MeAMSS
MAINE ASSOCIATION MEDICAL STAFF SERVICES

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THE LIGHTHOUSE

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

President's Message

By Frederica Jackson, CPMSM

Hi all – I hope everyone has been enjoying the summer weather.

On June 23, 30 members of our association attended the MHA Summer Forum at the lovely Samoset in Rockport. In addition to the most important business at hand – awarding Claudia her Golden Star Award (*article on Page 3)* – we were treated to some excellent speakers. One of them, Dr. Tom Atchison, spoke on the "Deeper Dimensions of Leadership". He talked a lot about effective leadership and how to create a positive environment where employees feel a sense of purpose and meaningful work. He described what leaders need to do – listen, reward and recognize, challenge and remove barriers in order to establish trust, respect, pride and joy for their followers. Without effective leadership, an organization can create a toxic work environment where productivity measures rule and employees are viewed as economic units. In this setting, employees look to financial compensation and other benefits as the only reward for their work. While they may achieve getting the big fat paycheck and premium parking, these employees lose their passion for their profession. They've sold their happiness and may not even know it.

Let me ask you each this – what would be the price for your happiness in your job? Would you trade the sense of pride and joy you feel for your profession for a job where you were working in a toxic environment but making the money you think you deserve? Are you working now in a toxic work environment and if so, what can you do to change it?

Dr. Atchison's message really hit home for me. Last summer I was faced with these very questions. Through a friend, I became aware of a very tantalizing opportunity for a career change. A manufacturing company here in Maine was looking for a Vice President for Corporate Affairs (fancy title for Human Resources Director). Although I have NO experience in Human Resources, the President of the company, whom I knew socially through my friend, courted me quite aggressively to take the job. The company consists of about 300 manufacturing and sales staff. I was looking at a SUBSTANTIAL pay increase – to the tune of $35,000. Yes, I said $35,000 over and above my current salary. Although I'm really not interested in working in the Human Resources field, the money was very enticing. Let's face it – I've never been good with money and this huge jump in salary could wipe out my debts. I could actually buy a new house, take expensive vacations, go out to dinner at nicer restaurants, and add to my already expansive wardrobe without guilt. My current salary is adequate, but wouldn't it be nice to have a little cushion...

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President's Message Continued

After about a month of hard soul searching, I decided not to pursue the job. No, I'm not crazy. I decided the money wasn't worth it. Let me tell you why. I gained a lot of insight into the company through my friend who worked there. The Executive Management Team was like a little shop of horrors. The President of the company would vacillate between being incredibly charming or verbally abuse and sexually inappropriate. Although he himself spent most of his time on the golf course, he expected all of his upper management to be at his beck and call 24/7. The CFO was a man who'd been fired from the company for inappropriate management of funds, only to be rehired a year later into the same position. My friend who worked there was the VP for Sales and Marketing. She, it turned out, had a borderline personality disorder and wasn't really much of a friend at all but was instead very destructive and diabolical. If I took the job, I'd have to commute an hour each way daily. Kind of a challenge since I don't drive. I'd have to depend on my "friend" to drive me every day. The company had no real structure at all. I'd have to start from scratch developing and implementing HR policies which I know nothing about and have no doubt would have been met with incredible resistance. It would be chaotic and nightmarish.

I love my job at Mercy. It's interesting, challenging and different every day. I work with some wonderful physicians and have amazing co-workers. My VPMA is kind, inspiring and supportive. He has all the all the attributes of an effective leader. I always feel respected and rewarded. I live 3 blocks away and never have to worry about how I'm getting to work. So I decided my happiness wasn't worth $35,000. Maybe I'll never get rich, but I know that it's worth it.

I think sometimes we forget to place value on our well being. Our well being doesn't pay the mortgage or the kids' college tuition, but it is vitally important. Don't forget that.

Freddie

ABMS Phases Out Two Source Verification Tools

By MaryCarol Rumsey, CPMSM

The American Board of Medical Specialties (ABMS) has eliminated two of its products for use as primary source verification for credentialing purposes.

The AMBS recently posted a credentialing advisory notice on its Web site (www.abms.org) that states that credentialing professionals should no longer use for primary source verification a CD-ROM or print directory because the information is not as up to date as other resources.

The two products are the ABMS Medical Specialists PLUS CD-ROM and the Official ABMS Directory of Certified Medical Specialists, 37th and subsequent editions, both published by Elsevier Inc. in cooperation with ABMS. The AMBS phased out the CD-ROM in June 2004 for primary source verification purposes.

According to the ABMS advisory, the change in verification status was made because information in these resources is not updated frequently and the complete physician date of birth – an important element for credentialing verification – has been removed from the directory. The availability of electronic data, which can be updated constantly, has changed how credentialing is performed and makes data that are updated only once or twice per year (as is the case with the print directory) less timely, the ABMS says. See the ABMS credentialing advisory notice on the Web site for more information about where to obtain ABMS data.

