ACTIVE SHOOTER AND WORKPLACE VIOLENCE PREPAREDNESS AND RESPONSE: A COMPLIANCE PERSPECTIVE

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On November 19, 2018, four people were killed in a shooting at Mercy Hospital in Chicago. On May 13, 2017, a patient obtained a handgun, held four nurses hostage, and sexually assaulted one of them.[1] Unfortunately, these horrific situations are not unique. Healthcare is particularly vulnerable to violence in the workplace.[2] According to the Bureau of Labor Statistics, 70% of the victims of workplace violence were healthcare or social service workers.[3] The Joint Commission (TJC) reported that, in 2017, "criminal events," such as shootings, homicide, physical assault, and sexual assault was the seventh most common sentinel event,[4] up from number nine in 2016.[5]

Compliance professionals have a role in developing policies and processes to prevent and respond to workplace violence. Federal law requires healthcare organizations to provide a safe working environment for employees and to manage safety and security risks.[6,7] The Occupational Safety and Health Administration (OSHA) and TJC have issued guidance on steps that healthcare organizations can take to prepare for, prevent, and respond to workplace violence. Both OSHA and TJC recommend that healthcare organizations develop and implement policies and training to address violence; analyze the worksite to determine risks, including tracking reports of violence or threats of violence; develop processes to prevent and control incidents; provide support for victims; and evaluate the program and policies to reduce incidents and root causes. These resources, however, do not provide direct guidance for compliance professionals in addressing policies and processes regarding active shooters.

Legal standards and guidance

The Occupational Safety and Health Act (OSH Act) imposes on all employers a general duty to furnish a place of employment that is "free from recognized hazards that are causing or likely to cause death or serious physical harm to its employees."[8] This general duty, however, does not specifically prescribe how employers are to eliminate or reduce employees' exposure to workplace violence. Last year, OSHA issued a request for information (RFI) regarding workplace violence in the healthcare and social services settings. The goal of the RFI was to implement a standard for organizations to follow to prevent, prepare for, and respond to violence, including active shooter situations. The comment period closed on April 6, 2017, but as of the date of this article, OSHA has not yet issued a formal standard.[9]

In the meantime, OSHA has issued guidelines to help healthcare organizations address the threat of workplace violence.[10] These voluntary guidelines recommend a comprehensive violence prevention program, and include detailed, research-based information on specific controls and strategies for various healthcare and social assistance settings to help employers and employees prevent violence. OSHA's guidelines consist of five core elements or "building blocks": (1) Management commitment and employee participation, (2) worksite analysis, (3) hazard prevention and control, (4) safety and health training, and (5) recordkeeping and program evaluation.[11]

In addition to the general duties under the OSH Act, hospitals must meet the health and safety Medicare Conditions of Participation (CoPs) in order to participate in Medicare.[12, 13] The CoPs—and for TJC accredited hospitals, the corresponding TJC standards—do not directly address workplace violence or active shooter situations, but they do require hospitals to provide a safe environment of care and to have processes in place to manage emergencies.[14, 15] TJC has nonetheless recognized that workplace violence implicates many of the accreditation standards (particularly those focused on the environment of care and emergency management) and recommends that organizations take action to address workplace violence, such as: (1) developing and implementing policies to address violence, (2) tracking and trending reports of workplace violence, (3) providing appropriate medical and psychological support for victims and witnesses of violence, (4) reviewing and analyzing each reported incident to determine contributing factors, and (5) developing quality improvement plans to reduce incidents.[16]

Hospitals should also be cognizant of state laws that may affect their plans and response to workplace violence. For example, several states have enacted laws that require employers of healthcare and/or social assistance workers to establish a plan or program to protect those workers from workplace violence (e.g., California, Connecticut, Illinois, Maine, Maryland, New Jersey, New York, Oregon, and Washington).[17] In Illinois, the Health Care Violence Prevention Act, which became effective January 1, 2019, seeks to address the risks of workplace violence, requires healthcare providers to comply with workplace safety requirements, and necessitates a workplace violence protection program.[18] Other state laws that may affect a hospital's response to threats of violence may include privacy protections, protections for victims of domestic abuse, laws relating to firearms, and any laws that require reporting of injuries to patients or employees. As healthcare employees continue to face violence in the workplace, they are working with state legislators to create or strengthen protections for healthcare workers and increase the penalties for assault on healthcare workers.[19, 20]

Additionally, while not binding, healthcare organizations can look to guidance and recommendations from OSHA,[21, 22] TJC,[23] the Centers for Disease Control and Prevention (CDC),[24] and security management organizations, such as ASIS International.[25] These resources may provide guidance on developing workplace violence prevention and response programs. ASIS International has issued comprehensive guidance on prevention and intervention for workplace violence (ASIS Standard).[26] The ASIS Standard is not a legal authority and is not binding, but it provides comprehensive guidance on developing and implementing a workplace violence prevention and intervention program.

Several states have enacted laws that require employers of healthcare and/or social assistance workers to establish a plan or program to protect those workers from workplace violence.

Preparation and prevention

Compliance professionals can play a key role in preparation and prevention of workplace violence, including active shooters. An organization can begin by assembling an interdisciplinary team to address the threat of workplace violence and active shooters, and by allocating sufficient resources to the team to carry out its mandate. This interdisciplinary team, which ASIS International calls a "threat assessment team," would ideally consist of representatives from security, human resources, compliance, legal counsel, risk management, public relations, union leaders, employee assistance programs, crisis management personnel, and any other key stakeholders.[27, 28] The threat assessment team may be tasked with developing

policies and training, as well as performing an initial investigation and response to any reported threats of violence.

An incident that involves an employee fatality must be reported to OSHA within eight hours, and work-related injuries... must be reported within 24 hours.

Policy development should begin with recognizing and defining workplace violence and assessing the organization's vulnerability to workplace violence. OSHA defines *workplace violence* as "any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It ranges from threats and verbal abuse to physical assaults and even homicide. It can affect and involve employees, clients, customers and visitors."[29] Michael Crane, a licensed attorney, private detective, and expert in conducting security and threat assessments, explains, "An active shooter incident should be viewed as a subset of workplace violence."[30] An organization should consider the risks to healthcare organizations generally, as well as risks specific to its organization, such as employees who work alone or at night, a location in an area that is at high risk for crime, or any history of violence or a culture of tolerating threatening behavior within the organization. The threat assessment team should also evaluate existing policies and practices to determine their completeness and effectiveness.

