Ted Henson (00:00:01):

Great. Thank you so much, Olivia. And hello, and welcome back, everyone to our three-part compliance and operational site visit training series. As Olivia said, my name is Ted Henson. I'm the director of health center growth and development here at NACHC and I'm very pleased to welcome you back to today's webinar. Thank you for making the time for today's webinar and to learn more about OSVs, because compliance matters, and not just episodic point in time assessments such as the OSV, but continuous compliance and creating systems that support continuous compliance and performance improvement. Our webinar faculty, over these three webinars, have thoughtfully approached each chapter of the compliance manual, with an eye towards key elements, common areas of noncompliance or hotspots and strategies for maintaining continuous compliance.

Go to the next slide here. And so today is the third webinar and final webinar of this series. Today's webinar will focus largely on the chapters related to clinical program requirements, form 5As and strategies for continuous compliance. We know from the survey that many of you all responded to before the webinars series, that form 5A was something that you have a lot of questions about and no surprises here. So I want to thank Kyle in advance for structuring the presentation in a way that we're going to front-load form 5A and pause about halfway through for questions on that. So I know we sent an email out to have that form 5A ready in front of you, so please have that handy.

So as I mentioned, Kyle's going to be a presenter today, and so we are lucky and I'm honored to welcome Kyle back as our featured presenter. For those of you who don't know Kyle, he is the CEO and co-founder of RegLantern, a company that provides tools and services to health centers that help them move toward continuous compliance. Kyle has served in a wide range of healthcare settings, including serving as the director of operations for social ministries for a large health system, provider relations for health system owned payer, the clinical quality director and director of operations for an FQHC and in a variety of other roles in long-term care, acute care, and even a hospital administration in a rural mission hospital in Tanzania.

Kyle also is an independent contractor, provides our HRSA site visit surveys for FQHCs across the United States. And he speaks around the country on various topics related to mission-minded care, value-based payment, population health management, PCMH, and of course, HRSA program requirements.

I've had the pleasure of working with Kyle in a couple of capacities over the past few years, mainly around compliance. And Kyle, thank you for making the time today. I know you have a lot of content to cover, so I'll let you take it away. Thank you.

Kyle Vath, BSN, MHA, RN (00:02:38):

Great. Well, thank you so much, Ted, and thank you for the opportunity. Hello everyone. And as Jen started out her presentation several days ago, just wanted to thank you all and be very aware of the challenging couple of years you all have had. And thank you for the service that you provide on the front lines and have been providing for a long, long time, but specifically, during these challenging past couple of years. Just to add, as Ted said, I do HRSA reviews through MSCG as an independent contractor. And so with that, I just have to remind everyone and make the disclaimer that this presentation is not endorsed by, I am not employed by and I'm not speaking on behalf of HRSA, BPHC, MSCG or NACHC. And anything that we talk about today should not serve as legal advice. We're going to be talking about some contracts and MOUs and some of those legal arrangements that we will give you some compliance answers on, but always make sure you talk with an attorney about those types of decisions when you're looking at contracts and MOUs and those types of things.

Also, as many of you know, we have things that change very, very quickly in the HRSA world. And so as of today, we are working off the May 27th, 2021 version of the Site Visit Protocol and the 2018 version of the Compliance Manual. So depending on when you're watching this recording, this is just released. So everything will be current as of the May 27th, 2021 Site Visit Protocol. But make sure if you're watching this at a later point, that this is still the most current up-to-date information.

And then also, especially with form 5A, and we're going to talk a lot about this, unfortunately, there are a lot of subjectivities that still remain in form 5A. HRSA's done a great job of removing as many of those as they have to this point. So it's much better than it used to be, but there are still some areas that you really need to talk with your project officer about and make sure you all are on the same page, but we're going to talk about a lot of best practices, a lot of recommendations, and a lot of things that are very, very clear, but always keep that in mind as well. And you should always have a great relationship with your project officer and be in continuous conversation and communication with them anyway. So just a reminder with that.

So we've already talked through the goals and as we said, we've got a lot of information to cover today, so I'm going to move pretty quickly through these things. I've got some icons that I want to call your attention to that you'll see throughout the presentation, you'll see a little alert button that points to these areas being the commonly missed areas. So areas that you really want to stop and focus on because so many people have trouble with it. You also see a best practice next to some of these areas. These may be areas that are not specifically spelled out in your HRSA Compliance Manual or Site Visit Protocol, but they're best practices, and there will be quite a few of those as we go along.

I also have written lots of blog posts about these types of things that can be found on my blog. If you go to my website at reglantern.com, you'll find a lot of the topics that we talk about I will dive into in great detail. And hopefully, you will find that to be very helpful. Also, on our website, there's a number of documents that we will talk about here. A lot of templates and samples that we keep on our website. So if you go to reglantern.com, you sign in and then go to resources, there's a ton of documents that we'll be talking about today. I get asked about them all the time, so I just put them up on the website and you can access those and they're all for free.

Element references, you'll see in some of these little parentheses with a number and a letter, those are references specifically to the element and the question number within the Site Visit Protocol. So if you have questions about a certain area, look for that little reference and go straight to that Site Visit Protocol. This is really going to be a key reference for you as you work on form 5A, as well as the other clinical co compliance areas, as well as finance and governance admin that we've talked about the last couple of days. So I always like to start out with the idea of FQHC hierarchy or health center, community health center hierarchy, and how important it is to build on the firm foundation of regulatory compliance. If you don't have that, you have an unstable organization and everything should build on that to have a very solidly founded organization based on regulatory compliance. So, that's one of the key areas that we'll be talking about today, is building everything on regulatory compliance. As I think Renee said yesterday, that is the basement. That is the bare minimum that you have to do to be a health center. And so of course there's lots of best practices and lots of other mission-guided things that you want to take into consideration and you should, but we're going to be primarily talking about the minimum regulatory compliance areas today and how to build on them.

I also think it's important to look at the theme of HRSA. What are they looking for when they come to do your HRSA operational site visit? When they give you your grant funds or when they deem you as a lookalike, what are they looking for? What are the big picture things? And by nature of that, what are reviewers looking for when they come to your operational site visit? So I would argue that it boils down to this one sentence. HRSA wants to see you providing continuous documentation that your

health center provides as many patients as possible access to the highest quality care that's responsive to the needs of the community, while being good stewards of the government's resources. So when we understand that theme and look through everything, look at everything through that lens, I think things get really, really clear of what we are looking for and what we need to show and demonstrate documentation of that access, that quality that we're responsive to the needs of the community and that we're good stewards of finances. So just be thinking about that as we talk through the different areas that we'll be talking about today in the clinical compliance areas.

We talked about the Compliance Manual of the Site Visit Protocol. I won't go into that. There's three different areas as you know, governance/admin, fiscal and clinical, and we're going to be talking about the areas of clinical consultant chapters today. There are a couple chapters that are most missed and we'll talk through those here in just a second.

I want to spend just a minute on this slide. This, as you saw, if you were part of Ted's first slide, there is a list of documents that, it's a little dated now, but this is the most recent we have. In 2019, HRSA released the top findings for health centers during operational site visits. And so these are the areas on the left, the ones that are identified on site, and then the ones on the right are the ones that went on to have findings and conditions after the site visits. So they were a little more difficult to fix past the compliance resolution of opportunity or what we call as the CRO period.

So when we look at these areas and we divide them into the governance/admin, clinical and fiscal areas, you'll see all the red areas are the clinical areas that we're going to be talking about today. And within those clinical areas, you can see required an additional services, that's about form 5A. Clinical staffing is primarily around credentialing and privileging. And one of those credentialing and privileging areas is also element F of clinical staffing, also overlaps with form 5A.

So you can see form 5A and credentialing and privileging are still the areas that we see people have the most trouble on. So in that survey that we received information about, that's right in line with what everybody is struggling with. And to be honest with you, form 5A is one of the hardest areas for reviewers and project officers to understand as well, so you're in good company.

So as I mentioned, we've got the two documents here. I've got a number of recommendations for continuous compliance. Because we're short on time and because we want to spend so much time on form 5A, I'm going to skip through most of these so that we don't waste time on that. And you will have them as a reference. They're going to be providing the slides here shortly after this, and you will have these to review at your own leisure.

All right. So let's jump into chapter four: Required and Additional Services, which primarily focuses on form 5A, and that falls mainly under element A; providing and documenting services within scope of project. So again, there's other areas within here where we're looking at limited English proficiency patients, we're making sure they have good access, providing culturally appropriate care. But our primary focus is element A. As we saw, that's the key area that people have trouble with.

If you're not familiar with form 5A, it is a form that outlines the services that you have agreed to provide and what you're required to provide in exchange for your grant funds. So in short, it's demonstrating how you are actually completing those required services that you agree to when you signed on that grant application.