As a result of the ABMS notice, the NCQA has changed credentialing standard **CR 3**, which details requirements for initial primary source verification.

The NCQA notes that "after January 2005, the only acceptable ABMS sources will be products or services specifically designed by the ABMS as an Official ABMS Display Agent/those directly from the ABMS and its member boards (but not

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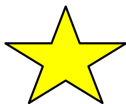
ABMS Verification *- Continued*

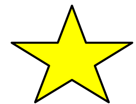
an agent or licensee) where a dated certificate of primary source authenticity has been provided."

Where Can I Go For Verification of Board Certification?
With the phase-out of two ABMS sources organizations can verify information through the following:

- ABMS CertiFACTS Online, ABMS Certifax service, ABMS products administered through ChoicePoint Services, Inc. and the online subscription service (www.boardcertified-docs.com).
- The American Osteopathic Association's (AOA) Physician Masterfile, or "AOA Physician Database," or *Official Osteopathic Physician Profile Report*
- The American Medical Association's (AMA) Physician Masterfile
- For the foreign board certification, confirmation from the Accreditation Council for Graduate Medical Education (ACGME) provided the organization has a letter on file from ACGME that the foreign board conducts a primary source verification of the education and training of each practitioner.

Source: Adapted from Verify and Comply: A Quick Reference Guide to the JCAHO and NCQA Standards for Credentialing, *published by HCPro, Inc.*





Golden Star Awarded to Claudia Edwards, CPMSM

By Rebecca West, Medical Staff Coordinator, Cary Medical Center

Many nominations were received and the votes were tallied. We are excited to announce the 2005 Golden Star Award recipient is Claudia Edwards, CPMSM. There were many wonderful comments made in support of Claudia, the following are a few of the comments received:

"*For all the wonderful articles she submitted as Lighthouse editor"*

"During her recent presentation at a MeAMSS education session, it was very apparent how much Claudia has grown within this organization."

"Her amount of dedication and work she devotes to the MeAMSS is outstanding. She also has done a remarkable job on "revamping" the Lighthouse. It is now, more than ever, a very informative and valuable learning tool for those of us in the credentialing area."

"Several of Claudia's articles from the Lighthouse have been reprinted in the NAMSS publication, Synergy."

"She is a never ending wealth of information and she has a memory like an elephant."

"Claudia's hard work and exceptional efforts put into the MeAMSS newsletter alone have provided an abundance of education to the membership."

"I find Claudia to be an approachable and highly qualified and a highly motivated businesswoman with great knowledge in regards to the Medical Staff Profession. She is very deserving of the Golden Star Award."

The Golden Star Award was presented to Claudia at the Maine Hospital Association Summer Forum June 23rd at The Samoset.

Congratulations to Claudia and **Thank You** for all your hard work!

Photos courtesy of Georges Nashan and Kim Pelletier.

2005 MHA Summer Forum

The Art of Vision by Erik Wahl

Mr. Wahl provided the group with lively entertainment about thinking outside the box. As he addressed the group, he began painting. Initially, the audience couldn't imagine what he was painting until he turned the painting upside down (photos). Einstein once said, "imagination is more important than knowledge".

'Almost all great accomplishments, be it in art, medicine, science, politics, business or even health care came because someone challenged the traditional rules. ***What rules can be challenged within your hospital to provide superior quality?'***

The Deeper Dimensions of Leadership

Presented by Thomas A. Atchison, Ed.D., President Atchison Consulting Group, LLC

As Freddie referenced in her article, Dr. Atchison presented an excellent discussion on the dimensions of leadership, defining leadership and management. "Leaders produce inspired followers. Managers produce predictable results. **Leaders have followers who commit to achieving a vision by building teams to manage change."**

"Having an impressive title does not make someone a leader. True leaders inspire commitment from executives, managers, physicians, and staff. Without this commitment, you have nothing but a title."

Dr. Atchison informed the group that every strategic plan should have accountabilities for trust and timelines included therein. 'Without trust, you can give a lot and your followers won't believe you.' Once a leader has trust from his/her followers, he/she earns their respect. He asked the group, 'how do you spend your time?' At a recent CEO boot camp, leaders noted that they spent less than 6 minutes as opposed to 30% of their day in a creative mode. A good leader is creative.

On motivation, leaders gain followers when they show them respect, provide them control about decisions that affect them and this leads to pride. When money is used as the only motivating factor, you lose respect and control. When people are treated like economic units, they become economic units.

Leaders don't motivate anybody. Leaders control the environment. They release the environment that allows creativity. As an example, the farmer prepares the soil to reap the benefits from the seed. It's never the seed; it's always the soil. Leadership is earned; without equity there is no accrual.