Organizations have wide latitude in developing a workplace violence prevention policy that is appropriate for its size, needs, and vulnerabilities. At a minimum, a workplace violence prevention and intervention plan could include the following elements:

- A clear definition of unacceptable behavior;
- Regulation or prohibition of weapons during work-related activities or on the premises, consistent with state law;
- Processes for reporting suspected policy violations or safety concerns, including multiple avenues for reporting (e.g., human resources, security, management, threat assessment team, a hotline);
- Assurance that reports will be treated with discretion and promptly investigated;
- Assurance that employees who report concerns in good faith will not face retaliation or negative job consequences as a result of the report; and
- Disciplinary consequences for policy violations, up to and including termination.

Encourage employees to inform clearly identified personnel (e.g., security or threat assessment team) of any protective or restraining orders that the individual employee has obtained that list the workplace as a protected area.

Organizations should work with law enforcement and emergency responders in advance to develop a response plan. Law enforcement should have access to building floor plans and be able to set up command centers onsite, in the event of a violent incident. Organizations should develop a communication plan with law enforcement and first responders, including a direct contact, types of information that should be reported if possible, an incident command structure, and advance notice and support for events that may involve a high risk of violence, such as layoff announcements or an adversarial termination. Law enforcement may also provide valuable information on other preventive steps that an organization can take, such as training and live drills.

Intimate partner violence

When developing and implementing a workplace violence policy, organizations must be aware of and address the magnitude of the threat of violence associated with intimate partner violence. As security expert Michael Crane explained:

> The statistics indicate that 75% to 80% of workplace violence is closely related to domestic violence. Human resource policies and procedures must be geared toward sensitizing the workforce to being alert to potential threats as they develop. For instance, it is important to take notice of an employee whose mood or normal disposition suddenly changes, or a particularly disgruntled worker, or a discharged employee who has expressed violent thoughts regarding the employer or the workplace, or a co-worker who has obtained a restraining order on a spouse or

significant other. These warning signs are often ignored and should instead be identified so that the employer can conduct a threat assessment and take appropriate follow up precautions. Healthcare facilities must review HR policies and procedures to ensure that they take into account a detailed threat assessment protocol and have their threat assessment team in place to evaluate the threat and determine the risk of potential violence.[31]

The ASIS Standard highlights the importance of integrating the issue of intimate partner violence into the organization's program and recommends that an organization foster a supportive environment and encourage employees to report safety concerns related to intimate partner violence, ensuring that employees know that they will not be subject to retaliation or negative job consequences as a result of reporting intimate partner violence.[32]

Training

A comprehensive workplace violence prevention program may include training for employees on the workplace violence policy, from a general perspective, as well as any job-specific training that may be appropriate. For example, security personnel may require additional training on the policy, including incident response and active shooter preparation. This training may include recognizing warning signs of potentially violent or threatening behavior, reporting suspected safety concerns, incident response, and understanding the organization's non-retaliation policy. Because of the correlation between intimate partner violence and workplace violence, an organization may wish to address intimate partner violence in its training program, including warning signs that an employee may be involved in an abusive relationship, circumstances and processes for appropriate reporting of an abusive relationship, and outside resources (such as employee assistance programs) for employees who may be in an abusive relationship.[33] OSHA, CDC, and TJC include training opportunities and ideas in their resources for healthcare employers and workers.

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Initial response and recovery

When an organization receives a report of a non-emergent threat, a threat assessment team may review and investigate the report. A team member could perform an initial investigation to determine if there is a cause for concern. If so, the team member may confer with other members of the threat assessment team and consider taking additional actions, such as consulting an expert to assess the threat and propose effective interventions, considering the need for additional security, and contacting law enforcement.

The organization should consider involving legal counsel in the investigation process. By working with legal counsel on the investigation, strategy sessions, investigation materials, and communications may be protected by attorney-client privilege. Additionally, legal counsel can advise on issues that may arise during the investigation, such as employment law implications of interventions, required notifications, obligations to warn potential targets of violence, and protecting individuals' privacy rights.

If a report or incident is an emergency, such as an active shooter, the organization should follow its policies and take appropriate actions,including contacting law enforcement and first responders, securing the building, protecting patients, and providing aid to any victims. The organization's policies should prioritize life safety (e.g., security, medical attention to injured personnel or patients), evidence preservation, and asset preservation. The organization should continue to assess additional threats, such as a continuing threat or the possibility of "copycat" incidents or multiple attacks. Finally, the organization should consider its communication plan for management, personnel, next of kin, regulatory authorities, and the media. Early and clear communication will help ensure that accurate information is shared, rather than speculation or misinformation.

When recovering from an incident, an organization should mobilize available resources, such as the threat assessment team, extra security, insurance, and temporary work staff. After a traumatic event, an organization should offer crisis mental health services to its employees and those affected by the incident, as well as a family representative program to assist family members of those affected by an incident. An organization should consider the continuity of its operations after different types of incidents, including when a temporary or permanent cessation of operations would be appropriate, the duration of a hiatus, and steps it would take to restore or continue operations.

Investigation, reporting, and recordkeeping

After an incident occurs and threats have been stabilized, the organization should conduct a full investigation and root cause analysis to determine the causes of the incident, as well as any vulnerabilities or missteps that led to the incident or permitted the incident to occur. The organization should also recognize any processes that worked well to prevent or mitigate further harm. The organization should again consider involving legal counsel in post-incident investigation processes to preserve the confidentiality and privilege of the investigation, and to obtain legal advice on the root causes and responses to the incident. After a report or investigation has been resolved, the organization should keep records of the report or incident and the organization's response.

When an incident occurs, the organization will likely need to report the incident to regulatory agencies. For example, an incident that involves an employee fatality must be reported to OSHA within eight hours, and work-related injuries resulting in inpatient hospitalization, amputation, or loss of an eye must be reported within 24 hours.[34] Additionally, incidents will need to be included in an organization's annual report to OSHA, summarizing all serious work-related injuries and illnesses.[35,36] States may also require reporting of injuries to employees or patients. If the organization is TJC accredited, it should consider Sentinel Event reporting.

The threat assessment team should keep records of all reports and incidents, including the organization's response to each. The data from these records should be evaluated at least annually when the organization reviews its policies and

workplace violence prevention, intervention, and emergency management programs.[37] The organization should examine the program, as well as the reports, to identify opportunities for improvement, additional vulnerabilities, and additional ways to address risks.

