

Top RHC Deficiencies and Survey Findings

Rural Health Clinic Technical Assistance Series Call

February 18, 2015, 1:00 pm ET

Coordinator: Welcome and I'd like to thank you for holding and inform you that your lines are on listen-only during today's conference until the question and answer session.

At that time to ask a question you'll press star 1 on your touch-tone phone. Also like to inform you today's call is being recorded. If we have any objections you may disconnect.

Now I'd like to turn it over to Bill Finerfrock. Sir, you may begin.

Bill Finerfrock: Thank you operator and I want to welcome all of our participants to today's call. My name is Bill Finerfrock and I'm the Executive Director of the National Association of Rural Health Clinics and I'm the moderator for today's call.

Let me take a moment to remind everyone to turn off your electronic devices but that's probably not going to be necessary if you're muted.

Today's topic is survey and certification, the ten most common deficiencies and how to fix them. And our speakers today are Tom Terranova with Quad A and Kate Hill with the Compliance Team.

As you all know about a year and a half ago the first accrediting organization for rural health clinics was approved and that was Quad A. And then last year the compliance team was also added as an accrediting organization for rural health clinics.

And our agencies now have the option of either going through state survey and certification or receiving RHC accreditation as a means of becoming or maintaining your rural health clinic designation.

We've asked Tom and Kate to talk to us about what they're finding as their surveyors are going out through the rural health clinics, what the common deficiencies are and how to fix them.

I wanted to mention that this Rural Health Clinic Technical Assistance series is sponsored by the Health Resources and Services Administration's Federal Office of Rural Health Policy in conjunction with the National Organization of State Offices of Rural Health and the National Association of Rural Health Clinics.

And the purpose of this series is to provide RHC staff with valuable technical assistance and RHC specific information.

Today's call is the 62nd in a series which began in 2004. And during that time there have been over 15,000 combined participants on these calls.

As you know there is no charge to participate and we encourage you to refer others who might benefit from this information to sign up and receive announcements regarding dates, topics and speaker presentations. And you go to the NARHC Web site and go to RHC Technical Assistance and get that information.

We will have a Q&A period. And when that opens up we request that the callers please provide your name and the city and state that you're calling from.

If you have any questions about this you can send an email to info, I-N-F-O@narhc.org and put RHCTA Questions in the subject line. Our plan today is to alternate between Tom and Kate on their most common findings or the findings of their survey.

Obviously there is overlap so although if you've downloaded the slides you'll see that we will try not to duplicate the findings but rather you do have all the findings of each organization.

With that I'd like to open it up and Tom will give you as the more senior accrediting organization we'll let you pick the first topic, first efficiency you wanted to focus on. Go ahead Tom.

Tom Terranova: Okay thank you Bill. And thank you all for inviting me to speak on behalf of Quad ASF and for attending this conference call.

I know sometimes these technical issues can be a bit dry but I think they're very helpful for learning the areas in which we see a lot of common miscommunication either between the surveyors and the clinics or between CMS and the regulations and what really is going on in the field.

So I think these are incredibly helpful for setting expectations and really learning some key lessons in achieving compliance. So with that said I am Tom Terranova. I've been the Director of Accreditation a Quad ASF for about two years.

Prior to that I was serving as Director of Legislative Affairs for Quad ASF so I've been around for about six years working with the various programs we have.

As Bill said we were approved in 2013, I think it was 2013 or 2012 for the RHC program. We're actually just up for our reapplication. I believe I'll be filing it probably in the third quarter of this year for renewing our deemed status at CMS.

My thought today is I'm just going to start with the most common deficiencies and as Kate chimes in and talks about the common deficiencies the compliance team finds I'll check them off so that I don't repeat any.

But if I have any different findings or unique findings or different thoughts I might chime in. Kate and I have discussed this before. And if she has come up with any different findings that I'm talking about she'll just chime in as well so that everyone gets kind of a full picture.

So with that said my most common deficiency cited and this has happened in, we're approaching 200 RHCs at this point in deemed the program and 63 surveys have produced this one deficiency.

So it's pretty common and it's that the clinic maintains a record for each patient receiving healthcare services identification and social data, evidence of consent forms, pertinent medical history, assessment of health status and health care needs of the patient and a brief summary of the episode, disposition and instructions to the patient. This corresponds to Code of Federal Regulations 491.10(a)(3)(i) if for those of you are scoring at home.

And our common findings regarding that citation are a lack of consent. And I saw about a 50-50 split whether it was a general consent or a specific consent for a type of treatment.

Advanced directives, when we get a little bit farther down the list and these are less common but still pretty prevalent. We have a fair number of facilities who demonstrate that they've checked for allergies, drug allergies but not necessarily documenting the response to allergies, the bleeding tendency and the medical history of the patient prior to treatment.

Kate I don't know if you've seen anything specifically different or widespread than I have talked about or maybe even in a different order of prevalence.

Kate Hill:

I have Tom. And thank you Bill for inviting me to speak as well today. It's a great opportunity to learn today and it's really all about getting better all the time. And mostly of this is all about the patient.

So let me just address that because on the consent one of my things that I'm seeing or we're seeing is the lack of dating.

When you print out a consent from an EMR if the patient didn't date it themselves it's printing with no date on it. And that could be a risky situation should that consent ever be needed for any reason that the patient required it for any legal things or anything like that. So it's really important to get those consents dated.

And then the other thing on consents was the relationship to the minor is often not filled in. And we will not accept that. That needs to be filled in.

You must state who or how you're related to that child especially in today's world and who's bringing those children in for care. Those are the two that I see differently (Tom), not differently but in addition.

Tom Terranova: Yes and I would echo the idea of the dating, not just EMR, and I think, you know, we discussed this a little bit, if someone's got an EMR system chances are that your system is auditing that and listing when you're making the change or when the patient's signing but maybe it's just not printing out on your form.

And it might just be a simple matter of getting the format of your printout changed.

But we've seen that also in paper documents where the patient just scribbles a signature, but they don't put a date or you've got one party consenting but not the other part where there is on occasions where you do need kind of cross signatures.

So I would think dating is an issue. But, you know, consent overall just there seems to be enough issues with consent overall that I would say that clinics should really pay attention to consent as a general topic because it does seem to be kind of all over the place. But consent is very common.

Bill Finerfrock: Okay. All right, Kate do you want to give one of yours?

Kate Hill: Yes all right, I think I'll start with expired medications and supplies since it tends to be the most common deficiency we see.

And my hope is that after today at least for the 200 or so people on the call maybe we won't see that so often. It is probably the most easily fixed issue in the clinic.