On the qualitative difference between leadership and management: The Chief Operating Officer ensures the trains run on time. The CEO lays the track. Someone needs to attend to the details; the CEO needs to create.

Change can be simple because 'I want it' and 'I control it'. Ask these questions:

1. What don't you understand?
2. What don't you want? and
3. What don't you control?

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Leadership *Continued*

The dynamics of change and the easy-to-hard continuum

Dr. Atchison went on to discuss the myths of employee satisfaction. 'Never use the words, employee satisfaction, because happy people don't change. Angry people don't change because they don't want to win. Use the word, pride, which is the deeper dimension that maintains the organization over time. As health care organizations face threatening workforce shortages, now more than ever they must retain high-performance employees if they want to maintain high-quality patient care. Many organizations, however mistakenly, continue to spend a great deal of time and money on employee satisfaction initiatives in an effort to reduce turnover, improve productivity, and increase customer satisfaction. Health care leaders should not be concerned about employee satisfaction; rather all of their efforts should focus on increasing employee pride.'

'Something sad has been happening in health care. People's pride, joy, and their sense of participating in work that has a noble purpose have been displaced by an obsession with the business aspects of our industry. Providing health care is viewed by a growing number of trustees and executives as the medium for maximizing profits. But health care requires a balance of two dimensions to succeed: tangible business elements and intangible human elements.'

Ask yourself, why do you do something? For honor. Leaders should focus on deeper dimensions. If one focuses on happiness, one never gets happy.

The tangibles of an organization include clinical and business processes that account for 35% of the organizational performance. Financial performers, patient safety and clinical quality result from living the strategic plan, departmental plans and the budget.

The intangibles of an organization are the human relations that account for 65% of organizational performance. The deeper dimensions include joy, pride, respect and trust. These four elements are the source of a sense of purpose and meaningful work as a result of living the mission, values and vision.

Leaders listen. There are three kinds of listening:

1. Selective and judgmental (one has begun 'waiting one's turn');
2. Active listening. The listener participates in a dialog by clarifying with questions; and
3. Reflective listening. In this situation one is confronted with someone who starts screaming and is upset. The listener focuses first on the emotion and then reflects on the problem.

Use F.U.N. to motivate: FOCUS, be **UNPREDICTABLE** and **NOVEL.**

As a caution, Dr. Atchison advised, 'the first time you give money for motivation to anyone, the next time the employee believes it is entitlement.'

Pride is a function of challenges met. Joy is a function of knocking down barriers.

Frustration results when someone throws up all these barriers. It is always important to remember to 'log in'. Always speak in the language of the receiver. Humans are beings with log-in wants. We don't always talk the same way with different people. Remember to understand the needs of your audience.

"Successful health care leaders spend as much time on the return on human capital as they do on the return of financial capital."

Interested persons may go www.atchisongroup.com to obtain surveys on the following:

1. *Pride Indicators*
2. *Followship Quotient*

Submitted by Claudia Edwards, CPMSM, Editor

At 1:00 p.m. MeAMSS broke away from the MHA Summer Forum activities to conduct its own educational session that included speakers Mary Dufort Finnegan and Denise Osgood.

The Nuts and Bolts of a Good Quality Program

Presented by Mary Dufort Finnegan, RN, BSN, M.Ed.

Mary Finnegan is the Director of Quality Improvement and Risk Manager at Goodall Hospital. She cited her experiences in developing that hospital's quality program but first provided the audience with recent peer review legislative issues that affect the medical staff.

Legislative Draft (LD) 1411 Sentinel Event Law – There was a proposal to remove the confidentiality of sentinel event reporting by hospitals and to open peer review information to the public. MHA testified on the perils of opening up peer review. Ms. Finnegan provided testimony on how this legislation came into existence. Its purpose was to develop a mechanism for hospitals to report threats to patient safety/care, generate root cause analyses so that hospitals could implement changes to prevent future problems. This information was intended to be shared in aggregate form for educational purposes to hospitals across the state. "What happens to anyone's report if it has your name attached to it? People stop reporting because people are afraid of retribution. With retribution comes exposure." **This proposal was defeated**. Under current regulation, peer review material is confidential and separate.

Recent changes in DHHS regulations raised the bar with quality by looking at meaningful data that are incorporated into the overall quality program. Physicians should be participating in quality initiatives and interpreting the data. The concept that "more is better is not good. It can be diluting."

With regard to the organization's quality plan, Ms. Finnegan suggested learning the current culture in your organization and then defining your program around it. But always keep in mind regulators have very definite ideas of what quality should be. In changing the culture of physicians, physician leaders should look at what is being reviewed and what should be continued or discontinued. Include your physician outliers: Physicians are now championing the development of order sets at Goodall.

