

NCALHD ATTENDANCE ROSTER

June 17, 1999

44

(M) = 1999 Dues Paying Member
(E) = Executive Committee Member

Initial	County/Health Director
1	<u>TAG</u> Alamance/Tim Green (E) (M)
2	Alexander/Shelley Carraway (M)
3	<u>JAR</u> Anson/James Roosen (M)
4	<u>ASB</u> Appalachian Dist/Danny Staley (M)
5	<u>SHW</u> Beaufort/Tamara Hower Williams (M)
6	<u>SAJ</u> Bertie/ ^{JOHN SHAW} Jo Ann Jordan, RN, Interim (M)
7	<u>MJO</u> Bladen/Myra Johnson (M)
8	<u>DY</u> Brunswick/Don Yousey (E) (M)
9	Buncombe/George Bond (E) (M)
10	<u>DR</u> Burke/Mr. David L. Rust (M)
11	Cabarrus/Dr. William Pilkington (M)
12	<u>DW</u> Caldwell/Douglas W. Urland (M)
13	Carteret/Dr. J. T. Garrett (M)
14	Caswell/Anne Scott (M)
15	<u>BA</u> Catawba/Barry A. Blick (M)
16	Chatham/Wayne Sherman (M)
17	<u>ER</u> Cherokee/Elaine Russell (M)
18	<u>JEP</u> Clay/Janice Patterson (M)
19	Cleveland/Denese Stallings (M)
20	<u>MD</u> Columbus/Marian Duncan (M)
21	<u>AS</u> Craven/Wanda Sandele (M)
22	Cumberland/Jesse Williams, MD (M)
23	Currituck/John B. Sledge (M)
24	<u>AT</u> Dare/Anne B. Thomas (E) (M)
25	Davidson/Diane Crouse (M)
26	Davie/Barry Bass (E) (M)
27	<u>HD</u> Duplin/Dr. Harriette Duncan (M)
28	<u>BL</u> Durham/Brian Letourneau (M)
29	<u>JRS</u> Edgecombe/James Baluss (E) (M)
30	<u>SK</u> Forsyth/Sherman Kahn, MD (M)
31	Franklin/Keith Patton (M)
32	<u>BP</u> Gaston/Bruce Parsons (M) (E)
33	Graham/Marlene Orr
34	Granville-Vance Dist/W. Rodwell Drake, MD (M)
35	<u>GH</u> Greene/Douglas Harr, Ph.D. (M)
36	<u>HS</u> Guilford/Harold Gabel, MD (E) (M)
37	Halifax/Chris Szwagiel, PhD (M)
38	<u>WR</u> Harnett/Wayne Raynor (E) (M)
39	<u>RW</u> Haywood/ <u>Robert Wood</u> (E) (M)
40	<u>JM</u> Henderson/Tom Bridges (E) (M)
41	<u>CD</u> Hertford-Gates Dist/Curtis Dickson (M)
42	Hoke/Donald Womble (M)
43	Hyde/Linda Mayo (M)
44	Iredell/Raymond Rabe (M)

Initial	County/Health Director
45	Jackson/Randall Turpin (M)
46	Johnston/L. S. Woodall, MD (M)
47	<u>VI</u> Jones/ Vacant (M) <i>Luth Little</i>
48	<u>ML</u> Lee/Mike Hanes (E) (M)
49	Lenoir/Joel Huff (M)
50	Lincoln/Margaret Dollar (E) (M)
51	Macon/Ann Hyder (M)
52	<u>KR</u> Madison/Ken Ring (M)
53	Martin-Tyrrell-Washington Dist/Bill Burgess (M)
54	<u>PS</u> Mecklenburg/Peter Safer (M) <i>Safir</i>
55	Montgomery/Vacant (M)
56	Moore/Robert Whittmann (M)
57	Nash/William Hill, Jr. (M)
58	<u>DR</u> New Hanover/David Rice (M)
59	Northampton/Sue Gay, Acting (M)
60	Onslow/Vacant (M)
61	Orange/Dr. Rosemary Summers (M)
62	Pamlico/Jenny Lassiter (M)
63	PPCC Dist/Howard Campbell (M)
64	<u>JA</u> Pender/Jack Griffith, PhD (M)
65	<u>MR</u> Person/Marc Kolman (M)
66	<u>JM</u> Pitt/John Morrow, MD (E) (M)
67	<u>MC</u> Randolph/Mimi Cooper (M)
68	<u>TJ</u> Richmond/Tommy Jarrell (M)
69	<u>BS</u> Robeson/Bill Smith (E) (M)
70	<u>GM</u> Rockingham/Glenn Martin (M)
71	<u>SW</u> Rowan/Leonard Wood (E) (M)
72	Rutherford-Polk-McDowell Dist/Joyce Sluder, Interim (M)
73	<u>WR</u> Sampson/Wanda Robinson, Interim (M)
74	<u>CEH</u> Scotland/Curtis Holloman (M)
75	Stanly/Jim Jones (M)
76	Stokes/Colleen Bridger (M)
77	Surry/Walter Linz, MD (M)
78	Swain/Emma Waldroup (M)
79	Toe River Dist/Tommy Singleton, Acting (M)
80	Transylvania/Terry Pierce (M)
81	Union/Lorey White, Jr. (M)
82	Wake/Lou Brewer (M)
83	Wayne/Robert Peck (M)
84	Warren/Dennis Retzlaff (M)
85	<u>GD</u> Wilkes/George O'Daniel (M)
86	<u>FW</u> Wilson/Dr. Louis Latour (M)
87	<u>DB</u> Yadkin/Gayle Brown (M)

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OTHER ATTENDEES/GUESTS

NAME REPRESENTING

Stephen R Keener - Medleyburg County

Edna Proctor - NCRPH MESA

Phillip Tarts - COLUMBUS co.

Off. M. ... - DASH

icwin byam DHHS - DPH

Carmine Rocca - ANCBM

Dennis Harrington - local health serv.

Barbara Fuller-Smith, Office of Minority Health

Jocie Snowden - Sedgwick of The Carolinas

North Carolina Association of Local Health Directors

**Treasurer's Report
June 17, 1999**

	<u>CHECKING</u>	<u>SAVINGS</u>	<u>MONEY MKT.</u>	<u>CD</u>
Account Balance Brought Forward	\$ 30,827.86	\$ 33.04	\$ 309.26	\$40,000.00
Receipts:				
Interest Payments:				
May 1999 Statement	\$ 80.20	\$ 0.10	\$ 1.20	\$ -
Federal Back-up Withholding:				
May 1999 Statement	\$ (21.52)	\$ (0.03)	\$ -	\$ -
Maintenance/Service Fee:				
May 1999 Statement	\$ (1.00)	\$ -	\$ -	\$ -
Deposits:				
Transfer from Checking	\$ -	\$ -	\$ -	\$ -
Transfer from Money Market	\$ -	\$ -	\$ -	\$ -
Dues	\$ -	\$ -	\$ -	\$ -
Total	\$ 30,885.54	\$ 33.11	\$ 310.46	\$40,000.00
Expenses:				
# 0777 NC HealthCare Info. - Acct. #116	250.00			
# 0778 Greensboro-High Pt Marriott - Acct #114	76.32			
# 0779 Harnett Co Health Dept - Acct #113	100.77			
Total Expenses May 1999	\$ 427.09			
Account Balance as of 6/17/99	\$30,458.45	\$ 33.11	\$ 310.46	\$40,000.00



SCOTLAND COUNTY HEALTH DEPARTMENT

1405 West Boulevard • Post Office Box 69
Laurinburg, North Carolina 28353-0069
Phone (910) 277-2440 Fax (910) 277-2450

Administration 277-2485
Adult Health 277-2449
Animal Control 277-2490
Child Health 277-2452
Environmental 277-2492
Family Planning 277-2455
Health Education ... 277-2432
Immunizations 277-2482
Maternity 277-2467
TB/STD/AIDS 277-2463
Vital Records 277-2471
WIC/Nutrition 277-2458

Curtis E. Holloman
Health Director

May 27, 1999

Dear Colleagues:

The Education and Awards Committee is pleased to invite you to nominate someone for Health Director of the Year. Recognition was bestowed last year upon Mimi Cooper, Randolph County Health Director. This distinction and the Ham Stevens Award are two opportunities for the Association to honor a local health director for outstanding performance and accomplishments.

Enclosed is background information regarding the award and criteria. Also enclosed, are the instructions and a Nomination Form. Information may also be retrieved from the N. C. Association of Local Health Director's Webb Site.

The deadline for submission of nominations is June ³⁰16, 1999. This will allow the committee ample opportunity to consider each nomination and announce the recipient at the Association of County Commissioners' Annual Meeting in July. Please send your completed nominations to:

Curtis E. Holloman, Chairman
Awards and Education Committee
Scotland County Health Department
P. O. Box 69
Laurinburg, N. C. 28353

We look forward to receiving your nominations. If you have any questions, please call me at (910) 277-2499.

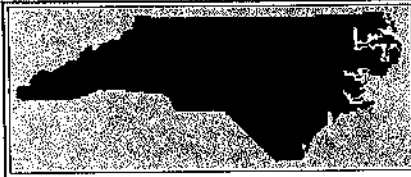
Thank you for your assistance.

Sincerely,

Curtis E. Holloman
Health Director

CEH/lm
Enclosures

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North Carolina Association of Local Health Directors

Scholarships to NACCHO Annual Conference

1. The North Carolina Association of Local Health Directors (NCALHD) will award \$ 3,000 in scholarships annually to association members to attend the National Association of county and City Health Officials (NACCHO) Annual Conference.
2. A local health director must submit all receipts to the Association for reimbursement of expenses to the NACCHO Annual Conference. The NCALHD will reimburse up to the amount allocated by the Executive Committee each year.
3. All members of the Association are eligible for the scholarships. However, we ask any health director who has monies budgeted for the NACCHO Annual Conference not apply for the scholarships, since the intent of the scholarships is to provide funding for those health directors who otherwise would have no means of attending the NACCHO Annual Conference.
4. Requests for scholarships will be made on a form provided by NCALHD, which can be found by [clicking here](#).
5. Application forms for scholarships will be mailed to local health directors annually by January, by the Chairman of the Education Committee. All requests for scholarships must be returned to the Education Committee Chairman by March 1.
6. Forms will be reviewed by the Education Committee to ensure that they are complete.
7. At the March meeting, the president will randomly select forms from a container holding the requests. The top ten selections will be documented so that if any of the candidates decide not to attend, alternates will have been selected to take their place.
8. Candidates receiving the scholarships one year will not be eligible to receive the scholarships the following year.
9. The Executive Committee has the authority to increase or decrease the number of scholarships and the amount of the scholarships awarded each year based upon the financial health of the Association and the cost of attending the NACCHO Annual Conference.
10. Requirements for application and granting of the scholarships include the following:

- a. Membership in NCALHD

<http://204.211.78.102/ncalhd/naccho.htm>

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5/27/99

NORTH CAROLINA HEALTH DIRECTOR OF THE YEAR AWARD

Background

The North Carolina Health Director of the Year Award was sanctioned by the North Carolina Association of County Commissioners (NCACC) and implemented through the North Carolina Association of Local Health Directors (NCALHD), an affiliate of the NCACC. The Awards and Education Committee of the NCALHD requests nominations to be made each Spring. Nominations are generally received from local health directors, local and state public health workers, local Boards of Health members, elected officials, and local citizens at large.

