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February 25, 2006

THE LIGHTHOUSE

The official publication of the Maine Association Medical Staff Services, published by and for the MeAMSS membership

President's Message

By Ron Lambert, CPCS

Well, here I am sitting at my computer on a Friday night trying to come up with my first "President's Message". I wish I could summon up the answers to all the questions of life and share them with you.

However, my first message to you is not so much a message as it is a request. This past week the board, your board, met for its regular board meeting and a strategic meeting intended to set goals and objectives for the coming year and possibly beyond. I am asking you to offer your suggestions as to what you would like to see from your association. I have heard from some of you already and thank you for your suggestions.

I would also like to remind you that all of our board meetings are open to any of you to attend. I mention this in case any of you might be interested in a board position.

Future Board Meetings:

- February 24, Bangor
- April 28, York
- June 16, Caribou
- August 4, Waterville
- October 13, Bangor

Please feel free to contact me with any of your suggestions, questions or concerns.

With all this said I would like to wish all of you
a happy and safe 2006.

Ron

KUDOS KORNER!



Congratulations to:
Cyndee Hougardy on becoming newly certified CPCS!
Allison Meyer, CPCS on being promoted to Director of Risk Management & Credentials

People on the Move

Effective December 31, 2005, Del Thomas retired from being Credentialing Coordinator to working per diem at Blue Hill Memorial Hospital. Welcome to Laurie Kelley, who is taking over the reigns from Del.

Welcome back, Pat O'Connor! Pat, who had moved to Colorado, is now back in Maine and working as an independent consultant for the Greeley Company as well as other organizations.

Kaye Pierson, LPN, formerly of Mid Coast Hospital, has retired to enjoy life with her husband. Kaye will also be working from time to time for the Greeley Company in the medical staff services field.

Please Join us in Welcoming the Following New Members!

Anne Corliss, Eastern Maine Medical Center
Donna Cramp, Millinocket Regional Hospital
Sandra Fickett, Synernet CVO
Sandy Guay, University Health Care
Laurie Kelley, Blue Hill Memorial Hospital
Debra Lane, Blue Hill Memorial Hospital
Cindy Metivier, Mid Coast Hospital
Diane Mosca, Neurology Associates of Eastern Maine, PA
Rebecca Shaw, Synernet CVO
Denise Sjogren, Dahl-Chase Pathology Associates

MARK YOUR CALENDARS!

Your Education Committee has been hard at work developing the program for the May 18 and 19 biennial conference. What makes this conference particularly special is that it marks the 10th anniversary of MeAMSS. This year's conference is shaping up to be one you won't want to miss. So, if you haven't made your room reservation yet, please be sure to contact *Village by the Sea* by calling 1-800-444-8862 or 1-(207) 646-1100. Details about the program will be forthcoming in a membership e-mail.

Credentialing Tidbits from the NAMSS Conference

*Submitted by Mary Gifford, CPMSM
Eastern Maine Medical Center*

Our thanks to Mary Gifford for submitting the following from her notes taken from a few sessions at the recent NAMSS conference.

Notes from presentations on 9/18 and 9/20/05 on tips for resolving medical staff issues, protecting peer review and JCAHO Standards:

Peer Review Concerns: The speakers stressed the importance to start very early in the process and to intervene early. If your process is followed as delineated by your bylaws and policies, should the hospital end up in court, a legal tracking mechanism exists. You want a system that shows trends.

The recommendation was to set up a specific policy that defines when collegial interventions occur such as generating an automatic letter each time a practitioner fails to:

1. comply with completing medical records and/or including required elements in the medical record (H&P, discharge summary);
2. visit acute patients daily and document progress notes;
3. provide requested consultations
4. follow the bylaws, rules and regulations, policies or protocols of the hospital.

As an example, the policy could state that, should a practitioner receive three such notices within a six-month period, then the practitioner might receive notification of another level of peer review. The caveat here is to keep the practitioner involved in the process from the beginning. Too many lawsuits are brought against hospitals or physician leaders because of failure to communicate or share information with the affected practitioner.

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MeAMSS Board

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Upcoming Education Sessions

March 10, 2006*

MaineGeneral, Waterville, ME

May 18 and 19, 2006

Biennial Conference

Village by the Sea, Wells, Maine

August 18, 2006*

Penobscot Bay Medical Center
Rockport, ME

November 3, 2006*

St. Joseph Hospital, Bangor, ME

**We're on the Web!
Check us out!
Meamss.org**

Credentialing Tidbits *Continued*

It's important to maintain collegial reviews. The bylaws should define these collegial reviews and indicate that such reviews are not reportable and thus do not trigger fair hearing rights. The bylaws could refer to informal collegial interventions, first because it can get the message across to the medical staff that there are other ways to take care of issues of concern; and, secondly, it is now identified as one of the peer review processes making the review protected from discovery. At the same time the bylaws should identify what individuals are authorized by the Medical Executive Committee (MEC) to perform informal collegial interventions as necessary. The interventions would need to be documented, followed by a letter to the affected practitioner.

