PINNES HEALTH SERVICES

Operational Site Visit - - July 11 – 13, 2017

REMEMBER: One OSV is One OSV
Context

• Last OSV was July 2013

• Results:
  • 19 of 19 program requirements found to be in compliance
  • 5 best practices identified by surveyors for subsequent use
  • Clinician comment: “If my family was traveling in Maine and anyone needed medical care, I’d go to Pines”
PREPARATION

• Previously used consultant retained for mock site visit, identified the following issues:
  • Bylaws did not contain mission statement
  • Table 5c (Sites) – one health center’s hours did not reflect current (20/week versus 24/week)
  • Credentialing & Privileging - - had not performed previously due to relationship with hospital and all providers on hospital staff - - no longer the case. We knew this would be a non-compliant finding for the OSV
    • Reviewed policy and procedures and initial files
  • Recent change of title for Director of Accounting to Director of Finance - - not reflected in QI plan and other policies & procedures
  • Review date for QI Plan not changed to current
  • Each program requirement has multiple elements, **ALL** of which must be met
July 2017 Survey

• Team not identified and confirmed until 2 weeks prior to survey

• Initial conference call for introductions held 2 weeks prior to survey
  • Only two of three surveyors on the call
  • Project Officer and Section Chief on the call
  • Theme articulated: We don’t give perfect scores; expect items to be found not in compliance

• Document request lists received from all three surveyors - - substantial overlap/duplication

• Electronic documents - - provided on thumb drives as well as ShareFile within 3 days; Team Lead replied in writing that he hated shared file systems, because they never worked, then acknowledged ours worked
Survey Results

- 5 of 19 program requirements found to be not in compliance
- No best practices
- Pines Board considered Team Lead to be unprofessional and borderline rude during requested private meeting with the Board on night #1 of survey
Specifics

• Program Requirement - - Staffing:
  • Not met due to credentialing and privileging of independent practitioner staff (MD, DO, DDS, DMD, FNP, PA-C, CNM) complete. Noted that this was in process. Strongly preferred in conversation with Medical Director to have all privileges specifically delineated, rather than a general description of “core privileges”

• Program Requirement - - Sliding Fee Discounts:
  • Not met due to date of last policy review indicated as 2010; ignored annual Board review and adoption of updated Federal Poverty Guidelines
Specifics, continued

- Program Requirement - Sliding Fee Scale, continued:
  - Annual review of patient/client eligibility needed
  - Annual Board review of continued appropriateness of any nominal fee (such as due to external economic impact)
  - Noted with approval the annual Board review of nominal fee, particularly based on input from those on the Sliding Fee Scale program
  - Sliding Fee Scale needs to be incorporated in all billing and collection policies
  - Referral agreements with outside organizations need to provide a Sliding Fee Scale at least as good or better than FQHC’s
Specifics, continued

• Program Requirement - - Scope of Project:
  • Not met due to Form 5a not accurate. Example - - if administer injections of FDA-approved drugs and/or provide samples of FDA-approved drugs to patients, health center is considered to be a pharmacy; look closely at the definitions incorporated in the Change in Scope web page for Forms 5a, 5b, and 5c. All change in scope requests require evidence of Board approval

• Program Requirement - - Board Authority:
  • Not met due to blanket approval by the Board, in the form of a resolution and incorporated in the Board minutes, authorizing CEO to submit grant applications (especially SAC and BPR/NCC) not allowed. Must be specific approval at the time.
Specifics, continued

• Program Requirement - - Board Authority, continued:
  • Bylaws changes required to remove - -
    • mention of CMO as “ex officio” (still considered by Team Lead to be a member of the Board, which is not allowed;
    • any mention of consultation with the Board regarding CEO’s appointment of health center officers and staff;
    • stipend payment, even if nominal, to Board members for meeting attendance not allowed. Must strictly be reimbursement for travel, lodging, food and childcare expenses incurred.

• Program Requirement - - Conflict of Interest:
  • Not met due to potential conflicts not listed by Board members when signing/completing annual disclosure document
• Comments from Team Lead:
  • Noted that 10 of 12 Board members are patients - - good. But, of the two who are non-patients, one derives more than 10% of income from health care. Translates to 50% of non-patients deriving more than 10% of income from health care, and HRSA upper limit is 50%. If 11 of 12 Board members were patients and the health-care employed member was not, the program requirement would be out of compliance (e.g. 100% of non-patients derived more than 10% of income from health care).
  • Questioned Board representation of communities served - - on current observation, did not see any under age 30, female Medicaid recipients. Numerous Board members responded about their childhood families.
CLOSING

• One OSV is one OSV

• Written report still not received from HRSA. Corrective actions that included additional Bylaws revisions and Changes in Scope have already been processed by the Board or submitted via EHB

• QUESTIONS ???
THANK YOU !!

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