Criteria

The following criteria are used by the Awards and Education Committee for selecting the recipient of the Health Director of the Year Award:

1. The Health Director of the Year will have been a health director in North Carolina for at least five years.
2. The Health Director of the Year will not have been President of the North Carolina Association of Local Health Directors during the past two years.
3. The Health Director of the Year will be a paying member of the North Carolina Association of Local Health Directors.
4. The nomination for the Health Director of the Year will describe the nominee's involvement/leadership/achievement in public health in North Carolina.
5. The nomination for the Health Director of the Year will describe the nominee's involvement/leadership/achievement in public health in North Carolina.
6. The nomination for the Health Director of the Year will describe the nominee's involvement/leadership/achievement in his/her community (church, civic clubs, etc.).

**NORTH CAROLINA ASSOCIATION OF LOCAL HEALTH DIRECTORS
HEALTH DIRECTOR OF THE YEAR AWARD
NOMINATION FORM**

Name of Nominee _____

Address of Nominee _____

Home Phone # of Nominee _____ Business Phone # _____

Name of Nominator _____

Address of Nominator _____

Home Phone # of Nominator _____ Business Phone # _____

INSTRUCTIONS

1. The Awards and Education Committee is very interested in the activities of the Local Health Director since January of the previous year. Career accomplishments will also be considered.
2. Nominations will be returned if they exceed four pages, including this page.
3. No letters of support will be accepted other than a letter from the nominator.
4. Nominations must be returned by June 16, 1999 to the Chairman of the Awards and Education Committee.

Environmental Health Committee
June 16, 1999
Minutes

Members Present: MiMi Cooper, Doug Urland, Terry Pierce, David Rice, John Morrow, Anne Scott,
Gayle Brown, Don Yousey

Guest Present: Linda Sewall

I. Update on Reorganization

Don Yousey reviewed the list of counties which have adopted the Reorganization Resolution. Seventy-five Boards of Health and sixty-two Boards of County Commissioners have adopted the resolution as of this date. Don and Carmine Rocco of the Association of Boards of Health contacted those counties who had not adopted and encouraged them to do so.

MiMi sent a letter concerning reconvening the stakeholders group to Secretary McDevitt and others. A response was received from Sherri Evans-Stanton agreeing with our concerns and to working with us in a stakeholder's format. The committee members were reminded that the House members of the ERC were not appointed during the session therefore a decision on reorganization would not take place until the next session of the General Assembly.

II. Hog Caucus

MiMi reported on the meeting of the Hog Caucus, a group of local health departments who share public health concerns over intensive livestock operations. The meeting was held in Wilson on June 4th and the following recommendations were made:

1. Send a letter to Dr. Roper commending him for the School of Public Health report on Human Health and Intensive Livestock Operations. Include a copy of the document that Melva Okum did for the Health Directors Association and encourage further study of several issues brought up in that document.
2. Send a letter to the legislators who are working on the moratorium on ILO's and encourage them to look at land use planning around other intensive farms in addition to hogs; chickens etc.
3. Encourage support of any efforts to promote statewide local well protection programs. This would include encouraging the NCALHD to make this a legislative priority.
4. Participate in the DAQ adoption of permanent rules for Odor Control with the purpose to strengthen the response.

The committee thought all these recommendations had merit and will assist the hog caucus in whatever way they need. Discussion then centered on the option of requiring well programs in counties before Community Development Block Grant funding could be received. Also discussion focused on the expansion of the straight pipe program to include the well program. Don Yousey asked for information about NC State University's research into closed systems for waste.

III. Division Report

Linda Sewall brought to our attention a document produced by FDA, Guide to Minimize Microbial Food Safety Hazards for Fresh Fruits and Vegetables along with ordering information. Linda reported the loss of two positions in the Division, one being the recent position moved from Milk Sanitation. The funds for Centralized Training were left in the budget but not as a recurring expense. Linda reported that Susan Austin, an intern from the Governor's Management program would be working with the Division for two years and will specifically be working on rural water and wastewater systems. In other business Linda reported:

- The restaurant rules review committee will meet and talk about the surveys from the pilot projects. A recommendation will go to the CHS in August.
- The Ecology of Health and the Environment Conference* is being planned in accordance with Dr. McBride's plan to host such a conference in our State. Leah Devlin is looking for input from local health directors.
- The revised reimbursement procedures for EH interns have been drafted into a memo as reported to our committee in May. The committee found the changes to be in keeping with our suggestions.
- The results of a survey done by the EH Supervisors Association were shared for our information.

Having no further business the meeting was adjourned.

MARK YOUR CALENDAR

One-Day Seminar For
Healthcare Professionals

HEPATITIS C: A Community Problem

Friday, August 20, 1999
Winston-Salem, North Carolina

Brochure to follow or
for additional information call the
Northwest Area Health Education Center
(336) 713-7000



The Wake Forest University School of Medicine
is accredited by the Accreditation Council
for Continuing Medical Education (ACCME)
to sponsor continuing medical education
for physicians.



Sponsored By:

- Forsyth County Department of Public Health
- Northwest Area Health Education Center
- Wake Forest University School of Medicine

Topics will include:

- ☞ Natural History of Hepatitis C Infection
- ☞ Diagnosis and Testing
- ☞ Mechanisms of Spread and Prevention of Transmission
- ☞ Management and Treatment of Hepatitis C
- ☞ Monitoring of Infected Persons
- ☞ Counseling
- ☞ Prevention and Control Measures
- ☞ Long Term Consequences of Infection
- ☞ Hepatitis C and Healthcare Professionals

Edgecombe County Health Department

Main Office
2909 Main Street
Tarboro, North Carolina 27886



Branch Office
107 Atlantic Avenue
Rocky Mount, North Carolina 27801

MEMORANDUM

TO: Barry Blick, Catawba County
Dennis Retzlaff, Warren County
Ann Thomas, Dare County
Shelley Carraway, Alexander County
Christopher Szwagiel, Halifax County
Harriette Duncan, Duplin County
Jack Griffith, Pender County
John Morrow, Pitt County
Steve Keener, Mecklenburg County
Robert Peck, Wayne County
Dennis Harrington, NC DHHS
Chris Hoke, NC DHHS
Torlen Wade, NC FAHP, Inc.
Jackie Sergent, Granville-Vance District
Joy Reed, NC DHHS

Marion Duncan - Columbus Co
Harold Gables - Guilford Co.

FROM: Jim Baluss, Chair

RE: Managed Care Committee Meeting

DATE: June 14, 1999

As your calendar hopefully records, we have a committee meeting set for 3:00 PM on Wednesday, June 16th at 1330 St. Marys Street, Raleigh. Marc Kolman, Chair of the Technology Committee and myself are encouraging a joint meeting based on the obvious convergence of our respective committee's interest in the development of an enhanced Public Health information system. Marc's committee will be meeting from 1-3 PM in the same place we are scheduled to meet from 3-5 PM. If your schedule permits, I urge all Managed Care Committee members to "come early" (i.e. 2:00 PM) for a briefing with the Technology Committee. Following that our regular meeting will commence at 3:00 PM.

If you are unable to attend, please contact Leigh Moore at (252) 641-7519 or e-mail me at ncs0845@interpath.com. Thank you and I look forward to seeing you at this important meeting.

c: Wayne Raynor
Maggie Dollar

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Edgecombe County Health Department

Main Office
2909 Main Street
Tarboro, North Carolina 27886



Branch Office
107 Atlantic Avenue
Rocky Mount, North Carolina 27801

MEMORANDUM

To: Member & Liaisons
NCALHD Managed Care/Reimbursement Committee

From: James R. Baluss, Health Director *J. Baluss*

Date: June 14, 1999

Re: "Home Work" Assignment for Wednesday's (16th) Committee Meeting

At our May meeting, there was considerable interest in a special project for our committee in which we would begin to define definitions for "billable encounters" for unique Public Health activities (known variously as "population based/preventive health services).

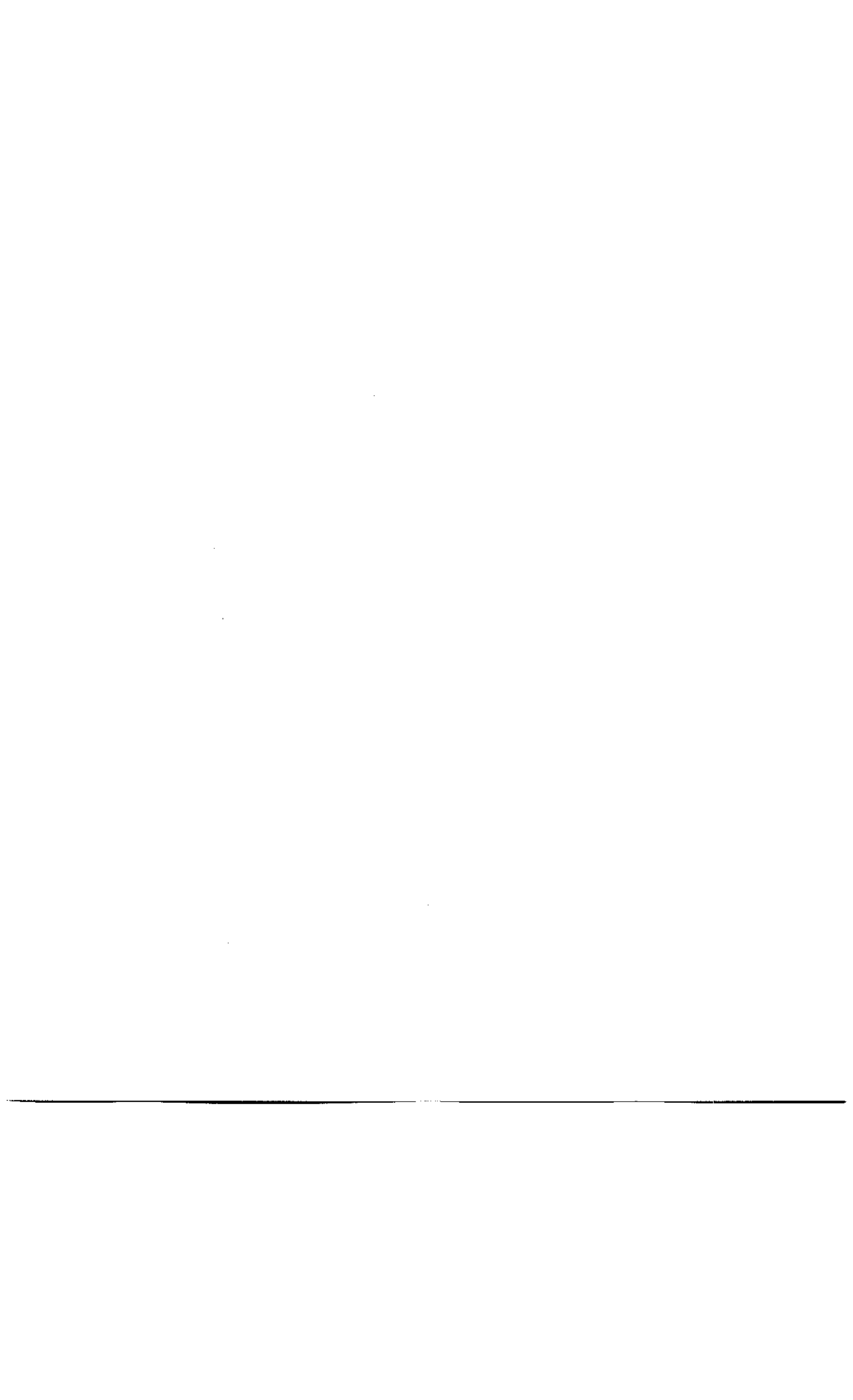
The purpose of this exercise is two-fold. First, we need to define and refine the definitions of these rather poorly understood, yet important services (e.g. we understand "core functions" but many do not). Secondly, to think about how to market these services to prospective pay sources (in Medicaid Managed Core Models) to private MCO's and/or to our DHHS "bundled service" payers.