So when we look at form 5A, one of the things that makes it so challenging to conquer is that it pulls from all types of different chapters in different areas that are applying to this one area of form 5A. So Renee yesterday talked a little bit about the two chapters that touch with form 5A, which are chapters 9 and 12: Sliding Fee Scale, as well as Contracts and Subawards. And today we're specifically going to be talking about the clinical areas, chapter four: Required Additional Health Services, which

we're talking about right now. And as I mentioned, chapter five: Clinical Staffing, which is primarily credentialing and privileging, also touches on form 5A. So, 4, 5, 9 and 12 are the key areas to remember when you are looking at your form 5A contracts and your MOUs. But specifically today, we're going to focus on four and five.

So, one thing to understand when you're looking at form 5A, is that you are looking at your scope of project and you're documenting your scope of project. And HRSA considers five different areas when we're talking about scope. So this is the what, the who, the how, the where, to whom you're providing services and the target populations that you're focusing on. So those areas are services for what and the providers for the who and how we'll start out with starting out initially.

So services provided, which are the what, there are definitions on HRSA's website that you'll see here. And if you just Google HRSA service descriptors, it'll pop right up, but it's not always easy to find. But just Google HRSA service descriptors and there's a list of all the definitions for each required additional and specialty service that you have and that you're required to provide. So that is a very key document that you want to have ready and prepared when you're looking at form 5A.

Then you are looking at the who and the how; the providers. Who are the providers that are providing this service and how are you delivering this service? And that's mainly looking at the columns, column one, column two and column three, that are indicated on your form 5A form. So there is also a definition for those columns that is on HRSA's website. And if you just Google HRSA delivery methods descriptors document, that will pop up as well. So a lot of people don't start out with these documents. They're not aware that they exist. So this is always a good idea to build on that foundation of understanding what are the minimum services that we have to provide when we're looking at the scope of project and specifically, the services and the columns by which you're providing them.

So there are also within those services, you have three different types of services that you are providing; required services, additional services and specialty services. So the definitions for each of those are: required services are the services that you are required to provide as describing health center, statutes and regulations in order to be a part of the health center program. So that's pretty straightforward. You are required to provide those and you are demonstrating by documenting on form 5A, how you are providing those.

Additional and specialty services are services that you can provide, but are not required. And so there is a slightly different methodology when we're looking at required services on form 5A, and then the additional specialty services within form 5A as well. Additional services or services that may be provided by health centers to meet the needs of the population served. Specialty services are additional, not required services that are specialized, and they're not primary care services generally, but they support primary care services, and of course, help meet the needs of the community that you are serving. So required additional and specialty services required. Services are the key areas that you really, really want to focus on and the areas that a lot of people have trouble with.

So we've got the different types of services that are offered within form 5A. Now we're going to look at the different columns, how you are providing each of those different services that are on form 5A. So that's column one, column two and column three. Column one is directly, column two is formal written contract or agreement and column three is formal written referral agreement. So we'll go into those a little bit more, and there are definitions on HRSA's website of how you define each of those. But again, we'll talk about that in great detail.

Element A is the first element that we have trouble with and that a lot of people stumble over, frankly. And everything under form 5A pretty much touches this element. So you see the caution sign here, because we're really going to slow things down here and talk about this element.

So the first question that is asked is: are all services listed in column one provided by the health center directly? So this is looking at these services and saying, "Are these services provided by W2 employees who are directly employed by the health center and they are paid for by the health center?" So that's generally pretty easy. If you have a health center service that is provided by a non W2 employee, so they're a 1099 or a contracted vendor, that is not a column one service. So this one is usually pretty easy and there's very little strings attached to column one. So this is a yes or no. So make sure you go down your column one and make sure all of those services are provided by a W2 employee of the health center, and that is paid for by the health center.

All right, now we're going to move to column two. Column two is where we maintain, it's asking, do we maintain formal written agreements for that column two service? So this is a really easy question. We're not looking at the compliance of the contract. We're not looking at the details of the MOU, we're simply looking at, do you have a document, a contract or an MOU for every single service in column two? So this is the first thing you want to do as you're looking at your form 5A. And if you have that there in front of you right now, you want to make sure that you have that for every column two service, you want to make sure you look out to the side and indicate, do you have a contractor MOU for that?

So I'll get you to pause just for a second and we'll go down and let's say, for example, you have an agreement with Lab Corp and it's a column two. You want to stop and think, "Do we have a contract for that, yes or no?" If that answer is no, then you got to start out by getting a contract for that, pair that up with that. If you do, then we'll look at all the details of it later. But this is one that people easily miss and it's an easy one to fix. Just make sure you have a contract or MOU in place for that question.

Next, now we're looking at the contractor agreement. How the health center will pay should be a clause in your contract or MOU. I've never seen a contract for services that did not have how they're going to pay for the service. So this is not an area that most people struggle with. If you've got an agreement where you are paying for something and it's in column two, obviously the vendor wants to be paid. So that's usually in there, you don't usually have to worry about that.

This next question is an area that has changed. And I won't go into what it was before, because it's new and it would just confuse some of you. But do pay attention that this is new, and this is actually helping make the form 5A process a little bit easier. It's now asking, does the health center have some way of supporting this idea? Maybe it's a procedure, a policy, of how information for that service will be making its way into the health center patient record, the EHR? So it used to say it had to be in the contract. Now you just need some policy, some procedure, that says with all of these column two services, we need to make sure that this is a policy in place for making sure that this service is going to somehow make it into our EHR. So, if you've been with the health center movement for a while, this is something that's new, so pay attention to that.

And then finally, patient records from the last 24 months. You just need to make sure you are documenting in the medical record just like this policy is requiring. If you are providing a lab service or a diagnostic radiology service, you should be able to prepare and submit for review, documents or documentation within your EHR, a patient record example of that service being provided. Most health centers do not have trouble with that. So I wouldn't worry too much about that, that's what you do every day. So I wouldn't be too concerned about that, but make sure you are prepared to submit those for review to demonstrate compliance.

All right, now we move on to column three, formal written referral arrangements. So formal written referral arrangements. Do you have a formal written referral arrangements for everything in column three? This is very similar to the column two question. Do you have an agreement for each service? So go down that list. If you have it in front of you right now, look at your column three and make sure you have a contract or an MOU ready to demonstrate and submit for review for each of

those services in column three. That's an easy one to miss, and it's an easy one to fix. So make sure you go down line by line and make sure every single service you offer in there has an MOU or contract in place.

This another area that has been updated. So if you've been with the health center movement for a while, pay attention to this, it's actually made it easier. And in the same way as the last question, you used to have some referral management clause in the documentation of the contract. Now it expands that and says other documentation can provide that. So most health centers have a referral management or referral tracking policy that they have as part of their health center policies or their patient center medical home policies. So this has gotten a lot easier to have. It doesn't have to be in the contract or the MOU anymore. It's a great idea to have it in there, but it doesn't have to be. And then the final question is, do you have documentation of that service in the patient record? Again, most health centers do not have trouble with that, as they do this every day.

All right. So final question, this is where people have a lot of trouble with, is, were the services recorded on your form 5A consistent with how they were offered? And so this is, are all the things in the right place, at the right location, and are they in the right columns or the right services? Are they being documented the way that they are actually being offered? This is the area that people have a lot of trouble with, because sometimes you'll have something in column one that should be in column two, or you don't have something in column two that should be there. And so make sure you spend lots of time on this before your site visit.

The other thing is that HRSA has released a self assessment document that usually your project officer will give you. If you don't have that, just Google HRSA form 5A self-assessment document, and it'll pop right up. There are still some subjectivities that are remaining, but it is a great step in the right direction of making some things very, very clear and giving you a checklist to walk through. And even if you don't have your site visit coming up right away, I recommend you do it as soon as possible, because it takes a lot of time to get changes in scope, to get contracts, to get MOUs in place. And so start early. And it's never too late to do that. And again, make sure that you are looking at these things as a continuous compliance type of mentality.

Now, one thing that has also changed, so if you've been with the health center movement for a while, this is a new question that they ask, is-

PART 1 OF 4 ENDS [00:23:04]

Kyle Vath, BSN, MHA, RN (00:23:00):

... for a while. This is a new question. If they ask, if everything is not correct, has a change in scope requests been submitted. And what is the actual tracking number for that change in scope, which the health center should have. So if everything's not in place, but you've already submitted the change in scope before your site visit, that's okay. Just make sure you have that tracking number and give that to your reviewer when they are reviewing your documentation. But again, it'd be ideal if you get these changes in scope done well in advance of your operational site visit.

All right, this is related to the clinical staffing area, but it does touch on the chapter five clinical staffing area. So for any of those column two or column three services that are falling under form 5A, you have to have assurances that they are credentialing or privileging their services, their providers that are providing that service.