Another advantage of this type of intervention is that the hospital would not be required to report this as an adverse action because the process is still an informal process and not considered an investigation.

Confidentiality must be maintained. This means being very careful where discussions occur. The bylaws could state that a peer review committee could be comprised of several individuals or one person thus allowing for a committee of one. When conducting the review, it is important that you be "in session" to protect the confidentiality of the peer review process and that the committee only speaks through its minutes. These steps enhance a hospital's position should a lawsuit ensue. There are exceptions to protection from discovery; e.g if a practitioner who was suspended claims discrimination. Now you trigger federal civil rights laws that don't recognize the sanctity of state peer review laws. Additionally, all documents within the peer review process should be identified as such to ensure protection from discovery.

At the close of hearings, make sure that all peer review material provided to attorneys, committee members, etc., is returned when the case is over even though they have already signed the confidentiality statement as it again ensures to the court that you take your peer review information seriously and you stand a better chance of obtaining protection by the court. If at all possible, do not send material to committee members off the hospital's campus as it's much harder to get it back.

Hearings: Before using expert witnesses, a written agreement should be signed by the hospital and its expert that outlines expectations such as what information you will provide them, what issue(s) raised the question or concern, and what information is protected under the Maine Health Security Act. Do not allow the expert to recommend action to be taken. If you don't follow their recommendation, it could create problems. You want to make your own recommendations.

Consider removing the affected practitioner from taking call and receiving referrals until any investigation has concluded. This is not necessarily restricting privileges, only limiting some of the practitioner's obligations.

The size of your hearing panel is important. Three is a good size whereas five is difficult to schedule. Members of the hearing panel should be experienced leaders and should not be in direct competition with the affected practitioner.

The hearing officer should not be someone who works for the hospital but should know hospital law. A good choice for the hearing officer would be a retired judge. The reason you may not want a physician as the hearing officer is that, usually when the process evolves to the hearing stage, you have exhausted everything else and the issue is likely to end up in court. The hearing report should be written by a legal expert to ensure that the hospital has met all the criteria of the Health Care Quality Improvement Act of 1986 (HCQIA)

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Credentialing Tidbits *Continued*

and to ensure proper format. Sometimes the incorrect language in the report could expose the hospital to loss of peer review protections.

Time frames for the hearing should be set to inhibit unnecessary prolongation of the process. Remember, the burden of proof belongs to the practitioner as it is presumed the hospital has followed the appropriate steps.

When reporting results to the Medical Executive Committee, ensure that the chief of service of the affected practitioner (if the chief is a member of the Medical Executive Committee) is recused to avoid any appearance of conflict of interest. It's important to remember that the MEC is only a recommending body to the Board.

Appeal to the Board: JCAHO requires that the bylaws allow the practitioner to appeal to the Board; however, you should establish that this is not a second hearing. A written statement from the practitioner should be submitted to a panel of the Board (recommend three Board members) for consideration.

Data Bank Reporting: We all know that hospitals are mandated to report adverse actions from investigations to the National Practitioner Data Bank. If at any time a practitioner has been suspended (whether an immediate suspension or as a result of the investigation), it was recommended to pick the "other" code as there have been many lawsuits alleging an inflammatory code was selected, which now adds another issue to the suit.

Bylaws: As timelines can create problems when scheduling such things as hearings, it was recommended to define timelines in the definition section of your bylaws. As an example, one could write, "Except as mandated by law, all time frames are guidelines specified for the purpose of guidance only and will attempt to move forward as expeditiously as possible." This avoids the possibility of not adhering to tight timelines such as five days (business or otherwise) and thus not adhering to your bylaws because you've run into scheduling problems. If timelines are defined in the definitions section of the bylaws, and not just in the hearing section, this would allow for use whenever any timelines are required.

Robert's Rules: They recommended removing any reference about Robert's Rules in your bylaws. The reason for this is that few can interpret them and one could spend a great deal of time in court arguing over a procedural question. It was recommended to use the phrase, "common sense prevails and would look to Robert's Rules for guidance.