Conclusion

From a compliance perspective, the law and accreditation standards that impose direct, specific requirements related to workplace violence and active shooters are not fully developed. Nevertheless, OSHA, CDC, TJC, and certain state laws recognize workplace violence as a serious risk—particularly to healthcare providers and social workers. In addition to following OSHA's general duty requirement, CoPs (and related TJC accreditation standards) related to environment of care, emergency management, and relevant state law, compliance professionals can play a key role in the development of policies and training programs to prevent and address workplace violence, including developing a threat assessment team, coordinating with law enforcement and other local resources, and investigating and acting on potential workplace violence risks. CT

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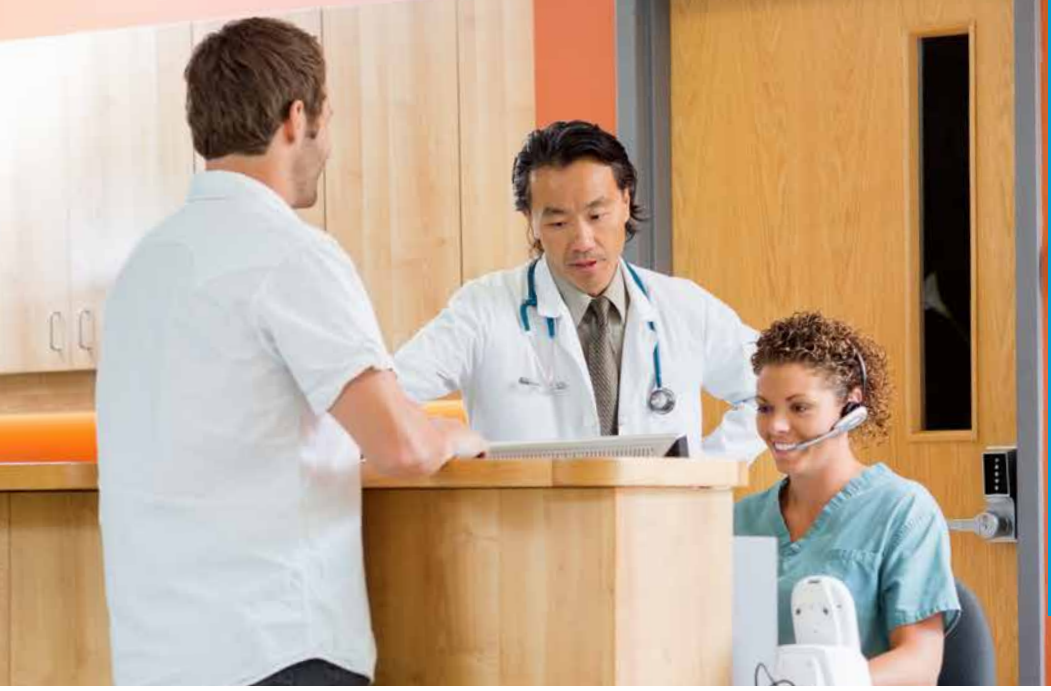
Takeaways

- Develop a way for employees to report threats of violence, including threats by intimate partners, and foster a supportive environment for reporting.
- Create a threat assessment team to evaluate and respond to potential threats.
- Maintain and evaluate policies and procedures for preventing and responding to workplace violence.
- Work with local law enforcement and emergency responders in advance to develop a response plan.
- Work with legal counsel to investigate incidents and report events to federal and state agencies.



SECURING THE SAFETY NET: CURRENT COMPLIANCE ISSUES IN FEDERALLY QUALIFIED HEALTH CENTERS

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Federally Qualified Health Centers (FQHC) are a crucial component of the nation's healthcare safety net, providing structured access to primary and specialty care in underserved communities. Operating an FQHC is a uniquely challenging endeavor. FQHCs are eligible for numerous federal and state benefits, such as grant funding under Section 330 of the Public Health Service Act, discounted drug pricing under the 340B Drug Discount Program (340B Program), enhanced Medicare payment under the Centers for Medicare & Medicaid Services (CMS) FQHC Prospective Payment System, cost-based reimbursement under the Medicaid program, protections from Anti-Kickback Statute restrictions, and access to various federal and state practitioner recruitment programs. Of course, in exchange for access to these benefits, an FQHC agrees to comply with a wide array of statutory and regulatory obligations.

This article describes contemporary hot topics in FQHC compliance with the goal of helping FQHC executives and compliance professionals update their compliance work plans to identify potential trouble spots before they develop into significant compliance concerns. Each section describes practical steps that a compliance professional can take to address these concerns.

340B Drug Discount Program

FQHCs can secure substantial savings on prescription drugs provided to patients in the office and through third-party retail pharmacies by enrolling in the 340B Program,[1] but doing so carries with it significant compliance obligations. One common challenge to 340B Program compliance is that oftentimes, shifts in program compliance are communicated through nonpublic audit findings rather than publicly available resources. Compliance professionals should be aware of three particular issues that have become prevalent in recent years: tracking of drugs purchased under the 340B Program; enrollment of FQHC-affiliated pharmacies; and ensuring that patients referred to other providers, through FQHC referral arrangements or otherwise, are appropriately accounted for.

A full description of the 340B Program is outside the scope of this article, but certain key concepts are important to the discussion that follows. Under the 340B Program, safety net providers such as FQHCs are eligible to purchase certain drugs at a significant discount. Participation in the 340B Program is elective, and entities that participate (called

"covered entities") are required to attest to 340B Program compliance on an annual basis. 340B covered entity status does not encompass all of a participating provider's operations; instead, a covered entity is only permitted to dispense *covered outpatient drugs*[2] to *eligible patients*.[3] Dispensing or transferring a 340B-purchased drug to any other person or entity is considered diversion, which can lead to significant penalties for the FQHC.

Clinical employees must understand the distinction between 340B and non-340B inventories and have appropriate guidance in determining which to use.

Diversion and floor stock

In recent years, some FQHCs participating in the 340B Program have struggled to document that "floor stock" (i.e., drugs that are stored outside of a central licensed pharmacy) has been administered to FQHC-eligible patients. Although it would stand to reason that all floor stock in an FQHC would be eligible for 340B discounts when administered as part of an FQHC visit, the Health Resources and Services Administration Office of Pharmacy Affairs (HRSA OPA), which oversees 340B Program compliance, has recently required FQHCs to be able to tie specific drug purchases and administrations/dispensations to specific episodes of care as documented in the patients' medical records. Of course, this is more complicated and important in the setting where an FQHC is co-located with non-FQHC operations.

As a result, covered entities must establish a system to keep track of their inventories of 340B drugs and refrain from dispensing 340B drugs to ineligible patients. The practice of stocking drugs away from a central pharmacy is not itself a violation of 340B Program guidance, but a decentralized system may make it difficult for an FQHC to keep track of 340B inventory. This is especially true where the FQHC maintains a separate physical inventory of 340B drugs, because clinical employees must understand the distinction between 340B and non-340B inventories and have appropriate guidance in determining which to use. This process may be made easier through the use of a virtual inventory system, where the FQHC dispenses drugs from a central stock, then determines whether to replenish the stock under the 340B Program based on the characteristics of the dispensing event, such as the identity of the patient, the eligibility of the drug for inclusion in the 340B Program, and whether the 340B price is the best price available to the FQHC. However, although a software-based virtual inventory may make it easier to track floor stock, inventory control is still crucial, because a virtual inventory system relies on accurate data to identify the patient who receives a drug.

