Maintaining Compliance in Your RHC

Thursday, January 26, 2023 3:00 PM • 1:14:06 total length

SPEAKERS

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Sarah Hohman 00:00

I'd definitely see folks still joining. But I know that we have a full presentation today and want to give lots of time for questions. So I'm gonna go ahead and get started and then and then folks can join throughout. So good afternoon, everyone and welcome. My name is Sarah Holman and I'm the director of government affairs for the National Association of rural health clinics and the moderator for today's technical assistance call. Today's topic is maintaining compliance in your rural health clinic. This webinar series is sponsored by hearses Federal Office of Rural Health Policy, and done in conjunction with us here at an RHC are supported by our cooperative agreement as you can see on your screen through fr HP, and that allows us to continue to bring you these webinars free of charge. The purpose of this series continues to be providing valuable technical assistance to RHC staff and others in the RHC community and provide Archie specific information to you all. So we ask that you help us to spread the word about these free webinars. I encourage anyone in your community to who may benefit from this information to join us and to sign up on our listserv to receive all the updates about these webinars and more. When we get to the question and answer portion of today's today's session, Tressel will be able to spend a good amount of time going through all of your questions. With the possibility or probability that Jessa covers a lot of answers to your questions throughout the presentation. The more that you can wait until the end in case she covers it, the better. But the q&a box is open to you. As with all webinars, were at the mercy of good bandwidth for all parties. As we know, connectivity can go up and down if you have any audio or visual issues, we suggest leaving and coming right back in that usually fixes the issue. But not to worry, as always, these webinars are posted on an rhc.org. And in just a second, I will I will pop the link the direct link to that in in the chat. And without further ado, I'm going to turn it over to our wonderful presenter for today's webinar. Trust us hickory from Health Services associates. Chester over to you.

Tressa Sacrey 02:24

Thank you sir, I appreciate the introduction. As Sarah mentioned, our goal today is to review the topic of maintaining compliance in your RHC. And as she mentioned, my name is Tressa FAKHRY. Some of you may be familiar with me, my role is the director of compliance and education at Health Services associates. And I appreciate the opportunity to join you today and hopefully give you some practical tools and tips to maintain compliance at your own RHC and facility. The idea of this presentation really comes back to the point of once you are certified into the RHC. There are ongoing requirements to continue maintaining compliance at your facility as you prepare for your next survey. And we're going to dive into some practical tools and tips. But we'll also cover some of those areas that you'll want to monitor on an ongoing basis and typical timeframes that we see these being completed in. So we're going to review the contents for an RHC evidence binder, we'll also discuss how to develop your own internal compliance program to make this process a

little bit easier as you're working day to day within your own facility. And then also providing some helpful tools to maintain compliance at your facility. I don't know if you can see the picture on the left hand side of your screen. But I will I like to think of this as a survival guide for managers as a survival guide for those that are responsible for the daily operations of the RHC and ensuring that compliance is at at 100% at all times. So we're going to go through these tools. We're going to go through these elements and then we'll give clarification regarding what's required versus what's recommended to promote easier maintenance of your program. The evidence binder is one of those elements that I like to state is good practice. It is not a requirement for the RHC to develop an evidence binder. It is a practical way to capture all of the information quickly that could be requested at time of survey. So the question on the screen is can you locate requested information quickly? So when a surveyor comes into your space, do you get that deer in the headlights look or do you feel confident and prepared that anything that they could ask for you're ready to answer. And so that's where this evidence binder really comes into play is developing, gathering all of these resources that we know we're going to need at time of survey and having it readily available so that you're not having to scramble and search for information. Of course survey is meant to be a snapshot of your clinic, where are we at? And are we in compliance with the rules set forth and 491, one through 12. But it's also a good opportunity to address those initiatives that you've been working on throughout the last few years, depending on the distance, of course between surveys. So again, we just want to give you tools give you tips give you tricks of how can I be successful, how can I be confident that my next survey is going to go well.

Sarah Hohman 05:40

being punched in of the

Tressa Sacrey 05:41

binder, again, allows you to keep all of the requested information available for quick access. But you do want to make sure that you keep it in a safe location, as it could contain some confidential information. One of the elements that you want to ensure is that you determine what format is going to work best for you in your organization. What I mean by this is quite a few clinics, especially those that are tied to a hospital system, some of the recommended contents of what could be requested at survey, you may already house in another department, such as HR, your credentialing department, your licensing department, your employee health department, if you have these elements already organized and easily assessable. In other areas of your organization, there's no reason for you to duplicate that into this evidence binder. It is, here's the items that are commonly asked for that survey, let's put them in an easy to access location. But if we can't, or if it's already covered in another area, then here's where we would communicate to access that information at time of survey. And then of course, create sections that are labeled for quick reference so that you can easily navigate your binder. In case a surveyor has a specific content that they're looking for. We do recommend if you determine that you want to set up this evidence binder that you review your binder quarterly to ensure that items are not expired, or that you're capturing those things that might expire and need to be updated and be kept current. A common one is that organizational chart and we'll get into some of the contents here shortly. But the organizational chart seems to be an ever growing process within clinics right now, with staff turnover with administration turnover. And so that's one of those examples of documents that you want to make sure you keep the most current version within this binder. And you want to also ensure that this evidence binder is kept in a location again, that safe because it could contain some confidential information. But also that's assessable. So if the person who's maintaining the evidence binders out of the office, someone else is able to access and provide it to the surveyor if survey were to happen when the person responsible for this element is out of the office. The document here is a recommended list of contents. And we're going to go dive into each of these elements a little bit more in detail. But this at least gives you a starting point of what are those things that a surveyor could ask for. If your clinic has not been certified yet, there's some pre work that you have to do to get into readiness for survey. The intention of this presentation or this webinar, though, is to speak to those who are already certified into the RHC program and provide elements that you need to continuously track and maintain between your

