FTCA Deeming Application Evaluation Self Checklist

CY 2017 HEALTH CENTER FTCA APPLICATION

2017

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The following forms are evaluation tools to help you evaluate your calendar year (CY) 2017 Health Center FTCA Application prior to submission. The information contained within this document is guidance on how to create strong policies for your FTCA application and to ensure that you are providing sufficient information related to the policies, procedures and activities that you have implemented within your health center. Please note, all areas of the application are not covered in this document. Please see Program Assistance Letter (PAL) 2016-03 for exact application information. You should also review Policy Information Notices 2001-16, 2002-22 and the FTCA Policy Manual for complete policy information and regulations. In addition, for more helpful resources please utilize the following sites:

ECRI Institute at ECRI Website

FTCA/BPHC Help Line:

Phone: 1-877-974-BPHC (877-974-2742)

9:00 AM to 5:30 PM (ET)

Online Contact: contact us

FTCA Website: **FTCA Website**

Forms in This Review Packet:

Referral Tracking (RT)

When reviewing the Referral Tracking policy, please ensure that the policy at a minimum addresses the following elements (Click link for Webcast: General Information and Risk Management)

Category	Element of Policy	Present	Not Present	Notes
RT.1	The health center has implemented a system to track all referrals from their origin until they are returned and evaluated by a provider. This tracking system should include: • The origin of the referral • Status of the referral • The administrative and clinical details of the referral			
RT.2	The health center follows up with referral provider(s) in a timely manner to ensure that information is received back from the referral provider(s). This must include: • Specific process and timeframes for the transmission and receipt of referral results. • Specific process and times frames for follow-up if results are not received in timely manner.			
RT.3	The health center clearly identifies titles of health center staff who are responsible for executing each of the duties throughout the referral tracking process.			
RT.4	The heath center documents all patient referrals in the patient's medical records and makes documented efforts to follow up with patients who miss referral appointments. This must include number of attempts that will be made and the manner in which those attempts will be made (i.e., two phone calls, one certified letter with mail delivery confirmation).			
RT.5	The policy has been signed and approved by the Governing Board or the individual or the committee that the Governing Board has delegated review and approval authority to. If delegation of authority has occurred, there should be a clear delegation of authority statement within the policy.			

Hospitalization Tracking (HT)

When reviewing the Hospitalization Tracking policy, please ensure that the policy at a minimum addresses the following elements (Click link for Webcast: General Information and Risk Management)

Category	Element of Policy	Present	Not Present	Notes
HT.1	The health center has a tracking and monitoring system for receiving information regarding hospital or ED admissions. At a minimum the tracking system must include: • Patient information • Date of admission or visit • Date of notification • Reason for visit, if known • Documentation received • Documentation requested (includes date requested) Follow-up initiated with hospital and or patient (includes date initiated). Note: This relates to admissions where the health center sends the patient to the ED and cases where the patient may have entered the ED on their own.			
HT.2	The health center has identified staff members, by title, who are responsible for receiving ED and hospital admission information and monitoring the mechanism that is utilized for receiving hospital and ED admission information.			
HT.3	The health center has implemented a mechanism to follow up with the patient, provider, or outside facility to request pertinent medical information (e.g., diagnostic studies, discharge summary) related to a hospital or ED visit.			
HT.4	The policy has been signed and approved by the Governing Board or the individual or the committee that the Governing Board has delegated review and approval authority to. If delegation of authority has occurred, there should be a clear delegation of authority statement within the policy.			

Diagnostic Tracking (DT)

When reviewing the Diagnostic Tracking policy, please ensure that the policy at a minimum addresses the following elements (Click link for Webcast: General Information and Risk Management)