So many, many clinics have lots and lots of sample medications. Some have actually done away with it all together. But if you have sample medications and

the prints on those little boxes is so small it takes an inordinate amount of time to check that closet once a month.

So one of our clinics came up with an ingenious idea, 12 different colored stickers -- very small-dime sized colored stickers, make a log for the door.

And as they come in mark March orange and April purple and whatever and face them all out and you have a very quick way to keep those drugs in date so you don't have an inspector coming around and all of a sudden you have a whole cabinet or a countertop full of expired medications. That's one easy way to fix that.

But whatever way you fix it we need to be on top of those. We can't have expired meds in that cabinet. And should you have expired meds they need to be kept in an - another place until they're properly disposed of not in with that in that same cabinet.

The other thing that expires very often and people tend to forget is needles, electrotrodes - I just had a clinic where the EKG pads were quite old actually so they're not going to give you a good reading on that EKG. That paste is no longer good so those kinds of things anything with a date on it needs to be checked and that's all for that one.

Bill Finerfrock: Tom did you have anything in that area?

Tom Terranova: Yes. And actually, I'll go a little bit out of what I initially intended in my order and I'll just transition straight from additional findings to my next one because it's very related.

So our second most common was the clinic keeping drugs and biologics appropriately stored so I think this goes directly with what Kate was saying.

Expired drugs and supplies is very prevalent. But also if someone is opening a drug to be used across multiple patients if it is a multi-patient, multidose drug that there's sometimes a lack of dating and initialing of the person who opened that.

And so, you know, the expiration date on the bottle might be a year or so or six months down the line but once you open it there's a whole different level of expectation in terms of expiration and when you would waste whatever is left over. And we've seen that that isn't very - that's very commonly not done.

Also things being stored in unlocked cabinets or unlocked doors in that patient - in an area where patients are left alone. And this again as Kate said goes to not just drugs but needles and things like that.

And then refrigerator checks, so that's all about the appropriateness of the drug storage and biological storage. And that's kind of the different findings.

Bill Finerfrock: This is one where I've heard some different conversations too where the - if it's a refrigerated drug that the only thing they can be in that refrigerator are the drugs. You can't put lunches in that same refrigerator. It has to be in a separate storage area from other things is that not correct?

Kate Hill: That is correct.

Tom Terranova: And the other and the other part about that is, you know, and why refrigeration popped up for me I saw in a few cases where the refrigerator themselves were, you know, they might of had a drug refrigerator but it was only being checked for consistency and temperature periodically and not frequently enough or not in accordance with the written policy so that was really why that popped up for me.

And again that was sort of my segue into one of our other common findings which was the clinic's policies for storage, handling, and administration for biologicals.

So it was very related to what we find in terms of the drugs and biologics, but also what the clinic's policies are. And so again my common findings, the narrative from our surveyors are that commonly RHCs use the hospital's policy if they're owned by the hospital, which is really okay as long as it is appropriate for the setting and that it's been internalized by the staff and you're not just sort of relying on "the hospital handles it and we don't really know how it works or what I'm supposed to be doing" or "It's just something I can get the hospital to fax over during the survey". You really want to make sure that it's something you can implement in the clinic.

And again it goes to how to waste, how to dispose, how to label particularly if you're opening a multi-use vile or a multidose drug and then, kind of setting up a routine for checking for expiration and how to do that.

So that was my related standard. And Kate I don't know if you have any other findings that might be related to that?

Kate Hill: One related to that that I want to bring up because I find it often is peroxide. Peroxide degrades very quickly after 30 days. So to Tom's point no matter what

the date is on that bottle once that peroxide is opened it needs to be dated and people don't tend to know that.

The issue there is that those bottles are so big. And in the clinic they don't use a whole bottle of peroxide in time in the 30 days. So I mean the only other option is smaller bottles obviously but that is very important.

It's why it's in a brown bottle to begin with. And so it's one of those that must be dated 28 or 30 days -- whatever your policy is.

Bill Finerfrock: Okay. All right Kate you want to pick one?

Kate Hill: Sure. I'm going to actually play right off what Tom said and that is the lack of policies for provider-based clinics. It isn't that they don't have policies. They follow XYZ hospital that they're attached to. But they must have their name on their policies.

Even if they have a sheet in their binder that says ABC clinic follows the HR policies, which is a very common one to follow the clinic they must make that attestation.

And to Tom's point they must adjust it to the specifics of the clinic. HR may be not so much but something like safety or pharmaceuticals for instance are very different in the little clinic than it is in a hospital setting.

But they must adapt those policies to the - to be specific to the clinic and have their name on the policy somewhere it's got to be their policy if they're an RHC.

The other thing is the hospital's -- correct me if I'm wrong but I believe that Joint Commission went to an every three year policy review. So if your hospital's Joint Commission that doesn't fly for rural health clinic.

And I just had this in a clinic in California. You must find a way to for the clinic staff those that are supposed to be reviewing the clinics to review those policies within the year because the RAC standard is quite clear about an annual review of policies so that gets a little touchy there when you're owned by the hospital.

Tom anything on that?

Tom Terranova: You know, I didn't have anything more generally about hospital-based policies but I mean I think everyone will see that as thread throughout here.

But I think this is interesting because we're, you know, I intended to go top deficiencies to Number 10. But we're very organically playing off each other.

And I'm searching for the right one that I was looking for before and it's actually my number nine deficiency and it's the program evaluation. This is a common finding, a common citation. And it plays right off of what Kate was just saying about the three year policy review.

Particularly we find initial survey new RHCs may not have the program evaluation and it's okay. You don't have to conduct a program evaluation at the time of an initial survey to be an RHC but you do have to have the plan set up. You have to have what you're going to do in that first year in place.

And so that's, you know, it probably isn't going to pertain to too many people on this call because they're all probably already participating. But the idea is that within the first year you're going to conduct your first plan. But it is related in some way to the overall policy development.

Because you're going to do your first review within the first year that standard is met if you haven't done it but you have a plan in place.

But you do have to have the initial policies. I mean you're going to review them after a year but you have to be able to open your doors and work safely and effectively and efficiently on day one.

And so that initial policy that's where we do see that sometimes clinics aren't prepared as they said "well we're going to do within the first year". That's the review but we - you actually have to set something to start off from and that's another finding that we see.

And I sort of double dipped here because they're so related that I can't quite get them apart but that's actually also our Number 8 citation most common citation is that the initial group of policies may not be done yet because the clinic was planning to do it in that first evaluation in that first program evaluation which doesn't have to take place until the first year is over or within the first year but you still need some - sort of something to work with, a starting point.