Contract pharmacy and referral partner relationships

FQHC compliance professionals should also be aware of issues that can arise in relationships with affiliated pharmacies. In many cases, an FQHC will wish to dispense its own 340B covered drugs through a separately licensed pharmacy owned by another entity, including both pharmacies located within the four walls of the FQHC and for-profit retail pharmacies located outside of the FQHC. HRSA permits this practice, provided that the relationship between the covered entity and the contract pharmacy is appropriately documented, and the covered entity records the relationship in the HRSA 340B database.

It is common for a retail pharmacy to have a 340B contract pharmacy relationship with a number of 340B covered entities. When this happens, it is often the case that a single patient will qualify as a patient of more than one 340B covered entity, so it can be unclear which entity's virtual stock is used to supply the patient with their prescription.

Additionally, as described in further detail below, FQHCs are required to provide a pre-defined slate of primary services to their patients. An FQHC can meet this obligation by providing care through employed providers, through providers under contract with the FQHC, or through formal referral arrangements. A patient who receives care from an FQHC-employed provider as part of an eligible on-site visit will typically be an eligible patient of the FQHC.[4] However, when the provider is employed by a different 340B covered entity, the FQHC must consider the relationships between itself, the provider, and the patient to determine whether it may dispense drugs to the patient from its 340B inventory through a contract pharmacy arrangement. It is possible that the patient will be an

eligible patient with respect to both the FQHC and the other provider. Additionally, complications can arise when the patient decides to fill their prescriptions with a pharmacy that has a contract pharmacy relationship with both the FQHC and the contracted provider's employer.

Steps for compliance professionals

Compliance professionals can help their FQHCs by including a review of floor stock practices and contract pharmacy relationships in their work plans. With respect to tracking of 340B-purchased drugs, activities could include a review of applicable policies, audits of records, and conversationswith staff to determine if drugs that are stocked away from the central pharmacy can be attributed to 340B eligible patients. Additionally, if the FQHC keeps separate physical inventories of 340B and non-340B drugs, the compliance professional should consider reviewing the guidelines that are used by staff responsible for choosing which inventory to use when a drug is dispensed. Spot checks may also be conducted to determine if the FQHC is able to determine the source of particular drugs. For FQHCs that maintain virtual 340B inventories, compliance professionals can audit clinicians' records to ensure that patients who received floor stock drugs can be reliably identified.

With respect to contract pharmacy relationships, compliance professionals should consider reviewing the licensure status of pharmacies operating within the FQHC. If the pharmacy is owned by a different entity or is separately licensed and maintains a retail pharmacy permit, the compliance professional can review the FQHC's enrollment records in the HRSA 340B database[5] to determine if the pharmacy is appropriately listed as a contract pharmacy and also that a compliant 340B contract pharmacy agreement is in place.[6]

Compliance officers should consider reviewing the agreements between the FQHC and its contract pharmacies and ensuring that contract pharmacies are complying with recordkeeping, diversion, and other operational requirements. If the FQHC has contract pharmacy relationships with retail pharmacies, it is often the case that a pharmacy will also be a contract pharmacy for other 340B covered entities. In this case, the compliance professional should consider reviewing both the contract pharmacy agreement and the referral agreement to determine if 340B patient attribution is addressed in a way that can be (and actually is) implemented by each entity's workforce.

Notably, when patient attribution is appropriately addressed in a contract pharmacy's agreements with 340B covered entities, each covered entity may see decreased 340B Program volume, because each dispensed prescription will count only one time for a single provider. However, 340B Program compliance is crucial to continued eligibility to participate in the program. 340B covered entities are ultimately responsible for compliance with HRSA guidelines, so it is incumbent upon them to ensure that contract pharmacies and other affiliates are abiding by 340B Program requirements.

Patient referrals

Patient referrals continue to be an area of concern for providers participating in the federal healthcare programs, and for good reason: The fraud and abuse laws generally prohibit anyone from paying for a referral of federal healthcare program business. Although FQHCs must abide by these restrictions, they face an additional complication not present elsewhere: Section 330 of the Public Health Service Act requires FQHCs to refer patients to other providers, including specialists and providers of substance use disorder and mental health services, as part of the health center's required primary care services.[7] FQHCs are also required to develop ongoing referral arrangements with one or more hospitals.[8] These requirements create unique challenges for FQHC compliance professionals.

Referral arrangement requirements

HRSA expects that FQHCs will enter into formal referral arrangements with other providers, and it has outlined key considerations for these relationships in its *Health Center Program Compliance Manual (Compliance Manual)*.[9] However, the *Compliance Manual* deals mostly with the laws that HRSA administers, and its discussion of referral arrangements does not address other authorities that the FQHC must abide by, such as the fraud and abuse laws and HIPAA. Most of the potential concerns under the fraud and abuse laws can be addressed by ensuring that a referral arrangement does not require the referral partner to pay the FQHC for referrals, that remuneration is fair market value, or that the FQHC Safe Harbor elements at 42 C.F.R. § 1001.952(w) are met and documented if the FQHC receives a Section 330 grant, but HIPAA compliance can present significant issues.

Handling protected health information

Recently, FQHCs have encountered difficulties when referral partners

use FQHC patients' protected health information (PHI) for purposes that require patient consent, such as marketing. FQHCs should ensure that their referral arrangements establish a compliant system for handling PHI. HIPAA and its attendant regulations allow HIPAA covered entities to share information with other providers for payment and treatment purposes without obtaining patient consent,[10] but consent is required before the covered entity can use or disclose PHI for marketing activities.[11] A covered entity will often ask a patient for consent as part of the intake process, but that consent will typically not authorize a referral partner to use PHI for marketing.

In that light, issues can arise when an FQHC transfers patient information to a referral partner, especially when the patient ultimately chooses not to obtain services from the partner. The referral partner provider will have access to the FQHC patient's PHI, but will typically not have an opportunity to obtain the patient's consent to use that PHI for purposes such as marketing. The FQHC should be confident that the referral partner has appropriate internal controls in place to ensure that the PHI is not used for any purposes requiring patient consent.

Steps for compliance professionals

FQHC compliance professionals should consider including a review of their organization's referral relationships in their compliance work plans. Pursuant to the *Compliance Manual*, each referral arrangement should address how referrals will be managed and the process for tracking and referring patients back to the health center for appropriate follow-up care.[12] When assessing fraud and abuse compliance, FQHC compliance professionals should consider not only the referral arrangement, but also all aspects of the financial relationship between the health center and a referral partner. Additionally, referral arrangements should address the referral partner's appropriate use of PHI and establish expectations for handling PHI of FQHC patients who do not ultimately seek care from the referral partner. In light of HIPAA's extensive rules regarding patient authorizations, including the general prohibition on compound authorizations, FQHC compliance professionals should be wary of addressing this issue by obtaining a patient's consent on behalf of the referral partner.