Peer review is a formal process to review physician performance in a planned, defined program. Peers are defined as professionals in the same specialty of professional practice or a related specialty as the professional being reviewed. At Goodall record reviews are performed. If a record falls out utilizing any of the hospital's criteria, the record comes before a committee and the physician whose record is being reviewed also attends. A detailed review is performed. Difficult questions are posed. The physician whose record was reviewed then receives a letter and a copy is placed in his quality folder. Ms. Finnegan suggested the audience consider utilizing the same review form so that all physicians know what to expect.

The revisions to the Medical Staff Chapter of the DHHS regulations are concerned with effective, timely, safe and efficient patient centered care and that the medical staff utilizes outcome measures.

The Goodall Utilization Review Committee has been directed to look at chest pain, heart failure and pneumonia indicators. Color-coded order sets have been created for each diagnosis. To implement these order sets, the Quality Department prepared data on these core measures and presented them to the medical staff. The medical staff were surprised at the data and thus the culture to change to preprinted orders evolved. The Committee is also looking at outcome data. It continually reviews readmission rates for these conditions and whether there is a particular physician with a higher readmission rate than his/her peers.

At each medical staff meeting, medical staff quality is the first item on the agenda. Data is presented. Initially, the data was presented in aggregate form; now individual report cards are presented.

Per the DHHS regulations, the Quality Committee must meet four times per year minimally. The members of the Goodall Medical Staff Quality Improvement Committee include two internists, an emergency room physician, a pathologist an anesthesiologist, radiologist and family practice physician. Hospital staff include the Vice President of Patient Care Services and Ms. Finnegan. The clinical leaders of the medical staff also serve on the hospital-wide Quality Committee.

The Hospital Quality Program and the medical staff program should be seamless. The Plan may be a stand-alone document or a clearly identifiable component of the overall hospital quality plan. The Plan should specify monitoring and improvement activities appropriate to the volume and complexity of the hospital. The Plan will include indicators related to the following key aspects of care:

Quality Program Continued

1. Operative, other invasive and noninvasive procedures looking at appropriateness of procedures, complications, screening of tissue removal and anesthesia and post-anesthesia care
2. Medication usage (adverse drug reactions, appropriateness of antibiotic usage, healthcare acquired infections, drug usage, safety and efficacy.
3. Blood usage
4. Unanticipated deaths
5. Complications and medical errors.

It should include patient safety initiatives, error reduction, and provide a culture of caring and respect. Core measures are implemented across every service or part of the hospital. Staff and the medical staff alike are given feedback on customer satisfaction evaluations as part of the Quality Program. Customer satisfaction equals treating one another with respect. The hospital is a community and people need to be kind to one another.

Some of the following are initiatives implemented at Goodall:

1. Review of blood transfusions. The American Blood bank criteria were studied and a patient consent form developed that enables the patient to know why he/she is receiving the transfusion and that the consent is in the medical record. Transfusions that don't meet criteria are reviewed.
2. SIPs (surgical infection prevention) are reviewed.
3. Root cause analyses are performed whenever something might be a problem or a threat.
4. "No Blame Culture" to improve reporting of problem areas – Staff look at processes and how physicians play a role in this. Information is presented to the medical staff about problem areas identified. A hot line was established for the reporting of medication safety errors.
5. Because pediatrics is a low volume census at the hospital, a close look is taken at this population. The medical staff determines what skill sets are required for this patient population and moves forward to implement the criteria.
6. Medical staff newsletter that is published every other month. The President of the Medical Staff has a section to discuss pressing issues, verbal and telephone orders requirements are discussed; medical staff standing in meeting critical values is presented.

Ms. Finnegan recommended combining as many committees as possible as the State regulations identify required functions, not necessarily under which committee the function must be reported.

Provider-based practices that are part of any hospital are now responsible for quality reporting as defined in the Quality Program. They are being reviewed under the same criteria because they have the same hospital identification number, must meet outpatient department regulations and are reviewed at the same time the hospital is surveyed. One of the tools utilized at Goodall with regard to patient safety was to give patients cards that ask: 'Did your physician ask you what your name and date of birth are?' This data is being incorporated in those physicians' quality data.

Some quality ideas for provider-based practices might be to perform record reviews looking for prohibited abbreviations and running an audit by practitioner-specific information.

Rural Health Clinics on the other hand have a separate billing number for Medicare. As a result, provider-based rural health centers are surveyed independently and then only every six years.

Physician Performance Feedback is a phrase that has replaced the term, Profile, at Goodall. The regulations do not require you to send each physician his/her performance feedback, but each hospital needs to develop a mechanism by which a physician is notified that his/her performance feedback is available to be reviewed. At Goodall, physicians are notified of the availability of their data and that they should set up an appointment during which the information could be reviewed.