And to Kate's point what we've seen is a lack of non-clinic member participation, so sort of a public member or that if they participate that might not be documented very well.

The nurse practitioner, the physician assistant or other mid-level maybe not represented on the committee that is establishing the policies or later reviewing the policies.

And again some of this is not necessarily that they don't participate, it is that their participation isn't documented. I think that something that's very important to note.

And Kate may have heard Medicare say this a lot and I know I certainly have if it's not documented it's not done is the way that Medicare looks at things.

And so, if the nurse practitioner's a really integral part of the creation of policies and the program evaluation but there's no documentation showing just how integral, no one knows that. And so take credit for it. And I think that's really important.

The timely routine review of policies again they might - you can say that you do it annually and you probably do but just documenting it in minutes and documenting the fact that you're doing the reviews is really important.

And again as I said the policy setting before accreditation actually takes place is important. You're going to do the review within a year.

But you have to have a starting point and that's, you know, very, very common. We see the citation as folks say well yes we're going to do it within the first year.

Kate Hill: Tom I'm with you 100% on that time. That's actually one of mine. And specific to the nurse practitioner or PA where they are clearly whether it's not written down or I had one recently that just was not involved in policy review and that's not acceptable. It's very clear in 491.8 that the physician assistant and nurse practitioner are two of the people who must be involved in the periodic review of policies.

So whether it's the signature page in the front of the binder with which policy they reviewed or on the particular policy or at the very least, the minutes of the meeting where XYZ policies were reviewed. And all of those are acceptable but they must, just to Tom's point I'm a nurse. So if you didn't write it down it didn't happen has been my mantra for a long long time. So I totally agree with that.

Bill Finerfrock: Yes. I think anybody who has been in healthcare that is not a concept that is unique to Medicare or survey and certification.

I remember hearing years and years ago when I first got into healthcare, you know, documentation, documentation. If it's not written down it didn't happen.

And so whether it's for survey and certification whether it's for it could be for a legal issue, it could be for, you know, what actually happened you're sending a patient on to somewhere else. The documentation is absolutely critical and I don't think that can be said enough. If it's not documented it didn't happen.

Can you the - because one of the things we do here and just to reiterate is this idea of the annual evaluation particularly for the new clinics. Because there was some confusion some people have said oh well, do I have to, you know, I'm going to become a rural health clinic. Do I have to have done my annual evaluation?

And I think what you both said is that no, it's acknowledged that as a new clinic you're not going to have had it done by when the surveyors come in.

But what you want to see is what is the plan? Where you're going to occur at six months, at eight months and how you're going to conduct your evaluation?

What is it that you're going to be looking for? Will you want a date, a time when it's going to occur, a text or an explanation of what they're going to do even though it won't have been done?

You're looking for something in a written document that says what we're planning to do or the clinic is planning to do?

Kate Hill:

Well I'm looking for a policy, the policy on how we are going to get the annual the annual evaluation accomplished.

So if you wait 12 months to review all the policies it's quite burdensome so why not - and this is just a suggestion. First quarter will review these five policies and then those five policies etc.

The law says they must be reviewed annually. It doesn't say they all have to be on the same date. So at any time someone came in to survey the clinic as long as they were all within a year you'd be fine. So yes we're looking for a plan on how you're going to accomplish that annual meeting.

And also with the new policies this is a new clinic just started up, how did those policies come to be and who participated in the creating of those policies?

Bill Finerfrock: Okay and then of course when - and then that you actually do it that when you, you know, when you come in if someone comes in for a reinspection or reevaluation where's the documentation that you actually followed your plan, that you carried out what you said you were going to do you did?

So, set out the plan, undertake the plan and then document what you did. I think those are things throughout survey and certification. Here's what my policy and procedure says what we're going to do. You do it and then you document that you did it.

Kate Hill: Well another thing (Bill) is do your policies reflect what you're actually doing in a clinic? So three months from now I might change a process in the clinic.

Did I go back and - rewrite the policy or add an addendum or whatever it takes to reflect the actual activities of the clinic? And that would be important as well.

Bill Finerfrock: Yes. That's a great point. I run into that in conversations with folks all the time. They'll say oh well, we're thinking of doing this or this is what we're doing.

And it's like okay that's great but what does your policy and procedures manual say you're going to do because it may make perfect sense to change what you're doing.

But if you haven't documented that or made the change in your policy and procedures manual even though what you may be doing is 100 times better than what your policy and procedures manual said you would be cited for a deficiency simply because you didn't do what your policy and procedures manual said you would do.

And so it is important to go back and review that. That's really I think an important point for existing RHCs particularly when you get new staff who may want to come in and change some things say hey, you know, I've got some ideas. I came from a different practice. This is how we did it.

And the rural health clinic says hey, that's great idea. Let's do it. Do you need to go back and look at your policy and procedures manual and make a necessary change there to reflect that change in policy?

Tom Terranova: I think that's a great point (Bill). And if I could add two things to that just you kind of touched a couple things. I was jotting some notes so I want to make sure I might have to go back a little bit on you.

But the very first part is from an approach standpoint a common problem I see across all of our programs is overpromising.

And it's, you know, you get someone who comes in and they're incredibly zealous and they say we're going to do X every quarter or every month.

And then so you promise to do it monthly and you only do it quarterly that's a deficiency even if the even if the regulation says it only needs to be done annually because you've basically overpromised and underperformed.

So I don't want to tell people don't try to do your best, but you have to be realistic with what staff can handle what allows the clinic to run efficiently and effectively.

And, you know, if you're trying to do check all these boxes on a monthly or quarterly basis and that's what your policy says that could be a problem for you and you might need to go back and rewrite the policy.

And I just ran across the facility actually in our ambulatory surgery program that said well, yes, I only do my fire drill annually because that's what the regulation said but their policy said they'd do it quarterly. And so, you know, I think that it's really important for clinics to be aware of that.

The other point that I want to make I thought you said it very early was I'm going to become an RHC.

I think it's really critical for everyone to realize that in Medicare's eyes - and this is - you won't find this in our standards and I doubt you'd find them in the compliance team standards because Medicare's very clear that we have to kind of stay out of the other manuals like the beneficiary's guidelines and things like that.

But from Medicare's point of view, when we come out to do a survey you have to already be operating as a RHC. Now you're not billing obviously as a RHC but you are for all intents and purposes a RHC.

And so, while a clinic might think 'I'm going to become a RHC' and in your mind the date in which you become a RHC is the day you get your billing number and the day you actually can do all of those things you have to be operating in that fashion when we actually come out to do a survey on an ongoing basis and you can't sort of shutdown and wait to get the number then to kind of reactivate.