Dr. Steve Keener has provided an excellent starting point in suggesting we use Public Health "performance measures" as a general framework for defining marketable and billable activities which reflect our (currently unfunded to a large degree) "core functions".

To aid us in brainstorming this concept, Steve has provided, and I am forwarding for your review, a document entitled "A Strategy for Measuring Local Public Health Practice".

Again, I emphasize the task: To attempt to begin defining basic Public Health functions in such a way as to enable marketing discreet, billable "encounters" which reflect consensus as to what Public Health should be about.

Please come to our next meeting!



DENTAL MEDICAID

Comparison of Per Visit vs. Fee-for-service Reimbursement

Introduction: Currently, health departments providing dental care to patients enrolled in Medicaid are reimbursed at a flat rate of \$100.00 per visit (PV) regardless of the number of services provided to that patient. Private dental practitioners, however, are reimbursed up to a maximum allowable Medicaid fee for each dental service provided, a system known as fee-for-service (FFS) reimbursement. Medicaid is planning to eliminate the per-visit reimbursement mechanism -- raising concern about the potential fiscal impact of this proposed change on Health Department dental clinics. Below is a table comparing reimbursements of typical dental visits.

Visit Type	Examples of Typical Dental Procedures	Per Visit Rate	Current Medicaid Rates ¹	80% UCR Medicaid Rates ²
New Patient Exam Visit	Initial exam (D0150) Two bitewing radiographs (D0272) Dental prophylaxis and topical fluoride (D1201)	\$100.00	\$76.43	\$99.36
Recall Exam Visit	Recall exam (D0120) Dental prophylaxis and topical fluoride (D1201) (Bitewing radiographs (D0272) likely will be provided at approximately half of all recall exam visits.)	\$100.00	\$61.56	\$30.16
Preventive Visit	Four dental sealants (D1351)	\$100.00	\$101.34	\$132.39
Simple Restorative Treatment	Two 2-surface amalgam fillings (D2110) One dental sealant (D1351)	\$100.00	\$94.76	\$123.19
Complex Restorative Treatment Visit	One pulpotomy (D3220) Two stainless steel crowns (D2930) One 1-surface composite filling (D2331)	\$100.00	\$295.52	\$384.13
Emergency Visit	Emergency exam (D0140) One periapical radiograph (D0230) One extraction (D7110)	\$100.00	\$83.56	\$108.63

1. Current Medicaid FFS Rates as of 1/1/99

2. Assumes a 30% increase in FFS reimbursement when Medicaid rates are raised to 80% UCR.

There are many factors that will affect how a conversion from PV to FFS reimbursement will impact the bottom line for a public health clinic. These include, clinic staffing pattern, level of experience of the dentist and auxiliary staff, facility size, hours of clinic operation, time required for various dental visits, dental needs for the patient population, mix of third-party payment sources (e.g., Medicaid, Health Choice, self-pay), and broken appointment rate.

In its report to the NC General Assembly, the NC Institute of Medicine Task Force on Dental Care Access chaired by Lt. Governor Dennis Wicker has recommended that the Division of Medical Assistance increase Medicaid reimbursement rates to 80% of usual, customary and reasonable (UCR) rates. If enacted, this increase would benefit Medicaid patients served by all dental providers including public health department dental clinics.

NORTH CAROLINA ASSOCIATION of LOCAL HEALTH DIRECTORS

An Affiliate of the North Carolina Association of County Commissioners

TO: Leah Devlin, D.D.S.
FROM: Maggie Dollar *MM*
RE: Medicaid Reimbursement for Dental Services
DATE: June 10, 1999

Leah, since our last Association meeting at which you reported for Dr. Steve Cline on the dental Medical reimbursement issue and handed out the current and proposed 80% UCR rates, four health departments with dental clinics have run the numbers and have reported back **PROJECTED LOSSES OF ANYWHERE FROM 10 TO MORE THAN 50% UTILIZING CURRENT RATES FOR FEE-FOR-SERVICE.** And we hear that the effort to raise Medicaid rates to 80% UCR (under which public clinics would still lose...just not as much) is "dead in the water".

So on behalf of NCALHD and those many health departments who have worked so hard to establish public dental clinics, and those still in the formative stages, I am writing to extend another request that Dr. Cline provide us with the numbers that will prove to us this is a good idea. Right now all we can see is that it is good for DMA, for they will save money. It won't be good for the thousands of children (and adults) who would otherwise have no dental care if it weren't for the existence of these health department clinics. Counties will not pick up the tab when clinics start losing money.

I thought I would send this to you since you were our last contact on this issue, with a copy to Dr. Cline. I will be in the office Monday and hope to hear from one or both of you then. All NCALHD Committees have been asked by Tim Green, State & Local Relations Chair, to look at this issue and provide feedback at our Association meeting next Thursday, June 17, 1999 at 9:00 at Wake Co. Public Health Center - Third Floor Board Room. We hope you and Dr. Cline can be in attendance. Since you are both dentists, we will rely on you to help us understand how this rate structure change will in reality help, not hurt, access to dental care in North Carolina.

As they say...**"SHOW US THE NUMBERS!!!"**

Thank you very much.

**Cc: Dr. Steve Cline - Acting Chief, Dental Health Services
NCALHD Committee Chairs & Officers
Dr. A. Dennis McBride - State Health Director
Dr. Ann Wolfe - Director, Division of Public Health
Mr. Dennis Harrington - Chief, Local Health Services Section**

President
Margaret B. Dollar, M.Ed.
Lenoir County Health Department
151 Sisson Road
Tiptonville, NC 28092
Tel: 704-736-8634
Fax: 704-732-9034
NC Courier #09-02-04

President Elect
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Fax: 828-692-4709
NC Courier #06-02-01

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Fax: 336-500-6746
NC Courier #17-12-03

Secretary/Treasurer
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Fax: 910-893-9429
NC Courier #14-73-01

Past President
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Robeson County Health Department
460 Country Club Road
Lumberton, NC 28358
Tel: 910-671-1700
Fax: 910-671-1484
NC Courier #14-02-02

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NORTH CAROLINA ALLIANCE
 OF PUBLIC HEALTH AGENCIES
 MINUTES
 May 20, 1999
 Marriott Hotel
 Greensboro, N.C.

Wilson County	Louis Latour, Ph.D., President	6/00
Robeson County	William Smith, Vice-President	6/99
Caswell County	Anne Scott, Secretary	6/99
Edgecombe County	Jim Baluss, Treasurer	6/00
Lincoln County	Margaret Dollar	6/00
Catawba County	Barry Blick	6/99
Davie County	Barry Bass	6/99
Nurs. Dir.-HH	Kay Cherry	6/01
Nurs. Dir.-PH	Barbara Stanley	6/01
DHHS	Dennis Harrington	6/99
State Health Dir. Designee	Joy Reed	Perm.
NC Assoc of Cty Comm	Ron Aycock	Perm.

The Alliance Board of Director's met on May 20, 1999. Members present were: Louis Latour, President; Barry Bass, Barbara Stanley, Maggie Dollar, Joy Reed, and Anne Scott. Additional guests attended as follows: Shelley Carraway, Chris Szwagiel and Diane Crouse.

The meeting was called to order by President Louis Latour. Ms. Maggie Dollar motioned to accept the April 14, 1999 minutes. Mr. Barry Bass seconded the motion and it was approved.

Dr. Latour presented a review of current fiscal information. After discussion, Ms. Maggie Dollar motioned to accept the May 17, 1999 Finance Report (included). Mr. Barry Bass seconded the motion. The Board of Directors approved the motion.

The nominating committee report from Mr. Baluss placed the following names in nomination for officers for the next term (starting July 1, 1999). The nomination for President/Treasurer is Dr. Chris Szwagiel, for Vice-President Bill Smith, and for Secretary Anne Scott. There being no additional nominations from the floor, Mr. Barry Bass motioned to accept the nominations as presented. Dr. Joy Reed seconded the motion and it was approved.

President Latour reported on the request from the NC Forest Service to provide physical exams for their officers. He detailed the many discussions that transpired between DFR (Division of Forest Resources), the Alliance and Dennis Harrington, representing DHHS. Over 25 counties expressed interest in providing services. In order to properly test the delivery system, six counties were chosen (Caldwell, Haywood, Rowan, Orange, Robeson and Wilson) to provide the physicals. Services will be billed through the Alliance at \$82 for "limited" and \$176 for a comprehensive physical. Alliance Board members expressed that this is truly what the Alliance was set up to do in the new order of doing business.

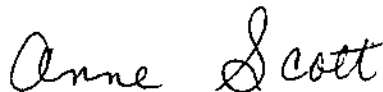
President Latour explained the efforts recently to discuss the possibilities of combining agencies under a common umbrella. The groups involved were the Health Director's Association, NC Association of Public Health, Association of NC Boards of Health and the Alliance of Public Health Agencies. The Board members discussed the positive feedback that all agencies involved were willing to move forward with such action.

A staffing report was discussed and is enclosed for your information.

Mr. Barry Bass motioned to commend President Louis Latour for a job well done as President and Acting Treasurer for the Alliance from July, 1997 to June, 1999. The motion was seconded by Ms. Maggie Dollar and approved.

Dr. Joy Reed motioned to adjourn, Ms. Maggie Dollar seconded and it was approved.

Respectfully submitted,



Anne Scott

Next meeting June 17, 1999 at 1:30 p.m. in Raleigh at Wake County Commons at room 104.