surveys. Some of those elements would be determination of Ahimsa, your Thai and notice from CMS once you receive your CCN a number, your most recent survey results. So if you have been certified for many years, and you've had multiple recertification surveys at your facility, you would want to keep maintain a copy of your recent survey results, whether you had a plan of correction, what actions you took to make those corrections. Or if you have the letter from your state office or from your creditor, regarding a perfect survey, depending on the outcome, of course of that last documentation, a copy of your CLIA we recommend keeping that in place so that it doesn't fall off the radar of monitoring that because they do expire. And you also want to double check your CLIA license to make sure that it reflects your current lab oversight person. And so we're gonna dive into each of these categories, but that's just a snapshot of some of the content that surveyors could ask for. And we're gonna go into each of these areas later. One thing I will note is where we mentioned earlier regarding, if you are part of an organization where different departments handle different areas listed on this table of contents, there's no reason to reinvent the wheel. What I would recommend to you is to take this tool and let it be a guide lying to you. Where can I find this information? If it's easily easy to locate, then you don't need to bring it into this documentation binder. However, if it takes you a couple of hours to find this information, then it might be helpful to keep a current copy in in an evidence binder. Another note that I have seen clinics do is they take this checklist and then they notate where it can be found within either their organization or their clinic setting. An example of that is your policy manual. You don't want to have to have everything in one binder because it can become a little bit cumbersome. But where would you locate your policy binder? And is it printed? Is it available online through something such as policy stat? Is it located in your managers office? Where would you find the information if the survey requested that. So just kind of doing a crosswalk, take this list, make it become a checklist of readiness for your next survey, and determine where you can locate that information within your clinic and either documenting it on this tool or gathering all of that information and putting it into a succinct binder. Now, this is kind of a funny slide, I use it because I'm a visual person. And so if you look at the table of contents here as tab 12345, and then it has the alphabetical elements of how I would locate each item. And then this goes at the front of the binder. And these are the tabs that I'm using because again, it's just easy to locate where can I find this information in a quick format to get the surveyor in and out of my space as quickly as possible. And so these are just a not promoting Avery, that's not the intention of it. I am just a visual person. So I wanted to provide to you how we typically set these up before creating them for a clinic. In that evidence binder, we talk about that certification. So that first tab within the binder, and again, getting a copy of your hips, a designation showing that you're in a current hip. So within the last four years, what is your final tion? Notice from CMS getting that certification number in your binder so you can locate it. Most survey read most recent survey results, what actions have you had to take in the past because typically what we find when surveyors come into your space, if you had a previous plan of correction, sometimes that's what they're going to come in with a focus on to ensure you've corrected the actions you said you were going to do that you are maintaining that monitoring process you defined in your plan of correction. If you had a perfect survey or zero deficiencies, then of course, just that letter of your continued certification process, and then a copy of your CLIA as we mentioned, because again, they do expire. In the physical plant section, we recommend creating an environmental inspection log, going through each area of your facility and determining what elements are we measuring for compliance within each area? What do we need to look at in our lab space? How are we setting up our exam rooms? What are what are are those physical plant check marks, that we're ensuring we're following safety protocols that we're monitoring our medication handling, that our rooms are safe for patient use? What is your process and getting those environmental rounding logs based on your facility and your specific structure and setup and breaking it down by the different area types. So creating those environmental grounding logs is really beneficial from a self auditing perspective. What do I need to look at in my lab area? What am I looking at in my nursing station area exam rooms lobby, what postings need to be present. What about the outside of my facility? What elements Am I looking at from a patient safety standpoint and from a compliance standpoint with 490 1.6. And then of course, you have your equipment inspection log proof that your biomed inspections are complete and current. And that there's a crosswalk between all of the Physical Plant items within your clinic that touches or measures a patient, a copy of your floor plan with your routes of egress for fire evacuation drill reports, if that's applicable to you have at least for your fire report, and then those ongoing after after action reports for your emergency preparedness plan having those present again, unless

you already have that as part of your emergency preparedness binder. Cleaning logs that's very much specific to your clinic setup. If you have a housekeeping contract or you have a specific set of standards that your nursing staff or your clinical support staff are doing between patients that you have that defined and if you're tracking that through documentation that you keep a copy within your binder here. And then your emergency care equipment your fire extinguishers AEDs oxygen tank that you're monitoring them to ensure that they're in working order and ready for use in case of an emergency. within your clinic setting, nother element that you would want to have within your emergency within your evidence binder is your chart audits results of those ongoing collaborative reviews, and results of the administrative audits that are taking place, this area gets a little bit fuzzy, because each state is a little bit different on how they measure this or what your percentage or number requirement is going to be. So you're determining what your state requires. If there's no state mandate for the collaborative piece, then then you would define that in policy. And that's what you're held to. But you want to make sure that you have documentation of proof that these elements are being completed. And you're capturing the evidence of what you are doing on a day to day basis or on a quarterly basis. Then evaluation, this is probably the piece that we find missing most often, when we are looking at recertification clinics, preparing for their next survey, the program evaluation and part of the reason I feel like this is missing quite often is because for initial certification, all you had to do was defined in policy, what you were going to do when it came time for the program evaluation, which is required two years after initial certification. And so when you finally get to that two year point, it's defined in policy, but you haven't put it into action yet. And so this is commonly something that we find missing when we're reviewing a clinics program is that the program evaluation meeting, or report at least has not been completed within the timeframe required. But within your evidence binder, you should have a copy of your meeting minutes or have the report that you pulled together data reports, supporting the information that you captured within that report. And then of course signature of participants to show that those that are required to participate were present, or at least reviewed the overall report and acknowledged participation in that. And the program evaluation again, for initial certification, you're just going to define in policy what you're going to do. And then every two years at least as long as your policy allows for that, you will review your overall program and have a report in place to show to the surveyor that you're in compliance with that regulation. And the stack Information section, you'll want to keep your organizational chart and keep that current. And then also keep a copy of your roster of staff with their FTE status. Keep a copy of your NP or PA schedule to show that they are there at least 50% of your operational hours, copies of licensing your DEA your BLS for all clinical staff. And then of course, clinical staff certification and BLS as required as well. If these areas are captured in your HR department, there's no reason to duplicate as long as you are able to easily access a time of survey.

Sarah Hohman 18:18

Hey, yes, um, quick question while we're on this specific staff section. Alyssa asks, we include job descriptions in our RHC evidence binder. Is this a requirement? Or can we remove this?