So one thing that has been clarified in the new site visit protocol, is how you can document those services. There was a little bit of ambiguity in this before and now HERSA has provided some

actual examples of how you can provide these assurances. So this is a great thing. It opens up a lot of opportunities when you're looking at your form 5A, column two and column three.

I won't read through all of these, but you can see that it's a lot of different pieces of documentation, whether it's CLIA compliance or their policy or accredited by some organization. There are lots of different ways to identify that they are credentialing and privileging their providers and their staff. So really pay attention to that.

So looking at contracts and MOUs, you want to start early. Again, there is not a time too late to get started too early, to get started on reviewing your MOUs. If you can't get some type of documentation for your contractor MOU, keep a paper trail. And we know as reviewers, we know that it's hard to get contracts and MOUs with some of these very, very large organizations. So keep a paper trail of all of your attempts, start early and keep that record of all the letters, the registered mail, whatever it is, and keep track of that. Most of the time, if you've shown your due diligence, the reviewers will be okay with that.

Also create a simple addendum. That includes all HERSA requirements that are not included. And sometimes if you don't have something in a review or in a contract or MOU, you can just create a little addendum and give that to the entity to make sure that they can just sign off on it and that you are hitting all those key pieces.

All right. I think we have... Oh, these are the last few areas of chapter four. So limited English proficiency patients. So you're just making sure that you have access to interpretation that they have translated documents. And again, most health centers do a really good job of that. You all focus on working with health centers and health center patients who need special care. And so you do a great job with that. You make sure you train your staff in culturally appropriate ways and they deliver that service in culturally appropriate ways. So that is the end of the credentialing and privileging piece. And we're going to pause for a second and look at questions. So Ted, do we have some questions here? It looks like there have been quite a few that come in here.

Ted Henson (00:26:35):

Sure Kyle, thank you. So we'll just start at the top. And these might be a little specific Kyle so [inaudible 00:26:43] that's fine. But the first one is this health center has transportation in the column two, does that need to be included in their EMR?

Kyle Vath, BSN, MHA, RN (00:26:51):

So I think what you're saying there is does the service exchange of that information, does it have to be showing up in the EMR and you have to have those services contracted or that they're documenting that service. If they sign up for a, if you send someone out with a Lyft or an Uber or something like that, does that have to be in the EHR? There are some areas that it actually, if you look at that self assessment form that HERSA made, it gives an exception for areas just like that. That are not necessarily clinical services and there would be really no reason to put that in your EHR. So you might, you might say you've arranged some services, but it does actually give an exclusion for that type of thing.

I see the next question is, what are the required services for FQHCs? And so if you look down form 5A, the required services that are on that form 5A are all the required services. So it's diagnostic lab, it's diagnostic radiology, general primary medical care, transportation, translation, those types of things. So if you look down that list, everything that it says under required services are the ones that you have to provide either by column one, column two or column three.

Ted Henson (00:28:05):

[inaudible 00:28:05]. There's a good question around tele-health. This person seemed very responsive to tele-health is a 5A service. I understand tele-health is not required for changing scope for form 5A, it is a method of delivery and it's not a service itself, correct?

Kyle Vath, BSN, MHA, RN (00:28:21):

Yes. And there's actually a, I think it's a PAL, a program assistance letter that came out I believe about a year ago when the pandemic started up. And it's a very, very detailed pal or pen, I can't remember which one it is. But it spells out all of the changes. And it was very specific to the coronavirus pandemic because lots of people were doing that very, very quickly. And so it gave very, very clear, it's a table that says, if you're doing it this way, you know, say your providers at home and they're delivering on a tele-health type of platform that's hosted at the health center, it gives all kinds of different specifics on all of those. So just because of the scope of this presentation, I didn't include that. But if you just Google HERSA tele-health change in scope, I'm sure it'll pop right up as one of the PENS or the PALS. And I can find that later today, the specific one, but it's pretty easy to find.

Ted Henson (00:29:20):

Kyle. Yeah, I should, just a good, a moment to stop for a second. So we have uploaded to the Dropbox link, the form 5A service descriptor guide, and also the service delivery methods PDF that Kyle mentioned. But I also put I think the form 5A self-assessment checklist that they have, we will add. I have the program assistance letter here from April of last year on tele-health. And so we'll make sure that that gets uploaded today for everyone.

Kyle Vath, BSN, MHA, RN (00:29:43):

Great. And I see about [crosstalk 00:29:46] 340B. 340B actually is something that needs to show up on your form 5A. That self-assessment form I talked about, that is, it says actually very clearly that 340B contract must be documented under column two. There are some variations of this, which I won't go into because it's a lot of ambiguities. But in general, HERSA says very clearly that 340B, contracted pharmaceutical services should be under column two on form 5A.

Ted Henson (00:30:22):

Kyle, if we could go back a second on transportation since we touched on that. The question is, if a health center offers transportation via Uber health or taxi, should this be reflected in column one and two, or just two?

Kyle Vath, BSN, MHA, RN (00:30:34):

Yeah. So if there is a contract where the services being provided... And this is all in that self-assessment as well. So if you are providing the service and like I think it says specifically, if you have a contract with an organization who's doing this and you're not paying for it, then that would be something under another column, probably three. Yeah, column three if you're not paying for it and you're just referring to it. If you have some contract where you are paying Lyft or Uber or something like that to deliver the service and you're not providing it directly, that would become two. And it says on that self-assessment form, if you're providing bus tokens or vouchers or something like that, I believe it says that that would be column one. So it's a checklist and it goes right down that list and you can ask yourself those questions.

Ted Henson (00:31:24):

Thanks Kyle, that's really helpful. Sorry, another question. And this relates to Renee's presentation from yesterday. But all contracts and MOUs need language related to a sliding fee scale as well, right?

Kyle Vath, BSN, MHA, RN (00:31:36):

Correct. And Renee, if you're on there, feel free to put some information on that. But so the question Renee was, for column two and column three services, you do need sliding fee discount language in those, correct?

Renee (00:31:51):

Yes, that's correct.

Kyle Vath, BSN, MHA, RN (00:31:53):

Yeah. So a lot of times I get questions column two. If you are providing the service and you're billing it directly, why do you need that? Correct me if I'm wrong, Renee, but I usually will advise them, you still need that language in there that they will fall under the health centers sliding fee scale. There needs to be that assurance. Now we know that that's kind of assumed, but that's what we're looking for in those column two agreements. Would you agree with that Renee or-

Renee (00:32:20):

Yes, absolutely. Yes, absolutely. And then HERSA has also indicated that they need to ensure that that's happening. So if you have documentation as well.

Kyle Vath, BSN, MHA, RN (00:32:28):

Great. Thank you. Thanks Renee.

Ted Henson (00:32:30):

A couple more, Kyle. If the contract for column two or three states that all the organization, everyone will be, will confirm that all staff will be licensed credential and privilege. Is that satisfactory to meet the requirement?

Kyle Vath, BSN, MHA, RN (00:32:42):

Yes. So that's talking about the question, I think it's element E or element F in chapter five clinical staffing where it's asking about credentialing and privileging assurances for column two and column three services. So yes, that would be a great way to do it. I think that really puts it in the contract form. So I think that's best practice. If it says very clearly that you are credentialing and privileging your staff, that's perfect. If you can't do that, as I've mentioned, there was that list of things that HERSA has now provided as a result of that May 27th date in the site visit protocol. That there's other ways to do that as well.

Sometimes people have trouble getting that documentation in the contract or MOU. So what you just said right there is perfect. And that's the recommended way to do things. It's the most airtight, because then you have a contract backing you up. And I get a lot of questions you know, what about these big box organizations, Walgreens, Lab Corps. Of course we know that they are doing that. I would argue that we've seen some of these big box places show up in the news for missing those types of

things. So what HERSA wants is they want us to do our due diligence to make sure that we are covering those bases.

Ted Henson (00:33:57):

Thanks, Kyle. A couple more. Another one kind of related to sliding fee, late fee in contract. Do we need sliding fee scale language in the contract, even if it is not a required service?

Kyle Vath, BSN, MHA, RN (00:34:07):

If column two service provided on site do we...

Ted Henson (00:34:10):

It went above the...

Kyle Vath, BSN, MHA, RN (00:34:13):

Yeah. So this-

Speaker 1 (00:34:15):

If it's on your form 5A, you're required an additional, you are required to have a sliding fee discount.

Kyle Vath, BSN, MHA, RN (00:34:23):

Right. Yep.

Ted Henson (00:34:24):

So if you put it on the form 5A, then the answer is yes.