And so I think when you look at it that way it's easier to kind of conceptualize that you have to put your policies in place, that you have to be starting out your plan to

do your review, that you have to be doing your, you know, whatever your routine processes and procedures are for say drills and things like that.

You have to be acting like you already have your number even though you don't yet because otherwise Medicare kind of says you're not operating as a RHC so we can't really approve you right now.

Bill Finerfrock: Right, no I think that's good. I also liked your point about being realistic. One of the areas that I would often I'll get a call from people say well, what percentage of charts or, you know, our doc has been reviewing 50% of the charts and we don't think that's necessary anymore. We'd really like to reduce it. Can we reduce the percentage of charts that the physician is reviewing? And the answer to that is yes. But what is your policy and procedures manual say?

If your policy and procedures manual says that the doc is going to review 50% of the charts and you've realized over time that's not necessary, it's no longer realistic; maybe, you had a brand-new PA or was a new relationship that made sense.

But if you're going to change and go to 10% or whatever percentage you want then make sure that your policy and procedures manual has changed to reflect that. But always try and be realistic in terms of what's doable in your clinic and otherwise you're liable to trip yourself up on something that you did to yourself.

Kate Hill: (Bill) I want to throw something in there that I think is being missed now and it's so important. Just because the government changed the two week on-site law first of all you have to see what your state did on that regard. Some of them have not. But just because they changed that does not mean they changed chart review.

It can be done remotely because of electronic records but it still must be done and to your point exactly what are the numbers that your policy states. But that's still very important process.

Bill Finerfrock: Right. I'm not sure whose up first here but why don't we go with Kate. Do you want to pick one?

Kate Hill: Sure I'll pick one. One of the things that the 498.1 says is that physician assistant or nurse practitioner must arrange for or refer patients to needed services that cannot be provided for their clinics.

So what we're missing a lot of times in our - on our surveys is that documentation. Do we have a logbook on referrals? Do we have an open spot on the EMR that would not be checked until we get some documentation?

We can make the appointment before the patient goes out the door but then what about the report that's coming back or any diagnostics studies that are coming back from that patient?

So it must be documented how you're managing your referrals for the patient side of the RHCs. And we're seeing that that's not happening in a lot of cases.

Tom anything to add on that?

Tom Terranova: No. I think you should get an award for have and the more unique one because I - we've - we're not seeing that one and I think that that's a really good one.

No I think it's a really good one. I can tell you anecdotally that we see similar issues with referrals and kind of outside services in our other areas. I wouldn't be surprised if that didn't eventually pop up here but it's just not on my data so far.

Kate Hill: Well you'll see it, maybe not on this call.

Bill Finerfrock: Okay. Tom you want to pick one?

Tom Terranova: Yes. So let's go back up to near the top of my list if anyone does have the handout. It's my Number 3 three of my top deficiencies.

And it's "the clinic provides medical emergency procedures as a first response to common life-threatening injuries acute illness and has available the drugs and biological commonly used in life-saving procedures, analgesics, anesthetics, antibiotics, anticonvulsants, antidotes, medics, serums and toxoids".

Okay so there's a couple of things here that I think are important. One of that - one part of it and I'm going to start out with it this way, is on us. And I'm retraining my surveyors, you know, and planning to retrain my surveyors going forward.

This is not supposed to be an exhaustive list and it's supposed to be an appropriateness list. And that's where a lot of times we get into things where a surveyor sees a list and they want to check them all off.

And we've gotten some much more clear, very recent feedback from CMS saying this is, you know, we want to see what's appropriate for the location and what's

appropriate for the setting and ability to respond to emergencies that is comprehensive not necessarily that you can check off each one of these things.

And very commonly it's emetics and antidotes that RHCs don't have and they go back and forth with the surveyor. So I do have to take some of the responsibility for that as an organization.

And I would say if any of you are being surveyed by one of our surveyors and you get into that sort of debate, contact our office so that we can help you and the surveyor through. And we are doing our best on our side to kind of get that information off better to our surveyors.

That being said, I do still see a fair amount of findings that should remain the citations for the standard. And some of those are things like I have an agreement with the EMS. And they're here within five minutes. That's not sufficient. Or there's another clinic next door they have it all and we just run next door and grab it. That's not sufficient.

The regs are pretty clear that it needs to be in your facility. It needs to be ready to go. You need to be able to respond to a patient emergency within your clinic. And so, it's next door or EMS is right around the corner is not sufficient.

However as I said if you have eight of these ten or so items and the surveyor is being a stickler about having emetics then that's a different discussion that I need to have with the surveyor and we need to talk about the appropriateness of those findings and those emergency response agents within the clinic rather than "this is one of the ten things I can't check off on my list".

So it's sort of a finding on your end, a finding on the clinic and then a finding on our end that I think is really helpful.

Kate Hill: So Tom I'm going to give you an award for hitting that because we went through the same thing. And we're more recently into this of course. And I challenged CMS on that. And I got that exact answer.

So what we're training our surveyors to do is to challenge the medical director or the nurse practitioner to say we want in the medical emergency box what your physician thinks they need on-site to treat an emergency, not that list of the medics and toxoids that we rarely use and go to waste oftentimes and at great cost to the clinics.

So as long as the medical director signed off what's in that box and it's all in date of course and then we're happy. The challenge we see is should the state come in behind us they're not on the same page that you and I are.

And so that's a possibility. But I just warned them about that and that they should challenge that if they should get written up for that. But that's great to put that up.

Bill Finerfrock: Yes I think that's an important point for our audience too that, you know, Tom as a representative of Quad A and Kate As a representative of the compliance team are accrediting organizations and they have their surveyors.

They are not the states. And both of their surveyors, the state always has the ability to come in and inspect a facility more so to make sure that they concur with the findings of the compliance team or the Quad A and their surveyors.

But I think one of the things that's important in survey and certification is to understand and whether they're it's the compliance team, the Quad A or the states is ultimately these are individuals who are going to be coming into your clinic.

And although whether it's the states, whether it's the compliance team, the Quad A there are standards and regulations that they've been citing here.

You also have individuals who are trying to interpret or apply these standards in individual situations. And you may get some disagreement on how an individual may interpret or apply a particular standard or requirement.

If an individual is being surveyed by or accredited by the compliance team or accredited by Quad A they have a disagreement with a finding of the survey.

So what would be the recourse that the individual would have? Would there be somebody should they contact you Tom or you Kate if they have questions about a compliance individual's respective? Don't call the Compliance Team if it's a Quad A and don't call Quad A if it's a Compliance Team.

Kate Hill: Yes that would be important.

Tom Terranova: I was going to...

