Policies that are specifically recognized as requiring BOD approval in the HRSA Compliance Manual and Site Visit Protocol (SVP)

- Sliding Fee Discount Program (See SVP Chapter 9 for details)
- QI/QA Plan (within the last 3 years) (See SVP Chapter 10)
- Billing and Collections Policy(s) specifically (See SVP Chapter 16) *Note: HRSA allows some B&C documents to be represented as procedures.*
    - ✓ Waiving or reducing patient fees (must be a policy)
    - ✓ Third party payor billing procedures and/or contracts
    - ✓ Provision for notifying patients of additional costs, etc.
    - ✓ Refusal to pay, if applicable (must be a policy)
- Financial Management and Accounting Systems (See SVP Chapter 15)
- Personnel (See SVP Chapter19)
- Patient Satisfaction (See SVP Chapter 10 and 19)
- Patient Grievances (Complaints) (See SVP Chapter 10 and 19)
- Incident Management (See SVP Chapter 10 and 19)
- All other policies related to the operations of the health center (See SVP Chapter 19)
- Purchasing, Procurement/Contracting, and Contract Management (unless this is a procedure. A procedure is acceptable by HRSA and does not require BOD approval) (See SVP Chapter 12)
- Conflict of Interest (may also be part of by-laws) (See SVP Chapter 13)
- Standards of Conduct (See SVP Chapter 13)
- Referral Tracking (See SVP Chapter 21)
- Claims Management Policy (See SVP Chapter 21)
- Tracking and Follow-Up of Diagnostic Testing (See SVP Chapter 21)
- Tracking and Follow-Up of Hospitalizations (See SVP Chapter 21)

Other BOD activities:

Note: It is suggested a BOD calendar be used to ensure the BOD performs and documents the activities below:

- Review and update needs assessment (at least once every 3 years)
- Use of UDS patient origin to define and review its service area as reflected by the zip codes included in Form 5B (annually)
- Use of needs assessment
- Assess barriers to access – site locations, hours of operation, language, travel distance between sites, etc
- Review and approval of changes in scope (sites and services)
- Strategic Plan (at least once every3 years)
- CEO Evaluation (annually)
- Evaluation/Assessment of barriers associated with sliding fee discounts (once every 3 years)
- Approve, select, dismiss CEO, as applicable
- Meetings (monthly)
- Budget, Federal, and non-Federal resources and revenue (annually)
- Evaluating health center performance based on the QA/QI improvement assessments (at least quarterly)

- Risk Management Assessment (at least quarterly)
- Ensuring appropriate follow-up actions of:
  - ✓ QI/QA program
  - ✓ Achievement of project objectives
  - ✓ Service utilization patterns
  - ✓ Quality of care
  - ✓ Efficiency and effectiveness of the center
  - ✓ Patient satisfaction including addressing any patient grievances
- Approving applications related to the health center project
- Monitoring financial status (usually monthly)
- Credentialing and Privileging of LIPS, if authority vested in BOD
- Review and evaluate Risk Management assessments (at least quarterly)