Tressa Sacrey 18:33

So one of the slides that's going to be later in the presentation is a no your standard slide. And so it's really dependent on who you're certified through. If you're under the state, if you're under the compliance team, or quad A each of them have their own list of what's required within HR files within the chart audit piece. And within the physical plant, they kind of have their own set standard of what their measurements are going to be to determine if you are in compliance. And so to answer your question directly, it would depend on if you're under the state quality or the compliance team to determine are job descriptions required? Are they reviewed at time of survey and what location should they be in? Most of the time, what we see is as long as you have them in their HR file, and staff are able to determine what their role is within the clinic acknowledge participation in that of what the expectations are for their actions within the facility setting, then you would be considered in compliance. Do they have to be within the clinic setting? No, as long as you can access them on the Day of survey if the surveyor were to request that. So looking at some of the additional binders.

There is a requirement in 491 Nine that you do have policies for your facility. And so typically we find that in a separate binder, most clinics are moving to an online platform such as policy stat or some version, where all staff are able to access the files at all times to determine what actions they should take based on the service being provided. But the policy manual you would want to locate, you would be able to locate that quickly and all staff have acknowledged understanding of the policies. Emergency Plan, that should be a printed version. So it's a grab and go type setting in an emergency situation. And so you should have a designated emergency plan. If you are part of an integrated emergency plan that's completely compliant, as long as the clinic is reflected appropriately within that medication logs, I actually have some sample versions regarding sample meds and controlled meds, those various logs that you have to keep track of regarding distribution. But usually, that's not captured in the evidence. There's a separate binder, or it's uploaded into a Google Drive or something where you're able to secure it and access it later if necessary. Plus the s sheets. Again, most of that is online now. But if you do keep a binder, then you would reference where that can be located in the clinic. And of course, your ongoing lab controls and documentation required for those point of care tests that's typically kept in the lab area. So it wouldn't necessarily be duplicated into the evidence binder. Moving in fill in creating your own internal compliance program. This is the big question that I get asked quite often is, or that I ask clinics quite often is are you ready for your next survey? Do you feel confident that if a surveyor were to walk into your clinic tomorrow, that you would pass that you feel confident that you're at 100% compliance at all times, there's been a lot of moving pieces and a lot of changes within especially the last three years regarding how the clinics are being observed. How clinics are being measured. Language within Appendix G, which is the surveyors guidelines for, or the interpretive guidelines for surveyors on how to measure your facility. There have been changes nonstop over the last three years. So how do you know if you're in compliance, and I am so thankful for the National Association for rural health clinics providing resources to clinics, so they can feel confident that their next survey, some of those compliance tasks that we'd like to break down is, we're gonna break it down into tiny increments. So what's do monthly what's do quarterly what's to annually what's do bi annually, we're gonna break it down into some of those easier to two pieces, if you will. But the intention of compliance is that you are required to maintain 100% compliance at all times within the RHC program, there are conditions for certification listed in CFR 491, one through 12. And you are required to be in compliance with all of those elements at all times. And the hard thing is, is that surveys are on announced, there are different reasons why you could have a survey one, there was a complaint that was issued, and that triggers a survey, maybe you are changing location, or you're expanding your facility and you've notified the expanse of space that could trigger a survey, or you're due for your next survey. Some state offices are every three years, some are every six years, some are every seven years, it really depends on the individual state, both of the accrediting organizations, so quality and the compliance team are on a three year rotation for survey. So you might be due for your next recertification survey. It is on announced and you are required, of course to be in full compliance at time of your survey, regardless of when that happens. So this is that slide. It's not super detailed, but it's really where Who are you subject to what? What is your manual, if you will, of how to ensure compliance at all times. You are required to know what your standards are, but whose rulebook Are you having to follow? And so it's really determining who are you certified through? Are you certified through your state? Are you certified through the compliance team? Or are you sorry, accredited through the compliance team? Or are you accredited through quad A? Each of these different elements follow a standard? It all is based on that CFR 491 through 12. But you want to make sure that you understand what measurements you're subject to the state offices if you are certified under the state, you will be subject to appendix G. Under the compliance team, they have their list of standards. They go in correlation right with 491 one through 12. But they list out how they measure you and you can take it and do a self out to station that you know you're in full compliance. Same with quad, eight, they have their list of standards, you can print out their list of standards, if that's who you're certified through or accredited through, and do a self attestation. And make sure that you are in compliance with all of the elements that are listed within their documentation. I like to look at these the survey as an open book test. So whether you look at Appendix G, if you're under the state or at the accreditors standards, that is your measurement, that is your test Study Guide to know if you're going to be successful at your next survey. And it's best to do that now. So you're prepared for your next survey, then to have that deer in the headlights look when the surveyor walks into your clinic. And there hasn't been any monitoring for quite some time in