Commingling of FQHC and non-FQHC resources

In 2018, the Centers for Medicare & Medicaid Services (CMS) updated its policy addressing commingling, defined as the sharing of resources between an FQHC and independent Medicare Part B or Medicaid fee-for-service practice that operates out of the same location.[13] CMS generally prohibits commingling as a means of preventing providers from filing duplicate claims or selectively choosing between reimbursement rates that could be available under the FQHC Prospective Payment System as opposed to the Medicare Physician Fee Schedule.[14] To compliance professionals who work with hospitals, the commingling standards will be somewhat familiar, because similar restrictions exist for provider-based hospital departments. As described below, though, the FQHC commingling requirements are both more definite and more flexible than CMS's stance on colocation of provider-based departments.

Provider-based restrictions: A comparator

One of the difficulties that hospital executives and compliance professionals face in implementing CMS's restrictions on collocated provider-based departments is that all applicable restrictions are not clearly established in formal policy guidance. As industry groups have noted, this lack of clear guidance has led to significant confusion; in some cases, hospitals have unwound existing collocation and shared services agreements.[15] Despite the lack of published guidance, many commentators have noted that hospitals have been held accountable to these standards when, for example, submitting provider-based attestations.[16] Typically, hospitals are advised to maintain separate, dedicated physical space from any providers operating in the same facility, not to share resources such as registration staff, and to ensure that the provider-based space is not used for other purposes when the department is closed.

Commingling requirements

In contrast to CMS's approach to provider-based collocation requirements, the FQHC commingling restrictions are established in the *Medicare Benefit Policy Manual*.[17] In short, they prohibit a provider who receives compensation from an FQHC for professional services from furnishing or separately billing for FQHC-covered services as a Part B provider in the FQHC's space, or in an area outside of the certified FQHC (such as a treatment room adjacent to the FQHC) during the FQHC's hours of operation.[18] Applying these restrictions becomes complicated in practice when an FQHC is located in a building with other providers. For instance, if a provider works part-time for

an FQHC (either for pay or as a volunteer) and also practices at a site adjacent to the FQHC, the provider may be prohibited from billing Medicare Part B for services provided in their private clinic if the services would be covered FQHC services if they had been provided in the FQHC. Additionally, there is some overlap between the provider-based public awareness requirement[19] and the requirement that space controlled by an FQHC that is located in in a larger facility be clearly defined.[20] If an FQHC is located in a building with other providers, patients should be able to determine which parts of the building are controlled by the FQHC.

Steps for compliance professionals

To address commingling issues, FQHC compliance professionals should consider assessing the FQHC's relationships with providers who work in the FQHC and in space adjacent to it. Reviewing provider contracts and auditing bills submitted by the FQHC and its employed and contracted providers can help a compliance professional discover potential commingling issues. Additionally, walking the facility can help a compliance professional determine if the FQHC is abiding by CMS's expectation that the FQHC's space be clearly defined.[21]

Employment of CEO/project director

Finally, one of the most significant shifts in FQHC program obligations is the requirement that an FQHC "directly employ" its chief executive.[22] Prior to 2018, an FQHC's independent governing board could decide to contract for the chief executive's services, subject to the approval of its HRSA project officer.

Reviewing provider contracts and auditing bills submitted by the FQHC and its employed and contracted providers can help a compliance professional discover potential commingling issues.

This change will require existing FQHCs to evaluate their relationships with supporting providers and could create difficulties for new health centers.

Implementing the direct employment requirement has proven to be a challenge for FQHCs. Although HRSA updated its *Compliance Manual* to take account of this change in August of 2018,[23] its revisions do not answer a crucial operational question: What does it mean to "employ" the chief executive?

HRSA guidance

Some guidance can be found in HRSA's Health Center Program Site Visit Protocol (Site Visit Protocol), which instructs surveyors on how to evaluate new and existing FQHCs. There, the surveyor is instructed to determine whether the FQHC's chief executive receives W-2 salary compensation from the FQHC.[24] This requirement is notably limited in its scope. For instance, it does not address whether the chief executive must be employed full-time by the health center, or if the executive may instead be employed part-time or be a dual employee of the health center and another organization.

Notably, HRSA's *Compliance Manual* updates do provide specific guidance for public entities that operate FQHCs under co-applicant arrangements. Although the public entity and the nonprofit governing board are typically taken together as the "health center" for FQHC compliance purposes,[25] HRSA created a more restrictive standard with regard to the direct employment requirement. In a co-applicant model, the public entity, as the recipient of the Section 330 grant or FQHC look-alike designation, must employ the chief executive.[26]

Steps for compliance professionals

Clearly, FQHC compliance professionals are unlikely to have direct control over the chief executive's employment relationship with the health center or a supporting organization. However, compliance professionals should ensure that the FQHC's executive is aware of the new restriction and help facilitate a compliant transition if necessary and appropriate. As noted above, significant questions exist as to how HRSA will expect FQHCs to implement this new requirement. For instance, in situations where a supporting organization employed the chief executive and provided them with services at a discount under the Health Centers Safe Harbor,[27] it may be appropriate to arrange for a dual employment relationship with a supporting organization until the health center is able to bear the financial burden of direct employment. Note that the viability of such an arrangement

will be affected by state employment law and the employers' benefit plan requirements. When changes are necessary, it will be important to work with the FQHC's HRSA project officer to ensure that the new arrangement is acceptable.

