategies		
Clinical outcomes are monitored, analyzed and reflected in the development of the Plan		
The Plan is closely related to and monitored by the quality management program		

SOURCES/NOTES _____

_____

IV. CLINICAL SYSTEMS

IV.A. Medical Records

Level 1. Requirements for All MHPs

1. Is there an individual responsible for the overall direction and supervision of the medical records system(s)?

Yes ___ No ___

If yes, is the responsible person qualified by education or experience? (*The education or experience appropriate should vary with the complexity of the medical records. A lay staffed MHP, for example, would have medical records which consist essentially of referral forms and reports from the provider which represent both the invoice and the diagnoses and services. Appropriate training or experience for taking responsibility for such medical records could involve only minimal self-study through review of BPHC guidance or reference materials on medical records functions for C/MHCs)*

Yes ___ No ___

SOURCES/NOTES _____

_____

2. Are medical records reviewed at least annually by the quality management committee, clinical consultant, or medical director to determine quality, completeness and legibility?

Yes ___ No ___

SOURCES/NOTES _____

_____

3. Is a clinical record maintained for every patient receiving care, or for which care is arranged, through the MHP?

Yes ___ No ___

SOURCES/NOTES _____

_____

4. Does a review of medical records reveal:

Medical Records	% In Compliance
Documentation conforms to MHP policies	
Uniform format and logical flow of information	
Information, including descriptions of prescriptions, is legible	
Timely entry of data	
Information appropriately dated	
Necessary patient and family identifiers are present	
Provider signature (only on voucher for Level 1, on-staff providers for Levels 2 & 3 should sign their medical record entries)	
Patient's home-base contact information available	
Tracking of referrals	
Information on enabling or wrap-around services needs	

Number of records reviewed: _____

SOURCES/NOTES (note discrepancies) _____

_____

5. For patient records is there:

Record Maintenance	YES	NO
Adequate safety and security (locked files/room and check out system)		
Protection of confidentiality		
Use of an acceptable record cataloging system		
Timely filing		
Periodic purging of patient records and storage of non-current records		
Procedures for release of information		
Knowledge of legal requirements		

SOURCES/NOTES _____

_____

6. Are patient records quickly accessed during office hours?

Note: The MHP's patient records should meet most needs for information requests, but some queries may need to be passed on to the referral provider.

Yes ___ No ___

SOURCES/NOTES _____

_____

7. Are confidentiality and release of information procedures documented?

Yes ___ No ___

SOURCES/NOTES _____

_____

8. Are policies in place that provide for confidential access by adolescent patients?
Note: State law may prohibit provision of clinical services without parent/guardian consent, but the MHP should encourage inquiries and offer non-medical counseling on an anonymous or confidential basis.

Yes ___ No ___

SOURCES/NOTES _____

_____

Level 2. Additional Expectations for MHPs Which Employ Any Licensed Health Professional

1. Are portable immunization records provided?

Yes ___ No ___

SOURCES/NOTES _____

_____

2. Does a review of medical records reveal:

Medical Records	% In Compliance
Problem oriented record in SOAP format	
- Documentation of reason for every visit	
- Past and present medical histories	
- Vital signs for those with acute problems	
- Plan (treatment, referral, follow-up, patient education)	
Signed consent for treatment, if required	
Patient education activities	
Referral or provision of health care maintenance, including immunizations	
Coordination of services among providers	
Evidence of case management	

Number of records reviewed: _____

SOURCES/NOTES _____

_____

3. Does a review of outreach and case management records reveal:

Outreach/Case Management Records	% In Compliance
Documentation conforms to MHP policies	
Uniform format and logical flow of information	
Information, including providers seen & prescriptions, is legible	
Problem list is present and current	
Timely entry of data and information appropriately dated	
Necessary patient and family identifiers are present	
Patient's home-base contact information available	
Tracking of referrals	
Patient education activities needed/provided	
Information on enabling or wrap-around services needs	

Number of records reviewed: _____

SOURCES/NOTES _____

_____

4. Is there adequate space for maintenance of patient records, procedures for tracking of files, and provision for access to records during periods of the year when the MHP is not open?

Yes ___ No ___

SOURCES/NOTES _____

_____

5. Is there a system in operation which incorporates all pertinent patient care information into the medical record, or links to separately maintained records, in order to assure continuity of patient care (e.g., data from psychosocial and special programs, home visits, outreach, screening clinics)?

Yes ___ No ___

SOURCES/NOTES _____

_____

Level 3. Additional Expectations for MHPs Which Employ Midlevel Practitioners or Physicians to Provide Patient Care

1. Is there a staff member or regular consultant who has appropriate medical records certification? (*ART or RRA)*

Yes ___ No ___

SOURCES/NOTES _____

2. Does a review of medical records reveal:

Medical Records	% In Compliance
Problem oriented record in SOAP format	
- Include findings from physical examinations	
- Documentation of special studies ordered	
- Documentation of clinical assessments or diagnoses	
- Plan (treatment, referral, follow-up, patient education)	
Conspicuous listing of drug allergies	
Evidence that the provider has reviewed consult reports, lab results, etc.	
Evidence of screening or referral for patients at risk for TB or HIV	
Current problem list	
Current medications list	
Lab and x-ray reports	
Special study and consult reports	
Hospital discharge summaries	
Immunizations	
Risk assessment for lifecycle	

Number of records reviewed: _____

SOURCES/NOTES _____

_____

3. Is additional information for perinatal patients included in the chart:

Perinatal Records	% In Compliance	Responsibility of Referral Provider*
Presence of LMP and EDC documented		
Documented HIV/AIDS education		
Blood pressure documented		
Weight documented		
Urinalysis done and documented		
FHR for visits after 12 weeks		
Ongoing risk assessment and management		
If referred locally for delivery, documentation of first post partum visit		
Childbirth and parity information		
If delivered in area, documentation of first well baby visit or referral for such at next planned migration site		

*Note: *For those patients referred off-site for prenatal care the MHP's records should indicate whether or not the referral provider routinely performs each of the above and/or which are the continuing responsibility of the MHP.*

SOURCES/NOTES _____

_____

4. Is there evidence that portable prenatal records are provided to pregnant migrants who leave the area before delivery?

Yes ___ No ___

SOURCES/NOTES _____

_____

5. Is an organized record keeping process for perinatal care employed if perinatal services are offered (e.g., Hollister, ACOG)?

Yes ___ No ___

SOURCES/NOTES _____

_____

6. Do medical records reflect adequate continuity of care (e.g., continuity of primary care provider, timely return after hospitalization or delivery, etc.)?

