



THE LIGHTHOUSE

FEBRUARY 2003

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

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REMINDER

The NAMSS Certification Board recently announced electronic CMSC & CPCS exams at over 700 computerized testing centers throughout the US. There is a two-week window for sitting for the exam.

You pick the date and testing site!

Exam Fees are as follows:

NAMSS members - \$325.00

Non-Members - \$475.00

Application Deadline

April 1, 2003

August 31, 2003

Exam Dates

June 14-28, 2003

November 1-15, 2003

PRESIDENT'S MESSAGE

"I have always been delighted at the prospect of a new day, a fresh try, one more start, with perhaps a bit of magic waiting somewhere behind the morning."

- J.B. Priestly -

Welcome to the first 2003 edition of the *Lighthouse*. I trust you all survived the holidays, the frigid temperatures, and are now well into the swing of things.

I would like to bring you up to speed on the progress of our new Board of Directors. Lisa Davis, CMSC, was elected as *Lighthouse* Editor, but shortly after our December meeting, her position at CMMC was eliminated. Lisa accepted another position elsewhere and is unable to fulfill the responsibilities of the Board. Thus, because Claudia Edwards also ran for the position, the Board offered it to her. Claudia accepted, and now we are back on track. Pat O'Connor has relocated to Colorado and will continue as past president.

The 2003 Board of Directors held its first meeting in January and immediately began working on the MeAMSS 2003 Strategic Plan. It is my intention to keep members informed of the progress of each meeting, expecting and valuing membership feedback that will assist us in our continued growth.

In closing, in light of the recent Columbia tragedy, I urge you to consider the quote above. Don't take life so seriously that you forget to really live it. I look forward to seeing each of you at our meeting in March.

Kim Pelletier, CMSC



MeAMSS UPCOMING EDUCATION AND BUSINESS MEETING

March 14, 2003
Acadia Hospital
Bangor, Maine

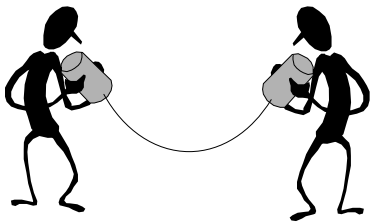
The Education Committee has secured the following speakers/topics as part of this program. Tom Shandera, Infection Control Nurse, The Acadia Hospital, will discuss "Failure Modes and Effects Analysis (FEMA)" and Brad Boylan, Quality Improvement, The Acadia Hospital will present "Physician Profiling". There will be other great presentations as well and you won't want to miss this educational opportunity.

ADDITIONAL MeAMSS EDUCATIONAL MEETINGS DATES

June 27, 2003

Waldo County General Hospital, Belfast
September 12, 2003

Mayo Regional Hospital, Dover-Foxcroft
December 5, 2003
in the Portland area (TBA).



ANNOUNCEMENT

In the February 2003 issue of "Credentialing and Peer Review Legal Insider", we were cautioned that state uniform applications do not always meet CMS, NCQA and JCAHO regulatory standards. Rest assured that the Maine Task Force did indeed take all these requirements, as well as hospital licensing requirements, into consideration and that the newly revised Maine applications meet these standards.

Cheryl Schilke, RN, CMSC

TEST YOUR KNOWLEDGE

Medical Terminology

Questions from last month's newsletter have been repeated with answers denoted in "bold".

1. Terms that denote direction:

Term	Answer
anterior =	front
distal =	away from center
lateral =	side
prone =	lying on belly

2. There are several structures associated with the digestive system. Which one of the following is NOT part of the digestive system?

pharynx, jejunum, appendix,
bronchi, liver, or pancreas

Answer: bronchi

3. Psychiatry is a specialty of clinical medicine that deals with the diagnosis, treatment and prevention of ?? illness. (**Answer: mental illness**)

Law Review

1. Negligent credentialing: the hospital failed to get information from another hospital about summary suspension. Also negligence in reappointment. Name the case. **Bell v. Sharp Cabrillo Hospital**
2. Which case came about because physicians allegedly conducted Anti-Competitive peer review thus violating HCQA? **Patrick v. Burget**
3. A doctor failed to disclose malpractice cases and lied about his privileges at other hospitals. This information should have been verified. Case was for failure of the initial credentialing process – again, negligent credentialing. **Johnson v. Misericordia Community Hospital**



RETIREMENT NOTICE

*Sandra Bethanis, RN, Assistant Director,
Division of Licensing and Certification at
DHS will be retiring on February 28.*

FROM THE JCAHO WEBSITE'S FREQUENTLY ASKED QUESTIONS (jcaho.org)

Verification of Credentials Information

Q: Can a documented phone conversation be utilized as primary source verification for licensure, education, training and experience, competence and peer references?

A: A documented telephone conversation **can** be utilized as primary source verification for all information including licensure, education, training and experience, competence and peer references. When verifying information via telephone, the following information should be documented:

- the date of the conversation
- the name and title of the person providing the information
- the name of the organization when appropriate; e.g. the school certifying board, employing organization, etc.
- the specific information provided
- the date and signature of the person receiving the information.