Category	Element of Policy	Present	Not Present	Notes
DT.1	A tracking and monitoring system is maintained for all diagnostic orders. The system must include at a minimum: • Patient information • Date test ordered • Ordering provider • List of tests ordered • Date results received • Provider who reviewed results • Follow-up recommended by provider • Communication of results to patient, including unsuccessful communication attempts and follow-up			
DT.2	The policy speaks to agreements with lab vendors which clearly define "critical lab values" and processes for contacting the health center providers. If the health center provides on-site lab services, the policy speaks to the lab policies and procedures, clearly defining "critical lab values" and notification procedures.			
DT.3	For **Critical Test Results**: • Time frame for communication of results to patients • Acceptable means of communication to provider and patient (e.g., verbal contact only) • Procedures for contacting back-up or surrogate providers if ordering provider is not immediately available to receive results • Every effort is made to contact patient for follow-up (e.g., visiting shelter, enlisting help from authorities) • Documentation of successful and unsuccessful attempts to contact patient • Tracking critical lab tests, monitoring to ensure no problems arise, audits reported to QI/QA committee as part of the program.			
DT.4	For **Abnormal Test Results**:			

Category	Element of Policy	Present	Not Present	Notes
	• Acceptable means of communication to provider and patient (e.g., verbal, electronic) • Timeframe for communicating results to patient (e.g., not to exceed 14 days) • Efforts made to contact patient for follow-up (e.g., visiting shelter, enlisting help from authorities) • Documentation of successful and unsuccessful attempts to contact patient (notification should include more than just a certified letter).			
DT.5	Responsibility is assigned for documentation of all pertinent diagnostic tracking activities and is maintained as part of the patient's medical record to include the following items: • Acknowledgment of receipt of result • Actions taken related to the patient • Patient notification, including date and time of notification, means used to communicate results (e.g., phone call, letter), and person spoken to (if applicable) • All attempts to contact the patient if the patient cannot be reached • Other clinical information as appropriate			
DT.6	The policy has been signed and approved by the Governing Board or the individual or the committee that the Governing Board has delegated review and approval authority to. If delegation of authority has occurred, there should be a clear delegation of authority statement within the policy.			

QI/QA Plan (QP)

For the purpose of this tip sheet, we have decided not to focus on the elements of the QI/QA plan. For additional QI/QA Plan guidance, please utilize the TA resources on the FTCA website (click link for webcast: Quality Improvement and Quality Assurance, Professional Liability and EHB Updates).

Category	Element of Policy	Present	Not Present	Notes
Quality Improvement and Quality Assurance Plan				
QP.1	The health center has included a Quality Improvement and Assurance Plan that has been board approved within the last 3 years.			

QI/QA Committee and Board Minutes (QM)

When reviewing the QI/QA minutes, please ensure that the minutes at a minimum addresses the following elements.

Category	Element of Policy	Present	Not Present	Notes
QI/QA Committee Meetings				
QM.1	The QI/QA committee minutes demonstrate that the QI/QA committee has met at least six times in the past year, or provides a valid explanation if less than 6.* The minutes must at a minimum include: • Dates of the meetings • Attendees and absentees, identified by title and name • Summaries			
QM.2	The QI/QA committee minutes demonstrate that the health center has clear data-driven performance goals and regularly discusses objectives, action steps, improvement activities and proactive problem identification. This includes the following: • Identification of responsible parties • Assigned tasks • Open action items • Closed action items			
QM.3	The QI/QA minutes demonstrate that the health center utilizes a recognized methodology to monitor, analyze, and evaluate their data driven QI/QA projects (i.e., PDSA).			
Board Minutes				
QM.4	The Board minutes demonstrate that the QI/QA committee has reported its findings and recommendations to the Board at least six times in the past year. This information includes the following: • Summary of QI/QA projects • Baseline measures • Performance goals • Projected outcomes			

* Explanations that may be considered permissible include, but are not limited to, natural disasters and serious health center emergencies that make it impossible for the health center to conduct the required meetings. Unacceptable explanations include, but are not limited to, lack of attendance and conflicting schedules or vacation plans. This is applicable to the six sets of QI/QA committee minutes and the six sets of Board minutes.

Category	Element of Policy	Present	Not Present	Notes
	• Recommendations • Other activities and concerns related to QI/QA.			
QM.5	The Board minutes demonstrate that the Board reviews and approves health center policies and approves credentialing and privileging.			

Credentialing/Privileging Plan (CP)

When reviewing the Credentialing/Privileging Plan, please ensure that the policy at a minimum addresses the following elements (Click link for webcast: General Information and Risk Management).