Yes ___ No ___

SOURCES/NOTES _____

_____

7. If the MHP arranges for perinatal care through a referral agreement or contract, is documentation present as to whether:

	YES	NO
Patients have received post partum care?		
Babies born to referred patients received the first well baby visit within 4 weeks?		
Medical records from the referral provider are retrieved and are in both the mother and baby's chart?		
Hospital records or summaries of the hospital course for both mother and baby are in the chart?		
Medical records from the referral hospital are retrieved and are in the patients' charts?		

SOURCES/NOTES _____

_____

IV.B. Clinical Tracking Systems

Level 1. Requirements for all MHPs

1. Are patients tracked to determine if they went to the referral?

   Yes ___ No ___

   SOURCES/NOTES _____

   _____

2. Have referral policies and protocols been implemented to allow for documentation and follow-up?

   Yes ___ No ___

   SOURCES/NOTES _____

   _____

3. Are policies and procedures for patient referrals that provide for the following in place:

	YES	NO
Adequate information to referral provider as to the reason for the referral		
Location of services		
Provision of needed enabling or wrap-around services when patient visits referral provider		
Communication between MHP and the referral provider		
Documentation and follow-up on the referral		

   SOURCES/NOTES _____

   _____

4. Does a mechanism exist to ensure continuity of care for all patients in all MHP services?

   Yes ___ No ___

   SOURCES/NOTES _____

   _____

5. Does the MHP meet reporting and tracking requirements of state and local health departments and other agencies?

   Yes ___ No ___

   SOURCES/NOTES _____

   _____

6. Are aggregate data available for use in QM, for planning, and for utilization review?

Numbers of patients seen by reason for visit/diagnosis	Yes ___	No ___
Numbers of referrals by referral destination	Yes ___	No ___
% of referral appointments kept by referral destination	Yes ___	No ___
Numbers of patients seen by date of visit	Yes ___	No ___
Utilization of enabling services by date	Yes ___	No ___
% of patients utilizing each type of enabling service	Yes ___	No ___
% of patients this year seen in previous year(s)	Yes ___	No ___

SOURCES/NOTES _____

_____

Level 3. Additional Expectations for MHPs Which Employ Midlevel Practitioners or Physicians to Provide Patient Care

1. Are policies and procedures in place (and followed) for the following, and do patient charts reflect documentation of referral and follow-up for this care:

Area of Tracking	YES	NO	DOCUMENTATION YES	DOCUMENTATION NO	FOLLOW-UP YES	FOLLOW-UP NO
Abnormal lab tests and X-ray studies						
Hospitalizations						
Acute care follow-up for significant conditions						
Routine preventive services:						
- chronic disease care						
- abnormal paps						
- immunizations						
Mammography						
Smears, lab results						
X-rays						
No shows						
STDs						
TB						
Family Planning						
Perinatal services						
Diagnostic Radiology						
Substance abuse services:						
- Alcohol abuse treatment						
- Drug abuse						
- Recovery planning						
- Group counseling						
- Rehabilitation						
- After care						

SOURCES/NOTES _____

_____

IV.C. Quality Management and Improvement Program

Level 1. Required For All MHPs

1. Is there a written quality management plan approved by the governing body?
Note: If the MHP is housed within a large organization, it may be sufficient to have the QM plan approved by the Advisory Board and Medical Director. However, because the governing body for any health care delivery organization is ultimately accountable for quality of care, responsibility for QM activities can be delegated, but not accountability.

Yes ___ No ___

If yes, does the plan provide for obtaining feedback from migrant users of the MHP for use in improving quality and satisfaction?

Yes ___ No ___

SOURCES/NOTES _____

_____

2. For each element of the quality management process, indicate if the element is *present and in use:*

Quality Management Process	YES	NO
Is there a QM Committee responsible for developing and implementing the plan, and which includes the clinical director?		
Does the QM Committee meet at least quarterly during the MHP's season?		
Are minutes of QM meetings taken and kept on file?		
Are QM minutes communicated to the Governing Board?		
Are QM findings used to modify policy and procedures?		
Has a procedure been established for selection of records for UR and quality review?		
Has the MHP gathered data which provides a baseline for quality improvement on selected criteria?		

SOURCES/NOTES _____

_____

3. Are patient complaints reviewed for patterns and appropriate corrective action taken?

a) With respect to individual complaints? Yes ___ No ___
b) With respect to patterns of complaints? Yes ___ No ___

SOURCES/NOTES _____

_____

4. Is there a protocol to handle patient complaints in languages other than English?

Yes ___ No ___ N/A ___

SOURCES/NOTES _____

_____

Levels 2 and 3. Additional Expectations for MHPs Which Employ Licensed Health Professionals

1. Does the QM plan include provision for assessing compliance of nursing and midlevel performance against appropriate protocols quarterly for year round sites, and at least once each year for seasonal sites?

Yes ___ No ___

SOURCES/NOTES _____

_____

If physicians are employed by the MHP, does the QM plan include provision for an annual peer review and/or medical audit activity of a sample of each physician's cases? *Note: MHPs are unlikely to employ many physicians and arranging traditional peer review may not be feasible. An option might be to examine "team performance" for a selected high prevalence condition. For example, the MHP clinical staff might select diabetes care as a topic. A sample of cases are reviewed and the clinical care and outcomes compared with an authoritative clinical guideline, such as published by the Agency for Health Care Policy and Research. The objectives of team performance review are to identify opportunities for improving quality of care, and should be followed by the design and implementation of interventions to improve care. Measurement of the effectiveness of the intervention in changing care patterns and outcomes is an essential component of the QM program.*

Yes ___ No ___

SOURCES/NOTES _____

_____

If dentists are employed by the MHP, does the QM plan include provision for an annual dental audit activity of a sample of each dentist's cases? *Note: As with physicians, MHPs are unlikely to employ many dentists and arranging peer review may be impossible. In such situations other options will need to be explored. Through the Migrant Clinician's Network it may be possible to arrange among dentists working with different MHPs or C/MHCs to exchange chart audits (each reviews a sample of the others' charts and x-rays). Because dental quality review requires an examination of the actual patient work, chart audits may not uncover potential opportunities for improving technique.*

Yes ___ No ___

SOURCES/NOTES _____

_____

V. CLINICAL SERVICES

V.A. Routine Clinical Services

Level 1. Required For All MHPs

1. Review the clinical services provided directly by or arranged by the MHP. Are the MHP's operating policies and procedures being followed?

Operating Policies and Procedures	USUALLY	SELDOM
Are routine clinical services consistently available during evening and/or weekend hours which do not conflict with agricultural work hours?		
Are there standards and systems which define appropriate treatments and reasonable use of diagnostic procedures? (*lay entry point MHPs will utilize only cursory triage procedures before referring acute patients to a provider for an assessment)*		
Are the treatments and diagnostic procedures consistent with written standards		
Are specialty care referrals available when needed by MHP staff, or by primary care providers to whom patients have been referred by the MHP?		
Are health education materials available in languages representing the migrant patient population?		
Is waiting time at the MHP for triage and referral reasonable?		
Is waiting time for appointment and office visits with referral providers reasonable?		
Are environmental services for migrants available (directly or through referral)?		