Kyle Vath, BSN, MHA, RN (00:34:28):

Exactly. And it's what I call form 5A liability. So if you put it on form 5A, column two or column three, then you got to have all those things in place in the contracts and the MOUs. From chapter four, chapter five, chapter nine, chapter 12. That is your liability. So once you put it on there and there are good reasons to do that, but once it's on the contract or on the form 5A, you got to have all those pieces in place.

Ted Henson (00:34:55):

But if it's not in form 5A, but it's in the contract, it does not need the sliding fee. Is that correct?

Kyle Vath, BSN, MHA, RN (00:35:02):

Well, yeah. I mean I guess it's kind of a weird way to... I'll let Renee say that. Say that again Ted?

Ted Henson (00:35:11):

So this is just the question is, if it's not a required service but it's in the contract. So the point is, if it's on form 5A, it needs the sliding fee.

Renee (00:35:11):

Yes.

Kyle Vath, BSN, MHA, RN (00:35:19):

Yes.

Renee (00:35:20):

Okay. We'll leave it there. And then the last question of column two service provided onsite, do you still need to include sliding fee language in the contract?

Kyle Vath, BSN, MHA, RN (00:35:32):

Yeah. So this goes back to the same thing. If they are providing the service and this contract is not provided by a W2 staff member, you are paying for it. But even if it's on your site, which a lot of people have, then yes. If it's on form 5A, column two or column three, you need that sliding fee language. And it may look a little different than sliding fee scale language in column three, because obviously you don't, you're not paying for that and it's falling under a sliding fee scale for that service provider. But if it's on column two and they are providing the service and you are paying for it and you're going to probably bill for that and those types of things, then it will just say that, yes, we're going to honor a HERSA approved site as a protocol or a HERSA sliding fee scale.

Renee (00:36:22):

Yes. And I also, Kyle sometimes they're onsite and they're providing the service and the health center is not billing for it. Same situation. You must have a sliding fee discount offer to patients.

Ted Henson (00:36:38):

Kyle here's one more, it might be a good segue into the next presentation, but the next part of it. But does having documentation of a contract and provider agencies FQHC status sufficient for assurance of credentialing? And it says similar to joint commission accreditation documents.

Kyle Vath, BSN, MHA, RN (00:36:54):

Yeah. So I've seen this come up several times. So I think what the question is, if you are working with a health center, so let's say that you have partnered with another health center to do, you have some providers that are providing services for you or maybe they have a lab or something like that. So according to the new updates I use, if I would have done this a couple of months ago I would have said no. Now that HERSA has clarified that, they have given examples that they are accredited by certain different entities and those types of things. If you have that accreditation, that should be more than fine. So yeah, I would just document that they're a health center, that they have a credentialing and privileging policy. But on the other side of this, if you're working with another health center, they know the requirements that you have and so they should make it really easy to provide their copy of their credentialing and privileging policy or something like that.

So I think we got all the questions. And just to stay on top of things that we probably need to move on to credentialing and privileging. Is that okay, Ted?

Ted Henson (00:38:00):

Absolutely. Thanks Kyle.

Kyle Vath, BSN, MHA, RN (00:38:01):

Okay, great. And if you have any other questions about form 5A, certainly keep those in there, but we'll move on to clinical staffing and we will leave some time at the end for that question as well.

All right. So moving on to clinical staffing, this is chapter five. So if you have your credentialing and privileging policy out, this is a good time to pull that out and start looking at that. If you haven't, make sure you pull it up on your screen or print it off, pull out that manual and pull that out so we can talk about that and you can have it right there to reference as we talk through things.

So most people know what credentialing and privileging is and what the definitions are. Credentialing is the process of assessing and confirming the qualifications of a licensed or certified healthcare practitioner. Privileging is the process of authorizing the specific scope and content of patient care services of a licensed or certified healthcare practitioner. And actually in the cases of HERSA site visit program requirements, it also includes unlicensed, uncertified, other clinical staff as well. And this is performed in conjunction with an evaluation of the health care practitioners clinical qualifications, and performance. So their fitness for duty, their competence as a provider.

So that's credentialing and privileging. And what I always say with this, I pause because there's great gravity with this area. I always say credentialing and privileging is the most important thing you do as a board of directors or as a health center leader. Because when you close that door, when that provider closes that door, you don't know what's happening behind that door. And that individual, that health center patient has put a lot of trust in that health center provider. And there's a great deal of power that that provider has. And so it is so important that you credential and privilege your staff well beyond the bare bones minimum basement foundation piece of requirements. This is an important piece to really spend time on.

So though this is probably the second most common finding that we have in actual operational site visits, I would argue, and I'm biased because this is my area, but I would argue that this is probably your most important job as a health center leader. So just really keep that in mind and it's not to scare anyone, but I just always like to remind people that this is such an important thing we're doing here. And that is well beyond the minimum requirements, but we're going to talk about the minimum requirements today, but really take that into consideration. If we have any board members online, this ultimately is your responsibility. It's not any more required to be your responsibility as signing off on it as it used to be, but it is still ultimately your responsibility of looking at the quality of the organization. So just keep that in mind.

When we look at clinical staffing chapter five, there are basically four different areas. We'll look at, do you have the appropriate staffing makeup and appropriate to provide access to your patients? And then you'll also look at, are you providing assurances that you are credentialing and privileging contractor to referral providers that we talked about in the last chapter. So we've already gone over that quite in detail. So those are the smaller areas. The biggest areas we're going to talk about today are the policies and the files. So we're going to look at all the requirements for that policy that you have, the credentialing and privileging policy. So again, get that out if you have that. And then the second part is the files. This is the actual credentialing and privileging file that you have on each clinical staff member.

So you can have one without the other. You can have a perfect policy, but you can have files that are missing things. And you can have perfect files, but they may be missing requirements in the policy. So they are mutually exclusive, but equally important. And people have trouble with both of them. I think the files piece is much easier. It's an open book test. When you look at the actual requirements, it's a checklist and there's actually a checklist on my website under resources. If you want to look at that checklist, it makes it real easy to find all the requirements, but that's easy. You have the

choice of selecting the files to present to the reviewers. So that's the easier part. The policies is it's a little more challenging and you got to make sure that you have everything in place, but again, very doable because it's an open book test.

So we'll start out by looking at the staffing to provide scope of services and access. This one again is pretty, pretty easy. Most people don't have trouble with this. So this question, first couple of questions ask, does your health center have a clinical staffing makeup that number one enables it to carry out your approved scope of project. So when you look at all of your column one services, again, this is tying back to your form 5A a little bit. Anything that you have in column one, do you have enough staff to provide those services? So you should be able to go down that list and anything that you have in column one, can you assign staff to each of those areas? And again, most people don't have trouble with that, but we're looking at, do you have enough staff to carry out those services you said you would agree to doing.

Next, does your clinical staffing makeup, is it responsive to the size demographics and the need of the patient population? So have you looked at, you know, if you serve a lot of kids, do you have appropriate numbers of pediatricians? Do your staff mimic the makeup, the demographic makeup of your community? If you have a lot of people who speak Spanish and you don't have any providers that speak Spanish, that might need to be something that you need to be more responsive to the needs of the community.

And then finally, the sufficient, is it sufficient to provide access? So what I look at, this one's a very subjective question, but what I will mainly look at is do you have a really long waiting list? Do you have not enough providers to reach the care of the needs that have in your community? So if there's a really long waiting list, if you had a big lay off a lot of people off on leave, whatever it is, those will be things that we look at to determine that compliance. Most people do not have questions or trouble with this area, so we'll keep moving on that.

So next area, we're going to look at policies. So this is one of the key areas that people struggle with. So there are three different types of clinical staff members who need to be credentialed and privileged at your health center. This is relatively new. If you haven't had a site visit in the last three years, this is something you really want to pay attention to. I will pick up a credentialing and privileging policy and I'd look at it, and if it only has, I can look at it generally in about 10 seconds and I can tell if they updated it since 2018. If they just have LIPs and OLCPs in their policy, I know they haven't looked at it since 2018. Because it's really important that you have other clinical staff in there because these are three specific areas that you have to define in your credentialing and privileging policy, and you have to credential and privilege them. So this is your LIPs, which are your licensed independent practitioners. These are your physicians, dentists, PAs, nurse practitioners. You have your OLCPs, your other licensed or certified practitioners. These are your Rns, your registered dieticians, LPNs, LVM, certified medical assistants, the certified or licensed clinical staff. So LIPs, OLCPs, those have been there for a long time.

The area that is newer and that I often will see people leave off is the other clinical staff. These are clinical staff members, so they're providing some clinical service on behalf of the health center who is not licensed or certified or required to be licensed or certified. So commonly these are non-licensed non-certified medical assistants, community health workers. Some states do require licensed or certified medical assistants, so those would fall under OLCPs. If you in your service, do not have any unlicensed or own certified clinical staff, then you do not need to include them in your policy. However, in my experience, it's very rare for people to not have those types of staff.

