

Hugh's Credentialing Tips

HUGH GREELEY OUTLINES THE GUIDING PRINCIPLES FOR CREDENTIALING SYSTEMS

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10 GUIDING CREDENTIALING PRINCIPLES - ETHICS IN PRACTICE

1. THE PATIENT COMES FIRST
2. HONOR THE PRACTITIONER
3. PROTECT AND ENHANCE THE ORGANIZATION
4. AVOID DENIALS AND PROACTIVELY MANAGE DISCIPLINE
5. SET RULES - LIVE BY RULES
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9. USE POLICY AS THE BLUEPRINT
10. USE OPPE AND FPPE TO VERIFY QUALIFICATIONS AND COMPETENCE

I THE PATIENT COMES FIRST

DOUBTS ABOUT A PRACTITIONER'S COMPETENCE AND INTEGRITY MUST BE RESOLVED IN FAVOR OF THE PATIENT.



MSPs have numerous and varied duties, positions and skills, but the number one priority is always the protection and quality of patient care. This is the core ideal of the health care industry. As a credentialing specialist, you govern the quality of patient care from the perspective of a gatekeeper. You have the dual responsibilities of looking after the best interests of the patient and keeping your medical staff in compliance on many levels.

Unfortunately, there are those who practice medicine fraudulently, incompetently or haphazardly. There are myriad ways to defraud the patient and the institution, ranging from something as simple as practicing with an expired license to full-on malpractice, plus everything in between. Take a look at this through the eyes of the patients. What means do they have to discover past infractions and false claims of licensure or specialization?



Patients rely on the power and competence of the MSP as their only means of protection against a fraudulent physician, nurse, physician assistant or technician because they simply do not have access to current, verified data that confirms their health care provider's education, training and experience. You and your credentialing team are charged with maintaining the integrity of the benevolent, well qualified health care providers as well as continuously keeping out the fraudulent ones.

2 HONOR THE PRACTITIONER

Health care practitioners create the culture of value in your health care organization. In other words, you can't function without them. When a practitioner comes into contact with your team seeking credentialing and privileging, your first priority is to offer a professional, welcoming and streamlined experience.

Technology such as the CheckMedic MedPass engineered by Verisys puts into play a sophisticated, turnkey electronic credentialing technology that ensures you and your staff will hear fewer comments like these:



- ***“Why must I complete another application? I just completed one for your managed care organization and for employment!”***
- ***“What is taking so long? I need to be on staff so that I can begin to treat my patients here!”***
- ***“No one ever told me that if I opened a surgicenter, my staff membership would automatically terminate! If I had known, I would not have invested in it.”***
- ***“Hey, this is not right! Why must I submit to three separate interviews (department chair, credentials committee and then the CEO)? This is so unprofessional!”***

3 PROTECT AND ENHANCE THE ORGANIZATION

LEGAL CHALLENGES

There are two distinct types of legal challenges that result from the hospital's credentials program:

Patient-centric: Brought by injured or angry patients who believe the hospital negligently allowed a physician to provide services.

Practitioner-centric: Lawsuits brought against the hospital and its medical staff leaders by physicians who have been denied appointment to the staff.



REGULATORY BODIES

Three distinct bodies of regulation apply to the credentialing activities of most hospitals: the Conditions of Participation (CoP) established by Congress for participation in federal health care reimbursement programs such as Medicare and Medicaid; the state requirements for hospital licensure; and the standards of the voluntary accreditation organizations [Healthcare Facilities Accreditation Program (HFAP), The Joint Commission (TJC) and Det Norske Veritas (DNV).]

CHALLENGES TO REPUTATION

An excellent credentials process is the key to maintaining or enhancing the reputation of many hospitals because it directly impacts upon the qualifications of the physicians on staff. Many hospitals report that their staffs are composed of physicians who are certified by their respective boards, but in today's world, board certification alone provides insufficient protection for hospitals. If a lawsuit is filed, media coverage often exposes the inner workings of the facility, the medical staff's processes and potentially its problems.

4 AVOID DENIALS AND PROACTIVELY MANAGE DISCIPLINE

Most denials for appointment or privileges are unnecessary.

Denials and disciplinary actions take a significant toll on every member of a medical practice. The denial of an application for appointment or privileges often triggers a complicated and costly fair hearing or judicial review. Avoiding denials and disciplinary actions requires not only great management and interpersonal skills, but a well-designed set of policies and procedures that covers a number of key areas. For example:

Membership or privilege qualifications: Maintaining qualification compliance is essential. An application that doesn't have all of the specified qualifications and experience will not be processed and consequently no denial decision can be made.