Note: Availability of environmental services for migrants may be demonstrated by lists of contacts/phone numbers for federal, state, and local government agencies responsible for pesticide exposure investigation, migrant labor camp standards enforcement, drinking water testing, and other conditions appropriate to the migrant work and living arrangements.

SOURCE/NOTES: _____

_____

2. Is there an appropriate policy for managing disruptive clients or clients compromised by:

a) Alcohol Yes ___ No ___
b) Drugs Yes ___ No ___
c) Mental impairments Yes ___ No ___

SOURCE/NOTES: _____

_____

3. Are interpreter services provided in the following circumstances, as appropriate?

	YES	NO	N/A
In the MHP facilities			
In referral physician offices			
In the hospital			
After hours			

SOURCE/NOTES: _____

_____

4. Are those who interpret trained in medical terminology?

Yes ___ No ___

SOURCE/NOTES: _____

_____

5. Are there providers with agreements/contracts with the MHP who are competent in languages spoken by the migrant patient population?

Yes ___ No ___

SOURCE/NOTES: _____

_____

6. Have MHP intake, triage, and clinical staff and high volume referral providers been provided with orientation/training to promote their knowledge about and sensitivity to the following with respect to the migrant patient population:

	YES	NO
Occupational hazards of farm labor?		
Migrant living conditions/lifestyles and impact on health care needs/demands?		
General cultural values and beliefs?		
Socioeconomic characteristics and limitations which result?		
Dietary patterns?		
Alternative healing beliefs?		
Attitudes/beliefs regarding male/female roles?		

SOURCE/NOTES: _____

_____

V.B. Preventive Services

Level 1. Required For All MHPs - None

Levels 2 and 3. Additional Expectations for MHPs Which Employ Licensed Health Professionals

1. Are immunization services provided directly or arranged by the MHP during all operating hours *as required?*

Yes ___ No ___

SOURCE/NOTES: _____

_____

2. Is there a tracking system to determine which active pediatric patients are in need of immunizations? Does the system provide for automatic recall or notification of outreach workers of these children?

Yes ___ No ___

SOURCE/NOTES: _____

_____

3. Does the MHP participate in state or local Immunization Action Plans?

Yes ___ No ___

SOURCE/NOTES: _____

_____

4. Does the MHP provide education to parents about immunizations, including the risks and benefits of immunizations?

Yes ___ No ___

SOURCE/NOTES: _____

_____

V.C. Dental Health Care

Level 1. Required For All MHPs

1. Indicate availability for each of the following dental services:

Dental Services	Onsite by Dental Staff	Onsite by Contract Dentist	Onsite by Other	Offsite	Not Provided
Level I - Palliative/Emergency Care *(Required, if locally feasible)*					
Level II - Oral Health Education *(Required only for MHPs which employ licensed health professionals)*					
Level II - Preventive Services *(Required for MHPs which employ midlevel providers, physicians or dentists)*					
Level III - Basic Dental Treatment Services					
Level IV - Rehabilitative Dental Services					

SOURCE/NOTES: _____

_____

Levels 2 and 3. Additional Expectations for MHPs Which Employ Licensed Health Professionals

1. Is community based dental screening or treatment provided or arranged (e.g., Migrant Head Start, Migrant Education)

Yes ___ No ___

SOURCE/NOTES: _____

_____

V.D. Ancillary Services

Level 1. Required For All MHPs

Note: Many MHPs refer medical patients to providers who order all ancillary services needed to diagnose and treat the patient. Arrangements for MHP involvement in the prior approval of ancillary services and in the selection of the ancillary service source may vary widely, depending primarily on the availability of alternative ancillary service providers and on the terms of the MHP's agreements with referral providers.

1. Are expectations concerning whether or not MHP prior approval is required for financial reimbursement of ancillary services explicit in the agreements between the MHP and referral medical providers? If not, is it explicit on the voucher sent with the patient?

Yes ___ No ___

SOURCE/NOTES: _____

_____

Levels 2 and 3. Additional Expectations for MHPs Which Employ Licensed Health Professionals

Note: Few MHPs will provide onsite lab or x-ray, unless justified by timeliness requirements. Thus, the emphasis of this section is on purchase of outside ancillary services when ordered by MHP clinical staff.

1. If the MHP provides onsite laboratory services:

Onsite Laboratory Services	Yes	No	NA
Is there a written (and current) laboratory Policy and Procedure manual?			
Has the lab been appropriately registered or certified under the CLIA regulations?			
Are activities, including handling of specimens, performed in accordance with the procedures written in the manual?			
Is internal quality control maintained through periodic calibration of equipment and validation of test results?			
Is review of lab services and procedures included as part of the MHP's QM plan?			
Are results of lab tests available on a timely basis?			

SOURCE/NOTES: _____

2. If the MHP contracts for lab services:

Contract Laboratory Services	Yes	No
Does the MHP document that the lab has proper licensure and meets federal, state, and local regulations?		
Does the MHP maintain a current list of lab services offered and price/fee schedule?		
Are duplicate copies of lab reports kept on file in the contract lab for at least a year?		
Are MHP clinical staff satisfied with the quality & timeliness of results and with the posting of results in the medical record?		

SOURCE/NOTES: _____

3. If the MHP provides onsite radiology services:

Onsite Laboratory Services	Yes	No	NA
Is there a written (and current) radiology Policy and Procedure manual?			
Are radiology services supervised by a certified technician or a physician?			
Are arrangements in place so that all x-rays are read/overread by a certified radiologist?			
Are all radiation safety and monitoring procedures followed by all staff using the equipment?			
Is review of radiology services and procedures included as part of the MHP's QM plan?			
Are MHP staff clinicians satisfied with the quality and timeliness of services and with the posting of results in the medical record?			

SOURCE/NOTES: _____

4. If the MHP contracts for radiology services:

Contract Radiology Services	Yes	No
Does the MHP document that the contractor has proper licensure and meets federal, state, and local regulations?		
Does the MHP maintain a current list of radiology services offered and price/fee schedule?		
Are duplicate copies of all reports kept on file by the contractor for at least a year?		
Are MHP clinical staff satisfied with the quality & timeliness of radiology services and with the posting of results in the medical record?		

SOURCE/NOTES: _____

V.E. Case Management

Level 1. Required For All MHPs - None

Levels 2 and 3. Additional Expectations for MHPs Which Employ Licensed Health Professionals
Note: Because of the short period during which migrants typically stay within the service area of a MHP, case management is short term and focuses on the immediate needs for follow-through on appointments, filling of prescriptions, and continuing care. Case management also includes an emphasis on upstream/down stream arrangements for continuing care when the migrant patient leaves the area.