For those hospitals with physicians on staff but who do not care for inpatients because there exists a hospitalist system, quality measures for the referring physician could include looking at whether patients met acute criteria or review criteria that was included in the patient's treatment plan at time of discharge.

Ms. Finnegan addressed the issue of using rosters. Providing medical staff rosters to each other meets the good standing requirements (citizenship) but do not meet quality requirements.

You may contact Mary Finnegan by direct line at 490-7334 or write to her at mfinnegan@goodallhospital.org for a copy of the Goodall Hospital Peer Review Case Rating form, the Chest Pain/Heart Failure Physician Order Set, or Pneumonia Physician Order Set. Linda Smith, Medical Staff Office, at 490-7449 can also provide you with this information.

Submitted by Claudia Edwards, CPMSM, Editor

Rather than hold a panel discussion on creating a good quality profile, we asked Denise Osgood, CNA, CPHQ, Manager, Division of Hospital Licensure and Certification to address the DHHS Regulations and questions that were posed to her from our members in advance of the meeting.

Ms. Osgood informed the group that DHHS has been reorganizing departmental responsibilities. Long-term care hospitals, home health, hospice, end stage renal disease and behavioral health are areas under her department's purview. There are two new physician surveyors: Dr. David Stuchiner, Emergency Medicine, and Dr. Mukesh Bhargava, an internist. Since there are many new staff members, all are experiencing a learning curve in conducting surveys and responding to complaints.

Physician practices owned by hospitals are now surveyed at the same time as the hospital and under the outpatient regulations. Hospital staff need to tie back quality initiatives in these practices into the hospital-wide quality program.

Rural Health Centers are only looked at once every six years. The department will be looking at a venue to do some education for rural health centers and have oversight of administrators.

It is a requirement that the medical and allied health staffs receive notification of their annual performance feedback. It is important to remember that the practitioner should not have to ask for it.

There were a few errors in the DHHS Medical Staff and Allied Health regulations that will be revised. These are errors that occurred in the process of proposed regulations to the final distributed version. Errors include:

- Critical Access Hospitals (CAH) - need old regulations language removed. The CAH Medical Staff Regulations were intended to mirror those of General & Specialty Hospitals.
- Within the Medical Staff and Allied Health Staff regulations for General & Specialty Hospitals, IX.F. Quality Management, Section 2 (a) Operative, other invasive, and non-invasive procedures (if applicable to the hospital's complexity and clinical services offered), (iii) *Delete "Management Plan or the Bylaws, Rules and Regulations, and Policies" and insert "Screening of all tissue removed surgically, except those tissues specifically exempted from review by the Quality Management Plan or Bylaws, Rules, Regulations and policies".

Additionally, in the section regarding psychiatric hospitals and units treatment plans language is outdated. There needs to be language that clearly defines the difference between types of active treatment planning for the different types of patients.

Hospice regulations will be reviewed and updated. The Department is seeing inpatient hospice requests. Hospice is certified federally but there is nothing in the State regulations.

Inpatient substance abuse will come under the hospital regulations.

Questions posed by MeAMSS Members:

1. What is expected of the credentialers in regards to the Crisis Intervention Workers in the ER? Review your bylaws. If the practitioners meet Medical Staff or Allied Health Staff criteria, they must be credentialed in the same manner as all other staff members. If they do not meet membership criteria, a contract between parties can be established and the facility can accept the credentials verification provided by the contractor.

2. CMS rules say the H&P must be within 7 days of admission. Will the State surveyors hold us to this rule or will they go with the more lenient JCAHO rules that say within 30 days with updates? The requirement is that the H&P must be within 7 days of admission for inpatients or within 30 days for outpatients. (Please note I met with Ms. Osgood after the meeting to discuss clarification of her answer). Below is her response:

I wanted to provide further clarification on the question regarding the CMS requirement for the H&P to be competed within 7 days of admission vs. the JCAHO requirement of 30 days.

You are correct in your interpretation of the CMS requirements which allow some flexibility for both the inpatient and outpatient admission.

The CMS requirement for the H&P is that the "***physical exam and medical history be done no more than 7 days before or 48 hours after admission"***

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As you noted the interpretative guidelines state the H&P will meet this requirement if:

- ***"The H&P was performed within 30 days prior to admission; and***
- ***An appropriate assessment performed by the MD/DO, which must include a physical assessment of the patient to update any components of the patient's current medical status that may have changed...***
- ***The update is "completed within 7 days prior to admission or 48 hours after admission"***
- ***The update and the original assessment are in the record in the aforementioned time frames.***

3. Will surveyors that license psychiatric hospitals have a nurse surveyor on the team who has psychiatric experience? Interviews are being conducted to hire a nurse with psychiatric experience to participate on these surveys.