ALLIANCE PHONE NUMBER---1-888-691-4967

**Financial Status & Projections
As of May 17, 1999**

	ASSETS	Liabilities	Balance
Nations Bank	= \$ 34,100.91		
SECU Checking	= 634.24		
SECU Savings	= 1,790.16		
	Sub-Total = \$ 36,525.31		
County Staffing Receivables	27,657.37		
	Sub-Total = \$ 64,182.68		
Liability Insurance (Due -0-)	=	\$ Pd.	
Payroll for May 1-15 (est.)	=	17,000	
FUTA & SUTA, etc. (thru Acct.)	=	11,000	
VGM (est.)	=	160	
Young, Miller & Assoc. (Accountants)	=	200	
Misc. (Tests, etc.)	=	250	
	Sub-Total =	< \$ 28,610 >	
County Billing (May 1-15)	= \$ 20,000		
			\$ 55,573

EMPLOYEE TAXES

PAY PERIOD	GROSS PAY	NET PAY	FICA SS	FICA M/CARE	FED. W/H	STATE W/H	TRAVEL
JANUARY 1 - 15, 1999	\$14,711.03	\$12,840.85	\$893.22	\$208.89	\$1,375.28	\$668.99	\$1,419.67
JANUARY 16 - 31, 1999	\$18,345.08	\$15,790.93	\$1,105.69	\$258.60	\$1,772.72	\$863.61	\$1,448.47
TOTAL	\$33,056.11	\$28,731.78	\$1,998.91	\$467.49	\$3,148.00	\$1,533.60	\$2,868.14
FEBRUARY 1 - 15, 1999	\$17,739.57	\$15,588.54	\$1,081.24	\$252.87	\$1,664.47	\$829.58	\$1,768.01
FEBRUARY 16 - 28, 1999	\$17,679.92	\$14,808.46	\$1,086.86	\$254.17	\$1,705.28	\$636.00	\$1,086.91
TOTAL	\$35,419.49	\$30,387.00	\$2,168.10	\$507.04	\$3,369.75	\$1,465.64	\$2,854.92
MARCH 1 - 15, 1999	\$16,008.64	\$13,927.30	\$864.00	\$230.15	\$1,434.55	\$720.82	\$1,428.31
MARCH 16 - 31, 1999	\$20,823.83	\$18,097.93	\$1,263.36	\$295.43	\$2,058.70	\$982.81	\$1,502.40
TOTAL	\$36,832.47	\$32,025.23	\$2,247.36	\$525.58	\$3,493.25	\$1,703.73	\$2,931.71
APRIL 1 - 15, 1999	\$17,936.84	\$15,655.96	\$1,112.06	\$260.08	\$1,644.17	\$600.14	\$1,611.58
APRIL 16 - 30, 1999	\$22,316.70	\$18,621.10	\$1,380.21	\$322.79	\$2,261.85	\$1,075.38	\$1,430.34
TOTAL	\$40,253.54	\$34,277.06	\$2,492.27	\$582.88	\$3,906.12	\$1,675.52	\$3,041.92
MAY 1 - 15, 1999							
MAY 16 - 31, 1999							
TOTAL	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
TOTAL	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
TOTAL FOR MAY	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
TOTAL FOR MAY	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

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BOARD REPORT FOR
MAY 1999

Added 1 CNA's
1 RN

Lost 2 RN's

Active for the month of March

RNs 5 full time
6 part time

LPTA 1 part time

ST 1 part time

CNA's 24

Counties using staff in April - 9

Looking for CNA's for North Hampton
CNA's for Warren
CNA'S for Halifax
LAB TECH for Edgecombe
CNA's for Edgecombe

Have new contract with Edgecombe

New contracts for 99 - 2000 have been mailed out

Respectfully Submitted,



Sharon Helsher

Henderson County

Department of Public Health

1347 Spartanburg Hwy., Hendersonville, NC 28792

(828) 692-4223

FAX: 697-4709

Thomas D. Bridges, MPH, Director William R. Walder, MD, MPH, Medical Director



Fax Memorandum

TO: Wayne Raynor fax 910/814-4060
FROM: Tom Bridges
SUBJECT: NCALHD Policy and Planning Committee Report
DATE: June 23, 1999

Please find in this fax the NCALHD Policy and Planning Committee Report on its June 16, 1999 meeting. Our next committee meeting has been scheduled for Wednesday, July 14, 1999, from 3:00 p.m. to 4:00 p.m. at the NC Hospital Association, Cary, NC. Directions can be obtained by calling 919/677-4137.

3 additional pages to follow...

NCALHD Policy & Planning Committee Report**Meeting Date: June 16, 1999 3:00 p.m. - 5:00 p.m.****Location: Deborah Rowe's House**

Tom Bridges, Chair

The NCALHD Policy and Planning Committee held a joint meeting with the NCPHA Policy and Planning Committee and liaisons.

Action Items:

Motion: *That the NCALHD support the concept of "front-loading" the Health Trust at the same ratio/percentage as the Tobacco Trust.*

Discussion Items:

1. Legislation to fund Healthy Carolinians is not doing well. The House version is to fund \$ 1 million on a non-recurring basis. The Senate version contains no funding provision at all. Please refer to the handout and contact your legislators about your interest in funding on a recurring basis as originally proposed (\$ 3.6 million).
2. At last month's NCALHD meeting the Policy and Planning Committee recommended opposing HB 968 Amend Contested Case Procedure. The motion was later made during the meeting to defer the bill back to Policy and Planning to hear more discussion on the bill. Policy and Planning discussed the bill and decided to not support, nor oppose the bill. It is hoped, rather that the Senate will support the Governor on defeating this bill.

Enclosure

EMERGENCY CALLS NEEDED

HEALTHY CAROLINIANS APPROPRIATIONS

Healthy Carolinians funding *did* appear in the House Budget for \$1,000,000. However, it *did not* appear in the Senate budget. The budget will now go to a Conference Committee made up of Senators and Representatives. The Conference Committee will work out the differences between the two versions of the budget. Key Senators and Representatives who are likely to be on the Budget Conference Committee are listed below. It is critical to call these legislators and urge them to fund Healthy Carolinians. If you have a Healthy Carolinians task force, alert the coalition leadership and membership. Ask them to call these legislators and request Healthy Carolinians funding. The main telephone number to the legislative buildings is (919) 733-4111.

SENATORS

These three Senators are Chairs of the Senate Appropriation Committee – *everyone should call them:*

1. Sen. Beverly Perdue (Craven, Pamlico and Carteret Counties)
2. Sen. Aaron Plyler (Union, Stanly, Anson, Montgomery, Richmond Counties)
3. Sen. Fountain Odom (Mecklenburg)

It will help greatly if the President Pro Temp of the Senate hears from you urging that the Senate put Healthy Carolinians into the budget:

- Sen. Marc Basnight (Dare, Beaufort, Camden, Chowan, Currituck, Hyde, Perquimans)

If these are your Senators, call them and ask them to put funding for Healthy Carolinians in the budget. There is a strong likelihood that these Senators will be selected to be on the Conference Committee:

1. Sen. Austin Allran (Catawba and part of Lincoln)
2. Sen. Betsy Cochrane (Davie and part of Davidson)
3. Sen. Jim Forrester (Part of Iredell, part of Lincoln, part of Gaston)
4. Sen. Tony Rand (Cumberland)
5. Sen. Wib Gulley (Durham, Granville, part of Person, part of Wake)
6. Sen. Charles Albertson (Duplin, part of Sampson, part of Pender, part of Onslow)
7. Sen. Walter Dalton (Rutherford, part of Cleveland)
8. Sen. Howard Lee (Orange, Chatham, part of Randolph)
9. Sen. Ed Warren (Pitt, part of Martin)
10. Sen. Jeanne Lucas (Durham, Granville, part of Person, Part of Wake)
Primary Sponsor of the Senate Healthy Carolinians Bill.
11. Sen. Bill Martin (Guilford)
12. Sen. Charles Dannelly (Mecklenburg)
13. Sen. Luther Jordan (Jones, part of Onslow)
14. Sen. Frank Balance (Northampton, Halifax, Hertford, Gates, Bertie)
15. Sen. Bob Martin (Pitt, part of Edgecombe, part of Martin)
16. Sen. David Weinstein (Part of Cumberland, Robeson, part of Bladen)
17. Sen. Don East (Watauga, Ashe, Alleghany, Surry, Stokes, Rockingham)

(over)

REPRESENTATIVES

These three Representatives are Chairs of the House Appropriation Committee – everyone should call them:

1. Rep. Ruth Easterling (Mecklenburg)
Primary Sponsor on Healthy Carolinians bill.
2. Rep. Thomas Hardaway (Halifax, part of Nash, part of Bertie)
3. Rep. David Redwine (Columbus, Brunswick)

It will help greatly if the Speaker of the House hears from you urging that the budget keep Healthy Carolinians funds:

- Rep. Jim Black (Mecklenburg)

If these are your Representatives, call them and ask them to *keep* funding for Healthy Carolinians in the budget. There is a strong likelihood that these Representatives will be selected to be on the Conference Committee:

1. Rep. Bill Owens (Pasquotank, Camden, Currituck)
2. Rep. Gene Rogers (Bertie, Martin)
3. Rep. Flossie Boyd-McIntyre (Guilford)
4. Rep. Warren Oldham (Forsyth)
5. Rep. Thomas Wright (Part of New Hanover, part of Pender)
6. Rep. Margaret Jeffus (Guilford)
7. Rep. William Wainwright (Jones)
8. Rep. Beverly Earle (Mecklenburg)
9. Rep. Edd Nye (Bladen)
10. Rep. Ted Kinney (Cumberland)
11. Rep. Paul McCrary (Davidson)
12. Rep. Bill Culpepper (Washington, Tyrrell, Dare)
13. Rep. Stanley Fox (Vance, part of Granville, part of Henderson)
14. Rep. Nelson Cole (Rockingham)
15. Rep. James Crawford (Person, Granville, Franklin)
16. Rep. Martha Alexander (Mecklenburg)
17. Rep. Alex Warner (Cumberland)

TECHNOLOGY COMMITTEE MINUTES

June 16, 1999

The Technology Committee of the Health Directors' Association met on Wednesday, June 16, 1999, at 1330 St. Mary's Street, Raleigh, North Carolina. A list of attendees is attached for reference. Marc Kolman called the meeting to order at 3:10 p.m.

In response to Marc Kolman's motion for comments and approval of the Minutes from the May 18 meeting, there were two revision requests, specifically:

1. Revise the HSMS Modules List attached with the Minutes:

From:

Module Group	Module	Status for Version 1.0 / Action
Clinical	DEC	Required

To:

Clinical	DEC	Not-Required
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The revised Minutes from the May 18, 1999 meeting were approved unanimously. A copy is attached of the revised Minutes, including the updated HSMS Modules List.