some areas. recommendations. So I'm going to give you a succinct document here in a moment that lists out the ongoing tasks that you have to complete post certification initial survey. Once you get that checklist, there is a space where you can delegate tasks, everything should not have to fall on your shoulders. If you're the person that's maintaining compliance at your facility, you might be able to delegate to your clinical support staff or to your receptionist depending on the type of task it is. But delegate the task and assign accountability of how you're going to monitor that and maintain it moving forward. And then set some reminders, I am constantly on the go. And so if it doesn't get into my Google calendar on my phone, it is gone, I forget. And so really give yourself a electronic reminders set tasks once a quarter or once a month, or once every year, set when your next action is due so that you have that visual reminder or that electronic reminder of what tasks you need to do next. Because as I'm sure you're aware, there are always things that are moving within clinic settings, there's always some fire that needs to be put out some staffing situation that needs to be taken care of. And so sometimes compliance gets set to the backburner because you are addressing so many things at once. But if you set these reminders within your calendar within some tickler system, and it brings it back to your reminder, it's going to help you maintain your compliance moving forward, and then obtain proof of completion. If it's not documented, it didn't happen. And commonly, the piece that we find missing in that obtain proof piece is that collaborative review taking place between your supervising physician or medical director and your APs. It's happening, they're having conversations, they're making notes, but you don't have documentation that you're meeting what you put either in policy or what your state requires for percentage amounts. And so obtaining proof documentation, document everything. It can be online, but it needs to be something where you can pull proof that you're in compliance with those objectives. And then of course, break down tasks into smaller increments. Don't say that policy review if you have 100 policies, and you know, you have to review them every two years. Don't save it for the month before that two year timeframe is up, break it down into smaller increments over that two year timeframe so that it's easier to process and maintain. So here's that helpful tool that I mentioned, and it just breaks it down into those miscellaneous items. What needs to be captured daily, monthly, quarterly, annually and by annually. Now one disclaimer with this document is you want to match your timeframes to what you have in policy. An example of that is quite a few clinics have determined that they like to keep their annual review or sorry, their program evaluation, emergency plan, review and policy review annual, even though the burden relief that was published in 2019 allows for the clinic to move to biannual every two years. Most clinics are maintaining an annual review because they want to capture struggles or issues compliance issues quickly. If your policy says annual, and your report says biannual, you would be considered out of compliance and receive a deficiency. So you want to make sure that your policy and your process match. We're going to break down these tasks based on recommended timeframes. But again, you'll want to go through this list match it to what you have in policy and process and then determine when is this next due and who's responsible for completing it. And we've just found this debt delegation task list helpful and clinics knowing what's expected after your initial certification as you prepare for your next recertification survey. So looking at those daily and weekly compliance tasks, what we would expect to see within the clinic is that you are keeping track of those temperature checks especially for your medication refrigerators. Those are due two times daily. And then for your lab refrigerators that's required to be tracked at least one time daily, most do two times because they've set a habit with their medication, refrigerators and freezers, cleaning, making sure that you're cleaning between patients. And then environmental rounding. Again, that depends on how you have that setup. Some clinics do environmental rounding weekly, some do that monthly, some do it quarterly, it really depends on the percentage of compliance within your facility on how often you should be reviewing your program, or reviewing your facility. There's here's a sample temp log, this is directly from VFC. You can update this to match your process, but it gives you space to track both am and pm temps. It's just a tool that clinics have used to maintain temperatures at their facility. And document that quite a few clinics have the ability of pulling a report from their temperature gauge. If they have a specific alarm system built in for their refrigerator and freezers as long as you're able to show that it's been checked twice daily. And you can show that there was no variance in temperature, then you would be considered in compliance. But we do recommend a documentation of that am and pm check and making sure that the pm check is not done at nine o'clock in the morning. Compliance tasks looking at the monthly so at least monthly checking your AED is it in working order fire extinguishers, beyond the one year review from your fire, maintenance people that the tank has been

reviewed, but at least monthly checking to see if it's still in that green area. And it's ready for use if needed. And then you're in use oxygen tank that has appropriate pressure and you're not grabbing an empty tank of a patient where to code. Here's some examples of how clinics are monitoring that and documenting that. And here's an example of an oxygen tank log, you can change it from a daily to a monthly, it does not have to be done daily. Some clinics, their maintenance department takes care of this for them. And they don't have to worry about it as long as you can pull proof that it's been reviewed. We already talked about the collaborative chart audit and the administrative chart audit. You have a couple of polls here regarding how you can monitor that moving forward. And so this is regarding that collaborative review. And most of the times what we find missing is the documentation that that review is taking place between the supervising and collaborative providers. And so this document here is a way to document that quarterly review if that's what you've determined to do, and which records were reviewed signature and notes from the supervising physician and then signature in response from the EPP. This is a an example of an administrative chart audit tool, it relates back to the 491 10 requirements for what has to be captured within your records. And it's just a way for you to keep those administrative chart audits happening. And it's a tool for your use. If that would be helpful to you. Then annually some of the elements that we recommend is doing an HR audit, making sure that you're capturing those OIG searches annually. There are some elements that you have to look at annually within the HR records. Are they current is licensing up to date? Is the DEA expired? Did the BLS expire? Do they have their updated training, at least on fraud, waste and abuse on your HIPAA and OSHA training and then Emergency Preparedness at least every two years proof of training on that. So just keeping an eye on where are our employees at and do we have documentation of their ongoing training. And then of course, that equipment inspection is due annually making sure that we're capturing correct measurements for our patients, that our equipment isn't faulty and that nothing got missed in the back of the storage closet. This tool here is in regards to staff competency for point of care testing. This is a document that we have found helpful instead of having to do a competency form for every test at the clinic level. You can combine it all into one sheet. And so this is something that you can use if that would be helpful to you. You just list out what tests you are doing at your facility. The four different ways that they can be monitored, which two were completed, and then acknowledgement of who the oversight person is to show competency and test competency. And that's what you're capturing in the record each year. And then by annually and again, I want to give a disclaimer here. If your policy still says annual, you either need to update your policy or maintain the annual process. If you updated your policy to allow for a biannual review, then you can move to a biannual. review of your policy review, your emergency plan policy review and your program evaluation documentation. One caution I would give here is that the emergency plan review can take place every two years where you review your risks, you review your policies, you review your training and testing program, and you review your communication plan to make sure everything is still correct and current. But there is ongoing yearly test testing requirements from those exercises and hazard exercise requirements. So it's not that you can wait two years to do your after action reports. There should be an after action report each year based on if you're in the required exercise or plan to exercise your timeframe. So yes, you can review your emergency plan every two years, but you want to make sure you're capturing those after action reports yearly as required. Policy Review, this is just a simple policy signature page to show that it's been reviewed over the last two years. Typically, what we find is a summary of recommended changes based on the review of your medical director, one a PP and a non staff member, they review your patient care policies over that two year timeframe make recommendations or lists of changes that were made, that's brought into your program evaluation. And then you have an updated signature page, either uploaded to your electronic version of policy or attached in the binder of policy to show that you've met that two year review requirement. And then the document here is a template agenda for the program evaluation, you do not actually have to have a meeting. But you do have to capture the data to review utilization of services. So proof that you reviewed both active and closed records, and then review of policies and determination if the clinic needs any changes. And if you follow policy over the last two years. So this is just a simple agenda that we utilize to facilitate program evaluations for clinics. And you can use that and update it to fit your structure. It gives you space to review your ongoing quality measures your improvement projects that you're doing at your clinic, what you're doing well as a facility. And then of course, those required elements that are listed in 491 11. And then those miscellaneous items that don't have a necessarily a specific timeframe attached to them.