4. What will the surveyors expect to see on the physician quality profile? The Quality Management plan will include at a minimum key operative and other invasive and noninvasive procedures, the appropriateness of the procedures and complications. Surveyors will be looking to see that there is a melding of quality throughout the entire hospital.

5. Regarding Telemedicine Privileges: Is it acceptable to just have a privilege form that says, "Trauma Telemedicine" or "Telemedicine" without specifics of what the telemedicine consultant will be doing? It is not sufficient to have a generalized privilege form.

6. Do we have to have copies of a practitioner's license in the file or is a copy of the verification from the BOLIM's or Osteo Board's website adequate proof of current licensure? (One hospital was dinged by one of the new surveyors recently.) Yes, it is acceptable to copy from the BOLIM's or Osteo Board's websites as proof of current licensure as well as no adverse information on file.

7. Is it all right to use staff rosters to verify no disciplines and that the practitioner is on staff? Use of rosters is acceptable for use in verifying citizenship and medical staff membership. It does not provide information on quality.

8. Quality data for allied health: For those allied health practitioners on staff but who are privately employed by physicians, is it okay to accept the supervising physician's evaluation of the allied health practitioner for quality purposes? Allied health practitioners should be held to the same quality criteria as medical staff members.

9. If not, then what should we do for those who have no/low volume hospital activity? If there is no activity or little volume, the regulations require that this information be solicited from the practitioner's primary facility.

10. Do we need to verify board certification at each reappointment when the physician's certification is "lifetime"? Board certification needs to be re-verified at time of reappointment.

Submitted by Claudia Edwards, CPMSM, Editor

Credentialing And Privileging For Providers From Joint Commission Accredited Organization

Q: We are a JCAHO accredited hospital and wish to contract with a JCAHO accredited Teleradiology company. What do we need to do about credentialing and privileging the Radiologists from that company?

A: As with any contract arrangement with a JCAHO accredited organization providing services outside of the hospital, you can accept the contractee's credentials and privileges in one of two ways:

- Specify in the contract that the contracted entity (in this case, the Teleradiology company) will ensure that all services provided by individuals who are licensed independent practitioners (in this case, the Radiologists) will be within the scope of his or her privileges granted by the contracted entity; OR
- Actually verify that all contracted individuals who are licensed independent practitioners who will be providing services have appropriate privileges, for example by obtaining a copy of the list of privileges from the contracted entity.

It is not necessary for JCAHO accreditation purposes to maintain a complete credentials file for each provider or fully credential the provider using your hospital's process.

Editor's Note: Always check DHHS regulations to ensure no conflict with FAQs from JCAHO. State regulations always supersede JCAHO.

In between speakers, a drawing was held for a beautiful picnic basket generously donated by Kandi Brown, Medical Staff Secretary at St. Joseph Hospital.

Did Everyone Get His/Her Name in for the Drawing?

And the Winner Is?

Beth Bunker-Anderson, RN, Quality Leader, Maine Coast Memorial Hospital

Congratulations Beth!

Some of the MeAMSS Attendees at the Awards Luncheon

From Left to Right:

Faye Nelder (2nd on left), MMC; Debbie Hall, MMC; Cheryl Schilke, Synernet; Sarah Wilkins, Synernet; Kim Hall, Houlton; Cynthia Scott, Mayo; and Betsy Balchen, Waldo County

Carol Wentworth, Inland; Kandi Brown, St. Joseph; Pat Stack, Anthem BC/BS; Claudia Edwards, Maine Coast; Melissa Tibbetts, EMMC; and Kim Pelletier, Acadia

Photos Courtesy of Georges Nashan, RN, MS, CPHQ, Director of Performance Improvement, St. Joseph Hospital