PART 2 OF 4 ENDS [00:46:04]

Kyle Vath, BSN, MHA, RN (00:46:00):

It's very rare for people to not have those types of staff in their staff makeup. So LIPs, OLCPs, other clinical staff, this is the number one area I probably see people leaving off and it's super easy to make sure you address. This is a little algorithm I made to try to determine if someone is an LIP, an OLCP or an other clinical staff member, and if they need to be credentialed and privileged.

So is the service a clinical service? That's a yes or no question. So if it's not, so if it's transportation, if it's translation, if they're providing some other service that you wouldn't determine as clinical, and it's kind of up to you on how you define that, but you just want to be consistent on determining this as a clinical service or a non-clinical service. And I'm sure this will probably be a question that comes up is, does a social worker count as clinical service or does a case manager count as clinical service? There is no clearly defined definition for that. So I would define it very clearly in your credentialing and privileging policy of, "These are the services that we provide that we deem as clinical services and these are not," and it just makes it very, very clear.

If it is a clinical service, then we ask ourselves the question, does the service utilize licensed or certified clinical staff or certified staff? So if it's, yes, then they are an LIP or an OLCP so those are pretty simple/ if it's no so if it's a clinical service staff member and they are not required to be licensed or certified, then that's a no, and they would be classified as other clinical staff. So again, LIPs, OLCPs, and other clinical staff all need to be in your policy and all need to be credentialed and privileged.

All right, now let's look at the specific requirements for initial credentialing only. So this is what needs to be done whenever you hire an LIP, an OLCP or other clinical staff member. So upon hire, you need some government issued picture ID verified, and you need verification of their education and training. So again, this is for LIPs, OLCPs and other clinical staff upon hire. So for education and training, though, you have the option to provide that either by primary source or for OLCPs, it can be primary or secondary source, but LIPs has to be primary source verification of that education training. So again, going back to those LIPs, that's the physicians, the nurse practitioners, those types of positions, they need primary source verification of education and training on hire.

For OLCPs, and other clinical staff, you can define how you want to do that. Maybe you want primary source for OLCPs and you want secondary source for other clinical staff, it's up to you. You define that, you make that very clear and explicit in your credentialing and privileging policy. Just from my experience, if I don't see that defined, I automatically assume it's primary source verification. So you really want to make sure that you have that clearly defined that it has to be primary source verification.

All right. So that was initial credentialing. Now we're going to look at initial and recurring credentialing procedures. So this is what you have to do for LIPs, OLCPs and other clinical staff upon hire and on a recurring basis. So LIPs, OLCPs other clinical staff upon hire and on a recurring basis. And this is for credentialing. So for LIPs. OLCPs and other clinical staff upon hire, and on recurring basis, you obviously need licensure for LIPs and OLCPs, and that needs to be primary source. It also needs DEA registration if that is applicable, if you don't have a DEA license or they don't need one, obviously you don't need that but if they have a DEA license, you need to make sure that you have that on hire and on a recurring basis.

Basic life support, this is required for all LIPs, OLCPs and other clinical staff upon hire and on a recurring basis. I do see from time to time health centers will only require their providers or only their nurses, but this is required for anyone who you classify as LIPs, OLCPs or other clinical staff upon hire and on a recurring basis. NPDB, this is also one that trips people up sometimes. It used to be a little more ambiguous, in February of 2020, they removed some language that made it a little clearer. And so the general consensus is that NPDB queries are wired for all LIPs, OLCPs and other clinical staff upon hire

and on a recurring basis. So just to be clear, your medical assistants who are not licensed are served, they need NPDB queries on hire and on a recurring basis, your registered nurses, they need NPDB queries upon hire and on a recurring basis. So hopefully that clears things up but I do see people struggling with that sometimes because they have the impression that's only for providers.

All right, element D, moving on to element D, and this is primarily looking at your privileging types of areas. So do the health centers' operating procedures address both the initial granting and renewal of privileges for clinical staff who are health center employees, individual contractors, or volunteers? So this is something that you just need to copy and paste, I will commonly see this missing from credentialing and privileging policies and it's so easy to put in there. Just make sure you copy and paste this language that this credentialing and privileging policy applies to employees, individual contractors, and volunteers. You don't get any extra credit points for creative writing. So employees, individual contractors, or volunteers, this policy applies to all of those areas.

What I recommend is you make the clause something like this, "This policy applies to LIPs, OLCPs and other clinical staff who are employees, individual contractors, or volunteers," and then define what needs to be done on hire and on a recurring basis, upon hiring on a recurring basis. So if you have a clause like that in there, that will cover 99% of all the things we just talked about. So really make sure that you just copy and paste that language and put it straight in there.

Next question is looking at, do the health centers' privileging procedures, so often combined with your credentialing and privileging policies, does it require verification of the following for providers upon hire and on a recurring basis? Actually, they put a new note in here that now it says for clinical staff. So this is something that is much clearer now and that people look at for all critical staff who are LIPs, OLCPs, and other clinical staff. So fitness for duty, are you defining that fitness for duty? And we'll talk about this a little more in detail. Immunization and communicable disease status, current clinical competence. These are the three areas, fitness for duty, immunization, communicable disease status, and current clinical competence that fall under privileging and that you can define. And we'll talk a lot more about this here in a second, but you can define how to do that.

And then does the health center have criteria and processes for modifying or moving privileges based on the outcomes of clinical competence assessments? So this, again, you just need to have this language in your credentialing and privileging of how you modify or remove privileges. So if something comes up in a clinical competency test, a peer review, something like that, you need to have some clause, some policy for how you will modify those privileges or how you remove them. If someone keeps missing a certain area of clinical care and it keeps showing up in peer review, how do you make sure that you have a policy for removing or modifying those privileges?

So there are also some clarification pieces of fitness for duty. This is now a clarification that was a part of the most recent site visit protocol update. It says that you have to be able to explain how you physically and cognitively verify that they are physically and cognitively fit for duty. So most people don't have any trouble imagining how you would verify physical fitness for duty, so people will do a physical exam, they'll do an occupational health self test attestation, those are pretty straightforward and that's what most people would do before. People were kind of scratching their heads on the cognitive fitness for duty, and I was actually on a training with the person, one of the reviewers asked this question and they just kind of scratch their heads and said, "I don't know, that's kind of for you to figure out."

So I think as we kind of go through things, people will have better ideas, but I've kind of thought through some of these ideas and I've got some examples of how you can verify cognitive fitness for duty. So you could verify board certification. So they had to take some test or some exam and that might be one requirement that would give you an indication of their cognitive fitness for duty. Maybe you verify, CME completion or scores, maybe the exam. Maybe you have a completion of a medication

dosage calculation tests for maybe your nurses. I know as a nurse, I used to have to do that all the time and if they can do that, you could say cognitively, they're able to make sound judgment. Maybe they have a completion of a skills test so maybe for your medical assistance or something like that, you have them check off on maybe it's a test where you have a picture of a six month old baby, and you have them circle where on the body they would give a certain injection. So all those types of things you could evaluate and define for your organization, how you evaluate physical and cognitive fitness for duty. And remember that these must be verified upon hire and on a recurring basis.

So now we move on to the files. This is the easier part that we're looking at the files that you provide. So they're basically looking at, do you have all of the things that you had said were required in your policy and are required in your site visit protocol, are they in those files? And just to really emphasize this, you have the choice of presenting the documents, the files that your reviewers will provide. There are some guidelines and that's in the site visit protocol, but you know ahead of time which ones you're going to provide to the reviewers. So please, please, please look through those files before you hand them to the reviewer. You would probably be surprised how many times I will get handed a credentialing and privileging file that is missing a large piece of what they should be required to keep track of.

So again, you should know, well in advance, go through with a fine tooth comb and make sure everything is in place that is on your checklist and again, I have that on my website if you just got a regularentry.com you can find that under resources, but make sure that you have gone through every single file that you are preparing to present. Again, organize the files and label them. These are just some best practice recommendations, organize them as they are organized in the site visit protocol. So the reviewer is going to go down these questions one by one, and they need to be able to find these things very, very easily. So make sure you check through those very thoroughly and organize it so it's easy to find for your reviewers. Don't waste time scanning and copying the credentialing and privileging files until you talk with the reviewer who will be reviewing those.

When I do reviews, I will often tell them, "Hey, don't scan them in, we're just going to hold up the file to the screen during the virtual site visit time and I'm going to look at them, don't waste your time." Some reviewers do want them scanned or copied in, and that's fine, they can do that, but I always tell the health centers I'm working with you don't need to do that and say make sure you know how they're going to provide them before you spend lots and lots of time doing that.