But we don't want to drop off the radar. So I wanted to make sure that we covered these as well. Those ongoing control logs the documentation of your point of care tests as required based on manufacturer guidelines, a copy of your organizational chart, we recommend reviewing that quarterly again, just keeping it current, your CLIA whenever that gets close to expiration making sure that it's current and up to date. And then your sample med logs and control med logs. Variance logs based on what type of medications you're storing in your clinic setting. If you have an autoclave, most clinics have moved away from that and they send instruments held for sterilization. Or they use disposable instruments only in their clinic setting. But if you do have an autoclave on site at still, you would want to make sure that you're keeping track have the required documentation for that both your score checks batch logs, depending on the type of machine that you're using for sterilization of instruments. This is a sample medication log, I do want to give a quick caution that formula is considered a sample. So if you're distributing items in the clinic that have a lot number that could have a recall, then you should be tracking who you're distributing that to. Some clinics say that their EMR system allows for them to pull a report if there were to be a recall, I would caution you to do a test trial and see if that's actually accurate. I know sometimes it can be difficult to pull reports from different EMR systems. So if you're using your EMR to track who you distribute medications to make sure you're able to run a report based on lot number if there were to be a recall. Otherwise, if your EMR doesn't have that capacity, then you should have a written log that you're tracking that and a lot of times it has pH I on it, so it should be somewhere that's considered secured. This is also a variance log for that ongoing accountability of if you have controlled medications stored on site. This is a way to maintain that and ensure that you always know what's been administered and or distributed and how much you have left and it matches what's actually in your dual locked container. Additional notes is really some things that could pull you out of compliance between your initial certification survey and your Next recertification survey, there are elements that if you have a change in your clinic structure in your clinic leadership, then there are items that you do have to report to either CMS and or your state or creditor. If you have a medical director change, that's a reportable change. If you have a change in location, you do want to confirm that where you're moving to is qualified in a HIPAA designation. And you do have to report that change of location. Same with ownership, if you have a change in ownership, there should be a notification. There's quite a bit of documentation requirements there, I'm not going to dive into the details of that I just wanted to bring this to your awareness. If any of these elements change, make sure that you do the due diligence of recording those changes appropriately as required. So then, we're going to tie all of us together with a pretty little bow. And, as I'm sure you found out from that lovely slide that shows the different tabs systems I like to use Organization is key when monitoring and maintaining compliance at your facility. So create some binders or electronic files to help you organize your information in an easy to navigate process. Keep documentation for everything, and make calendar reminders of your upcoming tasks so that it doesn't fall off the deep end. My email is here, please feel free to reach out if you have some additional questions. But I do want to leave some time for the q&a. And hopefully I can address some questions here live on the webinar. I see a few in the q&a. So I'm assuming you have some questions.

Sarah Hohman 41:41

Yeah, thanks, Tressa. This is incredibly helpful. And there are so many resources in here. So we are going to just get started going through going through questions. kind of all over the map. So we'll just get started. So Kylie asks, what is an FTE status?

Tressa Sacrey 41:58

Oh, I apologize. There is your full time equivalent. So if you have a provider that works 40 hours, that would be considered a one FTE. If you have providers that split their schedule, then that plays more into your cost report. piece. So I would reach out to your cost report preparer, because I'm I'm assuming that they already have that captured for you.

Sarah Hohman 42:22

Can you review what the final tion notice is?

Tressa Sacrey 42:25

That's where you get that letter back from CMS with your CNN included. So your certification letter.

Sarah Hohman 42:34

For emergency operations plans, can the RHC be included within the hospital or system they're aligned with? As long as there is defined clinic expressed in the overall plan? Or does the RHC need its individual emergency operations plan?

Tressa Sacrey 42:49

So for me 112 e allows for an integrated emergency plan, the caution that and that actually is a whole presentation all on its own. But I don't mind addressing the overarching question. Yes, you are allowed to be included in an integrated plan with the hospital. There are some cautions and pitfalls to consider when participating in a hospital plan. And really what it is is boils down to the question can the clinic enact the emergency plan within the four walls of the clinic. And so if your policies reflect operation room, the emergency room how to call codes within the hospital PR system, then it may not be applicable to the facility. But if the clinic is appropriately reflected within the documentation of the integrated emergency plan, I've seen some very successful integrated emergency plans. It is are both sides of the coin covered the hospital and the clinic. So each should have their own risk assessment. Even if they duplicate each certified facility should have their own risk assessment, the policy should be able to be put into action and meet what's set forth and 491 12. Your communication plan should come down to the clinic level including a call tree of the staff at the clinic space. And then your training and testing program if you participate in the hospital's emergency plan, community based drills and facility based drills that the clinic is appropriately reflected in that listed at the participant and the after action report includes them. So that's kind of a very broad statement regarding a very in depth topic. Easy answer is yes, you can be integrated. But there's a lot of moving pieces, you want to make sure you're able to check all of the elements that are listed in 491 12.

Sarah Hohman 44:38

Megan asks, we have kept all of our old certs in our binder back to 2015. Do we need to keep them all or can we filter out every couple of years.

Tressa Sacrey 44:48

So I think a easy way of doing that is I don't know that I get rid of everything. But I would upload them maybe into or scan them into a cloud drive where you can To access them if you need to. But the typical recommendation is that you keep information from previous survey to next survey. Now, the hard thing is, is that there are some states that are six years, seven years, eight years, some even up to 20 years between survey. And so it's hard to know how much information you actually are going to be required to provide. So at least between surveys, keep that information, anything between lat that survey and the one previously, I would upload until you feel confident that it's no longer going to be something requested at your next survey.

Sarah Hohman 45:35

And then some of these are like quick hitters on what needs to be included. But Teresa asks, Do LIG exclusions need to be in the evidence binder,

Tressa Sacrey 45:44

not necessarily in the evidence binder unless you can't show it through your through your HR documentation? Typically, where we find a struggle area with OIG searches is it's completed through credentialing or it's completed through a contracted service or an outside service provider. When you bring providers into your clinic. They forget to include all staff at the clinic, not just providers. So if you can't capture the information from your organization's standpoint, then yes, I would recommend doing it at the clinic level. So you know, you're covered. Because it's not the organization that's going to get the deficiency. It's the clinic.