The next order of business pertained to the status of the HSMS RFP project. Marc Kolman reported that the project continues adhering to the timetable presented at the May 18 Technology Committee meeting. Copies of the RFP draft are being distributed as scheduled today (June 16) to Steering Committee members for their review and comments.

Mark Kolman then reported on the status and activities of the NCALHD Steering Committee (SC), whose formation was approved at the May 18 Technology Committee meeting. The SC has achieved full membership. It has five voting members and three ex-officio (non-voting) members. The voting members are: Marc Kolman, Chair; George Bond, Dennis Harrington, John Sink, and Frances Taylor. The ex-officio members are: Donna Gregory, Kash Basavappa, and Chris Abernathy. The SC has met three times via teleconference in support of the RFP project. The members plan to continue meeting approximately once a week.

Mark Kolman presented a draft of the SC charter for comments and approval. The discussion that followed led to a motion for revision of the draft to the effect that final approval for system selection will be required by the NCALHD membership. The motion also proposed approval of the revised draft. The motion carried unanimously. (Note: The revised draft of the Steering Committee charter was subsequently approved at the NCALHD meeting on Wednesday, June 17, 1999.) A copy of the approved charter is attached.

HSMS Project Update

Marc Kolman introduced Kash Basavappa for a project update presentation.

Kash Basavappa began by thanking the members of the Technology Committee for their cooperation and assistance in advancing the project. He then reported on HSMS Product Selection Plan timetable. It remains on schedule. A copy of the timetable is attached.

Kash Basavappa then described the format of the HSMS Modules section of the RFP draft. As directed by the Technology Committee, the RFP mandates vendor responses to required functional module elements. The format also enables vendors to provide open-ended descriptions of their functional product elements applicable to any module, in the absence of mandatory response. The RFP draft consists of approximately 160 pages. It does not include HSIS or WIC interface specifications. The RFP draft states that the selected vendor will be asked to quote on providing WIC interface to New Mexico WIC system specifications. The New Mexico WIC software resides in the public domain.

Copies of the RFP will be distributed at the conclusion of today's meeting to Marc Kolman, John Sink, and George Bond, the SC members in attendance today. Copies for Frances Taylor and Donna Gregory will be distributed separately. (Draft copies were subsequently distributed according to plan.) Feedback following draft reviews is an agenda item at the SC meeting scheduled for Monday, June 21, 1999. The need to determine the RFP's issuing agency prior to release for bid is also on the agenda.

HSMS Implementation Models

Kash Basavappa presented diagrams outlining HSMS implementation models for inclusion in the RFP. The models will assist vendor RFP responses in evaluating and costing options for applications, hardware, and services. A copy of the HSMS Implementation Models hand out is attached. The models are:

1. Central Services Model

Pro	<ul style="list-style-type: none">• Most cost effective model for maintenance and support• Automatically feeding of HSIS data base• Potential for transitional replacement of HSIS over long term• Customized programs for any LHD(s) could be created , would feed central data base• Potential to establish NC Public Health information network, depending on vendor response
Con	<ul style="list-style-type: none">• Standardized screens may not appeal to every LHD• Up to 35 LHDs may not abandon existing systems• Incremental cost of customized programs for affected LHDs• New costs for vendor maintenance and support at conversion to HSMS by HSIS-only LHDs• Incremental costs for LHDs needing to add T-1 line linkage to HSIS

2. Distributed Services Model

Pro	<ul style="list-style-type: none"> ● LHD flexibility for customized screen designs ● Automatically feeding of HSIS data base ● Optimal response time versus Central Services Model ● Potential to establish NC Public Health information network, depending on vendor response
Con	<ul style="list-style-type: none"> ● Each LHD must bear cost of its own system support and maintenance of off-the-shelf software ● Necessity for conversion to HSMS by current HSIS-only LHDs ● Incremental cost issue for LHDs if T-1 lines needed for link to HSIS

3. Semi-Distributed Services Model

Pro	<ul style="list-style-type: none"> ● Enables two or more LHDs to share system resources ● Flexibility for customized screen designs among allied LHDs ● Automatically feeding of HSIS data base ● Optimal response time versus centralized ● Potential to establish NC Public Health information network, depending on vendor response
Con	<ul style="list-style-type: none"> ● Participating LHDs would need to agree on location of HSMS server ● Allied LHDs must bear cost for own system support and maintenance of off-the-shelf software ● Necessity for conversion to HSMS by current HSIS-only LHDs ● Incremental cost issue for LHDs if T-1 lines needed for link to HSIS

Presentation of the Central Services Model and its diagram evolved to a general discussion about the potential of HSMS to supplant HSIS over time. A question arose about the absence of reference to HSIS on the Central Services Model diagram. Kash Basavappa stated that none of the three model diagrams make reference to HSIS, since they are intended solely to assist vendors in formulating their responses to the RFP. An unresolved issue pertains the issuing agency for the RFP.

Marc Kolman reminded everyone that the outcome of issuing the RFP is to select a single vendor for HSMS. The Technology Committee agreed unanimously agreed that the single vendor selection plan is to remain in effect.

Y2K

Rajesh Virkar reported that completion of HSIS Y2K user acceptance testing anticipated by the end of July.

CPT Project

Dennis Harrington reported that the team led by Joy Reed has been assigned to determine which of the items that are presently bundled should be unbundled. A second team, consisting of three programmers under the leadership of Herman Geci, is working full time on a HCPC coding project for unbundled items. A committee is working to identify code items that cannot be unbundled to the extent desired by Medicaid. The committee is meeting and corresponding with Medicaid to reach a mutually satisfactory resolution on policy and technical issues pertaining to affected HCPC codes. Both sides have agreed to target project implementation for October 1, 1999.

There being no additional business, the meeting adjourned at 3:00 p.m.

HSMS MODULE GROUPS AND INDIVIDUAL MODULES

No.	Module Group	Module	Required Component
1.	Practice Management	Accounts Payable	
2.	Practice Management	Accounts Receivable	X
3.	Practice Management	Appointments and Scheduling	X
4.	Practice Management	Billing (Self-Pay & Third Party)	X
5.	Practice Management	Budgeting	
6.	Practice Management	Cash Management	
7.	Practice Management	Cost Analysis	
8.	Practice Management	Eligibility and Income	X
9.	Practice Management	Encounter Entry	X
10.	Practice Management	Fixed Assets	
11.	Practice Management	General Ledger	
12.	Practice Management	Inventory	
13.	Practice Management	Labor Distribution	
14.	Practice Management	Payroll	
15.	Practice Management	Purchasing	
16.	Practice Management	Registration	X
17.	Practice Management	Reports	X
18.	Case Management	Maternity Care Coordination (MCC)	X
19.	Case Management	Child Services Coordination (CSC)	X
20.	Case Management	HIV	X
21.	Case Management	Other Types of Case Management	X
22.	Clinical	Adult Health	X
23.	Clinical	Breast Cancer/Cervical Cancer Program (BCCCP)	X
24.	Clinical	Child Health	X
25.	Clinical	Children's Services	X
26.	Clinical	Chronic Disease Prevention / Community	X
27.	Clinical	Development Evaluation Centers (DEC's)	
28.	Clinical	Health Promotion	X
29.	Clinical	Communicable Disease	X
30.	Clinical	Comm. Health Case Mgmt./Home Health	X
31.	Clinical	Developmental Evaluation Centers (DEC's)	
32.	Clinical	Family Planning	X
33.	Clinical	HIV	X
34.	Clinical	Immunizations	X
35.	Clinical	Laboratory	X
36.	Clinical	Maternal Health	X
37.	Clinical	Patient and Referral Tracking	X
38.	Clinical	Refugee	X
39.	Clinical	School Health	X
40.	Clinical	Sickle Cell	
41.	Clinical	TB	X
42.	Clinical	Vasectomy	
43.	Clinical	Dental	X
44.	Clinical	School-Based Clinics	X
45.	Community	Community Nursing (Including Home Visits)	X
46.	Community	Outreach	
47.	Community	School Health	X
48.	Community	Dental Screenings	X
49.	Community	Health Screenings	X
50.	Environmental Health	Public & Private Environmental Health Data Set	X
51.	WIC	All WIC Data Requirements	X

**North Carolina Association of Local Health Directors
Technology Committee
Health Services Management System Steering Committee**

A. Purpose and Scope.

The Health Services Management System Steering Committee (HSMS SC) is hereby established to serve as a standing subcommittee of the North Carolina Association of Local Health Directors Technology Committee (NCALHD TC). The HSMS SC is the executive-level committee responsible for providing oversight to the HSMS Project Director in the definition, selection, procurement and implementation of a Health Services Management System. Additionally, the Committee will serve as a forum to facilitate the sharing of information, eliminate overlaps, identify and resolve cross-functional issues regarding the HSMS project.

B. Steering Committee Functions.

1. Assess and approve strategic, programmatic, budgetary, technical, and functional issues presented by the HSMS Project Director.
2. Review, approve, and monitor HSMS Project Plan.
3. Make recommendations to the North Carolina Association of Local Health Directors Executive Committee regarding HSMS strategic, operational, and financial issues.
4. Based upon recommendation by the HSMS SC, final approval of a statewide HSMS system will be made by the North Carolina Association of Local Health Directors.
5. Facilitate the exchange and sharing of HSMS information with all North Carolina Public Health Departments and other State and Federal Organizations.
6. Facilitate the HSMS implementation and training process with all North Carolina Public Health Departments.
7. Assess, prioritize, and approve HSMS enhancement requests.

C. Membership.

1. **HSMS SC Chair.** The Chair, NCALHD TC will serve or appoint a Chair for the HSMS SC.

2. **Members.** The Chair has the sole authority of appointing or dismissing members. The HSMS SC will be comprised of five members.
 3. **Voting Privileges.** Voting privileges will be extended to HSMS SC members only and cannot be designated to alternates.
-

4. Ex-officio Members.

- a. Representative from the North Carolina Department of Health and Human Services, Division of Information Resources Management to be appointed. Appointment made by the Director of Division of Information Resources Management.
- b. HSMS Project Director
- c. Other personnel as required by the Chair.

D. Chair Responsibilities.

1. Call and chair HSMS SC meetings.
2. Seek and represent HSMS SC consensus on issues discussed at its meetings to the NCALHD TC and NCALHD Executive Committee.
3. Establish working groups, as required, to address specific HSMS initiatives.
4. Review and approve HSMS SC Agenda submitted by HSMS Project Director.

E. HSMS SC Member Responsibilities.

1. Advise the Chair regarding HSMS issues.
2. Participate in assessments of HSMS.
3. Facilitate implementation of HSMS SC Decisions.
4. Provide representation to working groups, as required.

F. Operation.

1. The HSMS SC will meet/teleconference weekly, unless otherwise directed by the Chair.
2. The HSMS Project Director will maintain records of HSMS SC decisions and assigned actions.

3. Decisions are made by majority vote of the HSMS SC voting members present. Chair will be allotted two votes in the case of tie votes.