Acronyms One Should Know When Studying for Either CPMSM or CPCS

GME	Graduate Medical Education	The education requirements of medical residents.
GSA	General Services Administration	A central management agency that sets Federal policy in such areas as Federal procurement, real property management, and information resources management category.
HCQIA	Health Care Quality Improvement Act	The principal legislation that created the peer-review system in America today was the HCQIA of 1986. It was enacted under the Reagan Administration to reduce the number of medical mal-practice suits hospitals faced with by eliminating incompetent physicians.
HEDIS	The Health Plan Employer Data and Information Set (HEDIS®)	HEDIS is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to compare the performance of managed health care plans. The performance measures in HEDIS are related to many significant public health issues such as cancer, heart disease, smoking, asthma and diabetes. HEDIS also includes a standardized survey of consumers' experiences that evaluates plan performance in areas such as customer service, access to care and claims possessing. HEDIS is sponsored, supported and maintained by NCQA.
HIPAA	Health Insurance Portability and Accountability Act of 1996	To amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance, and for other purposes. Administered by the Office of Civil Rights.
HIPDB	The Healthcare Integrity and Protection Data Bank	The HIPDB is a data collection system offering valuable information on adverse actions taken against health care providers, suppliers, and practitioners. Congress mandated the establishment of the HIPDB in the Health Insurance Portability and Accountability Act of 1996, lodging joint ownership of the system with the Department of Justice, and Health and Human Services (DHHS). DHHS' Office of Inspector General (OIG) is responsible for the systems' business functions, and day-to-day operation of the data bank are entrusted to DHHS' Health Resources and Services Administration (HRSA). The HIPDB captures a wide array of adverse action information, but it is not meant to be the sole tool used in any investigation. Rather, it is meant to be a flagging system to alert users that a more comprehensive review is warranted of any provider, supplier, or practitioner on whom a report is received. HIPDB captures five types of final adverse actions: Health care related civil judgments entered in Federal or State courts; • Health care related criminal convictions entered in Federal or State courts; • Federal or state licensing and certification actions (terminations, etc.); • Exclusion from participation in Federal or State health care programs; and • Any other adjudicated actions or decisions that the Secretary establishes by regulations (this has been defined as formal or official actions taken against a health care provider, supplier or practitioner by a Federal or State governmental agency or a health plan which includes *Continued on Page 12*

	HIPDB Continued	• the availability of a due process mechanism, and which are based on acts or omissions that affect or could affect the payment, provision or deliver of a health care item or service). Medicare carriers and fiscal intermediaries (FIs) will be able to query HIPDB free of charge, via a secure password-based Internet access mechanism. Querying can only be done on-line at the following Internet address: www.npdb-hipdb.com. CMS does not anticipate that Internet access will be problematic, as contractors currently utilize the Internet to access the General Services Administration (GSA) debarment list. HIPDB does not include GSA debarment information, so utilizing the GSA debarment list will continue to be necessary.
HMO	Health Maintenance Organization	An organization providing health care to a group of enrolled members, who prepay in the form of monthly dues: Four Models: **Staff model, group model, network model and independent practice association.**
JCAHO	The Joint Commission on Accreditation of Healthcare Organizations	Its mission is to continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations. The Joint Commission is an independent, not-for-profit organization, established more than 50 years ago. Joint Commission is governed by a board that includes physicians, nurses, and consumers. Joint Commission sets the standards by which health care quality is measured in America and around the world. Joint Commission evaluates the quality and safety of care for more than 15,000 health care organizations. To maintain and earn accreditation, organizations must have an extensive on-site review by a team of Joint Commission health care professionals, at least once every three years. The purpose of the review is to evaluate the organization's performance in areas that affect your care. Accreditation may then be awarded based on how well the organizations met Joint Commission standards.
LIP	Licensed Independent Practitioner	Practitioner licensed by a state licensing board who can operate independently.
MCO	Managed Care Organization	Managed care is the distinct merging of cost of care considerations with the medical decision making process.
NCQA	National Committee for Quality Assurance	The NCQA is an independent, nonprofit institution established in 1979 that reviews and accredits managed care organization, managed behavioral healthcare organizations, new health plans and preferred provider organizations. NCQA offers certification programs for credentials verification organizations and physician organizations. Governed by a board of directors of managed care executives, purchasers, independent quality experts and union and consumer representatives, NCQA is a leading external review organization for the managed care industry. Its mission is to promote improvements in the quality of patient care proved through managed health plans. NCQA has five accreditation levels: **Excellent, Commendable, Accredited, Provisional and Denied.**

NPDB	National Practitioner Data Bank	The National Practitioner Data Bank (NPDB) is a flagging system that alerts users if a practitioner's record should be reviewed more closely. It identifies practitioners with a history of adverse actions and medical malpractice payments. The NPDB: • Improves the quality of health care by encouraging effective professional peer review. • Is a high-profile, nationwide database that captures information on physicians, dentists, and other health care practitioners. It provides the information to hospitals, health plans, professional societies, State licensing boards, and other eligible health care entities. • Keeps unprofessional or incompetent practitioners from moving from State to State in order to conceal their negative records. This vital information could prevent questionably competent practitioners from harming patients. • Is a fee-per-query database that processes over three million transactions a year and it processes practitioner self-queries for hundreds of thousands of physicians, dentists, and other health care practitioners nationwide. • Information is accessible through three secure electronic interfaces: the internet-based Integrated Querying and Reporting Service (IQRS), the Interface Control Document Transfer Program (ITP), or the Querying and Reporting Extensible Markup Language (XML) Service (QRXS). • Began operations in September of 1990. • Is prohibited by law to disclose information on a specific practitioner to the general public.
OIG	Office of Inspector General	The OIG Web Site provides information concerning reports issues, guidance and other related information concerning fraud, waste and abuse issues for the Department of Health and Human Services' programs. Office conducts audits, investigations, and evaluations that result in improvements in the effectiveness, efficiency, and economy of Departmental of Labor programs and operations.
OSHA	Occupational Safety & Health Administration	Government agency that establishes protective standards, enforces those standards, and reaches out to employers and employees through technical assistance and consultation programs.
UPIN	Unique Physician Identifier Number	The United States Congress authorized both the unique numbering of physicians and the publication of this directory. Section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985 required the Health Care Financing Administration (HCFA) to establish a unique identifier for each physician. HCFA developed the six-place alpha numeric UPIN, which was assigned to all physicians whether in solo or group practice. Section 4164 of the Omnibus Budget Reconciliation Act of 1990 required HCFA to publish a directory of UPINs. This directory will enable the health care community to place the UPIN of the referring or ordering physician on the Medicare and other claim forms. Effective January 1, 1992, carriers started rejecting claims which should, but do not, contain the UPIN of the physician who referred the patient for the consultation or ordered the service or supply being billed. Contact your local Medicare carrier for the coding and claim filing requirements.