Sarah Hohman 46:24

Is it acceptable to have the program binder and all other documents other than postings and logs in an electronic format?

Tressa Sacrey 46:34

So as I'm struggling on answering that only because there are so many there, every state, it depends again, on who you're subject to quality, the compliance team, I believe that they both accept everything to be electronic. But some state offices may want it to be printed. So I don't want to give you a blanket answer because it really is dependent on your specific situation and setup. You're not sure who you are certified through maybe your manager new to your position, and you kind of came into the program after you were already certified. I would look at or look for your previous your certification letter. And if you have any postings in your clinic that reference quality or the compliance team or a specific state that should help clarify who you're certified through, or who you're accredited, accredited.

Sarah Hohman 47:33

This is pretty specific. But first staff meetings, do you need to have a signature page? Or can you have checkboxes to document attendance if it's a virtual meeting, for example.

Tressa Sacrey 47:46

So some staff meetings what I've seen is a sign in log I have seen acknowledgement of meeting minutes with listing of who participated. It really is up to you of how you want to document as that proof of compliance piece.

Sarah Hohman 48:06

Our patient satisfaction surveys required in an RHC.

Tressa Sacrey 48:10

Again, that depends on who you answer to. So some states do most states do not require patient satisfaction surveys, I think it's a good practice. It's definitely a recommended practice. It's always good to get feedback from your patient population on how you're doing quality and the compliance team, I believe both require patient satisfaction surveys and review of that on a consistent basis with your staff.

Sarah Hohman 48:38

Christina says we were told to we have to keep logs on our staff refrigerator in our lunch room. Is that accurate?

Tressa Sacrey 48:45

I haven't unless you I have never heard of a food refrigerator requiring a log we do recommend having no signage on the refrigerator in the staff area. No patient care items or food only. We shouldn't see patient comfort items in there like if a diabetic patient comes in and you're storing juices for them. Patient items and employee items should not be stored in the same unit. But I've never heard of a food refrigerator requiring temp logs unless you're in some odd state that I'm not aware of.

Sarah Hohman 49:21

Um, are we only required to keep the last quarter of charts reviews reviewed? Or how long are we required to keep these audits?

Tressa Sacrey 49:29

Again, I would recommend from previous survey to next survey. And usually they're some states have a requirement of if it's part of their electronic record of how long you have to maintain medical record. An example would be six years. But you really want to be able to prove to the surveyor that you maintained compliance from previous survey to next survey and if there's a gap and compliance somewhere in the midst of that maybe there's a changeover in staff. Then you have documentation that You recognized the issue so that you can make up for that timeframe. And here's the initiatives that we put in place to correct the issue moving forward. Kind of a self disclosure, if you will, that you would keep in case they ask don't provide it unless they ask. It's kind of like going through the border patrol, you only answer the questions they asked me.

Sarah Hohman 50:23

Vanessa asks, who's considered a new patient in the RHC not seen in three years? If an Archie is owned by the hospital as an ER visit included in the three years? How would you define that,

Tressa Sacrey 50:34

that's really up to your policy, you define in policy, how you how you would clarify what you consider a new patient and or when you would require them to re establish as a patient. And I'm assuming that plays into that closed record review piece of what's considered a close record. Typically, you close records are considered either a deceased patient, a patient that has transferred out care, maybe they moved out of your area or moved to a different primary care provider, and then their records were released. And or an inactive patient, if that's what your policy allows for. So it's really reviewing your policy, how you define in policy, what a new patient is, and or what a an established patient is, and how you define a close record.

Sarah Hohman 51:31

Okay, if this is kind of a broader policies and procedures question, but if you have multiple RHC, is can you combine some of your policies if you reference all the RH C's? Or do you need to have a separate policy for each RHC when the actual policy has the same content?

Tressa Sacrey 51:48

And that's part of the struggle of answering that question from a national platform. Again, it depends on who you're subject to the compliance team allows for universal policies, as long as each clinic is appropriately reflected within that, and they take ownership of those policies, and they can be electronic. And I'm not sure on the answer from today's

perspective, I'd have to look into that a little bit more. And some states most states do allow for universal policies. But I know for an example Arizona, you would have to have your own policy binder for each location. It really is dependent on where you are located at and who you're certified through our accredited through.

Sarah Hohman 52:29

Christie says you mentioned after action reports, what would these be?

Tressa Sacrey 52:34

So in the emergency preparedness requirements, which are listed in 491 12, there is a space where you have to analyze the outcome of your ongoing exercises and drills that are conducted at your facility. So the after action report is that analysis where you summarize what happened during the event, what your strengths were, what areas of improvement came forth from the outcome of that event, how you corrected those areas, or what your plan is to correct them moving forward, and then an overall statement of the success of the drill or training or exercise for your facility. So it is the analysis document of the exercises and drills you're doing for your facility. There is a great sample from CMS actually, if you want to reach out to my email, I can send that to you of what an after action report should include. Wonderful.

Sarah Hohman 53:34

Daniel asks, if we have an event BP related but it does not involve outside entities does this count as a tabletop or community wide event?

Tressa Sacrey 53:47

Okay, so there has appendix z is the guideline for how the emergency plan for all provider types is measured at survey. And within appendix Z as in Zebra, there is a clarification. I like to call it a leapfrog of over two years. So the first year in your teen wrote your rotation of exercises and drills is a required exercise. The opposite year is a planned exercise. The required exercises being either a facility based drill, a community based drill or an actual event, the opposite year that planned exercise is either a community based drill facility based drill or a tabletop drill. So you can't report on the same thing every year, it has to relate back to your risk assessment. And if it is, based on the description that you provided, I would qualify that as a facility based drill. Community based drill means you bring all of the outside players into one exercise event and you run it as with all of the players in your community. facility based drill is combining education and action together. So an example would be You'd have in your local police department come in running through what your active shooter drill policy states, and then running an actual drill doing action and education together, then tabletop drill is that planned exercise where you do a scenario based question and answer based on a risk that you've determined for your facility.

Sarah Hohman 55:26

Oops, give me just one second. I lost my place

Tressa Sacrey 55:29

is much easier to define. If I had slides in front of me and could show you visuals I'm just saying.