[For those of you who receive Greeley's *Credentialing Connection* weekly e-mails, you might remember one from several years back where he mentioned that time of reappointment was not when negative issues are to be addressed with a practitioner. The practitioner should have been made aware of any infractions on an ongoing basis. Along a similar vein, the DHHS medical staff regulations also require at a minimum annual performance feedback (both positive and negative) with the intent to enable a practitioner to "improve" if necessary. You don't want to find yourself in a situation with a disruptive practitioner who rattled Administration staff several months ago at which time no action was taken who then does another recent infraction that causes everyone to want to suspend him/her immediately. If the infraction was so egregious, action should have been taken at the time of incident. The notes above are intended to provide you with some ideas as to how to establish a formal process for accomplishing some of this.]

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Credentialing Tidbits Continued

JCAHO: Of particular note was the discussion regarding verification of applicant's identity. The speaker stated that it was acceptable to verify identity on site. One could ask to see applicant's driver's license. However, the applicant's identity must be verified prior to granting privileges. A form should be utilized that indicates what type of picture identification was used (license, passport to name two) and the person who saw the picture identification should document this on the form. Staff in the Medical Staff Office, Human Resources, or the person responsible for issuing picture badges can do the verification of identity. The important point to remember is that you have a process and that you have documentation on file. There is no requirement in the JCAHO standards that specifically state that you have to obtain a picture and send it out to other institutions.

QUIZ CORNER

(SOURCE: MSSPNEXUS.COM)

JCAHO

1. 2005 JCAHO Standards allow for unilateral amendment of Medical Staff Bylaws under the following conditions:
 - a) When a good faith effort has been made by the Medical Staff to get approval from the Governing Body
 - b) When a good faith effort has been made by the Governing Body to gain agreement from the Medical Staff
 - c) This is not a true statement. JCAHO standards do not permit unilateral amendment of the Medical Staff Bylaws.
2. MS.2.10 states that the organized Medical Staff oversees the quality of patient care, treatment and services provided by practitioners:
 - a) Providing patient care
 - b) Actively practicing at the hospital
 - c) Privileged through the medical staff or an equivalent process
 - d) Privileged through the Medical Staff process.

Medical Terminology - Root

1. Aden
 - a) Joint
 - b) Heart
 - c) Gland
 - d) brain
2. rhin
 - a) chest
 - b) lung
 - c) tumor
 - d) nose

3. leuk
 - a) red
 - b) white
 - c) blood
 - d) lung
4. hepat
 - a) blood
 - b) liver
 - c) stomach
 - d) gall, bile

Answers in the March/April issue

Answers to last quiz questions from November/December issue

1. Members of the MEC: Members of the Active medical staff.
2. Ex officio who attends all MEC: Chief Executive Office
3. Corrective actions, fair hearing, appeal, credentialing & privileging must be identical to the process for adoption and amendment of the bylaws. FALSE. *The process may be different, however, both the medical staff and the governing body must approve, and the bylaws must define the approval process.*
4. MS.1.20 identifies 19 elements of performance to be included in the bylaws. Which is NOT an element? Description of the credentials committee function, size and composition.

Effective 01-01-06 the fee to verify ANCC certification went up to \$30.

Rural Health Clinic

Submitted by Claudia Edwards, CPMSM

The following is excerpted from the sources listed on Page 8:

What is a Rural Health Clinic (RHC)? Public Law 92-210, the Rural Health Clinic Service Act was enacted in 1977 and designated rural health clinics became eligible for enhanced reimbursement March 1, 1978. The purpose of establishing RHCs was to increase outpatient primary care services for Medicaid and Medicare patients in rural communities. RHCs are clinics located in areas that are designated by the Bureau of Census as rural and by the Secretary of DHHS as medically underserved. The ownership/governance structure of these clinics can be for-profit, non profit, or public. The main requirements to obtain RHC status include:

1. Clinic is NOT located in an urbanized area as designated by the U.S. Census Bureau and by the Secretary of Health and Human Services as a Health Professional Shortage Area (HPSA), or Medically Underserved Area (MUA), generally determined by information from the State Health Department.
2. The clinic must employ a mid-level practitioner (physician assistant, nurse practitioner or certified nurse midwife) 50% of the time the clinic operates.
3. The clinic must provide outpatient primary care services.
4. A physician medical director who must be on site at least once every two weeks.
5. At least six basic lab tests (urine, hemoglobin or hematocrit, blood sugar and examination of stool specimens for occult blood, pregnancy test and primary culturing for transmittal) on site.
6. Care for common life-threatening injuries and acute illnesses available.
7. Arrangements in place for in-patient hospital care, specialized physician services, specialized diagnostic and laboratory services, interpreter for (a) foreign languages, (b) deaf and devices to assist communication with the blind.
8. handicap accessibility.
9. A current and applicable policy and procedures manual.
10. Drugs and samples securely stored.
11. Medical records that are maintained at least six years.