((Crosstalk))

Tom Terranova: ...(unintelligible) that one.

Kate Hill: We have an appeals process that we - send out when we start with the clinic so they know exactly what their recourse is we would encourage that.

They must provide the proper documentation to say, you know, your surveyor got it wrong. Here's what's really there. But they have to prove to us that we're wrong and then - and we'll certainly accept that. But we have a whole appeal process.

Bill Finerfrock: Okay. And Tom I assume you have something similar to that?

Tom Terranova: Yes it's the same. I mean, it's not incredibly formalized because it's really that. It's, you know, this isn't a deficiency. I have the policy and your surveyor wouldn't look at it or, didn't see it or something like that.

Because there is a fine line between, you know, you need to go look in this book as opposed to the book that you're looking at. And we don't have that policy and I just typed it up while you're sitting here and then I'm going to email it to Quad A.

Bill Finerfrock: Right.

Tom Terranova: So it's a really fine line. And so yes we suggest that you call your - you contact your specialist, accreditation specialist. By the time you're being surveyed you're probably sick of hearing from them anyway. You know them better than you'll ever know me.

And it will immediately come to myself or to my associate director for accreditation, (Jeannie Henry). And we will go through the process of evaluating whether this citation should be removed.

Bill Finerfrock: And I think also it's an opportunity to perhaps point out that as accrediting organizations in order to achieve that status you are what are considered to be deemed entities. CMS has reviewed your accreditation standards of both of your organizations and deemed them to be as good as or better than the survey and certification requirements that a prospective RHC or existing RHC would be subject to by the state.

So you do not - you may not necessarily follow something that is in the state's in the survey and certification. You may have a different way to address a particular issue.

So there may be unique aspects to what you do, what the Quad A does or the compliance team does that Medicare has said okay we accept your way of looking

at that particular area. And what - the way that you're doing it is as good as or better than what we have set up through our survey and certification standards.

So individuals may pull down the interpretive guidelines, pull down the regulations and say oh but it says this. You may have your own standards in certain areas that are different than what Medicare specifies in the regs is that not correct?

Kate Hill: That is correct.

Bill Finerfrock: Right okay. So again if - and if somebody has a problem with the state surveyor who's coming in and they're not using either Quad A or the Compliance Team, coming to you to complain also would not be an appropriate action on their part?

Tom Terranova: You're right there's very little we can do about the states. And to be quite frank with everyone, when the Compliance Team and Quad A go through the deeming process, we're dealing directly with CMS's survey and Certification Team from Baltimore.

And they have a pretty close eye on us and they have a really direct working relationship with us whereas, you know, the states primarily work with the regions who primarily work with CMS.

And so there's a little bit - there's a level of diffusion there. And, you know, and a little bit of latitude for being a government agency as well as the states having their own regulatory requirement.

So quite often what we'll see is a little bit of a disconnect between the way say Missouri understands the requirement versus the way that the folks in Baltimore are telling us that we should really should understand it.

So we do our best all of the agencies, all of the deeming authorities to be on the same page but there is a level of difference sometimes in the way that state, region, central office, Quad A the compliance team sees the same language. And we try to limit that is much as possible.

But when you're running into a specific pain point the most important thing is to deal directly with the agency that is dealing with you on that point.

But I would say if you're experiencing, or if RHCs in general are experiencing a tremendous amount of concern about a certain area, I think it's always important to talk to the deeming authorities because we serve a very unique purpose in

addition to assuring or trying to ensure patient safety is that we can aggregate this concern and sort of de-identify it.

A lot of times people are afraid to go to the state or the region or the central office and say, I'm having a problem with this because they think it's going to cause a white-hot focus on them and they're going to be targeted as doing something wrong. Whereas the Compliance Team and Quad A has a much more continuous working relationship with CMS survey.

We can say here's an issue that we're hearing from the industry and it's not necessarily going to be this clinic or that clinic or this nurse practitioner is doing something different, or wrong, or is going to draw some sort of negative attention.

This is just sort of on the aggregate here's a problem that the industry is struggling with. How can we resolve it, how can we help? And that sometimes is a little bit of a better conversation than "hey I don't want to sign this paper this way or run this policy this way".

Bill Finerfrock: Okay. Good point.

Kate Hill: That's a good point Tom. And to that end all the accrediting organizations are going to Baltimore next month for these kinds of meetings. We'll be learning and we'll have opportunity I hope to bring up a few issues that we're seeing in many rural health clinics that may be looked at a little differently.

Bill Finerfrock: Okay. Kate we probably have maybe time for one more. We may - I'm assuming we're going to have some questions from the audience. So why don't you pick the last one? We'll go over that and then we'll open it up for questions.

Kate Hill: Okay. I'm going to go with not the most common one but something that's extremely important. It's off the provision of emergency services and it's about oxygen.

And what we found is that rural health clinics breathe it but they don't have a good handle on the storage and safety and storage of an oxygen tank. Even if you only have one or two in the clinic it's very important.

And to that end we want to be certain that those tanks are secured by a chain or a bungee cord or on a cart is ideal in a well ventilated area. And we really like now here's an example of something that we were just talking about. We would like to see one tank patient ready.

And this came out on one of the very first clinics where I asked the nurse I said okay I have a patient that needs oxygen. Could you get me the tubing and cannula and they couldn't find it.

And so we changed that. We petitioned CMS to make changes all the time. And we added one tank patient ready. And that would be a tank with a bag on it, a baggie with the tubing and cannula attached.

So we are patient ready for that patient who needs oxygen till the ambulance gets there or whatever.

I thought that was a really important one because it's not a common topic in rural health clinics. And we've been doing our best to educate those clinics on that very subject of oxygen.

Okay. And Tom any comments on that?

Tom Terranova: Very related. Just to be brief because I know you said you're running out of time, in terms of preventative maintenance and equipment in general, again I'm going to say that it's okay to use the hospital because a lot of times that's what happens. The hospital's biomed folks or the engineers come over to the clinic to work.

And it's okay if the hospital has a prioritization of equipment and things like that. But you have to be clear about it.

What I see a lot is that the standard says that all of the equipment and essential mechanicals and electricals have to be maintained in a safe operating condition.

And folks are cited because the policy says we look at everything electrical. And so when you get to things like lights and otoscopes those aren't being surveyed as frequently. And that's okay but you just have to have sort of a classification laid out with details.

And the same goes for like oxygen tanks and equipment like that. That's why I'm sort of lumping them together. The other thing I would say is new or retrieved equipment you have to make sure that that's checked. I mean new equipment's a little bit different.

But if you have something in storage and you're bringing it back and just like an oxygen tank you need to make sure it's properly functioning and it's not just something you grabbed out of storage and are going to use.