G. Deliverables.

1. Summaries of the HSMS SC meetings will be prepared by the HSMS Project Director, reviewed by committee members, approved by the Chair and distributed to the members.
-

H. Charter Expiration.

This charter will be reviewed annually and updated by the HSMS SC as required.

This Charter executed this _____ day of _____ 1999

Marc Kolman
Chair, Technology Committee
North Carolina Association of Local Health Directors

**Women's and Children's Health Liaison Committee
NC Association of Local Health Directors**

June 16, 1999

Present: Wanda Sandelé, Chair (Craven), Tommy Jarrell (Richmond), Harold Gabel (Guilford), Daniel Staley (App District), Glen Martin (Rockingham), Pamela Turner (Caswell), Peter Morris (Wake), Tom Vitaglione (DWCH), Doris Jefferson (NCALND) Dorothy Cilenti (DWCH)

- 1. Reimbursement for Lead Poisoning Prevention Environmental Assessments:** This matter referred from Managed Care Committee to seek interest/support in investigating the possibility of developing a Medicaid reimbursable service for asthma and lead poisoning prevention that could be marketed and billed for by local Health Departments. Interest and/or ability to provide this service varies from county to county. The Chairperson will work with Managed Care Committee Chair to see if a more solid proposal can be developed.
- 2. Accountability Work Group:** Met today with enthusiastic and lively participation. They began discussing the factors used in the past to group similar counties. Geographic location in the state may be not a good common factor, whereas other demographic and fiscal factors may make Health Departments comparable even at opposite ends of the state. They also discussed the advisability of not ranking health departments in comparison on individual objectives, because all objectives are not highly significant. Between now and September the group will develop a proposal for reworking the groupings and distribute for feedback. They will also bring recommendations for revising the ranking system.
- 3. Immigration:** Received clarification of the effect of non-cash assistance programs on applications for citizenship. Some clients concerned that the use of Medicaid or Health Choice will count against them when applying for citizenship, at which time they are not supposed to have been a "public burden". These programs do not impact on citizenship. See attachments.
- 4. Universal Neonatal Hearing Screening:** This summer, all hospitals will have implemented universal neonatal hearing screening. If screening is not accomplished during hospital stay, or if child does not show for follow up appointments, there will be an automatic referral to Child Service Coordination at the Health Department, object being to assure infants do not fall through the cracks for this screening. They will also be referred if a problem is discovered during screening. This program has been approved by the Pediatric Society and the Hospital Association.
- 5. Health Choice:** 56% of children projected eligible have been enrolled state wide. As expected at this point, the monthly numbers have decreased from approximately 5,000 to 4,000 applications processed. A major media campaign including major networks will be initiated soon.
- 6. Dental Coverage:** The legislation expanding Health Choice dental coverage passed the Senate. It will become effective with the passage of the budget Bill.

7. **Child Health Plan:** The Division of Women's and Children's Health is charged with presenting a "Comprehensive Child Health Plan" to the Legislature. The plan is to be developed between now and March, 2000 . the plan will include prenatal, reproductive health, mental health, and health.

8. **Asthma:** Funding will be available for Asthma projects with 7th and 8th graders. The grants will require the use of a coalition, the first round going only to counties with active Healthy Carolinian programs since they will already have a coalition to work with.

9. **Healthy Child Care:** There will be \$4,000,000 available over 3 years to enhance the quality of Child Care in North Carolina. This funding is to go to counties for nurses to work in the child care setting.

The next meeting will be Wednesday, July 14th at 3:00 at St. Mary's Street.



**UPDATE:
PROVIDING PUBLIC HEALTH
SERVICES TO IMMIGRANTS**

Background

The 1996 federal Welfare Reform Act (P.L. 104-193) declared that non-citizens who are not "qualified aliens," as defined by the Act, are ineligible for "federal public benefits." The Act defined federal public benefits to include "any . . . welfare, health, disability, . . . or other similar benefit for which payments or assistance are provided to an individual, household, or family" by an agency of the United States.

The Act provided some exceptions to the bar on eligibility, including exceptions for the following public health-related benefits and services:

- Medicaid benefits for emergency services (but not organ transplants);
- immunizations;
- testing and treatment of the symptoms of communicable diseases; and
- programs and services specified by the U.S. Attorney General that deliver in-kind (non-cash) services, do not condition assistance on the recipient's income or resources, and are necessary for the protection of life or safety. Programs and services in this category include:
 - medical and public health services necessary to protect life and safety;
 - activities designed to protect the life and safety of workers, children and youths, or community residents; and
 - any other programs, services, or assistance necessary for the protection of life and safety.

In November 1997, the U.S. Department of Justice issued a guidance document for agencies that administer federal public benefits to use: (1) to determine whether they need to verify the citizenship or immigration status of their clients; and (2) if they do, to assure that their verification procedures are in compliance with federal law. This document stressed that the first thing agencies should do is determine whether or not their agency is providing a "federal public benefit" that must be denied to non-qualified aliens under the Welfare Reform Act. It also cautioned agencies: "*If the federal program does not provide a 'federal public benefit' covered by the Act . . . , the benefit provider is not required to, and should not attempt to, verify an applicant's status, unless otherwise required or authorized to do so by law, because all aliens, regardless of their immigration status, are eligible for such benefits.*" (emphasis in original).

This raised the question, which (if any) of the public health services provided by North Carolina's local health departments constitute a "federal public benefit" which must be denied to non-qualified aliens?

Update

In August 1998, the federal Department of Health and Human Services (U.S. DHHS) issued an interpretation of the term "federal public benefit." The interpretation construes the term "federal public benefit" narrowly. According to U.S. DHHS a benefit must satisfy two conditions to be considered a "federal public benefit." First, the benefit must be a "retirement, welfare, health, disability, public or assisted housing, postsecondary education, food assistance, unemployment benefit" or a similar benefit. Second, the benefit must be provided to "an individual, household,

or family eligibility unit.” U.S. DHHS reasoned that the second condition narrows the set of benefits that fall within the categories described in the first condition. Accordingly, it concluded that benefits targeted to communities or specific sectors of the population—such as people with a particular physical condition (e.g., pregnancy), or people of a certain age—do not fall within the scope of the term “federal public benefit.”

U.S. DHHS ultimately concluded that, of the programs it administers, only certain ones provide federal public benefits that must be denied to non-qualified aliens. It provided a list of those programs, which included Medicare, Medicaid (except assistance for an emergency medical condition), and the Children’s Health Insurance Program. It also included several programs of the Administration on Developmental Disabilities (ADD); child care and development fund; health profession education and training assistance; mental health clinical training grants; refugee medical assistance; refugee preventive health services program; TANF; and programs funded by the social services block grant.

U.S. DHHS has directed all states and localities that administer programs supported by it to comply with its interpretation. Accordingly, non-qualified aliens in North Carolina remain eligible for all services and benefits supported by the federal DHHS that do not fall within its interpretation of “federal public benefit”—as far as I know, this includes essentially all federally-supported public health services. Since these services are not “federal public benefits,” they should not be denied to otherwise-eligible clients based upon their citizenship or immigration status.

Summary

The U.S. DHHS has interpreted the term “federal public benefit” in a manner that excludes virtually all public health services, and has directed agencies that receive funding through U.S. DHHS to abide by its interpretation. Accordingly, local health department services that are supported by U.S. DHHS funds must be provided to all otherwise-eligible individuals without respect to their citizenship or immigration status. Furthermore, to avoid civil rights violations, local health department personnel should not make any attempt to assess the citizenship or immigration status of individuals seeking those services.

Jill Moore
Institute of Government

TO: 6 MINUTES HEALTH
 FROM: JIM BALBUS, Chair, MGD Care / Rehab. Comm

This was handed out by Ms. Denise Lewis, Assistant to
 took place at 6.16.99 Comm. meeting

ACCESS II & III
 QUALITY IMPROVEMENT INITIATIVE

STATUS OF INDICATORS & GOALS AND QUARTERLY REPORT
 FOR ASTHMA DISEASE MANAGEMENT & EMERGENCY DEPARTMENT UTILIZATION

PROJECT	CONTACT PERSON	INDICATOR	RESULTS						
			BASE LINE	GOAL	1 st Quarter	2 nd Quarter	3 rd Quarter	4 th Quarter	
Project Name		1. Inpatient admission rate has decreased							
		2. Inpatient admission rate for Asthma has decreased							
		3. Emergency department utilization rate has decreased							
		4. ED utilization rate for asthma has decreased							
		5. Proportion of asthma patients staged							
		6. Proportion of asthma patients staged II/III/IV on corticosteroids							
		7. Proportion of asthma patients staged II/III/IV with peak flow / asthma mgt. plan							
		8. Percent asthmatics with flu vaccinations							
		9. Others to be defined by the individual sites							

Sedgwick

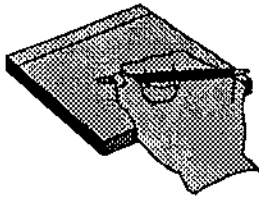
LOSS CONTROL TECHNIQUES:
DOCUMENTATION


Documentation for the Healthcare Professional

Joyce Benton, RN, MSA, ARM, DFASHRM
Senior Healthcare Consultant

The following program has been developed by CNA HealthPro to assist participants in understanding risks associated with the delivery of patient care and recommend ways of developing strategies to manage those risks. This program is not a comprehensive study of health care practices or liability and is not legal advice. CNA Health accepts no liability from any use or reliance on this program or any of its contents. Specific liability issues should be referred to an attorney specializing in healthcare law.

DOCUMENTATION



	<p>THE PATIENT'S CHART CAN BE YOUR BEST FRIEND OR YOUR WORST ENEMY - THAT DEPENDS ON YOU!</p> 

	<p>Purpose of Medical Record</p>
	<ul style="list-style-type: none"> ■ Prime communication medium for planning, coordinating, and orchestrating patient care ■ Public document ■ Legal Document <ul style="list-style-type: none"> - Legal requirements for birth, death, communicable disease, and other public health reporting

	<p>Purpose of Medical Record</p>
	<ul style="list-style-type: none"> ■ Defense against malpractice claims <ul style="list-style-type: none"> - Documenting care rendered for the purpose of defending a medical malpractice claim.


	Purpose of Medical Record
■	Basis for many other important activities – Documentation for patient care reimbursement – Documentation for teaching and medical research – Documentation for utilization, performance improvement and peer review purposes

	Common Problems in Documentation
■	Subjective remarks Gaps in time Finger pointing or chart wars Altering the medical record Improperly documenting late entries Missing information

	Common Problems in Documentation
■	Subjective remarks Gaps in time Finger pointing or chart wars Altering the medical record Improperly documenting late entries Missing information

	Common Problems in Documentation
	<ul style="list-style-type: none"> ■ Use of correction fluid ■ Illegible handwriting ■ Entries that are not dated or signed ■ Entry of a problem but no entry of a subsequent action ■ Lack of descriptions of observation following treatment


	Documentation Guidelines
	<p>Documentation must be legible, clear, and concise:</p> <ul style="list-style-type: none"> ■ Patient identification must be on every page. A record that cannot be clearly interpreted is of little benefit to a subsequent treating provider and/or months or years later in the face of a professional liability lawsuit.