Origination Date: September 14, 2001

Article for, or comments about, *The Lighthouse*? Please write to cedwards@mainehospital.org

ATTENTION NAMSS MEMBERS

The National Association Medical Staff Services invites you to participate in the 2003 member recruitment program. By recruiting a new member (individual membership only) you expose your colleagues to the world of benefits and services that only NAMSS membership offers. In turn, you have the chance to reward yourself through special prizes offered during this campaign. Your name will be entered into the drawing for each new member you recruit between January 15 and April 15, 2003.

First Prize: 2003 Annual Conference Registration and Airfare (up to \$500).
San Antonio, September 29 - October 4

Second Prize: 2003 Annual Conference Registration.

PROPOSED NEW MEDICAL STAFF CHAPTER UNDER DHS LICENSING REGULATIONS:

Ron Lambert, CPCS, previously forwarded the proposed revisions of Chapter IX, The Medical and Professional Staff, to the MeAMSS members. Per Sandra Parker, Esq., of the Maine Hospital Association, the Maine Hospital Licensing Board is currently working on the draft regulations with the State. The MHA membership is well represented on that Board. MHA has also sought comment from its full membership.

Attached are salient points members should consider. We urge you to carefully review Chapter IX and contact your hospital administrators with comments and/or concerns. Perhaps we can effect revisions with the aid of the Maine Hospital Association before the final language becomes part of the licensing regulations.

*Cheryl Schilke, CMSC
Claudia Edwards*



TABLE HIGHLIGHTING PROPOSED DHS REVISIONS
TO MEDICAL STAFF CHAPTER

Section	Change	Concerns/Recommendations/Comments
Overall Scope of Regulation 1(a) and throughout beginning on P. 1	Professional Staff is now defined as Allied Health Professional Staff	Many independent and dependent practitioners have a strong aversion to the term “allied health”
P. 1 - 1(a)(2) P. 1, 3 rd line	The Medical and Allied Health Professional Staff is responsible... for all medical care... “including that provided by healthcare professionals under contract to the hospital”...	Language in bold is new.
P. 1 - 1(a)(4)	Requires that those healthcare professionals who meet bylaws definition of medical staff or allied health professional staff and who provide services under the terms of a contract will be members of the medical staff	The intent probably refers to specialty practices such as radiology, pathology, and anesthesiology. Workers such as crisis response-type change positions frequently and credentialing each worker individually becomes an undue burden. If this language is not modified to some extent, bylaws or rules and regulations that don’t provide these workers with membership would need to be changed.
P. 38 in existing standards IXB. First paragraph	The old language in this area had a disclaimer “Nothing in the definitions below shall be construed to require or obligate a hospital to include a particular type of practitioner on its Medical or Professional Staff.” This has been deleted.	One could construe this to mean their current language “mandates” we include all independent and dependent practitioners.
P. 5 - 3(a)	New language requires department meetings must be face-to-face dialogue and prohibits “virtual meetings” conducted in any manner.	Experts have analyzed meetings and defined two types: (1) dissemination of information (much of which is accomplished by e-mail, teleconferencing, etc.); and (2) work session – these would require physical presence. Elimination of “virtual meetings” would actually decrease efficiency and consume valuable physician time unnecessary when all that is required is to disseminate information.

TABLE HIGHLIGHTING PROPOSED DHS REVISIONS
TO MEDICAL STAFF CHAPTER

Section	Change	Concerns/Recommendations/Comments
P. 8 – (b) Executive Committee (1)	Executive Committee (or equivalent) shall have at least one or more members elected at large from the active Medical and Allied Health Professional Staff	While the language is similar to previous, the fact that it now includes “a member at large from the Active Medical and Professional staff, it’s not clear whether the intent is to “require having allied health members on the Executive Committee”. The disclaimer on P. 38 of the current standards, IXB., has been eliminated.
P. 11 – Item 6	Allows bylaws to define which categories of medical staff are permitted or required to attend staff meetings with the following new phrase: although members who are actively involved with the care of patients on a regular basis may not be exempted from attending meetings.	
P. 11 – Item 7	Prohibits the virtual meeting for medical staff meetings.	Same concern as noted above.
P. 12 – Item (e)	The date of appointment shall not exceed two years. The date of initial appointment or reappointment shall be the date on which the Governing Board took action. ...credentials files ...must clearly document the date of initial appointment and all subsequent dates of reappointment.	Previously it said shall reappoint every two years. There is a concern that the Governing Board might not always meet the same time (and in some cases not at all in certain months), thus we risk exceeding the time frame. Previously, we were allowed to state in the body of the letter the beginning date of the reappointment. If your bylaws say you reappoint on the biennial of one’s birth date and your Governing Board doesn’t meet that month, there is a problem of not complying with the Bylaws.