1. Assess the availability of required case management services onsite:

Case Management Services	YES	NO
Is there a system in place to assess the patient's health/psychosocial risks?		
Is the assessment family-oriented?		
Is the primary care plan integrated with other MHP services (e.g., nutrition, social service, health education, dental) **How? __ protocol __ Team meeting __ chart review**		
Do clinical staff collaborate with other community care providers in the provision of comprehensive health services?		
Is the assessment and plan documented in the medical record?		
Are these needs/risks plans periodically reviewed? Communicated up/down stream?		
Are identified resources and services available and utilized in patient care?		
Are established linkages utilized, as appropriate?		

SOURCE/NOTES: _____

_____

2. Assess whether there are any supplemental case management services (Note: these services are optional unless required by other grants):

Supplemental Case Management Services	YES	NO
Outreach to labor camps and provision of transportation		
Assistance with program eligibility (e.g., WIC, Medicaid, food stamps, emergency housing)		
Social and emotional support		
Crisis intervention		
System and resource advocacy		
Patient/family education and training		
Direct counseling, individual and group		
Documentation/communication		
Follow-up on all medical/dental/psychosocial referrals		
Routine prevention screening		
Home/hospice/hospital services		
Infant and child follow-up		

SOURCE/NOTES: _____

_____

3. Are clinical services coordinated with the following services (*note that many of these services may not be available in rural areas served by MHPs and, if present, many migrants may not be eligible*):

	YES	NO
Social Security		
Department of Veterans Affairs		
AFDC		
Medicaid		
Migrant Education, Head Start, and Local School Systems		
Legal Assistance/Farmworker Legal Assistance		
Employment Assistance and Jobs Training (JPTA)		
Public Housing/Migrant Housing		
Migrant Housing Enforcement (if applicable)		
Family Planning		
MCH Programs		
Domestic Violence Programs		
Emergency and Transitional Shelters, including feeding centers		
Local Advocacy Groups, Church Groups, Voluntary Organizations		

SOURCE/NOTES: _____

_____

V.F. Emergency Services

Level 1. Required For All MHPs

1. Are current written protocols in place that cover "in house" patient emergencies?

Yes ___ No ___

SOURCE/NOTES: _____

_____

Level 3. Additional Expectations for MHPs Which Employ Midlevel Practitioners or Physicians to Provide Patient Care

1. Assess the following for emergency services:

Emergency Services	YES	NO	NOT EVALUATED
Are appropriate staff trained and certified in emergency procedures (BLS, ACLS, ATLS, etc.)?			
Is there one person responsible for assuring upkeep of the kit?			
Are staff trained in the use of emergency equipment?			
Are emergency kits adequately stocked with appropriate medications and supplies?			
Is there an inventory of the contents of the emergency kits and are all contents "in-date" and quickly accessible? (Review procedures for regular inspections)			
Are there adequate procedures for transfer of patients via emergency transport?			
Does program conduct regular cardio-respiratory "mock codes"?			

SOURCE/NOTES: _____

_____

V.G. Pharmacy Services

Level 1. Required For All MHPs

Are arrangements in place which allow patients to have written prescriptions to be filled for all patients (e.g., affordability, access, and convenience, use of vouchers and/or sliding fee discount)?

Yes ___ No ___

SOURCE/NOTES: _____

_____

Level 2. Additional Expectations for MHPs Which Employ Any Licensed Health Professional

1. Assess the following for pharmacy services:

Pharmacy Services	YES	NO
Is there an established pharmacy committee or other method of examining pharmacy issues and updating policy?		
Are there methods to assure that prescriptions are written to assure cost effectiveness (e.g., use of generic drugs, DUR programs, etc.)?		
Does the pharmacy(s) actively participate in the QM program?		
Are prescriptions legible?		

SOURCE/NOTES: _____

_____

Level 3. Additional Expectations for MHPs Which Employ Midlevel Practitioners or Physicians to Provide Patient Care

1. Assess the following for pharmacy services:

Pharmacy Services	YES	NO
Is there a formulary?		
Is the MHP formulary available to all prescribing providers?		
If samples or prepackaged drugs are used by MHP clinical staff, are proper inventory procedures followed?		
Are drugs stored, secured and dispensed as required by federal, state/local regulation?		
Are periodic stock inspections and regular stock rotations performed to eliminate outdated stock?		
Are outdated meds disposed of in an appropriate manner as indicated in the MHP Policy and Procedures Manual?		

SOURCE/NOTES: _____

_____

MIGRANT HEALTH PROGRAM
PRIMARY CARE
EFFECTIVENESS REVIEW

Reviewer's Manual
for

FISCAL

Migrant Health Program Grantee: _____

Date of Review: _____

Reviewer's Signature: _____

March 1998

PRIMARY CARE EFFECTIVENESS REVIEW
MIGRANT HEALTH PROGRAM
FISCAL PROTOCOL

TABLE OF CONTENTS

MIGRANT HEALTH PROGRAM
(non-clinic or voucher model)
PRIMARY CARE EFFECTIVENESS REVIEW
FISCAL PROTOCOL

1. INTRODUCTION TO FISCAL PROTOCOL

The reviewer should refer to the Introduction and General Instructions for details on conducting a Primary care Effectiveness Review (PCER) as described in Policy Information Notice 95-26. Use of the PCER as adapted for a Migrant Health Program (programs which do not follow the traditional medical clinic model) is described in the Introduction and General Instructions to the present manual, but a familiarity with the general PCER concepts will be helpful to the reviewer. Because a Migrant Health Program (MHP) may differ radically from a Migrant Health Center (MHC), it will also be helpful if the reviewer is familiar with the concepts and requirements described in the "Migrant Health Voucher Program Guidance", Policy Information Notice 94-7. The fiscal protocol is one of four review documents which survey elements of the MHP which are either required by law, regulation or program expectation, or recommended as good practice. The reviewer is reminded to work closely with other reviewers since areas of review involve overlap and the perspective of other team members is relevant to constructing an overall impression of the program.

In order to best utilize onsite time, certain documents should be reviewed prior to the visit.