	Documentation Guidelines
	<p>Note the time of each entry:</p> <ul style="list-style-type: none"> ■ Military time or an A.M./P.M., i.e., 7:00 P.M. This is particularly crucial in acute care records where multiple entries occur throughout the day. 

	Documentation Guidelines
■	Timely documentation: Chart entries should be entered immediately after seeing each patient to ensure accuracy and prevent any later question regarding credibility of the entry. Every entry should be signed. Entries should not be made ahead of time.

	Documentation Guidelines
■	Documentation of examinations: Include significant negative and positive findings. If you use a review of systems, do so consistently and include all systems every time.

	Documentation Guidelines
	Documentation of communication among the providers involved in a patient's clinical course should include: <ul style="list-style-type: none"> ■ Significant clinical events ■ Significant interactions with a patient ■ Telephone and/or informal consultations among providers

	<p>Documentation Guidelines</p>
	<p>Documentation of telephone calls:</p> <ul style="list-style-type: none"> ■ Clearly delineate the complaint, assessment, advice, call taker's signature, consulting physician signature, and date and time. 

	<p>Documentation Guidelines</p>
	<p>Documentation of patient education and discharge instructions should show:</p> <ul style="list-style-type: none"> ■ What information has been provided to the patient or to the family member or other person responsible for the patient. ■ That the person instructed understood the information.

	<p>Documentation Guidelines</p>
	<ul style="list-style-type: none"> ■ Corrections in medical records: <ul style="list-style-type: none"> - Single - Line - Initials - Date - Explanation

	Documentation Guidelines
<ul style="list-style-type: none"> ■ When should corrections be made? <ul style="list-style-type: none"> - As soon as the error is noticed, but not after you have notice of possible litigation. - Consider an organizational policy that reflects how changes will be made. - If a patient asks that a change be made in the record, it should be made as an addendum with appropriate documentation that the change was made at the request of the patient. 	

	Documentation Guidelines
<ul style="list-style-type: none"> ■ Alterations <ul style="list-style-type: none"> - An alteration is a deliberate attempt to change rather than correct what has been recorded. ■ Alteration detection <ul style="list-style-type: none"> - simple handwriting changes - spaces left - handwriting becomes neater - pen pressure - paper watermarks or date on forms - paper clip marks - staple holes do not match 	

	Documentation Guidelines
<ul style="list-style-type: none"> ■ Altering records can lead to allegations of spoliation of evidence and fraud. ■ Alterations can result in a waiver of the statute of limitations and punitive damages. 	

	Documentation Guidelines
	<ul style="list-style-type: none"> ■ Pages which have an error should not be removed from the chart. ■ Attempts to cover up errors in judgment through unexplained additions to the record have resulted in plaintiff's awards, even though the standard of care was met.


	Documentation Guidelines
	<ul style="list-style-type: none"> ■ Protection from alterations by others: <ul style="list-style-type: none"> - Leave no blank spaces in your documentation. - Make your charting so uniform that another person will realize that an alteration of your notes will be noticeable. - Highlight on the front of the chart when a copy has been prepared for anyone - a physician, insurance company, plaintiff's attorney, the patient, ANYONE!

	Documentation Guidelines
	<p>Personal opinions or subjective comments:</p> <ul style="list-style-type: none"> ■ Such comments do not belong in the medical record. The medical record should contain "objective" information. In the face of an ultimate professional liability lawsuit, such comments are perceived as a lack of respect for the patient.

	Documentation Guidelines
<ul style="list-style-type: none"> ■ Subjective <ul style="list-style-type: none"> - Charting your opinions or conclusion - Making personal statements ■ Objective <ul style="list-style-type: none"> - Charting your assessment based on observation and supported by facts 	

	Documentation Guidelines
<ul style="list-style-type: none"> ■ Subjective <ul style="list-style-type: none"> - Pt. appears to be SOB. ■ Objective <ul style="list-style-type: none"> - Pt. SOB with exertion. Dyspnea at rest. RR 32, irregular and shallow, slight expiratory wheezing noted with auscultation. 	

	Documentation Guidelines
<ul style="list-style-type: none"> ■ Use of organization-approved format: <ul style="list-style-type: none"> Clearly delineate the subjective and objective information, what was considered in the assessment, the specific plan and what the patient was told. State the facts. 	

	Documentation Guidelines
■	Use institution-approved abbreviations ESC 

	Documentation Guidelines
■	Avoid abbreviations such as these: - AMF - MFC - GORK - FLK



Common Documentation Problems

When numbers, letters, abbreviations and subjective entries are handwritten into the medical chart, it is possible for ambiguities to occur. Questions may be raised by its reviewer, such as "Is that a 7 or a 1?" "Does OD mean *every day* or *right eye* here?" "What does *quantity sufficient* mean?" Such confusion could not only result in serious patient errors, but could potentially result in patient injuries and subsequent medical malpractice lawsuits.

Another common clinical documentation problem encountered is that entries made reflect subjective (personal opinions) findings rather than objective (specific and factual) findings. Subjective entries can negatively influence patient care and potentially result in patient injury, since they:

- Do not provide accurate and complete patient information
- Can bias the opinions of others who are providing care to the patient
- Can result in misinterpretations since observations are not communicated in ways which are measurable

Subjective entries can also negatively influence the minds of attorneys, expert witnesses, juries and even their respective authors when the

medical records are scrutinized during medical malpractice lawsuits in later years.

The following numbers, letters, abbreviations and observations are examples of entries which may create confusion for medical record reviewers. Suggestions for improving the legibility and comprehension of these types of entries are provided. Additionally, other strategies to improve legibility may include use of dictation and transcription, computerized medical records, printing instead of writing, and author's habitual review of handwritten notes before closing. When reviewing the last few examples, identify the potential problems that these entries pose, and select strategies which could help reduce the possibility of interpretive errors. Potential answers are provided at the end of this bulletin.

Conclusion

When handwritten entries are difficult to decipher, the reviewer can help prevent misinterpretation by promptly consulting the author for clarification prior to providing patient care. Authors can help prevent interpretive errors by writing legibly, using abbreviations from only approved lists, writing out the entire word or phrase whenever possible, and recording objective patient assessments.



Entry	Potential Problem	Potential Strategy
cc	Can mean chief complaint, critical condition, creatinine clearance, common cold, cubic centimeters; can be confused with zeros	Write out phrase or use ml. if appropriate
Dig	Can mean digoxin or digitoxin	Write out complete name of drug
EOM	Can mean extraocular movements or external otitis media	Write out phrase or word
HS	Can mean heart sounds or hour of sleep	Write out phrase
The number 7	Can be confused with the number 1	Write a small horizontal line through the number 7's stem (7)
ARF	Can mean acute respiratory failure or acute rheumatic fever	Write out phrase
CA	Can mean cancer, chronological age or calcium	Write out phrase or word
CP	Can mean cor pulmonale, cerebral palsy, capillary pressure	Write out phrase
in OJ	Can be confused with OD or OS, and inappropriately administered in eye	Write out "orange juice"
BS normal	Can mean blood sugar, bowel sounds or breath sounds; "normal" is subjective finding	Write out phrase and quantify, such as "bowel sounds present in all four quadrants; abdomen soft and flat", or "breath sounds clear to auscultation all lobes; no cough"
q.o.d.	Can be confused with every day or q.i.d.	Write out "q other day" or "every other day"
The letter Z	Can be confused with the number 2	Write Z with a horizontal line through its middle (Z)
OD	Can mean once daily, overdose or right eye	Write out phrase
The letter G	Can be confused with the number 6	Print big and legibly
CHD	Can mean coronary heart disease or congenital heart disease	Write out phrase
CF	Can mean cystic fibrosis or cardiac failure	Write out phrase
The number 5	Can be confused with the letter S	Write 5 with two strokes instead of one
DOA	Can mean dead on arrival, date of admission of physical exam	Write out phrase
PE	Can mean pulmonary embolism or pelvic exam	Write out phrase
zero (0)	Can be confused with the letters c (as in cc's) or (as the symbol for unit)	Write 0 with a slash through it (Ø)
Appetite poor	Subjective observation; What does "poor" mean?	Quantify, such as "Ate 25% of dinner served"

Entry	Potential Problem	Potential Strategy
NR	Can mean normal range, not remarkable, normal reaction, nonreactive, not refillable	Write out phrase
The symbols for dram and minim	Often not understood or misinterpreted	Use metric system only
MI	Can mean myocardial infarction, myocardial ischemia, mitral insufficiency or mental illness	Write out phrase
per os	Can be confused with "left eye"	Write out "orally" or "by mouth"
q.d.	Can be confused with "q.i.d."	Write out
sub q	The q can be confused with "every"	Use "subcutaneous"
qn	Can be confused with "every hour" if n is illegible	Use "nightly"
Patient appears nervous before surgery	Subjective use of "appears" (personal opinion)	Patient states "I am really scared about my operation"
RA	Can mean right arm, renal artery, right atrium	Write out phrase
Drinking fluids qs	Needs to be quantified	Use objective wording, such as "Drank 250 ml clear liquids without nausea or emesis"
*po	Can mean _____	_____
	_____	_____
*Good relief from pain medication	_____	_____
	_____	_____

*Potential answers on back page

Entry

Potential Answers

Potential Strategy

po

Can mean by mouth, phone order or postoperative

Write out phrase or word

Good relief from pain medication

Subjective and meaningless

Chart objective findings, such as "Patient states that pain intensity is '2' on ten point scale" [ten correlates with most severe pain]

References

Bergerson, S. More about charting with a jury in mind. C. E. Handbook, Vol. 4. Princeton, NJ: The Nursing Institute, 1991.

Iyer, P. & Camp, N.H. Nursing documentation: A nursing process approach. St. Louis: Mosby Year Book, 1991.

Robinson, J. (Ed.). Documenting patient care responsibly. Horsham, PA: Intermed Communications, Inc., 1980.



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Medical Record Retention

Physicians, either as individual practitioners or as members of medical group practices, frequently inquire as to how long they should maintain medical records. The simple answer is *indefinitely*. If that is unacceptable, e.g. because of the cost of storage space, then local counsel should be consulted as to statutory, decisional and administrative law which will mold a reasonable alternative.

