CLINICAL VETTING PROTOCOL · 2026

The FQHC Mission-Fit Candidate Screening Framework

Three pillars, three scenario-based screening questions, and the listening rubric we use on every direct-hire candidate before we put them in front of you.

68% of FQHCs reported losing 5–25% of workforce in 6 months (NACHC Workforce Survey, 2022)	**70%+** of community health centers report primary care, nursing, or BH shortages (Commonwealth, 2024)	**13 elements** Required service deliverables under CMS APCM framework (2025)	**5 domains** Healthy People 2030 SDOH framework (HHS / ODPHP)

Hiring a provider from a traditional corporate fee-for-service background into an FQHC environment without rigorous mission-fit vetting is the single most expensive mistake in community health recruiting. NACHC's 2022 Workforce Survey documented that 68% of health centers lost 5–25% of their workforce in a single six-month window, with an additional 15% losing 25–50%. If a candidate doesn't understand the wrap-around, integrated nature of an FQHC, turnover is virtually guaranteed. This protocol screens for the three structural pillars that predict five-year retention.

Pillar 1 — Integrated Care vs. Siloed Mindset

Traditional fee-for-service care is delivered in silos — primary care here, behavioral health there, pharmacy somewhere else, social services nowhere in particular. The CMS Advanced Primary Care Management framework that defines the modern FQHC requires a **medical-home model** in which physical, mental, and social health are managed under one roof with thirteen distinct required service elements: 24/7 access, continuity of care, comprehensive care management, care transitions, population health, risk stratification, performance measurement, and more.

The Concept

FQHC providers must view themselves as the integration point for a patient's whole health, not just the prescriber of the current visit's chief complaint.

The Screening Question

> **ASK THIS VERBATIM**
>
> "Give me a concrete example of a time when you had to coordinate care with a behavioral health therapist, a clinical pharmacist, or a social worker to manage a single complex patient. How do you view the role of non-clinical social drivers — housing, transportation, food security — in your daily practice?"

What to Listen For

- **Strong signal:** Candidate names specific team members by role and describes warm hand-offs, shared care plans, or co-located workflows.

• **Weak signal:** Candidate describes “referring out” without follow-up loop closure, or treats SDOH as outside their clinical responsibility.

• **Red flag:** Candidate has never worked with a clinical pharmacist or LCSW in the same practice and cannot articulate why integration matters.

Pillar 2 — Value-Based Care & Panel Management

> *“Advanced Primary Care Management services are designed to support advanced primary care delivered to a defined population, with continuous patient-physician relationships and increased payments to support whole-person care.”*
>
> *CMS — Advanced Primary Care Management Services*

FQHC compensation models are shifting toward performance criteria and risk-adjusted panels rather than pure fee-for-service throughput. Candidates coming from RVU-driven environments will struggle if they cannot articulate how to manage a panel rather than how to maximize a daily schedule.

The Screening Question

ASK THIS VERBATIM

“How do you approach managing a patient panel with high-risk profiles, severe comorbidities, or social barriers like transit insecurity or food insecurity? How do you measure your own success as a provider when a patient's external environment interferes with treatment compliance?”

What to Listen For

• **Strong signal:** Candidate distinguishes “panel” from “schedule,” references HEDIS or UDS measures, talks about reaching out to no-shows.

• **Weak signal:** Candidate uses “productivity” as the primary success metric.

• **Red flag:** Candidate becomes frustrated when describing patients who don’t follow through on care plans; lacks a framework for SDOH-driven non-adherence.

Pillar 3 — Technology & Remote Patient Monitoring Adaptability

Patient volume in FQHCs is rising under Medicaid pressure. The providers who thrive are the ones who use modern technical channels — ambient AI scribes, telehealth, RPM codes, asynchronous care — to extend their clinical reach without burning out.

What FQHCs can bill in 2025–2026 that candidates should be familiar with:

• **RPM codes** — 99453 (setup, ~$22), 99454 (device supply, ~$47), 99457 (initial 20 min, ~$52), 99458 (additional 20 min, ~$41). FQHCs and RHCs receive separate payment per HHS.

• **2026 RPM expansion** — 99445 (2–15 days of data) and 99470 (10-minute management).

• **APCM** — G0556/G0557/G0558 (chronic-condition tiers) plus 2026 BHI add-ons G0568/G0569/G0570.

• **Telehealth** — Medicare flexibility for FQHCs as distant-site providers extended through 12/31/2027; behavioral health permanent.

The Screening Question

ASK THIS VERBATIM

"What is your experience with asynchronous patient care, remote patient monitoring data review, telehealth across state lines, or ambient AI dictation tools? Have you billed CPT 99457 or 99458 yourself, or worked with a care team that does? How would you adapt your workflow to integrate an AI scribe like Abridge, Suki, or Dragon Copilot?"

What to Listen For

- **Strong signal:** Candidate has used or evaluated an ambient scribe; understands the difference between RPM CPT codes; sees technology as workload reduction.
- **Weak signal:** Candidate uses telehealth but cannot describe documentation differences or asynchronous workflows.
- **Red flag:** Candidate views every technology adoption as a threat to clinical judgment or as added admin work.

How to Use This Framework with Clients

Show this protocol to FQHC HR leaders and CMOs *during the intake call*. It demonstrates that TPG doesn't just find warm bodies — we screen candidates specifically for the structural reality of community health, which is why our placements stick. The framework is also a defensible justification for our permanent placement fee: the cost of one mis-hired physician at twelve months (recruiting cost + signing bonus + opportunity cost + replacement) typically exceeds the fee multiple times over.

SOURCES & FURTHER READING

Citations supporting this guide

Every statistic, regulation, and benchmark cited in this document is sourced from a primary authority — federal agencies (HRSA, NHSC, CMS), peer-reviewed journals, industry associations (AAFP, AMA, ADA, ADHA, APA, NACHC, MGMA, AAPPR), or named research reports. Links below allow you to verify any claim directly.

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3. Commonwealth Fund — Community Health Centers Meeting Primary Care Needs: 2024 FQHC Survey
https://www.commonwealthfund.org/publications/issue-briefs/2024/aug/community-health-centers-meeting-primary-care-needs-2024-FQHC-survey

4. CMS — Advanced Primary Care Management Services (13 required service elements)
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5. AAFP — Advanced Primary Care Management coding guidance
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https://www.thoroughcare.net/blog/2026-advanced-primary-care-management-cpt-codes

7. HHS Telehealth.HHS.gov — Billing for Remote Patient Monitoring (FQHC/RHC separate payment)
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8. Prevounce — 4 Things to Know About Remote Patient Monitoring Reimbursement (2025/2026 codes)
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9. HHS Telehealth.HHS.gov — Telehealth Policy Updates (12/31/2027 extension; BH permanent)
https://telehealth.hhs.gov/providers/telehealth-policy/telehealth-policy-updates

10. ODPHP / Healthy People 2030 — Social Determinants of Health (5 domains)
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12. JAMA / PMC11829224 — Sale of PE-Owned Physician Practices and Physician Turnover
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