- Notice of Grant Award for past three years
- BHCDANET report, page 7 summary
- UDS, most recent, and prior UDS/BCRR for past three years
- Audited financial statement and management letter for the last year
- FSR - most recent
- Interim financial statements - most recent
- Grant applications - budget portion

If the MHP grantee is a public agency, use whatever financial statements are provided. Additional documents will be available at the time of the visit including:

- Audited financial statements and management letters for the preceding two years.
- Other internal management reports
- If available, Medicare/Medicaid cost reports - most recent (few voucher programs will qualify for FQHC status)
- Fee schedule, if relevant (services coordinator model MHPs may request minimum co-payments for referred services, but will not directly deliver services for which patients are charged - nurse staffed models are also unlikely to directly deliver services for which charges are administered, but midlevel practitioner staffed model MHPs will administer charges and a sliding fee procedure for direct delivery services)
- Sliding fee schedule and policy and procedures (services coordinator model may use a sliding adjustment to the requested minimum co-payments, others may use for any chargeable direct delivered services)
- Accounts payable listing and aging report
- Referral/encounter/invoice forms for external services
- Encounter forms for on-site services and source documents for charge data, if any
- General ledger and trial balance
- Financial policy and procedures manual including: fixed assets policy, billing and collection policy (if relevant), purchasing policy and travel policy
- Sample of timekeeping records
- If midlevel staffed model, provider productivity reports

- Interim report to the Board - most recent
- UDS file with all supporting workpapers
- Agreements with local providers:
  - Physicians
  - Dentists
  - Hospitals and clinics
  - Pharmacies
  - Other
- Invoices and utilization data tabulated from vouchers

II. PROJECT PLANNING AND TEAM COORDINATION

1. Is the fiscal officer familiar with the local health care environment and the bargaining position of the program for obtaining favorable voucher reimbursement rates?

   Yes ___ No ___

   SOURCES/NOTES _____

   _____

2. Is the fiscal officer familiar with the MHP's strategic plan, estimates of numbers of migrant and seasonal farmworkers present in the area for each month, and trends in agricultural labor needs?

   Yes ___ No ___

   SOURCES/NOTES _____

   _____

3. Does the fiscal officer believe that he or she has adequate input in the development of the MHP's strategic direction?

   Yes ___ No___

   SOURCES/NOTES _____

   _____

4. Does the fiscal officer feel he or she is included as part of an overall team in MHP operation?

   Yes ___ No___

   SOURCES/NOTES _____

   _____

III. UDS AND SPECIAL PROGRAM REPORTS

III.A. Staffing (Table 5)

Note that UDS reporting is not well designed to meet the special situations of many MHPs. Some tables in UDS may have been waived as inappropriate for a specific MHP, and special definitions needed for others. Because the reimbursements to local providers through vouchers is included as a cost to the MHP, reporting of the referred encounters is necessary in order to show a balanced cost per encounter. The general rule is that an encounter by a local physician which is accounted for through issuance of a combination referral/voucher form will be counted an a program encounter. If a nurse, acting independently of the referral provider, conducts triage and records signs, symptoms and vitals in a medical record at the MHP, and then prepares a referral/voucher form for sending the patient to an off-site physician, the physician visit and the nursing encounter are both counted. In a services coordinator model MHP, a lay person will triage and refer the patient and only the physician visit may be counted as an encounter. Count all encounters based on referrals for which the program makes a payment, or would have an obligation to make a payment if the patient's third party payment source refused to pay. If a local physician works on a contract basis and is reimbursed by the hour rather than on a fee-for-service basis, count the hours and convert to FTEs (1800 hours worked is approximately equivalent to one FTE after deducting 280 hours for vacation, holiday, and sick leave).

Another problem area for MHPs in completing the UDS is that of accounting for "in-kind" donations when a referral provider waives his or her fee. If the MHP was obligated to provide reimbursement, the amount which it would have paid may be considered to represent an in-kind donation. Negotiated discounted fees do not represent in-kind donations of the discounted amounts.

1. Is a system in place that allocates staff time to UDS Tables 5 and 8 cost centers?

   Yes ___ No___

   SOURCES/NOTES _____

   _____

2. Review the MHP's staff allocation. Is it consistent with program definitions for each category? Many MHPs represent small programs administered by large organizations which administer multiple programs. It is appropriate for the grantee to have employees allocate their time among two or more programs. Examine job descriptions and staff allocation for appropriate rules consistently applied. Is staff time allocated to both the MHP and another program(s)?

   Yes ___ No___

3. *If yes,* are the allocations to the Sec. 330(g) funded program reasonable?

   Yes ___ No___

   SOURCES/NOTES _____

   _____

4. Are employee staff appropriately included in the staffing table based on function rather than credentials (for example, a physician employed in an administrative role should be classified as administration)?

   Yes ___ No___

SOURCES/NOTES _____

_____

5. Have all personnel who work only part of the reporting period had their FTE adjusted to reflect this partial period?

Yes ___ No___

SOURCES/NOTES _____

_____

III.B. Total Costs Allocated to Cost Centers (Table 8)

1. Is Table 8 being calculated on an accrual basis *as required?*

Yes ___ No___

SOURCES/NOTES _____

_____

2. Are the salaries and fringe benefits allocated in Table 8 consistent with allocation of staff in Table 5?

Yes ___ No___

SOURCES/NOTES _____

_____

3. Does it appear that other costs entered in Table 8 have been allocated to the proper functional activities?

Yes ___ No___

SOURCES/NOTES _____

_____

4. How are the facility costs allocated? (If an alternative to the UDS recommended method of allocation based on square feet is used, explain in your note and evaluate its propriety -- particularly note if the voucher program is part of a large multi-program organization and is paying year round facility costs but using the facility only for a brief season.)

___ Square feet occupied

___ Square feet occupied plus other reasonable, documented method
___ Reasonable alternative methodology
___ No discernible method or inappropriate method

SOURCES/NOTES _____

_____

5. How are administrative costs allocated? (If an alternative to the UDS prescribed method of allocating based on total dollars expended by function, describe it in your notes -- particularly look for fairness in the allocations of shared functions among multiple programs operated by the grantee.)

___ Allocation consistent with UDS prescribed method
___ Reasonable alternative methodology
___ No discernible method, or inappropriate method

SOURCES/NOTES _____

_____

III.C. Collections, Receivables and Charges

Many MHPs, including services coordinator models, will administer a minimum co-payment for all or selected services (e.g., $2 per prescription) and will need a suitable accounting system. However, if the grantee operates primarily as a central contracting and monitoring entity, it may not directly be involved with charges, collections or receivables, although its contracted sites may be so involved (e.g., the pharmacy may collect the $2 copayment). If the expected copayment is to be collected by the provider and represents an off-set to the negotiated fee which the MHP would have paid, then the co-payment amount should be accounted for in this way by the MHP (e.g., show as program income).

1. Are systems in place to record all charges, sliding fee schedule adjustments, and collections at time of service?

Yes ___ No___

SOURCES/NOTES _____

_____

2. Is there a policy on credit and collections, including provision for writing off receivables after a prescribed period and after prescribed collection efforts?