And to itemize anything that you are surveying or anything that you are inspecting on a periodic basis. It's not okay to say room one is great.

You know, you have to list - what are the things in room one that you've checked? Have you checked the oxygen? Have you checked, you know, any AED -- things like that. You can't just say room one is good, room two is good.

Kate Hill: Tom that's my last one so I just wanted to throw two quick things in there, not only just the annual checking and calibration but the cleaning.

What does your policy say on how we clean that equipment, how we make sure we're not spreading infection instead of preventing it? What is the process? And so if you live by your process it doesn't matter to me what it is but what is your process?

And lastly for some strange reason we've had the baby scale be missed a couple times in the calibration. That scale's an important one. When you're talking ounces here and we want to make sure we're weighing that baby correctly. So that is a part of that equipment. It's not electrical but it must be calibrated once a year.

Bill Finerfrock: Before we open the line let me just make some concluding comments or observations here. And first I want to thank you both for the time and what you've gone over here. So thank you very much.

You know, I've been in the RHC program now for well over 20 years involved in it. And at various times I hear folks say oh, you know, the survey and certification process is onerous and why do we have to go through this?

And as I listen to what you're talking about and as I've been involved in this and I step back and I think about this as a patient if I were to go into a rural health clinic and all of the things that you talked about today are things that as a patient I would expect or hope that the practice whether it's a rural health clinic or not is doing.

And I think that in the rural health clinics world we can take pride in the fact that we do this process and it's something that others don't necessarily have to go through.

But our patients can have a higher level of confidence that these things are occurring and that that as a consequence of that when I come into a clinic and I'm in need of something that I can have confidence that it's going to work, that it's going to be available that it's going to be very timely.

And so when I've always looked at the survey and certification requirements for the most part I looking and go well this is common sense. These are things that as a patient I'm glad that they're doing and I think we can hold out in the RHC community as a badge of honor and say to the rest of the world, you know, we are going above that if you're a physician who's in where I'm sitting in Alexandria or Virginia they don't go through that in a physician's office.

You've set yourself apart, you've accepted. But in the end the patients are getting better care as a result of it I believe.

So with that operator why don't we go ahead and open it up for questions from the audience? And again if you would say your name and where you're calling from just so we can get a sense of the geographic breadth of our folks are calling from that would be appreciated. So operator if you would give the instructions.

Coordinator: Thank you sir. At this time if you'd like to ask a question please press Star 1 on your touch-tone phone. Due to the automated entry you must state your name to the automated service so that I can announce you. Again that's Star 1 to ask your question and Star 2 to withdraw your question. And one moment please.

Coordinator: The first question comes from (Brenda). Your line is open ma'am.

(Brenda): Hi. I was wondering...

Bill Finerfrock: Hi (Brenda).

(Brenda): ...you guys said - I'm from Nebraska - that this is...

Bill Finerfrock: (Brenda) okay.

(Brenda): ...being recorded. Where can we get this - get access to this recording?

Bill Finerfrock: It will be up on the Office of Rural Health Policy's Web site and you can go to that. It's www.hrsa.gov/ruralhealth/policy/confcall/index.html. If you just go to the first part of that hrsa.gov/ruralhealth you'll see a rural health clinic technical assistance icon. You can click on that if you don't want to write down that whole address. Or if you want to just email me at info@narhc.org I can send you the link as well.

(Brenda): Okay thank you.

Coordinator: Our next question comes from (Kathy). Your line is open. State your location please.

(Kathy): Hi, Cozad, Nebraska. The question I have is where were the slides at? I never did get a copy of the slides?

Bill Finerfrock: They're up on the National Association of Rural Health Clinics Web site. We sent the link out through the listserv. But if you go to the NARHC Web site and you go to Rural Health Clinic Technical Assistance click on that you should be able to find the slides. But if you want again send me an email info@narhc.org I will send you the link to the slides.

(Kathy): Thank you.

Coordinator: Next question will come from (Sharon). Your line is open.

(Sharon): Hi. This is (Sharon) from Ord, Nebraska. And I have a question on the comments you made about not being able to offer services that you document or the log sheet that you have those done. Tell me more about that?

We have an EMR. And say we need a patient to see somebody on a service that's not provided local we can do telemedicine. Those orders are in the chart. Do we need to do log sheets? Is that what I'm understanding you to say?

Kate Hill: I think that was my comment and I think that was about referring patients out of your clinic. So what's your process for following up on those patients? If you're doing your EMR right in your office, I mean your telemedicine I would think you're covered there because you're going to document that visit.

(Sharon): Yes. We have the order goes into the chart. And then when we get a correspondence from that physician then that order is moved over to completed. Until that order is moved over into completed it kind of sits out there as a new order waiting for something to come back into the chart. So that alone is good enough.

Kate Hill: That's perfect.

(Sharon): Okay super. Thank you.

Kate Hill: You're welcome.

Coordinator: Next question will come from (Lisa). Your line is open.

(Lisa): Hi. This is (Lisa) from Emmett, Idaho. And I...

Bill Finerfrock: And I was afraid we're only going to have people from Nebraska on today.

(Lisa): Thankfully I'm representing the great state of Idaho.

Bill Finerfrock: That's great. What's your question?

(Lisa): Thank you for providing this information. It's always good to know in any event that someone does come to Idaho to do a survey so I appreciate that. My question I am unsure about the training that we have to do for staff, specifically safety training. And we keep a log of the in service.

Is there a period of time that we are required to keep that documentation that this training has been done? I know it wasn't a deficiency but this question came up out of some OSHA training so I wondered how it related to RHC.

Tom Terranova: Well I can say in general very often our when you get to OSHA we sort of enforce by reference back to OSHA so, you know, kind of assuming you're in compliance with OSHA.

I'm looking for specifics because unfortunately I mixing programs in my head and we have things like, you know, ACLS training every so often in some programs. And I just want to make sure I don't misquote our RHC program.

So I don't know if Kate has any thoughts and I'll kind of do a little looking while she's talking.

Kate Hill: Yes. And I wish I had the computer in front of me. I also would think it's annual training is pretty much, orientation and then annual training. I don't have a specific date on how long you would keep it.

I wouldn't look back further than a year to see what you're doing, and when those people were hired and how they were trained and then did you train them manually? So I think that's kind of the standard.

But to Tom's point I would go to the OSHA Web site and check and see what they have to say about that because all that safety training comes up under OSHA.