Medical records:

- document the physician's periodic assessment and treatment of the patient in health and disease
- serve as a tool for clinical research and quality of care assessments
- provide the cornerstone of defense in possible future litigation

Considering Illinois as an example, its statutory law does not tell a physician how long to keep his/her records. One could infer from its statute of limitations, however, that for defense purposes records should be available for varying periods:

- up to 4 years for an adult "after the date on which occurred the act or omission or occurrence alleged to have been the cause of such injury or death." 1
- up to 8 years "where the person entitled to bring the action was, at the time the cause of action accrued, under the age of 18 years; provided, however, that in no event may the cause of action be brought after the person's 22nd birthday." 2
- up to an indefinite period if when the cause of action accrued, the person entitled was "(i) under legal disability other than being under the age of 18 years or (ii) imprisoned on a criminal charge. ... then the period of limitations does not begin to run until (i) the disability is removed or (ii) the person ceases to be imprisoned." 3

- up to 5 years after discovery that there has been fraudulent concealment. 4

A separate statute looks at the issue in a different light, one of patient accessibility:

Every physician shall, upon the request of any patient who has been treated by such physician, permit such patient's physician or authorized attorney to examine and copy the patient's records....

The requirements of this Section shall be satisfied within 60 days of the receipt of a request by a patient, his or her physician or authorized attorney.

Failure to comply with the time limit requirement of the Section shall subject the denying party to expenses and reasonable attorneys fees incurred in connection with any court ordered enforcement of the provisions of this Section. 5

Indeed, the Illinois Medical Practice Act makes as one of its grounds for suspension or revocation of license: "failure to transfer copies of medical records as required by law." 6

Illinois courts too have addressed the subject of medical records, its Appellate Court (1st District) stating:

In *Cannell*, ... this court was presented with the issue of whether a physician had a duty to disclose medical information to a patient on request. Relying on *Emmett* ... 396 F.2d 931, which held that both the hospital and the doctor had a duty to disclose medical records, this court found that such a duty did exist. This court stated that the fiducial qualities of the physician-patient relationship required the disclosure of medical data to a patient or his agent on request, and that the patient need not engage in legal proceedings to attain a loftier status in his quest for such information. 7

In addition to State law, of course, Federal law may come into play. Thus, physicians working in a "rural health clinic" appreciate that under administrative law, medical records must be "retained for at least 6 years from date of last entry, and longer if required by State statute." 8

In conclusion, for purposes of defense maintain your records indefinitely but if an alternative course is chosen, consult with local counsel as to the law's explicit or implicit requirements.

NOTES

1. Illinois Revised Statutes, 110 P 13-212
2. *Id*
3. *Id*
4. Illinois Revised Statutes, 110 P 13-215
5. Illinois Revised Statutes, 110 P 8-2003
6. Illinois Revised Statutes, 111 P 4-00-32-37
7. *Fox v. Cohen*, 84 Ill. App. 3d 744, 746-747
8. Code of Federal Regulations, 42 § 491.10 (10-1-87 edition)

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Abnormal Test Results: Loss Control Implications

Mrs. S., a 32 year old high school teacher and mother of four small children, was seen for a routine physical examination. Diagnostic work-up included a Pap smear. She was instructed to call her provider's office in a few days for test results, so follow-up, if necessary, could be established. Test results containing Mrs. S.'s abnormal Pap smear findings were subsequently filed in her medical record. Mrs. S., busy with school projects and relocation plans due to her husband's sudden job transfer, did not call the office back for her test results. She assumed that since she was not notified, test results were probably normal. She was later hospitalized for an extensive period of time for treatment of cervical cancer, requiring a hysterectomy and chemotherapy. Mrs. S. and her husband subsequently filed a medical malpractice lawsuit.

The issue often surfaces in a scenario similar to this—to what degree are health providers legally responsible for ensuring that their patients are made aware of abnormal diagnostic test results? Can patients be held jointly responsible by being told to call the office back for results? Review of literature suggests that the issue is a rather complex one.

Case law has held that establishment of a healthcare provider-patient relationship becomes necessary before a medical malpractice action can be brought. Once this relationship is created, the healthcare provider has a duty to use *reasonable* care and diligence in treatment of the patient. The patient, as the other party, also has a duty to act in a *reasonable* manner. When a provider initiates a treatment, the provider assumes the duty to follow through until the provider's services are not medically necessary or unless the relationship has been terminated in a proper manner (Henry, 1991). Potential liability exists when results of procedures and tests are not communicated to the patient and the patient suffers damages

Currently, few malpractice cases have narrowly focused on allegations of negligence due to failure to properly follow-up with a patient on an abnormal test result. Malpractice cases involving this issue may be more commonly grouped under diagnosis related allegations of negligence, such as "failure to diagnose" or "delay in diagnosis", and treatment related allegations of negligence such as "failure to treat", "delay in treatment" or "premature end of treatment", including "abandonment" (U.S. DHHS, 1990).

It is customary practice for physicians to order and interpret diagnostic testing, formulate a treatment plan, instruct the patient on treatment options, and recommend a course of treatment and follow-up care. The American Medical Association's *Risk Management Principles & Commentaries for the Medical Office* (1990) additionally suggests that "A physician ordering the tests bears the responsibility and should develop a mechanism for communicating test results to the patient should that patient leave the office before results are known" (p.9). The literature proposes that practices such as asking patients to telephone for results or calling patients only with abnormal findings may potentiate the chance that abnormal results will not be communicated to patients.

The extent to which a provider should follow up with a patient having abnormal test results, as well as the patient's responsibility for follow-up, has not been clearly defined from a legal perspective. Lawsuits tried on this issue would be examined on an individual basis, depending on the facts, circumstances, and the severity of damages the patient suffered due to the alleged negligence. *The patient's role in follow-up would be critically analyzed to determine whether he or she contributed to the injury or injuries*



Since providers have a general duty to communicate results to the patient and to exert reasonable effort to reach that patient, there are several loss control techniques which providers can implement:

- Develop office procedures to address follow-up on testing sent out of the office for completion, and use them consistently. Systems such as logs, suspense ("tickler") files and the provider's review of all test results before results are placed in medical records serve as reminder systems. A 1991 study of 1,371 claims (on which payment had been made or on which peer review had determined negligence had occurred even though no payment had been made) revealed that patient management errors (which included errors such as failure to notice a lab value) were the most frequently cited type of claim. These types of claims were also generally associated with a higher frequency and economic severity (Kravitz, 1991). Other literature reveals that a large number of medical malpractice claims can be associated with system failures.
- Incorporate a patient recall procedure once abnormal results are reviewed by the provider and follow-up is necessary. Office procedures should be similar to what other medical provider offices in same or similar circumstances are performing. Using duplication techniques to reach the patient (Henry, 1991), such as a direct telephone call which stresses the need for follow-up and scheduling an appointment, followed by certified letter with return receipt requested, may help minimize liability. The return receipt card could then be filed in the patient's medical record. Leaving test result messages on answering machines is not recommended, because this type of practice violates principles of patient confidentiality of medical information.
- Record accurately, completely and objectively within the medical record all

attempts made toward contacting the patient, such as the substance of telephone calls occurring with the patient; results of these contacts, such as "Scheduled appointment for January 15"; copies of follow-up letters sent to the patient; and retention of return receipt cards. Records should also reflect a note by the provider recognizing that results were noted to be abnormal and treatment plans for patient follow-up. Any non-action taken by the patient such as missed appointments, canceled appointments, or refusal of treatment, should be documented.

Providers can also limit liability by including the office's patient recall procedure and the patient's role in the procedure within office literature, and discussing the follow-up procedure during provider-patient informed consent discussions.

In summary, medical providers can use reasonable effort to track and communicate abnormal test results to patients, and accurately and completely record the recall procedures used, in order to reduce the frequency and severity of potential malpractice lawsuits.

References

- American Medical Association. Risk management principles & commentaries for the medical office. Chicago: AMA, 1990, 9.
- American Society for Healthcare Risk Management. Risk management pearls for physicians: Managing risk through effective communication. Chicago: American Hospital Association, 1993, 14.
- Henry, P. Abnormal laboratory test results: Going the extra mile. Nurse Practitioner Form, 1991, 2(1), 5-7.
- Kravitz, R. et al. Malpractice claims data as a quality improvement tool. JAMA (October 16, 1991), 266, 2087-2092.
- U.S. Department of Health & Human Services. National Practitioner Data Bank guidebook. Rockville, MD: U.S. Public Health Service, 1990.

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Strengthening the Office Medical Record Through Self-Assessment

Take this opportunity to evaluate your charting strengths and weaknesses by conducting a brief self-assessment of your office medical records. Fill out the following questionnaire based on your impressions of your current office medical record keeping practices. Try to be objective and assign a plus '+' or minus '-' in the appropriate column and then total your results.

PATIENT WORKUP	+	-
Do you chart the reason for the patient's visit, including all complaints?		
Do you chart patient's history, including past medical treatments, current medications, drug allergies, family history, etc.?		
Do your patients fill out a questionnaire on their current complaints and previous history?		
If yes, do you document your review and follow-up on the questionnaire?		
Also, do you document your investigation of question marks and blank spaces left on the questionnaire?		
Do you chart all your physical findings?		
Do you chart negative findings?		
Do you diagram size and location of suspicious lumps and lesions?		
If yes, do your patients sign or initial these diagrams?		

DIAGNOSIS	+	-
Do you chart the data used to support your diagnostic impressions?		
Do you review and initial all path, lab and X-ray reports?		
Do you review available previous medical reports and then chart appropriate data?		
Do you chart discussions with other providers that lead to the diagnosis?		

TREATMENT	+	-
Do you outline a treatment plan that is supported by the findings in the workup and diagnosis?		
Do you chart obtaining the patient's informed consent?		
When appropriate, do you chart the patient's informed refusal?		
Do you chart all instructions to the patient, including follow-up requirements?		

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FOLLOW-UP	+	-
Do you chart who is responsible for follow-up - patient or physician?		
Do you chart recommendations for referral to outside care or follow-up?		
Do you chart discussions with other providers about patient care?		
Do you chart consideration of previous findings in follow-up?		
Do you chart unchanged abnormal findings?		
Do you chart review of subsequent lab/x-ray reports?		
Do you chart patient compliance or non-compliance with recommendations?		

OFFICE CHARTING PROCEDURES	+	-
Are missed/canceled appointments (reason included, if known) noted on the chart?		
Are all telephone conversations (physician and staff) regarding patient care noted on the chart?		
Are all drug allergies noted prominently on the chart?		
Are all lab/x-ray reports seen and initialed by the physician before placement in the chart?		
Are signed, dated authorizations obtained and placed in the chart before copies of the chart are released?		
Is it noted on the chart where the copy is being sent?		
Is physician authorization required before records can be released?		
Is there a stated procedure for termination of care that is followed in your office?		

CHARTING HABITS	+	-
Are chart notes readable?		
Are all chart entries signed and dated?		
Are all no shows/cancellations noted in the chart?		
Are corrections and additions to the chart entered chronologically and dated and signed?		
In your absence, could a colleague using information from the medical chart provide your patients with immediate and appropriate care?		
TOTAL		

Then, to test your impressions, select a few office records which contain entries made in the last six months. Review them carefully. Answer each of the questions again assigning a plus "+" or a minus "-" where applicable and total your results.

When you are done, compare your "impressions" with "reality" and see where your office medical record keeping strengths and weaknesses lie. In today's legal climate, a deficiency involving any of the listed items could expose you to liability.

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