Yes ___ No___

SOURCES/NOTES _____

_____

3. Are bad debt write offs kept separate from sliding fee adjustments?

Yes ___ No___

SOURCES/NOTES _____

_____

4. Can all bad debts be traced to actual approved write offs?

Yes ___ No___

SOURCES/NOTES _____

_____

IV. SCHEDULE OF CHARGES/SLIDING-FEE SCHEDULE

Services coordinator model MHP sites will not charge for services, except that a nominal co-payment may be required for some services (e.g., $2. per prescription). No patient may be denied service (voucher or referral) because of an inability to pay. Nursing model MHP sites generally will not charge patients on a fee-for-service basis for nursing services (a nominal co-payment may be requested for vouchers for prescriptions and other ancillary services). However, midlevel staffed MHP sites should have charges and administer a sliding-fee schedule based on income and poverty guidelines. There should be no charge by the MHP for triage and referral. The patient may be required to pay all or a portion of the private provider's bill, based on the sliding-fee schedule or the availability of a third party payment source (e.g., the MHP may cover 50% of the provider's visit charge, with the patient charged the remainder, or the MHP may cover the Medicare or private insurance co-insurance, with the provider collecting the remainder from the third party payer).

1. Is the MHP grantee a contracting and monitoring organization that does not directly deliver chargeable services?

Yes ___ No___

SOURCES/NOTES _____

_____

If No, skip to question 6

2. *If Yes,* does the MHP contract with other organizations to operate program entry points at which medical services are directly delivered?

Yes ___ No___

SOURCES/NOTES _____

_____

If No, and neither the grantee nor its site subcontractors directly deliver chargeable services, skip to question 6 below.

3. *If Yes,* does the program grantee require contracting organizations to administer a charge/sliding-fee schedule for migrant and seasonal farmworkers (MSFWs) and members of their families who are eligible for voucher program benefits?

Yes ___ No___

SOURCES/NOTES _____

_____

4. *If yes*, does the charge/sliding-fee schedule requirement imposed by the grantee on its contractors include the following :

Fee schedule regularly reviewed and updated? Yes ___ No ___ How often? _____

Fee schedule based on community standards? Yes ___ No ___ If No, note basis below.

Fee schedule before discounts captures costs? Yes ___ No ___

Is sliding-fee discount applicable to all mandated in-house services *as required*? Yes ___ No ___

SOURCES/NOTES _____

_____

5. Are sliding fee discounts available for mandated services provided by out of house private providers, etc. through vouchers *as required*?

Yes ___ No ___

SOURCES/NOTES _____

_____

If MHP grantee directly delivers services and contracts with other organizations to operate service entry points, the following questions must be answered in addition to the above.

6. Does the program have a schedule of charges for on-site direct services?

Visits	Yes ___	No ___	
Procedures	Yes ___	No ___	
Laboratory	Yes ___	No ___	N/A ___
Radiology	Yes ___	No ___	N/A ___
Pharmacy	Yes ___	No ___	N/A ___
Dental	Yes ___	No ___	N/A ___

SOURCES/NOTES _____

_____

7. What was the most recent review and update of the fee schedule?

Date ___/___/___

On what is the fee schedule based (e.g., community standards, Medicare RBRVS)?

_____

8. Is the sliding-fee discount applicable to all mandated primary care services provided in-house *as required*?

Yes ___ No___

SOURCES/NOTES _____

_____

9. Are sliding fee discounts available for required mandated primary care services provided by private providers through vouchers or other contracted arrangements *as required*?

Yes ___ No___

SOURCES/NOTES _____

_____

10. Is the sliding fee discount based on the most recent federal poverty guidelines *as required* (generally published in February of each year)?

Yes ___ No___

SOURCES/NOTES _____

_____

11. Randomly select five sliding-fee scale determinations which indicate that a sliding-fee discount was given.

Is income documented at least annually? Yes ___ No ___
Is family size updated at least annually? Yes ___ No ___
Have proper determinations been made? Yes ___ No ___

12. Does the grantee or its site subcontractors have a nominal fee for all users or for specific services.

Yes ___ No___

SOURCES/NOTES _____

_____

13. *If yes*, for which services is the nominal fee collected (check all that apply):

__ Visits
__ Direct delivery services
__ Off-site ancillary services
__ Off-site pharmacy
__ Off-site physician referrals
__ Off-site dental referrals

SOURCES/NOTES _____

_____

14. Are all patients routinely screened for and assisted in obtaining eligibility for Medicaid, Medicare, or other third party coverage?

Yes ___ No___

SOURCES/NOTES _____

_____

V. BILLING AND COLLECTIONS

This section does not apply to those MHPs which represent services coordinator models, or which do not directly provide any chargeable services. Also, if the grantee contracts for all of its entry point operations, the questions here will apply to the subcontractors and the reviewer should focus on what contractual requirements were passed on to the subcontractors, and how the grantee is monitoring subcontractor compliance performance.

V.B. Encounter Forms

1. Do encounter forms used by the MHP include a place for check-off or write-in of all billable services rendered? Does a review of a sample of encounter forms indicate that all billable services are being charged?

SERVICE	On Form		Being Charged	
	YES	NO	YES	NO
Procedures				
Laboratory Tests				
Radiology				
Pharmacy				

SOURCES/NOTES _____

_____

2. Does the encounter form permit the entry of charges for off-site services provided by program staff, or is an alternative billing system in place and functional? Does the review of offsite charge forms indicate that appropriate services are being charged?

System in place Yes ___ No ___
Charges billed Yes ___ No ___

SOURCES/NOTES _____

V.B. Collections Policies and Procedures

1. Does the MHP have a set of written collection policies and procedures *as required*? These may be for use at program operated entry points, or represent minimum requirements for subcontracted sites.

Procedures manual exists	Yes ___	No ___
Being followed	Yes ___	No ___
Last revision	Yes ___	No ___

SOURCES/NOTES _____

_____

2. If the program and/or its subcontractors collect fees from clients prior to their seeing the provider, describe the procedure in your notes.

SOURCES/NOTES _____

_____

3. Are patients who are responsible for payments presented with a bill and asked for payment in full at the end of the visit?

Yes ___ No___

SOURCES/NOTES _____

_____

4. Does the MHP have written procedures stating how quickly or when patients and third party payers are supposed to be billed, *as required*? Is the policy being followed?

Yes ___ No___

SOURCES/NOTES _____

_____

5. Are third party payments reconciled to original billings and disputed items rebilled?

Yes ___ No ___ Not Applicable ___

SOURCES/NOTES _____

_____

6. Does the program prepare an accounts receivable aging report?

Yes ___ No___

If yes, is it monitored regularly?

Yes ___ No___

Are delinquent accounts diligently pursued on a timely basis?

Yes ___ No___

SOURCES/NOTES _____

_____

VI. ACCOUNTS PAYABLE CASH FLOW

VI.A. Accounts Payable

1. Are the functions involved in the incurring and paying of health center obligations adequately separated?

Yes ___ No ___

2. *If no,* is this because of the overall size of the program?

Yes ___ No___

SOURCES/NOTES _____

_____

3. What is the schedule for routine payment of accounts payable?

Times per month _____

SOURCES/NOTES _____

_____

4. Review the check register. Are any checks being written to "cash"? (If checks are written to cash, explain why in notes.)