Tom Terranova: If you - if generally you have an expiration, you know, that's what we're looking for is the current one. We're not going to - this isn't like, you know, financial

records we're really going to make sure that you've got three years' worth of compliance and records, you know, back, you know, and you can't purge them until they've reached a certain age. It's really just about the folks that are operating there right now, are they currently trained in those safety measures?

(Lisa): Okay.

Bill Finerfrock: And I think to amplify on that though, I think where you also need to look is what would legal counsel recommend because that could become an issue should there be a questionable care.

So let's say someone comes in and unfortunately decides to sue the practice for something that occurred two years ago and you needed to document that the individual was appropriately trained.

Would you be able to bring forward that documentation to show that the individual who did whatever was appropriately trained for that particular, let's say it's ACLS or whatever it may be?

So I wouldn't think exclusively in the context of just survey and certification but also what are the other venues in which you may have to provide documentation and what would be the expectation for how far back you might have to go in order to be able to document something in a another venue not just for RHC survey and certification?

(Lisa): Okay.

Kate Hill: And to your point Bill what's really most important about what you said is where is it documented who's training on what in that last year? That's really critical.

Bill Finerfrock: Yes.

(Lisa): Okay.

Kate Hill: If there's a log or it's in their HR file.

(Lisa): All right. Thank you very much.

Bill Finerfrock: Okay sure. Next question?

Coordinator: Our next question comes from (Joyce). Your line is open.

(Joyce): Hi. This is (Joyce) from North Dakota. And I have a doctor who keeps needles in an unlocked drawer in a patient's room. Is that out of compliance? The surveyors never said so before.

Tom Terranova: Yes. I can specifically thinking of one of the findings that went through that was exactly the case. It was, you know, a patient exam room, patient's left there unattended with needles in an unlocked drawer.

(Joyce): I used to just be concerned about children with that but nowadays adults could take those needles. I mean it's yes, that's a problem.

Tom Terranova: Yes.

Bill Finerfrock: Okay. Okay is that - do you have anything else? Okay next question operator.

Coordinator: Next question comes from (Teresa). Your line is open ma'am.

(Theresa): Hi. This is (Teresa) calling from Spectrum Health in Michigan. And we've had a couple of clinics that have recently went through certification with Quad A. And the question's regarding the advanced beneficiaries.

We were told - we were not finding that in the regulations that that's a rural health requirement. And we did push back to Quad A and they did retract that from our survey results. So I'm just wondering is it or is it not a rural health requirement because we have other clinics that are also going to apply for rural health status?

Bill Finerfrock: Can you be more - and maybe Kate you know what the question is but I'm not clear on what you said, an advanced beneficiary.

(Theresa): an advanced directive. Advance directive...

Bill Finerfrock: Oh an advanced directive, okay. I was thinking advanced beneficiary notice with regard to the service wasn't covered by Medicare. I'm sorry.

(Theresa): No. It's not required in any regulations that we have.

Tom Terranova: No, you know what it's - and it's actually I, you know, I kind of misspoke when I was saying that. There were some of my findings like you said that I think have since been challenged to talk about advanced directives. And so that was in some of the findings.

But if you read the regulation or the standard very clearly it talks about medical history, assessment of health status and health care needs, brief summary of episode disposition, consent forms, identification, social data.

And it's not advanced directives but that was in some of the narrative so it kind of gets a little bit, you know, because it muddies the water a little bit but no, it is not an exact requirement.

(Theresa): Okay. Thank you.

Tom Terranova: My pleasure.

Coordinator: Okay. The question will come from (Jennifer). Your line is open.

(Jennifer): Hi. I'm calling from Sparrow Hospital in Michigan. And I've got a couple questions for you actually. We're - I'm getting ready to turn our application for our rural health accreditation.

And I also manage another office that's had an accreditation for a few years now. So my big question is is the anti-convulsant issue. I know we have to have that in our emergency kit. But, you know, a big - I hear a lot of clinics say they have Ativan. However you need a special DEA for Ativan to be on your premises. And we don't have...

Kate Hill: (Jennifer) you do not need that anticonvulsant or the Ativan those from CMS are examples. Unless your physician thinks you need it in your emergency box you do not have to have either of those.

(Jennifer): So we can make the choice to not have an anticonvulsant at all? Because other things would be something like a Topamax or a (Dylia) and which aren't the drug of choice for a seizure anymore? So...

Kate Hill: It would be the one your medical director wants to have per the compliance team.

Tom Terranova: That's exactly what I would say as well. I think Kate said it really well earlier when she said, your medical director needs to identify what of those - this is what I would suggest and this is again this is not a direct requirement. But this is what I would suggest for your best bet at compliance and in demonstrating compliance as we talk about documenting things.

You've got that list there, that's a "such as" list from Medicare. So here are some things that you want to consider as sort of the whole host of comprehensive emergency treatment.

And have your medical director sit down and go through those and document that the medical director has just made a conscious decision of what will be stored and if you have a rationale and that will satisfy your surveyor.

And if it doesn't then that's a call that you need to make to either me or the compliance team or whoever so that we can make clear to the surveyor that this is a list that is a suggest list.

They did the same thing with equipment in ORs from Medicare. Once the medical director makes a conscious and informed professional medical decision that's sort of what the expectation is.

(Jennifer): Okay. So we could not have an anticonvulsant in our kit if we had...

Tom Terranova: Correct.

(Jennifer): ...or a justified reason why we don't carry it?

Tom Terranova: Right.

(Jennifer): Okay. And then I have another question about the equipment that's being checked yearly. We had a consultant come through to help us out which she said that the surveyors are looking to make sure our blood pressure cuffs are checked or calibrated yearly.

That's a new one. I don't know of anyone that checks blood pressure cuffs so I was wondering if they just want us to make sure that it's calibrated to zero on the, you know, on the meter or what they're looking for as far as checking...

Kate Hill: We don't look at that. But I'll tell you what the safest thing on this subject always is to go back to the manufacture and ask that manufacturer, do your cuffs need calibrating once a year? And then we'll all learn? A matter of fact I might just do that after this call. Because we have not looked...

(Jennifer): Right.

Bill Finerfrock: That was my problem.

Kate Hill: (Unintelligible) thing always to do.

Bill Finerfrock: My blood pressure wasn't elevated. They didn't have their cup calibrated.

(Jennifer): Well that was a big one. And, you know, we do a lot of our - all of our equipment is checked like you guys said electronically. You know, they come do it with the scanner and there's a sticker on it, doesn't have a date on it.

So I've created a list that has all of our equipment with the dates that they check it yearly just so I have it on-site. So would that be sufficient for someone that has all their stuff checked electronically?

Kate Hill: Absolutely.

Tom Terranova: Yes. You know some - the stickers are the easy test. And sometimes you get a surveyor who says well there was no sticker on that. Well that doesn't really matter.