Sarah Hohman 55:36

I'm Connie asks, If we cannot find our initial certification letter, how would we go about getting a new copy? Is that CMS regional office?

Tressa Sacrey 55:46

It might be I wish, okay. I'm wondering how much cuecore would be of assistance with that one. So in my company, I am compliance in education. And then my counterpart, Michelle Chriselle, is all things enrollment. So that would be who I defer to for that question.

Sarah Hohman 56:03

Yeah. I think it's Regional Office company. If you reach out to, to me, I will put my email down. But I'm happy to give you that contact, and then we can go from there. Okay. Megan says, I see you had a program evaluation meeting agenda, we currently don't have an agenda listed with questions and only a bi annual signature sheet stating that the annual review was completed? Do we need to include an agenda or more information than just that confirmation?

Tressa Sacrey 56:37

So my directive to you would be to look at 491 11, which is what outlines what has to be captured within the program evaluation. So how do you show that you review your utilization of services? How do you show that you captured the required chart audits with both open and closed records included? And how do you show that you reviewed your policies. So it's there's not a set framework for the program evaluation, but there are a set elements that you have to cover within that. So I would take your previous meeting or your previous report and compare it to 491 11. And make sure you can cross off every element that's listed there. The document that I provided the agenda, that's just a helpful tool of how we assist clinics with that process to make sure we hit all of the requirements.

Sarah Hohman 57:33

A couple questions in here kind of a along the lines of how long do you keep something in the binder, I'm just going to reiterate trusted said that she definitely recommends between survey to survey keeping more, you know, in the binder versus scanned into a location or something like that. A few a few questions along those lines. So I just wanted to remind folks of that,

Tressa Sacrey 57:57

I think the easiest process would be to create electronic folders where you can maintain that information so that you don't have this, like three inch binder that is overflowing and can't close. So there's there's a lot of information that you're having to maintain and retain, for survey. And so I recommend scanning it and creating electronic files. Some people prefer paper, if that's your process, then recommendation is keeping at least the current in the binder with an electronic backup of older versions. And if you don't have any electronic backup, then it should all be there between surveys.

Sarah Hohman 58:38

Do all policies need to be reviewed and updated every two years

Tressa Sacrey 58:42

patient care policies. That's the definition within 491 10. Your patient care policies have to be reviewed at least every two years by your physician, one a PP and a non staff member. Some clinics, track the review process through meeting minutes if they're meet monthly or quarterly. Some do a summary sheet where they have each of those required participants review policy and document what policies reviewed and when and any changes or recommendations based on their review, and bring that summary to the program evaluation. Some just sign that signature page every two years

acknowledging and attesting that they reviewed them and they have reviewed all of the patient care policies within that two year timeframe.

Sarah Hohman 59:36

If NPS have independent practice, or chart reviews by the Medical Director still required.

Tressa Sacrey 59:42

So this actually is something that has come up more and more in conversation over the last few years, especially as more states allow for a PPS to act with the full scope of their licensing, which is our goal right? That's where we want to get to if your state does not have oversight requirements, unfortunately the Fed Your federal reserve requirements listed in Appendix G still have that oversight requirement. And so if your state doesn't have a percentage or requirement, then you would define in policy, how many and how often, and that's what you're measured to. Unfortunately, it can't be zero, and all HPP should be included in that review. So an example of that if you're in a state that does not have an oversight requirement, you put in your policy that you're going to the supervising physician will or the medical director will review 10 records per quarter, and you have two APS one is there for 20 years. One is there for a year, you can do one record of the HPP. That's been there for 20 years, and nine of the a PP that's been there for one year. Some states break it down, depending on if it's a PA or an NP, what oversight requirements that are, you have to meet your state laws. That's how it's listed in 490 1.4. You have to meet all state, federal and local laws. But if your state, local or federal laws are not defining that for you, you define it in policy, ensure all are included and documented proof of that.

Sarah Hohman 1:01:14

Well, I want to be cognizant of of everyone's time, we're obviously getting through a lot of questions, and a lot of folks are sticking with us. But being aware of our presenters time that she's given to us so far, Tressa you okay to go for 10 minutes more or so? Or do you have a hard stop? If you do that? That's totally fine.

Tressa Sacrey 1:01:33

I'm available? I would say 314, which I think is for 15. Your time? Yes.

Sarah Hohman 1:01:39

Perfect. Okay. So someone asks, if you have a similar presentation for provider based clinics. So can you talk a little bit about what any differences if at all may exist, or this is this is already too straight up.

Tressa Sacrey 1:01:55

So the the only difference, I would say in the provider base versus independent clinic is where you locate information. What I mean by that is a lot of independent clinics, they're going to be housing HR on site, they are going to be maintaining documentation of those biomed inspections on site because they don't have a department at the hospital monitoring or providing that for them. The requirements for the RHC. So the CFR 491, one through 12 are for all provider types, independent and provider based. So I'm not sure what elements within this wouldn't be applicable to a provider based clinic, other than where you locate the information.

Sarah Hohman 1:02:38

Perfect. That's what I wanted to confirm. For mid levels, we understand that we are required to have a mid level, apa 50% of the time, if we only have one mid level and they go on maternity leave for three months. Is this okay? How would we handle this?

Tressa Sacrey 1:02:55

Oh, boy, from one, I would say the there are two requirements surrounding the HPP. One has to be an employee meeting a W two of the clinic. The other requirement is that you have proof that they are there 50% of your operational hours. Now some look at that in a monthly setting summit look at that as an overall year setting because providers are allowed to take vacation, and we have some that of course go on maternity leave, and they would like a certain duration for that. So in that light, if you can show that they met the 50% requirement over a timeframe, I would consider that in my understanding that would be considered in compliance. Most if you're through a provider based facility, you might be able to pull in a provider from another location and have them cover both clinics for a timeframe. I would also review your hours of operation and see if you're correctly posting your hours because that is where your equation is based on. What I mean by that is if you use the hours that you want to post that goes into that a PP 50% of the time requirement or when you operate. If you have outside business hours, if you have, then those should be designated as non RHC hours, because that doesn't go into your equation for that 50% requirement. So you want to make sure that you're clarifying business hours versus patient care hours. If you call us for lunch that should be taken out of that equation.