Yes ___ No___

SOURCES/NOTES _____

_____

5. Are canceled or spoiled checks accounted for and effectively voided?

Yes ___ No___

SOURCES/NOTES _____

_____

6. Review a random sample of 10 current payables in the most recent payable cycle. What is the average lag time between bill date (or bill receipt if they are stamped or logged in) and the actual check date? Are discounts for prompt payment being taken? Is interest being paid on late payments?

Average lag in days _____
Discounts taken? Yes ___ No ___
Interest paid? Yes ___ No ___

SOURCES/NOTES _____

_____

7. Review a random sample of 10 checks sent to vendors (other than medical service providers). What is the average lag time between check date and cashing date? Does the date indicate checks have been held after being written?

Average lag in days ____
Checks being held? Yes ___ No ___

SOURCES/NOTES _____

_____

8. Is the chart of accounts adequately detailed to permit appropriate allocation of expenses to cost centers? To adequate object classes? To multiple funding sources? To multiple sites?

Cost centers	Yes ___	No ___
Object classes	Yes ___	No ___
Funding sources	Yes ___	No ___
Multiple sites	Yes ___	No ___

SOURCES/NOTES _____

_____

VI.B. Cash Flow

Because most MHPs expend the bulk of their funding over a relatively short agricultural season, proportions spent as a function of the grant year may be meaningless. The reviewer must use judgment concerning the expected proportion of expenditures by category for pre-season preparations, seasonal services, and post-season phase down.

1. Are expenditures for the current grant year approximately within expectations, given the seasonal needs and current date?

Yes ___ No ___

SOURCES/NOTES _____

_____

2. Is there currently a cash shortfall at the MHP?

Yes ___ No ___

SOURCES/NOTES _____

_____

3. Are withholding taxes being paid on time?

Yes ___ No ___

SOURCES/NOTES _____

_____

4. Has the program established a line of credit?

Yes ___ No ___

SOURCES/NOTES _____

_____

If yes, what has it been used for? _____

SOURCES/NOTES _____

_____

5. a) Does the MHP budget include funds for a reserve account for prepaid services or for unanticipated expenditures?

Yes ___ No ___

b) Does the program currently have funded reserve funds?

Yes ___ No ___

If yes, what is the amount? _____

c) How are the reserve funds invested? _____

SOURCES/NOTES _____

VI.C. Credit Cards

1. Does the MHP use credit cards?

Yes ___ No ___

If yes, indicate who (by position) has a credit card:

Position: _____

Position: _____

Position: _____

Position: _____

SOURCES/NOTES _____

_____

2. If the MHP uses credit cards, is a written policy in place governing their use? Is it adequate?

Written policy? Yes ___ No ___
Adequate? Yes ___ No ___

SOURCES/NOTES _____

_____

3. Examine two or more billing months in the current or prior year. Is there written documentation for each item charged? Do all items appear to be valid corporate expenses?

Written documentation? Yes ___ No ___
Valid expenses? Yes ___ No ___

SOURCES/NOTES _____

_____

VII. FIXED ASSETS

1. Does the MHP have a written fixed-asset policy consistent with federal regulations (45CFR Part 74)?

Yes ___ No ___

If yes,
a) Does the policy require an inventory of all fixed assets worth $5,000 or more?

Yes ___ No ___

b) Must all fixed assets be tagged?

Yes ___ No ___

c) Must the inventory indicate the proportion of federal participation or make reference to federal ownership?

Yes ___ No ___

d) Must the inventory indicate the location of all fixed assets?

Yes ___ No ___

e) Does the policy call for periodic verification of the inventory?

Yes ___ No ___

f) When was last inventory taken? Date: ___/___/___

SOURCES/NOTES _____

_____

2. Does the Federal Government have a reversionary interest in any of the MHP's real property?

Yes ___ No ___

If yes, has that interest been recorded in the local government's land records *as required*?

Yes ___ No ___

Date of recording? ___/___/___

SOURCES/NOTES _____

_____

VIII. INVENTORY AND PURCHASING

1. If the MHP has any significant inventories, does it have a written inventory policy?

Yes ___ No ___ N/A ___

SOURCES/NOTES _____

_____

2. Are written purchasing policies in place to prevent the solicitation or receipt of remuneration or benefits by individuals or the MHP itself in return for purchasing, leasing, ordering, or arranging for or recommending the purchasing, leasing or ordering of any good, facility, service or item?

Yes ___ No ___

3. Do any potential problems under the Medicare/Medicaid anti-kickback statute and regulations appear to exist?

Yes ___ (explain fully) No ___

SOURCES/NOTES _____

_____

IX. PAYROLL

IX.A. Documentation of Time and Effort

1. Do all employees maintain a contemporaneous record of their time and effort and submit it on a regular basis for payroll use or is an after-the-fact certification system used?

___ All employees maintain contemporaneous time records
___ Mixture of contemporaneous and after-the-fact records used
___ All employees use after-the-fact records

SOURCES/NOTES _____

_____

2. For those who document all time: What method of documenting time is used (e.g., time clocks, filled-in time cards, attendance clerk, etc.)?

_____

_____

3. Are all time cards or other attendance documents signed by the employee? Are they signed by a supervisor as well?

Employee? Yes ___ No ___
Supervisor? Yes ___ No ___

SOURCES/NOTES _____

_____

4. What individuals or category of individuals do not document their time or effort?

_____

SOURCES/NOTES _____

_____

5. Do time records document the allocation of time among programs or responsibilities?

Yes ___ No ___

SOURCES/NOTES _____

_____

IX.B. Vacation and Sick Time

1. Is a procedure in place for accruing sick time and vacation time credits?

Sick time?	Yes ___	No ___
Vacation time	Yes ___	No ___

SOURCES/NOTES _____

_____

2. Are claims for sick time and vacation time verified with the accrued leave records before approval for payment in the payroll system?

Sick time?	Yes ___	No ___
Vacation time	Yes ___	No ___

SOURCES/NOTES _____

_____

3. Are payments made for accrued and unused sick time or vacation time?

Sick time?	Yes ___	No ___
Vacation time	Yes ___	No ___

4. *If yes*, are these payments allowed in the personnel policies and the MHP budget? Are there limitations on potential liability?

In policies?	Yes ___	No ___
In budget?	Yes ___	No ___
Limitations?	Yes ___	No ___

SOURCES/NOTES _____

_____

IX.C. Allocation of Time and Effort

1. Do source documents (e.g., time cards) indicate what location (including cost center) the employee is working in at any given time?

Yes ___ No ___

SOURCES/NOTES _____

_____

2. If employees are paid from multiple grants or programs, do time cards or other source documents (such as periodic time and effort reports) indicate which funding sources are to be charged for any given time period?