Category	Element of Policy	Present	Not Present	Notes
Scope and Policy				
CP.1	The health center policy defines which providers (licensed independent practitioners [LIPs] and other licensed or certified practitioners) will be subject to the credentialing and privileging policies.			
CP.2	Policy states that credentials and privileges are reviewed at least every two years.			
CP.3	Policy states that renewal is reviewed by the Medical Director and approved by the Board of Directors (or delegated).			
Licensed Independent Practitioners (LIPs)				
CP.4	Primary source verification is obtained for the following: • Applicant's license • Applicant's education, training, experience • Applicant's registration • Applicant's certifications • Applicant's current competence • Applicant's ability to perform services for which privileges are requested			
CP.5	At least secondary source verification is obtained for the following: • Government-issued photo ID • DEA registration (if applicable) • Hospital admitting privileges (if applicable) • Immunization and PPD status			
CP.6	The health center queries the National Practitioner Data Bank (NPDB) at least every two years for LIPs.			
CP.7	The health center outlines a detailed appeals process for denied credentialing and/or privileging			
Other Licensed or Certified Personnel				
CP.8	The policy states that the health center requires that primary source verification is obtained for other licensed or certified personnel's current licensure, registration, or certification, and requires at least secondary source verification for: • Education and training			

Category	Element of Policy	Present	Not Present	Notes
	• Identification • DEA registration (if applicable) • Immunization and PPD status			
CP.9	The health center queries the NPDB every two years for each licensed or certified practitioner			
Privileging				
CP.10	The health center's policy is to obtain primary source verification of current competence for each service for which LIPs request initial privileges.			
CP.11	The health center's policy is to obtain at least secondary source verification of current competence for each service for which other licensed or certified providers request initial privileges.			
CP.12	The policy states that LIPs and other certified healthcare providers are privileged for specific services that he or she will provide in each of the health center's care delivery settings.			
CP.13	The policy indicates processes for malpractice claim review.			
CP.14	The health center policy states that it obtains primary source verification for the following while re-privileging: • Expiring or expired credentials • Peer-review results for the previous two-year period • Relevant performance improvement information			
Temporary Credentials and Privileges				
CP.15	The health center policy states that current licensure and competence are verified before temporary privileges are granted.			
CP.16	Policy states that temporary privileges are never granted for more than 120 days or for administrative purposes, such as when the LIP fails to provide information or when the health center fails to evaluate information in a timely manner.			
Approvals and Review				
CP.17	The policy has been signed and approved by the Governing Board within the past three years.*			
CP.18	The Governing Board approves or denies credentialing and privileging of all applicants in writing.			

* Please not that PAL 2016-03 does not state the credentialing policy must be approved within the past 3 years, but at least every 3 years or more frequently is a good standard to follow.

Staff Credentialing List (CL)

When reviewing the Credentialing/Privileging List, please ensure that the policy at a minimum addresses the following elements.

Category	Element of Policy	Present	Not Present	Notes
Full Staff Representation				
CL.1	Staff list includes all levels of staff (LIPs and other license and certified practitioners).			
CL.2	Staff listed indicates a full range of services as indicated in the health center's federally approved scope.			
CL.3	List includes names, title, hire date, current credentialing date, and next expected credentialing date.			
CL.4	Individuals who are not required by state law to be certified or licensed are listed and the health center has indicated that state law does not require that the individuals be licensed or certified**.**			
Execution of Plan				
CL.5	All current credentialing dates are within the past two years.			

Professional Liability History (PL)

When reviewing the Professional Liability History, please ensure that the answers at a minimum addresses the following elements (click link for webcast: Quality Improvement and Quality Assurance, Professional Liability and EHB Updates).

Category	Element of Policy	Present	Not Present	Notes
PL.1	Does the health center describe a claims management process and procedures for actual or potential claims?			
PL.2	The health center must provide an explanation of claims that occurred in the past five years. The explanation must include the name of the provider(s) involved, area of practice/specialty, date of occurrence, and a summary of allegations.			