Sarah Hohman 1:04:32

Yeah, I also want to get to some of the questions that were submitted ahead of time. are rural health clinics allowed to do urgent care and advertise services provided as urgent care?

Tressa Sacrey 1:04:43

Oh boy. So there are some states that will not allow that at all. Most clinics use the term walk in. Yeah, I would. I would steer away from the term Urgent Care Services.

Sarah Hohman 1:04:56

Yes, that's what we hear a lot is to do not use not use urgent care, in many cases that is just walk in services. And there's certainly no, no problem with our 80s providing those type of services. But it's when it's when Urgent Care is used that some states have issues with that. So

Tressa Sacrey 1:05:15

it's more of a matter of how you're marketing it and how you're promoting it. There's always ways around things I would say you utilizing the term walking is much more appropriate.

Sarah Hohman 1:05:29

And I see some people saying we use the term walk in care, same day appointments, that kind of thing. So that's all great. How often should a clinic expect State Surveys of their rights?

Tressa Sacrey 1:05:41

So it really depends on what state you're in. I in there are 50 states, so I can't address all 50 states in the time allotted here. But most states are on a three to seven year rotation for recertification surveys. Some states I've been in have been there's been 20 years between surveys there, there's most are not that far out. A lot of state agencies are no longer doing initial certification surveys, or if they are is three, three months, sometimes up to 18 months, sometimes up to six plus years before they actually can be on site and do that survey because they're so understaffed and overworked. It they're it varies by state, it really does. But again, the clinic response to that is you are required to be at 100% compliance at all times regardless of when your next survey is due.

Sarah Hohman 1:06:42

If a nurse practitioner is doing telemedicine 50% of the time, does that count as compliant with that? Available 50% of the time?

Tressa Sacrey 1:06:52

That is a good question. And I'm not going to give a rote response live because I think that differs again by who you're serving entity is. Sara, do you have any insight on that? Otherwise, that might be something that we can follow up to the presentation on?

Sarah Hohman 1:07:09

Yes, I've heard. I'm not sure if Nathan's still on and available. And he could jump in if he is I think this is come up before I cannot remember exactly what we what we said. So we can we can follow up with you, Julie. Oh, hi. I'm Julie says if a nurse practitioners doing telemedicine 50% of the time, does that count as compliant with that requirement?

Nathan Baugh 1:07:40

Unclear. It's unclear. i My Nathan Boz interpretation is that the I believe the regulation says that the nurse practitioner or physician assistant must be providing services. At least 50% of the time the clinic is in operation. And I believe there's like there's a literally the word I n n is used in such a way that makes me believe that that you can't hit that requirement with a nurse practitioner doing telehealth services. But that that rule was certainly written before telehealth was really a thing. Right? So

Tressa Sacrey 1:08:35

it's a gray area. And that's why I didn't want to answer because there's there's not a set in stone. Exactly. Yeah. How do we measure this? How has this reflected that survey?

Nathan Baugh 1:08:47

Yeah, sometimes that's an answer and of itself. Supposedly, our we're gonna get more clarification on many things the next year. So at some point, certainly telehealth is not going away. So I would say that at some point, we will need an explicit a more explicit answer. I highly doubt that you would be able to meet the NPPA requirement through telehealth long term, but it might be permissible now.

Sarah Hohman 1:09:29

Thanks. There's a bunch of questions around the non staff member being involved in in program evaluations. Trust like can you talk to that a little bit and if you have any, like recommendations on who that non staff member can or should be?

Tressa Sacrey 1:09:51

So the non staff member the only place that the non staff member is actually listed in Appendix G or in the regulations. is in relation to policy patient policy review. There's no reference to that. Within the program evaluation section 491 11. There is an advisory group statement in relation to 491 11. So common practice over the last 20 something years, every thing that I have read, the community member has been in place at that non staff member and has always been part of the program evaluation part of the policy review. But again, the only place that you actually have documentation of this is required is within the patient care policy portion of the regulations. So a lot of clinics review financial information at their program eval, and they don't want someone that's not part of their entity participating in that conversation, which makes sense. And then there's a lot of gray area of who qualifies as that non staff member. And again, that really comes back to who surveys you. And that's a question I would pose to your surveying entity is, who can fulfill that role. Some say that you define it in policy, and that's what they hold you to. Some allow for, it has to be a peer meeting of provider. Some say that it can be anyone that's considered a professional that has the qualification to act in that role. It is different state by state and by each accrediting organization. So I can't give a blanket response to that question.

Sarah Hohman 1:11:32

Yep, no, entirely understood. And then the last one, after a site visit, how long to clinics have to correct deficiencies? Sure.

Tressa Sacrey 1:11:43

So if you are already certified into the RHC program, and then your next survey, you receive a plan of correction, meaning there was a standard level deficiency found, if it's a standard level deficiency, you have 16, well, they send you the plan of correction, within 10 days, you have a response 10 business days, you have to respond within 10 calendar days of what your plan of correction will be. And then you typically have 60 days to show evidence of completion. With a condition level deficiency, that timeframe shortens to, I believe you have 45 days to make that correction. And typically, it requires a second survey. So there's definitely timelines listed if you receive a plan of correction, those timelines should be defined to you so that you know when you have to respond and when things have to be completed. Wonderful.

Sarah Hohman 1:12:37

Thank you. And thank you, Tressa. For for all of this. As always, we have a ton of questions. And we will review all of these and look at chesses materials. And these slides are available to you. So we hope that that you use those and we'll we'll follow up with those questions that we weren't able to get to. Thank you for attending today's webinar for sticking with us past the official end. And especially thank you to Tressa for her wonderful presentation, all of these resources, as well as Federal Office of Rural Health Policy for sponsoring the RHC technical assistance webinar series. As always, if you have ideas for future topics, or considerations, can you please send those to either Nathan or myself? And be sure to let us know your ideas for CRH CP professionals. The CEU code for you can be found at the completion of the survey that you'll be prompted with when you leave today's webinar. Thank you as always, and when we schedule the next webinar, we'll be sending out a notice through our listserv. So ensure you're signed up for that to get those important updates. Thank you again and that concludes today's presentation. Thank you. Thank you Terrassa