Pull three of each category, LIPs, OLCPs or other clinical staff and newest hires and get those ready. Again, review them very, very thoroughly and keep in mind even if you have separate medical files as is required by the ADA, maybe you have your TB skin tests or your fitness for duty physical exams in a separate medical file, that's fine and that's the way you should organize them. But for the review, make sure you have everything organized. I've seen some places that they have totally different departments that manage each area and again, that's fine, but please don't make the reviewers wait to go get something out of storage or find out who has different things. Everything should be right there ready for the review.

All right. The final area we'll talk about is credentialing and privileging of contracted or referral providers. And so this is again, we talked about that in great deal with the form 580 so you want to make sure you have all of that in place. Another idea here is that you can combine a lot of work that goes into credentialing and privileging with work you're already doing. You're going to be looking at reference letters, you're going to be doing peer review, for the QI chapter you're going to be doing quality assessments. Also for QI you're going to be doing patient satisfaction surveys. These are all things that can go into current clinical competence evaluations. And so you don't have to reinvent the wheel, you can really save a lot of time.

There are other areas that are outside of the site visit protocol and HERSA program requirements that are very important to pay attention to, but just pay attention to those, they're outside of the scope of this presentation, but it may be OIG, exclusion letters, different research or local state payer requirements that you'll need to research. So there's a lot of other things that may be included in the credentialing and privileging process but for right now, we're just talking about health center requirements.

Briefly want to talk on temporary privileges. There was a time where temporary privileges were required, but what I'm seeing just kind of offline, it's not in the site visit protocol right now, but a lot of reviewers are actually, if they look into their credentialing and privileging policy and they find that a temporary privilege clause is not compliant, they will mark the whole thing noncompliant. So there are some very specific ways that you can provide temporary privileges. And it's not just if someone's going out on maternity leave, that's not okay. FTCA has spelled those out and is basically for declared emergency situations like Hurricane Katrina or the recent pandemic. So make sure you look at this PAL 2017-07, make sure it's at least compliant with that and if it's not, you need to either remove it or make sure it gets into compliance.

There are a number of areas of health center discretion, where who approves the credentialing and privileging files, this used to be required that the board does this, it's no longer a requirement so you determine whether it's a committee or the board, how you determined that credentialing and privileging a file. How often you credential and privilege? Most people do two years, I don't think I've ever seen someone who doesn't do every two years, but you define how often you credential and privilege. You define who the other clinical staff members are. And frankly, the LIPs and OLCPs too, you define that. You define what the requirements for fitness for duty, current clinical competence and immunization and communicable disease verification. So a lot of times people will ask about TB skin tests or flu shots or what is required, it doesn't matter, it's up to you, you just have to define it and then do it.

And then you also can define, as I mentioned, primary, secondary source requirement for education and training verification for OLCPs and other clinical staff. So you can define whether it's primary or secondary source verification. Other verification, or other reminders I'd recommend, remember that your credentialing privileging policy is considered as part of your QI program and it must be board approved every three years. Also, make sure that you organize your files or credentialing and privileging files around the site visit protocol requirements. Develop and maintain a system of periodic review of credentialing and privileging files. So what I did when I was at the health center, I ran all of this through our QI program every month to make sure all of our providers, our clinical staff were current and up-to-date, and it was just part of our system and then be careful with temporary privileges. So we're a little short on time here, as far as our progress, but Ted, we got some questions?

Ted Henson (01:02:33):

We do Kyle, we have a lot, so maybe we could do a few and then you sort of move on when you feel like we need to. There are a bunch about who should be certified, how do we do NPDB for other clinical staff if they, by definition, are not licensed or certified?

Kyle Vath, BSN, MHA, RN (01:02:55):

Sorry, can you say that again? If they're not licensed or certified...

Ted Henson (01:02:59):

Do we do it, how do we do NPDB for other clinical staff if they, by definition, are not licensed yet?

Kyle Vath, BSN, MHA, RN (01:03:04):

Okay. I missed the NPDB part. So NPDB can be done for unlicensed or uncertified staff. I find this as a pretty common misconception out there is that only licensed certified people can be NPDB queried and that's not the case. So any staff member, whether they're licensed or certified, you put in their identifying factors and they can be cleared and they need to be cleared.

Ted Henson (01:03:32):

If we could stay on there regarding NPDB, a HERSA reviewer had stated to this person that this should be done for any patient care staff that have a license certification registration. What about medical assistants who are not certified or registered?

Kyle Vath, BSN, MHA, RN (01:03:47):

So same answer, NPDB has to happen for LIPs, OLCPs or other clinical staff, whether they're licensed or unlicensed and it has to be done upon hire and on a recurring basis.

Ted Henson (01:04:00):

Do medical interpreters fall under other clinical staff not licensed?

Kyle Vath, BSN, MHA, RN (01:04:05):

So again, this goes back to how you define it. That's one of those areas whether it's translation or something like that, it's how you define that. So if you define that as a clinical service, I would put that under a clinical staff member, you would define them as an other clinical staff member if they're unlicensed, uncertified, and you believe that they are providing a clinical staff service. If they're not, then you don't need to worry about it. I would argue that a translator, who's not a medical assistant and they're just translating, I would say that they don't fall under clinical credentialing and privileging. Now I think from a best practice, they should be certified or have to take a test or those types of things, but from clinical credentialing and privileging, I personally would not probably define them as a clinical staff member that would fall under that. But again, it's up to you all how you define that and it needs to be explicit in your credentialing and privileging policies.

Ted Henson (01:05:04):

Do you have a similar answer for our fully licensed social workers, is that LIPs or OLCPs?

Kyle Vath, BSN, MHA, RN (01:05:13):

So same answer. If you feel that they are providing clinical services, then that would fall under that. If not, I would just, again, define it.

Ted Henson (01:05:25):

Here's an interesting question, Kyle, for you, the definition of other clinical staff feels a little vague, is there any easy way to know staff category should be included, for example, would case managers fall under this category?

Kyle Vath, BSN, MHA, RN (01:05:40):

Yeah, it feels vague because it is vague. Yes. Again, you define that. Define who your LIPs, your OLCPs and other clinical staff are and you define whether they fall under that or not, whether they're a clinical staff member. Remember go back to that algorithm, do you feel that they are providing a clinical staff service? If ye. And they're unlicensed or uncertified, then they would fall under other clinical staff. If you don't feel that they're providing a clinical staff service, then they would drop down to that no and they would not be needing to be credentialed and privileged.

Ted Henson (01:06:15):

Just a couple more if that's okay. Interesting question. Are digital credentialing and privileging files accepted if they're hosted in a cloud based solution and not on paper?

Kyle Vath, BSN, MHA, RN (01:06:24):

Yes. But again, this goes back to, you need to ask your credentialing and privileging or your clinical reviewer, who you're working with. Sometimes they will want... I love it when people do that, because they can just share their screen, pull it up there and really reviewers are supposed to go with whatever's convenient for the health center. And especially during this remote time, this virtual operational site visit time, a lot of times it's very easy for the reviewers to do things that way. Your staff member will pull it up, share their screen and they can walk through it, but you just need to make sure that that's okay with the reviewer when you do your pre site visit call.

Ted Henson (01:07:01):

Okay. Thank you for stressing the importance of that conversation. A different topic, can you verify fitness for duty based on self attestation by the clinician?

Kyle Vath, BSN, MHA, RN (01:07:11):

So, yes. Again, if you remember the fitness for duty, current clinical competence and communicable disease and immunizations, those are three areas that are up to you on how you define it, so you define it. The only thing with fitness for duty is that it specifically says that you have to describe how you're verifying their physical and cognitive fitness for duty. So as long as you can define that, it's up to you on how you do that. So I see self attestations, I see physical exams, I see all kinds of different things.

Now, there is a document, it's the credentialing and privileging site visit protocol resource document if you go onto the HERSA website under the clinical site visit protocol, you'll see a credentialing and privileging document. And it gives an example of fitness for duty, it gives examples of what you could be looking for and it gives an example of a licensed independent practitioner signing off on fitness for duty. But keep in mind, that's an example. Some people will say, "Well, that's, what's required, but it's clearly indicated that this is an example and the site visit protocol clearly says it's up to the health center on how you define that." So to answer your question succinctly, the way I look at that is, yes, it's okay to have a self attestation, as long as you can say physical and cognitive fitness for duty, and also this done on hire and on a recurring basis and you define specifically how you're doing that.

Ted Henson (01:08:40):

Here's another question. Thanks, Kyle, that's great. This might be something you want to hold to the end, it's more general, but what are recommendations around, I guess, means requiring vaccines for staff, is the organization defined, HERSA defined?

Kyle Vath, BSN, MHA, RN (01:08:54):

Yeah. So that's a legal question that as you can imagine with the COVID pandemic, it's a hot button topic that's all over the news.