URAC	American Accreditation HealthCare Commission/URAC now called the Commission/URAC	URAC, an independent, nonprofit organization, is well-known as a leader in promoting health care quality through its accreditation and certification programs. URAC offers a wide range of quality benchmarking programs and services that keep pace with the rapid changes in the health care system, and provide a symbol of excellence for organizations to validate their commitment to quality and accountability. Through its broad-based governance structure and an inclusive standards development process, URAC ensures that all stakeholders are represented in establishing meaningful quality measures for the entire health care industry. In the late 1980's concerns grew over the lack of uniform standards for utilization review (UR) services. UR is the process where organizations determine whether health care is medically necessary for a patient or an insured individual. As a result, URAC's first mission was to improve the quality and accountability of health care organizations using UR programs. In later years, URAC's mission expanded to cover a larger range of service functions found in various health care settings including the accreditation of integrated systems such as health plans to smaller organizations offering specialty services. Now, in its 15th year of operation, URAC has over 16 accreditation and certification programs. From conception, the founders of URAC recognized that an accreditation organization would not be accepted by regulators, health care providers and consumers if controlled by industry interests. To avoid this, several operating principles were incorporated into URAC's structure and bylaws. First, URAC was set up as an organization independent of any particular stakeholder group. Second, the governing Board of Directors was established with representatives from all affected constituencies: consumers, providers, employers, regulators and industry experts. Today, over 500 committee volunteers and 30 paid staff help run the organization.

It does not take much strength to do things, but it requires great strength to decide on what to do. – *Elbert Hubbard.* **Good Luck to all who are taking the CPCS or CPMSM exams!**

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qualityforum.org
credentialinfo.com
www.npdb-hipdb.com/npdb/html/00010_frameset.htm
www.npdb-hipdb.com/hipdb/html/00010_frameset.htm

Upcoming Education Sessions

September 09, 2005
Waldo County Hospital
Belfast

November 04, 2005
Mid Coast Hospital
Brunswick

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

Well, readers, we have a special treat for you! Cheryl Schilke, RN, CPMSM, Synernet CVO, developed this crossword puzzle for your intellectual pleasure. Thank you very much, Cheryl.

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ACROSS

1 Prefix meaning after
5 Root word meaning skin
6 What MSC may want to do when the Chief of Staff says "This guy needs temps this afternoon."
7 Adjective meaning coming on suddenly and/or severely
9 Common abbreviation for electrocardiogram
11 Root word referring to main passageway for air into lungs
12 Root word referring to teeth
13 Digit on foot
14 Prefix meaning against
15 Root word meaning disease
16 Adjective describing distance toward center of body
18 Prefix meaning before
20 Root word meaning bone
21 Suffix meaning study of
22 Root word referring to ear
24 Root word referring to muscle
25 Root word referring to cancer
27 Suffix meaning looking through an instrument
28 Root word referring to joint
29 Root word relating to female
30 Root word referring to heart

DOWN

2 Root word meaning sac
3 A dull moderately intense pain
4 Prefix meaning around
5 Prefix meaning painful
8 Common abbreviation for an infectious disease of the lungs
9 Suffix meaning surgical removal of
10 Common abbreviation for the digestive tract
12 Adjective describing distance away from center of body
13 Opposable digit on hand
14 Open your mouth and say ___!
15 Suffix relating to surgical repair or reconstruction
16 Root word referring to rectum
17 Root word relating to blood vessels
21 Suffix meaning surgical incision
22 A common yoga meditation word – something MSCs need to use often
23 Root word relating to ovary
26 Root word relating to cell
27 Bacterial infection of eyelid (var.)

Answers

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