Yes ___ No ___ N/A ___

SOURCES/NOTES _____

_____

3. If source documents do not provide the basis for payroll allocations to separately funded programs, how are the allocations made?

Method _____

Is the method appropriate? Yes ___ No ___

SOURCES/NOTES _____

_____

IX.D. Payroll Advances and Loans

1. Are payroll advances and loans to employees allowed in the personnel policies?

Yes ___ No ___

If yes, are the policies:
Appropriate? Yes ___ No ___
Followed? Yes ___ No ___

SOURCES/NOTES _____

_____

X. REVENUE AND COST ALLOCATION

X.A. Departmental Allocation

1. Do departments receive separate revenue and expense budgets for their operations?

Revenue? Yes ___ No ___
Expense? Yes ___ No ___

SOURCES/NOTES _____

2. Are occupancy costs, such as rent, depreciation, utilities, security, maintenance, etc., allocated to individual departments and/or programs?

Yes ___ No ___

SOURCE/NOTES: _____

3. Are communications costs, including reproduction, telephone, and postage, allocated to individual departments and/or programs?

Yes ___ No ___

SOURCE/NOTES: _____

4. Is staff time allocated to multiple departments and/or programs when required?

Yes ___ No ___

SOURCE/NOTES: _____

5. Are revenues from grants and patient services (including third party payments) allocated to individual departments and/or programs?

Yes ___ No ___

SOURCE/NOTES: _____

X.B. Programmatic Allocation

1. Do separately funded programs have revenue and expense budgets for their operations *as required*?

Revenue? Yes ___ No ___
Expense? Yes ___ No ___

SOURCE/NOTES: _____

2. Are occupancy costs, such as rent, utilities, security, maintenance, etc., allocated to these programs?

Yes ___ No ___

SOURCE/NOTES: _____

_____

3. Are communications costs, including reproduction, telephone, and postage, allocated to these programs?

Yes ___ No ___

SOURCE/NOTES: _____

_____

4. Are staff who work in multiple programs, and/or who have responsibilities that are paid for by multiple programs, allocated appropriately to these multiple programs?

Yes ___ No ___

SOURCE/NOTES: _____

_____

5. Are revenues from grants and patient services allocated to separately funded programs?

Yes ___ No ___

SOURCE/NOTES: _____

_____

XI. FISCAL REPORTING

1. Are the MHP's fiscal systems capable of providing each of the following reports (show the average lag time, defined as the amount of time between the end of the reporting period and the actual availability of the report)?

Reports	YES	NO	AVE. LAG
a) A report of accrued revenues and expenses compared to budget, with year to date variance showing whether it is over or under budget in any given area			
b) A cash flow statement			
c) MHP's balance sheet compared with either the same date last year or the last audited balance sheet			
d) A report of encounter activity and voucher activity compared to budget and prior year			
e) A report on vouchers issued but for which an invoice for payment has either not been received or payment not been made (IBNR)			

f) Entry site by entry site report of income, expenditures, and vouchering activity, if more than one site			
g) A report of MHP receivables by source showing the distribution by payer and by age of the receivable			

SOURCE/NOTES: _____

_____

2. How often are the reports listed in item 1 above provided to the following groups or individuals? (Note: M=monthly, Q=quarterly, A=annually, N=never, N/A=not applicable)

Group or Individual	(a)	(b)	(c)	(d)	(e)	(f)	(g)
Executive Director							
Voucher Program Director							
Board Fiscal Committee							
Total Board							

SOURCE/NOTES: _____

_____

XII. AUDIT

1. Have audits been conducted regularly and on time over the last three years in accordance with OMB Circular A-128 or A-133?

Yes ___ No ___

SOURCE/NOTES: _____

_____

2. Have the opinions for the last three years been unqualified?

Yes ___ No ___

SOURCE/NOTES: _____

_____

3. Have management letters been submitted by the auditor for each of the last three audits?

Yes ___ No ___

4. *If yes,* have management letter findings been acted on promptly?

Yes ___ No ___

SOURCE/NOTES: _____

_____

5. Has the Board received and reviewed all audit findings including management letter? Is this documented in the Board minutes? (Note: Reviewer is reminded to coordinate with Administrative and Governance reviewer.)

Yes ___ No ___

SOURCE/NOTES: _____

_____

6. For how many consecutive years has the current auditor been used?

Number of years _____

SOURCE/NOTES: _____

_____

XIII. FINANCIAL STATUS REPORT

1. a) Has a timely Financial Status Report (FSR) been prepared and filed?

Yes ___ No ___

b) Do the financial statements contain or does the voucher program have a reconciliation of the FSP to the audited financial statements or general ledger?

Yes ___ No ___

SOURCE/NOTES: _____

_____

2. On Form SF424A in the grant application, was all patient service revenue included in line 7 of Section B (program income) and was all non-patient service revenue (state, local and other funding) included in Section C (non-federal resources)?

Yes ___ No ___

Do line 7 of Section B and Section C total the non-federal support in column (f) of Section A of Form SF424A?

Yes ___ No ___

SOURCE/NOTES: _____

_____

3. Has Excess Program Income, if any, been properly calculated?

Yes ___ No ___

If no, fully explain in your notes and quantify the error.

SOURCE/NOTES: _____

_____

4. How much Excess Program Income, if any, has been generated in the last three years? N/A ___

Year _____ Amount $_____
Year _____ Amount $_____
Year _____ Amount $_____

SOURCE/NOTES: _____

_____

5. Has the MHP spent any of their Excess Program Income?

Yes ___ No ___ N/A _____

If yes, for what was it spent?

_____

_____

6. Was prior written approval from BPHC obtained for any construction expenditures consuming in excess of 50% of Excess Program Income from any one budget period?

Yes ___ No ___ N/A _____

SOURCE/NOTES: _____

_____

XIV. VOUCHER PRACTICES

1. Are all or most of the providers to which the program refers patients with vouchers under contract?

Yes ___ No ___

If no, how are the amounts to be paid determined?

___ Pay charges
___ Medicaid fee schedule
___ Negotiated discount from charges
___ Other (explain in notes)

SOURCE/NOTES: _____

_____

2. How were providers selected for contracts?

_____

_____

3. When vouchers are issued prior to the patient receiving the service, is a liability recorded against the voucher budget?

Yes ___ No ___

4. *If no,* does the program know at any time what its potential liabilities are for vouchers not yet returned with a bill?

Yes ___ No ___

SOURCE/NOTES: _____

_____

5. Are all invoices matched with the original voucher and approved for payment by the referrer? Is this done through an authorized for payment signature on the voucher?

Yes ___ No ___

SOURCE/NOTES: _____

_____

6. If the provider decides that laboratory testing, additional visits or some other ancillary service is needed, must authorization be received beyond the services specifically approved on the original voucher?

Yes ___ No ___

SOURCE/NOTES: _____

_____