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Section	Change	Concerns/Recommendations/Comments
P. 13 (h)	Language has been added to clearly define the expectation of a CVO or service providing information used by the hospital in the appointment/reappointment process.	
P. 15 (2)(a)(k)	Adds language that advanced practice nurses must provide evidence of the licensure for advanced practice nurses (not just their RN license)	
P. 15 (2)(b)	New language that applications must provide: “Documented registration with the Drug Enforcement Administration, maintained continually while appointment is in effect unless such registration is not permitted by the applicant’s licensure”.	This needs to be reworded. Currently, pathologists are allowed by licensure to have a DEA but most do not as they do not write prescriptions.
P. 16	Most of this is covered in our standard application except 3(c) at the top of P. 16. Applicants must provide peer attestations of experience, judgment and quality of clinical performance.	This is secondary source verification. Perhaps the wording should say that applicants will provide the names of peers who could attest to experience, judgment and quality of clinical performance.
P. 17 (c)	The proposal requires primary source verification within 90 days of Governing Board action for the following: <ol style="list-style-type: none"> 1. Current Maine license; 2. Current Board certification (even if it is not required in your bylaws, if an applicant claims to be board certified, this must be verified. 3. Liability coverage and claims history (provides guidance for what is required if a carrier no longer provides coverage in Maine) 	They do not mention verifications by hospitals or peers so the assumption is that they do not have to be within the 90 day period. However, this new requirement presents a time problem for those hospitals that must coordinate through department chairs/chiefs, credentials committees, medical staff and then on to the Governing Board. It forces a very tight timeline for those organizations who outsource the credentialing as well.

TABLE HIGHLIGHTING PROPOSED DHS REVISIONS
TO MEDICAL STAFF CHAPTER

Section	Change	Concerns/Recommendations/Comments
P. 17(c) Continued	4. NPDB verification	There is a problem with Item 2. Boards will not verify “eligibility”. Also, there is a fee incurred when verifying through the ABMS; many credentialing professionals group the verification process in order to save on costs.
P. 18 - 3(a)(1)(a)	Clearly sets forth that you can place in the quality files a statement that none of the applicant’s cases met preliminary criteria for detailed review.	This is helpful
P. 18 – 3(a)(1)(a)(i)	<p>Provides language regarding those reappointment applicants with little or no activity.</p> <p>Bylaws could include language that would allow an applicant to withdraw a request for clinical privileges without prejudice (allow membership with no privileges). If this is not permitted in your bylaws, the bylaws could provide language for those applicants with little or not activity that would allow the applicant to withdraw from reappointment without prejudice and these withdrawals shall not be deemed to constitute a relinquishment of privileges.</p>	<p>If the applicant has not had sufficient activity at your hospital, you must solicit information from other hospitals.</p> <p>This could answer a lot of problematic issues for some hospitals who have many practitioners with no activity.</p>
P. 19	12 th line from the top: “...may provide (typographical)	
P. 20 Reappointment	Information provided at reappointment now clearly states “since last appointment” instead of “shall not differ from initial appointment”.	Some might believe that this would eliminate the requirement to verify the last five years of malpractice history. One must remember these are minimum standards set forth and does not impede an organization from requiring this in their credentialing policy.
P. 21	Again there is the requirement of obtaining information within 90 days for reappointment action at the Governing Board level.	

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TO MEDICAL STAFF CHAPTER

Section	Change	Concerns/Recommendations/Comments
P. 22 – Item (g)	If a member of the Staff is not reappointed within two years of the last appointment or reappointment, regardless of fault or reason, the member may no longer admit patients or attend patients in the hospital. Bylaws will specify how the care is to be rendered...	Temporary privileges are expressly forbidden to bridge the gap for any late reappointments. NO EXTENSIONS.
P. 23 (4)(a)(1)(a-c)	Defines under what conditions temporary privileges can be extended.	No abbreviated applications are allowed.
P. 24 – Item 6	Temporary appointments can be 60 days with one 60 day extension.	It used to be 90 days for both.
P. 24 – Locum Tenens	You can now create a section in your bylaws for locum tenens with recurring short-term care.	
P. 25 – Item 3	Conditions for Telemedicine credentialing are defined.	All practitioners must be credentialed. For organizations contracting with a group or other hospital, acceptance of their credentials file is allowed. However, for individual practitioners, one must complete the entire credentialing process.
	There is a specific bylaws requirement for “periodic expansion” of (or) reduction of privileges based on experience or changes in [licensure, training, experience, competence]	One would think that provider evaluation and granting of privileges every two years would cover this but perhaps they mean a periodic review of the privilege forms, particularly moving procedures in and out of the core.
P. 27 2(b)	Emergency privileges end once the situation is under immediate control rather than 72 hours. Those providing ongoing treatment must apply for membership and privileges.	
	Quality Management: Annual quality information must still be provided to every member of the staff; however, it is no longer the responsibility of the department chair. Responsibility must be designated within the quality plan.	