While a private office receives RBRVS fee schedule under Medicare and fee for service under Medicaid, a free-standing RHC receives cost-based Medicare reimbursement capped at \$70.78 per encounter and fee for service prospective encounter rate based on the average 1999/2000 cost report data for similar clinics. So the advantage of creating an RHC is the enhanced reimbursement; however, the disadvantages are that there is sometimes a delay in obtaining funding; and there is a lack of understanding of the RHC by fiscal intermediaries at state and CMS levels.

The entire certification process from inquiry to effective billing date typically takes about one year. Any clinics interested in being classified as an RHC should do a financial assessment.

On December 24, 2003, CMS published final rules that became effective February 23, 2004 specifying where the RHC can be located and establishing rules for decertifying clinics that no longer meet these requirements. The rules set RHC payment limits and exceptions for hospital-based clinics, along with definitions of commingling, staffing requirements and quality assessment performance.

Federally Qualified Health Centers (FQHC)

Submitted by Claudia Edwards, CPMSM

What is an FQHC? Federally Qualified Health Centers (FQHC) are non-profit or public organizations that receive federal grants from the Health Resources and Services Administration (HRSA) Bureau of Primary Health Care (BPHC) through Section 330 of the Public Health Service Act. Section 330 of the Public Health Service Act defines federal grant funding opportunities for organizations to provide care to medically underserved areas or populations. Types of organizations that may receive 330 grants include: Community Health Centers, Migrant Health Centers, Health Care for the Homeless Programs, and Public Housing Primary Care Programs.

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FQHC Continued

A board of directors is required for each health center and the board must include a majority of active, registered clients of the health center who are representative of the populations served by the center. The governing board ensures that the center is community based and responsive to the community's health care needs.

Unlike RHCs that specify staffing requirements, FQHCs have no specific requirements for staffing only that there is a core staff of full-time practitioners. Staffing levels should facilitate 4,200-6,000 patient visits per year for each full-time equivalent health care practitioner. At a minimum, the clinic must be open 32 hours per week.

FQHCs must provide primary care services for all age groups including preventive health services on site or by arrangement with another provider. Other services that must be provided either on site or by other arrangement are: dental services, mental health and substance abuse services, transportation services necessary for adequate patient care, hospital and specialty care.

FQHCs must use a sliding fee scale with discounts based on patient family size and income and in accordance with federal poverty guidelines.

The benefit of creating an FQHC is the grant funding. New start-ups can receive funding up to \$650,000. Other benefits include:

1. Enhanced Medicare/Medicaid reimbursement
2. Medical malpractice coverage through the Federal Tort Claims Act.
3. Eligibility to purchase prescription and nonprescription medications at reduced cost.
4. Access to National Health Service Corps
5. Access to the Vaccine for Children program
6. Eligibility for various other federal grants and programs.

As noted above, malpractice coverage is through the Federal Tort Claims Act (FTCA). The Triton Group LLC is a contractor for the Health Resources and Services Administration and has been authorized to provide information on malpractice liability coverage to organizations seeking to verify coverage of providers associated with deemed healthcare facilities. FTCA coverage is comparable to an "occurrence" malpractice policy and has no monetary coverage limits. Hospitals and managed care plans are required to accept coverage under the FTCA as meeting their malpractice requirements or risk loss of Medicare and Medicaid reimbursement per 42 U.S.C. section (j) and (m). The Public Health Services Act does not require that individual provider names be identified with pending claims; however, if the claim is settled or if a judgment is entered against the United States and money is paid out to claimant/plaintiff, the name of the provider of record may be entered into the National Practitioner Data Bank. Please refer back to the November/December issue of *The Lighthouse*, where I have set forth the strict criteria required in order to bring a claim under the FTCA.

Sources:

Washington State Department of Health

Rural Assistance Center

www.doh.wa.gov/hsqa/fsl/HHHACS_Rural_Health.htm

Letter from the Triton Group, L.L.C.

2006 MEMBERSHIP RENEWAL NOTICE

Remember the advantages of MeAMSS membership and renew yours. And remember to share the advantages of membership with someone you know who isn't a current member. The 2006 MeAMSS Membership Invoice Form is available on the MeAMSS website www.meamss.org.

Thank you for your support,
Jamie Mark, CPCS, Membership Chair