If there was no sticker on it but you have a log that shows that here's my - here's the model number whatever, here's the serial number of this equipment and here's my spreadsheet and my report from my technician that's sufficient. You don't need to have that sticker.

(Jennifer): Perfect. Because will have the sticker that says Aramark and it's got the barcode which is, you know, they come through with the scanner and then we have a running list of everything too. So if that's efficient then we're in good shape. Thank you.

Bill Finerfrock: Yes good. Operator how many - do we have more questions in the queue or...

Coordinator: I have four questions left sir.

Bill Finerfrock: Okay. Tom and Kate I know we're up on the time here. Do you have time for a couple more questions or do you need to run or...

Kate Hill: Oh, absolutely.

Tom Terranova: I'll stay.

Bill Finerfrock: Okay. All right why don't we see if we can get through these but we're going to have to probably the - this - these four will have to be it.

Coordinator: Thank you.

Bill Finerfrock: Go ahead. Who's next up?

Coordinator: Our next question comes from (Molly). Your line is open.

Bill Finerfrock: Go ahead (Molly).

(Molly): Hi. This is (Molly) from Lancaster, Wisconsin.

Bill Finerfrock: All right.

(Molly): We are working on getting our clinics set up on rural health. And we are just having some questions as far as hour postings and stuff like that.

If your hours were to change for some reason you had to close a clinic due to weather or, you know, no provider on site or something what are the guidelines to be notified? Like we were told that, you know, you have to post it within so many hours and stuff like that.

Kate Hill: You need...

Bill Finerfrock: And so this is a unique situation. This is not so something acute episodic event occurred that you wouldn't have your clinic open for a particular day, weather, somebody sick or something like that as opposed to you have your signage out that says you're open, you know, 8:00 AM to 5:00 PM?

(Molly): Yes.

Bill Finerfrock: Okay.

Kate Hill: So it should be posted on the door. It should perhaps be on your answering machine and if you have a Web site it should be posted there when it's scheduled like you're talking about.

(Molly): Okay. So if we - as long as we change our voicemail and have it posted on the door that we need it - okay. We were - we would be good with that?

Bill Finerfrock: As long as it's just an acute episodic. If you're permanently changing, then your signage would need to change to reflect that but if it's an episodic event then it's just a type of notification.

(Molly): Okay all right. Thank you.

Bill Finerfrock: Okay, great next question.

Coordinator: Next question comes from (Tammy). Your line is open.

(Tammy): Hi. I'm from Marion, Kansas, and my question is on the multidose vials that they were subject to the 28 or 30 days once they're opened. Does that apply to immunizations also?

Tom Terranova: I am going to defer to Kate as the nurse because I am not clinical. But what I would say is again, you know, when you - most agents, you know, all of the drugs in agency whether cleaning supplies really everything has its own breakdown period I know.

And so I know we have a couple of drugs in the surgery realm where you have a week once it's opened. And so your expiration date might be six months out but you only have five days or six days after you open it.

And so I think wherever you - wherever your agency stores that appropriate information that's really what you need to be following and that's what they're checking.

And that's what you have to initial who opened it and when it was opened so that we can kind of gauge if it's gone too long. Kate do you have any other thoughts on that?

Kate Hill: Yes. It's an unfortunate one. But it's really all about aside from the degradation of the drug it's also all about sterility and how many times you're puncturing that rubber stopper and you're risking infection.

And so I - it's a cost issue with immunizations. I've come across this before. It's unfortunate but I believe it does hold to the 28 to 30 days.

(Tammy): Okay. Thanks so much.

Bill Finerfrock: Okay.

Coordinator: Next question will come from (Daphne). Your line is open (Daphne).

(Daphne): Hi. This is (Daphne) from Heart of America Johnson Clinic in Rugby, North Dakota. My question is in regards to consents.

Here at our facility we require patients to sign the consent upon check-in once a year. However if there is a consent that is needed for a procedure of some sort the nurses, doctor, practitioner will get that consent sign formed. Does it need to be more than once a year for a consent form general?

Kate Hill: Not to my knowledge no except for special procedures like you're talking about.

Tom Terranova: Correct.

(Daphne): Okay. Thank you.

Bill Finerfrock: Okay.

Coordinator: Our last question comes from (Janel). Your line is open.

(Janel): Hi. I'm (Janel) from Baudette, Minnesota. And the last gal from Rugby just answered my question so I'm going to make this real short. Thank you.

Bill Finerfrock: All right. Well thank you to everybody who participated in today's call. And in particular I want to thank Tom Terranova from Quad A and Kate Hill from the Compliance Team for taking time out of their schedules to chat with you today bring forward some of these issues. I have certainly found it helpful and educational. And we look forward to continuing to work with both the Compliance Team and Quad A.

And if you have questions did either of you want to give out any contact information for yourselves if folks had a question or wanted to follow-up with you directly? Here's an opportunity if you wanted to do that.

Kate Hill: Well thank you very much. I actually wanted to do that. So it's Kate Hill. And an email it's very easy is khill@tctinc.us. And certainly the phone number 215-654-9110. And thank you very much. This has been absolutely wonderful.

Bill Finerfrock: And just so people know, you're based in...outside - you're on the East Coast. You're in Pennsylvania. So...

Kate Hill: Right near Lancaster.

Bill Finerfrock: And Tom did you want to give out any contact information?

Tom Terranova: Of course. So mine is very easy as well. It's Tom T-O-M@aaaas "S" as in Surgery, "F" as in facility.org. And I am going to also throw my Associate Director of Accreditation, (Jeanne Henry) out to you because she is actually far better at the detailed standards questions than I am. And she's much more available than I am typically.

And her email is Jeanne J-E-A-N-N-E@aaaasf.org. And we are based just near Chicago so we're on the Central Time Zone and will do the best we can to respond to any questions you have as soon as possible.

Bill Finerfrock: Great. And again I want to thank everybody for participating. I want to also extend our appreciation to the National Organization of State Offices of Rural Health and the Federal Office of Rural Health Policy for supporting this Rural Health Clinic Technical Assistance Series.

I want to encourage everyone to if you know folks who would benefit from this please encourage them to go and sign up to be a participant and get the notification about our calls.

And also if you have subject ideas for topics that you'd like to hear a call about please send that to info@narhc.org and put RHCTA topic in the subject line.

We will have our next call hopefully in the next month or so and we'll be putting out an announcement on that. This concludes today's call and we appreciate everyone's participation. Operator?

Coordinator: At this time now we conclude today's conference. You may disconnect. And thank you for your attendance.

END