Reappointment to medical staff qualification: Practitioners wishing to reapply to the staff must be able to demonstrate recent (in the past 24 months) active support for the mission of the hospital and medical staff as evidenced by one of the following: admissions; performance of procedures; referrals; consultations; or significant medico-administrative work. Clearly defined rules eliminate difficulties in verifying competence at reappointment for practitioners who are inactive at a facility.



The consequences of being denied for any professional appointment or privilege can be extensive. Simple rules and clear procedures can radically improve the health of a practice. Whenever the possibility of engineering the right outcome exists, you should seize it.

This principle works in other situations, for example:

- **An undesirable applicant**
- **A good candidate, but not enough experience**
- **Suspected or alleged poor clinical or interpersonal behavior**
- **When faced with further action ... seek advice.**
- **Prepare for escalation.**

By following this general outline for “progressive involvement,” many issues can be resolved without the need for investigations or formal corrective action.

5 SET RULES - LIVE BY RULES

Processing applications doesn't have to be difficult and fraught with risk; all you need is a clear set of rules in place ahead of time.

Having a clear, well-defined set of rules in place will make the entire appointment and privilege-granting process much easier. Generally, medical staff bylaws do a fairly good job of defining minimum qualifications for staff appointment. But, unfortunately, even the most up-to-date documents aren't always bulletproof when it comes to satisfying the demands of the application process. Everything needs to be evaluated to determine whether it provides adequate guidance to MSPs and medical staff leaders who will be involved in the process. Here are a few areas that occasionally cause confusion:

- *Applicants must carry professional liability insurance in the amount stipulated by the board.*
- *Applicants must be board admissible or board certified in order to be considered for appointment. (Applicants in the last six months of an approved residency program will qualify under this rule, provided that they become admissible or certified prior to appointment.)*
- *Appointment to the "active" category requires:*
 - *Evidence of regular admission, surgery or consultation in the hospital.*
 - *At least one year of service on the "provisional" or associate category of the staff.*
- *The granting of clinical privileges will be based upon a review of relevant education, training, experience and clinical competence.*

Ideally, standards and rules governing appointment and re-appointment should be agreed upon by both the medical staff and the board so that the process becomes as transparent as possible. The goal should be appointment and privileging "by the book," leaving little necessity for reading between the lines and creative solutions.

Set rules. Govern by those rules. Be specific. Avoid issues.

6 PRIVILEGING MUST R-U-M-B-A

Realistic, Understandable, Measurable, Behavioral and Attainable.



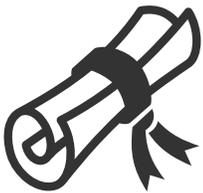
Realistic: Transparency throughout the entire privileging process is critical, but it should also be both easy to use and objective.



Understandable: Avoid designing privileging systems that aren't easily understood by clinicians.



Measurable: Hospitals often add to their own woes by approving policies or designing systems that defy measurement and therefore aren't useful for maintaining proper performance.



Behavioral: Privileges must allow leaders to assess the specific behaviors of physicians and others to whom they have been granted. Such behavior is always a demonstration of knowledge, skill, judgment or technique.



Attainable: Refrain from defining standards that are beyond the abilities of physician or others to attain. For example, some groups have defined the standard for advanced podiatric surgery privileges at a level so high that even the most qualified podiatrists have no chance of complying. Not doable equals not a workable standard.

7 ✓ PLACE THE RESPONSIBILITY ON THE APPLICANT

Be clear and exacting about assigning responsibility to the practitioner applicant for producing any information needed to process the application.

The practitioner, whether a new recruit or a privileged staff member, always has the absolute responsibility for producing any and all information reasonably requested by the facility. Once this is understood and the practitioner has a complete list of the documentation required, he or she must either fully satisfy the request or face the resulting delay in processing the application. There are no exceptions to this rule.



Widespread awareness about placing this responsibility where it belongs will help avoid last-minute finger-pointing as well as any pressure to move forward without proper documentation and process.

Requiring documentation from an applicant is not always as simple as it seems, however. The following scenarios illustrate possibilities for hidden pieces of data that can slow or halt the onboarding process.

Documentation of all residency programs

Undocumented off-site clinical activity used to sustain privileges

Interim malpractice suits

Substance abuse in the past

Placing the burden of collecting all the information needed for appointment, reappointment and privileges on the applicant avoids a denial, which could result in a fair hearing and/or legal liability. It's the wise thing to do.

8 FOLLOW THE 5-R CODE OF CONDUCT

Be Rigorous, Reasonable, Rational, Right and Responsible.

The credentialing policies and practices of the medical staff should be applied using the 5-R code of conduct, with little opportunity to deviate without specific authorization from the CEO, acting as the direct agent of the board. Occasionally, however, you might encounter special circumstances where an exception to long-standing practices might be needed to provide necessary patient care.