Conclusion

Healthcare regulations are a moving target for any healthcare compliance officer, and perhaps nowhere is this more true than in FQHCs. Due to the significant impact that compliance violations could have on an FQHC's ability to serve its community, health center executives and compliance professionals must remain vigilant to ensure that their compliance policies and practices are up to date. CT

Endnotes

1. 42 U.S.C. § 256b(a)(4)(A).
2. Defined at 42 U.S.C. § 1396r-8(k)(2) pursuant to 42 U.S.C. § 256b(b)(2).
3. 61 Fed. Reg. no. 207 (October 24, 1996) at 55156, 55157
4. Idem
5. Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs, Welcome to 340B OPAIS. https://340bopais.hrsa.gov/.
6. *See also* 75 Fed. Reg. no. 43 (March 5, 2010) at 10272 Notice Regarding 340B Drug Pricing Program—Contract Pharmacy Services
7. 42 U.S.C. § 254b(b)(1)
8. 42 U.S.C. § 254b(k)(3)(L).
9. HRSA, Bureau of Primary Health Care, *Health Center Program Compliance Manual,* Chapter 4, August 20, 2018, https://bit.ly/2UNuhDD .
10. 45 C.F.R. § 164.506
11. 45 C.F.R. § 164.508(a)(3).
12. Idem at 26
13. CMS: *Medicare Benefit Policy Manual*, CMS Pub. 100-02, Ch. 13, § 100, https://go.cms.gov/2TY5JdJ
14. Idem
15. *See* American Hospital Association letter to CMS, Sept. 19, 2017. https://bit.ly/2TgUJnm
16. *See, e.g.*, CMS Denial Letter to Provider, dated July 22, 2011. https://bit.ly/2CxsivZ
17. Ibid Ref #15
18. Idem
19. 42 C.F.R. § 413.65(d)(4).
20. Ibid, Ref #15
21. Idem
22. Public Health Service Act, Sec. 330(k)(3)(H)(ii) (42 U.S.C. § 254b(k)(3)(H)(ii), as amended by Bipartisan Budget Act of 2018, Pub. L. 115-123, Sec 50901.
23. HRSA, *Health Center Program Compliance Manual Revisions,* August 20, 2018, https://bit.ly/2Wez01r
24. HRSA, *Health Center Program Site Visit Protocol*, at 60, August 20, 2018, https://bit.ly/2HsqqbW
25. Ibid, Ref #11 at 75
26. Ibid, Ref #11 at 47
27. 42 C.F.R. § 1001.952(w) Exceptions, health centers

Takeaways

- FQHC compliance professionals should understand how routine practices, such as creating a floor stock of pharmaceuticals, can lead to diversion of 340B drugs.
- FQHCs' relationships with their affiliated and contract pharmacies are a key area of concern, especially if the FQHC participates in the 340B Program.
- Formal referral relationships should be audited for compliance with HRSA guidance and to ensure compliance with HIPAA permitted use rules.
- FQHC compliance professionals should act to make sure the center's practitioners abide by CMS's commingling restrictions.
- Complying with the new "direct employment" standard for FQHC CEOs may be a significant challenge for some health centers.

CREDENTIALING AND PRIVILEGING REQUIREMENTS FOR FEDERALLY QUALIFIED HEALTH CENTERS

by Robyn Hoffmann

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The Department of Health and Human Services (HHS) has eleven operating divisions, including eight within the Public Health Service (PHS). The Health Resources and Services Administration (HRSA), one of the divisions of the PHS, is responsible for the administration and funding of Federally Qualified Health Centers (FQHCs) throughout the United States.

What is a Federally Qualified Health Center?

FQHCs are community-based and patient-directed organizations that deliver comprehensive, culturally competent, high-quality primary healthcare services. The term "Federally Qualified Health Center" is a Medicare/Medicaid designation administered by the Centers for Medicare & Medicaid Services (CMS). Health centers that are designated as FQHCs by HRSA must comply with federal rules that pertain to the Health Center Program as authorized in Section 330 of the Public Health Service Act (42 U.S.C. §254b). Within HRSA, the Bureau of Primary Health Care (BPHC) oversees Section 330 program requirements.

FQHCs provide families and individuals with access to primary healthcare, pharmacy, mental health, substance use disorder, and oral health services in medically underserved communities in which economic, geographic, or cultural barriers limit access to affordable healthcare services. FQHCs play a significant role in the delivery of ambulatory health care in the United States. The BPHC highlights on its website[1] that more than 27 million people—1 in 12 nationwide—rely on a HRSA-funded health center for affordable, accessible, primary healthcare, including:

- One in 9 children 17 years or younger nationwide
- One in 3 people living in poverty nationwide
- One in 5 people living in rural communities
- More than 355,000 veterans

Unique resources and requirements for FQHCs

FQHCs have access to significant resources that help to support ongoing service to their target population and community. In addition to their annual federal award[2] under Section 330 from HRSA, all FQHCs receive access to the following resources:

- FQHC Prospective Payment System (PPS) reimbursement for services to Medicare and Medicaid beneficiaries
- 340B Drug Pricing Program discounts for pharmaceutical products
- Free vaccines for uninsured and underinsured children through the Vaccines for Children Program
- Assistance in the recruitment and retention of primary care providers through the National Health Service Corps
- Eligibility for medical malpractice liability protection through the Federal Tort Claims Act (FTCA)[3]
- The Accreditation and Patient Centered Medical Home Recognition Initiative[4]

FQHCs must meet a defined set of Section 330 standards that have been established by the BPHC and addressed in its *Health Center Program Compliance Manual*.[5] Following enactment of the Bipartisan Budget Act of 2018, which amended Section 330 of the PHS, the BPHC issued an update to its *Compliance Manual*. Subsequently, the BPHC revised its Site Visit Protocol in September 2018 to align with the statutory changes. Therefore, it is critical that FQHC-based compliance officers conduct a gap analysis to determine whether any enhancements or other modifications may be warranted for their Health Center's annual compliance work plan.

The BPHC's *Compliance Manual* outlines the following series of requirements for FQHCs:

- Chapter 1: Health Center Program Eligibility
- Chapter 2: Health Center Program Oversight
- Chapter 3: Needs Assessment
- Chapter 4: Required and Additional Health Services
- **Chapter 5: Clinical Staffing***
- Chapter 6: Accessible Locations and Hours of Operation
- Chapter 7: Coverage for Medical Emergencies During and After Hours
- Chapter 8: Continuity of Care and Hospital Admitting
- Chapter 9: Sliding Fee Discount Program
- Chapter 10: Quality Improvement/Assurance
- Chapter 11: Key Management Staff
- Chapter 12: Contracts and Subawards
- Chapter 13: Conflict of Interest
- Chapter 14: Collaborative Relationships
- Chapter 15: Financial Management and Accounting Systems
- Chapter 16: Billing and Collections
- Chapter 17: Budget
- Chapter 18: Program Monitoring and Data Reporting Systems
- Chapter 19: Board Authority
- Chapter 20: Board Composition
- **Chapter 21: Federal Tort Claims Act (FTCA) Deeming Requirements***

In the preceding list, chapters that have relevance for FQHCs' credentialing and privileging (C&P) policies and processes have been highlighted in bold font with an asterisk (*).

More than 27 million people—1 in 12 nationwide—rely on a HRSA-funded health centerfor affordable, accessible, primary healthcare.