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Kyle Vath, BSN, MHA, RN (01:09:00):

It's a hot button topic that's all over the news and there's lots of people with lots of law degrees at a lot higher pay level than me that are arguing that out. It does happen. I think it is in most cases legal to do that. But that's at the Supreme Court level right now. I've heard very, very recent allowances of that and discussions about that. Definitely talk with the attorneys about that.

Ted Henson (01:09:26):

Okay. There are more coming in, but I also want to be cognizant of time, Kyle. Do you want to just continue and then we can come back at the end?

Kyle Vath, BSN, MHA, RN (01:09:34):

Why don't we take maybe two or three more?

Ted Henson (01:09:37):

Okay. Please provide the HRSA naming conventions for documents to provide to the reviewers. I think we talked about that on Monday.

Kyle Vath, BSN, MHA, RN (01:09:46):

We did. Yep.

Ted Henson (01:09:47):

Okay. We can-

Speaker 2 (01:09:48):

Can I watch the [inaudible 01:09:49]?

Kyle Vath, BSN, MHA, RN (01:09:51):

Yeah. We will get those with HRSA. HRSA has those on the website and they will take care of that. There's a recent update. I'm not sure if it's been updated on the website, but yes. Make sure you name them appropriately and the main thing is though, you want to make sure it's very clear on what each document is.

Ted Henson (01:10:13):

Okay. Sorry, everybody. You've got to meet my other boss there. Do you recommend the C-suite and MPDB?

Kyle Vath, BSN, MHA, RN (01:10:22):

I don't think it's a bad idea, but it's not required for credentialing and privileging.

Ted Henson (01:10:29):

I'm sorry. Someone said the last three pages are missing from the link that was provided in the email invitation. We will look at that. Sorry. I'm not sure which link that is. If it's the slide deck, then we'll review those links and try to get them out to make sure the whole document's there. Do we need to obtain three peer references to document clinical competence for OCS at hire, or can we assess clinical competence within the first 90 days of hire?

Kyle Vath, BSN, MHA, RN (01:10:54):

This goes back to the three areas, fitness for duty, current clinical competence and immunization and communicable disease. Those three areas, you define how you determine those things. Specifically for current clinical competence, you need to provide that verification on hire and on a recurring basis. What I see most people do is they will do exactly what you just said. They'll have some reference letter from a person on hire, because obviously you don't have any history with them. You don't have peer review. You don't have any of those things before they start with you, but you do need to verify current clinical competence for that person upon hire. I would define that in your policy that we require three professional reference letters from prior supervisors or whatever it is, educators, professors. That's on hire.

Then on a recurring basis, you define what it is for that too. What I will commonly see is peer review. They'll use the peer review to determine current clinical competence on a recurring basis. For your OLCPs and your other clinical staff, if you're not doing the full documented peer review process, I often will see a competency exam, supervisory reviews. Those types of things for the recurring evaluation of current clinical competence. What you're doing, it's not required, but again, you define it in your policy and make sure you do it.

Ted Henson (01:12:19):

Thanks, Kyle. Thank you for clarifying, also someone, that it was the presentation that was... Thank you, Olivia, for uploading the full presentation. Here's a comment here generally about requesting NAC to provide a trained, dedicated solely to credentialing and privileging. Thank you for that comment. I'll get that back to our clinical affairs division colleagues. I know they do a lot in that space. We'll make sure we'll follow up with you if there's something coming up in the near future. Kyle, I believe we are caught up unless I skipped something that you can see.

Kyle Vath, BSN, MHA, RN (01:12:50):

Okay, perfect. We'll keep moving here. The next sections are going to move pretty quickly because again, most people don't have a lot of trouble with this. QI used to be a big area that people struggle with and people seem to be really getting a hold of that. QI program policies, this is just looking at your policies and do they contain the specific things that are listed here. Is it addressing the quality and utilization of services, patient satisfaction, patient grievances, patient safety, adverse events, your incident report or types of things? Make sure that that is in your policy and that you can tie that to what you do every day. Does the health center have people who are overseeing it? Most of you probably have a QI director. Most people don't have trouble with that. Based on interviews, the clinical reviewer will be asking these things and there'll be looking at job descriptions.

Do the people who are overseeing your QI program, are they ensuring the implementation of QI procedures? Are they making sure assessments are being done? Are they monitoring outcomes? Your UDS clinical performance measures, those types of things. Are they updating QI operating procedures?

Again, most of you are probably doing that. There are a number of different job descriptions. I recommend you just copy and paste the language right out of the site visit protocol into those job descriptions. Makes it super easy to check that off and the reviewer can keep on moving. If you've got a job description anyway, open up chapter 10 and look at the definition of what those QI directors need to do, copy and paste it, make it easy.

Processes. This just needs to be making sure that you have processes policies in place for following evidence-based clinical guidelines. Are you identifying, analyzing, and addressing adverse events? These are your incident report programs, adverse events, whatever you want to call those types of things. Then are you following up with things? Are you able to demonstrate that you have PDSA's and you have follow up and you're correcting things based on those incident reports? Are you running patient satisfaction? What I recommend is do this at least annually because you have to report on this at least annually to the board. It doesn't clearly say that it has to be done annually, but you have to report on it annually. Essentially I would say patient satisfaction should be annually and then processes for patient grievances, someone's not happy, what do you do? Make sure you have that policy.

Then a policy for making sure you have QI/QA assessments done at least quarterly. Most people are looking at their clinical UDS performance measures there. Again, most of you are doing that. Does the health center share reports on QI/QA for patient satisfaction, patient safety, at least annually? This is really, really important that you pay attention to because this touches in the admin governance area, as well as QI. Make sure you are talking about patient satisfaction and patient safety. You're elevating it up to the board every year and that you can document that in the meeting minutes that you talked about it. A few things about recommendations when you interact with the board. At least submit those patient satisfactions at least annually. I recommend you do patient safety at least six times a year. The reason why that is, in patient quality, is because it will ask in your FTCA application, if your FTCA deemed for six examples of when you've talked about quality in your board meetings.

That will set you up for that, but it's not specifically required. Prepare your board to be ready to share examples of how they are guiding the QA, how they are being provided information from your health center team to appropriately make decisions and oversee the organization appropriately. Are you giving them enough information to guide them. Then keep track of the topics that are discussed so that when you go back and you're talking to your reviewers and they're asking about these things, you can look down the list, "Oh, we talked about this back in April", or "We talked about this in January." You can easily go to those areas and make sure you're hitting on all the areas that you will need to address with your site visit protocol or your operational site visit.

All right, quarterly assessments of clinician care. This is an area that is a little less defined, but we typically call it peer review. This is looking at are the health center's QI assessments and again, we will typically call this peer review, are they conducted by licensed healthcare professionals? Is it data systematically collected and are they tracking and addressing issues? Is it done quarterly and meets all those criteria? I get occasional questions about peer review of what's required, how many charts we need to pull, those types of things. I'll answer that question right away. It's not required. There isn't a specific number of areas that are required. I would say in general, some good recommendations are that it needs to cover all of your services that are on Column One, Form 5A. If it's a service that you are providing, it should somehow touch your peer review.

They should go through a peer review process. It needs to happen quarterly. Again, doesn't matter how many charts you include, but it should be everything within your scope of service. It should be conducted by licensed healthcare professionals. It doesn't say that it has to be doctors or nurse practitioners. It just says a licensed healthcare professional. It's open to your discernment. Data systematically collected. I'm seeing more and more health centers use EHRs to pull the data and that's

perfectly fine as long as you can tie it to individual clinicians. That's appropriate and it's a really good use of your time, I think. It pulls all that data and you can usually run a gap report of what's missing. It's a great way to do it, but you need to be able to demonstrate that it's systematically collected, it's done by licensed healthcare professionals, and it's done quarterly, and that you are tracking and addressing issues.

This is kind of vague, but in general, what I'm looking for is if you have a peer review that you provide me to review, is there some followup? Did that provider sign off on it, that they reviewed it with the provider they're reviewing? Was there some action step that they're addressing an issue or was it just an exercise that they checked off the boxes and threw it in the closet somewhere? As long as you are doing this quarterly, it's conducted by licensed healthcare professionals, is systematically collected and you can demonstrate that you're tracking and addressing issues, it's up to you on how many charts you provide and how you rotate that. It's up to you on how you define them.

Retrievable health records. Most people don't have trouble with this. If you have a certified EHR, which all the big ones are certified, you'd pass this pretty easily. You don't have to worry a whole lot about this. If you have an off-brand DHR, if you're a really small health center and you're not using one of the big ones, then you might need to look at this more. But most of you don't have any problem with that. Confidentiality. Do you have record keeping procedures that again, most of you probably have? Are you training your staff on confidentiality and HIPAA? You have to be able to demonstrate that you're doing that and show records of that. That you're tracking that and that you require that.