The example below walks you through the application of the 5-Rs in just such a situation.

Example:

A well-known physician who has a long-standing excellent practice in the community has decided to begin practicing at your facility. He completes an application stating that he completed a pediatric surgical residency fellowship. He is sought for this specific expertise because of the volume of pediatric emergencies needing surgical assessment and treatment presenting at your facility. All available evidence shows him to be an excellent physician with impeccable credentials, admired clinical skills and no record of any type of problem in the past.

Unfortunately, his current hospital will not release a copy of his fellowship completion certificate (which they obtained from the original source.) Your hospital has a copy supplied by the applicant, but **rigorous**, longstanding practices and policies require confirmation from the original source. (The AMA profile also confirms completion.) His application is held pending receipt of the primary source verification. Accessing the **right** chain of command for this exception, the chief of staff and CEO could safely approve processing without the “confirming original.” (This is particularly true in this case, because the fellowship occurred more than 15 years ago.) Waiving the requirement would be the **rational** and **reasonable** action to take.

Subsequently, the hospital and staff should undertake a full evaluation of existing practices and policies in order to eliminate those that no longer serve any specific purpose. It’s responsible to use this opportunity to eliminate future delays if and when identical situations present.

9 USE POLICY AS THE BLUEPRINT

***If you have a policy, follow the policy.
If you have no policy, develop a policy.***

If you have a policy

If you think of your policy structure as a blueprint for building and sustaining your organization, you will be able to identify any individual policies that are redundant, obsolete or missing altogether.

Yet, unlike a blueprint, the policy structure also is like a living organism that responds and adapts to changing circumstances. Its framework should be reviewed regularly and updated to provide appropriate direction as regulatory, environmental, industrial and internal conditions change.

It's wise as well to review which policies typically are abused, perhaps because they have been written and/or enforced in a vague manner.

Another common cause of policy abuse is lack of awareness. In this case, consider a broad and rigorous communication campaign regarding the policy and its accompanying guidelines.

Develop a policy

The need to develop a policy can arise from a change in regulatory requirements, from a shift in institutional scope or as a response to a problem.

When developing a policy, research whether a system-wide policy already exists and if there are any related policy documents created either by your own organization or by others in the field. It's also vital to engage all stakeholders to ensure that your new policy does not interfere with another department's ability to provide patient care or operate in its current manner.

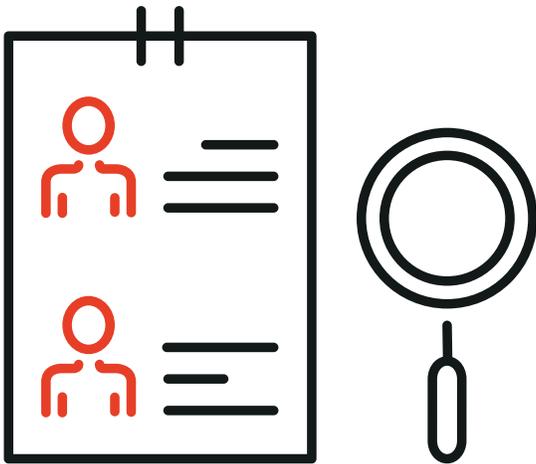
If a new localized policy mirrors a system-wide policy, your new policy can be more—but not less—rigid than the system's policy.

The key to measuring compliance to policy is through procedures. Procedures should be detailed, prioritized and measurable through role definition and performance assessment.

10 USE OPPE AND FPPE TO VERIFY QUALIFICATIONS AND COMPETENCE

Demonstrating continuous competency is mandatory.

Gone are the days when practitioners who affiliated with a health care facility were set up for life. Now, for many reasons—some tragic beyond belief—the health care industry is implementing continuous monitoring of practitioners' performance.



In 2007, TJC introduced the concepts of Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) and, in 2008, these standards were implemented. These screening tools were designed to work together to assure that practitioner performance never falls below a specified acceptable level.

OPPE is designed to continually evaluate a practitioner's professional performance. FPPE comes into play when possible areas of unacceptably low quality are identified during the OPPE process.

TJC's mandate requires that OPPE be conducted on a periodic basis, optionally every six to eight months (more frequently than annually) and that FPPE be applied whenever a situation mandates it.

OPPE also provides for regular gathering of data needed for granting continued practice privileges.

OPPE should apply to every practitioner, and any questionable or negative result it produces should trigger FPPE. Basically, it is a screening process designed to catch potential problems early. It can replace the peer review process if the OPPE process design includes the current peer review activity with at least the existing frequency and detail.

Appoint a review team that is consistent across all practitioner and procedure types to ensure uniformity.



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