FTCA deeming coverage for malpractice liability coverage

FQHCs may be deemed by HRSA as employees of the PHS for purposes of liability protections for the performance of medical, dental, surgical, and related functions pursuant to the Federally Supported Health Centers Assistance Acts (FSHCAA) of 1992 (Pub. L. 102-501) and 1995 (Pub. L. 104-73), as amended. On an annual basis, HRSA issues a Program Assistance Letter (PAL), which notifies FQHCs of the requirements for initial deeming or subsequent redeeming applications for FTCA malpractice coverage in the upcoming calendar year.

FQHCs' compliance officers should take note that the FTCA-related PAL is usually issued during the second quarter of a calendar year. It is judicious to check the BPHC's website on at least a weekly basis during the second quarter of

each calendar year to search for this PAL. Failure to respond to the FTCA PAL in a timely and/or complete manner can have serious consequences for FQHCs. For example, if FTCA coverage were to be withheld at the start of the next calendar year, then commercial "gap" malpractice coverage would need to be obtained until HRSA grants approval of the FQHC's redeeming application.[6]

Key components of the annual FTCA redeeming application focus on FQHCs':

- Risk management systems
- Quality improvement/quality assurance program
- FTCA-related claims management process
- Credentialing and privileging for clinical staff members

Failure to respond to the FTCA Program Assistance Letter in a timely and/or complete manner can have serious consequences for FQHCs.

HRSA defines *credentialing* as "the processing of assessing and confirming the license or certification, education, training, and other qualifications of a licensed or certified health care practitioner."[7] Privileging is defined as "the process of authorizing a health care practitioner's specific scope and content of patient care services."[8]

Monitoring

In addition to the submission of attestations pertaining to credentialing and privileging processes that are submitted by FQHCs in conjunction with their annual FTCA malpractice redeeming application, these functions are evaluated on-site by external organizations. Operational site visits (OSV) are conducted periodically by HRSA in its regulatory capacity and separately by external, independent accrediting organizations. Compliance officers should note that, in the future, HRSA intends to integrate its OSV process with the on-site visits that are conducted by ambulatory healthcare accrediting organizations.[9] However, that timeline has not yet been established.

On a triennial basis, OSVs are conducted at FQHCs by the BPHC. The importance of the OSV cannot be stressed too highly for FQHCs' compliance officers. As noted in its Health Center Program Site Visit Protocol, HRSA states that "unresolved Health Center Program conditions related to clinical staffing and/or quality improvement/assurance, requirements that apply to both Health Center Program and FTCA deeming, may impact FTCA deeming if they are not resolved by the time that HRSA makes annual FTCA deeming decisions."[10] Thus, due to the overlapping credentialing and privileging requirements that are outlined in Chapters 5 and 21 of the *Compliance Manual*, it is essential for an FQHC to conduct periodic internal audits of its credentialing and privileging (C&P) functions. These audits should be conducted internally, in advance of the OSV and ambulatory reaccrediting visits, if any mid-course performance corrections are warranted.

HRSA may also elect to conduct an on-site review to ensure compliance with the FTCA deeming requirements. Any of the following factors may trigger an FTCA site visit:

- Submission of an initial FTCA deeming application;
- Documentation submitted on the FTCA deeming application that indicates possible noncompliance;
- A history of repeated conditions, or current conditions, placed by HRSA on the FQHC's Health Center Program Section 330 award;
- The need for follow-up based on prior site visit findings or other identified issues; or
- A history of medical malpractice claims.

Another reason for compliance officers to be vigilant about C&P functions relates to FQHCs' achieving and maintaining ambulatory healthcare accreditation. To advance FQHCs' quality improvement efforts, HRSA established the Accreditation and Patient-Centered Medical Home Recognition Initiative in 2015.[11] Under this initiative, FQHCs may select to obtain ambulatory healthcare accreditation from either The Joint Commission (TJC) or the Accreditation Association for Ambulatory Health Care (AAAHC). In addition, FQHCs can seek to obtain Patient-Centered Medical Home (PCMH) recognition through the National Committee for Quality Assurance or PCMH certification by TJC. In support of this initiative, HRSA has offered annual financial recognition to FQHCs that have achieved PCMH designation.

Credentialing and privileging standards

There is considerable overlap between the C&P requirements set forth by HRSA in its *Compliance Manual* and its associated Site Visit Protocol and the Ambulatory Health Care Standards and related elements of performance that are issued by TJC. In planning for an FQHC's internal C&P audit, it is prudent to crosswalk HRSA's C&P requirements with the standards and elements of performance that have been set forth by TJC.[12]

If the FQHC maintains accreditation by TJC, then the compliance officer should also review the summary from the FQHC's most recent reaccreditation visit, particularly if there had been any findings that pertained to C&P functions.

Table 1 shows the C&P requirements set forth by HRSA in Chapter 5 (Clinical Staffing) of its *Compliance Manual*.[13]

Table 1: Credentialing and Privileging Standards for Clinical Staffing

Procedures for initial credentialing and re-credentialing of all clinical staff members:
Primary source verification of licensure, registration, or certification
Primary source verification of education at the time of initial credentialing
Completion of a query through the National Practitioner Databank (NPDP)
Obtaining a government-issued picture identification at the time of initial credentialing
Drug Enforcement Administration (DEA) registration (if relevant to the licensed independent provider's profession)
Current documentation of basic life support training

Procedures for the initial granting and renewal of privileges for clinical staff members:
Verification of fitness for duty, immunization, and communicable disease status
For initial privileging, verification of current clinical competence via training, education, and, as available, reference reviews
For renewal of privileges, verification of current clinical competence via peer review or other comparable methods (for example, supervisory performance reviews)
A process for denying, modifying or removing privileges based on assessment of clinical competence and/or fitness for duty

Internal auditing of C&P functions

The compliance officer should present the findings from internal C&P audits, as well as any proposed recommendations for performance improvement, with the FQHC's relevant administrators who have departmental responsibility for C&P functions. Following this dialog, audit findings and recommendations should be presented to the FQHC's compliance committee, as well as senior leadership, to highlight any best practices and/or opportunities for performance improvement.

A high-level summary from the C&P audit should also be prepared for the FQHC's board of directors, to familiarize members with these processes. During any site visits conducted by HRSA and TJC, the FQHC's board members will be interviewed, usually without staff being present, to assess the governance of the FQHC. Board members will be asked where responsibility rests for the FQHC's approval or disapproval of recommendations from the FQHC's C&P committee. Does this responsibility rest with the board? One of the hallmarks of any FQHC is the requirement that patients must comprise at least 51% of the board's membership. It is imperative that the compliance officer provide support to the board to ensure their confidence in discussions about governance functions, including those responsibilities that pertain to the approval or disapproval of C&P determinations.

Emerging health professions

On an annual basis, the FQHC's compliance officer should also reassess whether the state has recognized any new health professions for licensure. If so, has the FQHC added these professions to its panel of licensed independent providers (LIPs)? If the FQHC has hired new types of providers, then a sample of C&P records from this cohort of LIPs should be added to the internal audit process.