Do you have a basic life support, we're switching to chapter seven here, basic life support trained person onsite anytime the doors are open? Most people don't have trouble with this because this is a basic life support trained requirement for credentialing and privileging. Show that you have a clinical staff member, who's credentialed and privileged at every location whenever the doors are open. Don't spend too much time on that. Since there's a requirement for credentialing and privileging, you're doing that. Do you have systems and procedures in place for responding to emergencies during hours of operation? If someone falls down on the floor. We look at this during our tour, typically, do you have an AED? Do you have a crash cart? Do you have an emergency box? You have stuff on wall of your algorithms, whatever it is. Do you have procedures for handling those emergencies during the hours of operation?

After hours of operation, you also need policies for that. You need to provide information to your patients on how to access after hours care. Addressing barriers to after hours care. Have you tried to remove every barrier possible? Again, most people do that. The health center reviewer team will call your after hours call team member and make sure they can get through, that they can reach them if they're speaking a language that they do not speak. Most people do that, but make this a part of your process. Call it yourselves, have a board member call it every quarter, see what their experience is. I've had call systems hang up on me, be very rude to me, tell me to call back in the morning. I've had all kinds of experiences and you want to know not only what the reviewer experience is going to be, but more importantly, what your patients are experiencing when they're calling you after hours.

We've kind of talked about this. I'm going to speed through some of these things. Everybody's documenting their after hours call services. Most everybody has hospital admitting privileges. Make sure you have those documentation pieces in place. Either your providers have hospital admitting privileges or you have a relationship with someone who does. Most of you will have policies for exchanging information with hospitals as a continuity of care piece. Most people don't struggle with that. Again, FTCA, for those of you that are FTCA deemed, this is not part of the compliance process, but it is part of the operational site visit process. If you are FTCA deemed, make sure you look through this in great detail and that you are prepared to answer those questions.

If you just applied for FTCA, this is going to be really easy. Just make sure you go through it and check it. I have had some folks who they miss areas in this, and they said, "I just got approved for my FTCA deeming." There are some areas that don't fully overlap, but it's pretty rare for people to have trouble with this. Pay attention to that and make sure you don't miss anything. You will have access to all of these things. I go into lots of detail about risk management reports and those types of things, but that is probably for another day. So what questions do you have?

Ted Henson (01:23:23):

Thanks Kyle. We have a couple from this section and one or two to loop back with some previous chapters. Because we're catching up a little bit and I apologize for missing one or two. On peer review, who does the peer review for OB/GYN if we don't have another OB/GYN on staff?

Kyle Vath, BSN, MHA, RN (01:23:40):

This is up to you. It's vague. As I mentioned, it just says that it has to be done by a licensed clinical staff member. It's ideal if you can do that with someone on your team. I've seen some health centers share this with another health center or another team members. Sometimes people don't like to air their dirty laundry and like to keep that internally and I get that. But I have seen health centers do that, sharing those peer reviews, but it's up to you on how you define that. They just have to be a licensed healthcare staff member.

Ted Henson (01:24:12):

Thank you, Kyle. Can you elaborate on quarterly QI/QA reviews, incorporating chart review element seven.

Kyle Vath, BSN, MHA, RN (01:24:22):

I'm not sure what chart review number seven is, but as far as just quarterly QI assessments outside of peer review, a lot of people will just do clinical performance measures. They're their mammogram metrics, their A1C metrics, those types of things. Putting that before the board, running reports, doing QI efforts on that. If you're talking about peer review, which they call QI assessments, clinical assessments of patient care, that's more peer review and all the stuff I said with peer review would apply to that.

Ted Henson (01:24:54):

Thanks. Sorry if I'm limited those. Element seven is what she referred to.

Kyle Vath, BSN, MHA, RN (01:24:58):

Oh.

Ted Henson (01:24:59):

What if your peer review policy does not say quarterly, but you are doing both self and peer review twice a year?

Kyle Vath, BSN, MHA, RN (01:25:12):

In general, your policy needs to say quarterly and you need to be doing it quarterly. If it's not in your policy, I would recommend you put it in your policy. If you are doing things two here and two here, I

would just make that very clear that you are doing this assessment quarterly. I'm not sure if that's helpful or not. It's a little bit ambiguous. I would just try to make it as clear as possible that all of those criteria that are required for credentialing and privileging, that you're doing all those things and just define how you are doing those things.

Ted Henson (01:25:46):

Thanks Kyle. A couple more before we close out today. Going back to credentialing and privileging, are LPIs required to be board-certified or should that be defined within policy and then followed?

Kyle Vath, BSN, MHA, RN (01:26:01):

Is that like LPNs? Is that what they mean by LPIs?

Ted Henson (01:26:04):

I don't know. I was hoping you did.

Kyle Vath, BSN, MHA, RN (01:26:08):

I'm not sure what else that would be. Maybe if they provide that information, but again, you defined... Oh LIPs, providers. Okay. What was the question about that again now?

Ted Henson (01:26:20):

Are LPIs required to be board certified or should that be defined within policy and then followed?

Kyle Vath, BSN, MHA, RN (01:26:26):

It's not HRSA requirement. I think it's a good practice. It's not a requirement, but if you are using that to verify current clinical competence, then you clearly need to define that as how you define current clinical competence, but it's not a requirement.

Ted Henson (01:26:44):

[crosstalk 01:26:44]. If you could answer again, the question around digital credentialing and privileging files being accepted, hosted in the cloud based solution and not paper filing cabinets.

Kyle Vath, BSN, MHA, RN (01:26:59):

You can provide them. However, just make sure you talk with your reviewer ahead of time on how they would prefer to review them. You can use digital, you can use a credentialing and privileging software. You can use HR management software, you can use paper copies, it's up to you. They just have to complete and contain everything that's required.

Ted Henson (01:27:27):

Thanks, Kyle. There's a comment question. Will you be providing in the future a review of the risk management requirements and best practices?

Kyle Vath, BSN, MHA, RN (01:27:39):

It's definitely in the slides. It's up to you all. I don't know if you have any risk management trainings in the future. It's all on the slides and you can read through a lot of that if you'd like.

Ted Henson (01:27:52):

Yeah. Just to answer again, feel free to follow up with me directly, either through the trains@nac address or my email's in there THenson@nac. org. Happy to connect you with our Clinical Affairs Division colleagues who do a lot of that type of training. I know Kyle, you work with their quality center folk as well. I'm happy to connect folks to that team. I'll do a final call here. [crosstalk 01:28:21]

Kyle Vath, BSN, MHA, RN (01:28:21):

As we're totaling things up, go to www.reglantern.com and you can just put in your name and sign in and you can find, if you go to resources, you can find many of the checklists and cheat sheets that I created that we mentioned in the presentation. If you have any trouble, feel free to email me at kyle@reglantern.com and I can help you find those. Thank you for the opportunity and I know we covered a lot of information. Make sure you really focus on credentialing and privileging and form 5A. Those are going to be where you really are going to get the most bang for your buck in your time spent and your investment in preparing. Thank you.

Ted Henson (01:29:01):

Thank you, Kyle. I really appreciate that because I think the purpose of these webinars is not to go over every word in the compliance manual, but really highlight some of these hotspots. The three of you who are faculty really know that the best. Well thank you for being strategic about how you want to focus these slides.

Kyle Vath, BSN, MHA, RN (01:29:20):

Sure.

Ted Henson (01:29:20):

There are a bunch of questions around the slides, not being... I'm sorry, when we converted it from PowerPoint to PDF, it looks like not everything was updated. I think Olivia's already fixed that problem so check Dropbox. We'll send out the updated link. We'll make sure you have that in the last email in your inbox from us. Thank you all for attending this. Please, when you close out today, you'll be redirected to a link to do the evaluation. We've had really good response to that. Please, if you have other suggestions for things you'd like covered around... Thank you for sending the link. Around risk management, credential and privileging, let us know there so we can make sure we work on getting that content to you. In the meantime, I just want to thank my colleagues, Olivia for being such a great host and for Kyle, Renee, and Jen, whose not with us today for always just lending us your insight and expertise.

Hearing from people who are on the ground, doing reviews, working with health centers and who most importantly have the mission of health centers close to their heart and guiding with their work, it's really important. I want to also state the reviewers are objective, but they also care about the health center middle man. I know this from working with them. I think you all are in good hands and good luck as you continue to prepare for your OSBs, whether it's this month, next month or next year. Always let us know how we can continue to provide training and technical assistance to support your needs.

Thank you all.

Kyle Vath, BSN, MHA, RN (01:30:45):

Thank you very much.

PART 4 OF 4 ENDS [01:30:51]