For example, the Connecticut Department of Public Health recently submitted a legislative proposal[14] to the state's General Assembly. If approved, then Connecticut would recognize the practice of dental therapy. As proposed, a dental therapist

would be required to hold and maintain a dental hygiene license and a certification issued by an institution of higher education accredited by the state's Commission on Dental Accreditation for dental therapy. This proposal will be monitored to determine its implications for access to oral health services in Connecticut-based FQHCs.

Takeaways for FQHC-based compliance officers

It is critical to conduct periodic internal audits of your FQHC's C&P functions. Noncompliance with federal requirements can have seriowus repercussions for the status of an FQHC's Section 330 award from HRSA as well as its deemed FTCA malpractice coverage. Ineffective C&P functions can pose risk management issues for the FQHC, thereby increasing the likelihood of negative findings during ambulatory health care accreditation visits. CT

Endnotes

1. Health Resources and Services Administration (HRSA), *HRSA Health Center Program*, August 2018. https://bit.ly/2UHcPAB
2. 45 CFR § 75.2 (Definitions)
3. HRSA, Program Assistance Letter, Document Number 2018-01, "Calendar Year 2019 Requirements for Federal Tort Claims Act (FTCA) Coverage for Health Centers and their Covered Individuals" March 26, 2018. https://bit.ly/2Hqj34V
4. HRSA, Bureau of Primary Health Care, Program Assistance Letter, Document Number 2015-02, "Accreditation and Patient Centered Home Recognition Initiative" February 19, 2015. https://bit.ly/2ufamSk
5. HRSA, Bureau of Primary Health Care, *Health Center Program Compliance Manual,* August 20, 2018. https://bit.ly/2UNuhDD
6. Ibid, Ref #3
7. Ibid, Ref #5, p. 90
8. Ibid Ref #5, p. 92
9. Ambulatory Surgery Center Association, Accrediting Organizations. https://bit.ly/2CpTZXj
10. HRSA, Bureau of Primary Health Care, *Site Visit Protocol,* September 6, 2018, p. 2. https://bit.ly/2lsXrax
11. Ibid, Ref #4
12. The Joint Commission, 2019 Standards for Ambulatory Care. https://bit.ly/2TWy0RT
13. Ibid Ref #5, pgs. 27 – 29.
14. Connecticut Department of Public Health, Agency Legislative Proposal – 2019, *An Act Concerning The Department of Public Health Recommendations on Dental Practitioners.*https://bit.ly/2Jmcmm8

Takeaways

- Analyze the Health Resources and Services Administration's revised *Health Center Program Compliance Manual Requirements* to identify any gaps in your FQHC's compliance program.
- Monitor the Bureau of Primary Health Care's website regularly to promptly initiate your FQHC's annual Federal Tort Claims Act re-deeming application.
- Develop a credentialing and privileging (C&P) audit tool, based on HRSA's *Operational Site Visit Protocol* and your ambulatory health care accreditor's C&P standards.
- Conduct periodic internal auditing of C&P records to assure ongoing compliance with federal regulatory requirements for FQHCs and ambulatory care accrediting standards.
- Monitor your state's licensure regulations to assess whether any new health professions have become recognized by that agency.

CEU quiz for the May 2019 issue of *Compliance Today* magazine

To receive 1.0 non-live Compliance Certification Board (CCB)® CEU for the following quiz, at least three questions must be answered correctly. Only the first attempt at each quiz will be accepted.

Compliance Today quizzes are valid for 12 months, beginning on the first day of the month of issue.
This quiz expires April 30, 2020.

LEARNING OBJECTIVE

After reading **"Securing the safety net: Current compliance issues in Federally Qualified Health Centers" (page 18)** you should be able to answer the following question:

1. **What information is available in the Health Center Program Compliance Manual?**
   A. Guidance on applying the Seven Elements of an Effective Compliance Program to an FQHC.
   B. Information about the laws that the Health Resources and Services Administration administers governing FQHCs.
   C. Information on 340B compliance within an FQHC.
   D. Information about operating freestanding physician clinics.

2. **What key change to FQHC compliance requirements came about in 2018?**
   A. HRSA began auditing 340B floor stock practices.
   B. New HIPAA rules covering FQHCs went into effect.
   C. The OIG created an Anti-Kickback Statute safe harbor for health centers.
   D. The Public Health Service Act was amended to require FQHCs to directly employ their executive directors.

LEARNING OBJECTIVE

After reading **"Credentialing and privileging requirements for Federally Qualified Health Centers " (page 30)**, you should be able to answer the following question:

3. **How often must a Federally Qualified Health Center submit a reapplication to the Health Resources and Services Administration (HRSA) for continued malpractice insurance coverage through the Federal Tort Claims Act (FTCA)?**
   A. Once a year, following HRSA's release of a FTCA-related Program Assistance Letter (PAL).
   B. Once every three years, following the outcome of the FQHC's operational site visit by HRSA.
   C. No reapplication is ever needed, FTCA coverage is automatically renewed for FQHCs by HRSA.
   D. FTCA reapplication is only needed when a FQHC adds a new clinical site.

LEARNING OBJECTIVE

After reading **"Active shooter and workplace violence preparedness and response: A compliance perspective" (page 42)**, you should be able to answer the following question:

4. **When developing policies and procedures for workplace violence prevention and response, organizations should include ways to address _____, which is an underlying cause of 75% to 80% of workplace violence incidents.**
   A. Disgruntled former employees
   B. Intimate partner violence
   C. Unstable or unruly patients
   D. Disputes among staff

Compliance Today Continuing Education Form

For correctly answering HCCA's *Compliance Today* magazine quiz, you will receive 1.0 non-live Compliance Certification Board (CCB)® CEU.

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QUIZ ANSWERS: MAY 2019

Article: Securing the safety net: Current compliance issues in Federally Qualified Health Centers (page 18)

Please indicate your answer.

1. ○ A ○ B ○ C ○ D
2. ○ A ○ B ○ C ○ D

Article: Credentialing and privileging requirements for Federally Qualified Health Centers (page 30)

Please indicate your answer.

3. ○ A ○ B ○ C ○ D

Article: Active shooter and workplace violence preparedness and response: A compliance perspective (page 42)

Please indicate your answer.

4. ○ A ○ B ○ C ○ D

ATTENDANCE VERIFICATION

By signing below, I certify that I have read the HCCA *Compliance Today* articles that relate to the questions I have answered above. I further certify I will cooperate with the CCB in all administrative functions related to the accreditation of this program and its subsequent recognition as a program fulfilling candidate requirements for CCB certification.

Signature _____ Date _____